HOUSE OF REPRESENTATIVES
STANDING COMMITTEE
ON
FAMILY AND COMMUNITY AFFAIRS

INQUIRY INTO SUBSTANCE ABUSE IN AUSTRALIA

TASMANIAN GOVERNMENT SUBMISSION

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1. INTRODUCTION

Addressing issues associated with drug use including alcohol and tobacco, is a priority for the Tasmanian Government. It is considered critical to continually work towards and maintain a comprehensive strategy to reduce drug related harm and minimise the uptake and problematic use of both illicit and licit drugs. The holistic view of the Tasmanian Government in addressing drug related issues includes a commitment to:

- educating and supporting children and young people to make informed, health decisions in their lives;
- providing adequate access to, and encouraging users into and alcohol and support services;
- working from a whole of government and whole of community perspective; and
- maintaining an appropriate and effective legislative framework.

The problems associated with drug use are significant and impact upon almost all aspects of the community and government. Due to the complexity of the issues, however, it is extremely difficult to quantify the economic or social costs. Acknowledging this, the submission, aims to assist the Inquiry by providing relevant statistics where available and outlining anecdotal evidence of the substantial costs associated with illicit drugs use and problematic licit drug use.

Section 2 provides background information comparing the extent and pattern of drug use in the national and Tasmanian contexts. The specific areas of social and economic costs identified in the terms of reference are explored in Section 3. In addressing the terms of reference the submission recognises that there are specific groups within society that suffer particular drug related impacts from the community as a whole. Information relevant to these groups is provided where available.

For example, issues related to women's drug use are now becoming well documented. Previously research on treatment interventions focussed on male participants and women's treatment needs went unacknowledged. Details of the costs and patterns of the costs associated with problematic drug use for women are provided in Appendix A.

Broad principles for tackling drug issues across government and the community are set out in the National Drug Strategic Framework (NDSF) which emphasises a harm minimisation approach. The Tasmanian Government supports the NDSF and has established the Tasmanian Drug Strategic Plan 1996-2001 (TDSP). The NDSF and TDSP are outlined along with specific initiatives and strategies of the Tasmanian Government to reduce drug use, at Appendix B.

Brief mention should also be made of the terminology used in the drug field. Too often there is stigma surrounding drug use. The language associated with the drug problem itself has often indicated intolerance of those who used. Words such as drug addict, alcoholic and abuse are associated with those who are out of control and on paths of destruction for themselves and those around them. It can imply deliberate misuse and deliberate disregard for consequences. The World Health Organisation in 1981 issued a memorandum on nomenclature to try and clarify terminology and definitions for various drug usage.

Substance 'abuse' is no longer a term used in the alcohol and other drug field, as it does not define any particular level or pattern of drug use. Issues and problems associated with drug use are complex and vary according to the individual, family or society. It is suggested that governments, in their investigation of the social and economic cost of drugs, utilise the nomenclature referred to in the Monograph Series from the National Drug Strategy, documented by the Commonwealth Department of Health and Aged Care.

2. CONTEXT

The following sections provide a brief overview of drug use both nationally and within Tasmania to demonstrate the differences and similarities associated with drug use within this State.

2.1 National Context

With regard to health related impacts, the greatest harm from drug use is caused by tobacco, which killed 18,124 Australian people in 1995 or 80.5% of all deaths attributable to drug misuse. In the same year, deaths attributed to alcohol misuse were 3,642 (16.1%) and to illicit drugs, 778 (3.4%). These relativities are reflected in a 1992 analysis of the national social and economic costs of drug misuse - $12.7 billion (67%), $4.5 billion (24%) and $1.6 billion (9%) respectively. The costs for illicit drugs are, however, likely to be conservative as property crime to support illicit drug use was not included in the study.

In 1995, it was estimated that 24% of the Australian population aged 14 and over used tobacco regularly, and 76% of the population aged 11 and over use alcohol (43% regularly, 33% occasionally). It is estimated that up to 10% of the population over 15 years of age uses alcohol hazardously, and that 1% has significant alcohol-related problems. The illicit drug problem in Australia centres mostly around cannabis and heroin, with cocaine, amphetamines and other psycho-stimulants becoming increasingly prevalent. There has been a substantial increase in heroin-related overdoses and deaths in Sydney, Melbourne and Perth in recent years, causing major concern nationally, and contributing to the current focus on illicit drugs.

Alcohol is the most widely used and socially approved drug in Australia. In contrast to its level of public acceptance, the burden of disease, injury, and social disorder associated with alcohol consumption is considerable.

Alcohol is associated with a range of injuries which result in significant morbidity or death. In Australia 44% of fire injuries, 34% of falls and drowning, 30% of motor vehicle accidents, 50% of assaults, 16% of child abuse, 12% of suicides and 10% of industrial accidents have been estimated to be associated with alcohol consumption. Impaired driving and violence are the most commonly experienced causes of serious alcohol related harm.

Of the more prevalent illicit drugs, heroin and other opiates are generally self-administered intravenously and are the most addictive. Cannabis is generally smoked, cocaine and amphetamines are either injected or nasally ingested. Other psycho-stimulants are generally taken orally (eg ecstasy). The extreme addictiveness of opiates and the fact that they are predominantly injected make them very problematic. In mainland cities, there is evidence of increasing use of cocaine as an injecting drug, especially in conjunction with heroin. The misuse of benzodiazepines (eg. valium, serepax, rohypnol),

as drugs obtained illicitly, is a growing problem and are seen as common component in polydrug misuse. There is also evidence to suggest that there is an increased prevalence of these drugs being self-administered intravenously.

To quantify the number of recreational and dependent users of illicit drugs is extremely difficult. Surveys are conducted nationally in households and schools every three years but these surveys are not designed to clearly quantify dependent users and have sample and methodological problems associated with the illicit drug use questions. Estimates have, however, been attempted for opiate/heroin users in an effort to predict the demand for treatments like methadone. National estimates of dependent opiate users in the late 1980s/early 1990s suggest an increase from approximately 34,000 in 1987 to 59,000 in 1993. Evidence since then suggests a substantial increase in heroin use in the late 1990s and the number is now likely to be between 70,000 and 100,000.

2.2 Tasmanian Context

As expected, the majority of drugs that are identified as problematic at a national level are also represented in Tasmania. The distribution of use amongst different drug types, however, is markedly different in this State compared, particularly, with some of the larger urban centres. For example, while it appears that the prevalence of cannabis use in Tasmania is similar to most other States, (with 13% of the population aged 14 and over - or 55000 people - using cannabis in the past year), the situation with amphetamines and opiates use is different.

Opiate use in Tasmania is considered to be generally lower than in most other States, possibly associated with the lower levels of urbanisation. The choice of drug also differs. It is estimated that six out of seven opiate users in Tasmania use pharmaceutical morphine with the remaining one using heroin (source: needle exchange survey). This pharmaceutical morphine becomes available as interstate contraband (possibly sourced from robberies) and "doctor shopping".

The prevalent use of opiates within Tasmania has both costs and benefits with regard to potential impacts upon users. As Tasmanian opiate users know the exact strength of their doses (they generally break down identifiable tablets for injection), they tend to avoid the risks of overdosing that are associated with heroin. However, the practice of injecting substances made for oral ingestion brings with it its own specific risks, mostly associated with peripheral vein damage, and consequent damage to the eyes, kidneys, lungs and limb extremities.

It is understood that for every opiate user in Tasmania, there is one amphetamine injector. In addition, there is likely to be significantly more users of amphetamines who ingest the drug by other means. Cocaine use in Tasmania is believed to be relatively rare.

Quantifying the illicit drug problem in Tasmania presents problems. Nevertheless, a simplistic analysis suggests that there could be up to 1000 dependent users of opiates and more than 2000 recreational users of opiates. Using needle exchange survey data, it is suggested that there are 3000 - 4000 users of amphetamines in Tasmania.

3. TERMS OF REFERENCE

The following sections refer to the social and economic costs of substance use with particular regard to family relationships; crime, violence (including domestic violence) and law enforcement; road trauma; workplace safety and productivity and health care costs.

3.1 FAMILY RELATIONSHIPS

The social and economic costs of substance use for families are extremely difficult to assess or quantify. Alcohol and drug use is just one of a complex myriad of issues that may impact on the social and economic situation of families and their predisposition to requiring assistance or support. These factors may include:

- Alcohol and drugs;
- Unemployment;
- Family income; and
- Family break-up.

It is difficult to establish whether alcohol or drug use is a causal or consequential factor. For example, it is not clear to what level unemployment is a predisposition to alcohol and drug use or whether alcohol and drug use leads to higher rates of unemployment. It is likely that each factor may both contribute to and be consequential of other environmental factors experienced by families. It is suggested, therefore, that the impact of alcohol and drugs on families needs to be viewed in a broad social framework.

The difficulties associated with identifying causal relationships between factors impacting upon families does not undermine the importance of understanding the effects of drug use. This is highlighted in the high proportion of clients who present to the Tasmanian Government's Alcohol and Drug Service reporting that alcohol and drugs are significantly impacting on their family life. These clients often need intervention.

