The Parliament of the Commonwealth of Australia

Road to recovery

Report on the inquiry into substance abuse in Australian communities

House of Representatives
Standing Committee on Family and Community Affairs

August 2003
Canberra

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Foreword

It was the best of times, it was the worst of times …
(Charles Dickens, A tale of two cities)

Working on a bipartisan federal parliamentary committee is one of the more rewarding experiences of parliamentary life. Through these committees members are able to undertake more detailed investigation of issues that affect the Australian community. Through public hearings, roundtables, community forums, briefings and inspections, committee members are able to meet face to face with the Australian community to discuss issues, draw conclusions, make recommendations and ultimately improve services for the Australian community. These committees are a vehicle for change for the better.

However the task is difficult. There are time constraints on its members' time to undertake this work. The issues dealt with are often sensitive and difficult; and balancing the alternate views is never easy, nor is the achievement of consensus.

In this inquiry the House Family and Community Affairs Committee has had the opportunity to meet with members of the community affected by this distressing issue and also with those people who are committed to addressing it. Time after time the members were astounded at the level of commitment and professionalism these people brought to the table.

There were many challenges and difficulties faced by the committee of this parliament, as we had inherited an issues paper but no detailed conclusions nor recommendations. I am very proud and indeed fortunate to be a part of a committee whose members are able to work well together and consider issues in a balanced and reasonable way. Each and every committee member worked tirelessly to bring to the Australian people a report that would contain meaningful recommendations that would begin to ease the burden of substance abuse and misuse for all Australians.

In undertaking its work the committee appreciates the contributions it has received from those who made submissions and appeared at public hearings, the roundtable, private briefings and inspections. The committee has received excellent support from all of the Secretariat team, Clerk and Deputy Clerk of the House of Representatives and others in the Department.

The committee has now completed its work.

In its report, *Road to recovery*, the committee has made 128 recommendations which we believe, if implemented, will critically improve the way in which we, as a community, deal with substance use and misuse. Throughout the report consideration all members tested their conscience in trying to understand individual concerns and at times members moved from their personal stance in order to deliver a unified outcome. It is important to state that the report has absolute integrity in the desire to ensure better treatment programs that are accessible to all Australians.

It is a fact that many people never witness the strength and devotion of members of parliament as they undertake committee and policy work outside of their electorate duties. As chair, I appreciate the commitment and effort of all members of the committee, to this end I believe that the Australian people were well served!

Kay Hull MP
Chair

Membership of the Committee

40th Parliament

Chair Mrs Kay Hull MP

Deputy Chair Mrs Julia Irwin MP

Members
Hon Alan Cadman MP
Mrs Trish Draper MP
Mr Peter Dutton MP
Hon Graham Edwards MP
Ms Annette Ellis MP *(until 27August 2002)*
Ms Jennie George MP
Mr Chris Pearce MP
Mr Harry Quick MP *(from 29 May 2002)*
Mr Cameron Thompson MP
Mr Barry Wakelin MP *(from 29 May 2002)*

39th Parliament

Chair Mr Barry Wakelin MP

Deputy Chair Ms Annette Ellis MP

Members
Mr Kevin Andrews MP
Ms Julie Bishop MP *(from 13 April 2000)*
Hon Graham Edwards MP
Mrs Kay Elson MP *(until 31 May 2000)*
Mrs Joanna Gash MP *(from 31 May 2000)*
Ms Jill Hall MP
Mrs Julia Irwin MP *(from 13 April 2000)*
Mrs Deanne Kelly MP *(until 7 September 2000)*
Mr Tony Lawler MP *(from 7 September 2000)*
Dr Brendan Nelson MP *(until 31 August 2000)*
Dr Mal Washer MP *(from 31 August 2000)*
Mr Harry Quick MP
Mr Alby Schultz MP

Committee secretariat

40th Parliament

Committee Secretary	Ms Beverley Forbes
Inquiry Secretary	Dr Sarah Hnatiuk *(till 30 May 2003)*
Senior Research Officers	Ms Margaret Atkin
	Ms Jill Miller *(from June 2002 till March 2003)*
	Ms Rachelle Mitchell *(from 22 May 2003)*
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	Ms Belynda Zolotto *(from August 2002)*

39th Parliament

Committee Secretary	Mr Trevor Rowe
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	Ms Jane Sweeney
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	Ms Melissa Holland
	Ms Alime Smith
	Mrs Angela Nagy

Terms of reference

On 14 May 2002 in response to a request from the committee, the Minister for Health and Ageing, Senator the Hon Kay Patterson, re-referred the following inquiry to the committee.

In view of the level of community concern about the abuse of licit drugs such as alcohol, tobacco, over-the-counter and prescription medications, and illicit drugs like marijuana and heroin, the Committee has been asked by the Minister of Health and Ageing, Senator the Hon Kay Patterson, to report and recommend on:

The social and economic costs of substance abuse, with particular regard to:

- family relationships;
- crime, violence (including domestic violence), and law enforcement;
- road trauma;
- workplace safety and productivity, and
- health care costs.

The inquiry had initially been requested by the committee in the previous (39th) parliament and the reference initially provided by the Minister for Health and Aged Care, the Hon Michael Wooldridge MP, on 30 March 2000.

List of abbreviations

AAPS	Alcohol Advertising Pre-Vetting System
ABAC	Alcohol Beverages Advertising Code and Complaints Management System
ABCI	Australian Bureau of Criminal Intelligence
ADCA	Alcohol and other Drugs Council of Australia
ADIN	Australian Drug Information Network
AIDS	acquired immunodeficiency syndrome
ACC	Australian Crime Commission
AFP	Australian Federal Police
AIC	Australian Institute of Criminology
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
ANCAHRD	Australian National Council on AIDS, Hepatitis C and Related Diseases
ANCD	Australian National Council on Drugs
AOD	alcohol and other drugs
ATS	amphetamine type stimulants
AUSTRAC	Australian Transaction Reports and Analysis Centre
CFS	Commonwealth Forensic Services

COAG	Council of Australian Governments
Customs	Australian Customs Service
DASC	Drug and Alcohol Services Council
DUMA	Drug Use Monitoring in Australia
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ETS	environmental tobacco smoke
FAS	fetal alcohol syndrome
FFDLR	Families and Friends of Drug Law Reform
FSANZ	Food Standards Australia New Zealand
GPs	general practitioners
Health Outcomes	Health Outcomes International Pty Ltd
HIV	human immunodeficiency virus
LAAM	levo-alpha-acetylmethadol
MCDS	Ministerial Council on Drug Strategy
MMT	methadone maintenance treatment
NCA	National Crime Authority
NCADA	National Campaign Against Drug Abuse
NCETA	National Centre for Education and Training
NDARC	National Drug and Alcohol Research Centre
NDS	National Drug Strategy
NDS Household Survey	National Drug Strategy Household Survey
NEPOD	National Evaluation of Pharmacotherapies for Opioid Dependence

NGO	non-government organisation
NIDS	National Illicit Drug Strategy
NOHSC	National Occupational Health and Safety Commission
NRTC	National Road Transport Commission
NSP	needle and syringe program
NUAA	New South Wales Users and AIDS Association
OHS	occupational health and safety
PBS	Pharmaceutical Benefits Scheme
PHAA	Public Health Association of Australia
PHOFA	Public Health Outcome Funding Agreements
RBT	random breath testing
SIFs	safe injecting facilities
THC	tetrahydrocannabinol (the psychoactive agent in cannabis)
VCTC	VicHealth Centre for Tobacco Control
WET	wine equalisation tax
WFA	Winemakers Federation of Australia
WHO	World Health Organization

List of recommendations

3 Families and communities

Recommendation 1

The committee recommends that the Commonwealth government, in cooperation with the State and Territory governments, ensure that early intervention and prevention programs aimed at young people are expanded to:

- actively encourage and support young people to be involved in communities, families and with their peers in a way that is valued and recognised;
- create opportunities for them to connect with adults in schools, local neighbourhoods and families; and
- promote skills in young people and adults for making those connections. (para 3.32)

Recommendation 2

The committee recommends that the Commonwealth, State and Territory governments work in cooperation to ensure that all early intervention and prevention programs aimed at young people are delivered in conjunction with programs targeting areas of disadvantage such as poverty, poor housing, ill health and poor school attendance. (para 3.33)

