PROTECTING THE COMMUNITY

The Report of the Task Force

on Drug Abuse

Volume I

Reviews and recommendations

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We thank also the large number of organisations — government, non-government and community-based — which also made submissions, attended hearings or provided advice through consultations with Task Force staff. Their commitment and knowledge have been invaluable.

All the organisations and individuals who made submissions or provided consultation to the Task Force are listed in the Appendices. The Task Force, of course, spoke to many individuals and groups in a variety of settings and we apologise if we have unintentionally omitted any person or organisation.

We would also like to thank all those people around the State who assisted us in reaching a wide spectrum of the public; organisations and their members who provided venues, arranged meetings, gave the Task Force publicity and officiated at the public hearings.

The contribution of the Senior Government Officers Reference Group, the Non-Government Reference Group, and the academics’ round table to anticipate future trends are all gratefully acknowledged.

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The Task Force benefited from having access to local, national and international research and literature reviews prior to their publication and is very grateful to the individual academics, the Australian national research centres and the United Kingdom Task Force on Services for Drug Misusers, for making these available.

While the above groups, and others whose contributions are acknowledged in the text, were all of considerable assistance, they should not be held responsible for the views or conclusions presented in the report.

The secretariat of the Task Force on Drug Abuse consisted of the following people:

Michael Daube	Chairman
Terry Murphy	Project Manager
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VOLUME I

1. INTRODUCTION: BACKGROUND; INTERNATIONAL CONTEXTS AND POLICY PREMISES

1.1 INTRODUCTION

Drug abuse can affect anybody. There can be few, if any, in our society who have not come face to face with the consequences of drug abuse in their family or neighbourhood, or with the fear that they and their families might be affected by drug abuse.

It is important from the outset to set the Western Australian situation in context. The drug problem is not new, and it is not confined to Western Australia. At present, drug abuse in Western Australia does not approach the severity of what is the norm in many other countries, or even the more densely populated Australian States.

But we do have a problem. It is a serious and growing problem with health, social and economic consequences that reach far beyond the users; it is a problem that reflects both the emerging 'big city' status of Perth and the isolation of many rural areas; it is a problem that requires urgent action by government and community, working in partnership.

Over the years, many approaches have been tried: some people claim to have all the answers; some people claim there are no satisfactory answers; others advocate a single program or idea as being the solution to all our drug problems. What is required now is for us to draw on national and international experience and develop a strategy that is appropriate for Western Australia in the last few years of the 20th century.

We have much to learn from countries and other Australian States where the drug problem has reached a level we are seeking to prevent. But we must be prepared to learn from both their successes and their failures. Enthusiasm is to be welcomed, but the drug problem is too important for us to develop policies and strategies on the basis of enthusiasm alone. We must take a pragmatic and rigorous view so that we can ascertain what has worked elsewhere, what has failed, and what may be worth pursuing further.

This report is designed to develop appropriate policies, strategies and structures for Western Australia. It is not intended to cover all issues related to all drug problems — nor, given the scope of the area, could it ever hope to do so.

There is no doubt that had the Task Force on Drug Abuse been able to take two or three years over its task — as have some reviews and reports in this area — it would have been able to cover some topics more thoroughly; but the need for action is urgent, and there is little to suggest that the conclusions reached would have been significantly different if the process had been more prolonged. There are, however, some areas in which we recommend that more work be carried out.

As described in some detail below, the Task Force has divided its time between studying a substantial literature, consulting the community, obtaining expert information on what is being and has been done elsewhere in Australia and internationally, and meeting literally thousands of people and organisations in Western Australia.

To those we missed, we apologise — although we would note to anyone who might have felt excluded that many opportunities to participate were offered through press advertising, calls for submissions, public hearings, community meetings, letters, posters and other channels.

We have greatly appreciated the feedback we received from Western Australians, and been very much impressed by their willingness to contribute constructively to the development of a State strategy on a matter of great public concern. For this reason we have devoted a major chapter of the report (Chapter 2) to providing feedback on the views expressed to us.

It would be wrong to imply that there has been a lack of concern or action on drug problems in the past. Many people and organisations have worked with considerable dedication to reduce drug abuse. We hope this report will ensure that such work can continue in a manner consistent with the best available information and appropriate to Western Australia's current needs.

It is, however, worth stressing that there is now a very substantial body of literature and experience which can help point the way to the most effective approaches. In a world where resources must inevitably be limited, it is important to ensure that we benefit from the experience we and others have gained, and that we apply the same

kind of rigour to allocation of funding in the alcohol and drugs area that we would in, for example, the provision of health care services.

The key to the thinking underlying this report is our recommendation for a comprehensive approach. Drug abuse issues are enormously complex. There are many areas in which action is required, many drugs, many groups of people involved, and many perspectives.

Some of the submissions and comments made to the Task Force tended to take an 'either .. or' position; **either** health **or** law enforcement; **either** prevention **or** treatment; **either** control supply **or** control demand; **either** encourage people to give up and stay off drugs **or** reduce the harm for those who continue to use; **either** focus on licit drugs **or** focus on illicit drugs; **either** drug problems should be publicised **or** they should not be; **either** encourage an HIV control strategy **or** a drugs strategy; **either** encourage law enforcement **or** education; **either** focus on young people **or** on adults; **either** provide more metropolitan services **or** more country services.

We do not accept that the 'either .. or' approach is appropriate for a drug abuse control program. Indeed, it is probable that some specific aspects of a drug control and reduction program will be much less successful if not complemented by others.

This report therefore focuses on developing as comprehensive an approach as possible within the framework of what can be achieved by a State government.

There are inevitably some omissions from the report. In particular, we have focused more on traditionally recognised 'drug abuse' (including both alcohol and tobacco) than on the misuse of pharmaceutical products. This should not be seen as downplaying the importance of concerns about the latter, for which we support further attention, analysis and action. Similarly, while we comment on much of the work that has been carried out, it would have been impossible to identify by name all the excellent programs and activities that have been developed around the State — from the sizeable and committed non-government sector to the Kings Park rangers who removed 232 hypodermic syringes from the Park in 1993/94.

This report was commissioned by and makes recommendations primarily to the Government of Western Australia. Clearly, however, the drug problem is one whose resolution involves many other bodies. The State Government is limited in its capacity to act in some areas, and must work in co-operation with other governments and organisations. For example, there is a clear division between the responsibilities of Commonwealth and State agencies in terms of law enforcement. State agencies (primarily the Police Department) are responsible for most law enforcement within State boundaries, but Commonwealth agencies such as the Australian Federal Police and the National Crime Authority also carry a substantial part of the responsibility for pursuing drug offenders. Another Commonwealth agency, the Australian Customs Service, is responsible for policing the West Australian coastline and preventing illicit drugs from entering the country. There is already much co-operation between these groups, and our approach is intended to develop it further. It is, however, important to emphasise that good results will depend on action and co-operation from these groups, as from many others in the community.

During the 1970s and 1980s there was a series of inquiries and royal commissions into drugs in Australia. There were two main types of inquiries:

- those concerned with investigating the activities of organised criminal organisations in the importation and distribution of heroin and other illicit drugs, notably marijuana, and the consequences; and

- those concerned with determining a broader definition and description of drug use, especially the dimensions of licit drug use.

The Task Force has taken cognisance of the work of the inquiries, identified in Appendix 1.

1.2 HOW WE WORKED

Prior to preparing its report, the Task Force proceeded through three overlapping phases:

- information collection and assimilation;

- analysis of information; and

- development of policy positions and recommendations.

The Task Force was keen to gain access to all relevant information about the myriad issues pertaining to drug abuse, the current situation in Western Australia, and the current national and international situation.

Input from the Western Australian community was given a high priority. The Task Force wanted to hear the experiences of Western Australians, their attitudes and opinions, and their suggestions for dealing with drug abuse. A substantial program of public consultation was undertaken. It consisted of the following activities:

- Public hearings throughout the State — Sixteen public hearings were conducted. Five took place in Perth (Central Perth, Fremantle, Warwick, Midland and Mandurah) and ten in regional Western Australia (Albany, Bunbury, Geraldton, Kalgoorlie, Carnarvon, Karratha, Port Hedland, Broome, Kununurra and Northam). In addition, a Statewide hearing was held through the Western Australia Telecentre to enable people from other areas, even the most remote, to air their views directly.

  A total of 617 people attended the public hearings; a further (but unknown) number gathered in a wide range of locations for the Telecentre hearing. They came from all walks of life and included professionals in the various health and human services, hotel owners, parents, young people and others with a general concern about the issue.

- A telephone hotline was established and was widely publicised. A total of 77 calls were received. A number of further calls from members of the public were directed to members of the Task Force.

- Written submissions were invited from the public through newspaper advertisements and at the public hearings — 163 written submissions were received from private individuals, 93 from non-government and community organisations and 59 from public sector agencies.

Including the telephone hotline and other telephone submissions we received well over 400 specific submissions or responses, in addition to our surveys.

In addition to the public consultation, a range of specific consultations was undertaken with members of the community with particular perspectives on drug abuse. Consultations were conducted on an individual and group basis with the following:

- families who have experienced drug abuse;

- high school students;

- adult and juvenile prisoners; and

- clients of a drug treatment agency for youth.

A vast amount of information was provided to the Task Force by organisations working directly with drug abuse and by other organisations involved less directly. Information was sought through three avenues:

- Surveys requesting detailed information on expenditure and activity related to drug abuse were sent to all State Government agencies and a wide range of non-government organisations. Survey information was received from 170 State Government agencies and 118 non-government organisations.

- Written submissions were invited from all State and local government agencies, and a substantial number of non-government and community organisations. Written submissions were received from 59 public sector agencies and from 93 non-government and community organisations.

- Consultation meetings were held with a wide range of government and non-government organisations in Perth and regional areas. Over 200 meetings were held with some 150 relevant organisations in Perth and regional centres. All specialist alcohol and drug service providers in the State were consulted and general health, justice and welfare services, including youth services, were consulted extensively. Multiple meetings were held with some organisations, particularly the Police Department, Alcohol and Drug Authority, Health Department, Ministry of Justice and the Department for Family and Children's Services (formerly Department for Community Development). Most consultations involved groups of staff.

All available sources of data and local research that reflected upon the extent of drug abuse and its costs in Western Australia were accessed and analysed. By combining these sources with the information provided by agency surveys on expenditure and activity the Task Force has been able to assemble the most comprehensive description and analysis of drug abuse in Western Australia ever compiled.

The Task Force reviewed the extensive body of literature covering drug abuse and law enforcement issues, prevention approaches, treatment outcomes and specific drug issues. We read with particular interest a series of recent reviews of the literature and current activity in Australia, among them the reports of the National Drug Strategy's Quality Assurance in the Treatment of Drug Dependence Project, various publications of the Australian National Drug and Alcohol Research Centre and the National Centre for Research into the Prevention of Drug Abuse. We were fortunate to also have access to a number of as yet unpublished reviews prepared by the current Task Force to Review Services for Drug Misusers in the United Kingdom.

As discussed above, the Task Force reviewed the reports of previous Western Australian and national government inquiries and royal commissions related to the subject of drug abuse. It also considered and reviewed the current National Drug Strategic Plan and the Western Australian Drug Strategic Plan and examined the plans produced by other States. The current legislation pertaining to the control of drugs in Western Australia was reviewed.

The Task Force reviewed how some countries comparable to Australia (the United States, the United Kingdom and the Netherlands) have dealt with the abuse of illicit drugs. This included consideration of the recent national strategies produced by the United States (The White House 1994), England (Home Office 1995), and Scotland (Scottish Office 1994).

In addition, the Task Force consulted in some depth the National Drug and Alcohol Research Centre regarding treatment issues and the National Centre for Research into the Prevention of Drug Abuse.

Members of the Task Force visited South Australia, Victoria, New South Wales and the Australian Capital Territory in order to review structural arrangements for the National Drug Strategy and within the State jurisdictions; to be briefed on approaches to law enforcement, prevention and treatment; and to visit specific programs. The Task Force conferred with all Australian States regarding structures and initiatives.

The Task Force was assisted in its consideration and analysis of various issues by meetings of its reference groups. These were as follows:

- Senior Government Officers Reference Group. The Group comprised representatives of the Health Department, Education Department, Police Department, Ministry of Justice, Department of Commerce and Trade, Department for Family and Children's Services, Treasury, the Alcohol and Drug Authority, Office of Racing and Gaming, and the Aboriginal Affairs Department.

- Non-Government Organisation Reference Group. The Group comprised representatives of the Western Australian Network of Alcohol and other Drug Agencies, the Western Australian Council on Social Service, the Alcohol Advisory Council, the Australian Council on Smoking and Health, the Western Australian Council of State School Organisations, the Crime Prevention Council, and the Youth Affairs Coalition of Western Australia.

- A round table forum of academics. Academics who participated in a discussion of future trends were drawn from the National Research Centre for the Prevention of Drug Abuse, Curtin University; the Western Australian Institute for Child Health; the Faculties of Education and Medicine of The University of Western Australia; and the Epidemiology Branch of the Health Department.

The Task Force did not attempt to develop consensus positions among interested individuals and organisations. Recognising the wide divergence of views within the community, within relevant organisations and the dedicated alcohol and drug field, the Task Force deliberately took the approach of consulting widely, considering the impact of all suggestions and options, and developing its recommendations on the basis of the evidence available to it. The views expressed by the community, both the general public and those with expertise in relation to the issues under consideration, were nevertheless paramount in informing the deliberations of the Task Force.

We have tried to avoid the temptation to meld the various perspectives we encountered into compromise positions that would satisfy various constituencies in the short term but fail to make any real impact on the

problem. Rather, we have sought to develop a coherent set of proposals that embrace clear policy positions, simple and effective structures, and a range of initiatives that together constitute a comprehensive program to tackle drug abuse.

1.3 WHAT WE MEAN BY DRUGS AND DRUG ABUSE

The complexity of addressing drug issues starts with the definition of the term ‘drugs’. Expert groups have met in various countries under the auspices of health and other authorities for the apparently simple purpose of defining terms such as ‘drugs’, ‘drug abuse’ or ‘substance abuse’, but general agreement is yet to be reached.

Some submissions argued that in considering drug abuse and its consequences, the Task Force should confine itself to illicit substances; the great majority, however, thought that legal substances should be included in our considerations.

We preferred an inclusive to an exclusive approach. For our purposes, and as we made clear at the outset of all community consultations, 'drugs' were taken to include all substances that people normally think of as being drugs, whether legal or illegal. We therefore considered:

- illegal drugs — such as heroin, cocaine, cannabis[1], amphetamines, designer drugs;
- legal drugs — products such as alcohol and tobacco that people use for enjoyment or other reasons;
- pharmaceutical products — which may be used both legally and illegally, and both appropriately and inappropriately; and
- products used by some groups — ranging from solvents (used by some young people) to performance-enhancing drugs (used by sports people).

While terms such as 'use' and 'abuse' are widely used, there are no widely accepted definitions. We have therefore arbitrarily determined to write about 'abuse' rather than 'misuse', and to define 'abuse' as:

- any illicit use of drugs; or
- any use likely to cause damage or risk to the user, or to others.

1.4 PLANS AND TARGETS

We have considered the issue of setting targets in each of the various areas of concern. There is now something of a history of target-setting in health and related areas, but sometimes the targets have been too numerous and complex to meet.

We have therefore chosen not to recommend that Western Australia aim to decrease the use of one substance by *x* per cent or another by *y* per cent. Our preferred approach is to recommend the establishment of two benchmarks by which Western Australia's performance should be judged:

i) the lowest levels of drug abuse and harm in Australia; and

ii) following further research, the lowest levels of drug abuse and harm in comparable countries.

Such targets are realistic and allow for progress to be measured; moreover, they allow for the impact on Western Australia of national and international trends. Clearly, sub-targets for specific groups (high priority or hard to reach groups, and those for whom special programs may be required, such as Aboriginal communities) may prove to be appropriate and will arise from the constructive work on development of targets being carried out by the Health Department.

Accordingly, if we consider what the drug abuse situation should be in five years’ time, assuming the implementation of the recommendations of the Task Force, the State should be able to demonstrate: the lowest levels of illicit and licit drug abuse in Australia, substantial improvements in the problems pertaining to groups

[1] The term ‘cannabis’ has been used throughout the report in place of ‘marijuana’ except in direct quotation, as cannabis generally refers to all processed and unprocessed parts of the cannabis plant.

such as Aboriginal people and homeless youth; and a framework of programs and organisations to maintain these gains against national and international forces.

The Task Force acknowledges the important work that was entailed in developing the 'Western Australian Drug Strategic Plan for 1995-98', and notes that all States have developed such plans in accordance with the National Drug Strategy.

Our aim has been to take a step beyond strategic planning by recommending specific structures and initiatives to achieve the broad goals already outlined. Our approach is broadly consistent with the Strategic Plan, though there are some changes of emphasis and a more comprehensive and operationally focussed range of objectives.

It is important to recognise that drug problems change over time, partly because our society is far from static, but also because of factors relating specifically to the drugs, their users, those who manufacture, promote and sell them, and broader cultural changes. This means that some approaches adopted over the years may no longer be appropriate. It also means that we must be flexible in our thinking: indeed, part of the Task Force processes entailed considering what the major drug problems in Western Australia could be in five and ten years time.

We do not suggest that drug problems can be resolved overnight. Changing community attitudes and behaviour is inevitably a long-term process. We have found, however, from our consultations that the community wants action in this area. We are therefore proposing a two-year period at the end of which the developments we recommend would be in place; it should be possible to judge soon afterwards whether appropriate action and results are being generated. We therefore recommend that if the approach we propose is accepted, there should be a review of process and outcomes after its third year of operation.

1.5 DRUG ABUSE AND OTHER SOCIAL ISSUES

It is of course true that any strategy designed to address drug abuse issues must recognise the many factors impinging on drug use and abuse within our society. There are many who see drug abuse problems as representing the tips of a number of icebergs — as when disaffected youth turn to illicit drugs to escape reality, or commercial interests promote harmful products such as tobacco.

In its public consultations, particularly, the Task Force was frequently reminded that drug abuse is not a behaviour that develops in isolation. The Waratah Support Centre, for example, argued that drug and alcohol abuse are symptoms of a society which is failing to address the deeper social issues that leave individuals feeling alienated, isolated and alone; and that the problem will not disappear until these broader social issues are dealt with. Prolonged drug abuse is usually fuelled by a host of underlying personal and social problems experienced by the individual concerned. The problems might include poverty, a real or perceived lack of opportunity, trans-generational welfare dependence, inadequate recreational opportunities, youth alienation, any or all of which may in the extreme combine to produce behaviours characteristic of an underclass.

There are limits to how far a Task Force on Drug Abuse can address any general problems that underpin alcohol and other drug abuse. The Task Force has proceeded, however, on the premise that drug abuse is a problem in its own right and often, in addition, a symptom of other, deeper problems. The exact relationship between cause and effect has not and is not likely to be teased out precisely. But the Task Force considers that it is legitimate and effective to target drug abuse as a problem in and of itself. In doing so we can and must, in some instances, also address underlying social issues. We have therefore recommended co-ordination strategies that would involve all the major human service agencies of government as well as the private sector; encouragement of community action that might extend to areas such as recreation and employment creation; and a collaborative approach among service providers and within the community.

The Task Force could not, of course, take on the role of seeking solutions to all social problems. It is the responsibility of government as a whole and its various agencies, both in relation to their own mandates and in collaboration with each other, to promote overall social wellbeing. But we believe that with the implementation of our recommendations the alcohol and drug field can make a major contribution to improving community wellbeing by addressing drug abuse in its own right; it can have a broader impact because drug abuse exacerbates and perpetuates other social ills; and by collaborating with others it can help tackle some of the broader social needs.

The Government's programs and agendas in the areas of employment, law and order, health, welfare, education and others all come into play when considering the underlying causes of drug abuse. Specific initiatives such as the Task Force on Families in Western Australia, the reorientation of the Department of Family and Children's

Services, and the introduction of a family-focussed philosophy in the area of juvenile justice, are all examples of efforts to respond to some of the major systemic factors that influence drug abuse. It is in this context that the role of the drug and alcohol field and the recommendations of the Task Force on Drug Abuse need to be understood.

As the foregoing discussion indicates, in any report of this kind there is clearly scope for much overlap with other issues, policies and programs. Work on drugs, for instance, inevitably overlaps with work on HIV or youth issues.

We recognise the difficulty of co-ordinating activity in the various areas involved in drug issues, but believe that a specific overarching drug strategy is necessary at this stage; we believe, further, that it can be introduced in a manner that complements the work of the various agencies, with overlap being constructive rather than counter-productive.

In particular, it would be difficult to over-emphasise the importance of the inter-relationships between illicit drugs, crime, and the law enforcement and criminal justice systems. Elsewhere in the report we show that much criminal activity in Western Australia can be attributed, directly or indirectly, to drug abuse. There are three major categories:

- First, there is crime attributed to the use of illicit drugs. This comprises crimes carried out by those seeking money to buy illicit drugs, crimes carried out by those using the drugs, and crimes carried out as part of the manufacture and sale of the drugs. It is estimated that 9% of police activity and 25% of the justice system's activity in Western Australia relates to this area.

- Second, there is crime related to alcohol abuse. This relates primarily to criminal acts carried out by people under the influence of alcohol — both outside and inside the home. The police estimate that 20% of their activity occurs as a consequence of alcohol abuse — but much higher amounts in some areas of the State.

- Third, there is crime associated with other forms of drug abuse: solvent abuse, anabolic steroids, illicit use of pharmaceutical products, etc. Here crimes can occur in relation to activity carried out to obtain money to buy these substances or through actions carried out as a result of their use, imposing substantial costs on the law enforcement and health system.

It is vital that drug abuse control strategies be integrated with law enforcement and justice strategies, for effective drug control will lead to substantial reductions in the costs imposed on the criminal justice system.

The profiles of the typical criminal and the typical abuser of illicit drugs and alcohol reveal a crucial common characteristic: youth. As a recent report of the Crime Research Centre at The University of Western Australia illustrates (Indemaur 1995), most crimes are committed by young males between the ages of 15 and 25; the evidence on illicit drug use presented in Volume II of this report shows that most use of illicit drugs occurs in the same age group, as does most abuse of alcohol.

It is important not to focus on youth issues to the exclusion of all others, or to imply that young people are responsible for drug problems or indeed all crime in our society. It is, however, equally important to recognise that the vast majority of drug and alcohol abuse problems (and also many crime problems) occur among young people. There are broad implications to be drawn from this for government policy as a whole. It is also necessary to ensure that action directed to young people is not simply remedial action directed at those committing offences, but also includes preventive action.

1.6 DRUG ABUSE - WHOSE RESPONSIBILITY?

The need for a comprehensive approach has been indicated earlier. Drug problems should be seen as a high priority not only by individual agencies but also across all levels of government. This report therefore proposes a 'whole of government' approach to drug abuse. But governments alone cannot deal with problems of this kind; they need the support of the community, so it is vital for drug abuse to be regarded as a 'whole of community', as well as a 'whole of government' problem.

This report places substantial emphasis on the roles that government and non-government organisations can play in controlling drug abuse. Because drug abuse is a problem for the whole community, we also propose approaches that seek to involve individual members of the community in local action.

A large number of recommendations were made to us, and we have sought to incorporate as many as possible in this report. Inevitably, however, we have not been able to agree with some or incorporate all that we agreed with. We do, however, recommend more detailed reviews in certain areas. And we note that every recommendation made to us in the community consultations will be referred to the relevant government department for further examination. We have also sought to produce a report with a manageable number of recommendations.

The families of people with a drug problem have a special interest in drug issues. There is no stereotype that fits families whose children face drug abuse problems. They may come from anywhere in the community, be affluent, disadvantaged, or simply middle of the road. They all find themselves in the midst of a complex morass of social, health and law enforcement issues, as well as having to deal with the devastating personal impact on their lives.
Some of our recommendations are framed with a view to ensuring that these families receive appropriate levels of support and assistance. We were fortunate to obtain assistance from an experienced health professional who interviewed families of young people with drug problems for us. The report of these interviews appears as Appendix 6. We recognise that those interviewed have been influenced by their particular experiences, and that the comments, criticisms and recommendations they make cannot all be accepted at face value. Nonetheless, these views deserve to be heard and have been an important contribution to the work of the Task Force.

1.7 INTERNATIONAL CONTEXTS

1.7.1 IMPORTANCE OF BROADER CONTEXTS

As noted elsewhere in this report, the Western Australian Government carries limited constitutional responsibility for drug abuse control. Other State governments may implement policies that impinge directly on Western Australian circumstances; the Commonwealth Government is responsible for national programs and activities, and also for addressing Western Australia's role in the international context. The limitations to action by State governments are particularly noteworthy in the area of coastal surveillance and customs activity: State governments are generally responsible for law enforcement, but can only play a very limited role in influencing the importation of illicit drugs into Australia, and the extent of that importation will in turn reflect the operation of international drug markets.

Any consideration of drug issues must recognise the international contexts within which these problems occur. In this report we have sought to draw on international experience, while fully recognising that conclusions drawn and policies and strategies developed elsewhere, on the basis of trends and circumstances in other countries, may not be appropriate for Western Australia.

In terms of developing policy, international experience must be approached with some caution. Not only are circumstances often different, but methods of data collection and evaluation may vary. It is also necessary to adopt a circumspect approach to some of the claims made in relation to developments in other countries. In some areas (most notably cannabis use), the Task Force received submissions presenting directly contrasting views, not only on the conclusions to be drawn from experience in other countries, but also on the situation in those countries. Some submissions expressed strong views on approaches adopted elsewhere that depended heavily on anecdotal information. The USA experience was particularly subject to varying interpretations, comment and judgements.

Recent evidence in fact indicates a decline in illicit drug use in the USA, albeit from disturbingly high levels. *The Washington Post* (28 May 1995) reported:

> Americans spent an estimated $49 billion on illegal drugs during 1993, 23 per cent less than the $64 billion they spent in 1988, largely because of a decline in outlays for cocaine and heroin, according to a study prepared for Lee P. Brown, President Clinton's National Drug Policy Director.

In view of the international nature of drug problems we sought advice from several Australian and international experts as to whether there was any country whose approach to drug problems could be used as a model. The response was invariably to the effect that while there was much to be learned from other countries, no other country could be presented as a model, and there were indeed many areas in which Australia could be seen as a leader.

The international context, however, remains important from several perspectives:

- Australia's international obligations: Australia participates in many international activities and fora directed towards reducing drug problems, and is subject to a number of international treaty obligations.

- Learning from experience elsewhere: there is clearly much to be learned from the experience, successes and failures of others in dealing with drug problems.

- Anticipation: in Western Australia we are particularly well placed to anticipate developments here on the basis of international trends.

- Comparison: it is possible to assess our problems and progress on the basis of comparisons with information from other countries on both drug use and other relevant social issues. An important caveat here is that such comparisons must be approached with caution: data collection and circumstances may be very different.

- Recognising limitations: there should not be over-inflated expectations of the outcomes of action by State Governments, with so many external influences operating, whether social, cultural, legal or criminal.

1.7.2 INTERNATIONAL INDUSTRY INFLUENCES ON DRUG USE

Industry influences on drug use can be characterised as “open” and “concealed”. Open influences include the international companies responsible for the manufacture, sale and promotion of licit drugs such as tobacco, alcohol and pharmaceutical products; international government and non-government organisations; experience from treatment, prevention and other programs in the literature or otherwise, publicly conveyed. It is noteworthy that any action taken within Australia occurs against a backcloth of significant international interest in, and control over the industries that affect drug use in this country. For example, the four major tobacco companies that dominate the Australian market are all effectively controlled from outside Australia, as are many of the alcohol and pharmaceutical companies.

Concealed international influences, by contrast, are those connected to the illicit drugs industry which, by virtue of its illegality, cannot be open or direct.

The size and international significance of the illicit drug problem should not be underestimated. The recent US ‘National Drug Control Strategy’ (The White House 1994) estimates the size of the illicit drugs industry internationally as being close to $100 billion per annum. Several countries in South America and Asia derive significant economic benefit from illicit drugs and face apparently insuperable problems in efforts to control the manufacture and export of these products. While the industries associated with illicit drugs are illegal by definition, there can be no doubt that in various aspects they are well organised, highly sophisticated and successful. The United States has been at the forefront of international efforts to control the illicit drugs industry and to steer away from illicit drugs those countries currently unsuccessful at controlling drugs. This is clearly an area where it is not appropriate for a State government to intervene.

Reports from the Australian Bureau of Criminal Intelligence indicate that:

- Most marijuana used in Australia is produced within the country, but this is supplemented by high-quality leaf products imported from overseas. Virtually all hashish resin and oil for the Australian market is imported.

- The bulk of heroin consumed in Australia comes in refined form from source regions in South East Asia, South West Asia and the Middle East. Heroin is also produced in Mexico and Colombia.

- All known cocaine production occurs in countries in South America.

- The ‘Golden Triangle’ in South East Asia is the world's major opiate producing region and the main source for heroin seized in Australia. Conduits for opiates from Golden Triangle countries (South East Asia: e.g. Thailand, Burma, Laos) and Golden Crescent countries (South West Asia: e.g. Iran, Afghanistan, Pakistan) and other countries such as Lebanon include Hong Kong, Taiwan, Malaysia, Singapore and, more recently, countries from the former USSR. Opiates also come directly from the country of production, particularly Thailand and Lebanon.

The US National Drug Control Strategy discusses the international nature of the illicit drug industry, the problems faced even by countries as powerful as the US in controlling its influence, and the action being taken by the US Government. The report notes that:

- Implementation of global policy on illicit drugs must respond to the distinctly different challenges posed by the cocaine and heroin trades.

- Powerful cocaine syndicates, buttressed by enormous profits, rely heavily on corruption to protect their operations. This undermines the effectiveness and credibility of all democratic institutions, including the judiciary, police and military.

- Trafficker use of intimidation and violence in their host countries is commonplace.

- Collusion of Latin American drug traffickers with foreign criminal organisations and insurgence also weakens private institutions.

- If the power of the illegal drug trade is not curtailed, traffickers can gain virtually unobstructed influence at the highest levels of government as they did over a decade ago in Bolivia and more recently in Panama.

- From a tactical standpoint, anti-drug efforts in the source countries should provide the best opportunities to eradicate production, arrest drug kingpins and destroy their organisations, and interdict drug flow.

- In relation to heroin, at least 11 countries provide a total of 3,700 tons (US) of illicit opium for the international drug market — more than double the production a decade ago.

- Following the demise of the USSR, traffickers now use new smuggling routes that traverse the poorly guarded borders of the Caucasus, Central Asia and Eastern Europe.

- Given the decentralisation, breadth and diversity of the heroin industry, there is no alternative to a multi-dimensional and global approach to the heroin problem.

1.7.3 INTERNATIONAL APPROACHES TO DRUG ABUSE MANAGEMENT

In considering drug abuse in Western Australia, the Task Force paid particular attention to the approaches to the management of illicit drug abuse taken by the United States of America, the United Kingdom and the Netherlands. These countries provide significant contrasts in their policies and practices within cultures that are broadly similar to Australia's.

1.7.3.1 The United States

American policy has historically been dominated by what may be termed a 'supply reduction' approach. That is, the primary emphasis has been on vigorous law enforcement at both the domestic and international levels.

Other important concepts have been 'zero tolerance', which attempts to remove the distinction between users and traffickers, and 'user accountability' whereby individual users are held responsible for all the consequences of drug abuse, including the associated crime and corruption. The resultant 'climate of intolerance' has manifested in relatively widespread testing for drugs in the workplace, limitations on needle and syringe exchanges, and restrictions on methadone maintenance programs and the length of treatment.

The latest National Drug Control Strategy (The White House 1994) has, however, sought to adjust the approach to some degree with the provision of more opportunities for treatment, strategies to increase vastly the number of persons attending treatment, some extension of maintenance therapies such as the provision of LAMM and buprenorphine, and more emphasis on prevention programs and community policing.

1.7.3.2 The United Kingdom

The approach of the United Kingdom is often perceived as being dominated by the prescription of heroin for opiate addicts. In fact this system operated to a significant level only up to the late 1970s, after being restricted in 1965 to government clinics only. The prescription of heroin occurs now only to a very limited extent.

The 1980s saw the development of a range of community-based and specialist services for 'problem drug users' and a shift away from the view that drug abuse always involves dependence and requires a medical response.

The United Kingdom policy stance, reflected in both its 1990 and 1995 White Papers (Home Office), has been to emphasise law enforcement, prevention activities, and treatment and rehabilitation as equal strategies in tackling drug abuse.

The law enforcement approach to drug trafficking in the United Kingdom is very similar to that of the United States. British measures on sentencing, money laundering, forfeiture and seizure of assets, use of informants, covert operations and multiple jurisdiction projects generally follow American models and legislation. Law enforcement does not, however, generally target individual users, and while there are regional variations police and health agency co-operation, as in issues related to the provision of needles and syringes, is generally regarded as productive.

1.7.3.3 The Netherlands

The Netherlands provides the most obvious contrast with the United States and, to a lesser extent, the United Kingdom. Two dominant principles guide Dutch policy in relation to illicit drugs:

- First, the concept of 'normalisation' epitomises the view that drug users should be integrated into mainstream society with the same rights and responsibilities as other citizens. Hence, treatment services and facilities such as needle exchanges are made as accessible as possible. Street level services, low threshold methadone programs, and support for Junkiebonden (user organisations) are all consequences of this approach.

- Second, the 'expediency principle' in the Code of Criminal Procedure allows for the authorities to refrain from prosecuting offences if there are ‘grounds deriving from the public good’ for not doing so. Guidelines in accordance with this principle were established in relation to illegal drugs in 1976 and were endorsed most recently in 1987. They identify three areas as not warranting prosecution: possession of small quantities of 'hard drugs', dealing in small quantities of marijuana by a house dealer (in a youth centre) or a coffee shop; and dealing, possessing or producing a maximum of 30 grams of marijuana.

With respect to trafficking and manufacture of drugs other than marijuana, the approach of the Netherlands is little different to that taken by the other two countries discussed above.

1.7.3.4 Relevance to Western Australia

In an overview of the relative approaches of these three countries and Australia, Wardlaw (1992) concluded that probably the only general principle that is commonly accepted is that a comprehensive approach to drug strategy needs to integrate demand and supply reduction initiatives, and that the points of disagreement are about where the balance should be struck.

There should be no doubt that despite some of the approaches taken elsewhere and the views about them expressed to the Task Force, government activity in most countries comparable to Australia remains, and will remain, very heavily focused on combating illicit drug use. While Western Australia is inevitably only a very minor participant in the international context, the view of the Task Force is clearly that we too should oppose illicit drug use, a position which in any case is mandated by Australia's international treaty and other obligations.

1.7.4 CULTURAL INFLUENCES ON DRUG USE

As well as the drug-specific international influences that bear on the situation in Western Australia, any action in this area must also recognise the significance of cultural influences on drug use. These include a number of facets of youth culture, such as music, literature, and other forms of entertainment. It would be naive to suggest that influences of this kind are open to ready intervention by governments; it has to be accepted that much drug use and other activity will be influenced by cultural considerations, which should generally be seen as operating in an international context.

It is important in considering any of the above issues to differentiate the various international contexts in which our problems and activities take place, and to learn from international experience, but always to recognise that the circumstances in Western Australia may be very different from those in the countries where that experience was obtained.

1.8 POLICY PERSPECTIVES

1.8.1 INTRODUCTION

The Task Force's public consultation showed that there is a wide range of opinion as to the appropriate stance that governments should take towards drugs and drug abuse. Moreover, there was a distinct lack of clarity about what that stance currently is.

This section of the report sets out to develop a basic policy position for government that will specify a clear and unambiguous direction for the community and service providers.

Any policy development on drug abuse must recognise the complexity of this area. We are dealing with not one drug, but a growing number; there is not one 'single' drug problem, but many problems. There is inevitably overlap with other aspects of public policy. Drug users and their families are faced with complex problems, and there should be no cause for apology that policies and programs developed, however comprehensive, cannot cover all eventualities.

It is important to emphasise again also that the policy developed in this report is directed primarily towards the Government and community of Western Australia. This imposes some obvious limitations: there is, for example, a distinction between the responsibilities of the State and of the Commonwealth: the Commonwealth, for instance, is responsible for coastal surveillance.

The proposals developed in this report are, nevertheless, intended to constitute a comprehensive approach. There is no single solution to drug problems; and no single organisation or group should be expected to carry responsibility for implementation of all aspects of a Statewide program. As noted elsewhere in this report, in many areas where either one approach or another was commended to us we have sought to include elements of both. The comprehensive approach to drug problems implies recognition that a wide range of different solutions may be required, entailing the support and activity of an equally wide range of organisations and individuals.

1.8.2 PROTECTING THE COMMUNITY

The reason for acting on drugs, whether legal or illegal, is not moral fervour. It is because these drugs can be dangerous both to individuals and to the community as a whole. Those at risk are not only the people who abuse drugs but also their families and the many others affected by the criminal and other consequences of drug abuse.

Society has a right to be protected from such harm, and we take this to be the first priority of an effective drugs control strategy.

This report proposes a comprehensive Western Australian Drug Control Strategy, based on the following four principles:

- **Protecting the community:** this means that the Government will seek to protect the community and individuals from drug abuse and its consequences.

- **Opposing drug abuse:** this means that the Government will continue to take a strong line in opposing any form of drug abuse, will resolutely maintain its absolute opposition to illegal drug use, and will ensure that clear and unequivocal messages are provided on all aspects of the drug control strategy.

- **Rational harm reduction:** this means recognising the need to take such action as is necessary to reduce the risks and harm to those continuing to use drugs and to the wider community, while ensuring that this does not encourage or normalise drug abuse.

- **A comprehensive approach:** this means that the Government will seek to tackle drug issues on all fronts, co-ordinate activity on drugs both within government agencies and in partnership with non-government organisations and the community at large.

The most fundamental objective of drug abuse control policy is taken to be protection of the community.

The first priority is to achieve the lowest possible level of abuse; this is followed by the need to reduce harm for continuing users and the community. Rational harm reduction is seen as an important component of the overall approach, but not as the primary objective. This means recognising the importance of harm reduction, but also

placing it in context. It should also be recognised that approaches to harm reduction will vary from substance to substance.

1.8.3 PROHIBITION OF DRUGS

Despite all the evidence on abuse and harm presented in this report, most people in Western Australia do not use illicit drugs. Further, notwithstanding the extensive policy debates over 'prohibition' of illegal drugs and alternative approaches, it is important to recognise that with the present policies of 'prohibition', Western Australia has among the lowest levels of use of illicit drugs such as heroin and cocaine in the world. Recent trends argue the case for vigilance, for concern, for urgent action, and for a comprehensive approach; they argue for incorporating harm minimisation strategies in an overall approach; but they do not indicate that we should give up on opposition to illicit drug use and venture into the uncharted territory of legalisation.

There is much conjecture as to the possible impact of taking a softer line on illicit drugs, but no solid evidence to indicate that this would reduce the levels of drug use or consequent harm. Indeed, it may be argued that were the Government to soften its line on illegal drugs, this might be taken to indicate support for 'normalisation'. And if some forms of illicit drugs became more acceptable, young people wanting to take risks might move on to experiment with more dangerous drugs.

Some commentators nevertheless assert that the simplest and most effective way to 'solve' illicit drug problems would be to legalise all such drugs. This, they argue, would result in an immediate end to the need for any government activity aimed at control, together with the costs attached, particularly in the areas of law enforcement and justice.

Regrettably, there is no satisfactory evidence that such an approach would work. There is, however, overwhelming evidence that:

- illegal drugs are illegal because of the damage they cause;
- the greater the use of illegal drugs, the greater the damage caused to users, their families and the community;
- making any product more acceptable to the community (and particularly young people) leads to increased use, and increased harm; and
- if illegal drugs were legalised, there would be a major effort by their producers to extend their use in order to maintain profitability.

It is appropriate to draw comparisons between the consequences of tobacco use and those of an illicit drug such as heroin. Both are harmful to the user. Both are addictive. Tobacco has been available without constraint (other than legislation on sale to minors) since its discovery several centuries ago. After the introduction of mass-produced cigarettes in the 1880s its use became widespread; its health consequences make it the largest preventable form of death and disease in the community. There can be little doubt that if introduced now its use would not be permitted. Heroin is illegal; the number of heroin users is still far outweighed by the number of tobacco users; any government that moved towards legalising heroin or in any other way making it more accessible would be flying in the face of commonsense, and failing in its responsibility to the community.

One of the arguments most frequently used to oppose a firm line on illicit drug use is that the US experience shows such an approach to be doomed to failure. The proponents of this view argue that:

- There is doubt about the evidence on the harmful consequences of some illicit drugs, particularly marijuana.
- The highly publicised 'War on Drugs' US approach has led to enormous expenditures with virtually no benefits, but many adverse consequences.
- Illicit drug use in the US is out of control.
- In Australia we already spend substantial sums on seeking to control illicit drug use.
- Australia should learn from the US experience by taking a more radical view: this would entail at the least decriminalisation of some illicit drugs, with a consequent reduction in law enforcement activity and costs (the positions argued range from decriminalisation of marijuana to total legalisation of all drugs).

We recognise the sincerity of those who hold these opinions and discuss some aspects of their arguments in the report. It is grossly over-simplistic, however, to argue that legalisation would lead to a reduction in the problems associated with drug use.

In contradiction of the view that 'prohibition' must fail, a cogent submission to the Task Force from the youth area commented as follows:

> Having worked in the substance abuse field for 10 years, it is interesting to note that although the old campaigns, particularly the graphic heroin ones, were roundly criticised, they appear to have had an effect on the current generation of adolescent users with a retained message that heroin is not OK.

One of the most respected commentators on drug issues in Australia said to the Task Force that abstinence could co-exist with other approaches, and noted that we should not be over-influenced by evidence that illicit drugs are being used.

> For every example of people being willing to snub the law, there are many more who wish to recognise the law. One must therefore be very careful about changing the law.
>
> One must be concerned about people who have jumped the bar — but be concerned also for those who don't, who respect the law; recognise those who have stayed within the stable and are deterred by the law — and reinforce them. Because if you don't, by golly you're going to be in trouble.

Concern was expressed by another respected commentator that decriminalisation of any drugs gives the impression that they are 'safe'.

Some form of relaxation of prohibition might lead to a reduced need for law enforcement activity in the short term, but would very speedily lead to increase in use, increase in harmful consequences, an increased interest by those who promote illicit drugs in developing and promoting further products, a need for a specialised control system, and an increase in the associated costs to the community.

We do not accept that either the US experience or the reality of continuing illicit drug use leads inevitably to the view that Western Australia should decriminalise or legalise illicit drugs. On the contrary, there is overwhelming evidence that illegal drugs are illegal because of the damage they cause, and that on the balance of probabilities increasing their availability would do substantial harm to individuals and society. The Task Force has reached this view after consideration of the following:

- Levels of illicit drug use and the associated criminal activity in Western Australia, particularly in relation to 'hard drugs' such as heroin or cocaine, do not bear comparison with the levels common in the US. We therefore have the opportunity to prevent our problem from escalating to such levels.

- Arguments based on doubts about the evidence as to the harmful consequences of illicit drugs are often misinformed and support the need for the enhanced public education programs recommended in this report.

- In an area where changes could lead to dramatic increases in adverse health and criminal consequences, the onus of proof must rest with those who seek change, and we are entitled to demand a level of proof that provides government and the community with certainty, rather than speculation.

- Despite much speculation, there is no solid evidence that lessening controls on illicit drugs would do anything other than encourage and increase their use.

- In addition to earlier concerns about illicit drug use, the advent of HIV/AIDS and recognition of the contribution made by illicit drug users to the spread of other diseases such as Hepatitis C means that we should be more rather than less vigilant to control intravenous drug use.

- Contrary to some public perceptions, there is encouraging evidence that US efforts in this area have in recent years contributed to reductions in illicit drug use, despite all the complexities of the North American situation.

- If illicit drugs were to be made available in a controlled manner, it would be necessary to develop all the apparatus of a licensing and control system: this in itself would (as in the case of alcohol) prove expensive, and inevitably entail costs related to effective enforcement and policing.

- The illicit drug industry is controlled by dangerous criminal interests; it would be exceptionally unwise to offer further scope to such an industry in this State.

- Finally, the reality is that Western Australia does not exist in isolation and is bound by international conventions to oppose the use of certain drugs

All this is not to argue that maintaining a firm approach on illegal drugs should occur in isolation or blindly: it should be clearly prioritised and accompanied by rational harm reduction strategies by a concern to ensure that penalties are appropriate to the scale of the offence, and by action on licit as well as illicit drugs. But the primary focus should be on discouraging use.

1.8.4 HARM MINIMISATION

Volume II of the report describes the quantum of harm and cost borne by both individuals and the community as a result of drug abuse. We assume from the outset that as a basic policy premise, governments have an obligation to reduce this harm and cost.

In recent years, and particularly the last decade, the concept of 'harm minimisation' (or harm reduction) has been regarded as the principle that should underpin all drugs policy. 'Harm minimisation' has been variously described, but the approach was perhaps best summarised by the then Federal Minister for Health, Dr Neal Blewett, at an early stage of the National Campaign Against Drug Abuse:

> The National Campaign has as its aim to minimise the harmful effects of drugs on Australian society: its ambition is thus moderate and circumscribed. No utopian claims to eliminate drugs, or drug abuse, or remove entirely the harmful effect of drugs, merely 'to minimise' the effect of drug abuse on a society permeated by drugs. [NCADA: Assumptions, Arguments and Aspirations. Monograph Series No. 1 AGPS, Canberra 1987.]

The recent ACT Drug Strategy notes that its strategy is based on a concept of harm minimisation:

> Integral to this concept is the recognition that drug use occurs along a continuum and that abstinence is not an acceptable or desirable goal for all people. As such any drug policies and programs should strive to minimise the actual and potential harms associated with alcohol and other drug use, not just aim to eliminate use. In some cases, this may mean encouraging people to not start, or to stop the use of specific drugs, in other cases to use the drugs in a different manner or in different circumstances. For example, young people are discouraged from using alcohol, and adults, when they use alcohol, are encouraged to do this in a manner which will not increase the risks of immediate harm (such as road crashes, violence) and the longer term harm (such as alcohol related brain damage, alcohol dependency syndrome).

In some ways there is little new about harm minimisation. It can be argued that it has always been a generally accepted strategy for both individuals and the community: most individuals have aimed to keep their alcohol intake below harmful levels and/or avoid driving after drinking; the community has long accepted harm minimisation measures ranging from liquor licensing laws to reduction of cigarette tar, nicotine and carbon monoxide yield.

More recently, since the advent of HIV/AIDS, harm minimisation has led to acceptance of a number of strategies designed to reduce the risks for those people who continue to use illicit drugs, including activities such as needle and syringe exchange schemes.

Few would argue against the importance of taking action to contain the spread of HIV/AIDS. This clearly entails recognising the need to communicate with and change behaviour among illicit drug users. Thus far, the relatively low rates of HIV/AIDS in Western Australia attest to the value of this approach, together with others. The Task Force was provided by the National Centre for the Research into the Prevention of Drug Abuse with a copy of its submission to the Criminal Penalties inquiry of September 1994. It maintains that:

> largely as a result of the provision of (needles and syringes) to injecting drug users, Western Australia is thought to have one of the lowest rates of HIV infection among IDUs (injecting drug users) in the western world, with only about 1% of users infected compared with 50-60% in some parts of the USA and Europe.

A leading British medical historian (Berridge 1992), writing on historical perspectives on harm reduction, commented that:

> Some commentators have argued that AIDS has changed the direction of drug policy. The only examples of AIDS overriding established policy objectives have been in the field of drugs. The Government had abandoned its previous stance of augmenting its restrictive and punitive policies on drugs now that AIDS had come to be seen as the greater danger.

Certainly over time, and perhaps partly due to the seriousness of the AIDS crisis, 'harm minimisation' has come to be associated with the view that it is more important to reduce the risk to continuing users (particularly of illicit drugs) and the broad community, than to achieve a reduction in use per se. A problem arises, however, when the aim of 'harm minimisation' is interpreted as being to reduce some or all of the consequences of drug use without a commitment to reducing use. This view was recently summed up as follows:

> ... the essential feature of harm reduction is that it involves an attempt to ameliorate the adverse health, social and economic consequences of mind-altering substances without necessarily requiring a reduction in the consumption of these substances. (Heather, et al 1993)

This approach may well be appropriate for dealing with some aspects of drug abuse, including alcohol which is legal and entrenched in our culture, but it would be wrong for any government to adopt this approach as its **primary** position on all drugs.

Concerns have, indeed, been expressed that some harm reduction strategies carried out in isolation may assist in normalising drug use. If young people learn about 'safer' ways of using illegal drugs without also learning about the importance of avoiding such use, they may draw the conclusion that it is quite acceptable for them to use such drugs. Similarly, while needle and syringe exchange schemes are entirely appropriate as a means of reducing the risks of HIV/AIDS and other diseases, if they occur in the absence of strategies aimed at reducing use of illicit drugs and intravenous drug use they may be seen as encouraging continued use.

Our community consultations showed concern among a variety of groups, from ethnic communities to some in the treatment arena, that a public emphasis on 'harm minimisation' as the primary purpose of drug abuse policy led to a view that drug abuse was 'safe' and acceptable.

It is not the purpose of this report to argue whether one health and social problem is any more important than another. Clearly, the risks posed by HIV/AIDS are such that all appropriate containment action must be taken; equally clearly, the consequences of drug abuse are already such as to demand urgent action; if it became more widespread the consequences would be greater yet.

The approach taken in this report is to support harm minimisation, but in a broader context. The term 'harm minimisation' now carries so many different connotations for so many different groups active in the area of drug abuse, that it is no longer helpful to use this phrase as the basic rationale underpinning policy on drugs.

It should be emphasised that the approach we propose is not in any way intended to cast doubt on the importance of preventing the spread of HIV/AIDS. It is vital that these programs continue, alongside and in partnership with an effective drug control strategy. As Professor David Hawks has argued, ‘The trick for the government is to recognise both abstinence and harm minimisation. Encouraging abstinence is in no way contradictory to harm minimisation’.

The thrust of this section should therefore not be misunderstood. It is to argue for what we describe as rational harm reduction, but alongside and secondary to the primary objective of maintaining drug abuse at the lowest possible levels. It is not, and should not under any circumstances be seen as, an argument against rational harm reduction programs or activities designed to the reduce the spread of HIV/AIDS and Hepatitis C.

There has been a tendency to criticise those who warn against any use of illicit drugs, to imply that they are naive and to mock the concept of total 'abstinence' from illicit drug use as utterly unrealistic. Certainly, any educational strategies and messages must be realistically presented. Nonetheless, we believe that both

government policy and educational strategies should start from the fundamental premise that illicit drug use is wrong, harmful, and to be avoided.

It may be necessary to present this approach differently to different groups, but the fundamentals should remain the same.

1.9 THE REPORT OF THE TASK FORCE ON DRUG ABUSE

No examination of drug issues could fail to recognise the differences between the various drugs as well as the commonalities. One approach to this report might have been to take separately each drug under consideration, develop appropriate thinking and recommendations, and bring together all these sections in a final consolidated report. This approach would, however, have entailed substantial level of duplication. We therefore considered it appropriate to deal wherever possible with either drugs as a whole or drugs within certain categories. We have included some separate substantial discussion on policy and practice in relation to certain drugs (e.g. marijuana, alcohol and tobacco), where there were particular policy issues to be addressed. The absence of a specific section on an individual drug or behaviour should not be taken as any indication that we believe it to be lacking in importance: we have rather sought to incorporate the appropriate discussion and recommendations in the relevant sections of the report.

The aims of the Task Force, as we set out in some of our earlier documentation, have been:

- to identify what the problems are;
- to identify where the problems are;
- to identify what is being done;
-
- to look at experience elsewhere;
- to find out what people around the State think; and
- to recommend overall policies, strategies and structures.

The structure of the report is as follows:

First, having summarised the present extent of drug abuse problems in the State, we present in this chapter the context and the policy premises underlying our approach.

Second, we report on the community's views as they were expressed to us.

Third, we discuss the specific subject areas of drug abuse services, education and law enforcement.

Fourth, we set out a proposed structure, and frameworks for co-ordination and community action.

Fifth, we summarise our recommendations in the form of a comprehensive program.

Sixth, in the second volume of the report we present comprehensive information on drug problems, usage, harm, and the costs incurred, and describe the legislative background.

1.10 SUMMARY OF RECOMMENDATIONS

1. That Western Australia's performance in reducing drug abuse and harm be judged in relation to the lowest levels achieved elsewhere in Australia and in comparable countries.

2. That a WA Drug Abuse Control Strategy be based on the following policy principles:

    - protecting the community;
    - opposing drug abuse;

- rational harm reduction; and
- taking a comprehensive approach.

3. That if the approach recommended in this report is accepted, a review of process and outcomes be conducted after its third year of operation.

2. WHAT THE COMMUNITY SAID

2.1 INTRODUCTION

The consultation process undertaken by the Task Force included a number of activities: written submissions were requested through newspaper advertisements and letters to all State Government agencies and all relevant community organisations; a telephone hotline was established and utilised extensively; meetings were held with representatives of a wide range of organisations, in both Perth and regional centres; public hearings were conducted throughout the State, including a Western Australia Telecentre hearing that enabled participation from the most remote areas; and specific consultations were held with families who had experienced drug abuse, high school students, and adult and juvenile prisoners.

This chapter sets out without any endorsement a selection of the views that were put to the Task Force in the course of the consultation. Some comments made were controversial and some may even have been misinformed; together they do, however, represent the range of community opinion and all merit inclusion for this reason.

The chapter attempts to provide a fair reflection of the full range of views, opinions and suggestions proffered by the Western Australian community. A general summary is followed by a series of regional reports.

The full list of written submissions received by the Task Force appears in Appendix 4. A total of 315 were received from a wide range of individuals and community organisations together with 77 from the telephone hotline. Many indicated a direct involvement with drug abuse whether as service providers or as affected individuals, while many others expressed strong concern as members of the general community.

A considerable number of submissions were received from Government departments, many of which related to internal organisational matters that are not appropriate to include in this context. It should be noted that all State Government departments responded to our request for information; we are appreciative of those who also made submissions.

It is emphasised that in reporting what Western Australians said to us about drug abuse that the Task Force is not endorsing the views outlined. The opinions put to the Task Force were of great value in informing it of various issues and in assisting its analysis and development of the recommendations that are set out elsewhere in the report. In this section the community's views are presented as they were put to the Task Force.

2.2 IS DRUG ABUSE A PROBLEM IN WESTERN AUSTRALIA?

2.2.1 THE GENERAL PICTURE

Almost everyone who spoke or wrote to the Task Force was concerned at the level of drug abuse in Western Australia. The Australian Institute on Alcohol and Addictions (Holyoake) believes that:

> ... problems related to alcohol and other drug use constitute one of the, if not the, major health and social issues affecting the community of Western Australia. The economic cost alone is enormous, the direct costs to the health, justice, and welfare systems are well documented, and more attention is being given to the costs to business; more difficult to quantify, however, are the costs to families and the individuals within them.

Many submissions emphasised the profound indirect impact of drug abuse on families: parents, women and children, siblings and grandparents. The Advisory and Co-ordinating Committee on Child Abuse, for instance, wrote:

> Drug or alcohol misuse by parents can, in many instances, have a profound negative impact on their ability to care for their children, leading to child abuse and neglect. There is a growing awareness that children who have been abused may turn to drug and alcohol usage as adolescents, or when they are older, to deal with unresolved issues from their abuse.

This is a view supported by many comments made at public hearings throughout the State.

The effects of alcohol and other drug abuse extend beyond the family into the workplace and general community. The human resources manager of Drillcorp pointed out in his submission, for instance, that drug use

is a contributing factor in many industrial accidents and can lead to poor work performance and reduced productivity.

2.2.1.1 Legal drugs

It was widely stated, both by professional organisations and the general public, that the biggest drug abuse problems arise from legal drugs: alcohol and tobacco.

Concerns about alcohol abuse were raised again and again at public hearings, both in Perth and in regional areas, as a major hazard for the whole community. The Alcohol Advisory Council of Western Australia submitted recent statistics on the number of deaths and hospitalisations caused by alcohol abuse and the financial costs incurred, but went on to say:

> Of course, all of the statistics refer to people. It is people with families, jobs and commitments, who suffer the ill effects of alcohol. Family breakdown, loss of productivity due to the death or incapacitation of a skilled member of the workforce, social security costs through compensation, sickness or employment benefits, are all economic costs to the community. There is no way to accurately measure the suffering and pain of a long-term addiction experienced by the drinker or the people close to them.

The Western Australian branch of the Australian Association of Social Workers agrees:

> .. (alcohol) pervades the whole of society to a larger or lesser degree and can be found under most 'beds' — domestic violence, public violence, car accidents, poor work performance, financial problems, marital problems, divorce, homicide, mental illness. Certainly, alcohol is not the cause of every aspect of social disease, but it consistently underlies manifestations of many.

C P Brown, a police officer in Bunbury, summed up a common view:

> Alcohol is responsible for so much misery in our society.

The Liquor Industry Council of Western Australia joined in condemning alcohol abuse, partly because it gives the industry a bad name and because of the costs it imposes on the industry. But only a minority of drinkers, the Council maintains, abuse alcohol.

In defence of alcohol, the Distilled Spirits Industry Council of Australia maintains that alcohol is a valid part of the Australian way of life that offers many benefits, including the protective effect on the cardiovascular system of moderate drinking. The Council claims that by world standards Australians are moderate consumers of alcohol, and that Australia leads the world in reduced alcohol consumption.

Concerns about tobacco were raised with less frequency and vehemence than alcohol. This may have been due to awareness that there has been a reduction in the prevalence of smoking in recent years since the Quit campaign and other anti-smoking initiatives. The Headmaster of Guildford Grammar School wrote as follows:

> Experience at this school shows that fewer and fewer boys are smoking. The majority consider it a stupid habit and those that indulge in it are often frowned upon by their peers. This would be the result of the extensive anti-smoking publicity campaigns and the school's own anti-smoking policy, which is both educational and punitive in nature.

Other submissions warned that Western Australians must be careful to avoid complacency about smoking. The Australian Council on Smoking and Health pointed out that smoking is still the largest single cause of preventable disease and premature death in Australia, adding that 25% of adults in Western Australia are smokers, the majority having taken up the habit as teenagers. Murray Gomm, Albany Community Liaison Officer for the Cancer Foundation of Western Australia, drew attention to the costs associated with tobacco use: more than $6,800 million per year, compared to $1,500 million per year for illicit drug use.

Pharmaceutical drugs were also raised as being subject to abuse. The Pharmaceutical Council of Western Australia made a submission covering a number of matters of concern to pharmacists who dispense drugs on prescription or over the counter: sedatives being used to quieten infants; high school children taking quantities of travel sickness and anti-histamine tablets, often with alcohol; excessive use of laxatives to lose weight, especially by young girls and women; use of bronchilator and asthma sprays to enhance sporting performance; and excessive use of pain killers, especially paracetamol.

Mrs L M Harding is one of a number of people worried about over-prescription of drugs:

> I am personally convinced of the problems associated with amphetamines and benzodiazepines to the point where I consider that these drugs should be on the restricted list.
>
> In the case of benzodiazepines, doctors are still prescribing these drugs for long periods of time, and to people who need to work through their pain/grief/sleeplessness and so forth, not drown it in a haze of medications which do nothing to rectify the initial problem.

A District Nurse from a small country hospital phoned the Hotline to talk about her own concern:

> GPs in our country towns have told us that they are running a business, and if they don't give patients what they ask them for they don't get patients; the patients will go to another GP to get what they want, so it doesn't make any difference.

The Residential and Community Care Advocacy Service is particularly concerned about a perceived over-prescription of tranquillisers such as benzodiazepines for people in residential aged care; they believe they are being used to make it easier for staff to manage people and keep them quiet, in spite of adverse effects such as confusion, unclear thinking, loss of balance, personality changes and incontinence.

The submission from the Western Australian Faculty of the Royal Australian College of General Practitioners was critical of the opportunities offered by the present system for people to go doctor-shopping, whereby people move from one medical practitioner to another, repeating their story and collecting prescriptions for drugs.

2.2.1.2 Illegal drugs

John Duxbury, a police constable, drew attention to the link between illegal drugs and crime:

> Society is so overwhelmed with the drug problem that it is no longer recognised as the basis of such a great number of other problems within our community. Houses and business premises are being broken into every day for the purpose of financing people's drug addictions. Additionally, cars are being stolen at a furious rate, and are being used as payment for drugs. People are making and growing their own illegal substances in suburban residential areas.

Major General K J Taylor AO is also alarmed:

> When aged and frail grandmothers are knocked to the ground and robbed by youths seeking easy ways to feed their drug habits, it begins to be clear that the drug scene has caused massive changes in our culture and our way of life. It is time to say STOP!

A mother pointed out that drug abusers are themselves trapped in a cycle of despair:

> Most robberies, breaking and entry into shops, homes etc are because these people have no jobs and need money to obtain their drug supplies. I can truly say that neither of my boys has stolen for the fun or excitement, but only in desperation to feed a drug addiction.

An ex-addict wrote movingly of the impact of long-term drug abuse on her mind:

> There is no way to fix up your health when it has gone as far as my health. The whole time I used heroin all I did was nod off into the land of bliss where I could block out whatever was hurting me. When I used speed, the damage left on me was severe; it has left me very anxious and prone to paranoia. The use of LSD has similar effects, and the constant daily smoke of pot for ten years has left me with a very lazy attitude; it is very bad to use and there are times that I feel bad tempered. It often gets me angry when someone says to me 'What have you had today?', when I have not used a thing, because I am talking slowly. All drugs bend and damage your brain.

On the other hand, a substantial number of submissions maintained that many of the problems associated with illegal drugs arise less from the drugs themselves, but from the very fact that they are illegal and therefore uncontrolled. They argued that the link with crime, for instance, might be due to artificially high drug prices, and the damage to health exacerbated by the sale of impure substances.

2.2.1.3 Specific illegal drugs

A wide range of views was expressed to the Task Force on the subject of cannabis/marijuana. Some submissions advocated its benefits as a relaxant and pain-killer, and Rob Pensalfini maintained that:

> the social and personal ill effects of even extremely heavy marijuana use have been convincingly shown to be negligible.

Others are appalled at what they see as growing acceptance of a very harmful drug. Geraldine Mullins, Beth Stanley, and Elaine Walters all made lengthy submissions describing damage caused by marijuana to physical and mental health. They regard cannabis, moreover, as a 'gateway' drug because the majority of people who use amphetamines or narcotics have previously used cannabis.

Many people who attended the public hearings took a middle position: they perceive marijuana as a lesser evil than heavy drinking or amphetamines. It was often said that yes, marijuana is easily available and widely used, but no, it wasn't such a problem in that it doesn't lead to violence.

One theme that almost everyone agrees on is the extent to which cannabis is being used. Mrs Britt McGowan, Principal of the Bunbury Catholic College, wrote that:

> .. marijuana is now so widespread that it has become a de facto legal drug.

The vast majority of people who responded to the Task Force do not look with favour on any use of amphetamines; the common perception is that they are harmful to the user and conducive to risk-taking behaviour. There was one exception, a 44-year-old businessman and father who wrote:

> I and many of my friends, who are also professionals, are social users of amphetamines. We prefer the use of amphetamines to alcohol as the side effects, both mentally and physically, are far less damaging. None of us has ever felt the need to be violent or steal cars or drive recklessly while using amphetamines. I have been using amphetamines for 20 years and feel no physical dependency.

While narcotics were raised much less frequently than other types of drug, it was made clear that those who abuse them face very serious problems — and that anyone close to them is likely to suffer as well.

2.2.2 SPECIAL CONCERNS — YOUNG PEOPLE

The most common theme at hearings held by the Task Force was deep concern at the use of drugs by young people. The same theme recurred in many written submissions: from parents, teachers, individuals, and groups throughout the community. The Australian Family Association reflected the perception of many others:

> The past 10 years or so have shown an increase in the number of youth taking drugs ... The effects of drugs on adolescent bodies is more devastating (than on adults) as they are still developing.

A particular worry is the early age at which young people seem to be starting to use alcohol and other drugs. Margery Roberts wrote:

> The problem with waiting until children turn 16 before taking action to combat drug use is that by then most have become entrenched in the drug culture. Most of the children I came into contact with had been experimenting with drugs since they were 12 or 13 years of age (some even younger).

Mrs L M Harding, a social worker, is less concerned about when the drug taking starts than with what the children are taking:

> In our work with young people I see widespread experimentation with a range of drugs which occurs in the 10 - 20 year age group. The youngest person I know of who has experimented with drugs was an eight-year-old with solvents. This is not new. When I was about eight I experimented with tobacco ... The message is that drug taking is not new, neither is it the province of late teens and early 20s ... What is new is the variety of drugs available.

Sharon, a former drug abuser now 19 years old, confirmed Mrs Harding's experience:

> I have been actively involved in the rave scene, nightclub scene and casual all-night parties at which various drugs such as MDMA, acid and speed are readily available to people and children, in my case at 14.

Further evidence came from the Parents and Friends Federation of Western Australia, which arranged a series of meetings with students, staff and parents from Catholic secondary schools in the metropolitan area. The students said that alcohol and cannabis were always available at parties; amphetamines and LSD were also used, but were not as readily available because of the cost. They added that alcohol and marijuana were socially acceptable and used openly, whereas amphetamines and LSD were used more secretively. Drug use typically started in Years 9 and 10, the students said, although they insisted that not all teenagers were involved.

The Youth Justice Coalition (Western Australia) membership includes persons responsible for legal education sessions/workshops in schools. It reported that by Year 9 students have much greater familiarity with alcohol and cannabis than in Year 8. The Youth Legal Service further reported from sessions held with at risk, offending and unemployed youth, that there was widespread use of alcohol, cannabis and other drugs among these young people.

2.2.2.1 Alcohol

Despite parental fears of their children becoming involved in illegal drug use, most organisations working in the area see the main danger as lying elsewhere. Holyoake wrote:

> There remains a perception in the community that illegal drugs are the major problem with young people, however, the most harm to the most number of young people is as a consequence of their alcohol consumption, usually in the form of binge drinking.

The Perth City Mission agrees; its submission pointed out that 50% of the clients at Yirra, its residential facility for youth, are there because of alcohol abuse. At the hearings, too, excessive alcohol consumption by youth, particularly binge drinking, was raised again and again throughout the State. People are particularly alarmed at the tendency of young people to drink spirits, or as concerned hotel owners often put it ‘drinks off the top shelf’; Bourbon whiskies were frequently mentioned as being the preferred option.

Dr Hugh Cook, Child and Adolescent Psychiatrist at Princess Margaret Hospital, believes there may be a connection between excessive drinking and youth suicide:

> Children and adolescents who attempt or complete suicide are now frequently legally drunk. Drink may be associated in some adolescents with depression and may also contribute to impulsivity leading to suicidal behaviour.

A matter of grave concern to many is the trend for young people to mix alcohol/marijuana/pharmaceutical preparations/amphetamines in a potent and sometimes lethal ‘cocktail’ of drugs.

2.2.2.2 Illegal drugs

There is general community agreement that the illegal drug most commonly used by young people is cannabis. This view is supported by the Health Consumers Council:

> In Western Australia the pattern of arrests (4,553 arrests on marijuana related offences in 1993), the current literature on drug use in Western Australia, and anecdotal evidence would suggest that thousands of young people are using marijuana.

Drug-Arm Western Australia agrees:

> Among the youth we mix with, marijuana is unfortunately almost boringly common.

Many are alarmed at a perceived increase in the use of amphetamines (often referred to as speed) by young people. Holyoake considers that although alcohol causes the most harm overall:

> .. it remains a concern that the use of amphetamines (usually injected) is becoming more popular with a small but growing number of young people.

Drug-Arm Western Australia confirmed the trend to amphetamines:

> Increasingly, speed/LSD are becoming common. One of our sources from the streets stated a few days ago that the main drug used in their circles was speed. Speed was being 'mainlined' (intravenously injected) from the age of 14.

In its submission to the Task Force, the Western Australian AIDS Council reported that the average age of intravenous drug users recently dropped by almost three years, indicating that many more young people were injecting drugs than ever before. The Injecting Drug Use Initiatives Group discussed groups causing concern in the area such as Aboriginal youth, homeless youth, young offenders and first-time users.

2.2.2.3 Other substances

The Australian Association of Social Workers raised over-prescription as a youth issue:

> Another concern is the number of high school students being prescribed anti-depressant medication. A recent survey of Year 12 students in one high school showed that 40% of the group were on anti-depressants and this is excessive.

Solvent abuse such as petrol, paint and glue sniffing was raised from time to time at public hearings and meetings in regional centres. It was seen as being largely sporadic and localised, though a matter of serious community concern when it does occur. The practice was seen to be largely confined to children and young adolescents, being regarded as unacceptable by older teenagers.

2.2.2.4 Lack of awareness

Mrs Susan Warner believes that young people are not aware of the consequences of their experimentation:

> Young people don't realise how much their behaviour/judgement is impaired by a small quantity of drugs/alcohol.

Jen Barnard works with troubled young people, many of whom have been severely neglected and abused. He wrote:

> I see that most of my students are involved in substance abuse, not just Toluene or alcohol, but other substances like speed ... These young people are not admitting to the fact that they have a problem. In fact, they feel they are having a good time, or as one of my pupils put it 'wicked dreams'.

2.2.2.5 Sources of supply

The Parents and Friends Federation reported that all three groups it surveyed — students, staff and parents — agreed that the main sources of illegal drugs for young people were older brothers and sisters, peers/friends with access to drugs, young people who act as intermediaries between them and the suppliers, and the suppliers themselves. This confirmed what was said at the hearings.

Many people also expressed their anger and dismay at the apparent ease with which under-18-year-olds can obtain alcohol — either directly from liquor outlets or by paying others, including taxi drivers, to procure it for them. It was often said that some parents supply young people with alcohol or the money to obtain it.

2.2.2.6 Parents

Many parents of young people involved in alcohol and/or other drug abuse telephoned or wrote to the Task Force, or spoke at hearings, about their experience; many of them expressed great personal anguish. Geraldine Mullins echoed the distress felt by many when she wrote about:

> .. the sadness, .. the loss of expectations, the hopelessness and the fear of what the future will bring for our 'misfits' in society.

Parents are sometimes overwhelmed with having to cope with the practical problems of dealing with children who are out of control. One mother wrote as follows:

> I have two teenage children who have both used and abused drugs. As one of my children also engaged in criminal activities, it became very difficult to manage the family — in fact the family broke up. It took two years before I had the sort of help which enabled me to make some sense of the situation and cope to some degree.

Another mother wrote that most parents regard the 'system' as a whole as a failure, because it excludes them and makes them feel that they are to blame for their children's problems, often without offering any real support. A number of similar submissions said that it should be recognised that many young people who abuse drugs come from caring families who should be supported, not criticised, and that their role as guardians should be respected, not undermined.

The consultations conducted on behalf of the Task Force with families who had been affected by drug abuse strongly echoed the themes raised above. Many of these families felt disempowered by bureaucracy and frustrated in the search for effective assistance. The report of these consultations, including the breadth of change that the families consider desirable, is set out in full in Appendix 6.

2.2.3 OTHER SPECIAL CONCERNS

In addition to youth, a number of other groups were singled out for discussion.

2.2.3.1 Women

Women's Health Care House estimates that about 7,000 women in Western Australia have an alcohol dependency and that approximately 34,000 women are at risk of developing a dependency on prescribed psychoactive drugs. The Centre provided some interesting statistics:

- More than 500,000 scripts for minor tranquillisers are written per year for women in Western Australia;
- 30% - 34% of women using tranquillisers are addicted to them; and
- minor tranquilliser prescriptions given to women for stress, anxiety and sleep disorders account for 67 - 72% of overall prescriptions issued.

Ms Libby Lloyd, from the Centre for Women's Health at King Edward Memorial Hospital, reported that the number of women using drugs during pregnancy seems to be increasing.

Yet women are apparently reluctant to come forward for treatment. The Western Australia Council on Addictions (Cyrenian House) reported as follows:

> .. a West Australian tendency for only 30% of people in treatment for drug issues to be women is mirrored in both national and international figures. The influences that inhibit women from engaging in treatment are undoubtedly complex, but a certain outcome of this reservoir of unattended problems is the deleterious effect on the children and the viability of family life.

Sister Glenys of Centacare in Bunbury told the Task Force that she thought it was a profound sense of shame that prevented many women from coming forward for treatment.

Joan Last-Kelly, also of Centacare, carried out a study in Bunbury that showed women to be reluctant to seek help even when struggling to cope with the drug problems of another member of the family, such as a husband or child; apparently they feel they should be able to solve the other person's problem and that they have somehow failed if they cannot. Ms Last-Kelly came to the conclusion that the impact on their self esteem and general wellbeing can be crushing.

2.2.3.2 Aboriginal people

The particular problems faced by Aboriginal people in relation to drugs were raised at many of the hearings and meetings held at regional centres, although not often referred to in written submissions. The submission from the Kimberley Aboriginal Medical Service was an exception. It referred to the situation of Aboriginal youth in Perth:

> As we know, many of the Perth Noongar Aboriginal kids are confronted with serious problems in regard to alcohol and drug abuse. Loss of one's culture leads to loss of identity, to poor self esteem

> and self image, hence self destructive behaviour. It is believed by many semi-traditional Kimberley Aboriginal people that inner city Aboriginal youths are the 'lost souls' torn between two worlds, that of the black and white societies.

The regional reports that follow this general summary convey views relevant to Aboriginal people as expressed at hearings and meetings.

2.2.3.3 Children in homes where drugs are abused

Andrew, a prison inmate and former drug abuser, summed up the impact on children of growing up in a home where drugs are abused:

> The young children of families where parents are addicted to drugs miss out on the finer pleasures of life. To an addict, life revolves (as per his/her perceptions) around the substance to which he or she is addicted. Those substances are obtained all too often to the detriment of the children. Mum or Dad goes to gaol, the rent does not get paid, there is no food this week, no new clothes, no toys, no books, the TV has to go to the hock shop. These children have no security, their lives are constantly being turned upside down, while they are being pushed from pillar to post. The children of single mothers who use drugs are in a very dangerous position. I have seen such single mothers allow total undesirables into their homes and around their children, just because these undesirables have got or can get drugs.

Many others expressed similar sentiments both in written submissions and during regional visits.

2.2.3.4 Hyperactive children

A number of submissions were critical of the trend towards prescribing medication for hyperactive children diagnosed as having Attention Deficit Disorder. The Australian Association of Social Workers was one:

> Of concern is the number of youth, as young as six years of age, being prescribed medication for Attention Deficit Disorder. Western Australia has a particularly high number of young people on this medication in comparison with overseas numbers, and this is concerning as a trend to make parenting less stressful. No long-term study on the side effects or the addictive nature of the medications has been done, nor has this practice been challenged widely.

The Western Australian Branch of the Australian College of Paediatrics takes a similar position:

> We are especially concerned about the possible misuse of prescription drugs, in particular the stimulant medications utilised for improving concentration and control of behaviour in the classroom. It is our belief that there is an inappropriately high demand for this form of therapy in Western Australia, compared to other States, with a tendency to neglect alternative forms of management. As well as posing health risks for children, this creates unrealistic expectations of drug therapy and, we believe, a too ready acceptance of drugs as a solution to problems.

Nola Hosking, a teacher of mildly mentally handicapped children, wrote from personal experience:

> The difference a small dose of Ritalin makes to a hyperactive child who needs it, is quite incredible. It turns a raging monster into a happy child who will listen and comply with simple instructions that are necessary to his welfare and the welfare of others around him. However, I do not believe that some of the children to whom I have had to administer this drug really need it. Quite often, I am sure that it is the parent who cannot control the child, rather than the child who cannot be controlled. The latest words from a parent that really shocked me came just last week, 'He's on anti-depressants now, and they are making him high, so he might have to have Ritalin, as well, to bring him down,' she said.

Although most submissions on this issue expressed concern at the extent of diagnosis of Attention Deficit Disorder and the prescription of drugs for its treatment, some such as those from the Learning Attention Disorder Society and Dr Melvyn Wall presented a contrary position. As Dr Wall pointed out, the most conservative estimates of the prevalence of Attention Deficit Hyperactivity Disorder are between 2% and 5% of the child and adolescent population and the disorder is a major precursor of juvenile criminality and drug abuse. He argued that there is no evidence of over-prescription of medication in Western Australia and that the

substantial recent increase in diagnoses and pharmacological treatments is a result of greater community awareness, more paediatricians, and the frustration of parents unable to gain access to other services.

Dr Wall noted, however, that:

> it would be freely admitted that a significant number of children are placed on psycho-stimulant medication following appropriate diagnosis, who otherwise would be managed without its use. However, where there are no available facilities or services (educational in particular) which will provide for the needs of the child, the only appropriate and available treatment is psycho-stimulant medication. The consequences of non-intervention in these cases, could be grave indeed for the child ...

2.2.3.5 Injecting drug users

There seems to be general agreement that injecting drug use is on the increase. The Western Australian AIDS Council estimates that the number of injecting drug users (IDUs) in Western Australia is between 6,000 and 25,000, with substances being injected including heroin, morphine, methadone, Ecstasy, amphetamines, and minor and major tranquillisers. According to the Council, the practice is not confined to highly urbanised areas:

> Geographical data refute the commonly held belief that IDUs tend to be inner city dwellers. This sub-population is evenly spread both throughout the metropolitan area and through rural and remote areas of Western Australia.

The Western Australia Branch of the Pharmacy Guild of Australia reported a change in the typical pattern of injecting drug use:

> Anecdotal evidence supplied by members ... indicates a significant change in the user population of the syringes. Previously, the population comprised hardcore addicts; however, there is an ever increasing trend in sales to more affluent social (recreational) users and teenage weekend users. The trend tends to indicate that among the social users there is an increased acceptability of injectable substances ... during their social outings.

There is much concern among health professionals about the likely spread of HIV and Hepatitis C that may result both in the general community and in groups such as the prison population.

2.2.3.6 Drug abuse and psychiatric disorders

The Royal Australian and New Zealand College of Psychiatrists drew attention in its submission to the link often found between drug abuse and psychiatric disorders:

> All drug abuse is likely to be attended by abnormal behaviour and frequently psychiatric symptoms. Many drug abusers progress to drug-induced psychiatric conditions requiring psychiatric treatment. Furthermore, many individuals with pre-existing psychiatric conditions abuse either or both alcohol or other drugs, producing 'co-morbidity', often largely unrecognised and requiring urgent psychiatric intervention.

Dr Hugh Cook reported on the co-occurrence of amphetamine use and psychiatric disorders:

> The use of amphetamines by the young is now relatively common and young people who have suffered a psychotic breakdown have quite commonly been exposed to these drugs. It may be quite difficult to decide whether the psychosis is caused by the drugs (usually amphetamines) or whether the use of the drug is secondary to the onset of a major psychiatric illness such as schizophrenia.

Dr Cook is less worried about the possible danger to mental health posed by cannabis:

> Our experience is that marijuana used socially is no more likely to be associated with mental health problems than is, for example, alcohol.

The Australian Association of Social Workers is concerned about the treatment implications:

> It is recognised that although there has been some improvement over the last couple of years, there are still many problems when working with people who have the dual problem of a psychiatric

> illness and also drug problems. The problem of people being shunted from one service to another is still occurring.

The issue is a very practical one for the Bridge Programme run by the Salvation Army:

> We are finding the number of clients presenting with psychiatric disorders as well as alcohol and drug issues is on the increase. This poses a real dilemma for us, as we do not have any staff who are qualified in psychiatric diagnosis.

2.2.3.7 Non-drug addictions

Jeff Moss, a professional health worker, made a submission on the importance of addressing non-drug addictions:

> The development and/or maintenance of many drug related problems and drug addiction patterns in Western Australia are connected *inextricably* with the occurrence of other addiction behaviours in which psychoactive drugs are not the focus. Common non-drug addictions in our culture include people relating addictively to food, gambling, work, exercise, sexual activity, and other people. The links between the two areas can be both complex and profound. A substantial proportion of the large number of women who use food addictively, for example, come from families in which one or both parents use alcohol addictively.

This matter was raised at the hearing held in Warwick, where a number of people asserted on the basis of personal experience that there is a strong link between drug and non-drug addictions.

2.2.4 CONTRIBUTING FACTORS

A topic frequently raised at hearings and in written submissions was the vexing question of why people engage in drug abuse when it is so evidently self destructive and damaging to those close to them. As the National Council of Women put it:

> .. to effectively combat the rapid spread of licit and illicit drug taking we need to know WHY. Until we unearth some of the reasons why people resort to recreational drug taking, efforts to combat the devastating effects will never be more than bandaid treatments.

Generally speaking, people recognise that the reasons for drug abuse are complex and interactive, creating a motivational pattern that is unique to each individual. Some common contributing factors identified to the Task Force are discussed below.

2.2.4.1 Experimentation

Alcohol and other drug use is seen as beginning, very often, as an experiment with something that is new and forbidden — and therefore exciting. Most do not regard such activity as necessarily putting young people on the path to destruction. The Waratah Support Centre presented a fairly common view:

> While we believe that most young people experiment with drugs and alcohol, it is also our belief that children who are usually happy and well adjusted will not find it necessary to maintain drug use after experimentation.

The Youth Justice Coalition believes that a good deal of cannabis use is experimental in nature:

> .. the overwhelming proportion of drug offences that young people who present to the Youth Legal Service (YLS) are charged with relate to the possession of marijuana (60%). Of these young people, the vast majority cited to YLS that they were merely experimenting with marijuana, or were occasional social users. YLS staff noted that most of these young people did not perceive themselves to be, nor presented as, people who were experiencing or struggling with major difficulties in their lives.

2.2.4.2 Peer pressure

Many said that young people are urged to experiment with alcohol and other drugs by their friends and acquaintances. The Parents and Friends Federation wrote:

> ... the opinion (of the meeting) was that first drug use starts around Year 9 to 10, when parental supervision of social activities seems to be declining and young people are seeking expressions of independence. Peer pressure is also a factor ... Male use was linked to 'macho-ness' and peer pressure, whereas females felt they were under less pressure and found it easier to say 'no' to drugs.

Ian Dawson of the Australian Parent Movement feels that peer pressure puts students in a stressful position:

> There are many students who refuse to accept illicit drug experimentation and are often forced to say no to daily drug propositions.

The Youth Justice Coalition's submission explained how experimentation and peer pressure can interact:

> The experience of young people who the Youth Justice Coalition have contact with is that very few had initially deliberately sought out illegal drugs to use ... In most cases, they had come across small groups of friends or an older sibling using illegal drugs in a social setting, and participated out of sheer curiosity. It is interesting to note that a number of these young people have stated they felt obliged to participate as they feared that if they did not participate and the group were apprehended by the police, they would be perceived as the person who 'dobbed'.

2.2.4.3 School stress

School has always been a stressful experience for some young people, but many feel the level of stress has been exacerbated in recent years by pressures on young people to achieve high levels of academic success. The Youth Justice Coalition summed it up well:

> According to many of the young people and parents that members of the Youth Justice Coalition have contact with, the secondary school system is a source of great stress, particularly for those students who require individual attention, with learning difficulties, under achievers, and those who are experiencing instability and difficulties outside the school environment. Constantly reminded by teachers, parents and the media of the need for high levels of academic achievement, young people feeling inadequate and stressed by this unrelenting pressure seek solace through interludes with alcohol and drugs on the weekends.

A submission from the students, parents and staff at the Port Community High School suggested that many schools undermine young people's sense of self esteem:

> The main problem with high schools is the degree of stress and alienation that is generated by the huge size of the school which leads to students being treated as non-people. The pressures to perform and conform, together with parental expectations and unfair treatment by teachers, is just too much for many students when combined with the emotional turmoil of hormonal changes and the genuine lack of power or control over their own lives which many students experience.

2.2.4.4 Family stress

Ideally, young people should find their greatest support and encouragement within their family. A considerable number of submissions and comments to the Task Force indicate that this is not always the case. The Swan Emergency Accommodation Substance Abuse Project reported that:

> ... those most likely to be affected (by drug use) are those isolated from family networks, be it physical or emotional isolation. Young people in this category are the ones most likely to develop problematic drug use. At times it is difficult to detect those who are emotionally isolated from the family. A young person may be living at home, with everything appearing to be OK, but be experiencing emotional turmoil or trauma.

The submission by the Youth Services of the Uniting Church pointed out that many well-meaning parents may unwittingly aggravate their children's experimental drug use:

> ... the necessary adolescent developmental processes, which will include exploring and experimental use of licit and illicit substances, will frequently stress parents and result in distorted communications. Those parents experiencing adolescent usage which arises from stress and

> dysfunction in the family or related circles will frequently undertake strategies which exacerbate the problems, such as calling police and removing welcome from the home.

The same submission acknowledged the difficulties faced by parents today, referring to:

> ... the culturally naive parent blaming which characterises much public discussion and policy ... In many respects, parents have significantly limited powers in the upbringing of teenagers.

A theme that emerged over and over again during the consultation was that drug abuse (as opposed to experimental use) is often the means of escaping from a painful reality. The Australian Association of Social Workers put it like this:

> Sometimes, substance use by adolescents is experimental and developmental and they often do not develop addictions as they have their inner personal resources to counteract the impulsive pleasure seeking instinct. Sometimes, for children who have experienced unresolved pain in their lives, substance abuse may be more than experimental or 'recreational'. It may be the escape from reality which they have learned to see as the only solution to their pain. These children may lack the inner personal resources needed to guide them safely through this stage. It is the family that is primarily responsible for helping children to develop their inner personal resources.

Many people spoke at hearings about parents not understanding the need to communicate openly with their children and build their sense of self esteem or self worth over the years.

Jen Barnard wrote about the extremely troubled young people whom he teaches:

> They are caught up in backgrounds which resemble Bosnia, and entangle them in emotional issues which leave them resembling post-traumatic victims of war.

Margery Roberts believes that the absence of a good father figure puts boys at special risk of falling into drug abuse:

> My observation in the case of all the juvenile addicts with whom I have come into contact has been that in almost every case the addict has extremely low self esteem, paired in the case of male addicts with either no male role model, or a poor relationship with his principal male role model.

Brett is another prison inmate who used drugs as an escape:

> I am 22 years of age and have been using speed and heroin since the age of 13 years; at this age I was what you would call a street kid. Some people don't want to turn to drugs but they have to, just to escape what is going on around them, this could be anything from abuse to constant family fights.

Perhaps most likely to be damaged by the family situation are young people growing up in families where drugs are being used by their parents. As Andrew, a prison inmate and former drug abuser, explained, a tragic cycle is established:

> For the children of an addict, they are already growing up with a distorted view of life. Without the cushion of a properly functioning family to learn from, these children grow up lacking many of the basic skills of family and home life. The drug mentality is passed on from parents to children, elder siblings to younger ones, and in some cases from children to parents.

2.2.4.5 Boredom

Many complaints were made to the Task Force, most often from people living in regional centres and the outer metropolitan area (see the various Regional Reports), about the lack of activities for young people. It is thought that boredom is a powerful force that pushes many young people into taking up drugs. The Youth Justice Coalition discussed the matter at some length in its submission:

> Boredom is the most frequent reason given by both young people and their parents to members of the Youth Justice Coalition, explaining the young person's use/misuse of drugs. Across the metropolitan area, school students repeatedly report that because of financial constraints they have little access to activities that are of interest to them.

> While boredom is a significant problem for school students, it appears to be a more poignant issue for unemployed young people without the financial means to access appropriate recreational activities.

Mrs M A Ryan sees isolation caused by inadequate public transport as a significant factor, and one that affects not only young people:

> All this means that any of us in Ballajura who do NOT drive — the young, the old, the one-car family, the mum with kids — can get bored and frustrated, and turn to drugs and then the problems start.