Some of the main harms impacting on the social and economic well-being of families are:

Economic costs:

- Loss of family income because of the expenditure on alcohol and/or drugs;
- Loss of income for time away from employment for alcohol and/or drug related illness;
- Costs associated with drug related criminal activity such as legal fees and court fines. This may also include loss of income for time spent in a correctional facility; and
- Costs associated medical assistance as a result of alcohol and/or drug related illness or abuse.

Social costs:

- Family breakdown;
- Physical and/or sexual abuse;
- Welfare dependency; and
- Isolation.

3.1.1 Young People

There is little doubt, that the vast majority of young Australians will be faced with the decision to accept or decline the offer of drugs (including tobacco and alcohol). The patterns for substance use tend to be set during adolescence. It is therefore important that any policy development in this area involves and is credible to young people.

Current economic costs associated with caring for children and providing support to families includes:

- Actual costs of foster care and wages of professionals;
- Costs associated with contact arrangements, especially where these are supervised;
- Costs associated with treatments and therapies and support to families;
- Costs associated with legal action; and
- Costs associated with Criminal Injuries Compensation.

The social costs (especially where children enter care) can include:

- *Effects of disrupted relationships*

  These children may have difficulties forming attachments; they experience learning difficulties and exhibit anti-social behaviours in school and the wider community.

- *Effects of modelling behaviours*

  Children learn ways of coping from their parents and as a result turning to substances and use of violence is often reflected in their own behaviour as adults.

- *Effects of enabling behaviours in children*

  That is parenting behaviours (children caring for parents and other siblings) which can again lead to difficulties in personal relationships.

3.2 CRIME, VIOLENCE AND LAW ENFORCEMENT

In relation to community safety and drug-related crime, the extent to which crime is connected with drug taking is difficult to determine with any accuracy due to the absence of research in Tasmania. There is a widespread belief, based largely on anecdotal evidence and some 'best guesses', that the prevalence of drug use among arrestees is high. There is also concern that there may be a connection between drug use and property crime and that some proportion of all crime can be attributed to drug use. There is, however, no substantive research on the subject in Tasmania that can provide a valid estimate of the actual amount of drug use among arrestees or establish any causal relationship.

A limited amount of work has been undertaken by other jurisdictions which may provide some indication of the relationship between drug use and criminal activities. A New South Wales study (Ireland and Thomenny, 1993) showed that 62% of incidents attended by police in a four week period, were related to alcohol. Law enforcement reports that alcohol is implicated in offensive behaviour, offensive language, assault, and domestic violence. A similar survey (Nicholas and Williams, 1994) in South Australia found that the average police respondent estimated that 70% of their time was spent on drug related incidents. The Criminal Justice Commission, Queensland, found in 1991 that 70% of

robberies were related to drug use. These consequences are difficult to measure as they include both tangible and intangible costs. Kevin's 1992 prison exit study highlighted the key role of drug use in offending. Sixty Seven per cent of inmates reported that they were under the influence of a drug at the time of their most serious offence. The National Committee on Violence, reported in 1990 that 80% of armed robberies in NSW were drug related.

Whilst the costs associated with drug use and crime are difficult to quantify, it is clear that problem alcohol and other drug use has a major impact on the health and community safety of Tasmanians and results in a significant demand and impact on policing. An overview of the major areas of demand for Tasmania Police with regard to problematic alcohol and other drug use is outlined below.

Alcohol related incidents encountered by police	**Illicit, Pharmaceutical and Other Drug-related incidents encountered by police**
Crime	Community and public safety
Assault including verbal assault and violence against police officers	Drug related crime including drug possession, dealing, cultivation and drug trafficking
Road trauma	Property crime and fraud
Public drunkenness and physical sickness	Crimes against the person and violence
Public order/public nuisance	Intoxication
Mental illness and suicide	Road trauma
Domestic violence	Assault including violence against police officers
Fall injuries and drowning	Morbidity and mortality, including fatal and non-fatal overdoses
Vandalism and littering	Mental illness and suicide
Alcohol psychosis	Blood borne diseases
Community and public safety	Needle stick injuries
Morbidity and mortality	Domestic violence
Risk taking behaviour	Public order
Incarceration and entry within the criminal justice system	Incarceration and entry within the criminal justice system

The Drug Use Monitoring in Australia Project (DUMA) is being trialed by the Australian Institute of Criminology based on United States programme of research involving the interviewing and drug testing of arrestees. The trials are being conducted in Western Australia, Queensland and New South Wales. However, the nature of the Tasmanian illicit drug market is vastly different to the mainland capital cities, and the findings cannot be generalised to Tasmania.

The national extension of DUMA to include Tasmania would potentially provide an opportunity to more accurately identify and track any relationship between drug use and crime. An on-line charging system is being developed interstate which should facilitate

assessment of levels of drug related crime locally. In addition the development of a Domestic Violence Database will provide greater information concerning the relationship between alcohol use and other drug use and incidents of domestic violence attended by police. Surveys of officers have also consistently indicate a significant relationship between drug use and incidents attended by police.

3.2.1 Young People and Substance Abuse

Research has shown that for those in their early to mid-teens, there are strong correlations between illicit drug use and exclusion or truancy from school, break-up of the family and initiation into criminal activity. For older teenagers and people in their early twenties, there are strong correlations between drug problems and unemployment and other features of social exclusion (such as homelessness and prostitution). This does not necessarily mean that drug use is always the primary course. Indeed, during consultations undertaken in Tasmania during 1995, young people stated that they took drugs to hide from problems and cope with pain and stress. Tackling drug use may be an integral part of reducing social inequality but tackling social inequality may, in itself, reduce the incidence of drug misuse.

3.3 ROAD TRAUMA

In the period from May 1999 to April 2000 there were 1558 fatal crashes in Australia. Tasmania accounted for 43 of these deaths (Australian Transport Safety Bureau, April 2000). Comparing the first quarter of 2000 with the same period in 1999, fatalities in Tasmania decreased by one, to 14, and injuries decreased by 96 (or by 6.7% and 16.9% respectively) according to a quarterly report on road safety produced by the Land Transport Safety Division in conjunction with Motor Accidents Insurance Board, March 2000. This report also found that at least 57% of fatalities and 9.3% of injuries were associated with blood alcohol levels exceeding 0.05 gm/ml. Elsewhere, it has been estimated by the National Drug Research Institute (May 2000) that alcohol consumption is implicated in one third of all road crash deaths. Applying this to the national figures on fatal crashes for 1999/2000, it can be estimated that more than 500 deaths each year occur in situations where the vehicle controller or pedestrian has a blood alcohol concentration (BAC) of 0.05 gm/ml or more.

However, the incidence of drink driving has been substantially reduced over the past two decades. Federal Office of Road Safety data (Monograph 29, 1999) records that nationally in 1981, 44 per cent of all drivers killed in road crashes had a blood alcohol concentration (BAC) of 0.050 gm/100ml or greater. This had been reduced to 28 per cent during 1997. It is considered that this decline in alcohol related road fatalities is directly related to increased legislation, enforcement, public education and media advertising activity. Whilst a major reduction in alcohol-related road deaths was achieved as a result of national campaigns to reduce drink driving, further research to develop improved strategies should be considered as a priority issue.

Some groups are at higher risk or are over represented in fatality statistics. The VicRoads 1996 figures clearly show that 81% of drivers and riders killed on Victorian roads were males as were the majority of those suffering serious injury. Those men at particularly high risk include under 25 year olds and, particularly those living in country regions, blue collar or unemployed males, and middle aged males with very high BAC (cited in Federal Office of Road Safety: 1999). Other groups of individuals at particular risk of alcohol-

related fatalities include intoxicated pedestrians, alcohol dependent people, and motorists in country regions.

A dramatic impact in drink-driving related mortality and morbidity was achieved through the introduction of Random Breath Testing (RBT). RBT had been introduced in every Australian State and Territory by 1989. RBT conducted by Tasmania Police has been a very effective program that has significantly reduced alcohol related harm. The program's deterrence value is based upon constructing and maintaining an environment in which a perception is held by drivers, or potential drivers, that there is a high probability of being apprehended for driving while over the legal BAC limit. It is also dependent upon community understanding that having been apprehended, an offender will experience severe financial and/or other penalties such as the loss or suspension of driving licences that will adversely affect their lifestyle. There are also ongoing consequences such as difficulty in obtaining motor vehicle insurance or the need to pay increased premiums.

However, there is a need to avoid complacency, and as noted before, to ensure further research occurs into developing effective strategies to improve measures to reduce alcohol related road crash deaths and injury. For the first time in a decade, there is some evidence of an upsurge in drink-driving after the release of figures showing one in four men admit driving while drunk. The National Drug Strategy Household Survey shows a 70 per cent rise in the percentage of men and women who admit to driving while drunk. Whilst this trend has not been reflected in Tasmania, the Director of the NSW Bureau of Crime Statistics and Research, Don Weatherburn, described the results as "disturbing" and called for a review of RBT strategies. Figures from the Bureau of Crime Statistics show prescribed concentration of alcohol (PCA) offenses stood at 194 people in every 100,000 in 1995. Last year, it had risen to almost 230 per 100,000 - up by more than18 per cent. The drugs survey prepared by the Australian Institute of Health and Welfare for the Commonwealth Department of Health and Aged Care reveals that in 1995, 14.3 per cent of men and 6.6 per cent of women over the age of 14 admitted to the offense. But last year, the numbers jumped to almost 24 per cent of men and 11.4 per cent of women.