Recommendation 3

The committee recommends that the Commonwealth government, in cooperation with the State and Territory governments, give the highest priority to the implementation of the National Drug Prevention Agenda and its ongoing evaluation. (para 3.34)

Recommendation 4

The committee recommends that the Commonwealth government in conjunction with State and Territory governments ensure that adequate funding is provided on a long term basis for comprehensive school drug education programs that are part of a whole of school and community approach to dealing with drug use. Programs must be evaluated for effectiveness across a range of criteria. (para 3.53)

Recommendation 5

The committee recommends that the Commonwealth government in conjunction with State and Territory governments ensure adequate numbers of:

- teachers receive ongoing professional development (in-service) in order to provide effective drug education; and
- trainee teachers are specifically trained (pre-service) to provide effective drug education. (para 3.57)

Recommendation 6

The committee recommends that the Commonwealth, State and Territory governments ensure that schools:

- are sufficiently resourced to provide comprehensive assistance to substance using students and their parents;
- have adequately trained staff to deliver this assistance;
- this resourcing must be sufficient to enable schools to effectively liaise with health and welfare agencies dealing with students at risk of substance abuse; and
- are urged where appropriate not to use expulsion as the first or only response. (para 3.64)

Recommendation 7

The committee recommends that the Commonwealth, State and Territory governments continue to give a high priority to developing and maintaining effective school drug education programs. (para 3.73)

Recommendation 8

The committee recommends that the Commonwealth, State and Territory governments work together to:

- evaluate the effectiveness of family and community-focused interventions in relation to:

⇒ informing people about substance use;

⇒ providing people with the skills to be better parents and in particular to deal with substance use by family members and others; and

⇒ empowering communities to identify and implement appropriate local initiatives; and

■ ensure programs found to be cost-effective prevention measures are funded on a more generous, longer term basis than at present. (para 3.80)

Recommendation 9

The committee recommends that the Commonwealth, State and Territory governments support the provision of out-of-school activities for young people:

■ with particular attention to those areas where few such activities are currently available; and

■ ensuring that these activities form one component of a larger intervention that addresses other problem aspects of these young people's lives. (para 3.84)

Recommendation 10

The committee recommends that the Commonwealth, State and Territory governments ensure that the Good Sports Program or like programs are established and promoted in all jurisdictions. (para 3.87)

Recommendation 11

The committee recommends that the Commonwealth, State and Territory governments trial substance abuse prevention strategies that combine school, family and community-focused activities which have been tailored to the needs of the individual local communities where they are implemented. (para 3.91)

Recommendation 12

The committee recommends that the Commonwealth, State and Territory governments provide funding:

■ for programs that support families dealing with substance abuse;

■ for treatment regimes that allow families to be involved with the substance user's treatment; and

- to evaluate the success of these programs and regimes with a view to identifying best practice and disseminating information about that best practice. (para 3.98)

Recommendation 13

The committee recommends that the Commonwealth, State and Territory governments implement adequately resourced, coordinated, comprehensive services for drug-affected individuals and their families. (para 3.104)

Recommendation 14

The committee recommends that the Australian National Audit Office evaluate the Australian National Council on Drugs mapping exercise on Australian drug treatment capacity. (para 3.111)

Recommendation 15

The committee recommends that any Commonwealth, State and Territory agency or body, or NGO, in receipt of Commonwealth funding for drug related programs, be compelled as a condition of funding, to provide to the Australian National Council on Drugs data and information required for the facilitation of the Australian National Council on Drugs database. The information is to be provided in a timely manner to enable the database to meet its objective of providing all Australians with advice on available services. (para 3.112)

Recommendation 16

The committee recommends subject to the outcomes of the Australian National Audit Office evaluation that the Australian National Council on Drugs mapping exercise:

- urgently complete the mapping of available alcohol and drug services across Australia;
- identify any gaps in the data assembled which are needed for planning purposes;
- ensure those data are collected; and
- regularly update the information contained in this database. (para 3.113)

Recommendation 17

The committee recommends that the Commonwealth, State and Territory governments and non-government organisations working in the alcohol and other drug sector constructively engage with the media to promote better informed, rational debate on drug issues. (para 3.116)

Recommendation 18

The committee recommends that the Commonwealth Department of Health and Ageing liaise with representatives of the media in order to develop a voluntary media code for responsible reporting of substance use and abuse similar to that in place for reporting youth and other suicides. (para 3.119)

4 Health care

Recommendation 19

The committee recommends that the Commonwealth, State and Territory governments must work together to substantially increase the number of places and access to detoxification, including rapid detoxification, and rehabilitation services that are critical to the successful transition from abuse to non-use. (para 4.27)

Recommendation 20

The committee recommends that the Commonwealth, State and Territory governments, in order to achieve a substantial reduction in substance abuse, consult with non-government organisations to ensure that alcohol and other drug services offer a range of approaches to treatment and rehabilitation.

Governments should consult with non-government organisations to ensure they are mindful of the need for an appropriate mix of residential and non-residential services, making provision for family involvement if desired. (para 4.28)

Recommendation 21

The committee recommends that the Commonwealth government, in consultation with State and Territory governments:

- provide additional funding for alcohol and other drug treatment so that the shortfall in services is eliminated and adequate numbers of appropriately qualified staff are employed to work in these services, with the ultimate objective being to obtain a drug free status for the client; and
- pay particular attention to the needs of people who abuse substances and suffer mental ill-health, including those in prison. (para 4.37)

Recommendation 22

The committee recommends that the Commonwealth, State and Territory governments give priority to funding the ongoing medical, psychological

and community support systems required for those users who have undertaken detoxification in order to provide the optimal chance of successful transition to an alcohol or a drug free state. (para 4.38)

Recommendation 23

The committee recommends that the Commonwealth, State and Territory governments work with the alcohol and drugs sector, to improve the training available to workers in that sector by:

- supporting the development of a nationally agreed curriculum and accreditation system;
- providing adequate training opportunities to supply sufficient qualified staff, including ongoing access to new information and the implications of this new information for practice;
- sponsoring work on best practice in educating and training alcohol and drug workers; and
- encouraging senior professionals to inform themselves of the needs of other drug and alcohol service providers and fully participate in that education and training. (para 4.49)

Recommendation 24

The committee recommends that the Commonwealth, State and Territory governments, working with the non-government sector, give priority to coordinating and integrating the many professionals and agencies that serve substance-dependence people.

Attention should be given to:

- improved links between different parts of the health care sector and between the health care sector and social service agencies such as those dealing with housing, training and education; and
- the funding for medical, psychological and community support services as recommended in Recommendation 22. (para 4.57)

Recommendation 25

The committee recommends that the Commonwealth, State and Territory governments, working with assistance from the non-government sector, in the training and research that underpin the health services, also ensure the integration of:

- knowledge from different disciplines to better train drug and alcohol workers so they can deliver the best possible services; and

- research efforts which will advise the development of new, more integrated policies and programs. (para 4.61)

Recommendation 26

The committee recommends that the Commonwealth government, in consultation with State and Territory governments and all non-government stakeholders:

- evaluate the outcomes to date of the National Comorbidity Project;
- investigate the linkages between mental health, drug abuse and suicide; and
- identify from these outcomes and other sources what further steps must be taken to improve the treatment of and provision of services to people suffering from co-occurring mental ill health and substance abuse and their families and ensure their implementation. (para 4.68)

Recommendation 27

The committee recommends that Commonwealth, State and Territory governments continue to support and expand substance misuse programs that assist Indigenous planning processes to best achieve their objectives in delivering acceptable forms of treatment. (para 4.77)

Recommendation 28

The committee recommends that the Commonwealth government, State and Territory governments and Indigenous organisations work together to:

- collect information on Indigenous needs for alcohol and other drug services and how well those needs are currently being met;
- direct existing resources to regions of greatest need and provide additional funding where required; and
- identify and, in the light of emerging trends, respond to new needs by ensuring access to appropriate programs. (para 4.84)

Recommendation 29

The committee recommends that the Commonwealth, State and Territory governments institute programs to:

- combat increasing illicit drug use by Indigenous people; and
- provide improved training to Indigenous drug and alcohol workers. (para 4.86)