The submission from Youth Services of the Uniting Church confirmed Mrs Ryan's complaint about the inadequacy of services and facilities for young people in Ballajura, adding:

> Other suburbs reflect similar stresses. Each corridor of Perth has had rapid development without planning for the social and developmental needs of young people and without planning for the tasks that are not able to be undertaken by parents outside the front door of home.

The Willetton Youth Community Connection is similarly concerned:

> The organisation has grave concerns about the lack of facilities, other than sporting, that are available in this area to young people of all ages. The Willetton Youth Community Connection is of the view that this lack of community infrastructure is a major factor, along with an inadequate cross suburbs transport system, in young people congregating at local shopping centres and ovals, often leading to complaints to police and local government authorities.
>
> Anecdotal evidence presented at Willetton Youth Community Connection meetings suggests that young people are indulging in alcohol and amphetamine abuse often due to boredom. The Committee has in the past 18 months learned of the tragic deaths of two young local men in their late teens who died from drug overdose (in telephone boxes). Such instances of late are all far too common!

Youth Services of the Uniting Church referred to the same phenomenon of young people congregating in suburban public places:

> 'Parking problems' have been widely identified in Perth. This does not mean cars. It means reports of young people congregating in parks to talk, drink alcohol and smoke dope. Public concern has been raised on this issue in Duncraig, Leeming, Shenton Park, West Leederville, Subiaco, Langford, Willetton, Fremantle and many others. In the absence of adequate venues and relationship opportunities in central and suburban precincts many young people have no choice.

2.2.4.6 Unemployment

A point frequently made to the Task Force has been that unemployment, or the prospect of unemployment, makes people much more vulnerable to alcohol or other drug abuse. The Reverend Frank Roe from Esperance wrote:

> .. from our observations, the lure towards over consumption of alcohol is a very great one for people in financial distress or unemployment.

Simone Dyer, Co-ordinator of the Local Initiatives for Teenagers Program in Forrestfield, pointed out that employment has a major impact on a person's self esteem:

> Jobs for young people is the MOST IMPORTANT issue. Employment is about more than 'keeping kids off the streets' and giving them something to do — a job equals power over your own life, independence, choice, respect, a valued place in the community. If young people have this opportunity the need for escapism via substance misuse is negated.

Mrs Lorraine Paget agrees:

> I feel it really is necessary to get to the bottom of the problem — the cause, that is low self esteem brought about by unemployment. Unfortunately, after many job rejections our kids begin to feel worthless and it doesn't take too long before all their aspirations are dashed, with no job and no satisfaction from the short term fix, namely traineeships. After a time they find the dole becomes a way of life and associate with other people in the same situation — all depressed from one rejection too many — and thus the drugs become a crutch to dull the rejections and lost aspirations.

2.2.4.7 A rapidly changing society

The Youth Justice Coalition maintains that in order to understand what drives young people to drug abuse we must look beyond their immediate personal situation:

> Responses aimed at the prevention of drug abuse within the community will have little relevance and impact if they are not developed with an explicit appreciation that the phenomenon of drug abuse occurs within a much broader social context. To prevent drug abuse the social, cultural and economic conditions within society which bring about the demand for drug abuse must be recognised and acted upon. Australia, as with other western industrialised societies, is undergoing rapid social, economic and cultural change.

Young people, argued the submission from Youth Services of the Uniting Church, are particularly susceptible to the community stress created by rapid change. The submission offered a quotation from a speech delivered by Richard Eckersley to a National Youth Workers gathering in Canberra in 1993:

> The young are particularly susceptible in the uncertain culture of our times; they are the miners' canaries of our society. They face the difficult metamorphosis from child into adult, deciding who they are and what they believe, and accepting responsibility for their own lives. It is a transition best made in an environment that offers stability, security and some measure of certainty. Adults are to some extent 'cemented' into their lives by jobs and families; their values and beliefs are set. For youth, this is not the case — or should not be. They should be exploring, reaching out, finding out — determining their identities and values, finding their way in life. Yet modern Western culture, for all the complexity of our way of life, offers no firm guidance, no coherent or consistent world view, and no clear moral structure to help them make this transition.

2.2.4.8 A drug-taking culture

As the Australian Association of Social Workers wrote:

> Cultural attitudes condoning inebriation and other forms of impulsive, hedonistic behaviour are deeply ingrained in our social institutions and behaviours and encouraged in our modern communications and entertainment media. In our modern commercial world we are actively encouraged to avoid pain by seeking pleasure through consumption of goods, substances and experiences.
>
> Those parents and teachers who try to counteract this commercial influence are fighting an uphill battle and we can expect the children will grow up confused if they hear one thing (at home and school) and see another (in the streets and socially).

Simone Dyer put it less formally:

> As long as we continue passing on messages that 'some drugs are OK', by Mum swallowing a Valium to relieve stress, and Dad having a beer or two when he watches the footy, and older sister smoking and little brother being given a Panadol when he has a headache (excuse the stereotypes), our young people will be confused about what's acceptable and what's not. How do you tell a 14-year-old who has learned to take amphetamines regularly to control his ADD that now its not OK to do speed? We promote some drug use. I certainly don't advocate the prohibition of all (or necessarily any) drugs, but I believe we must be aware that as a society we normalise drug use.

Mrs E Hope believes that the problem begins very early:

> I sincerely believe that drug abuse starts with tiny little babies being given antibiotics when they are not only unnecessary, but also extremely harmful.

Alcohol, in particular, is seen as a ubiquitous feature of Australian life. It was mentioned again and again at public hearings, especially in remote areas, as being regarded as essential to virtually any social occasion or event. The Mayor of Port Hedland, Dr Alan Eggleston, said 'Nowadays, if you go anywhere at all in the North-West people don't offer you a cup of tea, they offer you a can.'

2.3 WHAT SHOULD BE DONE?

2.3.1 GENERAL APPROACH

Before proceeding to outline community opinion on the three broad ways in which we can try to influence drug abuse — treatment, prevention and control — we should reflect the range of views expressed to the Task Force on the general approach that should be taken and what the priorities should be.

2.3.1.1 Harm minimisation — for and against

The Health Consumers Council began its submission with discussion of harm minimisation as defined in the National Drug Strategy 1993 - 1997:

> Harm minimisation is an approach that aims to reduce the adverse health, social, and economic consequences of alcohol and other drugs by minimising or limiting the harms and hazards of drug use for both the community and the individual without necessarily eliminating use.

The Health Consumers Council went on to express its support for harm minimisation:

> Any comprehensive approach to drug use management must be based on harm minimisation principles which are clearly based on logic and the best interests of the community and individuals.

The majority of non-government organisations that made submissions to the Task Force support harm minimisation. The Injecting Drug Use Initiatives Group, for instance, wrote:

> The Group does not condone the use of illicit drugs, but recognises that for those people who choose to inject there need to be certain support structures in place which will minimise the harm associated with injecting behaviours.

A number of groups and individuals, however, have doubts about the value of harm minimisation. The Barrows Foundation is one of these groups:

> ... in relation to illicit drugs, the National Campaign Against Drug Abuse, based as it is on the objective of 'harm minimisation', has failed.
>
> Harm minimisation enables 'official' literature distributed by the Western Australia Alcohol and Drug Authority to advise the public that 'drug taking does not necessarily constitute a danger to health'.
>
> Harm minimisation allows a Curtin University associate professor to claim, 'No drug, no matter how bad its reputation, cannot be used wisely and well'.

An anonymous submission was equally critical:

> 'Risk minimisation' is a carefully orchestrated approach which suggests we have given up on the hard fight — we will always have this problem, let us do something about minimising the effects of the problem. Giving out free needles and placing container boxes out in the public for drug users to place their needles in is an acceptance of abnormal and wrong behaviour and does nothing to protect the innocent, naive, impressionable youth or upright citizen; rather, it is an affront to our senses.

The Woman's Christian Temperance Union believes that abstinence, not harm minimisation, is the answer:

> Health Department advertisements on TV are quite good, but the emphasis in them and in printed material is largely on the safe drinking level, whereas we maintain that they should be encouraging voluntary non-use. There is no true safe level for all people with any addictive substance as all individuals are different.

Much of the concern seems to be that harm minimisation initiatives might actually encourage people, particularly young people, to indulge in alcohol and other drugs. Some submissions suggested that steps should be taken to avoid such an occurrence, among them Mrs L M Harding's:

> Harm minimisation rather than abstinence or free rein seems to be the way to go for agencies who are setting realistic goals for their evaluations. This approach, however, must be supported through the development of tactics to reinforce the message that drug abuse is not acceptable behaviour in our community.

Holyoake takes a similar view:

> We have had a concern for some time that information regarding the safe use of drugs has been translated by some young people to mean 'drugs are safe'. Holyoake believes it is time for the information available to young people to include the message 'no psychoactive drug use is completely safe' as well as to continue to highlight how the harm related to the use can be minimised.

2.3.1.2 Balancing priorities: prevention vs treatment

Mrs L M Harding supports putting every effort into preventing drug abuse:

> As we know, an ounce of prevention is worth a pound of cure. Funds allocated to working at a preventative level may appear slow in altering current trends, but the value will be in the years to come.

Holyoake, however, warned that we must be careful not to direct funds away from badly needed treatment programs:

> We do have concerns that unless the whole continuum is taken into account and adequately addressed the tendency to target the less serious end of the problem, although potentially numerically affecting the most people, may result in resources being directed away from those with more serious problems. The consequences would be that much human suffering, not only for the individual but for the family will result, as well as a huge economic drain.

2.3.1.3 Balancing priorities: prevention vs control

An interesting difference of community opinion emerges on whether the most productive way of tackling drug abuse is by reducing the demand for alcohol or other drugs (prevention) or by limiting or cutting off the supply (control).

The submission from the Youth Justice Coalition is one of a number that strongly advocated reducing the demand for drugs by addressing the factors that contribute to their abuse:

> While supporting the need to tackle the top end organisers of the drug trade, the Youth Justice Coalition emphasises its belief that the most effective way to ensure a reduction in the use of both legal and illegal substances is to **reduce the demand** for drugs ... the best insurance against drug abuse by young people is to ensure the rights and needs of young people to a secure and safe environment, a caring and responsible family, meaningful education and employment, and community-based services to provide support.

David Sunkar, on the other hand, is one who believes the time is ripe for an all-out war on drugs and drug users:

> Start rounding up young people for drug use and fine them heavily, and use the fines to set up special drug units with serious intent to eradicate the trade in import and manufacture of drugs.

2.3.1.4 Balancing the Priorities: treatment vs control

The overwhelming majority of community opinion expressed to the Task Force was that while controls are certainly needed, in the case of drug abusers the emphasis should be on rehabilitation rather than simply punishment.

The Australian Family Association asked for more understanding:

> A more sympathetic attitude needs to be adopted if we as a community are going to help these people who more often than not are crying out for help. Nothing will be achieved much until everyone understands the problems faced by people who abuse drugs, more clearly and with an open mind.

Carol Perry summed up the attitude of many people in the community when she wrote:

> Get our drug addicts out of gaol where they don't belong and to places where they can be helped. And make a supreme effort to halt all imports and manufacture of hard drugs. They hurt us all in one way or another.

The Parents and Friends Federation included in their submission some figures derived from a series of meetings held with a small number of students, staff and parents from Catholic secondary schools in the metropolitan area. Each group was asked to answer the following question: For every $100 available to be spent in the drug abuse area, how would you spend the money? Their responses are provided below.

	Rehabilitation (Treatment)	Education (Prevention)	Police (Control)
Students	$20 - $30	$60 - $70	$10
Staff	$20	$70	$10
Parents	$10 - $30	$50 - $70	$10 - $25

2.3.2 TREATMENT AND OTHER SERVICES

2.3.2.1 A wider range of treatment programs

Although it was frequently put to the Task Force that more services were needed in Western Australia for treating people suffering from alcohol and other drug abuse, much of the emphasis was on provision of a more appropriate **range** of services to cover the spectrum of community needs.

David Wray made the general point in discussing the situation in the Goldfields:

> ... I would argue that there needs to be a more even-handed and 'considered' approach to addressing drug use issues. There need to be more appropriate services available ... particularly in rural areas where drug use is at its highest levels. Here in the Goldfields, we have Alcoholics Anonymous and Holyoake, both 12 Step Programs available full-time, and my own service available for counselling less than one day a week. Twelve Step Programs are recommended in the National Drug Strategy for heavily dependent drinkers. The reality of the Goldfields is that the bulk of drinkers are not dependent, but are in fact young guys with too much money who believe the coolest way to spend your nights and cash is drinking as much as you can. Possibly as high as two thirds of the consumers of these programs therefore should not be there and will gain little or no benefit. The focus ... needs to move away from the small percentage of drug users who become dependent (generally 10 - 15% of any drug user population) to the plethora of drug related harm that comes from occasional and binge type users. In the Goldfields, therefore, we need a range of strategies that will enable this majority group to drink more responsibly, not try to convince them by 12 Steps never to drink again.

The Holyoake submission agrees that binge drinkers have specific treatment needs and recommended that:

> ... the essential need for potential clients to have choice of a range of interventions be recognised as an important determinant of successful outcome.

Consistent with this, they also recommended that:

> ... adult men and women whose problems related to their alcohol or other drug use is at the 'harmful' or 'dependent' end of the continuum continue to be recognised as a large and important target group for intervention and service provision.

2.3.2.2 Residential programs still needed

Some service providers urged that residential programs not be cut back as other programs are developed. The Salvation Army Bridge Programme is one of them:

> There appears to be a move for more non-residential programs. While we acknowledge the need for such programs, and in fact are exploring this area ourselves, we still feel very strongly that there is a distinct role for residential programs. Many of our presenting clients have no fixed address, broken down relationships, no money, and are unable to see a way out of their present situation. These clients need the time and opportunity to move out of their crisis situations and to reassess their lifestyles.
>
> By providing the opportunity of a residential program, clients are helped to work through the issues and re-establish positive life skills which with ongoing support will enable them to return to the community as contributing members.

Palmerston Drug Research and Rehabilitation Association made a similar point:

> The trend towards brief intervention could completely overlook the needs of more seriously impaired clients who require medium-term residential treatment. Research has demonstrated that when these clients are not in rehabilitation, the cost to the community is enormous. One survey put that figure at $75,000 per year, and that may be quite conservative ... For most therapeutic communities the cost per client per annum varies from $15,000 to $30,000. Although a percentage of these clients do return to drug use and crime, the numbers who do so are significantly reduced and it is certain that hospitalisation and incarceration contribute very little to behaviour change in terms of reducing drug use or criminal activity.

2.3.2.3 Youth services

A large number of submissions, from both service providers and parents, claim that there is a significant service gap in the area of youth services: Joyce Anderson, for instance, pointed out that the entry age requirement for most treatment centres is 25. The various needs identified included the following:

- a non-medical detoxification centre specifically for young people;
- more youth rehabilitation centres;
- more youth residential care available in an isolated setting;
- early intervention involving mentor support;
- training of teachers and school psychologists to enable them to help in a drug related classroom crisis;
- more ‘detached’ youth workers;
- more services for Aboriginal children and youth; and
- more supported accommodation for troubled youth.

2.3.2.4 Parent support services

While much praise was given to existing support services provided by non-government organisations to parents of drug abusing children, many parents said that more services are needed. Their position was confirmed by Holyoake:

> Holyoake has found in the last five years working with parents in this area that parents lack information and often a way to proceed with their young person; they require support through the crisis, reassurance and some practical help with applying their parenting skills to this particular situation. If the problem has become quite serious parents may need support to re-establish parental authority and to allow the young person to face the consequences of their behaviour. Apart from the program described above, very little exists to meet this need.

2.3.2.5 People living in country areas and outlying suburbs

Throughout the consultation, people complained again and again about the lack of services available to people living outside the metropolitan area or in outlying suburbs of Perth. Mrs Lorraine Paget summed up the message:

> Urgent attention needs to be turned to setting up similar facilities in country regional centres — while drugs are everywhere, we need to provide residential programs and counselling in regions beyond the metropolitan area to give the country kids the same assistance and support, instead of having to go to the city.

The National Council of Women of Western Australia agrees:

> A more effective rehabilitation network is needed, particularly in outer suburban and country areas.

Holyoake, in discussing the need for more support for parents and young people before the latter get into trouble with the law as a result of drug abuse, wrote:

> Any such response to these adolescents and their parents would need to take into account the needs of individuals and families in the outlying suburbs. Holyoake has calls on a regular basis from people in this situation.

2.3.2.6 Services for women

In its submission, the Women's Health Association argued that women's substance use abuse treatment needs are not identical to men's, and that services must be sensitive to the difference. They believe there is a significant lack in services available to women abusing benzodiazepines, and that this is a particular problem because these women tend to be the least confident about approaching services. The Association suggested that outreach programs are needed for women who are socially and geographically isolated, and that services are also needed to meet the particular needs of Aboriginal and non-English speaking background women.

2.3.2.7 Methadone treatment

A number of submissions expressed dissatisfaction with the current methadone program. According to the Injecting Drug Use Initiatives Group there is a seven-week waiting list to get on the program; the Family Planning Association suggested that the waiting time be reduced or eliminated by expanding the program. The Australian Parliamentary Group for Drug Law Reform argued that broad-based methadone programs should be available for all heroin users.

The Western Australian Faculty of the Royal Australian College of General Practitioners is concerned that the current arrangement of a single central methadone program might dissipate some of the benefits of methadone treatment by keeping addicts in the situation from which they are trying to escape. The Injecting Drug Use Initiatives Group suggested that alternatives to central dispensing should be considered.

2.3.2.8 Other service gaps

Other groups identified as requiring additional services were:

- drug users with psychiatric problems;
- injecting drug users (IDUs); and
- people from non-English speaking backgrounds.

The Western Australia Branch of the Royal Australian and New Zealand College of Psychiatrists recommended that a consultant psychiatrist be appointed full or half-time to the Alcohol and Drug Authority to assist with co-morbidity cases.

The Western Australia AIDS Council recommended that the current IDU program be supported and expanded; it suggested a range of strategies to reduce the transmission of blood borne viruses among injecting drug users, including the establishment of a fixed-site needle exchange, expansion of the Mobile Needle Exchange Program to include outer metropolitan areas, and vending machines in rural and metropolitan areas.

2.3.2.9 Increasing public awareness of services available

It seems that people are often not aware of what services are already available. The Midland Community Youth Centre pointed out that there are some excellent specialised services operating in Western Australia that are not always used to their fullest potential, partly due to lack of public awareness of what they offer. The Midland Community Youth Centre went on to offer various ideas for raising awareness and increasing access to services.

Mrs L M Harding suggested that steps should be taken to inform parents, in particular, about available services:

> Brochures developed specifically for Western Australia, in which Western Australia resources are listed, to go to all parents who enquire for assistance at all the State Government health and human service agency offices and through hospitals and GPs, would be a help. Perhaps greater advertising of existing resources and agencies wouldn't go astray either. Many parents are intimidated about approaching drug agencies, and a brochure could ease that pathway.

2.3.2.10 Should treatment be compulsory?

Community opinion is divided on whether drug abusers should be obliged to undergo treatment. Many would agree with Simone Dyer:

> A person will not stop using drugs until they choose to, so compulsory rehabilitation programs are a waste of resources. However, there must be QUICK, EASY ACCESS to effective drug rehabilitation programs for those people who do choose to stop using. These programs need to be accessible to people in local communities, and meet the specific needs of individuals.

Others, like Bo Laidler, think that attendance at drug/alcohol rehabilitation centres should be compulsory for anyone convicted of drink driving or any other crime related to drug abuse that puts others at risk. Jen Barnard is particularly concerned about troubled young people who may not be in a position to make responsible choices:

> ... a lot (of services) are contingent on a person wanting to change. The psychological issues behind this are complex, but society needs to deal with those who don't see their drug abuse as a problem, but which is, in fact, threatening their health and wellbeing ... We need to make treatment mandatory (for these people) and part of a residential program which is locked up, as part of a sentence. I am a civil libertarian, and yet I can see the need to make decisions for minors who are destroying their health, with little awareness of this having an impact on their lives.

Some parents are desperate about their incapacity to compel their children undergo rehabilitation. One mother phoned the Hotline to express her frustration:

> Why can't parents have children put in for rehabilitation — why have children got more rights than parents? When you see your child slowly killing himself and there is nothing you can do ...

2.3.2.11 Other views about treatment

The National Council of Women laid emphasis on the need for treatment programs to be in the hands of professionals:

> A more effective rehabilitation network is needed, particularly in outer suburban and country areas. Non-government organisations involved in treating drug and alcohol sufferers should be staffed by experienced and professionally trained personnel and with sufficient ongoing funding to ensure continuity.

An ex-addict wrote with feeling about the lack of sympathy that many general practitioners show towards drug abusers:

> Doctors should treat you the same, not as a leper the minute your addictions come in the conversation. Being angry is enough to make you go scoring what you can.

The submission from the Western Australian Faculty of the Royal Australian College of General Practitioners acknowledged that many general practitioners are less than enthusiastic about accepting drug abusers as patients:

> Limited in drugs available, with minimal training, poor backups and constant harassing from the authorities, GPs as a group have attempted to avoid abusers.

The submission proceeded to identify a number of changes that would encourage general practitioners to become more involved in working with drug abusers. The suggestions included:

- training for general practitioners;
- a wider range of drugs to be available for GPs to prescribe;
- a solution to be found to the 'doctor-shopping' problem, such as a card with a photograph, to be carried by the abuser and signed by each doctor and pharmacist; and
- a change of attitude among general practitioners.

2.3.3 PREVENTION

Almost every submission, written and oral, made to the Task Force included comments on prevention of drug abuse. There is universal agreement that more needs to be done in this area, and, presumably, that the ultimate goal of prevention is a society in which nobody would be driven to escape from reality by means of drugs or anything else. Virtually everyone seems to accept, however, that although we should do everything in our power to pursue that goal, we must also act directly to tackle the existing realities of drug abuse. At this point, many differences of opinion emerge that seem to reflect two main schools of thought on what direct prevention means:

- One view is that we should work to prevent people from succumbing to the temptation of drugs, and that the way to achieve this is to educate them about how dangerous drugs are and how to resist peer pressure to experiment with them; any concession to illegal drug use, in particular, must be avoided at all costs.
- The other view is that although it might be desirable for people to abstain from drugs, a more realistic aim is to prevent people, as far as possible, from causing harm through drug use; this is to be achieved by educating people to ensure they are fully informed and by providing assistance to minimise any harm to themselves or others that might ensue from their drug use.

Both schools of thought are reflected in the summary of community opinion that follows.

2.3.3.1 Tackle the cause, not the symptom

Developing inner resources

Many people stressed the importance of education and counselling to help people develop the self esteem necessary to cope with life's difficulties. Bo Laidler recommended that education about dependency be available to all adults, and that school education should focus on the development of self esteem and social awareness. The Waratah Support Centre agrees:

> It is important to focus, not so much on the use of drugs, but on building self esteem, self respect, self worth, and value, as it is these things that assist a person to resist the peer group pressure.

Encouraging strong families

The Waratah Support Centre believes that families have a vital role to play:

> The promotion of a healthy family lifestyle also seems to be a way of addressing the issue of drug abuse.

Mrs Susan Warner wrote about the importance of bringing back commitment to family values and promoting in children a strong sense of personal responsibility. She believes the way to do this is by encouraging good communication in families, and interaction of children with a range of older people they can look up to and respect.

The Port Community High School agrees that people's awareness should be raised, perhaps through media campaigns, about the value of developing good family relationships within extended families; the School is also very concerned that fathers should be more involved in the bringing up of their children.

The need for general parent education on bringing up children was mentioned frequently in submissions and comments. The Waratah Support Centre made the following suggestion:

> Another way that governments and individuals may work together towards addressing issues of drug and alcohol use and abuse is to provide ongoing parenting programs. It is our experience that many of our clients are unaware of the enormous impact their behaviour has on their children. If parents feel good about themselves then their children are much more likely to feel the same way. Drug and alcohol abuse are symptoms of a society which is failing to address the deeper social issues that leave individuals feeling alienated, isolated and alone. The problem will not go away until these broader social issues are dealt with.

Mrs Nola Hosking believes that parent education might help reduce the number of children being diagnosed as having Attention Deficit Disorder:

> My strong suggestion ... is that some form of guidance or education be set up to teach parents how to handle their children. Speaking as a parent of three, now in their 20s, I can honestly say that parenting is the hardest, yet most rewarding, job of all. I was (as a teacher) trained how to handle children before I had mine. Why can't parents with difficult children be taught how to handle their children?
>
> Teach them to live with, love and enjoy their offspring, and we might reach the utopian dream of a more stable society. Drug the children and we get nowhere.

The submission from the Youth Services of the Uniting Church was one among a number that recommended providing more support for parents as a means of strengthening the family:

> The outcome from a serious understanding of the research and realities would be that parents receive a far more intentional backup in the raising of children and teenagers than has been the case in Western Australia to date ... Such backup needs to involve all levels of government, including local government.

Promoting youth activities, support

Another frequent comment, made throughout the State, was on the need to develop a wider range of recreational activities, especially for young people. People often talked about the need to break the association between alcohol/other drugs and having a good time. Blue Light Discos, alcohol-free concerts, creative activities, were all regarded as highly suitable. Mr M R Shedley, a grandfather from Kununurra, is a strong believer in the value of sport:

> Well trained, committed youth leaders to run organised sport could help reduce drug/drink offences.

The Midland Community Youth Centre is convinced of the importance of special centres for young people:

> The need for more and better equipped youth centres .. is present in all community areas. With more government funding going into the centres, professional help could be provided hands on to the youth at risk.

Simone Dyer argued that to be effective a youth centre must be adequately funded:

> Funding one worker to provide services to a large area is not acceptable (or effective). A youth centre servicing a specific area, for example, must be funded on an ongoing basis (at least three years) to employ a number of professional, qualified staff who can provide a range of services. These positions need to be secure, well paid and valued. This does not happen at present.

Ian Dawson, on the other hand, is worried about young people 'at risk' mixing together in isolation from the broader community:

> It is beneficial to direct youth away from youth groups that are set up to cater for the bored adolescents who mix with similar type people, often with low self esteem and negative views on their place in society.

As an alternative, he suggested that at risk or disadvantaged young people would benefit from being offered a sponsored place in the community club of their choice. He wrote:

> The membership and necessary equipment could be sponsored by the government programs which are set up to help youth ... The government or local business funding would provide the club with a boost and help them with accepting disadvantaged youth (a maximum of two only).

Mr Dawson added that an additional advantage of the scheme would be that job opportunities might arise for young people who showed promise from their acquaintance with club members.

Going beyond recreational activities to relieve boredom, Youth Services of the Uniting Church argued strongly that a key preventative strategy should be the provision of more 'detached' youth workers able to assist young people in their own settings and act as a back-up to their parents.

Creating employment opportunities

> A number of people made submissions about the importance of creating more employment opportunities. Mrs Lorraine Paget suggested that one way to do this would be to oblige people on unemployment benefits to do community service work in return; her other suggestion was that tax incentives might be introduced to encourage women to stay at home to bring up their children.

2.3.3.2 Education about alcohol and other drugs

What to teach

Some submissions advocated education specifically designed to build resistance to drugs. A pharmacist and mother wrote as follows:

> Use high schools to help prevent children turning to drugs ... The best and only way to get off drugs is never to touch them. It is the only way that works.

The Barrows Foundation believes that resistance education should be extended to all:

> Education programs should be implemented across the broad community starting with primary school children, their teachers and parents, the community generally and the law enforcement agencies. The objective of these education programs should be to remove the demand and thus very largely collapse the drug trade.

An American program, DARE (Drug Abuse Resistance Education) has been introduced in Karratha, and has been operating in the Northern Territory for some time. It was highly praised by Mr Kevin Richards in a written submission and by a number of people at the Karratha meeting. It was also promoted to the Task Force by Mr Gordon Carson, a representative of the American company Herbalife which is a major sponsor of DARE in the USA.

DARE involves drug education for primary school children provided by police officers. It is specifically directed towards developing resistant attitudes towards drug abuse.

Mrs Liz Atkinson believes it is important to impress on young people the dangers associated with drug abuse:

> We need our young people, through education, to be aware of the dangers of addiction and the deterioration of life that drugs can impose ... It has been my experience that young people are first using drugs after being introduced to them by school ‘friends’. This needs to be countered with strong anti-drug lectures, films and literature.

An anonymous submission went further, echoing a fairly common theme:

> Show children and young offenders the results of drug indulgence by taking them on visits to hospital wards, autopsies, mental wards and traffic accident scenes.

The Pharmaceutical Council of Western Australia considers that:

> School programs must impart education that emphasises the dangers of drug experimentation

The Port Community High School, however, warned against frightening people:

> Widespread availability of the **facts** concerning the health hazards of using drugs needs to be implemented. Scare tactics don't work, but people should be constantly reminded of the effects of different substances and of the dangers of cross-infection from sharing needles, syringes or other equipment used for preparation of intravenous drugs. Many will choose to ignore the facts, but at least they will have that choice.

An anonymous submission also maintained that education should be directed towards enabling people to make their own choices:

> It must be assumed that given the right information people will make the best choices about their drug use. This information must include both positive and negative factors about drug use, and valid statistics ...

Alannah MacTiernan MLC is another supporter of the view that education should embrace both the benefits and hazards of drug use:

> I personally take the view that any educational program or indeed drug policy which does not take into account the positive aspects that some drug use can have (for example, providing relaxation, stimulation, a sense of wellbeing and, in the view of some, a less ego-oriented perception of reality), then we will not go far.

Ms MacTiernan is one of a number of people who believe that a very negative approach to drug education may be counterproductive:

> In my own experience, the exaggeration of the harmful effects of popularly used drugs such as marijuana undermines the credibility of drug education campaigns about particular drugs or use frequency which in fact have potential to cause real and substantial physical or psychological harm.

People who favoured the harm minimisation approach were generally convinced that education should include the safe use of drugs; others were equally concerned that information of this kind should only be available in conjunction with warnings about the harmful effects of drugs, and in any case not to impressionable children and young people who might be encouraged to experiment.

Education — school

Some people, Mrs Y Cunningham among them, believe that drug education should begin early:

> On the subject of drug education, I would like to see this begin no later than Year 7. Year 9 would be too late for many ... I know that many more children are using drugs than surveys show, because drug abusers learn to be good liars.

The Parents and Citizens Association of the Wilson Park Primary School in Collie agrees on the need for an early start:

> We feel that the abuse of drugs should be explained at an early age, in primary school. Teenagers may then be able to see the consequences of this habit when it arises.

Many people feel that although education to build self esteem and the capacity to resist peer pressure should begin when children start school, specific drug education should wait until later, perhaps late primary school or the beginning of high school.

Some consider that school teachers are not the most suitable providers of drug education, either because they are symbols of authority to be flouted or because the teachers themselves might be involved in recreational drug use and ambivalent about drug education. Life Education Western Australia believes that there is a place for teachers in drug education, but that they need the right training for the job:

> We at Life Education see an urgent need for increased training of the classroom teacher in the delivery of drug education programs to the students.

Police around the State told the Task Force that they are quite commonly asked by schools to give lessons about drug abuse. As indicated earlier, DARE is a program that makes extensive use of local police interacting with primary school children. Mrs Britt McGowan, Principal of the Bunbury Catholic College, has been very impressed by the performance of police in providing drug education:

> I believe education is the key, and that it cannot be effectively accomplished by parents or teachers — both groups are forcefully rejected by most adolescents. Police seem to be more accepted in the message they deliver. (I confess this surprised me!)

Others are worried that the negative image that many young people, especially adolescents, have of the police may interfere with the message they are trying to put across. In addition, a caller from Merredin to the Western Australia Telecentre hearing conducted by the Task Force expressed concern at the incapacity of the police, given the illegality of some drugs, to adopt a harm minimisation approach — being sworn to uphold the law, she pointed out, they are not in a position to impart any information about how to minimise the risks of using any prohibited substance.

The submission from the Youth Services of the Uniting Church maintained that the education provided by police is sometimes in conflict with the approach being taken by other professionals:

> Police have characteristically presented marijuana in a way more reminiscent of the 'Reefer Madness' scenario than consistency with more recent reports and realities. There is a need for interaction and mutual exchange between police education staff and others ... who have involvement in school or wider community education regarding drugs.

Mrs Y Cunningham feels strongly that whoever is providing drug education should be someone who really knows what he or she is talking about:

> Drug education should be dealt with by experienced people such as youth workers who have 'field experience'. (Students are not going to relate well to a teacher, and teachers do not know enough to handle this.)

Various other suggestions were made about who should provide drug education in schools: ex-drug addicts, and PRYDE (Parents Reaching Youth Through Drug Education) were among them. The most common general proposal was that students will respond best to people who they respect and can relate to, and that this may mean looking for people who are relatively young.

Rotary International in Western Australia has made a very significant contribution to drug education; its submission contained several recommendations about the future of drug education in schools:

> Education is the centre plank, and we ask that the Task Force seek appropriate Government support to ensure that the necessary resources are available to train school teachers for this specialist role, and fund the ongoing development of the 'K-10' health syllabus. The delivery of the 'K-10' should be mandatory and we hope that the Task Force can recommend that.

The School Health Coalition of Western Australia believes that a comprehensive approach should be taken to school drug education in order to provide an environment in schools and their communities that reflects the health messages being delivered in the classroom. The Coalition put forward a number of recommendations to bring this about, including the following:

- compulsory health education from kindergarten to Year 12 (K-12), including drug education;
- a review of the current 'K-10' health education syllabus, to be followed by its revision;
- teacher training;
- school based drug policies in all schools;
- parent education to be provided by schools.

The Youth Justice Coalition is concerned at the ignorance of many young people about drug legislation in Western Australia:

> With an increasing judicial and community emphasis on the need for young people to be held more responsible and accountable for their actions, it becomes even more paramount that the same young people be given access to information and education that will enable them to evaluate and make informed judgements about their behaviour ...
>
> Many young people in Western Australia unwittingly place themselves at risk of being charged for offences under the Misuse of Drugs Act 1981 because of a lack of information about drug legislation. The Youth Justice Coalition is very concerned that the overwhelming majority of young people it has contact with, either as direct clients or through its legal education programs, have little knowledge of drug laws which may impact upon them at some time, particularly during their adolescence and early adult life.

Education — parents

One parent wrote that she had learned the hard way that her children were involved in illegal drug taking:

> There seems to be a lack of acceptance by the general public that drugs are a problem within the community ... I did not attribute my son's problems to drugs and yet when I look back I see how naive I was. More public information and awareness and, I guess, acceptance, would have enabled me to approach the problem sooner. I feel there must be thousands of parents floundering in the way I did.

Anthony Kiernan proposed a solution:

> If we as parents understand the extent of the problem, then we may be more prepared to become involved in the overall issue. Following on from this, I would suggest the Task Force recommend to the Government that it organises parent information nights in groups of schools.

A number of parents who attended hearings said they were concerned about their lack of knowledge of the appearance of various drugs (many said they couldn't recognise a cannabis plant), and their incapacity to determine from their children's behaviour whether they were using illegal drugs. They thought more parent education should be available to enable them to overcome their ignorance.

Media campaigns

At the hearings, many spontaneous comments were made about past and current media campaigns to tackle the abuse of alcohol and tobacco. There was general agreement that these campaigns have been very successful, particularly Quit, Respect Yourself and Drinksafe; most people thought that money spent on such campaigns was being put to very good use and that further campaigns should be developed.

In his submission, David Wray suggested that more media education should be directed at safe drinking, and Bo Laidler thought that a major campaign such as the Quit campaign was needed to address alcohol abuse.

The Gascoyne Public Health Unit supports a major campaign targeted at smoking by Aboriginal people.

The submission from the Western Australia Faculty of the Royal Australian College of General Practitioners suggested that some correction is needed to the heavy emphasis that has been placed on tobacco and alcohol:

> Kids repeatedly say that the big killers are cigarettes and alcohol, so that all the other drugs are not as bad — a view promoted repeatedly in print or on the air. When kids at seven are brainwashed into this view it is not surprising that they sniff inhalants or sample marijuana, often before they have their first tobacco cigarette.

The Health Consumers Council takes a different view:

> There is an undue focus on illegal drugs when the major problems facing Australian society arise from the use of substances such as alcohol and tobacco. The Health Consumers Council recommends that public health promotion continue to be a priority of the Health Department of Western Australia.

Mrs Liz Atkinson, however, believes that publicity campaigns are needed to warn people about the dangers of mind-altering drugs.

Along similar lines, the Council for Christian Action recommended that the State government introduce 'a well resourced Quit-style campaign publicising the dangers of cannabis use and urging young people not to start, and if they have started, to quit'.

The Perth City Mission believes that there may be a place for media campaigns that depict drug abuse in a graphic way:

> Having worked in the substance abuse field for ten years, it is interesting to note that although the old campaigns, particularly the graphic heroin ones, were roundly criticised they appear to have had an effect on the current generation of adolescent drug users with the retained message that heroin use is not OK.

Cyrenian House sees it differently:

> The use of mass media to mount campaigns to reduce drug related harm is strongly supported. However, sensationalism should always be avoided as it tends to undermine the message. This is particularly true in relation to people who are on the periphery of drug use culture. The image of the young man passing out at a party under the influence of speed in the 'Speed Kills' campaign is a case in point. Most speed users would not have witnessed such an occurrence, even though it is a possibility. The credibility of the campaign was thus undermined with at least some of its target population.

The Liquor Industry Council believes that media campaigns should be based on sound, commonsense advice:

> 'Over the top' emotive campaigns which blame the produce or the licensed retailer, or set artificially low recommended drinking levels, lack credibility and will therefore be ignored by consumers.

Joan Last-Kelly believes that advertisements, publicity campaigns and documentaries should all show the consequences of drug abuse for the family as well as for the abuser. She considers the media could be a force that empowers women and supports them in facing their problems.

Youth Services of the Uniting Church made a heartfelt plea for media campaigns to avoid slogans like 'Only Mugs Use Drugs' on the grounds that it is damaging to those who already have low self esteem and because it might encourage people to think that alcohol is not a drug, since it is socially acceptable.

Education — medical profession

A number of submissions recommended that members of the medical profession should be trained to be more cautious about prescribing drugs. J Mani suggested that:

> Doctors should be made more responsible towards their patients and be less eager to prescribe dangerous drugs.

Mrs M A Ryan expressed a similar view:

> Doctors should be strongly encouraged to actively discourage the constant use of tranquillisers and sedatives, and to actively encourage people to try meditation and other alternative methods rather than just pills all the time.

Encouraging safe practices — injecting drug use

The submission made by the Injecting Drug Use Initiatives Group stressed the importance of minimising the harm associated with injecting drugs. In addition to education programs and media campaigns that 'neither stigmatise nor glamorise injecting drug use' it recommended a number of initiatives, including:

- more needle and syringe distribution programs;
- better access in rural areas to sterile injecting equipment, HIV testing and counselling; and
- legal needle and syringe vending machines.

Kevin Moran of the Community Action Legislation Lobby, however, sounded a cautionary note:

> No doubt the provision of free needles has been of value in preventing the spread of AIDS. However, the laissez-faire distribution of these requires examination, as such unfettered handing out of needles does indicate to our youth a de facto type of acceptability of drug use by the community.

The Midland Community Youth Centre is concerned that prison inmates are excluded from many current preventive strategies:

> The prison system stands alone as a neglected blind spot of the IDU community. Introduction of reforms within the prison system need to be implemented to ensure that all prisoners, both IDUs and HIV/AIDS status people are accorded the same rights, support, treatment and counselling as the rest of the community.

2.3.4 CONTROL AND LEGISLATIVE CHANGE

Although many people who attended the public hearings did not seem to have a strong opinion on whether cannabis should be prohibited or not, a number did express forthright views and written submissions revealed a significant division of community opinion on this matter: about 400 people put their names to a form supporting decriminalisation/legalisation; on the other hand, a set of resolutions strongly opposed to decriminalisation was voted for unanimously by 320 people who attended a Community Drug Awareness Forum held in Albany on 8 April 1995.

Some of the principal arguments presented in individual submissions are outlined below.

2.3.4.1 Whether to decriminalise/legalise — arguments for Cannabis

Several submissions presented lengthy arguments in favour of legalising (or as Rob Pensalfini put it, re-legalising) cannabis. In addition, a group of campaigners for the decriminalisation of cannabis attended the Northbridge hearing and put their position forcefully. It is not possible to present all the arguments here, but some were summarised by a group of Merredin health professionals when they participated in the Western Australia Telecentre hearing:

> We feel that marijuana should be legalised and its sale controlled through licensed outlets, and the percentage of THC in the marijuana should be controlled too, just like alcohol. The big danger lies in marijuana being used in an uncontrolled way as it is at present. With marijuana being illegal, the market is opened up to clandestine sellers, and the users are at their mercy. Marijuana is in our community, it is being used; we should accept that and legalise it.

The Youth Services of the Uniting Church is another group concerned that the illegal status of cannabis is itself a cause of harm in that it precludes adequate controls:

> It is often felt in the community debate that 'liberalisation' of laws about marijuana, for example, would constitute going 'soft on drugs'. The research overwhelmingly supports the contention that current legislation, such as that in Western Australia, is in fact 'soft' on the black market.

Cyrenian House regards cannabis as a lesser evil:

> It is clear that a great deal of police and court time is consumed in pursuing marijuana cases. Also, a very high proportion of young people use marijuana at least once, and it is feared that this leads to a general weakening of respect for drug laws. The Western Australia Council on Addictions does not applaud or wish to promote drug use in any way, but in a hierarchy of risk and potential damage the evidence seems to support marijuana as relatively benign, especially in comparison with speed. Consideration should be given to the decriminalisation of marijuana, using the South Australian reforms as a model.

Other submissions, including that of the Australian Parliamentary Group for Drug Law Reform, also recommended the adoption of the decriminalisation model used in South Australia and the Australian Capital Territory.

Illegal drugs generally

Greg Mawson believes that since all drugs, including alcohol and tobacco, can be abused, having some legal and others illegal makes no sense.

Geoff Whyte, concerned at the harmful effects of prohibition, has come to the conclusion that all drugs should be operating 'out of the closet':

> I have reluctantly come to the viewpoint that **ALL** drugs of addiction ought to be legalised and made available through government controlled agencies at a very basic cost. It occurs to me that this may have the effect of:
>
> - taking out the criminal element and the huge profits they make;
> - reducing the risk of corruption within our enforcement agencies;
> - providing drugs with quality control assured;
> - facilitating the treatment of addicts because they will be known by virtue of purchasing through a controlled situation;
> - reducing the spread of AIDS and other diseases;
> - enabling the funding of a better directed and more effective education program;
> - removing the 'thrill' element of taking a prohibited substance;
> - providing the opportunity for parents to become aware of substance abuse by their children; and
> - reducing the power and control of the 'social engineers' who appear to have so much influence on the regulatory programs.

Barbara Morgan is also very concerned about the criminal element involved in illegal drugs:

> The true problem of drug abuse in 1995 is surely the criminal element that is going to flourish as long as we prohibit legal availability ... Surely we remember what Prohibition achieved in the USA — a criminal activity which has never been totally eradicated because, as long as we prohibit substances that are available through breaking the law, someone will always do that just to get hold of them.
>
> Any decriminalisation should go hand in hand with a massive drug education program so that no-one can be in any doubt about the effects of either soft or hard drugs. By taking away the criminal element, abusers can be encouraged to seek actively for help.

Dr Derek Pocock, a forensic pathologist, is of the opinion that there is no rational basis for the current distinction between legal and illegal drugs. He believes that the distinction should be removed by decriminalising all prohibited drugs; at the same time, strong legislation should be passed with respect to any offences committed against any person or property when the offender is under the influence of **any** drug.

Many people are concerned about the severe impact of current legislation on people who use illegal drugs, maintaining that drug abuse should be regarded as a health problem, not a criminal problem. Helen Cooney wrote:

> Drug addiction shouldn't be treated as a crime. Drug abuse is a very serious long-term physical, emotional and spiritual disease and should be treated as such.

The Youth Justice Coalition is concerned that the current drug legislation in Western Australia has a major impact on the lives of those charged, although the offences involved are mostly minor and victimless:

> It must be clearly stated that the Youth Justice Coalition is wholeheartedly supportive of the aims of police, government and wider community to identify and convict those responsible for the manufacturing and trafficking of illicit drugs ... At the same time we believe that the current legislation in relation to the use of illicit drugs is both archaic and harshly punitive in its effect on young people in Western Australia ... The Youth Justice Coalition strongly believes that the criminal justice system is not the most effective or appropriate place to deal with behaviour relating to the use of illegal drugs and supports the notion that simple offences relating to the personal use of both legal and illegal drugs be decriminalised.

2.3.4.2 Whether to decriminalise/legalise — arguments against

Most submissions against decriminalisation or legalisation focused on cannabis, although it was quite clear from the context that they would oppose at least as strongly any change to the legal status of any other drug that is currently prohibited.

Beth Stanley, a retired pharmacist and teacher, is very concerned that the harmful effects of cannabis on mental and physical health have been under-estimated:

> If the effects on the human body are detrimental enough then I can see no reason to allow another poison to be ingested along with alcohol and tobacco, with its cost in human sickness to individuals, cost burdens to the community, its cost in human misery to families, and a detrimental social change to society.

The Barrows Foundation is also strongly opposed:

> Marijuana is now documented as a highly dangerous and addictive drug; more dangerous than alcohol and tobacco ... Prohibition and criminal penalties are shown to be working in the USA. Why then do apparently intelligent and respectable people become so passionate in the cause of decriminalisation?

The Woman's Christian Temperance Union is anxious about the impact of the decriminalisation lobby:

> We trust that the Government will not succumb to pressure from some interested parties, even some academics and politicians, to decriminalise current illegal drugs. Otherwise we will ultimately have the same problem with them as we have now with legal drugs.

The Australian Family Association focused on the effect of decriminalisation on young people:

> The message that has been sent out to our youth, in particular, is that marijuana is a relatively harmless drug. However, as we have indicated earlier, this is not the case. The argument for the decriminalisation of marijuana has been conducted by academics, the media and other such groups; it is at present appearing to be very one sided. These groups are maintaining that marijuana use by mature adults should be allowed without them being penalised for doing so. What they are not saying is that a large number of people who use marijuana are in fact young people. No-one is considering the effect of marijuana on youth. Liberalising current drugs policy will not solve the problem, rather it runs the risk of making the problem of drug abuse worse, as more youth would have even easier access to marijuana.

Elaine Walters also believes that young people are a special case:

> Obviously there are many valid and convincing arguments in favour of the lifting of legal sanctions, but it is impossible to implement ways to make orderly drug controls and regulations without putting at risk the most vulnerable groups in our society, especially the young.

Since working at a Youth Health Clinic in Fremantle, Dr Cherry Martin, Research Fellow in Adolescent Medicine at Princess Margaret Hospital, has become convinced that cannabis should not be legalised. She reported that at-risk young people who use cannabis frequently seem to become dependent on the drug, lose motivation and be unable to organise their lives, even when they want to. The effect, she said, is for their self esteem and confidence to spiral downwards, often resulting in more consistent use of the drug.

Ian Dawson of the Australian Parent Movement believes that current laws prohibiting cannabis should be supported more by the community, but considers that the emphasis should not be on punishing offenders:

> Many people often espouse the view that the marijuana laws have failed. This cannot be true because the current law has criminal penalties for possession of marijuana and is enacted to prevent the use of marijuana in the community. What has failed is community support for this law due to pro-decriminalisation lobby groups gaining unwarranted press coverage, who minimise the harmful effects of marijuana on young healthy adults ... We should have an active law which has its main focus on educating the offenders about the harmful effects of drug abuse and its consequences. In this way, a more healthy community respect will be generated for the marijuana laws.

2.3.4.3 Other areas of possible change

Various suggestions were put forward, the majority directed towards tightening up control of alcohol and other drug use; some would require legislative change, while others could be achieved by government regulation or decision, or by industry self-regulation.

Alcohol

The Alcohol Advisory Council of Western Australia made a number of recommendations designed to control more effectively the promotion and consumption of alcohol; among them were the following:

- that the current Liquor Act be actively enforced, especially in relation to the continued serving of intoxicated individuals and under-age persons;
- the 18+ card be revamped to include a photo ID (this could also be used with alcohol sales) with strict enforcement in identified outlets;
- that host responsibility training be compulsory for all alcohol servers industry staff, and that it include cross-cultural training, with particular reference to Aboriginal issues;
- that consideration be given to support a greater tax differential between high and low alcohol products;
- the banning of promotional and other activities that promote irresponsible drinking practices;
- the introduction of mandatory health warnings on all alcohol advertisements; and
- legislation to prohibit lifestyle advertising of alcoholic beverages.

Many of the Council's recommendations reflect ideas that were spontaneously raised and received enthusiastic community support at public hearings. There was a strong feeling, for instance, that advertising should not link alcohol with sport or sporting heroes, and many people in regional areas, particularly, were concerned about the prevalence of 'Happy Hours', drinking competitions, and other practices that seem to encourage irresponsible drinking. The need for stricter enforcement of the current Liquor Act, and especially the provisions that apply to under-age drinking, was heavily emphasised both in written submissions and at the hearings.

The Liquor Industry Council maintains that licensed drinking premises already offer a highly controlled environment:

> Clearly, the safest place to consume alcohol is at licensed premises.

Nevertheless, the Liquor Industry Council supports compulsory training for licensees and managers, with the training to include responsible service of alcohol.

Lisa Airey, a former bar attendant, made a number of suggestions for reducing alcohol abuse on licensed premises. One was that doormen be used at peak times to keep out under-age drinkers and remove people who are intoxicated; another was that **all** bar staff be trained to be responsible servers of alcohol. She is also in favour of more effective law enforcement:

> In over three years as a bar attendant, I never encountered anyone checking whether the hotel was still serving drunks.

A Hotline caller suggested random testing for alcohol and other drugs in the workplace, particularly in the fishing and mining industries where he claimed a number of deaths were due to substance abuse.

Tobacco

The Health Consumers Forum reflected the sentiments of a number of submissions when it cited tobacco as a cause of major problems in Australia relative to other, particularly illicit drugs.

The Australian Council on Smoking and Health encapsulated the views of a number of organisations with a comprehensive list of recommendations to discourage smoking further. These included ending all tobacco promotion, more substantial health warnings and content information on plain cigarette packages, increased resources to promote compliance with the Tobacco Control Act, extension of regulations to declare smoke free places, an annual anti-smoking media campaign, and mandatory drug education in schools.

Submissions received from the Australian Medical Association and the Public Health Association echoed the thrust of these recommendations and were in broad agreement with them.

Pharmaceuticals

Mrs L M Harding believes there should be more controls imposed on the prescription of some drugs:

> I am personally convinced of the problems associated with amphetamines and benzodiazepines to the point where I consider that these drugs should be on the restricted list.

The Western Australian Branch of the Australian College of Paediatrics recommended close scrutiny of prescriptions being made for children diagnosed as having Attention Deficit Disorder:

> ... the Health Department of Western Australia has established criteria for prescription of these drugs. It is our belief that these need to be rigorously applied and access be restricted when the stated criteria are not met and benefit is not shown following use.

Dr Hugh Cook recommended that the availability of drugs such as paracetamol and antihistamines, both easily obtainable over the counter and liable to abuse, be restricted.

Solvents

The Swan Emergency Accommodation Substance Abuse Project (SEASAP) believes that something needs to be done to control solvent users and to keep them from harm:

> Currently there is no process for prohibiting or apprehending solvent users who put the community at risk. It has become evident that there is a growing need for some kind of policing of solvent usage. Solvent users are as potentially harmful as other drug users in that they are functioning in an altered state of mind and can become as violent or uncontrolled as someone influenced by alcohol. SEASAP does not seek to make solvent usage illegal and thus criminal, rather to minimise potential harm through police intervention. For example, if it is evident that a young person is intoxicated and putting themselves and the community at risk, police should have the power to intervene by escorting the young person to an appropriate service such as a detoxification centre.

Illegal drugs

While most people seem to believe that the person using drugs should not be treated punitively, many feel that there should be heavier penalties for dealers, manufacturers, growers and importers of prohibited substances.

For instance, the Albany Community Drug Awareness Forum organised by the local branch of the Council for Christian Action resolved in favour of the following:

> Prison sentences of a mandatory minimum of 25 years with no parole for convicted pushers, dealers, growers, manufacturers, financiers and drug related official or professional corruption, with confiscation of assets.

At the hearings, a number of people expressed disappointment that the police did not seem to be pursuing drug dealers with the alacrity and vigour they expected. John Duxbury, a police constable, submitted a plan for a pilot program in the Fremantle region — it is a plan for a small drug detection unit to assist suburban police stations in detecting small- and medium-level drug offenders.

The submission from the Western Australia Faculty of the Royal Australian College of General Practitioners supported increasing the powers of police to make it easier for them to apprehend drug dealers:

> Phone taps are probably the only way to catch the bigger dealers, and should become legal and recognisable in court. For too long victims have been punished and the parasites, often instant millionaires admired by their community, escape free.

The Perth City Mission made a practical suggestion for utilising the full impact of the law on young offenders to keep them in drug treatment:

> Currently, all young people referred by Juvenile Justice enter or are assessed for Yirra (the Youth Rehabilitation Centre) when sentencing is imminent. It would appear advantageous to emulate the Court Diversion Service for adults in the youth area. Specifically, allow for deferred sentencing for young people to enable substance abuse issues to be addressed, with pre-sentence reports becoming the norm in Children's Courts.

The Injecting Drug Use Initiatives Group believes that the current penalties, especially for possession, are inappropriate, inconsistent, and too harsh. The Group recommended changes to current legislation in regard to the possession of used needles, claiming that the current situation inhibits the exchange and adequate disposal of needles.

The Health Consumers Council recommended that the availability of heroin for use by chronic pain sufferers and people with terminal illnesses be reviewed in Western Australia:

> Heroin is an extremely effective tool for use in pain management, particularly for the terminally ill and people with chronic pain. Heroin has unique qualities for pain control not found in other drugs currently available. This drug is not available for use for these purposes in Australia, whereas it is in other countries. The illegality of heroin prohibits its use for therapeutic purposes. Legislative review is suggested to establish whether this drug could be used for specified purposes by special groups for whom it could be an appropriate therapy.

2.3.5 RESEARCH

Some research suggestions that emerged from community submissions are presented below, in no particular order:

- I believe that if Western Australia wishes to be proactive on this problem then it should allocate realistic resources to basic research on drug and alcohol abuse. This could be achieved by reserving a fixed percentage of State tax on alcohol and cigarettes, which would then be available to established Western Australian research teams through the normal competitive grant review process. Several American States have legislated for this approach, and as a result experienced and capable research groups have been attracted into the area, and understanding of mechanisms and possible solutions is now moving forwards.
  (Associate Professor Barry Madsen, Department of Pharmacology, The University of Western Australia)

- Greater understanding of tolerance levels and the reaction of an individual's chemical make-up to different substances will, hopefully, give us more insight as to why some people seem to be more susceptible than others. Every possible assistance should be given to this type of research even if it means redirecting funds away from more fashionable but less urgent areas.
  (National Council of Women)

- A greater commitment (is needed) to researching the area of alcohol, especially in the area of consumption and harm. Local communities require information that reflects the impact alcohol is having at the local level.
  (Alcohol Advisory Council of Western Australia)

- Research funds should be made available to help unravel the relationship between drug abuse, particularly amphetamines, and psychiatric illness.
  (Dr Hugh Cook)

- More local research is needed, particularly in the following areas:

  - how parenting is affected by drug and alcohol use and misuse;

  - the impact of parental drug use on children; and

- the distinctions between drug use and drug misuse or abuse.

- There is (also) a need for clear annual statistical data on the incidence of alcohol and drug abuse in child abuse cases to be collected, so that the extent of the problem can be clearly understood.

(Advisory and Co-ordinating Committee on Child Abuse)

- (Using) the skills of the Australian scientific community, a program of research should be implemented to study the effects of, and the accurate testing for, all substances used to affect the function of the human organism.

(Dr Derek Pocock)

- (There should be) provision of politically independent finance and support for properly conducted scientific studies into the treatment of drug users, or the use and misuse of drugs of dependence and psychotropic substances, including alcohol and tobacco.

(Australian Parliamentary Group for Drug Law Reform)

- Further research should be conducted into the pharmacological and psychological effects of marijuana, particularly in view of its widespread 'recreational use' in this State, and the lesser known heavy use syndrome.

(Dr Cherry Martin)

- Although research and prevention are crucial elements of a balanced approach to drug use, what is required by the field is action research to guide program development, not the bio-medical research currently funded.

(Perth City Mission)

- Methodologies which utilise action research tools such as detached work should be further developed and funded. Longitudinal studies are also possible and significant through such means .. Some areas deemed politically sensitive merit independent evaluation to ensure that public funds are being effectively applied; these would include the effect on families of programs such as Operation Noah.

(Youth Services of the Uniting Church)

- (It is recommended that):

  - Long-term research be conducted into the adverse health consequences for children growing up in a family where there are problems related to alcohol or other drug use of a primary care-giver; and

  - Western Australian research be conducted on the outcome for adults who experience a range of interventions, from minimal intervention to residential treatment, for problems related to their alcohol or other drug use.

(Holyoake)

2.4 WHO SHOULD DO WHAT

2.4.1 ROLE OF GOVERNMENT

Submissions from non-government organisations and the general public identified co-ordination, both across sectors and within government, and funding of non-government organisations as vital functions of government. In addition, several specific areas were suggested as belonging most appropriately with government.

2.4.1.1 Co-ordination

Holyoake favours comprehensive co-ordination:

> A co-ordinated whole-of-government approach be taken to identifying and addressing the alcohol and other drug issues in the community.

David Smith MLA agrees:

> When I was Minister for Community Services and Justice, I was never satisfied that prevention or rehabilitation programs, especially for the 10 to 21 year age group, were effective. I was also concerned that the Health Ministry, Drug and Alcohol Authority, Community Development and Justice programs were not well co-ordinated. Addicts, and their loved ones, often found that they

> were being given a bewildering range of advice on the services and the programs that were available, but gained little assistance from any of them, because there was not a comprehensive co-ordination of their resources and programs.

The Advisory and Co-ordinating Committee on Child Abuse addressed a particular circumstance in which it regards co-ordination among government agencies and between government and non-government agencies as essential:

> Early identification and intervention in cases where children are abused or neglected as a result of their parents' drug abuse is essential. Hence there is a need for Child Protection workers and drug and alcohol agencies to work jointly in an effective manner to provide a co-ordinated response to protect children who are abused or neglected because their parents abuse drugs or alcohol. The importance of liaison and networking between agencies is emphasised to facilitate these working relationships.

A teacher of troubled young people, Jen Barnard, also advocated well co-ordinated action:

> Education programs need to be initiated by Juvenile Justice, the Departments of Community Development, Education and Health, which take into consideration the fact that these children are not just misbehaving, they are maladjusted and severely dysfunctional people. As such, treatment should follow a team approach involving all the relevant expertise of these departments, as appropriate to this particular client group.

Jon Rose believes the State Government has a special role to play in co-ordinating service provision right across the government and non-government sectors:

> Because of Western Australia's situation, and the tendency for mainstream agencies to reject alcohol and other drug users and issues ... future changes need to incorporate a centralised service which would aim to facilitate the mainstreaming of service delivery at a local community level throughout the State. The centralised service would have the task of co-ordinating services between local, State and Federal governments, as well as aspects of the non-government sector, including the business sector. The centralised service would also provide ‘best practice’ support to mainstream services.

The Drug Action Group in Kalgoorlie suggested that service co-ordination would be facilitated if the State Government were to establish (and fund) a body to share information and advise government policy-makers in relevant agencies on key regional drug abuse issues. The advisory body would include a representative from each regional alcohol and other drug committee.

The Perth City Mission communicated its frustration at having to apply separately to a number of State Government departments in order to maintain a viable service at Yirra, its youth rehabilitation centre; apparently, separate funding agreements and reporting requirements are also involved. To avoid this, the Perth City Mission recommended that:

> Premier and Cabinet co-ordinate the amount of across-government funding available ... and centrally direct one government agency to tender and account for these funds.

2.4.1.2 Funding non-government initiatives

Many people who responded to the Task Force expressed the view, sometimes very forcefully, that more government funding was needed in the area of alcohol and other drug abuse treatment services.
Greg Mawson wrote:

> Funding of all drug rehabilitation and crisis centres should be greatly increased. New government-sponsored and controlled centres should be established, including in those areas which presently lack such facilities.

More commonly, people thought that government should direct more funding to non-government providers. Carole Perry wrote:

> Give our good non-government organisations all the assistance they need; close down the hopeless ones and create more opportunities for those of excellence.

The Salvation Army's Bridge Programme is one of a number of non-government agencies keen to attract more government funding:

> We acknowledge the funding we already receive from the Health Department. However, we believe that the non-government agencies are not given appropriate opportunities for increased funding to expand into new areas of service provision. We feel that a fresh look should be taken at the way funding is distributed between government and non-government agencies.

Most people also expect government to supply substantial funding to non-government organisations for preventative initiatives such as youth centres and services, and educational programs.

2.4.1.3 Specific functions

Most community members seemed to expect government to assume the lion's share of responsibility for control of drug abuse and for drug education in schools, although a number of suggestions were put forward for increasing the involvement of community groups in the latter area.

The Perth City Mission believes that although the State Government should shed the majority of treatment services, including detoxification and methadone treatment, a statutory authority with a clinical arm and the capacity to regulate and monitor non-government activities should be retained.

Palmerston also supports the retention of a statutory authority with responsibility for providing services such as training, management support and library resources to the non-government sector.

Government is also seen as having a special role to play in setting up reviews and inquiries into contentious areas. The Health Consumers Council, for instance, recommended:

> that a review be undertaken of over-prescribing of medications used to assist in behaviour management, with particular attention to the use of Ritalin for children and relevant medications used for the elderly.

Similarly, Dr Melvyn Wall advocated an official enquiry to develop an integrated policy on hyperactive children.

2.4.2 ROLE OF THE NON-GOVERNMENT SECTOR

Both at the hearings and in the written submissions, high praise was given to a number of non-government organisations that offer counselling and rehabilitation services.

Community opinion seems to support the view expressed in a number of submissions from organisations that the non-government sector has an important and distinctive role to play in the treatment and prevention of drug abuse.

SEASAP believes that non-government agencies are ideally placed to:

> ... service the needs of the community that government is unable to meet effectively. For example, non-government agencies often provide local, specialised services whereas government would provide a more generalised and broader-based service, seeking to meet the wider needs of society rather than the local community... Government can benefit from the feedback regionalised non-government services can provide. Considering community attitudes to government, non-government agencies are also able to gain greater access to public opinion.

Drug Arm Western Australia is also convinced of the need for treatment to be available locally, through community-based, non-government organisations:

> The community has to be the rehabilitative centre because that is the environment in which drug abusers must exist. It is the setting to which they must return after rehabilitation. People .. need to have centres that can help in their location. That is the big advantage of the non-government organisations: they work in the community; they know the community; they serve the community.

The Holyoake submission identified a number of other advantages that the non-government sector can offer the community:

- Non-government organisations have close connections with the community through client contact, committee membership, fund-raising activities and the use of volunteer staff. This enhances community ownership of the alcohol and other drug problem.

- The non-government sector has long acted as advocate for the client and the community, a role which would otherwise seem to have all but disappeared under the new health reforms.

- The non-government sector also has the capacity to adjust more quickly to changing trends and needs as they are not operating under the same level of constraint as some other sectors.

- Clients often report a more equal relationship when dealing with the 'private' sector rather than the 'public' sector. The non-government providers offer choice to potential clients which is essential in addressing the range of people presenting and the myriad problems experienced by the community.

Holyoake believes that the process of providing input to the State Government should be formalised. It recommended:

> That a mechanism be set up for the non-government sector, both individual organisations and the peak body for the sector, the Western Australian Network of Alcohol and Other Agencies, to provide input to Government policy-makers regarding community needs.

Cyrenian House agrees that the non-government sector can respond more quickly than the State Government to community needs, but pointed out that this comes at a price:

> It is an unfortunate corollary of this responsiveness that the non-government welfare field pioneers generally proceed at great personal and/or financial cost to themselves.

Palmerston believes the non-government sector has a special role to play in dealing with clients who have been using illicit drugs:

> .. we are community-based and do not operate within the confines of a Government bureaucracy. This is particularly valuable given that most of our clients are breaking the law by using illicit drugs and may view a government agency with suspicion.

In common with other non-government agencies, Palmerston would like the opportunity to grow:

> The calibre of staff we attract could enable us to do much, much more. It is our intention to expand our services into a number of the areas mentioned and, subsequently, our staff numbers and our facilities.

Despite their interest in expanding, non-government organisations consistently reported being under considerable pressure in terms of their current operations. The Bridge Programme at the Salvation Army voiced a common concern about the growing demands being made by government:

> We are firm believers in being accountable for the money we receive from government departments. However, our concern is that we seem to be heading towards a situation where reporting requirements are time-consuming and burdensome. With limited staff and increasing client demands, it is becoming more and more difficult for staff to collect the information and then be expected to write reports. We believe this is an area for reconsideration.

The Perth City Mission argued that in order to meet the new accountability requirements and to respond to consultations such as that mounted by the Task Force on Drug Abuse, additional resources were required: for salaries, for training and for equipment.

Funding in general is a sore point. The Perth City Mission wrote that although its residential facility for youth, Yirra, was meeting an important need in servicing groups identified as priorities in both the National and State Drug Strategic Plans, it was on the brink of closing down due to lack of resources.

Emerging from a number of submissions is a sense of resentment that the non-government sector is being used to provide services 'on the cheap'. Palmerston wrote:

> There have been ongoing difficulties between the government and the non-government sector. The non-government sector has been under-resourced with large caseloads and observed the government sector operating with relative ease: well-catered for in terms of facilities, conditions, salaries and resources.

Cyrenian House is concerned that inadequate government support is leading to an over-dependence on volunteers:

> ... a primary reliance on volunteers to operate a service in the drug/alcohol field cannot be endorsed. The cost to the community of drug/alcohol misuse is well documented and must be acknowledged as far too serious to rely on more than the assistance of voluntary staff.

The National Council of Women of Western Australia agrees:

> Non-government organisations involved in treating drug and alcohol sufferers should be staffed by experienced and professionally trained personnel and have sufficient ongoing funding to ensure continuity.

2.4.3 COMMUNITY ACTION

The non-government sector and the community are not, strictly speaking, distinct entities. As Youth Services of the Uniting Church put it:

> Many 'non-government sector' agencies have originated in community awareness causing persons to come together and initiate action.

Many Western Australians participate in the activities of non-government organisations by making donations, by assisting in a voluntary capacity with prevention and treatment programs, or by serving on boards and committees. The Task Force met many of these people during its consultation, as well as their professional colleagues, and was greatly impressed by the level of their commitment which sometimes extended to attending several separate meetings (wearing various hats) with the Task Force.

The consultation also made it abundantly clear that large numbers of people are contributing a great deal to the prevention of drug abuse through their dedication to their families and their involvement in community organisations of various kinds.

Rotary International Western Australia, for instance, participates in a number of initiatives directed at reducing drug abuse. It has been:

- the instigator of public meetings to inform communities of the dangers of legal and illegal drugs;
- a major sponsor of the Peer Support Program in high schools;
- a prime supporter of Life Education Centres;
- a supporter of rehabilitation centres and programs.

Rotary International Western Australia regards community-based projects as essential:

> .. so that the community does not avoid their responsibility to be aware of, and own, the problem, and contribute to the solution.

This was a sentiment echoed frequently at the hearings, with people saying spontaneously, ‘Drug abuse is a community problem, we own it, and we have to do something about it.’

The Willetton Youth Community Connection is convinced that youth drug abuse will yield to nothing less than concerted community action:

> .. only through members of the community coming together and working constructively, as we are now doing, will drug abuse by young people be turned around.

It was widely felt that the most valuable single contribution that the community as a whole could make would be to abandon the mixed messages being sent to our youth and develop a new attitude to drugs. The Australian Family Association put it this way:

> Powerful anti-smoking messages have seen cigarette smoking being portrayed as extremely dangerous and anti-social. We as a community need to start promoting the same attitude with regard to alcohol drinking and other drug taking to enforce our view that abuse of any drug, whether it be cigarettes, alcohol or Ecstasy etc, is not acceptable and can be extremely dangerous, not just to the user but to other people as well.

The National Council of Women of Western Australia took a similar view:

> Youth groups can play a very valuable role in providing meeting places with a positive atmosphere and exciting activities, but unless adults change and become less dependent on the socially acceptable drugs of alcohol and tobacco young people will copy them, although the dependency may differ, e.g. speed, Ecstasy etc.

A number of ideas were put to the Task Force that would enable the community to become more actively involved in tackling the problem of drug abuse; among them were the following:

- ... at risk-young people (but no more than two) to be placed at any one local club, to benefit from the activities offered and the company of other young people and responsible adults.
  (Ian Dawson)

- Alcohol and drug support groups to be developed in every town, both for users and their families.
  (Reverend Frank Roe)

- The community to give more support to new parents and the parents of young children, to reduce the stress they face.
  (Port Community High School)

- Community support groups to be encouraged to assist families dealing with drug abuse.
  (Australian Family Association)

- Public forums to be held where people have the opportunity to express their concerns and gain access to current relevant information about drug use.
  (SEASAP)

- Community newspapers to inform the community about services offered and drug education.
  (SEASAP)

2.5 REGIONAL REPORTS

At all hearings and meetings held in regional centres, including sub-regional centres in the Perth metropolitan area, discussion covered the full range of issues relating to alcohol and other drug abuse. While views about more general issues have been incorporated in the topic reports immediately preceding, these regional reports focus on community opinion about local matters.

As with the topic reports the information outlined reflects the perceptions of the community as put to the Task Force, and whether controversial or even misguided, are included for this reason. Again a descriptive rather than a detailed summary is provided.

In all regions the Task Force was able to hear from a wide range of people through the public hearings and individual consultations. State Government and non-government agency staff, professionals, hotel owners, parents and young people all put their views forward.

The reports are set out to cover the following regions: Perth-Mandurah; Bunbury and the South-West; Albany and the Great Southern; Kalgoorlie and the Goldfields; Northam and the Wheatbelt; Geraldton, Carnarvon and the Gascoyne; the Pilbara; and the Kimberley. Issues pertaining to individual suburbs or towns are highlighted as appropriate. For each region the report outlines: a description of the problem(s); issues specifically regarding youth; any recent local initiatives; control issues and proposals; and prevention and treatment issues and proposals.

2.5.1 PERTH — MANDURAH

The Task Force held public hearings at the following centres: Fremantle, 22 February 1995; Warwick, 1 March 1995; Midland, 15 March 1995; Northbridge, 22 March 1995; Mandurah, 10 April 1995. A total of 252 people attended these hearings. In addition, a number of written submissions touched on local issues, particularly in outlying suburbs.

The hearings in Fremantle and Northbridge, in particular, concentrated on general rather than local issues, which is perhaps hardly surprising given their central location. What seemed to be more important than specific location was distance from the centre of Perth: similar concerns tended to emerge in all outlying areas.

2.5.1.1 The problem(s)

Alcohol abuse was raised at various hearings as the most significant drug problem; people talked about it as a long-term problem in Australia that has been handed down from generation to generation and is showing no signs of abating.

Many people also expressed deep concern about what they perceive to be an overall increase in the abuse of illegal drugs, particularly amphetamines, and drug-related crime.

Even more than at the hearings in rural areas, people concentrated on expressing their anxiety about young people. It may be that the alcohol and other drug abuse problems of adults are more apparent in smaller communities.

2.5.1.2 Youth

Fremantle

Although the extent of youth drug abuse in Fremantle itself was not a major direct focus of comments at the hearing, concerns were expressed about youth drug abuse and the need for effective prevention and intervention. Drug Arm Western Australia reported in its submission that from its experience marijuana and amphetamines were the preferred drugs of young people in the area.

Warwick

It was reported as being common practice for young people to congregate in shopping centres and central locations on weekend nights, with children as young as 12 years of age drinking alcohol bought for them by older people. Part of the concern was the perceived connection between under-age drinking and offences that otherwise would not have been committed. It was reported that these groups of young people are moved on from time to time, but as someone said, ‘They just go somewhere else, so that doesn't solve the problem’.

Many people at the Warwick hearing were worried about the availability of illegal drugs in the area, saying that local dealers were active and well-known, and that amphetamines, in particular, were widely used. A mother from Ballajura reported that her 13-year-old daughter had claimed that cannabis was being given away in the toilets at school.

Boredom due to the lack of recreational facilities in some of the northern suburbs was suggested as being an important factor encouraging young people to experiment with alcohol and other substances. A similar situation was described in a written submission from the Willetton Youth Community Connection, as a mortgage-belt suburb that lies to the south of Perth.

Midland

In Midland, too, it was reported that young people drink on the streets and in parks; at one particular location, it was alleged that there is glue sniffing as well, and some adolescent prostitution to pay for alcohol and other substances.

Binge drinking seems to be the problem that causes most concern in Midland: the Task Force heard that the Sister-in-Charge of the Emergency Section at Swan District Hospital is alarmed at the amount of alcohol abuse she is seeing, and a publican said that some people are afraid to take the train at night because of the possibility of encountering inebriated, aggressive young people.

A teacher who works with young people between the ages of 12 and 15 who are in alternative education programs says that 75% of them drink alcohol if they can get it; they also sniff glue at times, he said, and use speed — although that is much less accessible because of the cost. He added that these children often say that the reason they dropped out of school was because 'they can't go a whole day without a smoke'.

Solvent abuse is certainly perceived as being more common in Midland than elsewhere, although not occurring on anything like the same scale as alcohol abuse. The Task Force was told that about 30 young people who attend the Midland Community Youth Centre are regular sniffers; they are said to sniff anything they can get their hands on. It was separately reported that there are about 20 young Aboriginal people in the area who not only abuse solvents, but are dependent on them.

People agreed that cannabis is widely used, often in combination with alcohol. It was said that young people tend to grow their own, so they are not dependent on suppliers. There was not the same concern expressed about cannabis as about alcohol, solvent abuse or amphetamines.

As in the northern suburbs, experimental drug taking is commonly put down to boredom and the lack of employment prospects for young people. Someone at the public meeting, speaking about his son's friends, said that when asked why they drink so much they answer, 'Why not? We have nothing to look forward to but the dole.'

Armadale

Although no hearing was held in Armadale, due to pressure of time, indications from written submissions, including one from the City of Armadale, were that the problems experienced there are very similar to those of Midland: incomes are also relatively low in Armadale and there is a very high youth unemployment rate (33.6%) associated with the heavy use of a range of substances, including solvents. Drug Arm Western Australia wrote that young people in the Armadale/Kelmscott area tend to begin on thinners or alcohol and move on to marijuana/amphetamines.

Mandurah

Parents said it was very common in Mandurah for 14- and 15-year-olds to be drinking alcohol and smoking cigarettes obtained for them by older people. Their observations confirmed the experience of Drug Arm Western Australia, which reported that alcohol was the substance most commonly used by young people in this area.

There was also a great deal of concern expressed about illegal drugs, particularly amphetamines. It was reported that a lot of used syringes were frequently found around Mandurah.

A woman reported that her daughter claimed that 'she could get anything at school', and that some young people were sniffing butane.

2.5.1.3 Control issues and proposals

Control issues did not seem to be particularly localised; most major concerns that follow were shared by some people at each hearing.

The supply of alcohol for under-age drinking by young adults/adults was widely frowned upon; at the Warwick hearing it was suggested that plain clothes police officers be stationed outside liquor outlets to apprehend the culprits.

Although some parents were very concerned about the effects of cannabis on young people, most people seemed not to regard it as a major problem; certainly, they did not put it in the same class as amphetamines and related drugs.

In Warwick and Mandurah, particularly, it was thought that the penalties for dealing in drugs such as amphetamines were inadequate to serve as an effective deterrent, and that dealers should be pursued more vigorously by the police.

In Mandurah, some parents were alarmed that implements for smoking marijuana (bongs) could be bought at the local markets; they suggested that the legislation should be amended to prohibit their sale.

2.5.1.4 Prevention and treatment proposals

The most frequent comments made about prevention and treatment concerned lack of services. For instance, at the Fremantle hearing a social worker said that specialist services in Perth were very centralised, with little available in Fremantle or Armadale, or anywhere around the edge of the metropolitan area. In Warwick and Midland, too, people said that more local services were needed; in Midland, people claimed that there was a real barrier preventing young people from going to Perth for treatment, even though minimal treatment was available in Midland for children and adolescents suffering from substance abuse. In Mandurah, it seems that services for adults are scarce: a woman said that every Friday evening she travelled to Perth with her brother, a recovering heroin addict, for counselling — she said there was nothing for anyone over 25 in Mandurah. Another woman in Mandurah said that she had been shunted between nine different organisations in a single day on the telephone, without receiving any help from anyone.

The overall perception seemed to be that treatment services are notably lacking in outlying areas and that prevention in the form of recreational activities and youth counselling is very much under-funded, even though Youth Centres in places like Midland and Bassendean are regarded as doing an excellent job.

Specific proposals made included the following:

- A detoxification centre to be established in the Midland area, with provision for long-term rehabilitation afterwards.

  (Midland)

- An adult sobering-up shelter to be established in Midland.

  (Midland)

- Funding to be provided to enable the position of Substance Abuse Officer for the Midland region to be retained after June 1995.

  (Midland)

- An Aboriginal outreach worker to be appointed in the Midland area.

  (Midland)

- More harm minimisation programs to be put in place, to ensure that information about safe use of drugs is available.

  (Midland)

- More containers to be provided for the disposal of needles and syringes.

  (Fremantle)

- Co-ordinated community action in Mandurah to bring together community groups and organisations and help them respond to clearly identified common needs.

  (Mandurah)

It will have been noted that the Midland community has been particularly active both in expressing its concern about the substance abuse problems of young people in the Midland area and in proposing solutions.

2.5.2 BUNBURY AND THE SOUTH-WEST

The Task Force visited Bunbury on 20 February 1995. A public hearing there was attended by 38 people. Meetings were held with the regional hospital, the youth accommodation program, representatives of justice and

welfare agencies, and the Aboriginal Progress Association. Written and oral (via the Telecentre hearing) submissions were received from Bunbury, Collie and Walpole.

2.5.2.1 The problem(s)

Problems were reported with the whole range of drugs and it was argued that drug abuse had become a fact of life.

Alcohol was perhaps cited most often and its associated reported damage — such as family violence, Homeswest evictions, unemployment — made it the priority issue for many people. Aboriginal people thought that as many as 70% to 80% of their families were affected in one way or another. Binge drinking was considered a major problem among adults and youth.

Illicit drug concerns predominantly focused on amphetamines with their use considered to be widespread and growing. Cannabis use was also referred to as widespread, the Bunbury Catholic College, for example, describing it as a de facto legal drug, and although there was a significant divergence of views and many concerns expressed, more often cannabis was regarded as not causing significant problems.

There was much concern expressed, particularly by health and welfare professionals, about various medications being too readily available or prescribed. Minor analgesics and benzodiazepine tranquillisers such as Valium and Serapax were mentioned most frequently.

It was reported that solvent abuse among youth occurred periodically but had not been a problem recently.

With respect to the community's capacity to respond to the issue, various people referred to a lack of communication and co-ordination between agencies, the need for prompt government financial support for community initiatives, and the ignorance of parents about drugs and how to handle the issue.

2.5.2.2 Youth

Alcohol abuse was generally regarded as the main problem among young people. Chaotic binge drinking, out of control parties, and its association among at risk youth with suicide, depression, accidents, crime and violence all made it a major issue in Bunbury.

The propensity of youth to combine use of alcohol and cannabis, which was reportedly the case for a 15-year-old who had drowned not long before the Task Force's visit to Bunbury, was referred to as more of a problem than cannabis itself.

Amphetamine use was considered to be an issue among young adults rather than youth.

2.5.2.3 Recent local initiatives

Participation in the local rock eisteddfod, which is sponsored by the National Drug Strategy and culminates in State and national competitions, was applauded as an excellent opportunity to promote a ‘drug free high’ for youth.

2.5.2.4 Control issues and initiatives

The issue of selling alcohol to people who are drunk was raised, and some police suggested that responsibility for enforcing the Liquor Act may be best met by a licensing squad rather than the Police Department which cannot make it a priority.

There were mixed views expressed about the danger posed by magic mushrooms which grow seasonally in some areas in the south-west. While police devote some not insignificant time to intercepting people seeking and using mushrooms, some asserted that this was a complete waste of valuable police resources.

Aboriginal people advocated that there should be more Aboriginal police and police aides.

2.5.2.5 Prevention and treatment issues

The need for more localised prevention initiatives was raised on a number of occasions.

Other prevention strategies that were frequently referred to included: banning alcohol advertising, drug education for children from the primary years to Year 12, and more support for parents. One person proposed that employers should have alcohol policies that focus on breaking down a culture of alcohol use.

Aboriginal people proposed that there should be more Aborigines in mainstream health, justice and welfare roles, and providing education for Aboriginal people.

The availability of a comprehensive range of treatment services; detoxification, outpatient counselling and residential rehabilitation; was requested frequently. The Collie Shire Council suggested that the Government could provide dollar for dollar funding for drug abuse workers for small towns.

2.5.3 ALBANY AND THE GREAT SOUTHERN

The Task Force visited Albany on 13 February 1995. The public hearing in Albany was attended by 46 people. The Task Force also met representatives of State health, justice and welfare agencies; the Albany Aboriginal Corporation and the Southern Aboriginal Corporation, together with Aboriginal health workers; the Albany Regional Drug and Alcohol Advisory Council; and a local general practitioner and pharmacist. Written and oral (via the Telecentre hearing) submissions were received from Albany, Katanning, Lake Grace and Walpole.

2.5.3.1 The problem(s)

In Albany, alcohol was identified as the main problem. This was also the case for Katanning and for most of the region. Binge drinking, public drunkenness and an increase in alcohol-related violence in recent years were cited as particular concerns.

It was reported that illicit drugs were available throughout the region. Cannabis use is apparently widespread, particularly in some centres where it is believed to be grown and where it is considered to be 'part of the local culture'. Both Aboriginal and non-Aboriginal people indicated concern about the extent to which it is used. It was said that both heroin and amphetamines are available in Albany, with the latter becoming more readily available (but still less so than in Perth). One professional worker reported that amphetamines were becoming increasingly popular with Aboriginal youth and that this was part of a process of 'Americanisation' with some young people.

Solvent abuse was referred to as a problem among Aboriginal children, sometimes involving those as young as eight years of age, but it was agreed that it occurred in waves rather than constantly.

A number of opinions were voiced as to why drug abuse has developed into a significant problem, ranging from one person's view that 'It's part of the degeneration of society', to the belief that some parents spend too little time with their children, to the recognition that adolescence is a time when the urge to experiment tends to coincide with the opportunity.

Concern was also expressed by a few people about doctors being too ready to prescribe drugs thus promoting a mentality that drugs cure all ills, and that more care needed to be taken in prescribing for the elderly particularly.

2.5.3.2 Youth

Two concerns dominated discussion about young people. First, it was reported that weekly binge drinking among 12 to 14-year-olds was fairly widespread, and in some cases an entrenched pattern of behaviour. It was claimed that young people pay taxi drivers five dollars a time to obtain alcohol for them.

Second, the attitude towards cannabis and its fairly widespread use troubled many people. As one person said:

> In the high schools, kids are convinced that everyone smokes marijuana and that it has no bad effects.

It was reported by a court worker that 90% of young people who appear in the courts are involved with alcohol and/or other drugs.

2.5.3.3 Recent local initiatives

- St Joseph's College, a Catholic secondary school, has declared itself to be a drug- free environment.

- The Albany Aboriginal Corporation has a project in conjunction with the National Research Centre for the Prevention of Drug Abuse to survey drug use among eight to 17-year-olds, in order to provide objective data to inform future programs.

- The Albany Port Authority was one of the first ports in Australia to sign a memorandum of understanding with the Australian Customs Service as part of their Front Line scheme. This is a campaign to enlist the assistance of industry to fight illicit drug trafficking through improved security, detection and follow up of information.

2.5.3.4 Control issues and proposals

A number of people argued that controlling the supply of illicit drugs is fundamental to tackling the issue. As one person demanded, 'Wherever they're coming from, stop them!' Some were uneasy that Albany as a port, and thus vulnerable to being used as an entry point, has only one customs officer.

The permissive attitude towards illicit drugs was a concern to many and one individual, representing the Christian Action Group, argued that:

> There are dissenting voices calling for the decriminalisation of drugs, especially marijuana; these voices need to be silenced.

There was a call for resources to be devoted to enabling police to conduct random tests for illicit drugs as they do with random breath testing to detect drink driving.

With respect to solvent abuse, some people advocated that, 'Shopkeepers shouldn't be allowed to sell solvents to kids'.

2.5.3.5 Prevention and treatment proposals

Education for children, youth and parents was promoted by many people. Some thought that education in schools should begin in the earliest years of primary school, others at the start of high school. There were calls for drug education for young people to be compulsory and one person also proposed that it be compulsory for parents before they could receive any social security benefits for children.

The importance of employment and training programs in preventing social problems such as drug abuse was emphasised by the Great Southern Development Corporation.

Other suggestions for prevention included removing taxation from low alcohol drinks, banning alcohol advertising, involving school chaplains and Junior Councils, and using embarrassment and humiliation as strategies to discourage further offences.

There were widespread calls for more treatment facilities including detoxification, residential rehabilitation and safe houses, as well as more outpatient services. It was often mentioned that 'going to Perth doesn't work'. A local pharmacist and doctor argued that methadone maintenance should be available and that it might be appropriate for 20 to 30 people in Albany.

2.5.4 KALGOORLIE AND THE GOLDFIELDS

The Task Force visited Kalgoorlie on 7 and 8 March, 1995. The public hearing was attended by 42 people; meetings were also held with the Kalgoorlie Drug Action Group, with representatives of Aboriginal organisations, and with representatives of government agencies. Written and oral (via the Telecentre hearing) submissions were received from Kalgoorlie, Esperance, Leonora and the Yilgarn.

2.5.4.1 The problem(s)

There was universal agreement that the most serious drug problem by far in the Goldfields is abuse of alcohol, because it is so widespread and because its impact in such areas as domestic and public violence, child neglect, drink driving is so great.

According to the Drug Action Group, the Goldfields is a region where heavy drinking is the norm: it is said to have the second highest level of alcohol consumption in the English-speaking world, and the amount of alcohol consumed per head there is twice the State average. Even worse, the view was put to the Task Force that the

level of alcohol-related problems there is **more than twice** as high on the grounds that the arrest rate in Kalgoorlie for crimes against another person is four times the State average.

'Work Hard, Play Hard' was said to be the guiding motto of many people in the region: people earn a lot of money and spend it quickly on drinking. The biggest problem is perceived to be not chronic dependency, but binge drinking, especially by young males.

Excessive drinking is supported by the practices of 'buying rounds' and 'shouts', and promoted through 'Happy Hours', and drinking competitions and cut price liquor. With 49 licensed premises, some opening at 6.00am, the hotel industry in Kalgoorlie is highly competitive. According to local publicans, however, drinking on licensed premises is only the tip of the iceberg: they say that 80% of drinking occurs elsewhere.

Suggested reasons for the high level of alcohol consumption included isolation and loneliness (the male to female ratio in Kalgoorlie is 5 : 1, and presumably is much higher in some mining communities); lack of entertainment options that don't involve alcohol; and the fact that much of the population is transitory, with many people regarding themselves as being in Kalgoorlie or in the Goldfields for a good time — not a long time.

It was repeatedly claimed, however, that an all-pervading cause is a deeply entrenched local culture, as old as Kalgoorlie itself, that glorifies binge drinking. As one submission put it:

> There is a myth that to be a real man in the Goldfields, you have to chuck up at least once a week.

Such attitudes prevent people from acknowledging they have a drinking problem, and have apparently attached a stigma to seeking help.

It was suggested that although Aborigines may be criticised for drinking by some non-Aboriginal people, they only attract attention because they prefer to drink in groups in public places and are therefore more visible.

