Appendices

Appendix 1: Sample school drug policies

Sample drug policy

Willetton Senior High School

Sacred Heart College

Sample school drug policy and response to incidents of drug use

Background

Drug use is a complex issue and drug use problems result from a combination of many contributing factors. The school's response is therefore as comprehensive as possible. The intention of this policy is to respond to incidents of drug use in a caring and consistent manner. A standardised approach to drug education and incidents of use will be implemented as a result of this policy.

This policy and subsequent procedures have been developed in consultation with school staff, parents and students and have been endorsed by the school decision making group.

The school drug policy is binding on all members of the school community while they are on school premises or at a school function where there are students present. This includes students, staff, volunteer staff, ground staff and other workers. The policy also applies to school visitors and any functions held on school premises unless otherwise negotiated with the principal.

Aim

This policy aims to contribute to a positive, healthy and caring school environment in which students can achieve their full potential and develop interpersonal skills that will help them face challenges both in and out of school, now and in the future. The policy seeks to be consistent with the administrative requirements of the Education Department of WA and to be consistent with State and Federal laws.

Prevention

The school has a comprehensive health education program that contains drug education as part of the curriculum. The program consists of factual information, attitude clarification and skill development appropriate to the age of the students. The program adopts a rational harm reduction approach to drug education. The school recognises the sensitive and demanding nature of teaching comprehensive health education including drug education. The school drug education program will adhere to the Education Department's controversial issues statement. Where possible, the program is delivered by teachers who are trained in using a balance of knowledge, attitude and skills activities to teach drug education. All health education teachers are allocated one day per year for teacher training and development.

All students will receive a minimum of 60 minutes of health education per week and the drug education components of the Western Australian Health Education K-10 Syllabus will be included. The health education program will adopt a rational harm reduction approach to drug education and will recognise that the drugs most likely to be used by young people are alcohol, medicinal drugs, tobacco and for older students, cannabis. The school will adhere to the *School health coalition's code of practice: use of guest speakers in schools*.

As the school is responsive to community needs, the health education program may be modified from time to time to reflect immediate community requirements. To assist in this, the school undertakes to liaise and involve the school community in its health education programs wherever possible. This includes the provision of parent awareness programs such as *Drugs in perspective*, and ongoing interaction with key community groups.

Intervention

The best intervention procedure is designed to address drug use incidents in a way which is in the best interest of all parties, while also conforming to legal requirements.

This school does not permit students, school staff, other workers or visitors while on school premises or at a school function (where students are present) to:

- smoke tobacco products;
- consume and/or possess alcoholic beverages;
- deliberately inhale solvents;
- possess drug related equipment such as syringes, bongs, pipes, etc (Misuse of Drugs Act 1981) except in cases of lawful medical use; for example, the use of needles by diabetics to administer insulin; and
- possess or use prohibited drugs in accordance with the Misuse of Drugs Act 1981.

Students, while on school premises, are not permitted to use prescribed medicines or analgesics unless this has been negotiated previously with the deputy principal who has been delegated by the principal to undertake this task. This is in accordance with the Education Department of WA Administrative Circular No. 205.

The school nurse, or person acting on his/her behalf during her/his absence, is the only staff member permitted to administer analgesics, or oversee the use of diabetic syringes.

Staff social functions involving alcohol will be held at venues other than the school premises.

Responding to incidents of drug use

The procedure outlined below has been developed with the health and welfare of the school students in mind. It should be followed where possible and any variations should be discussed with the principal and student services personnel.

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. The student should then be taken to the school nurse or to the deputy principal if the nurse is not available.

The principal should be notified by the nurse or deputy and a decision made regarding action to be taken. It is the principal's responsibility to notify the student's parents as soon as possible or to delegate this responsibility.

Smoking

All offences

Parents/guardians notified by the deputy principal and a letter sent home. Student to attend an interview with the deputy principal where he/she will be informed of the school rules relevant to smoking and the consequences should further incidents occur. Counselling will be arranged by the student services staff for the first and subsequent incidents. Students will be offered 'stop smoking' assistance.

First offence

Send a copy of the *Your child and smoking* pamphlet (available from Health Promotion Services, telephone 08 9222 2000) with letter to parents/guardian.

Second offence

Student to complete two days' detention after school with the health education coordinator and/or the school health nurse (during this time the student will be given appropriate drug education activities to complete).

Subsequent offences

Student(s) to face disciplinary action in accordance with the *School managing student behaviour* program.

Alcohol and solvents

Possession and/or consumption of alcohol or deliberate inhalation of solvents will require the deputy principal to contact parents/guardians and send a letter home. Counselling will be arranged by the school health services and the student(s) will face disciplinary action in accordance with the *School managing student behaviour* program.

Illicit drugs

If possession of an illicit drug is suspected, the deputy principal will ask the student to empty the contents of his/her school bag, pockets, etc. If the student refuses to do so, the deputy may call the police. School staff are not permitted to search students or their bags. Searches may be undertaken only by a police officer when reasonable suspicion exists.

In the case of possession, use or sale or supply of prohibited drugs, the parent/guardian will be informed immediately. The principal will inform the district superintendent and contact the police. In the absence of a student's parent or guardian, a teacher nominated by the student will always be present at any police interview that takes place on school premises. The student will be offered counselling and will face disciplinary action in accordance with the *School managing student behaviour* program.

Further action

Where appropriate, counselling will be made available to the student(s) by the student services staff. Outside counselling agencies may be contacted at this stage as intensive drug counselling is not usually the role of school personnel. Students will be referred to relevant agencies after discussion between the student, services personnel, the principal and the parents.

The students involved in all drug related incidents will face disciplinary action in accordance with the *School managing student behaviour* program. Confidential written records will be maintained by the school nurse about all incidents of drug use. If no drug use is detected but strong suspicion exists, it should be reported to the school nurse who will keep confidential written notes. Only staff members who need to know will be informed of any incidents of drug use and kept up to date with the case. However, in the case of a suspension, all staff will be notified verbally by the principal. All staff are required to maintain strict confidentiality and refrain from gossip.

Willetton Senior High School Drug Policy

Rationale

Willetton Senior High School acknowledges that drug use is a complex issue. Our policy therefore includes a drug education program as well as a variety of other prevention and intervention strategies.

Willetton Senior High School believes that incidents of drug use at school require a response which is consistent and caring.

Harm minimisation is defined as a commonsense 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 the community and the individual.

This philosophy accepts that drug use occurs in Australian society, and that there is a continuum of consequences - social, physical and psychological - associated with drug taking. While not condoning drug use, this philosophy allows for responses to drug use which minimise the possibility of negative consequences either to the individual or to the community at large.

Whilst abstinence is encouraged as a preferred option, the harm minimisation approach recognises that it is impossible to prevent or eliminate all alcohol or other drug use.

Outside the school environment, the media, peer group and the family, all transmit some form of drug education. The school is only one of the many influences on the individual. The harm minimisation (or harm reduction) concept is widely used by health and education professionals and is endorsed by State, Territory and Federal Governments. It has been government policy since 1985.

Status

This policy has been developed in consultation with school staff, parents and students and has been endorsed by the School Decision Making Group in accordance with the school aims and School Development Plan (students at risk).

Definition

For this document, a drug is defined as any substance, with the exception of food and water, which when taken into the body alters its function physically and/or psychologically. This definition includes all drugs, eg analgesics, alcohol, tobacco, cannabis, amphetamine.

While not classified as drugs, solvents (also called volatile substances) are included in the School Drug Policy, eg glue and petrol sniffing.

Prevention

- WSHS endorses and implements the WA government regulation that our school is a smoke free zone. This is binding on all members of the school community and visitors while they are on school premises or at a school function.

- WSHS has a compulsory, comprehensive health education program for 60 minutes per week for years 8 to 10. The program incorporates factual information, attitudes, values clarification and decision-making skills and the attainment of life skills in general to assist students to make healthy choices and decisions. Our program may be modified from time to time to reflect community requirements and will continue to interact with and call upon appropriate community resources to keep our course accurate and relevant.

- WSHS has a drug action committee working closely with the community based Local Drugs Action Group. These groups work cooperatively to work on strategies to combat the harmful effect of drug use in the local community.

- WSHS has a pastoral care team which students may access to discuss their personal concerns in confidence.

- WSHS is vigilant to ensure that the school is drug free.

- WSHS will monitor and evaluate this policy to maintain its effectiveness.

WSHS code of behaviour

Other than prescribed drugs, students on school premises and at school functions will not
- smoke tobacco products
- consume alcoholic beverages
- deliberately inhale solvents
- possess drug related paraphernalia
- possess or use prohibited drugs
- be under the influence of illicit drugs

Intervention

- WSHS will be PROACTIVE through education of students, staff and parents as the primary strategy of intervention.

- Students on prescribed medication are encouraged where possible to take their medication at home; and to inform the school nurse if drugs need to be taken during the school day.

- The school nurse is the only staff member to administer analgesics to students.

- If individuals supply illicit drugs to others, the school will notify police.

- Students suspected of being under the influence of drugs will be sent to the school nurse for monitoring.

Consequences of breach of the code

WSHS recognises that punishment often ignores the cause of drug use. Our policy recognises that punishment alone is inadequate unless supported by relevant education and counselling.

WSHS students breaching the code will be:
- involved in an educational task
- counselled by a designated staff member
- subject to an appropriate administrative action

These sanctions may include suspension, detention, loss of recess or lunch time, parental notification, demotion from office, suspension from school functions such as camps, excursions and social events.

Non compliance

Students who do not comply with the process will be suspended from school.

Suggested process for deputies and other personnel

- Consult drug policy statement.
- Consult student services personnel for relevant background on the student.
- Designate a member of student services or other appropriate staff to carry through the policy (education and counselling component).
- Make a decision re parent contact.
- For repeat offenders, involve parents.
- Suspend repeat offenders.
- Before return from suspension, students must go through student services personnel for parent involvement in risk reduction agreement.

Risk reduction agreement

This agreement is made between.....

on behalf of Willetton Senior High School and.....

is aware of the health risks associated with .....

.....and of the school's policy.

is entering into this agreement in order to reduce the risks to his/her health and to help him/her to comply with the school's policy.

..... has decided not to use.....

at school or during any activities sponsored by the school for these reasons:

1. .....
2. .....
3. .....
4. .....

At school recognises ..... he/she tends to use the drugs in these circumstances:

1. .....
2. .....
3. .....
4 .....

will reduce the risk to his/her health and comply with the school's policy by doing the following:

1. .....
2. .....
3. .....
4. .....

..... will keep in regular contact with

.....for .....

At the end of that time, this agreement will be reviewed. Contact will be maintained by:

1. .....

2. .....

3. .....

4. .....

In order to help ..... reduce the risk to his/her health and comply with school policy, the school will:

1. .....

2. .....

3. .....

4. .....

We have agreed upon the terms of this Risk Reduction Agreement for ..... and agree to review this agreement on the following date.....

Student's signature..... Date.....

Designated staff member's signature.....Date.....

Agreement review held on.....

Sacred Heart College Drug Policy

Introduction

Sacred Heart College is a Catholic Educational Community of people who live and interact on a daily basis in the real world. We recognise that society tolerates and condones the use of "drugs" in a wide range of circumstances. The college, in acknowledging the prevalence of the use of drugs and their effects in the wider community, seeks to restrict the use of these substances within our school. In attempting to ensure that the college is free of drugs it is accepting the mandate given by parents to educate their children in a safe and healthy environment.

Definition

A drug is defined (for the purposes of this policy) as "any substance, with the exception of food and water which, when taken into the body, alters its function physically and/or psychologically." This definition includes all drugs, eg analgesics, alcohol, tobacco, cannabis, amphetamines etc. While not classified as drugs, solvents (also called volatile substances) are to be included in the school policy.

Rationale

This drug policy has been established in an attempt to:

- illustrate clearly to the community the stand Sacred Heart College will take in support of the efforts made by families to rear their children in a well informed and safe environment;
- address measures of prevention, intervention and sanctions in regard to drug use; and
- be consistent with State and Federal laws, and the guidelines set down by the Catholic Education Commission of Western Australia.

Drug use is a complex issue and it is recognised that drug problems result from a combination of many contributing factors. The school's response, therefore, is as comprehensive as possible.

Prevention

As a means of education and awareness the college will undertake to provide:

- ongoing courses for students and parents;
- arrange appropriate inservicing of staff on the detection and identification of drug use;
- provide an opportunity within the religious education curriculum for students to reflect on, discuss and learn processes that assist in making correct decisions, forming a Christian conscience and living life true to Christian values;
- access for students, parents and staff to school personnel, the school chaplain and school psychologist to help in areas of communication and counselling;
- a school discipline policy that has well publicised deterrents;
- a practice of pastoral care within the school that allows each child to feel valued and has a sense of self worth;
- curriculum initiatives in various subjects; and
- promotional displays and activities.

Sacred Heart College has been declared a smoke free campus.

Intervention

The intervention procedure is designed to address drug use incidents in a way which is in the best interest of all parties, while also conforming to legal requirements.

Regardless of age when on school premises or at school functions, students are not permitted to:

- be in possession of or smoke tobacco products;
- be in possession of or consume alcoholic beverages;
- deliberately inhale solvents;
- possess drug related equipment such as syringes, bongs, pipes, etc (Misuse of Drugs Act, 1981) except in cases of lawful medical use;
- possess or use prohibited drugs in accordance with the 1981 Act;
- arrange for distribution and/or sale of illegal substances or to be involved in situations which may put other students at risk;
- be under the influence of non prescribed drugs.

We note that "on school premises or at a school function' includes any time a student is in uniform, or not, and includes travelling to and from school, on any school camp, retreat, excursion, or other organised function such as a social, school ball etc.

Sanctions

As a Christian community we are always seeking to forgive and be reconciled. There should not, however, be confusion between our calling to forgive and the necessity for sanctions to be applied when they are warranted.

The procedures outlined below have the emotional and physical health and welfare of the individual students involved as a priority. They also seek to protect the interests of the wider school community.

1) Each instance will be considered individually and independently according to the given set of circumstances at the time.

2) In each instance, the administration team (Principal, Deputies and the Year Coordinator) will determine which support services are to be called upon, who is to be informed, and any sanctions to be imposed.

3) With investigations relating to illegal drugs the college will inform the police and use them in the investigative process in instances where the truth is unclear.

Cigarettes

Students found smoking, in possession of cigarettes or supplying cigarettes to other students will be liable to a range of sanctions dependent on whether it is a repeated offence.

For a first offence:

- informing and consulting with parents
- suspension from school for 2 days
- watch video on the dangers of smoking

For a second offence:

- informing and consulting with parents
- suspension from school for 1 week
- essay on the short and long term consequences of smoking
- conference with parents and student with the Principal

For a subsequent offence:

- the student will be excluded from the school

Alcohol, solvents and misuse of legal drug

Students found drinking alcoholic beverages, in possession of alcohol, supplying alcohol to other students, or misusing solvents or legal drugs, will be liable to a range of sanctions dependent on whether it is a repeated offence.

For a first offence:

- informing and consulting with parents
- suspension from school for 1 week
- essay and viewing video on social consequence of alcohol abuse
- conference between parents and student with Principal
- possible referral to outside agency

For any subsequent offence:

- the student will be excluded from the school

Illegal drugs

The possession and/or sale of illegal drugs is an offence against the law. The school will view all offences involving illegal drugs as a very serious matter.

- Any student found in possession of/or supplying illegal drugs to other students will be excluded from the college. In such cases this action will be taken after consultation with parents and in accordance with guidelines established by the Catholic Education Commission.

- Any student who consumes an illegal drug when under the control of the college, as described earlier in this policy, should consider they have forfeited their right to a place in the school. The Principal reserves the right to make exceptions to this where special circumstances prevail. These circumstances however will be exceptionally rare.

Exclusion

The exclusion of students is not to be considered the final step. The college will endeavour to assist in

- re-enrolment in a suitable school
- recommending suitable counselling agencies for the student and his/her family.

Publicity

The college administration does not inform the wider school community when students are being disciplined over incidents involving drugs or any other matter. Only the essential elements of incidents are given to students and teachers. This is consistent with its approach to all discipline matters. Where drugs are involved the ramifications for the individual students and their families are usually quite serious. The privacy of the individuals involved is respected and the college will make no public comment about the matter.

Vaughan Sadler
Principal

Appendix 2: CDST Contracts

Request for tender

Service specifications metropolitan CDSTs

Service specifications country CDSTs

Request for tender

Request for Tender: 91097

for the Provision of: -

COMMUNITY DRUG SERVICE TEAMS (METROPOLITAN AND REGIONAL AREAS) ON BEHALF OF THE WA DRUG ABUSE STRATEGY OFFICE FOR A ONE (1) YEAR PERIOD WITH AN OPTION TO EXTEND FOR A FURTHER TWO (2), TWELVE (12) MONTH PERIODS AT THE DISCRETION OF THE DEPARTMENT OF CONTRACT AND MANAGEMENT SERVICES

1.1 SCOPE OF THIS TENDER

This Request for Tender (RFT) specifies the WA Drug Abuse Strategy Office's requirement for the provision of Community Drug Service Teams in the Perth Metropolitan Area and Country Regions as defined in Attachment A and B.

Four teams will be located in the following Metropolitan corridors (Attachment A):

- South (City to Mandurah);
- North (City to Yanchep);
- East (City to Mundaring); and
- South East (City to Armadale).

Six teams will be located in the following Country Regions (Attachment B):

- Great Southern;
- South West;
- Goldfields;
- Gascoyne/Murchison;
- Pilbara; and
- Kimberley.

1.2 BACKGROUND

The WA Strategy Against Drug Abuse Action Plan 1997 - 1999, ***Together Against Drugs,*** announced that Community Drug Service Teams will be established around the State to increase the extent of available alcohol and other drug services.

The teams will have both a prevention and a treatment focus.

It is anticipated that the teams will be closely linked with mainstream human service providers, and that they will assist towards the implementation of a comprehensive and coordinated approach to alcohol and other drug issues in their region, consistent with the State's drug strategy as described in ***Together Against Drugs***.

This requirement may involve the transfer of workers from the Alcohol and Drug Authority. Current Alcohol and Drug Authority teams exist in six country and two metropolitan locations. They provide approximately 1,650 occasions of service for treatment and approximately 350 for prevention annually.

Staff transferred from the Alcohol and Drug Authority to the WA Drug Abuse Strategy Office will continue in their current roles until Community Drug Service Teams are established. These staff will be given first option of transferring to positions in the new Community Drug Service Teams as a result of this Request for Tender, with a new employer and on the conditions offered by that employer (refer to Condition 4.11 of Special Conditions of Contract for Provision of Services).

1.3 PROPOSED CONTRACTS

The intended contract structure is as follows:

Metropolitan teams (four)
$272,000 each

South West Team
$157,000

Great Southern Team
$162,000

Goldfields Team
$183,000

Gascoyne/Murchison Team
$193,000

Pilbara Team
$238,750

Kimberley Team
$238,750

NOTE: For the Kimberley Region, separate tenders which propose one full time worker for specific locations will also be considered. The fixed price will be pro-rata.

The pricing structure is for a fixed price contract based on an indicative budget. The successful tenderer will, however, be able to allocate the budget flexibly provided the number of full time (equivalent) staff are maintained.

1.4 CONTRACT MANAGEMENT

The WA Drug Abuse Strategy Office will maintain overall management of this contract process supported by the Department of Contract and Management Services.

The day to day operation of the contracts will be managed by the WA Drug Abuse Strategy Office.

The performance of each contract will be assessed in accordance with the measurement of outputs and outcomes and provision of evidence that demonstrates the quality standards specified in the Attachments (A & B).

Client Liaison

The Client and the Contractor shall each nominate a representative to:

- monitor the continuing operation of the service;
- monitor the Contractor's submission of reports on services and the Client's payment of the contract fee;
- conduct negotiations on price variations under the terms and conditions of the contract; and
- meet promptly to attempt to resolve any disputes arising under the terms of the contract.

Reports

The Contractor will report as follows:

- Outcome and output measures six monthly from the commencement of the service; and

- Financial statements at six and twelve months following the commencement of the service and annually thereafter.

Reports are to be provided within one month of the expiry of the reporting period.

It is envisaged that a panel of suppliers will be appointed for this requirement. However, the Department of Contract and Management Services reserves the right to select a single supplier if

so desired. Tenderers are requested to nominate the teams and/or regions they wish to tender for in the Price Schedule.

2.12 QUALITY ASSURANCE PROVISIONS

2.12.1 It is a State Supply Commission Policy that Contracts will be awarded to Tenderers which have in place the Quality Assurance Type specified in the Tender Documents except where their Tenders do not in the Department of Contract and Management Service's opinion represent value for money or do not otherwise satisfy the requirements of the Tender Documents. A Tender not complying with the Quality Assurance requirement but which in the Department of Contract and Management Service's opinion does give value for money, may be accepted in this case.

2.12.2 The Quality Assurance requirement for this tender is

TYPE 5 (Provision of Services to the satisfaction of the WA Drug Abuse Strategy Office)

For an explanation of the type of quality assurance specified suppliers should refer to the booklet "State Supply Commission Quality Assurance Policy - Guidelines for Suppliers".

2.12.3 Where quality assurance types 1, 2 or 3 have been specified, suppliers are required to include with their tender submissions a photocopy of the relevant Certificate of Registration and Schedule issued by a recognised certifying body. In the case of types 4 or 5, suppliers should provide details of quality assurance that will apply on the basis of supporting documentation as required by the tender, or acceptance on inspection of product as detailed in the tender.

2.13 THE TENDERER

The identity of the Tenderer and the Contractor is fundamental to the Department of Contract and Management Services. The Tenderer shall be the person, persons, corporation or corporations named as the Tenderer in the INFORMATION TO BE SUPPLIED BY TENDERER and whose execution appears on the OFFER BY TENDERER at the end of these conditions. Upon acceptance of the tender, the Tenderer shall become the Contractor.

2.14 NO ASSIGNMENT

This tender is personal to not assignable or transferable by the Tenderer or the legal personal representative of the Tenderer without the prior written consent of the Department of Contract and Management Services.

2.15 NO WITHDRAWAL

This tender shall not be withdrawn by the Tenderer without the prior written consent of the Department of Contract and Management Services.

2.16 NO MASQUERADES

If the Tenderer is acting as agent or trustee for or jointly with another person, persons, corporation or corporations this must be fully disclosed by the Tenderer in the tender. If the Tenderer fails to fully disclose the identity of all participants and the nature of his relationship to those participants, the tender shall be null and void at the option of the Department of Contract and Management Services. No claims by undisclosed participants will be recognised by the Department of Contract and Management Services in the Contract or as having any right, title or interest under the Tender whatsoever.

2.17 OWNERSHIP OF TENDER RESPONSES

All documents, materials, articles and information submitted by the Tenderer as part of, or in support of a Tender shall become upon submission the absolute property of the Crown in right of the State of Western Australia and will not be returned to the Tenderer at the conclusion of the Tender process PROVIDED that the Tenderer shall be entitled to retain copyright and other intellectual property rights therein, unless otherwise provided in the Contract.

SPECIAL CONDITIONS OF TENDERING

3.1 COMPANY PROFILE

Tenderers shall supply a company profile , minimally it should include the following:-

- business name and address;
- contact person;
- brief history of the company (to include length of time in business, the names of the companies principals and the present number of full time employees and their designations);
- principal location of business; and
- organisational structure - to include details regarding ownership, management team and structure, history, major clients, industry expertise.

3.2 REFERENCES

The tenderer shall identify three (3) organisations for which Contracts of a similar nature have been completed. These references will be used to verify claims of relevant experience.

The information about each organisation must include:

- name and address of the organisation;
- name and telephone number of the contact person;
- Tenderer's affiliation, if any, with the organisation;
- Commencement and completion date of the Contract; and
- Scope of the work completed by the tenderer

The client referees must be willing to accept contact by either the Department of Contract and Management Services or the WA Drug Abuse Strategy Office to verify the reference information provided.

3.3 EVALUATION OF TENDERERS CAPACITY

Tenderers which cannot demonstrate sufficient capacity to fulfil the Contract will not be considered as a Contractor.

The Department of Contract and Management Services therefore reserves the right to inspect the premises/facilities of any Tenderer for the purposes of determining their ability to fulfil the Contract.

3.4 SUB-CONTRACTING

Tenderers must state if it is their intention, if successful, to sub-contract any of the services offered.

Tenderers must provide full details of the proposed sub-contractor.

These details must include:-

3.4.1 Name and address of Sub-contractor
3.4.2 Location of factory/premises
3.4.3 Number of people employed
3.4.4 Quality Assurance status of proposed sub-contractor

Tenderers must guarantee that all goods/services provided by sub-contractors and furnished under this Contract shall be free from deficiencies in design, performance, materials and workmanship.

3.5 PURCHASING CONDUCTED BY CONTRACTOR ON BEHALF OF THE AGENCY

The successful tenderer shall observe State Supply Commission policies and principles concerning open and effective competition, ethics and probity, value for money and industry development when conducting purchasing activities (including sub-contracting arrangements) under cover of this Contract. Tenderers are required to detail their procurement methods, commenting on how the above-mentioned principles and policies will be upheld, via their purchasing processes.

SPECIAL CONDITIONS OF CONTRACT FOR PROVISION OF SERVICES

4.1 PRINCIPAL

The Principal under the Contract, shall be the Department of Contract and Management Services.

4.2 PERIOD OF CONTRACT

The Contract shall be in force for the period stated on page 1 hereof, but in the event of the Contractor failing in any manner to carry out the Contract to the Department of Contract and Management Service's satisfaction, the Department of Contract and Management Services may forthwith determine the Contract by written notice to the Contractor. All orders placed under the Period Contract prior to its expiry shall be fulfilled by the Contractor.

The commencement date of the first 12 month period of the contracts will be staggered to occur in the period between the Letter of Acceptance and April 1998.

It is the intention of the Client Agency to contract for this service for a period of three years subject to satisfactory performance and the availability of funds as provided by the Parliament of Western Australia. Contractors will be engaged for a one year period with two, twelve month options to extend at the discretion of the Department of Contract and Management Services.

4.3 PERFORMANCE OF SERVICES

The Contractor shall perform and carry out the Services at all times in a conscientious, expeditious and professional fashion. Where the Contractor is required to provide or utilise equipment, such equipment shall be suitable for the Services and shall be maintained by the Contractor in good and proper working conditions.

The Contractor warrants that its employees and agents are competent and have all necessary skill training and qualifications to carry out the Services in accordance with these conditions.

4.4 CLIENT CONFIDENTIALITY

The nature of this service is such that the Contractor and all the personnel working on projects encompassed under this Contract shall be required to treat all aspects of projects, including verbal as well as written material made available during the project as confidential. A breach of confidentiality shall be considered a breach of the Contract and shall be grounds for termination of the Contract.

4.5 PUBLIC DISCLOSURE

The successful tenderer shall not use this Contract or the Client Agency name for promotional purposes, without the prior written consent of the Client Agency***.***

4.6 PAYMENT

Payment of the fees will be on a quarterly basis and would amount to one quarter of the total per annum fee allocated for the metropolitan and/or regional areas.

4.7 CREDIT CARD

Tenderers should be aware that some Government Departments are using Corporate Credit Cards for payment. No additional surcharges will be allowed to the tendered price, for Corporate Credit Card payments.

4.8 SECURITY

The Contractor shall, when attending the Client Agency premises or facilities, comply with all reasonable directions and Departmental procedures relating to occupational health (including the Agency's smoke free work place policy) and safety and security in effect those premises or in regard to those facilities, as notified by the Client Agency***.***

4.9 NEGATION OF EMPLOYMENT, PARTNERSHIP OR AGENCY

The Contractor shall not represent itself, and shall ensure that it's employees do not represent themselves as being employees, partners or agents of the Client Agency.
The Contractor shall not by virtue of this Contract be or for any purpose be deemed to be an employee, partner or agent of the Client Agency.

4.10 CONFLICT OF INTEREST

Prospective Contractors are required to disclose any information which might be relevant to an actual or potential conflict of interest.

The Contractor warrants that, at the date of signing this Contract, no conflict of interest exists or is likely to arise in the performance of its obligations under this Contract. If, during the term of this Contract, a conflict or risk of conflict of interest arises, the Contractor undertakes to notify the Client Agency, immediately, in writing of that conflict or risk.

The existence of, or failure to declare such conflict of interest will entitle the Department of Contract and Management Services to terminate the Contract.

4.11 EMPLOYMENT OF CURRENT SERVICE PROVIDERS

The process of selecting public sector employees by the preferred tenderer/s shall occur after the award of the contract.

Until such time as the contract manager arranges for interviews to be held between the preferred tenderer/s and the public service employees, no approaches shall be made by the tenderer to the public service employees for the purpose of selection or transfer of those employees to the contractor.

At the conclusion of the interviews, the contractor shall advise the contract manager of the selection process outcomes, including the names of employees to whom they wish to offer a position.

Upon agreement by the contract manager, formal offers of employment may then be made by the contractor, to the selected public service employees. The contractor shall advise the contract manager of the offers that were accepted.

4.12 PROVISION OF EMPLOYMENT OPPORTUNITIES FOR EXISTING STAFF

Respondents are required to state the estimated number of existing permanent employees that they would require and the terms and conditions of employment are to be specified.

There is no requirement for respondents to make offers of employment to existing employees, however offers to existing employees are desirable and the number, tenure and quality of any offers will be a factor in the tender evaluation process.

Respondents should address the following matters:

- salary, allowances and entitlements (including superannuation, leave etc) to be paid to employees;
- policy with respect to training and skills maintenance;
- policy with respect to occupational health and safety;
- details of any proposed shifts that are to be worked;
- basic hours of work for a full time employee; and
- the minimum period of employment that would be offered to existing permanent employees recruited.

Suitable job offers:

- are for employment with wages and conditions as close as possible to the employees existing position; and
- make provision for full protection of the sick leave entitlement accrued by existing employees at the time of proposed separation.

4.13 ALLOWANCE

Budget items for which there is an allowance indicated in the Specifications (A & B) will be subject to adjustment following review at six months following commencement of the contract.

4.14 INTELLECTUAL PROPERTY RIGHTS

The title, copy right and all other rights to the intellectual property in and to all documents, photographs, drawings, pictures, designs, films, slides, video tapes, audio tapes, objects, displays

and other materials of whatsoever kind produced, created, designed, devised or made by, or on behalf of the Contractor for the purposes of this Contract shall forthwith vest in the Client Agency upon payment to the Contractor of the Contract sum (or fees or whatever) hereunder.

4.15 RECORD OF SERVICES BY THE DEPARTMENT OF CONTRACT AND MANAGEMENT SERVICES

The Contractor/s shall be required to:

a) Maintain records of services provided under this Contract.
b) Make this information available to the Department of Contract and Management Services within 21 days of written request.

It is anticipated that the information will be required on an annual basis.

4.16 PUBLIC INFORMATION ON AWARD OF CONTRACT

Following the posting of Letters of Acceptance, the following information shall be made publicly available:

i) Contractor(s) name

ii) Contract Price(s); not including imported content or settlement discounts.

4.17 SUB-CONTRACTING

Should there be a requirement for the successful tenderer to employ outside organisations to undertake work for the tenderer in respect of this Contract, then such work shall not proceed without the prior approval of the Client Agency. Tenderers must guarantee that all goods or services provided by such organisations and furnished under the Contract shall be free from deficiencies in design, performance, materials and workmanship.

Any approval given to the Contractor by the ***Client Agency*** to engage a sub-contractor to provide any part of the services required under this Contract shall not relieve the Contractor from any of the liabilities or obligations under this Contract. The Contractor shall be responsible to the Client Agency for the work of the sub-contractor or any employee or agent of the sub-contractor.

4.18 AWARDS AND WORKPLACE AGREEMENTS

4.18.1 With respect to all work done in Western Australia under the Contract, the Contractor shall observe, perform and comply in all material respects with all relevant Industrial Awards, Registered Workplace Agreements, Industrial Agreements and orders of Competent Courts or Industrial Tribunals applicable to the work to be done under the Contract.

4.18.2 Failure by the Contractor to comply with 4.18.1, shall entitle the Department of Contract and Management Services by notice in writing to the Contractor to forthwith terminate the Contract, but without prejudice to any other rights or remedies of the Department of Contract and Management

4.19 CONTRACTOR PERFORMANCE RECORDS

The WA Drug Abuse Strategy Office will maintain appropriate records monitoring Contractor performance and shall call upon the Contractor to explain any instances of unsatisfactory performance. Unsatisfactory performance includes, but is not limited to, late delivery against agreed time-frames or frequent rejection of orders. Unsatisfactory performance may lead to termination of the Contract in addition to any other rights available to the Commission under the General Conditions of Contract for the Supply of Services.

Contractor performance records for this Contract may be examined when investigating a Contractor's capacity to perform other work, including future Contract work.

PRICE SCHEDULE

Provision of Community Drug Service Teams as specified in this document and Attachment A and B.

TEAMS	FUNDS ALLOCATED PER ANNUM	PLEASE INDICATE BY ✓ WHICH AREAS YOU WISH TO BID FOR.
Metropolitan		
South (City to Mandurah)	$272,000	
North (City to Yanchep)	$272,000	
East (City to Mundaring)	$272,000	
South East (City to Armadale)	$272,000	
Regional		
South West	Up to $157,000	
Great Southern	Up to $162,000	
Goldfields	Up to $183,000	
Gascoyne/Murchison	Up to $193,000	
Pilbara	Up to $238,750	
Kimberley	Up to $238,750	

Please note that Payment of the above fees will be on a quarterly basis and will be one quarter of the allocated funds for the metropolitan and/or regional areas.

Service specifications CDSTs metropolitan regions

Background

The WA Strategy Against Drug Abuse Action Plan 1997 - 1999, *Together Against Drugs*, announced that Community Drug Service Teams will be established around the State to increase the extent of available alcohol and drug services.

The teams will have both a prevention and a treatment focus.

It is anticipated that the teams will be closely linked with mainstream human service providers, and that they will assist towards the implementation of a comprehensive and coordinated approach to alcohol and drug issues in their region, consistent with the State's drug strategy as described in *Together Against Drugs*.

Service description

There will be four Community Drug Service Teams in metropolitan Perth. They will be located in the following corridors: south (city to Mandurah), north (city to Yanchep), east (city to Midland) and south east (city to Armadale).

The services will each consist of six full time workers.

This Community Drug Service Teams will provide:

- general alcohol and drug counselling services;
- support to other human service providers to manage alcohol and drug problems among their clients (through shared case management, consultation and education activities); and
- support to the local community to prevent alcohol and drug problems.

In implementing these services, the teams will provide a particular focus on:

- early intervention and family support;
- support for schools dealing with drug abuse incidents;
- outreach counselling for youth;
- attention to specific local problems (such as solvent abuse);
- support for Local Drug Action Groups; and
- support for regional coordination.

A fixed price of $272,000 per team per annum will be provided for the service. An indicative budget for the service is as follows:

Table: Indicative budget

	Estimated cost
Staff	
1 coordinator $40,947-$43,123 (Level 7 SACS award)	
5 other staff $29,067-$36,594 (Level 4-5 SACS award)	
Estimated sub total staff	205,750
+ 8% on costs	16,460
Professional development allowance	6,000
Accommodation allowance	18,000
Travel allowance	10,000
Consumables allowance	15,000
Total	271,210

Outcomes objectives

- Individuals are assisted to a) overcome drug problems, and b) reduce harm from continuing drug use.
- Families are supported to deal with drug use in the family.
- Families are engaged at an early stage of youth drug use.
- Schools are supported in dealing with drug use incidents.
- Youth who would not attend an alcohol and drug centre are engaged through outreach.
- Mainstream human service providers are supported to deal with the alcohol an drug use of their clients.
- Specific local problems (such as solvent abuse) are addressed through services and coordination of responses.
- Local Drug Action Groups continue and their activities are coordinated with other regional responses.
- Regional Co-ordination forums are assisted to plan and implement prevention and treatment responses across agencies.

Outcome measures

- Number of clients attending scheduled follow up (by categories: youth, adult, families).
- Estimated incidence of identified specific local problems (such as solvent abuse) (by a forum such as the Regional Co-ordination forum).
- Number of Local Drug Action Groups operating.
- Existence of a regional plan and number of activities implemented.

Outputs

- Individual counselling (youth, adult, family).
- Group counselling (youth, adult, family).
- Counselling sessions at other agencies (youth, adult, family).
- Shared care arrangements (schools, youth workers, methadone maintenance, Family and Children's Services, Ministry of Justice).
- Education activities (school staff, youth agencies, Family and Children's Services, Ministry of Justice).
- Support for Local Drug Action Groups.
- Participation in Regional Co-ordination forums.

Output measures

- Number of individual counselling (by categories: youth, adult, family).
- Number of group counselling (by categories: youth, adult, family).

- Number of counselling sessions at other agencies (by categories: youth, adult, family).
- Number of shared care arrangements (by categories of shared treatment/intervention: schools, youth worker, methadone maintenance, Family and Children's Services, Ministry of Justice).
- Number of education activities (by categories of recipient: school staff, youth agencies, Family and Children's Services, Ministry of Justice).
- Number of Local Drug Action Groups supported.
- Number of Regional Co-ordination forums attended.

Quality standards

The following quality standards will be part of the contract of service with the successful service providers. The agency will be expected to meet or to be working towards meeting these standards according to an agreed time frame and process. The service purchaser will, if necessary assist the agency to access support to develop towards the standards.

Organisational operation

- Staff undertake regular and relevant learning activities.
- The service has provision for formally accessing client and interagency feedback.
- The service details its programs, policies and procedures in a manual.

Counselling practice

- The Counsellor will access supervision regarding counselling practice and case management.

- Counselling will involve a structured and organised approach to intervention case management: problem solving, skill acquisition, motivational interviewing and relapse prevention, anticipating other client difficulties and planning and practising for them, using specific interventions to address problem areas, case notes.

- For youth, counselling will take a holistic perspective that encompasses the client's functioning in the areas of accommodation, employment/education, social and recreational skills and activities, and family relations; although the service should not, however, attempt all facets of this but work cooperatively with other agencies as appropriate.

- The family should be engaged to participate in the counselling process as a general rule, support should always be offered to families.

- Counselling should be gender sensitive with all clients offered a same gender counsellor where logistics allow.

- Aftercare appointments should be scheduled for all family and individual clients.

- Services should maintain a comprehensive knowledge of the communities they service, and they should liaise with other alcohol and drug as well as general health, justice and welfare services to ensure they are coordinated and complementary.

Selection criteria

- Capacity to deliver the outputs as outlined.

- Capacity to meet the quality standards as outlined.

- Value added to the contract (for example, through additional or complementary services, support of community networks, particular skills or agency tools).

Special conditions of the contract

- Agencies undertaking a contract may be required to give first refusal for a position to a person or persons referred by the service purchaser. Agencies may be required to accept a person or persons referred by the service purchaser for temporary secondment to a position before it can be filled.

- The commencement date of the four contracts will be staggered to occur in the period between advice of award of the contract and April, 1998. Agencies undertaking a contract will negotiate with the purchaser.

- Budget items for which there is an "allowance" indicated in the specifications will be subject to adjustment following review at six months following commencement of the contract.

- It is the intention of the purchaser to contract for this service for a period of three years subject to satisfactory performance and the availability of funds as provided by the Parliament for Western Australia. Agencies undertaking a contract will be engaged for one year with a review and renewal subject to satisfactory performance for a further two years.

Service specifications CDSTs country regions

Background

The WA Strategy Against Drug Abuse Action Plan 1997-1999, *Together Against Drugs*, announced that Community Drug Service Teams will be established around the State to increase the extent of available alcohol and drug services.

The teams will have both a prevention and a treatment focus.

It is anticipated that the teams will be closely linked with mainstream human service providers, and that they will assist towards the implementation of a comprehensive and coordinated approach to alcohol and drug issues in their region, consistent with the State's drug strategy as described in *Together Against Drugs*.

Service description

There will be six Community Drug Service Teams in country regions of Western Australia. They will be located in the following areas: Great Southern, South West, Goldfields, Gascoyne/Murchison, Pilbara and Kimberley.

The services will each consist of three full time workers.

It is anticipated that the best use of the resources will be to place the workers in various areas of the regions.

This Community Drug Service Teams will provide:

- general alcohol and drug counselling services;
- support to other human service providers to manage alcohol and drug problems among their clients (through shared case management, consultation and education activities); and
- support to the local community to prevent alcohol and drug problems.

In implementing these services, the teams will provide a particular focus on:

- early intervention and family support;
- support for schools dealing with drug abuse incidents;
- outreach counselling for youth;
- attention to specific local problems (such as solvent abuse);
- support for Local Drug Action Groups; and
- support for regional coordination.

A fixed price of $151,000 to $216,000 will be provided for the service according to its location.

An indicative budget for the service is as follows:

Table: Indicative budget

	Estimated cost
Staff	
1 coordinator $40,947-$43,123	
(L7 SACS award)	
2 other staff $29,067-$36,594	
(L4-5 SACS award)	
Estimated total	107,500
+ 8% on costs	8,600
Zone allowance (Pilbara and Kimberley)	6,750
Professional development allowance	6,000
Accommodation allowance	
Great Southern	Up to 15,000
South West	Up to 15,000
Goldfields	Up to 30,000
Gascoyne/Murchison	Up to 30,000
Pilbara	Up to 60,000
Kimberley	Up to 60,000
Travel allowance	
Great Southern	Up to 15,000
South West	Up to 10,000
Goldfields	Up to 20,000
Gascoyne/Murchison	Up to 30,000
Pilbara	Up to 30,000
Kimberley	Up to 30,000
Consumables allowance	10,000
Total	
Great Southern	Up to 162,000
South West	Up to 157,000
Goldfields	Up to 183,000
Gascoyne/Murchison	Up to 193,000
Pilbara	Up to 238,750
Kimberley	Up to 238,750

Outcomes objectives

- Individuals are assisted to a) overcome drug problems, and b) reduce harm from continuing drug use.
- Families are supported to deal with drug use in the family.
- Families are engaged at an early stage of youth drug use.
- Schools are supported in dealing with drug use incidents.
- Youth who would not attend an alcohol and drug centre are engaged through outreach.
- Mainstream human service providers are supported to deal with the alcohol an drug use of their clients.
- Specific local problems (such as solvent abuse) are addressed through services and coordination of responses.
- Local Drug Action Groups continue and their activities are coordinated with other regional responses.
- Regional Co-ordination forums are assisted to plan and implement prevention and treatment responses across agencies.

Outcome measures

- Number of clients attending scheduled follow up (by categories: youth, adult, families).
- Estimated incidence of identified specific local problems (such as solvent abuse) (by a forum such as the Regional Coordination forum).
- Number of Local Drug Action Groups operating.
- Existence of a regional plan and number of activities implemented.

Outputs

- Individual counselling (youth, adult, family).
- Group counselling (youth, adult, family).
- Counselling sessions at other agencies (youth, adult, family).
- Shared care arrangements (schools, youth workers, methadone maintenance, Family and Children's Services, Ministry of Justice).
- Education activities (school staff, youth agencies, Family and Children's Services, Ministry of Justice).
- Support for Local Drug Action Groups.
- Participation in Regional Co-ordination forums.

Output measures

- Number of individual counselling (by categories: youth, adult, family).
- Number of group counselling (by categories: youth, adult, family).
- Number of counselling sessions at other agencies (by categories: youth, adult, family).
- Number of shared care arrangements (by categories of shared treatment/intervention:schools, youth worker, methadone maintenance, Family and Children's Services, Ministry of Justice).
- Number of education activities (by categories of recipient: school staff, youth agencies, Family and Children's Services, Ministry of Justice).
- Number of Local Drug Action Groups supported.
- Number of Regional Co-ordination forums attended.

Quality standards

The following quality standards will be part of the contract of service with the successful service providers. The agency will be expected to meet or to be working towards meeting these standards according to an agreed time frame and process. The service purchaser will, if necessary assist the agency to access support to develop towards the standards.

Organisational operation

- Staff undertake regular and relevant learning activities.
- The service has provision for formally accessing client and interagency feedback.
- The service details its programs, policies and procedures in a manual.

Counselling practice

- The Counsellor will access supervision regarding counselling practice and case management.

- Counselling will involve a structured and organised approach to intervention case management: problem solving, skill acquisition, motivational interviewing and relapse prevention, anticipating other client difficulties and planning and practising for them, using specific interventions to address problem areas, case notes.

- For youth, counselling will take a holistic perspective that encompasses the client's functioning in the areas of accommodation, employment/education, social and recreational

skills and activities, and family relations; although the service should not, however, attempt all facets of this but work cooperatively with other agencies as appropriate.

- The family should be engaged to participate in the counselling process as a general rule, support should always be offered to families.

- Counselling should be gender sensitive with all clients offered a same gender counsellor where logistics allow.

- Aftercare appointments should be scheduled for all family and individual clients.

- Services should maintain a comprehensive knowledge of the communities they service, and they should liaise with other alcohol and drug as well as general health, justice and welfare services to ensure they are coordinated and complementary.

Selection criteria

- Capacity to deliver the outputs as outlined.
- Capacity to meet the quality standards as outlined.
- Value added to the contract (for example, through additional or complementary services, support of community networks, particular skills or agency tools).

Special conditions of the contract

- Agencies undertaking a contract may be required to give first refusal for a position to a person or persons referred by the service purchaser. Agencies may be required to accept a person or persons referred by the service purchaser for temporary secondment to a position before it can be filled.

- The commencement date of the four contracts will be staggered to occur in the period between advice of award of the contract and April, 1998. Agencies undertaking a contract will negotiate with the purchaser.

- Budget items for which there is an “allowance” indicated in the specifications will be subject to adjustment following review at six months following commencement of the contract.

- It is the intention of the purchaser to contract for this service for a period of three years subject to satisfactory performance and the availability of funds as provided by the Parliament for Western Australia. Agencies undertaking a contract will be engaged for one year with a review and renewal subject to satisfactory performance for a further two years.

Appendix 3: Guidelines for police attendance at overdoses

South Australian Police: guidelines for police attendance at drug overdoses

Victorian Police: attendance at incidents of drug overdose

WA Police: guidelines for attending drug overdoses

Tasmania Police: self administration overdose situations

Australian Federal Police: self administration overdose situations

South Australian police
Guidelines for police attendance at drug overdoses

Since 1993 there has been a disturbing increase in drug overdose deaths, the majority being intravenous drug users.

Recent research has shown that only 56% of those interviewed who were present at an overdose called an ambulance.

The major reason identified for failing to call for assistance was the fear of police intervention leading to prosecution for minor drug related offences, primarily self administration, contrary to Section 31(b) of the Controlled Substances Act.

The offence of "self administration" is currently under review by a National Drug Strategy sub committee.

Given the National Drug Strategy's major objective of *harm minimisation* and that law enforcement should be directed at suppliers rather than users, the enforcement of self administration laws should be limited to exceptional cases and only where it is absolutely necessary.

Against this background, and accepting that the saving of human life is a law enforcement priority, it is appropriate to establish guidelines for police attending drug overdoses. Attendance at a reported drug overdose will usually be at the direction of the Communications Centre as a result of:

- the death or imminent death of a person from an overdose
- a request by ambulance officers for police support

In the case of a death or imminent death, police will fully investigate the matter on behalf of the Coroner as they would any other sudden or suspicious death.

When called to standby at the scene of a non fatal overdose, once the welfare of the ambulance officers and overdose victim are assured, it is normally appropriate for police to leave the scene.

In some cases when attending at a non fatal drug overdose, there may be evidence of other drug related activity. In these circumstances, police should use their discretion as to whether the greater public interest of saving lives will be served by the further investigation of what may be considered as relatively minor offences.

In considering whether or not it is appropriate to further investigate, police should consider:

- the need for a "reasonable cause to suspect" before requesting names and addresses of possible offenders
- the need for full cooperation from potential witnesses at the scene in the case of a fatality
- the legal criteria for search and seizure under the Controlled Substances and Summary Offences Acts
- occupational health and safety issues involving the handling of used syringes and needles
- the likelihood of a successful prosecution for minor offences given that initial entry to any premises was not by way of a warrant under the Controlled Substances or Summary Offences Acts.

If illicit drugs are evident and ownership cannot be determined, they are to be seized and processed in the normal manner.

The above guidelines are in accordance with the National Drug Strategy and its stated objective of harm minimisation and are designed to give operational police guidance when investing drug overdoses.

The knowledge that police will be acting on these guidelines may well encourage victims and others in attendance to overcome their fear of prosecution and call an ambulance as soon as possible.

Victorian police
Attendance at incidents of drug overdose

Situation

Victoria Police is an active participant in the National Drug Strategy which is premised on a harm minimisation approach to illicit drugs. There are three broad types of activities that encompass the overall philosophy of harm minimisation:

- supply control;
- demand reduction; and
- problem prevention or risk reduction.

Police attendance at incidents of drug overdose must be based on harm minimisation. One of the force's roles in supply control is aimed at drug suppliers rather than drug users, and for this reason the following policy has been developed.

Attendance at incidents of non fatal drug overdose

Before pursuing any investigation for "use and possess" offences at incidents of non fatal drug overdose, members should consider whether this action is in the best interests of the community. Attending members are to consider each incident on its individual circumstances and, on most occasions, it may be in the greater public interest to overlook minor drug possession charges. This action may have the effect of removing fear of prosecution and encourage people present at incidents of overdose to call an ambulance without delay.

In all incidents, whether considering laying charges or not, members are to take possession of all drugs. These must be entered in the Station Property Book and handled as either an exhibit or disposed of according to Regulation 50, *Drugs, Poisons and Controlled Substances Regulations* 1995 (disposal on authority of an Officer).

Attendance at incidents of fatal drug overdose

Where a person dies of a suspected drug overdose involving illicit drugs, the investigation will be the responsibility of a member of the CIB. Members must take possession of any drug or article which may assist the investigation. Members are to refer to further instruction in section 9.4.2, *Operating Procedures*.

Consequential amendment

This Chief Commissioner's Instruction amends sections 1.3.6 and 5.1.7, Operating Procedures, *Victoria Police Manual*, and will be incorporated as an Update in due course.

The Gazette Monday 2 February 1998 No. 2

West Australian police
Guidelines for attending drug overdoses

In line with the National Drug Strategy's major objectives of harm minimisation and that law enforcement should be directed at suppliers rather than users, the use of discretion is encouraged at every stage in the enforcement of self administration laws.

Where police are called to attend the scene of a drug overdose and there is evidence of other drug related activity, if the offences only relate to self administration or simple possession, it is in the greater public interest to use discretion with regard to prosecuting simple offences. This action will have the effect of removing the fear of prosecution and encourage people present at overdoses to call for assistance without delay. In determining whether it is appropriate to charge those present at the scene with simple possession or use offences, consideration should be given to:

- the need for full cooperation from potential witnesses at the scene;
- the legal criteria for search and seizure under the Misuse of Drugs Act 1981; and
- occupational health and safety issues involving handling used syringes and needles.

If illicit drugs are evident they are to be seized and processed in the normal manner.

Inquiries to Acting Senior Sergeant Brennan, Alcohol & Drug Coordination Unit.

Tasmanian police
Self administration overdose situations

Introduction

Since 1993 there has been a disturbing increase in drug overdose deaths, the majority being injecting drug users.

Recent research has shown that only half of those interviewed, who were present at an overdose, called an ambulance.

The major reason identified for failing to call an ambulance was the fear of police intervention leading to prosecution for drug related offences, primarily self administration.

The National Drug Strategy has the underlying philosophy of harm minimisation and a policy approach of supply control which directs law enforcement strategies towards suppliers rather than users.

Tasmania police and the Tasmanian ambulance service agree that:

- the saving of life is the major priority for both organisations;
- police officers will only be invited to attend overdose situations:
- due to the death of a person from an overdose; or/and
- at the request of ambulance officers who require police support in a particular situation.

Tasmania police supports the notion that:

- the prosecution of self administration laws should be limited to exceptional cases or where they are used in conjunction with other offences;
- in the case of a death police will investigate the matter on behalf of the Coroner as they would in any sudden or suspicious death;
- when called to the scene of a non fatal overdose to protect the welfare of ambulance officers, with the exception of the overdose victim, police have the discretion to investigate any cases of serious harm or serious injury at the scene;
- when attending an overdose situation where there is evidence of other drug related activity police will use their discretion as to whether the greater public interest of saving lives will be served by further investigation, particularly where the offences are likely to be self administration offences;
- if illicit drugs or injecting equipment are evident when called to an overdose situation actions will be subject to the jurisdiction of the HIV/AIDS Preventative Measures Act and the Poisons Act.

The Tasmanian ambulance service will:

Instruct ambulance officers and hospital staff to complete a notification of drug overdose form to provide statewide data on drug overdoses. Names, addresses and other information which can be used to identify people or locations related to drug use will not be provided.

Memorandum of understanding between Tasmania Police and Department of Community and Health Services

Australian Federal police
Self administration overdose situations

Background

In 1996 as a result of a disturbing increase in drug related overdose deaths, the majority of which involved intravenous drug users, the practice was adopted that ACT region members would not, as a rule, attend non fatal drug overdoses.

The rationale behind this decision was to encourage intravenous drug users to contact the ambulance free of the fear of police intervention for the offence of self administration, section 171(2) of the *Drugs of Dependence Act 1989*. Since 1996 there has been a 45% reduction in drug overdose deaths.

Self administration

Given the National Drug Strategy's major objectives of harm minimisation and that law enforcement should be directed at suppliers rather than users, the enforcement of self administration laws should be limited to exceptional cases and only where it is absolutely necessary.

Against this background, and accepting that saving human life is a law enforcement priority, guidelines for police attending drug overdoses have now been established. The knowledge that members will be acting on these guidelines may further encourage victims and others in attendance to overcome their fear of prosecution and call an ambulance as soon as possible.

Police action

Members usually attend the scene of a drug overdose as a result of:

- the death of a user; or
- a request by ambulance officers for assistance.

Additionally patrol personnel performing beat duties may also respond to persons who have overdosed in public places (ie public toilets). In the case of a death, members are to fully investigate the matter on behalf of the Coroner and apply 'crime scene' requirements at the relevant location.

Other cases

In all other cases where members are called to assist at the scene of non fatal overdoses, once medical assistance is rendered, they should leave the scene. In some cases there may be evidence of other drug related activity by the person involved. In these circumstances, members should exercise discretion in determining whether the public interest of saving lives will be served by further investigating what may be considered a victimless crime and a health issue.

The same criteria of public interest is to be applied when considering preferring charges of self administer in other circumstances, ie person found using illicit drugs.

Administration of drugs by others – special considerations

These guidelines do not relate to circumstances where a person administers a drug to another person. They relate to self administer only. Particular caution is to be applied by members where any evidence exists to suspect that an overdose (or drug related death) may have been caused other than by self administration.

Australian Federal Police, ACT Region, Guideline for Best Practice 9/98
May 1998

Appendix 4: Guidelines for police relations with needle exchange programs

Victorian Police: needle exchange programs

WA Police: relations with needle and syringe programs

Queensland Police: relations with NSEPs

New South Wales Police: Support of NSEPs and methadone programs

Victorian police
Needle exchange programs

In order to reduce the need to re-use syringes/needles the Health Department has established a Needle Exchange Program. Drug users should not be deterred from participating in these programs and accordingly members should not carry out any unwarranted patrols or person check in the vicinity of needle exchange centres. Members should also be mindful that the possession of syringes/needles does not, of itself, constitute an offence and only in rare circumstances will be justified in seizing them.