Recommendation 30

The committee recommends that the Commonwealth government work with State and Territory governments and non-government organisations to:

- identify the best structures and practices to engage and retain young drug users in treatment;
- ensure that trained skilled health professionals are available to deal with young people who are substance-dependent; and
- ensure adequate support services are available to families and that families are getting the skills required as well as to cope with young people who are substance-dependent. (para 4.90)

Recommendation 31

The committee recommends that the Commonwealth, State and Territory governments, in consultation with non-government organisations:

- ensure the needs for regional detoxification, treatment and rehabilitation facilities are met;
- assemble information on best practice options for providing alcohol and other drug services in remote and rural areas, and disseminate that information widely; and
- provide additional funding where needed to implement best practice. (para 4.96)

Recommendation 32

The committee recommends that the Commonwealth, State and Territory governments, in consultation with the non-government sector:

- establish targets for all drug-related health programs against which their outcomes can be judged;
- use this information to evaluate existing programs and plan new ones; and
- report annually to their parliaments on their performance against targets for each program. (para 4.102)

5 Alcohol misuse: prevention and treatment

Recommendation 33

The committee recommends that the Commonwealth government continue to:

- fund the National Alcohol Campaign;
- support the targeting of young people and parents of adolescents in future phases of the campaign; and
- evaluate the effectiveness of the campaign and use the results, together with other research, to determine the content for future campaign phases. (para 5.21)

Recommendation 34

The committee recommends that the State and Territory governments must strictly police compliance laws regulating the supply of alcohol to minors and introduce harsher penalties against those found to be not complying. (para 5.24)

Recommendation 35

The committee recommends that the Commonwealth, State and Territory governments work to ensure that effective information is widely circulated to female adolescents, women and their partners on the dangers posed to unborn children by heavy drinking during pregnancy. (para 5.29)

Recommendation 36

The committee recommends that the Commonwealth Department of Health and Ageing table in parliament the report on the review of the effectiveness of the current regulatory system for alcohol advertising as soon as possible so the parliament can consider the need for appropriate legislation for the regulation of the advertising of alcohol. (para 5.43)

Recommendation 37

The committee recommends that the Commonwealth government implement requirements that all advertising of alcoholic beverages encourage responsible drinking, by including information on the National Health and Medical Research Council's Australian Alcohol Guidelines. (para 5.44)

Recommendation 38

The committee recommends that information from the National Health and Medical Research Council's Australian Alcohol Guidelines be included on alcoholic beverage container labels. (para 5.50)

Recommendation 39

The committee recommends that the Commonwealth government, in consultation with State and Territory governments, ensure:

- the vigorous implementation of responsible service practices in licensed premises by adequately trained staff; and
- that legislation that penalises irresponsible service practices is in place and strictly enforced, particularly in premises that trade late into the night. (para 5.55)

Recommendation 40

The committee recommends that the Commonwealth government investigate the social benefits of replacing ad hoc taxation on alcohol with an across the board regime based on alcohol content. (para 5.64)

Recommendation 41

The committee recommends that the Commonwealth, State and Territory governments:

- ensure that primary health care providers receive adequate training to deal with alcohol dependence and other alcohol use problems;
- provide incentives for medical practitioners to provide brief interventions for alcohol problems; and
- fund research into new approaches to treating alcohol dependence, including:
  - ⇒ trialling new drugs; and
  - ⇒ filling gaps in knowledge, like the efficacy of using the internet for brief interventions and the relative effectiveness of different psychological therapies. (para 5.70)

Recommendation 42

The committee recommends that the Commonwealth, State and Territory governments work together to run education campaigns that raise awareness of and level of knowledge about the risks associated with:

- the disparity in alcohol content within various alcoholic drinks; and
- the different levels of intoxication during the process of alcohol consumption. (para 5.72)

6 Tobacco: prevention and cessation

Recommendation 43

The committee recommends that the Commonwealth, State and Territory governments:

- run public education campaigns on the risks of smoking that target the whole community;
- continue to develop strategies for increasing awareness among school students, particularly young women, and older women of child bearing age and their partners, of the risks of tobacco smoking for reproduction and their children's health; and
- require updated more detailed written and graphic health warnings on cigarette packets. (para 6.34)

Recommendation 44

The committee recommends that the Commonwealth, State and Territory governments contribute funding for further research into why people commence smoking. (para 6.37)

Recommendation 45

The committee recommends that the Commonwealth, State and Territory governments:

- include tobacco as a priority in all relevant national, state and territory health strategies and make tobacco dependence a national health priority;
- promote attention to the status of tobacco as a national health priority by requiring the adoption of tobacco control policies and investment as a condition of health care financing at state, territory and agency levels;
- make free or low cost tobacco smoking cessation services and aids readily available throughout Australia particularly for pregnant women and their partners; and
- investigate the cost benefit analysis of subsidising aids such as nicotine patches under the Pharmaceutical Benefits Scheme to better assist cessation of cigarette smoking. (para 6.43)

Recommendation 46

The committee recommends a study of the price elasticity of tobacco and tobacco consumption in Australia be conducted to determine what is the minimum price increase that will stop large numbers of people smoking as a result of price alone. (para 6.49)

Recommendation 47

The committee recommends that the Commonwealth, State and Territory governments work together to develop and legislate for nationally consistent regulations governing the registration and licensing of the wholesalers and retailers of tobacco products, which should include registration fees and an emphasis on heavier penalties for the sale of cigarettes to minors than apply at present. (para 6.54)

Recommendation 48

The committee recommends the Commonwealth, State and Territory governments work together to ensure that all remaining forms of promotion of tobacco products be banned, including advertising, incentives to retailers, sponsorships and public relation activities. (para 6.61)

Recommendation 49

The committee recommends that the Commonwealth, State and Territory governments investigate removing nicotine's exemption from classification as a poison under the Commonwealth's Standard for the Uniform Scheduling of Drugs and Poisons and in State and Territory Poisons Acts. (para 6.68)

Recommendation 50

The committee recommends that the Commonwealth, State and Territory governments:

- develop and deliver a program to build community support for a ban on tobacco smoking in public areas where exposure to involuntary smoking is likely; and
- develop a similar program to further discourage smoking in private environments, such as homes. (para 6.76)

7 Illicit drug use: prevention and treatment

Recommendation 51

The committee recommends that, as a high priority, the Commonwealth, State and Territory governments:

- increase the proportion of heroin addicts in treatment from 45 per cent to 80 per cent of the total number of heroin dependent people in order to reduce heroin-related harm and deaths; and
- increase the target to include everyone who requests treatment, as resources permit. (para 7.26)

Recommendation 52

The committee recommends that, when providing:

- methadone maintenance treatment to save lives and prevent harm to people dependent on heroin, the ultimate objective be to assist them to become abstinent from all opioids, including methadone; and
- in addition, comprehensive support services must be provided to achieve this outcome. (para 7.32)

Recommendation 53

The committee recommends that the Commonwealth government, State and Territory governments provide funding to determine the extent of very long-term use of methadone, including dosage rates, by opioid dependent people and its effect on the user, including its impact on the user's workplace, community and family roles. (para 7.33)

Recommendation 54

The committee recommends that the Commonwealth, State and Territory governments ensure that sufficient funding is available to treatment services to provide comprehensive support to opioid dependent people who are receiving pharmacotherapy:

- for as long as it is needed to stabilise their lifestyle;
- if possible, to assist them to reduce or eliminate their use of all opioids, including methadone;
- support further research and trials of promising new medications and techniques;
- continue to fund research into pharmacotherapies for opioid dependence;
- make widely available as a matter of priority any treatments that are found to be cost-effective; and
- give priority to treatments including naltrexone that focus on abstinence as the ultimate outcome. (para 7.41)

Recommendation 55

The committee strongly recommends as a matter of urgency that the Commonwealth government fund a trial of naltrexone implants, coupled with the support services required for efficacy. (para 7.42)

Recommendation 56

The committee recommends that:

- the Australian National Council on Drugs urgently determine best practice models of residential rehabilitation in consultation with service providers;
- the Commonwealth, State and Territory governments ensure funding to establish these models throughout urban and rural areas;
- residential rehabilitation providers establish programs to instigate, where it is not already provided, ongoing support for those needing residential rehabilitation; and
- given the complexity of delivery of rehabilitation programs, responsibility and coordination should be undertaken by the Commonwealth Department of Family and Community Services. (para 7.46)