People agreed that cannabis is used, and some other illicit drugs, but most felt they faded into insignificance in comparison with alcohol.

The Public Health Physician, however, was concerned at the increase that has occurred in the past 18 months in the number of people with Hepatitis C, most of whom, he said, are intravenous drug users.

2.5.4.2 Youth

Drinking is perceived as being a significant problem for young people, as well as adults: one person said he had been told that 600 - 700 high school students in Kalgoorlie had a drinking problem.

A health worker reported that a favourite social activity of many Year 10 students in Southern Cross was watching videos or television while they consumed cannabis and alcohol.

Paint sniffing is apparently more common than petrol sniffing in Kalgoorlie, and is a matter of some concern, even though it is confined to a small group.

A major reason for young people indulging in alcohol and other drugs in Kalgoorlie was identified as the relative lack of recreational facilities. One person said:

> For kids without money in this town there is nothing to do. Even with the sporting clubs you need money to participate. The Aboriginal families here, and some non-Aboriginal families too, are on the outside looking in.

In addition, it was thought that growing up in a community and, particularly, in a family that habitually abused drugs made it very difficult for young people to avoid being 'sucked in'.

Peer pressure was identified as another powerful force, with young people being dared by their friends to experiment with alcohol and other drugs.

Representatives of Aboriginal organisations expressed great anxiety about their young people. They said many young Aboriginal people found the only units available to them at high school were not what they wanted to

learn, and that with jobs almost impossible to get they felt excluded from the system and without prospects for the future. Under these circumstances, they had no incentive to develop themselves and avoid drugs.

2.5.4.3 Local initiatives

- The Kalgoorlie Drug Action Group has recently ratified an 'Alcohol and Other Drug Plan'. Under the Plan, the top priority is for the Group to form links with similar committees around Western Australia, to enable issues to be addressed on a Statewide basis.

- Ninga Mia, an Aboriginal residential community on the edge of Kalgoorlie, has started a pilot program that covers basic self help skills; the program is employment related and includes literacy, obtaining a driver's licence, and first aid.

- A successful primary school program has been established at the East Kalgoorlie Primary School, under which teachers and pastoral care staff such as Health Care Workers go into homes and work with parents who are having difficulties; it is supported by an early intervention program that begins before the child enters school and is followed up by a secondary school program that provides work skills.

- The Aboriginal Community Patrol in Kalgoorlie was reported as being ‘one of the best things that has happened in this town’: operating three days a week, it was reported that the Patrol has cut the number of people going into the lock-up by 75%. Anyone found drunk on the street is taken home or to the sobering up shelter. The only problem, apparently, is finding enough volunteers to drive the bus.

2.5.4.4 Control issues and proposals

Many thought that the Liquor Licensing Act was not being adequately enforced, and that under-age drinking, in particular, should be monitored much more carefully.

It was suggested that more responsible serving practices should be required on licensed premises, and that consideration should be given to raising the minimum penalties for offences under the Liquor Licensing Act.

The 6.00am opening time that has been traditional in mining communities was criticised by a number of people.

A levy on the sale of alcohol was proposed, with the revenue raised to be directed to alcohol treatment and prevention projects.

2.5.4.5 Prevention and treatment proposals

Among the suggestions made were the following:

- Drug education to start in Years 1, 2 or 3.

- A realistic drug education program to explain safer drug use practices to youth.

- More education through the media to target safe drinking and encourage people to seek help.

- More resources for counselling that focuses on controlled drinking techniques, in order to reduce binge drinking.

- More low cost recreational activities to be made available to youth.

- More alcohol-free social events for young people to be given support.

- More appropriate counselling and support for Aboriginal families and fringe-dwellers.

- Effective decentralisation, with better housing and working conditions provided to encourage government offices to make a long-term commitment to the region.

- Better co-ordination of government and non-government activity.

2.5.5 NORTHAM AND THE WHEATBELT

The Task Force visited Northam on 3 April 1995. Some 28 people attended the public hearing held there. Meetings were also held with representatives of the Police Department, Health Department, Ministry of Justice, Department for Family & Children's Services and various Aboriginal groups. Written and oral (via the Telecentre hearing) submissions were received from Northam, Merredin, Mukinbudin, Nungaring and Pingelly.

2.5.5.1 The problem(s)

Alcohol was regarded as the main problem throughout the Wheatbelt. Weekend binge drinking was considered a particular problem. It was estimated that alcohol featured in some 20% of child protection cases managed by the Department for Family & Children's Services.

It was reported that cannabis use was widespread throughout the region and that it was grown locally in Northam.

The main illicit drug problem, however, was regarded as amphetamine use. A senior police officer reported that two recent murder investigations had involved amphetamine use and that it was regularly associated with crime. Northam suffered most obviously from the presence of amphetamines, perhaps because of its proximity to Perth.

2.5.5.2 Youth

Binge drinking among 14 to 18-year-olds was reported to be the main problem among youth.

It was thought that most illicit drug use by young people was more experimental than problematic.

There was some concern expressed that youth were often loitering on the streets late at night and that there is, among some young people, a sense of helplessness and hopelessness about their future prospects.

2.5.5.3 Recent local initiative

The Health Department reported that it had conducted a pilot peer education initiative, the Positive Outlook Project. The Project involved lifeskills training for Year 10 students who in turn trained Year 7 students. While not specifically targeting drug abuse, this approach acts indirectly to prevent the problem.

2.5.5.4 Control issues and proposals

The public hearing in Northam and various submissions reflected polarised views about how both licit and illicit drug abuse should be controlled:

- Some argued that the number of liquor outlets should be restricted, while others felt that hotels could be effective venues for family entertainment, providing models of moderate drinking behaviour and supervision of youth.

- Greater police powers to pursue drug traffickers and resistance to any move to liberalise laws regarding illegal drugs were advocated strongly by some, although others argued that the very illegality of some drugs was the source of most of the problems associated with their use.

2.5.5.5 Treatment and prevention proposals

Drug education at schools and more support for parents were both proposed frequently. (The Department for Family & Children's Services in Northam, however, advised that they had received little response when they provided parenting education courses.)

More alcohol and drug education was also suggested for the various health, justice and welfare professionals who work in contact with persons with alcohol and drug abuse problems.

A major theme emphasised by a number of people was that the community needs to take the initiative in supporting parents and youth, and acting to prevent drug abuse. For example, one person in Mukinbudin referred to the common association of heavy drinking with sport and the need to take local action to promote moderate drinking; he said, 'People need to know that it's OK to remember what you did'.

Aboriginal people referred to the need for more role models for young people.

The absence of professional treatment resources, and particularly the recent withdrawal of sessional counselling by the Alcohol and Drug Authority, was frequently bemoaned.

It was suggested by the local Member of the Legislative Assembly, Max Trenorden, that hospitals in small towns, which tend to be under-utilised, could develop the skills to deal with alcohol and drug abuse cases. The development of services at the Dalwallinu hospital was cited as a good example of what could be done.

Aboriginal people argued that an Aboriginal Medical Service should be established for the Wheatbelt Region and that there should be more Aboriginal Health Workers.

2.5.6 GERALDTON, CARNARVON AND THE GASCOYNE

The Task Force visited Geraldton on 27 February and Carnarvon on 16 and 17 March 1995. The public hearings in these communities were attended by a total of 59 people. Meetings were held in Geraldton with representatives of State and local government, youth services, the Geraldton/Greenough Alcohol and Drug Advisory Committee, the Yamatji Patrol, and senior officers of the Geraldton Regional Hospital. Meetings were also held with the Carnarvon Drug and Alcohol Advisory Committee and the Aboriginal Medical Service in Carnarvon. Written and oral (via the Telecentre hearing) submissions were received from Geraldton, Carnarvon, Meekatharra and Shark Bay.

2.5.6.1 The problem(s)

It was widely acknowledged that alcohol abuse is the major drug problem throughout the Mid-West and the Gascoyne. The average amount of alcohol consumed per year was quoted as being 14 litres in Geraldton and 16 litres in Carnarvon, both well above the State average of 11 litres.

Public drinking — in parks, on beaches, in the streets — was reported to be an activity that is largely, though not entirely, confined to Aboriginal people. Because public drinking is so visible, it was suggested, people tend to focus on it as the primary concern. Yet the Task Force was told in Carnarvon that non-Aboriginal people tended to drink heavily at home, and a health worker in Meekatharra said that at least 50% of the people there, from both the mining and Aboriginal communities, had a drinking problem. Health professionals perceive the lack of awareness of the widespread nature of alcohol abuse as a major problem in itself.

Significant health problems were identified as arising from alcohol abuse, including the appearance of illnesses associated with long-term chronic dependency at a much earlier age than has been typical. An increase in sexually transmitted diseases, including HIV, as a result of unsafe sex practices under the influence of alcohol was another matter of grave concern.

Domestic violence and child neglect/abuse were frequently mentioned as major regional problems almost always associated with the abuse of alcohol and sometimes other drugs. Domestic violence causes particular worries in isolated communities, including Carnarvon, because of the lack of crisis care services available. And in Geraldton the General Manager of the Regional Hospital said many neglected children finish up in hospital: ‘Kids get really sick in this town because of neglect, malnutrition or poor health care — and it's all due to alcohol and other drug abuse.’

Cannabis appears to be easily available and widely used. It is a matter of considerable concern to some, although others clearly regard it as preferable to alcohol on the ground that cannabis is not conducive to aggressive or violent behaviour.

Tobacco smoking was cited as a major health problem in Carnarvon, but most people seemed relatively unconcerned because, like cannabis, it is not associated with troublesome behaviour.

It was suggested that a rise in injecting drug use seems to be indicated by the relatively high numbers of needle sales in Geraldton. It was quite frequently put to the Task Force that right along the Gascoyne coast many fishermen use amphetamines to enable them to work long hours at sea, and also for recreational purposes when in port. Some deaths on boats were claimed to be related to drug abuse.

In Carnarvon the Task Force was told that what drives many people, particularly Aboriginal people, to alcohol and other drug abuse is boredom and frustration arising from the extreme difficulty of finding employment.

2.5.6.2 Youth

Geraldton

Binge drinking of alcohol (spirits for preference) is regarded as the biggest drug abuse problem, together with tobacco smoking. Alcohol is said to be supplied by older people to teenagers between 13 and 14, leading to unsupervised drinking, followed by vandalism and street fights.

Other drugs are perceived as coming into fairly common use from the age of about 15. The Task Force was told that teenagers tend to see smoking cannabis as a recreational activity, no different from smoking tobacco. Poly-drug use at parties, with young people consuming a combination of alcohol and cannabis, and sometimes amphetamines, was reported.

Experimental drug-taking by young people was largely ascribed to boredom, due to the lack of alternative recreational activities at night. Apparently large numbers of young people congregate on the streets at night, particularly on the weekend, around the hotels and the two nightclubs.

Carnarvon

In Carnarvon, too, under-age binge drinking is a major concern, especially given the perception that the age level at which young people start to drink is continuing to come down. Most under-age drinking is reported to take place at private parties rather than hotels, with adults (including some taxidrivers) supplying the alcohol.

The Task Force was told there are a few glue sniffers in Carnarvon, usually from families badly affected by alcohol where the children miss a lot of school in the first couple of years due to parental neglect, can't catch up on the work and then refuse to attend. After glue, the children are said to graduate to alcohol and cannabis. (A school teacher estimated that between 8 and 10% of the children in her school came from turbulent family backgrounds.)

2.5.6.3 Recent local initiatives

- The Yamatji Patrol in Geraldton received considerable praise, with one person (unconnected to the Patrol) citing it as ‘a good example of community action and commitment’. The Patrol, which has 28 volunteer workers, operates day and night shifts, with members talking to young people and sometimes taking them home. The Task Force was told that the day patrol has helped reduce truancy and shoplifting in town.

- In 1994, the Carnarvon Positive Outlook Project was introduced; it was a school program based on peer tutoring under which the Year 10s taught the Year 7s about various matters. The Task Force was told that if the project were repeated a half-time co-ordinator would be needed to manage it.

2.5.6.4 Control issues and proposals

In Geraldton, concern was expressed at the amount of illicit drugs in the community; a number of people feel strongly that producers, importers and suppliers of these drugs are not being pursued with the full force of the law.

Throughout the region many people perceive the penalties being imposed for drug offences as insufficient to act as a deterrent; a number of people thought stronger penalties should be imposed, at least on dealers.

In Carnarvon, it was suggested that if the police were given wider powers it would make it easier for them to apprehend drug suppliers, who were said to be very elusive.

A popular proposal made in Carnarvon was that the availability of liquor should be restricted by changing the opening time from 8.30am to much later — 11.00am or as late as possible, was one suggestion.

2.5.6.5 Prevention and treatment proposals

Proposals made included the following:

Geraldton

- A sobering-up shelter for people over 25, to provide a shower, a bed and a meal. (Note: planning is reportedly proceeding for a sobering-up shelter to be established.)

- A detoxification facility, either within the hospital or separate from it.

- Improved, more accessible methadone arrangements.

- Recreational facilities for young people; activities close to the beach, away from residential areas, were favoured. Support to be provided by local government and business.

- Better co-ordination and pooling of resources to achieve shared aims across government agencies, so clients don't fall between the gaps.

Carnarvon

- Counsellor/educator position to be established according to a proposal developed by the Carnarvon Drug and Alcohol Advisory Committee.

- A sobering-up shelter/alcohol treatment centre.

- A crisis care centre to provide safe accommodation for victims of domestic and other violence and child abuse.

The attention of the Task Force was drawn to the very limited alcohol and drug services available in the region, apart from Geraldton; health professionals in both Carnarvon and Meekatharra reported extreme concern.

In both Geraldton and Carnarvon, the shortage of jobs is regarded as a major cause of alcohol and other drug abuse. Creating employment opportunities, especially for young Aboriginal people, is therefore a very high priority for the community.

2.5.7 THE PILBARA

The Task Force visited Karratha on 20 March and Port Hedland on 20 and 21 March 1995. Public hearings in each place were attended by 88 people. Meetings were held in Karratha with Pilbara Youth Services and in Port Hedland with the Port Hedland Alcohol and Drug Advisory Committee, Aboriginal workers from a variety of organisations, health professionals at Port Hedland Regional Hospital and representatives of local, State and Federal government agencies. Written and oral (via the Telecentre hearing) submissions were received from Port Hedland, Karratha and Roebourne.

2.5.7.1 The problem(s)

Alcohol abuse was invariably reported to be the major problem throughout the Pilbara. Regional consumption is reportedly close to 50% more than the State average, and in Roebourne town it is 350% more. It was commonly said that the Pilbara has a ‘culture based on drinking’.

Three distinct alcohol problems were described: public drinking, usually by Aboriginal people and most heavily around social security payment times; consistent, heavy drinking by people in employment; and binge drinking, particularly by young people.

Illicit drug use, including heroin and amphetamines but most commonly cannabis, was described as widespread in Port Hedland and prevalent, although to a lesser extent, in Karratha. Young people, including those at high school, were identified as the predominant users of illicit drugs, but people of all ages and social groups seemed to be involved.

Solvent use appeared to be a sporadic problem among young people.

Many submissions to the Task Force emphasised factors that are considered to be the root causes of drug abuse: unemployment, housing, school failure, and the alienation of Aboriginal people from mainstream opportunities. Domestic violence and child abuse were frequently mentioned as problems associated with alcohol abuse.

2.5.7.2 Youth

A number of people reported claims that illicit drugs were readily available at high schools, particularly in Port Hedland. Young people are apparently able to gain access to alcohol through older associates, taxidrivers, and sometimes parents and directly from licensed outlets.

Some people made the observation that experimentation, usually with alcohol and solvents, was beginning increasingly early, and that in some groups children as young as eight years of age were involved.

Young people's alcohol and drug use was often referred to as a natural response to their parents' use. Mixed messages about illicit drugs, and a tendency to minimise the seriousness of cannabis use, were also considered to encourage young people to start using drugs.

2.5.7.3 Recent local initiatives

- The DARE program (Drug Abuse Resistance Education), as used in the Northern Territory adapted from the United States of America, has been introduced in Karratha and is delivered in primary schools by police officers. It receives significant support in the town.

- A variety of sport and recreation strategies such as employing the local policeman in Marble Bar to work with youth after hours, have been promoted by Pilbara Youth Services.

- The regional hospital at Port Hedland provides inpatient detoxification at a rate close to two admissions per week, and occasional outpatient detoxification, and offers a needle and syringe exchange service.

2.5.7.4 Control issues and proposals

There was widespread support for restricting the number and/or hours of liquor outlets in Roebourne and Port Hedland. The Liquorland Manager in South Hedland expressed her support for some restriction of hours provided that the same conditions applied to all distributors. The Halls Creek experience, described in the Kimberley regional report, was often cited as an example of effective community action controlling alcohol supply.

More vigorous enforcement of existing legislation, both the Liquor Act provisions regarding serving intoxicated and underage drinkers and the Child Welfare Act in relation to young people at risk, was promoted frequently. The supply of alcohol by taxidrivers was highlighted as a priority for action.

Some Aboriginal people argued that the introduction of controlled drinking in communities would be more effective than maintaining dry communities as the latter result in substantial numbers of people drifting to towns as fringe dwellers.

With respect to illicit drugs, a number of submissions called for stronger penalties for suppliers to be combined with a less punitive approach towards users. Some people, however, thought that legalising the supply of drugs to addicts might result in more control of the problem.

2.5.7.5 Prevention and treatment proposals

There was a strong emphasis on more and earlier education for school children to prevent drug abuse. A number of submissions stressed that preventative programs and initiatives had to reflect local information and local issues in order to be effective.

Measures to minimise the harm associated with public drinking by fringe dwellers were advocated, including the provision of drinking fountains and shelters for people in South Hedland. One written submission from local business people expressed the frustration of many people that so little appeared to have been done to address the issue and looked to local government, particularly, for some concerted though unspecified action.

One person in Karratha argued that any harm minimisation approaches to illicit drug use, for example methadone treatment and availability of needles and syringes, should be avoided in order to prevent addicts being attracted to the region.

There were widespread calls for more services although this was tempered by a recognition that a greater impact might be achieved by existing services with better co-ordination, and a recognition that one non-government alcohol and drug service in Port Hedland is grossly under-utilised.

Aboriginal people in Port Hedland, as well as stressing the fundamental need for more employment opportunities, supported the need for an Aboriginal patrol, Aboriginal community police officers, educational initiatives by Aboriginal people for children and prisoners, and a rehabilitation facility.

2.5.8 THE KIMBERLEY

The Task Force visited Broome on 27 March, Kununurra on 28 March and Wyndham on 29 March 1995. Public meetings held in Broome and Kununurra were attended by 64 people. Meetings were held in Broome with the Aboriginal, Police and Community Relations Liaison Committee, the Community Policing Committee, and the Milliya Rumurra rehabilitation centre. In Kununurra, meetings were held with health, justice and welfare professionals; the Waringarri Alcohol Project; and head wardens from the Balgo, Kalumburu, Oombulgarri, and Warnum communities. Meetings were held in Wyndham with the Wyndham Action Group and the Joorook Ngarni Aboriginal Corporation. Written and oral (via the Telecentre hearing) submissions were received from Brome, Derby, Kununurra and Wyndham.

2.5.8.1 The problem(s)

Alcohol was identified as the major problem throughout the Kimberley. Numerous people, in the various locations, described a culture in which drinking is almost inseparable from living. A welfare manager summed it up:

> Wherever people go here, they take their stubby holder with them, like a gentleman's handbag.

Alcohol was reported as being frequently associated with family violence, child abuse and neglect, vandalism, poverty, assault and suicide.

Some people reported that significant numbers of Aboriginal people from dry communities have been coming into the towns in order to drink, particularly from Halls Creek since the introduction there of restrictions on the availability of alcohol.

Cannabis use was said to be widespread throughout the Kimberley, especially in Broome where it is apparently accepted by many as normal. Its use in varying degrees in Aboriginal communities was also reported. The extent to which cannabis was regarded as a problem varied widely, but no-one argued that it was as serious as alcohol.

Other illicit drugs, specifically heroin and amphetamines, are apparently available in Broome, particularly during the tourist season, and to a lesser extent in Kununurra. 'Doctor shopping' for prescription drugs for non-medicinal purposes was also reported in Broome.

Solvent abuse was mentioned infrequently; it was reported as an occasional experimental behaviour in the towns and a periodic but not current problem in outback communities.

2.5.8.2 Youth

Alcohol was identified as the main drug used by young people, with use commencing at a very early age. In Kununurra, it was reported that between 30 and 40 Aboriginal children under 15 are drinking, and that although drinking usually begins at a slightly later age for non-Aboriginal youth, by 15 many are binge drinking.

Some people regard all young people as being at risk particularly in areas where illicit drugs are available. One person in Wyndham expressed the views of many when he bemoaned the fact that Aboriginal youth are disheartened about their prospects in life, and that many therefore go on to abuse alcohol.

2.5.8.3 Recent local initiatives

- Aboriginal patrols have been established in Broome and Kununurra.
- Substantial limits have been placed on alcohol sales in Halls Creek following an application by various local community groups to the Liquor Licensing Court.
- When it has a function licence, as for the Shinju Mardi Gras, the Lions Club of Broome, sells low alcohol drinks for substantially less than alcoholic drinks.
- The establishment of a Junior Council in Kununurra was promoted as a means of providing positive role models in a town whose transient population provides few older adolescents for young people to look up to.
- Broome and Kununurra regional hospitals accept admissions specifically for detoxification.

2.5.8.4 Control issues and proposals

There were constant calls for limits to the number of liquor outlets and their trading hours in Broome and Kununurra. The desirability of having 27 licensed outlets in Broome, with liquor available from 8.00am to 6.00am, was often questioned. There was a strong feeling that local communities should have a much more important role in determining the fate of licence applications.

The success of the Halls Creek community in restricting the availability of alcohol to reduce the amount of alcohol-related harm was, notwithstanding the drift of some heavy drinkers to other towns, regarded as an example for other towns to follow.

There were also widespread calls for more education about the Liquor Act, more policing of licensing hours, and increased penalties for liquor offences. Mandatory training of bar staff was advocated by some.

Head wardens reported that their power to control behaviour in Aboriginal communities was inadequate; they stressed the need for changes to legislation, more community education and more resources to enable them to play an effective role.

With respect to illicit drugs, there were representations from some that there should be harsher penalties for suppliers, and from others that cannabis should be decriminalised.

2.5.8.5 Prevention and treatment proposals

A strong theme of all proposals made in the Kimberley was that local problems needed local solutions, and that it is not appropriate for either prevention or treatment initiatives to be directed from Perth. Similarly, it was emphasised that initiatives needed to be culturally appropriate for Aboriginal people.

There were a number of calls for alcohol advertising to be limited, phased out or banned outright as a means of making some impact on the dominant drinking culture. There was considerable support expressed for low alcohol drinks to be cheaper than high alcohol drinks.

Other proposals aimed at prevention included:

- T-shirt advertising, such as one Aboriginal community group's suggestion: ‘We're happy without grog’.
- More education at school.
- More support and education for parents and guidance as to how they can handle the issue.
- Innovative youth activities such as alcohol-free concerts.

Sobering-up shelters were requested in each town visited and planning was reportedly proceeding for them to be established. Some people advised that the Aboriginal patrols would benefit from more support and organisation. In Broome it was considered that a halfway house could improve the outcomes of the Millya Rumara rehabilitation program.

In Wyndham, the Task Force was advised by the Wyndham Action Group that it planned to utilise a block grant made available by the Ministry of Justice following the closure of the local prison to establish services for women, youth, and alcohol abuse. The proposed alcohol abuse services include a sobering-up shelter, town-based counselling and residential recuperation facilities. The Wyndham Action Group may be seeking some $370,000 plus the costs for operating the sobering-up shelter in recurrent funding in order to maintain services after the initial block grant is expended.

3. CHAPTER THREE PROVISION OF SERVICES

3.1 INTRODUCTION

This chapter concentrates on the provision of services for the excessive use of alcohol and the illicit use of drugs.

Tobacco is referred to briefly, only to describe the current indicators of best practice, as it is subject to different concerns. More than 90% of those who give up smoking do so on their own and there is much less need for provision of dedicated treatment services, notwithstanding that there is substantial scope for brief intervention by doctors and other health professionals. Problems arising from the licit use of pharmaceutical drugs are not discussed in detail because such problems are in part addressed by the services considered and recommended, and they are generally more amenable to change through public and professional education than specific services.

3.1.1 WESTERN AUSTRALIA'S POPULATION AND GEOGRAPHY

The system of services to treat and address the range of drug problems in the community must meet the unique conditions of Western Australia's population and geography.

Perth with its population of over 1.2 million has developed into a 'big city' with both the problems that characterise large cities and the difficulties pertaining to addressing those problems. In a city of this size, neither the network of mainstream health and welfare services nor a core of centrally located specialist alcohol and drug services can address the problems adequately alone. The size of the population indicates a role for both mainstream and specialist services, and the spread of population indicates a need for both centrally located and regionalised services.

Country regional areas with a total population exceeding 450,000 are characterised by the wide geographical spread of population and the relatively small size of many of the major centres particularly to the north and east of Perth. This presents major difficulties in ensuring the availability of a comprehensive range of services. In the smaller population centres a wider range of activities is required of mainstream services in order that all issues can receive some attention. Even in the larger centres that can sustain some specialist services, greater flexibility and a broader range of interventions are required to be delivered by a single service in order to meet the variety of local needs.

Additionally Western Australia has a number of special populations whose needs or characteristics require some difference in approach from service providers in order to be effective. Problems that develop among youth, the Aboriginal population, people from a non-English speaking background and to at least some extent women, each develop in a way that reflect their own cultural experiences. Consequently any treatment or support has to proceed from a recognition of the specific nature of these groups' problems and be appropriate to their cultural and life experiences.

3.1.2 DEVELOPMENT OF CURRENT SERVICES

Western Australia's services for people with alcohol and drug problems have developed over the past 20 years or so, and have benefited from the dedication of practitioners in both the government and non-government sectors throughout this time. In 1974 the Alcohol and Drug Authority was established, its early services including detoxification in a hospital-like setting, a residential treatment program in a rural setting, the centralisation of all methadone maintenance, and some outpatient counselling. Prior to this, the Association for the Care and Rehabilitation of the Alcoholic and Homeless had been established in 1971 to provide residential support for chronically alcoholic persons, and longstanding church charities such as the Salvation Army and the Daughters of Charity had also provided services for this group.

It was not until the early 1980s that a significant number of specialist non-government agencies were established and the available services broadened to include residential programs for persons addicted to illicit drugs, outpatient services for families and services to industry. These received varying degrees of support from the Government through the Alcohol and Drug Authority's Non-Government Agency Support Program.

Many of these services were the product of the experience and drive of their founders and tended to reflect idiosyncratic approaches to the problems they were established to address.

A major boost to the development of specialist services in recent times came through the establishment of the National Campaign Against Drug Abuse in 1985. Many non-government agencies were put on a firm financial footing for the first time in their history and were able to expand their services to include a broader range of clients and their families. The Alcohol and Drug Authority was able to develop specialist services in court diversion and telephone information and advice.

In the late 1980s and early 1990s further specialist services have been established in the non-government sector for women, for youth, and to minimise the spread of HIV among intravenous drug users. Additionally, following the decriminalisation of drunkenness some six sobering-up shelters have been established in Perth and regional centres. During this time the Alcohol and Drug Authority has with varying degrees of success attempted to shift its focus more towards community development, earlier intervention and minimising the harm associated with illicit drug use, while maintaining its core services for those with chronic problems.

The increase in resources in the mid 1980s, though static for most non-government agencies since and diminishing for the Alcohol and Drug Authority from the late 1980s, together with an expansion of professional education and training has seen a marked increase in the professionalism and performance of alcohol and drug treatment services over recent years. It is still not, however, a field in which the strongly held belief systems of some practitioners have given way entirely to the more rigorous body of research and evaluation that has been building nationally and internationally.

3.1.3 IMPACT OF TREATMENT SERVICES

Given the relatively short history of alcohol and drug services it should not be surprising that it is still necessary to emphasise that treatment is not a panacea for alcohol and drug problems. The problems addressed by treatment agencies are far from straightforward, affected as they are by the physiology and psychology of the individual and the social circumstances in which they occur, and so are not easily amenable. They are certainly not generally responsive to the singular cures that are periodically promoted by some claiming to have the answer to addiction. It is also salutary to note that in the public hearings conducted by the Task Force and in the submissions it received, it has been the family and friends of drug users and those service providers who see drug users in a range of health and welfare settings who are at the forefront of demand for more treatment services, it is rarely the users themselves.

Nevertheless, but with these cautionary points in mind, it has been clearly demonstrated that the benefits of treatment easily outweigh the costs. In the United States, the National Institute on Drug Abuse in a 1991 study estimated that every dollar spent on drug treatment saves between four and seven dollars in reduced costs to the public and three dollars in increased productivity (The White House 1994), while a more recent study of programs in California cites benefit to cost ratios of between 3.2 and 10 depending on the type of treatment (Gerstein 1994). A more modest but nevertheless positive result is reported in a United Kingdom study that calculates that besides any benefits that may accrue, the cost of residential treatment is at least offset by the avoidance of various other health and social service costs which would otherwise have been incurred (Unell and Vincent 1994).

3.1.4 CHALLENGES FOR SERVICES

The system of service provision in Western Australia will have to meet a number of basic challenges if it is to maximise its effectiveness and thus have a real impact on the problems that occur in the State. These might be described as follows:

- First, given the variety of drug problems and the diversity in the State, the range of services must be sufficiently broad to provide adequate coverage of the various treatment needs.

- Second, the system should be effectively linked to the community in which it operates so that it addresses identified needs and is able to adapt to changing circumstances.

- Third, both the system and individual services need to be able to maximise the number of persons engaged into treatment and retain them in treatment for the optimal period.

- Fourth, the system should require and support individual services to reflect best practice in the field.

- Fifth, the system and individual organisations must be cost effective.

3.2 INDICATORS OF BEST PRACTICE

3.2.1 OVERVIEW

A very substantial body of national and international literature and at least two decades of experience are available to the alcohol and drug treatment field to inform its practice.

In Australia, the National Drug Strategy's Quality Assurance in the Treatment of Drug Dependence Project has effectively set the current benchmarks for best practice in this country. Its publications, A Treatment Outline for Approaches to Opioid Dependence (Mattick and Hall 1993) and An Outline for the Management of Alcohol Problems (Mattick and Jarvis 1993) set out clear and specific conclusions and recommendations for practice. These were drawn from three sources of information: an empirical and narrative review of controlled research on the effects of interventions and treatments, surveys of current treatments in Australia, and the views of persons with substantial expertise in the field. These sources are able to provide the most comprehensive assessment of current treatment practice available.

Additionally, the Task Force has been fortunate to have access to a series of international literature reviews produced in late 1994 and 1995 (and as yet unpublished) covering an exhaustive range of specialist topics in treatment and service provision for drug abuse. These have been made available through the Task Force to Review Services for Drug Misusers in the United Kingdom, and the National Drug and Alcohol Research Centre. They include reviews of detoxification (O'Brien 1995, Kleber 1995), maintenance approaches (Mattick 1994), youth drug abuse (Spooner 1995), juvenile crime and substance abuse (Copeland and Howard 1995), women and drug dependence (Copeland and Hall 1995), the consequences of drug treatment for criminal behaviour (Reuter 1994), current findings in syringe exchange research (Des Jarlais 1994) and reaching drug users who are not in treatment (Booth 1995).

While this extensive body of knowledge does not provide definitive prescriptions, there are nevertheless clear directions and practice standards emerging from the research and expert opinion.

The indications for best practice outlined below do not attempt to be exhaustive but rather provide a summary of the current state of the art, reflecting the conclusions of these reviews. Additionally comments from various consultations, including the issues identified in the two national reviews currently underway, long-term residential treatment (Ernst & Young) and methadone treatment (KPMG Peat Marwick) are included where they reflect promising developments towards best practice.

3.2.2 INTERVENTION, SETTING AND DURATION

It is important to recognise that there is no monolithic entity that constitutes a drug problem. Problems that require or that would benefit from treatment will vary with the type of drug involved, the intensity and duration of use and the personal and social circumstances of the individual. It follows that the nature of any intervention, and its setting and duration will vary in accordance with the problem being targeted.

3.2.2.1 Goals of intervention

Similarly interventions will vary with the goals that are being pursued. Traditionally the goal of all treatment for all drug problems was abstinence from all drugs. More realistic and individually focused goals have, however, gradually been adopted. For example, methadone maintenance provides a legal substitute drug for an illegal drug; controlled drinking has been shown to be a viable goal for at least some problem drinkers; and most recently the goal of safe drug-using practice has been accepted as preferable to unsafe use for those intravenous drug users who show no inclination to stop using, in order that the harm of that drug use is minimised for the individual and for the community.

Recognition of the need for a variety of treatments reflecting the range of problems and client goals has significant consequences for the extent to which the community can make an impact on drug abuse. To illustrate this theme, it may be observed that in the United States where services are relatively narrow and largely abstinence focused, only 10 - 30% of illicit drug users are in contact with treatment services; in the Netherlands on the other hand where there is a broad range of flexible services, some 60 - 80% are in contact (Wardlaw 1992, Bull 1992).

With respect to illicit drug use, the Quality Assurance Project notes that inconsistency in desired treatment goals among patients and treatment providers reduces the effectiveness of treatment and gives rise to the erroneous

view that treatment is not effective. It argues that goals need to be realistic and may include, if not abstinence which will still be appropriate for some persons at some times, then reduction in illicit drug use, a reduced risk of infectious disease (e.g. HIV, Hepatitis B and Hepatitis C), the improvement of physical and psychological health, the reduction of criminal behaviour and the improvement of social functioning. It also argues that the range of treatment options for illicit drug users is currently too narrow and insufficiently attractive and that there is a need to develop new forms of intervention that will bring more users into treatment.

3.2.2.2 Assessment and client matching

Ideally, assessment of clients will form the basis for matching them to the appropriate treatment regime and inform the process of treatment. This does, however, overlook the reality that clients self-select treatment approaches, that some interventions are not sought but rather are applied opportunistically (e.g. brief intervention for excessive drinking and the provision of health and treatment information for persons seeking needles and syringes), and that any matching will of necessity be a compromise between the abilities of a clinician, the beliefs of the client and the range of services available. Nevertheless, the Quality Assurance Project sets out practical guidelines for assessing clients and matching them to the most appropriate interventions.

Illicit drug users should be assessed for the consumption of illicit and other drugs (including alcohol) and the degree of dependence, HIV risk taking, general physical well-being, psychological adjustment, criminality, social adjustment and functioning, and their motivation for change. The assessment should culminate in a summary of the facts and a formulation of clear treatment goals and plan which are discussed with and acceptable to the user. With respect to matching, in the absence of further research, it is recommended that clinicians guide clients on the basis of their expertise and by providing them with a comprehensive and clear listing of the treatment alternatives so that the client can make an informed decision.

The assessment of people with drinking problems should provide information about the client's consumption of alcohol, level of alcohol dependence, cognitive functioning, psychological co-morbidity, family situation, physical wellbeing, and readiness for change. It too should culminate in a summary of facts and a formulation of a clear, mutually-acceptable treatment plan that structures a specific intervention to meet the needs of the individual. Clients should be matched in terms of the severity of their dependence to more or less intensive interventions and also in terms of the specific deficits, problems and co-morbid states apparent in assessment.

3.2.2.3 Outpatient and residential treatment

In reviewing the research comparing the outcomes obtained in outpatient and residential treatment settings for people dependent on alcohol, the Quality Assurance Project confirmed the conclusions of an earlier review by Miller and Hester (1986) that there is no evidence that treatment delivered on a residential basis is superior to intervention delivered on an outpatient basis. Further the project concluded that residential treatment is not superior to day patient intervention, or that a longer period of residential treatment is superior to a shorter period.

It recommends, however, that residential treatment will still be necessary in some circumstances: for clients in need of closely supervised detoxification; those with severe alcohol-related brain damage, who cannot function independently; those who show severe deterioration, malnourishment or social instability and who require shelter for humanitarian reasons; and possibly those who have repeatedly relapsed to drinking after intervention and whose home environment cannot support non-drinking. The current review of long-term residential treatment (Ernst & Young 1995) similarly is finding that clients of these services tend to be more complex, have a longer history of use, more legal problems and have unsuccessfully tried less intensive treatments.

The appropriate interpretation of these conclusions may be that the residential and clinical intervention components of treatment meet different individual needs and that for at least some clients outpatient intervention coupled with supported accommodation may be a more cost-effective approach than residential treatment per se.

For illicit drug users, residential treatment generally takes the form of a therapeutic community and the Quality Assurance Project concludes that these offer an effective form of treatment for the small proportion of drug users who find them acceptable. These drug users will be those who suffer the more severe consequences of the harm associated with their drug use, criminal activity and social disadvantage. They report that, in contrast to persons with primarily alcohol problems, stays in excess of three months are necessary before enduring changes in drug use and criminal behaviour can be expected and that residents who complete programs are more likely to be successful than those who do not.

It recommends that therapeutic communities include the following activities: stress management; social, occupational and assertiveness skills training; relapse prevention; a program of gradual reintegration into the general community; harm reduction strategies; and aftercare. It also recommends that they work co-operatively with methadone providers where possible to facilitate cross referral of clients who are unsuccessful in either mode.

The Quality Assurance Project also reports that drug-free outpatient counselling has been shown to be as effective as therapeutic communities, and methadone maintenance, for some types of client. The studies reviewed indicate that these clients tend to be poly-drug users rather than opiate-dependent and less socially disadvantaged.

3.2.2.4 Nature of intervention

Whatever the setting and duration of treatment, the Quality Assurance Project advocates a supportive and empathic approach to counselling that provides a base for a highly organised and structured approach to intervention and the acquisition of skills. Specifically, it recommends the development of problem-solving skills, interpersonal skills, relaxation skills, and skills to cope with negative mood states and urges to drink or use drugs. These approaches are favoured because they have research findings to support their use, they are well described and articulated, they lend themselves to easy implementation, they are already well accepted in the Australian treatment community, and they are not incompatible with other approaches (such as the 12-step approach of Alcoholics Anonymous or Narcotics Anonymous).

The Quality Assurance Project specifically recommends against interpretative psychotherapeutic approaches and suggests that the onus is on those who would assert that psychotherapeutic approaches are appropriate to treatment to provide evidence of their effectiveness, especially compared to other better evaluated interventions.

It is emphasised that agencies and their staff should be capable of delivering treatments in a faithful and consistent manner and so it is proposed that there is a need for well-developed and articulated treatment manuals and protocols. Such written protocols should be highly detailed with full specification of all treatment procedures and complete instructions about how the interventions are to be implemented. Further, this structured approach should be supported with training and supervision of staff.

3.2.3 BRIEF INTERVENTION

Brief intervention is relatively new as a service description and focus of research. It involves, however, strategies that have been employed for a long time. Advice given by GPs in the course of their interaction with patients has, for example, long been recognised as an inexpensive and effective intervention (Russell et al 1979).

Brief intervention as discussed here involves screening for detection of excessive drinkers and a minimal counselling intervention. The screening process typically involves direct questioning about levels of alcohol consumption or a standard questionnaire, while the minimal counselling interventions that have been researched include advice from a GP, information and a self-help booklet, and a single counselling session.

It is considered to be an appropriate intervention for persons who do not necessarily seek treatment for their drinking behaviour, but whose presentation at generalist health and welfare settings provides an opportunity for intervention to occur. In hospitals for example, estimates of the number of admissions that are attributable to alcohol abuse are usually as high as 15% or 20% (see for example Bell et al 1994) and even a low estimate of 3%, based on aetiological fractions by English et al (1995), represents a large number of individuals, and these persons are seen as appropriate candidates for brief intervention.

The Quality Assurance Project reports that intervention with excessive drinkers (who do not typically display alcohol-related problems or the signs and symptoms of alcohol dependence) will reduce their drinking after a minimal intervention and that this effect is maintained in the long term. It advocates strongly that screening and early intervention be promoted in as many primary health care and other settings as possible as a matter of urgency.

The more extensive use of brief or minimal interventions for problem drinkers has been advocated in Western Australia for some time. Most recently, the Clinical Health Goals and Targets for Western Australia (Dobson and Penman 1994) has recommended the introduction of screening for early alcohol abuse and minimal intervention counselling both in public hospitals and general medical practice by 1998.

Consultations by the Task Force with a sample of public hospitals indicated that the most practical method of introducing screening would be to incorporate it into the nurses' intake assessment but that additional specialist staff would be most appropriate for the brief intervention.

3.2.4 DETOXIFICATION

Detoxification refers to the process whereby an individual who is physically dependent upon a drug is taken off that drug either abruptly or gradually. As a treatment it is supervised so that withdrawal symptoms are minimised.

Detoxification may take place at home with support and supervision on an outpatient or outreach basis, or in a residential or inpatient setting. It may be undertaken without any medication to assist the process or with the aid of drugs which produce similar actions to the substance(s) to which dependence has developed or which provide symptomatic relief. The range of appropriate pharmacological assistance is well researched and established and is outlined in the Quality Assurance Project.

With respect to alcohol dependence, the Quality Assurance Project reports that the withdrawal syndrome is typically without any major consequences in its mild to moderate form but that it can be life threatening when it is severe. Consequently it is appropriate that a range of detoxification services is available. Specifically, inpatient detoxification is indicated if there is a history of severe withdrawal symptoms, the probability of a severe withdrawal syndrome, serious concurrent physical or psychiatric disorders, or a home environment that is unfavourable to detoxification. On the other hand, outpatient detoxification, which is far more cost effective, will be appropriate when there is no sign of severe withdrawal, no history of delirium tremens or withdrawal fits, no contraindicating physical or psychiatric illnesses, adequate social support and supervision, and no access to alcohol or other drugs at home. Similarly, the use of medication should depend on the severity of the withdrawal syndrome.

The Quality Assurance Project notes that with respect to illicit drug users, the role of medication is important but limited and that somatic therapies, counselling and reassurance will all assist the process. While it notes that many persons dependent on illicit drugs will have experienced some self detoxification, the necessity for a stable home environment for successful outpatient detoxification may preclude the viability of this approach for many opiate addicts at least. It also notes that the prevalence of poly-drug use that varies with each individual will make the specific approach to detoxification a matter for individual clinical judgement.

In his review, Kleber (1995) does report some success, in terms of completion, for outpatient detoxification of opiate addicts using methadone, noting that higher rates of completion are attained if longer periods (four to six months) and higher doses are used.

In assessing the success of detoxification as a treatment in terms of sustained behaviour change, reviewers emphasise that it is of little long-term value as a stand-alone treatment. Rather its importance, particularly for illicit drug users, lies in its role as a gateway to more extensive services and interventions, and its success should be evaluated in terms of both completion rates and engagement into longer term treatment (Bell 1992, O'Brien 1995, Kleber 1995).

3.2.5 SOBERING-UP SHELTERS

A significant service development in Western Australia in recent years has been the establishment of sobering-up shelters to deal with the issue of public drunkenness. This development follows the decriminalisation of drunkenness in this State in 1989 and is in accordance with the recommendation of the Royal Commission into Aboriginal Deaths in Custody (1991).

Sobering-up shelters do not of themselves represent an attempt to change drinking behaviour. Rather they are a pragmatic response to significant community and individual problems. These services do, however, provide a first response to a community's drug abuse problems and an opportunity for constructive contact with the individuals concerned, and they have been credited with preventing violent incidents and deaths.

A recognition of the benefits of sobering-up shelters was provided by the presentation of Violence Prevention Commendation Awards by the Australian Heads of Government Violence Prevention Committee to the Port Hedland shelter in March 1993 and the Halls Creek shelter in December 1993.

Some communities have enhanced the impact of sobering-up facilities by supplementing their efforts with community patrols or other outreach strategies, or by acting as a focus for community action. One shelter is part

of an integrated range of services providing the opportunity to progress from sobering up to detoxification and continuing treatment. Others have advised the Task Force of plans to develop similar treatment linkages or other creative initiatives such as safe, dry areas associated with the shelter.

While there is no research on the impact of sobering-up shelters, it is clear that in some communities they provide an effective pragmatic response to public drunkenness. It is also clear that they constitute an important strategic base from which to develop both individual/ and population/focused interventions.

3.2.6 MAINTENANCE APPROACHES

Maintenance as a treatment refers to either the provision of a drug of choice (e.g. heroin) or a substitute drug (e.g. methadone for heroin) to maintain a drug dependent person's drug use in a controlled and supervised fashion. In practical terms, methadone maintenance for opiate addicts is the only treatment that has been extensively implemented.

3.2.6.1 Methadone maintenance

Mattick (1994) reports that methadone maintenance treatment is the most extensively researched of all the treatment approaches for opiate dependent people. The research from different countries and varying client groups consistently shows benefits in terms of reduced opiate use, reduced criminal behaviour and improved social functioning. These outcomes are substantially greater than those achieved by detoxification, drug-free outpatient counselling or residential rehabilitation. Additionally, methadone maintenance results in a decrease in injecting drug use thereby reducing the risk of spreading infectious diseases (HIV, Hepatitis B, Hepatitis C).

Although there have been deaths associated with methadone overdose, most notably a spate of 14 deaths in Victoria in a six-month period in 1989, these have been caused by inexperienced practitioners commencing patients on too high doses, and adequate clinical training and monitoring has been shown to alleviate this risk. In fact, the evidence indicates that there is a lower risk of death associated with methadone treatment than arises from the risk of heroin overdose following detoxification or drug-free treatment.

Diversion of methadone is also a potential problem, as recent publicity concerning the operation of some clinics in NSW and the current national review of methadone treatment (KPMG Peat Marwick 1995) has highlighted, and indicates the necessity for supervised dosing and effective controls of any takeaway drug doses.

The research evidence indicates that better outcomes are associated with less severely dependent and criminally involved clients, higher doses of methadone, and retention in treatment with maximum benefits requiring two to three years' maintenance.

The impact of ancillary counselling and other services is uncertain in its impact on client behaviour, however, the Quality Assurance Project does recommend that such services be available, either within a program or by referral, and that they include crisis management and other counselling, health monitoring and medical service, HIV testing and education, psychiatric liaison, and a range of social welfare support services.

Withdrawal from methadone is recommended when a decision is reached jointly by the client and the clinician(s). At that time aftercare in the form of structured relapse prevention and self-help should be available.

While the positive outcomes associated with methadone maintenance are well established and most States in Australia have supported a substantial increase in the number of persons receiving this treatment over recent years, a cautionary note must also be sounded as one individual submission to the Task Force illustrates. This argued that there needs to be more support for withdrawal from methadone. The submission cited the experience of the author's parents who as a result of a two-and-a-half year heroin addiction had been addicted to methadone for the past 15 years. Consequently these patients have been committed to daily attendance at the one clinic in Perth for all that time, and having been on methadone for this period anticipated that they would continue to be so for the rest of their lives.

3.2.6.2 Other maintenance approaches

A number of other drugs have been proposed as suitable for maintenance treatment for opiate dependence. LAMM (levoff-acetyl methadol), essentially a long-acting methadone, would require dosing every second or third day as opposed to every day. Buprenorphine, an opiate analgesic with mixed agonist and antagonist effects, also has potential for alternate day dosing, is much safer in overdose and produces a less severe withdrawal syndrome. A proposal for a clinical trial in Australia is currently being developed with respect to buprenorphine

(by the National Centre for Drug and Alcohol Research and the Drug and Alcohol Services Council of South Australia).

Heroin, largely because it is the drug of choice of addicts and could thus provide a powerful incentive to engaging in a maintenance program, is also sometimes proposed as the most appropriate drug for maintenance treatment. This is despite the problems associated with its short half-life and the consequent costly administration and/or risks of diversion, the difficulty of stabilising patients adequately, and the ethical problem that might arise from an apparent legitimation of heroin use. It is noted that the prescription of heroin is canvassed as a treatment for existing addicts and as such, except insofar as it attracts more people into treatment, it would not affect the operation of the illegal heroin market as is sometimes argued.

A trial program to prescribe heroin has been under consideration for some time in the Australian Capital Territory (by the Centre for Epidemiology and Population Health), modelled on a similar trial in Switzerland. This would involve patients, selected from those currently on methadone maintenance, attending three times a day and self-administering the drug. The initial trial is proposed for 40 persons to be followed by larger trials in the ACT and other States. The anticipated costs of the trial treatment are $10,000 per client year compared to an estimated $2,000 average for methadone and $16,000 for therapeutic community programs.

There is little evidence regarding the impact of amphetamine or cocaine prescribing on drug use, injecting, criminal behaviour or social adjustment. There is currently a renewed interest in oral amphetamine maintenance in the United Kingdom although opponents of the approach argue that amphetamine users are not generally physically dependent, amphetamine use can lead to psychosis and increased use of other drugs, and there are possible long- term neurotoxic effects.

3.2.7 OTHER PHARMACOLOGICAL TREATMENTS

The use of medication apart from detoxification and maintenance treatments has not been widespread.

The Quality Assurance Project does report, however, that disulfiram (marketed as Antabuse) which produces an unpleasant physical reaction if taken in combination with alcohol, has been shown to have positive effects in supporting abstinence from alcohol when provided under supervision and in adequate dosage, and that its use should be given more attention. No other pharmacological interventions for alcohol problems are advocated.

It also reports that Naltrexone, an opiate antagonist, has potential as a useful treatment option with those opiate-dependent patients who are highly motivated to remain drug free but are exposed to environments where their drug of choice is freely available.

With respect to other illicit drug abuse, Kleber (1995) concludes that there is no adequate pharmacotherapy for cocaine dependence, amphetamine dependence or solvent abuse.

3.2.8 FAMILY APPROACHES

Family involvement in treatment is favoured by a number of programs in Western Australia. A variety of approaches attempt to provide support to family members of a drug-dependent person, assist them to avoid behaviours that enable the drug taking to continue, or seek to mediate between and reconcile parents and adolescents. Not all of these approaches have been well researched.

The Quality Assurance Project reports that there is some evidence that marital therapy has more impact on alcohol consumption than no therapy at all but that in a majority of comparisons, marital or family therapy has no advantage over individual alcohol treatment alone.

It recommends, nevertheless, that separate individual counselling for the spouse of a problem drinker is appropriate as an opportunity to assist the spouse. Moreover, it recognises that marital therapy may produce other benefits for the parties such as improved communication. It also notes that the self-help groups Al-Anon and Alateen for the family and teenage children of drinkers with serious drinking problems may be useful in some circumstances, specifically where that support appears to be important to the persons concerned and where the support is not available elsewhere.

With respect to illicit drug users there is a paucity of research and it concentrates on intense family therapies that proceed from an assumption that behavioural problems are in some way related to dysfunction within the family system. The only positive outcomes reported are with clients in methadone treatment who were able to assemble their whole family of origin for therapy. The Quality Assurance Project reports that there is no evidence that

family therapy is effective with opiate users under other conditions. It also notes that structural family therapy is an intense and directive intervention which requires considerable training and interpersonal skill on the part of the therapist, and that this makes it an expensive treatment with doubtful cost-benefit.

Research has demonstrated that family involvement in treatment with adolescents has a positive impact (Spooner 1995). Evidence regarding the efficacy of family reconciliation with estranged adolescents is lacking although there is a growing literature indicating the viability of mediation for conflict within families with teenagers (Van Slyck, Stern and Newland 1992). Consultations conducted by the Task Force with families and youth workers indicated a general agreement that reconciliation is a desirable outcome. There were significant differences between them, however, as to their assessment of whether it was appropriate in all or even most cases and whether youth workers and various other social agents helped or hindered the process. The differences arose from varying assessments as to what was in the young person's best interests which in turn tended to reflect whether primacy was given to information coming from the adolescent or the family. It appears that, except in those cases where there is a need to investigate allegations of abuse or where such allegations have been substantiated, there is considerable room for more widespread use of mediation and other strategies to improve outcomes.

3.2.9 SELF-HELP

The self-help groups Alcoholics Anonymous and Narcotics Anonymous are well established in Western Australia. Narcotics Anonymous particularly has seen substantial growth in Perth since its establishment in the early 1980s.

While research into the effectiveness of these self-help groups may be lacking, largely due to their voluntary nature, the Quality Assurance Project indicates that they fill a significant space in the spectrum of services for persons dependent on alcohol or other drugs. Their sheer availability extends well beyond that which formal treatment services can offer and includes innumerable hours of voluntary work as sponsors of new members, in crisis work with newcomers and in conducting meetings in a range of settings that can include rehabilitation centres and prisons.

For participants the empowering nature of self-help, the understanding received from other members, the structural security of the group, the spiritual benefits and the goal of helping others in similar predicaments are all thought to be of varying importance.

It is important to acknowledge that a degree of mutual antipathy has developed between some professionally trained drug and alcohol workers and some self-help adherents. Both the exclusion of professionals and the premise that alcoholism particularly is an illness which cannot be cured but can only be arrested through the maintenance of abstinence account for this antipathy. The gulf is maintained, however, by a degree of preciousness about beliefs and philosophy that is counterproductive. The ‘12 step’ literature states clearly the need to access the assistance of health professionals for serious problems that cannot be addressed by the self-help groups, while disagreement with the illness concept inherent in the approach has tended to blind some professionals to the support that these groups can provide.

The Quality Assurance Project recommends that all drug and alcohol counsellors should be familiar with the self-help groups in their areas and be acquainted with a range of sponsors. All clients who have been dependent on alcohol, opiates or other drugs should be made aware of these services and if they are willing to consider the goal of abstinence they should be encouraged to attend either Alcoholics Anonymous or Narcotics Anonymous for at least three visits so that they can assess the suitability of the approach for themselves. For referrals to Narcotics Anonymous particularly, the importance of matching clients to a group comprised of individuals with a similar social background is emphasised.

3.2.10 AFTERCARE

There is widespread acknowledgment that people who have received formal intervention will require assistance for some time after treatment has been completed.

The Quality Assurance Project reports that while research on aftercare is sparse, there is some strong evidence that it improves the outcomes for people with alcohol problems and for those who complete treatment for other drug problems. Moreover given the relapsing nature of drug problems the rationale for aftercare is persuasive.

It recommends that at the end of all formal intervention there should be some continued assistance available, that it should be structured and scheduled, and that the client should return for these appointments regardless of their drug-using or drinking status.

3.2.11 TREATMENT AND THE CRIMINAL JUSTICE SYSTEM

3.2.11.1 Drugs and crime link

There are strong links between criminal behaviour and the prevalence of alcohol or other drug problems.

Western Australian research, also referred to in Volume II of this report, has shown that there are high levels of problematic drug use among both adult and juvenile offenders. Among adult prisoners, Indemaur and Upton (1988) report that some 27% of men and 15% of women had been heavy alcohol users, and that 24% of men and 26% of women had been heavy/regular drug users. Among juvenile detainees, Watts (1992) reports that prior to reception 89% were using a drug other than tobacco with 47% using some drug every day. Daily use involved marijuana (27%), amphetamines (11%) and glue (10%). A more recent survey of juveniles in custody in Western Australia reports higher levels of daily use of marijuana (58%) and amphetamines (17%), though a slightly lower rate for solvents (6%) (Juvenile Justice Division 1995); while community-based juvenile justice officers estimate that substance abuse by offenders on their caseloads ranges from 40% to close to 100% (Juvenile Justice Division 1994).

Copeland and Howard (1995) report that among juveniles offenders in NSW, 54% of males and 64% of females indicate that they were drunk at the time of the offence, and 45% of males and 59% of females claim that their current crime was committed to obtain money for alcohol and/or other drugs. Among detainees, half the juveniles surveyed reported that they regarded themselves as having had a current or past problem with their substance use and 30% believed that they had required some treatment for this.

The exact nature of the link between crime and drug use, and particularly whether or not drug use causes crime, is not entirely clear. The theoretical basis for arguing that drug use is responsible for crime rests principally on two phenomena: first, the disinhibiting effect of drugs and alcohol; and second, the propensity for drug use to be funded by the proceeds of property crime. On the other hand, as Reuter (1994) reports, numerous American studies provide evidence that criminal behaviour predates drug dependence. It is perhaps equally plausible that both drug use and criminal behaviour are part of a delinquent culture, for example, as developed in Perth with respect to amphetamine use and motor vehicle theft in the early 1990s (Jackson 1992).

After examining these three possible causal scenarios — that drugs cause crime, that crime causes drug use or that something else causes both crime and drug use — Copeland and Howard conclude that no studies have demonstrated a clear causal linkage and that there are multiple pathways to the escalation of both drug abuse and delinquent behaviour.

Whatever the precise nature of cause and effect, there is agreement that the strong correlation between drug abuse and crime indicates the importance of appropriate interventions for offenders (Reuter 1994, Copeland and Howard 1995).

3.2.11.2 Treatment for offenders

In his review of the outcomes of treatment for offenders, Reuter reports that methadone maintenance programs and therapeutic communities generally show a strong positive effect on reducing the offence and arrest rates, while short-term programs on the other hand show no lasting effect on crime rates of users. Most significantly, coerced treatment is no less successful than apparently uncoerced treatment.

On the other hand, incarceration, in and of itself, has been shown neither to eliminate substance use nor have any effect on return to substance use following release. Moreover, it has been criticised as being criminogenic rather than rehabilitative in its impact (Platt et al 1988).

Given the positive outcomes that can be obtained for treatment of offenders and the possible counterproductive impact of imprisonment, intervention that diverts offenders from incarceration, if not the correctional system per se, would seem to be the most promising. This view is indirectly supported by a recent favourable evaluation of the Western Australian Court Diversion Service (Rigg 1994) and the opinions expressed in a range of consultations with the Task Force that cast serious doubts on the impact of treatment for both adults and juveniles while they are in detention.

As indicated earlier, methadone maintenance and therapeutic communities may be the most effective options for adult offenders, although the general finding that legal coercion does not reduce treatment effectiveness may also support the use of longer term structured outpatient programs.

For juvenile offenders, Copeland and Howard recommend engaging the young person in a comprehensive non-residential treatment service with the possibility of legal sanctions for non-compliance. As indicated in a number of consultations with the Task Force and discussions of residential treatment elsewhere in this chapter, a young offender's living circumstances may also legitimately incline a court towards favouring a residential option.

Within the treatment program, staff should be appropriately trained and have high levels of empathy; detailed assessment should be built around the technique of motivational interviewing; a relapse prevention model is recommended as the appropriate framework for therapy; and the family should be engaged in the treatment process.

3.2.11.3 Treatment in prisons

There is a paucity of literature regarding interventions for persons who are incarcerated. The Quality Assurance Project reports a large increase in the number of adult prisoners on methadone maintenance, and that the rationale has shifted its emphasis from reducing illicit opiate use in prison and preparing prisoners for release, to reducing needle sharing and thus the spread of infectious diseases.

Copeland and Howard indicate that any program for juveniles in custody should focus on building motivation, incorporate the same elements as recommended for a non-custodial program and be delivered in the period preceding release. These broad recommendations may also be applicable to adults.

3.2.12 YOUTH

3.2.12.1 Antecedents of drug abuse

A large body of literature indicates that a wide range of individual, family, social, environmental and other risk factors may be associated with youth drug abuse. Prominent among these are a belief that drug use is not harmful; early childhood antisocial behaviour; early initiation into drug use; family factors such as the quality and consistency of family management, communication and relationships, and parental role modelling; a low commitment to education and early academic problems; association with drug-using peers; labelling that provides a young person with an identity that they find appealing; social attitudes and personality traits that reflect a lack of bonding with society and others; and experience of childhood sexual or physical assault. Additionally the broad environment (including the price and availability of drugs, socio-economic conditions and prevailing attitudes towards legal and illegal drugs) as well as the nature of the specific drugs themselves also affect whether drugs are used at all, and how much and how often they are used.

It is important to note that many of these factors that are associated with youth drug use may be consequences as well as causes of drug abuse. Moreover, the reverse of each risk factor may inhibit drug abuse; for example, peer and family influences can restrain drug abuse.

A significant perspective on youth drug use that is currently under study in Western Australia is presented by Houghton and others (1994). It proposes that drug abuse by at-risk and delinquent adolescents is integral to enhancing or maintaining a reputation within a delinquent sub-culture. For these youths, who have otherwise failed to gain identity, respect and hope from participation in the mainstream activities of education and employment, drug abuse delivers substantially more rewards that it does for other youths.

3.2.12.2 Interventions with youth

Any intervention to remedy youth drug abuse needs to proceed from an understanding of normal adolescent characteristics. As Spooner (1995) outlines, these include risk taking, incomplete impulse control and a here-and-now orientation. Any drug treatment program has to deal with a tendency for young people to believe that their risks have no consequences, a limited attention span, a different concept of time to adults, and a lack of experience with communal responsibility. Not doing so will result in youths dropping out of treatment and feeling resentful towards service providers for not understanding their perspective, perhaps exacerbating the problem behaviour.

Brown (1991) in assessing adolescent drug treatment needs in Victoria noted that the implication of the factors associated with adolescent drug abuse, whether causes or consequences, is that drug use per se cannot be the sole target of intervention when at the same time an individual's problems may include homelessness, unemployment, limited social and recreational opportunities, and estrangement from families, school and other

elements of conventional society. Programs thus need to address the full range of personal and social deficits in a young person's life as well as the drug use.

Spooner reports a number of studies that indicate that youth have a negative perception of treatment services, regarding them as unapproachable, irrelevant, frightening, distasteful or not very useful, and recommends that low key access via street services may better engage youth. For those who do enter treatment, and considering that many will be under some coercion, whether from the juvenile justice system or families, dealing with a lack of motivation will be fundamental. Motivational interviewing may assist and the capacity to deal with reluctant or resistant clients will be necessary.

Young people consulted by the Task Force who were successful in controlling their drug use after treatment, credited the program with helping them to develop the will-power, confidence and self esteem that they believed were the main forces behind their success. Broader consultations with youth in treatment in Sydney, referred to by Spooner, emphasised positive drug-free experiences, particularly outings, talking about issues and being supported.

3.2.12.3 Staff in youth services

The nature of staff in youth drug services is important. Consultations conducted by the Task Force with youth in detention centres and a drug treatment program indicated a strong preference for ex-user/recovered staff for these services. Clients consider them to be more credible and less able to be manipulated and appreciate their impact as role models. It is noted that the literature shows that ex-users/recovered people are much less appropriate for broader educational programs. Spooner argues that training in individual counselling, group therapy, cognitive restructuring, behaviour modification and skills training are essential as these activities form the basis of the interventions referred to that are considered vital for positive client outcomes. She also notes Howard's (1994) conclusion that personal qualities such as humour, maintaining consistent limits, developing and maintaining trust, being in tune, and being honest are the core essential criteria for effective workers.

3.2.12.4 Youth with special needs

Spooner identifies a number of groups who will have special needs in adolescent treatment services. These include girls, for whom some single sex groups and female counsellors will be important; younger adolescents whose different developmental needs may mean separating them from older adolescents; Aboriginal youth for whom agencies need to be active in implementing localised strategies to make services attractive and effective; juvenile justice referrals whose specific issues such as conduct disorder and motivation to change have implications for worker selection and training, behavioural control and worker safety; and homeless youth who require a full spectrum of rehabilitative support.

3.2.12.5 Family involvement

Finally, Spooner reports that it is well recognised that the family needs to be considered in adolescent treatment, whether it is to enable some change in either the individual's or the family's behaviour that may have contributed to drug abuse, or to provide support for the adolescent. It is clear that family involvement has a positive impact on treatment outcome. It must be emphasised, however, that in many cases it can be difficult to engage the family and that it is even less likely to occur if it is not actively recruited.

Additionally it is often overlooked that families also suffer as a result of drug misuse. As noted with respect to adult treatment it is appropriate for services to be provided to support and assist the family to cope with this impact. The Task Force's consultations with families indicate this need strongly, particularly when a young person's behaviour is not responding to intervention.

3.2.13 IMPLICATIONS OF GENDER

There has been a growing awareness and interest in the specific treatment needs of women in recent years.

3.2.13.1 Women in treatment

It has been argued that because there are generally less women than men in treatment services, women are under-represented. As Copeland and Hall (1995) report, the extent to which this is true is unclear. Australian data does not in fact provide strong support for the claim of under-representation for women with either alcohol dependence or opiate dependence when estimates of the relative number of male and female users are compared to the treatment population proportions. Data on dependence on other illicit drugs and prescription drugs is insufficient to draw any conclusions on this issue with confidence.

It is also argued that because men predominate in the treatment services, and that the establishment and development of programs has been tailored to suit this population imbalance, then the operation of treatment services will be more attuned to male than female needs. However, while noting that women are under-represented in alcohol treatment research, both Copeland and Hall and the Quality Assurance Project drew on the review by Jarvis (1992) of some 30 outcome research studies conducted between 1953 and 1991, to report that men and women have had very similar outcomes from a variety of treatment programs.

3.2.13.2 Issues for women

The published research, recent evaluations of women-only services in NSW and Victoria, and a study of women who have recovered without treatment, nevertheless highlight a range of gender issues that are important in attempting to maximise the catchment of women into and their subsequent benefits from treatment (Copeland and Hall).

There is support and credence for the notion that there is greater social stigma attached to women with a substance abuse problem and that this may make women more reluctant to enter a treatment facility. Concerns about childcare and the fear of losing custody of children if a drug or alcohol problem is admitted may deter entry and encourage women to discontinue treatment. Homosexual women, who as a group have a higher incidence of substance abuse than heterosexual women, are extremely difficult to recruit into traditional treatment services. Mixed sex treatment services may compromise the treatment provided to women by their being more isolated in residential programs, by the domination of men in mixed groups, and by a tendency towards sex role stereotyping.

There is a high incidence of women with a history of sexual assault among those seeking treatment, Copeland and Hall report a recent study that found 66% of women with such a history. The issue is usually not well addressed in traditional mixed sex settings and requires a specialised approach. Experience of domestic violence may inhibit seeking treatment and also requires specialist support.

3.2.13.3 Services for women

The Quality Assurance Project concludes that women may be more attracted by and respond better to individualised approaches. It also makes the general point that while there is a need for more research to provide clearer direction on the gender issues outlined, treatments that accommodate gender specificity, for both women and men, may be more effective than other treatments.

Copeland and Hall make a number of specific recommendations for comprehensive women-only services. These include the provision of childcare facilities, female staff, a range of treatment options from detoxification to short- term residential and day and evening outpatient programs, and women-oriented telephone counselling services. They recommend that the drug specific treatment content for women reflect the recommendations of the Quality Assurance Project as outlined earlier, and that intervention for the reduction of HIV risk taking is also provided.

In relation to sexual assault they recommend sensitive assessment and handling of the issue. If it is acknowledged, the client should be asked if she would like to incorporate an exploration of its possible role in her drug problems into her current treatment, and if she wishes it then referral should be provided to a therapist who is able to take on the long-term management of the client during and after the drug abuse treatment.

The importance of addressing general welfare, housing, educational and vocational needs of clients is emphasised. The value of mutual help groups following discharge is acknowledged and the need for women-only alternatives to Alcoholics Anonymous and Narcotics Anonymous is noted.

Copeland and Hall argue that specialist women's services are important to attract a wider population and to serve as demonstration services for clinical teaching and research. They also indicate that many of their recommendations may be implemented in mixed sex services. In summary this would include separate bedroom and bathroom facilities in residential services, the option of a female therapist, frequent women-only groups with a female therapist and the provision of childcare.

3.2.14 PERSONS FROM A NON-ENGLISH SPEAKING BACKGROUND

A limited number of studies from NSW and Victoria have indicated that non-English speaking populations may have comparable levels of alcohol and other drug problems to those of the broader community (Westadd 1994).

Consultations conducted by the Task Force with alcohol and drug specialists who have developed linkages with ethnic services in Perth consider that the local situation is probably similar.

A substantial and recent consultation with ethnic communities in Victoria by Westadd, while not describing the local situation, can provide some indication of the issues that need to be addressed if persons from a non-English speaking background are to access services. The consultation concentrated on Spanish-speaking, Croatian and Vietnamese populations.

These groups gave alcohol and drug problems low priority relative to other, more immediate, areas of concern. Employment and the process of adapting to a new country with a new culture without losing ethnic identity were the most pressing issues, although problems arising from these may promote excessive use of alcohol. There was a lack of information about alcohol and drug issues and services. Material in community languages is restricted in both quantity and diversity of topic. Among Vietnamese people, the philosophy of harm minimisation was perceived to actively promote drug use, counselling was regarded as a foreign concept, and a more punitive treatment model was favoured. There was confusion between the roles of police, courts and alcohol and drug services particularly in relation to mandated interventions. Training for ethno-specific workers was considered very important and there appears to be a marked preference for dealing with such workers.

Westadd has produced a resource kit designed to guide agencies through the development of accessible services for non-English speaking background clients. Copeland and Hall's (1995) recommendation with respect to ethnic women has broad applicability, that services need to be based on local needs analyses, conducted in conjunction with local communities and that there should be positive discrimination in employing counsellors with pre-existing linguistic abilities.

3.2.15 ABORIGINAL PEOPLE

Alcohol abuse has had a devastating effect on Aboriginal communities and individuals but there have been few programs developed specifically to meet the needs of Aboriginal people (Royal Commission 1991, Task Force on Aboriginal Social Justice 1994). While a smaller proportion of Aboriginal people drink than non-Aboriginal people, the proportion who do so in excess is greater. Consequently, the damage sustained by the Aboriginal community is substantial, with hospital admission rates and deaths due to injury and poisoning for example, significantly greater than the rest of the population.

The nature of alcohol and other drug problems among Aboriginal people encompasses all drugs. As indicated earlier in this report and as the Task Force was advised in many consultations, the use of solvents and illicit drugs by Aboriginal youth particularly has increased markedly over recent years.

The Task Force on Aboriginal Social Justice warned against expecting instant solutions through treatment and intervention. This is sensible particularly when the degree and complexity of the social factors that underlie drug abuse problems among Aboriginal people are understood. The Quality Assurance Project has recommended that interventions need to be culturally appropriate and provided by skilled professionals. Moreover, it notes that given the high relapse rate to be expected among people returning to poor socio-economic situations, any treatment services need to be supported by culturally appropriate interventions at the population level.

Consultation regarding service development in Canada (Scott-Blunden 1995) revealed that the last decade has seen a major investment in community and residential treatment for indigenous people. The key components have tended to be the integration of treatment and prevention approaches in indigenous communities, and the incorporation of family and cultural renewal in the treatment programs.

3.2.16 CO-EXISTING PSYCHIATRIC DISORDER

Clients who exhibit both alcohol and other drug problems and psychiatric symptomology are a major difficulty for both alcohol and drug treatment services and mental health services. Burdekin (1993) has recently drawn attention to such clients, and the poor service they receive.

There is, however, an evident lack of clarity about who these clients are and how their problems should be addressed. The literature reports rates of prevalence of substance abuse in samples of psychiatric patients of between 7% and 66% reflecting a marked difference in the range of definitions for each disorder (Caton 1989). The Diagnostic and Statistical Manual for Mental Disorders (DSM IV) cites a broad range of symptoms including stress and anxiety under the heading of ‘dual diagnosis’. A number of consultations conducted by the Task Force were critical of a tendency to over-identify persons as having a dual diagnosis and argued that this was representative of an unhelpful trend to psychiatrise all aspects of problematic behaviour.

In some consultations conducted by the Task Force, there was a tendency to group together psychiatric patients who abuse drugs, a behaviour that has apparently increased in recent years, with traditional alcohol and drug clients who are experiencing severe psychological distress and label them all as suffering a 'dual diagnosis'. It is necessary and possible to be more precise about the different client groups where drug abuse co-exists with a range of psychiatric symptomology, and to distinguish between their treatment needs.

First, clients who suffer from substantial chronic psychiatric disorders and who abuse drugs are clearly the responsibility of mental health services. These services are faced with a new client management challenge rather than a new client group, and will need expertise in addressing alcohol and drug issues and there may be a need for some innovative service delivery.

Second, clients who are dependent on alcohol or other drugs who develop transient psychiatric sequelae are clearly the responsibility of alcohol and drug services. This is the case whether the symptomology is moderate as might be seen with the depression and anxiety that accompanies detoxification and early abstinence, or whether it is severe as in the case of drug-induced psychosis or mania. Alcohol and drug services will need assistance from mental health services to manage the severe transient disorders.

A third group is those for whom both a psychiatric disorder and substance dependence are longstanding and chronic conditions. This is the group for whom the description 'dual diagnosis' is perhaps most appropriate. It is the group who have traditionally received care and support from the church charities and who, according to some residential services, are becoming more prevalent and presenting at a younger age. Innovative services that provide fairly intensive case management for these clients, such as the De Paul Community Support Service, show considerable promise in ameliorating the problems of these persons.

The Quality Assurance Project recommends that assessment of psychological problems and psychiatric disorders among clients seeking alcohol and drug treatment be regarded as essential. They note that where a psychologist or psychiatrist is not available, other staff can effectively screen clients and refer to a suitably qualified professional for full diagnostic assessment when a problem is indicated. They emphasise that it is important to reassess clients after three or four weeks and to delay making a final diagnosis until this time has allowed for apparent disorders to resolve naturally.

If serious disorders are diagnosed among alcohol and drug clients it is essential that they are treated and it will be necessary for alcohol and drug treatment services to have the necessary links with mental health and other services that can address the disorders. If psychiatric clients are abusing alcohol and other drugs, mental health services will need to have developed the necessary counselling skills to address the issue, and they may need to access specialist services such as detoxification.

Some clients will not be easily differentiated, for example, those persons who might be rightly characterised as suffering a personality disorder or borderline personality disorder and for whom no effective psychiatric intervention has been developed, or those clients for whom extensive drug abuse precedes or induces the onset of a chronic psychiatric condition.

Effective co-operation between the services will be essential to ensure that these clients who may not be readily assigned to the primary care of one sector or the other as outlined, receive the treatment that can best manage their condition and that they do not either bounce or fall between the two services.

3.2.17 REDUCING TRANSMISSION OF HIV AND OTHER BLOOD BORNE VIRUSES

The AIDS epidemic has led to a general acceptance that the reduction of transmission of HIV is, in and of itself, a legitimate goal of intervention. Education about the virus, how it is transmitted and how to use drugs without risking transmission, has been incorporated into treatment programs; widespread availability of needles and syringes has been promoted; and the number of persons admitted to methadone programs has expanded. These strategies appear to have been effective in stemming the spread of HIV among intravenous drug users in Western Australia (Kerry 1994).

A number of consultations with the Task Force have emphasised that the recent identification of Hepatitis C and its widespread prevalence among intravenous drug users indicates the need to maintain and develop programs that continue to address this goal.

The widespread availability of needles and syringes has been at the forefront of strategies. As noted in Volume II of this report, some 1.7 million needles and syringes were purchased in Western Australia in 1994 for the

purpose of injecting drugs. This strategy has been widely researched throughout the world and its impact in reducing transmission of blood borne viruses is well established. Des Jarlais (1994) in his review also concluded that there is no evidence in the international research that needle exchange programs lead to increased illicit drug use, either through increases in injection frequency among exchange participants or through an increase in the number of new injectors.

The concerns of some members of the public and some drug and alcohol service providers that the number of persons who inject drugs is greater than it otherwise would have been in the absence of widespread availability must, however, be acknowledged. Indeed it is difficult to maintain a stance that increased availability has had no impact on the drug-using culture other than to supply existing users. In fact, a recent observed fall in the average age of intravenous drug users in Perth (Western Australian AIDS Council 1995) is in contrast to some of the international evidence, and does indicate that there are greater numbers of young people injecting drugs making moot the issue of whether this has been influenced by greater availability and easier access to needles and syringes. While the issue needs to be assessed in light of the achievement of the goal of reduction of blood borne viruses, it is clear that additional educational and other strategies are now required to address the issue of intravenous drug use per se.

Des Jarlais and Booth (1995) both argue also that needle availability programs should be developed within a wider system of HIV prevention activities that also include opportunities for non-judgemental health-oriented communication between health workers and injecting drug users. This is consistent with the specific recommendations of the Review of the Western Australia Injecting Drug Use Program (Kerry 1994).

3.2.18 TOBACCO

As indicated in the introduction, tobacco has been differentiated from excessive use of alcohol and illicit use of drugs. This is because while smoking is highly addictive (US Surgeon General 1988), between 90% and 95% of smokers give up on their own. Public encouragement to quit and minimal intervention by health professionals in the course of their day-to-day work have been demonstrated to be effective in securing high levels of smoking cessation (Russell et al 1979, Russell 1990). A variety of counselling assistance tends to be regarded positively by clients but relatively small numbers use such services. Recent evidence indicates increasing use of nicotine patches to assist withdrawal and that these significantly improve success for some individuals (Bittoun 1995), implying a case for promoting their easy availability, for example, through the pharmaceutical benefits scheme.

3.2.19 VOLATILE SUBSTANCE ABUSE

It is apparent from Western Australian and United Kingdom research that most volatile substance or solvent abuse is experimental and that this is fairly widespread, that there is some episodic use but that it is far less common, and that there are small but persistent groups of chronic solvent abusers (Rose, Daly and Midford 1992; Home Office 1995).

The most serious problem in Western Australia in the past has been petrol sniffing in Aboriginal communities. Consultations with the Task Force have advised that this has always been subject to geographic limitations and has been almost entirely resolved where affected communities have restricted the use of petrol in favour of Av-Gas for vehicles.

The problems that remain in a limited number of Western Australian locations are small groups of chronic solvent abusers.

As the Home Office emphasises, the available research evidence amply demonstrates that solvent abuse is a complex and socially embedded problem. For experimental and episodic use a variety of prevention and community intervention strategies have, however, been shown to have a positive impact. Specifically recommended is simple and informed advice from generic community resources such as schools and youth workers, as well as from appropriately knowledgeable friends and family.

There is, unfortunately, no research indicating successful intervention with persons who have developed a pattern of chronic abuse. In the absence of this information and given the apparently tenacious nature of the behaviour, the recommendation of Rose, Daly and Midford for an interagency case management approach to be undertaken at a local level appears to be the most promising. This involves a single case manager co-ordinating a range of resources (for example, education, welfare, recreation, family support) to meet the needs of the individual and implies a strongly proactive approach to client management.

3.3 ISSUES ARISING FROM CONSULTATIONS WITH SERVICE PROVIDERS

Consultations were held with well over 100 service providing organisations, with meetings held both in Perth and in regional centres. All specialist alcohol and drug service providers in the State were consulted and general health, justice and welfare services, including youth services, were consulted extensively. Multiple meetings were held with some organisations, particularly the Alcohol and Drug Authority, Health Department, Ministry of Justice and the Department for Family & Children's Services, and most consultations involved groups of staff. Nearly all of these service providers also made written submissions to the Task Force. While there was not a unanimity of opinion among organisations, and there were of course clear regional differences, there were a number of recurring observations and themes.

3.3.1 CLIENTS

Numerous agencies, particularly in Perth, reported that they are seeing younger clients, more poly-drug abuse at both alcohol and illicit drug oriented agencies, and more persons with psychiatric disorders. It was invariably reported that poly-drug abuse is the norm for youth clients. With respect to illicit drugs, recent years have seen a substantial shift in the primary drug of choice from heroin to amphetamines although at least one agency reported that this trend may be starting to reverse.

3.3.2 NATURE OF SERVICES

A number of organisations emphasised the need to target the whole spectrum of alcohol and other problems. Particular concern was expressed by the agencies involved with chronic alcohol-dependent people, for whom care and support are the practical and humane response, that they should not be overlooked.

Strategies to reduce the harm associated with drug abuse were generally endorsed by service providers. Some, however, echoed similar concerns to the general community, as described in Chapter 2 of the report, that the harm minimisation message has, among some sections of the population, been interpreted as condoning drug use.

More specific recommendations regarding the practice of existing services included an increased emphasis on the family, more co-operation between mental health and alcohol and drug services, making services more gender sensitive, taking a more proactive approach particularly with youth, maintaining central control and data collection for any decentralisation of methadone treatment, and retaining residential programs.

3.3.3 CURRENT SERVICE DEFICIENCIES

3.3.3.1 Specialist services

The client groups for whom service provision was regarded as inadequate were youth, persons from a non-English speaking background, Aboriginal people and to some extent women. A need for greater support for parents whose children are abusing drugs was also identified.

With respect to youth services there was general agreement that a range of adequately resourced specialist services is essential.

The need for an overnight shelter for intoxicated youth was put to the Task Force but not supported by a number of other consultations. There is general agreement that more co-operation is required to support efforts to intervene with intoxicated youth in the city centre. NASAS are pursuing the establishment of a drop-in centre for Aboriginal youth in the city centre which they argue would both prevent problems with intoxication and be a resource to assist in its management. NASAS have staff and a building and are awaiting Perth City Council approval. They envisage a city-based centre as an interim strategy pending the establishment of centres in suburban locations.

Numerous consultations made it clear that interventions with chronic solvent abusers are not adequate and that this group requires more attention. The number of entrenched, chronic abusers is difficult to estimate precisely based on the various submissions to the Task Force. The best information would suggest that there are between 50 and 100 individuals, mostly in Perth but also including a small number in Kalgoorlie.

With respect to women there was widespread support for services to be gender-sensitive. The need for a further women-only service was advocated only by the agency that has been developing the infrastructure for such a service.

The absence or inadequacy of specialist services in regional areas was constantly bemoaned by generalist service providers in these areas.

Non-government agencies voiced a general concern that they were under-resourced although this was often not in an absolute sense but rather relative to other, particularly government, service providers. Some agencies indicated areas where a small increase in resources such as an additional staff person could significantly enhance service effectiveness. Various individual agencies emphasised that sound administration, accountability, participation in consultation and delivery of best practice programs require adequate resourcing.

The need to decentralise methadone treatment and extend it to regional areas was advocated by the Health Department and the Alcohol and Drug Authority.

A demand for more residential programs that was expressed in public hearings was not echoed by service providers and indeed it needs to be noted that there is currently no strain on the bed occupancy of existing Perth services.

A number of agencies criticised the operation of the Alcohol and Drug Authority's Central Drug Unit arguing that it is expensive, over medicalised, and that there is incongruence between the treatment it provides and its target population of the more difficult clients. While there was some divergence of views, non-government organisations generally considered that its services could be more efficiently provided by the non-government sector.

3.3.3.2 Health, justice and welfare services

A general theme of many consultations and submissions was that the mainstream services in health, justice and welfare should do more to address the alcohol and other drug abuse problems of their clients. This was not, however, universal and indeed workers in the mainstream agencies expressed considerable concern regarding both their abilities and resources to address the issue.

Health

In the health sector, the provision of alcohol and drug services in teaching hospitals, the introduction of screening and brief intervention for excessive use of alcohol, and a greater capacity to provide interventions by general practitioners and community health providers, were all advocated by some parts of the sector. Youth health clinics were recommended by others. Increased education for general practitioners, nurses, and generalist health workers was promoted as a means of increasing the contribution of these groups although a number of consultations emphasised that education needs to be directed to a specific purpose.

The Health Department's Intravenous Drug Use Program provided its recent review to the Task Force which indicated a considerable degree of success to date and effective penetration of the program to provide clean needles and syringes. Nevertheless, it recommended a host of other developments. These included provision of a fixed site needle exchange program, support to determine the viability of a users group and peer involvement, and the provision of needles from regional hospitals and vending machines.

Justice

In the justice arena, most consultations put the view that interventions would be more effective if focused on offenders serving non-custodial sentences including parole. The formal extension of the Court Diversion Service to the Children's Court was supported by a number of agencies. It was evident that different sections of the Ministry of Justice have received varying degrees of training in alcohol and drug issues and intervention, and the need for more knowledge and skills was acknowledged.

Drug use in prisons is acknowledged as a significant problem in this State as it is in prisons around the world. The issue is vigorously pursued through a range of strategies including searches, sanctions and intelligence operations, and the extent of the problem, as indicated by the results of random sample urinanalysis, is less in Western Australia than other Australian States. Some consultations proposed that only quite draconian measures towards staff and inmates would limit use in prisons any further, but could probably not eliminate it entirely.

Increased surveillance of visiting areas was promoted as a practical and effective strategy to limit a major entry point for drugs.

A further problem associated with drug use by prisoners is needle sharing. It is generally agreed that this represents a significant risk for the spread of blood borne viruses. Potential strategies to limit this risk are, however, extremely problematic as they pose contradictions between the health of prisoners and the security of the prisons.

Welfare

Emphasis was placed on the need in the general welfare area for greater awareness of alcohol and other drug abuse as it affects child protection and domestic violence. Estimates of the proportion of welfare clients who experience substance abuse problems varied with regions but it was invariably significant and indicated a need for the issue to be targeted specifically.

Youth services expressed some ambivalence about their capacity to make an impact on their clients' drug abuse at least in the short term. Nevertheless, they saw youth work as a holistic strategy appropriate to most clients with drug abuse problems but not those with entrenched problems. Service providers identified increased resources and the absence of unrealistic demarcations and client goals as desirable. All indicated the need for ongoing alcohol and drug training.

3.3.4 ORGANISATION OF THE ALCOHOL AND DRUG FIELD AND THE PROVISION OF SERVICES

A consistently recurring theme of the consultations and submissions by service providers has been the need for a whole-of-government approach. No service providers believe that they, or their sector, can provide the range of services to adequately cover the treatment needs of the community. Government and non-government agencies also advocate improved co-ordination among the service providers. Clearly, the need for a whole-of-government approach applies to more than service provision alone and refers also to the integration of treatment, control and prevention strategies as described elsewhere in this report.

A strong emphasis on community linkages was also a related and recurrent theme. The establishment or formalisation of community advisory groups was specifically recommended.

There is general agreement that a core of specialist alcohol and drug treatment services is essential. The importance of links between specialist services and mainstream health and welfare services was emphasised in some submissions. The importance of the non-government sector was widely acknowledged though there was a divergence of view between government and non-government service providers as to the optimal extent of its role. Non-government agencies were generally of the view that most if not all specialist services could be delivered by the sector. A number of non-government organisations advocated a system of accreditation of service providers.

Evaluation of services was considered to be a fundamental issue for service providers. Peak organisations argued that it would be achieved most effectively through the outcome measures included in contracts and through service quality requirements included in contract specifications and a service accreditation system.

There was considerable support expressed by non-government agencies for a consolidation in the number of sources of funding for their services. The inconsistency and duplication of reporting requirements to multiple agencies which fund parts of the same service were criticised as wasteful and inefficient. Disquiet was expressed by some agencies which were funded as pilot programs and then precariously from year to year thereafter despite favourable evaluations and clear needs.

Non-government agencies expressed general support for the principle of separation between the purchaser and provider of services and considered that it promoted a more level playing field in the competition for resources.

A number of agencies expressed some frustration at the long lead time to introduce the anticipated system of competitive tendering for funding and indicated that it should be introduced sooner rather than later. They emphasised the need for transparency and contestability of funding arrangements, and noted that the definition of outcomes in contracts was considered problematic and a suitable area for research and negotiation.

Peak organisations raised a number of substantive issues regarding current trends in the organisation and funding of services; competitive tendering and contracting for services, separation of purchaser and provider, and privatisation of government services. These included: the potential for fragmentation of service provision

particularly with regionalised funding, a breakdown of co-operation between service providers in a competitive system, that 'marketisation' of welfare services is not appropriate where consumers do not have market power, the extent of civil liability that might be borne by service providers, and the need for services to be developed through a community development approach as well as a result of government direction. The recent Industry Commission Report on Charitable Organisations in Australia (1995) and its emphasis on full funding of services, accreditation of service providers, evaluation, and the need to fund some processes as well as services were cited as appropriate conditions for a funding system.

A number of submissions from State Government departments argued that the funding function should be undertaken in conjunction with a policy development role and that both demand expertise and knowledge of the alcohol and drug field. The non-government sector argued that there need to be mechanisms to enable it to provide input to the policy development process.

3.4 EXISTING SERVICES

Most services that address alcohol and drug problems are provided by specialist agencies. A very limited number of dedicated alcohol and drug services are provided by mainstream health, justice and welfare agencies. Mainstream agencies also confront this issue in their general case management. These three areas of intervention are outlined below respectively.