Members are asked to use discretion and common sense in relation to police activity around known needle exchange centres. Where there is a perceived problem requiring police attention the Station Commander must be informed and take an active interest so that any police action will not defeat the intention of the program.

Needle exchange centre managers are advised by the Health Department to liaise with local police and this should be encouraged.

West Australian police
Relations with needle & syringe programs

The AIDS Council of WA and the Aboriginal Medical Service provide a service to intravenous drug users by using two mobile facilities to exchange needles and syringes and injecting equipment. This service is a harm reduction approach to reduce the spread of blood borne diseases within the community.

The WA police service has an agreement with the needle exchange and methadone dispensing service that police officers refrain, wherever possible, from maintaining their presence in the proximity of these units, unless operational needs dictate otherwise.

In the past police have been known to target the clients of needle and syringe exchange units. This practice is not a recommended drug law enforcement strategy and has the potential for adverse health consequences for the users and the community at large.

Police officers are also required to use their discretion with regards to treatment agencies for alcohol and other drugs.

Queensland police
Police relations with NSEPs

Policy

The Queensland Department of Health operates needle exchange and methadone treatment programs from a number of Brisbane and regional premises. The goal of these programs is to prevent the re-use or sharing of syringes/needles in order to reduce the spread of communicable diseases.

Officers should be mindful of the need for intravenous drug users to freely use these services.

Officers are not to deter intravenous drug users from participating in these programs. Patrols, surveillance, or person checks in the vicinity of premises used for needle exchange or methadone treatment programs should not be conducted unless warranted and justifiable.

Officers in charge should ensure that officers under their supervision are made aware of the location of premises where these programs operate to avoid any unnecessary police presence in the area.

Procedure

Inquiries may be made with Biala Alcohol and Drug Services to obtain information about the location of needle exchange services and methadone treatment clinics in Queensland.

Inquiries about intravenous drug users attending needle exchange or methadone treatment programs may be made through the Inspector in Charge, Drug and Alcohol Coordination, Police Headquarters.

Officers should be mindful of the potential hazard of needle stick injuries from used syringes which may be in the possession of intravenous drug users or which have been discarded in the vicinity of such premises (see s. 16.10.2: 'Procedure for searches' of this Manual, and s. 21.7: 'Management of blood/body exposures and skin penetrations' of the Human Resource Management Manual).

Extract from Section 1.13.3 of the Operational Procedures Manual, Queensland Police Service

Peter Martin
Inspector, Drug and Alcohol Coordination, Queensland Police Service

New South Wales police
Police support of NSEPs and methadone programs

Public health benefits for the community through intersectoral cooperation

Both the NSW Police Service and the NSW Department of Health support needle and syringe and methadone programs as essential public health programs and agree to provide mutual support and assistance in the delivery of these programs. It is essential that policy, community groups and staff of area health services work together with the expectation that mutual assistance and support will be received in delivering these programs.

Benefits of sharing information across service sectors

There are obvious dilemmas involved in information-sharing between NSEPs and MPs and the Police Service. To promote good community relations police should open up informal lines of communication with health workers to discuss problems that both services are experiencing. If difficulties persist a workable approach would be to establish an advisory committee with representation from both NSEP and MP workers and management and senior members of the local police. This committee would meet regularly and talk frankly about current problems and issues that might raise and cause conflict in the future.

This is consistent with the NSW Needle and Syringe Exchange Policy and Procedures Manual which states "in order to achieve a good working relationship it is important that regular contact be kept with police".

The same would apply for any methadone maintenance program.

Possible issue areas

NSEPs and MPs have bi-partisan government support, and, in the case of needles and syringes, the Drug Misuse and Trafficking Act was amended in 1988 to permit syringes to be carried and distributed legally. While there has been support from police for those involved in the delivery of NSEPs and MPs, isolated problems have arisen largely because:

- The majority of clients use illicit drugs and are therefore associated with the illegal drug trade. For these reasons, needle and syringe exchange programs have an unusual role because their activities are legal but their clients are usually engaged in illegal activities.

- The objectives of NSEPs are to facilitate the use of clean injecting equipment and promote safer sex practices for health reasons. The objectives of MPs are to assist opioid dependent persons to improve their health and social functions and alleviate the adverse social consequences of their drug use by reducing and eliminating their illicit opioid use. Methadone programs also complement strategies to minimise the risks of HIV amongst injecting drug users – and from them to other members of the community. The aim of both programs is to provide information and referral services, sometimes on an outreach basis. In the past, service staff and clients have had a perception that police have targeted these services.

- Police objectives are to discourage the presence of drug dealers and injecting drug users by targeting and arresting dealers. Legislation enables police to stop, search and detain people whom they reasonably suspect of being involved in illegal drug trade. The former police circular (88/101), which specifically relates to needle exchange programs but can also apply to MPs, stated: *"Without restricting the day to day duties and obligations of police, they should be mindful not to carry out unwarranted patrols in the vicinity of these facilities which might discourage IV drug users from attending them."*

Feedback from outreach needle exchange and methadone treatment workers indicates that injecting drug users will not use a service if they feel it might make them vulnerable to arrest. However, while patrols cannot enter NSEP or MP premises for unwarranted reasons, if a police

presence is requested by workers for warranted reasons (eg staff safety or possible danger to premises) police should attend the site as soon as possible.

Establishing needle and syringe/methadone programs

The NSW Needle and Syringe Exchange Policy and Procedures Manual (May 1994), states, with reference to the establishment of needle and syringe exchange programs:

"Prior to establishing an NSEP, approval is required from the Department of Health. This approval will include authorisation for specific persons or class of persons to participate in NSEP. The authorisation exempts these persons from sections 19 and 20 (aiding and abetting) of the Drug Misuse and Trafficking Act."

Difference kinds of programs generate different kinds of issues for human service workers and clients. However, in general terms, the most important factors in the establishment of a successful needle and syringe exchange program are communication and education involving all parties.

The following sections have been divided into two parts which look at the responsibilities of both police and NSEP/MP workers in the establishment, monitoring and evaluation of a program.

NSEP/MP staff responsibilities

- The Area Health Service will provide information, training, support and supplies for needle and syringe exchange programs.

- The local police patrol commander should be contacted as early as possible about the proposed establishment of an NSEP or MP. This should not only involve liaising with the patrol commander's representatives but also, where possible, beat police.

    - Police should be consulted about possible sites for the programs. Sites should be identified which permit confidentiality, storage of supplies in a secure area, accessibility to clients etc. In certain circumstances, permission will be required to operate the programs from local government and/or local property owners.

    - The staff should nominate a regular and accessible contact person for police liaison and develop lines of responsibility and reporting mechanisms to service managers and/or supervisors.

    - Where possible, staff or representatives of the program should attend briefing sessions and parades at the police station to identify themselves and to explain the objectives and operational strategies. In addition, it is also a good idea to discuss possible issues with relevant beat police and seek joint strategies to pre-empt difficulties developing.

    - Staff will organise and attend regular meetings with the patrol commander's representative, and other key players where possible, and, if necessary, an ongoing advisory committee for the monitoring of programs should be established.

- All workers proposing to work in these programs must undertake training in regard to HIV prevention, MP and/or NSEP services. This can be arranged through the area health service. It is also sensible to encourage other workers who may not be directly involved in needle exchange, but who may be sharing the premises and/or service which provides needle exchange, to also attend HIV/NSEP training as this will often reassure them about operational issues.

- All workers involved in these programs must be registered through the area service and all workers must be issued with Health Department identification cards which include a passport photo of the worker. These should be worn or shown on demand. This is helpful to clients,

other service workers and the police since it clearly identifies who the workers are in the programs.

· Local government staff and staff of the area health service should be asked for assistance in the development of appropriate systems for disposal of used syringes.

Police responsibilities

· The patrol commander will nominate a regular and accessible contact person for liaison work and also develop clear lines of responsibility and reporting mechanisms to senior police regarding needle exchange and methadone management issues.

· The patrol commander will ensure that all police operating within the area of the programs are aware of their existence and familiar with their objectives.

· Police should assist workers to identify appropriate sites/locations for the establishment of a program, taking into consideration client accessibility, worker safety, level of usual police activity in the area, resident/business resistance to the program etc.

· Police should be prepared to attend briefing sessions with workers, when authorised by the patrol commander, to discuss issues of mutual concern.

· The patrol commander's representative should, by invitation, take part in an advisory committee which will assist with the development of the program, and have regular meetings with workers to assist in monitoring the program, undertake problem solving and jointly address issues which may emerge with regard to the operation of the service.

Dispute resolution

If problems arise between workers and police for any reason then it is essential that these are resolved as quickly as possible to ensure minimal impact upon the program. It is also important to attempt to define the area of the dispute as precisely as possible to facilitate a quick resolution. A suggested process for both workers and police is as follows:

1. For public services, the advisory committee should be used as the initial forum for discussing and attempting to resolve the dispute.

2. If this fails, the issue should be referred to the patrol commander, area health service administration and/or the management committee of a non government organisation. Difficulties arising involving private methadone clinics should be referred to the methadone policy manager of the NSW Health Department's Drug and Alcohol Directorate.

3. If this meeting also fails to resolve this dispute, consideration should be given to independent mediation. This process should involve police and area health service senior management as well as the drug enforcement agency of police and the NSW Health Department.

General obligations

Management and staff responsibilities

· Try to ensure that clients do not use premises to avoid police contact.
· Ensure that illegal activities (dealing etc) are not permitted at the service, and that all clients are aware of this.
· All staff must carry photo ID at all times whilst on duty.
· All staff must adhere to the NSW Department of Health Policy and Procedures Manual.

Police responsibilities

- Plain clothes police should be prepared to provide identification to staff when requested. Uniformed police will have a badge with either a name or number, and station, which obviates the need to ask for identification.

- Whenever possible, police should confer with staff prior to taking any action at or in the immediate vicinity of program premises.

Strategies

There are possible strategies for dealing with situations which may arise in programs which were jointly developed by police and staff. It is important to remember that police have the right to enter any premises in the course of law enforcement duties.

Where police are in pursuit of someone that they believe poses an immediate threat to clients or staff

Staff responsibilities

- Allow police to carry out their duties and assist where requested.
- Report the incident to management.

Police responsibilities

- Carry out duties to ensure public safety and law enforcement.
- Inform staff of the situation at the earliest opportunity providing identification where practicable, or after an arrest is made.

Where staff request police assistance

Staff responsibilities

- On requesting assistance from police, staff should give a brief, clear explanation of the situation and a staff contact name.
- Where assistance is required in moving people on, or an incident has occurred where charges are to be laid, staff should give a clear indication to police in the initial contact.

Police responsibilities

- Attend calls as promptly as possible when requested by program staff.
- Approach program staff contact person immediately upon arrival if this is practical.
- Intervene immediately upon arrival in crisis situations.
- Assist with moving people on where necessary.

Where police wish to make a referral to a program for information and referral from staff. For example, secondary NSEP outlets frequently receive referrals from police in cases of homelessness, clients who are drug affected, domestic violence victims etc.

Staff responsibilities

- Respond appropriately and as quickly as possible to police referrals.
- Where police request off site assistance, make an immediate assessment of the viability of the request, taking into account staff numbers and staffing policies etc, and inform police of staff ability to help or otherwise.
- Provide feedback to police in general terms of the outcomes of referrals through the service monitoring process of the steering committee.

Police responsibilities

Referrals may be made in three ways:

- Give details of services directly to client.

- Bring a client to the program where this is possible, and approach staff for assistance.
- Request staff attendance at another location to provide assistance.

Where an unusual level of police presence occurs in the vicinity of the program

Staff and management responsibilities

- Approach the officers concerned to seek clarification if possible.
- Contact the patrol commander's liaison officer or representative on the advisory committee as soon as possible.
- Report the incident(s) to program management.

Police responsibilities

- The patrol commander or his representative may make general information available to program management beforehand if a change in policing activity is likely to have an effect upon the service, providing that operational imperatives are not compromised.

Extract from New South Wales Police Service guidelines for support of needle and syringe exchange and methadone programs

Appendix 5: Victorian cannabis cautioning program pilot

Overview of Victorian cannabis cautioning program pilot

Executive summary of evaluation of cannabis cautioning program pilot (May 1998)

Notice "Cannabis and the law" on back of cannabis cautioning notice

Police copy of cannabis cautioning notice

Offenders copy of cannabis cautioning notice

Victorian cannabis cautioning program pilot

Introduction

In 1996 the Premier's Drug Advisory Council undertook an intensive examination into illicit drug use within Victoria and advised on how Victoria should tackle the drug problem. In their report *Drugs and our community, report of the Premier's Advisory Council (1996)*, a number of recommendations were made that sought alternatives to current practices in dealing with minor drug users.

As a result of these recommendations, the Policy Research Unit of Victoria Police examined diversion schemes such as cautioning as an alternative to prosecution for offenders using and/or in possession of small amounts of cannabis.

Cautioning minor offenders for use and/or possess cannabis should not be seen as a 'soft option' or as a form of decriminalisation. Cautioning has been widely used by Victoria Police for a number of years, particularly in the area of minor shop stealing and in an array of criminal offences committed by children. These programs are highly regarded and have been extremely successful in diverting persons from the Criminal Justice System. It is expected that once in operation, the Cannabis Warning Program will also provide an opportunity for minor drug users to address health issues associated with drug use.

Pilot

A pilot is to be conducted in "I" District commencing on 21 July 1997 for 6 months. It will be applied to use and/or possess cannabis offences detected by "I" District personnel within the Pilot District.

Purpose

The aim of the pilot is to test the viability of a system of cautioning offenders detected using and/or in possession of small quantities of cannabis.

Criteria for selection of offender

The decision as to whether a person is suitable for a caution will depend on the following criteria:

- the identity of the offender must be clearly established;
- the offender must be an adult (existing Police Cautioning Program for children will apply);
- there must be sufficient admissible evidence that the offence has occurred;
- the offence of use/possess small quantities of cannabis must be the sole offence;
- the cannabis only refers to dried leaf, stem, stalks and seeds of the cannabis plant (does not include hashish, hashish oil or a growing cannabis plant);
- the member must be satisfied that the cannabis is for personal use only;
- the specified amount must not exceed 50 grams;
- offender must have no prior drug offences;
- no more than two cannabis cautions are permitted;
- offender must admit the offence and consent to being cautioned; and
- offender must sign the required forms and audit bag containing the cannabis seized.

Why 50 grams of cannabis?

As mentioned earlier, the Cannabis Warning Program is aimed at offenders detected using and/or in possession of "small quantities" of cannabis. Schedule 11 of the *Drugs, Poisons and Controlled Substances Act* defines a small quantity as an amount not exceeding 50 grams. This amount is approximately the weight of the audit bag supplied for the containment of the seized cannabis.

No need for TRIM

Members may be concerned there is "no evidence" to support a charge of possession of cannabis (an indictable offence) without a TRIM interview. If the matter is subsequently referred to court within the 28 day specified period, there is sufficient evidence to sustain a conviction. Evidence that can be lead include:

- observations of members;
- signed audit bag containing the cannabis;
- continuity of exhibit maintained; and
- analysis of drug by botanist.

Procedure

Once the member is satisfied that the criteria is met, a caution may be administered at the scene of the offence. A sub officer must oversee the process.

When a caution is administered, the offender will receive a copy of the "Cannabis Caution Notice" that will have information about the legal and health ramifications of cannabis use. Members should encourage the offender to seek the services of a drug rehabilitation centre and also encourage them to contact the phone number on the Notice.

In administering the caution, the member must explain to the offender that the matter will be officially recorded and that detection of further offences of this nature may result in a court appearance.

Audit bag

The audit bag is a clear vinyl tamper proof bag used to store the cannabis seized until authority is given to dispose of it. These bags will be carried by sub officers and provided to members as required.

To ensure accountability, the audit bag will be signed by the offender, attending member and supervisor (if present at the scene of the offence) after the cannabis has been placed in the bag. The bag should then be sealed in the presence of the offender.

At the station, the sealed audit bag containing the cannabis is entered into the Property Book and secured. All audit bags have a sequential serial number. A reference to the audit bag serial number must be recorded on the 'cannabis receipt' section of the 'Cannabis Caution Notice' form and in the Property Book at the station.

Withdrawal of caution

If it is later found that a caution does not meet the criteria or it was not appropriate to administer a caution (for example, information supplied was later found to be false) a sub officer may withdraw the 'Cannabis Caution Notice' and apply the procedure as outlined in the guidelines authorised for the "I" District Pilot.

Benefits

The Cannabis Warning Program is a practical example of police adopting harm minimisation strategies. Offenders receive a warning rather than being subjected to the stresses and stigma of a court hearing. The cautioning notice which is handed to the offender contains information on the harms associated with cannabis use and provides a referral service.

It is anticipated that cautioning will have the following benefits:

- saves time and police resources;
- provides a process which ensures integrity and accountability;
- reduces delay between offence and disposition;
- reduces costs associated with processing and prosecuting offenders; and
- provides a fair opportunity for cannabis users to be diverted from the Criminal Justice System to a treatment program.

Evaluation

An evaluation is being conducted to assess the effectiveness of the Cannabis Warning Program. The aim of the evaluation is to identify and assess practical implications of the program, identify and recommend ways in which the program can be enhanced, and determine its appropriateness for statewide implementation.

Cannabis caution notice instructions

Criteria

- Verify the identity of offender.
- Must not be used for children.
- Must be sufficient admissible evidence that the offender is using or in possession of a small quantity of cannabis.
- There must be no other offence (criminal or traffic) involved or detected.
- Cannabis must be for personal use only.
- The amount specified is not to exceed 50 grams (approximately the weight of a 50 cent piece).
- Cannabis only refers to dried leaf, stem, stalks and seeds (not hash, hash oil or cannabis plant).
- Prior cautions or offences does not necessarily preclude an offender being cautioned, unless such priors relate to drug offences.
- Offender must admit offence.
- Offender must consent to caution.
- Offender must not be cautioned for cannabis on more than two separate occasions.
- Offender must sign the 'cannabis receipt' section of the 'Cannabis Caution Notice' form and audit bag (to be obtained from the supervising sub officer).

Procedure

1) Offender detected (without warrant) for use and/or in possession of a small quantity of cannabis for personal use.
2) Cannabis is seized and placed in the audit bag. Apply seals and sign where indicated.
3) All of the above criteria must be met.
4) If satisfied that a caution is appropriate, personally consult a sub officer who must be satisfied that the criteria is met and a cannabis caution is appropriate.
5) Complete 'Cannabis Caution Notice' form and administer the caution.
6) Ensure the serial number on the audit bag is recorded on the 'Cannabis Caution Notice' form.
7) Provide offender with a copy of the 'Cannabis Caution Notice'.
8) Convey the audit bag to the station (as soon as practicable) and enter the property into the Property Book (PB 36).
9) Ensure the serial number on the audit bag is also recorded in the PB 36.
10) Complete the Incident Report (L1) and the ("I" District Pilot) form and submit to sub officer for checking and subsequent faxing to the Central Data Entry Bureau.
11) Where the use of an interpreter is required, a caution may be administered at the station through the Telephone Interpreter Service if the criteria is met.

Extract from the evaluation of the cannabis cautioning program pilot, May 1998

Executive summary[1]

Overview

The Victoria Police has developed a number of strategies and policies consistent with the National and Victorian Drug Strategies, which are aimed at reducing the manufacture, supply and harmful effects of drug use in the community. Following a recommendation of an earlier report[2] Victoria Police Command approved the piloting of a Cannabis Cautioning Pilot Program (CCPP) which involved testing the viability of a system of cautioning persons detected using and/or in possession of small quantities of cannabis. The pilot was conducted in 'I' district over six months (21 July 1997 to 21 January 1998).

Objectives

The objectives established for the pilot were:

- To test the criteria and procedures established for the CCPP under actual working conditions.
- To assess the effectiveness of the CCPP in terms of training, administrative and operational efficiency.
- To test the supervision and accountability mechanisms associated with the pilot.

The purpose of the evaluation was to assess the objectives of the CCPP in terms of its findings and make appropriate recommendations including the appropriateness for statewide implementation.

Results

- Ninety seven (97) cautions were issued during the pilot period.
- Cautioned offenders were predominantly young males aged between 17-21 years.
- Of the 97 offenders cautioned, 57% were first time offenders and 44% had prior criminal involvement.
- In 82% of cautions issued, the amount of cannabis seized was less than five grams. Half of the offenders cautioned were detected with equal to or less than one gram of cannabis.
- Of the police members who responded to the surveys, 74% indicated that cannabis was located during a vehicle inspection or as a result of a minor traffic infringement.
- Despite the option of where to issue a caution, 77% of cautions were issued at a police station and 23% at the scene of the offence.
- Overall, the criteria and procedures as outlined in the guidelines were generally complied with by members issuing cautions with a few exceptions.
- Ninety three percent (93%) of police members surveyed believed that police resources were saved in terms of time and paperwork as compared with the previous process involved in prosecuting offenders.
- The Cannabis Cautioning Notice and the LEAP forms fulfilled the purposes of the pilot in terms of its content and format. Ninety eight percent (98%) of members found they were easy to use and complete.

Training

Most police members within the pilot district were trained prior to the commencement of the pilot. The pilot indicated that information needs for a cautioning program of this kind can be

[1] Strategic Development Department, Victorian Police Service. *Evaluation of the cannabis cautioning program pilot*. Melbourne, Victorian Police Service, 1998.
[2] Victoria Police, Policy Research Unit (1996), *Cannabis Caution Notices*.

accommodated in current instructional and other informational packages. With a comprehensive communication strategy, statewide training can be adequately delivered by DTOs at the district level.

Conclusion

The overall results for Victoria Police are very positive. The CCPP has a high degree of acceptability with members. Other policy considerations, in particular supervision and ethical standards were maintained to a high degree. From an internal perspective, the pilot indicated positively the direction Victoria Police should take in terms of cannabis cautioning.

Recommendation 1

The CCPP be continued in 'I' district, in its present form, pending statewide implementation of the Cannabis Cautioning Program.

Recommendation 2

That the cannabis cautioning program be implemented statewide.

Recommendation 3

That the strategic development department in consultation with general policing, ethical standards and business management departments:

- develop an implementation strategy for the statewide implementation of the cannabis cautioning program for approval by executive command by 1 May 1998. The target date for statewide implementation be 1 July 1998;
- include in the implementation strategy, advice on:
  - appropriate instructional material; and
  - a communication strategy;
- be responsible for all issues and matters concerning the implementation of the cannabis cautioning program; and
- be accountable to the cannabis cautioning program pilot steering committee (assistant commissioners strategic development department and general policing).

Recommendation 4

That the guidelines issued for the cannabis cautioning program pilot, including the use of audit bags, be the basis for a statewide program with the following adaptations, that:

- criteria 5.4 be amended to read from 'There must be no other (criminal or traffic) offence involved or detected' to 'There must be no other drug related offence involved or detected';
- section 6.1.5 which reads 'If a sub officer is satisfied that the criteria are met and a cannabis caution notice is appropriate, the cannabis caution notice form must be prepared and administered by the investigating member.' be deleted;
- section 6.3 be amended to read from 'A sub officer must oversee the process applied and the appropriateness of the caution' to 'role of supervisor';
- any reference to plain clothes member not being permitted to issue a cannabis caution notice be deleted; and
- the last dot point in section 7 of the guidelines under the heading 'Withdrawal of Caution' which reads 'If an offender within 28 days wishes to contest the caution, ensure the issue of identity is clarified and any interview be conducted using TRIM.' be deleted.[3]

[3] This change will have the consequence of removing reference on the Cannabis Cautioning Notice of the offender having an opportunity to contest the matter within 28 days.

Recommendation 5

That Victoria Police Command approve the use of the A5 size audit bags for the purposes of the cannabis cautioning program.

Recommendation 6

That the 'Cannabis Cautioning Notice' form be incorporated into a revised version of the existing VP Form L21 'Caution Notices' and include:

- offenders acknowledgment of consent to caution;
- 'Receipt of Property'; and
- reference to a confidential help and information service for cannabis offenders.

Extension to other drugs of dependence

On 3 April 1997 Victoria Police Command directed that the issu8e of cautioning offenders for use and/or possession of drugs of dependence other than cannabis be deferred until after this pilot was evaluated.

There are a number of issues relating to other drugs of dependence which could not be addressed by this pilot, and still other issues which arose as a result of this evaluation. All the issues surrounding the notion of cautioning offenders for drugs of dependence other than cannabis need to be identified and thoroughly investigated.

Recommendation 7

That a working party be established comprising representatives from:

- Strategic Development Department;
- Ethical Standards Department;
- Crime Department;
- General Policing Department; and
- Victorian Forensic Science Centre to examine the issues surrounding the extension of cautioning to other drugs (use/possession) of dependence and to report to Command by 1 July 1998 on the appropriateness of cautioning.

Notice on back of cannabis cautioning notice

CANNABIS AND THE LAW

What you should know about cannabis

The law in regard to cannabis

In Victoria you are breaking the law if you possess, use, grow or sell cannabis, hash or hash oil.

Penalties differ according to the amount of cannabis, the type of offence, whether the person has any prior convictions and other factors.

If you are found using or possessing a small amount of cannabis, the penalty is usually a good behaviour bond, but only if it is your first offence and there is no evidence that you're involved in selling drugs.

If you're caught a second time you may get a fine of up to $500.

Growing or selling cannabis are more serious offences and may lead to a fine of up to $250,000 and/or up to 25 years in prison.

The same penalties apply for hash and hash oil.

Driving: It is illegal and dangerous to drive while under the influence of any drug, including cannabis. It reduces concentration and coordination, impairs judgment and makes you drowsy.

Slows down your brain

The chemical in cannabis that affects you is called THC. It works by slowing down the messages that go between the brain and the body. In large doses it can sometimes have an hallucinogenic effect so that you see and hear things that aren't really there.

Immediate effects

When people are affected by cannabis they are said to be "stoned", "high" or "bent". The specific effects vary quite a lot, but can include:

- less control over what you do or say
- laughing and giggling
- craving for junk food
- altered awareness and perception
- poor coordination
- inability to think logically
- losing track of words and thoughts
- difficulty remembering things

Some people feel confused, paranoid, anxious, panic or have hallucinations.

Cannabis and alcohol

The effects of cannabis may be greatly increased if it is used with alcohol or any other drugs that slow down the brain. This is true for alcohol, heroin, and some medications (eg tranquillisers, antidepressants, and antihistamines). It is particularly dangerous to drive after using a combination of these drugs.

Other types

Other types of cannabis are now available. Sometimes called ‘skunk’ or ‘skunkweed’, the higher THC content of these types increase the likelihood of harmful effects on a person’s health.

Long term use may be harmful

Some people make the mistake of thinking that cannabis is a harmless drug. Using cannabis, hash or hash oil over a long period of time may lead to:

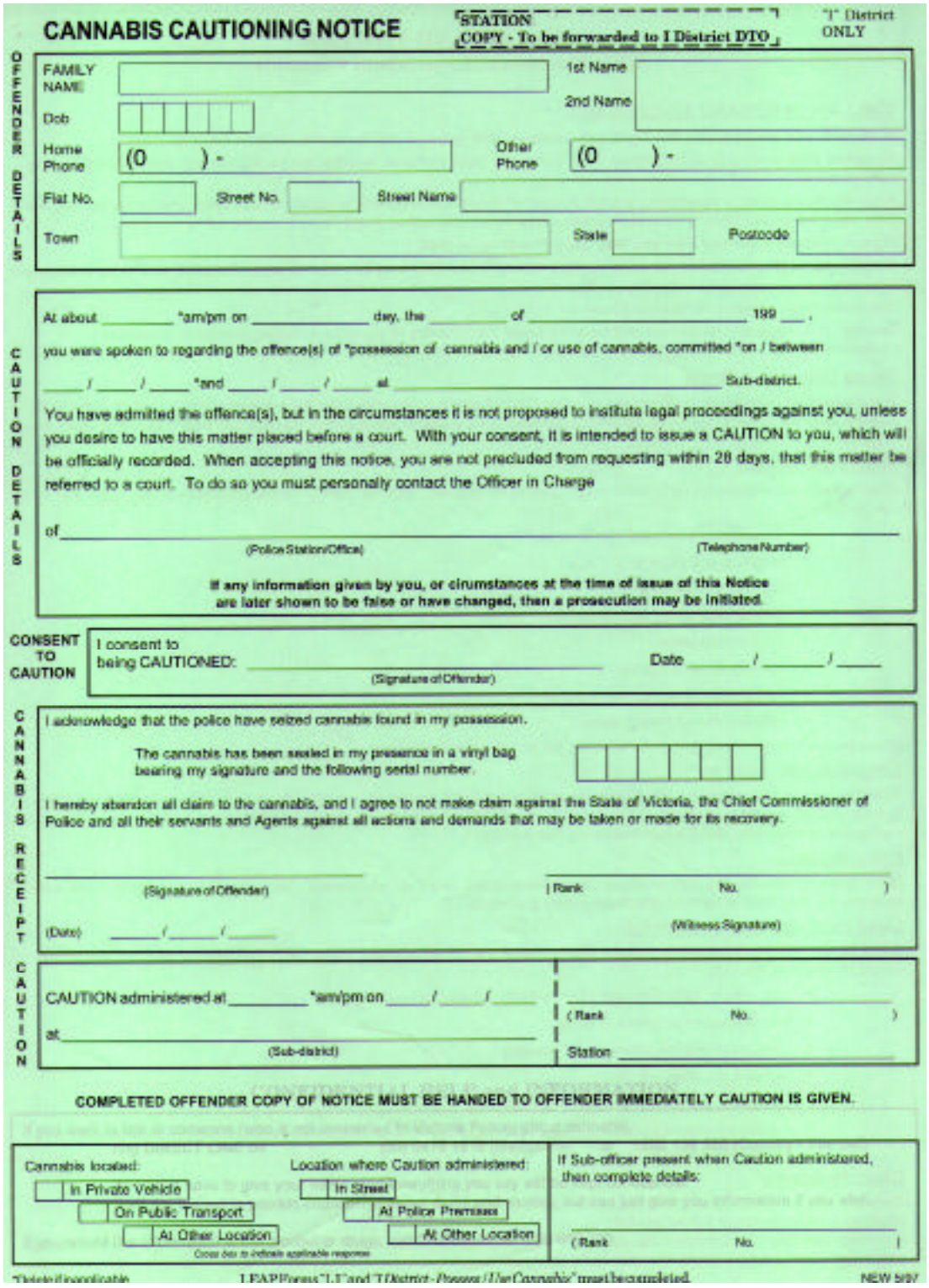
- lung cancer, bronchitis and other illnesses caused by smoking
- less motivation at school or work
- poor concentration, memory and learning
- reduced sex drive
- changes to hormones (and period problems for women)
- a small number of people may develop symptoms similar to schizophrenia (eg delusions, hallucinations, anxiety and paranoia).

Other problems

Cannabis can get you in trouble with the police, cause family arguments, cost you a lot of money, destroy relationships and affect your performance at school or work.

A criminal conviction for cannabis use can affect your work opportunities, family life and relationships. It can also jeopardise your chances of getting a visa to travel in some countries.

Police copy of cannabis cautioning notice



CANNABIS CAUTIONING NOTICE

STATION COPY - To be forwarded to I District DTO

"I" District ONLY

OFFENDER DETAILS

FAMILY NAME

1st Name

2nd Name

Dob

Home Phone (0) -

Other Phone (0) -

Flat No.

Street No.

Street Name

Town

State

Postcode

CAUTION DETAILS

At about _____ *am/pm on _____ day, the _____ of _____ 199 ___ ,

you were spoken to regarding the offence(s) of *possession of cannabis and / or use of cannabis, committed *on / between

___/___/___ *and ___/___/___ at _____ Sub-district.

You have admitted the offence(s), but in the circumstances it is not proposed to institute legal proceedings against you, unless you desire to have this matter placed before a court. With your consent, it is intended to issue a CAUTION to you, which will be officially recorded. When accepting this notice, you are not precluded from requesting within 28 days, that this matter be referred to a court. To do so you must personally contact the Officer in Charge

of _____

(Police Station/Office) (Telephone Number)

If any information given by you, or circumstances at the time of issue of this Notice are later shown to be false or have changed, then a prosecution may be initiated.

CONSENT TO CAUTION

I consent to being CAUTIONED: _____ Date ___/___/___

(Signature of Offender)

CANNABIS RECEIPT

I acknowledge that the police have seized cannabis found in my possession.

The cannabis has been sealed in my presence in a vinyl bag bearing my signature and the following serial number.

I hereby abandon all claim to the cannabis, and I agree to not make claim against the State of Victoria, the Chief Commissioner of Police and all their servants and Agents against all actions and demands that may be taken or made for its recovery.

_____ _____

(Signature of Offender) (Rank No.)

(Date) ___/___/___ (Witness Signature)

CAUTION

CAUTION administered at _____ *am/pm on ___/___/___

at _____

(Sub-district)

_____

(Rank No.)

Station _____

COMPLETED OFFENDER COPY OF NOTICE MUST BE HANDED TO OFFENDER IMMEDIATELY CAUTION IS GIVEN.

Cannabis located:

- In Private Vehicle
- On Public Transport
- At Other Location

Location where Caution administered:

- In Street
- At Police Premises
- At Other Location

Cross box to indicate applicable response

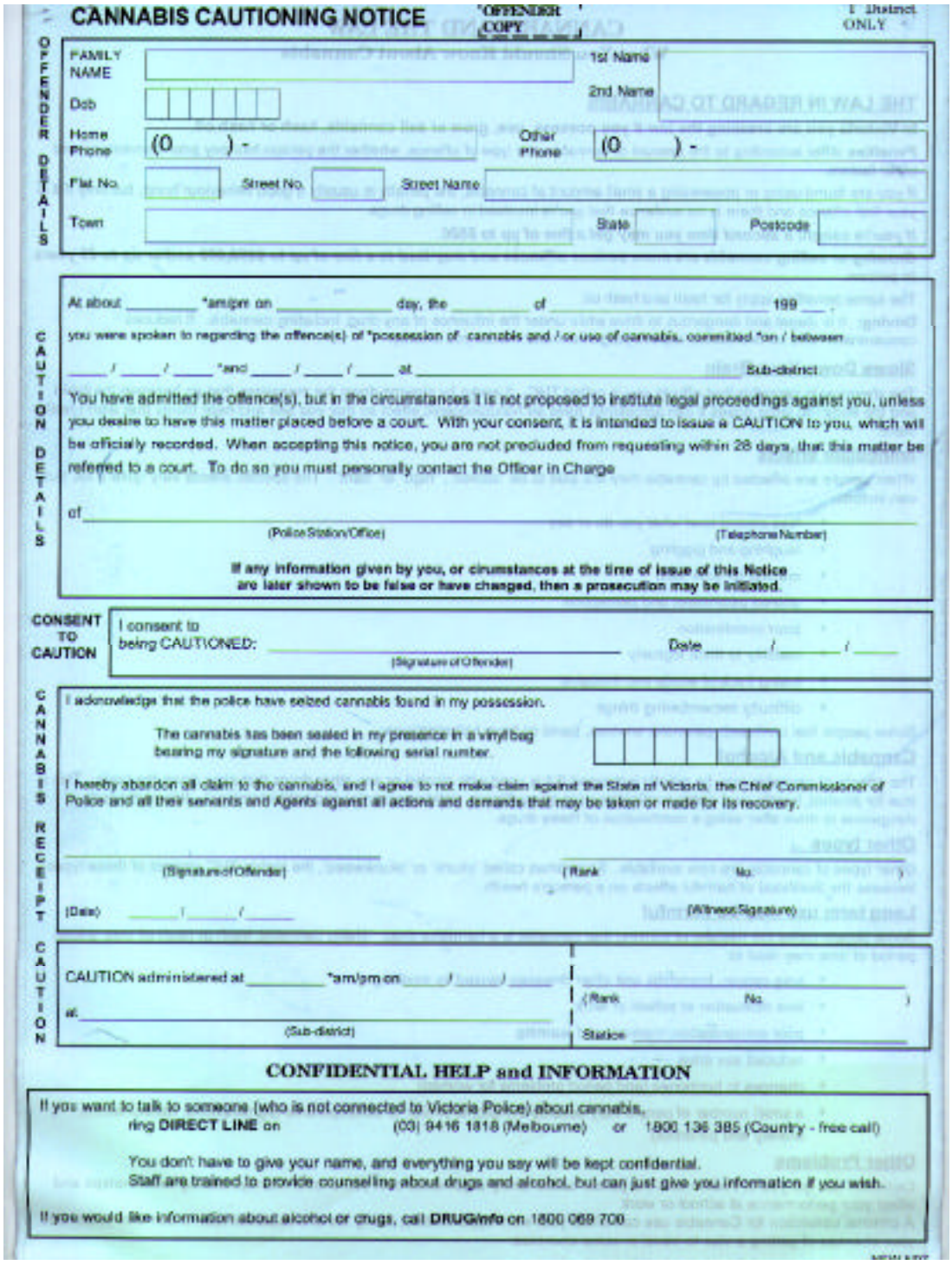
If Sub-officer present when Caution administered, then complete details:

_____

(Rank No.)

*Delete if inapplicable LEAP Forms "I.1" and "I District - Issues / Use Cannabis" must be completed. NEW SOV

Offenders copy of cannabis cautioning notice



CANNABIS CAUTIONING NOTICE — OFFENDER COPY — ONLY

OFFENDER DETAILS

FAMILY NAME — 1st Name — 2nd Name — Dob — Home Phone (0) - — Other Phone (0) - — Flat No. — Street No. — Street Name — Town — State — Postcode

CAUTION DETAILS

At about _____ *am/pm on _____ day, the _____ of _____ 199 ___ ,
you were spoken to regarding the offence(s) of *possession of cannabis and / or use of cannabis, committed *on / between
____ / ____ / ____ *and ____ / ____ / ____ at _____ Sub-district

You have admitted the offence(s), but in the circumstances it is not proposed to institute legal proceedings against you, unless you desire to have this matter placed before a court. With your consent, it is intended to issue a CAUTION to you, which will be officially recorded. When accepting this notice, you are not precluded from requesting within 28 days, that this matter be referred to a court. To do so you must personally contact the Officer in Charge

of _____
(Police Station/Office) (Telephone Number)

If any information given by you, or circumstances at the time of issue of this Notice are later shown to be false or have changed, then a prosecution may be initiated.

CONSENT TO CAUTION

I consent to being CAUTIONED: _____ Date ____ / ____ / ____
(Signature of Offender)

CANNABIS RECEIPT

I acknowledge that the police have seized cannabis found in my possession.

The cannabis has been sealed in my presence in a vinyl bag bearing my signature and the following serial number.

I hereby abandon all claim to the cannabis, and I agree to not make claim against the State of Victoria, the Chief Commissioner of Police and all their servants and Agents against all actions and demands that may be taken or made for its recovery.

_____ _____
(Signature of Offender) (Rank No.)

(Date) ____ / ____ / ____ (Witness Signature)

CAUTION

CAUTION administered at _____ *am/pm on ____ / ____ / ____ _____
(Rank No.)

at _____
(Sub-district) Station _____

CONFIDENTIAL HELP and INFORMATION

If you want to talk to someone (who is not connected to Victoria Police) about cannabis, ring **DIRECT LINE** on (03) 9416 1818 (Melbourne) or 1800 136 385 (Country - free call)

You don't have to give your name, and everything you say will be kept confidential. Staff are trained to provide counselling about drugs and alcohol, but can just give you information if you wish.

If you would like information about alcohol or drugs, call **DRUGInfo** on 1800 069 700

Appendix 6: Operational guidelines for rave parties, concerts and large public events

Rave parties, concerts and large public events operational guidelines

Background

The Government of Western Australia is concerned about the use of illicit drugs and disturbances to neighbouring residents caused by rave parties and other after hours noisy, unregulated events. In 1993 a Ministerial Working Party was formed as a result of an initiative by the Australian Institute of Environmental Health Officers. It was formed to develop protocols to allow early warning of events and a cooperative response from Police and Local Government. The report prepared by this Working Party was presented to the relevant Ministers in June 1994. Arising from the report was a proposal from the Attorney General and the Minister for Police that a committee be formed to coordinate large functions in public buildings to:

1) facilitate organisers to stage legitimate events that meet all legislative requirements; and

2) establish protocols to ensure applications are appropriately vetted and approved.

The proposal was subsequently approved by Cabinet on 11 October 1994.

The committee developed these guidelines to provide promoters and local authorities with an indication of the controls that need to be considered to conduct legitimate events and to ensure they cause minimal disruption and are acceptable to the community.

Not all rave parties attract adverse publicity. Many are held without knowledge or risk to the general public and with adequate cooperation between rave party organisers and the authorities. There is no reason why this should not always be the case. Once proper procedures are adopted and there is a general acceptance of these events, approval processes will be easier.

Promoters and operators must liaise with the appropriate local authority to ensure that community requirements are met. Some authorities will have unique requirements which may vary from these guidelines.

The Health Act (Western Australia) defines anywhere where people assemble for a common purpose as a public building and public buildings require council approval; it does not matter whether or not it is on privately owned land or if an admission charge is applied (refer Part VI of the Health Act).

The Committee noted in particular that the City of Fremantle publishes guidelines each year to define conditions with which promoters of outdoor concerts must comply. Some of these are referred to as practical examples of what local authorities may require. Full copies of the Fremantle guidelines are available on application to the Principal Environmental Health Officer at the City of Fremantle.

At the time of publication three major rave/dance party events had been held in accordance with these guidelines and all were successful. The experience gained from these events showed that they can be successfully held in safe venues without undue disruption to neighbouring communities.

- The largest attendance was approximately 2,200 patrons.
- The patrons were easily controlled.
- Security/crowd control was strict.
- There was no evidence of violence or brawls often associated with other large events.

The success of these guidelines will depend upon how and if they are used as they are not law. Laws are expensive to administer and inflexible and the nature of the entertainment industry is so

varied that controls are best kept flexible. However, if future events are uncontrolled, legislation with fixed parameters will probably be introduced which may affect the viability of many events.

It is expected that these guidelines will be reviewed periodically with the first review being planned for June 1996. If you can see any areas that need to be improved, do not wait for the review date. Send your comments straight away to the Manager, Applied Environmental Health, Environmental Health Service, PO Box 8172 Stirling Street, Perth 6849.

Scope

The guidelines are intended to prescribe requirements for rave parties and large concerts to ensure that venues are safe for patrons and do not disturb neighbouring properties.

A rave party is a pre-arranged event at which:

- amplified music is played for the enjoyment of the patrons;
- the music may be live; and
- commencement is often late in the evening extending until early and mid morning eg 10 am.

The actual name of the event is not important; it is the activity that determines the controls that are required.

Attendance numbers are not relevant because the main causes of concern apply equally to a group of 50 people as to 5,000, although the degree of control will vary.

The guidelines have been developed to give both the industry and statutory authorities an idea of what the general community considers to be appropriate controls for these types of events. They will operate in conjunction with the proposed voluntary Entertainment Industry Code of Fair Practice. If, however, these events continue to be held in inappropriate venues, stricter regulatory controls may need to be introduced.

Applications

Event applications must be lodged with local authorities at least two months prior to the event. Some will require more notice. This period is required because the applications may need Council approval. Most councils only meet monthly. If the application is rejected, then there is still time to arrange for an alternative venue.

An application should have as much information as possible about the type of event and the way that it will be run. It is the promoter's responsibility to organise the event and it will enhance the success of the application if the initial application shows that the event is being well planned. As much of the information on the check list at Appendix 1 as possible should accompany the application. Promoters should also submit details of previous events with which they have been associated. Those without experience should not be deterred from applying.

Dance party activities are unique and therefore a venue must be specifically approved as a public building for rave/dance party use.

Fees

Because of the cost to set and monitor conditions, most local authorities will charge a fee. The fee will vary according to the type of event (eg. concert, dance party, etc) and should reflect the costs incurred. It is not a revenue-raising exercise by the local authority.

Zoning

Rave party venues must be located in areas that are suitably zoned in accordance with any town planning schemes.

Deed of agreement

It is recommended that when specific arrangements are made outside normal legislative requirements that a deed of agreement between the promoter and local authority and/or building owner be entered into, so that both parties are bound by a legal document.
Deeds of agreement may not always be required and will tend to be limited to buildings owned by local authorities.

Bonds

In addition to the set fee, local authorities and/or building owners may elect to hold a bond to ensure that any conditional requirements are complied with. The extent of the bond will relate to the type of conditions. Bonds are often used to ensure that:

- noise limits are not exceeded;
- clean ups are completed on time;
- venue floors are protected;
- damage is made good.

Most local authorities will accept bank guarantees as an alternative to cash. Bonds are quite often part of a deed of agreement.

Insurance

The patrons must be covered by a comprehensive public liability insurance policy and the building should be adequately insured. Policy holders should be sure that their policy conditions cover this type of event.

Proof of public liability insurance and details of who holds the building's insurances should be included with the initial application.

The Municipal Insurance Broking Service recommends $5 million as the minimum acceptable public liability cover.

Communication with promoter

The promoter or his agent must be contactable at all times by the local authority or Police prior to and during the event. This person must be responsible for the event and have the authority to order the venue to be evacuated in an emergency.

A complaints 'hot line' numbers must be established and attended throughout the event. Ideally only one should be a mobile phone.

Building requirements

Any venue, even an outdoor venue, must be approved as a public building for entertainment purposes and be able to accommodate the number of people that will attend.

An approved public building can be identified as one that has been issued with a Certificate of Approval by the local authority; the certificate will detail how the venue can be used and how many patrons it can hold.

The number of people that the venue can hold is determined by:

Floor area - ratio of one person per square metre of available area. This may be varied by the Executive Director, Public Health, on application via the local authority, to as low as 0.5 square metre per person.

Toilet facilities - sanitary requirements vary according to the length of the event and the availability of alcohol. Suggested facilities are contained at Appendix 2, but where events are less than four hours the numbers may be able to be reduced to 80% of the values shown in the tables.

Toilets must be serviced throughout the event. When portable chemical type units or effluent holding tanks are used for events longer than four hours, they must be located so that they can be pumped out during the event.

Number of exits and distance of travel to a road or open space - refer to Building Code of Australia Section D.

Aggregate exit width - refer to Appendix 3 and Building Code of Australia.

Ventilation requirements - refer to Building Code of Australia (BCA) Section F.

For example, sports centres with large floor areas are approved public buildings, but they are restricted because of the toilet facilities and exit requirements. The numbers can usually be increased with minor alterations and by providing additional temporary toilet facilities.

Forms for Application for a Certificate of Approval and Application for Variation of Certificate of Approval are at Appendices 7 and 8.

Other public building criteria are:

Electrical installations

All electrical installations must comply with the supply authority or Office of Energy requirements plus any special requirements of the Health (Public Buildings) Regulations 1992.

An electrical contractor must certify that permanent and temporary electrical installations comply with the Health (Public Buildings) Regulations 1992 by submitting a Form 5 to the local authority. A sample Form 5 is at Appendix 6.

Lighting

All venues and egress paths must be able to be illuminated to 40 lux by lighting that is:

- independent of the event production lights;
- controlled from a central position;
- able to reach the required illumination within three seconds of being energised;
- supplied from the supply authority mains or a generator approved by the local authority.

Emergency lighting

Enclosed venues must have emergency lighting that will operate if the main electrical source fails. For buildings, it must comply with Australian Standard AS 2293 or for outdoor venues there must be at least two alternative power supplies. Two generators or a supply authority supply plus another generator are acceptable alternatives provided that the venue lighting supplies are distributed between both.

Exit signs

These must be installed in compliance with AS 2293 and be illuminated and clearly visible whenever the venue is occupied by the public.

Electrical leads and portable outlet devices

All of these items should be protected by a residual current device (safety switch).

The Health (Public Buildings) Regulations 1992 require that these items are tested every six months by a licensed electrical worker and that a tag to identify the item, test date and the electrical worker is fixed to the tested equipment. Details of the specific tests are at Appendix 9.

Double adaptors are not permitted and piggy-back plugs can only be used on stage lighting effects.

Exitways

Paths of travel to exit doors must be kept clear of obstructions and electrical apparatus.

Fire fighting appliances

Fire fighting equipment must be supplied:

- for buildings - in accordance with the Building Code of Australia;
- for other venues - as determined by the WA Fire Brigades Board.

Spectator stands, stages and lighting rigs

There are no specific regulatory requirements for these structures but specific guidelines are included as Appendix 10.

All stages and lighting rigs must be structurally sound. Local authorities usually require certification from a practising structural engineer. The structural certification should indicate if a roof and side drapes are included and the maximum wind speed. If a roof is included, then it must be designed and installed to shed rainwater. Suspended lighting rigs must have a secondary safety support system and any lighting effect suspended above the audience must have safety chains. Any drapes or effects etc. must be of smoke and flame-retardant material.

Noise

Noise pollution has been a major problem with previous rave parties. It is difficult to stipulate a maximum allowable noise output as this will vary with the venue conditions and the distance to neighbouring developments. The speaker placements have a critical effect on the noise output. Speakers should be positioned to ensure minimum disruption to residential areas.

Generally noise levels of 35 dB(A) at any neighbouring residential development including camping areas (unless the camping area has been established for event patrons) are not a nuisance. Noise levels on the dance floor need to be restricted to about 95 dB(A). To achieve this, each venue will have unique requirements.

Higher levels may be tolerated for short durations between 9am and midnight.

Promoters must liaise with the local authority to ascertain what restrictions will apply to particular events. The Department of Environmental Protection, Pollution Prevention Section is available to assist local authorities and promoters to ascertain what levels may be acceptable. It can also advise where noise level meters can be hired.

It is recommended that promoters, in conjunction with the local authority, provide their own noise controls. Part of this would be to establish and publicise at least two noise complaints numbers. Ideally only one should be a mobile phone.

Lasers

The use of lasers must be in accordance with the Radiation Safety Act.

Operators must be licensed. Lasers must not be aimed at people.

Any laser with an output power greater than five milliwatts, regardless of the application, is subject to the requirements of Radiation Safety Regulations under the WA Radiation Safety Act. The laser and its place of use must be registered and the user must obtain a licence to operate it. The licensed applicant must provide proof of his/her competence and experience in using lasers before the granting of a licence can be considered. Radiation Health Section provides laser safety courses and examinations for these purposes.

By regulation, all lasers must comply with the provisions of the Australian 'Laser Safety' Standard AS2211-91.

Inquiries can be made at the Radiation Health Section, 18 Verdun Street, Nedlands, WA 6009 or by telephoning (09) 346 2267. Local authorities should be provided with details of:

- the laser operator
- the size of the laser (eg. watts, milliwatts)

Special effects - fireworks - pyrotechnics

These require specific approval of the Department of Minerals and Energy, the Police and Local Government.

Police

The Police Regional Officer must be notified at least seven days before each event. They require:

- details of the promoters 'hot line' for complaints;
- name of the crowd control company;
- contact number for the crowd controller officer responsible for staff;
- number of crowd controllers;
- names of all crowd controllers;
- operational procedures;
- emergency procedures - evacuation plan.

The Police Regional Officer can be contacted via the officer in charge of the venue's nearest police station.

The Police Communications should also be notified as noise complaints may be received by them.

Notification of emergency services

Emergency services, Police, Fire Brigade and St Johns Ambulance should all have at least 14 days prior notice of any event.

Emergency procedures

There must be an evacuation plan in place which is known to all security personnel. All security personnel should be briefed immediately before each event. Copies should be presented to the Police and local authority seven days prior to the event.

Fire brigade

The Superintendent, Fire Safety Branch should be notified by phone (09) 323 9300 or fax (09) 323 9495.

Security - crowd control

Security is a term that can mean two entirely different things; it can refer to the building or venue security or crowd control. Sometimes they become an integral part of ensuring public safety; which is the prime function of the Health (Public Buildings) Regulations.

Crowd control is emerging as a major issue at large public building events and there is a recognised need for some directions to be given to prevent an unfortunate incident occurring.

The ultimate responsibility to ensure patron safety rests with the venue manager, and most large venue managers in Western Australia have adopted sound practices. However, there is a trend for large outdoor concerts to be held at alternative venues which have not been designed for concert use. These venues are not managed by people experienced in crowd control and this responsibility is left to promoters to arrange. Promoters are motivated by profit and may not be experienced with crowd control and as a consequence crowd control is sometimes inadequate.

The local authority has a part to play in that it may require proof that adequate precautions have been taken, however, in a lot of cases it will also be the venue manager.

There are no formal techniques or requirements for crowd control but some of the aspects that need to be addressed are:

- When is crowd control required?
- What is crowd control?
- What areas of a venue require crowd control?
- What ratio of crowd controllers per patrons is required?
- What are crowd controllers?
- How should they operate?
- What training should they have?
- Male and female controllers must always be available.

When is crowd control required?

Crowd control is required whenever there are large public gatherings, and greater controls are required for some events. History, to a large extent will show the degree of crowd control required eg. rock concerts, where the audience is unseated and has a large proportion of teenagers, require the most control. Symphony concerts with a seated audience are at the other end of the scale.

What is crowd control?

Crowd control is the control of crowds to:

- avoid personal injury due to crushing, overcrowding and unruly behaviour;
- enable injured or distressed patrons to be identified and moved to safety;
- prevent overloading of structures whether or not for spectator use. They include seating stands, advertising hoardings, stages, lighting and sound mixing towers;
- prevent overcrowding.

What areas of a venue require crowd control?

All areas available to the public require control.

- Venue entrances

- Stages
- Exits
- Aisles

What is a crowd controller?

A crowd controller is a person who is responsible for directing and or controlling people. There may be different categories of controller, eg. parking attendants, ushers, security guards, door attendants.

How should they operate?

They should operate to a set pre-arranged plan which is known to all controllers.

Standing orders and procedures should be developed for each venue.

What training should they have?

There are two basic groups of crowd controllers- passive and non passive:

- Passive - those that do not normally come in direct contact with patrons, such as ticket collectors, ushers, parking attendants.
- Non-passive - those that are in direct physical contact to control crowds and unruly behaviour, such as bouncers, security guards, etc.

There are no specific legislative requirements but the Police Crowd Controller legislation is expected to be passed in Parliament in the 1995 Spring Session. This will make it mandatory for non-passive controllers to be registered and not have a criminal record. In the future they may also require formal training.

All controllers must have good communication skills as this is the cornerstone of good crowd management.

Non-passive controllers must:

- be fit and physically active;
- be aged between 18 and 55 years of age;
- have good communication skills;
- have basic training in fire fighting;
- have basic training in evacuation procedures;
- have a basic knowledge in first aid and have the ability to recognise stress;
- have some knowledge of self-defence and how to control unruly behaviour;
- know their limitations on removing patrons.

Equipment required

Every controller must:

1) Have a distinctive uniform. Passive and non-passive uniforms should be different.
2) Be able to be easily identified. Unique identification must be formally issued at each event so that controllers can be easily identified.
3) Have a torch if the event is held at night and the controller is required to direct patrons to or from seats.
4) Have communication equipment that is effective under noisy concert conditions;
5) Have noise protection.
6) Have any equipment required by Worksafe WA.

Typical crowd controller requirements.

Crowd controllers should be:

- fit, active, no less than 18 and ideally no more than 55 years of age;
- properly trained and capable of carrying out their duties;
- informed in writing of all that they are expected to know and do. It should be made clear to them that they are deployed to assist in the safe operation of the ground, not to view the event.

The following list gives examples of typical tasks and duties that crowd controllers should be expected to carry out and for which they should be prepared. Each crowd controller should be given a written summary of the tasks, duties and responsibilities of the particular post to which he or she is allocated.