Importantly, it should be noted that measures to reduce alcohol related road crash deaths and injury are most effective when designed to affect all drivers, not just recidivist drink drivers, and when a range of prevention, education, and enforcement strategies are employed. The Victorian Branch of the Pharmaceutical Society of Australia has in 1996 described five groups in the community which need targeted public education programs on drugs and their effects on driver performance:

1. People likely to experiment with drugs, illicit and prescribed;

2. The general population, who may be unaware of possible impairment of their driving skills by prescribed an over-the-counter medication. (This group would include persons suffering from medical conditions such as hypertension, depression, anxiety and sleep disturbances);

3. High risk groups including young drivers, particularly males, persons suffering from diabetes, epilepsy or psychiatric conditions who may have slightly higher risks of traffic accidents as compared with unaffected persons;

4. Older persons, who may not be aware of the decrease in their driving performance due to reduced psychomotor skills, eyesight, decision-reaction time or the effect of legally prescribed medication; and

5. Persons whose employment is driving.

3.3.1 Drug Usage and Driver Impairment

Driving a motor vehicle is a multifunctional task involving visual search and recognition, vigilance, information processing under variable demand, decision making, risk taking and enough sensorimotor control to carry out all these activities simultaneously (Starmer *et al*., 1988). It is also an overlearned task, where critical high level demands are very infrequent but crucial.

Western Australian research by that State's Taskforce on Drug Abuse in 1995 identified 197 road deaths between 1992 and 1995 that involved mood altering drugs. Cannabis was detected in the bodies of 95 victims, 27 per cent of whom were found to have taken no other substance, whilst a mix of alcohol and marijuana was found in 49 cases.

Cannabis, smoked by about 10 per cent of drivers, slows the reaction times and reduces concentration, according to research published by the Royal Automobile Club in the UK, (Evening Express, Jan 19,1998). And about 12 per cent of UK drivers killed in road accidents have cannabis in their bloodstream.

A study undertaken in NSW (1989-90) found that cannabinoids were the most prevalent drug (other than alcohol) present in analysed blood samples. This was also the case in a 1998 study undertaken in South Australia.

The causal effect of drugs other than alcohol on motor vehicle crashes is not as well defined as for alcohol. At this time research has not been able to establish confidently the point at which drugs other than alcohol make a driver unsafe on the road. There is no clear relationship between drug dosage alone and crash risk.

The prevalence of potentially impairing drugs, particularly cannabis, in deceased and injured drivers is unacceptably high, suggesting that the use of cannabis may be a contributing factor.

Detection of cannabis levels in blood samples is made difficult due to the conditions that must be present to ensure retention of the active ingredient (THC). Presence of the *long-lived* metabolite (THC-COOH) in a blood sample is only an indication that cannabis had been ingested some time prior to the sample being taken and the metabolite can remain in the blood for lengthy periods following metabolism of the active ingredient.

Current Tasmanian legislation provides that a medical examination and subsequent blood sample analysis of drivers suspected of driving under the influence of drugs other than alcohol may only be undertaken where there is supporting evidence that the driver was unable to properly control the vehicle and was placing other road users at risk. During 1999, forty blood samples taken from suspected drug impaired drivers were forwarded for analysis. THC or THC-COOH was detected in 53% of these sample.

The Tasmanian Government Analytical and Forensic Laboratory is currently undertaking an extensive study in relation to the prevalence of drug involvement in motor vehicle

crashes in Tasmania. This study involves the analysis of blood samples, (post-mortem and ante-mortem) taken from drivers involved in crashes over the past five years, and analysis of likely crash causes to determine any causal effect of drugs other than alcohol. The blood samples being analysed include all those taken from drivers whether drugs other than alcohol were suspected at the time or not. This study is due for completion in November 2000.

3.3.2 Young People and Road Trauma

A 1994 profile of Tasmanian young people showed that this age group accounted for around 45% of all drink driving charges in a one year period. In addition, nearly 30% of all the charges laid by Tasmanian police against people under 25 related to alcohol. More than 50% of charges under the *Poisons Act* involved young people under 25. Tasmanian Transport Division statistics show that on average 50% of road users killed and 55% of road users injured are under 30 years old. More than 6% of fatal and injury accidents during 1999 stemmed from over consumption of alcohol.

3.4 WORKPLACE SAFETY AND PRODUCTIVITY

Very limited information is available to assess the social and economic costs of drug use within industry, particularly with regard to industrial accidents and productivity. As previously noted, it has been estimated that 10% of industrial accidents include alcohol as a contributing factor.

The expansion of policy development together with alcohol and other drug education and information in industrial environments can be a very important way of minimising harm from alcohol and other drug use. In Tasmania, the Alcohol and Drug Service is currently approaching industry to offer assistance with policy development, advice on duty of care, provision of individual treatments and education and training. New Occupational Health & Safety legislation also emphasises the "duty of care" obligations of employers and employees which include consideration of the impact of substance use on the workplace.

It is recognised that there is a need to undertake further research in this area to adequately quantify the impacts of drug use on the productivity of, and safety within, the workplace.

3.5 HEALTH CARE COSTS

Substance use, in all its service delivery, represents a significant cost for health care services. However, as with other areas, the actual costs to both the Government and non-government sector is extremely difficult to quantify. On reason for this is that the drug use is rarely the focus of treatment for health care professionals. It is more likely that a drug user will come into contact with the health services with conditions arising from the drug use. For example, it is difficult to estimate the proportion of costs for treatment of heart disease and lung cancer that is directly attributable to the use of tobacco.

Similarly, there is likely to be a significant share of health care costs that are indirectly attributable to drug use. These include increased palliative care, health care costs resulting from incidents where alcohol use was a factor (eg. hotel violence) and mental health services. Estimating these costs and attributing them to particular forms of drug use is extremely difficult.

Some work has been completed on attempting to estimate the costs associated with both alcohol and tobacco use it suggests that, in 1989-90, the cost of alcohol related disease in Tasmania was approximately $20 million per annum. The estimated cost of tobacco is around $34 million per annum. Due to the factors outlined previously it is unlikely that these represent the full costs associated with the use of these drugs.

The following areas include some of the more direct health care costs associated with drug use:

- The Alcohol and Drug Service budget and grants to non-government organisations (approximately $6 million for 1999/2000);
- Additional costs for non-government alcohol and drug organisations;
- The needle and syringe exchange program;
- Hospital costs;
- A proportion of the Cancer and Heart Foundation budget;
- The Hobart Clinic – private health funds;
- More intensive treatment for alcohol and other drug affected babies; and
- Road trauma.

The following information provides an indication of level of costs to hospitals that may be directly attributable to drug use based on 1999-98 data. These are the costs for only one Tasmanian institution, the Royal Hobart Hospital, and only represent the costs associated with treatment where the principle diagnosis is directly related to substance abuse. Note that, for reasons outlined above, these costs are likely to reflect only a small proportion of the total costs of drug abuse for Tasmanian hospitals.

DRG	**Total separations****	**Price/separation*** $	**Total** $
860 Alcohol intoxication and withdrawal	219	2,259.00	494,721.00
861 Drug intoxication & withdrawal	93	2,765.00	257,145.00
862 Alcohol use disorder & dependence	131	2,436.00	319,116.00
863 Other drug use disorder & dependence	86	2,025.00	174,150.00
888 Poisoning/Toxic effects of drugs age > 59 years or with complications	217	2,486.00	539,462.00

and co-morbidites			
889 Poisoning/Toxic effects of drugs age <60 years or without complications and co-morbidites	511	1,573.00	803,803.00
TOTAL	**1257**		**2588397.00**

(Source: **Tasmanian Morbidity System * National Hospital Cost Data Collection from Royal Hobart Hospital)

(Note that for comparison, in 1997-98 the total number of patient separations within the Royal Hobart Hospital was approximately 40,000 which represents approximately 55% of all public hospital separations and 30% of the total State's hospital separations).

The information is reported in terms of Diagnosis Related Groups (DRGs), which is the major inpatient classification system used throughout Australia. Each DRG has a cost attached, which reflects the average cost for all patients within that category. As the name suggests, DRGs are an aggregation of similar, but more specified diagnoses.

It should also be noted that the DRG classification is based on a single principal diagnosis only. In the information provided above, the principal diagnosis is directly related to drug use. There are numerous other admissions where the drug use is a causal factor, but is not the principal diagnosis and has not therefore been captured here. For example emphysema or lung cancer as a result of smoking, HIV as a result of drug injecting habits, or cirrhosis of the liver as a result of alcohol use. Accordingly, the table represents only the directly measurable admissions, and as such a minimum estimate of the problem.