3.4.1 SPECIALIST SERVICES IN ALCOHOL AND DRUG AGENCIES

The following chart outlines the substantive services that are available in Perth and regional Western Australia, provided for the most part by specialist alcohol and drug agencies.

Listings are restricted to the core services provided by agencies. While they may be an acknowledged and significant part of the service network or agency activities, the following are not included: public and school education, consultation to other service providers, assessment and referral, telephone information and counselling that is ancillary to an agency's identifiable programs, low threshold detoxification undertaken in the early phase of a residential program, childcare as a service in its own right, and specialist counselling on issues other than alcohol and drugs that draws a significant proportion of its clientele from drug users (e.g. HIV and Hepatitis C).

It is recognised that the distinction between alcohol services on the one hand and drug services on the other is not clear cut and involves considerable overlap. It is nevertheless a distinction that reflects service providers' own identity and a real differentiation between the clientele.

The chart illustrates that Perth has a broad base of services offering a range of interventions. It is noted that these agencies also represent a variety of philosophical and programatic approaches. Most services are heavily utilised, however, some attract a narrow clientele because of their approach or cost. Regional services are extremely limited particularly when it is appreciated that Western Australian Alcohol and Drug Authority regional services consist of two-person teams.

SPECIALIST SERVICES

Service	Alcohol and/or drug	Client target	Provider (s)
PERTH			
Sobering-Up Shelters	Alcohol Alcohol	Adults Aboriginal	Salvation Army NASAS
Detoxification	Alcohol and Drug Alcohol and Drug	Adult Adult Youth	Western Australia ADA (CDU) Salvation Army Cambridge (private hospital)
Outpatient Counselling	Alcohol and Drug	Adult	Western Australia ADA Holyoake Cambridge Hearth (Wesley)

	Drug	Women Aboriginal Adult Youth Family	Perth Women's Centre Hearth NASAS Cyrenian Palmerston Palmerston Holyoake Holyoake Palmerston Cyrenian Hearth Teen Challenge
Outreach Counselling	Alcohol and Drug	Adult Women Family Aboriginal Family Youth	Hearth NASAS Drug Arm
Residential	Alcohol Drug Alcohol and Drug	Adult Adult Youth	Serenity ACRAH Salvation Army Cambridge Cyrenian Palmerston Cambridge Yirra Teen Challenge Palmerston Cambridge

Service	Alcohol and/or drug	Client target	Provider(s)
Methadone	Drug (Opiate)	Adult	Western Australia ADA (WSC)
Court Diversion	Drug	Adult	Western Australia ADA (CDS) with Palmerston and Cyrenian
Telephone Information and Advice	Alcohol and Drug	Adult Youth Family	Western Australia ADA (ADIS)
Community Support and Development	Alcohol and Drug	-	Western Australia ADA (community teams regional services)
Day Centre Care and Support	Alcohol and Drug	Adult	De Paul St Pats
Needle Exchange	Drug	Adult Youth	Western Australia AIDS Council
Self Help and Support Groups	Alcohol	Adult	Alcoholics Anonymous
		Family	Al-Anon Alateen
	Drug	Adult	Narcotics Anonymous
		Family	Naranon
REGIONAL			
Sobering Up Shelters	Alcohol	Adult Aboriginal	Port Hedland Hall's Creek Fitzroy Crossing Roebourne Kalgoorlie
Outpatient Counselling	Alcohol and Drug	Adult Youth Family	Western Australia ADA (regional services) (Albany Bunbury Kalgoorlie Geraldton Karratha Port Hedland Derby)
			Rosella House (Geraldton)
			Holyoake (Port Hedland)
	Alcohol	Aboriginal	Mawarnkarra Health Service (Roebourne)
			Halls Creek Alcohol Centre (Halls Creek)
			Waringari Alcohol Project (Kununurra)
			Wyndham Action Group (Wyndham)

Service	Alcohol and/or drug	Client target	Provider(s)
Residential	Alcohol	Adult Aboriginal	Prospect Lodge (Kalgoorlie) Rosella House (Geraldton) Marolim (Waringari) (Kununurra vicinity) Millya Rumara (Broome)
Telephone Information and Advice	Alcohol and Drug	Adult Youth Family	Western Australia ADA (ADIS)
Community Support and Development	Alcohol and Drug	-	Western Australia ADA (regional services) (Albany Bunbury Kalgoorlie Geraldton Karratha Port Hedland Derby)
Self Help and Support Groups	Alcohol	Adult	Alcoholics Anonymous (some centres)

3.4.2 ALCOHOL AND DRUG SERVICES IN HEALTH, JUSTICE AND WELFARE AGENCIES

3.4.2.1 Health

The only dedicated alcohol and drug service in the general health sector is the Chemical Dependency Unit at King Edward Memorial Hospital. This provides support and medical management of pregnancy and birth for drug-dependent women.

HIV/AIDS services include an Intravenous Drug Users Program that funds a mobile needle exchange program, supplies of needle and syringes in 'Fitpacks' to pharmacists, and specialist staff in the Health Department and the Alcohol and Drug Authority who have consultation and education responsibilities.

Some regional hospitals, albeit a distinct minority, accept patients for the primary purpose of detoxification.

The Health Department has initiated a substantial alcohol abuse program for Aboriginal people, 'Living with Alcohol', which is discussed in Chapter 6.

3.4.2.2 Justice

The Ministry of Justice has a small dedicated alcohol and drug service, the Substance Abuse Resource Unit. Its main work is the provision of a self-help program for adult prisoners.

The Ministry also contracts non-government services to provide group programs in adult community-based corrections and juvenile detention centres. It funds two beds in each of the three non-government youth residential programs. Treatment for drug abuse is also an identified responsibility of the Psychological Services of the Juvenile Justice Division.

3.4.2.3 Welfare

The only dedicated alcohol and drug service in the welfare sector is the Swan Emergency Accommodation Substance Abuse Project for youth, based in Midland. This consists of a single worker providing a range of outpatient counselling interventions.

One voluntary service, Maddington Teen Scene assists parents whose teenagers are involved in a cycle of offending, drug use and delinquent behaviour.

The establishment of an assessment and care centre by the Department for Family & Children's Services for young people who are self destructive and in serious danger of hurting themselves, through various activities which may include drug abuse, was announced recently and will be operational in the latter half of 1996.

3.4.3 CASE PRACTICE IN HEALTH, JUSTICE AND WELFARE

The extent to which health providers including hospitals, community health centres, general practitioners, corrections officers in adult and juvenile jurisdictions, and officers of the Department for Family & Children's Services address alcohol and drug abuse problems was invariably reported in consultations to be very low and generally limited to referral to specialist services with varying degrees of success. When referral is the predominant intervention it will tend to be applied to only the most severe problems.

There is an apparent discrepancy between these reports based on consultation and the information indicating the amount of resources, in financial terms, that these agencies devote to alcohol and drug problems, as reported in Volume II. While the methodology will have varied between agencies, the resource information generally reflects estimates of the proportion of clients and/or client issues that are characterised by drug abuse. As such it is an effective indicator of the extent to which alcohol and drug problems impact on the agency's need for resources to service their client bases. The information provided in consultations reflects the nature of the service that the client actually receives. Thus, while alcohol and drug problems constitute a major drain on the resources of these agencies the strategies included in case practice do not necessarily involve direct interventions targeted at this issue except for referral.

Consultations with the youth field, on the other hand, indicate that workers regard their clients' drug abuse as an appropriate target for direct intervention.

Some non-government agency family violence programs specifically address the issue to some degree (Perth City Mission, Relationships Australia).

3.4.4 CURRENT SERVICE DEFICIENCIES

The identification of current service deficiencies reflects consideration of a number of factors including: what constitutes adequate coverage of treatment needs and opportunities, the capacity of different interventions or services to meet an identified need, the threshold at which an identified need should receive service, and the relative priority of competing needs. This process is necessarily one of informed judgement. The Task Force's broad consultations and reference to the available indicators of best practice, both of which are described in the report, inform this assessment and its conclusions.

If the most developed available numerical model to determine alcohol and drug service needs is applied to Western Australia, following the work of Rankin (1994) in NSW which is in turn based on the work of Rush in Canada and Reynolds in Queensland, the services that would be indicated are: 155 detoxification beds, 15 assessment full-time equivalent staff (FTE), 15 outpatient FTE, 37 day treatment FTE, 686 supported accommodation bed equivalents, 30 after care FTE, and 58 case management FTE. These resources presuppose a particular model of service and do not reflect either the desirability of building upon existing approaches or the need to meet local conditions. It is included for illustrative purposes only to indicate the quantum of services that may be required to meet the needs of a population exceeding 1.6 million people.

Requests by various communities for the establishment of sobering-up shelters have not been included as the planned development of these facilities is proceeding under the aegis of the Health Department in accordance with commitments it has made.

The following deficiencies have been identified as priorities that if met will provide a comprehensive range of services to cover the State's treatment needs.

- **Specialist alcohol and drug services in regions.**

  A basic core of specialist services such as detoxification, methadone maintenance, and outpatient counselling for adults, families and youth should be available throughout the State and is not currently.

- **Specialist alcohol and drug services in outer metropolitan areas.**

  Increased availability of basic localised services such as outpatient counselling for adults, youth and families has the potential to increase catchment and retention of clients.

- **Youth services**

  Although there are a number of existing specialist youth programs, they are small, narrow in focus or not providing the comprehensive service that would maximise their effectiveness.

  Intoxicated youths in the city centre, Midland and at times other suburban locations, are not being effectively managed in all locations.

  A small but persistent group of chronic solvent abusers are not being engaged in treatment.

  The youth field has a solid grounding of training, but its case practice could benefit from development.

- **Support for families**

  Although a number of agencies have family services and have further capacity, there appears to be considerable unmet or latent demand for support for families who have children who are abusing drugs and to assist families to respond to the issue before a problem develops.

- **Gender sensitivity**

  In order to maximise their effectiveness all programs need to ensure that they operate in a way that attracts and meets the particular needs of female clients.

- **Persons from a non-English speaking background**

It is probable that there are significant problems among these ethnic groups, but it is clear that few services are reaching them.

- **Methadone maintenance**

  The current waiting list to access methadone maintenance and its restriction to a single locality in Perth is substantially less than optimal.

- **Health services**

  The large number of hospital admissions related to excessive use of alcohol indicates a significant opportunity to intervene with this group. Other health settings provide similar if not so substantial opportunities. Development of the health system's capacity to respond to alcohol and drug problems that are either the primary or a secondary reason for presentation is considered prudent.

- **Mental health services**

  The ability of mental health services to address alcohol and drug abuse by their patients needs to be developed considerably.

- **Justice**

  The substantial proportion of offenders under sentence who have an alcohol or other drug abuse problem indicates both an opportunity and a responsibility to target these problems in a systematic and concerted fashion. While the Ministry of Justice does provide or contract a number of alcohol and drug services the coverage is piecemeal and could be more strongly supported through general case management.

- **Welfare services**

  The significant proportion of welfare clients who have an alcohol or substance abuse problem and the propensity for this problem to exacerbate the primary concern such as child protection or family violence, indicates both an opportunity and a responsibility to target these problems.

- **Community action and support**

  The community has expressed both a willingness to be involved in tackling drug abuse and practical ideas as to how it can assist, but it needs support to take action.

3.5 SERVICE INITIATIVES

If treatment and intervention is to reach and engage a larger number of people who have a drug abuse problem, and if it is to achieve better outcomes for the individuals and families affected, and thus make an appreciable impact on the problems and costs borne by the community as a whole, then the provision of a comprehensive range of services and a whole-of-government approach must be pursued by all participants in the alcohol and drug field and the health, justice and welfare sectors.

The range of initiatives outlined below is recommended to meet the current service deficiencies identified. Specialist services are recommended for both the alcohol and drug field as well as some in the health, justice and welfare (youth) sectors. Development of the abilities of staff and the extension of their case management ambit in the health, justice and welfare sectors is also recommended.

In developing these proposed initiatives, the Task Force considered the wide range of alternative strategies suggested to it by both the general community and those with expertise in the field. Many of these are reported elsewhere in the report. The recommended initiatives were developed to maximise both the reach and the impact of services.

Some initiatives described below presuppose elements of the funding system and criteria outlined in the next section. The following distinction needs to be anticipated. The development or extension of existing services is specified where there is only one practical or appropriate provider due to their established infrastructure and satisfactory operation. Existing agencies are not specified where a variety of providers may be capable of delivering the service.

3.5.1 SPECIALIST SERVICES

3.5.1.1 Community drug service teams

Community Drug Services Teams (CDSTs) will have a multifaceted role at the regional and local levels encompassing co-ordination and community action as well as direct service delivery. In areas with substantial Aboriginal populations, some team members will be Aboriginal. The teams' pivotal role in the overall organisation of responses to community drug abuse problems is also described in Chapter 7 and is reiterated here briefly to illustrate the ways in which their co-ordination and community action functions will facilitate service delivery.

Regional co-ordination will bring together local service providers including representatives of the health, justice and welfare sectors as well as local government and the private sector through the Regional Drug Co-ordinating Councils. The CDSTs will service the regional councils which will provide a forum for co-operation and collaboration in service delivery. Issues such as intoxicated youth in the city and other locations, and intervention with chronic substance abusers can be addressed through these structures.

Local community action will involve the establishment of Local Drug Action Groups and the CDSTs will assist the development of these groups and their activities. Initiatives suggested to the Task Force that would be within the capacity and ambit of these structures might include recruiting and supporting mentors for youth, developing local recreational activities, and assisting parent support initiatives.

Both the Regional Drug Co-ordinating Councils and Local Drug Action Groups will, like other groups, have the opportunity to apply to the Lotteries Commission, Healthway and other grant giving agencies for grants to pursue specific community development or community action projects and will be assisted to pursue this option actively.

The direct service provision role of the CDSTs is categorised as outpatient counselling for adults, families and youth. It should, however, involve a diverse range of interventions beyond appointment and centre-based counselling. The spectrum would include: case management and counselling; support for other case managers such as methadone providers, corrections or child protection officers, or youth workers; outreach work in settings such as youth centres; receiving disciplinary referrals from local schools; and sessional services in various settings.

The exact nature of services provided in each region will vary with local needs and resources. The teams will be required to target identified gaps in service as a priority. The management of intoxicated youth and intervention with chronic solvent abusers will be early priorities in some areas.

The mandate of the teams should encompass adults, families and youth, but a priority emphasis on families and youth is specified.

It is proposed that there will be four metropolitan teams each with between five and eight staff, and six regional teams each with between three and five staff.

3.5.1.2 Youth

Yirra

The youth program Yirra operated by the Perth City Mission is the only residential youth program in Perth that is both substantial and attracts a broad spectrum of clients. Palmerston has only two beds for youth aged 17+. Teen Challenge's potential client base is limited by its milieu as a long-term didactic Christian program, although it is well utilised and clearly appropriate for those it attracts. Cambridge, as a private hospital, restricts its clientele through cost. Yirra is generally well regarded, heavily utilised and considered by the field to be an essential service.

Currently, Yirra is approximately 50% government funded. After its establishment in 1992, Mission Australia provided the remainder of financial support for its first two years of operation only. The service was maintained in 1994/95 by one-off government funding through the Lotteries Commission. It requires secure funding to continue to operate.

The Yirra residential program also provides a suitable base for a more comprehensive range of services. Its capacity, retention of clients and effectiveness could be significantly enhanced by the addition of family and outpatient services.

It is, therefore, proposed that Yirra be resourced to maintain its residential youth program and to also provide outpatient and family services.

Expansion of residential program bed capacity

Demand for more residential placement options was expressed by the justice sector. Additionally, it is anticipated that the impact of other initiatives, in justice services and also the community teams, will be to further increase demand for residential placements. Currently, Yirra has eight beds, Palmerston two and Teen Challenge has 16 beds in Esperance. These agencies should be invited to respond to a tender for increased bed capacity.

Drug abuse workers in supported accommodation services

The Swan Emergency Accommodation Substance Abuse Project has provided an outpatient and outreach counselling service for youth utilising the accommodation service and in the local community. It was piloted in 1992/93, evaluated favourably in 1993 and has been funded on a year-to-year basis subsequently.

The Task Force consider that the project indicates a viable model for engaging a broader number of youth into treatment and an effective integration of specialist and mainstream services in the youth field. As such the model could be replicated in other youth accommodation services in areas of significant need. It is noted that the availability of this service in some supported accommodation agencies should also promote the development of complementary skills and activities in the accommodation programs and increase their capacity to engage and retain youth with drug abuse problems.

Four services consisting of a single worker are proposed for across Perth.

Intoxicated youth

A submission prepared in 1994 to provide a youth detoxification/overnight shelter was presented to the Task Force by the Midland Sobering Up Shelter Committee. This group still considers such a facility to be an appropriate response to a large number of intoxicated youth in Midland.

In the city centre there are regularly significant numbers of intoxicated youth. The Police Juvenile Aid Group supported by the Ministry of Justice's Killara program has managed this issue for some years by holding the young people (under S.138B of the Child Welfare Act 1947) until they are taken either home, to a responsible adult or to an emergency accommodation placement. The Juvenile Aid Group and Killara's capacity to maintain this service is under severe strain. The Juvenile Aid Group proposes that it can be maintained if it has support to co-ordinate the collaboration of other existing services and/or volunteers.

For the past four years the Department of Family & Children’s Services has set aside two beds in its hostels for intoxicated youth who cannot be accommodated elsewhere overnight. This service has not been well utilised for a variety of reasons.

In other States, South Australia has a dedicated youth overnight shelter while Queensland is currently exploring the option of developing dedicated bed capacity in existing supported accommodation services.

Two service initiatives are proposed.

First, as indicated earlier in the description of community teams, where it is practicable these teams will co-ordinate collaboration of service providers to support existing management approaches where they currently operate and promote their development where they do not.

Second, the Central Drugs Co-ordinating Office will explore the extent to which a need remains for dedicated overnight shelter accommodation for intoxicated youth, and should it be required, it will support the development of a suitable model of service to meet this need.

Chronic solvent abusers

An immediate priority for some Community Drug Service Teams will be to provide case management for chronic solvent abusers. To date a considerable expenditure of welfare resources has had minimal impact on these persons and a concerted and co-ordinated effort is required. Community Drug Service Teams are the appropriate groups to organise and lead such an effort.

Youth services mandate

While youth services recognise that their clients' drug abuse is an appropriate target for intervention, the skill and specificity with which it is addressed could be enhanced considerably. The pervasiveness of drug abuse and its centrality in perpetuating the other problems suffered by youth service clients, mean that it should be a primary focus for intervention. This can be promoted by including drug abuse intervention in contracts of service for youth services. It is proposed that the Central Drug Co-ordinating Office negotiate this inclusion with the Department of Family & Children's Services.

3.5.1.3 Families

Parent drug information service

A dedicated, separately identifiable telephone information and advice service will be established as an extension of the existing and successful Alcohol and Drug Information Service (ADIS). ADIS currently serves this role and is successful in referring a substantial proportion of the parents who attend parent support groups provided by the existing service network. ADIS will be expanded and its promotion developed to market the service to a wider market.

Parent support services

Support services for parents whose children are currently abusing drugs are provided by a number of agencies through a variety of approaches. There is capacity in these existing services to meet an increase in demand at this time. The Central Drug Co-ordinating Office will monitor demand and capacity and ensure that any need for increased capacity is met.

Parent education

Two initiatives are proposed and outlined in Chapter 4. These are the further development of specific and in depth education programs for parents, and the provision of information for parents to complement mandatory drug education in schools.

3.5.1.4 Women

The Central Drug Co-ordinating Office will negotiate with existing service providers to ensure that agency policies and procedures meet the basic best practice indicators described earlier. Agreed agency specific indicators will be included in contracts for service.

With respect to a proposal for an additional women-only service in Perth, it is noted that the city currently has two women-only services. Perth Women's Centre provides a range of outpatient services. This is meeting demand and it is anticipated that it will continue to do so for some time. The Hearth program operated by Wesley Central Mission specifically targets women and provides outreach and outpatient based interventions. Additionally, home detoxification has been supported from the Central Drug Unit and Palmerston's residential program accommodates women with their children if required. There is no residential women-only service in Perth; such services are established in Sydney and Melbourne.

A business plan incorporating a proposal to fund a women-only, 30-bed residential and outpatient service providing detoxification and a medium-term program has been presented to the Task Force by one agency. Capital infrastructure for this service has been funded by government and private sources and its construction is well under way. Recurrent funding has not been planned or provided for. During its consultations with both the public and service providers, the Task Force was on no occasion advised of the need for such a service. It appeared that other service providers were not generally aware of its development. Given the availability of the existing women-only services, the proposal to ensure that general services provide for the particular needs of women, and the absence of calls for such a service in an exhaustive consultation process, the Task Force does not consider that the need for this service has been demonstrated at this time.

3.5.1.5 Methadone treatment

The provision of methadone treatment should be expanded considerably by being substantially devolved to individual private practitioners throughout the State.

Western Australia has the benefit of learning from the experience of other States in expanding methadone treatment availability through private services. There have been obvious successes and failures in this process. Across Australia, programs have been greatly expanded, treatment has become more cost effective and general practitioners have been recruited into a field to which they were previously resistant. However, insufficient training and monitoring have in the past led to deaths from commencement on too high dose levels, absence of effective criteria and inadequate controls for takeaway doses have led to diversion of methadone to the black market in turn accounting for some opiate overdose deaths, and there are concerns about over-servicing from private clinics. Each of these system failures has been shown to be remediable.

The key elements of the preferred model that is proposed are:

- Predominance of treatment to be provided by general practitioners.
- Providers to have full management responsibilities including assessment and stabilisation.
- Providers to be limited to a maximum of 50 clients each.
- A limited number of psychiatrists to provide for clients with a co-existing psychiatric disorder.
- Predominance of dispensing to be provided by community pharmacies with a limit of 15 clients at any one pharmacy.
- Limited number of specialist methadone clinics for clients who are difficult or have special needs (for example pain management, HIV positive), and to provide clinical practice opportunities for medical trainers.
- Central systems for treatment policy; training, accreditation and monitoring of individual providers; and monitoring and evaluation of system functioning.

The aim of the devolution is to have as few as two specialist clinics, each with a capacity for 60 to 100 clients; and private capacity for 800 to 1000 clients which would require between 20 and 50 medical practitioners and between 50 and 100 community pharmacies. The system could be further expanded by the training and accreditation of additional private providers or the addition of a further specialist clinic.

Specialist clinics will be part of alcohol or drug agencies or public hospitals. The option of private methadone clinics as pursued in NSW is not proposed. While it would allow for speedier devolution, these clinics do not appear to confer any client management benefit; and the competitive economics of the clinics result in incentives being geared towards building and maintaining client numbers, providing more medical consultations than may occur otherwise, and relaxing criteria for takeaway doses.

The development and maintenance of central systems for policy; training, accreditation and monitoring of providers; and systemic monitoring and evaluation will involve, as appropriate, the State Division of the Royal Australian College of General Practice, the Pharmaceutical Guild of Western Australia, the Australian Medical Association, the Principal Medical Officer for alcohol and drug services and the Health Department, in a process co-ordinated initially by the Central Drug Co-ordinating Office. It will be essential for the systems of control to be tightly maintained and strictly enforced.

General practitioner providers will be able to access clinical advice from specialist medical officers in alcohol and drug services and local support from Community Drug Service Teams. The limited number of psychiatrist providers will also be able to access this support. Pharmacies will be able to access advice from the pharmaceutical services of the specialist clinics and Community Drug Service Teams.

Ancillary counselling for methadone patients will be available by referral to alcohol and drug agencies, Community Drug Service Teams and the various specific purpose providers.

Consultations with KPMG Peat Marwick, which is conducting a national review of methadone treatment, have indicated that this model of service delivery will be compatible with the various funding model options that its

consultants will be proposing. The model is also consistent with the current National Policy on Methadone (1993).

3.5.1.6 Review of individual specialist services

While the Task Force has been able to make a global assessment of the extent to which existing services are meeting current needs and thus identify priority areas of service deficiency, it has been beyond its scope to review the operation of the many individual specialist services in Western Australia.

A review of individual services is, therefore, proposed with the following purposes:

- Assist agencies to meet standards of best practice in program content and delivery.
- Identify and recommend any opportunities for minor service developments that would significantly enhance client engagement, retention and outcomes.
- Identify and recommend where funding should be redirected or services should undergo major redevelopment in order to meet identified client and community needs.

An independent reviewer will be selected by competitive tender.

The terms of reference for the review shall be developed by the Central Drug Co-ordinating Office in conjunction with the Western Australia Network of Alcohol and Drug Agencies and major service providers. The terms of reference will include request for comment and recommendations regarding the adequacy of management systems, information systems, treatment manuals and protocols, staff training and staffing levels.

The methodology of the review will involve the individual agency in its performance facilitated by the reviewer.

It is proposed that resources be available in 1996/97 to address priority needs identified through the review process.

3.5.1.7 Hospitals

Teaching hospitals

Teaching hospitals will be encouraged to introduce screening for excessive use of alcohol as part of intake assessment.

Alcohol and drug teams shall be established in each hospital to provide:

- brief intervention for persons identified by screening as excessive drinkers;
- referral to alcohol and drug services for persons with entrenched alcohol or other drug problems; and
- assistance to psychiatric services to deal with patients who also abuse alcohol and drugs.

Teams will consist of three people each at Royal Perth Hospital and the Sir Charles Gairdner Medical Centre, and two people at Fremantle Hospital.

Regional hospitals

All regional hospitals will be encouraged to provide detoxification as a primary service as is carried out in some locations. Support consisting of treatment protocols, training and ongoing clinical advice will be available to these hospitals.

Screening for excessive use of alcohol should be introduced as part of intake assessment. Brief intervention and referral to alcohol and drug treatment will be provided where appropriate by Community Drug Service Teams.

Small town hospitals

Consultations in regional areas indicated that a number of these hospitals are under-utilised though valued resources for their towns.

With appropriate support and training for staff, they provide a cost-effective means of delivering some services to small population centres.

The ability of small town hospitals to respond to alcohol and drug problems will be developed. Each should have the capacity to provide detoxification, screening and brief intervention, and some outpatient counselling.

3.5.1.8 Justice

The Ministry of Justice should be able to provide a limited range of specialist services providing key interventions, and do so in formal collaboration with alcohol and drug agencies. Other services should continue to be contracted in by the Ministry.

Two initiatives are proposed that focus on the crucial periods prior to sentencing and release from prison. It is during these periods that interventions will be most effective in engaging offenders into treatment. This engagement and subsequent retention in treatment is in turn assisted by the conditions that can be attached to the sentences of probation and parole. The Western Australian Magistracy, Judiciary and Parole Board are practised in applying drug abuse treatment conditions to probation and parole plans and accepting corrections officers' recommendations to this end. Two other initiatives are proposed for prisons.

Corrections drug service

The Substance Abuse Resource Team should be expanded and should form a larger and stronger team together with staff who are employed by alcohol and drug agencies. This is the same collaborative organisational model that has been used successfully for the Court Diversion Service.

The team would continue to deliver and improve its standardised self-help program in prisons. With the increased resources, there would be capacity for working with individuals in prison or detention prior to release in order to assess their needs, prepare parole or supervised release plans and engage the person with the alcohol and drug agency with which they would be required to continue treatment post-release. This increased individual work, which would involve the counsellor with whom treatment would continue after release, should make the process of parole planning more meaningful and realistic for detainees, rather than a bureaucratic necessity that engenders as much resentment as optimism.

The structure and mandate of the corrections drug service will enable the team to work with prisoners in adult prisons and the alcohol and drug agency staff to work with Juvenile Justice Division Psychological Services for detainees in juvenile detention centres.

The existing Substance Abuse Resource Team consists of three persons. A further five staff should be available for the corrections drug service, one employed by the Ministry of Justice and four employed by alcohol and drug services.

Extension of Court Diversion Service

The Court Diversion Service should be formally extended to the Children's Court. The current informal arrangements are not well recognised, promoted or resourced. The operation of the Court Diversion Service in the Children's Court should engage more young people with entrenched drug abuse problems into treatment and particularly residential treatment. The service currently consists of five people. An additional two-and-a-half staff, including a Juvenile Justice Division secondee and an alcohol and drug service representative would be necessary.

Methadone in prisons

The issue of methadone in prisons requires further consideration. The provision of methadone treatment for persons in prison has been implemented in a number of Australian States. It usually involves continuing prisoners on methadone, where they were already on a program, while on remand, when serving a short sentence, or if they are HIV positive or pregnant; providing graduated withdrawal for persons on methadone who are serving a long sentence; and possibly, commencing prisoners on methadone before release if there is a probability of returning to heroin use.

In the past, Western Australian prison authorities have resisted the introduction of methadone treatment for two reasons: first, the logistical and security problems; and second, a preference for all prisoners to be drug-free so that they can regain their health and make decisions about their future drug use.

These objections need to be assessed in light of the demonstrated positive impact of methadone treatment in reducing the risks posed to the community by drug users, by achieving reductions in drug use, needle sharing and criminal behaviour, and improvements in social functioning, when treatment can be maintained for two or three years; and the precise nature of the prison programs that have been developed. The approach of other States has been to use methadone treatment in prison more as an adjunct to continuing methadone maintenance in the community rather than as a long-term treatment in prison. This approach is compatible with the opportunity for long-term prisoners to be drug-free. Additionally, while the logistical and security issues are not under-estimated, it needs to be recognised that these have been resolved in other States.

Recognising the complexities of this issue, it is proposed that the Central Drug Co-ordinating Office and the Ministry of Justice establish a working party to review the experience of other jurisdictions and to assess the likely costs and benefits of making limited methadone treatment available in Western Australian prisons.

Video surveillance in prison visiting areas

To assist prison authorities to reduce the importation of drugs into prisons, resources should be made available to provide equipment for video surveillance of visiting areas in all prisons.

3.5.1.9 Volunteer program

The Alcohol and Drug Authority and Curtin University have been operating a professional volunteer program that provides a number of agencies with trained and supervised part-time volunteer staff. The program is to be replicated in South Australia and possibly then nationally.

There is an adequate supply of quality applicants, agency placements and professional supervisors to enable the program to be expanded substantially.

The volunteer program will in the first instance be doubled, and priority for placement of the part-time workers will be given to youth centres.

3.5.2 PRACTICE DEVELOPMENT PROJECTS IN HEALTH, JUSTICE AND WELFARE

The treatment of drug abuse will not make an appreciable impact on the damage experienced by the community as a whole if intervention is only provided to those who seek it deliberately. While such treatment will assist the individuals and families concerned, the limited catchment means that treatment and intervention does not make a significant contribution to any reduction in the prevalence of drug abuse problems. To achieve this, a much wider net of people needs to be reached and assisted.

Treatment provided under coercion, for example as an alternative to incarceration or loss of employment, is generally well accepted and has been shown to be no less effective than more voluntary participation. The opportunistic provision of treatment, such as through screening and brief intervention for hospital admissions, is becoming more accepted and has also been shown to be effective. There is not, however, a general acceptance of the need for intervention targeting alcohol and drug abuse as a fundamental feature of case practice in dealing with all clients who are presenting for other primary purposes but for which drug abuse is a contributing factor.

While the causal relationships vary and are in some areas a matter for ongoing enquiry, it is generally acknowledged that alcohol and drug abuse exacerbates the various primary health, justice or welfare problems that bring clients to the respective services. Equally clear is the fact that resolution of the drug abuse problem will assist, and in many cases is a prerequisite for resolution of the primary health, justice or welfare issue. This is particularly the case for a number of hospital admissions, a significant proportion of those offending, and a substantial number of child protection and family violence cases. In mental health, alcohol and drug abuse invariably tends to worsen the disorder and create major complications for its management.

Given the reality of the impact of drug abuse on the full spectrum of health, justice and welfare issues, and given that the knowledge and the techniques are available to address the issue, there is a clear responsibility on the part of health, justice and welfare agencies and case managers to directly target interventions to tackle this problem behaviour. Indeed, doing so represents an opportunity to improve the outcome of case practice as well as a responsibility.

For some years this has been the implicit rationale underlying the substantial efforts directed towards professional training in alcohol and drug issues and interventions. Training at undergraduate, post-graduate and

in-service levels has increased substantially since the mid-1980s. This training, while well regarded by participants, has not however, resulted in significant practice shifts in health, justice or welfare agencies.

For these agencies, change at both the organisational and individual worker level is required. To put it bluntly, these organisations need to adjust their policies and procedures as necessary to ensure that alcohol and other drug abuse is addressed in the course of normal program delivery and case management. This should not be regarded as an additional function for the agency to take on; rather it is an essential strategy to achieve the outcomes that are defined by the agency's mandate.

It is in this context that individual workers need to have the skills, and the support, to put the interventions into practice.

The literature in the area of vocational education and training and the work of the Australian National Staff Development Committee for Vocational Education and Training (NSDC) indicate that training alone is not adequate to achieve substantial and ongoing changes in practice. This field promotes a workplace learning model that emphasises organisational policy, structure and commitment and systems of learning that incorporate not only formal training but on-the-job supervision and transfer of learning at work (NSDC 1991).

In order to achieve the widespread incorporation of interventions targeting alcohol and drug abuse into routine case practice where it is required, a unique program of organisational development and skill formation will be necessary for the various health, justice and welfare agencies, and professional groups.

A series of practice development projects is proposed for the relevant organisations and professional groups. The projects will be a collaborative effort between the alcohol and drug field and the relevant organisation and reflect the nature and structure of the system that is the subject of the project. The following core steps are indicative of how a practice development project would be organised and proceed:

- A steering group is established for the project, convened by the Central Drug Co-ordinating Office and including the relevant organisation(s) and the alcohol and drug education provider.

- The organisation(s), in conjunction with the steering group, define the appropriate and feasible level of alcohol and drug intervention to be conducted in the course of existing client management procedures.

- The formal changes or developments in policies and procedures that are required to mandate the change of practice, are identified and implemented.

- The skill development necessary to deliver the change of practice is identified and defined.

- Programs to provide the necessary skill formation are undertaken.

- The organisational support and structures to facilitate and maintain changed practice are identified and implemented.

The organisations and professional groups for whom practice development projects are proposed, and the possible outcomes of the projects, are as follows:

- **General Practitioners**

  Assistance with demanding and chaotic drug abusers; strategies to limit ‘doctor shopping’; screening for blood borne viruses; screening and brief intervention for excessive drinking.

- **Community Health Providers**

  Screening and brief intervention for excessive drinking.

- **Mental Health Providers**

  Management of alcohol and drug consumption by psychiatric patients.

- **Ministry of Justice**

Intervention to reduce alcohol and drug abuse in the course of routine case management; engaging clients with the most severe problems in specialist services.

- **Family & Children's Services**

  Intervention to reduce alcohol and drug abuse in the course of routine case management; engaging clients with the most severe problems in specialist services.

- **Youth Services**

  Further development of existing alcohol and drug case practice, including the broader distribution and implementation of existing training and case practice resources (Youth Sector Training Council).

- **Ethnic community services and selected alcohol and drug agencies**

  Extension of the training initiatives currently being undertaken by the Alcohol and Drug Authority; adjustment of alcohol and drug agency policies and practice to enhance capacity to respond to persons from a non-English speaking background; development of opportunities for collaboration.

3.6 ORGANISATION OF SPECIALIST SERVICES

3.6.1 CURRENT MODELS OF ORGANISATION

Most alcohol and drug services are provided under the health portfolio and its current 'funder, owner, purchaser, provider' model of funding.

Services are provided by the State Government's statutory authority, the Alcohol and Drug Authority, and some 20 non-government agencies. Government services account for approximately two thirds of specialist service resources in the alcohol and drug field and non-government services for one third.

Both government and non-government services are funded predominantly through the Statewide services directorate of the State Health Purchasing Authority. Funding is for organisations to provide the services specified by contract; the nature of the services and their level of resourcing are historically based.

There are no designated policy or co-ordination functions pertaining to alcohol and drugs aligned to either the funding or service delivery roles of the State Government.

In other Western Australian government agencies, the Ministry of Justice, Department of Family & Children's Services and the Disability Services Commission, the provision of funding for non-government services and the direct service delivery functions have not been separated. All agencies are progressing towards a contract for service model and the introduction of competitive tendering for service funding. The Disability Services Commission is currently progressing the devolution of some service delivery to the private sector.

The models for the provision and funding of services vary markedly between the States.

In NSW, most services are provided by regional health authorities and have a medical health orientation, and there is a small but significant non-government sector largely oriented to illicit drug and chronic alcohol problems. Funding is split between regions with responsibility for State funds, and a drugs directorate of the Health Department with responsibility for Commonwealth funds and which also has policy functions.

In Victoria, all government alcohol and drug services are being devolved to either non-government or mainstream health providers. A small unit in the public health division of the Health Department has co-ordination responsibilities. Funding for devolved services is provided through fixed price tenders.

In South Australia, the government Drug and Alcohol Services Council is a separate statutory authority which serves as an incorporated health centre of the Health Commission. It has responsibility for direct service delivery, funding of non-government services, and policy.

In Queensland, an alcohol and drugs branch in the public health division of the Health Department has responsibility for managing Commonwealth funds for State Government and non-government services, and

policy development. The Health Department provides further funds to regional health authorities to deliver alcohol and drug services.

In the Northern Territory, an alcohol and drug directorate in the Health Department has responsibility for policy development and the 'Living With Alcohol Program' that funds a variety of Territory government and non-government services and initiatives from both Commonwealth and Territory funds that include an hypothecated alcohol levy.

There are a number of deficiencies in the current Western Australian system for the organisation and funding of the alcohol and drug field.

First, the field is almost entirely a part of the general health system. Alcohol and drug problems are not, however, exclusively health issues. Drug abuse is in fact a behaviour with predominantly psychological and social antecedents and for which deleterious health consequences are but one effect over an extended period. While there is a significant role to be played by the health sector in addressing the problem, as emphasised earlier, the alcohol and drug field will find it difficult to give leadership to a broad range of treatment and intervention responses in both specialist services and the health, justice and welfare sectors if it is a minor component of the health system only.

Second, the development of a system of contracting for services and the use of competitive tendering has been anticipated for some time but has not proceeded very far.

Third, the funding of the alcohol and drug field is not supported through its structure with knowledge and expertise. Currently, as a singular function within the Statewide Purchasing directorate, it relies on the experience of those who by historical accident are currently responsible for this role. There are no mechanisms established to access expertise, assess service operation or monitor trends. There are no linkages to community structures that would meet some of these needs.

Fourth, the State has no alcohol and drug policy development function. The importance of this is outlined elsewhere in the report. With respect to funding and service organisation, the absence of a coherent policy framework that responds to changing circumstances leaves service decisions to be made in an ad hoc and uncoordinated manner.

Fifth, funding and service provision are not aligned to any co-ordination function to address community-wide alcohol and drug problems. Without leadership or a co-ordination mandate, alcohol and drug services tend to be expected to meet a disproportionate and unrealistic number of the treatment needs that become apparent in a variety of health, justice, welfare and community settings; and opportunities to address problems through collaborative effort are foregone.

Sixth, while comparisons are complicated by both client and organisational factors, the Task Force is inclined to agree with submissions by the non-government sector that its services are more cost-effective than those provided by the State Government.

It is noted that neither interstate nor other Western Australian service systems have overcome all these deficiencies.

Additionally, the positive features of the current system of organisation need to be acknowledged.

First, non-government providers consider the separation of funding and service provision roles to be potentially equitable and efficient.

Second, State Government services particularly have developed some effective links with mainstream health, mental health and justice services.

Third, there are co-operative relationships between many, though not all, service providers.

3.6.2 PROPOSED MODEL OF ORGANISATION

The proposed model for the funding and organisation of alcohol and drug services, like the service initiatives previously outlined, is based on the need to ensure a broad, diverse, responsive, and cost-effective range of services provided by both the specialist alcohol and drug field, and mainstream health, justice and welfare agencies.

The system for service provision needs to be seen in the context of the overall organisation of responses to the drug and alcohol problems of the community. As described in Chapter 7 of the report, this involves the following structures:

- Central Drug Co-ordinating Office with responsibility for funding, policy and co-ordination.
- Regional Co-ordinating Drug Councils with responsibility for regional co-ordination and initiatives.
- Community Drug Service Teams which facilitate local co-ordination and community action through the Regional Drug Co-ordinating Councils, and have a direct service provision role.
- Local Drug Action Groups to undertake prevention or intervention initiatives at the local level, supported by the Community Drug Action Teams.

This structure provides a framework of strong central and regional co-ordination and community linkages within which the various service providers operate and collaborate.

The key elements of the proposed service delivery and funding system are as follows:

- Services to be provided by either non-government agencies or mainstream health, justice and welfare agencies.
- The services of the Alcohol and Drug Authority to be devolved, with State Government services limited to health, justice and welfare agencies.
- The Central Drug Co-ordinating Office to be the lead funder of alcohol and drug services, for both the non-government sector and State Government health, justice and welfare agencies. This role to be undertaken in conjunction with policy and co-ordination responsibilities.
- Funding to be provided by contract for service. Contract specifications to reflect current best practice indicators. The Western Australia Network of Alcohol and other Drug Agencies will be consulted regarding the development of standard contract specifications for various categories of service.
- Competitive tendering for funding will, in the first instance, be introduced for all new and redeveloped services where there is more than one potential provider. Thereafter, tenders will be let on a triennial basis for all services for which there is more than one potential provider.
- Development or extension of existing services, in order to introduce new initiatives or to enhance service operation, will be pursued when there is only one cost-effective provider or when the service provider is indicated by legislative mandate.
- Submissions for the establishment of new services or service initiatives will be accepted by the Central Drug Co-ordinating Office from Regional Drug Co-ordinating Councils.
- The Central Drug Co-ordinating Office will convene a Drug Abuse Services Funding Panel to advise the responsible Minister on funding allocations. The panel shall have an independent chair and both independent and representative membership.

The service delivery and funding system is designed to have the following benefits: integration of funding, policy and co-ordination; provision of a broad range of diverse and responsive specialist services in a cost-effective non-government sector; provision of key interventions by specialist services based in mainstream health, justice and welfare agencies, supported by the development of case practice in these agencies; and an effective balance of central direction, autonomous service providers, and community participation and development.

As the Central Drug Co-ordinating Office assumes responsibility for funding of specialist alcohol and drug services from the Health Department, it is noted that this would necessarily include resources to meet both current and planned commitments, for example, the development of sobering-up shelters.

3.6.3 DEVOLUTION OF THE ALCOHOL AND DRUG AUTHORITY

The Alcohol and Drug Authority's current role is to provide a range of clinical services and professional education. Its clinical services include detoxification, outpatient counselling, methadone treatment, court diversion, and telephone information and advice. Professional education is provided to a range of service providers in the alcohol and drug field and the health, justice and welfare sectors.

It has limited roles in providing consultation to other services (e.g. AIDS and intravenous drug use), fostering responses to specific issues (e.g. solvent abuse) and promoting community responses (through community and regional services). Its treatment services have developed effective linkages with some parts of the health, justice and welfare sectors, particularly some sections of mental health and adult correctional services.

As a service provider its positioning as a a government agency does not confer any advantages over non-government agencies. There is not a class of client that is better serviced by a government provider; non-government agencies can and do have effective intersectoral linkages; and mechanisms of accountability and quality control can be applied effectively to either sector.

The Task Force is inclined to accept the view of the non-government alcohol and drug sector that it can provide services in a more cost-effective manner than government agencies. The Western Australia Network of Alcohol and Drug Agencies has presented the Task Force with a comparison of the number of clients and client contacts per full-time equivalent staff person for non-government and government services which indicate substantial differences (WANADA 1992). These differences, of two-fold and four-fold magnitude respectively, are of such an order that they are unlikely to be eroded by adjustment for client characteristics or the significant increases in Alcohol and Drug Authority contacts that have occurred in recent years.

The cost-effectiveness advantages of the non-government sector lie in a lower salary structure, less corporate services, access to private funds and more extensive use of volunteer staff. It is accepted that some of these advantages may be reduced as the sector develops towards best practice and with the additional administrative requirements of competitive tendering, contracts for service and associated performance reporting. It is anticipated, however, that a net cost-effectiveness advantage will remain for non-government sector providers.

The Task Force is also in agreement with submissions from the non-government sector that its services enjoy a number of advantages over government services including: closer contacts with the community, flexibility in program development, and attractiveness to clients.

It is proposed that the core services currently provided by the Alcohol and Drug Authority should be devolved as follows:

- A detoxification unit, outpatient counselling, a specialist methadone clinic, and the Alcohol and Drug Information Service will be provided by a new central treatment and training agency.
- Methadone treatment will be substantially devolved to private practitioners.
- The Court Diversion Service will transfer to the Ministry of Justice and be funded through the Central Drug Co-ordinating Office.
- The AIDS service will transfer to the Health Department.
- Community and regional services will be incorporated into the Community Drug Service Teams which will function as incorporated organisations in their own right with their boards of management formed from a sub-committee of the Regional Drug Advisory Councils.
- Professional education will be provided by the new central treatment and training agency.
- The library will transfer to either the Central Drug Co-ordinating Office or the central treatment and training agency.

Other continuing services, projects and contracts will transfer to the most appropriate organisation.

3.6.4 CENTRAL TREATMENT AND TRAINING AGENCY

As indicated above, a central treatment and training agency will provide the core clinical and professional training services previously provided by the Alcohol and Drug Authority.

The Task Force has considered the merits of the central treatment and training agency remaining as a government organisation, being a streamlined version of the Alcohol & Drug Authority. This would be a feasible course of action and could, to some extent, be a less disruptive change. It would, however, have significant disadvantages including the following: there would still be substantial devolution of Alcohol & Drug Authority services; this would leave the organisation smaller and weaker but still subject to bureaucratic constraints; there is, as outlined previously, no convincing rationale for specialist government services; it would cost substantially more; and it would reduce the scope of the organisation to be entrepreneurial. It should further be noted that the role of the ADA has already changed substantially during the past 18 months, and that its major funding and policy advisory roles have already been significantly diminished.

It is proposed, therefore, that the agency will be a non-government organisation. It is further proposed that its first board of management be established through invitation by the responsible Minister and that it should include representation from the current non-government sector.

The central treatment and training agency will seek formal affiliations with research, university and mainstream health organisations. Specifically it will seek to enter into agreements with:

- Curtin University; as the institution responsible for the National Centre for Research into Prevention of Drug Abuse, and also the Addiction Studies Unit in the School of Psychology.

- The National Drug and Alcohol Research Centre; to pursue collaborative research and opportunities to translate research into practice.

- Royal Perth Hospital; to pursue collaborative opportunities in service delivery, reciprocal protocols for client transfer and consultation, and staff clinical placements.

The agency will further develop existing intersectoral linkages with mainstream health, including mental health, and justice and welfare organisations. It will continue to provide opportunities for training placements of medical and psychiatric registrars, and nursing, psychology, social work and other students.

The detoxification unit provided by the agency will replace the service provided by the Central Drug Unit. The new unit will be an adaptation of the model for community drug withdrawal services developed by the Department of Health and Community Services in Victoria and recently piloted and evaluated by Moreland Hall in Melbourne. The unit will treat moderately severe withdrawal syndromes. The model includes staffing by various professionals; nurse responsibility for continuous oversight of medical problems and pharmacotherapy and out of hours consultation; provision of emergency services according to an agreed protocol with an associated hospital; and an approach that emphasises consumer autonomy by collaborative treatment planning, guided self-administration of medication, self initiated primary health care, participation in domestic duties and fee payment. The service will encompass residential, outpatient and home detoxification. It is anticipated that this service will be provided for approximately 20% less than the cost of the current Central Drug Unit service.

A limited outpatient service will be provided by the agency to engage some clients after detoxification for whom referral to another agency is unlikely to be achieved. This service will be smaller than that currently provided by the Central Drug Unit as outpatient services will be expanded throughout the city through the Community Drug Service Teams. It will include the resources recently allocated for augmenting services provided to clients with a co-existing psychiatric disorder. These dedicated resources should provide an appropriate interim response for such clients pending the development of mental health services' capacity to intervene more effectively in the management of their patients' drug and alcohol use.

The central treatment and training agency will take over the William Street Clinic's methadone program. It will manage the devolution of this treatment to private practitioners in conjunction with the Central Drug Co-ordinating Office. As the devolution proceeds, the operation of William Street Clinic will wind down until a specialist clinic for 60 to 100 patients can be maintained. During this period the Central Drug Co-ordinating Office will seek to have a second specialist clinic established in conjunction with a public hospital.

The Alcohol and Drug Information Service will be managed by the central treatment and training agency. Its operation should be affected only by the development of the service initiatives referred to earlier.

The professional education service of the agency will be responsible for the practice development projects outlined earlier; a limited number of introductory and general courses suitable for new staff in health, justice and welfare agencies; in-service training for alcohol and drug specialists providing instruction in best practice treatment methods; and courses tailored to the specified needs of customers provided on a fee for service basis. The agency should be structured so as to extend education responsibilities to a wide field of staff so that all educators maintain some clinical work and experience. Medical officers will have a substantial education role with responsibilities in the areas of methadone treatment, blood borne viruses, brief intervention for excessive drinkers and managing alcohol and drug issues in general practice.

The central treatment and training agency should also be well placed to take an entrepreneurial approach to providing services and meeting other opportunities within its field of expertise.

The current business environment in both the public and private sectors favours contracting specialist services coupled with a desire to increase productivity and improve occupational health. With its expertise covering both intervention to treat drug abuse and education to prevent it, the central treatment and training agency should be able to develop programs to meet particular market needs and respond to advertised opportunities.

Services for private industry present a significant opportunity at this time. The Department of Occupational Health, Safety and Welfare has advised the Task Force that alcohol and drug services previously provided to industry have evolved toward more general management consultancy but that the need for specific services persists. The development and marketing of services that reflect current patterns in drug abuse, age groups, workplace standards and the industrial relations climate, could be effectively met by the central treatment and training agency.

Thus, a variety of consultancy, staff development services and direct interventions might be provided on a fee for service basis. Such opportunities should be pursued by the agency wherever possible. It should also respond to public tenders and seek grants for specific purposes where appropriate.

Similarly, the central treatment and training agency should seek to supplement its resource base by making application to establish itself as a beneficiary of philanthropic trusts. It should not, however, attempt to develop a dedicated fund raising program.

The management structure of the central treatment and training agency will involve a Chief Executive Officer supported by a Manager of Treatment Services, a Manager of Professional Education and a Principal Medical Officer.

Core funding will be provided to the agency for an initial three-year period at the end of which its services will be funded by competitive tender on a triennial basis in accordance with the general system of funding.

3.6.5 ACCREDITATION OF SERVICE PROVIDERS

The Western Australia Network of Alcohol and Drug Agencies (WANADA) represents most alcohol and drug service providers and is currently seeking to broaden that membership to include all specialist agencies and also non-specialist service providers. The Task Force commends its efforts in this direction. WANADA has proposed that there should be a systematic approach to quality management that would have as its ultimate goal a system of accreditation for drug abuse service providers.

The Task Force agrees that an accreditation system would be an important means of promoting the quality of services and accountability of providers. Indeed a number of consultations conducted by the Task Force indicated that accreditation is an important safeguard for both providers and funders when service delivery is undertaken predominantly by private organisations.

Such a system should be complementary to the best practice provisions of contracts for service. Progress towards accreditation and its eventual achievement could be a condition of continued funding.

It is proposed that the Central Drug Co-ordinating Office together with the Western Australia Network of Alcohol and other Drug Agencies develop a suitable system for the accreditation of specialist alcohol and drug services and determine a program for its implementation.

3.7 SUMMARY OF RECOMMENDATIONS

3.7.1 SERVICE INITIATIVES

COMMUNITY DRUG SERVICE TEAMS

4. That Community Drug Service Teams be established in four metropolitan and six regional locations (see Recommendations 127 and 128).

YOUTH SERVICES

5. That the proposed Community Drug Service Teams co-ordinate collaboration between service providers to address the issue of intoxicated youth.

6. That the proposed Central Drug Co-ordinating Office support development of a suitable model for overnight shelter for intoxicated youth as necessary (see Recommendations 118 and 119).

7. That the Community Drug Service Teams provide case management for chronic solvent abusers.

8. That drug abuse workers be established in four supported youth accommodation agencies.

9. That residential program bed capacity for youth be expanded through existing agency services.

10. That Yirra, the treatment facility for young people, be resourced to maintain its residential youth program and also to provide outpatient and family services.

11. That funding contracts for youth services specify intervention for drug abuse where appropriate.

FAMILIES

12. That a Parent Drug Information Service be established.

13. That the capacity of parent support services be expanded as and when demand requires.

14. That parent education programs be expanded and parents provided with education materials to complement mandatory drug education in schools.

See also Recommendation 43.

WOMEN

15. That all alcohol and drug services be required to ensure that programs are provided in a manner that meets the specific needs of women.

METHADONE TREATMENT

16. That methadone treatment be considerably expanded by being substantially devolved to individual private practitioners, subject to effective safeguards.

REVIEW OF INDIVIDUAL SPECIALIST SERVICES

17. That all individual alcohol and drug services be reviewed to enable them to meet best practice in program content and delivery, identify opportunities for minor service developments, and determine any areas where redirection of funding or major redevelopment of services is required. This review to be completed within a twelve month period.

HOSPITALS

18. That teaching hospitals be resourced to provide alcohol and drug teams to introduce brief intervention, referral, and support to psychiatric services.

19. That regional hospitals be encouraged to provide detoxification and be assisted to provide brief intervention.

20. That hospitals in small towns develop the ability to provide detoxification, brief intervention and outpatient counselling.

JUSTICE

21. That alcohol and drug services in the Ministry of Justice be expanded substantially, through a collaborative model with non-government agencies.

22. That the Court Diversion Service be extended to the Children's Court.

23. That the Central Drug Co-ordinating Office and the Ministry of Justice establish a working party to consider the provision of limited methadone treatment in Western Australian prisons.

24. That resources be made available to provide video surveillance equipment for visiting areas in all prisons.

VOLUNTEER PROGRAM

25. That the Alcohol and Drug Authority/Curtin University volunteer program be doubled and additional placements focused on youth centres.

PRACTICE DEVELOPMENT PROJECTS IN HEALTH, JUSTICE AND WELFARE

26. That practice development projects to develop alcohol and drug intervention skills and extend the ambit of client management to target alcohol and other drug abuse be undertaken in collaboration with:

- general practitioners;
- community health providers;
- mental health providers;
- Ministry of Justice;
- Family and Children's Services;
- youth services; and
- ethnic community agencies and selected alcohol and drug services.

SERVICE PROVISION

27. That alcohol and drug services be provided predominantly by the non-government sector.

28. That some dedicated alcohol and drug services be provided by State Government health, justice and welfare agencies.

DEVOLUTION OF THE ALCOHOL AND DRUG AUTHORITY

29. That the services of the Alcohol and Drug Authority be devolved to the non-government sector and mainstream health, justice and welfare agencies. This would involve:

- core services being devolved to a central treatment and training agency, to be established in the non-government sector;
- the AIDS service transferring to the Health Department;
- the Court Diversion Service transferring to the Ministry of Justice;

- community and regional services being incorporated into Community Drug Service Teams; and

- the Alcohol and Drug Authority library transferring to either the Central Drug Co-ordinating Office or the central treatment and training agency.

CENTRAL TREATMENT AND TRAINING AGENCY

30. That the proposed non-government central treatment and training agency provide the following core services devolved from the Alcohol and Drug Authority: detoxification, outpatient counselling, a methadone clinic, the Alcohol and Drug Information Service, and professional education. The centre should seek formal affiliation with Curtin University, Royal Perth Hospital and the National Drug and Alcohol Research Centre (see Recommendation 122).

FUNDING SYSTEM

31. That the Central Drug Co-ordinating Office be the lead funder for alcohol and drug services.

32. That the Central Drug Co-ordinating Office funding role be undertaken in conjunction with its policy and co-ordination functions.

33. That funding be provided by contract for service with contract specifications to reflect current best practice indicators.

34. That competitive tendering for funding be introduced.

35. That the funding system have limited provision for supporting the development of existing services and responding to submissions from the community.

36. That the responsible Minister be advised by a Drug Abuse Services Funding Panel regarding funding decisions.

ACCREDITATION

37. That a system of accreditation for service providers be developed by the Central Drug Co-ordinating Office and the Western Australia Network of Alcohol and Drug Agencies.

4. EDUCATION ABOUT DRUG ABUSE

4.1 INTRODUCTION AND BACKGROUND

Education about drug use and abuse is a vital component of any drug abuse control program. Almost all the comprehensive submissions to the Task Force emphasised the importance of education. This emphasis was endorsed at all our public hearings, as well as in many other meetings.

The trends reported in Volume II of this report indicate that drug use among young people in Western Australia is at levels that amply justify a substantial effort in both time and resources in drug education.

As we note in Volume II, the most recent reliable survey of drug use among young people in metropolitan Perth shows that in Year 10 49% currently use alcohol, 33% marijuana, 22% tobacco, 8% hallucinogens, and 5% amphetamines. Even where use is low (e.g. inhalants 2%, steroids 1%, heroin 0.5%) the numbers reflected across the entire school-age population are sufficient to cause serious concern. As the Parents and Friends Federation of Western Australia pointed out in their submission, it would be wrong to accept the 'false perception that virtually all teenagers are on drugs', but the problem is nonetheless substantial.

Drug-use levels among the adult community are also of concern, not only because of the implications for their own health and wellbeing, but also because of the undesirable yet significant influence of adult modelling on the drug-use attitudes and behaviours of young people. The Western Australia Child Health Survey (Zubrick et al 1995, p. 31) notes, for example, that 'the significantly lower rates of smoking among adolescents whose parents did not smoke suggests that prevention programs targeting adults to quit smoking may also have the indirect effect of reducing the percentage of children who take up smoking'. The importance of parental example has been demonstrated in similar surveys over the years in Australia and internationally. Drug education for young people needs therefore to be complemented by public education directed at the general community.

There is a substantial literature on drug education, both in isolation and in broader contexts such as health education or crime prevention. The literature does not provide any 'magic bullets', but it does provide helpful indications as to the directions that may be appropriate.

The literature on drug education, however, often raises almost as many problems as it resolves:

- Few drug education programs have been well evaluated, and most have not been evaluated at all.
- Much drug education is ad hoc and isolated, rather than planned and co-ordinated. Often drug education programs have been developed out of frustration and enthusiasm, rather than as part of a carefully planned comprehensive program.
- Much of the literature on drug education is outdated, and relates to different circumstances, contexts and trends than those existing today.
- Much of the international experience with drug education arises from conditions very different to those in Western Australia. It is therefore necessary to interpret the outcomes with some caution.
- Many of the programs or activities that have been implemented or evaluated are short-term programs dealing with one discrete form of drug use.

It is pertinent to note also that the expectations placed on drug education programs are often unrealistic. Much of the literature deploring the failure of drug education has falsely assumed that drug education programs are expected to be a panacea for all drug abuser problems. Sometimes the designers and implementers of drug education have contributed to this by their own overambitious expectations of what drug education can achieve.

Similarly, it would be simplistic to imply that because the young people who start using drugs are school students, the responsibility for their behaviour and any changes must rest solely with the schools they attend. There are many other influences on the behaviour of young people.

A report of this nature tends to focus on areas of 'bad news' — on behaviour and trends that are properly causes for concern in the community, and on action that can be taken to improve these trends. As a result, conclusions

may be drawn that do not reflect either the complexity of the issues or the 'good news' that also merits comment.

Use of drugs by young people is a case in point. Surveys of drug use by young people are generally carried out through the school system, because schools can provide the necessary organisation and support. Surveys are therefore generally reported in terms such as 'use by school students', leading to the conclusion that much of the use occurs in schools, and is the sole responsibility of schools. The reality is that very little drug use occurs in school premises, and that schools are only one of the groups with responsibility for the behaviour of young people. Much responsibility rests with others, particularly parents, and the young people themselves.

While we note the extent of drug use in Western Australia by young people — and others — this should be seen in context:

- Even despite the pressures of adolescence in the 1990s, there has been a significant decline in smoking among young people. A total of 80% of secondary school students are not smokers.

- Regular use of alcohol among young people has decreased since 1989.

- The percentage of school students reporting use of drugs such as heroin and cocaine remains constant at well below 1%.

- The situation is Western Australia is overall certainly no worse than in other States, and on some counts markedly better.

- While we recommend further implementation of drug education programs in schools, this is an area where Western Australia has historically led the other States.

There are occasional queries as to whether drug use occurs more in government than in non-government school students. Most major surveys of drug use by young people are carried out in government schools: this can lead to an erroneous assumption that the problems arise only — or to a greater extent — in those schools' students.

There is no reliable evidence to indicate that drug use trends are significantly different in government and non-government school students. In short, it is fair to conclude that trends in government and non-government school students are almost certainly much the same. One can conclude from the data that far from there being a clear socio-economic gradient, drug use is most likely to occur among those in the lowest and the highest socio-economic groups: the Western Australian Child Health Survey (Zubrick et al 1995 p. 32) notes that, 'adolescents in the middle income bracket were least likely to use marijuana'.

As this entire report highlights, drug use and abuse is a highly complex issue. Drug education is only one of the influences affecting drug use within our community, and drug education is but one element of the comprehensive approach required to reduce drug abuse. The outcomes expected from drug education should take account of the quantum and quality of education provided: limited activity leads to limited results. Further, formal programs, whether in schools or elsewhere, should not be expected to 'solve' all problems.

The expectations placed on education programs should not be too great. Education is part of a long-term strategy. If it achieves good outcomes in the short term, this is a useful by-product, but education must be introduced:

- As part of a comprehensive long-term program.

- Recognising that many of the behaviours that education seeks to affect are well-entrenched in the community (and sometimes subject to a wide range of opposing pressures).

- With adequate resources.

- Recognising the many broader contexts within which drug-taking behaviour occurs. (Some submissions, for example, understandably raised issues such as the provision of appropriate recreational facilities for young people: these are relevant, but could not be considered within the scope of this enquiry.)

The specific form and directions that drug education should take in Western Australia is itself a complex issue. Submissions made to the Task Force on Drug Abuse included some contrasting proposals, a selection of which are described below.

- Some proposed that drug education should occur in isolation; some that it should be built into a co-ordinated program.

- Some proposed that the various themes (alcohol, tobacco, illicit drugs, etc) should be treated separately; others that they should be taken together.

- Some suggested that single 'one-off' approaches should be effective; others that only a long-term approach should be considered.

- Some suggested that only certain groups should be targeted for drug education; others that it should applied across the board.

- Some suggested that drug education should occur only or primarily in schools; others that alternative approaches were desirable.

- Some suggested that only young people should be targeted, others that they should not be singled out.

- Some suggested that education in schools should be delivered only by experienced professional educators; others that ex-addicts or people with personal experience are more appropriate and effective in the school setting.

- Some suggested that the police should not be involved in drug education in schools; others that they have an important role to play.

As noted elsewhere in this report, an 'either ... or' approach to many of the above and other contrasting views may not be appropriate. Rather we would commend a comprehensive approach to drug education that includes as many viable strategies as possible.

In presenting an approach to drug education for Western Australia, one theme that cannot be over-emphasised is the importance of prevention and early intervention.

The evidence available on alcohol abuse, other drug abuse, crime related to alcohol and drug abuse and, indeed, many other social problems faced by the community, shows that these problems peak between the ages of 15-25, after which they decline. Opportunities for intervention through various legislative and other controls and education focused on the immediate consequences of abuse exist during this at-risk stage and later. The most important opportunities for intervention, however, occur before the relevant populations have reached this at-risk phase — before their attitudes and behaviour patterns are fixed.

In the words of John Ruskin, 'Education is not that we know more, but that we behave differently'. It is critical that drug education programs should be aimed first at preventing the uptake of behaviours that lead to drug abuse, then at both changing inappropriate behaviours and maintaining those that are appropriate. Less formally put, drug education should seek to follow the advice of the Welsh rugby union coach, Carwyn James, who advised his players to "get your retaliation in first".

4.2 DRUG EDUCATION IN WESTERN AUSTRALIA TO DATE

Much drug education is already in place in Western Australia, both formal and informal. The main activities are set out briefly in Volume II of the report. They include:

- Formal drug education in some State schools, as part of the K-10 syllabus.

- Formal drug education in some non-government schools.

- Informal drug education in schools, carried out by school staff and non-government organisations.

- Continuing public education programs, such as the Quit, Drinksafe and Respect Yourself campaigns run from the Health Promotion Services Branch of the Health Department.

- Ad hoc public education programs run from the Health Department and elsewhere.

- Public education programs on issues such as drink-driving conducted by the Police Department.

- National public education programs co-ordinated from outside Western Australia, primarily by the Commonwealth Department of Health and Human Services as part of the National Drug Strategy.

- Public education programs run by non-government organisations such as the National Heart Foundation and Cancer Foundation (often with funding from Healthway).

- Discrete education programs run by non-government organisations directed towards specific target groups (often with support from Healthway or other government agencies).

- Public education by advocacy groups, such as the Australian Council on Smoking and Health or the Alcohol Advisory Council.

- Aboriginal community education programs.

- Professional education programs.

- Public education run by professional organisations; medical, pharmaceutical, etc.

- National and local education programs run by service groups and community organisations (e.g. Rotary, Lions).

- Academic education programs.

- Education programs on other issues that include discussion of drugs (e.g. HIV/AIDS).

- Ad hoc public education by and through the media.

In some aspects of public and school-based drug education, Western Australia has been recognised as a national and even international leader. Examples include:

- The comprehensive school health curriculum (K-10) developed by the Education Department.

- Public education programs and campaigns such as Quit, Drinksafe and Respect Yourself.

- Active participation in public education and advocacy by health professionals through organisations such as the AMA.

- Drug information and education publications and resources, and mass media advertisements developed by the Health Department in Western Australia and subsequently adapted by other States.

- The contribution to media and other educational activity by academic researchers.

In reading our comments on drug education, and schools in particular, we urge that there be a recognition of the excellent and committed work in this area that has been carried out by teachers and schools over the years. Schools and teachers face a multitude of challenges and pressures, and while they can influence drug use by both example and practice, recognition of the various broader contexts is important.

Many Western Australian schools have implemented excellent and comprehensive drug education programs:

- Schools have consistently co-operated over the years with public education programs.

- The Western Australia K-10 Health Education syllabus has long been recognised as the national leader in this area.

- Policies on drug use have been effectively implemented in schools throughout the State.

- Teachers have recognised the important exemplar role they play.

- Many individual teachers have devoted much time, effort and commitment to both formal and informal activity aimed at preventing and reducing drug abuse.

The Task Force specifically wishes to acknowledge the efforts of all those schools and individuals within the education system who have worked in so many ways to control drug abuse.

It is important that the continuation of drug education programs in Western Australia capitalise on all these strengths.

4.3 A FUTURE DIRECTION FOR DRUG EDUCATION IN WESTERN AUSTRALIA

Drug education is but one element of a comprehensive approach to reducing drug abuse. It is a critical element nonetheless, and in itself requires a comprehensive approach for maximum effect.

The role of drug education is to prevent and discourage drug abuse. Drug education, as has been indicated elsewhere, should not be expected to solve drug problems on its own. It is to be expected that drug education will link with other components of a comprehensive program and, indeed, be one foundation on which such a program is built.

The two major components of drug education identified by the Task Force are those of school-based education and public education. Complementing and contributing to the effectiveness of school and public drug education are parent and professional education initiatives. This section of the report summarises our major findings and recommendations pertaining to drug education in schools; public education; drug education for parents; and professional education. Consideration is also given to some issues that are not primarily educational in focus, but that provide critical support for the effectiveness of drug education efforts.

4.3.1 DRUG EDUCATION IN SCHOOLS

Given the importance of prevention and early intervention in reducing problems of drug abuse, schools are clearly an appropriate setting in which to lay the foundations of drug education.

The School Health Coalition of Western Australia noted in a comprehensive submission to the Task Force that, 'the school is an ideal environment to reach the vast majority of children and parents with health information, and where early intervention needs can be identified and provided. Western Australian schools have direct access to more than 300,000 children for most days and weeks of the year. These children are required to attend school over an extended period of time during which they will form the foundations for current and many future health behaviours. There is the expectation by parents for their children to receive health education including drug education.' The Coalition noted that schools provide:

- an infrastructure for direct face-to-face education programs that represent a cost-effective environment for drug education and health promotion;

- a setting where appropriate role models can reinforce health enhancing behaviour and where peer influence can be used to influence health behaviour positively; and

- a setting that can regulate and influence health-related behaviour through policies and procedures such as smoke-free environments.

The variety of means by which this education occurs should be acknowledged: 'school drug education occurs when students learn about drugs and drug use in a formal school setting. This may be within a classroom lesson, delivered by the teacher and supported by other agencies and organisations. It may be addressed in a less structured way as a result of student or teacher interest, or in the context of student welfare and discipline' (Victorian Drug Education Strategic Plan 1994-1999).

Various viewpoints were expressed to the Task Force as to the appropriate age for intervention. A strong case can, indeed, be made for intervention at various different stages of the school curriculum, although the literature in this area is at its strongest on the importance of starting to intervene early. Many attitudes are already well in place even by Years 5 and 6, and evidence available to the Task Force showed that by these ages some young people are already starting to use and abuse drugs.

Given all the complications entailed in assessing school student behaviour in relation to drugs, and the difficulty of effectively evaluating programs, the literature in this area is understandably limited. Two major American studies, however, demand attention.

- A series of papers by Kandel and his colleagues (for example Kandel et al 1992) shows that early onset of alcohol and tobacco use is much more likely to lead to early onset of cannabis use, which is again much more likely to lead to early onset of 'hard drug' use. These results have been confirmed elsewhere. The positive conclusion to be drawn is that delaying onset of alcohol and tobacco use will lead to a delay in the onset of and, indeed, less cannabis use; and delaying or preventing onset of cannabis use will lead to less 'hard drug' use.

- While the literature on drug education in schools is generally limited to the results of single or short-term interventions, Botvin et al (1995) have recently demonstrated that long-term, sustained drug education programs in schools result in lower levels of drug use.

This important paper, reporting on a comprehensive and well designed long-term study, shows that drug abuse prevention programs in schools can produce meaningful and lasting reductions in tobacco, alcohol and marijuana use if they:

- teach a combination of social resistance skills and general life skills;

- are properly implemented; and

- include at least two years of booster sessions.

The Western Australian Child Health Survey (Zubrick et al 1995) stressed the importance of commencing education and prevention programs before the onset of regular tobacco, alcohol and cannabis use. The authors recommended on the basis of a primarily US-based literature that comprehensive education in these areas should commence 'from around 11 years of age', but also focused on the need for appropriate educational interventions to influence younger children.

4.3.1.1 Drug education in Western Australian schools to date

School drug education has been primarily addressed in this State through the Western Australian K-10 Health Education syllabus. This syllabus has very properly received much praise within and outside of Western Australia. When developed, the syllabus was ahead of its time, and the Education Department is to be congratulated for its initiative over the years in developing the K-10 syllabus. In the national context, health education 'learning outcome statements' are currently being piloted in schools including drug education Statements. The intention is that these be integrated into the K-10 syllabus.

Inevitably, implementation of the K-10 Health Education syllabus has always been somewhat patchy. Occasional surveys have shown that few schools implement the full syllabus; most implement it partially; and some implement the syllabus barely, if at all. Further problems arise in that the K-10 syllabus requires comprehensive support (from teacher training to support materials), and also has to compete with other non-core sections of the curriculum.

The K-10 syllabus also covers all aspects of health education. Even if a school has some commitment to the health education syllabus, it does not necessarily follow that a school, class or student receives any drug education as a result. Indeed, a concern expressed to the Task Force is that the drug education component of the syllabus may be neglected in favour of other health education topics or because of competing curriculum demands.

In addition to the K-10 health syllabus, a variety of other school drug education initiatives have been developed in Western Australia, mostly based on approaches tried elsewhere. Programs such as Life Education Centres, DARE, PRYDE and special peer support programs were enthusiastically advocated in some submissions to the

Task Force. Some of these programs have been developed and introduced in Western Australia by volunteers who deserve considerable praise for their dedication. These programs are often well-received by schools and parents, but are perhaps only most needed or sought after in the absence of certainty that drug education is being taught in schools. In the absence of such a certainty, they may well provide the only drug education that students receive.

The School Health Coalition expressed concerns about the gaps in delivery of the K-10 Syllabus at both primary and secondary levels, and about the apparent alternative use by some schools of one-off presentations by guest speakers. The School Health Coalition, in association with other groups, has developed a Code of Practice for the use of guest speakers in schools, which is commended to all schools. These guidelines note that 'all guest presentations should be a planned part of a comprehensive program ... disconnected, 'one-off' presentations are to be avoided ... presentations from guest speakers should conform to appropriate Education Department policies ... (and) there should be appropriate preparation and feed-back'.

The School Health Coalition also expressed concern that some teachers were not adequately trained in health education, noting that 'at one tertiary institution, for example, students receive a total of three hours of health instruction during their entire three-year-degree'.

The Coalition recommended a comprehensive approach including:

- Compulsory K-12 health education, and within this, drug education.
- A review of the current K-10 Health Education Syllabus.
- Adequate teacher training, both in service and pre-service.
- Mandatory development, implementation and maintenance of a school-based drug policy in all schools.
- Provision of drug information to parents by schools.
- Development of a Youth Drug Strategy, with schools performing a key role in this strategy.

As will be clear, however, we would be concerned if any interpretations of this report were seen to criticise WA schools on the basis that they are doing less than schools in any other jurisdictions, or with implication that they have failed in this complex area. Western Australian educators have been at the forefront of both health education and drug education. While we note the areas where more can be done, it is encouraging that virtually all government primary schools teach health education, and that some health education is taught in the substantial majority of secondary schools.

4.3.1.2 The proposed direction for drug education in Western Australian schools

We recognise that there are many pressures on the school curriculum. Nonetheless, we believe that drug abuse is an issue of such importance as to warrant specific and separate attention. Further, despite good intentions over many years, drug education programs in schools will only be fully implemented if there is central direction and support.

Many of those submitting or commenting to the Task Force urged the introduction of either mandatory health education or mandatory drug education in schools.

Health education in the drug arena has been most comprehensively reviewed in the area of smoking.

Given the differences between education systems, it is difficult to identify countries where such issues are a mandatory part of the school curriculum, or precisely how much time this entails. In the USA, for example, nearly half the States have enacted laws requiring education on smoking and health in both primary and secondary schools. In countries such as Norway, Finland and Sweden, health education on tobacco and related issues is compulsory in either primary or secondary schools or both. Similar legislation applies to some South and Central American Countries (Roemer 1993).

Research on the effectiveness of school-based health education programs is subject to a variety of methodological problems. The US Surgeon General's report on 'Preventing Tobacco Use Among Young

People' (1994) notes that, 'the primary issues have included questions of mixed units of analysis, attrition of the subject (student) population, integrity of implementation, and homogeneity of the subject population'.

Several meta-analyses demonstrate that drug-use prevention programs in schools have an overall significant impact on behaviour skills and knowledge. It is clear from the literature reviews and more detailed studies that in relation, for example, to smoking, even despite all the complexities entailed in studies of different types of education in different contexts over different time periods:

- '... given the number of research studies, the variability in program format and scope, the various communities and cultures in which these studies were undertaken, and the potential threats to internal and external validity in school-based research, the consistency of overall findings and reductions in smoking prevalence across all these studies is rather remarkable' (Surgeon General 1994).

- Shorter-term intervention results in shorter-term outcomes. School health education on drugs is most effective when continuous, long-term, and part of a comprehensive program that also includes factors such as community activity and mass media programs.

These findings have more recently been confirmed by the studies referred to earlier reported by Botvin et al (1995).

The merits of mandatory drug education in schools are recognised and accepted by the Task Force. The access to, and participation of, all students in comprehensive drug education during their formative years has the potential (in conjunction with other elements of a comprehensive program) to have a significant impact on future drug use and abuse trends and problems in Western Australia. Without some form of prescription, drug education in Western Australian schools will continue to battle against competing curriculum demands and its implementation will not be complete. Moreover, it is only through mandatory drug education that Statewide consistency can be achieved in terms of the quantum, quality, and content of drug education delivered to students.

The Task Force is concerned also that the absence or minimal presence of drug education in schools implies to young people that drugs are not an issue of priority or concern. Mandatory drug education in schools would help to redress such a distorted perception.

Clearly there are costs and significant implications for the Education Department associated with mandatory drug education, and these are acknowledged in the recommendations and discussion of teacher training that follow.

Current developments in the work of the Education Department of Western Australia are especially conducive to the introduction of further drug education programs in schools. The 'Temby Committee' on curriculum development in Western Australia and the 'Schooling 2000' reports are anticipated shortly, and are expected to set the scene for significant changes. The approach proposed in the 'Schooling 2000' report is particularly timely, and provides both the opportunity and the means through which drug education can be more comprehensively introduced. An especially important aspect of this approach is the development of a common curriculum for government and non-government schools.

Education ministers nationally have already accepted the need for eight key learning areas, one of which has been identified as 'Health and Physical Education'. Within this context, it would be possible to include drug education as a specified area, with requirements for appropriate learning area statements and student outcomes.

As part of a comprehensive approach to drug education in schools, we recommend that all schools be guided by the following principles:

- Drug education is sufficiently important that it should be a mandatory part of the school curriculum.

- Drug education should be taught as a discrete and specified component of health education courses.

- Drug education should be the subject of learning area statements required and student outcomes.

- Drug education should be taught consistently throughout a school student's education career.

- Adequate support should be provided through teacher training, professional development of teachers, and curriculum materials.

- Drug education in Western Australian schools should be based on a revised version of the drug education components of the K-10 syllabus.

- Drug education should be complemented by appropriate mandatory school policies on drugs.

- Individual educational institutions should be able to complement the standard drug education curriculum with programs such as Life Education or DARE if they consider it appropriate, but this should always be as well as rather than instead of their standard program.

Other than in specialised instances, the Task Force sees no reason to differentiate between the government and non-government system, and urges that equal attention be paid to drug issues by both systems.

For drug education in schools to be effective, it is reliant upon the commitment of schools to implement drug education, and the ability of teachers to deliver it. It is also important that the school policies regarding drug use issues are consistent with the messages being communicated to young people in the classroom and broader community. Teacher training and school drug policy are therefore fundamental to achieving effective drug education in schools.

4.3.1.3 Teacher training

As noted in the School Health Coalition submission, most teachers receive little training in health education during their tertiary studies, and their access to, and participation in professional development pertaining to health education once teaching is sporadic. This is even more apparent when specific areas of health education such as drug education are considered.

It is important that all Western Australian teachers receive adequate training in the area of drug education. Training only specialist health teachers is not sufficient, as the 'health education portfolio' is often assigned to generalist teachers, particularly at the primary school level. Moreover, drug use and abuse is a community and school-wide issue, and it is important that all staff within the school environment are conversant with the principles of effective drug education and drug abuse prevention.

Adequate teacher training is particularly critical if our recommendation of mandatory drug education in schools is accepted. The introduction of mandatory drug education would require an increase in the level of drug education training received by tertiary students training to be teachers, as well as the inservicing of the many teachers already working in schools throughout the State.

Clearly there are significant resource implications to providing comprehensive drug education training to all teachers at the preservice (i.e. during tertiary training) or inservice level. We have not been able to calculate specific costs in this regard, but acknowledge that they will be considerable, and that a phasing-in approach may be required.

The Task Force also acknowledges the need for considerable planning to proceed the implementation of mandatory drug education and the associated teacher training required.

Given the importance of mandatory drug education and complementary teacher training in a comprehensive program to reduce drug use and abuse in this State, but acknowledging the resource and planning implications of effecting this, it is recommended that: the requisite planning be commenced at the earliest opportunity by the Education Department and appropriate academic organisations; that in the interim, steps should be taken to increase the quantum of inservice and pre-service training, and some additional funding be specifically allocated for this purpose.

4.3.1.4 School drug policy

In addition to educational activities in schools, the attention of the Task Force was drawn to the importance of appropriate school policies on drug issues. As mentioned previously, it is essential that young people receive consistent messages about drug use both in the classroom and the external school environment. To this end, it is logical that all schools should have in place, for students and staff, policies regarding access to and use of drugs in the school environment or affiliated settings. Such a policy should reflect and reinforce what is being taught to students as part of the schools drug education program. An exemplar policy is attached as Appendix 8.

The importance of comprehensive school drug policies is also highlighted by community concerns expressed to the Task Force. Tobacco smoking is an inherent part for some students of the 'before school, recess/lunchtime, after school' culture, and schools need to be prepared to deal effectively with the issue of students smoking in or within the proximity of the school environment. Concerns about alcohol consumption appear more confined to extracurricular activities, but school drug policies may need to extend to some of these situations also. Tobacco and alcohol consumption by staff and/or parents on school premises or at affiliated functions needs to be encompassed by the drug policy, and should ensure that any adult modelling of drug use within the school environment is consistent with the messages and rules being communicated to students.

During the work of the Task Force, various groups asked whether it would be true to characterise schools as locations where *illicit* drugs are sold on a day-to-day basis. The Task Force was not able to investigate this issue in detail, but it was raised with a wide range of relevant groups including police, teachers, parents, and schools students themselves.

No firm evidence was provided that illicit drugs are sold in schools on anything other than an occasional basis. It is probable that — as with other products — there is some low-key exchanging or sale of cannabis among friends; but the clear consensus is that illicit drugs are primarily sold or distributed outside school premises. We also wish to acknowledge the vigilance with which the vast majority of schools in Western Australia have addressed this difficult issue. This should not, however, be taken as a complacent view that there is no cause for concern in this area. As the attached policy indicates, any form of sale or distribution of illicit drugs in schools requires urgent attention, action and appropriate police involvement.

Regardless of whether a particular school believes it has a problem with drug use (licit or illicit) among students, the merits of having a comprehensive school drug policy cannot be overstated. In addition to the reinforcement it provides to the school's drug education program, the development of a drug policy within each school ensures a proactive approach that can often prevent drug use issues from arising in the first place. Moreover, a school's response to drug use problems when they do arise is likely to be more appropriate and well thought through if drug policy guidelines are already in place. For these reasons, our recommendation is that drug education in schools be complemented by appropriate mandatory school policies on drugs.

4.3.2 PUBLIC EDUCATION

4.3.2.1 Rationale for public drug education

Public education programs are for the purposes of this report defined as those programs or activities directed primarily through the media towards either the entire community or substantial components thereof.

In the past, concerns have been raised as to whether public education programs could be effective in terms of changing either behaviour or the precursors to behaviour change. It is true, certainly, that changes to health behaviours are more complex and difficult to 'sell' and market than changes to consumer purchasing behaviour in relation to commercial products. Commercial products can offer instant gratification, while the benefits of healthy behaviour change are often delayed and not readily visible. Moreover, drug use attitudes and behaviours are usually more complex and entrenched, and the community is not always receptive to public messages about foregoing pleasurable behaviours.

These constraints on the ability of public education campaigns to influence health behaviours, including drug use, are acknowledged. There is, however, now overwhelming evidence in the literature and in practice, that the health promotion programs of which public education activity forms a major part have the potential to make a very substantial contribution towards changing attitudes and behaviour, and the circumstances affecting behaviour.

In addition to the direct impact that public education programs and campaigns can have on health knowledge, attitudes and behaviours, public education efforts serve to underpin and reinforce drug education and control interventions occurring at the school or community interface.

Despite the complexities entailed in evaluating health promotion campaigns (ranging from technical difficulties to unreasonable expectations of both the intervention and evaluation) the most authoritative recent review concludes that:

> Taken as a whole, there is no doubt that in the last two decades, health promotion has made a major contribution to improving the health of populations. Following a concerted health promotion effort

> in Western Australia in the 1980s, in two-thirds of the 35 health-trend indicators related to the States, 12 priority areas improved by more than 10%. Most notable was an 18% reduction in smoking, coupled with a fall in cancer in males for the first time since records began; an 18% reduction in unsafe alcohol consumption ... (Holman et al 1995, p.101).

The same review notes that the use of the media in health promotion is effective.

There are a number of sound justifications for the use of mass media strategies in public education initiatives targeting drug use:

- The media are coming to be identified by the general public as a major source of health information.
- Mass media education utilises existing communication channels, and can reach a large proportion of the population, including some population subgroups who are difficult to reach through other means.
- Mass media interventions are relatively cost effective and less labour intensive than many other approaches to modifying health risk behaviours. While paid media public education campaigns often sound expensive, the cost per capita reached is usually small.
- Use of the mass media has the potential to influence a large proportion of the population immediately and simultaneously.
- The media can be used to foster a climate conducive to structural, environmental or legislative interventions to reduce health risk behaviours.

This report views public education programs as a necessary component of any comprehensive program designed to reduce drug problems. Such programs should have the aims of:

- Changing or reinforcing attitudes regarding drug use.
- Changing or reinforcing drug use behaviour.
- Underpinning and providing public support for other components of the program.

4.3.2.2 Public education in Western Australia to date

There is a long history of public education programs on various aspects of drug abuse. These have been run by both government and non-government organisations, with a variety of messages and approaches. Until the early 1980s, such activities tended to be occasional and sporadic. More recently, there has been a recognition of the need for a comprehensive, co-ordinated and long-term approach.

The lead in public education in Western Australia has been taken by the Health Promotion Services Branch of the Health Department, which has earned a reputation as a national and even international leader in this area.

Since 1984, the Health Promotion Services Branch has conducted large-scale public education campaigns to raise community awareness of the health risk of smoking, and encourage and assist smokers to quit. Independent and rigorous market research indicates that these campaigns have had a significant impact on smoking-related knowledge, attitudes and behaviour. This is evidenced by the 21% decline in adult smoking prevalence that has occurred since these campaigns commenced eleven years ago. In addition to the general adult Quit campaign, Health Promotion Services has also conducted effective public education campaigns for particularly high risk groups. A good example is the 'Quit because you can' campaign established in 1991 to raise young women's awareness of the female specific health risks of smoking, and encourage smoking cessation among this important target group. The success of the comprehensive young women's campaign conducted over a four-year period is reflected in the fact that smoking prevalence among young women in Western Australia declined from 32.6% in 1991 to 27.5% in 1994, a reduction of nearly 16%.

In the late 1980s Health Promotion Services established an alcohol public education campaign under the slogan 'Drinksafe'. The Drinksafe campaign does not advocate abstinence, but aims to raise awareness of the health risks of excessive alcohol consumption, and provide the community with user-friendly information and tips pertaining to moderate alcohol use. In 1990 a complementary alcohol campaign, 'Respect Yourself', was developed to target the binge-drinking behaviour of young people. Independent market research indicates that

both Drinksafe and Respect Yourself have been effective in educating the public about the hazards of excessive alcohol consumption, and in providing the community with information about modifying alcohol consumption to a more moderate level.

The work of the Health Department's Health Promotion Services Branch has been supported by government and non-government organisations and complemented by funding provided by agencies such as Healthway. Other major contributors to public education have included the Police Department, particularly through their work on prevention of road trauma, and the various programs arising out of the National Campaign Against Drug Abuse.

Traditionally in Western Australia public education on drug issues, particularly through the media, has focused on tobacco and alcohol. Although some media programs have been conducted elsewhere in Australia and internationally on illicit drug use, these have not historically been considered appropriate for Western Australia. The main reasons for this have been:

- Absence of funding.
- Absence of appropriate precedents.
- Given limited funding, the generally accepted need to focus initially on tobacco and alcohol abuse as the major preventable causes of mortality and morbidity in the community.
- Concern about normalising illicit drug use through public education programs (i.e. giving the impression that this is common practice where it might not be).
- Concerns that public education through the media on illicit drug use may be counterproductive, and may engender experimentation.
- Recognition that Western Australia has lower levels of illicit drug use than many other States and countries.
- Concern that media approaches tried elsewhere may be inappropriate for Western Australia.