Crowd controllers should:

1) Monitor the crowd throughout the ground for signs of distress or overcrowding and take action in accordance with standing instructions.
2) Prevent overcrowding by ensuring compliance with the crowd limits in various parts of the ground.
3) Prevent spectators, as far as possible, from climbing fences and other structures eg light towers, advertising hoardings, speaker columns, mixing towers etc., and from standing on seats. Where by virtue of the scale of the incident, stewards are unable to prevent this, they should immediately report the matter to the Security Controller.
4) Ensure all parking area approaches and emergency exits are kept clear and that vehicles are correctly parked.
5) Ensure that gangways and exits are kept clear.
6) Control all exits including openings in perimeter fence.
7) Assist in the diversion of patrons to other parts of the venue, including the closing of turnstiles, when the capacity for any area is about to be reached.
8) Identify and investigate any incident or occurrence among spectators, and report their findings to the Security Controller.
9) Know the location of, and be able to operate effectively, the fire-fighting equipment at the venue.
10) Know the location of first aid posts.
11) Direct distressed or unwell patrons to first aid posts.
12) Be fully conversant with any methods or signals used to alert staff that an emergency has arisen.
13) Be capable of recognising potential fire hazards and suspect packages, reporting such findings immediately to the security controller.
14) Comply promptly with any instruction given in an emergency by a police officer or the security controller.
15) Remain at their allocated posts as instructed unless authorised or ordered to do otherwise by the security controller.
16) Report to the security controller any damage or defect which is likely to pose a threat to patron safety, eg. a damaged crush barrier.
17) Assist as required in the evacuation of the venue.
18) Assist in the identification of spectators who are banned from the venue, who do not possess tickets, or who are in possession of forged tickets.
19) Assist in the prevention of breaches of venue regulations.

Rave party crowd control

Experience indicates that rave party crowds are not aggressive; hysteria and crushing does not occur. The most common problem is dehydration. Distressed patrons must be escorted to the first aid station for medical attention. Toilet areas should be patrolled every thirty minutes. Crowd controllers at the ratio of one per 200 patrons is considered adequate for these events.

Concert crowd control

Each event will have unique requirements. For large events when popular performers attract young audiences, the following may be required:

Front of stage

- At least one controller per metre of stage, including length of screamers (side extensions of the main stage) must be provided. Their principal duties are to prevent patrons climbing onto the stage and to remove injured or distressed patrons from the crowd.
- Stage barriers of suitable design must be provided (refer to section on stage barriers).
- Egress from the audience area must be provided at either end of the stage
- barrier.
- Patrons must be prohibited from the stage unless arrangements are made with the authority prior to the event.
- Patrons must be prohibited from climbing on any structures within the venue. ie. stage, mixing and lighting towers, hoardings and spectator stands.

General

- In addition to the front of stage security there must be a minimum of one crowd controller per 150 patrons within the venue. Additional security agents may also be required for backstage, perimeter and performer security.
- There should be at least one crowd controller at each egress point from the venue. The controller's principal duty is to ensure that the gates are open when required and that both sides are free from obstructions.
- All crowd controllers must be briefed before each event.
- General procedures, routine orders, evacuation procedures, the names of crowd controllers and the crowd control roster must be submitted to the local authority prior to the event and no later than the pre-event briefing.
- There must be sufficient controllers to allow relief for meal breaks and sickness etc.
- Controllers must be on site at least one hour before the venue is opened.
- Where an egress point also serves as an entry there must be at least two controllers.
- Crowd control companies must be registered.

Stage barriers

Stage barriers must:

- be purpose built to withstand the forces that can be exerted by a large audience;
- be designed so that there are no exposed bolts, finger entrapments or sharp extrusions;
- have a convex or substantially padded top;
- have a non-skid floor. They should be convex and never concave so that patrons tend to be forced to the outside and not the centre;
- have an elevated platform so that crowd controllers are higher than the audience to allow them to identify distressed patrons and pull them over the barrier;
- have at least 1.5 metres clear space between the front of the stage structure and stage barrier to allow injured patrons to be carried to safety behind the security staff.

The promoter must restrict the number of patrons to the number nominated on the Certificate of Approval. Provision must be made for patrons to queue once the venue is filled to capacity. The promoter must know the number of patrons in the venue at any time.

Doors and exit ways must remain clear of obstruction and never be locked.

First aid

Whenever large numbers of people congregate, qualified first aid personnel should be in attendance. Traditionally, this has been done by the St John Ambulance Australia (WA Operations), but other agencies such as Red Cross are also available. St John Ambulance officers are volunteers but they rely on donations to enable training equipment and medical supplies to be purchased. The number of first aiders and first aid posts will vary with the type of event but as a guide the figures below have been suggested by St John Ambulance Australia.

Patrons	First aiders	First aid posts*
500	2	1
1000	4	1
2000	6	1
5000	8	2
10000	12	2
20000	22+	4

* The number of first aid posts required would depend on what first aid room facilities are available. Every venue should have at least one room where there is power and running water.

First aiders are generally not required for events smaller than 500 patrons and which are held in close proximity to central ambulance/hospital services, eg. Northbridge and central metropolitan areas.

First aid posts

These should be conspicuous and identified by an illuminated sign at night. Ideal locations are near the main entry, and for large concerts one should be behind the stage barrier.

Casualties

Experience from previous events has shown that most casualties are from:

- heatstroke, dehydration, respiratory distress;
- cuts from broken glass and drink can ring pulls;
- fainting and exhaustion from a combination of hysteria, heat, and alcohol, and this often occurs at or near the stage barrier;
- trampling or crushing from crowd pressure at the stage barrier;
- illicit drug and alcohol abuse;
- epilepsy attacks brought about from strobe lighting.

Parking

There should be adequate parking so that neighbouring properties are not disturbed by vehicles visiting the venue. Local authorities are responsible for parking and with prior notice additional facilities may be able to be arranged, eg. car parking stations remaining open for extended periods. Access to venues should not be via roads through normally quiet suburban streets.

Transport

If public transport is available for patrons, the event should coincide with transport times.

The promoter should ensure that transport is available to transport patrons both to and from the venue. Metrobus and private bus companies can provide quotes to deliver this service.

The cost to provide a charter service should be included in the ticket price so that cash fare transactions are eliminated and the cost is disbursed amongst all of the patrons.

Metro bus charter inquiries should be directed to: The Secretary, Special Events Committee, Department of Transport, 5/19 Pier Street, Perth WA 6000

For rural locations it may be preferable to have patrons camp overnight. If this option is taken, additional conditions may be set by the local authority.

Water

An adequate supply of water must always be available for fire fighting, hygiene purposes and for dousing heated patrons during summer events. Dousing should be in a specific area and only on request.

Potable drinking water must always be available free of charge or at a nominal cost.

Food and drink

For events longer than four hours, food and drinks must be available to the patrons. If alcohol is served, then low and non-alcoholic drinks must also be available. Their cost should reflect the alcoholic content.

If alcohol is to be available, a liquor licence must be obtained from the Department of Liquor Licensing (phone 9223 3123).

Food and drinks should only be available in unbreakable containers (no glass or crockery).

Food and drink providers must comply with the Health (Food Hygiene) Regulations 1994.

Telephones

Patrons should have access to public phones. Where permanent facilities are not available, Telecom Australia can arrange for temporary pay phones. Contact (09) 377 8444 for information about this service.

Ticketing arrangements

Money for advance ticket sales received by venue operators or independent booking outlets shall be held by them in trust to cover refunds should the performance be cancelled.

Promoters who supply satisfactory guarantees may be exempt from this requirement.

Patrons shall be entitled to a full refund or ticket exchange option in situations such as:

- Main attraction/event cancelled or re-scheduled;
- Main attraction/star performer(s) is cancelled and substitute arranged.

Clean up

It is the promoter's responsibility to liaise with the local authority and building owner to ensure that the venue and surrounding areas are left clean and tidy. Generally clean-ups should be completed within 24 hours of the event's conclusion.

Toilet cleaning

Toilets must be kept clean and serviceable throughout the event.

Rubbish removal

For events longer than four hours, arrangements need to be made to ensure that toilets are kept clean and resupplied with toilet paper. Rubbish bins may need to be emptied during the event.

Syringe disposal

Syringe disposal is becoming a problem at entertainment venues. The Health Department of WA recommends that cleaning staff be briefed on the dangers associated with used syringes and that sharps containers be used for collecting used syringes.

Sharps containers come in different sizes and are available in the metropolitan area from most medical supply wholesalers. The costs range from $3 for a half litre container. Some companies offer a disposal service, for example Medi Collect charge $15 to supply and dispose of a one litre container. In country areas, containers may be available from hospitals.

The Communicable Disease Control Unit policies on 'Safe Collection and Disposal of Discarded Needles and Syringes' and 'Needlestick Injuries - The Risks' are at Appendices 7 and 8.

Summary

It is the promoter's responsibility to:

- lodge an application and advise the local authority of an event. These applications must be lodged with the local authority at least two months prior to the event unless advised otherwise;
- advise the Emergency Services, Police, Fire Brigade and St John Ambulance of the event;
- comply with any conditions set by the local authority;
- arrange patrons transport requirements if regular public transport is not available;
- ensure that adequate security staff attend;
- ensure that adequate first aid personnel attend;
- ensure that exits are always unobstructed and unlocked;
- arrange adequate insurance cover;
- arrange for suitable refreshments to be available at the venue;
- prove to the local authority that they are capable of organising the proposed event;
- arrange briefing and debriefing meetings as required;
- advise police of security and crowd control arrangements.

It is the local authority's responsibility to:

- judge each application on its merits;
- liaise with other statutory organisations to confirm that the promoter has considered their specific concerns - Police, Fire Brigade, Ambulance etc;
- ensure that the event is monitored for compliance with its conditions;
- ensure that neighbouring developments are not unduly disturbed;
- monitor the event and to attend to any complaints promptly.

Contacts for additional information [4]

1) General information - local authority principal environmental health officer.

2) Police - Police Department - Contact relevant regional officer via the officer in charge of the nearest police station to the venue - 131444.

3) Noise - Department of Environmental Protection, telephone 9222 7000.

[4] As at 1 August 1995

4) Laser requirements - Health Department of WA - Radiation Health Section, 18 Verdun St, Nedlands, telephone 9346 2260.

5) Buildings/Structures - Local Authority or - Health Department of WA, Mr Sid Brodie, telephone 9388 4962.

6) Electrical and Lighting - Health Department of WA, Mr Sid Brodie, telephone 9388 4962.

7) Structural - Local Authority or Health Department of WA, Mr Sid Brodie, telephone 9388 4962.

8) Emergency procedures - WA Fire Brigades Board, Fire Safety Branch, telephone 9323 9300 or Health Department of WA.

9) First Aid - St John Ambulance First Aid, 9325 4088 or Red Cross, telephone 9325 5111.

10) Stages and lighting rigs - Health Department of WA, telephone 9388 4962.

11) Fire Brigade - Event notification - Supervisor Operations Officer, telephone 9323 9368 or fax 9323 9319 - General Information - Fire Safety Officer, telephone 9323 9300

Appendix 1: Suggested check list for local authority applications

As much of the following information as possible should accompany an application to hold an event. The information will enable council to process your application quickly. Any application should be accompanied with a drawing to show how the venue will be set up. It should show the stage, exit/entry points, concessions, toilets etc.

Name and address of applicant .....

Contact numbers for applicant - Phone ..... Fax ..... Pager .....

Name and address of proposed venue .....

Type of event - dance party - concert - other .....

Name of main attraction .....

Name previous events that you have held .....

Name and principal of security firm .....

Who is the Regional Police Officer .....

Expected number of patrons .....

Insurance cover proposed .....

Name of electrical contractor .....

Parking arrangements .....

What transport arrangements have been made .....

Who will be supplying first aid service .....

Number and types of toilets proposed .....

What arrangements have been made for the disabled .....

What refreshments will be available .....

Details of rubbish removal and site cleaning .....

Tickets - how and who will sell them .....

What size lasers will be used .....

Who is the laser safety officer and licence no issued by Radiation Health

Appendix 2: Toilet facilities

Table: Toilet facilities for events where alcohol is not available

Patrons	Males			Females	
500	1 WC	2 urinals	2 hand basins	6 WC	2 hand basins
1000	2 WC	4 urinals	4 hand basins	9 WC	4 hand basins
2000	3 WC	8 urinals	6 hand basins	12 WC	6 hand basins
3000	4 WC	15 urinals	10 hand basins	18 WC	9 hand basins
5000	5 WC	25 urinals	17 hand basins	30 WC	15 hand basins

This table is based on Health Department Guidelines for Sporting Venues.
At least one unisex toilet for the disabled is required at each venue.
For events less than four hours - these may be reduced by 80%

Table: Toilet facilities for concerts licensed to sell alcohol

Patrons	Males			Females	
500	3 WC	8 urinals	2 hand basins	13 WC	2 hand basins
1000	5 WC	10 urinals	4 hand basins	16 WC	4 hand basins
2000	9 WC	15 urinals	6 hand basins	18 WC	6 hand basins
3000	10 WC	18 urinals	10 hand basins	20 WC	10 hand basins
5000	12 WC	25 urinals	17 hand basins	33 WC	17 hand basins

This table has been extracted from the City of Fremantle Concert Guidelines

At least one unisex toilet for the disabled is required at each venue.

Note: Toilets must be serviced throughout the event. When portable chemical type units or effluent holding tanks are used for events longer than four hours, they must be located so that they can be pumped out during the event.

Appendix 3

Table: Exit widths extracted from Building Code of Australia D 1.6

Aggregate exit width in metres	No. of people - gradient less than 1:12	No. of people - gradient more than 1:12
1X 1000	0 - 50	0 - 50
2X 1000	50 - 200	50 - 200
2.5	200 - 275	200 - 260
3	275 - 350	260 - 320
3.5	350 - 425	320 - 380
4	425 - 500	380 - 440
4.5	500 - 575	440 - 500
5	575 - 650	500 - 560
5.5	650 - 725	560 - 620
6	725 - 800	620 - 680
6.5	800 - 875	680 - 740
7	875 - 950	740 - 800
7.5	950 - 1025	800 - 860
8	1025 - 1100	860 - 920
8.5	1100 - 1175	920 - 980
9	1175 - 1250	980 - 1040
9.5	`1250 - 1325	1040 - 1100
10	1325 - 1400	1100 - 1160
10.5	1400 - 1475	1160 - 1220
11	1475 - 1550	1220 - 1280
11.5	1550 - 1625	1280 - 1340
12	1625 - 1700	1340 - 1400
12.5	1700 - 1775	1400 - 1460
13	1775 - 1850	1460 - 1520
13.5	1850 - 1925	1520 - 1580
14	1925 - 2000	1580 - 1640
14.5	2000 - 2075	1640 - 1700
15	2075 - 2150	1700 - 1760
15.5	2150 - 2225	1760 - 1820
16	2225 - 2300	1820 - 1880
16.5	2300 - 2375	1880 - 1940

Appendix 4: Briefing meeting

A briefing meeting should be held for all large or unusual events. It needs to be held when all of the final arrangements are known but it should be between seven and fourteen days prior to the event.

The purpose of the meeting is to get all major parties together so they all know each other and that any concerns can be addressed.

It is important that there is an agenda so that everyone knows in advance what will be discussed. If they have any special concerns, time should be allocated to allow these concerns to be discussed. It is also an ideal time to distribute required documentation ie. standing orders and procedures, emergency evacuation procedures, insurance cover notes etc, electrical and structural certification, event and control personnel contact numbers for the event.

Who should attend?

The list below is provided to give an idea of some of the people who may be required to attend a briefing meeting.

1) Anyone who has a critical role in the operation of the event or venue approval.
2) Promoter and his deputies.
3) Chief security officer.
4) Police - general duties and liquor and gaming representatives if liquor is to be consumed at the event.
5) Local authority representatives.
6) Transport operator.
7) Noise pollution officers.
8) Parking controller.
9) Fire Brigade representative.
10) First aid representative.
11) Ground controller.
12) Representatives from major neighbouring developments that may be adversely affected by the event.
13) Health Department electrical supervisor.

Some of the things that need to be discussed are:

- What conditions will cause the event to be cancelled or postponed - excessive rain or wind, insufficient ticket sales, main performers unavailable etc. These things need to be set prior to the event and no later than the final briefing meeting.
- Contingency plan if more than the anticipated number of patrons arrive.
- What noise limitations have been set and by whom. How and where will these be monitored.
- Access route for emergency vehicles, Ambulance, Fire and Police.
- Time, date and location of debriefing meeting. It is important that this is organised at the briefing meeting so that it is known that problems experienced can be discussed and resolved for future events.
- Contact numbers and radio frequencies and channels to be used during the event.
- Location of crowd control command post and first aid posts.

Appendix 5: Debriefing meeting

A debriefing should be held for each event because it provides a forum where the experience gained from the event can be recorded and input on how improvements can be made for future events. Any problems or difficulties can also be discussed.

It should be held within 14 days of the conclusion of the event.

Who should attend

1) Anyone who had a critical role in the operation of the event or venue approval.
2) Anyone who experienced any operational deficiencies or can offer suggestions to improve future events.
3) Promoter and his deputies.
4) Chief security officer.
5) Police - general duties and liquor and gaming representatives if liquor is to be consumed at the event.
6) Local authority representatives.
7) Transport operator.
8) Noise pollution officers.
9) Parking controller.
10) Fire Brigade representative.
11) First aid representative.
12) Ground controller.
13) Representatives from major neighbouring developments that may be adversely affected by the event.
14) Health Department electrical supervisor.

Appendix 6: Health Act 1911, Health (Public Buildings) Regulations 1992 Certificate of Electrical Compliance

(Form 5 - Regulation 10)

To the City / Town / shire of: ..... Date: .....

I hereby certify that the electric light and / or power installation, alteration, addition at the undermentioned premises has been carried out in accordance with the Health (Public Buildings) regulations 1992.

Name & Initial of Occupier: .....

Details of public building

Name: .....

No. ..... Street .....

Suburb / Town ..... Post Code .....

Particulars of installation

Describe any work for which you are not responsible in these premises .....

.....

.....

Signature of licensed electrical contractor or electrical worker authorised to sign on behalf of the electrical contractor / in-house installer.

Signature .....

Contractors / In-house Electrical Installers Details

Phone No. ..... Business Name .....

Registration No. ..... Address .....

Forward this form to the local authority when the work is completed.

Appendix 7: Safe collection and disposal of discarded needles and syringes

1. There is no need to be alarmed.

2. Avoid touching the needle with your fingers or hands.

3. Pick up the used needle or syringe by the blunt end, away from the point. When doing this it is preferable to wear gardening gloves or to use a brush and pan or tongs.

4. Never attempt to replace the protective cover of the needle if the needle is exposed.

5. Put the needle and syringe in a container with a well-secured lid.

   Rigid plastic containers with lids are best (eg. plastic bottle with a screw top lid). Do not use glass which may shatter or aluminium cans which may be squashed.

6. Make sure the container is tightly sealed.

7. Put the sealed container in a rubbish bin.

For further information contact:

Communicable Disease Control Unit on 9388 4999, an environmental health officer at your local council, the ADIS Information Line on 9421 1900 or 008 198 024, or the WA AIDS Council 9429 9900

Appendix 8: Needlestick injuries - the risks

A person who is pricked or scratched with a discarded needle has only a very remote risk of being infected with Human Immunodeficiency Virus (HIV) from blood in the needle. There is, however, a possibility of Hepatitis B or Hepatitis C infection. Like HIV/AIDS, Hepatitis B and Hepatitis C can both be caused by blood-borne viruses.

Tetanus spores which live in the soil may also cause infections if they are transported into the body through broken skin caused by a discarded needle.

What do you do if you have a needlestick injury?

1. Wash the area gently with soap and running tap water as soon as possible.

2. Apply an antiseptic and sterile dressing.

3. Contact your local doctor or hospital emergency department as soon as possible.

   - Tests may be done to see if you are already protected from Hepatitis B. If not a course of vaccinations may be given. This will be most effective if begun within 24 hours following the injury.
   - If you are not vaccinated against tetanus this should be done immediately.
   - Antibiotics may be given as a protection against other infections.

4. The needle and syringe should be disposed of safely (see 'Safe Collection of Discarded Needle and Syringes').

For further information contact the Communicable Disease Control Unit on 9388 4999 or your local doctor.

Communicable Disease Control Unit
Health Department of WA
March 1995

Appendix 9: Testing of extension cords and RCDs (safety switches)

The testing of electrical extension cords and RCDs used in circuses' travelling shows and other temporary installations is a requirement of the Health Act (Public Buildings) Regulations 1992. It is also a requirement for building and construction sites.

Note: RCDs are also known as safety switches or ELCBs.

The specific tests required are set out in clause 13 of AS 3012 - Electrical Installations - Construction and Demolition Sites.

Extension cords etc. should be tested every six months and RCDs every three months.

Once a test has been carried out a tag should be fixed to the device. The tag should identify who carried out the tests and when they were done.

Details of the required tests are:
Extension Cords (single and three phase)

- Check that the insulation is in good order.
- Check that the plug sockets and plug tops attached to the cord are the correct rating.
- Check the continuity of each conductor.
- Check that the conductors are correctly connected (correct polarity).

Residual Current Devices

*test 1: Residual non-operating current

A current between 40% to 50% of the rated tripping current should be passed between active and earth for five seconds. The RCD should not trip.

*test 2: Tripping current and time test

A current equal to the rated tripping current of the RCD should be passed between active and earth. The RCD should trip within its specified time - usually 30 milliseconds.

Note:
The recommended tripping current is 30 milliamps.
Instruments are readily available from electrical wholesalers. Clipsal and HPM are two companies that manufacture suitable test instruments.
In addition to the above RCD tests, the inbuilt test facility should be operated each day that the unit used.
Portable outlet devices (such as Kambrook multiple outlets) require a combination of all of these tests.

More information can be obtained from Sid Brodie on 9388 4962 or fax 9388 4955.

Appendix 10: Temporary structures at public events, safety guidelines

There are no specific regulatory requirements for these stands. When they are erected at entertainment and sporting venues they require approval as part of a public building.

Set out below are guidelines for seating and other temporary structures that may be erected at public building venues.

When they are not subject to a building licence, they must be approved in accordance with the Health Act.

Section 176(2)(b) authorises the local authority to request anything that it may require to ensure that the venue, in this case the stand, is 'safe'.

Application

An application to erect a stand must be made to the local authority. The application must be accompanied by:

- full structural details, including size and spacing of all materials, method of jointing, sole plate dimensions etc;
- a block plan showing the position of the stand in relation to surrounding structures, toilets etc;
- seating layout showing the relationship between seats and aisles and the total number of seats.

Structural

Certification from a practising structural engineer should be provided to certify that the structure is suitable for the proposed use. It should be constructed in accordance with industry standards and methods.

Footings

Most temporary structures do not have deep footings and merely sit on the ground. In these cases they should bear on a substantial hardwood base, recommended size 300mm x 200mm by 40mm thick. Smaller and/or soft wood types or bricks are not acceptable.

Stairs

Steps

- Going should be between 280mm and 355mm
- Risers should be between 115mm and 190mm.

Steps within aisles must

- be the full width of the aisle;
- be uniform in size (both the riser and going).

There shall be no more than 18 risers in a flight and no more than two flights without a change in direction of at least 30 degrees.

In some instances, because of sight lines it may be necessary to increase aisle risers to 200mm. If this occurs additional guard rails will be required. Risers in stairways or transverse aisles must never exceed 190mm.

Treads must be of solid construction (not mesh or perforated) and have a non-skid finish.

Guard rails and balusters

Every raised area of seating and any change in level which may present a hazard (eg. drops of one metre of more) shall be provided with a balustrade. Where aisle risers are more than 190mm high, hand rails are required at each row of seats.

Balustrades and /or hand rails must be:

- 950mm above flood level (FFL);
- installed on both sides of stairways;
- installed on raised areas and landings which are 1000mm above the surrounding floor or ground

Balusters must not present hand or toe holds between 150mm and 760mm above FFL or permit a 125mm diameter sphere to pass through.

Aisles

- Minimum width of an aisle shall be 1000mm.
- Aisles are required on both sides of every row of seats that is more than nine seats long.
- No seat shall be more than six metres from an aisle.

Seating

The clearance between rows of seats shall be:

- 300mm if the distance to an aisle is less than nine seats.
- 500mm if the distance to an aisle is more than nine seats.

All seats shall be securely fixed to the floor unless fastened together in lengths of no less than six seats.

Lighting

Aisles and the tread of each step shall be illuminated whenever the venue is open to the public after sunset. Generally this will only apply to indoor stands used for theatrical applications.

Width of platts

The minimum width of a platt for seated patrons is 950mm.
The minimum width of a platt for standing patrons is 600mm.

Kick boards

Kick boards and infills are required for stair risers and between levels of platts.

Fire hazards

- Flammable material should not be installed on any stand.
- Flammable materials must not be stored under any stand.
- Stage curtains or fabric screens must be non-flammable. Materials that have a spread of flame index of no more than six and a smoke developed index of no more than five are regarded as being suitable.

Exit widths

Exits shall be designed to allow the stand to be evacuated within 2.5 minutes in an emergency.

There must be alternate means of egress from each stand eg. in large stands at least two exits from the front and two towards to rear. The rear exit must be at least mid-way from the front of the stand and the stairs should discharge toward the rear.

Table: Exit requirements for stands

NO. OF PEOPLE	NO OF EXITS	AGGREGATE WIDTH
0 - 1000	2	2000 mm
1001 - 1500	3	3000 mm
1501 - 2000	3	4000 mm
2001 - 2500	4	5000 mm
2501 - 3000	4	6000 mm
3001 - 3500	5	7000 mm
3501 - 4000	5	8000 mm

Number of exits increase at the rate of 1/1000 or part thereof.
Aggregate width of exits increases at the rate of 1000mm/500 people.

Appendix 7: Major effects of drugs

- **Tobacco**
- **Caffeine**
- **Amphetamines**
- **Cocaine**
- **MDMA and ecstasy**
- **Alcohol**
- **Minor tranquillisers**
- **Opioids**
- **Cannabis**
- **Volatile substances**
- **Hallucinogens**

Major effects of drugs

Substance	Immediate effects	Use with pregnancy	Continued heavy/regular use	Ways of taking
Tobacco	Lasts $^1/_4$ - 2 hours. Increased heart & pulse rate.	Harmful	Heart & lung disease, cancer, high blood pressure, bronchitis & breathing difficulties.	Smoking
Caffeine	Lasts 2 - 4 hours. Increased alertness. Large doses can delay sleep.	Doctors advise less than 4 cups tea/coffee per day.	Restlessness, upset stomach. Can be harmful for people with heart problems.	Oral
Amphetamine Speed	Lasts 4-8 hours. Highly stimulating. Excitement, increased activity & decreased appetite. Large doses delay sleep.	Harmful	Inability to sleep, restlessness, headaches, aggression. Can cause severe mental or emotional disturbances.	Snorting Injecting Anally Oral
Cocaine	Can last up to 4 hours. Feeling of self confidence & power, increased energy & decreased appetite.	Harmful	Loss of concentration & motivation. Dizziness, aggression & mental disturbances. Can cause psychiatric complications. Snorting can lead to tearing of the nasal wall.	Snorting Injecting Oral Anally
MDMA Ecstasy	Can last up to 6 hours. Increased blood pressure, confidence & a feeling of closeness with others. Sensation of floating, anxiety, nausea & paranoia can occur.	Harmful	Sensation of floating & other disturbed perceptions. Can cause convulsions, irrational behaviour, insomnia, depression.	Oral Injecting Anally
Alcohol	Slurred speech, loss of inhibitions, relaxation, feelings of happiness & wellbeing or depression. Large doses can cause unconsciousness or hangover.	Harmful	Can result in brain & other nervous systems damage, heart, pancreas, stomach & liver damage & sometimes death. Withdrawal can produce sweating, tremor, convulsions & delirium.	Oral
Minor tranquillisers Valium, Rohypnol, Serepax	Lasts 12-24 hours. Relief of anxiety & tension, drowsiness (possible sleep), lack of muscle coordination, blurred vision. In some cases excitability.	Harmful. Use only under medical supervision.	Depression, lack of muscle and speech coordination. Withdrawal symptoms such as anxiety, insomnia, tremor & convulsions can also occur while on a stable dose.	Oral Injecting Anally
Opioids Heroin, Morphine, Codeine, Pethidine, Methadone, Opium	Lasts 4-24 hours. Relief of pain & anxiety, feelings of wellbeing, decreased awareness of outside world. Vomiting, drowsiness & sleep in some. High doses can cause unconsciousness & death.	Harmful. Use prescribed preparations only under medical supervision.	High risk of overdose. HIV and hepatitis if sharing needles. Withdrawal symptoms are anxiety, sweating, cramps, runny nose, vomiting, insomnia, pain.	Oral Injecting Smoking Snorting
Cannabis Marijuana	Can last up to 5 hours. Relaxation, laughter, increased appetite, slowing down of time, loss of concentration, decreased coordination & bloodshot eyes. Can be hallucinogenic.	Long term effects are still to be assessed.	Respiratory complications. Can decrease concentration & memory. Psychiatric problems possible if schizophrenic condition already exists.	Oral Smoking
Volatile substances Petrol, Blue, Aerosol cans, Butane Gas	Lasts 1 - 3 hours. Petrol sniffing effects can last up to 6 hours. Feelings of happiness, relaxation & drowsiness. Large amounts can cause illness & possibly sudden death.	Harmful	Liver, kidney & brain damage can result. Suffocation caused by plastic bags, choking on vomit.	Inhalation
Hallucinogens LSD, Magic mushrooms, Trips	Lasts 6 - 12 hours. Hallucinations, ie seeing, hearing, feeling or thinking things that don't exist. Anxious feelings, panic & nausea can occur.	Harmful	Can increase the risk of severe mental disturbances. Can cause 'flashbacks' (where the drug experience can recur at anytime).	Oral

Source: CEIDA (NSW Centre for Education and Information on Drugs and Alcohol)

Appendix 8: On Track, Safe Transitions Youth Project

On Track, Safe Transitions Youth Project

Project summary

The "On TRACK" project will provide support to the Police and other frontline services which deal on a daily basis with vulnerable youth in the inner City.[5]

The project will provide an alternative option to placement in a police facility pending reunification with parents or other caregivers. For street present services the project will provide another resource after hours when they make contact with an intoxicated or disorientated young person who cannot get home unaided.

Upon referral to the "On TRACK" project the young person will be escorted to the project facility which will be located within close proximity of the City Police Post at the western end of the railway concourse.

The "On TRACK" project facility will have a warm, friendly, unthreatening atmosphere, with some recreational equipment such as television, video, pool table, etc. There will also be toilet facilities and a small room where if necessary a young person can lie down for a sleep. The option to make a phone call to home, make a hot drink and a snack will be available.

While waiting to be picked up by parents/caregivers the young people will be screened by staff for "at risk" behaviours. Staff will have youth work and counselling skills enabling them to use a variety of tools for making quick, accurate assessments of risk for the young person in terms of physical health, emotional stability and accommodation issues. Where necessary follow up referrals will be made to other PCM services or to appropriate agencies for accommodation, parent/teen mediation, substance abuse counselling, etc.

The facility will not be a secure unit with the young person being free to leave if they insist. However, where staff are concerned about the young persons safety the police will be advised immediately.

Overview of project

In order to develop a "youth friendly" name for the Safe Transitions Youth Project a number of young people were asked for their views on an appropriate name.

Those consulted were told about the aims and objectives of the proposed service, its likely location in the Central Railway Station and asked to develop a name that young people likely to use the service would feel comfortable with. The name that was developed was "On TRACK".

Background

Since 1990 staff from both non-government and government agencies have voiced concern about the need for a special facility for vulnerable youth in the inner city area.

Although Perth City Mission staff were conscious of these concerns, in order to satisfy themselves that the project was a viable option representatives from key frontline services were invited to participate in a reference group.

Representatives included: The Police Aboriginal Affairs Section, The Police Juvenile Aid Group, Western Australian Drug Abuse Strategy Office, Family and Children's Services, Central Police Station, The Office of Aboriginal Health, City of Perth, Ministry of Justice and Noongar Alcohol Substance Abuse Service.

[5] Text of submission by Perth City Mission for funding to the 1998 Burswood Community Support Program

The reference group were involved in developing the project and ensuring that it addressed the needs of the frontline service providers, as well as the youth. The following specific issues were identified:

- The average waiting time is 95 minutes for young people in police facilities pending collection by their parents or caregivers.

- Due to the restrictive nature of the police facilities a young person held for welfare reasons can end up being charged with disorderly conduct or abusive behaviour.

- A high percentage of police contacts in the City are with youth under the influence of a substance rather than for offending.

Justification

Over a 12-month period in 1996/97 the Noongar Alcohol Substance Abuse Service assisted the Juvenile Aid Group with transport of 510 young people. Of these young people:

- 57% were female, 43% male
- 38% were aged 12 or under
- 93% were aged 15 or under

In 1995/96 the Killara Youth Support Service responded to 1,997 referrals, the majority of referrals coming from police.

Despite this support police are still experiencing difficulties with an average of 30 young people per week who are detained in police facilities.

As a result police are removed from their primary policing role and young people face a risk of escalating their contact with the justice system.

Aims

The vision is to pilot a unique and innovative service which will address a significant issue in the City of Perth by providing:

A safe place for vulnerable youth in crisis which is available after-hours and provides an alternative to custody.

A transition place which links the young person to families and caregivers and has partnerships with other service delivery agencies to meet assessed needs.

Objectives

Objective 1

To provide an alternative placement option to police custody and reduce the number of young people held in Central and City Police Stations by agreed operational protocols for the referral and receiving of young people by the centre.

Protocols to be developed with:

- Juvenile Aid Group
- Family and Children's Services
- Killara Youth Support Service
- Noongar Alcohol and Substance Abuse Service

Police Service to retain responsibility for locating and contacting the young person's family or caregiver.

Objective 2

To provide support to the young person and assistance in reuniting them with their families or alternative caregivers by providing a service for vulnerable youth referred by police or other street-present services operating within the defined area.

A safe and supervised waiting area pending collection by parents or alternate caregivers, alternate transport home and alternate placement.

- Access to facilities to enable speedy contact with families or alternate caregivers
- Provision of a screening and assessment service for vulnerable young people
- Follow up with parents/caregivers of young people who have had more than three contacts.

Objective 3

To provide an assessment and referral service linking the young person and their families to other support agencies:

Provision of assessment and referral service to young persons linking them and/or their families to appropriate support services by:

- provision of risk assessment
- placement
- referral as per agreed protocols with Agencies such as:
- Family and Children's Services
- Princess Margaret Hospital
- Royal Perth Hospital

Objective 4

To secure support through the pilot project for ongoing funding through a partnership with government and the corporate sectors:

The pilot period will enable the project to be tested and refined. Data will be kept on the numbers of young people seen, their issues and the outcomes achieved for both youth and police.

The "Reference Group" will monitor the project with a formal review to be conducted at the 9-month point. This review will form the basis of an approach to either government or the corporate sector for ongoing funding.

Project description

Hours of operation

The 'On-TRACK' Youth Project will operate four nights a week during peak demand periods. These will be Friday, Saturday and Sunday nights and either Thursday or Monday night. The Project will be open between 5pm and 8 am.

Staffing

The Project will be staffed as follows:

- A coordinator who will work 38 hours per week with 6 hours dedicated to administration. Weekday shifts will be from 4pm to 12 pm, and on weekends from 5pm to 1am.
- One youth worker will work a 32 hour week from 12pm to 8 am

- One youth worker will work a 16 hour week from10pm to 2am.
- Approximately 15 to 20 volunteers will be recruited and trained.

Volunteers

The role of the volunteers will be to supplement paid staff on the project and particularly to cover the high demand hours of 10pm to 4am on Fridays , Saturdays and Sundays.

Recruitment will be conducted through tertiary institutions, Church groups and through the corporate sector

Volunteers will be mature young people (probably aged between twenty to thirty five years) who have an interest in and affinity with young people. Each volunteer will be offered a "learning contract" which specifies the relationship and learning expectations of the role for both the Mission and the individual.

The tasks that volunteers will be involved in as a support to the paid staff include:

- Welcoming young people to the centre in a warm and non judgemental way.
- Sitting and talking with young people who may be quite disorientated or distressed due to substance use.
- Providing supervision of young people using the facility.
- Monitoring health of clients (short term) and reporting concerns or issues to staff.
- Providing practical assistance such as making hot drinks, toast or sandwiches as required.
- Where appropriate providing an escort for young people from the police post to the On TRACK centre or back again.

Unique characteristics

There is no service filling this role or need in the City of Perth.

There are few comparable services in Australia which offer such a unique partnership between as this between Perth City Mission and the Police Service to assist youth at their point of need.

The "On TRACK" project will be overseen by a reference group of key agencies who are at the frontline to ensure that duplication is avoided and collaboration maximised. At the suggestion of the Police Service the catchment area of the pilot project is that broadly defined by the Central Area Transit bus system.

While it is difficult to be certain of numbers it is expected that over the 12-month period a minimum of 2,000 young people will utilise the service which could be based in the Western Concourse of the Railway Station.

Benefits to the community

Safer streets

There is little doubt that our streets are becoming more dangerous. Part of this problem, in the inner City area, is the fact that many young people are drawn to the bright lights, yet once there they find that there are few recreation facilities and "hanging out" in public spaces has risks associated with it. This is reflected in a recent City of Perth youth
consultation which found that safety and security was the most important issue for young people coming into the City.

Many of these safety and security issues revolve around intoxicated youth and the behaviour of the young people who come to the notice of the Police JAG unit. In other words the target group of this project.

Crime prevention

The young people in the target population are either already engaged in offending behaviour or at serious risk of starting to offend. Criminal career research has generally found:

- A peak age of onset between 13 and 15 years of age.
- That males first convicted at the earliest age (10-13) tended to become the most persistent offenders with a criminal career lasting, on average, 9.9 years.

There is clear evidence of a relationship between contact with police, court appearance at an early age and the development of an offending lifestyle. The provision of an alternate placement option for police decreases this likelihood and contributes to crime reduction.

Help for vulnerable youth

Many of the young people who will be the recipients of this service are among the City's most damaged and "at risk" youth.

The range of issues many of these young people face are likely to include:

- Substance abuse
- Family breakdown
- Physical and sexual abuse
- Homelessness
- Socio-economic deprivation
- Discrimination
- Health problems

The "On TRACK" project will provide a safe environment with trained staff capable of conducting risk assessments at the time and point of need. Referral and follow up will ensure that the young person is provided with the opportunity and support to begin to address their problems

A case study

At 12.30 am, following a complaint about unruly behaviour, a police Juvenile Aid Group patrol picks up a group of three young Aboriginals including Sarah, a 14 year old girl, from the Midland area.

From the presence of a chrome substance on her fingers and around her mouth it is clear that Sarah has been sniffing paint. She is unsteady on her feet and does not seem to be able to stand still. Sarah is very challenging towards the police and needs a safe place to cool down. The JAG Officers are concerned about her and take the group to the City Police Post but no offences have been committed.

They are unable to contact Sarah's family by telephone so a police car from Midland visits the home at 12.55 am. There is no-one at home. The neighbours report that Sarah's mother was fighting with her boyfriend and she had left with him in a friend's car, both had been drinking heavily.

Sarah has now been in the police station for 30 minutes and a decision is made to transfer Sarah to "On TRACK" while the police continue to try and find a responsible adult to take care of her. A police officer escorts her to the project facility which is just a few minutes walk away.

A staff member meets the police officer and takes over responsibility for Sarah. At the centre Sarah has a comfortable space in which she can sober up and cool down. After some time the staff

member learns that Sarah lives with her mother, her mother's boyfriend and four of her five siblings in a Homeswest house.

Sarah and her mum fight a lot about the boyfriend's violent behaviour towards her mother. Sarah often stays with a friend to escape the violence. Drunken fights are a daily reality, they are always short of money to pay their bills and the children steal to survive.

Most Friday and Saturday nights Sarah goes to Northbridge with her friends. Many of Sarah's friends use drugs to blot out the hassles of home and the sense of hopelessness their life seems to have. They have little money and tend to sniff paint and other solvents to get high.

As the effects of the sniffing begin to wear off Sarah becomes less agitated and asks for something to eat and drink. She has a sandwich and a cup of coffee then she is taken into another room where she is able to lie down.

The worker contacts the Police Post and is told that the Noongar Alcohol Substance Abuse Service (NASAS) think they have located one of Sarah's aunties who may be willing to look after her. The time is now 2.40 am and a police officer from the local station goes out to talk to the aunty.

At 2.55 am the Police Post contacts the "On TRACK" project to advise that NASAS have agreed to transport Sarah to her auntie's house. At 3.05 Sarah leaves the facility.

Over the next few weeks Sarah is a frequent visitor at "On TRACK", resulting in staff organising a case discussion with Family and Children's Services and Aboriginal Health.

The case discussion results in a planned intervention focusing on providing Sarah with the support and help she needs to overcome her problems.

Part of this support is provided by Perth City Mission's crisis accommodation program which provides alternative accommodation for Sarah while Family and Children's Services staff work with her mother and her boyfriend on their relationship difficulties.

Although this is a fictional family there are many young people like Sarah who could be greatly assisted by a service such as "On TRACK".

Table: Budget for Safe Transitions Youth Project

Salaries		$68,276
Project Coordinator(38 hrs/week)	$34,420	
Youth Worker (32 hrs/week)	$22,571	
Youth Worker (16hrs/week)	$11,285	
Shift allowances		$22,983
Relief staff		$ 8,400
On costs (7.5%of staffing cost)		$ 5,420
Consumables		$ 4,000
Client expenses (taxis, buses)		$ 4,000
Power and water		$ 1,000
Communications		$ 1,000
Rent		$ 6,000
Postage		$ 200
Printing and stationery		$ 3,000
Insurance		$ 1,000
Travel and parking		$ 1,000
Staff training		$ 2,000
Motor vehicle lease		$ 2,800
Motor vehicle expenses		$ 3,000
Admin charges		$ 3,000
Sub total		**$137,079**
Fit out costs		
Computer/printer		$ 5,000
Furniture and fittings		$ 6,500
Mobile phone/facsimile		$ 1,500
Sub total		**$ 13,000**
Total		$150,079

Appendix 9: List of major alcohol and other drug resources in Western Australia

The following list contains a short description of programs and services that have a major or significant involvement in preventing or addressing the harms from the use of alcohol and other drugs in Western Australia.

The list has been organised under the name of the parent organisation and where appropriate includes details of major sub-programs.

Al-Anon

251-257 Hay Street (PO Box 6306, Hay Street, East Perth 6892), East Perth, 6004
☎ (08) 9325 7528

A fellowship for relatives and friends of alcoholics seeking guidance in solving problems caused by alcoholism in the home. Regular group meetings are held in Perth city and suburbs and some country areas. The office is open from 10.30 am to 2.30 pm weekdays, and telephone contact is available after hours.

Alateen

251-257 Hay Street (PO Box 6221, Hay Street, East Perth 6892), East Perth, 6004
☎ (08) 9325 7528

A fellowship for teenage children of alcoholics seeking guidance in solving problems caused by alcoholism in the home. Regular group meetings are held in the Perth metropolitan area and country areas and details are available from the office from 10.30 am to 2.30 pm weekdays. An answering machine (for messages) is available after hours.

Alcohol & Drug Authority

7 Field St, Mt Lawley, 6050
☎ (08) 9370 0333

The ADA is a statutory body[6] which was established in 1974 and helps people who have problems related to alcohol and or other drugs. The ADA operates the Alcohol and Drug Information Service (ADIS), and conducts the State's public methadone program (William St Clinic) and detoxification unit (Central Drug Unit). It also provides training programs and ongoing professional development to health care providers.

The ADA library has a comprehensive collection of material covering all aspects of alcohol and other drug problems such as books, journals, reports, videos, posters, pamphlets, subject files etc. The library is extensively used by secondary and tertiary students and other members of the public. Books may only be borrowed through inter-library loan through a local library.

William Street Clinic

354 William St, Perth, 6000
☎ (08) 9328 3066, Fax: (08) 9227 5148

William Street Clinic offers assessment and outpatient services for illicit opioid (eg heroin) dependent adults. Treatment includes the provision of methadone, assistance with medical, social, psychological and legal problems. The clinic undertakes comprehensive HIV/HCV assessment and counselling.

The clinic does not treat patients with iatrogenic opioid dependency or patients with painful conditions necessitating opioid treatment.

Central Drug Unit

32 Moore St, East Perth, 6004
☎ (08) 9421 1833, Fax: (08) 9221 3089

[6] The enabling legislation is the Western Australian Alcohol and Drug Authority Act 1974.

The present CDU, which is located in East Perth, was opened in January 1989 and provides a two stage medical detoxification program for persons dependent on alcohol and/or other drugs.

In the first stage people are admitted to the 17 bed residential facility for detailed assessment of an alcohol or other drug problem which would be difficult to manage on an outpatient basis. The average length of the inpatient detoxification period is 3-5 days. Children may be admitted by arrangement in special circumstances.

The second stage is an outpatient program which comprises provision of medication for symptomatic relief, one to one counselling and group work. Other specialist services including psychology, psychiatry and social work are provided for more complex cases.

Alcohol and Drug Information Service

PO Box 8165, Perth Business Centre, Perth, 6894
☎ (08) 9442 5000, Freecall country 1800 198 024

ADIS commenced in April 1986 and operates as a 24 hour 7 day per week Statewide confidential alcohol and other drug information service. The object of the service is to provide information on request, crisis intervention for individuals and their families where substance abuse is a problem and referral to appropriate service for assistance.

Parent Drug Information

PO Box 8165, Perth Business Centre, Perth, 6894
☎ (08) 9442 5050, free call country: 1800 653 203

PDIS is a 24 hour 7 day per week Statewide confidential information service specifically provided to assist families involving substance abuse by young people. Callers are provided with information and referred to appropriate agencies.

Opiate overdose prevention strategy

Carrellis Centre, 7 Field Street, Mount Lawley, 6050
☎ (08) 9370 0333, Fax: (08) 9272 6605

The opiate overdose prevention strategy (OOPS) is designed to enable measures developed through cooperative arrangements between community based groups and provider organisations to reduce the risks from injecting drug use. The OOPS initiative was implemented in the latter part of 1997 and at this time involves a peer education project and an emergency department project.

Peer education project

The peer education project was established as part of OOPS in mid 1997 to increase the knowledge and skills of IDUs to deal with heroin and other opioid overdose situations. The project is intended to foster closer working relationships between the police, ambulances and drug and alcohol service agencies who are involved in responding to heroin overdoses. The project will also develop peer networks of IDUs to develop education strategies and disseminate resources and information to prevent opioid overdoses.

Emergency department project

As it is believed most opioid users have little access to mainstream health services, this project is designed to enhance IDUs' skills to assist those who have overdosed and to increase the utilisation of emergency services. In addition to the peer support component this project includes contact following an overdose of a person who has been admitted to hospital through a network of volunteers. These support workers will be available on a 24 hour basis to make brief interventions to provide educational and support services.

Alcohol Advisory Council of Western Australia Inc

Lotteries House, 79 Stirling St, Perth, 6000
☎ (08) 9220 0661, 9220 0643, Fax: (08) 9272 6605

The AAC is a NGO that promotes the prevention of alcohol-related harm. The AAC monitors and responds to issues associated with the drinking environment, and the actions of the alcohol industry and consumers. The AAC also conducts conferences, seminars and workshops as well as producing publications, with the aim to reduce alcohol related problems throughout the community. Personal and organisational membership is available.

Alcoholics Anonymous

251 Hay St, East Perth, 6004
☎ (08) 9325 3566, Fax: (08) 9325 3551

AA is a self help group which targets alcoholics and their families. The only requirement for membership is a desire to stop drinking. There are a number of autonomous AA groups which meet on a regular basis on different times and days of the week in inner city, metropolitan suburbs and country areas.

Association for the Care and Rehabilitation of Alcoholics, Drug Addicts and Homeless Persons Inc ACRAH

13 Field Street, Mt Lawley, 6050
☎ (08) 9272 1333, Fax: (08) 9370 1527

The major focus of this service is to provide accommodation to homeless males who are affected by alcohol and other drug use. ACRAH focuses on stabilising social relationships to promote independent living. Residents are encouraged to control their drinking behaviour and seek treatment as appropriate. Crisis and long-term clients are the main target group with a support program designed to enable clients to live independently in the community.

Australian Council on Smoking and Health

334 Rokeby Road Subiaco, 6008 (PO Box 327)
☎ (08) 9388 3342, Fax: (08) 9382 4611

ACOSH maintains a comprehensive resource collection and provides a consultancy service on smoking and health. It is also refers people to other organisations and professionals with expertise on how to stop smoking.

Australian Institute on Alcohol and Addictions Inc

Holyoake

65 Newcastle Street, Perth, 6000 (PO Box 8207 Perth Business Centre, 6849)
☎ (08) 9328 9733, Fax: (08) 9227 5019

Holyoake offers a large range of non residential individual, group and family client focussed services, as indicated below. Fees are payable for a number of these programs.

Male dependency program

This program is for men who are experiencing problems related to their alcohol and/or other drug use.

Female dependency program

This program is specifically for women experiencing problems with their use of alcohol and/or other drugs. The program focuses on special issues for women.

Co-dependent's program

The co-dependency program is for spouses, partners, parents and adult children who have been, or who are experiencing problems related to another persons alcohol and/or other drug use and aims to promote coping skills.

Childhood in perspective program

This program is available to adults who grew up in families where there were alcohol or other drug related problems.

Young people's program

This program is for children and adolescents aged 8 to 18 years from families where there are alcohol and/or other drug related problems. Age appropriate information and activities are aimed at increasing coping skills, learning to express feelings and increasing self esteem.

Tots program

This program is aimed at children aged 4 to 7 years old who are living in families with a parent with an alcohol and/or other drug related problems.

Adolescent program

This program is primarily a diversionary program for young people aged 13 to 18 years appearing before the Children's Court. It is aimed at increasing a young person's awareness of alcohol and/or other drug use, health risks and possible connections between these and offending.

Parent talk program

This program is designed to provide information, education, skills and support for parents who are concerned about their adolescents' use of alcohol and/or other drugs. The program aims to provide parents with a range of skills and options appropriate to their unique situation and which will contribute to a quality of life that is supportive to all family members.

Choices program

This program is designed to raise awareness for people over 18 years of age surrounding their drinking patterns. This is a practical, informative course which will provide you with skills for a healthier way of living.

North East Metropolitan CDST

152 Morrison Rd, Midland, 6056
☎ (08) 9274 7055, Fax: (08) 9274 7066

The NE Metropolitan CDST was opened in March 1998 and provides a treatment and prevention focus in relation to:

- general alcohol and other drug counselling services;
- support to other health and welfare providers to manage alcohol and other drug problems among their clients (through shared case management, consultation and education activities); and
- support to the local community to prevent alcohol and other drug problems.

Alcoholics Recovery and Rehabilitation Foundation of Mandurah Inc

7 Cooper St, Mandurah, 6210
☎ (08) 9535 3174

This 11 bed residential facility provides a short or long term alcohol free environment for sober adult men who had previously been dependent upon alcohol. The program is based on the 12 step AA model. This facility is presently managed by Holyoake.

Anglicare

Stepping Out Program

42 Colin Street, West Perth, 6005
☎ (08) 9321 7033, Mobile: 0418 942 475

This program is funded by the Department of Family and Children's Services and operated by Anglicare. The aim of the service is to assist young people who frequent or reside in the Perth inner city area to access information, accommodation, counselling and support to meet their needs. The target population is young people aged between 12 and 18 years who are at risk due to homelessness, alcohol and other drug abuse, have a background of substance abuse, have a history of offending etc.

A mobile resource centre, a bus, is located in a number of locations in the inner city areas frequented by young people. Youth workers provide counselling, support, information, advocacy and referral to assist young people. There is also the Wednesday recreation program, which provides positive leisure activities for young people not in employment or at school.

The bus is located Mondays to Fridays near the Perth Children's Court, 11.00 – 11.30 am and from 11.30 – 3.30 pm at the Perth train station (Wellington Street forecourt). The bus is also located on Thursdays and Fridays from 5.00 – 7.00 pm at the Perth train station and 7.00 – 10.00 pm in James Street cul-de-sac (near the Alexander Library).

Bega Garnbirringu Health Services Aboriginal Corp

Kalgoorlie Sobering Up Centre

8 McDonald Street, Kalgoorlie, 6430
☎ (08) 90 913 199, Fax: (08) 90 911 039

The centre's prime purpose is to provide a safe, care oriented environment in which persons found drunk in public may sober up, thus diverting them from police lock ups. The Kalgoorlie SUC was opened in June 1994.

Bloodwood Tree Association Inc

36 Roberts Street (PO Box 2099), South Hedland, 6722
☎ (08) 9172 3115, (08) 9172 3622, Fax: (08) 9140 1474

The association provides counselling to Aboriginal people with alcohol related problems, in conjunction with other service providers in the region.

Cambridge private hospital

178-184 Cambridge St, Wembley, 6014
☎ (08) 9381 4178, (08) 9381 6966, Fax: (08) 9388 3179

Cambridge Hospital offers detoxification and therapeutic interventions for people who are alcohol or other drug dependent on either licit or illicit drugs. Private hospital insurance is necessary, otherwise the cost is $304 per day. Patients are required to attend groups which include cognitive behavioural, AA, and other therapy techniques.

Carnarvon Medical Service Aboriginal Corp

PO Box 278, Carnarvon, 6701
☎ (08) 9941 2499, Fax: (08) 9941 2024

This is a health service primarily for Aboriginal people. It is also available for others in the community. Alcohol treatment involving individual and group counselling and detoxification with medical supervision are provided. A community development approach is taken in regard to alcohol and other drug awareness and health promotion.

Centrecare

456 Hay St, Perth, 6000
☎ (08) 9325 6644, Fax: (08) 9221 3631

Centacare Bunbury

Centacare Bunbury is a separate organisation that is affiliated with Centrecare and is responsible for the operation of the South West CDST.

South West CDST

103-105 Clarke St, Bunbury, 6230
☎ (08) 9721 5177, Fax: (08) 9791 1056

The South West CDST opened in March 1998 and provides a treatment and prevention focus in relation to:

- general alcohol and other drug counselling services;
- support to other health and welfare providers to manage alcohol and other drug problems among their clients (through shared case management, consultation and education activities); and
- support to the local community to prevent alcohol and other drug problems.

Centrecare Goldfields

Goldfields CDST

7 Dugan St, Kalgoorlie 6430
☎ (08) 9091 1833, Fax: (08) 9021 8673

The Goldfields CDST opened in March 1998 and provides a treatment and prevention focus in relation to:

- general alcohol and other drug counselling services;
- support to other health and welfare providers to manage alcohol and other drug problems among their clients (through shared case management, consultation and education activities); and
- support to the local community to prevent alcohol and other drug problems.

Curtin University of Technology

A number of Schools at Curtin University are involved in teaching courses which include some content about alcohol and other drug problems. Examples of these courses include the Centre for Health Promotion Research and units taught in psychology and pharmacy courses.

School of Psychology

The School of Psychology which is located in the Division of Health Sciences has for a number of years provided a course for the training of volunteer counsellors. This course is undertaken in conjunction with Palmerston and graduates from the course are provided with a diploma which is regarded as an acceptable qualification by many non government service providers.

The School of Psychology offers a post graduate diploma in health sciences with a major in addictions for students who have a degree in psychology or another acceptable qualification.