Recommendation 57

The committee recommends that trials of heroin prescription as a treatment for heroin dependence not proceed. (para 7.53)

Recommendation 58

The committee recommends that the Commonwealth government ensure that proven pharmacotherapies are available at low cost to all opioid dependent people undergoing treatment. (para 7.59)

Recommendation 59

The committee recommends that the Commonwealth government list naltrexone on the Pharmaceutical Benefits Scheme for the treatment of opioid dependence, particularly for heroin and methadone dependence. (para 7.61)

Recommendation 60

The committee recommends that the Commonwealth, State and Territory governments investigate the potential to deliver cost-effective treatment to opioid dependent people by the greater use of general practitioners. (para 7.64)

Recommendation 61

The committee recommends that the Commonwealth, State and Territory governments:

- widely disseminate information to inform the Australian community about the levels of cannabis use including impacts on mental health and possible gateway to addiction and other drug use;
- evaluate the effectiveness of these information campaigns;
- trial innovative, preventive approaches to reduce the use of cannabis;
- develop consistent national policy and legislation which reflect the dangers of cannabis use; and
- in the interim monitor the effect of State and Territory specific legislation dealing with cannabis use and regularly report on the health, social and criminal outcomes for each State and Territory. (para 7.86)

Recommendation 62

The committee recommends that the Commonwealth, State and Territory governments fund research into pharmacological and psychological treatments for dependence on cannabis. (para 7.87)

Recommendation 63

The committee recommends that the Commonwealth, State and Territory governments give priority to funding research into the nature of the link between cannabis use, opioid and other drug use, and mental health. (para 7.88)

Recommendation 64

The committee recommends that the Commonwealth, State and Territory governments continue to fund research into pharmacological and psychological treatments for dependence on psychostimulants. (para 7.96)

Recommendation 65

The committee recommends that the Commonwealth, State and Territory governments, as part of the National Drug Strategy, urgently inform and warn the Australian community about the dangers of psychostimulant use. (para 7.97)

Recommendation 66

The committee:

- recommends that a complete evaluation of needle and syringe programs be undertaken by the Australian National Audit Office. Issues that should be assessed are distribution, inadequate exchange, accountability and associated education and counselling programs and the impact on both HIV and hepatitis C; and

- supports the recommendation of the Australian National Council on Drugs calling for the removal of legislative impediments to the proper disposal of used injecting equipment, specifically offences related to self administration and possession of injecting equipment. (para 7.123)

Recommendation 67

The committee recommends that the Commonwealth, State and Territory governments work to establish a wider range of detoxification and rehabilitation centres bolstered by a range of ancillary programs to give maximum support to individual drug users. (para 7.139)

Recommendation 68

The committee recommends that the Commonwealth, State and Territory governments continue to give a high priority to funding education campaigns to:

- target the general population as well as at high risk groups; and

- inform high risk groups about HIV/AIDS and hepatitis C and, in particular how to prevent the transmission of these diseases. (para 7.147)

Recommendation 69

The committee recommends that the Commonwealth government evaluate the outcomes of the 2003-04 budget funding for the National Hepatitis C Strategy over the four year period to ensure that the issues outlined in 7.153 are being adequately addressed. (para 7.157)

Recommendation 70

The committee recommends that the Commonwealth, State and Territory governments continue to fund research into the prevention and management of hepatitis C infection. (para 7.158)

Recommendation 71

The committee recommends that the Commonwealth government take a leading role as a matter of urgency in establishing a national committee

to coordinate policy and programs to prevent the use of inhalants and treat dependent users. (para 7.169)

8 Crime, violence and law enforcement

Recommendation 72

The committee recommends that the Commonwealth, State and Territory governments build evaluation into all their law enforcement initiatives related to substance abuse and misuse. (para 8.16)

Recommendation 73

The committee recommends that Commonwealth, State and Territory governments put in place as soon as possible all components of the new national framework to combat multi-jurisdictional crime. (para 8.28)

Recommendation 74

The committee recommends that the Commonwealth, State and Territory governments urgently examine the need for Commonwealth initiatives, to supplement that available in the States and Territories, directed at supporting local community drug control initiatives. (para 8.38)

Recommendation 75

The committee recommends that the Commonwealth government play an active role through the ministerial councils on police, corrective services and justice in establishing best practice and promoting nationally consistent policies and practices in policing and sentencing as they relate to drugs. (para 8.44)

Recommendation 76

The committee recommends that, with respect to the Australian Customs Service, the Australian Federal Police, the Australian Crime Commission and the Commonwealth Forensic Services, the Commonwealth government:

- undertake an independent external review by the Australian National Audit Office every three years of the adequacy and funding of these agencies' capacity to gather the intelligence about drug-related crime that is needed to intercept supplies; and
- funding levels recommended by the review be set as the minimum for the subsequent period. (para 8.48)

Recommendation 77

The committee recommends that the Commonwealth, State and Territory governments give high priority to:

- further standardising the drug-related data collected by different jurisdictions; and
- ensuring that such data is consistently collected and capable of being reported to reveal what is happening at the local, state and national level. (para 8.53)

Recommendation 78

The committee recommends that the Commonwealth, State and Territory governments devote more resources to overcoming barriers to communication between jurisdictions and agencies dealing with drug-related crime, including barriers within information management systems. (para 8.57)

Recommendation 79

The committee recommends that Commonwealth, State and Territory government agencies dealing with drug-related crime:

- extend the cooperation and collaboration between them; and
- develop performance measures to report on improvements in inter-agency cooperation and outcomes. (para 8.61)

Recommendation 80

The committee recommends that the Commonwealth, State and Territory governments work together to develop nationally consistent legislation relating to illicit drugs. (para 8.74)

Recommendation 81

The committee recommends that Commonwealth, State and Territory governments cooperate to develop robust performance measures for supply reduction strategies of illicit drugs. (para 8.82)

Recommendation 82

The committee recommends that legislation be introduced by governments at the Commonwealth, State or Territory level to:

- require that the loss or theft of the precursors of amphetamine-type stimulants be reported to the police;
- amend Schedule VI of the *Customs Act 1901* to include the precursors of amphetamine-type stimulants;

■ restrict the supply of the precursors of amphetamine-type stimulants by:

⇒ placing ceilings on orders by retailers;

⇒ limiting replacements by wholesalers; and

⇒ requiring the pharmaceutical industry to report high-use customers to the police. (para 8.93)

Recommendation 83

The committee recommends that:

■ the National Working Group on Diversion of Precursor Chemicals identify a way to make legislation sufficiently flexible to be able to regulate immediately the changing precursors that are found in amphetamine type stimulants;

■ the Commonwealth government amend its *Standard for uniform scheduling of drugs and poisons* to make all substances containing pseudoephedrine a Schedule 4 Prescription Only Medicine; and

■ State and Territory governments adopt the proposed legislative and scheduling proposals developed on pseudoephedrine, as outlined in the two dot points above, as soon as possible after their identification. (para 8.94)

Recommendation 84

The committee recommends that the Commonwealth works collaboratively with all State and Territory governments to establish effective court diversion programs and drug courts in all States and Territories. (para 8.103)

Recommendation 85

The committee recommends that the Commonwealth, State and territory governments provide training and support for police, magistrates and court personnel to enable them to effectively refer offenders to proven diversion programs where outcomes can be measured. (para 8.113)

Recommendation 86

The committee recommends that the Commonwealth, State and Territory governments fund research to:

■ establish best practice in relation to existing diversion programs and disseminate the results widely; and

- explore strategies to identify drug users or young people at risk at an earlier stage through precursive or associated behaviour that may present to the criminal justice or welfare system. (para 8.114)

Recommendation 87

The committee recommends that the Commonwealth fund a national evaluation of the drug courts to determine their success in achieving beneficial outcomes for offenders, their families and communities. (para 8.115)

Recommendation 88

The committee recommends that better resourced, more efficient and effective systems be established to monitor non-custodial sanctions imposed on drug offenders. (para 8.116)

Recommendation 89

The committee recommends that Commonwealth, State and Territory governments examine the establishment of a regime that would highlight options of appropriate coerced treatment and rehabilitation programs for young offenders and repeat drug-dependent offenders. The regime should include the use of good behaviour bonds and incentive sentencing as an option and sanctions for pulling out of the program. (para 8.121)