Some Commonwealth programs have been directed towards illicit drug use, primarily a mass media program on heroin following establishment of the National Campaign Against Drug Abuse in 1985 and a more recent campaign on amphetamine use ('Speed Kills'). The decision taken in Western Australian in 1986 was that a public education campaign focusing solely on heroin, without adequate support activity and without adaptation for local circumstances would be inappropriate for Western Australia. Evaluation results of the national heroin campaign were at best equivocal. Results of the more recent amphetamines campaign are also at best equivocal, although this may in part because the campaign was little more than a 'one-off' exercise.

The funding currently provided by government for public education on drug issues is outlined in Chapter 2 of Volume II. It entails direct funding through the Health Department and law enforcement agencies and indirect support through agencies such as Healthway. The amount being spent by the Health Department on public education media programs on alcohol and tobacco issues in the current financial year is approximately $2.7 million. This represents a fall in real terms from recent years. It is recognised, however, that during this period the advent of Healthway has resulted in a variety of activities supportive of public education being developed through various government and non-government organisations.

4.3.2.3 Future directions for public education

Public education programs must be well co-ordinated, carefully planned and targeted and well evaluated. Continuity is vital, and changes should not be expected overnight. Informed observers frequently pointed out to the Task Force that while public education programs in areas such as smoking and health were now seen as successful, they had taken many years to reach this status.

To be effective in the community, drug education programs organised from government agencies should be complemented by local community education and awareness activity. Elsewhere in this report we recommend the establishment of structures including Community Drug Service Teams and Local Drug Action Groups to ensure that there is, among other initiatives, effective development of drug education and awareness activity in the community.

There is no generally accepted approach to gauging the resources appropriate for public education campaigns. There is sometimes an understandable concern that governments should be cautious in spending apparently large sums of money on advertising and promotional programs, particularly when the costs of such programs are directly contrasted with the cost of providing certain specific immediate treatment services. In this context, it should be stressed that the view presented in this report is not that public education campaigns should replace treatment or care, but that they should be complementary.

An alternative concern frequently expressed, however, is that to be effective, public education programs must be adequately funded. Public education on drug issues seeks to affect the attitudes and behaviour of the entire community, as well as specific component groups; programs in this area are often seeking substantially greater changes in attitudes and behaviour than commercial advertisers; and yet the funding available is much more limited than that available in the commercial arena. It is acknowledged, however, that government agencies working on drug issues are able to develop support activities that are not open to commercial advertisers, and are much more likely to attract complementary unpaid media support.

The best conclusion that can be reached therefore is that public education programs should be funded at levels sufficient to enable them to be comprehensive, continuous and appropriately targeted.

Some representations were made to the Task Force that public education campaigns should be directed to children and young people rather than adults. There is, however, clear evidence that attitudes and behaviour among adults require intervention through public education programs; such education programs have been effective, and young people are both directly and indirectly affected by programs directed towards adults, as well as by changes of behaviour among adults who are often their role models.

The position taken in this report is that public education programs should not be directed solely to adults or to young people, but to both as part of a comprehensive program. This does not mean that all programs directed towards adults and young people should have identical approaches and messages or be developed simultaneously, but that there should be a planned and targeted approach depending on the specific campaign.

Some public education programs can be directed towards the entire community; others (such as the Health Department's current alcohol campaigns in rural areas) are more appropriately directed to specific target groups or populations. Decisions on targeting and tailoring of education programs must be taken on the basis of the evidence and specific local or other needs.

As noted earlier, public education programs to date have primarily (and justifiably) focused on tobacco and alcohol use. In the last decade however, the advent and spread of HIV/AIDS has changed many attitudes to the use of mass media in relation to illicit drugs.

Even though the number of intravenous drug users in Western Australia is still low compared with some other States and countries, sharing of needles and syringes has the clear potential to cause health problems (such as HIV/AIDS and Hepatitis C) far beyond those previously associated with illicit drug use. Although education programs in this area have played a major role in minimising the spread of HIV/AIDS in Western Australia, there is good evidence that youthful and other illicit drugs users all too frequently put themselves and others at risk through sharing needles and syringes. Further, concern has been expressed by a number of quarters that some of the ‘harm minimisation’ messages understandably presented to intravenous drug users and potential IDUs may not adequately convey either the severity of the problems caused by sharing needles and syringes, or the importance of avoiding any such drug use if possible.

Concern both about intravenous drug use or ‘normalisation’ of illicit drug use, and that inappropriately run programs might encourage experimentation, must be borne in mind. The reality of the Western Australian situation, however, as demonstrated in Volume II is that for many in the community, and for young people in particular, some forms of illicit drug use are already almost normal behaviour. In Years 11/12, more than 45% of school students have used cannabis, and 37% are current users. While one should be cautious about over-interpreting this information, it should also be considered alongside the evidence that previous use of cannabis is the best indicator of likely use of other illicit drugs such as heroin.

There is reliable evidence as to the adverse effects of cannabis, but there are few, if any means currently of communicating this information to the broader public, and particularly young people. There are currently no substantial public education programs about the effects of cannabis, whether in isolation, in combination with other drugs or while driving.

We believe that in this difficult and sensitive area public education programs should generally be State-specific, particularly given the variation in local circumstances. They should also be very carefully planned, researched and targeted to ensure maximum impact and to avoid any counter-productive effects.

We recommend that public education activity on drugs should at this time be extended to include a major comprehensive public education program on illicit drugs. This should:

- Be carefully planned, researched and tested.
- Be directed towards all sections of the community, but focused particularly on prevention of drug abuse.
- Recognise the need for such programs to be truly comprehensive. This means first ensuring that media programs are complemented by other activity, and second, ensuring that prevention and harm reduction messages do not appear to be inconsistent.
- Recognise that the extent of cannabis use in Western Australia is now such that changes in attitude and behaviour will require not only law enforcement and other activity, but a major long-term program of public information and education.
- Include specific programs on intravenous drug use and amphetamine abuse.
- Link with other public education activity in this area, such as education on law enforcement or on issues such as HIV/AIDS.

4.3.3 PARENT EDUCATION

Drug education for parents is an important component of a comprehensive program to reduce drug abuse, and can serve to complement and reinforce drug education in schools and at the broader community level. The need for parental drug education is evident from the fact that many parents are anxious about the possibility or occurrence of drug use by their child, and that often parents are ignorant or misinformed about drugs and the appropriate response to their use by youth. Moreover, the drug-use behaviour modelled by parents can have a significant influence on their children's attitudes towards drugs, and their predisposition to experiment with drug use. Drug education for parents is often able to address the issue of parental example as a secondary objective.

Parent education programs on drugs have been organised in Western Australia by both State Government and non-government organisations over a period of several years. Drug education courses for parents are conducted by the Health Department (Drugs in Perspective) and Teen Challenge. The Lions and Rotary also hold periodic drug awareness seminars. The Drugs in Perspective course is well regarded by professionals but tends to attract variable numbers of parents. Teen Challenge courses are well attended.

As well as the above courses, some education of parents also occurs through the distribution of drug information resources for parents by the Health Department; counselling of parents concerned about their child's drug use by the Alcohol and Drug Information Service; and some initiatives of non-government agencies such as the National Heart Foundation's home-based health smoking resource package.

Such programs and materials are an important means of complementing school and community education programs. They ensure that parents are suitably informed about broad drug issues, gain an appreciation of the approaches being taken to the education of young people, and receive advice about appropriate means of dealing with their own children's concerns and behaviours.

In addition to the role of dedicated drug education courses for parents, families will also benefit if parents can receive the same information as their children receive in drug education in schools. This would serve the dual purpose of providing parents with basic factual information and establishing a simple means through which discussion of drug issues can be facilitated in families.

It is recommended that drug education should be available to parents by the following means:

- Existing programs for parents should continue and be further developed as part of a comprehensive drug education program.

- The Central Drug Co-ordinating Office should invite submissions from organisations; alcohol and drug agencies, Regional Drug Co-ordinating Councils, Local Drug Action Groups, education organisations, and other service providers; to provide courses and other interventions to meet this need.

- Brief materials suitable for parents should be developed from each school year drug education syllabus, and be distributed to parents at the time when the drug education lessons commence in each year.

- The Alcohol and Drug Information Service should develop a specific Parent Information Service to provide support for parents with immediate concerns.

4.3.4 PROFESSIONAL EDUCATION

Professional education for a wide range of groups must be an integral part of any comprehensive drug education program. As previously outlined, effective drug education in schools is to a large extent dependent on the quantum and quality of professional education received by teachers. The delivery of public drug education is also facilitated by the education of a range of professionals who serve as intermediaries or points of access to the target group. Many professionals can play a particularly important role in providing the local community level support or interpersonal contact that should complement and reinforce broader mass media and public education initiatives.

Professional education pertaining to drug issues already occurs to some extent with many key groups, such as health professionals, teachers and law enforcement officers.

Professional education programs in Western Australia are currently funded by both Commonwealth and the State. The medical school in Western Australia has made a very significant contribution to education of doctors through the appointment of a well-respected professional to co-ordinate alcohol and drug education programs. This appointment has brought significant benefits not only within the medical school, but also in the wider community.

Curtin University has for many years taken a lead in developing professional education programs on health education and drug education. Courses incorporating drug education components are now also offered by The University of Western Australia (Master of Public Health Program) and Edith Cowan University (Addiction Studies), and will be commencing shortly at Murdoch University (School of Psychology).

Professional education has also been conducted on a more ad hoc basis through the training section of the Alcohol and Drug Authority and to a lesser extent the Drug Education Programs of the Health Promotion Services (Health Department Western Australia).

Professional organisations also promote professional education and the role of the Western Australia Centre for Remote and Rural Medicine is, among others, noteworthy for its sustained involvement.

A notable absence in professional education at the tertiary level is in nursing courses. This is particularly significant when it is considered that nurses are the largest single group of health professionals and that they are active in a wide range of institutional and community settings.

It is important that education on drug issues be provided not only to those professionals directly concerned with drug problems, but also for many other groups. There is no current register of all the professional education on drugs within Western Australia, nor any formalised co-ordinated process of promoting or encouraging the participation of appropriate professional groups.

The Task Force recommends that:

- The Central Drugs Co-ordinating Office develop a register of professional education on drugs available in Western Australia.

- The CDCO then develop a program to ensure that a component on drug issues be a part of all relevant professional education curricula.

- Co-ordinators of drug and alcohol education be appointed to the two tertiary schools for nurse education.

4.4 STRUCTURE AND CO-ORDINATION OF DRUG EDUCATION IN WESTERN AUSTRALIA

Within this State, there has traditionally been an informal division of responsibility for the delivery of different areas of drug education. Historically, the Alcohol and Drug Authority has co-ordinated drug treatment services and clinical education; the Education Department has been primarily responsible for in-school drug education curriculum and activity; and the Health Department of Western Australia (Health Promotion Services) has assumed responsibility for public education on drug use, while also supporting the implementation of drug education policy, curriculum and activities in Western Australian schools. In addition, some non-government organisations have been involved on an ad hoc basis in public education pertaining to some forms of drug use (e.g. Alcohol Advisory Council on standard drinks labelling) or in school-based initiatives (e.g. National Heart Foundation's efforts to encourage smoke-free policies and activities in schools).

While this informal sharing of responsibility has resulted in many effective drug education programs and initiatives in this State, there are obvious advantages to a more formally co-ordinated approach. In particular, a more co-ordinated division of responsibilities would;

- avoid problems of duplication;
- ensure that the breadth of drug education programs (public and school-based) in Western Australia are complementary and consistent;
- clarify the parameters and areas within which different organisations are to assume responsibility; and
- ensure that no major aspects of drug education are neglected because of a belief that it is someone else's responsibility.

In some jurisdictions of Australia, more formal agreements exist between organisations as to the division of drug education responsibilities, and Western Australia would benefit greatly from a more co-ordinated approach for the reasons outlined above.

In formalising the co-ordination and division of responsibilities for drug education, it is timely to review the historical delineation of roles, and to consider what part other organisations (government or non-government) can play. The division of drug education programs and services should be structured so as to ensure the most effective delivery of comprehensive drug education in this State.

This section is primarily concerned with drug education programs run under the auspices of State Government departments. We recognise, however, that many other organisations are active or willing to be active in this area.

Any formalised division of responsibilities should not preclude those organisations or groups in the community who wish to contribute to the delivery of drug education in Western Australia. It is critical, however, that the overall approach remain co-ordinated and co-operative, and that the involvement of other players is consistent with agreed objectives, policies and guidelines for ensuring effective drug education.

We recommend that the following approach to the co-ordinated delivery of drug education in Western Australia be adopted:

- Clinical education to be a responsibility of the proposed central treatment and training agency.
- The tertiary education sector be encouraged to compete to meet professional training needs.
- School education activity to remain appropriately the preserve of the Education Department and the non-government system, with input and/or support from the Health Department or other organisations as appropriate.
- Public education to be administered from the Health Promotion Services Branch of the Health Department.
- The importance of involving other key government agencies should be recognised. To this end, it is recommended that the Health Department establish a small steering committee for its public education programs on drugs to include representation at a senior level from the Police and Education Departments and the Central Drug Co-ordinating Office.

4.5 OTHER ISSUES PERTINENT TO EFFECTIVE DRUG EDUCATION

4.5.1 ROLE OF LAW ENFORCEMENT

There has been a substantial involvement by police officers, both formally and informally, in drug education activity over the years. Police from various sections are in frequent demand by schools and others. It should also be noted that school- and community-based police play a valuable informal as well as formal role; further, some police drug education activity occurs in the community where police officers play a valuable role in developing a wide range of programs. These activities should be fostered and encouraged.

It is unfortunate that there has been a lengthy and often unhelpful debate about the role of police in drug education, particularly in schools. The debate has been unhelpful primarily because it has often been adversarial, with some advocating that the police should have no role in schools, and others advocating that drug education programs are most appropriately conducted by police.

These issues are discussed further in Chapter 5 which covers police and law enforcement. The position we take is that much police work in schools is valuable and should be encouraged. Specific education on drugs should, however, be the primary domain of dedicated agencies with specific expertise in this area, such as the Health Promotion Services Branch of the Health Department or the Education Department.

The role of the police should therefore entail:

- Support for drug education programs.
- Participation as appropriate, following discussions with those responsible.
- Participation in local community activity.
- Maintaining efforts of school and community based police.
- Law enforcement activity and law enforcement education.

The Task Force was impressed by the examples set in New South Wales and Queensland, where a senior police officer has been funded to take the role of drug and alcohol co-ordinator within the police. The role of this officer is not to engage in drug education him or herself, but to co-ordinate police activity and to ensure that the police link with other organisations in the area. We recommend, therefore, that the police establish a position of drug and alcohol co-ordinator at a senior level, with the position to be funded from current NCADA/NDS or other funding.

4.5.2 ABORIGINAL PEOPLE

Aboriginal issues are also discussed in Chapter 6. The approach we take seeks to recognise that there should be no stigmatisation of Aboriginal people; indeed, while problems among Aboriginal people who drink are different from those of the broader community, a smaller percentage of Aboriginal people drink than non-Aboriginal people.

Aboriginal people should be served by overall programs directed towards the community, but also addressed by discrete programs. These programs in particular should follow appropriate consultation with Aboriginal people.

4.5.3 COMMONWEALTH AND STATE ROLES

Expenditure on drug education throughout Australia increased significantly following the launch of the National Campaign Against Drug Abuse (NCADA) in 1985. The National Campaign complemented activity then under way with a range of cost-shared Commonwealth/State programs and Commonwealth specific programs.

The overall level of drug education activity increased in most States as a result of NCADA's establishment. As Western Australia already had many more drug education initiatives underway than most other States, it perhaps benefited less from NCADA than some other jurisdictions.

In terms of public education, the main addition for Western Australia lay in some major national media campaigns run by the National Campaign Against Drug Abuse in Canberra, together with some cost-shared funding for State programs. These programs were and are technically joint Commonwealth/State activities. While there is some consultation and co-ordination between the Commonwealth and the States regarding the development of these campaigns, from a State perspective there are inevitably some disadvantages to programs of this nature. In particular:

- Consultation may not be sufficient to reflect State perspectives.
- A program appropriate for the entire country may well not fit local circumstances, particularly when (as with Western Australia) some State-specific campaign themes are already well-recognised in the community.
- The timing may not fit local circumstances.
- Development of national programs in the eastern States invariably costs substantially more than would be the case in Western Australia.
- The level of funding available is inevitably such as to permit only brief or spasmodic advertising, rather than a consistent level of activity.

A State such as Western Australia, with unique circumstances, faces considerable frustration in working with and around public education campaigns that are directed from elsewhere, run to times that may be inappropriate for our purposes, and presenting approaches that do not capitalise on the impact of public education programs in Western Australia. As with other Commonwealth/State issues, the sharing of responsibilities for drug education is inevitably complex. We believe, however, that in terms of achieving reductions in drug use, the Commonwealth and State would be much better placed by having a single focus for drug education programs in Western Australia. The economies of scale gained through running national programs are, as far as Western Australia is concerned, substantially outweighed by the organisational problems and expenses incurred through additional production and costs engendered by development of programs outside Western Australia.

We are strongly of the view that there should be as much co-operation between jurisdictions as possible, and note that this has frequently occurred in the public education arena where there is a tradition of jurisdictions being aware of each other's programs and exchanging materials at no cost. All jurisdictions have units responsible for development of public education programs on health and/or drug issues, and informal and formal networks of communication between these units already exist.

The Task Force recommends that:

- Western Australia should advocate to the Commonwealth and other jurisdictions the case for NCADA/NDS public education funds being distributed among the States on a per capita basis.
- There be a formalised commitment among States and territories regarding co-operation and avoidance of duplication.

4.5.4 INVOLVING COMMUNITY LEADERS

Community leaders and role models can make an important contribution to opposing drug abuse both by supporting any campaigns in this area and by setting an example with their own behaviour. Some of the most important role models for young people are figures with whom they come into day-to-day contact, such as parents, teachers and peers. As those involved in marketing not only health but also commercial products have found, however, the comments and views of well-known public figures can also play a significant part in influencing the attitudes and behaviour of the community as a whole, and of young people in particular. Prominent figures who are likely to appeal to young people have already shown their willingness to participate in a wide range of public education programs directed towards young people.

Demonstrations of opposition to drug abuse by community leaders and role models are especially important given the inevitable publicity that attaches to prominent personalities who either now use, or at earlier stages have used, drugs; they may be exceptions, but partly because of their exceptional behaviour they attract substantial attention.

Every effort should be made to enlist the support of potential positive role models for young people in public education programs.

As a part of a demonstration to the community at large, as well as to young people in particular, that there is comprehensive opposition to drug abuse, a register should be developed of all community leaders who are willing to commit themselves personally to opposition to drug abuse.

We recommend therefore that as part of the program of public education, a register be maintained continuously of Community Leaders Against Drug Abuse (CLADA). This should comprise both role models for young people and leaders from all sections of the community; it should be regularly updated, and the extent of support for the CLADA register should be publicised appropriately by both the Central Drugs Co-ordinating Office and public education programs on drugs.

4.5.5 MEDIA

Many submissions and comments to the Task Force commented on the role of the media in reporting on drug issues and shaping attitudes in the community.

Drug use is covered in many different aspects of the media, such as news reporting, advertising and portrayal in television programs. Issues reported range from drugs and crime to drug abuse by athletes. The reportage inevitably tends to focus on the exceptions that are 'news', with some of the portrayals of drug problems, especially on television, reflecting a picture that occurs in other countries rather than in Australia, but may help to shape the perceptions of Australians.

Some comments to the Task Force expressed concern that media coverage might either sensationalise or normalise drug abuse; others felt that the media could be encouraged to participate further in community drug education activity.

The literature on the presentation of drugs in the media and the influence of such presentation is not extensive. The Task Force therefore requested the National Centre for Research into the Prevention of Drug Abuse to carry out some preliminary work to determine how both legal and illegal drugs are portrayed in the West Australian print and electronic media. This review, which considered all references to drugs and drug issues in selected print and electronic media over a two-month period, confirms both that substantial attention is paid by the media to drug issues and that further work and analysis in this area would be valuable. The review also noted the extent of advertising for alcohol beverages and licensed premises.

Issues relating to alcohol advertising are addressed separately in Chapter 6 of the report.

When considering day-to-day media coverage of drug issues, it is important to recognise that the role of the media is not normally to present a particular viewpoint on an issue, but rather to report objectively. Similarly, the Task Force fully acknowledges the autonomy of the media in relation to editorial and other judgements. It should also be recognised that various participants in the media in Western Australia and elsewhere have played a valuable role in drawing attention to drug problems. The media themselves operate on the basis of various codes of practice in relation to both editorial and advertising content; some of these impinge specifically on the reporting of drug issues. It is further sometimes overlooked that the coverage provided by the media on specific issues often reflects the material with which they are provided: if agencies do not make an effort to ensure that the information they wish to see publicised is made available to the media, there can be little cause for complaint if it receives no attention.

In a report addressed primarily to government, we make the following points in relation to the media:

- Most media organisations are as concerned as their readers about the importance of accuracy. Some years ago the Health Department produced a short summary of information on drugs as a readily accessible source of information for journalists and trainee journalists on drug issues. We recommend that this be reproduced in a format that is conducive to regular updating.

- Public education programs should recognise the importance of working closely with the media and encourage reporting that avoids normalising drug abuse and, where feasible, provide support for the broad policy objectives set out in this report.

- Further research and analysis should be developed with a view to providing the media with objective information on the impact of their reporting on drug abuse issues.

- There is every reason to echo the concerns expressed to the Task Force about the "normalisation" of drug use by its presentation in television and cinema programs emanating from the US. We recommend that the relevant media organisations commission research in this area and develop specific codes of practise to avoid presenting inappropriate role models to Australian children.

4.6 SUMMARY OF RECOMMENDATIONS

SCHOOL EDUCATION

38. That all schools be guided by the following principles:

    - Drug education is sufficiently important to be a mandatory part of the school curriculum.

    - Drug education should be taught as a discrete and specified component of health education courses.

    - Drug education should be the subject of learning area statements and student outcomes.

    - Drug education should be taught consistently every year.

    - Adequate support should be provided through teacher training, professional development of teachers, and curriculum materials.

    - Drug education in Western Australian schools should be based on a revised version of the drug education components of the K-10 syllabus.

    - Individual educational institutions should be able to complement the standard drug education curriculum with programs such as Life Education or DARE if they consider it appropriate — but this should always be as well as, rather than instead of, their standard program.

39. That a co-ordinated process involving a range of government and non-government agencies be established by the Education Department to support and monitor the implementation of drug education in all schools.

40. That the requisite planning for mandatory drug education and complementary teacher training be commenced at the earliest opportunity by the Education Department and appropriate academic organisations; that in the interim, steps be taken to increase the quantum of in-service and pre-service training, and some additional funding be specifically allocated by government for this purpose.

See also Recommendations 81 and 85.

SCHOOL POLICIES

41. That drug education in schools be complemented by appropriate mandatory school policies on drugs.

PUBLIC EDUCATION

42. That public education activity continue and develop the approaches taken on tobacco and alcohol abuse but also be extended to include a major comprehensive public education program on illicit drugs. This should:

    - be carefully planned, researched and tested;

    - be directed towards all sections of the community, but focused particularly on the prevention of drug abuse;

    - recognise the need for such programs to be truly comprehensive;

- include specific programs on intravenous drug abuse and amphetamines;

- recognise that the extent of marijuana use in Western Australia is now such that changes in attitude and behaviour will require not only law enforcement and other activity, but a major long-term program of public information and education; and

- link in with other public education activity in this area, such as education on law enforcement or on issues such as HIV/AIDS.

See also Recommendations 59, 60, 68, 80, 81, 85, 102 and 103.

PARENT EDUCATION

43. That drug education be made available to parents by the following means:

- Existing programs for parents should continue and be further developed as part of a comprehensive drug education program.

- The Central Drug Co-ordinating Office should invite submissions from organisations, alcohol and drug agencies, Regional Drug Co-ordinating Councils and Local Drug Action Groups, education organisations, and other service providers to provide courses and other interventions to meet this need.

- Brief materials suitable for parents should be developed from each school year drug education syllabus and distributed to parents at the time when the drug education lessons commence in each year.

- The Alcohol and Drug Information Service should develop a specific Parent Information Service to provide support for parents with immediate concerns.

See also Recommendations 12 and 14.

PROFESSIONAL EDUCATION

44. That the Central Drug Co-ordinating Office develop:

- a register of professional education on drugs available in Western Australia; and

- a program to ensure that a component on drug issues be a part of all relevant professional education curricula.

45. That co-ordinators of drug and alcohol education be appointed to the two tertiary schools for nurse education.

See also Recommendations 91, 99 and 102.

CO-ORDINATION OF DRUG EDUCATION

46. That the following approach to the co-ordinated delivery of drug education in Western Australia be adopted:

- Clinical education to be the responsibility of the proposed central treatment and training agency.

- The tertiary education sector be encouraged to compete to meet professional training needs.

- School education activity to remain the preserve of the Education Department, with input and/or support from the Health Department or other organisations as appropriate.

- The Health Department's Health Promotion Services Branch to be the lead provider of public education.

- The importance of involving other key government agencies to be recognised. To this end, it is recommended that the Health Department establish a small steering committee for its drug education programs to include representation at a senior level from the Police and Education Departments and the Central Drug Co-ordinating Office.

See also Recommendations 56 and 60.

POLICE DRUG AND ALCOHOL CO-ORDINATOR

47. That the Western Australian Police establish a position of drug and alcohol co-ordinator at a senior level, with the position to be funded from current National Campaign Against Drugs/National Drug Strategy (NCADA/NDS) or other funding (see Recommendation 57).

COMMONWEALTH/STATE ROLES IN PUBLIC EDUCATION

48. That Western Australia advocate to the Commonwealth and other jurisdictions the case for most NCADA/NDS public education funds being distributed among the States on a per capita basis.

49. That there be a formalised commitment among States and Territories regarding co-operation and avoidance of duplication.

See also Recommendation 116.

INVOLVING COMMUNITY LEADERS

50. That as part of the public education program, a register be maintained continuously of Community Leaders Against Drug Abuse (CLADA). This should comprise both role models for young people and leaders from all sections of the community; it should be regularly updated, and the extent of support for the CLADA register should be publicised by both the proposed Central Drugs Co-ordinating Office and public education programs on drugs.

INFORMING THE MEDIA

51. That the short summary of information on drugs produced by the Health Department for journalists several years ago be reproduced in a format that is conducive to regular updating.

52. That public education programs recognise the importance of working with the media, and encourage reporting that avoids normalising drug abuse.

53. That further research and analysis be developed with a view to providing the media with objective information on the impact of their reporting on drug abuse issues.

54. That the relevant media organisations commission research regarding the “normalisation” of drug use by its presentation in television and cinema programs, and further that the media industry develop specific codes of practice to avoid presenting inappropriate role models to Australian children.

5. CHAPTER FIVE POLICE AND LAW ENFORCEMENT ISSUES

5.1 OVERVIEW

Issues of policy and practice relevant to law enforcement are covered in several chapters in this report. Matters relevant to the justice system as a whole are considered in some detail in Chapter 3 with regard to the provision of services and in Volume II with regard to current activity and costs. This section addresses some specific matters primarily relating to the police and law enforcement.

As in the health arena, there is a substantial international literature on law enforcement and drug abuse, although it can be characterised as providing more commentary on policy and practice than on the technicalities and content of programs. There is much to be learned from this literature, but given the very different drug problems faced in other countries it must be approached with some caution. Some of the conclusions to be drawn from countries such as the United States are helpful; others are much less relevant to Western Australian circumstances.

This report takes an unashamedly 'hard line' on illicit drugs, and recommends the active involvement of the police in pursuance of this approach. While the literature on the American experience in dealing with drug abuse problems is noteworthy, it is sometimes difficult to recognise in it patterns that resemble those in Western Australia or, indeed, police attitudes and practices corresponding to those here.

It may well be that a report on drug abuse in New York or Detroit would take a different approach, possibly informed by sheer despair at the magnitude of local drug problems and the associated violence and crime. Western Australian circumstances are, however, very different.

There is no need here for any counsel of despair: rather, there is every reason to believe that action taken now by police and others can prevent the problem from escalating to the levels common in the US.

People sometimes overlook the major role played by the police in dealing with virtually all drugs, legal as well as illegal. Police activity includes the involvement of:

- specialist groups such as the Drug Squad and the Liquor and Gaming Division;
- sections whose work inevitably entails some focus on drug issues: e.g. school- and community-based police, or the Road Traffic Board; and
- the general police force.

We discuss in Volume II the extent and cost of this activity. It should be emphasised that the figures provided there are conservative estimates of both the cost and level of police activity associated with drug abuse issues.

As in other areas, it is important to recognise that in addressing drug abuse the Western Australian police have developed a wide range of successful initiatives, many based on national and international experience. They range from the achievements of the Drug Squad and the work of the school- and community-based officers to their drink-driving campaigns. There is widespread evidence that around the State, police officers participate in action relevant to drug abuse, not only as part of their work, but also in their own time as a contribution to their local communities.

In submissions to the Task Force, there were many comments on either police activity or the need for police action. There was generally a high level of support for a strong law enforcement role in drug control programs.

Most criticism of police involvement in drug abuse issues fell into one of two broad categories:

- practice: concerns that the police could act differently or do more in some specified drug-related areas; or
- broad policy: some argued, usually citing the US experience, that police involvement in drug abuse entailed the expenditure of vast sums of money for little return.

We make a number of recommendations in this report designed to assist further development of police practice as part of a comprehensive program. We also recommend that legislation be amended to ensure access by the Western Australian police to powers available to police in other jurisdictions, so as to increase further the focus on higher level traffickers rather than occasional users.

Although a number of submissions made to us commented on operational or internal police matters, it was not appropriate for this Task Force to become involved in such aspects of police activity. The Police Department is part way through a process of change designed to increase its effectiveness, internal co-ordination and responsiveness to community concerns. The recommendations of this report are intended to be consistent with the approach on which the process is based.

We were fortunate to have the advice of many present and past police officers at all levels throughout the State. The Western Australia Police Department submission to the Task Force noted that the focus on enforcement by the CIB Drug Squad accommodates changing trends in illegal drug activity. For example, the Drug Squad has appropriately responded to the increase in offences relating to drugs such as amphetamines and LSD. The Police Department's submission to the Task Force also noted the need for appropriate powers to be provided to the police, a matter which is addressed below.

Some submissions and public comments argued that a degree of corruption is inevitable in any law enforcement process concerned with drug abuse. We do not see this as an acceptable premise, and neither do those responsible for police activity in Western Australia. Further, no specific evidence was provided to us in this area. We note that there has in recent years been a considerable emphasis on prevention of corruption in law enforcement agencies. It is clearly not part of the role of this Task Force to address this area further other than, as might be expected, to express strong support for current anti-corruption measures.

The major thrust of this report is that a State program to control drug abuse must be comprehensive. Law enforcement activity is one of the crucial components of any such program: without strong and effective law enforcement, other components of the program will fail. It is, however, important that the law enforcement activity on drug abuse occur not in isolation, but as an integrated part of the State's overall strategy and co-ordinated effort.

Some of the comments made to us reflected a view that the police may in the past have tended to pursue their own agendas, rather than acting as part of a co-ordinated strategy. Our perception was, however, that around the State police officers play a major role in community activities related to drug abuse and connected issues. It is also clear that in recent years there have been substantial moves, from both within and outside the police, to ensure that police officers at all levels are more broadly involved in the development of drug abuse policy and strategies, and that there has been increasing emphasis on day-to-day co-operation.

There has, however, been on occasion a perceived lack of involvement by police in broader strategies and policy development and this may have arisen for a number of reasons, not least the failure of other agencies to take positive action to ensure that the police are involved in their processes.

It cannot be sufficiently emphasised that police action on drug abuse is not only important in itself, but much more effective when part of a comprehensive and co-ordinated strategy. There are almost innumerable opportunities for other agencies and the police to work together. An excellent example is provided by the recent agreement between the Police and Health Departments to work co-operatively on a pilot regional program aimed at reducing alcohol abuse.

Those responsible for data collection in the Police Department were helpful and co-operative. We noted, however, that there are a number of areas in which data is collected, that the means of collection vary, and that there is scope for consolidation and more effective use of data. We make recommendations in this area in Volume II, Chapter 4.

5.2 THE ROLE OF THE POLICE IN CONTEXT

All comments on police activity in this report are made in recognition of the broad context within which the police work. Much police activity is inevitably reactive; police officers have to deal with the consequences of crime, and are often dealing with situations and individuals when they are at their worst, in circumstances that can be exceptionally difficult.

The popular perception of police involvement in drug matters tends to focus on illicit drugs and the Drug Squad, without recognising the vast range of additional police involvement in all other forms of drug abuse. Volume II presents estimates from police officers as to the percentage of their time that is taken up by dealing with the consequences of alcohol abuse. Police involvement also extends to areas such as tobacco offences, illicit use of pharmaceutical products, and the use of anabolic steroids.

It is particularly noteworthy that in addressing HIV/AIDS the police in Western Australia have successfully established a sensitive balance between taking a firm line in opposition to illicit drug use and ensuring that illicit drug users are encouraged to use rational harm reduction approaches, such as clean needles and syringes.

The approach we have taken to police involvement in the proposed Western Australian Drug Abuse Control Strategy can be summarised as follows:

- The police should be full partners in a comprehensive program designed to control drug abuse.

- Police activity should be supported by clear messages from Government as to what is and is not acceptable, by strong opposition to the sale and use of illicit drugs, and by provision of necessary powers and support to the police in this area.

- Unless the police continue to see drug abuse issues as requiring both a high priority and strong commitment to action, the rest of the program will fail.

- It is important in a State context to clarify the limitations of police action on drug abuse. In particular:

    - The Western Australian police can only act in relation to enforcement of legislation within the State. Importation of drugs into Western Australia and certain other areas are the province of Commonwealth agencies.

    - Current legislation provides the police with more limited powers than those available in other Australian jurisdictions.

    - As noted above, despite a commitment to prevention, the role of the police must to a large extent be reactive: their approach and activities must be sensitive not only to action by individuals, but also to a wide range of external, even international influences.

- While it was not appropriate for this Task Force to become involved in internal and operational issues, we have made recommendations in some areas where we believe that these will be of assistance.

It would be surprising if the vast Western Australian coastline were not attractive to drug traffickers, and there are indeed grounds for believing that Western Australia serves as a point of entry for many of the drugs brought in from overseas for use in other States.

The successes achieved by law enforcement in preventing the importation of illegal substances are to be applauded; but these should not blind us to the reality, which is that they are only occasional: it has been variously estimated that at best only between 5-10% of illicit drugs transported to Australia are successfully interdicted. Coastal surveillance is a Commonwealth responsibility, exercised in co-operation with State agencies. Recognising the co-operation that exists, and the commitment of the agencies and officers concerned, we nevertheless note that the most fundamental way to prevent abuse of drugs such as heroin is to prevent their importation into the country. In this context, the most fundamental responsibility of the Commonwealth is to ensure adequate resources for coastal surveillance and other means of interdiction. We were not able to investigate this area, but it is self-evident that the resources currently available are inadequate to the size and importance of the problem. We recommend that the State request the Commonwealth to increase the resources available to coastal surveillance.

In recognition of the pivotal role that police can play in community activities and the examples of this that the Task Force has seen, it is recommended that police officers be strongly encouraged to participate in the proposed Local Drug Action Groups.

5.3 INTEGRATION OF LAW ENFORCEMENT EFFORTS IN WESTERN AUSTRALIA

The major responsibility for law enforcement within the State rests with the Western Australian Police Department. Other agencies active in this area, however, include the following Federal agencies: the Australian Federal Police, the National Crime Authority, the Customs Service, and the Bureau of Criminal Intelligence.

These organisations all have discrete roles, powers, structures, data collection systems, and activities. The Task Force was encouraged by advice that there is good co-ordination on both the strategic and practical levels, but there is also undoubtedly potential for inefficiencies. We strongly support the co-operative processes that have been set in place. It is noteworthy that in the Northern Territory the response to the multiplicity of agencies working on drug issues was to establish a Drug Enforcement Unit under the auspices of the Territory Police Department. This entailed bringing together staff from relevant Territory and police agencies in a Task Force approach; there was recognition of the need to accept the ultimate responsibility of officers to their own agency, but also that these officers would work together much more effectively if based in a single unit within the Territory Police Department. This approach, which was pioneered by the current Federal Police Commissioner, Mick Palmer, while Commissioner of Police in the Northern Territory, appears to have merit and provides some indication of what might be achieved in larger States such as Western Australia.

Considering the experience of the Northern Territory and other Australian States, and following consultation with the WA Police Department, it is recommended that the Police Department explore, together with the relevant Federal agencies, the advantages and viability of a Standing Joint Task Force on Drug Operations convened by the WA Police Department.

5.4 CO-ORDINATION OF WESTERN AUSTRALIAN POLICE ACTIVITY

Initial funding provided for drug education and treatment as a result of the National Campaign Against Drug Abuse gave very little emphasis to police activity. As a result of extensive negotiations through the NDS and its Senior Officers Committee at the national level, there was an agreement that funds rising to 10% of the cost shared total should be allocated to police departments. The transfer of funds was slow to occur in Western Australia, but there is now agreement that the police will receive funds ($160,000) on this basis. There are clearly limitations as to what can be achieved at a State level with such funding.

An approach developed in New South Wales and Queensland which appears to have met with considerable success is the appointment from such funds of a liaison officer at a senior level. This officer takes responsibility for co-ordination of all police activity related to drugs and alcohol, and also for co-ordination on a day-to-day basis with health, education and other relevant departments within the State. The success of these appointments seems to be conditional on a number of factors:

- Appointment at a relatively senior level.
- The appointed officer covering the full range of police activity — not only the work of the Drug Squad which, however important, is sometimes wrongly seen as being the sole source of police involvement in drug issues.
- Recognition that the role of the police in drug education is to complement and support the work of other agencies, rather than to run free-standing programs.

This approach is recommended for the Western Australian Police Department.

It is equally important, as emphasised in this section, that recognition be given to the role of police as an integrated part of the comprehensive drug abuse control program. To assist this end, it is recommended that the proposed Central Drug Co-ordinating Office should include police officers under secondment.

5.5 POLICE AND LAW ENFORCEMENT

The approach adopted by the Western Australian Police Drug Squad in recent years has entailed an increasing focus on higher-level traffickers. We endorse this approach in various sections of the report dealing with illicit

drugs. Some of our recommendations on legislation are specifically designed to enhance the capacity of the police to focus on higher level traffickers.

The reasons for such a focus are clearly that the higher level traffickers are the primary source of illegal drugs: it is more cost-effective to focus on dealers at this level. This is also a more effective approach to prevention: if the drugs do not reach lower-level users, the resources of the Drug Squad will have been well used.

Senior police officers also note, however, that to control the spread of illicit drugs a further major police responsibility is to focus on the conduits through whom such drugs reach most users. Clearly, the activities of the Drug Squad and other police and law enforcement agencies should place as high a priority as possible on deterring not only the highest-level dealers, but also the key conduits for illicit drugs to the wider community such as street level dealers.

On many occasions and in many communities a view was expressed by members of the public along the following lines: we know that there are local dealers; everybody knows who they are; even children know who they are. Why aren't the police doing something about them?

There were also many who (whatever their views on cannabis) commented on the apparent imbalance that results in over 90% of police illicit charges relating to cannabis use.

We are conscious of the constraints faced by the police, and also of the sheer numerical weight of users that, among other reasons, results in the larger number of cannabis offences. We believe that it would, however, be valuable for there to be a well-publicised police policy that sets out a hierarchy of concern in a manner that is clearly understood by the public:

- First, the highest-level dealers;

- Second, the "street dealers" and key conduits for illicit drugs to the wider community, and to young people in particular;

- Third, those whose offences require attention, but are less significant than the first two categories.

It is in our view essentially not only that police focus should be on those who traffic in drugs, but that this should apply throughout the State, and be a policy that is as clearly communicated to the public as it is to members of the police force.

Changes needed to expand the powers or resources available to the police include the following:

- Telephone interception legislation: such legislation exists in most other jurisdictions; its introduction in Western Australia is supported by the Task Force as a means of enhancing the ability of the police service to detect and prosecute significant drug traffickers.

- Legislation relating to listening devices, video surveillance and remote tracking devices: legislation increasing police powers in these areas is supported as a means of enabling the police service to detect and prosecute significant drug traffickers.

- Amendments to the Misuse of Drugs Act to enable the police to supply precursor chemicals and other prohibited drugs in undercover work. Some specific precursor drugs used in the manufacture of prohibited drugs such as amphetamines and Ecstasy (MDMA) have been classified as prohibited drugs under the Misuse of Drugs Act in order to stem the increasing emergence of clandestine laboratories. There may, however, be occasions on which undercover police operations would benefit from the ability to supply prohibited precursors to those involved in the organisation of underground laboratories. Recognising the complexities of this area, further legislation is nonetheless supported.

- Disposal and destruction of prohibited drugs. Legislation has recently been introduced by the Minister for Police to enable the destruction of prohibited drugs and plants prior to the trial of offenders, subject to appropriate safeguards. This would both save the costs of storage and security and reduce the potential for inappropriate use of such drugs. Some drugs obtained by the police could, however, also be used by them for the purposes of investigatory work. The proposed legislative amendments are therefore supported.

- Penalties in relation to possession of firearms while involved in drug trafficking: there are no increased penalties within the Misuse of Drugs Act to deter offenders from carrying firearms during their drug trafficking. In the context of overall community concerns about the possible uses of firearms, such legislation is strongly supported.

- Financial resourcing of major drug investigations: for specific investigations the Drug Squad may require additional or more flexible funding. The Task Force recommends that the Police Department consider means of ensuring a more flexible funding approach to support major drug investigations.

We believe that implementation of the above legislative and organisational changes would enable and encourage the police to focus yet further on higher-level traffickers in drugs and those we describe as key conduits on street level dealers.

5.6 POLICE AND EDUCATION

Police involvement in drug education has been a subject of considerable discussion over the years. The views taken on this range from those who argue that there should be no police involvement whatever in drug education to proposals that drug education should be law enforcement based. The extent of police participation in drug education programs varies not only from jurisdiction to jurisdiction, but also within jurisdictions, and often reflects the interest of individual officers at the time. While there is a substantial history of police participation in drug education, the literature on this involvement is sparse and generally descriptive, with little focus on evaluation.

The 1995 Commissioners of Police Conference recently confirmed the National Police Drug Education Guidelines. Major themes from these guidelines included:

- Community need: demand from the community based on the perception of expertise and credibility.

- Crime prevention and community policing: an overall context for police community drug education.

- Co-ordinated approach across agencies: the need for police to participate co-operatively with other agencies.

- Best practice: a framework to ensure most effective involvement of police.

- Key principles: involvement in the National Drug Strategy; recognition of harm minimisation, focus on crime prevention, a community development approach, recognition of jurisdictional differences, recognition of social justice, the need for intersectoral collaboration, and the need for evaluation.

- Specific guidelines: consistency of policy; recognition of appropriate roles and responsibilities; the need for appropriate infrastructure development, sustainability, resourcing, and training; appropriate marketing; and evaluation.

- Each State and Territory to develop police community drug education implementation plans based on the above themes.

Police involvement in drug education in Western Australia has covered a wide range of activities, including the following:

- Participation in local or national programs co-ordinated by other agencies.

- Direct public education through the media.

- Proactive drug education in schools (i.e. initiating direct involvement in drug education).

- Reactive involvement in schools (i.e. participating on the basis of requests).

- Support activity for other agencies.

- Active participation in programs such as DARE.

- Specialist involvement (e.g. on issues such as liquor licensing).
- Indirect involvement (e.g. through community education programs, Blue Light Discos).
- As part of the day-to-day work of police officers at all levels.
- Training of police officers.

Concerns were expressed by some groups as to the possible counterproductive nature of police involvement in drug education. Some cited drug education programs (generally from the past or from other countries or States) which had been inappropriately designed and delivered, in some cases providing substantially more information about 'how to use drugs' than might have been intended. Concern was also expressed that some police involvement in school drug education might be untrained or counterproductive. In Western Australia, however, there has for some time been an acceptance by police (as by other agencies) that drug education is best carried out by those with specific training, and that the role of the police should be supportive. Nonetheless, the balance in this area is delicate and often unclear, and will often depend on specific individuals and circumstances.

It is entirely proper to assert in principle that police should not play a direct role in drug education in schools. This is the generally accepted position where such drug education is appropriately provided. As we note elsewhere, however, there are still many schools in which drug education is either minimal or not provided. There are also circumstances under which schools quite appropriately invite police officers to participate as part of a co-ordinated drug education program. We would wish to emphasise that while we see the role of police and drug education as being primarily supportive, we do not wish in any way to discourage some of the excellent initiatives being taken by police officers, either in the context of community education and school activities or in their day-to-day work around the State.

It is proposed that the role of police in drug education be based on the following themes:

- The major role of the police on drug issues is in law enforcement. The police should continue to take the lead role in education about law enforcement issues including education in specific areas of direct police concern or priority, such as drink-driving.
- Police involvement in other drug education should be primarily as a support agency, and as part of an integrated approach.
- This should not be seen as precluding any police involvement in drug education, especially at the local level.
- There must also be a pragmatic recognition that police officers have to meet demands placed on them, particularly by local communities and in the absence of some of the other action that should be in place.
- Any police involvement in drug education should be based on the National Police Community Drug Education Guidelines.
- It is noted that for police to undertake this educational role, and to enhance other areas of their performance, education on drug issues should form a substantial component of their training. Similarly the inclusion of cross- cultural training would be of considerable assistance.

The attention of the Task Force was drawn to an innovative program in Victoria known as the 'Gellong Local Industry Accord'. This commenced as an agreed Code of Practice involving the police, operators of local licensed premises, the Liquor Licensing Commission representative, local government and other relevant agencies and people. It has since further developed in a manner that recognises the mutual needs and concerns of all participants. The accord seeks a collaborative approach in minimising the harmful effects of inappropriate consumption and irresponsible service and consumption of alcohol.

We would anticipate that similar local initiatives could be developed by the police in conjunction with the Liquor Industry Council and the Hotels and Hospitality Association as part of the proposed Alcohol Abuse Reduction Program outlined in Chapter 6.

Finally, it is emphasised that there is a need for police participation in programs co-ordinated by other agencies. Co-operation must be part of a two-way process. Too often in the past, the police have not been appropriately involved at senior levels in development and planning of drug education. Agencies with the lead responsibilities

in these areas (such as the Health and Education Departments) must ensure that more than lip-service is paid to the involvement of police officers at a senior level in the planning and development of their programs and approaches.

5.7 DRINK DRIVING

Many of those with whom the Task Force met emphasised the importance of a strong law enforcement thrust to reduce alcohol abuse. Police officers from various parts of the State also noted the extent to which their time is engaged in either seeking to prevent alcohol abuse or, more commonly, attending to its consequences. The police in Western Australia have in recent years placed special emphasis on drink-driving; the Task Force strongly supports this emphasis, which is entirely consistent with the approach taken in this report to alcohol abuse, which is described as use that puts the user or others at risk.

There is clear evidence not only of the impact of measures such as random breath-testing, but also that these are most effective when accompanied by good media and public education activity. We recommend that there be continuing and major public education programs about drink-driving, emphasising where possible the likelihood of arrests, should drivers exceed the appropriate limits. These programs are vital in supporting the activity of police on the ground, and in creating a climate in which there is less likely to be drink-driving.

Police public education programs in areas such as drink-driving have been developed under the auspices of the Road Traffic Board. The extensive work of the Road Traffic Board in this area is strongly endorsed. Recognising the benefits of capitalising on expertise where it exists, and of reducing overheads, we believe that it may be possible for the Police Department, the Road Traffic Board and the Health Department to discuss a modus operandi which would enable to the Police and Road Traffic Board to contract out some of their work to the Health Department on the basis that police authorities retained direction and public recognition.

Given that drink driving is one of the most fundamental causes of harm generated by alcohol abuse, it is important that the penalties for drink driving offences reflect the seriousness of this behaviour. We note that a range of organisations including the Police Department and the Road Traffic Board have called for increased penalties, and that recommendations of the Select Committee on Road Safety to this effect are currently before the Government. The Task Force expresses its support for the broad thrust of these recommendations.

The Task Force also notes that the Road Traffic Board is funding the Health Department to develop a mandatory program to be undertaken by people who have had their licence suspended due to a drink-driving (excess 0.08%) offence, and expresses its support for this approach.

5.8 SUMMARY OF RECOMMENDATIONS

INTEGRATION AND CO-ORDINATION

55. That the Police Department investigate with the relevant Commonwealth agencies the advantages and viability of a Standing Joint Task Force on Drug Operations convened by the Western Australian Police Department.

56. That the Police Department be involved at all levels in policy development, co-ordination and implementation of action to reduce drug abuse. As part of this process:

- the Central Drug Co-ordinating Office should include police officers on secondment; and
- police officers should be encouraged to participate actively in local community programs and support the proposed Local Drug Action Groups.

57. That the Police Department apply its NCADA/NDS or other funding to the appointment of a senior officer responsible for co-ordination of alcohol and drug activity, on the basis of the model piloted in New South Wales and Queensland.

ENFORCEMENT LEGISLATION

58. That to support an emphasis on higher level traffickers and street dealers, legislation be amended to ensure access by the Western Australian police to powers available to police in other jurisdictions. In particular, legislation should be developed to:

- empower police to make appropriate use of telephone interception, listening devices, video surveillance and remote tracking devices in the detection and prosecution of significant drug traffickers;
- enable police to supply precursor and other prohibited drugs in undercover work; and
- increase penalties related to the possession of firearms during drug trafficking.

POLICE AND EDUCATION

59. That the police continue to take the lead role in law enforcement education, including drink driving.

60. That police involvement in drug education be primarily as a support agency, although this should not be seen as precluding police involvement in drug education.

61. That any police involvement in drug education should be based on the National Police Community Drug Education Guidelines.

62. That there be continuing and major public education programs about drink driving and that the Road Traffic Board, Police Department and Health Department explore opportunities for contracting some work to the Health Department with police authorities maintaining direction and public recognition.

See also Recommendations 38, 42, 43 and 46.

DATA COLLECTION

63. That Police Department data collection systems be consolidated and improved.

See also Recommendations 144 and 145.

COASTAL SURVEILLANCE

64. That the State request the Commonwealth to increase the resources available to coastal surveillance.

RESOURCE FLEXIBILITY

65. That the Police Department consider means of ensuring a more flexible funding approach to support major drug investigations.

6. SPECIFIC ISSUES

In this report, issues arising from the use of specific drugs and the problems of particular groups are covered in almost every section: the introduction including policy premises and international contexts, community comments, provision of services, education, police and law enforcement, and proposals for appropriate structures, co-ordination and community action. This coverage is underpinned by the provision of a comprehensive range of information about illicit drug use, costs and associated activities.

This chapter discusses a number of specific issues which, whilst they are treated in a manner consistent with the overarching policy positions and the comprehensive strategy outlined in previous chapters, warrant some additional focus because of either the extent of community concern that attaches to them or because of their particular nature.

First, most of the drugs or drug groups are discussed. These include psychostimulants with particular emphasis on amphetamines, heroin, cannabis, volatile substances, alcohol, tobacco, pharmaceuticals, and performance enhancing drugs.

Second, a number of significant issues are considered. These include HIV/AIDS and other blood borne viruses, Aboriginal community issues, and research on drug abuse.

6.1 PSYCHOSTIMULANTS

The term 'psychostimulants' is commonly used to encompass drugs such as cocaine, amphetamines and designer drugs, and sometimes refers to the hallucinogen LSD.

The products, their mode of use, the harm they cause and trends in their use are described in Volume II.

Trends in use of psychostimulants vary from country to country, and depend not only on the attitudes of users and potential users, but also on the ingenuity of manufacturers and their ability to market these illicit products.

This area encompasses one of the most significant differences between drug problems in Australia and those in countries such as the United States. In the United States and elsewhere, cocaine has long posed significant problems in the community, further extended by the development of crack cocaine. Concerns have been expressed in recent decades about the possibility that Australia might be targeted, and that use of cocaine and crack cocaine could become as common as in the US. It would always be unwise to discount such a possibility, and appropriate preventative strategies must be in place, but thus far there is a consensus that the use of cocaine is relatively uncommon in Australia, and that many of the conditions which are conducive to the spread of its use in the United States do not apply here. In Western Australia there has been one cocaine related death in the last decade.

Law enforcement, health and other authorities should continue to be alert to any evidence of increases in cocaine use, but in the context of psychostimulant drugs, the major community concern must focus on amphetamines.

While this section focuses on amphetamines, many of the observations made apply equally to products known as 'designer drugs'.

There can be no doubt of the increase in use of psychostimulants, primarily amphetamines, in Western Australia in recent years.

- The number of police charges in relation to amphetamines increased from zero in 1985 to 816 in 1994.
- Admissions to Alcohol and Drug Authority programs in the amphetamines category rose from 17 in 1988 to 320 in 1994.
- By 1994 there were more than twice as many psychostimulant referrals to the Court Diversion Service as opioid related referrals.

- The Alcohol and Drug Information Service (ADIS), which is a useful indicator of community concern, found that while they received very few calls until the end of 1989 (about 20-50 per quarter), over the period 1990-1994, the number of psychostimulant calls received per quarter increased to a peak of 686 calls in the first quarter of 1995.

- Since mid-1990 amphetamine-related calls have constituted more than 10% of illicit drug calls to ADIS, peaking at about 18% of illicit drug calls in the later part of 1993.

- As shown in Volume II, the increase in use of psychostimulants has been reflected in increases in their adverse health consequences.

- National health surveys show that in Australia, amphetamine use doubled amongst 14-24 year olds between 1988-1991, and is the most widely used illegal drug after cannabis.

- A recent survey of Western Australian teenagers showed that 3% of 12-17 year olds used amphetamines - but use increased with age, such that 5% of the older youths were amphetamine users.

- As noted in Volume II, there are also reliable reports that amphetamines are used by some occupational groups - such as long-distance truck drivers.

Public policy must be informed not only by the direct consequences to users of psychostimulants, but also by their indirect consequences for the community. The associations between use of psychostimulants and crime, particularly motor vehicle theft and high speed car chases, but also assaults and property crime, have been well reported. Amphetamines are often injected, so their use puts young people and others at risk of diseases such as HIV/AIDS and Hepatitis C. Additionally, people affected by amphetamines can become violent, and are also likely to drive dangerously, especially when amphetamines and alcohol are mixed.

As with other illicit drugs, most users of psychostimulants are relatively young. For example, of psychostimulant admissions to the Alcohol and Drug Authority, 85% are aged under 30.

Unlike some other illicit drugs, psychostimulants need not be imported into Australia, but can be manufactured within the country.

In addition to amphetamines, a range of synthetic drugs has been introduced in recent decades. Some, such as MDMA (widely known as 'Ecstasy') have been rediscovered from earlier research; some are newly formulated. These drugs are further discussed in Volume II.

As the Director of the National Centre for the Prevention of Drug Abuse commented to the Task Force, the potential range of designer drugs is limited only by the imagination of the chemists rather than by chemistry itself.

The reality of all such products is that there is no effective quality control. Many are made by 'basement chemists' and toxic by-products are often contained in the drug. Tragic side-effects are consequently not uncommon.

In summary:

- While Western Australia has not as yet been affected by the once-anticipated 'cocaine epidemic', use of psychostimulants and particularly amphetamines has increased dramatically over the last decade.

- The consequences of amphetamine use can be severe to both the user and others in the community.

- The harmful consequences of amphetamine use have been widely documented, but are not be as widely known.

- There is justifiable concern in the community about the increase of amphetamine use, particularly as it may be associated with crime, is often intravenous, and occurs primarily among young people.

Concerns have been expressed recently by the Director of Public Prosecutions that it would be appropriate for the courts, when determining sentences, to consider amphetamines to be as dangerous a drug as heroin. As the penalties for indictable offences are equivalent for these drugs under Western Australian legislation, it is

necessary for this change to be achieved through the courts. The Task Force strongly supports the position of the DPP.

Clearly, the use of amphetamines in the community is now widespread and cannot be regarded as either a minor problem or a 'flash in the pan'. This position was amply reflected by concerns expressed to the Task Force in our community consultations throughout the State.

Approaches to amphetamines and other psychostimulants are outlined either separately or in broader context in several sections of the report. The broad approach we adopt can be summarised as follows:

- Amphetamines are a major problem for the community and a major threat to the health and well-being of our young people.
- The significant increase in amphetamine use in recent years requires urgent action.
- The State should co-operate in national activities designed to reduce amphetamine use.
- The Task Force strongly supports a focus of law enforcement activity on amphetamine use, with an especial emphasis on manufacturers, higher-level traffickers and street dealers.
- All education programs (public, school and specialist) should incorporate an emphasis on prevention of amphetamine use. There should also be specific major new public education programs on amphetamines, targeted appropriately, for example to young people.
- A number of service developments have been recommended that are appropriate to tackle amphetamine abuse, particularly amongst young people, and it is vital that more persons with chronic problems are engaged into treatment services through, for example, legal coercion as part of a court order.
- The increase in amphetamine use should serve as a particularly important key area for concern and action by the proposed Local Drug Action Groups, in some areas.

As the data on police activity shows, the increase of amphetamine use has been mirrored by an increase in concern and effort in this area by law enforcement agencies. There has also been some public education activity, including a national campaign developed by the Commonwealth government in co-operation with the states under the auspices of the National Drug Strategy. This media campaign may have been well-intentioned, but has been criticised on various grounds, including its short-term nature.

A new approach to amphetamines is currently being developed by a sub-committee of the National Drug Strategy, and it is anticipated that State and Federal initiatives would be co-ordinated to achieve maximum effect in Western Australia.

6.2 HEROIN{PRIVATE }

Heroin abuse is a longstanding and substantial illicit drug problem in Western Australia.

The nature and incidence of heroin abuse is described in some detail in Volume II of the report and specific strategies for the treatment of heroin dependence are discussed in Chapter 3. The targeting of heroin abuse is also foremost in the discussions of education and law enforcement initiatives.

Heroin is largely used by persons who are dependent on the drug rather than on an occasional basis. A heroin addiction is extremely expensive and so addiction tends to be linked to crime, whether dealing in drugs or property crime. Almost all heroin use is by intravenous injection and so it has been, through needle sharing, the vehicle for the spread of Hepatitis C amongst users and is an ever present threat for the spread of HIV/AIDS both amongst users and into the general population.

It is encouraging that the overall incidence of heroin use has not increased over recent years and that a growing proportion of people dependent on heroin are being retained in methadone maintenance treatment. There is, however, a need to remain vigilant as there are anecdotal reports of a rise in use by some young people and the volume of world production of raw opium, from which heroin is produced, has doubled in the last decade.

The approach taken in this report - a comprehensive strategy of law enforcement, treatment and preventive education initiatives - is considered necessary to address both existing problems and arrest any potential for an upsurge in heroin abuse.

6.3 CANNABIS

6.3.1 BACKGROUND

On few issues during our community consultations was debate so varied as on the approach appropriate to cannabis. The tenor of the discussion is reflected in the summary of views we received from the community. A forceful case was mounted by campaigners for the decriminalisation or legalisation of cannabis that there should be a radical change in the State's approach and that such change is inevitable over time. On the other hand, a large number of submissions and views put at public hearings vehemently opposed any revision to cannabis' status as an illegal drug.

Issues relating to cannabis have been very widely debated in Western Australia and elsewhere. Debates over the appropriate course of action raise high emotions and generate conflicting claims, often based on very different perceptions of the evidence. As with some other illegal drugs, there are also different views about some of the most fundamental estimates, from the extent of current use to the consequences of different policy approaches.

The challenge for the Task Force was put succinctly in a submission from a school principal: 'In this atmosphere of lack of knowledge and with apparent ambiguities related to illicit drugs, it is hard for a school to reflect a community standard or hold to a particular line of punishment, rehabilitation or admonition with any certitude.'

The most substantial recent examination of cannabis issues in Australia was carried out on behalf of the National Drug Strategy under the auspices of a National Task Force on Cannabis established by the Ministerial Council on Drug Strategy in 1992. The National Task Force on Cannabis commissioned four major reviews and produced a final report with 27 recommendations in September, 1994. The four major reviews covered:

- the health and psychological consequences of cannabis use;
- legislative options for cannabis in Australia;
- patterns of cannabis use in Australia; and
- public perceptions of cannabis legislation.

Five possible approaches to public policy and legislation in this area in the report were identified:

- total prohibition;
- prohibition with civil penalties;
- partial prohibition;
- regulation; or
- free availability.

The overall thrust of the report of the Task Force on Cannabis was to recommend:

- further research and monitoring in several areas;
- a public education campaign designed to increase awareness of risks of cannabis use and to delay the onset of cannabis use among adolescents;
- further analysis of legislative options; and
- support for the second legislative option set out above ('prohibition with civil penalties').

The Task Force on Cannabis recommended that the 'prohibition with civil penalties' approach should involve the following:

- Activities relating to the possession, unsanctioned cultivation, sale and non-therapeutic use of cannabis in any quantities should remain illegal.

- The law enforcement focus on the detection and prevention of the importation, sale and unsanctioned cultivation of cannabis should be maintained.

- Jurisdictions should consider discontinuing the application of criminal penalties for the simple personal use or possession of cannabis, without compromising activities aimed at deterring marijuana use.

Further work on legislative issues is currently being undertaken by the Australian Institute of Criminology (AIC). On the basis of the partial results released recently (AIC 1995), the conclusions from the AIC report can be expected to complement and develop further the approach taken in the report of the Task Force on Cannabis.

At the time of the release of the AIC report a statement by the Federal Justice Minister noted that:

- Cannabis law enforcement in Australia in 1991 cost $329 million, representing 73% of the total cost of illegal drug enforcement.

- More than 47,000 offences for possession and use of cannabis are reported by police throughout Australia each year.

- When personal cultivation and possession of marijuana smoking equipment is added, the total rises to more than 61,000 minor cannabis offences a year.

The conclusion drawn by the Federal Justice Minister was that:

> The money we spend enforcing our drug laws must be money well spent, and that means our cannabis laws must be as effective and appropriate as possible ... but more research is needed in a number of areas before we can embark on law reform.

Some submissions to the Task Force argued that effective police action to control cannabis use would lead to use of other drugs such as amphetamines as an alternative. Only anecdotal evidence was presented in support of this assertion and any notion that this has occurred is belied by the high levels of cannabis use reported below. It is clearly important that any policy on illicit drugs be consistently applied, and that law enforcement activity be designed to curb use of all illicit drugs, rather than one in isolation.

One of the problems for any commentators on cannabis is in presenting a position on cannabis in isolation, rather than in the context of comparisons with other drugs. As a result, a review by the Director of the National Drug and Alcohol Research Centre notes, "a fair appraisal of the public health significance of cannabis use has been hampered by the polarised opinions about its health effects expressed by partisans on both sides of the debate on its illegal status" (Hall, 1995).

In any hierarchy of concern about individual use of illicit drugs, it is undeniable that cannabis falls below, for example, intravenous use of heroin or amphetamines. But the fact that it is of less concern than some other drugs should not be used to imply that it is a cause of no concern. A suitable analogy might be that a road accident at 20 kilometres per hour is clearly of less concern than one at 120 kilometres per hour - but it is a concern nonetheless, and should be prevented.

Hall concludes that,

> the major probable public health risks of cannabis use in Australia ... appear to be, in order of approximate public health importance: adverse psychological affects; motor vehicles accidents; cannabis dependence respiratory disease; precipitation and exacerbation of schizophrenia in vulnerable individuals; low birth weight babies; and perhaps subtle cognitive impairment. On current patterns of use, cannabis use is a modest public health concern by comparison with alcohol and tobacco, although given the scale of public health damage caused by the latter drugs, and the currently low prevalence of regular cannabis use, this is not cause for complacency.

Given recent evidence on the increase in cannabis use, particularly amongst young people, it is also pertinent to note Hall's observation that, "in aggregate, *on current patterns of use* the health consequences of the cannabis user are unlikely to be comparable to those currently produced by alcohol and tobacco. This is largely because, on current patterns of use, the proportion of the population that uses cannabis heavily over a period of years is much smaller than the proportion that use alcohol or tobacco in a comparable way".

6.3.2 THE WESTERN AUSTRALIAN SITUATION

- Current legislation on cannabis is described in Volume II of the report. The approach of the Western Australian legislation is consistent with that taken in most developed countries and with Australia's international treaty obligations. The 1925 Geneva Convention on Opium and Other Drugs required parties to limit cannabis availability to medical and scientific purposes, and this remains the situation in Western Australia.

- The focus of law enforcement activity over recent years has been to emphasise drug traffickers rather than drug users.

- Some commentators have noted that the rate of apprehensions in Western Australia for cannabis offences is higher than in other jurisdictions in Australia. The police reported that many of the apprehensions for cannabis offences occur in conjunction with police investigations into other matters.

6.3.3 PREVALENCE OF CANNABIS USE

Data on the prevalence of illicit drug use is difficult to obtain and sometimes unreliable. Nevertheless, the National Drug Strategy Monograph, 'Patterns of Cannabis Use in Australia', was able to conclude as follows:

- Cannabis continues to be the most widely used illicit drug in Australia, with approximately a third of persons aged 14 and over reporting that they had used the drug.

- The prevalence of cannabis use seems to have been low ... in the early 1970s ... (but) increased substantially throughout the 1970s and 1980s, levelled off the in late 1980s, and has probably shown a small increase in the early 1990s.

As we show in Volume II of the report use of cannabis is now commonplace among young people as well as adults. Recent Western Australian research shows that more metropolitan high school students are current users of cannabis than of tobacco. In a survey of metropolitan high school students, 23.7% were current cannabis users, which compared with 19.6% who were current tobacco users. In Years 11/12, 37.1% were current cannabis users (tobacco: 25.8%). Of these cannabis users, 58.9% used cannabis frequently, 22.3% occasionally and 18.8% rarely.

The National Task Force on Cannabis noted that: ' ... it is probable that current prevalence of ever having used cannabis is higher in Australia than Canada, the United Kingdom and the United States, and comparable to that in New Zealand. The current prevalence in Australia is not as high, however, as the peak prevalence of cannabis use observed in the United States in the late 1970s' (p. 32).

In most respects, patterns of cannabis use are very similar in different countries, with the prevalence of use higher among men than it is among women, and highest among young adults in their early 20s. The prevalence of regular cannabis use is much lower than that of experimental or occasional use.

There may, however, be cause for concern that the already high levels and patterns of cannabis use are changing: the Western Australia high school student survey, for example, shows little difference between use of cannabis by males and females, and some limited evidence indicates that users of cannabis are continuing beyond their 20s more than in previous generations.

A submission to the Task Force from a Research Fellow in Adolescent Medicine at Princess Margaret Hospital noted special concern that 'among at-risk young people, there is a group who have particularly "heavy" use of cannabis. When used in this manner, it appears to be far from a benign, "harmless" drug'.

Research on the natural history of cannabis use is limited by its illegality. The National Drug Strategy (NDS) monograph on 'Patterns of Cannabis Use in Australia' (Donnelly and Hall, 1994) notes that:

- more is currently known about predictors of drug-use initiation than is the case for drug-use continuation; and

- most of the research carried out in these areas is based on the US experience, although there is some evidence indicating consistency between the Australian situation and the findings of American longitudinal studies.

The NDS monograph further notes that:

- There may be several causal pathways to cannabis use and any theory attempting to explain drug use will need to account for this heterogeneity.

- A consistent finding from many studies has been a strong association between peer and sibling drug use and the initiation of drug use.

- Parental cannabis was not a predictor of the person's marijuana use (although, 'this is not surprising perhaps, because these studies were conducted at a time when relatively few parents would have used cannabis. As over time, progressively more parents have experimented with cannabis, parental cannabis use may become a more predictor of their children's cannabis use, as parental use is predictive of adolescent use of tobacco and alcohol' (p. 58).

- Variables which predicted the onset of cannabis use also predicted the continuation of its use.

- Variables which predicted the cessation of cannabis use included having fewer drug-using friends, religious affiliation, high regard for one's health, getting married, non-participation in minor delinquency and lower use of deviant behaviour.

- The strongest predictor of continued involvement was the extent of prior involvement in drug use.

- Those who had initiated use at a younger age, were heavier users, had used other illicit drugs, and who used for psychological (as opposed to social) reasons were more likely to continue their use.

- A study of Sydney adolescents in the 1980s reached conclusions broadly similar to those of American studies.

The recent Western Australian Child Health Survey (Zubrick et al 1995) also notes that cannabis use in the teenage years carries a particular risk of continued heavy use into adulthood.

In marked contrast to most other illicit drugs, most cannabis used in Australia is grown within the country. Western Australian climatic conditions are particularly conducive to cultivation of cannabis.

As distinct from products such as alcohol and tobacco, there is no 'quality control' for cannabis. There is, moreover, concern that some imported marijuana (particularly variants known as 'skunkweed'), deliver high levels of THC (delta-9-tetrahydrocannabinol), the primary psychoactive constituent in cannabis.

6.3.4 OPTIONS FOR POLICY

Recent discussion about the cannabis plant has also entailed consideration of its use for other than recreational purposes. There are some potential uses of marijuana for medicinal or scientific purposes, and there are also proposals that some forms of cannabis can be used commercially for construction of rope, paper and materials. This report is concerned only with use of cannabis as a drug of abuse and does not take account of these other uses for the substance.

While the National Task Force on Cannabis considered the five possible policy options referred to earlier, in reality these can be narrowed down to three:

- permissive reform: reducing penalties and obstacles to use;

- maintaining the status quo; or

- restrictive reform: extending in any way the present approach to make use and access more difficult.

6.3.4.1 Arguments for permissive reform

The case for the permissive reform approach is generally based on the following arguments:

- Policy on cannabis should recognise that its use is so commonplace that some degree of legitimisation is the only sensible approach.
- The harmful health consequences of cannabis have been exaggerated and may not be significant.
- The adverse consequences of cannabis are much less significant than those of drugs such as alcohol and tobacco.
- Current policy on cannabis serves to make criminals out of people whose only 'crime' is to use cannabis.
- As a consequence of the above, a vast amount of law enforcement time and cost is devoted to dealing with cannabis.
- More permissive approaches have been successful in other countries and States.
- The decriminalisation approach in South Australia and the Australian Capital Territory has proven a worthwhile experiment.
- Prohibition poses a greater threat to personal and community health than the system of controlled availability.
- Change of this nature is inevitable: we should be proactive in this area rather than reactive.

6.3.4.2 The South Australian and Australian Capital Territory experience

Changes to the penalties pertaining to cannabis use in South Australia and the Australian Capital Territory are a focus for much of the debate and disagreement about cannabis policy. The South Australian Cannabis Expiation Notice Scheme was introduced in 1987, and a similar scheme was introduced in the Australian Capital Territory in 1992. These schemes involve notices that incur an 'on the spot' standardised fine without a criminal conviction for use or possession of small amounts of the drug.

The views of commentators from various perspectives notwithstanding, it is simply too early at this stage to draw any clear conclusions from the legislative approaches taken in South Australia and the Australian Capital Territory. The evidence thus far lends support both to those who support and to those who oppose decriminalisation. For example:

- The recent Australian Institute of Criminology report argues that cannabis use in South Australia and the Australian Capital Territory has not escalated to a greater extent than other jurisdictions.
- On the other hand, there has been a significant increase in the total number of minor cannabis offences in South Australia; and it appears that only approximately 45% of minor cannabis offenders have paid their fines. This means that many go to court, where they are invariably convicted, thus leading yet again to the problems in terms of increasing pressure on the legal system that in part led to acceptance of the case for decriminalisation. It should also be noted that those who fail to expiate their offences are largely people from lower socio-economic groups. (It has, however, been noted that the approach and enforcement of fines now in place in WA might over time have averted some of the problems faced in South Australia.)
- Objective commentators have noted that the South Australian legislation was introduced with good intentions, but with insufficient preparation for evaluation. In the absence of significant changes, it would clearly be premature to claim either 'success' or 'failure' for legislation of this nature on the basis of evidence from the first two or three years only. Further long-term research will be required before either the South Australian or the Australian Capital Territory experience can be seen as justifying change elsewhere.
- A recent report on "the effects of partial decriminalisation of cannabis use in South Australia, 1985-1993" (Donnelly, Hall and Christie 1995) presents conclusions that effectively indicate the need for further time and research. The authors note that while "there were increases in cannabis use in South Australia in 1985-1994, they cannot be attributed to the effects of partial decriminalisation, because similar increases incurred in other States". They note that "it is not possible to say with certainty whether a greater increase may have

incurred in South Australia" than in other States, but that, "larger sample sizes in subsequent national household surveys and special purpose surveys of high risk groups, such as high school youths and young adults in technical training will allow more reliable comparisons of cannabis use rates in different States to be made. This would allow a more definitive assessment of whether any observed increases in cannabis use rates can be attributed to the Cannabis Expiration Notice system in South Australia".

6.3.4.3 Arguments against permissive reform

Many of the assertions on which the case for permissive reform is based are, at the least, open to argument.

- Any discussion about the harmful health consequences of cannabis must start by recognising that while the evidence in this area is far from complete, there is clear evidence about the damage to health caused by both acute and chronic cannabis use. Good epidemiological studies in this area are, however, particularly difficult, given the illegality of cannabis use in countries where such epidemiological studies have traditionally been conducted. It is noteworthy that had the adverse consequences of tobacco been recognised when use of mass-produced cigarettes became popular in the late 19th century — or even for some time afterwards — the sale of cigarettes would not have been permitted. It would be unwise to take any action that encouraged further use of marijuana in any way in the absence of adequate long-term epidemiological studies demonstrating clearly the long-term consequences involved. The fact that such studies may be difficult to conduct should not increase the pressure to legitimate the use of cannabis.

- A comparison between the adverse consequences of cannabis and those of alcohol or tobacco is irrelevant. It is well recognised that cigarette smoking and alcohol abuse are major preventable causes of a wide range of health and social problems: it is not necessary that other drugs have caused as many health or social problems for them to justify restrictive action by governments and the community.

- There is already considerable evidence on the adverse consequences of cannabis use. These consequences have been well set out in the National Drug Strategy monograph on 'The Health and Psychological Consequences of Cannabis Use' (Hall, Salowij and Lemon 1994). The report concludes that a wide variety of adverse behavioural and health consequences pertain to the use of cannabis.

- Whether the identified adverse consequences justify maintaining the illegal status of cannabis is clearly a matter of judgement for policy makers. The position taken in this report is that such an approach is more than merited.

- It is not policy that makes criminals out of cannabis users, but a conscious decision by the users themselves. Nonetheless, current police practice emphasises the trafficker more than the ordinary or occasional user. Further, as noted earlier in this report, much police activity in relation to cannabis use is reportedly a by-product of other primary police interest.

- It is true that law enforcement activity of cannabis results in substantial costs to the State. It is, however, at best an ethically weak argument that police efforts to curtail any criminal activity should be curtailed because they are expensive. Again, the police focus is, and should be, not on the low-level user, but on higher level traffickers and on those who sell at the 'street level'.

- There is at best considerable doubt as to the beneficial outcomes achieved by more permissive approaches elsewhere. Circumstances in other countries such as the Netherlands, Switzerland and the USA are so markedly different from those in Western Australia that it is difficult to draw any compelling conclusions for practice in this State from their experience; further, commentators differ markedly in their views as to whether the outcomes of more permissive approaches in these countries have been positive or negative.

- As noted earlier, there is even debate about conclusions that can be drawn from the decriminalisation experiments in South Australia and the Australian Capital Territory. Such evidence as is available indicates little change in patterns of consumption, but shows that the expected reduction in costs to the courts and police has not occurred. The introduction of expiation notices has certainly not served as a panacea for those concerned with either the health or economic consequences of cannabis use.

- Although there are some who argue that change is inevitable, such arguments have been presented for many years, and there has in fact been very little change around the world. Australia remains subject to

international conventions categorising cannabis as a product that should remain illegal, and it is unlikely that these international conventions will change in the near future.

Arguments in favour of permissive reform generally fail to take into account some of the likely consequences of the approach. For example:

- There would be a significant impact on public attitudes and behaviour following a change in emphasis by governments. Cannabis use is already widespread. If the Government were to adopt a more laissez-faire position, the public at large, and young people in particular could reasonably assume that the use of cannabis was acceptable; it is probable that the prevalence of cannabis use among both adults and young people would increase.

- A more permissive approach to cannabis would also be seen as a signal that other illicit drugs were more acceptable. There would be significant adverse consequences if cannabis were to be seen as a 'safe' drug, and there were flow-on effects to other drugs.

- It is axiomatic that any increase in the use of cannabis would in turn increase any adverse consequences of its use for both the individual user and the community. Cannabis use poses risks not only to the user, but also to the non-user through behaviours such as driving in conjunction with cannabis.

- Permissiveness towards cannabis would tend to undermine the impact of public education programs. Fewer people would take seriously public or school education programs designed to reduce illicit drug use if at the same time the authorities were sending out signals that an illegal product known to be harmful could be more freely used.

One of the most important arguments against a more permissive approach to cannabis lies in its role as a 'gateway' drug. It would be wrong to argue from the evidence that those who experiment with cannabis will inevitably go on to use heroin or other hard drugs. There is, however, overwhelming evidence of a predictable sequence of involvement with licit and illicit drugs. The National Drug Strategy Monograph, 'Patterns of Cannabis Use in Australia' cites major American cohort studies, concluding that, 'for the majority (87%) of men, the pattern of progression is one in which the use of alcohol precedes cannabis; alcohol and cannabis precede other illicit drugs; and alcohol, cigarettes and cannabis precede the use of prescribed psychoactive drugs'... (while) ... 'among the majority of women (86%) either alcohol or cigarettes precedes cannabis; alcohol, cigarettes and cannabis precede other illicit drugs; alcohol and either cigarettes or cannabis precede prescribed psychoactive drugs' (Donnelly and Hall p. 60). These conclusions have since been confirmed by other studies in the US and Australia (Chen and Kandel 1995).

It needs to be emphasised again that it would be wrong to conclude from the above that those who experiment with cannabis will inevitably go on to use heroin. There are clearly a number of other factors affecting the onset of drug use. Nonetheless, it requires an extraordinary interpretation of the evidence not to conclude that use of cannabis is an important precursor to use of heroin and other drugs. It is reasonable and responsible to conclude that delaying onset of alcohol and tobacco use is a major factor in preventing onset of cannabis use, and that delaying onset of cannabis is one of the most important steps we can take to prevent young people from becoming interested in or exposed to the use of other drugs.

Indeed, commentators specifically note that use of cannabis makes young people more willing to participate in illicit drug use, particularly as it exposes them more clearly to a sub-culture in which other drugs are acceptable and to traffickers who make other 'harder' drugs available.

The Task Force recognises that the current situation with cannabis is unsatisfactory. The public needs a clear signal from the authorities as to whether marijuana use is acceptable or unacceptable.

We recognise the sincerity of those presenting arguments for permissive reform. We also note that some of the arguments presented clearly merit serious consideration. As in many debates about legislation, it would be wrong to assert that this is a completely 'black and white' issue, or that there is not some validity to some of the arguments presented. The role of policy-makers, however, is to weigh up the various arguments and reach a conclusion that is appropriate for present circumstances.

It may be that circumstances or evidence change over time. If that is the case, there will clearly be cause for re-examination of the policy decision and approach recommended here. On the basis of the present circumstances

and evidence, however, we cannot accept the arguments presented for permissive reform for the following reasons:

- As the National Drug Strategy report on 'Patterns of Cannabis Use in Australia' points out, 'in general, and all other things being equal, the more freely available a drug is, the higher would be the prevalence of its use in the population' (p. 48).

- There is clear evidence that cannabis use causes adverse consequences to the user.

- There is also good evidence that cannabis, particularly when associated with use of other drugs or behaviours such as driving, can cause adverse consequences for the community.

- There is good evidence that cannabis use is an important precursor to the use of other drugs; by contrast, an important means of preventing the onset of 'hard' drug use is to prevent onset of cannabis use.

- We already face a range of problems in dealing with the drugs that are legal for historical reasons. No case has been made for adding to these problems.

- There is insufficient evidence to support the claims made that decriminalisation of cannabis use would lead to any significant benefits.

- A permissive approach would add legitimacy to the activities of those who currently sell not only cannabis but also other illegal drugs.

- There is no 'quality control' for cannabis: there are concerns about the strength of cannabis either on the market or likely to become available; and short of establishing an exceptionally expensive apparatus or legitimating a new industry, there are no means of ensuring satisfactory controls on the product being sold.

- There are no reliable tests, equivalent to the breathalyser for detecting alcohol use, to enable police to control driving under the influence of cannabis.

- Those who argue for 'controlled availability' have not developed this argument further to include the costs of any structures that would be required to 'control' availability. The precedent of alcohol indicates that such structures are substantial and costly. Further, there are ample precedents to demonstrate that such controls require legislation, which in turn requires policing. In short, developing controls could well lead to more complex legislation, more offences, more law enforcement activity and more costs.

- In any circumstances where long-standing legislation is to be changed with possible adverse affects for the community, the onus of proof rests with those who advocate change. There must be clear and unequivocal evidence both the change will bring benefits and that it will not result in adverse consequences. The arguments for change are not supported by sufficient conclusive evidence about either benefits or lack of adverse consequences.

- But perhaps above all, there is a logical inconsistency in an approach that seeks to curb and reduce drug abuse to a minimum and a permissive approach to a product that is illegal and known to be harmful. The credibility of any public education program on illicit drugs could be weakened in the face of a permissive approach; young people would receive messages that were more mixed than ever; and the authorities would be sending out signals that drug use is acceptable.

6.3.4.4 Public education

Public education on cannabis was commended to the Task Force by a variety of groups, including supporters of permissive reform, supporters of the status quo and supporters of restrictive reform. We recommend that a major program of public education on cannabis be developed as part of a comprehensive drug education program (both addressed to the public and more specifically targeted to groups such as school students). We believe this to be necessary for the following reasons:

- It is clear from many submissions to us that many members of the public are inadequately informed about the adverse consequences of cannabis use.

- Public education will be necessary to explain and complement the overall approach we believe appropriate on cannabis use in the community.

It was also clear that for a variety of reasons, the public have been receiving 'mixed messages' about cannabis. A major public education program would assist in resolving this problem, and clarify to the community not only that the authorities are opposed to marijuana use, but the reasons for their opposition.

6.3.4.5 The impact of simple offences

The overriding position taken in this report is that illicit drug use is not acceptable. This includes cannabis although it is clearly not the most damaging of the illegal drugs. The focus should, therefore, be primarily on clear messages, good public education, and law enforcement efforts targeting high-level traffickers and key street-level dealers.

Having established this position, a major issue that has been raised with the Task Force and needs to be considered within this context is the effect of criminalising a behaviour that is so widespread and, notwithstanding the consequences of cannabis use and driving, is frequently victimless.

The number of simple offences involving cannabis use and possession processed by the Courts of Petty Sessions in Western Australia in 1992/3 was 4,590. The questions raised by these figures are:

- whether the criminal justice resources applied to these offences and the penalties imposed on the individuals contribute to the policy objective of discouraging cannabis use; and

- whether a large number of individuals, though a very small proportion of those committing the same offence, suffer a penalty that by its imposition of a permanent criminal record may be disproportionate to the behaviour.

Different jurisdictions have attempted to ameliorate the impact of the illegality of cannabis use on both individuals and the criminal justice system in different ways. In Australia, as noted earlier, South Australia and the Australian Capital Territory have introduced a system of expiation notices, or 'on the spot fines', for simple offences. In the Netherlands, the 'expediency principle' enshrined in the Code of Criminal Procedure empowers the prosecuting authorities to refrain from bringing criminal proceedings if there are 'grounds deriving from the public good' for not doing so, and simple offences are not pursued as a matter of policy.

These overt policy positions have been considered but are not supported by the Task Force as being appropriate for Western Australia at this time for the reasons outlined. The current priority is for the State Government to provide a clear and unambiguous message that it is opposed to the use of cannabis and to support this position through clear and effective public education. The adoption of any formal changes to cannabis laws that could be perceived as diluting these laws would send a signal at odds with the recommended policy stance.

Nevertheless, the possible inappropriateness of criminal prosecution for simple offences of possession or use of cannabis must be addressed. The question is whether a position can be achieved that is compatible with public policy that is unambiguous in its opposition to cannabis use and public education that seeks to discourage use.

As cannabis is much more widely used than other illicit drugs, it is not surprising that it should feature more heavily in the statistics on policy activity. Nonetheless, there are understandable concerns as to whether it is appropriate that marijuana offences should be responsible for more than 90% of police charges on illicit drugs as is the case in Western Australia.

An argument raised with the Task Force was that Western Australia has legal mechanisms in place that would allow existing cannabis laws to be applied with discretion, enabling simple offences to be kept out of the courts and avoiding the imposition of disproportionate penalties for cannabis users. Formal cautions from police are currently imposed for a range of offences, usually simple offences where it is deemed that a caution will be adequate enforcement and /or where a criminal prosecution and conviction would be unjustified.

By eschewing any change to cannabis laws and merely acknowledging the appropriateness of the application of existing discretionary procedures for simple offences, while at the same time strengthening the capacity of police to pursue serious and indictable cannabis offences involving commercial cultivation and supply, it may be that the unambiguous policy of opposition to cannabis need not be compromised.

Consideration of the adoption of the use of these discretionary procedures for simple cannabis offences would, however, need to occur within the context that we should be seeking to keep all drug abuse to a minimum. The overall position taken by this report, on cannabis as on other illicit drugs, is as outlined:

- The Government's position should be unambiguous: any use of illicit drugs is unacceptable.
- The lack of knowledge about illicit drugs should be rectified through public and targeted education.
- Law enforcement efforts should focus above all on those who trade in illicit substances for financial gain.
- There should be strong support for those who oppose the use of illicit drugs.

We do not consider it timely to take a position on the use of discretionary procedures before further investigation into the feasibility of a change in practice that would not detract from a clear message to the public regarding the unacceptability of illicit drug use. We therefore consider that the Police Department should examine the area of formal cautioning for simple cannabis offences, and report back to government on this issue.

6.3.5 PROPOSED APPROACH

It is thus proposed that there be no change to the legal status of cannabis and that the immediate approach towards cannabis involve four substantive aspects:

- Strong and continuing emphasis by law enforcement agencies, particularly in relation to cannabis, on the high-level traffickers and major street dealers throughout the State.
- For occasional users, the main focus to be on change of behaviour through education.
- Consideration of alternative mechanisms to address simple cannabis offences.
- Strengthening the capacity of policy to pursue indictable cannabis offences involving commercial cultivation and supply.

The specific recommendations of the Task Force pertinent to cannabis, as set out at the end of the chapter, focus on the policy position of unambiguous opposition to cannabis use, the law enforcement emphasis on high level traffickers and street dealers and the proposed public education program.

6.4 VOLATILE SUBSTANCE ABUSE

The abuse of volatile substances, often referred to as solvents or inhalants, was raised at a number of the Task Force's public hearings as a serious cause for concern. The nature and prevalence of the problem, how it is best managed, and specific recommendations to address the problem where it arises are outlined in the appropriate chapters of the report. This section provides an overview of the relevant issues.

There are numerous everyday substances that can be abused. These include such items as petrol, aerosol propellants, glue, correction fluids, soda syphon cylinders and paint thinners. The widespread availability of these products has obvious implications for the occurrence of abuse. Medical problems are associated with high doses and chronic abuse, and deaths can occur.

It appears that most abuse is experimental and that this is a fairly common occurrence, that there is some episodic use but that it is far less common, and that there are small but persistent groups of chronic abusers. From the array of estimates provided to the Task Force as to the number of chronic abusers, the best estimate may be that this group numbers between 50 and 100 youths who are located mostly in Perth.

Petrol sniffing has been a serious problem in some Aboriginal communities, 35 deaths having been attributed to this practice between 1980 and 1988. As has been described elsewhere in the report, the problem has been almost entirely resolved where affected communities have replaced petrol with Av-Gas for vehicles.

Three levels of strategy have been identified to tackle the occurrence of volatile substance abuse:

- For experimental and episodic use, a variety of low-key prevention and community intervention strategies can have a positive impact. Most significantly, simple and well-informed advice will deter most youth from

experimenting at all or continuing with the behaviour. Alternative activities for youth will be important where the problem shows signs of persisting.