National Centre for the Research and Prevention of Drug Abuse

PO Box U1987, Perth, 6001
☎ (08) 9368 2055, Fax: (08) 9367 8141, http://www.curtin.edu.au/curtin/centre/ncrpda/

The NCRPDA is one of two national centres funded by the Commonwealth Department of Family Services & Health. The other centre, the National Drug & Alcohol Research Centre, is located at the University of New South Wales.

While the Perth centre has specialised in alcohol related matters it has also undertaken research into a number of areas concerned with illicit drugs. Areas of illicit drug research have included cross jurisdictional studies of the impact of cannabis laws, high risk practices of injecting drug users, transmission of HCV and other BBVs and of young people's attitudes to the risk of overdose and their usage of emergency services.

Daughters of Charity Services (WA) Ltd

Marrilac Centre

33 Shenton Street, Northbridge, 6003
☎ (08) 9328 7682, Fax: (08) 9328 9130

The Marrilac Centre, formerly known as the De Paul Centre, provides a day centre, meals service and comprehensive support service in Northbridge. The service is targeted at people aged 20 years and older on a low income, who may be socially marginalised and may have psychiatric, serious problematic alcohol and drug use.

East Pilbara Health Service, HDWA

Pilbara CDST

Morgans St, Port Hedland, 6721
☎ (08) 9158 1794, Fax: (08) 9173 2964

The Pilbara CDST opened in March 1998 and provides a treatment and prevention focus in relation to:

- general alcohol and other drug counselling services;
- support to other health and welfare providers to manage alcohol and other drug problems among their clients (through shared case management, consultation and education activities); and
- support to the local community to prevent alcohol and other drug problems.

Eastern Goldfields Halfway House Inc

Prospect Lodge

11 Porter St, Kalgoorlie, 6430
☎ (08) 9080 5655, Fax: (08) 9080 5855

This residential facility incorporates a therapeutic work program for the rehabilitation of alcoholic dependent persons who may in some cases also be dependent on other drugs. The program is based on the 12 step AA model.

Edith Cowan University

School of Health Studies

The School of Health Studies, based at the Joondalup campus, is part of the Faculty of Health and Human Services, provides input into a wide range of undergraduate courses taught at ECU. The University is the major provider of undergraduate courses which have a component concerned with responding to addictive behaviour and related social and health problems.

Garl Garl Walbu Alcohol Association Aboriginal Corp

Derby Sobering Up centre

PO Box 571, Derby, 6728
☎ (08) 9193 1455, Fax: (08) 9191 2042

The centre's prime purpose is to provide a safe, care oriented environment in which persons found drunk in public may sober up, thus diverting them from police lock ups. The Derby SUC opened on 19 May 1998.

Genesis Counselling & Training Service Inc

15 Carey St, Kensington, 6151
☎ (08) 9474 1020, Fax: (08) 9367 9867

This is a non-residential Christian counselling and training service targeted at individuals and families experiencing difficulties which may include alcohol and/or other drug problems.

Geraldton Health Service & COMPARI Inc

COMPARI CDST

Community Health Centre, Shenton St, Geraldton, 6530
☎ (08) 9921 4155, Fax: (08) 9921 7001

The COMPARI CDST provides a treatment and prevention focus in relation to:

- general alcohol and other drug counselling services;
- support to other health and welfare providers to manage alcohol and other drug problems among their clients (through shared case management, consultation and education activities); and
- support to the local community to prevent alcohol and other drug problems.

Gurri Gunja Wangka Mia

431 Sherlock Street (PO Box 59), Roebourne, 6718
☎ (08) 9182 1324, (08) 9182 1054, Fax: (08) 9182 1135

This organisation provides counselling, intervention and family support services for people with alcohol and other drug problems.

Halls Creek Alcohol Education and Counselling Centre

Thomas St, Halls Creek, 6770
☎ (08) 9168 6049, Fax: (08) 9168 6127

The centre provides a program which includes one to one counselling, education and health promotion in school and Aboriginal communities and an outreach program. Bush camps are organised for adults at risk of alcohol problems.

Halls Creek People's Church

Halls Creek Sobering Up Centre

Neighbour Street, Halls Creek, 6770
☎ (08) 9168 6265, Fax: (08) 9168 6688

The centre's prime purpose is to provide a safe, care oriented environment in which persons found drunk in public may sober up, thus diverting them from police lock ups. The Halls Creek SUC was opened in September 1992.

Health Department of WA

Office of Aboriginal Health

Volatile substance project

3rd Floor, B Block, 189 Royal St, East Perth, 6004
☎ (08) 9222 4466, Fax: (08) 9222 4113

The VSP was formerly administered by the ADA and provides a coordinated interagency response to the problems of volatile substance use by:

- direct intervention and prevention services to address and reduce problems;
- education and training to increase the knowledge, confidence and competence of human service workers;
- community development to initiate and support projects aimed to address the problems;
- monitoring and evaluation of projects;
- public awareness through the projection of various publications and through cooperation with the media; and
- consultation with regard to legislative, and law and order measures.

Drug & Alcohol Policy Planning Unit

2nd Floor, C Block, 189 Royal St, East Perth, 6004
☎ (08) 9222 4099, Fax: (08) 9222 2351

The Drug and Alcohol Policy Planning Unit is a program area in the Mental Health Services Division. It has a primary responsibility to administer and manage clinical services and programs provided by the ADA, such as the Central Drug Unit, the methadone program and ADIS. It also carries out a number of functions including research, policy advice, funding and coordination of programs concerned with drug and alcohol related issues pertinent to the health system.

Health Promotion Service

Ground Floor, C Block, 189 Royal St, East Perth, 6004
☎ (08) 9222 2028, Fax: (08) 9222 2088

The HPS is involved in many initiatives to prevent health related problems. It is responsible for enforcement of the provisions of the *Tobacco Control Act 1990*, which includes restrictions on advertising and sale of tobacco products to minors. The HPS also provides programs to educate the community to develop and maintain environments which support health enhancing behaviours and reduce health compromising behaviours. Examples of major strategies include the Quit, Drinksafe, Respect Yourself and Fruit 'n' Veg Eat it! campaigns.

The HPS also supports other campaigns provides a wide range of educational materials and undertake media campaigns to reduce the impact of health problems due to the abuse of licit and illicit drugs. The HPS participates in surveys and analyses a large range of research data concerned with trends in the prevalence of alcohol, tobacco, prescription drugs and illicit drugs by West Australian adults and secondary school students.

Health Information Centre

1st Floor, C Block, 189 Royal St, East Perth, 6004
☎ (08) 9222 4231, Fax: (08) 9222 4236

The HIC collects and analyses a large range of health data. This includes information from community based surveys, epidemiological research and analysis of information contained in the hospital morbidity data system. Information is available in published reports and is used to monitor changes in illnesses and behaviours attributable to the abuse of alcohol and other drugs.

Disease Control Branch

Grace Vaughan House, 227 Stubbs Tce, Shenton Park, 6008
☎ (08) 9388 4999, Fax: (08) 9388 4877

The Disease Control Branch is responsible for a number of programs concerned with public health issues. An area relevant to drug related problems involves maintaining a register of notifications for HIV and other communicable and infectious diseases. The Branch also supports community based services targeted at injecting drug users who may engage in high risk behaviours that can transmit HIV, HBV and HCV. The Branch is responsible for the licensing of needle and syringe exchange programs and maintains a database of the distribution of needles and syringes in fitpacks through community pharmacies and other approved outlets.

Drugs and Poisons

Grace Vaughan House, 227 Stubbs Tce, Shenton Park, 6008
☎ (08) 9388 4999, Fax: (08) 9388 4888

Drugs and poisons is responsible for administering the *Poisons Act 1964*, which deals with the dispensing and prescribing of pharmaceutical drugs in this state. The branch is also responsible for maintaining a confidential database of persons who are notified addicts as stipulated in the Health Act and monitors the use of drugs of addiction (ie Schedule 8) and other drugs that may be abused.

Hepatitis C Council of Western Australia Inc

PO Box 8060, Perth Business Centre, 6849
☎ (08) 9328 8216, Fax: (08) 9227 6545

The Hepatitis C Council of WA aims to provide information and support to those people with Hepatitis C or those at risk of contracting it. The Council:

- maintains a telephone information and support service;
- holds monthly meetings;
- produces a monthly newsletter;
- provides printed information packs;
- lobbies for resources for prevention and management of Hepatitis C; and
- provides input to government and non-government organisations about policy and practice relating to all aspects of the disease including research, education, prevention, testing, treatment, counselling and general management.

INDRAD Services Inc

251 Adelaide Tce, Perth, 6000
☎ (08) 9225 4522, Fax: (08) 9225 4533

INDRAD provides a comprehensive counselling, consulting and training service to public and private industry in the implementation and maintenance of employee assistance programs (EAPs). These broad programs address psycho-social problems and include alcohol and other drugs.

INDRAD also provides group training programs and services to organisations in the following area:

- professional counselling and assessment;
- 24 hr critical incident response;
- human resource consultation and training;
- management and supervisory training;
- work place mediation;
- organisational change and development;
- alcohol and other drugs in the work place; and
- work place support and group training.

Workshops can be designed to meet organisational needs. INDRAD'S counselling service offers assessment and therapy within a short term (6 session) framework to people from organisations which contract INDRAD. Referral, if necessary for specialist assistance or longer term support is provided.

Inner City Health Service

Youthlink

70-74 Murray Street, Perth, 6000
☎ (08) 9224 1700, Fax: (08) 9224 1711

Youthlink was established by the HDWA. It is now administered by the Inner City Health Service and provides a number of services.

- Counselling, therapy and case management for "at risk" young people (especially homeless youth) with emotional, social and/or behavioural problems including substance use problems.
- Education and training for workers with young people, in a wide range of areas such as substance use issues and intervention strategies, and working with socially/behaviourally disturbed adolescents.
- Consultation for workers experiencing difficulties with individual cases.

Youthlink services are metropolitan wide, free of charge and can be provided within the setting of the requesting agency. Services are provided primarily to workers with non-government organisations and young people who are unable to access government or "mainstream" support services.

Irrungadgai Group

C/- Post Office, Nullagine, 6758
☎ (08) 9176 2040, Fax: (08) 9176 2005

The purpose of this organisation is to work with Aboriginal people who have alcohol related problems. Counselling, referral and ongoing support are available.

Junjuwa Community Inc

Fitzroy Sobering Up Centre

PO Box 30, Fitzroy Crossing, 6765
☎ (08) 9191 5061, Fax: (08) 9191 5137

The centre's prime purpose is to provide a safe, care oriented environment in which persons found drunk in public may sober up, thus diverting them from police lock ups. The Fitzroy SUC was opened in March 1994.

King Edward Memorial Hospital for Women

Antenatal Chemical Dependency Clinic

374 Bagot Rd, Subiaco, 6008
☎ (08) 9340 1379, Fax: (08) 9388 1780

The ACDC provides obstetric and neonatal services for women and families. Antenatal care, in liaison with drug rehabilitation programs is offered to women who are using alcohol or other drugs

during pregnancy. Experienced medical, nursing and social work staff are available for consultation throughout the pregnancy and after delivery.

The purpose is to encourage effective antenatal care for women. There are no conditions of rehabilitation and the focus is on healthy parenting. There is a creche available for daytime appointments.

Kununurra/Waringarri Aboriginal Corp

Kununurra Sobering Up Centre

717 Mistletoe Street, Kununurra, 6743
☎ (08) 9168 3296, Fax: (08) 9168 3295

The centre's prime purpose is to provide a safe, care oriented environment in which persons found drunk in public may sober up, thus diverting them from police lock ups. The Kununurra SUC opened in September 1996.

Waringarri alcohol awareness and rehabilitation project

2229 Speargrass Road (PO Box 436), Kununurra, 6743
☎ (08) 9168 1528, Fax: (08) 9168 2081

This project aims to disseminate information to schools, communities and the public on the physical and social problems related to alcohol abuse. Provides rehabilitation programs for drinkers and their families.

Life Education Australia

Life Education WA Inc

2nd Floor, Wesley Centre, 93 William St, Perth, 6000 (PO Box X2222, Perth, 6847)
☎ (08) 9321 9711, Fax: (08) 9322 6530

Life Education WA has, since the late 1980s, provided a health education program to WA primary schools which has a primary goal of preventing drug abuse. There is a metropolitan based program with separate life education committees based in the Pilbara/Kimberley and Midwest regions as follows:

- Midwest Life Education Centre Inc; and
- Pilbara/Kimberley Life Education Centre Inc.

In the metropolitan area there are 4 mobile classrooms employing six qualified teachers who have specialist training on the delivery of drug education programs. There is a separate curriculum for each of the 7 years of the primary school program, as well as a program targeted at parents.

The service is funded from fees provided by students when they visit vans which come to their school, with donations received from businesses and individual Rotary clubs. Financial assistance has also been provided by the Health Department of WA. The program is delivered by a trained teacher from a specially fitted out semi-trailer targeted at pre-school and primary aged children, providing information about alcohol and other drugs.

Mawarnkarra Health Service Aboriginal Corporation

504 Crawford Way (PO Box 59), Roebourne, 6718
☎ (08) 9182 1054, Fax: (08) 9182 1135

This is a health service to assist Aboriginal people with alcohol related problems. Activities include clinical services, individual and group counselling in both home and bush settings, and follow-up care.

Midwest Alcohol Rehabilitation Service Inc

Rosella House

11 Bayley St, Geraldton, 6530
☎ (08) 9921 7409

Rosella House is a residential program based on the AA and self-help philosophy for the recovery of alcohol dependent persons. This service is offered on a user-pay basis and includes a live-in manager. Where necessary professional and community input will be provided to enhance the program.

Milliya Rumurra

78 Great Northern Highway, Broome, 6725 (PO Box 857)
☎ (08) 9192 1699, Fax: (08) 9193 5996

This is a centre which provides counselling, assessment and referral services for Aboriginal people with alcohol, solvent and other drug-related problems. It also provides education in community, schools and prisons. Support is given to the outlying communities of Lombardina, Beagle Bay and La Grange.

It also incorporates a 22 bed residential alcohol rehabilitation centre for Aboriginal people, run by Aboriginal people. The service promotes and respects Aboriginal culture and values. The total program incorporates AA; medical and nutritional aspects; diversional skills; women's program for dependents; children's program; life skills; budgeting and social skills training. The centre involves a separate area for families and women and offers up to 3 months length of stay.

Ministry of Justice

Substance Use Resource Unit

68 Milligan St, Perth, 6000
☎ (08) 9266 0177, Fax: (08) 9324 1838

The SURU is responsible for facilitating and providing services throughout Western Australia for prisoners with substance use problems. Programs offered cover education and awareness with an emphasis on preparation and skill development for managing alcohol and other drug use issues upon release. The unit provides advice to releasing authorities, such as the Parole Board, on program participants prior to their release.

Court Diversion Service

7 Field St, Mt Lawley, 6050
☎ (08) 9370 0320, Fax: (08) 9371 1652

The CDS is an assessment and referral service which diverts illicit drug users, except cannabis users, referred by the courts into the drug treatment network while maintaining them in the criminal justice system. Clients or other organisations can initiate contact with the CDS. However, formal referral is dependant upon court approval.

Narconon WA

PO Box 65, Forrestfield, 6058

Narconon has developed a program modelled on principles originally developed in the late 1960s in the United States by L Ron Hubbard, with assistance provided by the Church of Scientology. There are nearly 40 Narconon centres throughout the world including the one established in Western Australia.

From 1978 to the early 1980s Narconon operated from rented premises in East Victoria Park and after some years of non activity was reformed in May 1997. The program promotes the use of a combination of minerals and vitamins to assist in detoxification as a prerequisite to a more intensive therapeutic and lifeskills program.

Narcotics Anonymous

☎ (08) 9227 8361

NA is a self help group which targets drug dependent adult. The only requirement for membership is a desire to remain abstinent from opiates, other illicit drugs and alcohol. There are a number of NA groups which meet on a regular basis on different times and days of the week in Perth and some country areas.

National Heart Foundation (WA Division)

334 Rokeby Road (PO Box 1133), Subiaco, 6008
☎ (08) 9388 3343

This NHF regularly runs stop smoking groups for people who need assistance with quitting smoking. Groups are held throughout the metropolitan area. Assistance to stop smoking in the work place is also available. The NHF provides literature, posters, audio visuals and other information on smoking and health.

Ngangganawili Aboriginal Community Health and Medical Service Corp

Wiluna Sobering Up Centre

PO Box 40, Wiluna, 6646
☎ (08) 9981 7063, Fax: (08) 9981 7029

The centre's prime purpose is to provide a safe, care oriented environment in which persons found drunk in public may sober up, thus diverting them from police lock ups. The Wiluna SUC opened in April 1996.

Ngnowar Aerwah Corporation

PO Box 250, Wyndham, 6740
☎ (08) 9161 1496, Fax: (08) 9161 1049

Alcohol and drug free residential community centre

The centre provides a living environment free of alcohol, including after care and integration back into the community and to improve social functioning. The centre will also offer assistance to clients' family.

Town based counselling/referral centre

The centre provides assessment and non-residential treatment for people experiencing problems associated with the use of alcohol and other drugs.

Objectives are:

- to engage clients for counselling, assessment and treatment;
- to improve clients health, psychological and social functioning; and
- to provide support to families impacted by hazardous and harmful use of alcohol and other drugs.

Ninga Mia Village Aboriginal Corp

C/- PO Box 421, Kalgoorlie, 6430
☎ (08) 9021 4682, Fax: (08) 9021 4668

A community established for transient and homeless people gearing itself towards permanent residency but still catering for homeless and transients. The community permits moderate alcohol consumption with the aim that residents reduce their substance abuse and eventually become abstinent.

Noongar Alcohol and Substance Abuse Service Inc

176 Wittenoom Street East Perth, 6004 (PO Box 8105, Perth Business Centre, Perth 6849)
☎ (08) 9221 1411, Fax: (08) 9221 1585

The philosophy of NASAS is to offer counselling, referral, workshops and alcohol awareness and education courses that are culturally sensitive. Emphasis is on service to the Aboriginal community of Perth, from children to the elders' age group. A "hands-on" and community development approach is practiced. Counselling is available to control or stop the abuse of the particular drug.

In conjunction with the Noongar Regional Councils of the Aboriginal and Torres Strait Islander Commission (ATSIC), NASAS has developed programs to cater for the Aboriginal population in both the Perth metropolitan area and the South West region.

Youth activities and education centre

NASAS operates a youth centre from an inner city building, which offers alternative activities to prevent the misuse of alcohol and other drugs amongst young Aboriginal people in the metropolitan area.

North East Regional Youth Council

276 Great Eastern Highway, Midland, 6056 (PO Box 1328, Midland, 6056)
☎ (08) 9274 3488, Fax: (08) 9274 2704

The NERYC was established in 1986 and encompasses the shires of Swan, Mundaring and the Town of Bassendean. It is a community based organisation formed out of concerns about the availability of information, understanding of issues impacting on youth to provide improved coordination and responses to inadequacies and resources and to encourage participation of service providers and youth in service planning and policy development.

In 1990 NERYC established its first direct service project and now presently employs a total of 14 staff, half of whom are Aboriginal. Its target population are disadvantaged young people who usually have problems such as homelessness, drug abuse, offending, may have experienced sexual and physical abuse and have literacy problems.

The organisation has a number of projects which are directed to assisting 'at risk' young people in the catchment area in the east metropolitan region, as follows. NERYC receives funds from a number of organisations including the WA Drug Abuse Strategy Office and the Office of Aboriginal Health.

Midland Gate street work project

This project commenced in 1990 and is funded by the Midland Gate shopping centre, Family and Children's Services and the Midland Enterprise Centre. The project was established following concerns from the management of the Midland Gate shopping centre about inappropriate use of the shopping centre by young people. Youth workers employed by the project encourage young people to become involved in alternative socially acceptable recreation activities and to assist them finding employment.

Community youth centre

This is a social venue for young people aged 14 to 20. It provides an unstructured exercise and boxing program and has recreational facilities such as table tennis, pool and video nights. Food is provided at a basic cost. School holiday programs, educational activities such as cooking and encouraging entrance to TAFE courses are also provided.

Inroads

This project employs a project officer who assesses unemployed young people to assist them to gain entrance into employment, education or training.

Substance inhalation abuse project

The major object of this project is to identify young people between the ages of 8 and 18 who are at risk of or have become involved in substance abuse, particularly volatile substances. The project provides alternatives for this group such as recreational activities and information sessions to reduce the harm associated with their drug using behaviour. Support is provided to enable young people to regain control of their lives by initially reducing the use of drugs with the longer term aim of becoming drug free.

As the project is targeted particularly at Aboriginal young people it has close relationships with the wider Aboriginal community through support groups to assist young people and their families through a difficult period in their lives. The project provides young people with improved life skills to enable them to access further opportunities, such as entrance to employment programs, admission to TAFE courses or to complete their schooling. A four week program is operated at Hillstone (located in a semi rural setting in the hills) which is targeted at young people who have had a chronic history of 'chroming' (inhaling paint).

Northwest Mental Health Services

Kimberley CDST

Notre Dame Campus, Guy St, Broome, 6725
☎ (08) 9192 3322, Fax: (08) 9192 3623

The Kimberley CDST was opened in March 1998 and provides a treatment and prevention focus in relation to:

- general alcohol and other drug counselling services;
- support to other health and welfare providers to manage alcohol and other drug problems among their clients (through shared case management, consultation and education activities); and
- support to the local community to prevent alcohol and other drug problems.

Palmerston Association Inc

Palmerston Centre

134 Palmerston Street, Northbridge, 6003
☎ (08) 9328 7355, Fax: (08) 9227 9158

Palmerston was established in 1980. The philosophy of the program is to encourage self responsibility and lifestyle change to empower clients to take control of their situations by providing a range of treatment services for problem users of illicit drugs and their families.

Palmerston Centre provides a number of outpatient counselling services (listed below) and a residential therapeutic community encompassing client groups who:

- use illicit and other drugs;
- are experiencing difficulties with someone else's drug use, eg a partner;
- have multiple/dual diagnoses, eg mental health and drug problems;
- are experiencing problems with the consequences of criminal activity and drug use; or
- have been instructed through the justice system to attend, who may or may not be experiencing problematic drug use.

Palmerston provides counselling, training, education and support for users of drugs, their families and friends, professional groups, schools and the wider community.

The agency's aim is to minimise drug-related harm by improving awareness, developing coping skills and minimising social dislocation, enabling consumers to deal with issues surrounding their drug use. The model of treatment endorses a psychosocial basis and a harm minimisation focus working with the individual at their own pace and level. The process of treatment utilises motivational interviewing, problem solving, goal setting, cost benefit analysis in counselling, activities, creative or therapeutic group work, urine analysis and referral.

Adult program

This program is for persons aged 25 years and older who want to change their drug use behaviour and includes individual and group counselling.

Youth program

Is targeted at youth aged 14 to 24 years who are experimenting with, or encountering difficulties with, drug use. The program consists of active group work, individual counselling and practical activities.

Court diversion service

Is an assessment and referral service for clients referred through the courts.

Parents and friends program

Groups are held at Palmerston Centre and Fremantle for people who are experiencing difficulties because of someone else's drug use.

Palmerston farm

Is a residential drug free therapeutic community. Admission is by assessment at Palmerston Centre. There is an initial program of 3-4 months. There are currently 12 places available for clients from 17 years of age and accompanying children. Fees are charged for admission to this program, usually based on a proportion of social security payments.

A commercial market garden and orchard are attached to the farm. The program includes involvement in the therapeutic community, farm work, individual counselling, group therapy, wilderness expeditions and art and craft work.

South Metropolitan CDST

223 High St, Fremantle, 6160
☎ (08) 9335 8156, Fax: (08) 9335 9437

The South Metropolitan CDST was opened in February 1998 and provides a treatment and prevention focus in relation to:

- general alcohol and other drug counselling services;
- support to other health and welfare providers to manage alcohol and other drug problems among their clients (through shared case management, consultation and education activities); and
- support to the local community to prevent alcohol and other drug problems.

Great Southern CDST

Unit 3, 145 Lower Stirling Tce, Albany, 6330
☎ (08) 9842 8008, Fax: (08) 9841 5922

The Great Southern CDST was opened in March 1998 and provides a treatment and prevention focus in relation to:

- general alcohol and other drug counselling services;
- support to other health and welfare providers to manage alcohol and other drug problems among their clients (through shared case management, consultation and education activities); and
- support to the local community to prevent alcohol and other drug problems.

Parents Reaching Youth through Drug Education

PO Box 176, Geraldton, 6530
☎ (08) 9938 1174

The major purpose of PRYDE is to raise community awareness about drugs to encourage young people to follow a drug free way of life and behaviour.

Perth Aboriginal Medical Service

Needle & syringe exchange program

192 Lord St, East Perth, 6004
☎ (08) 9228 9199, Fax: (08) 9228 9125

This service is operated by the PAMS and is targeted at Aboriginal young people who may be injecting drugs and exposed to risks from BBVs. The NSEP provides sterile injection equipment, educational literature and information 4 evenings per week (Wednesday to Saturday) in Northbridge and on Friday afternoons in the Northbridge area.

Perth City Mission Inc

129 Hill St, East Perth, 6004
☎ (08) 9421 1199

As well as an extensive array of family services targeted at those in need in the community, PCM also offers programs to assist young people in the metropolitan area aged 15 to 18 years old. Services offered for young people include crisis assistance and supported accommodation, and support for young people who are homeless or at risk of becoming homeless.

This assistance is available through a number of programs in the metropolitan area and commonly these young people have related drug problems. Examples of these programs include *Beyond the wall*, a program to divert graffitists into legal urban art activities, a graffiti clean up service, groups for young people and their families to develop better behaviour management and improve communication, and a youth and family counselling services.

Yirra

Administration

143 Lake Street, Northbridge 6004
☎ (08) 9328 6755, Fax: (08) 9328 4799

PCM's youth substance abuse services aims to provide a comprehensive service for at risk young people by providing access to a range of services which include:

- alcohol and drug treatment services;
- accommodation (crisis and medium term);
- youth and family counselling; and
- employment and training.

Yirra provides a residential and non-residential community based youth substance abuse service for young people aged 13 - 17 years, which consists of:

- motivational assessment
- case management
- therapeutic groups
- individual counselling
- intensive residential treatment
- family counselling and support
- wilderness intervention program.

Counselling/assessment

143 Lake Street, Northbridge 6004
☎ (08) 9328 6755, Fax: (08) 9328 4799

A motivational assessment is provided for all referrals in order to determine the individual needs of the client and the most appropriate service. Motivational assessments can also be completed as a once only intervention.

This service is targeted at young people under the age of 18 who wish to clarify their use of alcohol and other drugs.

Individual counselling is available to a young person and their family in the following circumstances:

- when a young person's use of drug and alcohol is not severe enough to warrant removal from their current environment;
- when issues within the family result in family counselling being the most useful option; or
- if the young person has employment, training or schooling, which excludes them from being able to participate in a residential treatment program or structured day program.

Additionally, individual counselling may be offered to a young person who simply wishes to consider the issues faced by them but who is not yet certain as to how they wish to address them. If appropriate, admission to Yirra's residential treatment service, structured day program or wilderness adventure therapy program may be offered at a later stage. During individual counselling, urine analysis may be requested if appropriate.

This service is targeted at young people under the age of 18 and their families or significant others, who wish to address the young person's use of alcohol and other drugs.

Day program centre

2 Church Street, Northbridge 6004
☎ (08) 9328 6755, Fax: (08) 9328 4799

Yirra provides a structured day program that is available on weekdays between the hours of 9.00 am and 3.00 pm. The day program is staffed by youth workers who are qualified in the areas of adolescence and substance use.

The day program includes:

- therapeutic groups;
- individual counselling;
- innovative and challenging recreational activities; and
- employment, education and training assistance.

The day program is targeted at young people who identify a need to address their substance use, who are motivated to commit themselves on a weekly basis to this program and who are available during the day.

Family program

143 Lake Street, Northbridge 6004
☎ (08) 9328 6755, Fax: (08) 9328 4799

Individual counselling sessions may be provided for parents of young people with alcohol and drug issues, should parents identify a need for support. Additionally, a combined family group will be held during each of our adventure therapy camps, for the parents, families and significant others of those young people attending the camp.

This service is targeted at any parent of a substance user who is under the age of 18.

Residential house

696 Beaufort Street, Mt Lawley, 6050
☎ (08) 9370 5244, Fax: (08) 9370 3271

A residential option, "Yirra House", is available to young people while they are engaging in the day program. The program is delivered in a residential setting to enable a break away from the drug using lifestyle and contacts, and to give both young people and their families "time out".

The house is supervised by a team of live in carers, and by a residential coordinator who is based at the Lake Street agency and provides the link between the residential service and the day program. It is important to note that young people are not detained on the premises and therefore, must be 'voluntary' participants.

Young people entering the residential program must participate in a structured day program, away from the residence, that explores the impact which drug use has had on their lives and to determine a change in their life direction. The day program provides a broadening of life experiences, education options, recreational experiences, therapeutic groups, individual counselling and enhancement of life skills.

This service is targeted at young people who have a problematic drug using lifestyle who are motivated to attend the program and are aged between 12 and 18 years.

Wilderness adventure therapy program

143 Lake Street, Northbridge 6004
☎ (08) 9328 6755, Fax: (08) 9328 4799

All young people who attend Yirra programs are encouraged to participate in the wilderness program. The program is based on the South Coast Wilderness Enhanced Program that was established in 1990 by the NSW Department for Education.

The expedition usually involves up to six days of backpacking through remote bush near Walpole, 6 hours south west of Perth, followed by 3-4 days canoeing on the Frankland River to the Nornalup inlet.

The participants should be:

- able to process the outdoor experience as something which will provide 'time-out' to contemplate their family, friends or current drug using situation;
- having difficulties initiating personal change through current therapeutic strategies; and
- willing to undertake a remote wilderness experience as a 'voluntary' participant.

This service is targeted at young people under the age of 18 who have significant substance use problems.

Youth outreach counsellor service

143 Lake Street, Northbridge 6004
☎ (08) 9328 6755, Fax: (08) 9328 4799

Outreach counselling and comprehensive follow up are services offered to young people who are in detention and have identified problematic substance use, possibly linked to their offending behaviour. The services are delivered at Banksia Hill and Rangeview and involve motivational assessment, individual counselling, and follow up counselling on release from detention.

Young people are invited to explore their drug use and the impact it has had on their lives. This counselling service may provide young people with the opportunity to address possible changes in their life direction and to examine their drug use in relation to offending behaviour.

Young people may experience problems when leaving detention and it is therefore important to assist them in negotiating services and resources where appropriate. Issues such as

accommodation, education and training, and family may be addressed prior to release from detention.

This service is targeted at 13 to 18 year olds who are currently in detention or on remand with possible substance use issues.

South East Metropolitan CDST

Unit 2/15-17 Blackburn Rd, Maddington, 6109
☎ (08) 9421 1199, Fax: (08) 9221 0362

The South East Metropolitan CDST was opened in March 1998 and provides a treatment and prevention focus in relation to:

- general alcohol and other drug counselling services;
- support to other health and welfare providers to manage alcohol and other drug problems among their clients (through shared case management, consultation and education activities); and
- support to the local community to prevent alcohol and other drug problems.

Perth Inner City Youth Service

PO Box 1062, West Leederville, 6007
☎ (08) 9388 2791, ☎ (08) 9388 2792, Fax (08) 9388 2793

The PICYS was established in 1980 to address the needs of young people in the Perth inner-city area. At present it has a number of facets to its activities including a household network and a drug support program.

Household network

The purpose of the household network is to provide medium to long term inner suburban accommodation for young people who would otherwise be homeless. The organisation provides advocacy, referral and counselling support. Family mediation services are also offered by PICYS.

Young people are provided with assistance to develop personal support networks in the wider community and to assist those living in transitional housing. The network includes access to a resource base of individuals who provide short term accommodation on a voluntary basis for young people. Accommodation is in shared houses and units in the West Leederville area and is open to young people aged between 16 and 25 years. Young people must receive an income and be able to maintain rental commitments.

Drug support program

This is a specialist support and information resource to young people using or at risk of using drugs. Young people in 'at risk' situations are counselled by youth workers with PICYS and are encouraged to attend programs offered by other organisations which can assist young people abusing drugs.

Pinakarra Counselling Service

St John's Centre, Baker St, Broome, 6725
☎ (08) 9193 7103, Fax: (08) 9193 6298

Pinakarra was set up in 1992 in response to community demand for an Aboriginal counselling service. As often these problems involved difficulties due to the abuse of alcohol and other drugs a wide spectrum of services are offered including:

- crisis intervention and counselling (24 hours a day);
- follow-up support to individuals and families;
- court advice;
- liaison with and referral to other agencies;
- workshops in Aboriginal awareness and counselling; and
- Aboriginal awareness education (talk to schools, prison, community groups).

Port Hedland Sobering Up Centre Group Inc

Port Hedland Sobering Up Centre

Forrest Circle, South Hedland, 6722
☎ (08) 9172 3666, Fax: (08) 9140 1372

The centre's prime purpose is to provide a safe, care oriented environment in which persons found drunk in public may sober up, thus diverting them from police lock ups. The Port Hedland SUC opened in April 1991.

Relationships Australia (WA) Inc

PACE WA

755 Albany Highway, East Victoria Park, 6101
☎ (08) 9472 1243, Fax: (08) 9470 5139

PACE[7] WA, a division of Relationships Australia (WA) Inc offers a wide range of services:

- employee assistance program providing counselling, training, seminars and critical incident debriefing. The EAP service addresses personal, relationship and work related difficulties including alcohol and other drug problems;
- consultation for development and implementation of family oriented work policies and practices;
- training seminars and workshops for all levels of an organisation's personnel; and
- counselling and related services for employees and families.

PACE WA operates five centres at East Victoria Park, Fremantle, Midland, Mandurah and Bunbury.

Roebourne Sobering up Shelter Inc

Roebourne Sobering Up Shelter

474 Crawford Way, Roebourne, 6718
☎ (08) 9182 1363, Fax: (08) 9182 1044

The centre's prime purpose is to provide a safe, care oriented environment in which persons found drunk in public may sober up, thus diverting them from police lock ups. The Roebourne SUC was opened in February 1993.

[7] Acronym for programs assisting companies and employees

Salvation Army (Western Australia) Property Trust

Bridge House

15 Wright Street, Highgate, 6000
☎ (08) 9227 8086, Fax: (08) 9227 7302

The Salvation Army offers a three-phase program to persons affected by alcohol and other drug use. Bridge House provides sobering up, non-medical detoxification and assessment facilities for 40 people. A non-residential program includes groups in alcohol awareness, motivation, AA, 12 steps and communication. There is no charge for those admitted for sobering up, but there is a charge for other residential services.

The Bridge Program is a nationwide residential program for the treatment of people with alcohol and other drug problems with the aim of influencing men and women towards rehabilitation. It operates through three main centre in Perth, with admission only occurring after assessment at Bridge House.

Harry Hunter Adult Rehabilitation Centre

2498 Albany Highway, Gosnells, 6110
☎ (08) 9398 2228, Fax: (08) 9490 2376

The Harry Hunter Adult Rehabilitation Centre is a medium term residential alcohol and drug service for chemically dependent males and females. The Centre fulfils the second phase of the Salvation Army's treatment program. The aim is to reduce the harm associated with drug and alcohol use to enable participants to function independently in the community.

Perth Sobering Up Centre

15 Wright Street, Highgate, 6000
☎ (08) 9227 8086, Fax: (08) 9227 7302

The centre's prime purpose is to provide a safe, care oriented environment in which persons found drunk in public may sober up, thus diverting them from police lock ups. The Perth SUC opened in May 1990.

Lentara

Cnr Short and Nash Streets, East Perth, 6004
☎ (08) 9328 3102

Lentara is a 58-bed hostel, 16 of which are emergency beds under SAAP funding, for men with alcohol, other drug or psychiatric illness or who are homeless. No drinking is allowed on the premises but total abstinence is not required from residents. There are charges levied.

Tanderra

68 Guildford Rd, Mt Lawley, 6050
☎ (08) 9271 1209

Tanderra is a 20 bed hostel which provides accommodation and support to homeless men, particularly those who are severely damaged by alcohol use. Some drinking is tolerated but not on the premises. There are charges levied.

Serenity Lodge Inc

106 Lewington Street, Rockingham, 6168
☎ (08) 9527 9999, Fax: (08) 9592 4711

Serenity Lodge provides medium term residential services for adult dependants over the age of 18 years, based on the AA 12 Step program. A new focus for the current financial year will be after-hours/weekend services and the development and provision of non-residential family services. There are charges levied.

Seventh Day Adventist Church

PO Box 134, Gosnells, 6110
☎ (08) 9309 9440 Fax: (08) 9398 5164

Quit now program

This is a group program consisting of eight $1/^{1}/_{2}$ hour sessions incorporating films, lectures and group discussions. Participants receive educational and other support material. Groups are conducted by a professional and are run on request throughout the metropolitan area in the evening. Fees are charged for courses.

St Bartholomew's House Inc

St Bartholomew's House

78 Brown St, East Perth, 6004
☎ (08) 9325 3831, Fax: (08) 9325 3699

The object of this service is to provide emergency, medium and long-term support and accommodation to men over the age of 18 years who are affected by alcohol and/or drugs, in order that they achieve a better quality of life and return to living within the community.

St Bartholomew's night shelter

111 Kensington St, East Perth, 6004
☎ (08) 9325 3831

Adjacent to St Bartholomew's House, the night shelter provides overnight and emergency accommodation for men, many of whom have alcohol and/or other drug related problems. There are charges levied.

St John of God Community Services

North Metropolitan CDST

127 Grand Boulevard, Joondalup, 6027
☎ (08) 9300 3746, Fax: (08) 9300 3904

The North Metropolitan CDST was opened in March 1998 and provides a treatment and prevention focus in relation to:

- general alcohol and other drug counselling services;
- support to other health and welfare providers to manage alcohol and other drug problems among their clients (through shared case management, consultation and education activities); and

· support to the local community to prevent alcohol and other drug problems.

St Patrick's Care Centre

9 Parry Street, Fremantle, 6160
☎ (08) 9430 4159, Fax: (08) 9430 7974

St Patrick's offers an assessment, counselling, advocacy and referral service to homeless and socially disadvantaged clients aged 21 years and over, presenting with alcohol and other drug problems. These services are offered at the agency's day centre in Fremantle. The day centre provides an opportunity for informal social interaction, recreation, meals and a social work assessment and follow-up service.

Swan Emergency Accommodation Inc

5/294 Great Eastern Highway, Midland, 6936
☎ (08) 9274 5382, Fax: (08) 9250 1513

This service provides crisis, short term and medium term housing to families, couples and in particular youth who are homeless. Many of these residents are affected by their alcohol or other drug use. Educational sessions, counselling and support are provided for residents with alcohol and other drug problems, to enable residents to manage their alcohol and drug issues in the supported accommodation service. The focus of the service is on homeless youth, males and females and couples between the ages of 15 and 25.

Teen Challenge Perth Inc

56 Creaney Drive, Kingsley (PO Box 277, Greenwood, 6924)
☎ (08) 9309 5255, Fax: (08) 9409 6203

Teen Challenge operates a Christian residential rehabilitation centre at Esperance for those aged 16 to 35 years experiencing problems in living including alcohol, tobacco and other drug problems. Assessment for admission to the residential program at Esperance is conducted in Perth. Esparancho Ranch is a 260 acre farm in Esperance providing a 12 week non medical detoxification program. It is a 25 bed facility with male and female accommodation.

Criteria for admission are an acceptance of an interdenominational Christian treatment approach and that the person has a problem with substance abuse or other personal difficulties. The program emphasises an educational approach to problem solving, including recreation, survival courses, social skills, relationship counselling based on academic, vocational and spiritual principles

Thamkrabok Foundation Inc

252 High Rd, Riverton
☎ (08) 9354 1182, Fax: (08) 9354 4580, email: info@thamkrabok.org.au

The foundation is a world wide agent for those who seek admission to the Monastery of Thamkrabok. This facility is about 120 kms from Bangkok and operates a 21 day live-in detoxification and rehabilitation program. The program is carried out under austere conditions with dependent persons using emetics and other homoeopathic medicinal substances to achieve abstinent. People who are dependent on any kind of drug or suffer from alcoholism may be admitted for detoxification at the monastery. The all inclusive cost including airfares is $4,000.

Uniting Church in Australia Property Trust (WA) - Wesley Mission

1st Floor, 283 Murray Street, Perth, 6000 (GPO Box X2222)
☎ (08) 9321 9711

Hearth program

McDonald House, 11 Vale Rd, Mount Lawley, 6050
☎ (08) 9370 3272, Fax: (08) 9370 3025

Hearth is a family service targeted at families who have children under the age of 18 years and those primary or secondary caregivers of children who have problematic drug use. There are a casework and family therapy components to the program

A casework component is designed for primary caregivers with alcohol and other drug problems, for three hours per week over a three month period, in clients' homes. This approach is designed for the special needs of women with small children and the associated problems of childcare and transport.

The family therapy service is available to individuals, couples and whole families where a primary or secondary caregiver has an alcohol and other drug problem.

Wesley Mission operates a variety of programs which are targeted at men with alcohol dependency problems. The services include emergency accommodation at a night shelter, and medium to long term supervised accommodation for men who have achieved sobriety.

Trinity Youth Options

8 Pier St, Perth, 6000 (PO Box B65, Perth, 6838)
☎ (08) 9325 9239

TYO is a detached youth work service for 'at risk' young people based in the Perth inner city area and is funded by Perth Trinity Parish of the Uniting Church in Australia. TYO operates from within a detached youth work model that utilises a welfare rights approach involving three modes of operation:

- a base in the Perth inner city area that young people can come to;
- a street work component where workers go out and meet young people in the inner city; and
- a mobile service that meets young people in settings that they feel safe in.

WA AIDS Council Inc

664 Murray St, West Perth, 6005 (PO Box 1510)
☎ Office (08) 9429 9900, Fax: (08) 9429 9901

WAAC is a community based organisation with a significant volunteer program. The major client groups of the WAAC are people with HIV/AIDS, their families, partners and their friends, men who have sex with men and bisexual men, IDUs and all other people whose aspects of their behaviour may have put them at risk of HIV infection.

The WAAC provides a:

- Support services program provides practical and emotional support to people living with HIV/AIDS, their families, friends and significant others.

- Counselling and information services provides counselling which may include education, support, advocacy as well as short to medium term psychotherapy to individuals living with HIV/AIDS and their partners, family, friends and significant others.
- Public speaking project provides trained speakers to address the demand for up to date and relevant HIV/AIDS education in schools and to community groups.
- Provides a range of education programs for gay men and men who have sex with men.

Mobile needle & syringe exchange van

WAAC's NSEP provides education and prevention service for injecting drug users and their partners. The service includes a mobile needle exchange service operates seven days a week in a number of locations in the inner city, Fremantle and in a number of suburbs. A small cost is levied for N&S and other injection paraphernalia, although new injection equipment is exchanged at no cost for used items that are returned to the van.

The mobile NSEP also distributes a broad range of educational materials on injecting drug use, blood borne viruses and HIV. It also gives information to young people and other IDUs who require assistance with their drug problems by referral to appropriate agencies.

WA Council on Addictions Inc

349 Newcastle Street, Northbridge, 6003 (PO Box 49, Northbridge, 6865)
☎ (08) 9328 9200, Fax: (08) 9227 7431

The WA Council on Addictions operates under the name of Cyrenian House, providing a range of residential and day programs to people with drug and/or alcohol misuse/abuse problems. All residential programs are provided at Saranna, which is located at 920 Gnangara Road, Cullacabardee.

Cyrenian House draws on a wide range of approaches including 12 step recovery models, family systems theory, cognitive behavioural therapy and social learning theory. Assessments and admissions to all programs are undertaken at its main office in Northbridge (349 Newcastle Street). A number of outpatient programs are offered at the Northbridge office.

Cyrenian House therapeutic community (residential)

920 Gnangara Road, Cullacabardee ☎ (08) 9302 2222, Fax: (08) 9302 2237

In June 1998 Cyrenian House relocated its residential program which was previously located in Palmerston Street, Northbridge to Saranna, a purpose built facility on 12.92 hectares of land at Gnangara. Saranna was originally conceived, consistent with the organisation's concern for those caring for dependent children, to provide a longer term residential program for women with substance use problems to have access to treatment and detoxification. It now provides a comprehensive program for men and women with drug dependencies. It is envisaged that women with young children will have access to this program in the near future.

Cyrenian House residential program is a therapeutic community for people voluntarily seeking to change their drug/alcohol using patterns. It is located in a semi rural setting in the outer northern suburbs of the Perth metropolitan area. The restoration of physical, mental and spiritual well being is pursued in a balanced program which includes individual counselling, educational and therapeutic groups, social and recreational activities, good nutrition and attendance at 12 step meetings.

The community offers a number of staged modules. The initial eight week 'safety net' phase has been designed to offer a viable treatment option for those persons assessed as not wanting or needing a more intensive program. A 'transition' phase begins after completing six weeks of the safety net program during which clients assess whether they want, or are ready, to continue

further with the program. The longer term 'treatment' phase will provide an opportunity to explore identified issues in greater depth and develop strategies for dealing with them on an ongoing basis.

The environment of the therapeutic community provides a safe haven for experimenting with new lifestyles choices and provides support for re-entry into the community and setting realistic goals for the future.

Cyrenian House outpatient program

349 Newcastle Street, Northbridge, 6000
☎ (08) 9328 9200

This a day program for voluntary clients who are experiencing difficulties relating to either past or present addictive behaviours. Individual treatment plans are negotiated with emphasis on restoration to health and wellness. Withdrawal regimes from prescription and over-the-counter medications can be supervised with access to counselling and group support. Relationship/couples counselling is offered as appropriate.

Cyrenian House conditional program

349 Newcastle Street, Northbridge, 6000
☎ (08) 9328 9200

This is an outpatient program designed for people who are motivated to seek treatment for their drug/alcohol misuse by court, employer, parole, etc. Individual counselling and group work are available as well as supervised urine collection.

Cyrenian House family program

349 Newcastle Street, Northbridge, 6000
☎ (08) 9328 9200

The family program provides support, counselling and information to those who are being or have been affected by the drug/alcohol use of someone close. A family and friends group meets once a week offering support and information to family members, partners and friends of the dependent. Other groups offered to clients include family of origin workshops based on the work of John Bradshaw, as well as personal growth and intimacy and relationship workshops.

Cyrenian House creche

419 Newcastle Street, Northbridge, 6000
☎ (08) 9328 9200

The creche provides a safe and supportive environment for the children of clients attending any of Cyrenian House's programs. Structured to give priority to children's health and welfare, physical development, and cognitive, social and emotional wellbeing.

WA Drug Abuse Strategy Office

1st Floor, 6 Thelma St, West Perth, 6005
☎ (08) 9483 8244, Fax: (08) 9483 8299

The WADASO has assumed a number of functions previously undertaken by the Alcohol & Drug Authority and the Health Department of WA. It was established in June 1997. WADASO has a number of responsibilities, including:

- implementation of the WA government's drug abuse strategy, ***Together Against Drugs***;
- coordination of the planning, funding and provision of drug treatment services;
- provision of policy advice to government;
- development of cross government relationships; and
- develop a network of community based organisations to identify and tackle drug problems at a local and regional level.

WA Network of Alcohol & Other Drug Agencies Inc

79 Stirling St, Perth, 6000
☎ (08) 9220 0618, Fax: (08) 9220 0607

WANADA coordinates and represents the non government sector of the alcohol and other drug treatment services. It also provides a mechanism for consultation with government in planning and development of treatment, education and prevention.

WA Substance Users Association Inc

440 William St, Northbridge, 6004 (PO Box 290, Maylands, 6391)
☎ (08) 9227 7866, Fax: (08) 9227 7855

WASUA is funded by the Health Department of WA to assist with the reduction of transmission of blood borne viruses in WA by providing a peer based education, referral and outreach service for injecting drug users which incorporates a fixed site needle and syringe exchange and disposal service in inner city Perth.

WASUA is funded primarily to prevent the further transmission of blood borne viruses. During the course of WASUA's day to day activities people may also be provided, at their request advice, on drug related issues such as overdoses. This service is on a voluntary capacity and in addition to WASUA's current funding arrangement.

Wanneroo Accommodation & Support Services Inc

10 Lockeville Close, Beldon, 6027
☎ (08) 9307 4520, Fax: (08) 9307 2263

This service provides crisis, short term and medium term housing to families, couples and in particular youth who are homeless. Many of these residents are affected by their alcohol or other drug use. The drug education and support worker is involved in the provision of educational sessions for the residents on alcohol and drugs, counselling and support to those residents intent on addressing their drug use, and consultation and support to staff in order for them to manage alcohol and drug issues in the supported accommodation service. The focus of the service is on homeless youth, males and females and couples between the ages of 15 and 25.

Winjan Aboriginal Corp

Lot 1, 1 Wanjeep Road (PO Box 1009, Mandurah 6210), Coodanup, 6210
☎ (08) 9535 5908, Fax: (08) 9535 5942

Provides social structure for Aboriginal people in areas of education, employment, cultural awareness, training and small business enterprise. Counselling in areas relating to alcohol and other drug use is available.

Women's Health Care House Inc

100 Aberdeen St, Northbridge, 6003
☎ (08) 9227 8122

Perth Women's Centre

122 Aberdeen Street, Northbridge, 6003
☎ (08) 9227 5762, Fax: (08) 9227 5860

Women's Health Care House operates the Perth Women's Centre, a substance abuse program targeted specifically at women. The program provides a range of culturally appropriate services to support women who are experiencing difficulty due to their own or a significant other's drug use. The format of the service includes a non-residential treatment service, counselling, and community education to raise awareness of women health issues related to drug use and dependence.

YMCA

Streetsyde

57 Short Street, Perth, 6000 (PO Box 8505, Stirling Street, Perth 6849)
☎ (08) 9227 4111, Fax: (08) 9227 6738

Streetsyde counselling services for young people and/or their families to assist with problems relating to personal issues, relationships, family conflicts, sexuality, alcohol and other drugs, stress and anxiety, depression.

Yorgum Aboriginal Family Counselling Service

190 Treasure Rd, Queens Park, 6107
☎ (08) 9350 6735, Fax: (08) 9458 7941

This organisation provides support and counselling for Aboriginal people. The service is operated by Aboriginal people in areas that include substance abuse, grief and loss, crisis trauma, family violence, sexual assault, Aboriginal identity and racism.

Appendix 10: Alcohol and Drug Authority Act

ALCOHOL AND DRUG AUTHORITY ACT 1974

ARRANGEMENT

ALCOHOL AND DRUG AUTHORITY ACT 1974

AN ACT for the purposes of constituting a body corporate with the functions of providing, treatment, management, care, and rehabilitation of persons who are suffering from the consumption or use of alcoholic or other intoxicating liquors or drugs to excess; promoting and subsidising research and educational facilities directed at prevention and treatment of alcohol and drug abuse, and with further functions related thereto, and for incidental and other purposes.

[*Assented to 4 November, 1974*]

BE it enacted -

PART I - PRELIMINARY

Short title

1. This Act may be cited as the *Alcohol and Drug Authority Act, 1974*.

Commencement

2. The provisions of this Act shall come into operation on such day or days as is or are, respectively, fixed by proclamation[1].

Arrangement

3. The arrangement of this Act is as follows -

Interpretation

4. In this Act, unless the context requires otherwise -

``**Authority**'' means the Western Australian Alcohol and Drug Authority established under this Act;

``**Chairman**'' means the Chairman of the Authority;

``**Centre**'' means premises maintained by the Authority for the assessment, treatment, management, care, or rehabilitation of persons suffering from alcohol or drug abuse;

``**Deputy Chairman**'' means the Deputy Chairman of the Authority;

``**medical practitioner**'' has the meaning assigned to it in section 3 of the *Medical Act, 1894*;

``**member**'' means a member of the Authority;

``**section**'' means section of this Act;

``**subsection**'' means a subsection of the section wherein the term is used.

[*Section 4 amended by No. 32 of 1994 s.19.*]

PART II - ALCOHOL AND DRUG AUTHORITY

Division 1 - Establishment and Terms of Office

Establishment and incorporation

5. (1) For the purposes of this Act an authority shall be established consisting of four members appointed by the Governor, one at least of whom shall be a medical practitioner.

(2) The Governor shall appoint one member to be Chairman and another member to be Deputy Chairman of the Authority.

(3) The Minister shall cause notice of appointments to the respective offices of members to be published in the *Government Gazette*.

(4) When notice of the appointment of the first four members is so published the Authority is thereby incorporated as a body corporate by the name of ``Western Australian Alcohol and Drug Authority'' and under that corporate name -

(a) has perpetual succession;

(b) shall have a common seal;

(c) may sue and be sued in any court;

(d) may take, purchase, and hold real and personal property including property devised, bequeathed, or given to the Authority;

(e) may, with the approval of the Governor, sell, alienate, mortgage, charge, and demise real or personal property;

(f) may sell, assign, or charge personal property; and

(g) may do and suffer all other things which bodies corporate may by law do and suffer.

(5) All courts, judges, and persons acting judicially shall take judicial notice of the common seal of the Authority affixed to a document, and presume it was duly affixed.

Term of office

6. Subject to this Act, each member shall hold office for such period not exceeding three years as the Governor may fix at the time of the member's appointment.

Re-appointment

7. All members, on the expiration of their term are, unless otherwise disqualified, eligible for re-appointment.

Leave of absence

8. The Authority may grant leave of absence to a member on such terms and conditions as the authority determines.

Dismissal of members

9. The Governor may terminate the appointment of a member for inability, inefficiency, or misbehaviour.

Vacation of office

10. If a member -

(a) dies;

(b) resigns his office by writing under his hand delivered to the Minister;

(c) is a person in respect of whom an administration order is in force under Part 6 of the *Guardianship and Administration Act 1990*;

(d) is an undischarged bankrupt or has his affairs under liquidation by arrangement with his creditors;

(e) is convicted of an indictable offence;

(f) is absent without leave of the Authority for more than three consecutive meetings of the Authority;

(g) has his appointment terminated under section 9; or

(h) being a medical practitioner at the time of his appointment ceases to be one,

his office shall become vacant and shall be filled as a casual vacancy in accordance with section 11.

[*Section 10 amended by No. 24 of 1990 s.123*]

Casual vacancy

11. Where a casual vacancy occurs in the office of a member the vacancy may be filled by such person as the Governor thinks fit, and the person who fills the vacancy shall, subject to this Act, hold office as member for the residue of his predecessor's term of office, but, if by reason of the vacancy there is no member who is a medical practitioner, the person who fills the vacancy shall be a medical practitioner.

Acting members

12. (1) Where the Minister is satisfied that a member is prevented by illness, absence, or other reasonable cause from performing his duties as a member, the Minister may appoint such person as the Minister thinks fit to be an acting member to act for the member and that person, while he so acts, shall be deemed to be a member, but, if the member is the only member who is a medical practitioner, the person appointed to act for him shall be a medical practitioner.

(2) The Minister may at any time terminate the appointment of an acting member.

Meetings of the Authority

13. (1) The Authority shall hold such meetings as are necessary for the exercise of its functions.

(2) The Chairman, or if the Chairman is absent, or his office is vacant, the Deputy Chairman, may convene meetings of the Authority.

(3) If the Chairman is absent from a meeting of the Authority the Deputy Chairman shall preside at the meeting, and when doing so, shall have all the powers and duties of the Chairman.

(4) At a meeting of the Authority two members shall constitute a quorum.

(5) Subject to this Act, the Authority may regulate its procedure in such manner as it thinks fit.