Recommendation 90

The committee recommends that the Commonwealth government encourage State and Territory governments to ensure that treatment is provided to all drug dependent prisoners. (para 8.132)

Recommendation 91

The committee recommends that every prisoner should be assessed to determine their exposure to drug use and an appropriate drug-related treatment and management strategy should be implemented if substance abuse or risk thereof is determined. (para 8.138)

Recommendation 92

The committee recommends that State and Territory governments ensure that they provide a range of treatments for drug-dependent prisoners to the standard to which they are available in the wider community. (para 8.139)

Recommendation 93

The committee recommends that, as part of the trial recommended in Recommendation 55, naltrexone implants also be trialed to treat opioid dependent prisoners. Should the trial be successful, then the use of

naltrexone implants be an ongoing treatment for opioid dependent prisoners. Participation in the trial must be voluntary and agreed between the doctor and patient. (para 8.140)

Recommendation 94

The committee recommends that the Commonwealth government work with State and Territory governments to facilitate:

- the establishment of independent drug free units in correctional centres;
- drug free units should incorporate education programs including drug education;
- admission to the drug free unit should be on a voluntary basis by inmates who are assessed to be willing to achieve drug free outcomes;
- numeracy, literacy and life skills should form part of an education program in the unit;
- compulsory blood or urine tests should be undertaken during the time of the program to ensure participants remain drug free; and
- remissions should be offered as an incentive to become engaged in successful completion of the program. (para 8.141)

Recommendation 95

The committee recommends all personnel employed in correctional facilities should be subject to mandatory random blood or urine tests. (para 8.142)

Recommendation 96

The committee recommends that State and Territory governments promote best practice in drug treatment in prisons and recognise those organisation which achieve best practice. (para 8.143)

Recommendation 97

The committee recommends that the Commonwealth, State and Territory governments initiate specific programs for women and children to address drug treatments in prisons and make available support services post-release from prisons. (para 8.150)

Recommendation 98

The committee strongly recommends that the Commonwealth, State and Territory governments:

- fund research into the nature of the links between coexisting substance abuse, mental illness, crime and violence; and
- ensure sufficient research workers with appropriate skills are available in Australia to carry out this work. (para 8.153)

Recommendation 99

The committee recommends that State and Territory governments ensure that:

- arrangements are put in place to provide closely coordinated pre-release and post-release treatment and support services for drug-dependent prisoners with the objective of assisting them to become drug-free; and
- in particular a strong focus on education and employment should form the basis of post-release support. (para 8.155)

Recommendation 100

The committee recommends that the Commonwealth government make equivalent medicare benefit funding available to corrections health services to enable the level of treatment described in previous recommendations to be provided to eligible drug-dependent prisoners. (para 8.158)

Recommendation 101

The committee recommends that the Commonwealth government, in consultation with State and Territory governments, establish minimum standards for the health care of people in custody and the best practice in the delivery of health care. (para 8.161)

9 Road trauma

Recommendation 102

The committee recommends that the Commonwealth government, in consultation with State and Territory governments, continue to strengthen random breath testing practices and maintain and improve this process. (para 9.11)

Recommendation 103

The committee recommends that the Commonwealth government, in consultation with State and Territory governments:

- modify the conduct of random breath testing in country areas to:
  - ⇒ use smaller, mobile testing units;
  - ⇒ reduce the usual blitz-like approach and predictability of location and time; and
  - ⇒ move activities to times that impact early in the chain of decision to drink; and
- ensure that there is consistency of approach in random breath testing between country and city areas. (para 9.15)

Recommendation 104

The committee recommends that the Commonwealth government, in consultation with State and Territory governments, ensure the imposition of more severe penalties for repeat drink driving offenders than are currently in place. (para 9.21)

Recommendation 105

The committee recommends that the Commonwealth government, in consultation with State and Territory governments:

- impose the use of alcohol ignition interlocks on repeat drink driving offenders; and
- promote the voluntary installation of alcohol ignition interlocks. (para 9.22)

Recommendation 106

The committee recommends that all new cars made in, or imported into, Australia be fitted with alcohol ignition interlocks by 2006. (para 9.23)

Recommendation 107

The committee recommends that the Commonwealth, State and Territory governments give high priority in the National Road Safety Action Plan to:

- work towards all States and Territories making it an offence to drive with any quantity of illicit drug present within the system;
- have all States and Territories enacting legislation to test and prosecute drug drivers;

- fund and coordinate roadside drug testing with a model similar to that of alcohol random breath testing; and
- continue research into the relationship between drugs and driving impairment. (para 9.38)

Recommendation 108

The committee recommends that the Commonwealth, State and Territory governments work with industry to complete and implement the new policy for managing fatigue among heavy vehicle drivers that is currently being coordinated by the National Road Transport Commission. (para 9.44)

Recommendation 109

The committee recommends that the Commonwealth government continue to vigorously promote the implementation of chain of responsibility legislation applying to the road transport industry. (para 9.48)

Recommendation 110

The committee recommends that the Commonwealth government, in consultation with State and Territory governments, develop and run campaigns to inform drivers about the dangers of driving while using illicit and licit drugs. (para 9.51)

Recommendation 111

The committee recommends that the Commonwealth government, in consultation with the State and Territory governments, continue to vigorously promote the drink and drug driving reduction strategies of the National Road Safety Action Plan. (para 9.55)

Recommendation 112

The committee recommends that the Commonwealth government, in consultation with State and Territory governments:

- ensure that the effectiveness of the measures adopted in the National Road Safety Action Plan are evaluated and research carried out on promising new approaches;
- contribute funding if necessary to ensure that evaluation and research proceed leading to the direct introduction of effective measures; and
- produce a publicly available report on the nationwide results of implementing measures in the National Road Safety Action Plan. (para 9.56)

Recommendation 113

The committee recommends that the Commonwealth government work with the State and Territory governments to ensure that drug and drink driving are targeted for deterrence and prevention. (para 9.57)

10 Workplace safety and productivity

Recommendation 114

The committee recommends that the Commonwealth, State and Territory governments, with input from unions and industry, fund a well-designed study coordinated by the National Occupational Health and Safety Commission to investigate:

- the prevalence of substance abuse in Australian workplaces; and
- the relationship of substance abuse to impairment, harm and lost productivity, in the context of other factors that also impact on workplace safety and productivity. (para 10.23)

Recommendation 115

The committee recommends that the Commonwealth government, through the National Occupational Health and Safety Commission:

- promote the development of standard methodologies for collecting data relating to workplace harm;
- ensure the standards developed encourage safe practices; and
- work with State and Territory governments and other stakeholders to ensure that these data are collected in all jurisdictions. (para 10.24)

Recommendation 116

The committee recommends that the Commonwealth, State and Territory governments fund a study coordinated by the National Occupational Health and Safety Commission to:

- investigate existing workplace policies and interventions to reduce the impact of drugs on workplace safety and productivity, with the aim of identifying best practice and areas that need change;
- trial innovative approaches to reducing the impact of drugs in the workplace;
- disseminate widely the best practice findings of these investigations and trials; and

- recommend any legislative changes deemed necessary to promote the adoption of best practice. (para 10.38)

Recommendation 117

The committee recommends that the Commonwealth, State and Territory governments promote the implementation and monitoring of workplace alcohol and other drug policies by developing national guidelines and appropriate legislative frameworks. (para 10.42)

Recommendation 118

The committee recommends that the Commonwealth, State and Territory governments, with input from unions and industry, fund a large-scale study to assess the efficacy of devices that purport to measure workplace drug use and impairment. (para 10.52)

Recommendation 119

The committee recommends that the Commonwealth, State and Territory governments identify the privacy concerns relating to drug testing in the workplace, examine the need for legislative changes to address these concerns, and enact any needed changes. (para 10.53)

Recommendation 120

The committee recommends that, following finalisation of the studies recommended in Recommendations 114, 116 and 118, the Commonwealth, State and Territory governments develop guidelines for best practice implementation and use of workplace drug testing. (para 10.54)

Recommendation 121

The committee recommends that the Commonwealth government:

- convene a national summit on the issues relating to reducing the impacts of alcohol and other drugs on workplace safety and productivity that will;
- involve all stakeholders and relevant international speakers; and
- develop proposals for the further development of the initiatives recommended in Recommendations 114-120 in this chapter. (para 10.56)

11 Final comments

Recommendation 122

The committee recommends that the Commonwealth, State and Territory governments replace the current focus of the National Drug Strategy on harm minimisation with a focus on harm prevention and treatment of substance dependent people. (para 11.18)

Recommendation 123

The committee recommends that the Commonwealth, State and Territory governments strengthen and better communicate the principles, policies and programs of the National Drug Strategy to both the general public and the alcohol and other drugs sector. (para 11.21)

Recommendation 124

The committee recommends that the Commonwealth, State and Territory governments ensure that any additional funding for the prevention of drug use and abuse is not provided at the expense of expenditure on treatment. (para 11.27)

Recommendation 125

The committee recommends that the Commonwealth, State and Territory governments:

- ensure that the programs and policies of the National Drug Strategy continue to be evidence-based;
- establish an overarching national drug research strategy;
- examine the national drug-related data collections with a view to improving their value for monitoring and planning purposes; and
- establish a reliable and consistent data methodology in conjunction with the Australian Bureau of Statistics. (para 11.40)

Recommendation 126

The committee recommends that the Australian National Audit Office undertake a performance audit of the research element of the National Drug Strategy by:

- compiling a list of funded research programs;
- identifying duplication;
- investigating the cost-effectiveness of the research performed; and
- assessing the efficiency with which the evidence base is incorporated into policies and programs. (para 11.41)

Recommendation 127

The committee recommends that the Commonwealth, State and Territory governments make proven benefits of research to those affected by substance abuse and misuse a prerequisite for continuing and new funding of projects. (para 11.42)

Recommendation 128

The committee recommends that the Ministerial Council on Drug Strategy ensure that steps be taken to improve the effectiveness of the National Drug Strategy to dealing with the changing nature of substance use and abuse. (para 11.47)

1

The committee's inquiry

1.1 The House of Representatives Standing Committee on Family and Community Affairs of the 39th Parliament (1999-2001) (the former committee) started its inquiry into substance abuse in Australian communities in the context of the National Drug Strategy. The situation in relation to drugs in Australia at that time was characterised by:

- a stable level of alcohol and tobacco consumption during the 1990s, with Australia ranked 19th in the world for per capita alcohol consumption and 17th for tobacco;
- men being more likely than women to smoke and drink regularly as well as hazardously;
- an increasing use of almost all illicit drugs, most of them from a very low base; and
- a shortage of heroin in 2000-01.[1]

1.2 On 30 March 2000 at the committee's request the then Minister for Health and Aged Care, the Hon Michael Wooldridge MP, referred the inquiry into substance abuse in Australian communities to the House Family and Communities Affairs Committee with the following terms of reference:

> In view of the rising level of community concern about the continuing abuse of licit and illicit drugs, the committee investigate and report on the social and economic costs of substance abuse with regard to:
>
> - family relationships;

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1 House of Representatives Standing Committee on Family and Community Affairs, *Where to next? - A discussion paper: Inquiry into substance abuse in Australian communities*, FCA, Canberra, September 2001, pp 8-9, 74.

- health care costs;
- crime, violence and law enforcement (including domestic violence);
- road trauma; and
- workplace safety and productivity.

1.3 The former committee received 222 written submissions from government agencies, non-government organisations and individuals. Between August 2000 and June 2001, it visited all the major capital cities and some regional centres where it held nine public hearings; it also spent an additional 21 days on private visits and consultations with communities around the country.

1.4 The outcome of the former committee's investigations was summarised in a discussion paper entitled *Where to next? – a discussion paper: Inquiry into substance abuse in Australian communities*, that was tabled in the parliament in September 2001. The paper provided an overview of what was 'happening in relation to substance abuse in Australia'[2] but did not draw detailed conclusions nor make recommendations. The former committee advocated for the inquiry to be continued in the next parliament.

1.5 At the start of the present parliament on 12 February 2002, the situation in relation to substance abuse in Australia appeared to have changed relatively little since the former committee commenced its inquiry. Under these circumstances, the current committee, which was formed on 21 March 2002, decided that it needed to continue and complete this important work. It needed to finalise the review started by the former committee into the problems caused by substance abuse and recommend on the appropriateness of existing government policies and programs aimed at addressing these problems. The committee approached the Minister for Health and Ageing, Senator the Hon Kay Patterson, to refer to it the same terms of reference as the former committee had. This she did on 14 May 2002.

1.6 This committee sought not to duplicate the work of its predecessor. Rather its emphasis was on finishing the task. Accordingly, the committee carefully targeted the additional work that needed to be done. It gave previous submitters the opportunity to update their contributions to the inquiry, it only undertook visits to locations to inform new committee members and, where new treatments or information needed to be collected, it heard from leaders in the field and met with those who had new information to present. The committee:

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2 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p xv.

- examined a range of preventative techniques and treatments;
- evaluated the success of rehabilitating substance abusers back into mainstream society;
- examined the definition of harm minimisation and current practices associated with the term;
- attempted to obtain a clear and precise account of where government funds were being spent; and
- investigated the proliferation of research and assessment teams.

1.7 The present committee received 77 further submissions, held a two-day roundtable and a public hearing in Canberra, visited selected facilities and held necessary meetings in Adelaide, Melbourne and Sydney.

1.8 The appendices to this report provide information about the evidence collected for the inquiry by both the former and current committee.

- The submissions are listed in Appendix A.
- The exhibits are listed in Appendix B.
- Details of the public hearings, inspections, informal consultations and the roundtable can be found in Appendix C.

1.9 In the context of this report the term parent is taken to include those persons responsible for the care and upbringing of children.

1.10 The committee notes the wide discrepancies in the data available on many of the issues addressed in its report.

The committee's final report

1.11 This report continues and finishes the work reported in the former committee's discussion paper. The report is broadly structured according to the inquiry terms of reference. Chapter 2 provides an overview of alcohol and drug harm in Australia and places Australia in an international context. Chapter 3 reviews the impacts of substance abuse on families and communities and the steps that should be taken to address these impacts. The next four chapters examine the demands placed on the health care system by substance misusers. Chapter 4 covers the general aspects of health care for substance misuse with the other chapters devoted to alcohol (Chapter 5), tobacco (Chapter 6) and the illicit drugs (Chapter 7). Chapters 8, 9 and 10 deal respectively with crime, violence and law enforcement; road trauma; and workplace safety and productivity. In the final chapter the committee discusses some general points about the

nation's drug policy and recommends on improvements for a better outcome in meeting the challenges of substance misuse in Australia.

2

Alcohol and drug harm in Australia

Introduction

2.1 Drugs are part and parcel of everyday life and have been so for thousands of years. Scenes of alcoholic fermentation appear on Mesopotamian pottery dating from 4,200 BC.[1] The opium poppy, domesticated about 8,000 BC and first written about in 3,100 BC, was included in 700 different concoctions described by Theban physicians in 1,552 BC.[2]

2.2 Many licit drugs can be used to great benefit. However, abuse and misuse of drugs can also lead to damaging effects including death, and this is what makes managing their use so difficult. Drugs can variously relieve symptoms of illness and pain; in addition they may also cause sleep or induce euphoria; and change visual, auditory and other perceptions. The use of some drugs also leads to dependency and sometimes psychotic disturbance. Taken in large quantities, they cause serious physical damage to the body.

2.3 Attitudes to the use of drugs have varied over time. In many societies, their use has been generally accepted and they have become central elements in religious ceremonies. At other times and in other places they have been controlled by the authorities, sometimes to the extent of being totally prohibited. Over the last few centuries, the pendulum has swung between more and less tolerance of drug consumption as societies have experienced the relative benefits and drawbacks of drug use. Personal,

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1 *World Book 2002*, World Book Inc, Chicago, 2002, vol 1, p 337.

2 Davenport-Hines R, *The pursuit of oblivion: A social history of drugs*, Phoenix Press, London, 2002, p 8.

community, political and economic concerns have at different times and to different extents driven attitudes and practices in relation to drug use.