- A variety of harm reduction strategies have been promoted. It is not always recognised, however, that this approach is relevant only to chronic abusers and only in conjunction with interventions targeting a cessation of the behaviour. These strategies include using less harmful substances and avoiding sniffing alone.

- Interventions with chronic abusers are clearly demanded but have not been well established or their effectiveness demonstrated. As outlined in Chapter 3, in the absence of clear direction from research literature a proactive case management strategy at the local level has been recommended for this group.

The issue of legislation to ban or restrict the sale of items that can be abused has been raised with the Task Force. The United Kingdom passed legislation in 1985 that makes it an offence to supply minors with volatile substances if the retailer suspects that they may be abused. Submissions to the Task Force pointed out that the peak level of deaths in the UK was in the period following the introduction of this legislation and that it has resulted in very few actual prosecutions. These submissions also argued that legal restrictions may have the undesired effect of encouraging abusers towards the most accessible but often more dangerous substances, thus resulting in more harm.

Authorities in Western Australia have in recent years considered and rejected the option of dedicated legislation. Three specific strategies have been pursued in the absence of such legislation:

- scheduling of the most abused and/or most dangerous substances under the Poisons Act;

- apprehending intoxicated youth under Section 138B of the Child Welfare Act; and

- pursuing voluntary restrictions to the supply of some substances.

Notwithstanding the significant problems that persist with groups of chronic abusers, it does appear that this approach has prevented the substantial escalation of solvent abuse. Continued vigilance will be necessary and the structures and strategies recommended in the chapter outlining the Task Force's proposals for the provision of services should enable this.

One strategy could be developed further. Voluntary restrictions to the supply of volatile substances have been very successful in some areas and with some organisations. It is proposed that the Central Drug Co-ordinating Office should build on these successes by pursuing the development and adoption of a formal code of conduct by appropriate retailers. Additionally, the Community Drug Service Teams together with Local Drug Action Groups should, where solvent abuse is a significant problem, vigorously pursue restrictions on the availability of these products at the local level.

6.5 OTHER ILLICIT DRUG ISSUES

6.5.1 LEGALISING/DECRIMINALISING ILLICIT DRUG USE

Some of the arguments adduced in support of changing the current legislation on cannabis are also used to support legalisation or decriminalisation of all drugs that are currently prohibited. It will be clear from the policy positions recommended earlier in this report that we do not accept the validity of these arguments. The preceding discussion on cannabis in this chapter largely summarises our reasons for recommending against legalisation or decriminalisation of any illicit drug; similar arguments, which are articulated well in the chapter describing the range of community comments and set out also in Chapter 1, apply to other illicit drugs, with the caveat that given the yet more harmful and addictive nature of some of these substances, the arguments apply even more strongly.

6.5.2 THERAPEUTIC USES OF ILLICIT DRUGS

There has been occasional discussion of the therapeutic uses of illicit drugs such as heroin or marijuana. While noting this as an important issue, we have regarded it as being beyond the scope of this report.

6.5.3 CHANGING TRENDS

The latest available information on the use of illicit drugs is summarised in Volume II of the report. It is important to note, however, that owing to the illicit nature of these drugs:

- Survey information often follows trends, sometimes by a longer period than would be desirable.

- The unpredictable nature of the illicit drug industry, both within Australia and internationally, makes some trends difficult to predict.

- Trends in drug use can surprise even the experts. Although some argue that there is a predictable 'natural history' of drug use, the history of drug use shows that this is far from the case, or that trends in use are subject to so many different influences that one must be careful about drawing conclusions from the history of one drug and applying them to another. Some forms of drug use have all but disappeared for lengthy periods only to reappear (e.g. LSD); others have developed unexpectedly (e.g. designer drugs); and others have thus far not developed as expected (e.g. the 'crack/cocaine epidemic' which was being confidently predicted for Australia in the 1980s).

The approach taken in this report is that illicit drugs should be addressed as part of a comprehensive approach to all forms of drug abuse. Most of the measures recommended will be appropriate to all illicit drugs (education, law enforcement, provision of services, support for families, etc). There will, however, on occasion be a need for a targeted approach towards specific drugs as indicated by the latest available evidence (e.g. concerns about amphetamine use among young people); specific law enforcement programs; and the recently announced 'early warning' system to identify deaths from use of 'high quality' heroin.

6.6 ALCOHOL ISSUES

6.6.1 BACKGROUND

6.6.1.1 The problems and their context

The extent of alcohol use and abuse in our community, the harm caused by abuse of alcohol, and the social and economic costs engendered as a result, are described in both the comments of the Western Australian community in Chapter 2 and in the data set out in Volume II of the report.

The report also summarises some of the work being carried out by a wide range of government and community groups to address or prevent problems that result from alcohol abuse. No list of such organisations could be complete without recognising the wide-ranging nature of the problem: alcohol may be a direct concern to some specified government organisations (e.g. Health, Police, Alcohol and Drug Authority) and non-government organisations that focus directly on alcohol treatment, but few, if any organisations, are untouched by alcohol problems. Alcohol abuse and its consequences provide 'core business' for health workers, law enforcement agencies, the criminal justice system, community welfare services, Aboriginal organisations, academic institutions and many others. There is widespread recognition in the community of the many direct and indirect consequences of alcohol abuse from road trauma to domestic violence.

The magnitude of problems associated with alcohol abuse can be gauged from the recent Commonwealth Government report, 'The Quantification of Drug Caused Morbidity and Mortality in Australia' (English et al 1995), which estimated that in Australia in 1992 'hazardous' and 'harmful' alcohol use caused the loss of 4,139 lives and 69,992 person-years of life before 70 years. There was also a net occurrence of 73,715 hospital episodes and 735,952 hospital bed days caused by hazardous and harmful alcohol consumption.

Alcohol consumption patterns and trends are described in Volume II of the report. It may be noted that there is considerable variation across the State in terms of both type and quantity of alcohol consumed, as well as the place of consumption.

As Chapter 2, outlining the views and perceptions of West Australians, shows there is widespread community concern about alcohol issues. In written submissions and at public hearings, and in all parts of the State, concerns were expressed about problems related to alcohol, often with a depth of feeling that was almost palpable. Indeed, alcohol abuse was often regarded as the major drug problem in the State. These concerns were expressed by individuals and organisations, by families of those affected, by professional groups such as police, teaching and health professionals, and by those responsible for the sale of alcohol.

Special concern was expressed about the use of alcohol by young people. The perception of the community, justified by the evidence, is that young people are:

- drinking at earlier ages;

- regarding ‘binge drinking’ as the norm;
- drinking a mix of products and sometimes combining alcohol with other drug use; and
- damaging themselves and putting others at risk as a result of increasing alcohol consumption.

Some submissions also, however, expressed concern that young people should not be the sole focus for any program designed to reduce alcohol abuse. They pointed out that many others in the community abuse alcohol, and that their impact as role models is important.

Those responsible for areas such as law enforcement and health drew our attention to the many unforeseen and unintended consequences of alcohol abuse: from petty criminal activity to domestic violence, and from drink-driving to casual and unprotected sexual activity.

While the evidence on the harm caused by alcohol abuse is manifest, it is indeed evidence of harm caused by **abuse**, not use. Alcohol is unlike, for example, tobacco or amphetamines, where the best advice on health grounds is to avoid any use of the product. Indeed, any objective review of the scientific evidence must also conclude that:

- moderate use of alcohol provides a number of social benefits; and
- moderate use of alcohol is highly likely to confer a protective effect in relation to ischaemic heart disease.

Extensive use of alcohol is a reality in Australia, reflected in the country's culture, social life, history and economy. Even if it were desirable (which is not the position taken in this report) that all alcohol use should be discouraged, such a position would be totally unrealistic. The reality is that alcohol has always played an important part in Australia's social life, brings pleasure to many, and provides both employment in the community and revenue to the Federal and State governments.

It must be recognised that action designed to reduce the harm caused by alcohol abuse occurs within this cultural context. The Australian ‘drinking culture’ is unlikely to change in the foreseeable future.

It would, moreover, be wrong to think of alcohol consumption in Australia as occurring within a single ‘drinking culture’. Attitudes to alcohol consumption vary from region to region, from community to community and from age group to age group. While strategies to reduce alcohol abuse should be guided by a single coherent philosophy, they must also recognise the need for different approaches in relation to the different groups. To take one obvious example, the approaches appropriate for middle-aged metropolitan drinkers may be very different from those required in mining and other non-metropolitan towns where there is a large population of relatively affluent young males with much accessible money and little to spend it on.

Given the nature of alcohol and its consequences, this report does not seek to resolve all the controversies associated with its use and abuse. We seek rather to present accurate information about use and abuse, consequences and costs, to discuss some of the relevant issues, and to recommend an approach that is appropriate for the Western Australian Government and community.

6.6.1.2 Proposals for action

Many different views and approaches were suggested to us both formally and informally. For alcohol, as for other drug problems, there were some who believed that the approach they proposed represented the only desirable course of action, and that this course would solve all our problems; equally, a number of submissions pointed to the magnitude of the problem, expressed concern bordering on desperation, but rather than suggesting specific approaches argued that ‘somebody should do something’.

Submissions such as those from the Alcohol Advisory Council and the National Centre for Research into the Prevention of Drug Abuse drew attention to the magnitude of the problem, and called for urgent remedial action by the Government. The Alcohol Advisory Council submission, which was perhaps the most comprehensive submission received on alcohol issues, set out a broad range of concerns and made recommendations in the following areas:

- Health measurement: that appropriate data bases be established and maintained.

- Alcohol and legal issues: recommendations including extension of blood alcohol limits (BAL), amendments to and more strenuous enforcement of liquor licensing legislation; a revamped '18+' card to include photographic identification; more use of liquor licensing legislation by local communities; new host responsibility rules and compulsory training.

- Education: including greater emphasis on school-based alcohol and tobacco programs in the curriculum; inservice education for teachers; accreditation programs for professionals.

- Alcohol tax, advertising and promotions: including means of collecting liquor licensing data; consideration for a greater tax differential between high and low alcohol products; funds to be allocated from alcohol taxation for harm reduction strategies and treatment services; banning promotional strategies which are seen as irresponsible; mandatory health warnings on all alcohol advertisements; an independent body to scrutinise all alcohol advertisements.

- Aboriginal issues: full implementation of the recommendation of the Royal Commission into Aboriginal Deaths in Custody; more involvement, information and action through local communities; and non-discriminatory enforcement of liquor licensing legislation.

- The role of the non-government sector: support for public-health based alcohol advocacy.

Alcohol poses, and has always posed, particular problems for policy-makers because:

- it cannot be readily characterised as 'good' or 'bad'; and

- it has a place in our culture, history and society that cannot be denied.

A program of action on alcohol must recognise:

- the history of concern and action in this area;

- the wide range of organisations and individuals currently active;

- the policy documents (such as the National Health Policy on Alcohol) which already exist;

- the many programs already in place or being planned; and

- the many activities currently under way in related areas such as domestic violence and community crime prevention.

A program aimed at reducing alcohol abuse and its consequences must be comprehensive: simplistic solutions or 'magic bullets' are not appropriate.

A comprehensive program must seek to gain the support and involvement of as many sectors of the community as possible.

The program must set realistic targets: as elsewhere in the report, we propose that in the first instance and in full cognisance of the high levels of alcohol consumption in some areas of the State, Western Australia should seek the lowest levels of alcohol abuse and consequent harm in Australia.

The program must be based on a proper, balanced assessment of the scientific evidence. On the one hand, opposition to any form of substance abuse should be based not on moral fervour, but on opposition to what has been shown to be harmful. On the other hand, where there is good scientific evidence as to benefits they should be acknowledged, even if those benefits are considered to be outweighed by the harm caused.

There are some who argue that the only way to reduce alcohol abuse is to reduce all alcohol use. 'Prohibition' apart, this debate has engaged academics, industry representatives and policy-makers for several decades, most notably since development of the 'Liederman hypothesis' in the 1950s. This hypothesis led to the argument that the clear aim for those concerned to reduce abuse should be reduction of per capita consumption of alcohol in the community.

More recently, much discussion on alcohol policy has focused on a concept described as the 'prevention paradox'. This concept, developed by Kreitman, argues that the greatest proportion of total alcohol-related harm comes from moderate drinkers: some therefore argue that more attention should be focused on the relatively larger number of moderate drinkers than on heavier drinkers. This can lead to some unnecessary conflicts. The concern of the community is not with sensible use of alcohol, but with alcohol abuse, whether by heavy drinkers or by moderate drinkers who abuse alcohol occasionally, or through particular behaviours such as drink driving. There should be no paradox in a policy that seeks to reduce all forms of alcohol abuse, while not discouraging sensible use of alcohol.

Some respected commentators have, indeed, also recently noted that an overt aim by governments and others to reduce per capita consumption will lead only to adversarialism, whereas an overt aim of reducing alcohol abuse is much more likely to achieve co-operation. Additionally, given the evidence on alcohol and ischaemic heart disease, recent research points to the somewhat surprising conclusion that a simple reduction in alcohol consumption by all drinkers (aged 35 and over) by one drink per day could even result in excess risk to the population as a whole (English et al 1995).

The concern of government and the community is, it is emphasised, with the consequences of alcohol **abuse**. There are undoubtedly a number of adverse consequences likely to arise from use of alcohol over the long term, but the primary concern of society is rightly with the short-term consequences of alcohol abuse. The longer term consequences are significant, but they do not put the drinker or others at immediate risk; further, long- term health and other consequences may be seen as falling into the same category as, for example, inappropriate dietary habits. Our discussion of harm and costs does not distinguish between immediate and longer term harm, as such a distinction is not commonly made in the literature, and will require a substantial amount of further elucidation. We recommend that there be further research so that the harm and costs of the immediate consequences of alcohol abuse can be quantified. This is the area that should be legitimately identified as cause for immediate and urgent action.

There are also some who argue that all policies aimed at reducing alcohol abuse should focus on the product and those who sell it, rather than those who use it. This is, however, an unnecessary 'either ... or' choice.

While a program in this area must be comprehensive to be effective, it must also focus where the needs and pressures are greatest. This will entail careful targeting, for example:

- By region, in recognition of the different patterns of consumption around the State.

- By age group, since most problems of alcohol abuse occur among young people in the 15-29 age range. (It should be noted, however, that in the long term one is less likely to influence the behaviour of young problem drinkers directly than through educational or other programs designed to influence them **before** the problems develop).

- By specific target groups or locations (e.g. worksites).

Whilst recognising the role played by alcohol abuse in areas such as domestic violence, we do not seek to replicate the work of groups such as the Government's Task Force on Domestic Violence which will report separately.

6.6.1.3 Alcohol terminology

Concern was expressed to the Task Force that despite the vast literature on alcohol issues, some of the terminology used is ill-defined. As so much of the Australian literature is based on the various National Health & Medical Research Council (NHMRC) definitions, we have used these where appropriate. We note, however, that it will be necessary over time to develop an agreed new lexicon that has meaning to both researchers and the broader community. It is particularly important that there is agreement on terms such as 'alcohol abuse', 'safe' or 'unsafe' drinking and 'binge drinking', and what is meant by 'harmful' and 'hazardous' drinking - or the appropriate alternative terms. It should be noted that where these terms are cited in this report, it is on the basis that they have been used by the researchers and organisations whose work is cited: this does not imply endorsement of any specific terminology.

A consensus conference may be required to address the issue of terminology, and it is recommended that the proposed Central Drug Co-ordinating Office convene such a conference. For the purposes of this report, however:

- Alcohol abuse or unsafe drinking is defined as use likely to cause immediate damage or risk to the user or others.

- Safe or sensible drinking is defined as drinking at levels that will not put the user or others at risk.

- Binge drinking is defined as drinking at a single session to such a level that the drinker is intoxicated or likely to put him or herself or others at immediate risk.

6.6.1.4 Advice on levels of drinking

As in other areas, the scientific evidence on alcohol does not stand still. There has been some recent debate in the medical literature as to whether it is appropriate to convey the results of research demonstrating possible health benefits arising from alcohol use to the general public — lest they be misinterpreted.

There is still room for debate as to the advice on drinking levels that should be given to the general public. Advice generally given is taken from the NHMRC report, 'Is there a safe level of daily consumption of alcohol for men and women?' This report, first published in 1987 and reprinted in 1992, sets out guidelines as follows:

- the concept of a standard drink, or unit, containing approximately 8-10 grams of absolute alcohol (should) be adopted for clinical and educational purposes;

- consumption of alcohol by men should not exceed 4 units or 40 grams of absolute alcohol per day on a regular basis, or 28 units per week; that 4-6 units per day or 28-42 units per week be considered as hazardous and that more than 6 units per day or 42 units per week be regarded as harmful;

- that the consumption of alcohol by women should not exceed 2 units per day or 14 units per week on a regular basis; that 2-4 units per day of 14-28 units per week be considered hazardous and that more than 4 units per day or 28 per week be considered harmful;

- that 'binge' drinking is potentially hazardous;

- that all Australians (should) have at least two alcohol-free days each week;

- that abstinence (should) be promoted as desirable in pregnancy;

- that persons who intend to drive, operate machinery or undertake activities in hazardous or potentially hazardous situations should not drink;

- that specific information (should) be given to drinkers about practical ways of reducing alcohol consumption in social situations.

These guidelines are now widely promoted, but it may be opportune to reconsider some aspects of both the advice and the manner in which it is presented.

Since publication of the NHMRC report, the authoritative National Drug Strategy report, 'The Quantification of Drug Caused Morbidity and Mortality in Australia (English et al 1995) has presented 'probably ... the most recent and most precise meta-analysis of alcohol and all-caused mortality now available'.

The conclusions of the NDS report support the recommendations of the NHMRC concerning the different levels of hazardous and harmful drinking in men and women. However, it also shows a protective effect for all-caused mortality at levels up to the recommended "safe levels".

The NHMRC report, which pre-dates the NDS report and some of the evidence it considers by three years, had considered the possible health benefits of alcohol consumption but concluded that 'in view of the considerable controversy we believe that this issue remains an open question ...', and that, 'there is also the danger of prematurely proclaiming the protective effect of alcohol and the tendency for this effect to be generalised to other conditions'.

The conclusions from the NDS report are, however, so clear that it would be wrong now to deny the potential benefits of moderate alcohol consumption, while recognising that these must be accurately represented in the context of the various acknowledged risks.

There is, however, a need for further research as to precisely how advice should be given on the basis of the NDS conclusions: advice is generally given on the basis of 'drinks per day', but this is an average only. The research currently available does not permit health authorities to present specific advice as to whether, for example, up to four a day is any better or worse than up to eight in two days, other than in terms of possible immediate consequences if, for example driving.

On the basis of the evidence now available, there is substantial room for doubt as to the recommendation that 'all Australians have at least two alcohol-free days each week', and possibly even about the recommendation that 'abstinence be promoted as desirable in pregnancy'.

As the NHMRC report notes, 'binge drinking' is a poorly defined term. Similarly, various other terms used about alcohol consumption are either poorly defined or poorly researched in terms of their impact on the public. Little is known, for example, about public understanding and acceptance of terms such as 'safe', 'healthy', 'harmful', 'hazardous', etc.

A further problem lies in the importance of ensuring that advice given is not only consonant with the best evidence, but is perceived as realistic and that can reasonably be acted on. Many drinkers are not at any immediate risk, do not drink and drive or put others at risk, and yet may consume more than four standard drinks (males) or two (females) on a particular day, or drink on six or seven days a week. An additional difficulty for those formulating advice designed to change behaviour is that there are some drinkers who regard advice of the 'four and two' nature as so far from their normal practice as to be unrealistic. These problems are compounded yet further by the need to give advice in a manner that distinguishes between consumption of alcohol under normal circumstances, and consumption when driving or otherwise carrying out activities in which drinking is inappropriate. There is also an increasing emphasis in research and discussion papers from the National Research Centre into the Prevention of Drug Abuse on the need to focus on specific occasions of drinking, rather than overall consumption patterns.

It is therefore recommended that the proposed Western Australian Alcohol Abuse Reduction Program (described below), develop at the earliest opportunity a program of action that will result in development of clear messages that are epidemiologically sound, credible, and acceptable to consumers. These should be developed on the basis of:

- a review of the epidemiological evidence (already available through the NDS report); and

- market research among drinkers and non-drinkers.

The messages presented should clearly distinguish between normal, acceptable use of alcohol and abuse, which is drinking in such a manner as to put the consumer or others at immediate risk. Market research should further be conducted to ascertain whether positive as well as negative messages may be desirable. For example, it may be more effective to tell drinkers what they can do, rather than (or as well as) what they should not do.

Despite all the concerns expressed in this report and elsewhere about alcohol abuse, we believe that it should further be possible to develop messages and advice that can be acceptable to health and law enforcement authorities and the liquor industry. The industry has consistently noted the importance of preventing alcohol abuse, and we believe that it should be possible to devise messages that are consistent with the evidence while also proving acceptable to the industry. Two examples may suffice:

- There is no doubt that the industry would strongly support messages aimed at reducing the road trauma that results from drink-driving.

- It should be possible to find non-judgemental terminology about sensible levels of drinking that can be used by the liquor industry as well as by health authorities.

This would also resolve the debate as to whether it is appropriate or not for health authorities to advise on possible benefits of moderate alcohol consumption. Thus, we would propose (subject to market research) use of a term such as 'preferred levels' for the drinker of, on average, 0-4 drinks a day (male) and 0-2 (female).

The fairly recent conclusive evidence about the protective effect of moderate alcohol consumption, together with the again fairly recent moves towards lower-alcohol products, has led to some complex ethical debates.

- How far is it possible to give advice about benefits of drinking without this being misinterpreted?
- How far is advice about possible benefits from sensible drinking consonant with very necessary campaigns against drink-driving?
- How far is it possible to encourage consumption of lower-alcohol products without encouraging alcohol abuse?
- Should advice be given on the basis of daily consumption when the evidence is not generally developed on this basis?
- How and to what extent should the ever-increasing complexities of research conclusions in this area be reflected in public and school education programs?

It would be idle to pretend that these questions can be easily resolved, but we believe that they should be considered as a high priority by both research authorities and the proposed Western Australia Alcohol Abuse Reduction Program. We believe that this would be a particularly useful forum, particularly if it can comprise representation from government, health agencies and the liquor industry.

6.6.2 THE LIQUOR INDUSTRY

Any consideration of alcohol issues must take into account the role of the liquor industry. Some submissions took the simple view that the liquor industry is responsible for alcohol problems, and that any program to reduce these problems will founder unless it is firmly controlled.

The 'liquor industry' is not a single entity. Those involved in the production, sale and promotion of alcohol cover a wide range of groups and employment categories.

While there are clearly issues on which different sections of the liquor industry disagree, the Liquor Industry Council of Western Australia made a consolidated submission to the Task Force, as did specific component groups. We were able to discuss a number of issues with representatives of the industry; sections of the industry were also particularly helpful in terms of providing us with data; and individuals from within the industry both wrote to us and participated in our public hearings.

The Liquor Industry Council (LIC) submission argued that: 'Alcohol is a legal product which is consumed by the vast majority of adults in a responsible manner. It is beyond dispute that alcohol brings to society both benefits and risks. It is the abuse or misuse of alcohol by the minority which is of concern to both the Liquor Industry and the Western Australia Government alike'.

The Liquor Industry Council submission also noted that: 'There has been a remarkable increase in the sales of low and reduced alcohol beers to the extent that this alcohol segment now equates to approximately 40% of all beers sold in Western Australia'.

Specific groups within the liquor industry (such as the Australian Associated Brewers, the Distilled Spirits Industry Council and the Wine Industry Association) presented similar overall approaches, noting also the role of the industry in public education.

The LIC submission:

- condemns the abuse of alcohol;
- urges the Government to adopt appropriate guidelines for sensible consumption, with realistic education and information programs;
- sets out the views of the LIC on a number of issues of policy and practice;
- describes the contributions of the industry to education and host responsibility programs; and

- expresses a willingness to work with the Government with a view to finding mutually acceptable solutions to common problems.

The approach proposed in this report to many of the areas of concern, raised by both critics of the liquor industry and the industry itself, is that there is much more scope for genuine co-operation than may have been accepted in the past. Some of the areas of concern are discussed briefly below, but this discussion should be seen in the context of the establishment of a co-operative program of action that can benefit both the public interest and the industry.

Governments, health and law enforcement agencies and the drinks industry will invariably set out from different perspectives. It would be disingenuous to suggest that there can be agreement on all issues, or that in some areas government should not proceed to implement controls that the industry may feel the need to oppose. (There are, indeed, also areas in which there are clear differences of opinion within the industry itself, such as aspects of licensing, taxation policy, etc.)

There have, however, been clear indications, particularly within Western Australia, that the time may be right to attempt a comprehensive approach based not on adversarialism but on co-operation. This will require some movement and trust on the part of both sides, but there is already evidence, for example, from the Drinksafe and Respect Yourself campaigns that such movement and trust can be rewarded. For governments and public health advocates, the movement required is primarily in recognising the legitimacy of the liquor industry's normal activities and its potential to support public education, and also that there is now good evidence on some benefits deriving from moderate alcohol consumption. For the liquor industry, the movement involves accepting that it follows from the fact that abuse of the product can be damaging, that the industry itself must exert effective controls over those in it who act less than responsibly.

The Task Force, like others both inside and outside the industry, is concerned about any practices that encourage either excessive drinking or the inappropriate attraction of young people into licensed premises. We believe that while most licensed premises seek to act responsibly, there are some engaging in unacceptable practices (such as ‘shooters’ and encouragement of ‘binge drinking’, however defined) as drawn to the attention of the Task Force. The recent response by the Minister for Racing and Gaming to the Review of the Liquor Licensing Act 1988 addresses many of these concerns. We recommend that there be strong support for the approaches adopted by the Minister for Racing and Gaming to ensuring that all licensed premises act responsibly in their dealings with both adults and young people, including industry host responsibility programs.

Some submissions to the Task Force argued that as the major portion of alcohol is consumed outside licensed premises (the precise percentage being the subject of some debate), the focus of education and control measures should move away from licensed premises. Other submissions claimed that while this may be the case, most harm caused by excess consumption (assaults, drink driving) emanated from licensed venues. We recognise that it would be wrong to ‘blame’ licensed premises for all the problems of alcohol abuse that occur and also that it is necessary to distinguish between the issues and behaviours pertinent to hotels on the one hand and other venues such as night clubs on the other. We note also that the Australian Hotels and Hospitality Association has taken some very positive steps towards reducing problems caused by alcohol abuse. The question of whether to focus on one setting or another is, however, an unnecessary case of ‘either ... or’, as any effort to combat abuse must address the full range of liquor outlets with strategies appropriate to each setting.

All alcohol sales outlets provide an ideal opportunity to target drinkers for educational messages, and the proposed program to deal with the issue, described in detail below, should focus on development of messages and means of delivery that can be effectively communicated to drinkers, as well as being acceptable to the industry. It is particularly noted that:

- While the current ‘drinking environment’ is unlikely to change significantly in the short term, there is much to be learned from the experience of some European countries where alcohol is regarded as a product to be enjoyed alongside food and in a moderate manner, rather than to be used in isolation and to excess. The hotels and hospitality industry should be encouraged to continue its moves towards the use of alcohol in this context.

- There appears to be common ground between both liquor industry and alcohol control advocacy organisations for the further development of the ‘18+’ card with photographic identification. We strongly support development of such identification cards as part of the proposed comprehensive program.

The following sections address some of the areas which are traditionally contentious, but where in the context of the co-operative program there should be scope for significant progress.

6.6.3 DRINK DRIVING

The issue of 'drink-driving' was raised on many occasions, and is one of the most obvious examples of alcohol abuse where such abuse clearly affects those other than the drinker. Police activity on drink-driving has been firm, well-publicised and often effective. There is good evidence both nationally (where Victoria has not only shown the way, but demonstrated that effective programs lead to significant reductions in drink-driving and its consequences) and internationally that strong law enforcement activity complemented by good public education can be effective in this area. For this reason, we support the Police Department's intervention (such as "booze buses" random breath testing) and public education programs, and would further support any proposals that they be enhanced.

Some representations to the Task Force argued that penalties in this area are inadequate. This issue has recently been considered by the Select Committee on Road Safety whose recommendations are currently under review. We support the broad thrust of the Select Committee's report and note the need to reconsider current penalties.

Further discussion of this topic and associated recommendations are included in Chapter 5 which covers police and law enforcement issues.

6.6.4 WORKSITE INTERVENTION

A number of submissions also discussed problems relating to alcohol and the worksite. The Department of Occupational Health, Safety and Welfare noted that: as Indrad Services seems to have moved its focus 'away from alcohol and other drug abuse toward a more general management consultancy service', there is now 'a considerable gap in the provision of alcohol and other drug services to industry'. We recommend that the gap be filled by the proposed central treatment and training agency.

6.6.5 LIQUOR LICENSING

The area of liquor licensing (including taxation relevant to the State) has recently been the subject of a comprehensive review (the 'Mattingley Report'), with conclusions recently announced by the Government. It would clearly be fruitless in this report to review the same ground. Our intention is to complement rather than duplicate this activity. We therefore note support for the broad approach taken by government towards updating and clarifying this legislation with a greater focus on community concerns and involvement, training, host responsibility, community awareness, crowd control, promotions, discounting and binge drinking, trading hours and conditions.

6.6.6 ALCOHOL TAXATION

Many submissions and comments to the Task Force considered the issue of taxation (liquor licence fees). This report strongly endorses a view that; if possible, the liquor licence fee approach should be amended so as to encourage the maximum possible diversion of drinkers to lower alcohol products.

Liquor licence fees were discussed in the Mattingley Report, with a recommendation that the fee structure be changed to 12% on regular alcoholic drinks and 6% on low alcohol drinks. Some health and other agencies argued that the overall levels of taxation on alcohol should be increased, and that there should be further differentials between low alcohol and other alcoholic products.

The position taken by the State Government is that: 'current liquor licence fees will be retained at this stage. However, the Government will consider increasing the differential between the liquor licence fee on high and low alcohol products.'

The Task Force recognises the evidence that higher prices discourage consumption among all sectors of the community, and particularly the young. We note also, however, that in the context of a product which is recognised as being socially acceptable when sensibly used, there is much scope for debate as to the desirability of using price increases as a disincentive to consumption, particularly when the levels of taxation are already fairly high by international standards.

The Task Force is, however, very supportive of further increases in the differential between the liquor licence fees on high and low alcohol products, and recommends that this should be considered as a basis for future policy.

An issue of significant concern that should be considered first in this context relates to levels of tax on wine.

Tax on wine has been under consideration by the Industry Commission hearings into the Wine Grape and Wine Industry in Australia. Interim publications from the Industry Commission have signalled an interest in increasing the differential tax on cask wine. Submissions from the Health Department of Western Australia also stressed that cask wine is known to be a substantial source of abuse in Western Australia, particularly in remote areas.

There is no rational argument to support the situation whereby cask wine — a product easily abused, and all too easily chosen for this purpose — should be significantly cheaper than other forms of wine and lower alcohol beverages which may also be more difficult to abuse. The Northern Territory Government has recently moved to amend this anomaly at the jurisdictional level. Such a change in Western Australia would lead to better public health and safety outcomes, as well as increased revenues for the State Government.

While it would be naive to ignore the realities of special interest pleading, we note that a submission from the Australian Associated Brewers Inc (AAB) understandably commented on issues in relation to taxation of cask wine.

The AAB provided the Task Force with copies of its submissions to the Federal Government on alcohol beverage taxation, from which the following table is taken.

Table 1: Summary of estimated total taxes on alcohol beverages ($ per litre, 1995)

Product	Taxes per litre of beverage	Product	Taxes per litre of alcohol in beverage
Spirits	19.79	Spirits	52.77
Table wine premium quality	4.01	Table wine premium quality	33.43
Table wine medium quality	2.68	Regular beer	25.34
Beer regular	1.24	Beer (keg)	22.78
Beer (keg)	1.12	Table wine medium quality	22.29
Table wine cask	0.61	Low alcohol beer	20.36
Beer low alcohol	0.56	Cask wine	6.07

It is hard to avoid the conclusions reached by the AAB that: ‘the net effect of the tax structure is to distort consumer choice and industry development ... it is difficult to see why beer is more heavily taxed than cask wine, which are both consumed by lower to middle income earners ... if there is any intention to restrict consumption in the interests of public health, the present taxation system certainly does not achieve that objective. There can be no logic in taxing a litre of pure alcohol at $25 a litre in light beer and $4 a litre in cask wine’.

Similarly, concern has also been expressed to the Task Force about beverages described as “alcoholic sodas”, which are attractive to young people, but for technical reasons attract lower levels of tax. This anomaly would also appear to require attention.

This is an issue which must ultimately be resolved at the Federal level. The Task Force has no doubt on the basis of the national and international evidence that price policy can play an important role in reducing alcohol abuse. As indicated, the Northern Territory Government has recently introduced measures at the jurisdictional level to increase the level of tax levied on cask wine. Recognising that a similar increase in Western Australia would ensure the diversion of some cask wine drinkers to other products, we nonetheless note that could raise up to $8 million a year. We recommend that such an increase be sympathetically considered, and that consideration also be given to devoting part of any revenue derived from the increase to the initiatives recommended in this report.

6.6.7 ADVERTISING

A number of submissions to the Task Force expressed concern about the content and quantum of advertising for alcoholic products.

Alcohol advertising is, as the Advertising Federation of Australia noted through its Western Australian division's submission, controlled through a voluntary system managed by the Media Council of Australia (MCA). The MCA has developed an Alcoholic Beverages Advertising Code which includes a voluntary pre-vetting system, and the Advertising Federation and the alcohol industry have jointly carried out alcohol moderation publicity programs.

We note the codes currently in place, and the sense of moderation that applies to media advertisements relating to alcohol. We also note, however, concerns expressed to the Task Force about some aspects of alcohol advertising — although it should be noted that most of the advertisements about which concerns were expressed emanated from outside Western Australia. It is clear that while some manufacturers seek to advertise responsibly, and primarily to adult drinkers, there are others whose policies are more open to doubt. Some advertisements drawn to the attention of the Task Force appeared clearly directed towards both encouraging significant levels of drinking and promoting drinking among young people, with the implication that alcohol consumption would lead to increased social success. These advertisements may well breach the current voluntary advertising codes, but experience of those who have complained about such codes in the past is that there can be significant variations in interpretations of those who complain and those who adjudicate. We recommend that the issue of advertising codes be addressed specifically by the proposed Alcohol Abuse Reduction Program on a voluntary, Western Australian basis, and that this examination commence from the starting point that alcohol should not be promoted to young people.

Some concerns in this area were also expressed about sponsorship of sporting events that related to alcoholic products. Our view at this stage is that such sponsorship in Western Australia has generally been responsibly developed, and has, indeed, contributed to the promotion of lower alcohol products. It would therefore be difficult to develop an argument against such sponsorship in Western Australia, although there should always be a caveat that sports sponsorship should be carried out on the basis of responsibility and subject to appropriate voluntary codes of practice. We believe that it should be possible to capitalise on and develop further the voluntary approach already in place by developing further State codes of conduct for advertising promotion as part of the alcohol abuse reduction program proposed below.

The promotion of lower alcohol products has already met with marked success in Western Australia. The Swan Brewery was an initial leader in this area, and its example has been followed by other breweries. Recognising that alcohol consumption, and particularly beer consumption, will be a continuing feature of Australian society, we strongly support measures to encourage drinkers to drink lower alcohol products, and indeed, to ensure that for beer drinkers, lower-alcohol beers are the product of choice. This can be achieved in part through taxation, but also through the advertising and promotional support of the breweries, in conjunction with government agencies.

6.6.8 CURRENT STRUCTURES AND INITIATIVES

The Western Australia Consultative Council on Alcohol (WACCA) was established with a view to providing a forum in which issues of common concern could be discussed between representatives of the liquor industry of Western Australia and representatives of government departments. This forum, whose membership comprises key relevant government agencies and the Western Australian Hotels and Hospitality Association (WAHHA), as well as the producers of alcohol, meets on an occasional basis with an independent chairperson.

Members of the Council have in various contexts expressed the view that while such a forum has potential value, the present status of the Council does not provide it with adequate means to ensure that its views are appropriately communicated, and that there appears to be some lack of clarity about its role.

It is of course inevitable and entirely appropriate that specific liquor industry organisations (such as the Liquor Industry Council, the WAHHA and individual companies) should deal separately with ministers and government agencies on issues that affect them directly. It would also, however, be desirable to maintain a forum in which representatives of the industry could discuss matters of common concern with representatives of the State Government. The WACCA has demonstrated that there is value in this process, but that it might be more effective with a different structure and approach if it took account of concerns of present members of the Council.

We therefore recommend that the Central Drug Co-ordinating Office facilitate twice annually, meetings between representatives of key State Government departments and liquor industry organisations, to be followed where appropriate by meetings with the relevant ministers at which matters of common concern can be raised.

Although we recommend that these meetings be held twice annually as a matter of course, it should clearly be open to the CDCO to organise meetings of this kind on an ad hoc basis should the need arise.

6.6.9 ALCOHOL EDUCATION

Throughout this report, we have expressed support for public education as an important part of any comprehensive program designed to reduce drug abuse. The major public education programs in this area within Western Australia have been run from the Health Department of Western Australia (Drinksafe and Respect Yourself) and from the Police and Road Traffic Board. There is encouraging evidence of the effectiveness of these campaigns. Police campaigns on drink-driving are appropriately hard-hitting. The Drinksafe and Respect Yourself campaigns have been innovative, and have derived particular value from the continuity of approach that marks them out from the general run of 'one off' public education programs on alcohol. The successes of these programs have been achieved despite funding levels significantly less than those normally provided to commercial advertising campaigns. This report recommends the continuation of the approaches taken by Drinksafe, Respect Yourself and the Police drink-driving campaigns be continued, with support for any funding increases that can be achieved.

Public education programs such as these must, however, occur in a broader context. This should include a range of activities, from school health education to programs such as the Community Alcohol Intervention Project in Halls Creek, described in the regional reports in Chapter 2, which could be seen as providing a model for other communities.

One area where there is undoubtedly common ground is concern about drinking among young people. Throughout the community consultations, a major focus of public concern was that young people were drinking more, at a younger age, and with more potentially harmful consequences than in previous generations. The evidence also clearly shows that concern about 'binge drinking' by young people is justified. However 'binge drinking' is defined, many young people drink on occasions at levels that are likely to put them and others at immediate risk. Trends in alcohol consumption preference vary, but there is again sufficient evidence to justify concern that young people not only drink inappropriate quantities on occasion, but also higher alcohol products, and in a manner that leads to drunkenness and consequent damaging and illegal behaviour. Concern from the community on this issue was matched by concerns expressed by representatives of the liquor industry, who noted the difficulties they faced in this area.

Some of the measures to be introduced following the Review of the Liquor Licensing Act will address sales practices, and there is clearly also an important role in this area for police activity. Any realistic assessment of the problem must also recognise that 'binge drinking' is part of a complex series of behaviours as young people pass through adolescence. Nonetheless, for the safety of these young people, as well as the concerns legitimately felt by their parents and the community, we believe that there should be specific focus in educational programs on reducing binge drinking among young people. We recognise that education programs in this area cannot be expected to achieve dramatic changes overnight, and for this reason, education programs developed should be continuous and consistent, following the example already set by the Respect Yourself campaign and linking in with Police Department drink-driving and related programs. We note further that dealing with young people is a matter that causes significant difficulties for those selling alcoholic products: while the Task Force was provided with clear examples in some locations of inappropriate promotional and sales practices, we also recognise that responsibility cannot rest totally with vendor. Non-forgeable proof of identify should assist significantly in reducing under-age sales; but thereafter a considerable degree of responsibility rests with the purchaser as well as the vendor.

In the area of 'binge drinking' by young people, we therefore recommend that:

- School education programs should include discussion of the dangers to both the consumer and others of 'binge drinking'.

- The public education programs recommended in this report should include a continuing component focusing on 'binge drinking' by young people.

- In addition to the other measures now being implemented, as part of the proposed Alcohol Abuse Reduction Program, the Western Australia branch of the Australian Hotels and Hospitality Association should develop specific further guidelines for its members on their role in preventing 'binge drinking'.

6.6.10 AN ALCOHOL ABUSE REDUCTION PROGRAM

As anticipated in the foregoing discussion, it is proposed that the State Government adopt a multi-faceted approach to reducing the harm resulting from alcohol abuse. This should have as its primary focus reducing to the lowest possible levels the adverse outcome of short-term alcohol abuse.

The approach should be fully comprehensive: this means support from all sections of government, non-government organisations and the community.

The approach should also be co-operative: this means genuine co-operation not only with various organisations in the community, but also with the liquor industry.

A co-operative program should entail some comprehensive activities, but also where appropriate, local action or joint activity between specific groups: a good example might be co-operative activity between the police and liquor industry as piloted in the "Geelong Local Industry Accord" program that entails both agreed Codes of Practice and further joint strategies.

While there have been some limited developments in terms of co-operation between government agencies and the liquor industry on alcohol education programs in Australia and internationally, there is no precedent for a genuinely co-operative program that entails acceptance of the same overall objectives, agreement on appropriate messages, and agreement on certain specific controls, joint educational activities and positive activities designed to reduce alcohol abuse.

Recognising that alcohol problems must be addressed in the context of a range of other issues, it is recommended that there be a comprehensive Alcohol Abuse Reduction Program.

The Alcohol Abuse Reduction Program (AARP) would be co-ordinated by the Central Drug Co-ordinating Office.

The AARP would involve the participation of the following:

- Central Drugs Co-ordinating Office;
- Police Department;
- Health Department;
- Office of Racing and Gaming;
- Education Department;
- Family and Children's Services;
- Ministry of Justice;
- Western Australian Network of Alcohol and Drug Agencies;
- Liquor Industry Council;
- Western Australia Hotels and Hospitality Association; and
- National Centre for Research into the Prevention of Drug Abuse.

The objectives of the AARP would be to:

- prevent and minimise abuse of alcohol;
- prevent and minimise harm resulting from the inappropriate use or abuse of alcohol;
- prevent and minimise under-age use and abuse of alcohol; and

- encourage sensible and responsible use of alcohol by drinkers.

The messages to be promoted by the AARP would concentrate on both positive and negative messages and focus on the reduction of alcohol abuse.

The main developments to be co-ordinated and overseen by the AARP would be as follows.

6.6.10.1 Public education

- Continuation of the Drinksafe campaign and approach.
- Continuation of the Respect Yourself campaign and approach.
- Commitment by the State Government to increased funding of public education activity on alcohol abuse. This program to be developed and co-ordinated by the Health Promotion Services Branch of the Health Department in conjunction with others.
- Activity by Health, Police and other Departments as set out in relevant chapters of the report.

6.6.10.2 YOUTH

- Public education programs to focus especially on young people between the ages of 12-25.
- At-risk groups: special programs to be developed to reach special at-risk or 'hard to reach' groups.

6.6.10.3 SCHOOLS

- Alcohol education to form part of the mandatory drug education in schools as proposed elsewhere in this report.
- Alcohol education to form part of the teacher training programs proposed elsewhere in this report.
- Materials for school education on alcohol and drug education to be developed by the Health Department and Education Department.
- School drug and alcohol policies.

6.6.10.4 SPECIAL GROUPS

Discrete programs to be continued and developed for special groups: e.g. worksite and at risk groups as above.

6.6.10.5 Treatment and provision of services

- Support for the approach to treatment and other services outlined in Chapter 3.
- Development of worksite programs through the proposed central treatment and training agency and other relevant agencies.

6.6.10.6 Aboriginal people

Programs are currently being developed by the Health Department and others arising out of earlier work and events such as the Western Australia Aboriginal Alcohol Summit and the 'Living with Alcohol' program and approach.

The emphasis of the AARP should complement this development with both positive and negative components.

- The positive components will indicate what people can do, what is acceptable and what may be beneficial. This will range from education programs to treatment and immediate response activities such as community patrols and sobering up shelters.

- The negative components will take a firm and unremitting stance against alcohol abuse that puts individuals or the community at immediate risk.

It is especially important in this context to recognise that a smaller percentage of Aboriginal people drink than that of the total population. The emphasis should not be on stereotyping Aboriginal people, but rather on focusing efforts on those who do drink to excess.

6.6.10.7 Professional education

- Clinical education: through the central treatment and training agency and other groups.

- Professional education programs especially targeted for all relevant groups, with a particular focus on health and education professionals.

6.6.10.8 Products

- The AARP would encourage the liquor industry to develop lower alcohol products and to promote them responsibly.

6.6.10.9 Controls

- The AARP would support price differentials so as to encourage the production and responsible promotion of lower alcohol products.

- The AARP would support moves to ensure that all alcohol products are taxed on a volumetric basis (i.e. tax levied by litres of alcohol rather than by litres of liquid. This is primarily an issue for the Federal Government).

- A particular emphasis is that cask wine should be taxed as the same levels as other forms of wine and other alcohol products.

- The AARP would support development of codes of conduct for all sections of the industry. These will include issues such as: advertising, promotion, labelling, server responsibility.

- The AARP would encourage those responsible for liquor licensing to take account of community concerns in their decision-making processes, and will encourage community groups to participate as appropriate in the liquor licensing process. The AARP would not seek to take on the role of the Office of Racing and Gaming, but it would develop a policy that could be commended to the State Government as a common position on the number and location of sales outlets.

- The AARP would support the measures recently announced by the Minister for Racing and Gaming following the review of the Liquor Licensing Act 1988.

  These include:

  - Clarification of the act and definitions therein.

  - Expanding the objects of the Act to support activities that promote a responsible approach to the sale and consumption of alcohol.

  - Revised approaches to liquor licensing procedures.

  - Further development of appropriate industry training and education and establishment of a host responsibility program.

- Appropriate consultation with Aboriginal communities and action arising as a result.
- Action on: crowd controllers, promotions, discounting and binge drinking.
- Amendments to licensing hours.
- Greater controls on sales to juveniles, including a non-forgeable proof of age act.
- More resources for policing of the Liquor Licensing Act, with stronger penalties for breaches.

6.6.10.10 Law enforcement

- The AARP would strongly support all activities of the Police and other agencies designed to prevent and control illegal activity and activity that clearly puts others at risk.
- The Police are strongly encouraged to develop further programs aimed at reducing drink-driving through public education and police practice.
- The AARP would support and encourage measures to enforce legislation on sale of alcohol to minors.
- The AARP would support measures such as random breath testing designed to control and discourage drink-driving.
- The AARP would support firm action by the Police to enforce licensing legislation both generally and in specific areas such as ending the practice of 'secondary sales' of alcohol, for example, through taxis to Aboriginal communities, and youth.

6.6.10.11 Co-operation with liquor industry

The AARP would place special focus on seeking a co-operative approach between the State Government and the liquor industry in reducing alcohol abuse. This is to be based on a recognition that the liquor industry has a legitimate role to play in such a program, and shares the concerns of the State Government that alcohol abuse should be minimised.

Areas of co-operation include:

- Liquor Industry Council and Hotels and Hospitality Association representation on the alcohol abuse reduction program.
- Industry development of codes of conduct.
- Agreement on the basic objectives of programs.
- Agreement on messages to be delivered to the public.
- Development of host responsibility programs by the industry.
- Support for compulsory photographic identification on drivers licences issued to persons under 21 years, or other means of photographic identification to assist licensees' to identify juveniles.
- Recognition by the AARP that a significant majority of liquor consumed is consumed outside licensed premises, and that attention must be focused not only on licensed premises, but also on inappropriate consumption elsewhere.
- Industry support for State Government education programs through: distribution of materials, use of industry advertising to carry agreed references to government educational messages; industry advertising for lower-alcohol products to coincide with governmental education programs.

- Joint programs in areas including: server responsibility, cross-cultural training of staff; specific programs for Aboriginal communities.

6.6.10.12 Regional activity

- The AARP would support regionally based programs designed to address specific regional issues and concerns.

- The AARP would emphasise local activities in its messages and through action by local AARP groups that may form in conjunction with the proposed Regional Drug Co-ordinating Councils and the proposed Local Drug Action Groups.

- Active support from local Health Department Health Promotion Officers.

6.6.10.13 Treatment

- Treatment needs to be recognised as an important part of a comprehensive program.

- As discussed in Chapter 3, a range of service development initiatives, including services in hospitals and extending the ambit of case practice in the health, justice and welfare sectors, can make a significant contribution to the specific Alcohol Abuse Reduction Program.

6.6.10.14 Data collection

As outlined in Volume II, Chapter 4, co-ordination of data collection from all relevant groups including support for the current MAPP (Measurement of Alcohol Problems for Policy) project being conducted by Curtin University and the Health Department; and the development of other appropriate systems.

6.7 TOBACCO

6.7.1 BACKGROUND

Tobacco is a product which became socially accepted before evidence established that it contains an addictive substance (nicotine), carcinogenic compounds, poisons, mutagenic agents and radioactive compounds.

The evidence on the harmful health consequences of tobacco is overwhelming and widely accepted. Smoking kills approximately 19,000 Australians each year. Smoking is part of a worldwide problem. Peto et al (1994) estimate that:

- On the basis of present trends, the current global total of about three million deaths per year from tobacco will reach about ten million per year about the time the children of today reach middle age.

- About half of all regular cigarette smokers will eventually be killed by their habit.

More than 80% of those who smoke started smoking regularly before the age of 15. The greatest risk for smokers is among those who started smoking cigarettes regularly in their teenage years. But it is important to emphasise that, as Peto et al comment, ‘stopping smoking works: even in middle age, stopping **before** having cancer or some other serious disease avoids most of the later excess risk of death from tobacco, and the benefits of stopping at earlier ages are even greater’.

While smoking is a major preventable cause of death and disease, it is also worth noting that reduction in smoking in the community does not simply result in additional health care costs and burdens among the elderly. Holman et al (1995) have demonstrated that for the cost of an additional week in hospital and an additional month in a nursing home, not-smoking yields a return of an extra three years of life in men and one-and-one-half years in women, all in good health, plus a four to nine month reduction in the time that would otherwise be spent in the community in poor health.

The focus of this section is almost entirely on cigarette smoking. Cigarette smoking is the major cause of diseases attributed to smoking, and less than 2% of smokers are regular pipe or cigar smokers. Although the

risks are different (partly because of the different nature of the product and its use), the risks attributable to pipe or cigar smoking have been well documented. For the purposes of this report, a smoking control program is taken to include pipe and cigar smoking. Similarly, while the market for hand-rolled cigarettes is very small, these products should also be subject to the measures appropriate for a smoking control program.

Research has been vital to demonstrating the harmful health consequences of smoking and the benefits of smoking cessation.

In 1995, however, there are no good grounds for further funding by a State Government of research that seeks to demonstrate the harmful health consequences of smoking. Any research funding should be provided only for research that will evaluate, monitor and assist in further development of strategies designed to reduce smoking in the community. This includes surveys designed to establish prevalence either in the overall community or in specific groups, with such research to be very carefully funded on the basis that the major effort must be seen to be devoted to reducing smoking rather than to research for its own sake.

Smoking trends, the health consequences of smoking in Western Australia and the costs of smoking to the community are summarised in Volume II of this report.

Current trends offer grounds for cautious optimism. The Health Department of WA reports that, over the last two decades, smoking in Western Australia has been declining gradually:

- In Western Australia, 25.4% of adult men and women were reported to be regular smokers in 1994.
- Overall smoking prevalence in Western Australia fell by 21% between 1984 and 1994.
- Recent reports have demonstrated a decline in male lung cancer deaths for the first time since the start of the smoking epidemic in Australia, more than 70 years ago.

There should be cause for some satisfaction that ‘only’ 25% of the adult population smoke. Nonetheless, there is no room for complacency. Specific concerns arising from the evidence and presented to the Task Force include the following:

- As noted above, one quarter of the adult population still smoke, and tobacco is still responsible for some 1,500 avoidable deaths each year in Western Australia.
- The decline in smoking among adults has not recently been mirrored among young people. While the Health Department reports that the most recent large-scale survey of Western Australian school children (conducted in 1993) demonstrated the start of an encouraging downward trend in most adolescent cohorts, 19% of school boys and 26% of school girls were still smoking regularly by the age of 15 years.
- Young male smokers in Western Australia currently have a higher smoking prevalence than any group in the State. Approximately 36% of males aged 18-29 smoke.
- Between 1984 and 1994, smoking prevalence among women aged 18-29 declined only from 35% to 27.5%, and the proportion of female smokers who want to quit is not increasing. This is particularly disturbing in view of the special risks faced by women who smoke.
- Smokers from lower socio-economic backgrounds (whether measured by education or occupation) report a higher prevalence of smoking than other segments of the population.
- Smoking prevalence among Aboriginal people remains far higher than in the general population. Studies around the State have reported that 50% or more Aboriginal adults smoke, and that the smoking rate among Aboriginal males is close to 60% (ABS). Smoking is increasingly being recognised as a major factor in the reduced life expectancy of Aboriginal people as compared to non-Aboriginal people.

Encouraging trends should not mask the continuing case for action: a decline in smoking prevalence may be pleasing but while a quarter of the adult population still smoke, cigarette smoking remains the largest preventable cause of death and disease in our community. Any drug that is demonstrably addictive and responsible for 1,500 deaths annually in Western Australia alone must remain cause for the utmost concern.

6.7.2 COMPREHENSIVE APPROACH

Governments and health authorities around the world have accepted the broad approach recommended in reports of the World Health Organisation and the International Union Against Cancer. This entails adoption of a comprehensive approach, including:

- public education;
- specific education;
- advertising control;
- health warnings;
- control of and information on harmful components;
- restriction on sales to minors;
- price policy;
- workplace safety measures; and
- protection for non-smokers.

Western Australia has for some years been seen as playing a leading role in the development of smoking control programs both within Australia and internationally.

While primary responsibility for action on smoking within government rests with the Health Department of WA, its work is complemented by that of other government agencies such as Healthway and the Education Department, and by non-government organisations such as the Australian Council on Smoking and Health (ACOSH), the National Heart Foundation and the Cancer Foundation of Western Australia. The case for maintaining and further developing a smoking control program has been consistently advocated by health and related organisations, led by the Australian Medical Association.

6.7.2.1 Government

In Western Australia, the Government's approach is underpinned by the Tobacco Control Act 1990, which prohibits almost all advertising and promotion of tobacco and mandates the establishment of the Western Australia Health Promotion Foundation (Healthway). Its purposes are:

- the active discouragement of the smoking of tobacco by:
    - encouraging non-smokers, particularly young people not to start smoking;
    - limiting exposure of children and young people to persuasion to smoke; and
    - encouraging and assisting smokers to give up smoking.
- the promotion of good health and the prevention of illness.

The Tobacco Act 1990 was recently reviewed for the State Government by Minter Ellison Northmore Hale, whose report has been released for public comment by the Minister for Health. This review endorses the broad approach of the Tobacco Control Act, and makes some suggestions for its further improvement, particularly in the areas of controlling the activities of tobacco manufacturers and protecting young people. We support almost all the recommendations in the review and recommend their implementation when this is feasible. The key findings and recommendations of the review are reprinted in Appendix 9.

6.7.2.2 Healthway

The Western Australian Health Promotion Foundation, Healthway, has been exhaustively reviewed, most notably in the ‘Report on the Evaluation of the Western Australian Health Promotion Foundation’ (Holman, Donovan and Corti) recently published by the Department of Public Health and the Graduate School of

Management at The University of Western Australia. This report concludes that 'Healthway is now a leading edge organisation, setting national and international standards not only for health promotion foundations as corporate entities, but also for the theory and practice of health promotion and health promotion evaluation'. Healthway's funding has contributed significantly not only to health education activity and research, but also to sporting and arts organisations, and to the negotiation of structural changes such as smoke-free areas which 'if sustained, have considerable potential for enhancing health'. Healthway has also been separately reviewed by KPMG Peat Marwick Management Consultants, whose report was recently released for comment by the Minister for Health.

The role of this report is not to replicate the various reviews of Healthway. We note, however, that Healthway has played a significant role in ensuring the continuation of Western Australia's reputation as a national and international leader in smoking control activity.

6.7.2.3 Non-government organisations

As indicated above, action on tobacco in Western Australia occurs within a generally well co-ordinated framework. The Health Department, Healthway (and Healthway-funded groups), ACOSH, AMA, National Health Foundation, Cancer Foundation and other organisations work together with remarkably little duplication and a commitment to common objectives. This has been confirmed by a recent joint project involving several of these agencies that is directed towards reducing smoking among young people.

The Young People and Smoking Project (YPSP) has received funding from Healthway and will be conducted by the Australian Council on Smoking and Health, National Heart Foundation Western Australia, Cancer Foundation of Western Australia, Asthma Foundation of Western Australia and the Health Promotion Services Branch, HDWA. The project will address factors uniquely and fundamentally associated with adolescent smoking behaviour and will endeavour to reduce both the demand for cigarettes and the supply of cigarettes to young people. The primary target group will be youth aged ten to 14 years and the major components based on extensive research will be the use of mass media to ensure that the messages are appropriate and meaningful to young people.

The YPSP will also take an active role in promoting changes in policy, interventions through the school system and programs aimed at people who act as role models for adolescents. This last component would be a separate smaller campaign focusing on what the adult (whether as parent, coach, P&C member, politician, shopkeeper, or club president) can do to support a smoke-free generation, emphasising:

- the Quit message;
- role model/passive smoking messages; and
- the establishment of places to which youth have access as smoke-free venues.

6.7.3 TOBACCO COMPANIES

Three tobacco manufacturers currently operate in Australia: Rothmans Holdings Ltd, WD & HO Wills Holdings Ltd and Philip Morris (Australia) Ltd. Rothmans also holds the manufacturing and distribution rights to brands owned by a fourth company, the American-based RJ Reynolds Tobacco Inc.

In common with most other developed countries, Australia represents a declining market for tobacco companies. Overall consumption of tobacco products has fallen 19% in the last decade, and per capita consumption by 31% over the same time period. These declines in consumption mean that the companies are engaged in fierce competition for an ever-diminishing market. The Australian market is, nevertheless, worth an estimated $5.4 billion a year in retail sales.

The Australian cigarette market is distinctly segmented, with brands categorised by price, style and packaging. The value-for-money end of the market is the major battle-ground, and this segment will clearly remain the most vital for the industry, as smoking has increasingly become stratified by socio-economic levels.

6.7.4 SUPPORT FOR SMOKING CONTROL MEASURES

Public opinion surveys consistently show strong support for smoking control measures, usually from both non-smokers and smokers. Information provided by the Health Department about areas of current concern shows that:

- 81% of metropolitan Western Australians who were aware of the 1994 Quit Campaign approved of it. (Quit Campaign Evaluation Report).

- 66% of Western Australians are in favour of replacing tobacco advertising with health message advertising (Holman et al 1995).

- 62% of Western Australians are in favour of replacing tobacco sponsorship of sport, racing and the arts with health message sponsorship (Holman et al 1995).

- 83% of Western Australians believed that other people's cigarette smoke can affect non-smokers' health (HDWA 1994).

- 58% of Western Australians believed there should be no smoking at all in restaurants, and 38% believed there should be separate zones for smokers (HDWA 1994).

- 77% of Western Australians believed there should be no smoking at all on planes during flights of 2-5 hours (HDWA 1994).

- In 1991, 60% of the full-time working population thought that smoking should be completely prohibited in the workplace, and a further 34% thought there should be some restrictions (Marketing Centre 1991).

6.7.5 CURRENT ACTIVITIES

6.7.5.1 School health education

Health education in schools plays a vital role in any effective smoking control program. Education on smoking should be a major component of the mandatory school drug education programs recommended in Chapter 4. There are good grounds for arguing further that effective public education programs on tobacco will assist in delaying and preventing the uptake of cannabis and other illicit drugs.

Regular surveys of the situation regarding health education and health promotion in schools in Western Australia have been conducted by the National Heart Foundation and The Australian Council of Health, Physical Education and Recreation. The findings, which are also reported in Volume II of the report, show that only 50% of students will be exposed to the smoking prevention section of the K-10 Health Syllabus.

6.7.5.2 Public information

Representations were made to the Task Force that the level of funding available for public education is now significantly less in real terms than it was a decade ago.

The Health Promotion Services Smoking and Health Program was initiated in 1983/84 and was originally funded from the Anti-Smoking Trust Fund. The sum of $2 million was allocated for this initiative. The Fund was used to finance the Quit campaign and other campaigns conducted by the Smoking and Health Program, and to appoint nine new Health Education Officers who were employed to provide health education services in country regional centres.

The State Tobacco Licence Fee, which was 13.5% in 1983, has been increased on several occasions since, most recently to 100% in late 1993. Expected revenue from the State Tobacco Licence Fee in the financial year 1994/95 will be approximately $213 million. A total of $12.9 million is allocated from revenue generated from the State Tobacco Licence Fee for disbursement by the Western Australian Health Promotion Foundation (Healthway).

Any assessment of State Government expenditure must recognise the addition of funding provided through Healthway, albeit recognising that much of this funding is directed towards indirect as well as direct health promotion, and towards health promotion messages other than those on tobacco.

The Health Promotion Services Branch's submission to the Healthway Review indicates that in 1994, the total funds available for the Smoking and Health Program and implementation of the Tobacco Control Act amounted to $1.273 million, including the cost of salaries. This submission also noted that inflation has dramatically reduced the buying power of the dollars allocated to the Smoking and Health Program to conduct Statewide mass media education and information campaigns.

As circumstances and types of activity funded have changed so much, it is impossible to make direct comparisons between 1995 and 1983 levels of funding, but the Task Force considers that as a broad principle the aim should be to ensure that direct public education on tobacco is funded in real terms at levels no less than those obtained in 1983.

Although the Quit Campaign has been in existence for more than a decade and has a reputation for innovation, there is still scope for both new and innovative approaches and further development of approaches previously piloted, such as the use of postal advice on smoking cessation, and community-based programs such as those pioneered in Stanford (US) and North Karelia (Finland).

6.7.5.3 Support for cessation of smoking

Tobacco, when considered using established criteria of dependence, is classified as an addictive substance. Nicotine has been identified as the component in tobacco with addictive properties.

Giving up smoking is the most important single course of action an individual can take to benefit his or her health. There is broad community awareness of the benefits of giving up smoking. It is important that the difficulties of giving up smoking should not be overstated. Millions of people across Australian have given up smoking. In Western Australia, while 25% of the population smoke, a further 30% are former smokers. This means that more than 300,000 Western Australians have successfully given up smoking.

The evidence on smoking cessation shows the following:

- The best predictor of success is the number of previous efforts to give up. In other words, the more you have tried, the more you are likely to succeed.
- The two crucial periods are the first two weeks and the first three months. If you can get through these periods, you are much more likely to remain a non-smoker.
- The best way to give up is to quit ‘cold turkey’, rather than to try to give up gradually.
- It is never too late to give up, nor to gain benefits from giving up.
- More than 90% of those who give up do so on their own.

The last observation is important for smokers trying to give up. There is no single ‘miracle cure’ that will relieve smokers of the need to give up themselves; and for most of those who give up, no smoking cessation aids should be necessary other than support and encouragement.

There is, however, unequivocal evidence that health professionals can play a major role in encouraging and assisting patients to give up smoking. While this has been most publicised in relation to doctors, there is similar evidence in relation to the role of nurses and other health professionals. There is also unfortunately evidence that only limited (albeit increasing) numbers of health professionals take advantage of the remarkable opportunity open to them to assist in improving the health of patients and prolonging their lives. Much responsibility must rest with health professionals themselves, but any government-funded public education program on smoking should include a major emphasis on encouraging health professionals to assist their patients in this way. This could include:

- Making available to health professionals the evidence on the role that health professionals can play.
- Providing support materials and continuing encouragement.
- Working with organisations of health professionals.

For those smokers who require additional aids, there is reliable evidence supporting the use of nicotine replacement, particularly in conjunction with appropriate advice from general practitioners or other health professionals. This is normally provided through either nicotine patches or nicotine chewing gum. The evidence supporting use of nicotine patches is stronger than for any other form of smoking cessation aid. The Commonwealth Pharmaceutical Benefits Advisory Committee has recently recommended that nicotine patches

should be available under the Pharmaceutical Benefits Scheme, but the Commonwealth Government has to date rejected this advice.

6.7.5.4 Advertising controls

Ranked by stringency of advertising restrictions, Australia is currently equal fifth among the 22 OECD countries. The provisions of the Tobacco Control Act 1990 and the Federal Tobacco Advertising Prohibition Act 1992 have meant that the only remaining advertising in Western Australia is at the point-of-sale and through sports events which hold an exemption from the Acts. At the point of sale, manufacturers and retailers have devised means of advertising using packs and cartons in displays. Special promotions using value-added components such as offers of lighters, music cassettes, calendars and books remain pervasive forms of advertising.

6.7.5.5 Health warnings

Western Australia initiated strengthened health warnings in 1993 which were later reduced by a compromise with other States to the current use of six rotating warnings on the top of the front of the pack, an explanation of the warning on one-third of the back of the pack, and content labelling on one side of the pack.

Research conducted in Western Australia and Victoria has established that plain packaging (a standard colour for all brands) would further reduce the appeal of cigarette packaging.

6.7.5.6 Control of harmful substances

The Commonwealth Government has responsibility for the content of tobacco products. Nicotine in tobacco is exempt from scheduling under Commonwealth and State Standards for Drugs and Poisons, although nicotine in all other forms is included in Schedules S3-S7.

The provisions of the Trade Practices (Consumer Product Information Standards) (Tobacco) Regulations 1994, specify the maximum permitted levels of 1.5 mg nicotine, 16 mg tar, and 20 mg of carbon monoxide per cigarette.

The Commonwealth Government has considered evidence regarding the content of tobacco in the form of smokeless tobacco and has done so in the context of a new, rather than an established product. This arose from concern about the many health problems, such as oral cancers, caused by the widespread use of relatively new forms of smokeless tobacco in the US. As a consequence, a permanent ban on the sale of smokeless tobacco was imposed in 1989. Western Australia has already taken preliminary action to ensure this outcome at the State level.

6.7.5.7 Restrictions on sales to minors

In Western Australia it has been illegal to sell or supply tobacco products to anyone under the age of 18 years since 1917. Following the passage of the Tobacco Control Act 1990, the penalties for the offence were raised. A comprehensive approach including community and retailer education, systematic monitoring, and, where necessary, prosecution of retailers has been implemented since 1991.

The restriction of the supply of cigarettes to children is a necessary complement to strategies to decrease the demand for cigarettes by children. Evidence from other countries indicates that programs to restrict supply of cigarettes must be maintained to ensure continued compliance. Relaxation of activity inevitably results in a decline in compliance.

Another aspect of the supply of cigarettes is the large number of outlets for tobacco sales. Currently tobacco may be sold without restriction by anyone in the State. Monitoring of sales through a licensing system is one option that has been proposed to ensure compliance with sales to minors regulations, although this may not presently be appropriate and would entail substantial bureaucratic and other costs.

6.7.5.8 Pricing policies

Both health authorities and tobacco manufacturers are aware that increases in price result in a decline in the consumption of cigarettes. Evidence from Canada and the US shows that the major effect of price rises is on preventing tobacco use among young people. In recent years, substantial increases in the real price of cigarettes in Australia have coincided with a sharper decline in tobacco consumption. This mirrors the experience of other countries such as Canada and New Zealand following price increases. However, in Australia this effect has been

undermined by the availability of lighter, cheaper cigarettes in large pack sizes. The reason for this anomaly lies with the method of levying tobacco excise at the Federal level. At the State level it is important to continue to implement increases in State tobacco licence fees to maintain real increases in the price of cigarettes.

6.7.5.9 Restrictions on smoking in workplaces and public places

In Western Australia and throughout Australia, provisions of the State Occupational Health and Safety Acts require that workplaces should be, wherever practicable, free of hazards. Environmental tobacco smoke has been established as a 'Group A Human Carcinogen' by the US Environmental Protection Agency and has also been established as a cause of respiratory illness and heart disease.

Legal decisions have established precedents that have hastened moves to provide smoke-free workplaces, although such moves have been slower in some areas, such as the hospitality industry.

The restriction of smoking in public places can be justified on three grounds:

- protection of non-smokers from the adverse health consequences of passive smoking;
- protection of non-smokers from the irritation of passive smoking; and
- encouragement of a non-smoking environment as a contribution to public education on smoking.

As there is now clear evidence that passive smoking can be harmful to the health of the non-smoker, particularly the young non-smoker, the first of these grounds alone should suffice to encourage the development of the non-smoking environment. The State Government has already made substantial moves in this direction, both through constraints on smoking in government buildings and by means of other health and safety requirements.

Further moves towards development of a non-smoking environment are to be encouraged, subject to the caveat that smokers should not be made to feel unduly penalised or victimised. Surveys show that most smokers recognise the legitimacy of providing a non-smoking environment for non-smokers, and even support moves in this direction. Every effort should therefore be made to encourage such moves in a cautious and non-adversarial manner. The principle should be that non-smokers, particularly young non-smokers, have the right to a smoke-free environment.

6.7.6 PROPOSED POLICY DEVELOPMENTS

Recognising the continued magnitude of the tobacco problem, the following approach is recommended on tobacco:

- Continuation of policy based on policy recommendations of the World Health Organisation and the International Union Against Cancer.

Given the current level of activity and co-operation in the area of smoking control in Western Australia, as well as the general consensus on the appropriate attitude to this major public health and drug control problem, we did not consider that it would be necessary to develop yet again the rationale for, and components of, a comprehensive smoking control program. We have rather sought to make recommendations that will continue the broad thrust, and will assist in fine-tuning of, the approaches presently being taken.

Many of the recommendations on tobacco made to the Task Force are directed more appropriately to the Commonwealth Government than to the State. These range from the manner in which tax is levied at the national level to the administration of Commonwealth legislation on tobacco advertising. In the context of this report, it is not appropriate for the Task Force to make recommendations to the Commonwealth Government. There is a general consensus among Commonwealth and States Governments as to the appropriate manner in which tobacco should be addressed, with only relatively minor differences. Important areas where changes in the Commonwealth approach would assist the smoking control programs in Western Australia, however, include:

- Action to make nicotine patches available to substantial numbers of those smokers requiring them under the Pharmaceutical Benefits Schedule.
- Ensuring that the welcome funding provided for 'national' media and associated campaigns on smoking is directed primarily through the States, for programs appropriate to State circumstances.

- Ensuring that negotiations with tobacco manufacturers on matters such as product, content and information be carried out on the basis of expert advice and participation from the States.

Some media campaigns are also organised by the Commonwealth Department of Health and Human Services through the National Drug Strategy, and the Federal Government recently announced a commitment to development of such activity. As with other National Drug Strategy media and related programs, there are common objectives and a commitment to co-operation, but also some obstacles to full co-operation within a context that entails programs being run on a national basis that may not be appropriate in terms of target group, content or timing for the Western Australian situation. Matters related to the National Campaign Against Drug Abuse/National Drug Strategy are addressed elsewhere in this report, with a recommendation that NDS media and related funding should be directed through the relevant State body. This should also apply to public education programs on tobacco, where there is a unique level of expertise and activity in Western Australia as well as circumstances that differ in some respects from those elsewhere.

Some submissions to the Task Force took an 'either ... or' approach, recommending that there should be an emphasis on either adults or children. As elsewhere, we take the view that a comprehensive approach is appropriate. There may be times when it is necessary to target young people and times when it is necessary to encourage adults to give up. Further, campaigns that encourage smokers to "quit" can quantify their success not only in terms of numbers of "quitters", but also in terms of premature deaths prevented, or "lives saved".

Overall, the Task Force supports a continuation of the comprehensive and co-operative approach to smoking control which has been a feature of the health arena in Western Australia in the past two decades.

Targets of smoking control activity have generally been formulated in terms of reducing the prevalence of smoking by x% in either the community as a whole or specific groups, or in broader terms such as developing a 'smoke-free' generation. The target for the Western Australian program should, as with other forms of drug abuse, be to achieve the lowest smoking rates in Australia and in comparable countries. There should, however, be a special focus on preventing smoking by school-age students. The key to stopping the trend to smoking currently seen among young people between 18-30 lies in preventing smoking among children and adolescents. There are good grounds for believing that mandatory drug education programs in schools, together with other components of smoking withdrawal strategy being implemented or recommended, will play a major role in achieving this objective.

The following specific developments are proposed by the Task Force.

6.7.6.1 Education

- Tobacco to form part of the mandatory school drug education programs proposed elsewhere in this report.
- Commitment to mandatory drug education on a similar basis by non-government schools.
- Commitment by the Education Department to a completely smoke-free environment in schools.
- Inclusion of tobacco as part of the mandatory teacher training programs in drug abuse recommended elsewhere in this report.
- Commitment to continuation of public education programs on tobacco at levels no less in real terms than those obtained in 1984. This should include funding committed to public education on tobacco by the Commonwealth as part of the National Drug Strategy: as recommended in Chapter 7, this funding should be administered directly through the State.
- Public education programs to be comprehensive, but to pay special attention to key groups, including:
  - young people;
  - women;
  - Aboriginal people, for and with whom special programs should be designed and implemented; and
  - multicultural groups.

As in other areas, some recommendations were made to the Task Force about specific components of smoking control programs (particularly public education) that could be tried or amended. There are inevitably a number of different views about the manner in which public education programs on such issues should be targeted or composed. There is clear evidence from around the world that:

- Public education programs on smoking are effective as part of a comprehensive smoking control program.

- As with other forms of marketing, increased expenditure is likely to bring better results, so long as that expenditure is carefully planned and monitored.

We have therefore not made recommendations about specific themes to be adopted in public education programs, but recommended rather that such programs should continue to be based on sound scientific evidence, carefully planned and rigorously evaluated.

6.7.6.2 Controls

- Maintenance of the Tobacco Control Act 1990, with any further recommendations from the Review of the Act that complement its broad approach.

- Maintenance of the role of Healthway, subject to recommendations in the Report of the Evaluation of Western Australia Health Promotion Foundation.

- Consideration that the Tobacco Control Act 1990 be amended to remove anomalies that permit the continuing inappropriate promotion of tobacco in Western Australia. Strengthening on such controls, as recommended in the Review of the Tobacco Control Act 1990.

- Negotiation with other jurisdictions to ensure that tobacco health warnings are maintained and strengthened on the basis of evaluation, along with effective content information and disclosure of ingredients.

- Support for Health Department activity designed to ensure compliance with the Tobacco Control Act, particularly in relation to the sale of tobacco products to minors.

- Examination of other measures such as licensing retail outlets to limit the availability of cigarettes.

- Legislative action to protect non-smokers through the provision of smoke-free public places and workplaces.

- Maintenance of the current State and Commonwealth approach to ensuring that cigarette prices are at least maintained in real terms.

6.7.6.3 Smoking cessation

- Development of a substantial program by the Health Department, in conjunction with other agencies, to ensure adequate provision of its service and advice to those who wish to give up smoking. This should include encouragement of doctors and other health professionals to advise, encourage and assist their patients to give up smoking.

- A review of counselling services for smoking cessation to ensure efficient delivery to target groups.

6.8 PHARMACEUTICALS

6.8.1 INTRODUCTION

No drug is perfectly safe. However, drugs have proven to be of enormous benefit to mankind. Their contribution to our quality of life over the past 50 years is scarcely comprehensible with, for example, the development of effective local and general anaesthetics, effective anti-psychotic medication, effective treatments for malaria and other serious infectious diseases as well as the safe and effective remedies for everyday illness we obtain at our local pharmacy.

Compared to the benefits, the adverse consequences of inappropriate use or abuse of pharmaceutical products are relatively minor. However, action should be consistently taken and monitored to ensure that misuse is kept to the lowest possible levels, as the individual consequences of misuse can be severe.

Data on use of both prescription and over the counter (OTC) drugs in Australia are severely limited (Hurley et al 1988, Dawes 1994). The number of Pharmaceutical Benefit prescriptions per person in Australia has risen steadily over many years. In reviewing the information available, Dawes (1994, p. 26) concluded that 'it seems likely that Australians consume a large quantity of therapeutic drugs by world standards. Certainly the growth of prescription drugs use in Australia is greater than in the USA'. Nevertheless, Dawes concludes that while older people take more drugs than younger people, there is little evidence that the elderly as a group are taking vastly excessive quantities of drugs.

This report is concerned primarily with drugs which are abused. It is not appropriate to consider in detail all the issues related to the development, marketing, prescription and use of medications. Further information in this area is available from the publication of the House of Representatives Standing Committee on Consumer Affairs, 'Prescribed Health: A Report on the Prescription and Supply of Drugs'.

Submissions to the Task Force expressed a number of concerns in relation to pharmaceutical products. They fell into two broad categories:

- illicit use of pharmaceutical products, usually prescription drugs; and
- use of pharmaceutical products that is legitimate but perceived as inappropriate as a result of action by the user or the prescriber.

Pharmaceutical use and misuse are rarely considered in publications dealing with drug caused morbidity and mortality. For example, they are not discussed in the National Drug Strategy's recent authoritative report 'The Quantification of Drug Caused Mortality and Morbidity in Australia 1995'. However, there are certain specific issues which require attention if misuse is to be minimised. Many of these have been raised in the various submissions made to the Task Force. Concerns raised by medical, pharmaceutical and social agencies or organisations include the following:

- pharmacies being targets for break-ins or hold-ups by people in search of drugs;
- inappropriate administration of legal medications to children by parents unable to cope in other ways;
- travel sickness and antihistamine medication abuse by children;
- excessive use of laxatives;
- abuse of asthma sprays;
- abuse of non-medical aerosol sprays;
- excessive availability/use of paracetamol and similar pain-killers;
- conversion of medicines containing codeine to 'home-bake' heroin;
- gender differences in type and acceptability of drug misuse; and
- excessive use of minor tranquillisers (benzodiazepines).

The following suggestions were among those put forward as ways of minimising misuse:

- review of penalties for illicit use;
- review of drug controls under both poisons and pharmaceutical legislation;
- replacement of illegal supply with controlled legal supply and counselling in some situations;
- better media messages when drug issues are reported;
- education of doctors, pharmacists and health workers;

- effective public education programs; and

- drug screening in the work place.

All matters and proposals raised with the Task Force will be referred to relevant agencies for consideration. Only issues that are particularly salient in the context of a report on drug abuse or which were raised by several submissions will be discussed specifically.

6.8.2 CODEINE-CONTAINING ANALGESICS

Excessive demand for codeine-containing analgesics (i.e. demand other than that which can be explained by normal use) has been a problem in terms of both over-the-counter and prescription supplies. Strong action by the Pharmaceutical Council of Western Australia has largely controlled over-the-counter supplies of these products. Prescription supply remains a problem where the user is either directly dependent (possibly iatrogenic) or is obtaining supplies for conversion to 'home-bake' heroin. Possible controls on 'doctor shoppers' obtaining codeine this way are discussed in the section on prescription drugs. These controls have the potential to reduce the problem greatly.

6.8.3 ABUSE OF ANTIHISTAMINES

Concerns were expressed about the abuse of antihistamines by youth. If antihistamines are taken in excessive doses a toxic reaction (hallucinations or a 'trip') occurs which is transient but unsafe. Hospitalisation may occur but is not common enough to be an indicator of the true frequency of abuse and it is difficult to estimate the size of the abuse problem.

Antihistamines are widely consumed by the West Australian community, which seems particularly prone to allergy. The extent to which one prevents responsible consumption by many because of abuse by a few has to be considered. In recent years antihistamines with greatly diminished effects on the brain have been marketed. Thus there is a safe alternative to the older types of antihistamines which are subject to abuse.

The uncompounded preparations of the 'sedating' antihistamines could be returned to prescription-only status without restricting community access to satisfactory allergy medication.

These substances are also included in many products in association with other medicaments. The compounded products should retain over-the-counter status but should be kept under review to ensure abuse is minimal.

It is recommended that the older 'sedating' antihistamines be considered for re-scheduling in schedule 4 (prescription only). The Heath Department of Western Australia should prepare a submission to this effect.

6.8.4 AEROSOLS AND ASTHMA SPRAYS

Submissions proposed that bronchodilator (asthma) sprays were being abused and required tighter control. The need for these sprays to be used under medical supervision (on one hand) and to be readily available to those who need them (on the other) led to national debate at the highest level in recent years. The actual abuse potential is considered to be small and the adverse effects few. Given the danger to asthmatics if they are not available in acute illness, no change to the control of asthma sprays can be supported on the basis of non-medical use.

Abuse of other aerosols is considered in the section on volatile substance abuse.

6.8.5 ANALGESIC ABUSE

In one submission and at several public hearings, it was argued strongly that paracetamol was being significantly over-used and concern was raised at the toxicity of paracetamol in acute over-dosage. The risk of this must be assessed using the information available on acute toxicity and balanced against the therapeutic benefit to the community.

Paracetamol is a well-tolerated, effective analgesic and anti-pyretic (relieves pain and lowers temperature). It is widely available, in small packs from stores and in larger packs from pharmacies. It is widely consumed by people of all ages without evidence of significant morbidity. Surveys suggest that 35-40% of the adult population has used an analgesic in the preceding two weeks.

Doses of 10 g (20 tablets) of paracetamol or more have a capacity to overwhelm the liver's metabolism with this substance, leading to irreversible liver damage and consequently death. The phenomenon is now well understood and an effective antidote is readily available.

Accidental poisoning with paracetamol is most common in children. In Western Australia during 1984-88 the rate of hospitalisation in children 0-5 was 177 per 100,000 person years of which 8.4% was due to paracetamol. Data collected by the Child Accident Prevention Foundation in Western Australia indicates that well over half the paracetamol poisonings are likely to be due to liquid preparations (pharmacy sales only).

Examination of coronial data from 1988-91 indicated there were about four deaths in the four-year period attributable to paracetamol, of which three were attributed to accidental cause and one was suicide. No children were involved.

The evidence suggesting that significant paracetamol misuse is occurring and leading to substantial illness is weak. Furthermore, it does not support restriction to pharmacy-only sales as being an effective intervention to prevent poisoning.

On balance, the further restriction of paracetamol is not supported by the data and would place Western Australia out of step with other States. Restriction could lead to increased consumption of less safe alternatives. However, education programs and information through pharmacists and other media should advise people about appropriate levels of use, stressing that while safe at normal dosage, an excessive single intake can be fatal or cause permanent injury.

6.8.6 PRESCRIBING PRACTICES

The Task Force was made aware of concern in the community about inappropriate or over-prescription of prescription medication, particularly psychotropic substances such as antidepressants or minor tranquillisers.

People expressing these concerns felt that non-drug alternatives were not adequately promoted. In some cases this was thought to reflect patient expectations that a prescription would be written and a parallel concern that a prescription tends to close the consultation for both patient and doctor. Concerns were further expressed that neither doctors not pharmacists provided adequate information on any potential adverse effects of drugs prescribed.

Data supporting these concerns is limited. However, there can be no doubt that Australia has passed through an epidemic of minor tranquilliser use which has had substantial morbidity associated with it. It is heartening to see that the use of benzodiazepine tranquillisers continues to fall, viz, from 10.6 million prescriptions in 1990 to 8.7 million in 1993 (Mant and McManus 1994).

The Health Department of Western Australia has run a campaign highlighting the non-drug alternatives to prescribing psychotropic medication. This campaign was well evaluated but limited funding has prevented a more intensive effort in this area. The Commonwealth's initiatives through PHARM and the more recently formed Australian Pharmaceutical Advisory Council (APAC) are also worthwhile initiatives. It remains to be seen whether these bodies will be resourced sufficiently to make a real impact in this important area. Their profile at a local level is low to non-existent. It is recommended that further information regarding education programs on prescribing practices be developed by the relevant government departments and professional organisations. These should include a focus on specific high-risk groups.

6.8.7 ATTENTION DEFICIT DISORDER

Many submissions raised concerns with the Task Force about matters relating to Attention Deficit Disorder and the prescription of Ritalin and Dexamphetamine. Most (including submissions from groups such as the Health Consumers Council) were concerned about a trend they perceived towards the over-identification of Attention Deficit Disorder and the over-prescription of these drugs, although some took a contrary view.

The Task Force recognises the sincerity of the differing views held on this complex issue. We note that the Government is establishing a working party to consider matters relating to Attention Deficit Disorder, and therefore, make no specific further recommendations on this issue.

6.8.8 DIVERSION OF LICIT DRUGS OF DEPENDENCE FOR ILLICIT PURPOSES

In 1986 Western Australia established a fully computerised prescription tracking system for all Schedule 8 (drugs of dependence) prescriptions written in Western Australia (the Monitoring of Drugs of Dependence System, MODDS). This computer system monitors every prescription written for any S8 drug and provides early warnings of patients receiving significant amounts of these drugs without appropriate authorisation. Patients with a disease causing chronic pain and needing constant treatment with these drugs (such as cancer) are flagged in the system which then ignores their drug use. Other patients, who may be visiting several doctors or be under treatment by the Alcohol and Drug Authority or other treatment agencies for drug dependence cannot obtain prescriptions without it coming to the attention of the Health Department. The Health Department can then advise the medical practitioners treating the person that they are under treatment elsewhere. This allows early intervention in what otherwise may become accelerating drug use. This has been very effective in diverting people at risk to early treatment and supporting them in their treatment therapy. It is not intended to be punitive on patients in any way.

The system also greatly helps in assisting doctors to 'say no', as they might otherwise be convinced or cajoled that they should write a prescription. Generally medical practitioners under pressure are relieved to be able to point to the scrutiny of the Department as a reason not to prescribe for some difficult patients.

MODDS has been extremely successful in controlling drugs of dependence in Western Australia. However, it is restricted in scope. Monitoring of prescription drugs such as benzodiazepines is beyond the scope of the system simply because of the volume of prescriptions and the relatively low potential for harm compared to the opiates. Monitoring of the benzodiazepine tranquillisers is best done through the Pharmaceutical Benefits Scheme and a discussion on action by the Commonwealth in that regard is set out in Volume II of the report.

6.8.9 DOCTOR SHOPPING

Various groups were perturbed about the activity known as 'doctor shopping'. As privacy legislation prevents access to information by anyone outside the Health Insurance Commission, action must be taken by the Health Insurance Commission to minimise 'doctor shopping' for both health and financial reasons.

Concern was expressed by pharmacists and others about the diversion of tablets containing paracetamol 500 mg, codeine phosphate 30 mg into home-bake heroin production. Doctor shoppers obtain substantial amounts of these products, far more than an individual could consume legitimately. Together with the benzodiazepine tranquillisers, these are the substances most commonly requested by doctor shoppers.

Action has been slow to occur, although recently the Health Insurance Commission in Western Australia has developed a series of graduated responses to doctor shopping. As a last resort, prosecution under Commonwealth legislation can be taken and Medicare privileges could be revoked. Very recently a prosecution under the Crimes Act was taken for doctor shopping practices, but no revocation of Medicare privileges has ever occurred.

The graduated response has seemed to be the best option for the management of doctor shopping. The Health Insurance Commission is to be commended for its activity in this area, which is a first in Australia.

It is recommended that the Health Commission continue to pursue doctor shoppers using the graduated response developed by them.

Organisations such as the Alcohol and Drug Authority and professional groups have also considered this issue in the past. It is recommended that a joint working group of the Health Department and the AMA be convened to consider further approaches that might be appropriate at the professional level.

6.8.10 PROFESSIONAL EDUCATION

Most drug education which doctors and pharmacists receive is provided by the pharmaceutical company marketing the drug.

New drugs are particularly expensive and are promoted very heavily, regardless of whether they represent a real advance in therapy. As the Commonwealth meets most of the cost of the Pharmaceutical Benefits Scheme, responsibility for rational prescribing based on sound professional education must lie with the Commonwealth. The Commonwealth manages the Adverse Drug Reaction Reporting System, has set up mechanisms to do this (PHARM and APAC) and has established a Drug Utilisation Sub-Committee of the Pharmaceutical Benefits

Advisory Committee which monitors drug use once marketing approval has been granted. The Commonwealth continues to publish the Australian Prescriber which is a quarterly journal on therapeutics. It also runs occasional campaigns directed at professionals or the community on proper drug use. In addition, the Medical Journal of Australia carries much valuable information on drug prescribing to doctors.