Validity of acts of Authority

14. No act, proceeding, or determination of the Authority shall be invalid on the ground only of any vacancy in the office of any member or of any defect in the appointment of any member or in the appointment of any acting member.

Remuneration of members

15. The members shall be paid such fees and allowances as may from time to time be fixed by the Governor.

[***16.*** *Section 16 repealed by No. 18 of 1984 s.3.*]

Division 2 - General Functions, Powers, and Duties

Administration of this Act

17. (1) Subject to subsection (2), the Authority shall carry out the administration of this Act.

(2) The Minister may from time to time give directions to the Authority with respect to its functions, powers, and duties, either generally or with respect to a particular matter, and the Authority shall give effect to those directions.

Functions of the Authority

18. The functions of the Authority include the following -

(a) to provide assessment, treatment, management, care, and rehabilitation of persons suffering from alcohol or drug abuse, and to subsidise and otherwise support, as the Authority thinks fit, any other persons or organisations providing any one or more of those things;

(b) to establish and maintain premises for the assessment, treatment, management, care, and rehabilitation of persons suffering from alcohol or drug abuse, and to subsidise and otherwise support, as the Authority thinks fit, other persons and organisations establishing or maintaining premises for any one or more of those purposes;

(c) to establish and maintain accommodation for persons for whom assessment, treatment, management, care, or rehabilitation services are provided under this Act and to subsidise and otherwise support, as the Authority thinks fit, other persons and organisations establishing or maintaining such accommodation;

(d) to provide such other facilities and services as the Authority considers necessary or desirable for the purposes of this Act;

(e) to determine the persons or classes of persons for whom the Authority may provide facilities or services under this Act, or in respect of whom the Authority may subsidise or otherwise support other persons and organisations providing facilities and services consistent with the purposes of this Act;

(f) to coordinate, promote, and subsidise, in Western Australia, research into and education on the causation, prevention, and treatment of alcohol and drug abuse;

(g) to inquire into the respective provisions of the laws of this State with respect to offences in which the use of alcohol or drugs, or both, is an element, and with respect to the penalties for those offences, to consider the desirability or otherwise, in the community interest, of repealing or modifying any of those provisions, and to make such recommendations thereon to the Minister and the Attorney General as the Authority thinks fit;

(h) to cooperate and enter into agreement with other persons and organisations, in this State or otherwise, to such extent as may be necessary for the purposes of this Act; and

(i) such other functions as are prescribed by any other Act or regulation, local law, by-law, or rule made under any other Act.

[*Section 18 amended by No. 14 of 1996 s.4*.]

Powers

19. The Authority may do all such acts and things as may be necessary to enable it to perform its functions effectively.

[***20.*** *Section 20 repealed by No. 98 of 1985 s.3.*]

Division 3 - Staff

Officers and wages employees

21. (1) For the purposes of this Act and subject to it, the Authority -

(a) may appoint such officers of the Authority as the Authority thinks fit; and

(b) may appoint such wages employees of the Authority as the Authority thinks fit.

(2) Subject to any relevant award or industrial agreement under the *Industrial Arbitration Act, 1912*, the terms and conditions of appointment and employment of officers and wages employees of the Authority, including the salary and wages payable, shall be such terms and conditions as the Authority, with the approval of the Public Service Board, determines.

(3) Where a person so appointed was, immediately before being so appointed, an officer or a wages employee in the service of a department of the Public Service of the State -

(a) he retains his existing and any rights that may have accrued to him under the Act pursuant to which he was then serving, and, subject to section 22 of this Act, in particular his rights if any under the *Superannuation and Family Benefits Act*, 1938; and

(b) for the purpose of determining those rights his service as such an officer or a wages employee shall be taken into account as if it were service with the Authority.

(4) A person appointed under the provisions of this section is not a person appointed under Part 3 of the *Public Sector Management Act 1994*, and the provisions of the *Government Employees (Promotion Appeal Board) Act, 1945*, do not apply to or in relation to an officer or a wages employee of the Authority.

(5) Notwithstanding anything in this section, to the extent that there is in the case of a person who is appointed under subsection (1) (a) to be an officer of the Authority and who is a member of the Senior Executive Service within the meaning of the *Public Service Act 1978* an inconsistency between this Act and that Act that Act shall prevail.

[*Section 21 amended by No. 113 of 1987 s.32; No. 32 of 1994 s.19.*]

Superannuation

22. (1) The Authority may request the Minister to whom the administration of the Superannuation and Family Benefits Act, 1938, is committed to recommend that the Authority be included as a corporate body in the term ``department'' for the purposes of that Act, and the Treasurer may, on such recommendation and upon the Authority complying with the requirements of that Act, approve of the Authority as, and the Authority shall thereupon be deemed to be, a department for the purposes of that Act.

(2) An officer or a wages employee of the Authority is not obliged to become a contributor under the Superannuation and Family Benefits Act, 1938.

Co-opted and seconded staff

23. (1) The Authority may, with the consent of the Minister administering any department of the Public Service of the State, for the purposes of this Act, co-opt the services, whether of an administrative, professional, technical, or other nature, of any person employed in any of those departments, or request the secondment of any such person, upon such terms as may be agreed between that Minister and the Authority.

(2) Where the services of any person are co-opted or a person is seconded under the provisions of this section, it does not prejudice that person's existing or accruing rights under the Public Service Act, 1904, or under any other Act applying to him as a public servant, and his service with the Authority under this Act shall be regarded as service in the Public Service of the State for the purposes of determining those rights.

[*Section 23 amended by No. 32 of 1994 s.19.*]

Contractual Services

24. (1) The Authority may engage under contract for services such professional, technical, or other assistance as may be necessary to enable the Authority to perform it functions effectively.

(2) A person engaged under the provisions of subsection (1) is not a person appointed under Part 3 of the *Public Sector Management Act 1994,* and subject to this Act and to any award or agreement in force under the *Industrial Arbitration Act, 1912,* the Authority may effect, suspend, and terminate the engagement subject to such terms and conditions as the Authority thinks fit.

[*Section 24 amended by No. 32 of 1994 s.19.*]

PART III - ALCOHOL AND DRUG CENTRES

Centres

25. The Authority, may with the approval of the Minister, from time to time with respect to any Centre -

(a) prohibit or regulate the admission of persons to or the right Of persons to remain in, the Centre;

(b) fix fees for any facility or service provided and determine the persons or classes of persons who are liable for payment to the Authority of those fees in full or in part or who may be exempted from such payment.

Procedure on deaths in Centres

26. (1) An inquiry shall be held by the Authority as to the death or injury caused to any person in a Centre while he is there for assessment, treatment, management, care, or rehabilitation.

(2) The person in charge of a Centre shall report to the Authority with respect to the circumstances surrounding the death or injury to any person in a Centre, while he is there for assessment, treatment, management, care, or rehabilitation.

PART IV - FINANCIAL PROVISIONS

Application of the *Financial Administration and Audit Act 1985*

27. The provisions of the *Financial Administration and Audit Act 1985* regulating the financial administration, audit and reporting of statutory authorities apply to and in respect of the Authority and its operations.

[*Section 27 substituted by No. 98 of 1985 s.3.*]

Funds of the Authority

28. (1) The funds available to the Authority for the purpose of enabling it to exercise its functions, powers, and duties under this Act are -

(a) moneys from time to time appropriated by Parliament for that purpose;

(b) moneys received by the Authority by way of fees, gifts, bequests, or otherwise;

(c) moneys borrowed by the Authority under this Act; and

(d) moneys made available to the Authority for the purposes of this Act.

(2) The moneys referred to in subsection (1) shall be -

(a) credited to an account at the Treasury, forming part of the Trust Fund constituted under section 9 of the *Financial Administration and Audit Act 1985*; or

(b) paid into and placed to the credit of an account at a bank approved by the Treasurer,

and the account is to be called the Western Australian Alcohol and Drug Authority Account.

(3) All expenditure incurred by the Authority for the purposes of giving effect to this Act, including the repayment of moneys borrowed by or advanced to the Authority in accordance with this Act, shall be charged to the account referred to in subsection (2).

[*Section 28 amended by No. 49 of 1996 ss.48 and 64.*]

Power to borrow money

29. (1) The Authority has power to borrow money upon the guarantee of the Treasurer of the State for the purposes of carrying out its powers and functions under this Act.

(2) The Authority is authorised with the prior approval in writing of the Treasurer to borrow money upon such terms and conditions only as the Treasurer approves.

(3) The Treasurer is hereby authorised to so approve and to give the guarantee, including the guarantee of interest, in subsection (1), for and on behalf of the Crown in right of the State.

(4) Any moneys borrowed by the Authority under this section may be raised as one loan or as several loans and in such manner as the Treasurer may approve, but the amount of the moneys so borrowed shall not in any one year exceed in the aggregate such amount as the Treasurer approves.

(5) Before a guarantee is given by the Treasurer under this section, the Authority shall give to the Treasurer such security as the Treasurer may require and shall execute all such instruments as may be necessary for the purpose.

(6) The Authority shall use all moneys borrowed under the power conferred by this section for the purposes of carrying this Act into effect.

Power of the Authority to invest certain moneys

30. Where any money standing to the credit of the Western Australian Alcohol and Drug Authority Account is not immediately required for the purposes of this Act, the Authority may invest it in any investments authorised by law as in force immediately before the coming into operation of the *Trustees Amendment Act 1997* as those in which trust funds may be invested.

[*Section 30 amended by No. 1 of 1997 s.18*.]

[***31.*** *Section 31 repealed by No. 98 of 1985 s.3.*]

Application of moneys received by the Authority

32. The Authority shall apply for the objects of the Authority all fees and other moneys received by it under this Act or otherwise.

[***33.*** *Section 33 repealed by No. 98 of 1985 s.3.*]

PART V - MISCELLANEOUS PROVISIONS

Recovery of fees

34. In any court of competent jurisdiction an officer of the Authority, who is authorised in writing by the Authority in that behalf, may recover for the Authority any fees that are payable to the Authority and have not been paid.

Protection of members

35. (1) Any person who is, or has at any time been, a member or an acting member of the Authority is not personally liable for any act done, or omitted to be done, in good faith by the Authority or by him as a member or an acting member.

(2) Acceptance of or being in the office of member or acting member of the Authority by any person does not of itself render the provisions of *Part 3 of the* Public Sector Management Act 1994, or any other Act applying to persons as officers of the Public Service of the State, applicable to that member or acting member, or affect or prejudice the application to him of those provisions if they applied to him at the time of the acceptance of or being in that office.

[*Section 35 amended by No. 32 of 1994 s.19.*]

Regulations

36. (1) The Governor may make such regulations, not inconsistent with this Act, as he considers necessary or desirable for the proper administration of this Act or for achieving the purposes of this Act.

(2) Without limiting the generality of subsection (1) the Governor may make regulations -

(a) for maintaining order and discipline and regulating the general conduct of inmates of and visitors to a Centre or any other place at which accommodation is provided by the Authority under this Act;

(b) for prohibiting and preventing trespass on the Centres.

(3) The regulations may prescribe penalties, not exceeding a fine of forty dollars, in respect of a breach of any of the regulations.

(4) The regulations may require that any information, account, document, or form required to be given or furnished thereunder shall be verified by statutory declaration.

(5) A regulation -

(a) may be limited in its application to time, place, or circumstance; and

(b) may provide that any act or thing done shall be done with the approval or to the satisfaction of a specified person or class of persons and may confer a discretionary authority.

NOTES

[1] This is a compilation of the *Alcohol and Drug Authority Act 1974* and includes all amendments effected by the other Acts referred to in the following Table.

Table of Acts

Act	Number and Year	Assent	Commencement
Alcohol and Drug Authority Act 1974	32 of 1974	4 November 1974	29 November 1974 (see *Gazette* 29 November 1974 p.5167)
Acts Amendment and Repeal (Disqualification for Parliament) Act 1984, Part II	78 of 1984	14 November 1984	1 July 1985 (see *Gazette* 17 May 1985 p.1671)
Acts Amendment (Financial Administration and Audit) Act 1985 (as amended by No. 4 of 1986), section 3	98 of 1985	4 December 1985	1 July 1986 (see section 2)
Acts Amendment (Public Service) Act 1987, section 32	113 of 1987	31 December 1987	16 March 1988 (see *Gazette* 16 March 1988 p.813)
Guardianship and Administration Act 1990 section 123	24 of 1990	7 September 1990	S.123: Proclaimed 20 October 1992 (see *Gazette* 2 October 1992 p.4811)
Acts Amendment (Public Sector Management Act 1994, Part 4	32 of 1994	29 June 1994	1 October 1994 (see *Gazette* 30 September 1994 p.4948)
Local Government (Consequential Amendments) Act 1996, section 4	14 of 1996	28 June 1996	1 July 1996 (see section 2)
Financial Legislation Amendment Act 1996, sections 48 and 64	49 of 1996	25 October 1996	25 October 1996 (see section 2 (1))
Trustees Amendment Act 1997, section 18	1 of 1997	6 May 1997	16 June 1997 (see section 2 and *Gazette* 10 June 1997 p.2661

Appendix 11: West Australian Drug Strategy

Together Against Drugs

WA Strategy Against Drug Abuse

Action Plan 1997 – 1999

(June 1997)

Foreword

Drug abuse is a problem for Western Australia as it is nationally and internationally. It is a major concern for our whole community. It particularly confronts those of us who are parents.

Together Against Drugs is a comprehensive and continuing program to deal with abuse of both legal and illegal drugs in the State. It assumes that no single strategy is enough and that there are no simple solutions to this complex problem.

Together Against Drugs charts the Coalition Government's action plan for 1997 to 1999. It includes $5 million in new funding over the two year period. It aims to prevent, as well as respond to, existing drug abuse problems.

Together Against Drugs follows nearly two years of progress in implementing the recommendations of the Task Force on Drug Abuse (1995) which was initiated by the Premier, the Hon. Richard Court MLA.

These recommendations resulted in initiatives such as the school drug education program for all schools, information sessions for parents, the 'Drug Aware' campaign and the expansion of much needed services such as the methadone treatment. The recommendations also resulted in community action through Local Drug Action Groups.

Drug abuse is, however, an ever changing problem. It is affected by fluctuations in international supply and cultural trends. There is no room for complacency now and there is not likely to be in the future.

Together Against Drugs develops a comprehensive approach that is fundamental to the WA Strategy Against Drug Abuse. The range of strategies necessarily includes education, health services, community supports, law enforcement and community action. *Together Against Drugs* also introduces important changes to the way the Government coordinates its approach to addressing drug abuse as well as how it can work in partnership with the community.

As the Minister responsible for the WA Strategy Against Drug Abuse, I am aware of the great challenge of drug abuse confronting us. We can and will deal with this challenge in Western Australia as we work *Together Against Drugs.*

Rhonda Parker MLA
MINISTER RESPONSIBLE FOR THE WA DRUG STRATEGY
26 June, 1997

Executive Summary

Together Against Drugs is a comprehensive across government plan with more than 70 initiatives, including responses through public education, health services, community support services, law enforcement and community action

Drug abuse is an issue for which the State Government can provide vital leadership and essential services but it is not an issue that it can solve on its own. *Together Against Drugs* will establish a partnership between Government and the community in this campaign against drug abuse.

Together Against Drugs will further provide a clearer structural focus to the State Government's response to the drug problem. This will ensure that funding for the WA Drug Abuse Strategy will be more effectively allocated.

The Ministerial Council for the Strategy Against Drug Abuse will be formed immediately. The Ministers for Police, Health, Education, Aboriginal Affairs, Family and Children's Services, Youth and the Attorney General will comprise the Council which will provide coordination across Government. There will be a corresponding senior officers group including officers with portfolio responsibility for drug issues in their agencies. The Council will work with the new WA Drug Abuse Strategy Office (WADASO) which will coordinate the implementation of the strategy.

A specialist **Alcohol and Drug Services Unit** will be established within the WA Health Department. The unit will be a centre of excellence in the provision of treatment for alcohol and drug problems. This will bring the current services of the Alcohol and Drug Authority into the context of the broad health system.

The Western Australian Foundation for Community Action Against Drug Abuse will be established as a trust fund with a $1 million Government grant. Its aim will be to empower the community in the fight against drug abuse and to work in partnership with the Government.

A **Leaders Against Drug Abuse Team** is being formed to support the community's opposition to drug abuse. The team will take part in public education campaigns and school drug education initiatives. His Excellency, the Governor of Western Australia, Major General Michael Jeffery, AC MC, is the first member.

Community Drug Service Teams will be established across Western Australia. The teams will be made up of professionals in the areas of alcohol and drugs, youth and family services. There will be six teams in the country and four in the metropolitan area. The teams will provide a focus on early intervention and family support; support for schools dealing with drug abuse; and counselling and attention to specific problems such as solvent abuse. Families who need help to deal with drug abuse will be able to seek support at an early stage. The teams will link closely with, and support, Local Drug Action Groups.

Local Drug Action Groups will be expanded across Western Australia with an extra 20 groups to make a State-wide network of 40. The Local Drug Action Groups will be developed and strengthened through the involvement of police, local government, schools, Family and Children's Services and the provision of training.

A major program will be developed with The Pharmacy Guild of Australia (WA Branch) to make information available through local pharmacies. This will mean that more parents and families, as well as people who are drug users, will be reached with information, advice and support.

Drug education courses for parents will be available throughout Western Australia. Education materials will be developed in tandem with school drug education and as 'Drug Aware' parent resources.

School drug education will be expanded to reach all years in every school throughout the State with new curriculum and training for teachers. This project has been developed with the support of the Catholic Education Office, the Association of Independent Schools and the Education Department of Western Australia.

Methadone treatment will be expanded through general practitioners and community-based pharmacies to meet the demands of heroin dependent people who require methadone treatment.

A **Heroin Overdose Strategy Group** will develop, implement and evaluate a comprehensive strategy aimed at preventing heroin deaths. The group will include representatives from ambulance and hospital emergency medical services, the WA Health Department, alcohol and drug agencies, the WA Substance Users Association, the WA Police Service, the Pharmacy Guild of Australia (WA Branch) and the National Centre for Research into the Prevention of Drug Abuse. The strategy will include information and education for drug users, outreach and peer education for users, ensuring that emergency services employ the best approaches including the appropriate use of Narcan, investigating the feasibility of new proposals to get assistance to users and fast-tracked research with users to increase the effectiveness of education strategies.

Street dealing of drugs will be the target of a new and concerted operation by the WA Police Service.

The penalties for high level and major drug suppliers will be strengthened with the penalties for all drug suppliers being reviewed through a Parliamentary Select Committee.

The capacity to seize and confiscate assets of drug suppliers will be strengthened with new laws building upon existing laws. Seized assets could be used to tackle drug problems in the community.

The next phase of the 'Drug Aware' public education campaign will focus on heroin. This campaign is due to start soon.

Together Against Drugs concentrates on preventing drug abuse and responding to existing problems, as well as dealing with the challenges as they arise.

The ultimate aim is to engage a total spirit of support so that the entire community is working *Together Against Drugs*.

Policy Framework

The WA Strategy Against Drug Abuse sets out a strong and clear policy to guide the work of government agencies. It reflects the community's opposition to drug abuse and the need to respond in a practical way to existing problems

The Government's policy framework in relation to drug abuse stresses the need for a comprehensive approach and emphasises two principles:

- First and foremost, opposition to drug abuse; and
- Second, harm reduction, recognising the need for strategies to reduce the risks and harm to those continuing to use drugs and to the wider community, whilst taking care that such strategies do not encourage or normalise drug abuse.

The comprehensive approach developed in this action plan includes responses through public education, health services, community support services and law enforcement.

The Government will implement its program in close partnership with the community, community organisations, non-government agencies, schools, local governments, churches, the private sector and all professionals engaged in the alcohol and drug field.

Education to prevent drug abuse

The prevention of drug abuse is a critical priority. Long term education is a major focus of the WA Strategy Against Drug Abuse, covering both alcohol and other legal drugs as well as the illegal drugs. Education strategies will target parents, young people, the broader community, and

professional groups. Information and education strategies to reduce the harm associated with existing drug abuse are also essential

- Effective drug education will be provided in all schools through the continuing implementation of the School Drug Education Project over the next three years. This will include development of curriculum, professional development for teachers, drug policies in all schools, and the involvement of parents and the community.

- Parents will receive education materials developed as part of the curriculum for the primary and secondary schools, so that they and their children can learn and talk together about drugs.
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- More parents, families and drug users will be reached with information and advice regarding drugs through a major program with the Pharmacy Guild to make information available through local pharmacies.

- Drug education courses for parents, piloted in the last year, will be assessed, further developed and promoted.

- The "Drug Aware" public education campaign on illicit drugs will, in addition to supporting parents, target the use of particular drugs by youth and include a strong focus on heroin.

- Educational materials outlining lifesaving strategies will be developed and distributed to drug users.

- Drug users will be reached with information through peer education initiatives with support from the WA Substance Users Association.

- A comprehensive program of education initiatives will tackle the contribution of both alcohol and drugs to the road toll.

- In co-operation with industry, targeted drug education initiatives will be developed to focus on the dangers posed by drug abuse to work safety.

- Strategies will be developed in co-operation with local media outlets to limit the normalisation of illicit drug use occurring through the entertainment media and popular culture.

- Information and education for health and other professional services, such as general practitioners and youth workers, will be expanded substantially.

- A State Drug Education Co-ordination Group comprising the WA Drug Abuse Strategy Office, the Health Department, the Education Department, the Police Service and the Office of Road Safety will assess and co-ordinate the ongoing effectiveness of drug education programs.

Health services

It is essential that the health system can provide effective responses to drug and alcohol problems, both through core specialist services and by responding to the needs of general patients. Specialist health services are being enhanced and improved through the development of a health and medical services centre of excellence

- An Alcohol and Drug Services Unit that will be a health and medical centre of excellence, providing treatment for alcohol and drug problems, will be established within the Health Department. This will bring the current services of the Alcohol and Drug Authority into the context of the broad health system.

- Methadone treatment will be expanded further through general practitioners and community based pharmacies in order to meet the demands of heroin dependent people who require this treatment.

- New pharmacotherapies for heroin and other opiate dependence (such as buprenorphine, LAAM, and naltrexone) will be introduced if current Australian trials prove successful.

- An alcohol and drug policy unit within the Health Department will ensure that the broad health system, including hospital and community health services, can respond to the alcohol and drug problems of its patients.

- Hospital services will expand treatment of alcohol and drug problems through responses such as regional hospitals admitting inpatients in conjunction with general practitioners, and development of a program for the introduction of screening and brief counselling for alcohol problems.

- More people will receive treatment for alcohol and drug problems in community health centres and other health settings with support and training for professional staff being expanded. Work based learning programs, currently being piloted with Family and Children's Services, will support this development.

Community support services

Families need support at an early stage if drug problems are emerging. Community based services for young people and adults, and their families, will provide early intervention and support. Those services will be expanded and improved, especially in outer metropolitan and country regions. The responses of mainstream human services and services for offenders with drug and alcohol problems will also be enhanced

- Services for young people and adults, and their families, will be expanded in metropolitan and country regional areas through the establishment of ten Community Drug Service Teams.

- Community Drug Service Teams will provide a focus on:

    - early intervention and family support;
    - support for Local Drug Action Groups;
    - support for schools dealing with drug abuse;
    - outreach counselling for youth;
    - general counselling service where services are currently minimal; and
    - attention to specific problems such as chronic solvent abuse.

- Support and training for the various human services agencies and professions will be expanded so that they can deal with the drug and alcohol problems of their clients.

- Offenders with alcohol or drug problems, serving custodial or community based sentences, will be able to access treatment during and following their sentences. An integrated range of interventions for both treatment and management of offenders, including detection and deterrence, medical management and general treatment strategies is being developed.

- Intoxicated youth will be assisted through support for sobering-up shelters to meet their needs.

- Services and community responses addressing alcohol abuse with Aboriginal people will be developed in accordance with the Aboriginal Alcohol Summit Report, "Living with Alcohol".

- Services for Aboriginal people in Perth, provided through the Noongar Aboriginal Substance Abuse Service, will be improved and enhanced through a review and a services development plan.

- Drug abuse treatment services for agencies providing supported accommodation for youth, piloted in the last year, will be assessed and further developed in conjunction with Family and Children's Services.

- Youth agency contracts will be assessed to ensure that all young people using drugs receive appropriate intervention.

- Alcohol and drug agency services will be enhanced and service agreements will be reviewed to ensure that best practice in alcohol and drug treatment is being provided.

Law enforcement

Law enforcement is an essential part of the comprehensive approach of the WA Strategy Against Drug Abuse. It ensures that the State's law enforcement is a credible deterrent, with a new operational focus on street dealing, a review of penalties for drug suppliers, and support for Police targeting major suppliers with task force approaches. At the local level, the strategy develops community policing approaches to drug law enforcement.

- Street dealing of drugs will be the target of a new concerted operation by the Police Service.

- The penalties for high level and major drug suppliers will be strengthened with the penalties for all drug suppliers being reviewed through a Parliamentary Select Committee.

- The capacity to seize and confiscate assets of drug suppliers will be strengthened, and could be used for tackling drug problems in the community, with new legislation building upon existing laws.

- The ability of the Police Service to target drug suppliers and mount large scale operations will be enhanced through:

- the implementation of the telephone interception and listening device powers;
- legislation to support covert operations and provide for higher penalties where firearms are used by offenders; and
- further action to deploy Joint Task Forces on Drug Operations in co-operation with Commonwealth police agencies.

- Drink driving will be tackled through a proposed increase in penalties, raising the likelihood of licence loss and higher fines, and by simplifying procedures to reduce court time and delays.

- A practical schedule of penalties and testing procedures for driving under the influence of drugs will be developed subject to the outcome of a current feasibility study.

- Police will work closely with health and welfare agencies and community groups to develop a community based approach to drug law enforcement. Pilot programs will be established in the Mirrabooka metropolitan region and the Geraldton country region.

- Training of police officers will be enhanced through:

    - the integration of specialist Police Service education packages - covering illegal drugs, alcohol and crime, harm reduction, and working with youth - into regular Police training programs;

- education of new and serving police officers about enforcement of the Tobacco Act; and
- a Police Drug Information Guide for use by operational, school based and community policing officers as a resource for dealing with the community.

Community action

Drug abuse is an issue for which the Government can provide vital leadership and essential services but it is not an issue that it can solve on its own. The community needs to take an active role in any action against drug abuse. The WA Strategy Against Drug Abuse places a special emphasis on supporting the community to take action and will establish a Foundation For Community Action Against Drug Abuse, extend and strengthen the State-wide network of Local Drug Action Groups, under the patronage of His Excellency the Governor of Western Australia, and support prominent members of the community to provide leadership for the community's opposition to drug abuse

- A Foundation for Community Action Against Drug Abuse will be established with a $1 million grant from the Government, to support the community action and community based initiatives.

- A further 20 Local Drug Action Groups will be established around the State, with a special emphasis on country regions, to make a State-wide network of 40 groups.

- Local Drug Action Groups will be developed and strengthened through:

  - the participation of police officers and representatives from local governments, schools and Family and Children's Services;
  - support being provided by linking with Community Drug Service Teams;
  - training for the groups and their broader community networks; and
  - an annual Community Action on Drug Abuse conference.

- A "Leaders Against Drug Abuse Team", involving His Excellency the Governor of Western Australia, will support the community's opposition to drug abuse, participating in public education campaigns on alcohol, tobacco and illicit drugs, and school drug education initiatives.

- The role models program, *Reach for the Dream* (managed by the WA Football Commission Community Service Division) will support public education campaigns on alcohol, tobacco and illicit drugs, and school drug education initiatives.

Specific issue initiatives

The ever changing nature of drug abuse requires the continuing development of strategies to address problems as they arise and to prevent the growth of potential problems. This includes a strategy to deal with heroin overdoses and initiatives to tackle the problems of groups that are difficult to reach such as solvent abusers and steroid users. Alcohol abuse, which causes substantial harm to the community, also requires a continuing focus by the WA Strategy Against Drug Abuse

Heroin overdose strategy

- A Heroin Overdose Strategy Group will develop, implements and evaluate the approaches outlined below. Convened by the WA Drug Abuse Strategy Office, it includes ambulance and hospital emergency medical services, the Health Department, alcohol and drug agencies, the WA Substance Users Association, the Police Service, the Pharmacy Guild and the National Centre for Research Into the Prevention of Drug Abuse.

- Information and education for users regarding high levels and variations in the strength of street heroin, the danger of mixing drugs including alcohol, and the need to call an ambulance to any overdose will be provided through posters and postcards at appropriate sites, warnings on fitpacks, and through users themselves.

- Outreach and peer education for users to educate other users regarding these hazards and simple resuscitation methods will be developed.

- Emergency services will employ the best approaches based on evidence, including the appropriate use of Narcan, and procedures which do not deter users from contacting them.

- The availability of methadone treatment will be expanded.

- Trends through the Coroners Office and ambulance services will be monitored, and fast-tracked research with users will support the effectiveness of education strategies.

- The feasibility of new proposals to get assistance to overdose victims will be investigated.

- The next phase of the "Drug Aware" public education media campaign will focus on heroin.

Steroids

- The growth of problems with steroids will be targeted with an education program together with law enforcement.

Solvent abuse

- A comprehensive approach to solvent abuse in regional centres and communities will be led and coordinated by the Health Department.

- Chronic solvent abusers in Perth and regional centres will be treated by expanding the availability of intensive case work through Community Drug Service Teams, working collaboratively with other government departments and youth agencies.

- The needs of intoxicated youth and associated community problems will be met by ensuring that sobering up facilities meet the needs of solvent abusers where appropriate.

- New avenues to protect solvent abusers who are a danger to themselves and the community will be developed in cooperation with the Minister for Police.

- Local Drug Action Groups will work with retailers to limit the supply of solvents.

Alcohol abuse reduction program

- Responsible behaviour by social and licensed hosts, and by drinkers themselves, will be promoted through a program of strategies under the banner of "host responsibility" including:

    - public education of consumers and both social and licensed hosts;
    - enforcement of alcohol serving practices in licensed venues, including a demerit point system for licensees; and
    - monitoring advertising of alcohol products according to a State code of practice.

- A study will be commissioned to examine the practical feasibility for alcohol taxation measures to reduce alcohol abuse and raise revenue to deal with alcohol problems.

- Alcohol Accords, implemented successfully in Fremantle, Perth and other centres, will be further developed in regional centres.

Tobacco

· Local Drug Action Groups will work with retailers to limit the supply of tobacco to juveniles.

· Quit smoking services are being reviewed and their availability publicised through the Quit campaign.

Pharmaceuticals

- The safe and effective use of pharmaceuticals, particularly with respect to driving and minimising 'doctor shopping' will be supported in conjunction with Commonwealth health initiatives, and the medical and pharmaceutical professions.

Aboriginal people

- Services, prevention programs and community responses addressing alcohol abuse with Aboriginal people will be developed in accordance with the "Aboriginal Alcohol Summit Report, "Living with Alcohol".

- Services for Aboriginal people in Perth, provided through the Noongar Aboriginal Substance Abuse Service, will be improved and enhanced through a review and services development plan.

- As a major cause of early death, smoking will be tackled through a range of education initiatives.

- Specialist training in methadone treatment will be provided to medical officers employed by the community controlled Aboriginal health services where this is needed.

- Treatment for Aboriginal people's alcohol and drug problems may be further enhanced through practice development projects with the community controlled Aboriginal health services, using work based learning approaches to enhance the interventions to address the problems of existing clients.

Inner city issues

· Issues in the inner city will be addressed through a comprehensive strategy that co-ordinates law enforcement and service provision.

Information and research

Effective action requires that timely and up to date information is available to the Government, relevant agencies and the community. The WA Strategy Against Drug Abuse will ensure that Western Australian strategies are informed by national and international developments, and will co-ordinate the production and availability of local information as well as commission research into areas of immediate policy need.

- The ability of the Government and the community to respond to drug abuse problems will be improved by providing regular and timely production of:

    - local statistical profiles,
    - Statistical Bulletins on issues of significance,
    - WA drug abuse indicators, and
    - comparative indicators with other States.

- Police resources will be better targeted through the development of local statistical profiles of drug and alcohol incidents. A pilot program will be conducted in the Fremantle region.

- Health and other resources will be better targeted through undertaking studies to monitor and analyse the Western Australian morbidity associated with alcohol and other drugs.

- The effectiveness of major developments will be assessed by the evaluation of initiatives such as community based methadone treatment and the School Drug Education Project.

- Trends in the quantity of youth drug abuse will be monitored in Western Australian surveys that include alcohol, tobacco and illicit drugs.

- The effectiveness and co-ordination of treatment services will be enhanced by the redevelopment of the treatment data system for non-government organisations.

- Local crime prevention initiatives and the responses of the Police Service and the Ministry of Justice will be enhanced by the results of research analysing the links between burglary, armed robbery, property crime and drug abuse in Western Australia.

- The use of research to inform policy and practice will be substantially improved by convening a WA Research Co-ordination and Policy Advice Group.

Co-ordination and structure

A Minister responsible for the WA Strategy Against Drug Abuse, a Ministerial Council to support a whole of government approach and a WA Drug Abuse Strategy Office working together with a range of government, non-government, and community organisations, will sustain comprehensive, focused, and effectively coordinated State-wide activity

· A WA Drug Abuse Strategy Office will co-ordinate implementation of the WA Strategy Against Drug Abuse and provide policy advice to Government, administer funding for the strategy, and co-ordinate the availability of information.

· Co-ordination across government will be achieved through a WA Ministerial Council for the Strategy Against Drug Abuse with the Ministers for Police, Health, Education, Aboriginal Affairs, the Attorney General, Youth and Family and Children's Services; and a corresponding Senior Officers Group that will include officers with portfolio responsibility for drug issues in their agencies.

· Co-ordination at the local level will be achieved through bodies including senior regional representatives of Police, Health, Education, Aboriginal Affairs, Family and Children's Services and Justice, integrated where appropriate with existing structures such as alcohol and drug committees or District Crime Prevention / Community Policing Committees.

Implementation

A continuing focus by the Government, effective co-ordination and substantial new funding will ensure the full implementation of the WA Strategy Against Drug Abuse Action Plan 1997 -1999

· *Together Against Drugs* provides $5 million in new funding over the two year period, to prevent as well as respond to existing drug abuse problems. Within the same time, the WA Drug Abuse Strategy Office will administer funding of nearly $25 million.

· The Action Plan for 1997 to 1999 charts the Government's strategy for the next two years. It is not a static program. Rather, it provides the capacity and the organisation to listen to the community and to work with it to respond to existing and newly emerging issues.

Appendix 12: British Drug Strategy

Tackling Drugs to Build A Better Britain

The Government's ten-year strategy for tackling drugs misuse

Presented to Parliament April 1998

HMSO Cm 3945

The government's ten-year strategy for tackling drugs

The problem

Drugs are a very serious problem in the UK. No one has any illusions about that. Illegal drugs are now more widely available than ever before and children are increasingly exposed to them. Drugs are a threat to health, a threat on the streets and a serious threat to communities because of drug-related crime.

Some progress has been made. The last Government's strategy for England 'Tackling Drugs Together' was an important step in the right direction. It has been implemented with some success. For the first time, Drug Action Teams set up partnerships to tackle the problem. We will build on that valuable work. But a fresh long-term approach is now needed.

Vision

There are no easy answers. To really make a difference in tackling drugs, goals must be long term. Our new vision is to create a healthy and confident society, increasingly free from the harm caused by the misuse of drugs. Our approach combines firm enforcement with prevention.

Drug problems do not occur in isolation. They are often tied in with other social problems. The Government is tackling inequalities through the largest ever program to get people off benefit and into work and a series of reforms in the welfare state, education, health, criminal justice and the economy. And a new Social Exclusion Unit is looking at many of the problems often associated with drug taking.

The Government will promote action against drugs that makes substantial progress over the long term. Action will be concentrated in areas of greatest need and risk. All drugs are harmful and enforcement against all illegal substances will continue. And we will focus on those that cause the greatest damage, including heroin and cocaine.

Partnership is the key to the new approach, building on the good work that has already been done. This strategy is based on an extensive review by the UK Anti-Drugs Coordinator, Keith Hellawell and his Deputy, Mike Trace. They analysed all the available evidence and together consulted over 2,000 people and organisations.

The strategy has four elements.

Young people

To help young people resist drug misuse in order to achieve their full potential in society.

Communities

To protect our communities from drug-related anti-social and criminal behaviour.

Treatment

To enable people with drug problems to overcome them and live healthy and crime-free lives.

Availability

To stifle the availability of illegal drugs on our streets.

This is a framework for designing and implementing policies to tackle drugs. It is just the beginning of a long-term strategy.

In the first year of the strategy, clear, consistent and rigorous targets will be set to help achieve our aims. The performance of the Government and its agencies therefore will be readily

measurable against these targets. And the UK Anti-Drugs Coordinator will publish an annual report to check progress.

Partnership

Because of the complexity of the problem, partnership really is essential at every level. At government level, the work will be led by the Cabinet Sub-Committee on Drug Misuse chaired by Ann Taylor and by other groups chaired by Keith Hellawell and his Deputy Mike Trace.

These will bring together key players in the field from the statutory, voluntary and private sectors and others with an interest. They will work closely with the local partnerships set up by Drug Action Teams. The Drug Action Teams are the critical link in the chain, ensuring that this strategy is translated into concrete action. To assist in that, detailed guidance notes are being issued to those working in the field putting this strategy into practice.

Resources

In central and local government alone, well over £1 billion a year is spent on tackling the drugs problem. And yet the number of addicts is going up and availability and drug-related crime are on the increase. We need to improve the efficiency and coordination of anti-drugs work. And eventually, we hope to achieve better results. If we invest wisely now, there is a real chance of breaking the cycle of drugs and crime which wrecks lives and threatens communities. Along with the obvious benefits of creating a healthier society, there could also be significant savings through big reductions in crime and health risks.

To achieve that, all government departments have committed themselves to the principles guiding the allocation of resources described in Keith Hellawell's report. There will be a progressive shift away from reactive expenditure, dealing with the consequences of drug misuse, to positive investment in helping prevent them ever arising. The Coordinator's report takes into account work currently being done on the comprehensive spending review of drugs-related spending which will be completed later this year. And for the first time, a proportion of assets seized from drug barons will be channelled back into anti-drug programs to help those who have suffered at their hands and on whose misfortune they have prospered. The Government is considering how this can best be achieved. More details of these considerations will be issued later this year.

The way ahead

The strategy is a challenging work program to which all relevant agencies will need to respond. Work must be properly coordinated. The Government will make clear what it expects from its key agencies with an interest - police forces and authorities, probation committees, prison establishments, health authorities, local authorities (including Directors of Education and Social Services), HM Customs and Excise, the National Crime Squad and the National Criminal Intelligence Service. Similarly, with Drug Action Teams.

Although the strategy focuses mainly on England, it is relevant to Scotland, Wales and Northern Ireland and it highlights our international responsibilities. We will make sure it gets the widest circulation. And our international effort remains vitally important, working with our European and other partners, to stem the flow of illegal drugs into the UK.

The legal framework provided by the Misuse of Drugs Act 1971 and other legislation provides some of the tools needed to crack down on the availability of drugs and reduce the misery they cause. But enforcement alone will never be enough. We need to ensure that young people have all the information they need to make informed decisions about drugs; that we follow up tough words with decisive action; and that there really is proper partnership to tackle the problem. If we can make our vision a reality, we have the chance to make Britain a better place. This new strategy presents a real opportunity to do that.

The drugs problem: where we are now

”Tackling Drugs Together”, published in May 1995, was the first genuinely strategic response in England to the complexities of the drugs problem. It had cross-Party support and has been successful in sustaining a coordinated approach to a difficult issue. The fact that all 88 of the tasks required in that White Paper have been completed indicates good progress. It remains one of the best and most influential strategies for effective action against drugs. But in building on its success, we need to recognise its weaknesses:

- it focused on structures rather than results, with the general public insufficiently engaged as a consequence;
- it treated drug misuse largely in isolation from other social and environmental factors;
- it advocated partnership without making sufficient structural and fiscal changes to support it; and
- it was too short-term and did not bring together common research, information and performance bases.

Alongside "Tackling Drugs Together", there have been other important developments:

- A strategic review of **international drugs activity** - with a clear overall commitment of all the law enforcement, intelligence and diplomatic agencies to reduce the flow of illicit drugs to the UK.
- **Strengthened links** between a wide range of national agencies, working together to achieve collaborative goals on drug prevention/education and enforcement - an approach which has been confirmed by recent reports from the statutory Inspectorates on the Police, Probation, Prisons, Education and Social Services.
- Increased **collaboration on resources** between the statutory, private and voluntary sectors - for example, the £2 million drugs Challenge Fund in 1996/7 and 1997/8 respectively has generated a total of over £2.5 million resources from those sectors.
- The creation and development of **Drug Action Teams** and their Reference Groups which has been very encouraging, with substantially greater cohesion of effort and sharing of resources amongst health and local authorities, criminal justice agencies and other key players, agreed action plans and better prioritisation of local needs.
- Community initiatives which have generated a diverse range of projects, clearly highlighting that local people are best placed to tackle local drugs problems. Evidence of this has been disseminated, in particular by the Home Office **Drugs Prevention Initiative**.

Significant progress too has been made in Scotland, Wales and Northern Ireland:

- in **Scotland**, the 1994 strategy "Drugs in Scotland: meeting the challenge" has been implemented, along with the development of the Scotland Against Drugs campaign and a Scottish drugs Challenge Fund. The emphasis has been on an integrated approach to service provision, the development of a national information base and strong partnership links with the private and voluntary sectors;
- in **Wales**, a drug and alcohol strategy "Forward Together" was launched in 1996. The Welsh Drug and Alcohol Unit oversees the strategy, and is committed to developing a national prevention campaign, action on treatment and rehabilitation, and guidance for those involved in combating drug and alcohol misuse;
- in **Northern Ireland**, the Central Coordinating Group for Action Against Drugs was established in 1995 to oversee coherent efforts against drug misuse within a clearly defined policy statement. The key action areas are education and prevention, treatment and rehabilitation, law enforcement, information and research - including a major publicity campaign - and monitoring and evaluation.

The scale of the problem

Despite this progress, the drugs problem remains formidable. For example:

- record levels of drug seizures reveal the increasing threat of a widening range of trafficking routes to the UK, against a background of expanding global production;
- offenders dealt with under the Misuse of Drug Act 1971 are up from 86,000 in 1994 to 95,000 in 1996;
- of 16-24 year olds questioned in 1996 had ever used illegal drugs compared with 45% in 1994 (and 18% had used in the last month, compared with 17% in 1994);
- the number of drug misusers attending services was 24,879 in the six month period ending September 1996, 48% higher than the equivalent period three years earlier; and
- the number of deaths in the UK attributable to the misuse of drugs has risen from 1,399 in 1993 to 1,805 in 1995.

In addition, more localised trends - particularly the increasing availability and use of cheap, smokeable heroin - suggest growing exposure and consumption by increasingly younger people.

The underlying principles of the strategy

Integration

Drug problems do not occur in isolation. They are often tied in with other social problems. The Government is tackling inequalities through the largest-ever program to get people off benefit and into work and a series of reforms in the welfare state, education, health, criminal justice and the economy. And a new Social Exclusion Unit is looking at many of the problems often associated with drug taking such as school exclusions, truancy, rough sleeping and poor housing. It is important to remember these connections, and that key results in other areas of activity, such as general take-up rates for further and higher education and employment, relate clearly to the development of this strategy.

Evidence

Drug misuse can be a highly-charged subject. Learning about an illicit activity can be difficult but our strategy must be based on accurate, independent research, approached in a level-headed, analytical fashion.

Joint action

Partnership is not an end in itself, and can be an excuse for blurring responsibilities and inactivity. But the evidence is that joint action - if managed effectively - has a far greater impact on the complex drugs problem than disparate activities.

Consistency of action

While activities must relate to local circumstances and priorities, drugs misuse is a national problem requiring fairness and consistency in our response.

Effective communication

We need to be clear and consistent in the messages we send to young people and to society – in particular, the importance of reinforcing at every opportunity that drug-taking can be harmful.

Accountability

Through the Coordinator's Annual Report and Plan of Action Against Drugs, we can dispassionately and objectively track progress. The structures, resources and performance mechanisms set out in this report exist solely for that purpose, so that we can be sure our achievements are real. A special focus will be given to the four key objectives identified below - one for each aim.

Aim 1: Young People

To help young people resist drug misuse in order to achieve their full potential in society

Young people, and those responsible for them, need to be prepared both to resist drugs and, as necessary, to handle drug-related problems. Information, skills and support need to be provided in ways which are sensitive to age and circumstances, and particular efforts need to be made to reach and help those groups at high risk of developing very serious problems. Prevention should start early, with broad life-skills approaches at primary school, and built on over time with appropriate programs for young people as they grow older via youth work, peer approaches, training and wider community support. The aim is for approaches to be better integrated nationally and locally.

Key objective

Reduce proportion of people under 25 reporting use of illegal drugs in the last month and previous year.

Drugs and young people: the facts

We now know a great deal about the relationship between drugs and young people. Many never take drugs at all, many who do experiment grow out of it quickly, but a small hardcore develop very serious problems. In particular:

- drugs misuse is most common amongst people in their teens and early twenties, but the average age of first drug use is becoming younger;[8]

- almost half of young people are likely to take drugs at some time in their lives, but only about one-fifth will become regular misusers, (ie at least once a month), with a tiny minority of that group taking drugs on a daily basis;

- most young people who take drugs do so out of curiosity, boredom, or peer pressure - and continue misusing drugs through a combination of factors ranging from enjoyment to physical and psychological dependency;

- cannabis is easily the most commonly-used drug amongst the young, followed by amphetamines, poppers, LSD and ecstasy - while there are some identifiable groups such as cannabis users , dance drug users and addicts, the trend is towards more indiscriminate use, based on price and availability;

[8] Drug Misuse Declared in 1996: Key Results from the British Crime Survey" - Ramsy H an Spiller J, Home Office Research Findings 56 (1997)

- there is a very strong correlation between the use of illegal drugs and the use of volatile substances, tobacco and alcohol amongst young people;

- there is increasingly strong evidence that the earlier a young person starts taking drugs, the greater the chance that he or she will develop serious drugs problems over time;

- for early to mid-teenagers, there are strong links between drugs problems, exclusion or truancy from school, break-up of the family, and initiation into criminal activity;

- for older teenagers and people in their twenties, there are strong links between drugs problems and unemployment, homelessness, prostitution and other features of social exclusion; and

- whatever other influences affect young people, the role of parents throughout this process is crucial.

Program of action

All activity supported by this strategy will:

- inform young people, parents, and those who advise/work with them about the risks and consequences of drug misuse, linked to other substances - including alcohol, tobacco and solvents - where appropriate;

- teach young people from the age of five upwards - both in and out of formal education settings - the skills needed to resist pressure to misuse drugs, including a more integrated approach to Personal Social and Health Education in schools, and with particular reference to the forthcoming 1998 DofEE guidance;

- help make the misuse of drugs less culturally acceptable to young people, including the use of effective and targeted national and local publicity and information;

- promote healthy lifestyles and positive activities not involving drugs and other substance misuse;

- ensure that the groups of young people most at risk of developing serious drugs problems receive appropriate and specific interventions;

- ensure that young people from all backgrounds, whatever their culture, gender or race, have access to appropriate programs; and

- build on and disseminate good practice in identifying what works best in prevention and education activity.

Assessment

Performance indicators for each of these activities will be introduced to monitor achievement and specific targets set for agencies against the following objectives:

- reduce proportion of people under 25 reporting use of illegal drugs in the last month and previous year - **Key Objective**;

- increase levels of knowledge of 5-16 year olds about risks and consequences of drug misuse;

- delay age of first use of illegal drugs;

- reduce exclusions from schools arising from drug-related incidents;

- reduce the number of people under 25 using heroin; and
- increase access to information and services for vulnerable groups - including school excludees, truants, looked after children, young offenders, young homeless and children of drug-misusing parents.

Research and information

To support these objectives we will make use of the best available sources of information and plan as a priority to commission additional research as follows:

- comprehensive surveys of young people (age 5 upwards) and drugs misuse;
- qualitative studies of patterns of misuse of regular young users;
- long-term evaluations of effectiveness of prevention and education programs;
- qualitative and long-term assessment of impact on drug misuse of wider social factors; and
- operational summary of effective prevention and education.

Aim 2: Communities

To protect our communities from drug-related anti-social and criminal behaviour

Helping drug-misusing offenders to tackle their drug problems and become better integrated into society has a significant impact on levels of crime. Local partnerships can work successfully to tackle local drug problems, and to improve the quality of life for communities.

Key objective

Reduce levels of repeat offending amongst drug misusing offenders.

Drugs and the communities: the facts

Drugs and crime are of concern to all communities, particularly drug possession, manufacture and trafficking, the involvement of criminal syndicates in the drugs trade, the acquisitive crime committed by drug misusing offenders to feed their habits, and the anti-social behaviour and feeling of menace that the drug culture generates within neighbourhoods. It is very clear that effective enforcement under the 1971 Act remains vital to minimising the availability of drugs and the threats to the community that the drug culture carries in its wake. The criminal justice system operates with considerable discretion within this framework but we must guard against this resulting in inconsistencies. The growing clarity of the relationship between drugs and crime has highlighted that:

- many police forces estimate that around half of all recorded crime has some drug related element to it, whether in terms of individual consumption or supply of drugs, or the consequent impact of it on criminal behaviour;
- a small number of people are responsible for huge numbers of crimes - 664 addicts surveyed committed 70,000 offences over a three month period;[3]
- latest indications from a random sample of suspected offenders arrested by the police suggest that over 600/0 of arrestees have traces of illegal drugs in their urine;[4]

- emerging evidence suggests that effective and targeted treatment for drug misusing offenders can have a major impact on reducing subsequent offending;[3]

- the general costs to the criminal justice system of drug-related crime are, at a very conservative estimate, at least £1 billion every year;[5] and

- community safety partnerships - which target specific drugs problems in the community - such as disrupting visible markets, drugs in pubs and clubs, drugs in the workplace and drugs and driving - have great potential where the approach taken is locally based, properly resourced, consistently delivered and long-term.

Program of action

All activity supported by this strategy will:

- develop sustained and collaborative treatment for those committing drug-related crime - including support for the piloting of Drug Treatment and Testing Orders, promotion of Caution Plus schemes (according to Home Office and ACPO guidelines) and associated projects within existing legislation, ensuring that their lessons are spread and implemented as widely as possible;

- target police resources on the detection of drug-related crime and refer offenders where appropriate;

- provide visible deterrence and public reassurance through the consistent punishment of drug dealers and suppliers, and the disruption of their markets;

- ensure community support in achieving a consistent application of the drugs laws, including compatibility in dealing with low level possession offences amongst different prosecution agencies;

- energise and involve local communities through collaborative responses to local drug problems - with imaginative use of existing and planned community safety/estate action/drug network partnerships - so that positive outcomes, focused on the drugs and the people that cause most damage and danger, are achieved;

- increase take-up rate of further education and employment by former addicted criminals through welfare to work, New Deal and other means;

- tackle drugs in clubs in line with recent Home Office guidance;

- implement drugs in the workplace initiatives in line with Health and Safety Executive guidance for employers; and

- enhance detection and underline the social unacceptability of driving while influenced by drugs.

Assessment

Performance indicators for each of these activities will be introduced to monitor achievement and specific targets set for agencies against the following objectives:

- reduce levels of repeat offending amongst drug misusing offenders - **Key Objective**;

- increase the number of offenders referred to and entering treatment programs as a result of arrest referral schemes, the court process and post-sentencing provision;

- reduce levels of crime committed to pay for drug misuse;
- reduce drugs market places that are of particular concern to local communities;
- reduce levels of drug-related absenteeism/dismissals from work; and
- reduce numbers of road deaths and injuries where drugs are a contributory factor.

Research and Information

To support these objectives we will make use of the best available sources of information and plan as a priority to commission additional research as follows:

- long-term evaluations of community safety programs within high risk communities;
- further assessment of cost-effective treatment in the criminal justice system;
- practices that have led to sustained reductions in drug-related crime and community fear; and
- studies into the links between drug misuse and absenteeism, and between drugs and road deaths.

Aim 3: Treatment

To enable people with drug problems to overcome them and live healthy and crime-free lives

Many of those with the most serious drugs problems have a range of other problems, including lack of housing or employment. We will ensure that specific, appropriate and timely help is provided to those with drug problems and that their needs are recognised and addressed by wider Government programs.

Key objective

Increase participation of problem drug misusers, including prisoners, in drug treatment programs which have a positive impact on health and crime.

Drug treatment: the facts

There is growing evidence that treatment works. In particular, harm reduction work over the last 15 years has had a major impact on the rate of HIV and other drug-related infections. And rehabilitation programs have shown real gains in crime reduction. The rate of demand for treatment services amongst seriously dependent drug misusers shows no sign of abating, and the supply of effective treatment services is failing to match that demand. In particular:

- the number of addicts has risen steadily - there were 38,000 people notified in England as drug addicts in 1996, compared with 22,000 in 1992;[6]
- the total number of seriously problematic drug misusers in this country is estimated to be between 100,000 and 200,000, many of whom do not seek or cannot get access to effective services;[7]
- the scope, accessibility and effectiveness of available treatments are inconsistent between localities and generally insufficient. There is considerable insecurity about funding and disparity in provision. Consequently, there is rarely immediate access for a drug misuser to a treatment program - given the urgency of the needs of most drug misusers, this is unacceptable. The Department of Health report “The Task Force to Review Services for Drug Misusers" (1996)

points a clear way forward for developing effective treatment provision in this country - as does the Health Advisory Service report on "Children and Young People - Substance Misuse Services" (1996) with respect to services to adolescents. The challenge is to put the recommendations of these two reports firmly into practice;

- the most significant health risks for this group beyond drug dependency are HIV, hepatitis B and C, and a wide range of psychiatric and psychological problems. Drug related deaths - proportionately rare but probably under-reported - are increasing. Injecting, however, appears to be continuing its fall, with only 2 in 5 addicts now admitting ever injecting;[8]

- there is increasing evidence of the links between health problems of individual drug misusers and public health concerns - notably mental health problems, alcohol abuse and tobacco use, and social exclusion.

Program of action

All activity supported by this strategy will:

- ensure all problem drug misusers - irrespective of age, gender, race and drug with which they have a problem - have proper access to support from appropriate services - including primary care - when needed, providing specific support services for young people, ethnic minorities, women and their babies;

- provide problem drug misusers with accurate information, advice and practical help to avoid infections and other health problems related to their misuse;

- support problem drug misusers in reviewing and changing their behaviour towards more positive lifestyles - linking up where appropriate with accommodation, education and employment services;

- provide an integrated, effective and efficient response to people with drugs and mental health problems;

- ensure that prescription of substitute medications (eg methadone) in particular and dispensing of clinical services in general (including prescribed legal drugs) are in line with forthcoming Department of Health clinical guidelines;

- improve the range and quality of treatment services provision specifically for the under 25s, in line with Standing Conference on Drug Abuse guidance;

- ensure that throughcare and aftercare arrangements for drug misusing prisoners are coherent, focused and linked to community provision; and

- develop collaborative, coherent, accessible and cost-effective service provision through Drug Action Teams.