3.5.1 Young People

There is evidence that use of drugs and alcohol among young people can and does lead to:

- Attempted suicide and suicide;
- Nervous breakdown;
- Unwanted pregnancy;
- Prostitution;
- Death;
- Crime; and
- Addiction.

Teenage smokers experience more asthma and respiratory symptoms than non-smokers and suffer poorer health in general.
The sharing of needles offers opportunity for the spread of viruses such as HIV and Hepatitis B and C. Research has shown that around 3% of intravenous drug users are likely to be HIV infected and that over 50% of intravenous drug users are likely to be infected with Hepatitis C (across all age groups). Most of needle exchanges in Tasmania occur through youth oriented health services/centres.

Overuse of alcohol and illicit drugs may result in collapse or fatality. During the 1998/99 financial year over 120 young people (between 12 and 24 years old) were admitted to public hospitals in Tasmania for drug related treatments.

3.5.2 People Aged 65 Years and Over

As Tasmania has an ageing population, there is a concern about the increasing health costs associated with this group in the community. Of particular concern is the use of large numbers of prescription medications. There is a high risk of contraindications when an individual is using five medications or more.

4. CONCLUSION

Estimating the costs associated with problematic drug use is extremely difficult due to the complex array of both direct and indirect impacts that it has on the families, the community and Government services. To date, this level of complexity has inhibited any accurate picture being drawn of the overall costs of drug use within Tasmania.

The absence of accurate estimates of social and economic costs should not, and does not, reduce the priority given by the Tasmanian Government to addressing drug related issues. To this end, the Tasmanian Government has established a Cabinet Subcommittee on Drugs to reflect its priority and to address issues from a whole of government and community perspective. The State is also in the process of developing a revised Tasmanian Drug Strategic Plan which will engender a balanced approach to reduce drug related harm and minimising the uptake and problematic use of illicit and licit drugs.

The Tasmanian Government appreciates the opportunity to provide input into this Inquiry and would strongly support any opportunities to participate in initiatives that seek the further the understanding of the implications of problematic drug use within society.

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5. APPENDIX A - Women and Substance Use

The main issues surrounding substance use affecting women in Tasmania are:

- Use of **tobacco** including the effects of smoking on women's health, women as primary care givers, the economic cost to families, and workplace safety;
- Use of **alcohol** including social costs of alcohol use, and it's use by victims of crime;
- Use of **tranquillisers** including over-prescription; and
- Use of **illicit drugs** particularly use by older women and girls, and lack of appropriate rehabilitation services for women.

5.1 Use of Licit Drugs

5.1.1 Tobacco

In Tasmania, it is estimated that about 100,000 adult Tasmanians smoke. Tobacco related illnesses cost up to $15 million a year in health care. This cost includes treatment for illnesses such as:

- lip, mouth, pharyngeal, oesophageal, laryngeal and lung cancer;
- coronary (heart) disease;
- stroke; and
- chronic bronchitis.

Between 1990 and 1995, 13,673 Tasmanians died from illnesses associated with smoking. The total costs to the Tasmanian economy of smoking are around $34 million a year.[1]

Smoking among young people is increasing and in some rural areas of the State, about 50% of girls over 12 years of age smoke regularly. Female lung cancer rates amongst young women in Tasmania, now exceed that of younger males, although more males still smoke. [2]

While more men than women smoke, National studies have shown that women who smoke tend to smoke more than men who smoke.[3] Younger women are more likely than younger men to smoke.

Daily Smoking by Gender and Age, Tasmania 1998[4]		
Age	% females	% males
18-24	22.6	22.4
25-44	24.8	26.8
45-54	16.6	21.0
54-64	15.2	16.6
65-74	8.8	11.1
75+	3.6	5.8

[1] From www.dchs.tas.gov.au/services/publichealth/pages/polic6.html#Anchor pol6
[2] From www.dchs.tas.gov.au/services/publichealth/pages/polic6.html#Anchor pol6
[3] Provisional Results from the 1998 National Drug Strategy Household Survey, Australian Institute of Health and Welfare, July 1999 page 14.
[4] First Results of the Healthy Communities Survey 1998, Department of Health and Human Services

5.1.1.1 Women's Health and Smoking[5]

As well as being at risk of suffering the general health effects of smoking, such as cardiovascular disease and cancer, women are at risk of developing a number of sex-specific problems due to smoking:

- **Smoking and the Contraceptive Pill**.
  The risk of heart attack, stroke and other cardiovascular diseases in women is increased by approximately tenfold if they smoke and use oral contraceptives. Women aged between 20 and 24 are most likely to use the pill (56%) and most likely to smoke.

- **Fertility**
  Women who smoke have decreased fertility. Smokers have about 72% of the fertility of non-smokers and are 3.4 times more likely to take more than a year to conceive than non-smokers, all other factors being equal. Female smokers experience a reduced rate of fertility once contraceptive measures have ceased to be taken. Actual fertilisation and implantation of the zygote may be impaired in smokers. Smokers enrolled in IVF-ET (in vitro fertilisation and embryo transfer) and GIFT (gamete intra-fallopian transfer) programs have a poorer outcome than non-smokers.

- **Menstruation and Menopause**
  Smokers experience a greater prevalence of secondary amenorrhea (absence of menstruation), and irregularity of periods. Smokers are also more likely to experience unusual vaginal discharge or bleeding. Smoking causes women to reach natural menopause one to two years earlier than non-smokers or ex-smokers. This may be due to a toxic effect on ovaries caused by smoke exposure, or to the significantly lower levels of oestrogens in smokers noted in many studies.

- **Osteoporosis**
  Cigarette smoking contributes to osteoporosis, an increase in bone fragility that accompanies aging. Smoking reduces bone density, possibly through its effects on oestrogens.

- **Cancers of the Uterine Cervix and Vulva**
  Women who smoke cigarettes have a greater risk of developing cancers of the cervix and vulva. For cervical cancer the relationship appears to be dose-responsive, with one study finding an 80% increased risk of developing the cancer among heavy smokers. It is estimated that 19% of cervical cancer and 40% of vulvar cancer is caused by smoking.

5.1.1.2 Women as Carers[6]

Women are the major care givers to children, from conception to adulthood.

[5] Information from Tobacco in Australia: Facts and Issues, A joint initiative of the Commonwealth Department of Human Services and Health, ASH Australia, Victorian Smoking and Health Program, New South Wales Drug and Alcohol Directorate and the Health Department of Western Australia. See www.quit.org.au

[6] Information from Tobacco in Australia: Facts and Issues, A joint initiative of the Commonwealth Department of Human Services and Health, ASH Australia, Victorian Smoking and Health Program, New South Wales Drug and Alcohol Directorate and the Health Department of Western Australia. See www.quit.org.au

Studies have estimated that between a quarter and a third of Australian women smoke during pregnancy. Pregnant teenagers are also more likely than other pregnant women to be smokers, reflecting coinciding patterns of high risk behaviour.

Smoking affects the well-being of the foetus and the pregnant woman. According to the 1990 report of the US Surgeon General, *'Smoking is probably the most important modifiable cause of poor pregnancy outcome among women in the United States.'* Nicotine, carbon monoxide and other toxic constituents of tobacco smoke cross the placenta readily, having a direct effect on the oxygen supply to the foetus, and the structure and function of the umbilical cord and placenta. A number of tobacco smoke constituents that cross the placenta are known carcinogens. Nicotine has a direct effect on foetal heart rate and breathing movements. Nicotine is also found in the breast milk of women who smoke.

Spontaneous abortions and complications of pregnancy and labour occur more frequently in smokers. Smokers have a higher risk of ectopic (tubal) pregnancy and have a greater tendency to deliver pre-term. Women who smoke during pregnancy have a 25 to 50% higher rate of foetal and infant deaths compared with non-smokers. Maternal smoking exerts a direct growth retarding effect on the foetus, resulting in a decrease in all dimensions including length and circumference of chest and head. Infants of smokers weigh on average 200 grams less than the infants of non-smokers, and smokers have double the risk of having a low birth-weight baby.

Maternal smoking may predispose the child to respiratory illness. Parental smoking has been linked with decreased pulmonary function and asthma in children. Smoking during pregnancy and in the infant's first year of life is considered one of the major risk factors for sudden infant death syndrome ('SIDS' or 'cot death'). Research has suggested that smoking by either parent during pregnancy is associated with a higher incidence of all childhood cancers combined, but especially acute lymphocytic leukaemia and lymphoma. A recent meta-analysis suggests a small but statistically significant association between maternal cigarette smoking during the first trimester of pregnancy and increased risk of having a child with cleft lip/palate or cleft palate.

Other reported long term effects of maternal smoking on the infant include impairment of behavioural, intellectual, and physical characteristics. A recent study found a strong and significant positive association between cigarette smoking in mothers during pregnancy and attention deficit/hyper-activity disorder in their children.