The State has three key sources of information for professionals. First, the drug information services in each of the larger hospitals, which can provide detailed information to doctors on particular drugs or drug-disease questions they may have. Second, the Poisons Information Service provided from the Princess Margaret Hospital for Children provides valuable information on poisonings, be they from drugs, plants, household chemicals or even spiders and snakes. The State also provides information to professionals and the public via the Alcohol and Drug Information Service, a telephone service for anyone who has questions about drugs, particularly in relation to their abuse.

There is a need to co-ordinate Commonwealth and State activity to ensure a comprehensive rather than piecemeal approach is taken in educating and informing doctors, pharmacists, other health professionals and the community about prescription and over-the-counter drugs. A summary of the Commonwealth's initiatives has been prepared in the 'Medicines in Australia Information Handbook' available from the Pharmaceutical Benefits Scheme Information Service.

6.8.11 PUBLIC EDUCATION AND INFORMATION

Greater public education on the use of pharmaceuticals becomes more urgent as both use and users' expectations increase. The Commonwealth for its part, is moving towards approved Consumer Product Information leaflets (CPIs) which are intended to be supplied by the pharmacist when a prescription drug is dispensed. This system has been implemented in the United Kingdom with great success and is being developed in Australia. This overcomes the problem of the patient having to absorb oral information in a doctor's surgery (an unfamiliar environment) in restricted time and often when the patient is not well. Unfortunately, CPIs do not seem to have had much (if any) impact; any barriers to their distribution should be identified and addressed to ensure the CPI is received by the patient.

Education on prescription and over-the-counter drugs in adult life is often too late. People have become accustomed to taking medicines and seeing others in school or work situations doing so. Peer pressure against at-school use of pharmaceuticals is often a very important impediment to correct medication, for example in asthmatics. Appropriate education is critical for school children, to meet both their immediate and long-term needs. School health education on drugs should have a significant section devoted to pharmaceuticals, both prescription and over-the-counter. The syllabus should educate on both the benefits and risks of drug-taking. Special education programs should also be directed to groups at higher risk or where innovative strategies may be appropriate, such as the elderly and Aboriginal people. It is recommended that this area be incorporated into school health education for all students, and that the Health Department develop proposals for targeted public education programs.

6.8.12 PHARMACISTS' ROLE IN DRUG EDUCATION

Pharmacists are very readily available to provide information at low cost to the community. It is incumbent upon pharmacists as professionals to be proactive in communicating effectively with the public about the medicines they take. They have been, and continue to be, key sources of public information and the profession is keen to maintain the image of pharmacists as an authoritative and readily available source of information. It is important that pharmacists and their professional organisations be seen as active and essential participants in any public education and information activity on drug issues.

6.8.13 LABELLING ISSUES

One of the most critical source of information for the public is the label on the medicine received. Apart from standard directions, medicines frequently have additional warning labels about the time the medicine is to be taken, its interaction with alcohol, effects on driving or other motor skills and several others.

Some years ago, the Health Department of Western Australia initiated a campaign using a red triangular symbol, the same as that used in Europe, to provide a more readily recognisable warning about driving or operating machinery in conjunction with taking drugs likely to impair motor co-ordination or cause drowsiness. Unfortunately, despite the fact that the red triangle now appears on labels throughout Australia, the campaign to associate it with harm has not been picked up by other States or by the Commonwealth.

The lack of supportive education indicates a failure to recognise that reading medicine labels requires good comprehension and effort, and may be beyond the ability of many members of the public. Much of the information provided on labels may be scientifically or technically accurate, but is presented in language and format that could almost have been designed to deter any but the most literate and determined readers.

The recent labels on tobacco products are a good example of effective communication. The information provided is scientifically valid, but has also been carefully researched to ensure that it is well understood by consumers.

Consideration should be given to reviewing and simplifying, using symbols where necessary, the current information provided with pharmaceutical products and the warning Statements added to medicines by pharmacists.

The changes, when they occur, would require a campaign to ensure the new labels were drawn to the public's attention and correctly interpreted.

It is recommended that the Commonwealth commission comprehensive evaluations of the present information provided with pharmaceutical products and the additional warning labels used by pharmacists to ensure that they are understood and to make recommendations for change when they are not.

6.9 PERFORMANCE-ENHANCING DRUGS

6.9.1 DRUGS IN SPORT

The use of performance-enhancing drugs in sport has been investigated on a number of occasions. As a result of concerns expressed both in sporting circles and in the wider community, a number of controls have been set in place to monitor and minimise the use of performance-enhancing drugs in sport.

It is appropriate for the Task Force to review the use of performance-enhancing drugs in sport separately because it is both a symptom of the more widespread use of drugs in society, and, if current trends are not contained, will contribute further to the normalisation of illicit drug use and intravenous drug use.

The Ministry of Sport and Recreation expressed the view to the Task Force that a comprehensive report in this area should make some mention of drugs in sport and noted that the issue is increasingly attracting media attention and public discussion. Information provided by the Ministry includes the following:

- Performance-enhancing drugs are banned from sport for legal, ethical and health reasons. A list of banned substances has been developed by the International Olympic Committee. The main classes of banned substances are anabolic steroids, stimulants, narcotic analgesics, diuretics and peptide hormones. The use of alcohol, cannabis, beta blockers, corticosteroids or local anaesthetics is subject to certain restrictions.

- The Commonwealth Government legislated through the Australian Sports Drug Agency Act in 1990 to establish the Australian Sports Drug Agency (ASDA) in 1991.

- The Ministry of Sport and Recreation is not aware of any specific estimates of the use of performance-enhancing drugs by elite athletes in Western Australia or in other States.

- ASDA, however, conducts annual surveys of elite Australian athletes who are subject to drug testing. Results from these surveys, the percentage of positive results obtained by the ASDA, and the attitudes of elite sports people assessed in an ASDA report indicate that elite sports people agree that drug taking is cheating and not acceptable.

- ASDA achieves its aims through drug testing and education programs and is seen as having been effective in addressing the various harms associated with drug use in sport.

- Western Australian athletes at national and international level are subject to ASDA competition and out-of-competition testing programs. Approximately 10% of ASDA's 2,800 tests are conducted in Western Australia annually. ASDA conducts testing in approximately 50 sports across Australia, including professional leagues.

- The incidence of positive tests obtained by ASDA is approximately 2%.

- Education programs implemented by ASDA are sport and school-based, and aimed at coaches, medical staff and national or international level athletes. They provide information on banned/permitted substances and drug testing procedures.

  The school-based programs target a wider group but the resources on which the programs are based are not widely distributed in Western Australia.

- Under the ASDA Act 1990, ASDA is not able to drug test athletes competing at State or lower levels of competition. The Western Australian Sporting Association and the Western Australia Institute of Sport support the position that drug testing for State-level competitors should occur.

- The Sport and Recreation Ministers Council agreed at its July 1994 meeting on the need to develop a national response to the use of drugs in sport. It is intended to cover education and policy issues as well as the testing of athletes.

- The Western Australia Minister for Sport is currently investigating the possibility of proceeding to draft legislation complementary to the ASDA Act 1990 which will allow the testing and education of State-level competitors. The Ministry notes that to support testing, education programs should be available to athletes, coaches, administrators and parents to provide information on the ethical, health and legal reasons for banning performance-enhancing drugs, and that it would be desirable to create a climate of willing rather than reluctant compliance.

- Before the establishment of the Australian Sports Drugs Agency, drug testing programs in Western Australia were organised under the auspices of the Western Australia Institute of Sport.

- Despite the efforts of ASDA, there must be some concern as to whether drug testing programs currently penetrate to the extent that would be desirable.

  - Only certain elite athletes are tested.

  - Many young and other athletes who may still risk the use of performance-enhancing drugs are neither tested nor are likely to be tested.

  - There is very little if any testing in normal sporting activity.

  - There are various means by which athletes can avoid testing.

  - Arrangements in place with other countries are not believed adequate to enable appropriate testing to occur when athletes are overseas.

- There must be cause for concern that absence of a comprehensive testing program in Western Australia or a program directed towards any other than certain specific elite athletes will lead to a laissez-faire approach to performance-enhancing drugs. There would seem to be a prima facie case for the establishment of procedures enabling testing to occur not only at the elite level, but at lower levels of sport in Western Australia. Such programs could be conducted either by the ASDA or (whether independently or on behalf of the ASDA) by bodies such as the Western Australia Institute of Sport.

In relation to drugs in sport, it may be concluded that:

- Western Australia, like all countries with elite and aspirant-elite sports people, must recognise the reality that some of these sports people and their coaches will seek to use and encourage use of performance-enhancing drugs.

- All the major sporting bodies and authorities have set in place a firm policy opposing the use of performance-enhancing drugs in sport for health and other reasons.

- Western Australia is part of a comprehensive national program to test, monitor and oppose performance-enhancing drugs in sport.

- Further action to consolidate the above position could include:

  - legislation to allow the testing of State-level competitors;

  - investigation by the Ministry of Sport and Recreation of the potential for a Western Australia-based testing program directed to sports people other than elite athletes;

  - education programs directed towards sports people;

  - school drug and sports education programs that include information and resources on the damage to health that can occur as a result of using performance-enhancing drugs;

  - education programs addressed to performers, coaches, administrators and parents to be developed by the Ministry of Sport and Recreation or relevant sporting organisation; and

  - assistance to be sought from the media in continuing to portray the users of performance-enhancing drugs in a negative light, so that they do not become role models for young sports people.

6.9.2 BODY BUILDING DRUGS

While the use of performance-enhancing drugs among elite sports people is subject to continued monitoring and controls, there is perhaps cause for more immediate concern about the extent of use of some of these products, particularly anabolic steroids, well beyond the recognised sporting community.

- The Ministry of Sport and Recreation notes that anecdotal evidence suggests that anabolic steroids are used for body image purposes by sectors of the gym industry, body builders and male adolescents.

- Western Australia, like most Australian States and Territories, has legislated to prohibit the supply of anabolic steroids.

- It is clear, however, from the anecdotal and limited survey evidence available that the current legislation is at best only partially effective.

- A recent survey of Western Australian gymnasium users showed that 16% of **those who responded** used anabolic steroids. Users reported substantial adverse effects, as well as perceived benefits (Chee et al 1995).

- Although the survey of drug use among Perth metropolitan school students reported in Volume II shows only relatively small numbers of students using steroids, it should be a matter of considerable concern that even approximately 1% of high school students claim to be current users of steroids, and most of these are frequent users.

The focus of the Ministry of Sport and Recreation is primarily on the use of performance-enhancing drugs by sports people, rather than by those who use such drugs for image or ‘cosmetic’ purposes. It may indeed be open to question as to whether such use is not primarily a concern of agencies such as the Police and Health departments.

Regulations have been introduced to specify anabolic steroids in the Misuse of Drugs Act, with the consequence that major responsibility for their control rests with the Police Department.

6.9.3 VETERINARY SUPPLIES

Anabolic steroids are widely used in veterinary medicine, unlike human medicine and many of the seizures of anabolic steroids in Western Australia have been of veterinary origin.

The Veterinary Surgeons Act is being amended and the strengthening of some sections of this Act may assist in reducing availability through veterinary surgeons.

Interstate wholesale traffic is difficult to control. Comprehensive controls in movements of these drugs would be very resource intensive. Nevertheless, it may be possible to establish strategic checks which would reduce diversion. Health authorities should work with veterinary wholesalers and Departments of Agriculture on this issue, which requires a national approach.

6.9.4 HEALTH RISKS AND SHARING NEEDLES

Needle sharing puts the user at risk of HIV, Hepatitis B and Hepatitis C, all of which carry substantial health risks.

While needle sharing is not a common feature of anabolic steroid use, it may occur under some circumstances.

This group of potential needle sharers has not been the subject of intense campaigning as to the risks that other needle using groups have been; they are possibly less conscious of the danger involved. It is vital that this issue be recognised and the subject of educational action by sporting and other relevant authorities.

6.9.5 ENFORCEMENT

Enforcement of the Poison Act by pharmaceutical inspectors in health agencies can control the diversion of illicit use of medical supplies of anabolic steroids from pharmacists and pharmaceutical wholesalers. They cannot control use in gyms for several reasons:

- they have no power of entry and search;
- they cannot mount undercover operations; and
- they are not likely to be able to manage the dangerous situations they may find themselves in.

Nevertheless, more could be done by more intensively visiting and scrutinising records of the veterinary wholesalers. This would require:

- application of a higher level of resources; and
- information on interstate movements of veterinary anabolic steroids.

There has in the past been little emphasis on enforcement by police throughout Australia. Police in Western Australia have done at least as much as those elsewhere in Australia, but the outcomes are few; anabolic steroids seem to be being traded illegally with impunity, despite the penalties being as high as those for heroin or cannabis use.

The key to controlling anabolic steroids use would appear to be comprehensive enforcement. This would require 'inside information' and an integrated approach between customs, police, health and sports agencies. A small number of prosecutions would have an effect on supply and price. Given the existence of other priorities, it is recommended that at least on an occasional basis, anabolic steroids trafficking should be 'blitzed'.

6.9.6 USE OF ANABOLIC STEROIDS BY 'BOUNCERS'

The nature of the work means that security guards (bouncers) at nightclubs and smaller events are potential users of anabolic steroids. The Task Force heard of bouncers using steroids to 'pump themselves up' before events which are likely to be particularly 'heavy'. This is disturbing because of the profound effects of anabolic steroids on mood. They are well described as causing aggression and occasional 'uncharacteristic' and uncontrollable violent acts, even leading to homicide.

The State Government has taken action to control the behaviour of bouncers. Legislation is currently proceeding through Parliament that will require bouncers to be registered, enable random urine or blood testing for drug abuse, and provide for deregistration if steroids are used. It is to be hoped that the effect will be to prevent or minimise future violence of this kind.

6.9.7 LICENSING GYMS

It has been argued that gyms should be licensed in order that those in which anabolic steroid traffic occurs can have their licences revoked, after due process. A system of 'demerit points' could be used to provide a graduated approach.

Gym licensing has been considered in the past but has found little favour. Nevertheless, the data shows that there is a substantial percentage of anabolic steroid use in gyms so this strategy should not be dismissed. The degree to which the gym operator should be held accountable for the action of a third party on the gym premises is clearly a vexatious one.

This strategy is not recommended for the present, but may require further consideration if other means of control do not prove effective.

6.9.8 EDUCATION

A recent University of Western Australia survey of gym users showed that the users knew more about anabolic steroids than most doctors or pharmacists would know. Clearly information provision alone is not enough. While education as to long-term dangers should be undertaken, it is unlikely to be the key strategy in any comprehensive campaign, simply because the coach and peer influence is too strong. This is why the enforcement strategy is critical.

6.9.9 ROLE MODELS

As has been outlined above, elite sports participants are comprehensively screened. In the public health realm, elite athletes are significant as role models. Their opposition to anabolic steroid use (for example, the statements of Kieran Perkins) is extremely valuable in the sporting world.

The impact of such statements is reduced, however, in a gym focused on body building, which is not a 'sport' at all by some standards since the use is purely for cosmetic reasons (to look 'good' without having to weight train too extensively). Unfortunately, the converse does not seem to apply: a 'super athlete' found to be using steroids tends to be used to justify use by this group.

6.9.10 ACTION ON ANABOLIC STEROIDS

The drive by sporting authorities to reduce and ideally eliminate performance-enhancing drugs in sport is admirable and should be encouraged. It should, however, be matched by moves from all relevant agencies to discourage the use of performance-enhancing drugs for body building, image and 'cosmetic' purposes: this practice is likely to affect substantially larger numbers of people, is subject to few if any organisational controls, and can cause substantial long-term damage to the health of users.

A sub-committee report to the National Drug Strategy Committee has developed some proposals about the use of anabolic steroids by the community. The Task Force was advised by the relevant officer at the Department of Community Services and Health as follows:

- A draft paper has been presented to the National Drug Strategy Committee.
- There was support in principle for action on anabolic steroids.
- The draft paper proposed a focus on school activity.
- The National Drug Strategy preferred the emphasis to be more directly placed on body builders who are most likely to use anabolic steroids in the immediate future.
- A further paper was to be prepared.

This is clearly an area in which further information and research are required. Nevertheless, and while noting the need for caution, a State program should be developed as a matter of some immediacy. The program should be based on good information, careful planning and pragmatic proposals for action that can be implemented in the near future. It is important that any action recognise that this practice is in large part a law enforcement problem rather than one to be resolved by sports authorities.

Components of a program might include:

- further research to elucidate the extent of use of performance-enhancing drugs in the community;
- investigation into the modes of supply of performance-enhancing drugs;

- education programs directed towards gyms, adolescents and sporting clubs;

- inclusion in school drug education programs components on performance-enhancing drugs; and

- a focus by the Police Department on law enforcement strategies, including periodic blitzes on trafficking and consideration of legislative amendments, should this be necessary.

A State strategy should clearly seek to complement any national strategies. The State strategy should, however, be developed as a matter of immediacy rather than as part of the implementation of national strategies which may yet take some considerable time.

To develop and implement a State strategy on performance-enhancing drugs, we recommend the following:

- Action on performance-enhancing drugs by elite athletes should continue to be monitored and controlled by the Ministry of Sport and Recreation and sporting organisations such as the ASDA.

- A new program of action to reduce use of performance-enhancing drugs for image, body building and cosmetic purposes should be developed under the auspices of the State's Drug Control Strategy. This should be led by the Police Department, with support from the Ministry of Sport and Recreation and the Health Department, and in co-operation with the relevant non-government organisations.

- The Health Department and Ministry of Sport and Recreation should develop specific education and information programs, including the involvement of general practitioners.

6.10 HIV/AIDS AND OTHER BLOOD BORNE VIRUSES

The already complex field of drug abuse has been further complicated by the advent of HIV/AIDS, and more recently concerns about increases in Hepatitis C in the community. We present in Volume II of this report data on HIV in relation to drug abuse. It would clearly be inappropriate for this report to seek to re-visit the entire area of HIV/AIDS, which has been so comprehensively addressed in other forums. It is, however, inevitable that there will be some overlap between programs on drug abuse and HIV, as well as some different policy perspectives and priorities on which it will be necessary to reach effective and pragmatic resolutions. It is particularly important that those responsible for policy on HIV and drug abuse issues work closely together and co-ordinate their efforts.

We stress throughout this report that there are many areas where an ‘either ... or’ approach is not appropriate. Nowhere is this more evident than in the area of HIV/AIDS and drug abuse. We believe that there is no inconsistency between overall policy objectives specifying both minimum possible levels of drug abuse and rational harm reduction. In an ideal world, it could be argued, total abstinence from drugs would result in a significant reduction in the risks of HIV/AIDS and Hepatitis C. The reality, however, is that while intravenous drug use continues, it will be necessary to combine abstinence messages with appropriate messages to ensure that the risks of HIV/AIDS and Hepatitis C are minimised for both users and those with whom they come into contact.

Among submissions received by the Task Force, those from the Health Department's Injecting Drug Use (IDU) Implementation Working Group and the Western Australian AIDS Council set out a range of proposals in relation to HIV and IDU. These and other submissions noted that Western Australia has very low rates of HIV among injecting drug users (IDUs) but that continuing action is necessary to ensure that we do not experience the same rapid spread of HIV that has occurred in other countries. With this in mind, the Task Force's approach encompasses continuation and further development of the services currently provided to IDUs by health and other agencies, in the context of the clear policy objective that illicit drug use should be actively discouraged.

Noting, therefore, that HIV/AIDS policy is essentially the domain of other groups, we recommend that:

- There should be regular and frequent liaison between those responsible for drug abuse policy and programs and the HIV/AIDS, Hepatitis C and other relevant bodies.

- Within the context of the broad policy on drug abuse proposed in this report, there should be a continuing focus on work with IDUs to ensure that those who continue to inject drugs do so with a minimum possible risk to both themselves and others.

- The programs for IDUs should include:

  - Access to sterile injecting equipment which is affordable and accessible.
  - Education programs which should be both general and specifically targeted.
  - Continuing dissemination of information.
  - Education programs for relevant health workers and others about the importance of rational harm reduction within the context of a drug abuse control program.

- Those responsible for HIV/AIDS education programs should ensure that they incorporate as far as is pragmatically possible messages about the desirability of non-use, as well as harm reduction. One example could be in re-design of the 'fitpack' labels and similar communication strategies. The current 'fitpack' label includes much useful information, but no explicit message to the effect that intravenous drug use is harmful to health and should be avoided. If cigarette packs can now carry a primary message that 'SMOKING KILLS', it would seem appropriate that similar messages be provided on packages for equipment provided to intravenous drug users.

6.11 ABORIGINAL COMMUNITY ISSUES

6.11.1 THE PROBLEM(S)

Any discussion of drug use and Aboriginal people must recognise the additional complexities that the experience of Aboriginal people adds to an already complex area. Many of the issues for Aboriginal people are the same as those for the wider community. Aboriginal people, however, are so disadvantaged in so many significant areas that they should benefit from additional supports and programs. These should, as a matter of course, be developed in consultation with Aboriginal people and organisations.

The most obvious disadvantage faced by Aboriginal people is that the expectation of life at birth for an Aboriginal person is still some 18 years less than that of his or her non-Aboriginal counterpart. The situation is almost paradoxical:

- Aboriginal people are dying younger because of 'lifestyle' diseases caused by behaviours such as smoking and alcohol abuse; so

- many Aboriginal people do not live to the ages at which some of the consequences of longer term drug abuse take their full toll.

Many reports have examined aspects of drug use among Aboriginal people, but the major focus has been on alcohol problems. The report of the Royal Commission into Aboriginal Deaths in Custody (1991) focused particularly on problems arising from alcohol abuse and, measures that could lead to the prevention of such abuse, as well as appropriate treatment and other responses.

The report of the Task Force on Aboriginal Social Justice (1994) noted that, 'while concern has been expressed about drug use among Aboriginal people, such evidence as is available indicates that Aboriginal people are no more prone to use of illegal drugs than the wider community. In urban settings, young Aboriginal people particularly may be at-risk in the same manner as their non-Aboriginal peers. Given the lack of access to and limited use of conventional health services by many Aboriginal people, it may be assumed (in the absence of good evidence) that illicit use of pharmaceutical products currently poses less of a problem among Aboriginal people than elsewhere in the community'.

The only study in Western Australia on prevalence of drug use other than alcohol which reported by race was a Perth study which found that drug use per se was not more prevalent among Aboriginal youths than their non-Aboriginal counterparts, but that those who do use drugs tend to start earlier and use drugs more frequently.

The Task Force was made aware that some Aboriginal and non-Aboriginal people are perturbed about various forms of illicit drug abuse among Aboriginal people. These reports merit serious attention by the relevant Aboriginal and other organisations, but it is important not to take them out of context: such concerns were also expressed about non-Aboriginal communities.

As the Task Force on Aboriginal Social Justice noted, the term 'substance abuse' is generally used to cover the problems arising from glue sniffing, volatile substance abuse and related behaviours. There is a substantial

literature on ‘substance abuse’, which has been a matter of especial concern for Aboriginal people, and on which a significant amount of work has been undertaken both at the State level and nationally. Treatment and services for substance abusers are addressed in the relevant sections of the report. It is, however, worth noting that a little publicised but positive development of recent years has been the move by many Aboriginal communities to use aviation fuel; this has led to a significant decline in the extent of petrol sniffing which was previously a matter of major concern. Substance abuse such as glue sniffing is still a matter of concern, particularly in specific locations. For Aboriginal substance abusers, as for others, most substance abuse appears to be a rite of passage. The hard core of substance abusers, which has been variously estimated and is likely to number between 50-100 non-Aboriginal and Aboriginal youths, will require special attention.

The two drugs most used by Aboriginal people — as by others in the community — are alcohol and tobacco. The survey of Perth metropolitan schools students reported in Volume II shows no significant differences in any forms of illicit or licit drug use between Aboriginal and non-Aboriginal students. In country areas, however, the trends appear to be different: Aboriginal people, for example, are far more likely to be smokers.

Further, as the Task Force on Aboriginal Social Justice noted, ‘there is an overwhelming recognition of the fundamental nature of problems caused to Aboriginal communities by alcohol abuse. There are few issues on which the consensus is so strong ... as with the general population, the problem for Aboriginal people is one of misuse, rather than one of use ...’

The theme that recurs, however, is that while alcohol misuse causes an almost immeasurable degree of damage to the Aboriginal community, it is wrong to create a stereotype of Aboriginal people as being more prone to excessive drinking than the rest of the community. A greater proportion of Aboriginal than non-Aboriginal people are non-drinkers, the problems arise as the result of those who do drink — and drink to excess.

6.11.2 CURRENT AND PROPOSED ACTION ON ALCOHOL

Following analysis of Aboriginal alcohol issues, the Task Force on Aboriginal Social Justice recommended that:

> A reduction of alcohol related problems should be one of the highest priorities for the State's Aboriginal affairs strategy.
>
> There is a need for a comprehensive program to address the problems of excessive alcohol consumption among Aboriginal people. This program should comprise: information and planning; treatment/immediate response; education; control measures; and support components. The issue is of such importance that there should be a State Aboriginal alcohol program ... under the auspices of the Health Department that aims to engage the co-operation of all sectors of the community in reducing the harm associated with excessive alcohol consumption among Aboriginal people. The program should seek maximum co-operation not only from the Aboriginal community, but also from groups such as the drinks industry.

The Task Force made a further 22 recommendations on alcohol issues on relation to Aboriginal people. These were intended to complement the recommendations of the Royal Commission into Aboriginal Deaths in Custody. The Health Department and the Aboriginal Affairs Department (in association with other Aboriginal and non-Aboriginal groups) have taken significant action to ensure implementation of the Task Forces recommendations. In particular, it may be noted that a State Aboriginal alcohol program, entitled ‘Living with Alcohol’, has been established. This entailed 17 regional Aboriginal alcohol conferences which preceded a State ‘Living with Alcohol’ summit, where Aboriginal people agreed on action that should be taken.

This report endorses the approach taken by the Aboriginal Alcohol Summit, and in particular recommends further development of:

- a major educational program directed at alcohol abuse among Aboriginal people;
- the further development of community patrols, sobering-up shelters, outreach programs, access to detoxification services, and rehabilitative opportunities;
- co-operation with the liquor industry to enforce legislation, promote lower alcohol products, develop server responsibility and encourage those who drink to drink moderately;
- appropriate use of liquor licensing legislation;

- involvement of communities in licensing issues; and

- co-operation between Aboriginal organisations and the police services.

The approach taken by the 'Living with Alcohol' summit is consistent not only with the literature on damage caused to Aboriginal communities by alcohol abuse, but also with some innovative work carried out by The University of Western Australia's Department of General Practice in collaboration with Aboriginal Medical Services. This study looked not only at those who drink, but also at the process of 'learning from non-drinkers'.

It is noted that the Aboriginal Affairs Department estimated that it allocated $177,000 to alcohol and drug activities during the last year; this complements the expenditure noted in Volume II by agencies such as ATSIC and other government and non-government organisations. The estimates provided may be significant underestimates, as many Aboriginal organisations engage in activity designed to reduce alcohol abuse that is voluntary or cannot be quantified: the largely voluntary community patrols are an outstanding example of such activity. The recent contributions by ATSIC to major service developments are welcomed and regarded as appropriate.

6.11.3 TOBACCO

With respect to tobacco, the Task Force on Aboriginal Social Justice noted that, 'while cigarette smoking is declining in the Australian community as a whole, all the evidence available indicates that Aboriginal people have been largely excluded from successful community campaigns. Aboriginal people smoke at approximately the same level as those common in developed countries after the Second World War, before the evidence indicting smoking as a major cause of premature deaths and disease had either been discovered or publicised.'

Some initiatives on tobacco have been developed by the Health Department, ATSIC, and other government and non-government organisations. Given that surveys show smoking in Aboriginal communities at levels as high as 70%, and that much of the premature Aboriginal mortality can now be attributed to factors such as smoking, there is a need for an increasing sense of urgency in Aboriginal communities and health services to ensure that Aboriginal people receive the same benefits from a reduction in smoking that have been felt by the wider community.

The Health Department's report 'The Impact of Tobacco Smoking and Alcohol Consumption on Aboriginal Mortality in Hospitalisation in Western Australia: 1983-1991' concludes that, 'if death rates for tobacco and alcohol-caused conditions had not been higher for Aborigines than for non-Aborigines, 469 Aboriginal deaths would have been prevented during the nine year period 1983-1991 — an average of 52 lives each year (or one each week) ... If hospitalisation rates for tobacco and alcohol-caused conditions had not been half as large again for Aborigines as for non-Aborigines, 10,478 Aboriginal hospital admissions would have been avoided ... These extra admissions were responsible for the use of 65,347 hospital bed days, at an estimated cost of $38 million — an average of $4.2 million per year.'

6.11.4 PROPOSED DEVELOPMENTS

It is clear therefore that there is considerable urgency to act on a range of substance abuse issues involving Aboriginal people, that this urgency has been recognised in various quarters, but that the action taken must be within appropriate contexts and carefully planned and developed. Four major contexts to consider are:

- The broad range of programs being developed by government organisations to remedy the disadvantages faced by Aboriginal people. These have been co-ordinated in Western Australia by the Aboriginal Affairs Department.

- The general programs being undertaken by government and non-government organisations on alcohol and drug abuse.

- The views and activities of Aboriginal people and organisations.

- The special concerns and sensitivities that must attach to work with Aboriginal people, particularly the importance of effective consultation and communication with Aboriginal people.

We have noted at various stages in this report the need for special attention to be paid to Aboriginal concerns, issues and trends. The approach we support is based on that taken by both the Royal Commission into Aboriginal Deaths in Custody and the Task Force on Aboriginal Social Justice.

We therefore recommend:

- All organisations developing programs in alcohol and drug abuse seek to identify the special needs of Aboriginal people and to develop activities in these areas where appropriate.

- All programs developed in relation to Aboriginal alcohol and drug abuse should entail consultation with, and involvement of, Aboriginal people and organisations.

- There should be a further continuation of discrete programs developed for Aboriginal people within the context of an overall alcohol and drug strategy.

- Given the nature and history of alcohol abuse in relation to Aboriginal communities, this issue should be addressed specifically in and of itself. This approach is currently being taken by the Western Australia 'Living with Alcohol' program, which is being co-ordinated by the Health Department in association with Aboriginal organisations, and which we strongly support.

- The focus on tobacco use by Aboriginal people which has developed in recent years should be maintained and developed. As the life expectancy of Aboriginal people remains significantly below the community average, so tobacco will come to be seen as an increasing cause of mortality and morbidity. One of the predictable tragedies of the next century is that as smoking declines in the wider community, tens of thousands of Aboriginal people will die prematurely because they smoke. There may not as yet have been adequate recognition by Aboriginal communities and organisations of the importance of tobacco as a cause of death and disease. We recommend that as a matter of urgency, a major new program on tobacco in Aboriginal communities be developed under the auspices of the Health Department of Western Australia, in conjunction with other relevant organisations.

6.12 RESEARCH ISSUES

6.12.1 INTRODUCTION

Research must be a vital component of any program designed to reduce drug abuse. Research demonstrates, quantifies and monitors the damage caused by drug abuse; it is also necessary to ensure that the action being taken is effective and that new approaches are considered, piloted and evaluated. Those responsible for policy in any country must clearly be aware of and sensitive to the outcomes of national and international research.

The various aspects of drug abuse have been the subject of extensive international research, and as we note throughout this report we are fortunate to have had access not only to the international literature, but also to some authoritative and as yet unpublished literature reviews.

Western Australia is fortunate in that both in its academic institutions and elsewhere, a number of outstanding researchers are currently well placed to make a major contribution to developments both within the State and nationally.

The responses from universities to our survey of expenditure and activity showed a substantial degree of interest in drug issues. There is no doubt that a further, more detailed survey would show more activity underway than was initially reported to us. Several of the government agencies involved in drug issues also fund research activity or undertake such research themselves. Research on drug abuse issues occurs in a wide variety of settings and it is important to note that work in areas as diverse as crime research and general medical practice can contribute to the drug abuse control armamentarium.

After the establishment of the National Campaign Against Drug Abuse in 1985, there was a substantial injection of funds into research specifically on drug abuse issues. The most evident single benefit for Western Australia has been the establishment of the National Centre for Research into the Prevention of Drug Abuse at Curtin University and funding of major research projects, such as that on the quantification of drug caused mortality and morbidity at The University of Western Australia. The Centre, which is nationally funded, is bound to take a national rather than a State perspective in determining its priorities. Nonetheless, both the Centre as a whole and its staff as individuals have made a significant contribution within the State, and have established a strong record

on the basis of pragmatic and policy-oriented research agendas. Their work has placed a major emphasis on the prevention of alcohol abuse, but has also covered all other forms of drug abuse, together with attention to related issues such as HIV/AIDS. The breadth of the Centre's interests was reflected in its wide-ranging and comprehensive submission to this Task Force, and members of the Centre's staff were a valuable source of information and advice.

The National Campaign Against Drug Abuse also saw the establishment of the National Drug and Alcohol Research Centre at the University of New South Wales, with a focus on treatment issues. This Centre has been responsible for the Quality Assurance in the Treatment of Drug Dependence Project which, as discussed elsewhere in the report, has set the current benchmarks for best practice in drug abuse treatment in Australia. The Task Force was fortunate to be able to consult widely with the Centre and to have access to its latest work.

Local research efforts have been further complemented by the advent of funding sources such as the Healthway Research Program.

Areas in which specific research programs or projects would assist the State's programs are covered in relevant sections of the report. As our work is directed towards ensuring an effective drug abuse program for the State, rather than towards generating broad research agendas, we have placed a special focus on data collection and monitoring, and evaluation through outcome measurement and quality management processes.

The Task Force became aware of many areas in which research had been carried out, but was either not used or not even known to those carrying out relevant intervention programs. In some cases carefully targeted research to address a specific problem had been carried out in a local community where intervention programs were being run to address that specific problem — but without apparent knowledge of either the research or its conclusions. At a broader level, it is clear that the area of drug abuse is one in which the literature has developed substantially in recent years. In the treatment field, for example, where once little was known and it was perhaps necessary to proceed on the basis of faith and enthusiasm, there is now a sound basis of research on which to base programs.

In discussions with researchers in Western Australia, four broad themes relevant to research within the State emerged and are outlined below.

6.12.2 SUPPORT IN PRINCIPLE FOR CONTINUING RESEARCH

When finances are constrained, there is temptation to discard research, as it may not be seen as providing direct and immediate benefits. Research, however, is vital to ensuring that we know where to act, what to do, how to do it, how well we are doing it, and whether there are better ways of doing it. Support for research and evaluation should be built into our program. This report does not recommend a substantial increase of funds for research, as we believe that the level of funding for research on drug abuse is broadly satisfactory. We do, however, urge that those Federal and State bodies responsible for research on drug abuse maintain these levels, and continue to place a high emphasis on the importance of research.

6.12.3 PRIORITISING RESEARCH DEMANDS

We note in the section on tobacco that there is no benefit to be derived from research demonstrating yet again that, for example, smoking is the major cause of lung cancer. Research is most valuable when it is original and when it focuses on areas where action is feasible. There is an onus on researchers to tailor their work to the needs of the community; but there is also an onus on policy-makers and administrators to indicate where their priorities lie. For example, we know much about those who take up and use drugs, but far less about those who do not and the reasons for this. The proposed Central Drugs Co-ordinating Office (CDCO) should use the processes of consultation with researchers in Western Australia that are outlined below, and other formal mechanisms as appropriate, so as to ensure the best possible fit between the Government's requirements and the long-term as well as short-term research programs being developed.

6.12.4 CO-ORDINATION

As in other areas, co-ordination of research on drug abuse issues in Western Australia could be improved. When the Task Force organised a meeting of researchers to discuss possible future trends in drug abuse, it was clear that some researchers with common interests either had not met, or maintained only minimal contact. This is understandable, given the different disciplines and universities in which researchers work, as well as the many other contributions they make in individual capacities. It should be noted that there is good co-operation between some key researchers, and it would clearly be inappropriate to suggest a complex co-ordination structure. There are also national conferences and meetings within the State such as the annual Mandurah

Addiction Research Symposium which entail participation from some researchers, albeit with participation from other parts of the field also. In the final analysis, however, although much useful work is being carried out within the State, there are no good mechanisms for ensuring either that researchers and others are aware of its full extent, or that its results are widely disseminated. We therefore believe that it is appropriate to propose:

- A register of research relevant to drug abuse in Western Australia should be maintained. It should include so far as possible research conducted both at academic institutions and in government agencies. It should also include market research, as well as more academically oriented research.

- A Drug Abuse Research Forum should be organised twice annually, with the intention of bringing together all those who participate in research activity within Western Australia. This should not be a forum for service providers and others who simply have an interest in research, but for the researchers themselves to meet and discuss matters of common interest.

- The register and forum proposed above should require very simple organisation, which could be carried out by a part-time staff member with appropriate support at one of the Western Australian universities. We recommend that the proposed CDCO liaise with the relevant institutions to ensure that a suitable proposal is made to a grant-giving body such as Healthway to establish of a small secretariat for the Drug Abuse Research Forum for an initial three-year period.

- The CDCO should review funding provided by State government agencies on alcohol and drug issues to academic institutions, and develop appropriate policies and recommendations on the future of such funding. This should include the identification of any areas of duplication, overlap or otherwise less than optimal use of funds; and also further areas in which there is potential for academic institutions to carry out work on behalf of government.

6.12.5 TRANSLATING RESEARCH INTO ACTION

A concern expressed by some leading researchers, most notably the Director of the National Centre for Research into the Prevention of Drug Abuse, is that research all too often exists in a vacuum. Researchers carry out their work, publish their findings and proceed to their next task; policy-makers and administrators may either not be aware of their work or provide themselves with no means of benefiting from their advice. This often means that researchers believe that their work is being ignored and see no means of influencing public policy other than through participation in advocacy groups or use of the media.

By contrast, for those charged with implementation and public policy there is often some difficulty in accepting at face value conclusions that may seem straightforward to the researcher. The conclusions to be drawn from a particular piece of research must be carefully evaluated, and considered in a wide range of broader contexts.

It would be beneficial if a process could be established that enabled the State's decision-makers on drug issues to benefit from the expertise of our leading researchers, while it also provided the researchers with some direct and reliable means of involvement in the policy-making process, albeit with the understanding that policy must be informed by a range of other considerations.

A group of senior researchers would also be able to advise the State Government on research priorities and practices relevant to drug issues within government.

We therefore recommend that the Central Drug Co-ordinating Office establish a Research and Policy Advisory Group. This should comprise some of the State's leading researchers on issues relevant to drug abuse. This should include leading figures not only from groups such as the National Centre for Research into the Prevention of the Drug Abuse and the UWA Department of Public Health, but also the Crime Research Centre and the Child Health Research Institute and others. This Research and Policy Advisory Group should have terms of reference that explicitly include:

- advice on co-ordination and development of research within the State;

- advice on research priorities; and

- involvement so far as is possible in advice on policy development and priorities.

Volume II of this report makes a number of specific recommendations with a view to improving data collection systems. Among them is the recommendation that a small co-ordinating unit should be established within the proposed Central Drugs co-ordinating Office to develop a drug indicator database. It would operate on the principle of maximising public access to and understanding of drug-related information through a variety of means, including:

- regular statistical publications;
- analyses of regional drug problems;
- production of well-researched studies utilising relevant data; and
- collaborative projects across sectors.

The proposed review of funding by the CDCO to identify further areas where there is potential for academic institutions to carry out work on behalf of the State Government might include consideration of the establishment over time of a unit analogous to the Crime Research Centre to carry out these information functions.

With respect to clinical practice, it has also been recommended in Chapter 3 of this report that the proposed central treatment and training agency seek formal affiliation with the National Centre for Drug and Alcohol Research, in order to promote its capacity to be an exemplar in the implementation of best practice in treatment.

6.13 SUMMARY OF RECOMMENDATIONS

PSYCHOSTIMULANTS

66. That urgent action, consistent with the broad strategies outlined in this report, be taken to tackle amphetamine abuse, including:

    - a focus of law enforcement activity on amphetamine use, with an especial emphasis on manufacturers, higher level traffickers and street dealers;
    - specific major new public education programs on amphetamines, targeted appropriately, for example to young people; and
    - engaging more persons with chronic problems into treatment services through, for example, legal coercion as part of a court order.

CANNABIS

67. That cannabis policy:

    - reflect unambiguous opposition to the use of cannabis and actively seek to discourage its use; and
    - entail continuing focus by law enforcement agencies on higher level traffickers and street dealers throughout the State.

68. That a major program of public education on cannabis be developed as part of a comprehensive drug education program and be addressed both to the general public and to more specifically targeted groups such as school students.

See also Recommendation 42.

VOLATILE SUBSTANCE ABUSE

69. That the Central Drug Co-ordinating Office pursue the development and adoption of a formal code of conduct by appropriate retailers, and facilitate local action where appropriate, with the aim of limiting the supply of volatile substances to minors.

See also Recommendation 7.

ALCOHOL

70. That a comprehensive Alcohol Abuse Reduction Program be established, co-ordinated by the Central Drug Co-ordinating Office and involving the participation of the following:

- Central Drugs Co-ordinating Office;
- Police Department;
- Health Department;
- Office of Racing and Gaming;
- Education Department;
- Family & Children's Services;
- Ministry of Justice
- Western Australian Network of Alcohol and Drug Agencies;
- Liquor Industry Council;
- Western Australian Hotels and Hospitality Association; and
- National Centre for Research into the Prevention of Drug Abuse

71. That the proposed Alcohol Abuse Reduction Program oversee developments in areas that include the following:

- public education, including programs focusing on youth and special at-risk groups;
- alcohol education and policies in schools;
- professional education;
- treatment and provision of services;
- programs to assist Aboriginal people;
- controls on the consumption of alcohol;
- law enforcement;
- regional initiatives; and
- co-ordination of data collection.

See also Recommendations 38 and 42.

72. That the Central Drug Co-ordinating Office convene a consensus conference to develop agreed terminology relating to alcohol use and abuse.

73. That the proposed Western Australia Alcohol Abuse Reduction Program develop at the earliest opportunity a program of action that will result in the preparation of clear messages that are epidemiologically sound, credible, and acceptable to consumers.

74. That there be further research so that the harm and costs of the immediate consequences of alcohol abuse can be quantified.

75. That there be strong support for the approaches adopted by the Minister for Racing and Gaming to ensure that all licensed premises act responsibly in their dealings with both adults and young people.

76. That the gap in the provision of alcohol and other drug services to industry be filled by the proposed central treatment and training agency.

77. That an increase in the level of tax levied on cask wine be considered, and that consideration also be given to devoting part of any revenue derived from the increase to the initiatives recommended in this report.

78. That the issue of advertising codes be addressed specifically by the Alcohol Abuse Reduction Program on a voluntary, Western Australian basis, and that this examination be based on the understanding that alcohol should not be promoted to young people.

79. That the Central Drug Co-ordinating Office facilitate six monthly meetings between representatives of key government departments and liquor industry organisations, to be followed where appropriate by meetings with the relevant Ministers at which matters of common concern could be raised.

80. That the approaches taken by Police drink-driving, Drinksafe and Respect Yourself campaigns be continued and developed, with support for any funding increases that can be achieved.

81. That in relation to young people and binge drinking:

- School education programs include discussion of the dangers to both the consumer and others of 'binge drinking'.
- The public education programs recommended in this report include a continuing component focusing on 'binge drinking' by young people.
- The Western Australia branch of the Australian Hotels and Hospitality Association develop specific further guidelines for its members on their role in relation to young people.

TOBACCO

82. That the key findings and recommendations of the recently released review of the Tobacco Act 1990 be implemented where feasible.

83. That the approach taken on tobacco be a continuation of policy based on the recommendations of the World Health Organisation and the International Union Against Cancer.

84. That there be a continuation of the comprehensive and co-operative approach to smoking control which has been a feature of the health arena in Western Australia for the past two decades.

85. That the following educational initiatives be pursued:

- Tobacco to form part of school drug education programs proposed elsewhere in this report.
- Commitment to drug education on a similar basis to be sought from non-government schools.
- Commitment to be made by the Education Department to a completely smoke-free environment in schools.
- Tobacco to be included as part of the teacher training programs in drug abuse.
- Commitment be made to the continuation of public education programs on tobacco at funding levels no less in real terms than those obtained in 1984. This should include funding committed to public education on tobacco by the Commonwealth as part of the National Drug Strategy.

86. That public education programs be comprehensive, but pay special attention to key groups, including:

- young people;
- women;
- Aboriginal people, for and with whom special programs should be designed and implemented; and
- multicultural groups.

87. That the following means of controlling tobacco use be adopted:

- Maintenance of the Tobacco Control Act 1990, with the implementation of any further recommendations from the Review of the Act that complement its broad approach.
- Maintenance of the role of Healthway, subject to recommendations in the Report of the Evaluation of the Western Australia Health Promotion Foundation.
- Consideration that the Tobacco Control Act 1990 be amended to remove anomalies that permit the continuing inappropriate promotion of tobacco in Western Australia. Strengthening of such controls, as recommended in the Review of the Tobacco Control Act 1990.
- Negotiation with other jurisdictions to ensure that tobacco health warnings are maintained and strengthened on the basis of evaluation, along with effective content information and disclosure of ingredients.
- Support for Health Department activity designed to ensure compliance with the Tobacco Control Act, particularly in relation to the sale of tobacco products to minors.
- Examination of other measures such as licensing retail outlets to limit the availability of cigarettes.
- Legislative action to protect non-smokers through the provision of smoke-free public places and workplaces.
- Maintenance of the current State and Commonwealth approach to ensure that cigarette prices are at least maintained in real terms.

88. That a substantial program be developed by the Health Department, in conjunction with other agencies, to ensure adequate provision of its service and advice to those who wish to give up smoking. This should include encouragement of doctors and other health professionals to advise, encourage and assist their patients to give up smoking.

89. That counselling services for smoking cessation be reviewed to ensure efficient delivery to target groups.

See also Recommendations 38, 42 and 106.

PHARMACEUTICALS

90. That the older 'sedating' antihistamines be considered for re-scheduling in Schedule 4 (prescription only). The Health Department of Western Australia should prepare a submission to this effect.

91. That further information about education programs on prescribing practices be developed by the relevant State Government departments and professional organisations.

92. That the Health Insurance Commission continue to pursue 'doctor shoppers' using the graduated response developed by them.

93. That a joint working group of the Health Department of Western Australia and the Australian Medical Association be convened to consider additional means of ensuring the safe and effective use of pharmaceuticals that might be appropriate at the professional level.

94. That the proper use of pharmaceuticals be included in health education for all students, and that the Health Department develop proposals for targeted public education programs for at risk groups.

95. That the Commonwealth commission comprehensive evaluations of the present information provided with pharmaceutical products and the additional warning labels used by pharmacists to ensure that they are understood, and to make recommendations for change when they are not.

PERFORMANCE-ENHANCING DRUGS

96. That action on performance-enhancing drugs by elite athletes continue to be monitored and controlled by the Ministry of Sport and Recreation and sporting organisations such as the Australian Sports Drug Agency.

97. That at least on an occasional basis, anabolic steroids trafficking be 'blitzed' by the police.

98. That a new program of action to reduce use of performance-enhancing drugs for image, body building and cosmetic purposes be developed under the auspices of the State's Drug Control Strategy. This should be led by the Police Department, with support from the Ministry of Sport and Recreation and the Health Department, and in co-operation with the relevant non-government organisations.

99. That the Health Department and Ministry of Sport and Recreation develop specific education and information programs, including the involvement of general practitioners and relevant non-government organisations.

HIV/AIDS AND OTHER BLOOD BORNE VIRUSES

100. That there be frequent, regular liaison between those responsible for drug abuse policy and programs and public health authorities and other organisations responsible for HIV/AIDS, Hepatitis C and other relevant issues.

101. That within the context of the broad policy on drug abuse proposed in this report, there be a continuing emphasis on work with injecting drug users (IDUs) to ensure that those who continue to inject drugs do so with the minimum possible risk to themselves and others.

102. That programs for IDUs include:

- access to sterile injecting equipment which is affordable and accessible;
- education programs that are both general and specifically targeted;
- continuing dissemination of information; and
- education programs for relevant health workers and others about the importance of rational harm reduction within the context of a drug abuse control program.

103. That public health authorities and other organisations responsible for HIV/AIDS education programs ensure that they incorporate as far as is pragmatically possible messages about the desirability of non-use, as well as harm reduction.

ABORIGINAL COMMUNITY ISSUES

104. That the general approach taken with Aboriginal community issues entail the following:

- All organisations developing programs in the area of alcohol and drug abuse seek to identify the special needs of Aboriginal people and to develop activities appropriate to those needs.

- All programs developed in relation to Aboriginal alcohol and drug abuse entail consultation with and the involvement of Aboriginal people and organisations.

- There be a continuation of discrete programs developed for Aboriginal people within the context of an overall alcohol and drug strategy.

- Given the nature and history of alcohol abuse in relation to Aboriginal communities, the issue be addressed specifically in and of itself. This approach is currently being taken by the Western Australian 'Living with Alcohol' program, which is being co-ordinated by the Health Department in association with Aboriginal organisations, and which we strongly support.

105. That as a matter of urgency, a major new program on tobacco in Aboriginal communities be developed under the auspices of the Health Department of Western Australia, in conjunction with other relevant organisations.

106. That the approach taken by the Aboriginal Alcohol Summit be pursued by, among others, the following means:

- a major educational program directed at alcohol abuse among Aboriginal people;

- the further development of community patrols, sobering-up shelters, outreach programs, access to detoxification services, and rehabilitative opportunities;

- co-operation with the drinks industry to ensure compliance with the relevant legislation, promote lower alcohol products, develop server responsibility and encourage those who drink to do so moderately;

- appropriate use of liquor licensing legislation;

- involvement of communities in licensing issues; and

- co-operation between Aboriginal organisations and police services.

RESEARCH ISSUES

107. That those Federal and State bodies responsible for research on drug abuse maintain current funding levels, and continue to place a high emphasis on the importance of research.

108. That a register of research relevant to drug abuse in Western Australia be maintained. It should include as far as possible research conducted both at academic institutions and by government agencies. It should also include market research, as well as more academically-oriented research.

109. That a Drug Abuse Research Forum be organised twice a year, with the intention of bringing together all those who participate in research activity in Western Australia.

110. That the Central Drug Co-ordinating Office liaise with relevant institutions to ensure that a suitable proposal is made to a grant-giving body such as Healthway to establish a small secretariat for the Drug Abuse Research Forum for an initial three-year period. The secretariat would also establish and maintain the proposed relevant register (see Recommendation 108).

111. That the Central Drug Co-ordinating Office review funding provided by State Government agencies on alcohol and drug issues to academic institutions, and develop appropriate policies and recommendations on the future of such funding.

112. That the Central Drug Co-ordinating Office establish a Research and Policy Advisory Group, comprising some of the State's leading researchers and including leading figures not only from groups such as the National Centre for Research into the Prevention of the Drug Abuse and the UWA Department of Public Health, but also the Crime Research Centre, the Child Health Research Institute and others. The terms of reference should explicitly include:

- advice on the co-ordination and development of research within the State;

- advice on research priorities; and
- involvement in so far as is possible in advice on policy development and priorities.

113. That co-ordination of drug data collection be a function of the Central Drug Co-ordinating Office (see also Recommendation 140).

7. STRUCTURE, CO-ORDINATION AND COMMUNITY ACTION

7.1 INTRODUCTION

Specific aspects of action, co-ordination and structure are addressed in the relevant components of this report. The following chapter addresses the overarching issues of:

- national co-ordination issues;
- central co-ordination of policy and action;
- regional co-ordination;
- community action; and
- co-ordination of service provision.

As with other aspects of public administration, there is no single 'gold seal of approval' model for the administration and co-ordination of responses to alcohol and drug issues. Approaches taken vary both internationally and within Australia. Even within Australia, there have been substantial changes over time. Decisions about administration have been made sometimes on the basis of considerations specific to the area, sometimes as a result of other arrangements and policies within governments and government departments.

The organisation and administration of the area presents a unique challenge as drug abuse crosses a number of traditional administrative boundaries: law enforcement, health, education, community welfare, correctional services, regulatory authorities and economic departments; all have responsibilities that either bear upon the issue or are affected by it.

There have been many Royal Commissions and Parliamentary Committee Reports at both State and Commonwealth level, either directly about drugs or about matters relating very closely to drug issues. They are listed in Appendix 1. The last major parliamentary report specifically about drug issues in Western Australia was the Report of the Select Committee Of The Legislative Assembly Appointed To Inquire Into Alcohol And Other Drugs (the 'Hill Report'), which was published in 1984.

The Hill Report made 76 recommendations, focusing mainly on treatment issues and arrangements. Some recommendations were acted on, but there was no systematic implementation or monitoring process. Circumstances in the area changed shortly after publication of the Report, primarily because of the impact of the 'Drug Summit' and the National Campaign Against Drug Abuse, but also because of reorganisation within the Health Department and elsewhere.

7.2 NATIONAL ORGANISATION AND STRUCTURE

The most fundamental changes to the quantum and organisation of alcohol and drug programs in Australia in recent decades arose out of the 'Drug Summit' — the Special Premiers Conference on Drug Abuse. The Drug Summit was convened by the then Prime Minister on 2 April 1985 and attended by all Premiers and Chief Ministers together with Ministers responsible for Health and Law Enforcement.

As a result of the Drug Summit, major changes occurred in the following areas:

- Media and public attention was focused on drug issues in a carefully planned manner before, during, and after the Drug Summit.
- There was a clear and firmly stated commitment made by all Australian Governments to act on drug abuse.
- Health and law enforcement Ministers and agencies were brought together.

- A new co-ordinating structure was established at the national level, and to a greater or lesser extent mirrored in most jurisdictions.

- A substantial amount of additional funding was provided for action on drug abuse at both Federal and State levels.

The main specific outcomes included:

- establishment of a Ministerial Council of Drug Strategy (MCDS) with membership including Ministers responsible for health and law enforcement from all jurisdictions;

- establishment of the MCDS Senior Officers' Committee (SOC);

- establishment of a number of MCDS and SOC sub-committees to establish and develop policy and specific programs in a co-operative manner;

- establishment of the National Campaign Against Drug Abuse (NCADA) both as an umbrella title for activity on drug abuse and as the basis for media and information programs; and

- a substantial range of new or expanded activities nationally and at the State level as a result of funding provided under the NCADA.

Funding provided after the Drug Summit and through subsequent NCADA activities focused primarily on addressing the behaviour of individuals, whether through prevention, information, research or treatment. Little additional funding was provided for new law enforcement activities. This was initially decided on the basis that such activities were already funded from different sources, but in recent years there has been a commitment from all jurisdictions that 10% of NCADA cost-shared funding will be allocated to police and law enforcement agencies.

Following the Drug Summit, there was an initial commitment to new funding to the level of $20 million a year, part to be cost-shared and part to be provided unilaterally by the Commonwealth.

The cost-shared funding allocated to the States was devoted primarily to treatment and prevention activities. The most notable impact in Western Australia was to increase significantly the funds available for treatment services in both the government and non-government sectors. The Commonwealth-specific funding was devoted to media programs, other education/information activity, co-ordination, publications and research.

From the research funding provided through NCADA, Western Australia has benefited most notably through:

- establishment of the National Centre for Research into the Prevention of Drug Abuse at Curtin University; and

- funding initially provided from NCADA for the collection of valuable data on drug abuse issues. (Some of the funding provided for data collection at the State level has since been discontinued.)

Overall funding through the NCADA has continued, with both Commonwealth-specific and Commonwealth/State cost-shared programs.

There have been evaluations of both the NCADA and its specific components. While these lend support to the development of activity designed to reduce drug problems, any evaluation of a program such as the NCADA founders on the difficulty of demonstrating whether specific changes can be attributed to a single funding stream in the context of much additional activity and many other influences. As with so much else in the area of drug abuse, evaluation tends to comment on process rather than outcomes.

The structures established by the Drug Summit have been in place for ten years. There have been some changes: the Ministerial Council on Drug Strategy now meets less frequently than in the past; the National Campaign Against Drug Abuse is now described as the National Drug Strategy; the Senior Officers' Committee is now described as the National Drug Strategy Committee, but the overall approach remains that which was introduced in 1985.

While there may be some criticisms of the way in which the NCADA was established and some of its component parts, the NCADA and the funding which resulted have made a significant contribution to efforts aimed at reducing drug abuse in Australia.

Ten years on, however, it is appropriate to comment that circumstances have changed significantly. There is a strong case for reviewing the present structures and for developing approaches more in tune with the needs of the 1990s. Indeed, the National Drug Strategy Committee has, at its most recent meeting, been asked to review its own structures.

The NDS has lost some impetus; there has been a gradual lowering of its profile; and there is no longer the sense of urgency that existed ten years ago. Some of the activities generated by the NCADA are no longer in place; some of the premises on which it was based may no longer be valid; perhaps above all, both the community and drug problems have moved on.

Further, it must be recognised that neither the NDS nor the activities in support of the campaign occur in isolation, whether in the Commonwealth or in the States. For example, while the MCDS is technically the primary forum for Ministers dealing with drug issues, the issues are frequently also discussed at other Ministerial meetings such as the Australian Health Ministers Conference and the Australian Police Ministers Council. At the Commonwealth level, the MCDS/NDS Secretariat rests in the Department of Human Services and Health, where it can do little to influence or co-ordinate the work of many other Commonwealth agencies that directly or indirectly play a major role in the area, such as the Department of Employment, Education and Training; the Aboriginal and Torres Strait Islander Commission; the Australian Federal Police; the National Crime Authority; Customs; the Bureau of Criminal Intelligence. At the State level, Health, Police and other departments develop policy in conjunction with NDS, but also in other contexts.

One of the most contentious areas since the inception of the NCADA has been the allocation and control of resources between the Commonwealth and States. Although many programs are cost-shared, they must often conform to specific conditions set by the Commonwealth, and the States are not free to develop their programs as they consider appropriate.

Some media programs (advertising and promotional campaigns, public relations activities etc) are developed centrally by the Commonwealth Department of Human Services and Health. While there is a commitment to consultation, and there are often co-ordinating committees or steering groups with State and Territory representation, the reality is that such media programs are generally both conceived and administered centrally. This has led to continued concerns about effective consultation with the States, co-ordination with State programs, and timing.

There is clearly an overwhelming case for co-operation between the jurisdictions, as occurs in many other areas. It is hard, however, to discern the value to the jurisdictions of some media and other public education programs being directed centrally, rather than within jurisdictions that have both local knowledge and a strong track record in the area. Similarly, the main benefit to be derived from central involvement in the allocation of funds to treatment and related services should come through participation in establishing broad principles.

Ten years after the Drug Summit and the establishment of the NCADA, it is time to learn from the experience of the NCADA/NDS processes and to develop at the national level co-ordination mechanisms that are more appropriate for the circumstances of the 1990s.

It is recommended that:

- Views be sought from all jurisdictions as to whether the Ministerial Council on Drug Strategy should continue in its present form.

- It be proposed to the Commonwealth Government that the current National Drug Strategy structure be reviewed by an international authority in a manner similar to the recent review of the National Health and Medical Research Council.

- All National Drug Strategy funding, other than that required for central administration, research and policy development, be distributed to the States on a per capita basis for drug prevention and treatment services.

7.3 STATE ORGANISATION AND CO-ORDINATION

A review of international approaches to the administration of alcohol and drug services shows that other countries face all the problems and dilemmas apparent in Australia. We asked many experts whether there was a single model in existence elsewhere that would be appropriate for adoption in Western Australia, but there were no ready responses.

We also considered the approaches currently in place in other Australian jurisdictions. This entailed some difficulties, as at least four are currently perceived as being in a state of flux!

All jurisdictions recognise that there must be discrete roles for the main agencies concerned with health and law enforcement; all recognise the importance of co-operation both within the State and between jurisdictions; all take slightly different approaches. Selected points of interest from other jurisdictions in Australia include:

- The New South Wales Government established a separate Directorate of the Drug Offensive (DODO) shortly after establishment of the NCADA, together with a separate Ministerial Portfolio as the Minister for the Drug Offensive. The Directorate of the Drug Offensive was established through legislation; its CEO reported directly to the Minister for the Drug Offensive, who was also Minister for Health. The Directorate of the Drug Offensive retained a high profile for a few years, but gradually became subsumed within the Health Department, losing its profile and high level policy and co-ordination role.

- The Victorian Government has recently established a new non-government organisation, 'Turning Point', which carries responsibility for administration of some of the treatment services that were previously located within the Health Department's Drug Services Victoria. The Health Department maintains a small branch with some co-ordination responsibilities.

- The South Australian Drug and Alcohol Services Council (DASC) is a separate statutory body which serves as an incorporated health centre of the Health Commission, with responsibility for most of the functions carried out in Western Australia by the Alcohol and Drug Authority and some of those carried out here by other agencies.

- The Northern Territory Police Department, under the leadership of its then Commissioner, Mick Palmer (now Commissioner of the Australian Federal Police), established a Drug Enforcement Unit. This sought to resolve the problem posed by the existence of a multiciplicity of Commonwealth and Territory law enforcement agencies by combining them into a single agency under the auspices of the Northern Territory Police Department, but with dual reporting arrangements where required. The New South Wales Police Department also has a Drug Enforcement Agency, but this comprises New South Wales Police only: the New South Wales Police on occasion collaborate with the Australian Federal Police on a joint Task Force basis.

- In Victoria and Queensland, NCADA funding has been used to establish a senior position in the Police Department responsible for the co-ordination of drug and alcohol activity within the Department and liaison on educational, policy and other matters with other government departments.

In Western Australia, the major State Government organisations can be summarised as follows:

- First tier — the agencies most directly concerned with drug issues and policies. They include:

  - Health Department of Western Australia: treatment through hospitals and community health services; administration of legislation; specialist activity on tobacco, alcohol, pharmaceutical products, solvent abuse; public education; school education; policy.

  - Police Department: full range of operational activity; policy.

  - Alcohol and Drug Authority: treatment and clinical services; professional education.

  There has historically been some overlap between these three agencies, but also some informal agreements as to where each would concentrate its resources. For example, the Health Department takes the lead in the area of public education, while the Alcohol and Drug Authority concentrates on professional education and the Police Department on supporting the educational activities of others; all seek to co-operate with and support the work of the Education Department.

- Second tier — agencies with major concerns about drug problems, but not generally involved in development of central drug policy:
    - Ministry of Justice.
    - Education Department.
    - Aboriginal Affairs Department.
    - Office of Racing and Gaming.
    - Department for Family and Children's Services.
    - Healthway.
- Third tier — agencies with some involvement in alcohol and drug issues, but not as a leading component of their work. Examples include:
    - Ministry of Sport and Recreation.
    - Department of Occupational Health Safety and Welfare.

In addition many organisations outside the State Government are involved in alcohol and drug issues. They include:

- Commonwealth Government agencies: Department of Health and Human Services, DEET, ATSIC, AFP, Customs, etc.
- Alcohol and drug service agencies: most of these are represented by the Western Australian Network of Alcohol and other Drug Agencies (WANADA).
- Advocacy organisations: these include the Alcohol Advisory Council and the Australian Council on Smoking and Health.
- Professional organisations: e.g. the Australian Medical Association, the Pharmaceutical Council, the Pharmacy Guild.
- Organisations specifically concerned with Aboriginal issues.
- Community organisations with a particular interest in alcohol and drug issues, ranging from Rotary clubs and church groups to organisations such as the Western Australian Council of State School Organisations.

There are some notional co-ordinating mechanisms and there has been much good co-operation between the various groups above; but it is also true that much of the co-ordination has been ad hoc, and that the co-ordinating processes have often been less than satisfactory. Concerns have been expressed in the past by WANADA and other groups about the role of the Alcohol and Drug Authority, particularly prior to introduction of a separation of the roles of ‘purchaser’ and ‘provider of services.

As Volume II of this report demonstrates, problems caused by drug abuse are responsible for a wide range of problems that affect the entire community and are of direct relevance to several portfolios within government. Action in these areas must be co-ordinated at the highest levels, to be effective.

Many different approaches were proposed to and considered by the Task Force. These included the approaches currently in place in Australia and elsewhere, and options ranging from the status quo, to total devolution of all services from government, to the establishment of a single major agency responsible for all aspects of drug and alcohol services. The experience of other States and countries, while not providing a ready-made model, has indicated where significant improvements might be achieved and major pitfalls avoided.

The approach that is recommended is designed to incorporate the following elements:

- the simplest possible structures for a complete area of administration and service delivery;
- minimal but effective central bureaucracy;
- effective central and regional co-ordination of State Government and community responses;
- a mechanism to provide government with policy advice that integrates the perspectives of its various agencies;
- good information collection and monitoring capacity;
- continued separation of the 'purchaser' and 'provider' roles in core treatment and prevention services;
- the capacity to maintain existing services with minimal disruption;
- strong focus on expanding the provision of services to the regions; and
- the capacity to build on effective outcomes and experience from Western Australia and elsewhere.

The approach and recommendations that follow seek to develop a coherent and practical structure that is appropriate for Western Australia's circumstances.

7.3.1 CENTRAL STRUCTURES AND CO-ORDINATION

It is recommended that the State Government establish a Western Australian Drug Abuse Control Strategy. It should be established on the basis of:

- the policies, initiatives and structures outlined in this report;
- implementation of all the proposed changes during the first two years of operation; and
- review and evaluation in the third year of operation.

7.3.1.1 Ministerial arrangements

Drug abuse is a problem which affects many portfolios. Co-ordination has sometimes been problematic because of the perception that it must rest with either the Health Department or the Police Department, which will then be seen as the dominant agency. An approach is required that combines clear ministerial responsibility with the capacity to integrate the roles of the various government agencies when appropriate.

First, it is recommended that there be a Ministerial Committee on Drug Abuse, its members to comprise the Ministers responsible for Health, Police, Education, Justice, Family and Children's Services, Aboriginal Affairs, and Racing and Gaming. This Committee should be chaired by the responsible Minister. The Ministerial Committee should be supported by a Senior Officers Co-ordinating Committee with representatives from each portfolio.

Second, in order to ensure effective co-ordination, and also to demonstrate the importance attached by the Government to drug issues, it is recommended that a single Minister take overall responsibility for co-ordination of drug abuse control issues. The Minister would be supported by a Central Drugs Co-ordinating Office, whose functions are described below. The Minister would specifically carry responsibility for:

- co-ordination;
- policy development;
- funding allocations;
- representing the Government at national meetings and otherwise as appropriate;
- monitoring and evaluation; and

- overseeing implementation of the proposed Western Australia Drug Abuse Control Strategy.

Many senior figures have expressed the view that the most appropriate Minister to take carriage of drug issues in Western Australia would be the Premier. This would:

- ensure the clearest possible demonstration of public commitment to action; and

- provide effective leadership across a range of major portfolio areas.

7.3.1.2 Central drug co-ordinating office

The Central Drugs Co-ordinating Office (CDCO) should be established with the following functions:

- Policy: co-ordination of current policy; policy development; policy advice; further development of policy in areas indicated in the report; working parties as necessary on specific issues or functions, e.g. funding, methadone, best practice in service provision.

- Central co-ordination: support for the proposed Ministerial Committee on Drug Abuse and Senior Officers' Co-ordinating Committee; ensuring information on co-ordination of activity by government agencies; ensuring co-ordination and liaison with local government and non-government agencies; continuation of Non-Government Organisations Reference Group established by the Task Force.

- Development of regional co-ordination and community action: establishment of the proposed regionally based Community Drug Services Teams (CDST); Regional Drugs Co-ordinating Councils; specific officer/s with responsibility for regional co-ordination in CDCO; support for the establishment of the proposed Local Drug Action Groups.

- Co-ordination of the collection and provision of information: information on expenditure, activity, trends and usage, cost and harm to the community; monitoring and evaluation.

- Co-ordination of State representation at Commonwealth/State and similar forums.

- Liaison with the non-government sector.

- Advice on funding allocations: responsibility for advising the responsible Minister on all non-government organisation specialist service funding; responsibility for advising appropriate Ministers on specialist drug services in government agencies.

The CDCO should be a small unit, with 20-25 FTEs, the resources drawn from those currently allocated to drug issues. It should include staff with experience of health and police matters, including some seconded from the relevant agencies. It should also include staff with specialist expertise in both prevention and treatment issues. Through its work on allocation of funding it should retain a close liaison with the treatment field. Its involvement in the allocation of funding should ensure that the separation of the roles of ‘purchaser and provider’ is maintained in this area.

The CDCO should report to the responsible Minister.

The role of the proposed CDCO in the co-ordination of the collection and provision of information is especially important. During the course of our work we have identified many government and non-government agencies with a substantial investment in the collection of information relevant to drug issues, but very few mechanisms to co-ordinate the information (and sometimes inadequate co-ordinating mechanisms within those agencies). A Western Australian Drug Data Collection Unit was established in the Health Department under the auspices of the NCADA, but funding for this position ceased in 1993.

State Government agencies producing relevant information include the:

- Health Department;

- Police Department;

- Office of Racing and Gaming;

- Aboriginal Affairs Department;
- Department for Family and Children's Services; and
- Ministry of Justice.

In addition, many non-government agencies and private sector organisations (not least those in the liquor industry) have the capacity to assist with provision of much useful information.

While some of the information presented in this report has appeared elsewhere, there is much that is new. No report has previously documented the level of activity and cost engendered by government and non-government agencies on drug issues in Western Australia. No program on drug abuse should continue in the absence of good information; this information should cover both issues relating to drug use and harm and the action being taken by government and non-government organisations. The role of government departments in this context is not to conduct academic research; it is to ensure that the necessary information is both collected and appropriately used.

We therefore recommend that in establishing the Central Drug Co-ordinating Office there should be special emphasis on its information functions. These functions should comprise:

- information on drug use;
- information on harm and costs caused to the community by drugs; and
- information on activity and expenditure by State and Federal government and non-government organisations on drug issues.

While information is an important function of the CDCO, it should work closely with academic and other units, and should require no more than three FTEs.

Various options for the organisational status of the CDCO might, depending on the other portfolios of the responsible Minister, be:

- within the Ministry of the Premier and Cabinet;
- within a related department such as the Ministry of Justice, so as to obtain corporate support, but reporting directly to the Minister; or
- establishment as a new agency.

Co-ordination activity among State Government agencies should occur through the Ministerial Committee on Drug Abuse and the Senior Officers' State Co-ordinating Committee, with the Central Drugs Co-ordinating Office servicing both. Both of these should meet only as frequently as required: day-to-day co-ordination should occur under the auspices of the CDCO, as well as the normal co-operation between government agencies.

There were proposals to the Task Force that participation in a single central co-ordination body should also involve Commonwealth agencies and the non-government sector. The Task Force believes that liaison with these groups can and should be effectively carried out through other means. To do otherwise would dilute the effectiveness of the co-ordination of State Government responses. The CDCO should, however, establish at an early stage a process to ensure effective co-operation with these groups, and also with influential and well-informed groups such as the judiciary.

7.3.1.3 Organisation of services

Chapter 3 on the Provision of Services describes in some detail the treatment and other services provided within Western Australia and outlines the proposed model of organisation for these services.

The key elements of the proposed service delivery and funding system, to link with other initiatives recommended in this report, are as follows:

- Services to be provided by either non-government agencies or mainstream health, justice and welfare agencies.

- The services of the Alcohol and Drug Authority to be devolved, with government services limited to health, justice and welfare agencies.

- The Central Drug Co-ordinating Office to be the lead funder of alcohol and drug services for both non-government sector and government health, justice and welfare agencies. This role to be undertaken in conjunction with policy and co-ordination responsibilities.

- Funding to be provided by contract for service. Contract specifications to reflect best practice indicators. Consultation with the Western Australian Network on Alcohol and Drug Agencies on development of standard contract specifications for various categories of service.

- Competitive tendering for funding to be introduced in the first instance for all new and redeveloped services where there is more than one potential provider. Thereafter, tenders to be let on a triennial basis for all services in which there is more than one potential provider.

- Development or extension of existing services (to introduce new initiatives or to enhance service operations) to be pursued when there is only one cost-effective provider or when the service provider is indicated by legislative mandate.

- Submissions for the establishment of new services or service initiatives to be accepted by the Central Drug Co-ordinating Office from the Regional Drug Co-ordinating Councils.

- The Central Drug Co-ordinating Office to convene a drug abuse service funding panel to advise the responsible Minister on funding allocations. This panel to have an independent chair and both independent and representative membership. To ensure effective continuity of policy and approach the drug abuse services funding panel should, if possible, be chaired initially by the current Chairman of the Alcohol and Drug Authority.

Chapter 3 and also Chapter 8 with reference to the overall implementation process describe in further detail the means through which devolution of services from the Alcohol and Drug Authority can occur. Chapter 3 also proposes as a central focus for drug abuse services a new non-government organisation, a central treatment and training agency. The Task Force recommends that an easily recognisable and appropriate name for the agency be sought.

The central treatment and training agency should be established as a non-government organisation with:

- State Government funding for the provision of specified services;

- the capacity to raise funding from the private sector and elsewhere;

- the capacity to compete for other work;

- funding provided to the agency for an initial three-year period at the end of which its services should be funded by competitive tender on a triennial basis; and

- a Board appointed in the first instance by the State Government, to include:

    - an independent chair person who should ideally have specific expertise; and

    - membership from the non-government sector, the business community, and other sectors relevant to the control of drug abuse, with the head of the CDCO as an ex-officio member.

As noted earlier, in Victoria the government alcohol and drug services have ceased operation and a non-government organisation, ‘Turning Point’ has been established to undertake some of those services. It needs to be emphasised that whilst the developments proposed in this report will reflect elements of the experience from other States, the model is predicated on local conditions, and the proposed central treatment and training agency does not seek to replicate the model provided by Victoria’s ‘Turning Point’.

Devolution of the Alcohol and Drug Authority's services and establishment of the central treatment and training agency will require repeal of the Alcohol and Drug Authority Act. During the last year, the functions of the ADA have already changed significantly, and some of its staff have been transferred to the Health Department. It would be important in further devolving the responsibilities of the ADA and establishing a new non-government agency to ensure that ADA staff were appropriately placed, and provided with opportunities to transfer to positions either within government or in the new non-government organisation.

Recognising the complexities involved in the devolution of the Alcohol and Drug Authority and the establishment of a new organisation, and drawing on experience from elsewhere, it is expected that the establishment of the central treatment and training agency should take approximately six months.

7.3.2 REGIONAL STRUCTURES AND CO-ORDINATION, AND LOCAL COMMUNITY ACTION

It is essential that co-ordination of responses occurs not only at the State and national levels but also at regional and local levels. Drug abuse problems occur in communities and should, in the first instance, be the focus of action by local service providers and the local community. Effective co-ordination in regions should facilitate co-operation and collaboration between the agencies responsible for control, prevention and treatment strategies, and the communities in which they work.

7.3.2.1 Regional drug co-ordinating councils

Regional Drug Co-ordinating Council (RDCCs) should be established in each region of the State. The role of the Councils would be to:

- provide a forum for regional co-ordination and collaboration between agencies;
- promote community action;
- provide local advice to government through the Central Drug Co-ordinating Office; and
- be the avenue through which the community can make submissions to the Government, through the Central Drug Co-ordinating Office, for local service development.

In the first instance, four RDCCs should be established in the Perth metropolitan area, two in the north and two in the south of the city, and six RDCCs should be formed in the regional areas covering the Kimberley, Pilbara, Gascoyne/Murchison, Goldfields, Great Southern and South West regions.

It is anticipated that the RDCCs would monitor problems and responses in their regions, develop strategies to address regional issues, and initiate the implementation of these strategies.

The responsible Minister should appoint the chair of each Regional Drug Co-ordinating Council and invite relevant persons to participate. Membership should be appropriate to regional circumstances and be drawn from the following:

- State Government agency representatives: Health, Police, Justice, Family and Children's Services, Education, Aboriginal Affairs;
- Commonwealth agencies: ATSIC, Human Services and Health;
- local government;
- non-government alcohol and drug, youth or other relevant service providers; and
- private sector and community leaders.

Membership should be kept at or below 12 people in order to maintain a workable group.

Each Council should have a budget to provide for committee expenses, and be able to apply for project funds from Healthway or the Lotteries Commission.

7.3.2.2 Community drug service teams

Community Drug Service Teams (CDSTs) should be established in association with the Regional Drug Co-ordinating Councils, to:

- facilitate local co-ordination through the Regional Drug Co-ordinating Councils;
- facilitate local community action; and
- provide such services as are appropriate to the needs of the locality.

The Community Drug Service Teams will act as the secretariat for Regional Drug Co-ordinating Councils, convening meetings, setting and maintaining agendas, providing information and co-ordinating the regional strategies initiated by the RDCCs. They will act as both facilitators of action and the human resource to take action as appropriate.

CDSTs will be established as non-government organisations whose articles of association will reflect the multi-faceted role described. The boards of management shall be drawn from the RDCCs, effectively operating as a sub-committee of the RDCC.

The CDSTs will be developed from the community and regional services devolved from the Alcohol and Drug Authority, and will be funded and contracted through the Central Drug Co-ordinating Office. As with the RDCCs, in the first instance there should be four CDSTs in the Perth metropolitan area, each with between five and eight staff, and six in country Western Australia, each with between three and five staff. This represents a doubling of current Alcohol and Drug Authority community and regional services.

7.3.2.3 Local drug action groups

The Task Force was impressed by the interests of many individuals and organisations around the State in participating in action to reduce drug problems.

One difficulty has traditionally been that for those members of the public who wish to become involved in action on drug abuse, there is little that they can do unless they wish to become involved in virtually a full-time capacity; even then there is little guidance as to what would be most useful, and few structures to enable individuals to participate.

It is important that any moves towards further development of community action capitalise on the excellent work being carried out already in some areas, both outside and within government services. The purpose of developing a new level of activity is not to replace what is already under way, but to provide a good structure that will underpin it and an opportunity for people in as many communities as possible to participate.

It should be recognised that many individuals and non-government organisations already contribute substantially in this area. Rotary clubs, Lions groups, the community involved with the DARE program, are all involved in drug-specific activities. This report, like others, would also wish to pay tribute to the contribution of those working with Aboriginal Community Patrols. There are also many other groups, such as Police, Citizen and Youth Clubs, that are involved in work on drug issues both directly and indirectly.

To complement the activities currently in place and the structures proposed in this report, and to capitalise on the enthusiasm expressed by many individuals around the State, we recommend the development of Local Drug Action Groups.

The intention of establishing Local Drug Action Groups is not that they should be bureaucratic organisations or that they should all follow a specific course of action. They should be established in towns and local communities by individuals concerned about drug problems, with a focus on developing strategies and taking action appropriate to those communities.

Some limited seed funding should be provided by the Government, through grants of up to $500 for each Local Drug Action Group. Thereafter, we recommend that either Healthway or the Lotteries Commission be requested to establish a special fund to support grant applications for community action projects from Local Drug Action Groups and Regional Drug Co-ordinating Councils.

The Task Force recognises the invaluable contribution made by many existing groups, and the need for maximum possible involvement by all service groups, church organisations and other community organisations. In order to facilitate this involvement we recommend that a single service group be requested to take on as a commitment the establishment of a network of Local Drug Action Groups around the State over a two-year period.

Following discussions with leading figures in the Western Australian Rotary movement, we recommend that the Rotary Clubs of Western Australia be requested to take the lead role in this initiative, in co-operation with other organisations. We recommend further that a target be set by Rotary that at the end of a two-year period, Local Drug Action Groups be established in every significant community in Western Australia.

It is anticipated that Rotary will work closely with the various Community Drug Service Teams and Regional Drug Co-ordinating Councils in initiating the Local Drug Action Groups. Moreover, the regional councils and community teams will be able to assist in the formation of the groups and provide support for their activities.

It is important to stress that these groups should link in as well as possible with other community crime prevention and related activities. For example, where a community group has already been established with a role very close to what we envisage, it would be sensible to combine the two rather than to duplicate the efforts currently being undertaken. We note also that several Rotary clubs and other service groups, particularly the Lions, are already engaged in work on drug abuse: the Local Drug Action Groups should complement rather than replace this activity.

A project of this nature will work much more effectively if there is some limited administrative support. The administration provided should not be such as to create a bureaucracy. It would also be appropriate that any administration be located outside rather than inside government departments. It is therefore proposed that there should be some limited administrative support provided to Rotary for the two years required to establish Local Drug Action Groups, and to ensure continuing co-ordination and support of such groups. This would entail funding for one Executive Officer with secretarial assistance and capacity to produce limited support materials at a total sum of $100,000 per annum. It is recommended that funding for such support should be sought from either the Lotteries Commission or Healthway.

Local Drug Action Groups could have some or all of the following roles:

- monitoring local issues and trends;
- developing community education and awareness;
- parent education;
- ensuring availability of educational and other materials;
- ensuring that local media are interested, informed about and involved in drug awareness issues;
- school liaison and support;
- parent and family support groups and mechanisms;
- developing alternatives to drug use (e.g. youth recreation programs);
- developing mentor systems for at-risk users;
- supporting treatment initiatives where appropriate;
- addressing specific local problems (e.g. solvent abuse);
- supporting law enforcement initiatives (this could cover not only illicit drugs, but also matters such as alcohol and tobacco sales to minors, responsible serving practices in alcohol sales outlets);
- developing locally relevant submissions on issues from liquor licensing for funding for local projects;

- developing locally appropriate activities or support for those already in place (e.g. Aboriginal Community Patrols);

- encouraging local retailers to observe legislation and voluntary codes of conduct; and

- complementing and monitoring the work of government agencies.

7.3.2.4 Community drug abuse hotline

The Community Drug Abuse Hotline has provided a simple and effective avenue for the general public to communicate its concerns and ideas to the Task Force. It would assist the Central Drug Co-ordinating Office in its work to be able to receive feedback from the public in this simple and immediate manner. It is thus recommended that the CDCO maintain the Community Drug Abuse Hotline and periodically promote its availability to the public.

7.4 SUMMARY OF ORGANISATIONAL CHANGES

In summary, therefore, the main organisational and structural changes proposed are:

Organisational changes

- Ministerial portfolio for drug abuse control.
- Establishment of the Central Drugs Co-ordinating Office.
- Devolution of the Alcohol and Drug Authority functions and establishment of a central treatment and training agency (non-government).
- Establishment of Community Drug Service Teams.
- Establishment of Local Drug Action Groups.

Co-ordinating groups

- Ministerial Committee on Drug Abuse.
- Senior Officers' Co-ordinating Committee on Drug Abuse.
- Regional Drug Co-ordinating Councils.

7.5 SUMMARY OF RECOMMENDATIONS

NATIONAL CO-ORDINATION

114. That views be sought from all jurisdictions as to whether the Ministerial Council on Drug Strategy should continue in its present form.

115. That it be proposed to the Commonwealth Government that the current National Drug Strategy structure be reviewed by an international authority in a manner similar to the recent review of the National Health and Medical Research Council.

116. That all National Drug Strategy funding, other than that required for central administration, research and policy development, be distributed to the States on a per capita basis for drug prevention and treatment services.

STATE STRUCTURES AND CO-ORDINATION

117. That the Western Australian Government establish a Western Australia Drug Abuse Control Strategy on the basis of:

- the policies, initiatives and structures outlined in this report; with

- implementation of all the proposed changes during the first two years of operation; and

- review and evaluation after the third year of operation.

118. That there be a Ministerial Committee on Drug Abuse, its members to include the Ministers responsible for Health, Police, Education, Justice, Family and Children's Services, Aboriginal Affairs, and Racing and Gaming. The Committee should be chaired by the responsible minister. The proposed Ministerial Committee should be supported by a Senior Officers Co-ordinating Committee with representatives from each portfolio.

119. That a single Minister take overall responsibility for co-ordination of drug abuse control issues. Many senior figures have expressed the view that the most appropriate Minister would be the Premier. The Minister for Drug Abuse Control would be supported by the Central Drug Co-ordinating Office, whose functions are described below. The Minister would specifically carry responsibility for:

- co-ordination;
- policy development;
- funding allocations;
- representing the Government at national meetings and otherwise as appropriate; and
- overseeing implementation of the proposed Drug Abuse Control Strategy.

120. That a Central Drug Co-ordinating Office reporting to the responsible Minister be established, with the following functions:

- policy;
- central co-ordination;
- developing regional co-ordination and community action;
- co-ordination of the collection and provision of information;
- co-ordination of State representation at Commonwealth/State and similar forums;
- liaison with the non-government sector; and
- advice on funding allocations.

121. That the Central Drug Co-ordinating Office be a small unit, with 20-25 FTEs, the resources drawn from those currently allocated to drug issues.

122. That the Central Drug Co-ordinating Office place special emphasis on its information function (see also Recommendation 140).

123. That a non-government central treatment and training agency be established with:

- State Government funding for the provision of specified services;
- the capacity to raise funding from the private sector and elsewhere;
- the capacity to compete for other work;
- funding provided to the agency for an initial three-year period at the end of which its services should be funded by competitive tender on a triennial basis;
- a Board appointed in the first instance by the State Government, to include an independent chairperson who should ideally have specific expertise, and membership from the non-government sector, the business community, and other sectors relevant to the control of drug abuse. The head of the Central Drug Co-ordinating Office would be an ex officio member of the Board.

See also Recommendations 29-36.

124. That an easily recognisable and appropriate name be identified for the proposed non-government organisation that is to function as a central treatment and training agency.

REGIONAL STRUCTURES AND CO-ORDINATION

125. That Regional Drug Co-ordinating Councils (RDCCs) be established in each region of the State. The role of the councils would be to:

- provide a forum for regional co-ordination and collaboration between agencies;
- promote community action;
- provide local advice to the State Government through the Central Drug Co-ordinating Office; and
- be the avenue through which the community can make submissions to the State Government, through the Central Drug Co-ordinating Office, for local service development.

126. That initially four RDCCs be established in the Perth metropolitan area (two in the north and two in the south of the city), and six RDCCs be formed in the regional areas covering the Kimberley, Pilbara, Gascoyne/Murchison, Goldfields, Great Southern and South West regions.

127. That the proposed responsible Minister for Drug Abuse Control appoint the chair of each RDCC and invite relevant persons to participate. Membership should be appropriate to regional circumstances and be drawn from the following:

- State government agency representatives: Health, Police, Justice, Family and Children's Services, Education, Aboriginal Affairs;
- Commonwealth agencies such as ATSIC, Human Services and Health;
- local government;
- non-government alcohol and drug, youth and other relevant agencies; and
- private sector and community leaders.

128. That Community Drug Service Teams (CDSTs) be established in association with the RDCCs to:

- facilitate local co-ordination through the Regional Drug Co-ordinating Councils;
- facilitate local community action; and
- provide such services as are appropriate to the needs of the locality.

129. That the CDSTs be developed as non-government organisations from the community and regional services devolved from the Alcohol and Drug Authority, being funded and contracted through the Central Drug Co-ordinating Office. As with the RDCCs, in the first instance there should be four CDSTs in the metropolitan area, each with between five and eight staff, and six in country Western Australia, each with between three and five staff.

COMMUNITY ACTION

130. That Local Drug Action Groups be established in towns and local communities by individuals concerned about drug problems, with a focus on developing action plans and taking action appropriate to those communities.

131. That some limited seed funding be provided by the Government through grants of up to $500 for each Local Drug Action Group, and that either Healthway or the Lotteries Commission be requested to

establish a special fund to support grant applications for community action projects from Local Drug Action Groups and Regional Drug Co-ordinating Councils.

132. That the Rotary Clubs of Western Australia be requested to take on, in co-operation with others as appropriate, the establishment of a network of Local Drug Action Groups around the State over a two-year period. We recommend further that the aim be to establish a Local Drug Action Group in every significant community in Western Australia by the end of the two-year period.