Assessment

Performance indicators for each of these activities will be introduced to monitor achievement and specific targets set for agencies against the following objectives:

- increase participation of problem drug misusers, including prisoners, in drug treatment programs which have a positive impact on health and crime - **Key Objective**;
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- increase the proportion of problem drug misusers in contact with drugs services;

- reduce the proportion of drug misusers who inject, and the proportion of those sharing injecting equipment over previous three months;

- reduce numbers of drug-related deaths; and
- reduce numbers of drug misusers being denied immediate access to appropriate treatment.

Research and information

To support these objectives we will make use of the best available sources of information and plan as a priority to commission additional research as follows:

- the clinical and social care of people with drugs and mental health problems;
- the cost-effectiveness of current treatment and care options;
- the effectiveness of treatment interventions for young people;
- the lessons from the Advisory Council on the Misuse of Drugs study of drug-related deaths; and
- the links between recreational drug misuse (including cannabis) and later health problems;
- the treatment of stimulant drug dependency.

Aim 4: Availability

To stifle the availability of illegal drugs on our streets

Constant vigilance is needed to tackle availability where it matters most, close to home. It is crucial to gain a better understanding of which activities have the most impact on local availability and to pursue them, improving partnership between agencies along the way.

Key objective

Reduce access to drugs amongst 5-16 year olds.

The drugs trade: the facts

The drugs trade is an international multi-billion pound industry. A 1997 report by the UN Drug Control Program estimates that the industry's turnover amounts to about 8% of total international trade, approximately the same as textiles, oil, gas or world tourism. The threat is ever present and growing. And, however impressive the enforcement activity in general, there have been no signs of street level availability reducing over recent years. The facts are:

- the routes into the UK for heroin and cocaine have become increasingly complex, but remain primarily, for heroin, the Golden Crescent through Turkey and the Balkan route and, for cocaine, South America and the Caribbean - over half of all seizures arrive in the UK via other EU countries;
- the routes for synthetic drugs have been characterised by heavy ecstasy production in the Netherlands and increasing flows of manufactured drugs from Eastern Europe;
- the UK is primarily an importer of drugs. Domestic production, although limited, is increasing - proven cases of internal corruption within enforcement agencies are few, but the threat is real and requires constant vigilance;
- the impact on street level availability of activity against supplies is difficult to assess and the price of drugs within the UK has generally shown a stable or downward trend. However, there is a marked difference between the price of drugs here and in source and transit countries - for

example, heroin is sold at £850 per kg in Pakistan, £7,000 in Turkey, £15,300 in the Netherlands and £24,000 in the UK, which then translates into £72,000 on our streets. There is therefore evidence to suggest that effective enforcement is a factor in pushing up those prices;

- the direct impact of enforcement on short term availability is difficult to establish. There is, however, Home Office research evidence which suggests that focused and coordinated activity on local drug markets can make a significant and sustained impact on availability, reducing supplies, pushing prices up and reducing the threat of exposure of young people to drugs; and

- the drugs trade also includes significant quantities of drugs which have been legally manufactured and then "leaked" on to the illicit market, primarily via the prescription system.

Program of action

All activity supported by this strategy will:

- reduce the acreage of drug crops produced and the amounts processed; control the illicit supply of chemicals and materials used in production and manufacture of drugs; and control the movement of drugs from producer to processing countries;

- raise the commitment and effectiveness of interdiction efforts in countries which pose a threat of drug supplies to the UK;

- reduce the amount of drugs coming to and crossing the UK borders through seizures and by dismantling or disrupting trafficking organisations;

- reduce the growth, manufacture and distribution of drugs within the UK, preventing them from reaching local dealers through seizures and by dismantling or disrupting internal networks;

- target money launderers and increase the amount of assets confiscated and recovered from drug activities;

- reduce levels of street dealing and the availability of drugs in communities;

- reduce the availability of drugs within prisons; and

- ensure full cooperation and collaboration, at every level, amongst the enforcement and intelligence agencies, with the focus clearly on tackling activity which causes the most damage to local communities.

The respective roles and responsibilities of the police and HM Customs and Excise are well defined. Within that framework, the creation of the National Crime Squad as of 1st April 1998 will enhance the effectiveness of the police service. During 1998/99 we shall look at how the objectives of the various agencies engaged in stifling availability can be further coordinated to secure increased effectiveness.

Assessment

Performance indicators for each of these activities will be introduced to monitor achievement and specific targets set for agencies against the following objectives:

- reduce access to drugs amongst 5-16 year olds - **Key Objective**;
- increase the effectiveness of the overseas diplomatic and operational effort;

- increase the value of illegal drugs seized and/or prevented from entering or distributed within the UK;
- increase the number of trafficking groups disrupted or dismantled;
- increase the numbers of offenders dealt with for supply offences;
- increase the amount of assets identified, and the proportion confiscated and recovered from drug trafficking and money laundering; and
- reduce prisoner access to drugs.

Research and information

To support these objectives we will make use of the best available sources of information and plan as a priority to commission additional research as follows:

- harness all the information gathering agencies, both within our control and those with whom we have influence, to produce a common data model which has strategic as well as operational benefits;
- establish the quantity, quality and type of drugs reaching our streets; its place of origin, distribution network and means of transport; and the most effective methods of intervention at each stage of the process;
- establish the quantity and type of precursor chemical manufactured, its place of origin, its destination and its route of passage;
- establish an objective base for the level of assets and money associated with the drug industry mapping the agencies and individual concerned; and
- establish the relationship between street level prices, availability and demand.

Resourcing and managing the work

For the strategy to be effective, clarity about the delivery mechanisms - the structures, resources, responsibilities, accountability and basis for audit and evaluation - is essential.

UK coordination

Genuine collaboration across Government is the driving force behind this strategy. The role of individual departments, agencies and the voluntary and private sectors is to contribute to the overall vision and aims, in addition to their own specific tasks. The Cabinet sub-Committee on Drug Misuse - known as HS(D) - will be the Ministerial body responsible for ensuring that this occurs.

The UK Anti-Drugs Coordinator and his Deputy report to HS(D). Their role on behalf of Ministers is to provide the day-to-day leadership and focus on implementing and developing the Government's strategy. The Coordinator will, in particular, scrutinise rigorously the performance of departments and agencies - individually and collectively - against the actions, objectives and performance indicators set out in this report; and produce a National Anti-Drugs Plan for implementation in each succeeding year. Departments will continue to be responsible for their own policies and resources, and accountable to their Ministers accordingly. But the Coordinator's responsibility to the Government for the production of his Annual Report and Plan, means that progress across the board will be coordinated and open to scrutiny.

To aid his role, the Coordinator will chair a new body named the UK Anti-Drugs Strategic Steering Group, which will meet regularly to help the Coordinator assess overall progress in implementing the strategy, including its resources; consider relevant developments in the rest of the UK and internationally; and plan to account for progress and the way forward via the Coordinator's Annual Report and Plan.

Representation on the Strategic Steering Group will include senior officials from within Government, and individuals from independent bodies, professional drug agencies, local government, business and Drug Action Teams.

The Deputy UK Anti-Drugs Coordinator will, in turn, take forward the key elements of this White Paper through four newly formed Strategy Support Groups - one group for each aim of the strategy, each group meeting regularly. The key tasks of these groups will be to monitor progress against each aim; assess the need for further support in its implementation; consider emerging training, research and information needs; and monitor resource implications. These groups will report back to the Steering Group.

The Coordinator's and Deputy's roles can only be effective through collaboration and involvement of a wide range of supportive groups and individuals. To this end they will have support from the UK Anti-Drugs Coordination Unit (previously known as the Central Drugs Coordination Unit), a Unit in the Privy Council Office, reporting to the President of the Council, whose funding arrangements will be put on a long-term basis. The UKADCU's role will be to support the monitoring and effective implementation of this strategy. To fulfil this role, the UKADCU will work very closely with Departments, Drug Action Teams and individual agencies to develop a comprehensive network of resources and support mechanisms geared towards the strategy's implementation.

Resources

Government expenditure in tackling drug misuse is considerable but poorly coordinated. As a result of the work on drug-related spending carried out for the Comprehensive Spending Review, we know that total Government expenditure for 1997/98 was in the region of £1.4 billion. This big increase in estimated expenditure - compared to £500 million in 1993/94 - relates primarily to a more realistic assessment of the drugs related proportion of generic police/prison/probation/education/health activity. We estimate that 62% of this total is currently spent on enforcement related work, much of it reactive and not drugs-specific (eg police, court, probation and prisons) and therefore, not straightforwardly transferable to preventative programs; 13% on treatment; 12% on prevention and education; and 13% on international supply reduction. No more than a third of that total expenditure is currently spent on preventing drug misuse (as opposed to coping with the consequences of the problem). Minimum estimated costs of the social problems generated by severely dependent drug misusers alone are in the region of £3-4 billion annually.

Existing resource provision is ad hoc rather than strategic; allocation mechanisms are largely historically driven; the pattern of the delivery of resources to local anti-drugs projects is complicated and random; efforts to realise substantial confiscated assets from drug-related activity have not previously been successful; and there has been a lack of clear coordination between objectives, resources and outcomes. In moving forward, it is clear that the Government's resources must be linked to this strategy.

An announcement on funding from 1999/2000 will be made later in the year, following the outcome of the Government's Comprehensive Spending Review. Reforms will be guided by the following principles:

- drug-related expenditure should over time shift away from reacting to the consequences of the drugs problem and towards positive investment in preventing and targeting it;

- the bulk of targeted resources should be spent on collaborative projects which tackle high priority groups - in particular vulnerable young people, drug-related offenders and problem drug misusers;

- resources for drug-specific activities should receive priority within health authorities budgets, and on the basis of partnership work wherever appropriate. **Health authorities** should be required to deliver this strategy through the NHS Priorities and Planning Guidance. The

development of the new NHS and Public Health White Papers should be used to ensure that health authorities give adequate provision to meeting the aims of the strategy through central guidance. Health authorities will be expected to include anti-drugs measures in their Health Improvement Program;

- an element should be identified within health authorities' drug allocation for developing specific young people's services. This should enable health authorities to develop services in line with Department of Health guidance;

- funding for the purchase of community care services for drug misusers should be given adequate priority by **local authorities**. The Department of Health should take steps to ensure that this money is used for drug-specific partnership work, with mechanisms put in place to ensure that current expenditure on drug misusers from local authority community care funding is protected;

- **police forces** should aim to direct resources from within their budgets to drugs-specific partnership work, with explicit priority given to this work in Police Authority Annual Policing plans and the national key policing objectives, set by the Home Secretary and performance indicators and targets aligned explicitly to the new strategy;

- the **Prison Service** should aim to direct resources from within their budget to drugs-specific partnership work, including treatment provision, with explicit priority given to this work in the Prison Service business plan, and performance indicators and targets aligned explicitly to the new strategy;

- **probation services** should aim to direct resources from within their budgets to drugs-specific partnership work, with explicit priority given to this work in local plans and the national key probation objectives, and performance indicators and targets aligned explicitly to the new strategy;

- **local education authorities** should include clear policy statements on drugs education, and any performance indicators and targets aligned to the new strategy, within their behaviour support plans. An LEA's anti-drugs strategy will also be reflected in its education development plan where this emerges as a priority;

- **HM Customs and Excise** should maintain their commitment to funding drug-related activity - and ensure that partnership work is reaffirmed strongly in their management plans, with performance indicators and targets aligned explicitly to the new strategy;

- the **National Criminal Intelligence Service** should ensure that partnership work is reaffirmed strongly in their service plan, and to consider in consultation with the Coordinator the development of objectives with performance indicators and targets aligned explicitly to the new strategy;

- the **National Crime Squad** should ensure that partnership work is reaffirmed strongly in their service plan, and to consider in consultation with the Coordinator the development of objectives with performance indicators aligned explicitly to the new strategy;

- **Drug Action Teams** should be the principal mechanism by which agencies will develop the resource partnerships outlined above, and will assess regularly whether the spending plans and projected outcomes of all agencies represented on them are aligned explicitly to the new strategy;

- the value for money of Government and other anti-drugs expenditure against outcomes should be monitored at national level via the UK Strategic Steering Group and Strategy Support Groups and locally via the Drug Action Teams; and

- securing partnership funding should be given high priority at every level, led by the national partnership between Government and Business in the Community.

For the first time, a proportion of assets seized from drug barons will be channelled back into anti-drugs programs to help those who have suffered at their hands and on whose misfortune they have prospered. The Government is considering how this can best be achieved. More details of these considerations will be issued later this year.
The efficient and effective delivery of the strategy's objectives will, of course, determine the specific resources required over time, and resource provision will accordingly be regularly reviewed in the Coordinator's Annual Report and Plan of Action Against Drug Misuse.

Regional coordination and delivery of strategy

Drug Action Teams, supported by their Reference Groups, have worked well in most parts of the country in forging partnerships against drugs amongst the key local agencies. The time is right to step up a gear in relation to this partnership activity, so that a sharper focus is brought to bear on implementing this strategy. This should link up where necessary with other local partnership initiatives on welfare-to-work, health, education, housing, community safety, youth justice, local democracy and social exclusion. Links with these other partnerships will develop over time, but will not diminish the importance of the work against drugs at local and regional level, via Drug Action Teams. The strategic requirements set out below reinforce both the need for a continuing focus on local drugs problems and ensuring that other social partnerships contribute to that work.

All Drug Action Teams in England are to agree corporate plans annually with the UK Anti-Drugs Coordinator by the end of each calendar year. Templates will be provided by UKADCU. These plans will feed into the Annual Report and Plan and include:

- an assessment of current progress against the new strategy;
- an analysis of existing local resources upon which each DAT has influence both within its own organisations and jointly targeted;
- proposals for allocating those resources to match the priority aims and actions set out in this strategy;
- specific outcome measures against all relevant areas under the aims set out in this strategy - including services for vulnerable young people, criminal justice/treatment; rehabilitation of problem drug misusers and disruption of local drug markets;
- proposals for short, medium and longer-term targets against those measures in line with the national targets to be developed; and
- agreement with all other Drug Action Teams within their metropolitan or shire county area on the basis of a corporate and strategic overview to the plans individual DATs have drawn up. This is to ensure strategic coherence to the plans across each county, a genuinely senior level of strategic input from the key players, and consonance with the development of other relevant shire and metropolitan county partnerships. Where appropriate, DATs will wish to liaise with relevant regional tiers of government. **This overview will be the most important part of the plan in enabling the Coordinator to take stock of progress**. Those DATs which currently do not operate on a shire or metropolitan county level will have a more complex process to go through than the 26 DATs currently operating on those lines. The focus of our support will therefore be on the remaining 80 DATs.

These plans will deliver greater consistency and provide the basis for attracting additional resources - including some drugs-specific funding from central Government, Lottery funding and partnership money from the private and voluntary sectors - and will be assessed on that basis. The Government and the Coordinators will be engaging directly with Drug Action Teams across England to ensure that the planning process is as clear and unbureaucratic as possible.

Drug Action Teams must develop as the mechanism for ensuring local resource collaboration in line with this strategy. Their corporate plans will provide the benchmark for distributing resources from 1999/2000 onwards - further guidance to DATs will be provided later this year taking forward this challenging remit. This will include more information about the future of centrally provided development funding.

This funding has helped DATs in providing essential local coordination. Most DATs have demonstrated best value in using this resource through an identifiable coordinator, working closely to the DAT Chair, and with a clear role and set of requirements. This coordination role must include coherent representation to the DAT of the views and expertise available from local communities. The Chair of each Drug Action Team will continue to have overall responsibility for the formulation and implementation of corporate plans. Clearly that responsibility, which also entails some accountability to the Coordinator, can only be discharged by individuals with considerable authority and influence within their DAT area. The personal qualities of any individual Chair are far more significant than the agency from which they come.

Representation on DATs - beyond the core agencies of health authorities, education, social services, police, prisons and probation - will continue to be a local matter, with the exception that all DATs should include senior representatives from local authority housing. They should also liaise more closely with the Crown Prosecution Service, key sentencers, the Employment Service, the voluntary sector, Training and Enterprise Councils and Chambers of Commerce. DATs must also actively engage their elected members and Members of Parliament, to ensure that there is no "democratic deficit" to their activity. Developing the representation and function of Drug Reference Groups and other networks in support of the agreed plans of the Drug Action Teams will be a local matter, but will need to ensure effective community involvement, consultation networks and clarity of responsibilities for implementation.

Drug Action Teams or their equivalents in Scotland, Wales and Northern Ireland are invited to consider their own development in the light of this strategy, as part of the overall response to the Coordinator by February 1999.

Partnerships

Action against drugs problems cannot be undertaken effectively by any single agency. The performance of all statutory agencies, accountable to central Government Departments, will be scrutinised to assess their progress in forging effective, enduring and practical partnerships with other agencies. The following are being developed as a priority:

The FCO's Special Representative's international coordination committee will continue under the Chairmanship of the Special Representative to ensure the strongest possible links with our European partners to give continuing effect to the leading role of the UK in the fight against drugs established during our Presidency of the EU from January to June 1998. The UK will also take a visible lead in international coordinated efforts against drugs, through the UN and other mechanisms, where that has a direct contribution to make to this strategy's vision. Our resources will be made available accordingly;

statutory Inspectorates - each HM Inspectorate will continue to have direct responsibility for monitoring the impact of drugs policies for which their agencies are responsible. The importance of collaborative working across and beyond the Inspectorates is recognised by all of them. A multi-disciplinary review process - involving representatives from HM Inspectorate of Constabulary, HM Inspectorate of Prisons, HMI Probation, OFSTED and the Social Services Inspectorate - will be established by December 1998. The importance of monitoring health authorities in this context will need further examination;

national program delivery - the role of Government is to facilitate and enable this strategy's implementation through leadership and resource provision. In areas such as publicity, spreading of best practice, project programs, information collation, and specialist guidance, there is already expertise and experience among a number of organisations, funded by Government or others. In

view of its valuable contribution to date, it is planned that there should be some successor arrangements to the Home Office Drugs Prevention Initiative after its current program ends in March 1999, which will support this strategy and promote community-based drugs prevention across England. Other bodies with a role to play include the Standing Conference on Drug Abuse, the Institute for the Study of Drug Dependence, Alcohol Concern, the Substance Misuse Advisory Service, the Local Government Drugs Forum and the Health Education Authority. To avoid unnecessary duplication of effort, any work the Government commissions in support of the vision, aims and actions set out in this strategy - contracted to one or more of these agencies - will only be provided on the basis of clear partnership agreements;

Advisory Council on the Misuse of Drugs - the ACMD has the statutory responsibility to advise Government on the continuing operation of the Misuse of Drugs Act 1971, and to any changes to the law necessary in the light of emerging evidence. The Council will continue to exercise that vital function. In addition, the Council has produced many extremely valuable reports on specific issues - most recently on drugs and the environment which will be published soon. Its composition and focus of work need to be harnessed as closely as possible to the thrust of this long-term strategy and to the work of the Coordinator, and its future work priorities will evolve in that context;

private sector - the private sector plays a vital role at national, regional and local level in working to combat drug misuse. Many businesses now recognise the commercial benefits and ethical imperatives of involvement in this work. Some - such as BT, Boots, Proctor and Gamble, Marks & Spencer, Royal and Sun Alliance, McDonald's, Lloyds TSB - have already contributed significant resources and commitment to this work. Business in the Community is driving forward a major strategy program to engage the private sector as systematically as possible - especially through initiatives aimed at young people;

voluntary sector - much of the energy and innovation in tackling drug misuse, as well as professional and cost-effective delivery, comes from the voluntary sector. We are determined to maximise the contributions that this sector can make set against this strategy. The UK Anti-Drugs Coordinator will convene an annual national stocktake of voluntary sector providers, in concert with the Standing Conference on Drug Abuse, to ensure that their interests and contributions to the developing strategy are fully developed and properly used, and that best practice is being implemented;

the media - responsible and informed coverage of drugs stories can make an important contribution to the strategy's vision. We will engage extensively with national, regional and local media to try to ensure a good level of informed debate, analysis and coverage;
parents/young people/communities - drugs impact on all of us, our lives, worries and aspirations. We will consult and engage with people in schools, clubs, at parents meetings, with users, at community events and in all locations where there is real concern and real commitment to addressing it.

Audit and evaluation

Objective and rigorous assessment of the effectiveness of implementing this strategy will be a central feature of its development, and necessary adjustments will be made as a consequence. The key components of this process will be as follows:

- the Coordinator's Annual Report and Plan of Action Against Drug Misuse which will be published every Spring, based on the strategic framework set out here, together with data on progress and proposals for future priorities;

- annual reports from Drug Action Teams in England made to the Coordinator - these will be submitted as part of the corporate planning process at the end of each calendar year. Results and best practice will be incorporated into the Coordinator's Annual Report and Plan;
- the statutory Inspectorates - regular thematic and multi-disciplinary reviews will be published by these bodies;

- quality indicators for the core statutory agencies - these will reflect the fact that the quantitative indicators to be set out need harnessing to more qualitative assessments of progress, which will form part of the DAT reporting process at local level and of an overview from the Coordinator's Annual Report and Plan;
- research and information - this will be regularly assessed against each of the strategy's four aims by the four strategy support groups, as an integral part of the implementation process. They will consult a wide range of external bodies as necessary, and report collectively to the Strategic Steering Group;
- independent strategic evaluation - over the longer term, we will all need to be satisfied that the implementation of this strategy is achieving the most effective results possible. The National Audit Office and the Audit Commission will be engaged in discussions about what might be undertaken over the next decade to fulfil this remit; and
- consultations - the continual process of "listening and learning" which the Coordinator and his Deputy have undertaken from day one, will form a more informal, but essential, part of evaluating the strategy. They will continue this consultation for the rest of their appointments, so that progress on the ground - where it really matters - can be properly assessed.

Appendix 13: Detailed tables of data

Table 1: Prevalence of adult drug use, WA, 1997
Data from 1997 Tobacco, Alcohol and Illicit Drug Consumption Survey

	Age groups					All ages (18+)		
	18 – 24	25 – 34	35 – 44	45+	18 – 34	Males	Females	Persons
	n=360	n=609	n=613	n=1,223	n=969	n=1,223	n=1,591	n=2,814
Cannabis								
Used in last 12 months	**46.9**	**21.4**	**13.8**	**1.7**	**31.5**	**19.5**	**10.7**	**15.1**
	(41.7 – 52.1)	(18.1 – 24.7)	11.1 – 16.5)		(28.7 – 34.5)	(17.4 – 21.8)	(9.2 – 12.2)	(13.8 – 16.4)
Used in last month	**32.8**	**13.4**	**9.1**	**0.9**	**21.2**	**14.1**	**5.9**	**10.0**
	(28.0 – 37.6)	(10.7 – 16.1)	(6.8 – 11.4)	(0.3 – 1.3)	(18.6 – 23.8)	(12.2 – 16.0)	(4.7 – 7.1)	(8.9 –11.1)
Used in last week	**20.1**	**8.0**	**4.5**	**0.4**	**12.8**	**9.0**	**2.6**	**5.8**
	(16.0 – 24.2)	(5.8 – 10.2)	(2.9 – 6.1)	(0.1 – 0.9)	(10.7 – 14.9)	(7.4 – 10.6)	(1.8 – 3.4)	(4.9 – 6.7)
Amphetamines								
Used in last 12 months	**13.1**	**4.8**	**0.5**	**-**	**8.2**	**4.3**	**1.8**	**3.1**
	(9.7 - 16.7)	(3.1 - 6.5)	(-0.6 – 1.1)		(6.5 - 9.9)	(3.2 - 5.4)	(1.2 - 2.4)	(2.5 - 3.7)
Used in last month	**6.2**	**2.2**	**0.2**	**-**	**3.7**	**1.7**	**1.1**	**1.4**
	(3.6 - 8.6)	(1.0 - 3.2)	(-0.2 - 0.6)		(2.5 - 4.9)	(1.0 - 2.4)	(0.6 - 1.6)	(1.0 - 1.8)
Ecstasy								
Used in last 12 months	**9.8**	**3.7**	**0.2**	**-**	**6.2**	**3.2**	**1.3**	**2.3**
	(6.7 - 12.9)	(2.2 - 5.2)	(-0.2 - 0.6)		(4.7 - 7.7)	(2.2 - 4.2)	(0.7 - 1.9)	(1.8 - 2.8)
Used in last month	**2.5**	**1.2**	**0**	**-**	**1.7**	**1.0**	**0.3**	**0.6**
	(1.0 - 4.3)	(0.3 - 1.9)			(0.9 - 2.5)	(0.4 - 1.6)	(0.03 - 0.6)	(0.3 - 0.9)
LSD								
Used in last 12 months	**15.9**	**4.7**	**0.5**	**-**	**9.2**	**5.2**	**1.7**	**3.4**
	(12.0 - 19.6)	(3.0 - 6.4)	(-0.6 – 1.1)		(7.4 - 11.0)	(4.0 - 6.4)	(1.1 - 2.3)	(2.7 - 4.1)
Used in last month	**4.2**	**1.7**	**0.2**	**-**	**2.7**	**1.6**	**0.4**	**1.0**
	(2.2 - 6.4)	(0.7 - 2.7)	(-0.2 - 0.6)		(1.7 - 3.7)	(0.9 - 2.3)	(0.1 - 0.7)	(0.6 - 1.4)
Heroin								
Used in last 12 months	**1.7**	**1.7**	**0.2**	**-**	**1.7**	**0.8**	**0.5**	**0.7**
	(0.4 - 3.0)	(0.7 - 2.7)	(-0.2 - 0.6)		(0.9 - 2.5)	(0.3 - 1.3)	(0.2 - 0.8)	(0.4 - 1.0)
Used in last month	**0.8**	**0.8**	**0.2**	**-**	**0.9**	**0.5**	**0.2**	**0.4**
	(-0.1 - 1.7)	(0.1 - 1.5)	(-0.2 - 0.6)		(0.3 - 1.5)	(0.1 - 0.9)	(0 - 0.4)	(0.2 - 0.6)
Cocaine								
Used in last 12 months	**2.5**	**1.5**	**0.3**	**-**	**2.0**	**1.4**	**0.2**	**0.8**
	(0.9 - 4.1)	(0.5 - 2.4)	(-0.1 - 0.7)		(1.1 - 2.9)	(0.8 - 2.1)	(0.0 - 0.4)	(0.5 - 1.1)
Used in last month	**0.5**	**0**	**0**	**-**	**0.2**	**0.1**	**0.1**	**0.1**
	(-0.2 - 1.2)				(-0.1 - 0.5)	(-0.1 - 0.3)	(-0.1 - 0.3)	(0 - 0.2)
Injecting drugs								
Used in last 12 months	**5.3**	**2.0**	**0.2**	**-**	**3.3**	**1.9**	**0.7**	**1.3**
	(3.0 - 7.6)	(0.9 - 3.1)	(-0.2 - 0.6)		(2.2 - 4.4)	(1.2 - 2.6)	(0.3 - 1.1)	(0.9 - 1.7)
Used in last month	**2.8**	**1.9**	**0.2**	**-**	**2.3**	**1.5**	**0.3**	**0.9**
	(1.1 - 4.5)	(0.7 - 2.9)	(-0.2 - 0.6)		(1.4 – 3.2)	(0.8 - 2.2)	(0.00 - 0.6)	(0.6 - 1.2)

Source: Health Promotion Services, Health Department of WA.
Note: Use in the last month for all illicit drugs except cannabis was less than 1% for the total sample.

Table 2: Estimated prevalence (%) drug use Western Australia vs other jurisdictions, 1993 & 1995 NDS Household Surveys

Type of abuse	1993		1995		Change 1993-1995
	WA	Range low-high	WA	Range low-high	WA
Hazardous alcohol consumption by adults (usual drinking day)					
• Males	15.0	6.9 (Qld) - 25.5 (NT)	13.4	12.2 (ACT) - 20.6 (NT)	**- 10.7%**
• Females	21.7	17.1 (Qld) - 24.0 (ACT)	18.6	15.7 (NSW) - 26.0 (NT)	**- 14.3%**
Harmful alcohol consumption by adults (usual drinking day)					
• Males	14.5	8.3 (SA) - 16.3 (Tas)	13.1	8.9 (ACT) - 27.8 (Tas)	**- 9.6%**
• Females	11.0	(5 2 (ACT) - 16.0 (NT)	10.8	8.9 (ACT) - 17.4 (NT)	**- 1.8%**
Regularly smoke tobacco					
• Males	39.2	31.9 (ACT) - 56.9 (NT)	35.0	26.7 (SA) - 42.0 (Vic)	**- 10.7%**
• Females	36.8	26.4 (ACT) - 47.0 (NT)	36.4	30.8 (NT) - 57.8 (Tas)	**- 1.1%**
Cannabis ever used					
• Males	43.4	36.1 (Tas) - 61.5 (NT)	41.5	32.1 (Qld) - 56.9 (NT)	**- 4.4%**
• Females	32.7	24.3 (Tas) - 51.5 (NT)	31.9	20.9 (NSW) - 48.4 (NT)	**- 2.4%**
Cannabis used in last 12 months (adjusted for all males and all females)					
• Males	24.4	12.0 (Qld) - 30.8 (NT)	20.1	14.0 (Qld/SA) - 20.2 (NT)	**- 17.6%**
• Females	13.8	7.1 (Qld) - 26.5 (NT)	12.7	6.6 (Qld) - 23.0 (NT)	**- 8.0%**
Amphetamines ever used					
• Males	7.0	4.3 (Qld) - 18.5 (NT)	10.9	4.6 (SA) - 10.9 (WA)	**+ 55.7%**
• Females	5.4	3.5 (Tas) - 14.7 (NT)	6.1	1.2 (Tas) - 10 3 (NT)	**+ 13.0%**
Heroin ever used					
• Ever used	2.1	0.6 (Qld) - 3.3 (NSW)	3.8	0.8 (SA) - 3.8 (WA)	**+ 81.0%**
• Used in last month	1.4	0.4 (Qld) - 2.5 (ACT)	0.6	0.3 (Qld) - 1.7 (ACT)	**- 57.1%**
Cocaine ever used					
• Males	3.1	0.5 (Qld) - 5.2 (NSW)	4.4	0.8 (Tas) - 4.4 (NSW)	**+ 41.9%**
• Females	2.0	0.8 (Qld) - 5.0 (ACT)	2.0	0.8 (Tas) - 6.3 (NT)	**0%**
Natural hallucinogens ever used (eg psilcyobin)					
• Males	NA	Not asked	9.0	3.7 (Tas) - 9.0 (WA)	**NA**
• Females	NA	Not asked	2.2	2.2 (WA) - 7.8 (NT)	**NA**
Other hallucinogens ever used (eg LSD)					
• Males	NA	Not asked	11.3	3.2 (Tas) - 11 3 (WA)	**NA**
• Females	NA	Not asked	5.5	2.1 (Vic) - 10.8 (WA)	**NA**
Inhalants ever used					
• Males	4.7	3.1 (Vic) - 7.6 (ACT)	5.2	1.1 (Tas) - 7.0 (ACT)	**+ 9.6%**
• Females	2.4	1.3 (Vic) - 4.0 (Tas)	0.5	0.5 (WA) - 8.5 (NT)	**- 79.1%**
Ecstasy/designer drugs ever used					
• Males	5.2	0.5 (Qld) - 5.5 (NSW)	5.4	1.1 (SA) - 5.4 (WA)	**+ 3.8%**
• Females	2.0	1.2 (SA) - 5.6 (Qld)	4.9	0.2 (Tas) - 4.9 (WA)	**+ 145%**
Ever injected illegal drugs					
• Males	2.6	1.4 (Qld) - 3.3 (ACT)	4.6	0.7 (Vic) - 4.6 (WA)	**+ 76.9%**
• Females	2.1	0.4 (Qld) - 2.1 (WA)	0.6	0.3 (Qld) - 1.4 (SA)	**- 71.4%**

Source: NCADA National Household Surveys 1993, 1995

Table 3: Estimated number and prevalence (%) of illicit drug abusers Western Australia, 1995 NDS Household Survey

Type of use	%	n
Cannabis ever used		
• Males	41.5	238,400
• Females	31.9	218,200
• Persons	36.7	501,600
Cannabis used in last 12 months		
• Males	48.5	137,400
• Females	39.9	87,000
• Persons	44.7	224,400
Amphetamines ever used		
• Males	10.9	74,600
• Females	6.1	41,600
• Persons	8.5	116,200
Heroin ever used		
• Males	3.8	26,000
• Females	0.6	4,400
• Persons	2.2	30,400
Cocaine ever used		
• Males	4.4	30,200
• Females	2.0	13,500
• Persons	3.2	43,700
Natural hallucinogens ever used (eg psilcyobin)		
• Males	9.0	61,600
• Females	2.2	15,100
• Persons	5.6	76,700
Other hallucinogens ever used (eg LSD)		
• Males	11.3	76,800
• Females	5.5	37,900
• Persons	8.4	114,700
Inhalants ever used		
• Males	5.2	35,600
• Females	0.5	3,300
• Persons	2.8	38,900
Ecstasy/designer drugs ever used		
• Males	5.4	36,500
• Females	4.9	33,200
• Persons	5.1	69,700
Ever injected illegal drugs ever used		
• Males	4.6	31,200
• Females	0.6	4,300
• Persons	2.6	35,500

Source: NCADA National Household Surveys 1995

Table 4: Number and prevalence (%) ever used heroin by persons aged 14 years and older, 1995 NDS National Household Survey

	14-19	20-24	25-34	35-54	55-69	70 +	All ages
Number of persons							
WA		9,500	12,700	4,100	4,100		30,400
NSW	6,800	6,200	30,500	7,000			50,500
VIC		7,000	17,300	48,200			72,500
TAS			1,200	900	700		2,800
SA		2,800	4,100	3,000			9,900
QLD	4,000	5,300	11,500	4,800			25,600
ACT			3,300	400			3,700
NT	200	500	200	1,200	200		2,300
Australia	**11,000**	**31,200**	**80,600**	**69,700**	**5,000**		**197,500**
Persons (%)							
WA		7.1%	4.7%	0.8%	1.9%		2.2%
NSW	1.1%	1.8%	3.2%	0.4%			1.0%
VIC		2.0%	2.4%	3.9%			2.0%
TAS			1.7%	0.7%	1.0%		0.8%
SA		3.1%	1.8%	0.7%			0.8%
QLD	1.1%	2.6%	2.3%	0.5%			1.0%
ACT			6.4%	0.5%			1.5%
NT	1.5%	3.1%	0.6%	2.5%	1.6%		1.8%
Australia	**0.6%**	**2.6%**	**2.9%**	**1.4%**	**0.2%**		**1.4%**

Table 5: Number and prevalence (%) ever used heroin by persons aged 14 years and older, Western Australia, 1993 vs 1995 NDS National Household Surveys

	14-24	25-39	40+	All ages
1993				
Wtd base	290,000	406,000	618,000	1,418,000
Persons	11,000	8,000	4,000	23,000
%	3.8%	2.0&	0.6%	1.6%
1995				
Wtd base	290,100	433,100	643,100	1,366,300
Persons	9,500	16,800	4,100	30,400
%	3.3%	3.9%	0.6%	2.2%

Source: National Drug Household Survey 1993, Detailed Table Set 3, Table 369

Table 6: Number and prevalence (%) ever used amphetamines by persons aged 14 years and older, 1995 NDS National Household Survey

	14-19	20-24	25-34	35-54	55-69	70 +	All ages
Number of persons							
WA	10,100	32,400	44,100	28,000	1,600		116,200
NSW	10,600	39,000	134,200	21,800	13,100		218,700
VIC	23,100	80,000	129,500	49,500	2,200	6,300	290,600
TAS		1,500	2,400	7,500			11,400
SA	2,600	13,900	29,600	11,100			57,200
QLD		22,300	43,200	24,000	3,000		92,500
ACT	500	3,400	7,200	3,000		200	14,300
NT	200	2,900	7,200	1,300			11,600
Australia	**47,200**	**195,600**	**397,300**	**146,300**	**20,000**	**6,500**	**812,900**
Persons (%)							
WA	6.5%	24.1%	16.2%	5.7%	0.7%		8.5%
NSW	1.7%	11.2%	14.1%	1.3%	1.6%		4.5%
VIC	6.3%	22.5%	18.2%	4.0%	0.4%	1.9%	8.1%
TAS		6.4%	3.5%	5.8%			3.1%
SA	1.9%	15.5%	13.0%	2.7%			4.9%
QLD		10.9%	8.5%	2.7%	0.7%		3.6%
ACT	1.6%	11.8%	14.0%	3.4%		1.5%	5.9%
NT	1.5%	18.2%	21.9%	2.7%			9.3%
Australia	**2.7%**	**16.3%**	**14.1%**	**3.0%**	**0.8%**	**0.5%**	**5.7%**

Table 7: Number and prevalence (%) ever used amphetamines by persons aged 14 years and older, Western Australia, 1993 vs 1995 NDS National Household Surveys

	14-24	25-39	40+	All ages
1993				
Wtd base	290,000	406,000	618,000	1,418,000
Persons	36,000	34,000	11,000	81,000
%	12.4%	8.4%	1.8%	5.7%
1995				
Wtd base	290,100	433,100	643,100	1,366,300
Persons	42,500	57,500	16,200	116,200
%	+14.7%	+13.3%	+2.5%	+8.5%

Source: National Drug Household Survey 1993, Detailed Table Set 3, Table 247

Table 8: Number and prevalence (%) ever injected drugs by persons aged 14 years and older, 1995 NDS National Household Survey

	14-19	20-24	25-34	35-54	55-69	70 +	All ages
Number of persons							
WA	2,000	10,900	16,200	3,100	3,300		35,500
NSW	15,900	4,500	42,000	5,700			68,100
VIC		3,500	12,300	5,400		6,300	27,500
TAS		800	4,600				5,400
SA	4,600	5,500	12,800				22,900
QLD	4,000	5,300	9,200	4,800			23,300
ACT		700	1,600	400			2,700
NT	200	500	300	1,000			2,000
Australia	**26,800**	**31,800**	**99,100**	**20,500**	**3,300**	**6,300**	**187,800**
Persons (%)							
WA	1.3%	8.1%	5.9%	0.6%	1.5%		2.6%
NSW	2.5%	1.3%	4.4%	0.3%			1.4%
VIC		1.0%	1.7%	0.4%		1.9%	0.8%
TAS		3.4%	6.6%				1.5%
SA	3.4%	6.1%	5.6%				2.0%
QLD	1.1%	2.6%	1.8%	0.5%			0.9%
ACT		2.4%	3.1%	0.5%			1.1%
NT	1.5%	3.1%	0.9%	2.0%			1.6%
Australia	**1.5%**	**2.6%**	**3.5%**	**0.4%**	**0.1%**	**0.5%**	**1.3%**

Table 9: Number and prevalence (%) ever injected drugs by persons aged 14 years and older, Western Australia, 1993 vs 1995 NDS National Household Surveys

	14-24	25-39	40+	All ages
1993				
Wtd base	290,000	406,000	618,000	1,418,000
Persons	20,000	7,000	4,000	31,000
%	6.9%	1.7%	0.6%	2.2%
1995				
Wtd base	290,100	433,100	643,100	1,366,300
Persons	12,900	19,400	3,300	35,600
%	4.4%	4.5%	0.5%	2.6%

Source: National Drug Household Survey 1993, Detailed Table Set 3, Table 586

Table 10: Prevalence of drug use by West Australian school students, 1996, Data from 1996 Australian School Students' Alcohol and Drugs national survey

	12-15 years		16 - 17 years		12 - 17 years		
	Males	Females	Males	Females	Males	Females	All
Tobacco							
Used in last 12 mths	**33.3** (30.5 – 36.1)	**32.5** (30.0 – 35.0)	**46.1** (41.2 – 51.0)	**51.7** (47.3 – 56.1)	**36.0** (33.6 – 38.4)	**36.9** (34.7 – 39.1)	**36.4** (34.8 – 38.0)
Used in last month	**17.9** (15.7 – 20.1)	**20.5** (18.3 – 22.7)	**29.1** (24.7 – 33.5)	**35.3** (31.1 – 39.5)	**20.2** (18.2 – 22.2)	**23.9** (21.9 – 25.9)	**22.0** (20.6 – 23.4)
Used in last week	**14.0** (12.0 - 16.0)	**17.4** (15.3 - 19.5)	**24.5** (20.3 - 28.7)	**29.2** (25.2 - 33.2)	**16.2** (14.3 - 18.0)	**20.1** (18.2 - 22.0)	**18.1** (16.8 - 19.4)
Cannabis							
Used in last 12 mths	**33.5** (30.7 - 36.3)	**28.4** (25.9 – 30.9)	**59.5** (54.7 - 64.3)	**57.2** (52.8 - 61.6)	**38.9** (36.5 - 41.3)	**33.5** (31.3 - 35.7)	**36.2** (34.6 - 37.8)
Used in last month	**23.6** (21.1 - 26.1)	**16.0** (14.0 - 18.0)	**40.8** (36.0 - 45.6)	**34.9** (30.7 - 39.1)	**27.2** (25.0 - 29.4)	**20.4** (18.5 - 22.3)	**23.8** (22.4 - 25.2)
Used in last week	**16.3** (14.1 - 18.5)	**9.4** (7.8 - 11.0)	**30.8** (26.3 - 35.3)	**21.5** (17.9 - 25.1)	**19.3** (17.3 - 21.3)	**12.1** (10.6 - 13.6)	**15.8** (14.6 - 17.0)
Inhalants							
Used in last 12 mths	**18.1** (15.8 - 20.4)	**18.5** (16.4 - 20.6)	**8.9** (6.1 - 11.7)	**11.8** (9.0 - 14.6)	**16.2** (14.3 - 18.1)	**17.0** (15.3 - 18.7)	**16.6** (15.3 - 17.9)
Used in last month	**11.3** (9.4 - 13.2)	**8.1** (6.6 – 9.6)	**3.8** (1.9 - 5.7)	**3.0** (1.5 - 4.5)	**9.8** (8.3 - 11.3)	**7.7** (6.5 - 8.9)	**8.8** (7.8 - 9.8)
Used in last week	**6.6** (5.1 – 8.1)	**4.7** (3.5 – 5.9)	**2.4** (0.9 – 3.9)	**2.5** (1.1 – 3.9)	**5.7** (4.5 – 6.9)	**4.2** (3.3 – 5.1)	**5.0** (4.3 – 5.7)
Tranquillisers							
Used in last 12 mths	**11.7** (9.8 - 13.6)	**12.9** (11.1 - 14.7)	**11.8** (8.6 – 15.0)	**18.9** (15.5 - 22.3)	**11.8** (10.2 - 13.4)	**14.3** (12.7 - 15.9)	**13.0** (11.9 - 14.1)
Used in last month	**4.5** (3.3 - 5.7)	**4.4** (3.3 - 5.5)	**4.6** (2.5 - 6.7)	**6.2** (4.1 - 8.3)	**4.5** (3.5 - 5.5)	**4.9** (3.9 - 5.9)	**4.7** (4.0 - 5.4)
Used in last week	**2.6** (1.7 – 3.5)	**2.0** (1.2 – 2.8)	**2.1** (0.7 – 3.5)	**3.5** (1.9 – 5.1)	**2.5** (1.7 – 3.3)	**2.3** (1.6 – 3.0)	**2.4** (1.9 – 2.9)
Amphetamines							
Used in last 12 mths	**5.0** (3.7 - 6.3)	**3.5** (2.2 - 4.5)	**9.5** (6.6 - 12.4)	**8.0** (5.6 - 10.4)	**5.9** (4.7 - 7.1)	**4.5** (3.5 - 5.5)	**5.2** (4.4 – 6.0)
Used in last month	**2.4** (1.5 - 3.3)	**1.7** (1.0 - 2.4)	**4.7** (2.6 - 6.8)	**1.6** (0.5 - 2.7)	**2.9** (2.1 - 3.7)	**1.7** (1.1 - 2.3)	**2.3** (1.8 - 2.8)
Used in last week	1.4 (0.7 – 2.1)	1.1 (0.5 – 1.7)	1.6 (0.4 – 2.8)	0.8 (0.0 – 1.6)	1.5 (0.9 – 2.1)	1.0 (0.5 – 1.5)	1.2 0.8 – 1.6)

Source: Health Promotion Services, Health Department of WA.

Table 11: Prevalence of drug use by West Australian school students, 1996, Data from 1996 Australian School Students' Alcohol and Drugs national survey

	12-15 years		16 - 17 years		12 - 17 years		
	Males	Females	Males	Females	Males	Females	All
LSD							
Used in last 12 mths	**7.1** (5.6 - 8.6)	**5.6** (4.3 - 6.9)	**19.7** (15.8 - 23.6)	**17.7** (14.3 - 21.1)	**9.7** (8.2 - 11.2)	**8.3** (7.0 - 9.6)	**9.1** (8.1 - 10.1)
Used in last month	**3.8** (2.7 - 4.9)	**2.4** (1.6 - 3.2)	**9.7** (6.8 - 12.6)	**7.1** (4.8 - 9.4)	**5.1** (4.0 - 6.2)	**3.5** (2.6 - 4.3)	**4.3** (3.6 - 5.0)
Used in last week	**2.4** (1.5 - 3.3)	**1.1** (0.5 - 1.7)	**4.2** (2.2 - 6.2)	**2.5** (1.1 - 3.9)	**2.7** (1.9 - 3.5)	**1.5** (0.9 - 2.1)	**2.1** (1.6 - 2.6)
Ecstasy							
Used in last 12 mths	**2.8** (1.8 - 3.8)	**1.9** (1.2 - 2.6)	**6.3** (3.9 - 8.7)	**5.6** (3.6 - 7.6)	**3.5** (2.6 - 4.4)	**2.8** (2.0 - 3.6)	**3.1** (2.5 - 3.7)
Used in last month	**1.4** (0.7 - 2.1)	**0.9** (0.4 - 1.4)	**2.7** (1.1 - 4.3)	**0.8** (0.0 –1.6)	**1.7** (1.1 - 2.3)	**0.9** (0.5 - 1.3)	**1.3** (0.9 - 1.7)
Used in last week	**0.8** (0.3 – 1.3)	**0.4** (0.1 – 0.7)	**1.0** (0.0 – 2.0)	**0.7** (0.0 – 1.4)	**0.8** (0.4 – 1.2)	**0.5** (0.2 – 0.8)	**0.7** (0.4 – 1.0)
Heroin							
Used in last 12 mths	**2.2** (1.3 - 3.1)	**1.9** (1.2 - 2.6)	**2.7** (1.1 – 4.3)	**2.7** (1.3 - 4.1)	**2.3** (1.5 - 3.1)	**2.1** (1.4 - 2.8)	**2.2** (1.7 - 2.7)
Used in last month	**1.1** (0.5 - 1.7)	**0.5** (0.1 - 0.9)	**0.6** (-0.2 - 1.4)	**1.1** (0.2 – 2.0)	**1.0** (0.5 - 1.5)	**0.7** (0.3 - 1.1)	**0.8** (0.5 - 1.1)
Used in last week	**0.8** (0.3 – 1.3)	**0.4** (0.1 – 0.7)	**0.2** (-0.2 – 0.6)	-	**0.7** (0.3 – 1.1)	**0.3** (0.0 – 0.6)	**0.5** (0.3 – 0.7)
Cocaine							
Used in last 12 mths	**1.9** (1.1 - 2.7)	**2.2** (1.4 - 3.0)	**2.7** (1.1 - 4.3)	**1.3** (0.3 - 2.3)	**2.0** (1.3 - 2.7)	**2.0** (1.4 - 2.6)	**2.0** (1.5 - 2.5)
Used in last month	**1.3** (0.6 - 2.0)	**1.2** (0.6 - 1.8)	**0.3** (-0.2 - 0.8)	**0.3** (-0.2 - 0.8)	**1.1** (0.6 - 1.6)	**1.0** (0.5 - 1.5)	**1.0** (0.7 - 1.3)
Used in last week	**0.9** (0.3 – 1.5)	**0.9** (0.4 – 1.4)	-	**0.3** (-0.2 – 0.8)	**0.7** (0.3 – 1.1)	**0.7** (0.3 - 1.1)	**0.7** (0.4 – 1.0)
Steroids							
Used in last 12 mths	**1.6** (0.9 - 2.3)	**0.5** (0.1 - 0.9)	**0.9** (0.0 - 1.8)	**0.2** (-0.2 - 0.6)	**1.4** (0.8 - 2.0)	**0.4** (0.1 - 0.7)	**0.9** (0.6 - 1.2)
Used in last month	**1.0** (0.4 - 1.6)	**0.3** (0.0 - 0.6)	**0.7** (-0.1 - 1.5)	**0.1** (-0.2 - 0.4)	**1.0** (0.5 - 1.5)	**0.2** (0 - 0.4)	**0.6** (0.3 - 0.9)
Used in last week	**0.7** (0.2 – 1.2)	**0.2** (0.0 – 0.4)	**0.3** (-0.2 – 0.8)	-	**0.6** (0.2 – 1.0)	**0.1** (0.0 – 0.2)	**0.4** (0.2 – 0.6)

Source: Health Promotion Services, Health Department of WA.

Table 12: Prevalence of drug use by metropolitan high school students by school year, 1994

Drug	Year	Current users		Ex-users		Non-users	
		No.	%	No.	%	No.	%
Alcohol	8	68	19.5	16	4.6	264	75.9
	9	149	33.7	23	5.2	270	61.1
	10	180	49.2	17	4.6	169	46.2
	11/12	145	61.2	14	5.9	78	32.9
Cannabis	8	34	9.8	13	3.8	299	86.4
	9	88	20.0	29	6.6	323	73.4
	10	120	32.8	38	10.4	208	56.8
	11/12	88	37.1	20	8.4	129	54.4
Tobacco	8	43	12.3	41	11.7	265	75.9
	9	86	19.5	74	16.8	280	63.6
	10	82	22.4	79	21.6	205	56.0
	11/12	61	25.8	45	19.1	130	55.1
Hallucinogens	8	2	0.6	2	0.6	344	98.9
	9	18	4.1	5	1.2	411	94.7
	10	30	8.2	5	1.4	329	90.4
	11/12	18	7.7	7	3.0	210	89.4
Amphetamines	8	4	1.1	3	0.9	343	98.0
	9	11	2.5	2	0.5	424	97.0
	10	19	5.2	3	0.8	343	94.0
	11/12	5	2.1	9	3.8	222	94.2
Inhalants	8	6	1.7	8	2.3	332	96.0
	9	12	2.8	14	3.2	405	94.0
	10	6	1.7	19	5.2	338	93.1
	11/12	7	3.0	4	1.7	224	95.3
Steroids	8	5	1.4	1	0.3	342	98.3
	9	4	0.9	4	0.9	429	98.2
	10	5	1.4	1	0.3	355	98.3
	11/12	3	1.3	4	1.7	228	97.0
Cocaine	8	4	1.1	2	0.6	344	98.3
	9	3	0.7	2	0.5	435	98.9
	10	1	0.3	0	0.0	365	99.7
	11/12	5	2.1	4	1.7	228	96.2
Poppers	8	6	1.7	0	0.0	339	98.3
	9	7	1.6	0	0.0	421	98.4
	10	4	1.1	0	0.0	357	98.9
	11/12	6	2.6	0	0.0	227	97.4
Heroin	8	3	0.9	2	0.6	344	98.6
	9	4	0.9	7	1.6	426	97.3
	10	2	0.5	3	0.8	360	98.6
	11/12	1	0.4	3	1.3	232	98.3
Benzodiazapines	8	3	0.9	5	1.4	337	97.7
	9	1	0.2	6	1.4	424	98.4
	10	7	1.9	4	1.1	348	96.9
	11/12	3	1.3	4	1.8	221	96.9

Source: Odgers P, Houghton S, Douglas G. Prevalence and frequencies of drug use among Western Australian metropolitan high school students (unpublished).