5.1.1.3 The Cost of Quitting Smoking

Many smokers would like to quit. However, this is difficult without adequate support. Programs to stop smoking can be expensive. The cost of giving up smoking can be more than the cost of smoking. As an example the average smoker might spend $28 per week smoking, but the recommended use of nicotine patches would cost $33.[7] This is a particular concern to women as they have lower incomes - the average

[7] based on:

	Consumption per week	Total Cost	Cost per week
Cigarettes	100	$8.50 for 30	$28.36
Patches (Nicorette)	7	$33.80 for 7	$33.80

Tasmanian women earns $418 per week and the average Tasmanian man earns $672.[8] Pregnant or breastfeeding women who smoke have less options for quitting as nicotine patches and gum are not suitable.

5.1.1.4 Workplace Safety: Passive Smoking

It has been established that:

- Involuntary smoking is a cause of disease, including lung cancer, in healthy non-smokers.
- The children of parents who smoke compared with the children of non-smoking parents have an increased frequency of respiratory infections, increased respiratory symptoms, and slightly smaller rates of increase in lung function as the lung matures.
- The simple separation of smokers and non-smokers within the same air space may reduce, but does not eliminate, the exposure of non-smokers to environmental tobacco smoke.[9]

There are more than 2,500 women working in pubs, bars, cafes and restaurants in Tasmania. Women represent 62% of the workforce in these industries. Fifty three per cent of bar attendants and 86% of waiters are women.[10] Exposure by pregnant women to workplace passive smoking and paternal smoking has been associated with lower birth-weight, a higher risk of prenatal mortality and spontaneous abortion, particularly in the second trimester (mid three months) of pregnancy.[11]

5.1.2 Alcohol

Men are more likely than women to drink alcohol.[12] Women who drink alcohol regularly consume smaller amounts than men who drink. However women have lower safe consumption levels.

5.1.2.1 Social Costs of Alcohol

Women are far less likely to undertake hazardous or anti-social activities while under the influence of alcohol. For example in 1999, 24% of men and 11.4% of women had driven a car and 6.6% of men and 3.2% of women created a public nuisance while under the influence of alcohol in the past year.

Men's experience as victims of alcohol related crime changes as they age, peaking in their twenties and consistently reducing through the following decades. Their exposure to danger changes with lifestyle changes. Women do not display this pattern. They continue to be victims of alcohol related crime throughout their lives.

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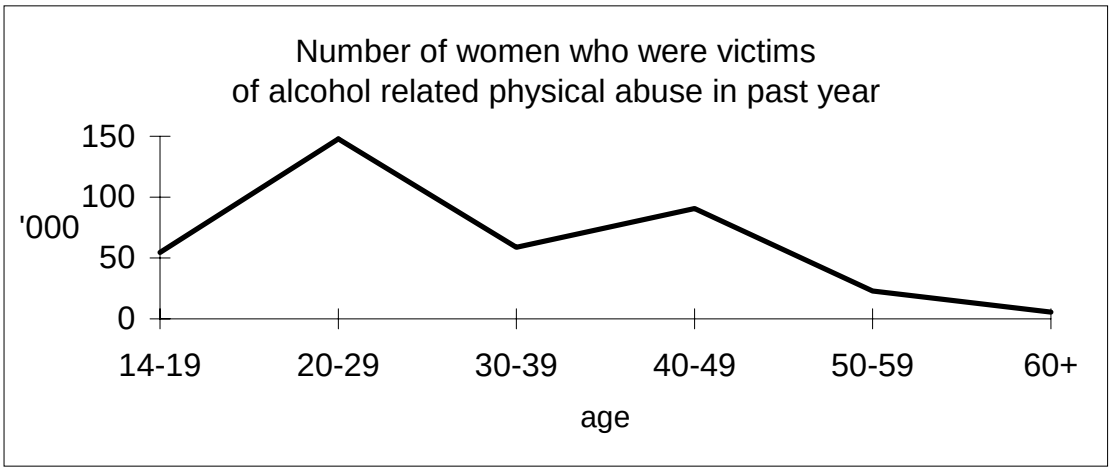
[8] ABS TABLE 13F. Average Weekly Earnings, Tasmania (Dollars) 4 quarter average to August 1999.

[9] Information from Tobacco in Australia: Facts and Issues, A joint initiative of the Commonwealth Department of Human Services and Health, ASH Australia, Victorian Smoking and Health Program, New South Wales Drug and Alcohol Directorate and the Health Department of Western Australia. See www.quit.org.au

[10] 1996 Census figures obtained from DEWSB

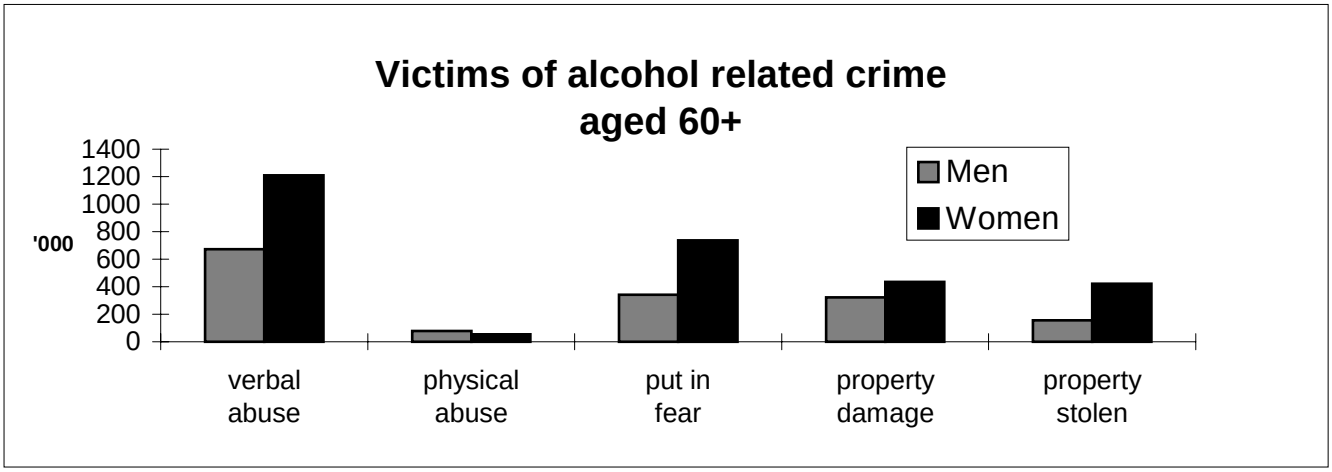
[11] Information from Tobacco in Australia: Facts and Issues, A joint initiative of the Commonwealth Department of Human Services and Health, ASH Australia, Victorian Smoking and Health Program, New South Wales Drug and Alcohol Directorate and the Health Department of Western Australia. See www.quit.org.au

[12] Provisional Results from the 1998 National Drug Strategy Household Survey, Australian Institute of Health and Welfare, July 1999 page 16.



Source: *Provisional Results from the 1998 National Drug Strategy Household Survey*, Australian Institute of Health and Welfare, July 1999

By the time women are in their sixties they are more likely than men to be victims of alcohol related crime. Fifty eight per cent of those people aged over 60 suffer property damage, 64% experience verbal abuse, 68% are put in fear and 73% who have property stolen are women.



Source: *Provisional Results from the 1998 National Drug Strategy Household Survey*, Australian Institute of Health and Welfare, July 1999.

5.1.2.2 Use by Victims

Studies in the United states and Australia reveal that a very high proportion of women being treated for alcohol dependency have experienced child sexual abuse, particularly incest. Women with alcohol dependency are far more likely than women in the general population to have experienced both physical and sexual abuse as a child. Alcohol dependent women experience higher levels of moderate to severe physical and psychological abuse than the women in the comparison group. It has not been established whether the alcohol dependencies eventuated in response to the violence or whether women's alcohol dependency makes them more vulnerable to assault.[13]

[13] Alcohol and Violence Against Women and Children in the Home, National Symposium on Alcohol Misuse and Violence, page 32.

A study conducted at a residential detoxification centre in NSW found that a large proportion of the women had been sexually abused in adulthood, 68% had been physically abused in adulthood, and overall 86% had been physically and or sexually abused at sometime in their life. [14] This appears to be the case in Tasmania as well.

5.1.2.3 Alcohol and Domestic Violence

When alcohol is present with domestic violence it is not causal. This is in contrast to a commonly held belief that alcohol causes violence. In most cases where the perpetrator drinks, domestic violence occurs with or without alcohol. Only in a minority of cases does abuse occur only when the perpetrator is drinking.[15] Alcohol can provide a socially acceptable "excuse for male violence in the home". It can provide a powerful reason for men to avoid taking responsibility for their actions.

5.1.3 Tranquillisers[16]

Minor tranquillisers are prescribed for anxiety and insomnia associated with social and personal problems such as grief, domestic violence, coping difficulties with children, marital difficulties, sexual assault, or work or school problems. They can also be prescribed for anxiety or insomnia associated with physical problems such as muscular pain, skin conditions, dementia, high blood pressure and gastrointestinal symptoms. Minor tranquillisers can quickly relieve symptoms but are effective for only a short period. Dependency can develop with long term use and withdrawal can increase the initial problems. Unwanted effects such as depression, confusion and mood swings are common.