133. That there be some limited administrative support provided for the two years required to establish Local Drug Action Groups, and to ensure continuing co-ordination and support of such groups. It is recommended that funding for such support should be sought from either the Lotteries Commission or Healthway.

134. That local government be encouraged to support the Local Drug Action Groups.

135. That the Community Drug Abuse Hotline be maintained by the Central Drug Co-ordinating Office.

8. IMPLEMENTATION

8.1 THE WESTERN AUSTRALIA DRUG ABUSE CONTROL STRATEGY

The recommendations of the Task Force combine to form a comprehensive 10-point program to combat drug abuse in Western Australia.

The Western Australia Drug Abuse Control Strategy includes the following elements:

- Policy framework.
- Law enforcement.
- Provision of services.
- Education.
- Community participation.
- Alcohol abuse reduction program.
- Specific issue initiatives.
- Information and research.
- Co-ordination and structure.
- Implementation strategies.

8.2 OVERVIEW OF THE IMPLEMENTATION PROCESS

The implementation of the recommendations of the Task Force that form the Western Australia Drug Abuse Control Strategy constitutes a substantial exercise in the devolution of government services, the development of major initiatives, and the mobilisation of government and community resources.

The process of implementation, as anticipated in the themes and recommendations of this report, will involve the participation of a number of government agencies, non-government and community organisations, and community leaders.

The structures of government proposed by the Task Force: the drug abuse control portfolio, the Ministerial Committee, the Senior Officers Co-ordinating Committee and the Central Drugs Co-ordinating Office (CDCO) would ensure the necessary co-ordination and participation of the various agencies, and provide direction for the process.

The CDCO would be the agency responsible for the implementation of the Task Force recommendations. The approach of the CDCO in fulfilling its mandate should be collaborative as it works with other organisations to meet the various recommendations.

A number of specific consultative and responsible committees have been anticipated elsewhere in this report in relation to various initiatives that would be directed from the CDCO. These include, among others, the Drug Abuse Services Funding Advisory Panel; a committee to undertake the development and implementation of methadone policy and structures; consultative arrangements to develop best practice contract specifications; steering committees for each practice development project in the health, justice and welfare sectors; and the Alcohol Abuse Reduction Program Steering Committee. Other formal and informal consultative mechanisms would be established as appropriate.

It is noted that funding for the initiatives recommended by the Task Force will be met substantially by the savings achieved from the devolution of the Alcohol and Drug Authority and that a source of revenue has been recommended that would greatly exceed the remaining costs.

8.3 TIMEFRAME

The implementation of the Western Australia Drug Abuse Control Strategy proposed by the Task Force would occur over a two-year period, and be reviewed and evaluated after a further year.

The proposed stages of implementation and the timeframe within which each could occur following the Government's decision to proceed are as follows:

• Establishment of the key government structures: drug control portfolio, ministerial committee, Senior Officers Co-ordinating Committee	Within three months
• Establishment of the Central Drug Co-ordinating Office	Within three months
• Commencement of Regional Drug Co-ordinating Councils	Within six months
• Commencement of Community Drug Service Teams	Within six months
• Devolution of the Alcohol and Drug Authority and establishment of the central treatment and training agency	Within six months
• Reforms to the funding of services: best practice contract specifications, competitive tendering	In conjunction with new initiatives, throughout for 1996/97
• Implementation of the preventive education initiatives	Commence between six and 12 months
• Implementation of the various service developments and initiatives	Within 12 months following establishment of CDCO
• Practice development projects in the health, justice and welfare sectors	Within 12 months following establishment of CDCO
• Law enforcement initiatives	In accordance with the legislative timetable
• Establishment of Local Drug Action Groups	Over the two years
• Devolution of methadone treatment to private practitioners	Over the two years

8.4 MINISTERIAL ARRANGEMENTS

The establishment of a drug abuse control portfolio and a Ministerial Committee immediately upon the Government's decision regarding the Task Force's recommendations would greatly expedite their implementation. The Minister for Drug Abuse Control would be the Minister responsible for the CDCO. The Ministerial Committee would be in a position to monitor the implementation process and its members to provide

the necessary directions to the responsible government agencies; it would be capable of co-ordinating as necessary any activities at the government level.

8.5 CENTRAL DRUG CO-ORDINATING OFFICE

As the office responsible for the implementation of the Western Australia Drug Abuse Control Strategy, it is important that the CDCO be established within a short period following a decision by the Government to proceed. As an office of an existing Public Service department this could be readily achieved, although full staffing and implementation of management systems would take more time.

The CDCO should assume its policy and co-ordination functions upon its establishment. Responsibility for funding should be transferred, in co-operation with the agencies currently performing this function, in a short period once the necessary processes are established.

8.6 SENIOR OFFICERS CO-ORDINATING COMMITTEE

The CDCO would co-ordinate the process of forming the Senior Officers Co-ordinating Committee. The Committee should be convened as soon as possible by the CDCO in order to assist the implementation of the various elements of the Drug Abuse Control Strategy.

The Committee would meet regularly throughout the implementation process, although not more often than is practical. The nominated senior officers would, it is anticipated, perform a pivotal role in their agencies with respect to drug abuse issues and act as the senior ongoing contact between the CDCO and the agencies.

8.7 REGIONAL DRUG CO-ORDINATING COUNCILS

The CDCO in consultation with the Alcohol and Drug Authority's regional services would advise the responsible Minister as to the appropriate membership of the various Councils. Their establishment should follow the necessary formal procedures thereafter.

Initially, pending the devolution of the Alcohol and Drug Authority and the establishment of the Community Drug Service Teams, the Councils should be serviced by the Alcohol and Drug Authority's regional services.

8.8 COMMUNITY DRUG SERVICE TEAMS

The establishment of Community Drug Service Teams as new non-government organisations should be managed by the CDCO in conjunction with the formation of the Regional Drug Co-ordinating Councils from which the Teams' management committees will be drawn.

As the Community Drug Service Teams would be an extension and development of the Alcohol and Drug Authority's regional services, their commencement would coincide with the devolution of the Alcohol and Drug Authority.

8.9 DEVOLUTION OF THE ALCOHOL AND DRUG AUTHORITY AND ESTABLISHMENT OF THE CENTRAL TREATMENT AND TRAINING AGENCY

The CDCO and the Alcohol and Drug Authority would establish a working party to manage the devolution process. The Public Sector Management Office could assist the working party as appropriate.

Redeployment and transfer of Alcohol and Drug Authority staff would take place in accordance with established government regulations under the Public Sector Management Act 1994.

The Alcohol and Drug Authority would continue to operate services to be transferred to the central treatment and training agency up to the point of their devolution. These services are the William Street Clinic methadone program, the Central Drug Unit detoxification and outpatient programs, the Alcohol and Drug Information Service, metropolitan and country regional services, and clinical education services. There should be no break in client services as these programs are devolved.

The Alcohol and Drug Authority should transfer the services to be undertaken by other government agencies once these agencies have developed the necessary processes and infrastructure to accommodate them. These are the AIDS service, the Court Diversion Service, and the library.

Administrative staff who are essential to maintain the operation of the Alcohol and Drug Authority until its closure should not be eligible for redeployment until that time.

All staff not in positions in the services to be devolved or transferred, or the core administration, should be eligible for redeployment following a decision to proceed with the devolution.

Transfer of staff to devolved services would occur at the point at which the Alcohol and Drug Authority ceased operation and the central treatment and training agency and the Community Drug Services Teams commenced. It is hoped, and indeed anticipated, that most existing Alcohol and Drug Authority staff employed in the services that are to be devolved would choose to maintain their valuable contribution to the field and take up positions in the new organisations. It is noted that there would also be new opportunities for employment in the field in the various service initiatives proposed by the Task Force.

The necessary steps to establish the central treatment and training agency would be commenced following the establishment of the CDCO. The CDCO and Alcohol and Drug Authority Working Party would oversee staff recruitment and property arrangements for the central treatment and training agency.

The Working Party would also undertake, where necessary, the development of structures, policies and procedures for the devolved services where they would operate differently as part of the central treatment and training agency. This would be the case for the detoxification, outpatient and clinical education services. William Street Clinic, pending the devolution of methadone treatment as outlined in some detail in Chapter 3 of this report, and the Alcohol and Drug Information Service should be able to transfer with minimal adjustment.

8.10 INITIATIVES IN THE PROVISION OF SERVICES

The implementation of initiatives in the provision of services would be undertaken by the CDCO in accordance with its funding and co-ordination responsibilities.

Where the initiatives involve the development of existing services, as identified in Chapter 3 of the report with respect to the extension of services or practice development projects in the health, justice and welfare sectors, the CDCO would work in collaboration with the organisation(s) concerned.

Where there was a choice of provider to undertake the initiatives, it would be determined by competitive tender in accordance with established public sector policy and procedures.

8.11 PREVENTIVE EDUCATION INITIATIVES

The development and implementation of drug education in schools and drug policies for schools would be undertaken by the Education Department. The CDCO and the Health Promotion Section of the Health Department would provide assistance as appropriate.

Public education campaigns would be undertaken by the Health Promotion Services Branch of the Health Department.

The CDCO and other relevant organisations would participate in the co-ordination of preventive initiatives through the Drug Abuse Prevention Steering Committee anticipated in Chapter 4 of this report.

8.12 LAW ENFORCEMENT INITIATIVES

Law enforcement initiatives would be undertaken and directed by the Police Department.

Co-ordination of activities with police would be promoted centrally through the Ministerial Committee and Senior Officers Co-ordinating Committee and locally through the Regional Drug Co-ordinating Councils.

8.13 DISSEMINATION OF THE REPORT

It is proposed that the report be disseminated widely for information and that as part of the implementation process a series of seminars be organised for key interest groups.

8.14 SUMMARY OF RECOMMENDATIONS

136. That the Western Australia Drug Abuse Control Strategy, comprising the recommendations contained in this report, be implemented.

137. That the Central Drug Co-ordinating Office be the agency responsible for the implementation of the Western Australia Drug Abuse Control Strategy. In fulfilling its mandate the Office should take a collaborative approach.

138. That the implementation process involve the participation of the various structures and organisations as set out in the specific recommendations.

139. That the report be disseminated for information, and that a series of seminars be organised for key interest groups.

APPENDIX 1

LIST OF INQUIRIES INTO DRUGS AND DRUG RELATED MATTERS IN AUSTRALIA SINCE 1970

Senate Select Committee on Drug Trafficking and Drug Abuse (1971) [Marriott report].

Western Australia Honorary Royal Commission (1973) [Williams inquiry]. This inquiry examined the need for a separate statutory organisation to provide treatment services, develop drug prevention programs and undertake research into drug use in Western Australia. It resulted in the formation of the Alcohol and Drug Authority.

Senate Standing Committee on Health and Welfare (1975) [Brown report]. This was a follow-up to the 1971 Marriott inquiry.

Senate Standing Committee on Social Welfare (1977) [Baume inquiry]. This committee investigated the use of alcohol, tobacco, prescription drugs and marijuana.

New South Wales Joint Parliamentary Committee Upon Drugs (1978) [Durick inquiry]. The Committee examined the extent of drug problems and reviewed the performance of drug treatment programs in New South Wales.

New South Wales Royal Commission into Drug Trafficking (1979) [Woodward inquiry]. The inquiry was sparked by the disappearance of Donald Mackay in Griffith due to his revelations about large-scale marijuana-growing in the Riverina area.

South Australian Royal Commission into the Non-Medical Use of Drugs (1979) [Sackville inquiry]. This inquiry adopted a 'big picture' approach, i.e. policy issues from drug use. A hallmark of this inquiry was its sponsorship of well researched studies and careful examination of the social consequences of licit and illicit drug use in South Australia.

Australian Royal Commission of Inquiry into Drugs (1980) [Williams inquiry]. A comprehensive inquiry which involved the Federal, Queensland, Victoria, Tasmanian and Western Australian governments and investigated a large number of matters concerned with drug trafficking, eg activities of the 'Mr Asia' syndicate.

Senate Standing Committee on Social Welfare (1981) [Walters inquiry]. It undertook a detailed analysis of the use of prescription drugs in Australia.

Royal Commission into Drug Trafficking (1982) [Stewart inquiry]. This was a joint inquiry of the New South Wales, Victorian, Queensland and Federal governments.

Royal Commission into the Activities of the Federated Ship Painters and Dockers Union (1982) [Costigan inquiry]. This far ranging inquiry uncovered links between the union and criminal groups involved in heroin and other drug trafficking.

Western Australian Select Committee Inquiry (1984) [Hill inquiry]. Reviewed treatment services in Western Australia, in particular the relationship between the statutory and non government services and training and educational programs for health and welfare workers.

Report on the Non-Government Drug and Alcohol Services System (1985) [Lansley Hayes and Storer report]. Investigated non-government drug treatment agencies in New South Wales with the object of demonstrating 'the special characteristics and attributes of the non-government services system.'

Committee of Review into Drug and Alcohol Services in New South Wales (1985) [Kerr report]. Was concerned with the apportionment of funding between government and non government treatment

services, policy questions of the availability of alcohol and other licit drugs, and of means to increase the effectiveness of programs.

Joint Parliamentary Committee on the National Crime Authority (1989) [Cleeland inquiry]. Investigated the policy consequences associated with the prohibition of drugs in Australia.

Select Committee Inquiring into the National HIV/AIDS Strategy White Paper (1990). [Watson report]. The Select Committee of the Legislative Assembly of the WA Parliament considered responses that should be taken at the State level in response to the issues outlined in the Commonwealth's White Paper. In the section concerned with injecting drug use changes were recommended to the laws applicable to injecting drug users. Changes were also recommended for non custodial sentences for those convicted of minor drug offences.

ACT Committee Inquiring into HIV, Illegal Drugs and Prostitution (1991) [Moore inquiry]. This

National Centre for Epidemiology and Population Health (1991) [Bammer report].

Criminal Justice Commission (1994) This investigation involved an examination of the social and legal issues related to the use cannabis. The report includes an economic analysis of the cannabis market in Queensland.

National Task Force on Cannabis (1994) [Ali inquiry]. The Task Force reviewed published research on the health and psychological effects of cannabis (including chronic use), examined trends in use of the drug over time according to variables such as age group and sex, considered a range of data from public opinion surveys and outlined the various legislative options available for regulating cannabis. The results of the inquiry were published as four separate NCADA monographs.

Select Committee on the Control and Illegal Use of Drugs of Dependence (1995) [Pickles and Pfitzner inquiry]. This committee examined a number of matters, trends in the abuse of prescription drugs and heroin and the operation of the South Australian cannabis expiation notice scheme.

Task Force on Drug Abuse (1995) [Daube inquiry]. The Task Force was commissioned by the Premier of Western Australia and as a consequence of its deliberations provided a blueprint that encompassed a range of areas, including changes in the delivery of services, the expansion on education and related preventive activities and the encouragement of greater activism by community groups in responding to social problems at a local level to discourage drug use.

Victorian Premier's Drug Advisory Council (1996) [Pennington inquiry]. This inquiry dealt with a large range of issues and proposed wide ranging reforms concerned with education, community development, treatment etc. Following the implementation of most reforms (with the exception of the proposed decriminalisation of the personal use of cannabis), a Select Parliamentary Committee formed to oversee the implementation of the major recommendations. It is understood the Committee has intensively examined a number of matters and will report back to the Victorian parliament as part of an ongoing process of reform in that State.

Royal Commission into the New South Wales Police Service (1997) [Wood Royal Commission]. The Royal Commission was set up to determine reforms required to enable the NSW police service to improve their competence and integrity in being able to properly deal with serious crime associated with areas such as prostitution, gaming and racing, liquor licensing and illicit drugs. Areas relating to illicit drugs covered in the first report of the Royal Commission starkly illustrate the formidable difficulties police may experience in being able to properly enforce drug laws. The report provides a comprehensive reform agenda involving a large number of measures concerned with the NSW police service, such as training and management, as well as other options for resolving deficiencies through administrative as well as legislative change.

APPENDIX 2
TASK FORCE CONSULTATIONS

The following organisations and senior officials were consulted by the Task Force. Many were consulted on multiple occasions and in both metropolitan and regional locations. A total of 105 are listed and should include all formal consultations. The Task Force, of course, spoke to many individuals representing organisations in a variety of settings and we apologise if we have unintentionally omitted any group.

ALCOHOL AND OTHER DRUGS FIELD

Albany Regional Alcohol and Drug Advisory Council

Alcohol Advisory Council

Alcohol and Drug Authority (various central and regional)

Association for the Care and Rehabilitation of the Alcoholic and Homeless

Australian Council on Smoking and Health

Cambridge Private Hospital

Carnarvon Drug and Alcohol Advisory Committee

Cyrenian House (Western Australia Council on Addictions)

De Paul Community Centre Support Service

Drug Arm

Geraldton/Greenough Alcohol and Drug Advisory Committee

Hearth (Wesley Central Mission)

Holyoake (Australian Institute on Alcohol and Addictions)

Indrad Services Inc

Kalgoorlie Drug Action Group

Liquor Industry Council

Palmerston (Drug Research & Rehabilitation Association)

Perth City Mission

Perth Women's Centre

Port Hedland Alcohol and Drug Advisory Committee

Rosella House (Geraldton)

Salvation Army

St Pat's Care Centre

Swan Brewery

Teen Challenge

Western Australia Consultative Council on Alcohol

Western Australia Hotels and Hospitality Association

Western Australia Network of Alcohol and Other Drug Agencies

JUSTICE SECTOR

Broome Community Policing Committee

Bunbury Community Policing Committee

Chief Justice of Western Australia

Crime Prevention Council

Crime Research Centre

Legal Aid Commission

Magistrates

Ministry of Justice (various central and regional)

Parole Board and Supervised Release Review Board

Police (various central and regional)

President of the Children's Court of Western Australia

HEALTH SECTOR

Australian Medical Association

Bunbury Regional Hospital

Fremantle Hospital

Geraldton Regional Hospital

Graylands Hospital

Health Department (various central and regional)

Healthway

Hepatitis C Council of Western Australia

Osborne Park Hospital

Port Hedland Regional Hospital

Princess Margaret Hospital

Public Health Association

Royal Perth Hospital

Western Australia AIDS Council

WELFARE SECTOR

City of Geraldton Community Services

Department for Family and Children's Services (various central and regional)

Disability Services Commission

Homeswest regional offices

Relationships Australia

Town of Port Hedland Community Services

Western Australia Council on Social Services

Wyndham Action Group

YOUTH FIELD

Anchors Youth Centre (Whitfords)

Andrea Way Child Health Service

Balga Detached Youth Service

Balga Youth Health

Bunyap Youth Support Service (Bunbury)

Fremantle Youth Outreach

Girrawheen Uniting Church

Koondoola and Girrawheen Youth Inc

Koondoola Neighbourhood Centre

Lockridge Youth Service Inc

North East Region Youth Council

Perth Inner City Youth Service

Pilbara Youth Support Services

STAY Short Term Accommodation for Youth (Geraldton)

Step 1

Support Program for Youth (Mirrabooka)

Swan Emergency Accommodation Service

Swanview Youth Centre

Youth Affairs Council

Youth Legal Service

EDUCATION SECTOR

Education Department

Craigie Senior High School

Girrawheen Senior High School

Western Australia Council of State School Organisations

ABORIGINAL FIELD

Aboriginal Medical Service (Carnarvon)

Aboriginal Medical Service (Kalgoorlie)

Aboriginal and Torres Strait Islander Commission (various regions)

Aboriginal Wardens from Oombulgurri, Warnum, Kalumburu and Balgo communities (Kimberley)

Albany Aboriginal Corporation

Broome Aboriginal/Police and Community Liaison Committee

Kanarny Aboriginal Centre

Kardajula Patrol (Carnarvon)

Kuwinywardu Aboriginal Resource Agency (Carnarvon)

Kuljak Aboriginal Employment, Training and Cultural Centre

Milliya Rumurra Rehabilitation Centre (Broome)

Nyungar Alcohol and Substance Abuse Services

Ninga Mia Village Aboriginal Corporation (Kalgoorlie)

Pundulmurra College (and various Aboriginal groups Port Hedland)

Southern Aboriginal Corporation

Special Government Committee on Aboriginal, Police and Community Relations

Waringarri Aboriginal Corporation (Kununurra)

Wartu Kutju Aboriginal Corporation (Kalgoorlie)

Yamatji Patrol, Geraldton

UNIVERSITIES AND RESEARCH ORGANISATIONS

Curtin University

Edith Cowan University

National Centre for Research into the Prevention of Drug Abuse

The University of Western Australia

TVW Telethon Child Health Research Institute

INTERSTATE

New South Wales

Australian Federation of AIDS Organisations

Central Sydney Alcohol and Drug Services

East Sydney Alcohol and Drug Services

Langton Centre

National Drug and Alcohol Research Centre

New South Wales Health Department

New South Wales Police Department

Regent House

Victoria

Moreland Hall

Turning Point

Victorian Association of Alcohol and Drug Agencies

Victorian Department of Health and Community Services

Victorian Police Department

WESTADD

South Australia

Drug and Alcohol Services Commission

Ernst & Young (Review of long-term residential services)

KPMG Peat Marwick (Review of methadone services)

SAVIVE

Australian Capital Territory

Australian Federal Police

Australian Institute of Criminology

Commonwealth Department of Human Services and Health

OVERSEAS VISITORS

Richard Ives, UK consultant (solvent abuse)

Robyn Scott-Blunden, Canadian consultant (treatment and prevention for indigenous people)

Professor Robert Solomon, University of Ontario (alcohol policy)

APPENDIX 3
PUBLIC HEARINGS

Public hearings were held at each of the following locations during 1995 on the dates indicated.

Albany, Monday 13 February

Bunbury, Monday 20 February

Fremantle, Wednesday 22 February

Geraldton, Tuesday 28 February

Warwick, Wednesday 1 March

Kalgoorlie, Tuesday 7 March

Midland, Wednesday 15 March

Carnarvon, Thursday 16 March

Karratha, Monday 20 March

Port Hedland, Monday 20 March

Central Perth, Wednesday 22 March

Broome, Monday 27 March

Kununurra, Tuesday 28 March

Northam, Monday 3 April

Western Australia Telecentre hearing, Thursday 6 April

Mandurah, Monday 10 April

APPENDIX 4

SUBMISSIONS RECEIVED

PUBLIC SECTOR AGENCIES/WORKING GROUPS/OFFICERS

Alcohol and Drug Authority
ABC Radio Albany
Albany Port Authority
Commissioner for Occupational Health, Safety and Welfare
Curtin University of Technology
- Faculty of Education
- Pharmacology and Toxicology Clinical Biochemistry

Department of Minerals and Energy Mining Operations Division
Department of Sport and Recreation
Disability Services Commission
Edith Cowan University Department of Health Studies
Education Department
- Responses from various schools to the Curriculum Branch
- Hollywood Senior High School

Great Southern Development Commission
Health Department
- Injecting Drug Use Implementation Working Group
- State Health Laboratory Services
- State Health Laboratory Services, Pharmacology and Toxicology
- Community and Public Health Unit — Inner City Health Service
- Environmental Health Branch
- Health Promotion Services Branch
- Clinical Co-ordinator, Rockingham/Kwinana Psychiatric Service
- Wheatbelt Public Health Unit
- Gascoyne Community and Public Health Services

King Edward Memorial Hospital Chemical Dependency Clinic
Kings Park and Botanic Garden
Lotteries Commission
Ministry of Justice
Ministry of Sport and Recreation
National Centre for Research into the Prevention of Drug Abuse
Office of Racing and Gaming
Office of Women's Interests
Pilbara Development Commission
Police Department
Princess Margaret Hospital
- Head of Adolescent Services
- Child and Adolescent Psychiatrist
- Research Fellow in Adolescent Medicine

Rottnest Island Authority
Screen West
Sir Charles Gairdner Hospital Social Work Department
South Metropolitan TAFE College
Swan District Hospital
The University of Western Australia
- Department of Paediatrics
- Department of Pharmacology

LOCAL GOVERNMENTS

City of Armadale: Community Services Division
City of Kalgoorlie-Boulder
City of Melville
City of Rockingham
Dandaragan Shire
Shire of Collie
Shire of Collie
Shire of Leonora
Shire of Ngaanyatjarraku, Alice Springs
Shire of Pingelly
Shire of Roebourne
Shire of Shark Bay

NON-GOVERNMENT AND COMMUNITY ORGANISATIONS

Advertising Federation of Australia
Advisory and Co-ordinating Committee
Advisory and Co-ordinating Committee on Child Abuse
Albany Regional Alcohol and Drug Advisory Committee Inc
Alcohol Advisory Council of Western Australia
Alcohol Advisory Council of Western Australia Inc
Alcohol and other Drugs Council of Aust
All Saints' College
An informal group of Roebourne service providers
Association of Independent Schools of Western Australia (Inc)
Australian Association of Social Workers (Western Australia Branch)
Australian College of Paediatrics
Australian Council on Smoking and Health
Australian Family Association
Australian Medical Association
Australian Parent Movement of Western Australia Inc
Australian Parliamentary Group for Drug Law Reform
Australian Pharmaceutical Manufacturers Association
Broome Regional Policing Committee
Building Trades Group of Unions Drug & Alcohol Committee
Bunbury Catholic College
Bunbury Regional Prison
Cammarata & Co
Cancer Foundation of Western Australia
Carnarvon Alcohol and Drug Advisory Committee
Cellarmasters
Centacare Bunbury: Research Project Report
Christian Science Committee on Publication
Committee for the Establishment of an Adult Sobering-Up Facility in Midland
Community Action Legislation Lobby
Community Health Department South Hedland
Community Policing Council of Western Australia (Inc)
Community Youth Consultancy of the Uniting Church in Western Australia
Cyrenian House (Western Australia Council on Addictions)
Department for Family and Children’s Services, Cottesloe
Department of Minerals and Energy
Distilled Spirits Industry Council of Australia Inc
Drillcorp Limited
Drug Action Group (Kalgoorlie)
Drug Arm Western Australia
East Kimberley Regional Youth Service
Eastwood Parents & Friends' Federation

Family Abuse Service
Family Planning Association of Western Australia: Quarry Health Centre
Forensic Advisory Service
Fremantle Nyungar Community
Goldfields Community Policing Committee
Guildford Grammar School
Health Consumers' Council of Western Australia Inc
Hollywood Senior High School
Holyoake (Australian Institute on Alcohol and Addictions)
Hope Naturopaths
Hyperactive Help
Injecting Drug Use Initiatives Group
Inner City Health Service
Kimberley Aboriginal Medical Services: Health Promotion Unit
Learning and Attention Disorders Society
Life Education Western Australia Inc
Lions Club of Broome
Lockridge Youth Services
Marion Merrell Dow Aust P/L
Marnja Jarndu Women's Refuge
Marnja Women's Refuge, Broome
Midland Community Youth Centre
Midland Debt Counselling Service Inc
Milliya Rumurra Rehabilitation Centre (Broome)
MISSAP
Mobile Information Service and Substance Abuse Program
Modern Dreamtime Dance Group (Broome)
Montessori School, Kingsley
National Centre for Education & Training on Addiction
National Council of Women of Western Australia Inc
Neighbourhood Watch: Leeming Area Co-ordinators
Palmerston (Drug Research and Rehabilitation Association)
Parents and Friends' Federation of Western Australia (Inc)
Pensioners' Action Group (Inc)
Perth City Mission
Pharmacy Guild of Australia (Western Australia Branch)
Pharmacy Guild of Western Australia
Port Community High School
Research Fellow in Adolescent Medicine
Residential & Community Care Advocacy Service
Roebourne Sobering-Up Shelter Inc
Rotary International District 9450 East Perth
Rotary International in Western Australia
Royal Flying Doctor Service of Australia: Victorian Section
Samaritan Befrienders
School Health Coalition of Western Australia
School Health Coalition of Western Australia Inc
St Vincent de Paul (Narrogin)
Swan Emergency Accommodation
The Australian Associated Brewers Incorporated
The Barrows Foundation
The Council for Christian Action
The Liquor Industry Council of Western Australia Inc
The Pharmaceutical Council of Western Australia
The Royal Australian and New Zealand College of Psychiatrists
The Royal Australian College of General Practitioners
The Salvation Army Bridge Programme
The Women's Christian Temperance Union of Western Australia Inc
Twigs Nursery & Reticulation

Western Australia Council on Addictions Inc (Cyrenian House)
Western Australia Network of Alcohol and other Drug Agencies
Western Australia Primary Principals' Association
Waratah Support Centre
Western Australian AIDS Council
Western Natural Health Centre
Wheatbelt Agcare: Family Counsellor
Willetton Youth Community Connection
Wilson Park Primary School P & C Association
Women's Health Care Association — Perth Women's Centre
Wyndham Action Group
Youth Co-ordinating Committee Area North East and
Youth Justice Coalition

PRIVATE INDIVIDUALS

Andrews Judy
Airey Lisa
Anderson Joyce
Atkinson Liz
Bailey Rod
Baker John A
Bernard Jen
Blood Kate
Brajkovich P
Brown C P
Calderbank Keri
Cammarata G A
Campbell Ford
Chapman E G
Cooney Helen
Cousins C L
Cunningham Y
D'Cruz Nigel
Dewar R B
Duxbury John F
Dyer Simone
Foster Aladina
Gossman Anna
Hankinson Jan
Harding L M
Horton David
Horton T P
Hosking Nola
Hudson Jan
Hunt Brett
Inglis L N
Johnson M F (two submissions)
Kavanagh Darren
Kielty Reg
Kieran Anthony W
Konstek Aida
Laidler Bo
Landgren M A
Lidington D
MacTiernan Alannah MLC
Mani J
Mawson Greg
McConigley Christine
Moran Kevin
Morgan Barbara
Moss Jeff
Mullins Geraldine
Needs Peter
Needs Raymond
Odgers Trevor and Janice
Paget Lorraine
Pensalfini Rob
Perry Carole
Phease Robert A
Pocock Dr Derek A
Richards Kevin
Roberts Margery
Roe Rev Frank R
Rose Jon
Ryan M A
Scott Brett
Shedley M R
Smith David MLA
Smyth B & W M
Smyth Wayne
Stanley Beth
Stapleton Guy
Stoker R W
Sullivan Helen
Sunkar S S
Taylor Major General K J
Tyers Merle
Vernon Lynda
Wall Dr Melvyn
Walters Elaine
Warner Susan
White Homer
Whyte Geof
Wray David
Zani Pauline

12 anonymous submissions.

A further 63 submissions, the majority anonymous, were received after public hearings.

APPENDIX 5

AGENCIES RESPONDING TO THE DRUG ABUSE EXPENDITURE SURVEY

GOVERNMENT ORGANISATIONS

Aboriginal Affairs Department
Aboriginal and Torres Strait Islanders Commission
Agriculture Protection Board
Albany Port Authority
Animal Resources Authority
Bunbury Port Authority
Bush Fires Board of Western Australia
Curtin University of Technology
Dairy Industry Authority of Western Australia
Dampier Port Authority
Department for Family and Children's Services
Department for the Arts
Department of Occupational Health, Safety and Welfare
Department of Agriculture
Department of Environmental Protection
Department of Land Administration
Department of Local Government
Department of Minerals and Energy
Department of Productivity and Labour Relations
Department of Resources Development
Department of State Services
Department of Transport
Edith Cowan University
Education Department
Equal Opportunity Commission
Fisheries Department
Fremantle Port Authority
Gascoyne Development Commission
Gold Corp Australia
Goldfields-Esperance Development Authority
Government Employees Housing Authority
Government Employees Superannuation Board
Great Southern Development Authority
Health Department of Western Australia
Hedland College
Homeswest
Karratha College
Keep Australia Beautiful Council
Kimberley Development Commission
Law Reform Commission
Library and Information Service of Western Australia
Lotteries Commission
Main Roads Department
Mid-West Development Commission
Ministry of Fair Trading
Ministry of Justice
Ministry of Sport and Recreation
Ministry of the Premier and Cabinet
Murdoch University
National Trust of Australia

Office of Auditor General
Office of Information Commission
Office of Multicultural Interests
Office of Non-Government Education
Office of Racing and Gaming
Office of Seniors' Interests
Parliamentary Commissioner for Administrative Investigations
Peel Development Commission
Perth Market Authority
Perth Theatre Trust
Pilbara Development Commission
Police Department of Western Australia
Port Hedland Port Authority
Public Trust Office
Rottnest Island Authority
Rural Housing Authority
Small Business Development Corp
South West Development Authority
State Government Insurance Commission
State Taxation Department
Subiaco Redevelopment Authority
Totaliser Agency Board
University of Western Australia
Valuer General's Office
WA Alcohol and Drug Authority
WA Department of Training
WA Electoral Commission
WA Film Council
WA Industrial Relations Commission
WA Museum
WA Potato Marketing Authority
WA Sports Centre Trust
Westrail
Wheatbelt Development Commission
Workcover
Zoological Gardens Board

LOCAL GOVERNMENT ORGANISATIONS

Albany Shire Council
Albany Town Council
Armadale City Council
Ashburton Shire Council
Augusta-Margaret River Shire Council
Bayswater City Council
Beverley Shire Council
Boddington Shire Council
Boyup Brook Shire Council
Bridgetown-Greenbushes Shire Council
Broome Shire Council
Broomehill Shire Council
Bruce Rock Shire Council
Bunbury City Council
Busselton Shire Council
Capel Shire Council
Carnamah Shire Council
Chittering Shire Council
Claremont Town Council

Cockburn City Council
Collie Shire Council
Coolgardie Shire Council
Cottesloe Town Council
Cranbrook Shire Council
Cuballing Shire Council
Cue Shire Council
Dalwallinu Shire Council
Dowerin Shire Council
East Fremantle Town Council
Esperance Shire Council
Exmouth Shire Council
Fremantle City Council
Gingin Shire Council
Gosnells City Council
Greenough Shire Council
Halls Creek Shire Council
Kalamunda Shire Council
Katanning Shire Council
Kellerberrin Shire Council
Kent Shire Council
Kojonup Shire Council
Koorda Shire Council
Leonora Shire Council
Mandurah City Council
Manjimup Shire Council
Meekatharra Shire Council
Menzies Shire Council
Merredin Shire Council
Mingenew Shire Council
Moora Shire Council
Morawa Shire Council
Mukinbudin Shire Council
Murchison Shire Council
Murray Shire Council
Nannup Shire Council
Narrogin Shire Council
Northam Shire Council
Northam Town Council
Northampton Shire Council
Nungarin Shire Council
Peppermint Grove Shire Council
Pingelly Shire Council
Plantagenet Shire Council
Quairading Shire Council
Ravensthorpe Shire Council
Rockingham City Council
Roebourne Shire Council
Serpentine-Jarrahdale Shire Council
Shark Bay Shire Council
Stirling City Council
Subiaco City Council
Swan Shire Council
Tambellup Shire Council
Tammin Shire Council
Three Springs Shire Council
Trayning Shire Council
Victoria Plains Shire Council
Wandering Shire Council

Waroona Shire Council
Westonia Shire Council
Williams Shire Council
Woodanilling Shire Council
Wyalkatchem Shire Council
Yalgoo Shire Council

NON-GOVERNMENT ORGANISATIONS

Aboriginal Legal Service
ACTIV Foundation
AIDS Pastoral Care
Alcohol Advisory Council
Anglican Homes
Anglicare Health and Welfare Services
Association Civilian Widows
Association for Advancement of Brain Injured Children
Association for Welfare of Children in Hospital
Asthma Foundation of Western Australia Inc
Australian Institute of Welfare and Community Workers
Australian Association Social Workers
Australian Council on Smoking and Health
Australian Lions Drug Awareness Foundation
Australian Red Cross Society
Baha'i Centre
Bassendean Youth Service
Belmont Community Advice Service
Bunbury Community Group
Bunbury Community Legal Centre
Bunbury Diocesan Anglicare Council
Busselton Youth Outreach
Carnarvon Shire Council
Catherine McAuley Family Centre
Catholic Church
Christian Science Churches
Churches of Christ in Western Australia
Citizen's Advice Bureau
CLAN Association, Community Link and Network
Collie Welfare Council
Coptic Orthodox Church
Cottage Hospice
Council to Homeless Persons
Creative and Therapy Activities Disabled Group
Crossroads West
Cyrenian House
Developmental disability Council
Diabetes Association of Western Australia Inc
Djooraminda
Eastern Goldfields Halfway House
Eastern Goldfields Sexual Assault Group
Even Keel (Manic Depressive Support Association)
Family Planning Association of Western Australia
Family Support Association
Financial Counsellors Resource Project
Frontier Services — Uniting Church
Geraldton Home Help
Geraldton Regional Community Education Centre
Goldfields Women's Health Care Centre

Gosnells District Information Centre
GROW Inc
Halls Creek People's Church Sobering Up Centre
Harvey Home and Community Care
Heart Kids (Western Australia) Inc
Holyoake Institute
Homes of Peace
Kimberley Aboriginal Medical Service Council
Koolkuna Women's Refuge
Koondoola Neighbourhood Centre
Laverton Community Youth Centre
Leeming Centre Link
Lions Club International 201 W1
Local Information Network
Lockridge Community Group
Lockridge Youth Centre
Lyla Elliott Family Day Care Association
Meeralinga Young Children's Foundation
Melville Cares Inc
Midwest Life Education Centre
Mullewa Home & Community Care
Multiple Sclerosis Society
National Heart Foundation of Australia
NGALA Family Resource Centre
North West Metro Youth Service
Palmerston Drug Research and Rehabilitation
Paraplegic-Quadriplegic Association
Parents Without Partners
Peel Women's Health Group
Perth City Mission
Perth Inner City Housing Association
Pilbara Youth Services Inc
Pilbara-Kimberley Life Education Centre
Project with Young People
Religious Society of Friends (Quakers)
Restoration Inc
Royal Flying Doctor Service
Roebourne Sobering Up Shelter
Rosella House
Rotary Club District 9470
Schizophrenia Fellowship of Western Australia
Second Harvest Australia Inc
Seventh Day Adventist Church, Headquarters
Sexual Assault Referral Centre
Silver Chain Nursing Association
Soundworks
South Care Inc
South West Social Development Council
Spina Bifida Association
St Bartholomews House Inc
St John Ambulance Association
Tom Price Youth Centre
Uniting Aid Inc
Variety Club of Australia (Western Australia Chapter)
Volunteer Centre of Western Australia
Volunteer Task Force
WA Deaf Society
WA Epilepsy Association
Wanslea Family Support Services

Waratah Support Centre
Welfare Rights Advocacy Service
Western Institute of Self Help
Women's Health Information Service
Wyndham Action Group
Yaandina Family Centre
Yirra (Perth City Mission)
YMCA Perth
YWCA
ZONTA House Refuge Association

APPENDIX 6

CONSULTATION WITH FAMILIES WHO HAVE EXPERIENCED DRUG ABUSE

INTRODUCTION

The Task Force was fortunate to have the assistance of Ms Keri Calderbank who, in a voluntary capacity, conducted consultations with 20 families who have experienced drug abuse.

The families were asked to participate after attending either a Task Force public hearing or a drug and alcohol treatment agency. The sample of families is not presented as representative of the experience of all families, but rather provides some indication of the experience of many.

The consultations provide a valuable insight into the impact that drug abuse has on families and the inordinate frustration that parents particularly experience in seeking help to address their problem.

While any assessment of the various agencies' responses to drug abuse, as described here, must be tempered by the realisation that drug abuse involves deliberate individual choice, even when the individual is a child, the various agencies and the community need to recognise the views of the families concerned.

In considering the suggestions put forward by the families, it is clear, as the Task Force itself has proposed, that curtailing drug abuse demands action from the whole of government and the community itself. The Task Force in its recommendations has addressed some of the concerns of these families where they are within its mandate. Other suggestions, as is the case for all recommendations put in submissions to the Task Force, will be forwarded to the agencies with the appropriate responsibility.

It is noted that many of the suggestions propose a change in attitude or approach by various agencies and their staff rather than changes in structures and programs. Requests for understanding, an absence of prejudgement and respect for the role of parents should strike a responsive chord in all areas of the human services.

In presenting the experiences of these families and their criticisms of some organisations, the Task Force is keenly aware that the expectations or demands placed on agencies, and particularly the statutory agencies of last resort, are often unrealistic and indeed not possible in the face of severe and entrenched drug abuse. Agencies will be attempting to achieve the outcomes desired by families but where this is not achieved some level of criticism is inevitable. The experiences reported here need to be considered in this context.

With the exception of minor editorial or stylistic changes, the report is presented as it was provided to the Task Force with one exception. Agencies have been identified but not named in the report because the consultation did not reflect a representative sample and the relevant agencies have had no opportunity to respond to the specific circumstances giving rise to the various comments. As indicated, the report and its suggestions will be forwarded to the specific agencies. Again it is emphasised that the report is intended to provide insights rather than to represent the experience of all families or the overall performance of various agencies. The Task Force is most grateful to Ms Calderbank for her time and effort and the valuable contribution she has made to the Task Force's work. Report of the Consultation

BACKGROUND

A number of families of people with drug problems were interviewed. The families were approached by the Task Force for a detailed interview either after one of the public hearings or on the recommendation of one of the various agencies. The purpose was to try and build up a picture of drug abuse and its effects from the point of view of one of the major victim groups, the families of those

with a serious drug problem. The views of the families were sought as to how they thought the problem started, which agencies, if any, they turned to for help and whether the services provided by the agencies were helpful. Most importantly, the families were asked what changes they thought were necessary to the various programs and agencies, based on their real-life experiences.

Twenty families were interviewed, a total of 24 family members having had a major drug problem.

1. Person with the drug problem

Son	15
Daughter	6
Husband	3
Wife	0

In 17 of the 20 cases, only one family member was reported as having a drug problem.

2. Nature of the problem(s)

Marijuana	15
Alcohol	12
Amphetamines	8
Tobacco	4
Heroin	4
Prescription drugs	2
Cocaine	1
Solvents	1
LSD	1

In all cases where the person used marijuana, he/she also had another drug problem — principally alcohol or amphetamines or both. Also, all those with an amphetamine problem used Rohypnol or heroin to come down — this abuse of prescription drugs or heroin is not included in the above, because the families did not regard it as being the main problem. Also, properly prescribed drugs such as pain-killers (primarily Panadeine Forte and Doloxene) to help the drug abuser cope are not included in the above. Finally, most families admitted they did not know the full extent of the drugs used by their affected member.

3. Socio economic status of family

Two parent/two income	13
Two parent/one income	2
One parent/one income	4
One parent/welfare	1
Two parents/welfare	0

In some cases, the income is from a part-time job. Three of the single parent families received a top-up to their income from the Department of Social Security.

4. First drug tried

Marijuana	17
Alcohol	3
Tobacco	3
Solvent	1

All those families who reported that the problem started with marijuana also reported that the affected person started smoking tobacco around the same time, so it is not always clear which was the first drug used.

5. Current status

Problem significantly cured	5
Problem 'on the mend'	9
Problem continues	10

6. Living at home

Living at home most of the time	7
Living away from home about 50%	10
Living away from home mostly	7

EFFECT ON FAMILY

In all cases families described the impact of the drug abuse as traumatic. The specific effects, and the frequency of occurrence within the group of 20 families and 24 drug abusers, speak for themselves.

Person violent towards other family members	23
Stole from family	24
Frequent lies to family	24
Mood swings	24
Manipulative	24
Committed crimes (other than drug crimes) outside family	18
Suicide attempts	10
Caused family breakdown	12
Family had to move	10

AGENCIES

The families reported using a wide range of agencies. Their general comments are as follows:

POLICE

Most families had a significant level of involvement with the police through the offending of their drug affected member(s). In all but two cases, the families rated the police very highly. It was generally thought that, of all the agencies, the police appeared to have the best understanding of the problem and of the difficulties faced by the families. All but two of the families felt the police were supportive and sympathetic. Most commented that the police seemed somewhat jaded by the enormity of the drug problem, as it relates to the carrying out of crimes, and the performance of the Children's Court and the various other government agencies involved in the juvenile justice system.

Those families in which the father/husband was drug-affected reported that the police were unable to deal effectively with the domestic violence and intimidation, but all recognised that the police do what they can under the law and within their resources.

The main concern of the two families who had negative comments about the police were that the police seemed half-hearted in trying to catch the drug dealers.

HOSPITALS

About a third of the families interviewed had extensive contact with hospitals in relation to the drug problem.

Those families who sought the help of hospitals to deal with drug overdoses felt that the hospitals were unhelpful. They thought that the hospitals assumed they were dysfunctional and therefore to blame for the drug problem, and generally reported feeling excluded from the issue by the hospital staff.

The families whose drug-affected member attempted suicide were generally satisfied with the medical assistance given, but reported that they felt the hospital staff were judgemental of the family and didn't adequately involve the family during the crisis.

DRUG REHABILITATION AGENCIES AND OTHER SERVICE PROVIDERS

23 of the 24 drug affected people in the families tried rehabilitation agencies.

The families were mixed in their assessment of the agencies and programs.

The 10 families that used Agency A were all positive about its value. In particular, they reported that Agency A was especially good for the families of drug affected people and they learnt useful skills and strategies for dealing with the drug problem in their families. Most reported that progress for the drug affected person was slow but, in most cases, eventually helpful for the individual.

The three families that used Agency B made comments similar to those that used Agency A. The comment was often made that Agency B did not pay as much attention to the personal problems of the drug-affected individual as Agency A. But both Agency A and Agency B were regarded as being very supportive of families and therefore very "user friendly".

The four families that became involved with Agency C rated it poorly. Claims were made that drugs were entering the premises. All reported that Agency C had a policy (either formal or informal) that excluded families from being involved. Also, all reported that there was no follow-up programs for people leaving Agency C.

The four families that used Agency D reported that the individual did not make any progress in dealing with his/her drug problem but, if anything, the problem became worse. In all cases the referrals were ordered by the Children's Court and the individuals could be regarded as being resistant to any help. This report also needs to be balanced by other consultations conducted by the Task Force with former residents of this program who credited the agency with assisting them in overcoming their drug problems (as described in the main report). The families reported that the staff at Agency D were helpful and dedicated, but many were young, naive and prone to be manipulated by the drug affected patients who were, after all, there against their will.

The six families that used Agency E found it of limited help. They reported that they had difficulty convincing Agency E that a crisis actually existed. Most of the families that used Agency E were from the country, where there is no local help for families or drug affected individuals.

The six families that became involved with Agency F all reported that Agency F appeared most willing to believe stories of abuse etc told to it by the drug affected child, without checking with the parents. Where Agency F apparently believed an allegation of abuse by the parents, in no case did Agency F investigate whether other children in the family were also at risk of abuse. All families commented that where Agency F counsellors they encountered were young, inexperienced and had no children of their own, they were of no assistance. The advice given to the families was invariably "theoretical" rather than practical and the families felt that there was an attitude of presumption and blame and an assumption that the counsellor knew more than the parent. However, the families did have some positive comments about those Agency F counsellors who had children of their own. All families reported that other agencies they had dealings with all held a very negative attitude towards Agency F and the police in particular tended to regard Agency F as contributing to the overall problem.

The four families that used Agency G were all very negative about its value. All said Agency G was used as a "doss house" where drug affected children could get a bed for the night. All families reported that the children that used Agency G all claimed drugs were entering the premises.

The five families that used Agency H reported that the program was very good providing the drug affected person was motivated to kick the habit. All reported that Agency H involved the person's family thoroughly and provided very useful support for the families. They also reported that the follow-up program was good and provided ongoing support for the family as well as the individual.

Only two families had significant experience with Agency I. Both used Agency I for the specific reason that the program is conducted away from Perth. Both found the program to be excellent - in particular that it went beyond simply dealing with the drug problem and gave the patients the lifeskills necessary to develop a permanent freedom from drugs. The families found that Agency I supported them as well. The Agency I program involves a substantial period of "no outside contact" at the start of the program.

Five families had a substantial level of experience with the Children's Court. These asserted that the Court showed little interest in recognising that a drug problem existed. They saw the Court's interest as being to refer some juvenile offenders to Agency D, with no provision for any follow up, or a vague order to Agency F that the juvenile undergo drug counselling, with no effective provision to ensure that the counselling actually happens. In all cases, the families reported that Children's Court orders relating to drug counselling were mostly ignored and the counselling did not occur.

As some families were referred to the Task Force by some of the agencies themselves, the sample of families is unlikely to represent a "typical pattern" of experience of the agencies. All families interviewed knew of other families with drug problems. Their comments suggest that a high proportion of those other families do not use any agencies, other than those they use involuntarily - the police, Children's Court, Agency F.

SUGGESTED REFORMS FOR JUVENILES

EDUCATION PROGRAMS

- Parents need to be able to better identify the early warning signs that their child is dabbling in drugs. A broad program targeted at parents generally and a specific, information-loaded program that parents can access easily if they feel the need.

- A much clearer message on the issue of alcohol and marijuana use. Currently there are conflicting messages. Perhaps a ban on alcohol advertising and a more aggressive "Quit" type campaign aimed at alcohol and marijuana.

- Parents need a sympathetic hotline advice service to provide instant information on how to deal with a juvenile who is high on drugs.

- A concerted campaign to promote the rights and responsibilities of parents in bringing up children. At the same time, all education campaigns relating to children's rights should also promote (teenage) children's responsibilities.

- The drug problem would be significantly less if we could undo the "anti dobbing" attitude that prevails in WA. People should be taught that it is their civic duty to "dob" on drug dealers. Further, teachers, other parents and others who are in a position to know if a child is at risk of becoming involved in drugs should be encouraged to contact the child's parents and raise the alarm.

- Parents need the skill to be able to recognise and deal with negative peer pressures on their children.

- There needs to be a more positive attitude towards the role of discipline in child-rearing. Reasonable discipline should never be regarded as abuse and parenting programs should never portray reasonable verbal discipline as undermining a child's development.

- A major problem is that many parents (baby boomers) have a soft attitude towards drugs themselves. Caring parents often find that pro-drug messages can come from other parents, into whose care they sometimes allow their children (ie sleepovers etc). Parents need to be more united in taking a strong and consistent stand on drugs. Perhaps an education program reinforcing parents' responsibility in this issue.

- There needs to be more support for families who do not accept that getting drunk is acceptable behaviour for a person within that family. For example, a wife who stands up to her husband's excessive drinking should not have her stand undermined in front of her children by the extended family or by friends. An education campaign promoting the value of people who stand up against excessive drinking might be valuable.

LEGISLATION

- Much harsher penalties for drug dealers, including changing the law so that the courts can more easily seize the assets of big dealers.

- Child Welfare Act should be changed so that police powers to take children off the streets at night and return them home are clarified.

- The drinking age should be increased to 20 or 21.

- The law should be amended to ensure that schools have the unqualified right to search school bags etc for drugs.

- It should be a criminal offence for a person to encourage another to use illegal drugs or encourage a minor to use alcohol or tobacco. This should include advertising and any public statement that dishonestly represents the use of a drug as harmless.

- The law should ensure that employers, teachers etc have the right to carry out a random drug test (similar to RBT for alcohol) if they suspect the worker or student is under the influence of drugs.

FAMILY SUPPORT

- Operation Noah should be able to receive complaints from family members. At present, it does not do so.

- The confidentiality of information about a child (on DFCS files, doctor's records etc) should not apply to parents. These confidentiality provisions have prevented parents from knowing the extent of a problem or being able to seek timely help and they are an impediment to dealing with a juvenile's drug problem.

- Parents should have the unqualified right to commit a drug affected child to a detoxification centre for as long as it takes the juvenile to "come down" and start to behave reasonably. The detoxification centres should have a lock-up facility so that drugged juveniles can be dried out irrespective of their wishes.

- The truancy program needs to be reviewed so that parents are informed more quickly if their child fails to turn up at school.

- After hours access to police is a problem in many areas. There needs to be better access to some form of instant help for families that are under immediate threat of violence from a drug affected member.

- Schools should take more responsibility for reporting suspected drug dealers amongst the student body or that come onto the premises to sell to the students. The law should be checked to ensure that teachers acting in good faith are given full protection from any legal action arising from such a report.

- Operation Sweep was a significant move in the right direction. It should form the basis of normal police practice in the future.

- The Young Homeless Allowance has been a major problem for families in the past. There has been some tightening up of the program, but it remains too easy for children who want to leave a good home to tell the appropriate lie to become eligible.

- The Government should direct resources away from Agency F and the juvenile lobby groups and towards developing a Statewide program of parent support.

- There needs to be an agency acting as a parent advocate for parents in the early stages of dealing with other agencies in relation to a drug problem.

- There needs to be an effective "one stop shop" where parents can find out what programs are available. Currently, parents do not choose between programs because they do not know the range available. They tend to try one program after another until they find one that works for them. This takes up valuable time if the drug problem is escalating in the meantime.

- There needs to be some independent evaluation of the various programs so that parents can make an informed choice.

- Government funding should be targeted towards programs that work and that support families, and directed away from agencies and programs with a poor track record.

AGENCIES AND COUNSELLORS

- Those who counsel families or children should, as a matter of course, be parents themselves or have extensive experience in dealing with families and children.

- Counsellors need to develop the equivalent of a "bedside manner" when dealing with families. It is not acceptable for counsellors, however highly educated, to assume superiority over parents or assume greater knowledge of the individual child. The arrogance of some counsellors has been a major problem for many families.

- Counsellors should understand that most drug affected juveniles are less than honest about their habits and their relationship with their families.

- Agencies should involve caring parents in rehabilitation programs, except where isolation is part of the program (ie part of the Agency I program).

- Agencies A, B, H, and I have programs that are highly regarded. Funding should be diverted away from other programs that are failing and used to develop programs that "fill the gaps" that exist between the successful programs.

- There is virtually no help for drug problems in the country, other than a 008 number. In establishing country programs, care should be taken to recognise that the relative anonymity that exists for people attending programs in the city may not be easily achieved in country towns.

- If the attitude of hospitals to overdose victims cannot be changed, the Government should underwrite a 24 hour emergency GP service to deal specifically with these cases.

SUGGESTED REFORMS FOR ADULTS

- Many of those suggested for juvenile drug problems were also suggested for adult problems.

- There is a waiting list for adults with an alcohol problem. This is ridiculous, given the nature of the problem. Some form of immediate help, both for the adult alcoholic and for his/her family members (who may be under immediate threat of violence) is essential.

- Police have inadequate powers to deal with a situation where a drunken family member is threatening violence towards his/her spouse or children. It is not always possible to get a restraining order.

- Adult alcohol problems are not being given the same priority, in terms of programs and funding, as juvenile drug problems. Adult programs in country areas are virtually non-existent.

CONCLUSION

The extreme stress on other family members and the family unit itself caused by drug abuse needs to be recognised. Agency counsellors need to be able to understand and identify these stresses and the potential for family breakdown.

The stereotyped view that parents whose children abuse drugs must by definition be lousy parents has to be overcome.

All drug rehabilitation and other services should involve the family, respond to its needs and recognise the caring family's role. A significant part of any program should be aimed at showing the family how to cope with the situation.

APPENDIX 7

WHAT ARE THE DRUGS — AND WHAT DO THEY DO?

The following brief summary of the main drugs that are abused is taken largely from the British White Paper on drug abuse, 'Tackling Drugs Together' (Home Office 1995).

Alcohol (wine, beer, spirits, liqueur) is made from fermentation of fruit, grain and vegetables. Low doses produce mild euphoria, relaxation, increased confidence. Higher doses will also produce dizziness, unclear judgement, unco-ordinated movements, slow reactions, blurred vision and slurred speech. Its bad effects include aggression and severe physical and mental damage when used chronically in large amounts.

Tobacco (cigarettes, cigars) contains nicotine, tar, carbon monoxide and 4,000 other chemicals. Smoking increases the pulse rate and can suppress the appetite. Prolonged use, at any level, can result in a variety of heart and respiratory disorders and cancers.

Heroin (smack) derives from the opium poppy. Heroin produces initial euphoria followed by drowsiness and 'drunken' appearance. Overdosing can produce unconsciousness. Regular, frequent use produces dependence. In these situations, sudden withdrawal can cause effects similar to flu.

Cocaine (coke) derives from the coca plant. Cocaine makes people excited, over-alert, indifferent to pain and feel strong both physically and mentally, overcoming fatigue and tiredness. Depression and insomnia can, however, follow. Heavy use can produce psychological dependence and paranoia. Crack is cocaine in a smokable and rapidly absorbed form, carrying higher risks of addiction.

Amphetamines (speed, goey) are synthetic stimulants which make the user initially energetic and confident, but anxiety and restlessness can follow. High doses can produce delirium, panic and paranoia.

Tranquillisers (benzodiazepines including Valium, Serapax, Rohypnol) are supplied legally on prescription but unauthorised supply is an offence under the Misuse of Drugs Act 1981. Possession of these drugs is not illegal as long as they are in the form of a medicinal product. Complex and potentially lethal interactions are caused when taken with amphetamines, cocaine, heroin or alcohol.

LSD (acid) produces hallucinations and intense thoughts and emotions, but depending on the circumstances, can cause depression, dizziness and paranoia.

Ecstasy ('E' or MDMA) produces increased energy and feelings of well being, but prolonged high doses can lead to anxiety, panic, insomnia and hypothermia. There is growing evidence that long-term use might cause liver damage in some people.

Marijuana (pot, dope, hash, grass, cannabis) comes from bushy plants found in most parts of the world. Marijuana causes mild euphoria, perceptual disturbance and affects judgement. Its bad effects include confusion, anxiety and impaired short-term memory. Long-term use may cause lung disease and can precipitate psychotic illness. More potent varieties may carry more risk of serious side effects.

APPENDIX 8
A SCHOOL DRUG POLICY

This is the drug policy of Hollywood Senior High School. The Task Force is grateful to the school for providing the policy and permission for its reproduction.

RATIONALE

Schools today are having to address drug use and associated problems. This policy attempts to reflect the attitude of our school community towards these issues, that is:

'Hollywood Senior High School will be promoted as a drug-free environment for the students.'

The intention of the drug policy is to respond to incidents of drug use in a caring and consistent manner. A school drug policy that addresses prevention as well as intervention better ensures that the school's response to such incidents is pre-planned and clearly understood by everyone.

This drug policy seeks to:

- Promote and maintain a positive and caring school environment in which the welfare of the school community is a priority.
- Combine an educational and preventative approach while acknowledging that incidents of drug use will be dealt with in a consistent manner.
- Address intervention and sanctions with regards to drug use and establish guidelines that are relevant to Hollywood Senior High School.
- Be consistent with the administrative requirements of the Education Department.
- Be consistent with State and Federal laws.

For the purpose of these guidelines a drug is defined as 'any substance, that when introduced into the body can alter physical and psychological structure or function.'

PREVENTION

Drug use is a complex issue and the role of the school in its prevention requires a comprehensive approach. Hollywood Senior High School will therefore implement the following strategies.

- Develop and maintain this drug policy.
- Provide drug education and assist students to develop interpersonal skills through a comprehensive Health Education program consistent with the K-10 Syllabus. The program should ensure a minimum time allocation of 60 minutes per week for all students in lower school (ensuring Health Education has adequate time on the school timetable). The Health Education program should be adequately resourced and taught by appropriately trained staff.
- Provide, where necessary, professional development for staff to provide current and relevant information about youth drug use issues, drug identification and recognition of individuals under the influence of drugs.
- Improved staff communication and confidentiality of specific student situations. A staff member is not bound to disclose information given to them by a student in confidence.
- Secure and maintain a support link with the local police.

- Secure ongoing support from the local community by providing opportunities for parents to learn about and discuss drug-related issues. This will ensure parents are informed and aware and the students are receiving accurate information reinforced by their parents.

- Reinforce 'Drug Awareness' in Upper School.

INTERVENTION

The intervention procedure is designed to address drug-use incidents in a way which is in the best interest of all concerned, while also conforming to legal requirements.

This school does not permit students while on the school premises, at a school function, or excursions or camps to:

- smoke and/or possess tobacco products
- consume and/or possess alcoholic beverages
- deliberately inhale solvents
- possess and/or use illegal drugs in accordance with the Misuse of Drugs Act, 1981
- possess and/or use drug-related equipment such as syringes, bongs, pipes etc except in the cases of lawful medical use.

The school nurse, or person acting on her behalf during her absence, is the only staff member permitted to administer analgesics, or oversee the use of diabetic syringes.

The school staff, other workers and visitors will comply with the Education Department Policies and Regulations.

RESPONDING TO INCIDENTS OF DRUG USE

In a situation where drug use is suspected an assessment of the condition of the student should be made. If necessary First Aid should be administered by the School Nurse or deputised person. The student should then be taken to the Deputy Principal who will follow the established procedures as set out below:

SMOKING

First Offence

The parent/guardian is contacted by the Deputy Principal and a letter is sent home (see Appendix A). The student is required to attend an interview with the Deputy Principal where she/he will be informed of the school rules relating to smoking, and of the consequences should further offences take place. Counselling will be arranged by the School Nurse for the first and subsequent offences.

Second Offence

The parent/guardian is contacted requiring them to attend an interview with the student and Deputy Principal. The student is required to complete two days' detention after school for 30 minutes supervised by the Health Education Co-ordinator and/or School Nurse.

Subsequent Offences

Any further offences will result in a two-day suspension.

Smoking — Camps/Functions/Excursion

The student will be informed that on his/her return to school the above procedures will operate.

ALCOHOL AND SOLVENTS

As a result of possession and/or consumption of alcohol or deliberate inhalation of solvents, the Deputy Principal will contact the parent/guardian and the student will be suspended immediately for a minimum of two days.

ILLEGAL DRUGS

The possession and/or sale of illegal drugs is an offence against the law. The school will view this as a very serious matter. The sanctions will be as follows:

In the case of a student being found in possession, using, and/or selling/supplying illegal drugs, the parent/guardian will be informed, the student will be suspended immediately for a minimum of five days, and as a general rule the Principal will report the matter to the police.

Consultation will then begin with the police, school, student and parent or representative.

(Drug related equipment found in a student's possession will be confiscated and disposed of immediately or referred to the appropriate authorities.)

Alcohol, Solvents and Illegal Drugs — Camps/Functions/Excursions

The same procedure as for 'in-school' incidents will operate.

FURTHER ACTION

Where appropriate follow-up procedures will occur and counselling will be made available to the student. Outside counselling agencies may be contacted at this stage.

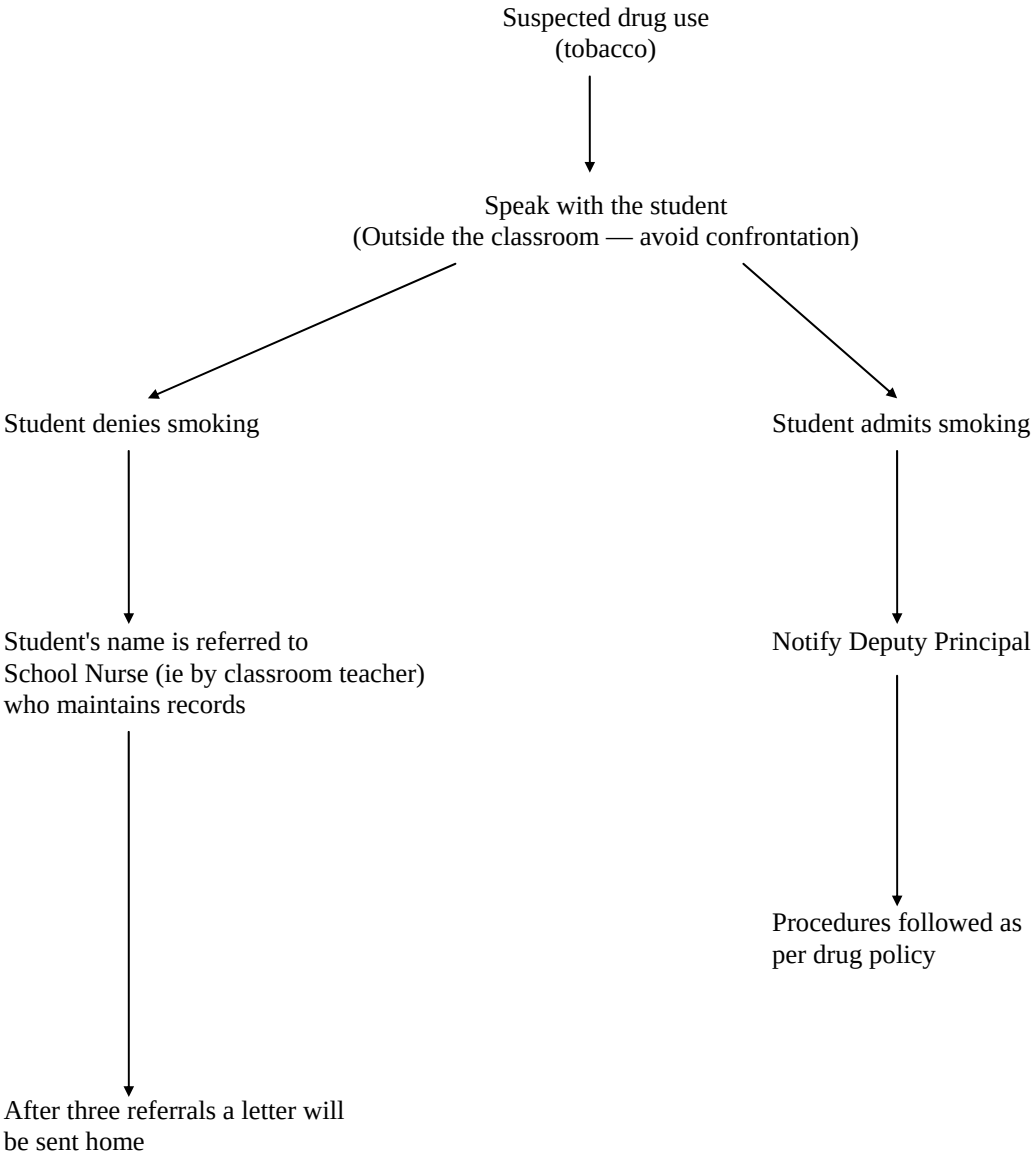
Confidential written records will be maintained by the school about all incidents of drug use, and will not appear on the student's academic record. If no drug use is detected but strong suspicion exists, it should be reported to the School Nurse who will endeavour to monitor the situation. All teaching staff will be verbally informed of any cases of drug use that result in a suspension. This will be the responsibility of the Principal.

Communication with staff involved regarding the outcome of drug-use incidents will be conducted at a professional level. Confidentiality will be maintained (gossip avoided).

NB. It is the responsibility of the enrolling officer to ensure new students to the school receive a copy of the school drug policy, and their parents are also familiar with its contents.

SITUATION 1

DESCRIPTION ... A student presents to class smelling distinctly of cigarette smoke.

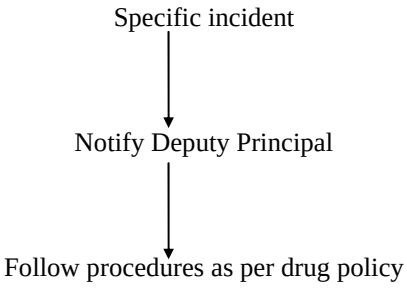


SITUATION 2

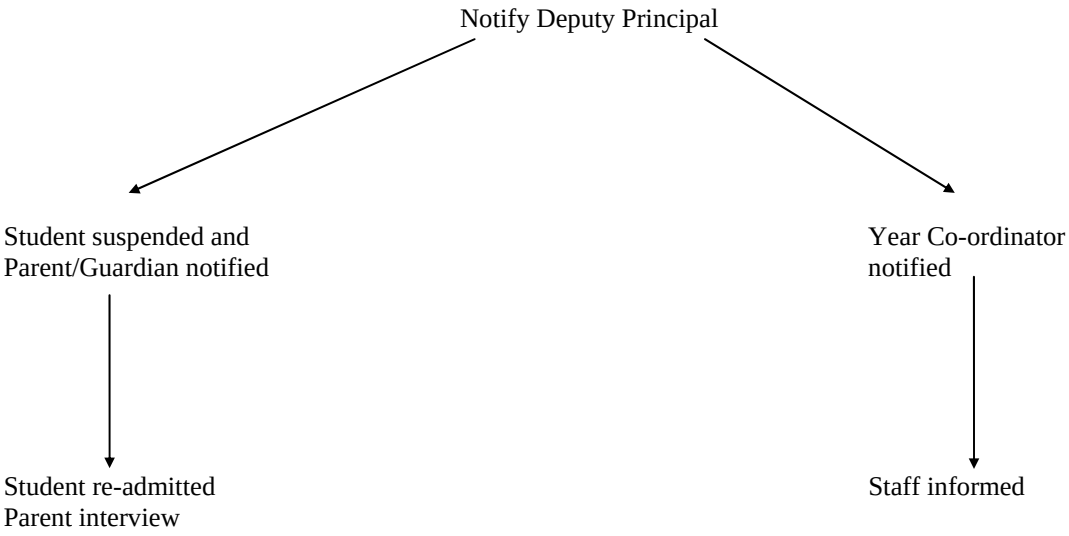
DESCRIPTION... A student presents to class smelling distinctly of marijuana/alcohol, i.e. not tobacco.

SITUATION 3

DESCRIPTION... A staff member, during school hours, for example while on duty, encounters a student or group of students violating the school drug policy.



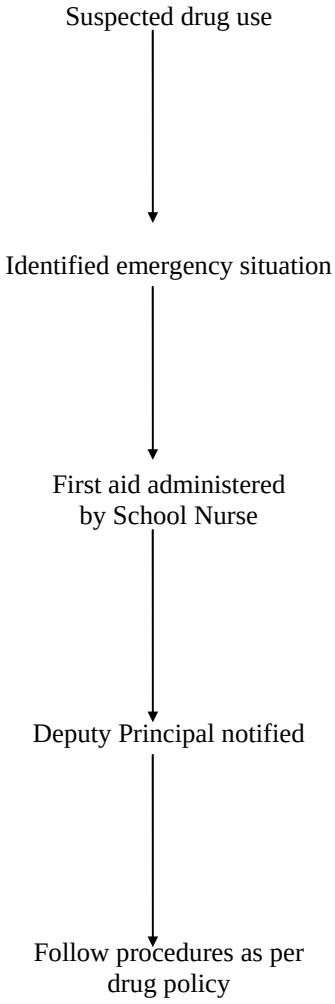
e.g. Cannabis use



Nurse informed of student
return by Deputy Principal —
counselling

SITUATION 4

DESCRIPTION... A student is under the influence of a drug and requires immediate medical attention.



SAMPLE LETTER TO PARENT/GUARDIAN

Dear _____

Hollywood Senior High School is promoted as a drug-free environment for our students. The school drug policy states that smoking is not permitted by students on school premises or at school functions.

As a school we have a responsibility to all students to ensure that the rules are enforced. As educators it is also our responsibility to discourage activities that are hazardous to the health of our students and to make sure that all students are fully aware that smoking is a health hazard.

Your son/daughter/ward_____ has been found smoking at school today during _____.

The consequences for breaches of the non-smoking rule are outlined below:

First Offence
The student will be sent to the Deputy Principal who will remind the student of the school rule relating to smoking and inform him or her of the consequences should further offences take place. The parent/guardian will be contacted by letter, the receipt of which is to be acknowledged by the parent/guardian. Counselling will be arranged by the School Nurse for first and subsequent offences.

Second Offence
The parent/guardian is contacted requiring them to attend an interview with the student and Deputy Principal. The student is required to complete two days' detention after school for 30 minutes supervised by the Health Education Co-ordinator and/or the School Nurse.

Subsequent Offences
Any further offences will result in a two-day suspension from school.

Should you wish to discuss the matter further, I would be pleased if you contact the school for an appointment.

Yours sincerely

Deputy Principal

Reply Slip — Smoking

Student's Name _____

Please complete and return to Deputy Principal, Hollywood Senior High School.

I have received your letter dated _____ concerning _____ smoking at school.

Signed:_____ Date: _____
(Parent/Guardian)

APPENDIX 9

KEY FINDINGS AND RECOMMENDATIONS OF THE REVIEW OF THE TOBACCO ACT (1990) (MINTER ELLISON NORTHMORE HALE)

1. Controls Relating to Tobacco Products

(a) Advertising

There is no doubt that the Act has had a significant impact on the sale and promotion of tobacco products in this State. It has eliminated, or virtually eliminated:

- all outdoor advertising of tobacco products;
- tobacco advertising in publications printed or published in Western Australia;
- the supply of free samples; and
- tobacco sponsorship.

Under the regulations, in particular, increasingly more stringent restrictions have applied to:

- advertising within retail outlets; and
- packaging and labelling requirements.

There are a number of instances, however, where problems have been experienced either by those responsible for the administration and enforcement of the Act and regulations or by those required to comply with their provisions. In relation to tobacco advertising, the major area of concern relates to point of sale advertising in retail outlets. Problems have also arisen in connection with dummy displays, price boards, discount notices and publications.

We have recommended that the Act and regulations should be amended to strengthen a number of controls including those relating to:

- the size, number and purpose of dispensing units within a retail outlet;
- advertising on packages or cartons of cigarettes;
- the use of discount signs advertising tobacco products;
- advertising appearing on sporting event programs and leaflets;
- promotional items supplied to purchasers of tobacco products;
- the display, outside the boundaries of a retail outlet, of packages or cartons which contain a tobacco product; and
- the scope of the packaging and labelling requirements.

We have also recommended that the terms and commencement of the new health warning requirements which are due to come into force on 1 March 1995 be reviewed by the Minister. The Minister should also review the commencement date of the new packaging and labelling requirements due to take effect on 1 April 1995.

(b) Juveniles

The submissions made to us contained considerable discussion, reflecting strongly held and widely divergent views, about issues affecting juveniles. The major issue was whether juveniles should be subject to prosecution for smoking-related activities such as obtaining, smoking or being in possession of a tobacco product. On balance, we have taken the view that they should not.

In relation to other issues affecting juveniles we have recommended that the Act be amended to require tobacco retail outlets to display signs warning customers and others that it is illegal to sell or supply a tobacco product to a person under the age of 18 years. We have also recommended that the Act be amended to allow the use of an averment to prove that a particular person is, or was at a specified date, under the age of 18 years.

2. Exemptions

Section 14 of the Tobacco Control Act enables the Minister for Health to grant exemptions from the prohibitions on tobacco advertising and sponsorship. Many of these provisions are no longer operative and we have recommended that they should be repealed. Currently, the only remaining ground on which an exemption may be granted is where it is necessary or appropriate to facilitate the promotion and conduct of a sporting, racing or arts event or function of national or international significance.

A similar exemption power, limited to international events, is contained in the Federal Tobacco Advertising Prohibition Act.

Very few applications for exemption under the Tobacco Control Act are now being received and only four have been granted since 1992. While recognising that the proposal to remove entirely the exemption power had much to support it, we have recommended that the exemption power should be retained but in a modified form so that it:

1. is restricted to events of international significance;

2. enables the Minister to determine guidelines for the exercise of the power;

3. restricts the grounds on which an exemption can be granted; and

4. facilitates the imposition and enforcement of conditions of exemption.

3. Enforcement

At present a prosecution for an offence under the Act cannot be commenced without the written consent of the Commissioner of Health or a person authorised by him or her. Some submissions suggested that this requirement was justified because it operated as an appropriate filtering mechanism and also helped to ensure consistency in the application of prosecution policy. Nevertheless, it is apparent that the Act would have greater impact in changing attitudes and behaviour relating to the use of tobacco products if enforcement were to be more widespread. That would be more likely to occur if the class of persons authorised to initiate prosecutions were to be extended. For these reasons we have recommended that the Act be amended to enable the Commissioner of Health and certain ‘authorised persons’ to commence prosecutions. For this purpose, ‘authorised persons’ would include:

a) a member of the Police Force;

b) ane environmental health officer appointed under the Health Act 1991; and

c) any other person authorised in writing by the Commissioner of Health.

The level of penalties under the Act and regulations was also addressed. At present, the maximum penalty for a breach of the Act, in the case of an individual is $5,000 for a first offence and $10,000 for a second or subsequent offence and, in the case of a body corporate is $20,000 for a first offence and

$40,000 for a second or subsequent offence. The maximum penalty for a breach of a regulation is currently $1,000. We have recommended that that penalty be increased to $5,000.

Those responsible for the enforcement of the Act and regulations have encountered difficulties in the course of investigating possible breaches of the Act. To overcome these difficulties we have recommended that the Act be amended to increase the powers of an authorised officer to obtain information relating to an investigation and to enter premises and obtain records for the purpose of an investigation.

We have also supported the proposal that would facilitate prosecutions under the Act be enabling the use of averments to prove that:

1. a substance is tobacco;

2. a person is under the age of 18 years;

3. premises are licensed premises; and

4. the person bringing the complaint is an authorised officer.

Claims have been made that the enforcement of the Act has been inconsistent, particularly when a comparison is made between urban and rural areas of the State. The widening of the class of 'authorised officers' who are empowered to initiate prosecutions has the potential to lead to further inconsistencies. To address this problem we have recommended that the Act be amended to enable the Minister to formulate and publish guidelines for the enforcement of the Act.

A number of submissions expressed the view that the Tobacco Control Act should contain enforcement measures, other than prosecutions, for offences under the Act. The three alternatives that we considered were formal warnings, infringement notices and the use of licence conditions. Neither of the first two were considered to be appropriate. However, we have recommended that it be made a condition of any licence granted under the Business Franchise (Tobacco) Act 1975 that the licence holder undertakes to comply with the provisions of the Tobacco Control Act and that the licence may be revoked in the event of non compliance.

4. Regulation Making Power

Some submissions expressed criticisms that the regulations made under the Tobacco Control Act had been drafted without consultation with tobacco manufacturers or retailers. It was claimed that one of the consequences of the lack of consultation is that breaches of the regulations occur daily either through ignorance or an inability to understand how they are intended to operate.

The question of prior consultation in the regulation making process raises wider issues relating to the need in this State for statutory control and regulation in respect of the making and operation of subordinate legislation. Laws of this type exist in both Victoria (the Subordinate Legislation Act 1962) and NSW (the Subordinate Legislation Act 1989). A Bill dealing with the same subject matter is currently before Federal Parliament.

In the absence of general legislation of that type in this State, we do not consider that it would be appropriate to amend the Tobacco Control Act introducing subordinate legislation requirements that would apply only to regulations made under that Act. Instead, we have recommended that this problem be addressed administratively. To this end, procedures should be devised and followed to ensure that officers from the Health Department of Western Australia consult at an early stage with tobacco industry representatives and other interested parties about the form and content of proposed regulations.

5. Compensation

There are two aspects of the issue of whether compensation should be paid as a result of the operation of the Tobacco Control Act. These are:

1. whether organisations which have been precluded from receiving income or benefits as a result of tobacco company advertising or sponsorship are entitled to compensation and whether they should continue to be entitled to replacement funding by Healthway; and

2. whether tobacco companies are entitled to and should be compensated for the loss of benefits from advertising contracts.

In relation to both aspects, the starting point is that at the State level there is no constitutional right to compensation even where there has been an acquisition of property by or on behalf of the State. In this State there is no equivalent to the 'just terms' guarantee contained in s.51(xxxi) of the Federal Constitution.

The question whether Healthway should continue to provide replacement funding for tobacco advertising and sponsorship is considered in the accompanying report (at 8.4.2 and in the findings and recommendations following 8.4.3).

As for the remaining issue, tobacco companies have argued that they should be compensated because of the losses they have suffered in losing the benefit of lucrative advertising contracts banned by the Tobacco Control Act. Whatever merits that argument might have had at the time of the commencement of the Tobacco Control Act, the fact that four years have elapsed would make it entirely inappropriate to amend the Act to include a right to compensation in these circumstances.

6. Constitutional Right to Free Speech

The so called 'right of free speech' is the basis for one of the major arguments put forward by tobacco manufacturers and retailers in support of submissions to eliminate, or at least relax, the current restrictions on tobacco advertising.

Support for a constitutional guarantee of freedom of communication, at least in relation to political or government affairs - and operating at both the Federal and State levels — can be gleaned from a series of High Court decisions over the past two years.

Despite this, the High Court has yet to consider a case in which the free speech argument has been applied, or sought to be applied, in a commercial advertising context. Our analysis of the decisions to date suggests that it is most unlikely that a challenge to the validity of State or Federal tobacco advertising legislation on the ground of the implied constitutional freedom of communication would be successful.

7. Other Issues

(a) Exposure to Cigarette Smoke

The harmful effects of passive smoking are becoming more widely known and accepted. In many submissions it was argued that the scope of the Tobacco Control Act should be widened to effectively codify the law in the use of tobacco products and that it should include provisions relating to smoking in restaurants, on public transport, in the workplace and in public places generally.

While there appear to be good reasons to support that argument, we have not had an opportunity to consider the proper scope or timing of such restrictions or to assess the impact that a proposal of that type would have not only in terms of health outcomes but also by reference to economic, social and administrative consequences.

In these circumstances, we have recommended that a task force should be established to examine the issues relevant to a more comprehensive legislative response to the dangers of passive smoking in public places including:

(a) the extent to which restrictions on the use of tobacco products should be applied in the workplace, premises where food is prepared or served for consumption by the public and other public places;

(b) when the restrictions should be introduced;

(c) how the restrictions are to be enforced and the level of penalties that are to apply; and

(d) whether the restrictions should be incorporated into the Tobacco Control Act and regulations.

(b) Confectionery and Toy Cigarettes

There was some support for a proposal that the Tobacco Control Act should be amended, along the lines of the approach taken in South Australia, NSW and the ACT, to prohibit the sale of toy cigarettes or products that are intended to resemble cigarettes. One of the potential difficulties with that proposal is that it would constitute a distraction from the other provisions of the Act and would detract from the credibility of the legislation. In any event we do not consider that, on the evidence available to us, the nature and extent of the sale of confectionery and toy cigarettes in this State is a problem that would justify a legislative ban.

(c) Further Reviews

Under section 34 of the Tobacco Control Act the Minister is obliged to cause only one investigation and review to be conducted concerning the operation of the Act.

In our view regular monitoring is required to assess not only the extent to which the Act meets the needs and expectations of the public but also whether the terms of the Act or its administration might be improved having regard to changes introduced by the Federal and other State Parliaments. For these reasons we consider that it is important that the Act be reviewed periodically and have recommended that a review be carried out every four years.

APPENDIX 10

LIST OF ABBREVIATIONS AND ACRONYMS

ADA	Alcohol and Drug Authority
A&E	Accident & Emergency
AAD	Aboriginal Affairs Department
ABS	Australian Bureau of Statistics
ACHPER	Australian Council for Health, Physical Education and Recreation
ACOSH	Australian Council on Smoking and Health
ACTU	Australian Council of Trade Unions
ADCA	Alcohol and Other Drugs Council of Australia
ADIS	Alcohol and Drug Information Service
ADR	Adverse drug reaction
AFADD	Australian Foundation on Alcoholism and Drug Dependence
AIDS	Acquired Immuno-Deficiency Syndrome
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
ANCO	Australian National Classification of Offences
ASR	Age-standardised rate
ATC	Anatomical Therapeutic Chemical
ATSIC	Aboriginal & Torres Strait Islanders' Commission
BCF	Bromochlorodifluoromethane
BLS	Bureau of Labour Statistics
CAI	Confederation of Australian Industry
CCOP	Crimes (Confiscation of Profits) Act
CDCO	Central Drugs Coordinating Office
CDCU	Communicable Diseases Control Unit
CDS	Court Diversion Service
CDU	Central Drug Unit
CNS	Central nervous system
COHSW	Commission of Occupational Health, Safety & Welfare
COPO	Commonwealth own purpose outlays
COTSA	Client of Treatment Service Agencies
CRF	Consolidated Revenue Fund
CTRA	Cash Transaction Reports Agency
D&A	Drug and alcohol
DARP	Drug Abuse Reporting Program
DCD	Department for Community Development
DDC	Drug Dependency Clinic
DEET	Department of Employment, Education and Training
DFTC	Drug-free therapeutic communities
DHSH	Department of Human Services & Health
DUSC	Drug Utilisation Sub Committee
EAP	Employee Assistance Program
EB	Epidemiology Branch
EIA	Enzyme immunoassay
ETP	Extended Trading Permit
FOPP	Funder/Owner/Purchaser/Provider
FORS	Federal Office of Road Safety
FPIA	Fluorescence polarisation immunoassay
FTE	Full-time employment
GC	Gas chromatography
GC/MS	Gas chromatography/mass spectrometry
GHB	Government Health Bureau
GIS	Geographic information system
HA	Health authority
HACC	Home and Community Care

HBV	Hepatitis B virus
HCV	Hepatitis C virus
HDWA	Health Department of Western Australia
HEO	Health Education Officer
HIC	Health Insurance Commission
HIV	Human immuno-deficiency virus
HMDA	Methylenedioxyphenyl-3-aminobutane
HMDS	Hospital Morbidity Data System
HS	Health service
HSB	Health Statistics Branch
HSPB	Health Services Promotion Branch
ICD9	International Classification of Diseases
ICU	Injury Control Unit
IDU	Intravenous drug use
IM	Intra muscularly
IV	Intra venously
LGA	Local Government Authority
LGB	Liquor Gaming Branch
LISWA	Library Information Service of Western Australia
LLD	Liquor Licensing Division
LR	Licensed restaurant
MAPP	Measurement of Alcohol Problems for Policy
MCDS	Ministerial Council on Drug Strategy
MDA	Misuse of Drugs Act
MDMA	Methylenedioxymethamphetamine
MEK	Methyl ethyl ketone
MFP	Matched Funding Program
MHS	Mental Health Services
MIBK	Methyl iso-butyl ketone
MMTP	Methadone Maintenance Treatment Program
MOJ	Ministry of Justice
MRAR	Mines Regulations Act Regulations
MVA	Motor vehicle accident
N&S	Needles and syringe
NADDIC	National Alcohol & Drug Dependence Industry Committee
NCA	National Crime Authority
NCADA	National Campaign Against Drug Abuse
NCRPDA	National Centre for Research into the Prevention of Drug Abuse
NDADS	National Drug Abuse Data System
NDARC	National Drug and Alcohol Research Centre
NDS	National Drug Strategy
NGO	Non-government organisation
NHF	National Heart Foundation
NHMRC	National Health and Medical Research Council
NHS	National Health Survey
NISU	National Injury Surveillance Unit
NMG	National Methadone Guidelines
NSAP	Needles and Syringes Access Program
NSEP	Needle and Syringe Exchange Program
ORG	Office of Racing and Gaming
OTC	Over the counter
PBS	Pharmaceutical Benefits Scheme
PCP	Phencyclidine
PH	Pharmaceutical heroin
PHS	Public Health Service
POC	Proceeeds of Crime Act
PSA	Prices Surveillance Authority
PYLL	Person years of life lost
RACGP	Royal Australian College of General Practitioners

RACP	Royal Australian College of Physicians
RANZCP	Royal Australian & New Zealand College of Psychiatrists
RBT	Random breath testing
RCIADIC	Royal Commission Into Aboriginal Deaths in Custody
RFDS	Royal Flying Doctor Service
RHA	Regional health authority
RIA	Radioimmunoassays
RIA	Rottnest Island Authority
RPBS	Repatriation Pharmaceutical Benefits Scheme
SAAP	Supported Assistance Accommodation Program
SAODAP	Special Action Office for Drug Abuse Prevention
SEIFA	Statistics Socio-Economic Indexes for Areas
SHLS	State Health Laboratory Service
SHPA	State Health Purchasing Authority
SSASS	Secondary schools alcohol and smoking survey
SUDP	Standard for the Uniform Scheduling of Drugs and Poisons
TASC	Treatment Alternatives to Street Crime
TC	Therapeutic communities
TEL	Tetra-ethyl lead poisoning
THC	Tetrahydrocannabinol
TLC	Thin-layer chromatography
UWA	University of Western Australia
VDNR	Voluntary S4 Drug Notification Register
VSA	Volatile substance abuser
WAAC	Western Australian Aids Council
WAADDIC	Western Australian Alcohol & Drug Dependence Industry Committee
WACHS	Western Australian Child Health Survey
WADDCU	Western Australian Drug Data Collection Unit
WANADA	Western Australia Network of Drug Agencies
WHO	World Health Organisation

APPENDIX 11
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