Table 13: Number of quarterly ADIS drug-related telephone calls, major drug groups, June quarter 1986 - 1998

Year	Quarter	THCA	Illicit opioids	Psycho-stimulants	Hallucin-ogens	Volatile substances	Ecstasy	Alcohol	All drugs
1986	January-March	na	na	na	na	na	na	na	na
	April-June	293	124	0	0	0	0	132	899
	July-September	200	166	36	22	0	0	371	1,143
	October-December	145	169	32	3	0	0	474	1,242
	Total	**638**	**459**	**68**	**25**	**0**	**0**	**977**	**3,284**
1987	January-March	190	166	36	4	0	0	486	1,197
	April-June	246	163	41	8	0	0	479	1,238
	July-September	212	147	34	11	0	3	515	1,316
	October-December	257	196	83	17	0	15	808	1,843
	Total	**905**	**672**	**194**	**40**	**0**	**18**	**2288**	**5,594**
1988	January-March	289	214	70	18	0	25	721	1,764
	April-June	236	185	42	6	0	20	831	1,747
	July-September	264	196	115	29	0	44	875	2,101
	October-December	219	186	123	23	0	24	810	1,907
	Total	**1,008**	**781**	**350**	**76**	**0**	**113**	**3237**	**7,519**
1989	January-March	206	162	83	10	0	16	706	1,547
	April-June	298	201	143	31	40	29	790	2,526
	July-September	263	178	119	23	43	20	767	2,081
	October-December	211	190	130	20	49	13	685	1,747
	Total	**978**	**731**	**475**	**84**	**132**	**78**	**2948**	**7,901**
1990	January-March	265	169	168	26	41	14	822	2,039
	April-June	350	190	217	19	40	26	820	2,571
	July-September	290	207	290	43	45	17	859	2,370
	October-December	279	181	323	46	37	16	725	2,136
	Total	**1,184**	**747**	**998**	**134**	**163**	**73**	**3226**	**9,116**
1991	January-March	369	177	327	45	55	13	824	2,396
	April-June	411	201	298	54	54	30	719	2,526
	July-September	439	202	436	80	81	45	770	2,742
	October-December	386	203	352	74	42	47	837	2,502
	Total	**1,605**	**783**	**1,413**	**253**	**232**	**135**	**3150**	**10,166**
1992	January-March	474	202	329	90	47	49	965	2,729
	April-June	500	193	387	83	51	64	806	2,720
	July-September	496	183	401	86	48	103	805	2,642
	October-December	436	239	455	73	54	87	837	2,715
	Total	**1,906**	**817**	**1,572**	**332**	**200**	**303**	**3413**	**10,806**
1993	January-March	463	215	453	85	31	56	822	2,701
	April-June	563	179	499	98	54	45	672	2,716
	July-September	463	183	487	85	85	28	677	2,598
	October-December	374	191	404	63	35	32	682	2,188
	Total	**1,863**	**768**	**1,843**	**331**	**205**	**161**	**2853**	**10,203**
1994	January-March	392	208	443	87	50	54	719	2,475
	April-June	549	223	540	81	74	50	854	3,215
	July-September	518	254	526	71	74	39	849	3,039
	October-December	466	252	512	90	57	44	925	3,052
	Total	**1,925**	**937**	**2,021**	**329**	**255**	**187**	**3347**	**11,781**
1995	January-March	619	335	703	154	88	63	1183	3,993
	April-June	688	346	467	100	78	23	1101	3,988
	July-September	692	462	365	92	80	54	1274	3,921
	October-December	490	437	273	54	66	36	879	2,755
	Total	**2,489**	**1,580**	**1,808**	**400**	**312**	**176**	**4437**	**14,657**
1996	January-March	526	416	215	45	46	46	963	2,880
	April-June	574	440	177	66	46	27	864	2,929
	July-September	530	528	191	64	45	28	887	2,986
	October-December	550	678	270	57	42	33	847	3,074
	Total	**2,180**	**2,062**	**853**	**232**	**179**	**134**	**3561**	**11,851**
1997	January-March	477	580	229	60	34	29	739	2,860
	April-June	463	604	186	33	51	21	649	2,702
	July-September	547	703	237	39	40	24	611	3,078
	October-December	488	663	276	29	23	49	630	2,797
	Total	**1,975**	**2,550**	**928**	**161**	**148**	**123**	**2,629**	**11,437**
1998	January-March	455	632	289	30	24	37	585	2,669
	April-June	553	592	301	23	37	27	625	3,259
1986-98		**19,664**	**14,111**	**13,113**	**2,450**	**1,887**	**1,565**	**37,276**	**120,243**

Table 14: Number of admissions to ADA residential detoxification programs by admission type and sex, 1988-1998

		New admissions			Readmissions			All admissions		
Year	Quarter	Males	Females	All	Males	Females	All	Males	Females	All
1988	January-March	na	na	na	na	na	na	na	na	na
	April-June	82	24	106	2	3	5	84	27	111
	July-September	128	47	175	16	5	21	144	55	196
	October-December	98	34	132	35	15	50	133	49	182
	Total	**308**	**105**	**413**	**53**	**23**	**76**	**361**	**131**	**489**
1989	January-March	100	46	146	40	18	58	140	64	204
	April-June	82	28	110	45	15	60	127	43	170
	July-September	62	27	89	56	9	65	118	36	154
	October-December	57	33	90	49	16	65	106	49	155
	Total	**301**	**134**	**435**	**190**	**58**	**248**	**491**	**192**	**683**
1990	January-March	73	37	110	56	18	74	129	55	184
	April-June	59	34	93	51	21	72	110	55	165
	July-September	68	22	90	46	15	61	114	37	151
	October-December	77	30	107	67	22	89	144	52	196
	Total	**277**	**123**	**400**	**220**	**76**	**296**	**497**	**199**	**696**
1991	January-March	86	44	130	70	21	91	156	65	221
	April-June	50	21	71	34	6	40	84	27	111
	July-September	73	30	103	41	14	55	114	44	158
	October-December	54	22	76	56	17	73	110	39	149
	Total	**263**	**117**	**380**	**201**	**58**	**259**	**464**	**175**	**639**
1992	January-March	57	23	80	49	19	68	106	42	148
	April-June	44	24	68	32	18	50	76	42	118
	July-September	54	23	77	41	20	61	95	43	138
	October-December	57	20	77	41	15	56	98	35	133
	Total	**212**	**90**	**302**	**163**	**72**	**235**	**375**	**162**	**537**
1993	January-March	50	22	72	55	21	76	105	43	148
	April-June	46	24	70	30	16	46	76	40	116
	July-September	53	24	77	45	22	67	98	46	144
	October-December	54	25	79	37	19	56	91	44	135
	Total	**203**	**95**	**298**	**167**	**78**	**245**	**370**	**173**	**543**
1994	January-March	54	34	88	32	26	58	86	60	146
	April-June	51	25	76	42	11	53	93	36	129
	July-September	50	26	76	54	27	81	104	53	157
	October-December	52	30	82	45	14	59	97	44	141
	Total	**207**	**115**	**322**	**173**	**78**	**251**	**380**	**193**	**573**
1995	January-March	83	51	134	57	22	79	140	73	213
	April-June	60	44	104	57	34	91	117	78	195
	July-September	68	49	117	70	34	104	138	83	221
	October-December	70	47	117	66	43	109	136	90	226
	Total	**281**	**191**	**472**	**250**	**133**	**383**	**531**	**324**	**855**
1996	January-March	69	40	109	67	37	104	136	77	213
	April-June	44	32	76	73	45	118	117	77	194
	July-September	58	28	86	57	26	83	115	54	169
	October-December	58	39	97	58	33	91	116	72	188
	Total	**229**	**139**	**368**	**255**	**141**	**396**	**484**	**280**	**764**
1997	January-March	58	32	90	74	28	102	132	60	192
	April-June	60	39	99	53	32	85	113	71	184
	July-September	64	44	108	65	28	93	129	72	201
	October-December	63	32	95	59	40	99	122	72	194
	Total	**245**	**147**	**392**	**251**	**128**	**379**	**496**	**275**	**771**
1998	January-March	67	38	105	58	40	98	125	78	203
	April-June	65	28	93	51	29	80	116	57	173
1988 (qtr 2) - 1998 (qtr 2)		**2,658**	**1,322**	**3,980**	**2,032**	**914**	**2,946**	**4,690**	**2,239**	**6,926**

Table 15: Average ages of admissions to ADA residential detoxification programs by sex, 1988-1998

		New admissions			Readmissions			All admissions		
Year	Quarter	Males	Females	All	Males	Females	All	Males	Females	All
1988	January-March	na	na	na	na	na	na	na	na	na
	April-June	36.4	35.5	36.2	36.5	35.7	36.0	36.4	35.5	36.2
	July-September	37.5	34.6	36.7	37.3	35.0	36.7	37.5	35.0	36.7
	October-December	38.5	33.1	37.1	39.1	33.5	37.4	38.7	33.3	37.2
1989	January-March	40.1	34.6	38.3	38.7	36.7	38.0	39.7	35.1	38.3
	April-June	35.5	40.1	36.7	40.2	34.3	38.7	37.2	38.1	37.4
	July-September	36.4	32.3	35.2	36.5	34.1	36.1	36.5	32.8	35.6
	October-December	36.5	29.8	34.1	39.8	36.9	39.1	38.1	32.1	36.2
1990	January-March	37.5	35.2	36.8	38.1	35.6	37.5	37.8	35.4	37.1
	April-June	36.2	34.5	35.8	39.8	30.6	37.1	37.8	33.0	36.2
	July-September	33.7	29.2	32.6	37.3	37.4	37.4	35.2	32.5	34.5
	October-December	37.0	31.0	35.3	35.7	33.6	35.2	36.4	32.1	35.3
1991	January-March	36.8	36.0	36.5	38.3	35.9	37.8	37.5	36.0	37.0
	April-June	38.7	34.4	37.4	44.5	31.7	41.3	41.1	33.4	39.0
	July-September	33.6	33.1	33.5	40.4	35.9	39.2	36.1	34.0	35.5
	October-December	34.7	31.1	33.7	37.5	36.4	37.2	36.1	33.4	35.4
1992	January-March	35.3	32.9	34.6	38.7	33.7	37.3	36.9	33.3	35.9
	April-June	35.9	36.4	36.1	38.6	36.9	38.0	37.1	36.6	36.9
	July-September	35.2	30.2	33.7	37.6	34.6	36.6	36.3	32.2	35.0
	October-December	36.1	29.7	34.4	39.9	31.3	37.6	37.7	30.4	35.7
1993	January-March	34.9	33.1	34.4	38.3	32.3	36.6	36.7	32.7	35.5
	April-June	36.3	33.7	35.4	39.1	35.7	37.9	37.4	34.5	36.4
	July-September	37.6	33.3	36.2	39.1	38.7	38.9	38.3	35.9	37.5
	October-December	37.0	37.7	37.2	38.5	33.3	36.7	37.6	35.8	37.0
1994	January-March	40.0	31.7	36.8	40.3	35.1	38.0	40.1	33.2	37.2
	April-June	36.2	38.8	37.1	42.7	36.9	41.5	39.1	38.2	38.9
	July-September	33.4	31.1	32.6	40.2	39.1	39.8	36.9	35.2	36.3
	October-December	33.3	33.4	33.3	37.4	36.8	37.3	35.2	34.5	35.0
1995	January-March	34.7	32.0	33.7	41.0	41.7	39.1	37.6	34.1	36.4
	April-June	32.9	32.1	32.6	38.5	35.9	37.5	35.6	33.8	39.4
	July-September	33.9	30.6	32.6	37.4	37.1	37.3	35.7	33.3	34.8
	October-December	32.3	30.7	31.7	36.4	35.6	36.1	34.3	33.0	33.8
1996	January-March	36.1	31.4	34.4	33.7	33.1	33.5	34.9	32.2	33.9
	April-June	33.9	28.8	31.8	38.0	35.0	36.9	36.5	32.4	34.9
	July-September	36.2	32.4	35.0	37.1	36.3	36.9	36.7	34.3	35.9
	October-December	33.9	27.9	31.5	39.6	36.5	38.5	36.8	31.9	34.9
1997	January-March	32.6	32.7	32.6	37.9	35.8	37.3	35.6	34.1	35.1
	April-June	33.1	28.2	31.2	40.4	36.7	39.0	36.6	32.0	34.8
	July-September	30.4	28.4	29.6	36.6	36.5	36.6	33.6	31.5	32.9
	October-December	33.7	33.5	33.6	37.9	32.2	35.6	35.7	32.8	34.6
1998	January-March	30.6	35.5	32.3	39.7	36.4	38.4	34.8	36.0	35.2
	April-June	31.4	29.1	30.7	37.8	36.0	37.2	34.2	32.6	33.7

Table 16: Number of admissions to ADA residential detoxification programs by principal drug problem and age group, 1988-1997

Principal drug problem	Year	Age group						
		10-19	20-29	30-39	40-49	50-59	60+	All ages
Alcohol	1988	5	36	65	67	48	14	235
	1989	5	41	118	91	55	34	344
	1990	6	35	97	67	41	12	258
	1991	8	59	94	89	46	25	321
	1992	4	49	111	82	39	13	298
	1993	2	45	100	94	40	22	303
	1994	2	40	109	91	59	20	321
	1995	3	65	131	105	64	26	394
	1996	0	34	111	86	54	18	303
	1997	0	34	111	94	52	20	311
Illicit opioids	1988	2	50	32	4	0	0	88
	1989	1	55	41	0	0	0	97
	1990	6	57	61	3	0	0	127
	1991	3	43	37	3	0	0	86
	1992	1	35	35	2	0	0	73
	1993	5	36	33	8	0	0	82
	1994	5	46	47	6	0	0	104
	1995	6	113	101	25	0	0	245
	1996	19	144	114	21	3	0	301
	1997	34	154	91	19	1	1	300
Prescribed opioids	1988	0	7	8	1	0	0	16
	1989	0	22	24	0	0	0	46
	1990	1	11	15	0	0	0	27
	1991	1	8	13	0	0	0	22
	1992	0	10	12	3	0	0	25
	1993	0	15	25	7	2	0	49
	1994	1	9	23	9	0	0	42
	1995	4	30	34	15	3	0	86
	1996	1	20	43	19	5	1	89
	1997	0	22	45	13	2	0	82
Benzodiazepines	1988	3	10	6	5	1	0	25
	1989	1	19	27	3	0	2	52
	1990	1	17	19	1	2	0	40
	1991	3	17	16	6	1	0	43
	1992	1	17	22	5	2	0	47
	1993	2	16	23	3	2	0	46
	1994	0	11	18	4	1	1	35
	1995	2	10	17	14	2	0	45
	1996	4	6	9	9	0	0	28
	1997	1	7	14	10	2	0	34
Amphetamines	1988	1	14	2	0	0	0	17
	1989	5	26	12	3	2	0	48
	1990	7	44	20	0	0	0	71
	1991	7	30	5	4	0	0	46
	1992	3	22	17	1	0	0	43
	1993	2	34	15	2	0	0	53
	1994	5	37	17	2	0	0	61
	1995	8	38	9	0	0	0	55
	1996	1	10	6	0	0	0	17
	1997	1	8	4	0	0	0	13
Cannabis	1988	0	1	0	0	0	0	1
	1989	0	7	2	0	0	0	9
	1990	0	2	0	0	0	0	2
	1991	2	0	0	0	0	0	2
	1992	0	0	0	0	0	0	0
	1993	0	2	1	0	0	0	3
	1994	0	0	0	0	0	0	0
	1995	0	14	3	0	0	0	17
	1996	1	7	2	2	0	0	12
	1997	1	13	2	3	0	0	19

Note: Barbiturates, cocaine and other drug group excluded.

Table 17: New admissions to all ADA programs by principal drug problem and age group, 1988-1997

Principal drug problem	Year	Age group						
		10-19	20-29	30-39	40-49	50-59	60+	All ages
Alcohol	1988	52	189	144	126	27	18	556
	1989	62	212	226	125	50	35	710
	1990	54	200	215	123	29	29	650
	1991	73	210	162	111	37	26	619
	1992	64	244	184	116	38	19	665
	1993	75	217	189	113	47	28	669
	1994	64	244	207	125	42	24	706
	1995	67	311	264	172	70	26	913
	1996	46	240	203	139	70	21	719
	1997	45	177	151	103	32	9	519
Illicit opioids	1988	6	159	75	5	0	2	247
	1989	7	103	54	4	1	0	169
	1990	7	80	56	4	0	1	148
	1991	4	90	62	5	0	2	163
	1992	3	88	57	9	1	0	158
	1993	25	88	79	16	1	1	210
	1994	14	100	75	11	0	0	200
	1995	44	151	168	35	0	0	498
	1996	95	333	166	42	3	0	639
	1997	129	386	130	24	0	1	673
Prescribed opiates	1988	0	12	7	5	2	0	26
	1989	0	5	6	3	0	0	14
	1990	0	10	5	1	0	0	16
	1991	0	13	9	4	0	0	26
	1992	2	4	9	2	0	0	17
	1993	0	11	16	4	1	1	33
	1994	1	24	14	8	1	0	48
	1995	9	52	50	22	1	1	135
	1996	3	38	54	19	5	2	120
	1997	1	33	33	9	1	0	77
Benzodiazepines	1988	2	7	13	7	8	8	45
	1989	0	11	12	7	4	7	41
	1990	2	13	6	9	6	1	37
	1991	3	15	7	14	5	5	49
	1992	3	5	13	6	1	2	30
	1993	0	6	8	2	4	2	22
	1994	1	12	12	5	0	0	30
	1995	11	15	19	14	8	0	61
	1996	8	10	11	9	1	0	42
	1997	4	7	9	5	3	0	28
Amphetamines	1988	1	13	3	0	0	0	17
	1989	6	29	4	0	0	0	39
	1990	15	40	15	0	0	0	70
	1991	34	94	17	1	2	2	150
	1992	38	115	28	2	0	3	186
	1993	53	137	21	1	0	3	215
	1994	56	212	45	6	0	1	320
	1995	45	136	31	4	0	0	216
	1996	15	57	14	4	0	0	90
	1997	16	60	16	3	1	0	96
Cannabis	1988	6	12	6	0	0	1	25
	1989	6	26	3	2	1	0	38
	1990	5	12	3	2	0	0	23
	1991	25	29	13	2	0	1	70
	1992	45	52	16	4	0	5	122
	1993	20	39	14	1	1	1	76
	1994	26	59	23	5	1	1	115
	1995	33	72	19	2	1	0	127
	1996	44	73	22	7	1	0	147
	1997	23	62	33	4	1	0	123

Table 18: Trends in ADA methadone program by sex and admission status 1982-1989

Year	Quarter	All admissions				New admissions
		Males	Females	Persons	% females	
1982	January-March	77	41	118	34.7	26
	April-June	80	50	130	38.5	18
	July-September	88	57	145	39.3	36
	October-December	92	59	151	39.1	20
1983	January-March	93	56	149	37.6	27
	April-June	81	51	132	38.6	20
	July-September	82	52	134	38.8	15
	October-December	78	48	126	38.1	15
1984	January-March	87	52	139	37.4	26
	April-June	124	76	200	38.0	49
	July-September	141	92	233	39.5	49
	October-December	145	94	239	39.3	34
1985	January-March	148	90	238	37.8	33
	April-June	182	113	295	38.3	58
	July-September	194	136	330	41.2	73
	October-December	202	156	358	43.6	73
1986	January-March	179	144	323	44.6	60
	April-June	171	129	300	43.0	29
	July-September	163	121	284	42.6	19
	October-December	174	122	284	42.9	47
1987	January-March	160	110	270	40.7	26
	April-June	150	119	269	44.2	26
	July-September	166	130	296	43.9	36
	October-December	181	137	318	43.1	37
1988	January-March	201	149	350	42.6	37
	April-June	207	157	364	43.1	47
	July-September	243	165	408	40.4	66
	October-December	274	183	457	40.0	80
1989	January-March	262	193	455	42.4	47
	April-June	271	204	475	42.9	54
	July-September	250	182	432	42.1	25
	October-December	246	183	429	42.6	20

Source: Alcohol and Drug Authority.
Note: New refers to persons not previously admitted to the WA program.

Table 19: Number of males, females and new admissions participating in ADA methadone program, 1990-1998

Year	Quarter	All admissions				New admissions
		Males	Females	Persons	% females	
1990	January-March	259	188	447	42.1	38
	April-June	254	192	446	43.0	26
	July-September	265	204	469	43.5	46
	October-December	266	201	467	43.0	39
1991	January-March	270	202	472	42.8	34
	April-June	294	220	514	42.8	47
	July-September	303	212	515	41.2	31
	October-December	294	214	508	42.1	41
1992	January-March	295	215	510	42.2	34
	April-June	292	213	505	42.2	34
	July-September	301	216	517	41.8	53
	October-December	308	227	535	42.4	42
1993	January-March	320	232	552	42.0	47
	April-June	331	243	574	42.3	51
	July-September	348	253	601	42.1	53
	October-December	356	255	611	41.7	46
1994	January-March	362	255	617	41.3	52
	April-June	376	269	645	41.7	46
	July-September	386	281	667	42.1	55
	October-December	401	288	689	41.8	49
1995	January-March	402	295	697	42.3	61
	April-June	428	307	735	41.8	56
	July-September	460	337	797	42.3	62
	October-December	459	350	809	43.3	72
1996	January-March	473	363	836	43.4	76
	April-June	486	363	849	42.8	54
	July-September	502	363	865	42.0	67
	October-December	531	382	913	41.8	75
1997	January-March	573	424	997	42.5	117
	April-June	600	448	1,048	42.7	96
	July-September	629	455	1.084	42.0	87
	October-December	638	476	1,114	42.7	118
1998	January-March	606	444	1,050	42.3	44
	April-June	561	423	984	43.0	24

Source: Alcohol and Drug Authority.
Note: New refers to persons not previously admitted to the WA program.

Table 20: Number of persons participating in ADA methadone program by age group, 1986-1998

		Persons					
Year	Quarter	15-19	20-29	30-39	40+	All ages	Mean age
1986	January-March	2	193	118	10	323	29.1
	April-June	2	181	108	9	300	29.6
	July-September	1	161	112	10	284	29.7
	October-December	-	171	114	11	296	29.8
1987	January-March	1	145	112	12	270	30.1
	April-June	1	138	119	11	269	30.3
	July-September	2	152	131	11	296	30.6
	October-December	2	156	149	11	318	30.5
1988	January-March	1	164	169	16	350	30.7
	April-June	2	160	186	16	364	30.7
	July-September	2	182	206	18	408	30.7
	October-December	1	211	226	19	457	30.8
1989	January-March	-	208	228	19	455	30.8
	April-June	-	212	244	19	475	30.9
	July-September	1	169	241	21	432	31.4
	October-December	1	162	244	22	429	31.7
1990	January-March	1	165	255	26	447	31.7
	April-June	2	159	255	30	446	32.0
	July-September	2	150	284	33	469	31.9
	October-December	2	159	273	33	467	31.7
1991	January-March	1	122	308	41	472	32.8
	April-June	2	141	328	43	514	32.6
	July-September	1	139	335	40	515	32.6
	October-December	2	139	326	41	508	32.5
1992	January-March	1	120	331	58	510	33.5
	April-June	1	122	324	58	505	33.3
	July-September	-	140	325	52	517	33.0
	October-December	-	151	332	52	535	32.8
1993	January-March	0	125	360	67	552	33.6
	April-June	1	133	369	71	574	33.6
	July-September	2	147	379	73	601	33.5
	October-December	4	164	376	67	611	33.0
1994	January-March	3	134	379	101	617	34.0
	April-June	6	141	390	108	645	33.9
	July-September	8	142	408	109	667	33.8
	October-December	9	159	417	104	689	33.6
1995	January-March	3	138	421	135	697	34.5
	April-June	4	141	449	141	735	34.5
	July-September	7	163	480	147	797	34.2
	October-December	8	180	470	151	809	34.0
1996	January-March	5	166	470	195	836	34.8
	April-June	6	170	472	201	849	34.7
	July-September	5	184	472	204	865	34.6
	October-December	9	197	499	208	913	34.4
1997	January-March	4	205	525	263	997	35.0
	April-June	8	235	547	258	1,048	34.5
	July-September	17	268	546	253	1,084	34.0
	October-December	21	314	535	244	1,114	33.4
1998	January-March	11	271	482	286	1,050	34.5
	April-June	9	254	443	278	984	34.6

Source: Alcohol and Drug Authority.

Table 21: Number of persons participating in ADA methadone program by length of stay, 1986-1998

		Length of stay (months)						Total
Year	Quarter	0 - 5 9	6 - 11.9	12 - 23.9	24 - 59.9	60 +	mean	
1986	January-March	106	89	66	56	6	15.3	323
	April-June	82	62	81	68	7	17.4	300
	July-September	67	60	86	62	9	18.8	284
	October-December	94	48	81	62	11	18.4	296
1987	January-March	90	26	67	75	12	20.9	270
	April-June	81	40	47	88	13	21.8	269
	July-September	94	54	42	90	16	21.3	296
	October-December	110	53	46	90	19	21.0	318
1988	January-March	124	62	51	90	23	20.5	350
	April-June	123	66	64	84	27	20.7	364
	July-September	147	80	76	77	28	19.6	408
	October-December	181	91	77	82	26	18.5	457
1989	January-March	162	92	81	83	37	19.9	455
	April-June	148	109	94	84	40	20.3	475
	July-September	124	89	94	85	40	22.5	432
	October-December	92	95	109	88	45	24.1	429
1990	January-March	120	87	100	89	51	24.0	447
	April-June	120	67	114	87	58	24.4	446
	July-September	134	78	112	91	54	22.6	469
	October-December	128	86	95	106	52	23.6	467
1991	January-March	127	86	102	102	55	24.2	472
	April-June	143	97	95	123	56	24.0	514
	July-September	126	98	107	130	54	24.9	515
	October-December	124	91	112	130	51	25.3	508
1992	January-March	124	88	110	137	51	24.2	510
	April-June	118	83	118	134	52	24.2	505
	July-September	125	75	110	153	54	27.1	517
	October-December	137	82	109	152	55	26.8	535
1993	January-March	131	88	118	150	65	27.5	552
	April-June	144	81	114	162	73	28.0	574
	July-September	160	89	112	162	78	27.8	601
	October-December	151	107	111	157	85	27.9	611
1994	January-March	143	120	106	162	86	28.0	617
	April-June	146	105	135	169	90	28.4	645
	July-September	151	104	149	168	95	28.9	667
	October-December	160	108	150	170	101	29.1	689
1995	January-March	143	113	159	174	108	30.3	697
	April-June	161	113	143	202	116	30.6	735
	July-September	187	110	161	211	128	30.3	797
	October-December	172	121	165	222	129	31.1	809
1996	January-March	167	140	170	224	135	31.6	836
	April-June	168	134	171	231	145	32.1	849
	July-September	161	133	173	251	147	32.7	865
	October-December	186	131	183	258	155	32.6	913
1997	January-March	238	134	197	266	162	31.1	997
	April-June	257	145	194	285	167	31.2	1,048
	July-September	235	189	189	300	171	31.4	1,084
	October-December	253	211	172	305	173	31.0	1,114
1998	January-March	160	193	204	311	182	34.2	1,050
	April-June	73	172	249	294	196	37.4	984

Table 22: Quarterly admissions to ADA residential detoxification programs by principal drug problem, 1988-1998

Year	Quarter	Alcohol	Illicit opioids	Licit opioids	Barbit-urates	Benzo-diazepines	Amphet-amines	Cocaine	THC	Other	All drugs
1988	January-March	0	0	0	0	0	0	0	0	0	0
	April-June	49	26	4	0	6	2	0	1	24	112
	July-September	89	32	5	1	13	6	0	0	51	197
	October-December	97	30	7	2	6	9	0	0	33	184
1989	January-March	108	23	14	0	10	14	0	6	29	204
	April-June	85	28	7	0	15	13	0	0	22	170
	July-September	75	19	15	0	15	8	2	1	19	154
	October-December	76	27	10	0	12	13	0	2	15	155
1990	January-March	59	32	7	0	16	12	0	0	23	149
	April-June	70	30	3	0	11	21	0	1	29	165
	July-September	57	33	5	0	5	20	0	1	31	152
	October-December	72	32	12	0	8	18	1	0	53	196
1991	January-March	93	31	7	0	15	15	0	1	59	221
	April-June	64	15	4	0	8	4	0	0	45	140
	July-September	80	22	6	0	10	11	0	0	4	133
	October-December	84	18	5	0	10	16	0	1	0	134
1992	January-March	77	26	8	0	12	12	0	0	7	142
	April-June	57	14	6	0	11	10	0	0	4	102
	July-September	75	15	7	0	18	11	0	0	12	138
	October-December	89	18	4	0	6	10	0	0	6	133
1993	January-March	84	28	8	0	12	16	0	0	2	150
	April-June	62	16	12	0	8	13	0	2	3	116
	July-September	82	16	10	0	19	13	0	1	5	146
	October-December	75	22	19	0	7	11	0	0	2	136
1994	January-March	80	32	12	0	10	11	0	0		147
	April-June	80	17	10	0	6	14	0	0	2	129
	July-September	82	31	10	0	12	19	0	0	3	157
	October-December	79	24	10	0	7	17	1	0	3	141
1995	January-March	98	44	27	0	10	26	0	3	5	213
	April-June	95	44	22	0	11	15	0	6	3	196
	July-September	103	69	17	0	18	7	0	5	2	221
	October-December	98	88	20	0	6	7	0	3	4	226
1996	January-March	75	91	23	0	7	6	0	5	6	213
	April-June	73	73	26	0	12	3	0	2	6	195
	July-September	76	61	16	0	7	4	0	4	1	169
	October-December	79	76	24	0	2	4	0	1	2	188
1997	January-March	86	74	16	0	7	5	0	2	5	195
	April-June	69	71	24	0	10	1	0	6	3	184
	July-September	75	91	20	0	7	1	0	4	3	201
	October-December	81	64	22	0	10	6	0	7	4	194
1998	January-March	86	69	23	0	10	7	0	5	3	203
	April-June	53	72	23	0	12	7	0	5	3	175

Table 23: Population of Health Zones by Health Service, 1995 and 2001

	1995	2001
East Metropolitan Health Zone		
Bentley Health Service	118,381	119,957
Kalamunda Health Service	48,251	54,477
Inner City Health Service	51,173	51,886
Swan Health Service	160,010	185,512
Sub total	377,815	411,832
North Metropolitan Health Zone		
North Metropolitan Health Service	450,211	491,581
Sub total	450,211	491,581
South Metropolitan Health Zone		
Armadale/Kelmscott Health Service	176,286	192,871
Fremantle Health Service	123,030	123,183
Rockingham/Kwinana Health Service	134,814	163,628
Sub total	434,130	479,682
Great Southern Health Zone		
Central Great Southern Health Service	11,204	10,577
Lower Great Southern Health Service	39,312	43,181
Upper Great Southern Health Service	18,901	19,311
Sub total	69,417	73,069
Goldfields Health Zone		
Northern Goldfields Health Service	40.877	43,187
South East Coastal Health Service	14,951	15,656
Sub total	55,828	58,843
Kimberley Health Zone		
Kimberley Health Service	24,960	28,518
Sub total	24,960	28,518
Midlands Health Zone		
Avon Health Service	15,998	16,708
Central Wheatbelt Health Service	7,140	6,996
Eastern Wheatbelt Health Service	12,988	12,442
Western Health Service	17,350	17,930
Sub total	53,476	54,076
Midwest Health Zone		
Gascoyne Health Service	10,210	10,754
Geraldton Health Service	32,022	35,786
Midwest Health Service	13,503	14,048
Murchison Health Service	4,386	4,760
Sub total	60,121	65,348
Pilbara Health Zone		
East Pilbara Health Service	20,833	22,515
West Pilbara Health Service	22,113	23,127
Sub total	42,946	45,642
South West Health Zone		
Bunbury Health Service	40,883	43,563
Harvey-Yarloop Health Service	15,035	17,055
Peel Health Service	50,640	64,263
Vass Leeuwin Health Service	24,800	28,857
Warren/Blackwood Health Service	17,367	18,162
Wellington Health Service	13,533	14,277
Sub total		

Source: Health Information Centre, Health Department of WA

Table 24: Estimated number of drug related bed days by Health Zone, sex and major drug group, 1995

Health Zone	Sex	Tobacco	Alcohol	Other drugs	All drugs
Great Southern	M	2,059	1,220	107	3,386
	F	982	1,243	142	2,367
	All	3,041	2,462	249	5,752
Goldfields	M	2,119	1,833	128	4,080
	F	780	1,058	124	1,962
	All	2,899	2,892	252	6,043
Kimberley	M	886	1,541	28	2,455
	F	644	909	44	1,597
	All	1,530	2,450	72	4,052
Midlands	M	2,601	1,094	94	3,789
	F	1,026	847	108	1,981
	All	3,627	1,942	202	5,771
Midwest	M	2,095	1,646	130	3,871
	F	1,045	897	157	2,099
	All	3,140	2,543	287	5,970
Pilbara	M	831	1,034	62	1,927
	F	479	682	91	1,252
	All	1,310	1,716	153	3,179
South West	M	5,779	3,743	273	9,795
	F	2,918	2,921	445	6,284
	All	8,697	6,664	718	16,079
East Metro	M	14,259	7,171	1,413	22,843
	F	6,742	7,094	2,003	15,839
	All	21,001	14,265	3,416	38,682
North Metro	M	10,640	5,971	995	17,606
	F	5,699	6,432	1,563	13,694
	All	16,339	12,403	2,558	31,300
South Metro	M	11,742	5,700	1,111	18,553
	F	6,222	5,598	1,539	13,359
	All	17,964	11,298	2,650	31,912
Total	M	53,011	30,953	4,341	88,305
	F	26,537	27,682	6,215	60,434
	All	79,548	58,635	10,557	148,740

Source: Health Department of WA.
Note: Alcohol hospitalisation data one year average for the period 1993-1995.
Smoking hospitalisation data for actual year.
Other drug hospitalisation data one year average for the period 1991-1995.

Table 25: Estimated cost ($) of drug related hospitalisation by Health Zone, sex and major drug group, 1995

Health Zone	Sex	Tobacco	Alcohol	Other drugs	All drugs
Great Southern	M	905,960	536,653	47,168	1,489,781
	F	432,080	546,773	62,392	1,041,245
	All	1,338,040	1,083,427	109,472	2,530,939
Goldfields	M	932,360	806,667	56,408	1,795,435
	F	343,200	465,667	54,384	863,251
	All	1,275,560	1,272,333	110,792	2,658,685
Kimberley	M	389,840	677,893	12,232	1,079,965
	F	283,360	399,960	19,448	702,768
	All	673,200	1,077,853	31,680	1,782,733
Midlands	M	1,144,440	481,507	41,272	1,667,219
	F	451,440	372,827	47,432	871,699
	All	1,595,880	854,333	88,704	2,538,917
Midwest	M	921,800	724,240	57,376	1,703,416
	F	459,800	394,827	68,904	923,531
	All	1,381,600	1,119,067	126,280	2,626,947
Pilbara	M	365,640	454,813	27,280	847,733
	F	210,760	300,080	40,040	550,880
	All	576,400	754,893	67,320	1,398,613
South West	M	2,542,760	1,646,920	119,944	4,309,624
	F	1,283,920	1,285,240	195,888	2,765,048
	All	3,826,680	2,932,160	315,832	7,074,672
East Metro	M	6,273,960	3,155,387	621,808	10,051,155
	F	2,966,480	3,121,360	881,232	6,969,072
	All	9,240,440	6,276,747	1,503,040	17,020,227
North Metro	M	4,681,600	2,627,240	437,888	7,746,728
	F	2,507,560	2,830,080	687,808	6,025,448
	All	7,189,160	5,457,320	1,125,696	13,772,176
South Metro	M	5,166,480	2,508,147	488,752	8,163,379
	F	2,737,680	2,463,120	677,336	5,878,136
	All	7,904,160	4,971,267	1,166,088	14,041,515
Total	M	23,324,840	13,619,467	1,910,128	38,854,435
	F	11,676,280	12,179,933	2,734,776	26,590,989
	All	35,001,120	25,799,400	4,644,904	65,445,424

Source: Health Department of WA.
Note: Alcohol hospitalisation data one year average for the period 1993-1995.
Smoking hospitalisation data for actual year.
Other drug hospitalisation data one year average for the period 1991-1995.

Appendix 14: Recommendations of Pennington Inquiry

Recommendations of the Victorian Premier's Drug Advisory Council

Recommendation 1

The Victorian government support a sustained and integrated information and education strategy that deals with both illicit and licit drugs such as alcohol and tobacco.

- Drug education should be included as a core component in the health curriculum in schools.
- Action should be taken as a matter of priority to ensure sufficient teaching staff are trained in drug education.
- Guidelines on the approach to drug education to be used in schools should be circulated as a matter of urgency. The guidelines should be based on the principles detailed in the *Get Real* package recently prepared by the Directorate of Education.
- Targeted marketing strategies should be developed to improve community awareness of existing telephone information and advice services.
- Opportunities for the integration of the two specific drug telephone services should be explored and more consistent data gathering systems introduced.
- Arrangements for providing information to people from differing ethnic and cultural backgrounds should be enhanced.
- Printed materials should be reviewed and, where appropriate for use in conjunction with other information dissemination activities, be translated into languages other than English.
- Media campaigns should be used to communicate major changes in policy and arrangements in Victoria. Where appropriate, this should be in cooperation with the Commonwealth government.
- Course structure and content for selected tertiary courses should be amended to ensure that appropriate and relevant graduates have a basic knowledge regarding drugs and the harm minimisation framework.
- Expanded in service training and professional development opportunities should be provided to assist various workers to communicate with and assist people dealing with drug issues.
- Consideration should be given to including drug and alcohol studies within the Master of Public Health Program.
- Strategies should be developed to provide information to parents to assist them provide information and support to their children. These strategies should include information about where they get further information, or personal assistance for themselves or for their children.
- Peer education and outreach services should be developed in consultation with drug user groups.

Recommendation 2

The Victorian government support the establishment of a youth substance abuse service.

- A specialist outreach service should be developed to support vulnerable young people involved in substance abuse.

- The management and administration of the service should be developed in such a way as to ensure that it is effective at street level, and has the knowledge and technical backup to deliver high levels of drug expertise to the field.

- A flexible funding pool should be established to enable the outreach team to supplement the funding on a case by case basis, of agencies dealing with serious drug misuse.

- Expanded training, professional supervision and consultation should be offered to a broader (but targeted) group of youth workers to expand the pool of workers skilled in drug and alcohol issues.

- An intensive support residential facility should be established to care for young people experiencing acute toxic shock. The facility should be managed by an agency with experience in drug and alcohol issues in association with an acute hospital.

- Services to be established to monitor, evaluate and research issues to do with youth substance abuse.

Recommendation 3

The Victorian government substantially upgrade services for people who come into contact with the adult corrections system and who have serious problems resulting from their drug misuse.

- An independent and specialist court advice service should be established to provide pre sentence advice regarding treatment of offenders to all courts as needed.

- An independent service should assess offenders and purchase treatment services for those given a community based disposition with treatment conditions, and for those on parole with similar conditions.

- Community corrections staff should be deployed in ways that ensure the appropriate level of supervision is provided while people are subject to orders that include treatment requirements.

- The range, quality and access to support and treatment services available in correctional institutions should replicate those in the community.

- The Justice Department should involve relevant external expertise across the government and community sectors in defining the service development strategies and priorities.

Recommendation 4

The Victorian government support the continued development of appropriately designed drug and alcohol services.

- Following a review of existing post withdrawal support and counselling services, appropriate additional services should be established.

- Steps should be taken, as a matter of urgency, to ensure the establishment of the further specialist methadone and withdrawal services already approved by the State government.

- A review of the funding and related specifications for recently established withdrawal services should be undertaken in the near future.

- A trial cannabis treatment service for problem cannabis users should be established with suitable links to alcohol and tobacco services.

- The development of the methadone program should continue and particular focus should be given to ensuring access for particular groups including rural and ethnic communities.

- Improved monitoring systems statewide, and at the practitioner level, should be established as part of a quality assurance mechanism.

- Increased counselling services should be available on a non compulsory basis to people involved with the methadone program.

- Priority should be given to developing research-based clinical trials on the pharmacological alternatives such as LAAM, buprenorphine and naltrexone.

- Victoria should encourage the Commonwealth to support the ACT heroin pilot study and, if appropriate, the subsequent clinical trial of heroin prescribing.

- A review of police standing orders to be undertaken and followed by an assessment of practice to ensure that appropriate health care services are available to prisoners experiencing withdrawal.

- The ambulance service should document and disseminate guidelines and protocols to assist ambulance officers in the post acute management and care of people who have overdosed on drugs.

- Workers in the primary care and generalist health care facilities (particularly emergency care) should be made aware of the resources available to assist them to more effectively respond to the health and other care needs of individuals with drug problems.

Recommendation 5

The Victorian government support the development of an agency for drug dependency to provide leadership and coordination in this area.

- The Agency for Drug Dependency provide appropriate organisational support to the Youth Substance Abuse Service and the organisation providing the adult corrections service.

- The Agency for Drug Dependency coordinate the organisations involved in research, training and other relevant initiatives.

- The Agency for Drug Dependency contribute to the development of improved state level systems links between drug services and other health, community services and law enforcement agencies.

Recommendation 6

Victoria Police ensure that a comprehensive and coordinated strategy on policing in relation to the manufacture, supply and use of illicit drugs is documented and implemented across the force.

- Victoria Police should ensure harm minimisation strategies govern operational practice at all levels of the force.

- Victoria Police should document and disseminate material that describes the roles and responsibilities of various sections of the force in implementing police drug strategies.

- Victoria Police should ensure coordination of the activities of the Drug Squad, other relevant specialist squads, and operational police with respect to strategic planning, and recording, interpretation and circulation of critical information and joint initiatives to reduce drug trafficking in Victoria.

- Victoria Police should ensure that induction and inservice training for members of the force include theoretical and practical input on harm minimisation and Victoria's drug strategy.

- Victorian Police should work collaboratively to enhance the operational integration between police, health and community agencies and education to ensure, at each level, effective action based on harm minimisation strategies and priorities.

- Victoria Police should ensure adequate resources are available for community policing. This will involve prevention and community involvement initiatives designed to reduce the use and harms of drugs.

- Victoria Police should ensure that career recognition is provided for members who are actively and effectively involved in harm minimisation and community work.

- Victoria Police should upgrade and enhance existing monitoring and evaluation arrangements to include the impact of the strategy and guidelines referred to above.

- Victoria Police should investigate opportunities to enhance the use of data provided through AUSTRAC and other sources.

- Administrative arrangements and structures should be put in place to more effectively follow up confiscations ordered by the courts.

Recommendation 7

The Victorian government amend the *Drugs Poisons and Controlled Substances Act 1981*.

- Use and possession of small amounts of marijuana should no longer be an offence. 'Small quantity' should be defined as no more than 25 grams (half the amount currently specified in the ACT).

- Cultivation of up to five cannabis plants per household for personal use should no longer be an offence.

- Sale of marijuana should remain an offence. Sale of small quantities by an adult to an adult should incur a caution delivered by Victoria Police for a first offence with an adjourned bond the preferred penalty for a second offence. Maximum penalties for sale to young people should be maintained at present levels: up to 25 years gaol and a $250,000 fine for quantities above 100 kilos and up to 15 years and/or a $100,000 fine for quantities between 25 grams and 100 kilos.

- Provisions of the *Summary Offences Act 1966* should be reviewed to ensure offensive behaviour under the influence of marijuana can be dealt with by police. Similarly, local government should establish by-laws that restrict consumption in public places.

- Legislation should be introduced to expunge all recorded convictions for possession and use of small quantities of marijuana.

- Use and possession of heroin, cocaine, amphetamines, ecstasy and cannabis products (including small quantities) other than marijuana, should remain an offence. (*A range of penalties involving cautions and referrals to drug treatment are proposed.*)

- Penalties for bond breaches or subsequent drug use offences by adults and juveniles should include escalating penalties for subsequent offences. Penalties should include, for example, fines and community based orders. Imprisonment should be used as a last resort for drug users.

- Penalties available for drug trafficking are severe and should remain so. Investigation is required, however, of the levels and patterns of sentences actually imposed by courts for drug trafficking. Review findings should inform government decisions about whether penalties imposed by courts are appropriate.

- Amendments to existing legislation in line with Council's recommendations should take account of international treaty obligations entered into by the Australian government. Expert legal advice should be obtained by the Victorian government to inform its decisions about legislative reform.

- Dangerous, reckless or careless driving under the influence of a drug to such an extent as to be incapable of proper control of the vehicle are already offences under the *Road Safety Act 1986*. Learner or provisional permit drivers found guilty of careless, reckless or dangerous driving while impaired by marijuana should be disqualified from driving for an extended period and required to participate in education programs. Protocols should be developed to assist policing of these provisions.

- Research should be funded to establish a test for short lived metabolites of cannabis products in saliva or breath to allow, in due course, the introduction of roadside testing for cannabis in a manner comparable to alcohol breath testing.

- The impact of legislative changes made above should be monitored and, if implementation of the Council's recommendations begins to realise the stated goals, consideration should be given to appropriate next steps.

Recommendation 8

The State government encourage and support coordination of local responses and establish statewide structures to monitor and advise on further developments of Victoria's drug response.

- Funds should be made available to support proposals for local community initiatives that focus positively on responding to drug use and misuse.

- Guidelines to support the development of local action in responding to drug issues should be developed and widely disseminated.

- Local early warning and monitoring systems should be piloted to ensure that effective use of available information is maximised, and that users, local interest groups and broader policy makers are informed.

- An expert reference group should be established to advise the Premier regarding illicit drugs.

- The role of the reference group should include:

- Providing advice on implementation issues arising from this PDAC report.
- Preparing further advice regarding issues identified in this PDAC report, but not subject to recommendation.
- Assessing the effectiveness of the implementation of recommendations and advising on refinements as necessary.
- Developing proposals for evaluation and research.
- Advising on options for further reforms as requested.

- The reference group should have access to appropriate support services.

- Membership of the senior officer group that coordinates the Victorian Drug Strategy should be upgraded.

- Relevant government agencies, including Victoria Police, should introduce common core data sets and consistent collection arrangements regarding illicit drug issues.

- A system of regular service and program evaluations designed to take into account the cross sectoral impact of services should be implemented.

- A research agenda should be developed that takes account of the Commonwealth research program in this area.

- That appropriate awards be created to recognise quality practice, achievements and contributions to the harm minimisation approach to illicit drugs.

Appendix 15: Bibliography

Bibliography

Alchin TM, Tranby HW. *Some economics of antidepressant use in Australia. Working paper 93/13*. Department of Economics, University of Western Sydney, 1993.

Alder C, Read H. *The reintegration problems of drug using young offenders*. Canberra, Australian Government Publishing Service, 1992.

Ali R, Miller M, Cormack S. *Future Directions for Alcohol and Other Drug Treatment In Australia*. Canberra, Australian Government Publishing Service, 1992.

Ali R, Christie P (eds). *Report of the National Task Force on Cannabis*. Canberra, Australian Government Publishing Service, 1994.

Ali R, Christie P, Lenton S, Hawks D, Sutton A, Hall W, Allsop S. *The social impacts of the cannabis expiation notice scheme in South Australia*. Canberra, Commonwealth Department of Health & Family Services, 1998.

ANCARD Working Party. *The national indigenous Australian's sexual health strategy, 1996-97 to 1998-99*. Canberra, Department of Human Services and Health, 1997.

Anderson et al *Mortality of indigenous Australians*. Cat No. 3315.0. Canberra, Australian Bureau of Statistics, 1996.

Anderson P, Lehto G. "Prevention policies". (1994) *50 British Medical Bulletin* 171-185.

Ashworth K. "Sniffer dogs in school drug raid". *West Australian* 2 July 1998.

Ashworth K. "School raids a deterrent: police". *West Australian* 4 July 1998.

Ashworth K. "Search for drugs, schools told." *West Australian* 17 August 1998.

Atkinson L, McDonald D. "Cannabis, the law and social impacts in Australia". *Trends and Issues* No. 48

Australia, Commonwealth Attorney-General's Department, Criminal Law Division. *Serious drug offences in commonwealth jurisdiction – Criminal code and Customs Act 1901*. Canberra, Commonwealth Attorney-General's Department, 1997.

Australia, Department of Health and Family Services, Mental Health Branch. *National mental health report 1996*: *Fourth Annual Report, changes in Australia's Mental health Services under the National Mental Health Strategy 1995-96*. Canberra, Department of Health & Family Services, 1997.

Australia, Department of Health and Family Services. *National policy of methadone treatment*. Canberra, Australian Government Publishing Service, 1997.

Australian Broadcasting Corporation. "HIV-AIDS in prisons". Radio National Transcripts The Health Report. 18 November 1996.

Australian Broadcasting Corporation. "Ultra rapid opiate detoxification". Radio National Transcripts The Health Report 13 October 1997.

Australian Bureau of Criminal Intelligence. *Australian illicit drug report 1996-97*. Canberra, Australian Bureau of Criminal Intelligence, 1997.

Australian Bureau of Statistics. *1989-90 National Health Survey - summary of results Australia*. Cat No. 4364.0. Canberra, Australian Bureau of Statistics, 1991.

Australian Bureau of Statistics. *Mental health and wellbeing: profile of adults, Australia, 1997*. Canberra, Australian Bureau of Statistics, 1998.

Australian Broadcasting Corporation. Safe injecting rooms (transcript). *Health Report, Radio National* 3 August 1998.

Australian Broadcasting Corporation. Heroin prescription and needle exchange in prison (transcript). *Health Report, Radio National* 10 August 1998.

Australian Law Reform Commission. *Integrity: but not by trust alone – AFP and NCA complaints and disciplinary system*. Sydney. Australian Law Reform Commission 1996.

Bailey GW. Perspectives in drug abuse in youth. (1989) 28 *Journal of the American Academy of Child and Adolescent Psychiatry* 151-162.

Baily S. *Planning prevention strategies for alcohol and other drug related problems among women*. Sydney, Drug and Alcohol Directorate, NSW Health Department, 1991.

Baines P. *Community research project, volatile substance use among young people in the north east region of the Perth metropolitan area*. Perth, North East Region Youth Centre, 1992.

Banks A. "Anwyl: need for drug rehab centre". *Kalgoorlie Miner* 2 June 1998.

Baum RM. "New variety of street drugs poses growing problem". (1985) 63 *Chemical and Engineering News* 7.

Bell DS. "Australia and New Zealand". In Einstein S (ed). *The community's response to drug use*. NY, Pergamon, 1986, 36.

Bell J et al "Hepatitis C virus in intravenous drug users". (1990) 153 *Medical Journal of Australia* 274-276.

Bell M. "Treatment". In Wardlaw G, Strang H, Bull M, MacDowell D, Norberry J. *Comparative Analysis of Illicit Drug Strategy*. Canberra, Australian Government Publishing Service, 1992.

Bellis MA, Weild AR, Beeching NJ, Mutton KJ, Syed Q. "Prevalence of HIV and injecting drug use in men entering Liverpool prison". (1997) 315 *British Medical Journal*.

Berridge V. "Harm reduction: an historical perspective". (1992) *National AIDS Bulletin*.

Bertram S, O'Reilly B. *Summary of the 1996 Australian secondary school alcohol and drug survey. Northern Territory findings*. Casuarina, Northern Territory Health Services, 1998.

Bird AG, Gore SM, Hutchinson SJ, Lewis SC, Cameron S, Burns S. "Harm reduction measures and injecting inside prison versus mandatory drugs testing: results of a cross sectional anonymous questionnaire survey". (1997) 315 *British Medical Journal*. 21-24.

Blaze-Temple D, Lo SK. "Stages of drug use: a community survey of Perth teenagers". (1992) 87 *British Journal of Addiction* 215–225.

Bond P. "The development of good practice and treatment in the rehabilitation of alcoholic and drug addicted inmates in Her Majesty's prisons." (1998) 33 *Alcohol & Alcoholism* 83-88.

Botvin GJ, Baker E, Dusenbury L, Botvin EM, Diaz T. "Long term follow-up results of a randomised drug abuse prevention trial in a white middle class population". (1995) 273 *Journal of American Medical Association* 1106-1112.

Bowman J, Sanson-Fisher R. *Public perceptions of cannabis legislation*. Canberra, Australian Government Publishing Service, 1994.

Brady M. *Heavy metal. The meaning of petrol sniffing in Australia*. Canberra, Aboriginal Studies Press, 1992.

Brady N. "Agencies support new police approach. Welfare workers welcome moves to keep drug users out the courts." *The Age* 7 July 1998

Brooks A, Stothard C, Moss J, Christie P, Ali R. *Costs associated with the operation of the cannabis expiation notice scheme in South Australia*. Adelaide, Drug & Alcohol Services Council, 1998.

Brown BS, Needle RH. "Modifying the process of treatment to meet the threat of AIDS." (1994) 29 *International Journal of Addictions* 1739.

Bulletin on Narcotics. "Legal trade in narcotics". (1953) 5 (2) *Bulletin on Narcotics* 48.

Burke KC, Burke JD, Reiger DA, Rae DS. "Age at onset of selected mental disorders in five community populations". (1990) 47 *Archives of General Psychiatry* 511-518.

Burrows D, Dickie M, Langenberg J, Wodak A. *AIDS and intravenous drug use - overcoming the obstacles to change. Proceedings of national workshop, Canberra May 1989*. Canberra, Australian Government Publishing Service, 1990.

Burrows D. "Injecting equipment provision in Australia: the state of play." (1998) 33 *Substance Use & Misuse* 1113-1127.

Butler TG, Dolan KA, Ferson MJ, McGuinness LM, Brown PR, Robertson PW. "Hepatitis B and C in New South Wales prisons: prevalence and risk factors." (1997) 166 *Medical Journal of Australia* 127-130.

Byrne J, Chong D. "White powder, what a hell of a way to integrate into this community. Reflections on the phenomena of heroin usage within the Vietnames youth population." *VAADA Vine* November 1997 14-19.

Cameron I, McBride N. "Creating health promoting schools: lessons from the Western Australian School Health Project". (1995) 5 *Health Promotion Journal of Australia* 4-10.

Campbell B. "School's no place for men in black". *Fremantle Herald* 1 August 1998.

Caplehorn JRM. "Deaths in the first two weeks of maintenance treatment in NSW in 1994: identifying cases of iatrogenic methadone toxicity." (1998) 17 *Drug & Alcohol Review* 9-17.

Carroll T. "Social marketing and teenage drinking. The development and impact of national drug offensive adolescent alcohol campaign 1988-1995". In proceedings from *Reshaping the future: drugs and young people conference*. Melbourne, Australian Drug Foundation, 1996.

Carruthers S, Ewers-Verge J, Boots K, Midford R. *Investigations of alcohol and illicit drug use among a study group of West coast fishing industry workers*. Perth, National Centre for Research Into the Prevention of Drug Abuse, Curtin University of Technology, 1997.

Chalmers EM. "Volatile substance abuse." (1991) 154 *Medical Journal of Australia* 269.

Centre of Alcohol Studies, Rutgers University. *Socioeconomic evaluations of addictions treatment. Prepared for President's Commission on Model State Drug Laws*. Centre of Alcohol Studies, Rutgers University, 1996.

Chen R, Mattick RP, Baillie A. *Clients of treatment service agencies March 1992 census findings*. Canberra, Department of Health, Housing, Local Government and Community Services, 1994.

Chesher G. "Designer drugs - the 'what's' and the 'whys'". (1990) 153 *Medical Journal of Australia* 157.

Christie P. "The cannabis expiation notice system in South Australia: its effects on cannabis use". In White J (ed). *Drug problems in society, dimensions and perspectives*. Parkside, SA, Drug & Alcohol Services council, 1992. 109-114.

Christie P. *Cannabis offences under the cannabis expiation notice scheme in South Australia*. Adelaide, Drug & Alcohol Services Council, 1998.

Chowdhury A N. "Cannabis; a note from Bengal. Comments on Hall et al's Australian national drug campaign monograph no. 25 'the health and psychological consequences of cannabis use". (1996) 91 *Addiction* 759–773.

Clark JC, Milroy CM, Forrest ARW. "Deaths from methadone use." (1995) 2 *Journal of clinical Forensic Medicine* 143-144.

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

Collison M. *Police, drugs and community*. London, Free Association Press, 1995.

Commonwealth Department of Community Services & Health. *National HIV/AIDS strategy. A policy information paper*. Canberra, Australian Government Publishing Service, 1989.

Commonwealth Department of Health. *National Campaign Against Drug Abuse. Campaign document issued following the Special Premier's Conference, Canberra, 2 April 1985*. Canberra, Australian Government Publishing Service, 1985.

Connexions. "Methadone: through a glass darkly". (1989) *Connexions* September/October 11-24; November/December 2-9.

Coombs RH, Paulson MJ, Richardson MA. "Peer vs parental influence in substance use among Hispanic and Anglo children and adolescents." (1991) 20 *Journal of Youth and Adolescence* 73-88.

Coutino RA. "HIV and hepatitis C among injecting drug users." (1998) 317 *British Medical Journal* 424-425.

Crofts N, Hopper JL, Bowden DS, Breschkin AM, Milner R, Locarnin SA. "Hepatitis C virus infection among a cohort of Victorian injecting drug users". (1993) 159 *Medical Journal of Australia* 237.

Crofts N. "A cruel and unusual punishment. Sentencing prisoners to hepatitis infection as well as to loss of liberty is a violation of human rights." (1997) 166 *Medical Journal of Australia* 116.

Cyle K. "Alcohol Drug Authority staffing is serious". *Daily News* 13 October 1976.

Daily News. Abbott S. "The drug you don't get hooked on". *Daily News* 6 January 1984.

Dalton MS, Duncan D, Taylor N. "Methadone blockade in the treatment of opiate addiction: a follow up study". (1976) 1 *Medical Journal of Australia* 755-756.

Dalton MS, Duncan DW. "Fifty opiate addicts treated with methadone blockade - eight year follow up". (1979) 1 *Medical Journal of Australia* 153, 154.

D'Anger J. "Sniffer dogs on prowl." *Fremantle Herald* 4 July 1998.

Darke S, Ross J. "Polydrug dependence and psychiatric comorbidity among heroin injectors". (1997) 48 *Drug & Alcohol Dependence* 135-141, 136.

Darke S. "Injecting drug users and the Human Immunodeficiency Virus what do we know?" (1992) 11 *Drug and Alcohol Review* 153.

Davies S. *Shooting up heroin - Australia*. Sydney, Hale & Iremonger, 1986.

Department of Health & Family Services, Mental Health Services Branch. *National mental health report 1996: fourth annual report, changes in Australia's mental health services under the National Mental Health Strategy 1995-96*. Canberra, Department of Health & Family Services, 1997, 142.

Des Jarlais D, Friedman SR, Strug D. "AIDS among intravenous drug users: a sociocultural perspective". In D Feldman and T Johnson (eds.). *The social dimensions of AIDS: Methods and theory*. New York, Praeger, 1986.

Des Jarlais DC, Friedman SR, Choopanya K, et al. "International epidemiology of HIV and AIDS among injecting drug users." (1992) 6 *AIDS* 1053.

Des Jarlais DC, Friedman SR. "Shooting galleries and AIDS: infection probabilities and 'tough' policies". (1990) 80 *American Journal of Public Health* 142-144.