It has been estimated that 4.5% of the population have taken minor tranquillisers. Women outnumber the men in the use of all psychotropic drugs, minor tranquillisers in particular. Seventy per cent of tranquillisers are prescribed for women. Those prescribed are more likely to live in urban areas, have lower socio-economic status and have lower educational levels. Those prescribed are often "housewives", unemployed people and elderly people.

5.1.3.1 Over-prescription

Women have higher levels of anxiety and depression as they are more socially isolated and many of women's roles are repetitive, unthanked and relentless. Women are more likely than men to be misdiagnosed as psychologically disturbed. Once diagnosed women are more likely than men to be prescribed treatment including drugs. Women patients are targeted in drug promotion. Whereas women and men figure equally in antibiotic advertising, in advertising for psychogenic drugs women are portrayed 15 time to each portrayal of a man.

It has been suggested that General Practitioners have difficulty dealing with the complex emotional health issues of their patients due to the time limitations of

[14] Copeland, et al, Evaluation of a Specialist Drug and Alcohol Treatment Service for Women: Jarrah House, National Drug and Alcohol Research Centre Technical Report 17, from Alcohol and Violence Against Women and Children in the Home, National Symposium on Alcohol Misuse and Violence

[15] Alcohol and Violence Against Women and Children in the Home, National Symposium on Alcohol Misuse and Violence, page 2

[16] Information taken from *Women Tranquillisers and Mental Health*, by Hayley Tristram, presented at *Flying High with Mental Health*, a seminar of the Australian and New Zealand College of Mental Health Nurses, Inc, Tas Branch May 1999.

consultations, lack of training and lack of awareness of other options. When General Practitioners suggest alternatives these may not be attractive to patients as many alternatives including counselling or mental health measures, such as regular child care, are not cost effective for patients because they are not covered by private or public health care.

5.1.3.2 Use in Pregnancy

Minor tranquillisers freely cross the placenta and appear in the foetus. Taken during foetal development the foetus can experience withdrawal after birth. High use can result in floppy infant syndrome, poor muscle tone and sucking response.

5.1.4 Drugs and Safety

> *It is estimated that in the 12 months preceding the survey there were over four million victims of alcohol related verbal abuse and over 1 million Australians had property damaged in alcohol related incidents.*[17]

Women are less likely than men to be the victims of drug related harm. They are less likely to be verbally or physically abused. However the numbers of women who are victims of drug related harm is still unacceptably high. Twenty six per cent of women have experienced alcohol related verbal abuse and 17.6% have been put in fear. Almost nine per cent of women have experienced verbal abuse related to other drugs and 8.4% have been put in fear.

5.2 Use of Illicit Drugs

There are limited statistics available as low rates of illicit drug use and the small sample sizes of national survey data make it difficult to meaningfully analyse data by gender. For example in the 1998 National Drug Strategy Household survey held by the Australian Institute of Health and Welfare only 6 Tasmanians sampled were injecting drug users.

Illicit drugs can include illegal drugs (such as cannabis), prescription drugs when used for illicit purposes (such as tranquillisers) and other substances (such as naturally occurring hallucinogens).

National figures reveal that use of illicit drugs is increasing, up from 39.3% of the population in 1995 to 46% of the population in 1998. Men are more likely than women to use illegal drugs. Twenty five per cent of men and 19.1% of women had used illicit drugs in the past 12 months. However, older women are far more likely than older men to using illicit drugs with 13.4% of women in their fifties and 6.3% of women over 60 years old used illicit drugs in the past 12 months. This compares to 7.2% and 5.2% of men respectively.[18]

[17] Provisional Results from the 1998 National Drug Strategy Household Survey, Australian Institute of Health and Welfare, July 1999 page 36.
[18] Source report Provisional Results from the 1998 National Drug Strategy Household Survey, Australian Institute of Health and Welfare, July 1999, page 19.

5.2.1 Amphetamines[19]

Amphetamines have been identified as easy to obtain. The typical Tasmanian amphetamine users resides in Hobart, is aged between the late teens to 30's has an English speaking background and is male. It is estimated that from 70% upward of amphetamine users are men.

The numbers of amphetamine users presenting to services has increased. A decrease in age and increase in numbers injecting was noted. Mental health problems such as psychosis was seen to be increasing (particularly amongst regular opioid and high use cannabis users).

		1996/97	1997/98	1998/99
Consumers	**female**	**3**	**5**	**0**
	male	15	9	4
	unknown	0	1	2
	Total	18	15	6
Providers	**female**	**0**	**0**	**0**
	male	2	0	1
	unknown	0	0	0
	Total	2	0	1
Total Arrests		20	15	7

Source: Australian Bureau of Criminal Intelligence
[Note: "*Consumers*" refers to people charged with use type offences]

5.2.2 Opioids [20]

Opioids have been identified as easy to obtain. The typical Tasmanian opioid user resides in Hobart, is aged in their 20s, is unemployed has an English speaking background and is male. It is estimated that the majority of opioid users are men, with most informants estimating around 70%.

There is an increased number of people using opioids, with a decrease in average age and increase in number of female users (although this may be due to women feeling more comfortable in using drug services). Most users inject and there are increased rates of injecting. The most commonly injected opioids are morphine and methadone. Diverted pharmaceutical opioids are more prevalent than illicit opioids.

5.2.3 Cannabis[21]

Cannabis has been identified as very easy to obtain. The 1998 National Drug Strategy Household survey found that 37.5% of Tasmanians had used cannabis at some time in their lives.

The typical Tasmanian cannabis user resides in Hobart, is aged in their teens to late 20s, is unemployed or a student, has an English speaking background and is male. It is estimated that at least 70% of users are men.

[19] Tasmanian Drug trends 1999, Findings from the Illicit Drug Reporting System (IDRS), Raimondo Bruno and Stuart McLean, National Drug and Alcohol Research Centre Technical Report No 84.
[20] Tasmanian Drug trends 1999, Findings from the Illicit Drug Reporting System (IDRS), Raimondo Bruno and Stuart McLean, National Drug and Alcohol Research Centre Technical Report No 84.
[21] Tasmanian Drug trends 1999, Findings from the Illicit Drug Reporting System (IDRS), Raimondo Bruno and Stuart McLean, National Drug and Alcohol Research Centre Technical Report No 84.

		1996/97	1997/98	1998/99
Consumers	**female**	**91**	**115**	**108**
	male	437	520	564
	unknown	0	272	15
	Total	528	907	687
Providers	**female**	**100**	**37**	**11**
	male	451	179	38
	unknown	0	73	0
	Total	551	289	49
Total Arrests		1079	1196	736

Source: Australian Bureau of Criminal Intelligence

5.2.4 Other Drugs[22]

Heroin use varies dependant on availability and quality but use of this substance is increasing. Most Tasmanians who have used heroin in the past have done so whilst residing interstate.

Ecstasy use tends to be recreational and occasional with increased rates reported. With regard to cocaine, there is reported minimal availability of this substance. Injection of benzodiazepines is common amongst opioid users.

5.2.4.1 Use by Older Women

Nationally figures reveal that while young and middle aged women are less likely than men to use marijuana or cannabis, older women are more likely than older men to use. There are 65,900 men and 93,300 women over 50 years old who are recent users. The issue of older women and illicit/illegal drug use, its implications for policy and client servicing are largely ignored.

5.2.4.2 Use by Girls

Nationally figures reveal that while women overall are less likely than men to use heroin or inject drugs, the use by teenage girls exceeds that of teenage boys.[23] It is impossible to provide reliable figures on use of drugs by age and gender in Tasmania so it is not clear whether use by teenage girls is a significant problem

[22] Tasmanian Drug trends 1999, Findings from the Illicit Drug Reporting System (IDRS), Raimondo Bruno and Stuart McLean, National Drug and Alcohol Research Centre Technical Report No 84.
[23] Provisional Results from the 1998 National Drug Strategy Household Survey, Australian Institute of Health and Welfare, July 1999, page 24-27.

5.2.5 Rehabilitation Service

Access to rehabilitation services for women with dependant children is difficult. Women with young children may have to place their children into care and risk losing custody of them.

6. APPENDIX B - Drug Strategies and Programs

6.1 National Drug Strategy

The Tasmanian Government strongly supports the National Drug Strategic Framework 1998-1999 to 2002-2003 which provides a strategic framework for addressing drug-related harms throughout Australia.

The National Drug Strategic Framework has as its mission:

> *To improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in Australian society.*

Its objectives are:

1. to increase community understanding of drug-related harm;
2. to strengthen existing partnerships and build new partnerships to reduce drug-related harm;
3. to develop and strengthen links with other related strategies;
4. to reduce the supply and use of illicit drugs in the community;
5. to prevent the uptake of harmful drug use;
6. to reduce drug-related harm for individuals, families and communities;
7. to reduce the level of risk behaviour associated with drug use;
8. to reduce the risks to the community of criminal drug offences and other drug-related crime, violence and anti-social behaviour;
9. to reduce the personal and social disruption, loss of quality of life, loss of productivity and other economic costs associated with the harmful use of drugs;
10. to increase access to a greater range of high quality prevention and treatment services;
11. to promote evidence-based practice through research and professional education and training;
12. to develop mechanisms for the cooperative development, transfer and use of research among interested parties.