Experiences of harm

2.4 The harm caused by licit and illicit drug abuse has an impact at every level of society from the individual person to the global community. A snapshot of how drug use affected one user and her family is reflected in comments by her mother to the former committee:

> … my youngest daughter, Sarah, has battled drug addiction for eight years. There is no drug she has not used, and she has singularly fragmented a strong family unit.
>
> We have struggled to keep faith in Sarah, to love and protect her, to support her, to keep having hope. It has not been easy and, in truth, it has torn the family to its heart. She is nearly 20 years old now; of high intellect. She is articulate and talented and yet she prostituted herself on every level to support a heroin habit almost to the point of death, which at the time, was acceptable to her in oblivion. But that has now become an intolerable memory and a burden almost too heavy to bear. We no longer grieve for 'what if?' or 'if only'. There are no easy solutions, but in this prolonged journey of supporting them in their illness it becomes even harder to help them bridge the gap between the world they have made their own and ours ...[3]

2.5 The disruption to a family's life that is caused by addiction is mirrored in the upsets experienced in the communities where drug users live.

2.6 Crime associated with drug use is also deeply concerning, adding to unease in the community. Families and Friends for Drug Law Reform (ACT) said:

> Crime and other dysfunctional activity largely contributed to by illicit drugs is a corrosive influence on the fabric of our society. Old people are set against the young; children against parents; drug users needing treatment against the rest of the community. Users themselves who are drawn overwhelmingly from the young are exposed to a criminal world that is beyond the protection of the law. Our justified insecurity it [*sic*] fanned by a security and insurance industry. Our fears encourage us to withdraw inside our home made secure by bars and alarm system. In lots of little ways

3 Stratton P, transcript, 21/2/01, pp 614-615.

> we "take precautions" and withdraw just that bit more from neighbourhood and community involvement. The glue that holds us together as a community is loosened.[4]

2.7 At a national level, the impact is visible in economic losses due to harm, diminished productivity, and damage to property. In addition, the services that governments put in place to address crime, trauma and ill health are costly.

Prevalence and costs

2.8 The 2001 National Drug Strategy (NDS) Household Survey of 26,744 Australians estimated that 14.7 per cent of Australians aged 14 years and over had not used any alcohol, tobacco or illicit drugs in the previous 12 months. Among the other 85 per cent of Australians, alcohol was the most widely used substance; four in five had consumed alcohol. Comparable figures for tobacco and illicit drugs were much lower. Fewer than one in four Australians had smoked and almost one in six had used illicit drugs.[5]

2.9 The most commonly used illicit drug in 2001 was cannabis, which had been used in the previous year by 12.9 per cent of the people surveyed. Other illicit drugs were much less frequently consumed; the next most common after cannabis were amphetamines, pain killers / analgesics, and ecstasy / designer drugs, taken respectively by 3.4 per cent, 3.1 per cent and 2.9 per cent of people.[6]

2.10 As shown in Table 2.1, the consumption of several substances in 2001 had fallen since the last survey in 1998, among them tobacco, the use of which fell from 24.9 per cent to 23.2 per cent. The decline in the use of illicit drugs was statistically significant, down from having been used by 22.0 per cent of Australians in 1998 to 16.9 per cent in 2001. The consumption of alcohol had increased from 80.7 per cent to 82.4 per cent of Australians.[7]

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4 Families and Friends for Drug Law Reform (ACT), sub 77, Inquiry into Crime in the Community, House of Representatives Standing Committee on Legal and Constitutional Affairs, pp 21-22.

5 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, Drug statistics series no 9, AIHW, Canberra, May 2002, pp xiii-xiv, 3.

6 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, p 3.

7 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, p 3.

Table 2.1 Summary of drugs recently[(a)] used: proportion of the population aged 14 years and over, Australia, 1998-2001

Drug/behaviour	1998	2001
	(per cent)	
Tobacco	24.9	23.2
Alcohol	80.7	82.4
Illicits		
Marijuana/cannabis	17.9	12.9 #
Pain-killers/analgesics[(b)]	5.2	3.1 #
Tranquillisers/sleeping pills[(b)]	3.0	1.1 #
Steriods[(b)]	0.2	0.2
Barbiturates[(b)]	0.3	0.2
Inhalants	0.9	0.4 #
Heroin	0.8	0.2 #
Methadone[(c)]	0.2	0.1
Other opiates[(b)]	n/a	0.3
Amphetamines[(b)]	3.7	3.4
Cocaine	1.4	1.3
Hallucinogens	3.0	1.1 #
Ecstasy/designer drugs	2.4	2.9
Injected drugs	0.8	0.6
Any *illicit*	22.0	16.9 #
None of the above	14.2	14.7

(a) Used in the last 12 months. For tobacco 'recent use' means daily, weekly and less than weekly smokers.
(b) For non-medical purposes.
(c) Non-maintenance.
2001 result significantly different from 1998 result (2-tailed $\alpha = 0.05$).

Source: Derived from Australian Institute of Health and Welfare, 2001 National Drug Household Survey: First results, Drug statistics series no 9, AIHW, Canberra, May 2002, p 3.

2.11 20-29 year olds are a particular cause of concern as they have been shown to smoke more tobacco, use more illicit drugs, and put themselves at greater risk of long-term alcohol-related harm than any other age group. Furthermore, 15.1 per cent of teenagers (14-19 year olds) smoked tobacco daily in 2001, more than a quarter (27.7 per cent) had used illicit drugs, and 11.7 per cent drank so much alcohol that they put themselves at risk or high risk of long term harm.[8] Indigenous people, for example, have reported smoking at twice the rate of non-Indigenous Australians (49.9 per cent and 22.8 per cent respectively).[9]

8 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, pp 12, 18, 21.

9 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: Detailed findings*, Drug statistics series no 11, AIHW, Canberra, December 2002, p 24.

2.12 The Commonwealth Department of Health and Ageing said that although drinking alcohol was less common among Indigenous than among non-Indigenous Australians, those who drank alcohol were more likely to do so at hazardous levels. Volatile substance misuse, such as petrol sniffing, was very prevalent in some Indigenous communities.[10]

2.13 The most recent available estimates for Australia of the social costs of abusing legal and illicit drugs have been reported by Collins and Lapsley, based on information from 1998-99 (Table 2.2). They showed that the total cost was $34.4 billion. Of this cost 61.2 per cent was due to tobacco; alcohol contributed 22.0 per cent of the costs and illicit drugs 17.6 per cent.[11] These costs included estimates of losses caused by death, pain and suffering (the intangible costs), as well as tangible costs such as police and hospital costs.[12]

Table 2.2 Social costs of drug use, 1998-99

	Alcohol $m	Tobacco $m	Illicit Drugs $m	All Drugs $m
Tangible	5,541.3	7,586.7	5,107.0	18,340.8
Intangible	2,019.0	13,476.3	968.8	16,099.0
Total	7,560.3	21,063.0	6,075.8	34,439.8
Proportion of total	**22.0%**	**61.2%**	**17.6%**	**100.0%**

Note: The sum of the individual costs of all drugs differs from the "All Drugs" total as a result of adjustment for the effects of interaction on the aggregation of the individual aetiological fractions, and because the "All Drugs" total includes some crime costs attributed jointly to alcohol and illicit drugs.

Source: Collins DJ & Lapsley HM, Counting the cost: Estimates of the social costs of drug abuse in Australia in 1998-9, Monograph series no 49, Commonwealth Department of Health and Ageing, Canberra, 2002, p 59.

2.14 The highest tangible costs associated with the misuse of drugs were borne in the home ($7.6 billion), followed by the workplace ($5.5 billion); costs relating to crime ($4.3 billion), road accidents ($2.3 billion) and health care ($1.4 billion) were progressively smaller (Table 2.3).[13] The government sector bore a proportion of the tangible cost of drug abuse (24.4 per cent of

10 Commonwealth Department of Health and Ageing, sub 238, p 10.

11 Collins DJ & Lapsley HM, *Counting the cost: Estimates of the social costs of drug abuse in Australia in 1998-9*, Monograph series no 49, Commonwealth Department of Health and Ageing, Canberra, 2002, p ix.

12 How these costs compare with those made in previous estimates is not clear as the methods used to calculate these and earlier estimates differ.