Didcott P, Reilly, D, Swift W, Hall W. *Long term cannabis users on the NSW north coast*. Sydney, National Drug and Alcohol Research Centre, University of NSW, 1997.

Dobbin M. "Methadone related deaths in Victoria 1993-9." In Godding R, Whelan G (eds). *Proceedings of the 1995 Autumn School of Studies on Alcohol and Drugs*. Melbourne, St Vincent's Hospital, 1995.

Dobinson I, Ward P. Drugs and crime. *A survey of NSW prison property offenders 1984*. Sydney, NSW Bureau of Crime Statistics and Research, 1985.

Dolan K. "AIDS, drugs and risk behaviour in prison: state of the art". (1997) 8 *International Journal of Drug Policy* 7.

Dolan KA, Wodak A, Hall WD. "Methadone maintenance treatment reduces heroin injection in NSW prisons." (1998) 17 *Drug & Alcohol Review* 153-158.

Dolan KA, Wodak A, Hall W, Kaplan E. "A mathematical model of HIV transmission in NSW prisons." (1998) 50 *Drug and Alcohol Dependence* 197-202.

Dole VP, Nyswander ME, Warner A. "Successful treatment of 750 criminal addicts". (1968) 206 *Journal of American Medical Association* 2708-2711.

Dole VP, Nyswander ME. "A medical treatment for diacetylmorphine (heroin) addiction. A clinical trial with methadone hydrochloride." (1965) 193 *Journal of American Medical Association* 80-84.

Dole VP, Nyswander ME. "Heroin addiction - a metabolic disease." (1967) 120 *Archives of Internal Medicine* 19-24.

Donnelly N, Hall W. *Patterns of cannabis use*. Canberra, Australian Government Publishing Service, 1994.

Donnelly N, Hall W, Christie P. "The effects of partial decriminalisation on cannabis use in South Australia, 1985 to 1993". (1995) 19 *Australian Journal of Public Health* 281-287.

Donnelly N, Hall W, Christie P. Effects of the CEN scheme on levels and patterns of cannabis use in South Australia. Evidence from the NDS Household Surveys 1985-1995. Adelaide, Drug & Alcohol Services Council, 1998

Dorn N, Murji K, South N. *Traffickers: drug markets and law enforcement*. London, Routledge, 1992.

Dorn N, Baker O, Seddon T. *Paying for heroin: estimating the financial cost of acquisitive crime committed by dependent heroin users in England and Wales*. London, Institute for the Study of Drug Dependence, 1994.

Drucker E. "Drug prohibition and public health: it's a crime". (1995) *Australian & New Zealand Journal of Criminology* 67-73.

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

Drummer OH, Opeskin K, Syrjanen M, Cordner SM. "Methadone toxicity causing deaths in ten subjects starting on a methadone maintenance program." (1992) 13 *American Journal of Forensic Medicine and Pathology* 346-350.

Drummond DC, Taylor JA, Mullin PJ. "Replacement of a prescribing service by an opiate-free day program in a Glasgow drug clinic." (1986) 81 *British Journal of Addiction* 559.

Durante AJ, Hart GJ, Brady AR, Madden PB, Noone A. "The Health of the Nation target on syringe sharing: a role for routine surveillance in assessing progress and targeting interventions." (1995) 90 *Addiction* 1389-1396.

Edwards G et al. *Alcohol policy and the public good*. Oxford, Oxford University Press, 1995.

Ellis AS. *Investigation into drugs and alcohol 1971*. Perth, Mental Health Services, 1971.

Elmquist DL. "A systematic review of parent oriented programs to prevent children's use of alcohol and other drugs." (1995) 25 *Journal of Drug Education* 251-279.

Esmail A, Warburton B, Bland JM, Anderson HR, Ramsey J. "Regional variations in deaths from volatile solvent abuse in Great Britain." (1997) 92 *Addiction* 1765-1771.

Evanko D. "Designer drugs - treating the damage caused by basement chemists". (1991) 89 *Postgraduate Medicine* 67.

Ezeh A, Sundberg B, Roth P, Thoreson R, Scott-Pinkney G. *Uniform Facility Data Set (UFDS): data for 1996 and 1980-1996*. Rockville MD, Office of Applied Studies, Substance Abuse & Mental Health Services Administration, 1997.

Fank G, Ashworth K. "School drug blitz widens". *West Australian* 3 July 1998.

Federal Office of Road Safety. "Road safety advertising: an empirical study and literature review". *Market research report 9/95*. Canberra, Federal Office of Road Safety, 1995.

Fox R, Mathews I. *Drug policy: fact, fiction and the future*. Annandale, NSW, Federation Press, 1992.

Fremantle Gazette. "Drug plan for schools". 17 February 1998.

Fremantle Gazette. "Students approve police presence". 3 July 1998.

Fremantle Gazette. "Checks dispel drug myths: principal". 10 July 1998.

Gaughwin MD, Ali R. "HIV infection among injecting drug users in the South Australian methadone program." (1995) 162 *Medical Journal of Australia* 242-244.

Geraldton Guardian. "Drug and drink changes". *Geraldton Guardian* 1 December 1997.

German D, Skidmore M. *Young people and solvent use in the Armadale area*. (unpublished paper Welfare Studies course, Perth Central Metropolitan Campus TAFE), 1994.

Gibson R. "Schools come under surveillance". *The Age* 4 July 1998.

Gleick E. "Kicking the habit of 30-day, inpatient treatment, substance-abuse clinics retool for managed care". (1996) 147(6) *Time Magazine*.

Gleghorn AA, Wright-De Aguero L, Flynn C. "Feasibility of one time use of sterile syringes: a study of active injection drug users in seven united States metropolitan areas." (1998) 18 Supplement 1 *Journal of Acquired Immune Deficiency Syndrome and Human Retrovirology*

Goldstein A, "Heroin addiction – sequential treatment employing pharmacologic supports". (1976) 33 *Archives of General Psychiatry* 353-358.

Goodheart RS, Dunne JW. "Petrol sniffer's encephalopathy." (1994) 160 *Medical Journal of Australia* 178.

Gore C. *Report of the pilot heroin overdose peer education project March 1997*. Rozelle, Centre for Education & Information on Drugs and Alcohol, 1997.

Gore SM, Bird AG, Ross AJ. "Prison rights: mandatory drugs tests and performance indicators for prisons". (1996) 314 *British Medical Journal*.

Gore SM, Bird AG. "Drugs in British prisons". (1998) 316 *British Medical Journal* 1256-57.

Gowing L, Ali R, Christie P, White J. *Therapeutic uses of cannabis*. Adelaide, Drug & Alcohol Services Council, 1998.

Gray N, Daube M (eds). *Guidelines for smoking control*. London, International Union Against Cancer, 1980.

Green P, Purnell I. *Measuring success of law enforcement agencies in Australia targeting major drug offenders relative to minor drug offenders*. Payneham SA, National Police Research Unit, 1996.

Hagan H. "Hepatitis C virus transmission dynamics in injection drug users." (1998) 33 *Substance Use & Misuse* 1197-1212.

Hall W (ed). *Proceedings of an international opioid overdose symposium, Sydney, 14-15 August 1997*. Sydney, National Drug and Alcohol Research Centre, 1998.

Hall W, Solowij N, Lemon J. *The health and psychological consequences of cannabis use*. Canberra, Australian Government Publishing Service, 1995.

Hall W. *The demand for methadone maintenance treatment in Australia*. Sydney, National Drug and Alcohol Research Centre, University of NSW, 1995.

Hall W. "The health risks of cannabis". (1995) 24 *Australian Family Physician* 1237-1240.

Hall W. "The recent Australian debate about the prohibition on cannabis use". (1997) 92 *Addiction* 1109-1115.

Hall W. "The role of legal coercion in the treatment of offenders with alcohol and heroin problems." (1997) 30 *Australian and New Zealand Journal of Criminology* 103-120.

Hall W. *Cannabis and psychosis*. Sydney, National Drug and Alcohol Research Centre, University of NSW, 1998.

Hall W, Nelson J. *Public perceptions of health and psychological consequences of cannabis use*. Canberra, Australian Government Publishing Service, 1995.

Hall W, Nelson J. "Correlates of the perceived health risks of marijuana use among Australian adults". (1996) 15 *Drug & Alcohol Review* 137-143.

Hamid A, Curtis R, McCoy K, McGuire J, Conde A, Bushell W, Lindenmayer R, Brimberg K, Maia S, Abdur-Rashid S, Settembrino J. "The heroin epidemic in New York city: current status and prognosis." (1997) 29 *Journal of Psychoactive Drugs* 375-391.

Hancock L, Walsh R, Redman S, Hennrikus D, Sanson-Fisher RW, Gibberd RW. "Psychotropic drug use in the Australian community: benzodiazepines". In White J (ed). *Drug problems in society - dimensions and perspectives*. Adelaide, Drug and Alcohol Services Council, 1992.

Hando J, O'Brien S, Darke S, Maher L, Hall W. *The illicit drug reporting system (IDRS) trial: final report*. Sydney, NDARC, University of NSW, 1997, 21-26.

Harding TW. "Do prisons need special health policies and programs?" (1997) 8 *International Journal of Drug Policy* 22-30.

Health Department of WA. 1997 tobacco, alcohol and illicit drug consumption survey results for licit and illicit drug usage (adults 18+). (unpublished).

Health Promotion Services, Alcohol and Other Drugs Program. *Guidelines for developing a school drug policy*. 2nd ed. Perth, Health Department of WA, 1996.

Health Promotion Services, Health Department of Western Australia. *Developing an effective public education program on illicit drugs* (unpublished), 1996.

Health Promotion Services. 1996 ASSAD survey (school students) (unpublished), 1997.

Health Promotion Services. 1997 Tobacco, alcohol and illicit drugs consumption survey. (unpublished data).

Health Promotion Services. *Formative qualitative research for drug aware heroin prevention campaign* (unpublished). Perth, Health Promotion Services, Health Department of WA 1997.

Health Promotion Services. How parents influence adolescent alcohol consumption. *Alcohol and Other Drugs Bulletin No. 2*. Perth, Health Promotion Services, Health Department of WA 1996.

Health Promotion Services. *I guess if it was there and someone offered me it I'd probably take it.* (unpublished). Perth, Health Promotion Services, Health Department of WA 1997, 10.

Healy M. *Road crashes in Western Australia 1993*. Perth, Research and Statistics Branch, Police Department, 1994.

Heather N et al (eds). *Psychoactive drugs and harm reduction: from faith to science*. 1993

Heaven PCL *Adolescent health*. London, Routledge, 1996.

Henderson GL. "Designer drugs past history and future prospects". (1988) 33 *Journal of Forensic Sciences* 569.

Henham R. "Drug offenders and sentencing policy". (1996) 2 *Web Journal of Current Legal Issues*.

Herrman H, Mcgorry P, Mills J, Singh B. "Hidden severe psychiatric morbidity in sentenced prisoners: an Australian study". (1991) 148 *American Journal of Psychiatry* 236-239.

Hewitt S. "Dog on scent of drug teens". *Sunday Herald* 5 July 1998.

Hough M. *Drugs misuse and the criminal justice system: a review of the literature*. London, Central Drugs Prevention Unit, Home Office, 1996.

Hulse G. "Naltrexone – defining a framework for use". *APSAD Newsletter*, Summer 1998.

Humeniuk R, Brooks A, Christie P, Ali R, Lenton S. *Social impacts and characterisation of offenders under the cannabis expiation notice scheme in south Australia.* Adelaide, Drug & Alcohol Services Council, 1998.

Hurley SF, Jolley DJ, Kaldor J. "Effectiveness of needle exchange programs for prevention of HIV infection". (1997) 349 *Lancet* 1797-1800.

Inciardi JA, Martin SS, Butzin CA, Hooper RM, Harrison LD. "An effective model of prison-based treatment for drug-involved offenders". (1997) 27 *Journal of Drug Issues* 261-278.

Incorvaia D, Baldwin S. "Drugs behind bars (part 1): a multi-dimensional approach to correctional services settings." (1997) 2 *Journal of Substance Misuse* 69-76.

Indermaur D, Upton, K. "Alcohol and drug use patterns of prisoners in Perth". (1988) 21 *Australian and New Zealand Journal of Criminology* 144.

International Narcotics Control Board. Report for 1997. Geneva, International Narcotics Control Board, United Nations, 1997.

Jagger EASM. "The policing of glue sniffing." (1996) 36 *British Journal of Criminology* 237-254.

James R, Harrison D, Laughlin D. *Community mobilisation for the prevention of alcohol related injury. Progress report year 1: problems with parachuting in*. Perth, National Centre for Research Into the Prevention of Drug Abuse, Curtin University of Technology, 1993, 36.

Jaroff L. "How good is ER's R?" *Time* 1 June 1998 51.

Johns A. "Volatile solvent abuse and 963 deaths (editorial)." (1991) 86 *British Journal of Addiction* 1053.

Kafka RR, London P. "Communication in relationships and adolescent substance use: the influence of parents and friends." (1991) 26 *Journal of Adolescence* 587-598.

Kalgoorlie Miner. "Principal continues tough stand on drugs." 13 June 1998

Kandel DB. "Issues of sequencing of adolescent drug use and other problem behaviours". (1988) 3 *Drugs and Society* 55–76.

Kandel DB, Yamaguchi K, Chen K. "Stages of progression in drug involvement from adolescence to adulthood: further evidence for the Gateway theory" (1992) 53 *Journal of Studies into Alcohol* 447-457.

Kandel DB, Davies, M. "Progression to regular marijuana involvement: phenomenology and risk factors for near-daily use". In Glantz M, Pichens R (eds). *Vulnerability to drug abuse*. Washington, DC, American Psychological Association 1992.

Kelly B "Drugs in prison – Part 1". *ABCI Intelligence Digest*, July 1996, 29-32.

Kelly B "Drugs in prison – Part II". *ABCI Intelligence Digest*, January 1997, 13-17.

Kelly B, McGregor D. "Models of alcohol and other drugs service delivery among women". In Copeland J, Swift W (eds). *1994 national women and drugs conference: challenge, consensus and change. Issues papers*. Sydney, Drug and Alcohol Directorate, NSW Health Department, 1994, 69.

Kerr CB, Challenor W, Morey S, Sergent T, Whitlam F. *Final report of committee of review into drug and alcohol services in NSW*. Sydney, NSW Department of Health, 1985.

Kevin M. *Drug and alcohol exit survey. Part one: drug and alcohol background of inmates*. Sydney, Department of Corrective Services, 1992.

Kirsch A, Goos C, Gossop M. *AIDS among drug users in Europe. Second review*. Copenhagen, WHO Regional Office for Europe, 1993.

Klee H, Morris J. "Factors that characterise street injectors". (1995) 90 *Addiction* 837-841.

Koester S, Hoffer L. "Indirect sharing: additional HIV risks associated with drug injection". (1994) 9 *AIDS Public Policy Journal* 100-105.

Koester S. "Waters, cookers and cottons: additional risks for intravenous drug users". In National Institute on Drug Abuse. *Epidemiologic trends in drug abuse. Proceedings of the Community Epidemiology Working Group*. Rockville, MD, National Institute on Drug Abuse, 1989.

Koester S. "Waters, cookers and cottons: additional risks for intravenous drug users". In National Institute on Drug Abuse. *Epidemiologic trends in drug abuse. Proceedings of the Community Epidemiology Working Group*. Rockville, MD, National Institute on Drug Abuse, 1989.

Koondoola and Girrawheen Youth Inc. *Speeding in the northern suburbs, problems of a group of young amphetamine users*. Perth, Koondoola and Girrawheen Youth Inc, 1993

Kozel NJ, Sloboda Z. *Assessing drug abuse within and across communities. Community epidemiology surveillance networks on drug abuse*. Rockville, MD, National Institute on Drug Abuse, 1998.

Kutin JJ, Lintzeris N, Ezard N, Muhleisen P. *Evaluation of the specialist methadone service at Turning Point Alcohol & Drug Centre and Western Hospital Footscray*. Melbourne, Turning Point, 1997, 2.

Lane J. Nu-Hit. *Nunga users HIV intervention team. A report for the AIDS Council of South Australia*. Adelaide, AIDS Council of South Australia, 1992-93.

Lenton S. *Illicit drug use, harm reduction and the community: attitudes to cannabis law and needle and syringe provision in Western Australia*. Perth, National Centre for Research Into the Prevention of Drug Abuse, Curtin University of Technology, 1994.

Lenton S. *Cannabis offenders in the Western Australian criminal justice system 1993-1995*. Perth, National Centre for Research into the Prevention of Drug Abuse, Curtin University of Technology, 1998.

Lenton S, Donoghoe M, Loxley W, Ovenden C, Carruthers S. *IDUs, needle and syringe provision and harm reduction: the English and WA experience*. Perth, National Centre for Research Into the Prevention of Drug Abuse, Curtin University of Technology, 1994.

Lenton S, Ferrante A, Loh N. "Dope busts in the West: minor cannabis offences in the Western Australian criminal justice system". (1996) 15 *Drug & Alcohol Review* 335-341.

Lenton S, Christie P, Humeniuk R, Brooks, A, Bennett M, Heale P. *Infringement versus conviction: the social impacts of a minor cannabis offence under a civil penalties system and strict prohibition in two Australian States*. Perth, National Centre for Research into the Prevention of Drug Abuse, Curtin University of Technology, 1998.

Lenton S, Bennett M, Heale P. *The social impact of a minor cannabis offence under strict prohibition – the case of Western Australia*. Perth, National Centre for Research into the Prevention of Drug Abuse, Curtin University of Technology, 1998.

Lintzeris N. "Mortality and methadone treatment in Victoria." In Godding R, Whelan G (eds). *Proceedings of the 1995 Autumn School of Studies on Alcohol and Drugs*. Melbourne, St Vincent's Hospital, 1995.

Lintzeris N, Koutroulis G, Odgers P, Ezard N, Lanagan A, Muhleisin P. Stowe A. *Report on the evaluation of the community methadone services in Victoria*. Melbourne, Turning Point, 1996.

Lo SK, Blaze-Temple D, Binns CW. "Perth teenage drug consumption - differences between students and non-students". (1985) *Drug Education Journal of Australia*.

Lockwood A, Berbatis C. "Psychotropic drugs in Australia: consumption patterns". (1989) 153 *Medical Journal of Australia* 604-611.

Loxley W, Davidson P. *Forgetting to breathe: opioid overdose and young injecting drug users in Perth*. Perth, National Centre for Research Into the Prevention of Drug Abuse, Curtin University of Technology, 1998.

Lynskey M, Hall W. *Jurisdictional trends in opioid overdose deaths, 1988-1996*. Sydney, National Drug & Alcohol Research Centre, University of NSW, 1988, 4.

MacDonald M, Wodak AD, Ali R, Crofts N, Cunningham PH, Dolan KA, Kelaher M, Loxley WM, Van Beek I, Kaldor JM. "HIV prevalence and risk behaviour in needle exchange attenders: a national study." (1997) 166 *Medical Journal of Australia* 237-240.

Maclean S. "Students caught with cannabis in school raids." *Cockburn Community Gazette* 3 July 1998

Maher L. "Age, culture, environment and risk: contextualising high risk practices among new injectors in South West Sydney". Paper presented at the *VII International Conference on the Reduction of Drug Related Harm*. Tasmania, March 3-7 1996.

Maher L, Dixon D, Lynskey M, Hall W. *Running the risks: heroin, health and harm in South West Sydney*. Sydney, National Drug and Alcohol Research Centre, University of New South Wales, 1998.

Mahlberger A. "AIDS in the injecting drug population: a public health challenge." (1994) 1 *Drugs: education, prevention & policy* 259-273.

Makkai T, McAllister I. *Marijuana in Australia: patterns and attitudes*. Canberra, Australian Government Publishing Service, 1997.

Makkai T, McAllister I. *Public opinion towards drug policies in Australia, 1985-95*. Canberra, Australian Government Publishing Service, 1998.

Makkai R, McAllister I. *Patterns of drug use in Australia, 1985-95*. Canberra, Australian Government Publishing Service, 1998.

Manderson D. *Proscription and prescription*. Canberra, Australian Government Publishing Service, 1987, 28.

Manderson D. "Drug abuse and illicit drug trafficking." (1998) 168 *Medical Journal of Australia* 588-589.

Manning PK. *The narc's game: organisational and informational limits on drug law enforcement*. Cambridge, Mass, MIT Press, 1980.

Marks RE. "Cannabis laws: an analysis of costs". (1994) 13 *Drug & Alcohol Review* 341-346.

Marmour M, Des Jarlais DC, Cohen H, Friedman SR, Beatrice ST, Dubin N, El-Sadr W, Midvan D, Yancovitz S, Mathur U, Holzman R. "Risk factors for infection with human immunodeficiency virus among intravenous drug abusers in New York City". (1987) 1 *AIDS* 39-44.

Marsh A. "Young people with drug problems: why some and not others?" In Wilkinson C, Saunders B (eds). *Perspective on addiction*. Perth, Montgomery, 1996.

Martin C. "Drug recovery centre planned". *West Australian* 1 December 1975.

Martin C. "Perth's heroin addicts". *West Australian* 21 January 1977.

Mason D, Birmingham, Grubin D. "Substance use in remand prisoners: a consecutive case study". (1997) 315 *British Medical Journal* 18-21.

Matheson A. "Addicts die after drug clampdown". *Weekend News* 2-3 June 1984.

Mattick RP, Bell J, Daws LC, White JM, O'Brien S, Harris SJ. *Review of the evidence on the effectiveness of antagonists in managing opioid dependence*. Sydney, National Drug and Alcohol Research Centre, University of NSW, 1998.

Mattick RP, Hall W. *A treatment outline for approaches to opioid dependence. Quality assurance in the treatment of drug dependence project*. Canberra, Australian Government Publishing Services, 1993.

Maxwell JC, Davey J, Dillon P. *Comparison of patterns of illicit drug use in Australia and the United States*. Austin, Texas Commission on Alcohol and Drug Abuse, 1997.

Mayman J. "Patients back ADA staff". *Sunday Independent* 19 September 1976.

Mazza D, Dennerstein L, Ryan V. "Psychotropic drug use by women: current prevalence and associations". (1995) 163 *Medical Journal of Australia* 86-89.

McAllister I, Moore R. *Drugs and public opinion the sociology of drug use in Australia*. Canberra, Department of Community Services and Health, 1988.

McBride N, Cameron I, Midford R, James R. "Facilitating health promotion in Western Australian schools: key factors for success". (1995) 5 *Health Promotion Journal of Australia* 11-16.

McBride N, Midford R, James R. "Structural and management changes that encourage schools to adopt comprehensive health promotion programs". (1995) 5 *Health Promotion Journal of Australia* 17-23.

McCoy AW. *Drug traffic narcotics and organised crime in Australia*. Artarmon, NSW, Harper & Row, 1980.

McDonald A, Cui J. "The pattern of diagnosed HIV infection and AIDS in women in Australia, 1984-1996." (1997) 13(2) *Australian HIV Surveillance Report*, 1-7.

McDonald D, Moore, R, Norberry J, Wardlaw G, Ballenden N. *Legislative options for cannabis in Australia*. Canberra, Australian Government Publishing Service, 1994.

McDonald M. "HIV prevalence and incidence among injecting drug users attending needle and syringe exchanges in Australia, 1995-1997." (1998) 14(1) *Australian HIV Surveillance Report*, 1-5.

McGregor C, Darke S, Ali R, Christie P. "Experience of non fatal overdose among heroin users in Adelaide, Australia: circumstances and risk perceptions." (1998) 93 *Addiction* 701-711.

McKay & Associates. *Review of funding of methadone programs in Australia*. Canberra, Department of Community Services & Health, 1989, 7.

Mckey J. "Dual diagnosis – joining forces." (1998) 17(4) *Connexions* 5-11.

Melville-Fremantle Community. "Support, criticism for police searches". 14-20 July 1998.

Metrebian N, Shanahan W, Wells B, Stimson GV. "Feasibility of prescribing injectable heroin and methadone to opiate dependent drug users: associated health gains and harm reductions." (1998) 168 *Medical Journal of Australia* 596-600.

Mills M. "Addicts try to kick the habit". *Sunday Independent* 8 January 1984.

Milner G. "Guest editorial methadone". (1976) 2 *Medical Journal of Australia* 551-553.

Ministry of Justice, Juvenile Justice Division. *Survey of drug use patterns amongst young offenders in detention*. Perth, Ministry of Justice, 1995.

Miotto K, McCann MJ, Rawson RA, Frosch D, Ling W. "Overdose, suicide attempts and death among a cohort of naltrexone treated opioid addicts". (1997) 45 *Drug and Alcohol Dependence* 131-134.

Moore MH. Supply reduction and drug law enforcement. In M Tonry and JQ Wilson (eds). *Drugs and Crime*. Chicago, University of Chicago Press, 1990.

Moskowitz JM "The primary prevention of alcohol problems: a critical review of the research literature". (1989) 50 *Journal of Studies on Alcohol* 54-87.

Mumola CJ, Bonzcar TP. *Substance abuse and treatment of adults on probation, 1995*. Washington DC, Bureau of Justice Statistics, US Department of Justice, 1998.

Mundy J. "Decades of dope". (1997) *Connexions*. April/May 16–17.

Mundy J. "Lessons to be learned: the challenge of teaching about drugs." 1996 April/May *Connexions* 4-12.

Murdoch L. "Soaring drug use changes attitudes." *The Age* 7 July 1998

Murray "Drugs kill Perth beauty queen". *Daily News* 10 May 1984.

Murray K. "Doctor supplied 24,000 shots". *Daily News* 10 May 1984.

Murray K. "Tragic story of double suicide". *Daily News* 15 June 1984.

National Drug Strategy Household Survey. *Urban Aboriginal and Torres Strait Islander Peoples Supplement.* Canberra, Department of Human Services & Health, 1994.

National Drug Strategy. *Report of the National Task Force on Cannabis*. Canberra, Australian Government Publishing Service, 1994.

National Health & Medical Research Council. *Draft report on a strategy for the detection and management of hepatitis C in Australia*. Canberra, National Health & Medical Research Council, 1996.

National Health and Medical Research Council. *National policy on methadone*. Canberra, National Health and Medical Research Council, 1977, section 3.1.2.

NCADA: Assumptions, arguments and aspirations. Canberra, Australian Government Publishing Service, 1987.

Needle R, Cesari H, Koester S. "Multi person use of drug injection equipment: HIV transmission risks associated with drug preparation and injection practices". Paper presented at the 10th International Conference on AIDS. Yokohama, Japan, August 1996.

New Scientist. Special report on marijuana. *New Scientist*. 21 February 1998, 3-31.

New South Wales, Parliament, Joint Committee Upon Drugs. *Progress report and minutes of proceedings 1976-78*. Sydney, Government Printer, 1978, 102.

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

New Zealand, Ministry of Health. *A National Drug Policy for New Zealand 1998-2003*. Wellington, Ministry of Health, 1998 [http://www moh.govt nz]

New Zealand Drug Foundation. *New Zealand should regulate and tax cannabis commerce. Final report of the Drug Policy Forum Trust, 30 March 1998*. [http://www/nzdf.org nz]

Nutbeam D. "Creating health promoting environments: overcoming barriers to action". (1997) 21 *Australian & New Zealand Journal of Public Health* 355-359.

Odgers P, Houghton S, Douglas G. Reputation enhancement theory and adolescent substance use (unpublished).

Office for Aboriginal and Torres Strait Islander Health Services. *Review of the Commonwealth's Aboriginal and Torres Strait Islander substance misuse program*. Canberra, Department of Health & Family Services, 1998.

Ostor AG. "The medical complications of narcotic addiction". (1977) *Medical Journal of Australia* 410-415, 448-451, 497-499.

Ouellet LJ, Jimenez AD, Johnson WA, Wiebel WW. "Shooting galleries and HIV disease: variations in places for injecting illicit drugs". (1991) 37 *Crime and Delinquency* 64-85.

Parkes P, Byrne J. *Young injecting drug users project. The introduction of a peer education process in the ACT within groups of young injecting drug users*. Canberra, ACT IV League, 1995.

Parr MJA, Low HM, Botterill P. "Hyponatraemia and death after 'ecstasy' ingestion." (1997) 166 *Medical Journal of Australia* 136-137.

Pennells S. "School suspends two boys, 10, for dealing". *West Australian* 20 June 1998.

Perkins et al "The prevalence of drug use in urban Aboriginal communities". (1994) 89 *Addiction* 1319-1331.

Perneger TV, Giner F, Del Rio M, Mino A. "Randomised trial of heroin maintenance program for addicts who fail in conventional drug treatments." (1998) 317 *British Medical Journal* 13-18.

Perry CL, Williams CL, Komro KA, Veblen-Mortenson S, Forster JL, Bernstein-Lachter R, Pratt LK, Munson KA, Farbakhsh, K. Project Northland – Phase II: community action to reduce adolescent alcohol use. *Paper presented at 1998 Kettil Bruun Society thematic meeting, Fourth Symposium on Community Action Research and the Prevention of Alcohol and Other Drug Problems*. 8-13 February 1998. New Zealand.

Petry NM, Bickel WK. "Polydrug abuse in heroin addicts: a behavioural economic analysis." (1998) 93 *Addiction* 321-335.

Phung H, Bodilsen G, Webb A, Briscoe N. *Results from the 1996 ACT secondary school students' survey*. Canberra, Epidemiology Unit, ACT Department of Health & Community Care, 1998.

Plant A, Macaskill P. Lo SK, Pierce J. *Report of the evaluation of the anti-heroin campaign*. Sydney, Department of Public Health, University of Sydney, 1988.

Pryer W. "Expert attacks heroin hope". *The West Australian* 30 March 1998, 11.

Queensland, Government Statistician's Office. *Drug related deaths, Queensland, 1989-92*. Brisbane, Government Statistician's Office, 1997.

Rankin J, Holst V, McKnight J, Moait S, Rae A. *Report of the New South Wales Committee of Inquiry Into the Legal Provision of Heroin and Other Possible Methods of Diminishing Crime Associated With the Supply and Use of Heroin*. Sydney, NSW Health Commission, 1981.

Rankin J, Mattick RP. *Review of the effectiveness of methadone treatment and analysis of St Mary's Clinic, Sydney*. Sydney, National Drug and Alcohol Research Centre, 1997.

Rankin J. *The use of methadone in New South Wales for the management of opiate dependent individuals: a review and recommendations for change*. Sydney, Health Commission of NSW, 1981.

Rawson RA, Hasson AL, Huber AM, McCann MJ, Ling W. "A 3 year progress report on the implementation of LAAM in the United States." (1998) 93 *Addiction* 533-540.

Rechichi V. "Students strip searched". *West Australian* 1 August 1998.

Reed J, Lyne M. "The quality of health care in prison: results of a year's program of semi-structured inspections". (1997) 315 *British Medical Journal* 1420-24.

Reid DJ, Killoran AJ, McNeill AD, Chambers JS. "Choosing the most effective health promotion options for reducing a nation's smoking". (1992*) Tobacco Control*, 185-197.

Reilly D. "Methadone: a perspective on methadone services in NSW". (1988) *Connexions* 25.

Reilly D. Methadone: a perspective on methadone services in NSW. (1988) *Connexions* May/June.

Reuband KH. "Drug use and drug policy in Western Europe". (1995) 1 *European Drug Addiction* 32-41.

Reynolds I, Di Giusto J, McCulloch R. *A review of the New South Wales Health Commission treatment services for narcotic dependent persons*. Sydney, Division of Health Services Research, NSW Health Commission, 1976.

Reynolds L, Magro D. "The use of methadone as a treatment tool for opiate addicts: a two year follow up study." (1976) 2 *Medical Journal of Australia* 560-562.

Reynolds L, Magro D. "The use of methadone as a treatment tool for opiate addicts: a two year follow up study." (1976) 2 *Medical Journal of Australia* 562.

Rhodes W, Langenbahn S, Kling R, Scheiman P. *What America's users spend on illegal drugs, 1988-1995*. Washington DC, Office of National Drug Control Policy, 1997.

Roberts P. "No breach over addicts say ADA". *Weekend News* 22 November 1976.

Robertson R. "The Edinburgh epidemic a case study". In Strang J, Stimson G (eds). *AIDS and Drug Misuse*. London, Routledge, 1990, 101.

Rogers RW. "A protection motivation theory of fear appraisals and attitude change". (1975 91 *Journal of Psychology* 93-114.

Rose J, Daly A, Midford R. *Report on the usage patterns of volatile substances users in Perth*. Perth, Alcohol and Drug Authority, 1992.

Ross J, Darke S. "Benzodiazepine dependence and psychopathology among heroin users". In Dillon P, Topp L, Swift W. (eds). *Illicit drugs: current issues and responses. Proceedings from the eleventh NDARC annual research symposium, November 1997*. Sydney, National Drug and Alcohol Research Centre, 1998.

Ross J, Darke S. *Benzodiazepine dependence and psychopathology among heroin users in Sydney*. Sydney, National Drug and Alcohol Research Centre, University of NSW, 1997.

Russac RJ, Powell RS. "Reasons adolescents don't use drugs: exploring a 'depth of acceptance' model." (1997) 27 *Journal of Drug Education* 349-361.

Russell K. "Inmates with alcohol and other drug problems". (1995) 7 *Current Issues in Criminal Justice* 245-257.

Russell K. *Strengthening for leverage for change. Report on the NSW forum on diversion of offenders with alcohol and other drug problems*. Canberra, Alcohol & Other Drugs Council, 1997.

Salmelainen, P. Money, drugs and juvenile crime. *Paper presented at the Australian and New Zealand Society of Criminology 10th Annual Conference Crime, Criminology and Public Policy*. Sydney 27-30 September 1994.

Sarre R. "The partial 'decriminalisation' of cannabis: the South Australian experience". (1994) 6 *Current Issues in Criminal Justice* 196-207.

Saum CA, Inciardi JA. "Rohypnol misuse in the united States." (1997) 32 *Substance Use & Misuse* 723-731

Schaps E, Battistich "The etiology of problem behaviours". In Goplerud (ed). *Preventing adolescent drug use: from theory to practice*. Washington DC, US Department of Health & Human Services, 1991.

Schippers GM, Van Den Hurk AA, Breteler MHM, Meerkerk GJ. "Effectiveness of a drug free detention treatment program in a Dutch prison." (1998) 33 *Substance Use & Misuse* 1027-1046.

Schuster P, Lieb R, Lamertz C, Wittchen HU. "Is the use of ecstasy and hallucinogens increasing?" (1998) 4 *European Addition Research* 75-82

Seaman SR, Brettle RP, Gore SM. "Mortality from overdose among injecting drug users recently released from prison: database linkage study". (1998) 316 *British Medical Journal* 426-428.

Sellman JD, Hannifin J. Deering D, Borren P. *Delivery of treatment for people with opioid dependency in New Zealand: options and recommendations. A commissioned paper for the Ministry of Health*. Christchurch, National Centre for Treatment Development, Christchurch School of Medicine, 1996.

Serafino S, Swensen G, Thomson N. *Attempted suicide in Western Australia, 1981-1993*. Perth, Epidemiology Branch, Health Department of WA, 1996.

Sheth JN, Frazier GL. "A model of strategy mix choice for planned social change". (1982) 91 *Journal of Psychology* 93-114.

Sidney S, Beck JE, Tekawa IS, Quesenberry CP, Friedman GD. "Marijuana use and mortality". (1997) 87 *American Journal of Public Health* 585-590.

Shilton T, McBride S, Cameron I, Hall M. "Advocacy for school health: the power of data". (1995) 5 *Health Promotion Journal of Australia* 24-29.

Silburn SV, Zubrick SR, Garton A et al. *Western Australian child health survey: family and community health*. Perth, Australian Bureau of Statistics and TVW Telethon Institute for Child Health Research, 1996.

Sinclair-Jones M. "Addicts call for better deal". *Western Mail* 19 March 1983.

Sinclair-Jones M. "Relief for addicts to become easier". *Western Mail* 11 June 1983.

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

Smart RG, Mann R, Suuvali H. "Do increased levels of drug abuse treatment lead to fewer drug-related problems?" (1997) 23 *American Journal of Drug & Alcohol Abuse* 421-429.

Solowij N, Lee N. *A survey of ecstasy (MDMA) users in Sydney*. Sydney, National and Alcohol Research Centre, University of NSW, 1991.

Spooner C, Flaherty B, Homel P. *Results of a street intercept survey of young illicit drug users in Sydney*. Sydney, Directorate of the Drug Offensive, NSW Department of Health, 1992.

Stafford K. "Implementing best practice in drug education: examples from the Western Australian School Health Project. In *Proceedings of Conference on Reshaping the Future: Drugs and Young People*. October 1996 Sydney.

Steinberg L. "Adolescent transitions and alcohol and other drug use prevention". In Goplerud (ed). *Preventing adolescent drug use: from theory to practice*. Washington DC, US Department of Health & Human Services, 1991.

Stockwell T (ed). *Drug trials and tribulations: lessons for Australian drug policy*. Perth, National Centre for Research into the Prevention of Drug Abuse, Curtin University, 1998.

Submission of the Obstetric Social Workers Group in the Inner Metropolitan Area to New South Wales, Parliament, Joint Committee Upon Drugs. *Progress report and minutes of proceedings 1976-78*. Sydney, Government Printer, 1978, Annexure E.

Sunday Times. "Anger at planned alcoholics hospital". *Sunday Times* 23 May 1976.

Sutton A, James S. *Evaluation of Australian drug anti trafficking law enforcement*. Payneham, SA, National Police Research Unit, 1996.

Sutton A, McMillan E. *A review of law enforcement and other criminal justice attitudes, policies and practices regarding cannabis and cannabis laws in South Australia*. Adelaide, Drug & Alcohol Services Council, 1998.

Swensen G, Unwin E. *Indicators of drug use in Western Australia, 1982-1992*. Perth, Epidemiology Branch, Health Department of Western Australia, 1995.

Swensen G, Westlund G, Baker MR. *Sales of Needles and Syringes in WA - the SS5 Pack Project 1987-1990*. Perth, Health Services Statistics and Epidemiology Branch, Health Department of WA, 1992.

Swensen G. "Opioid deaths in Western Australia, 1974-1984". (1988) 7 *Australian Drug & Alcohol Review* 181-185.

Swensen G. *Indicators of drug use in Western Australia 1982-1992*. Perth, Epidemiology Branch, Health Department of WA, 1995.

Swensen G. *Indicators of illicit drug use in Western Australia 1981-1989*. Perth, Epidemiology & Research Branch, Health Department of WA, 1991.

Swensen G. *Indicators of illicit drug use in Western Australia 1981-1989*. Perth, Epidemiology and Research Branch, Health Department of WA, February 1991.

Swift W, Hall W, Copeland J. *Cannabis dependence among long term users in Sydney, Australia*. Sydney, National Drug and Alcohol Research Centre, University of NSW, 1997.

Teesson, M, Gallagher J, Ozols S. *The Gemini Project: an evaluation of a treatment program for persons with serious mental illness and substance misuse*. Sydney, National Drug and Alcohol Research Centre, University of NSW, 1998.

Toy MA. "Radical new drug program. First time cannabis users across Victoria will get a caution after a successful trial program." *The Age* 7 July 1998

Unwin E. *Drug-caused deaths in Western Australia 1984-1994*. Perth, Health Information Centre, Health Department of WA, 1996.

Van Beek I, Dwyer R, Dore GJ, Luo K, Kaldor JM. "Infection with HIV and hepatitis C virus among injecting drug users in a prevention setting: retrospective cohort study." (1998) 317 *British Medical Journal* 433-437.

Van Solinge TB. *The Swedish drug control system. An in-depth review and analysis*. Amsterdam, Uitgeverij Jan Mets & Centre for Drug Research, 1997

Victoria, Parliament, Drugs and Crime Prevention Committee. *Interim report of the inquiry into the Victorian government's drug reform strategy*. Melbourne, Victorian Parliament, 1997.

Victoria, Premier's Drug Advisory Council. *Drugs and our community*. Melbourne, Victorian Government, 1996, 199.

Ward J, Mattick R, Hall W. *Key issues in methadone maintenance treatment*. Sydney, University of NSW Press, 1992.

Watts P. *Youth in custody project - a profile of juvenile offender's drug use patterns*. Perth, Youth Suicide Steering Committee, Health Department of WA, 1992.

Weatherburn D, Lind B. *Drug law enforcement policy and its impact on the heroin market*. Sydney, NSW Bureau of Crime Statistics and Research, 1995.

Weatherburn D, Lind B. *Drug law enforcement policy and its impact on the heroin market*. Sydney, New South Wales Bureau of Crime Statistics and Research, 1995.

Webb C. "Anger as schools call in sniffer dogs to fight drug abuse". *The Age* 2 July 1998.

Webster P, Mattick RP, Baillie A. *Clients of treatment service agencies March 1990, census findings*. Canberra, Department of Health, Housing and Community Services, 1991.

Weisheit, R (ed). *Drugs, crime and the criminal justice system*. 1995.

West Australian. "Doctor protests at drug curb". 28 December 1983.

West Australian. "GPs treat most drug addicts - doctor". 18 January 1977.

West Australian. "Police to probe heroin availability". 10 May 1984.

Western Australia, Committee of Inquiry Into the Rate of Imprisonment. *Report*. Perth, Government Printer, 1981, 130.

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

Western Australia, Parliament, Legislative Assembly. *Report of Select Committee Appointed into the National HIV/AIDS Strategy White Paper*. Perth, Government Printer, 1990.

Western Australia, Parliament, Select Committee Into the Misuse of Drugs Act 1981. *Interim Report. Taking the profit out of drug trafficking*. Perth, Legislative Assembly, 1997.

Western Australia, Parliament. *Report of Honorary Royal Commission to Inquire Into and Report Upon the Treatment of Alcohol and Drug Dependents*. Perth, WA Government Printer, 1973.

Western Australia, School Drug Education Task Force. *Drug education: principles of best practice*. Perth, Education Department of WA, 1997.

Western Australia, School Drug Education Task Force. *Strategic Plan 1997-2000*. Perth, Education Department of WA, 1997.

Western Australia, Task Force on Drug Abuse. *Protecting the community: the report of the Task Force on Drug Abuse.* Perth, Ministry of Premier & Cabinet, 1995.

White HR, Brick J, Hansell S. "A longitudinal investigation of alcohol use and aggression in adolescence". (1993) 11 *Journal of Studies on Alcohol* (Supplement) 62-77.

White J. "Does increasing the availability of methadone reduce heroin deaths?" In Lenton S, Stockwell T, Ali R (eds). *Proceedings of a national workshop on the prevention of heroin overdose, Sydney, August 1997*. Perth, National Centre for Research Into the Prevention of Drug Abuse, Curtin University, 1997.

White JM, Bochner F, Irvine RJ. "The agony of ecstasy. How can we avoid more ecstasy related deaths?" (1997) 166 *Medical Journal of Australia* 117-118.

Williams G. "Staff quit, condemn drug centre's policy". *Daily News* 18 November 1976.

Williams P. *Progress of the National Drug Strategy: key national indicators. Evaluation of the National Drug Strategy 1993-1997, statistical supplement.* Canberra, Department of Health & Family Services, 1997.

Williamson PA, Foreman KJ, White JM, Anderson G. "Methadone related deaths in South Australia, 1984-1994." (1997) 166 *Medical Journal of Australia* 302-305.

Wodak A, Des Jarlais DC. "Strategies for the prevention of HIV Infection among and from injecting drug users". (1993) 45(1) *Bulletin on Narcotics* 47-60.

Wodak A. "The treatment of heroin dependence - an overview." (1985) 65 *Proceedings of Australian Institute of Criminology* 27-44.

Wodak A. "Harm reduction: Australia as a case study." (1995) 72 *Bulletin of NY Academy of Medicine* 339-347.

Wodak A. "Public health and politics: the demise of the ACT heroin trial." (1997) 167 *Medical Journal of Australia* 348-349.

Wodak A. "Injecting nation: achieving control of hepatitis C in Australia." (1997) 16 *Drug & Alcohol Review* 275-284.

Wodak A. "Prescribing heroin: nothing to fear but fear itself?" (1998) 168 *Medical Journal of Australia* 590-591.

Wood C. "Cannabis research and treatment". *Connexions* December 1997/January 1998.

Wood C. "Overcoming overdose". *Connexions*, December 1997/January 1998.

World Health Organisation, Program on Substance Abuse. *Cannabis: a health perspective and research agenda*. Geneva, Division of Mental Health & Prevention of Substance Abuse, WHO, 1997.

Zimmer L, Morgan JP. *Marijuana myths, marijuana facts*. NY, Lindesmith Center, 1997.

Zubrick SR, Silburn SR, Barton A, Burton P, Dalby R, Carlton J, Shepherd C, Lawrence D. *Western Australia Child Health Survey: developing health and well-being in the nineties*. Perth, Australian Bureau of Statistics and Institute for Child Health Research, 1995.

Appendix 16: Financial statements

Statement of expenditure

Expenses incurred by the Committee

	$
Advertising	16,500
Consultants	4,500
Research staff	45,000*
Conferences	2,500
Travel (intrastate and interstate)	34,000
Printing	22,000*
General (postage, stationery, refreshments etc)	13,200
Total	137,700

* Totals include estimated cost for printing and postage of the final report, and salaries of research staff to 31 August 1998.

Appendix 17: List of submissions received

List of submissions received

Australian Democrats, WA Division
Australian Family Association
Australian Family Association, WA Branch
Australian Medical Association, WA Branch
Australian Medical Procedures Research Foundation
Australian National Council on AIDS and Related Diseases
Babbage, Jack
Barrett, Margaret & David
Barrows Foundation
Bellemore, Jane
Bentley Support Group of Carers for the Mentally Ill
Benz, A
Berbatis CG, Sunderland VB (School of Pharmacy, Curtin University)
Blaskett, Jackie
Bloor, Cindy
Boam, Peter S
Booth, Barbara
Boylen, Robert
Bruce, J
Byng, George
Byrne, Peter and Lynne
Cable, Mark and Sue
Calcott, Audrey
Christian Democratic Party (WA) Inc
Citizen's Against Crime Association (Inc)
Citizens Electoral Council of Australia
Clarke, D
Community Action Legislation Lobby
Court Diversion Service
Cranley, Pat
Croasdale, James
Dear, Robyn
Douglas, Chris
Dowling, Dean
Down, RL
Edwards, Barry
Farrell, Peter J
Fawcett, MV
Fenner, John
Fletcher-Hughes, Penni
Gent, Elizabeth
Greenwood, Jane
Grosvenor, IH
Hainsworth, Frederick Richard
Hawley, Peter
Health Promotions Services Branch, Health Department of WA
Heath, James David
Herlihy, Astrid
Heron, Mary
Hewitt, Johnny Edward
Hoare, Nick and Debbie
Hulse, Gary
Jackson, Sari
Jacobsen, Allen
Johns, M

Kate Orr & Associates
Kenneison, CJ
Kenneth, Leslie A
Learning & Attentional Disorders Society of WA Inc
Lidington, Dennis
Life Education WA (Inc)
Ligtermoet, Henny
Loftus, BK
Longdon, Mary
Mann, Jenny
Marovac, Halko and Lorraine
Martin, Gloria
Martley, George & Isobel
Masters, Bernie MLA
McKay, John H
Millar, MJ
Moran, Sandy
Mottram, Allan
Mullins, Geraldine
Mummery, Malcolm
Munns, Seta
Narconon Drug Rehabilitation & Education Services of WA
National Centre for Research into the Prevention of Drug Abuse (Curtin University)
National Council of Women of WA Inc Ltd
O'Donnell, Tony
O'Gorman, Betty
Orya, JA
Parkhill, Jane
Perth City Mission
Price, David
Prisoners Advisory Support Services of WA
Pugsley, Ray
Quigley, Dr Allan
Ravlich, Denis
Reid, Judith
Robertson, Donald
Russell-Brown, Graeme J
Sartar, John
Seares, Margaret
Sexual Health Program, Diseases Control Services, Health Department of WA
Shenton, Michael
Shields, Jayde
Slack, Charles
Small, Clive
Smith, Yuthika
Stay Alive Australia
Taylor, Norah
Thamkrabok Foundation
Traylen, Ian
Troughton, Ron
Tweedy, M
Victory Over Illegal Drugs
WA Alcohol and Drug Authority
WA Association for Mental Health Inc
WA Police Service
WA Small Business & Enterprise Association Inc
WA Substances Users Association
Williams, Barbara

Woman's Christian Temperance Union of WA Inc
Youth Affairs Council of WA
Youth Services of the Uniting Church

Appendix 18: List of witnesses who appeared before Committee at hearings conducted at Parliament House, Perth

Agius, Mr John, Senior Counsel

Australian Customs Service
Mr Brian Hurrell, Regional Director
Mr Michael Roche, Deputy Chief Executive Officer

Australian Federal Police
Mr Andrew Wells, General Manager
Mr Adrian Whiddett, Deputy Commissioner

Australian Medical Association
Dr Scott Blackwell, President (WA Branch)
Mr Richard Ellery, Project Officer (Youth Access Program, Australian Medical Association Foundation)

Australian Medical Practices Research Foundation
Dr George O'Neil, Medical Practitioner
Mr George Smith, Retired Social Worker

Banovich, Ms Michelle, Pharmacist

Chemistry Centre (WA)
Mr Neil Campbell, Chief, Forensic Science Laboratory
Mr Robert Hanson, Forensic Chemist

Commonwealth Attorney General's Department
Mr Kerry MacDermott, Senior Adviser, Drugs Policy
Mr Geoffrey McDonald, Senior Adviser, Criminal Law Reform

Commonwealth Director of Public Prosecutions
Mr Ian Bermingham, Deputy Director

Crime Research Centre
Ms Anna Ferrante, Research Fellow
Mr David Indermaur, Research Fellow

Criminal Law Association
Ms Julie Wager, President

Curtin University of Technology
Ms Alison Marsh, Lecturer in Addiction Studies, School of Psychology
Professor Bill Saunders, Associate Professor, Clinical and Health Psychology

Director of Public Prosecutions, Office of
Ms Sarah Linton, Professional Assistant to the Director
Mr John McKechnie, Director

Health Department of WA
Ms Judith Bevan, Senior Project Officer, Sexual Health Program
Mr Gary Kirby, Coordinator, Alcohol and Other Drug Programs, Health Promotion Service
Mr Kevin Larkins, Director, Operations Division
Ms Susan Lievers, Coordinator, Research and Evaluation, Health Promotion Service
Dr Lewis Marshall, Medical Coordinator, Sexual Health Program
Mr Robert Moyle, Manager, Drugs of Dependence
Mr Murray Patterson, Coordinator, Pharmaceutical Services
Mr Emmanuel Stamatiou, Contracts Manager, Alcohol and Drug Services
Mr Maurice Swanson, Director, Health Promotion Service

Legal Aid WA
Mr Alexander Payne, Solicitor in Charge, Criminal Law Section

Ministry of Justice
Mr John Bourchier, Manager, Substance Use Resource Unit
Mr Brian Ellis, Project Officer, Policy, Programs and Projects, Offender Management Division
Dr Philip Hames, Medical Officer, Casuarina Prison
Mr Terence Keating, Director, Juvenile Custodial Services
Mr James Schilo, Deputy Superintendent, Casuarina Prison
Mr Keith Shiers, Acting Manager, Planning and Development, Community Based Services
Mr Peter Varga, Acting Director, Juvenile Community Based Services
Mr Ian Vaughan, Acting Director, Policy Programs and Projects

Mirikai
Ms Mary Alcorn, Director

National Centre for Research into the Prevention of Drug Abuse
Ms Susan Carruthers, Researcher
Mr Simon Lenton, Research Fellow, Clinical Psychologist
Dr Wendy Loxley, Senior Research Fellow
Professor Timothy Stockwell, Director

National Crime Authority
Mr John Broome, Chairperson
Mr Michael Cashman, Regional Director, Perth Office

Parole Board
Mr James Hosie, Secretary
Mr Justice Barry Rowland, Chairman

Perth Aboriginal Medical Service
Ms Heather D'Antoine, Deputy Director
Ms Colleen Knight, Coordinator, Needle and Syringe Exchange Van

Perth Women's Centre
Ms Ann Deanus, Director
Ms Trish Heath, Education Officer

Pharmaceutical Society of WA
Mr Robert Brennan, Registrar
Mr Kevin McAnuff, President

Prisoners' Advisory Support Service of WA (Inc)
Mr Kevin Bourne-McRae, Executive Officer
Mr Brian Steels, Coordinator Programs

Royal Australian and New Zealand College of Psychiatrists
Dr Mark Rooney, Chairperson
Dr Helen Slattery, Consultant Psychiatrist, Department of Psychiatry

School Drug Education Project
Ms Diane Alteri, Coordinator, Catholic Education Office
Ms Shelley Beatty, Researcher, Centre for Health Promotion Research, Curtin University
Mr Ian Cameron, Chairperson
Mr Richard Crane, Coordinator
Mrs Audrey Jackson, Executive Director, Association of Independent Schools
Ms Margaret Trinder, Association of Independent Schools

Ms Cheryl Vardon, Director General, Education Department of WA

Sir Charles Gairdner Hospital
Dr Clive Cooke, Chief Forensic Pathologist

St John Ambulance WA
Mr Kenneth Ford, Dsirector, First Aid Services and Training
Dr Harry Oxer, Medical Director

Teen Challenge
Mr Stephen Nurse, Director
Mr Malcolm Smith, Executive Director

Trinity Youth Options
Ms Martine Noonan, Coordinator

TVW Telethon Institute for Child Health Research
Mr Sven Silburn, Clinical Psychologist and Senior Lecturer, Division for Psychological Research
Dr Stephen Zubrick, Associate Professor and Head of Division for Psychological Research

University of WA
Dr Stephen Houghton, Associate Professor, Department of Education

WA AIDS Council
Ms Sally Rowell, Health Educator
Ms Ruth Wykes, Acting Executive Director

WA Alcohol and Drug Authority
Mrs Christine Anderton, Acting Coordinator, Court Diversion Service
Mr Chris Baldwin, Director, Treatment Services
Mr Carlo Calogero, Acting General Manager
Professor David Hawks (Board Member)
Mr Shane Moore, Injecting Drug Use – Blood Borne Virus Coordinator
Mr Lynton Piggott, Acting Manager, Central Treatment Services
Dr Allan Quigley, Principal Medical Officer
Ms Maureen Steele, Project Officer, Opiate Overdose Prevention Strategy

WA Drug Abuse Strategy Office
Ms Melanie Hands, Acting Principal Policy Officer
Mr Terry Murphy, Acting Executive Director

WA Network of Alcohol and other Drug Agencies
Mr Chris McDonald, Director
Mr David Ryder, Chairperson

WA Police Service
Mr Brian Brennan, Detective Sergeant, Research and Liaison Officer, Drug Squad
Mr Gary Budge, Acting Detective Inspector, Drug Squad
Mr Robert Falconer, Commissioner
Mr Ferdinand Gere, Acting Detective Superintendent, Drug and Organised Crime Division
Mr Kenneth Gregson, Acting Detective Superintendent, Covert Operations Division
Mr Robert Kucera, Assistant Commissioner
Mr Richard Lane, Acting Detective Commander, State Crime Squad
Mr Jack MacKay, Assistant Commissioner
Mr Philip McLachlan, Sergeant
Mr David Picton-King, Police Superintendent
Mr Ray Sharkey, Inspector

Mr Leon Smith, Officer in Charge, Asset Investigation Squad

WA Substance Users' Association
Ms Katherine Gauci, Outreach Worker, Secretary
Ms Tamara Speed, Chairperson

Youth Legal Service
Mr James McDougall, Coordinator