The approach set out in the Strategic Framework includes:

- **harm minimisation** – encompassing supply reduction strategies to disrupt production and supply of illicit drugs, demand reduction strategies to prevent the uptake of harmful drug use, harm reduction strategies to reduce drug related harm for individuals and communities.
- **A coordinated, integrated approach** – stressing responsibility for action by law enforcement, criminal justice, health and education agencies, government agencies at all levels, the community based sector, business and industry, research institutions, local communities and individuals.
- **A partnership approach** – recognising the need for a cooperative effort between all levels of government, community based organisations, researchers, health professionals, educators, law enforcement authorities, drug users and the wider community to reduce the harmful social, health and economic effects of drug use.

- **A balanced approach** – seeking a balance between supply reduction, demand reduction and harm reduction strategies. Also this approach seeks a balance between strategies to reduce the harm caused by both licit and illicit drugs.
- **Evidence based practice** – emphasising that all strategies should reflect evidence based practice which is based on rigorous research and evaluation, including the cost effectiveness of interventions.
- **Social Justice** – seeking to develop strategies that recognise the unique settings of local communities, are culturally responsive, meet the needs of marginalised population groups and improve access to local services.

6.2 State Drug Strategy

The State Government has also established its own drug strategy (Tasmanian Drug Strategic Plan 1996 - 2000) within this broad national framework. This Strategy recognises that the most commonly used drugs are alcohol and tobacco and it is these drugs which cause the most harm to Tasmanians. The Strategic Plan also recognises that reducing alcohol and drug related harm requires a broad range of intervention strategies, only some of which focus on treating people with alcohol and drug problems. Prevention and early intervention strategies are also needed which target the broader population.

The State Government is currently developing a revised drug strategic plan for the period 2001 and beyond. The existing strategic plan has been extended until July 2001 to enable full consideration of the appropriate directions that need to be taken to address issues associated with the problematic use of drugs within Tasmania.

6.3 Illicit and Pharmaceutical Drugs

The major strategies relating to illicit drugs and the illicit use of pharmaceutical drugs aim to reduce both the supply and demand for these drugs while minimising the harm arising from their use.

The Tasmania Government views that a comprehensive and balanced approach is necessary to deal with the problems associated with the use and misuse of drugs. This includes both maximising the availability of support and services to users, reducing alienation of users, and ensuring that there is legislative and regulatory parameters to discourage possession or use and minimise purchase or cultivation, manufacture and distribution of controlled drugs.

6.4 The Poppy Industry

The alkaloid poppy industry is an important enterprise in Tasmania, adding approximately $200 million to the State's economy. Tasmania is the world's largest legal producer of opiate alkaloids, providing over 40 per cent of the world's licit supply.

The area of land under poppy cultivation has grown to more than 20,000 hectares (see below). Sowing is early winter to spring, flowering in early summer and harvesting in mid to late summer (December to March). Biologically mature plants are harvested when the seed capsules, which appear after flowering, are dry.

Season	1991_92	1992_93	1993_94	1994_95	1995_96	1996_97	1997_98	1998_99	1999_00
Hectares harvested Morphine poppies	8013	6026	6735	8139	8363	9521	10682	11555	15009
Hectares harvested thebaine poppies							809	1978	5600
Total hectares	8013	6026	6735	8139	8363	9521	11491	13533	21609

6.4.1 Securing The Crop

A working group of Commonwealth and State Government officials - the Committee on Poppy Industry Security - has been established to address security issues. Its main objective is to ensure that there are no weak links in the security chain from poppy field to export of finished products.

Tasmania has laws prohibiting unauthorised cultivation and possession of any part of a poppy plant, with sever penalties in place.

Licences to grow the *papaver sommiferum* plant are issued to farmers only after they have been contracted to grow and dispose of the crop (when harvested) to a licensed manufacturer.

Farmers must also have obtained security clearance from Tasmania Police and provide a detailed site plan of the cultivation site.

Tasmania's three-pronged approach to security includes industry, government and the rural community:

- General surveillance and reporting of suspicious activity by growers, harvest operators and company field officers;
- Investigation of thefts, apprehension and prosecution of offenders and intelligence by a special Tasmania Police Drug Investigations Service Task Force; and
- Coordination of security efforts by the PACB. In addition, regular frequent inspections of crops are conducted by PACB field officers in collaboration with Government and poppy company field officers.

6.4.2 Tasmania Police Poppy Task Force

The 1999/2000 poppy season has seen a further expansion in the Tasmanian poppy industry. Tasmania Police security arrangements involve a dedicated Statewide Poppy Task Force under overall command of OIC Southern Drug Investigation Services plus of uniformed and other officers tasked to perform targeted patrols. The Task force is assigned to three geographical regions of the state for 6 months (South, 4 officers; North, 4 officers; and West, 4 officers). The Tasmania Police Poppy Task Force and targeted patrols by other police represents a significant resource allocation by Tasmania Police to drug law enforcement.

6.5 Overview of Specific Jurisdictional Demand and Supply Law

Enforcement Strategies By Tasmania Police

6.5.1 Diversionary Approaches

Tasmanian Drug Diversion Initiative (also referred to as the Tasmanian Early Intervention and Diversion Framework or the Framework).

The adverse effects of drug use on the community are of major concern to the Tasmanian Government. Although police diversion programs are already in place in many jurisdictions, including Tasmania, the need for further diversionary measures that seek to minimise or prevent the progression of people with drug dependencies into the criminal justice system is widely acknowledged.

In April 1999 the Council of Australian Governments agreed to make a new investment in combating drugs by combining strong national action against drug traffickers with early intervention strategies to prevent a new generation of drug users emerging in Australia.

The centrepiece of this early intervention and prevention approach is a nationally consistent diversion initiative. This initiative will target illicit drug users early in their involvement with the criminal justice system. Police will divert targeted offenders to compulsory drug education or assessment, from where they will be referred to a suitable drug education or treatment programme. Some offenders may also be diverted by Courts under this initiative.

The Ministerial Council on Drugs (MCDS) was asked by COAG to develop a national framework for the diversion initiative. Ministers tasked the Intergovernmental Committee on Drugs (IGCD), in consultation with the Australian National Council on Drugs (ANCD), to identify the crucial components of a diversion scheme and the linkages between them.

The resulting national framework provided a basis for implementation of the diversion approach. It facilitated national action and cooperation whilst providing States with the flexibility to respond to local priorities and conditions.

It was in this broader COAG context that development of the Tasmanian Drug Diversion Initiative occurred, although it should be noted that many States, including Tasmania already had in place diversionary approaches to drug law enforcement. Commencing during July 1998, the Tasmanian Commissioner of Police initiated a Cannabis Cautioning Program for first time offenders. This was subsequently adapted within the Tasmanian Diversion Initiative and the eligibility criteria relaxed.

At the State level, the Interdepartmental Committee on Drugs (comprising senior officials and chaired by the Secretary of the Department of Premier and Cabinet) managed the process for developing a Framework for the early intervention and diversion of offences relating to the use and possession of all illicit drugs and drugs used illicitly (with the exception of alcohol and tobacco). The framework integrates services provided by the Departments of Police and Public Safety, Justice and Industrial Relations, Health and Human Services and, indirectly, Education.

Following finalisation of a bilateral agreement between Tasmania and the Commonwealth, the Diversion Initiative commenced operation on 29 February 2000.

Under the agreed national diversion arrangements it was recognised that the diversion initiative may be implemented in stages in each State and Territory. This would allow the approach to be tested fully in a mix of urban and rural areas, target groups, or areas with special needs. Extensive coverage across all jurisdictions is expected to be achieved within four years.

A reference group is to be established in each State/Territory to provide advice to the Commonwealth and State Governments on the implementation of the COAG diversion initiative. At a minimum, these groups will include representatives of:

- The Commonwealth Department of Health and Aged Care;
- State and Territory Health Departments (or other appropriate agency)
  State and Territory Police, and
- An appropriate representative of the ANCD (or the non-government sector) as determined bilaterally between each jurisdiction and the Commonwealth.

In the case of Tasmania, an ANCD representative and a non-government service provider representative are included on the State Reference Group. It also includes representation from Departments of Police and Public Safety, Justice and Industrial Relations, Health and Human Services and, Education, and is chaired by the Department of Premier and Cabinet.

Voluntary admissions to treatment will not be displaced as the Commonwealth will provide approximately $105 million ($3.8 million for Tasmania) over the four years for new assessment, treatment and education places and for capacity building and training for the compulsory diversion initiative. States and Territories will also ensure an appropriate match between the number of people diverted and the number of education and treatment places funded.

In addition to the central diversion initiative, COAG also endorsed a range of measures to:

- reduce supply of illicit drugs;
- support families and communities to tackle the drug problem;
- educate children and the broader community about the dangers of drug use; and
- address drug use in prisons.

The Commonwealth has committed approximately $109 million to the first three of these measures.

- The Tasmanian Early Intervention and Diversion Framework has two (2) broad components:

  1. Diversion of Illicit Drug Offences (other than cannabis) into Assessment and Treatment

  - Offenders identified by police for the use or possession of illicit drugs other than cannabis will, if eligible, be diverted into assessment and brief intervention or treatment. A ‘brief intervention’ will involve a session of face-to-face contact with a health professional.

- Offenders apprehended for drug offences *only* are diverted directly to the Alcohol and Drugs Services of the Department of Health and Human Services for assessment and referral into brief intervention or treatment.
- Offenders with drug offences and co-related non drug offences (eg. burglary) may be referred to Community Corrections for assessment of their drug offences in light of other co-related offences. Community Corrections may divert the drug offence, however, any co-related offence will continue through the Criminal Justice System.
- Criminal charges for the drug offence will not be pursued and offenders will not be required to attend Court if they attend assessment and comply with the recommended education or treatment options.
- The charges will be pursued if the offender fails to attend assessment or comply with treatment requirements.

2. Cannabis Diversion

1st Level Cannabis Diversion - Police Caution

- All first offenders for the use or possession of cannabis are cautioned by Tasmania Police and provided with educational material.
- Cautioning is dependent on a number of criteria including an admission of guilt, positive identification and sufficient evidence for a prosecution.
- Offenders are not required to attend Court and do not receive a criminal record for first offence cannabis use or possession.
- Any co-related non-drug offences and pursued within the current Criminal Justice System.

2nd Level Cannabis Diversion - Diversion into Education

- All second offenders for the use or possession of cannabis are diverted into a brief intervention session that provides a face-to-face intervention with a health professional.
- Criteria for the second level diversion is the same as for first level diversions.
- Users will only be prosecuted if they fail to attend the brief intervention session.
- Any co-related non-drug offences are pursued within the current Criminal Justice System.

3rd Level Cannabis Diversion into Assessment and Education or Treatment

- The process for third time cannabis offenders follows that prescribed for the diversion of illicit drug offences (other than cannabis) described above.

- The level of treatment that is mandated by an 'assessor' is proportional to the likely penalty that would be imposed by the Courts for that offence. Assessors may, however, prescribe 'voluntary' treatment programs for offenders that extend beyond the mandated treatment requirements.
- All assessment and treatment under the Framework can be conducted by both Government and non-government providers. Assessment and treatment is

coordinated by the Alcohol and Drug Service of the Department of Health and Human Services.

- Offenders are *not* be eligible for diversion if the drug offence is associated with any violent offence.
- A principle of the Framework is to provide assessment and treatment services within the offender's own community. For offenders within rural communities, assessment is conducted using the established 'outreach' program or utilising 'Telehealth' facilities.
- Maximum permissible drug quantities have not been prescribed for the purposes of the framework (except for cannabis where they are up to two plants and less than 50 grams of leaf). Rather, an offender is not deemed eligible for diversion if the circumstances of the offence are such that a drug charge greater than use or possession (eg. trafficking) is likely to be successful. Guidance for Police Officers in this regard is provided in relevant legislation and police instructions
- The use of alcohol and tobacco by young people under 18 years was noted when developing the Framework. The use of these substances was not, however, included within the Framework due to the existence of other strategies to address this issue. It was also noted that issues associated with the illicit use of alcohol and tobacco were significantly different to those associated with the illicit use of other drugs.
- Resources required for both the implementation of the Framework and on-going services will be sourced from either the COAG Illicit Drug Package funding or absorbed within existing agency allocations. The Commonwealth have provided approximately $3.85M over four years for the implementation and on-going management of this framework.
- The particular needs of juveniles, women, indigenous offenders and offenders from diverse cultural backgrounds are taken into account within the framework.
- The expected benefits include:
  the capacity through cannabis cautioning and/or referral to education and assessment (for cannabis and other illicit drugs) to reinforce community disapproval of drug misuse by directing offenders away from the criminal justice system without diminishing public perceptions of the risks and respectability of the use of cannabis and other illicit drugs.
- a legal avenue for police and courts to direct eligible people away from the criminal justice system and towards treatment where this is a better alternative;
- savings in court time and expenditure, which also allows deployment of operational police in areas of need;
- the capacity for offenders to engage in treatment, and by doing so, to expiate their offence; and
- from a social justice perspective, minimising likelihood of offenders being jailed for non-payment of fines imposed.

6.6 Other Police Drug Strategies

6.6.1 Street Level Control

Whilst not comparable to the highly visible, large scale and concentrated illicit drug markets in other jurisdictions, some street level dealing does occur, with particular locations identifiable with obtaining quantities of illicit drugs, such as cannabis, amphetamines and illicit pharmaceutical drugs. Although heroin is available, the supply and quality remains irregular, and data from the various sources, including returns from the Needle and Syringe supply outlets, indicates that a street heroin market has not emerged in this state. Nevertheless, targeting street level drug markets is an important strategy in the removal of drug-related problems within the community. Strategies may include the surveillance of known drug activity locations or ensuring an increased uniformed police presence as a demand reduction strategy.

6.6.2 Community Policing

This approach seeks to establish and maintain partnerships between the police and citizens as crime reduction strategies. Specific programs include: Neighbourhood Watch, BushWatch, Adopt-a-Cop, Crime Prevention Council, Community Liaison, Police and Citizens Youth Clubs, Operation NOAH.

Establish and maintain inter-sectoral collaboration and cooperation with government and non-government health providers of alcohol and drug services, including needle and syringe exchanges. Police policy is to avoid undue concentration of policing presence in the vicinity of needle and syringe exchanges.

6.6.3 Community Drug Education Program

To meet community demand, Tasmania Police has in place a drug prevention and education program. This involves trained officers who conduct presentations consistent with national principles of drug education to diverse community groups such as local community and service groups, schools, parents and TAFE.

6.6.4 School Support Program

Each Drug Bureau has appointed a School Liaison Officer who has responsibility for maintaining regular contact with government and non-government schools. Through regular contact with schools, officers develop an understanding of the school situation, and are able to provide a constructive approach in dealing with drug related matters involving the school, parents and students.

6.6.5 Principals' Forum

Regular contact is maintained with school principals from government and non-government sectors by means of 'Principals' Forum' meetings held each term. This provides an opportunity for Tasmania Police and schools to network, share information, discuss and resolve concerns and to examine options to develop better ways of handling drug use in the school environment.

6.6.6 Problem-orientated Policing

A problem-orientated policing approach has been adopted to reduce the incidence of drug-related crimes such as burglary and robbery. It involves identifying crime problems, analysing the factors contributing to these problems and developing appropriate elimination or reduction strategies.

6.6.7 Policing Hot Spots

Law enforcement focusing on the place at which drug deals are transacted and targeted methods to deter illegal activity from re-establishing.

6.6.8 Random Breath Testing

Random Breath Testing has been and remains the single most important contributing factor to the reduction in deaths and injuries on Tasmanian roads.

6.6.9 Enforcement of Liquor Licensing Legislation and Initiatives to Reduce Violence in and Around Licensed Premises

Tasmania Police has a Licensing Section tasked with the enforcement and monitoring of liquor licensing. Pro-active initiatives have been undertaken in conjunction with licensees and Licensing Commission to reduce violence and drunkenness in and around licensed premises by developing local industry accords and responsible service of alcohol training.

6.6.10 Multi-agency Supply Reduction Approaches

Tasmania Police has representation on Australia's national common police services and access to other Commonwealth agencies such as the National Crime Authority which provide for the collection, collation, analysis and dissemination of intelligence and other law enforcement services between jurisdictions.

Tasmania Police also rotates members to positions with other agencies including the Australian Bureau of Criminal Intelligence and the National Crime Authority to facilitate exchange of expertise, training and application of intelligence to investigations and procedures. The current Deputy Director of the Australian Bureau of Criminal Intelligence (ABCI), Peter Edwards, is a serving member of Tasmania Police.

6.6.11 Memorandum of Understanding with the Department of Health and Human Services on Self-Administered Overdoses.

Research indicated that the major reason identified for failing to call an ambulance to an overdose situation was the fear of Police intervention leading to prosecution for drug related offences, primarily self administration.

Tasmania Police and the Tasmanian Ambulance Service have agreed that the saving of life is the major priority for both organisations, and 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.

6.6.12 The National Heroin Signature Program

Tasmania Police supports the National Heroin Signature Program which will determine the unique signature of any heroin sample seized and so determine the source country. It will also help establish common features between seizures from the same production batch and so help trace distribution networks in Australia.

6.6.13 Drug Analysis Information

Results of analysis of drugs seized can reveal presence of more harmful or hazardous substances or an unexpected increase in street purity that pose a threat to users. Mechanisms are in place to ensure that this important and accurate information can be passed by Tasmania Police to those in contact with drug users and through the media to reduce and minimise harm.