13 Collins DJ & Lapsley HM, p x.

alcohol-attributable costs, 11.3 per cent for tobacco and 33.3 per cent for illicit drugs). By contrast, business carried a higher proportion of the costs (38.6 per cent for alcohol, 29.8 per cent for tobacco and 57.2 per cent for illicit drugs).[14]

Table 2.3 Selected tangible drug abuse costs, 1998-99

	Alcohol $m	Tobacco $m	Illicit Drugs $m	Alcohol & Illicit Drugs Combined[(c)] $m	Total $m
Crime	1,235.3	-	2,500.4	582.3	4,318.0
Health (net)	225.0	1,094.9	59.2	-	1,379.1
Production in the workplace[(a)]	1,949.9	2,519.5	991.2	-	5,460.7
Production in the home [(b)]	402.6	6,880.0	344.8	-	7,627.5
Road accidents	1,875.5	-	425.4	-	2,300.9
Fires	-	52.1	-	-	52.1

(a) Drug abuse can have an important impact upon the productivity of the paid workforce in three ways:

(a) Reduction in the size of the available workforce as a result of drug-attributable deaths and illnesses causing premature retirement;

(b) Increased workforce absenteeism resulting from drug-attributable sickness or injury;

(c) Reduced on-the-job productivity as a result of drug-attributable morbidity.

(b) Estimates of the value of production losses in the household sector are based upon ABS estimates of unpaid work in the publication *Unpaid Work and the Australian Economy 1997.* The definition of unpaid work used in an earlier ABS study is as follows:

'Household production consists of those unpaid activities which are carried on, by and for the members, which activities might be replaced by market goods or paid services, if circumstances such as income, market conditions and personal inclinations permit the service being delegated to someone outside the household group.'

A household activity is considered as unpaid work in an economic unit other than the household itself could have supplied the latter with an equivalent service. The ABS estimates take account of domestic activities, childcare, purchasing of goods and services, and volunteer and community work.

(c) Some component of crime costs is causally attributable jointly to alcohol and illicit drugs. It is not possible to indicate what proportion of these joint costs is attributable to either alcohol or illicit drugs individually.

Source: *Collins DJ & Lapsley HM, Counting the cost: Estimates of the social costs of drug abuse in Australia in 1998/9, Monograph series no 49, Commonwealth Department of Health and Ageing, Canberra, 2002, pp x, 27, 29, 47.*

The National Drug Strategy

2.15 Fitzgerald and Sewards history of significant events at a national level of Australia's drug policy revealed, Australia's response to drug problems

14 Collins DJ & Lapsley HM, pp 62-63.

has been based, in part[15], on the recommendations of the 1977 report of the Senate Standing Committee on Social Welfare. That committee recommended a pragmatic approach to limiting the adverse effects of drug abuse. It emphasised the importance of balancing efforts to reduce the demand for drugs with measures to restrict the supply of drugs. It also stressed the desirability of viewing drug abuse as primarily a social and medical problem rather than a legal one.[16]

2.16 Fitzgerald and Sewards reported that in 1985 following completion of an Australian commission of inquiry and a royal commission, a Special Premiers Conference was held to discuss a national coordinated approach to drug problems. This led to the establishment of the Ministerial Council on Drug Strategy and the National Campaign Against Drug Abuse (NCADA).[17] The NCADA's overall aim was minimising the harmful effects of drugs on Australian society. The approach was to be national and cooperative across jurisdictional boundaries and comprehensive in addressing problems related both to legal and illegal drugs, supply control and demand reduction strategies were to be integrated, and reliable data were to be collected to enable program monitoring and evaluation.[18]

2.17 These same principles underpin the current NDS which started in 1999. In summary those principles, as set out in the National Drug Strategic Framework 1998-99 to 2002-03, are:

- harm minimisation, a term used to refer to policies and programs aimed at reducing drug-related harm;
- a coordinated, integrated response to reducing drug-related harm in Australia in association with related areas of law enforcement, criminal justice, health and education rests with government agencies at all levels, the community-based sector, business and industry, research institutions, local communities and individuals;
- a partnership approach with a close working relationship between the Commonwealth, state and territory and local governments, affected communities (including drug users and those affected by drug related harm), business and industry, professional workers, and research institutions;

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15 For a history of significant events on drug policy at the national level see: Fitzgerald JL & Sewards T, *Drug policy:The Australian approach,* ANCD research paper 5, Australian National Council on Drugs, Canberra, 2002, pp 5-6.

16 Senate Standing Committee on Social Welfare, *Drug problems in Australia - an intoxicated society?*, Commonwealth Government Printer, Canberra, 1977, pp 1-2.

17 Fitzgerald JL & Sewards T, p 6.

18 Intergovernmental Committee on Drugs, sub 50, p 5.

- a balanced approach which seeks a balance between supply-reduction, demand-reduction and harm-reduction strategies emphasising the need for integration of drug law enforcement and crime prevention into all health and other strategies aimed at reducing drug-related harm. It also seeks a balance between strategies to reduce harm caused by licit and illicit drugs. Achieving a balance between other components of the NDS is more difficult and complex, for example, involving among other things allocating resources between prevention, treatment, training and research or meeting the needs of special populations and other groups. Better allocation of resources would be facilitated by increased emphasis on coordination of research, monitoring, evaluation and reporting;
- an evidenced-based practice where all supply-reduction, demand-reduction and harm-reduction strategies should reflect evidence-based practice, which is based on rigorous research and evaluation, including assessment of the cost-effectiveness of interventions; and
- social justice – strategies for tackling drug-related harm not only must target the particular drug or drug causing problems but must also develop with regard to the broader context of the needs of and problems facing the affected community.[19]

2.18 As a result of these principles, the mission for the National Drug Strategic Framework 1998-99 to 2002-03 is:

> 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.[20]

2.19 The objectives of the National Drug Strategic Framework 1998–99 to 2002–03 are:

- to increase community understanding of drug-related harm;
- to strengthen existing partnerships and build new partnerships to reduce drug-related harm;
- to develop and strengthen links with other related strategies;
- to reduce the supply and use of illicit drugs in the community;
- to prevent the uptake of harmful drug use;
- to reduce drug-related harm for individuals, families and communities;
- to reduce the level of risk behaviour associated with drug use;

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19 *National Drug Strategic Framework 1998-99 to 2002-03: Building partnerships: A strategy to reduce the harm caused by drugs in our community*, Ministerial Council on Drug Strategy, Canberra, November 1998, pp 15-18.

20 *National Drug Strategic Framework 1998-99 to 2002-03*, p 19.

- to reduce the risks to the community of criminal drug offences and other drug-related crime, violence and anti-social behaviour;
- 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;
- to increase access to a greater range of high-quality prevention and treatment services;
- to promote evidence-based practice through research and professional education and training;
- to develop mechanisms for the cooperative development, transfer and use of research among interested parties.[21]

2.20 The NDS operates under the direction of the Ministerial Council on Drug Strategy with the assistance of the consultative and advisory groups shown in Figure 2.1.[22]

2.21 The National Drug Strategic Framework 1998–99 to 2002–03 stresses that the effectiveness of the framework depends on cooperation within a wide range of sectors of Australian society, that is, across the three levels of government, families and communities, community-based organisations, and business and industry.[23]

2.22 In relation to families and communities the framework notes that they have a vital role in the development of attitudes to and values concerning drug use.[24]

2.23 The framework highlights the significant role that individuals and community-based organisations have under the NDS and summarises that role as: the provision of counselling, support, and treatment and care; the provision of education, information and support to prevent and reduce drug-related harm; contributing to the development, delivery and evaluation of policies and programs; and advocating for specific policies or programs.[25]

2.24 In relation to business and industry the framework points out that both employers and employees are responsible for occupational health and safety and some industries such as the pharmaceutical, alcohol beverage and hospitality industries have a responsibility to promote safe and responsible use of their products.[26]

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21 *National Drug Strategic Framework 1998-99 to 2002-03*, p 19.

22 Intergovernmental Committee on Drugs, sub 50, pp 9, 22.

23 *National Drug Strategic Framework 1998-99 to 2002-03*, pp 37-42.

24 *National Drug Strategic Framework 1998-99 to 2002-03*, p 37.

25 *National Drug Strategic Framework 1998-99 to 2002-03*, pp 37-38.

26 *National Drug Strategic Framework 1998-99 to 2002-03*, p 38.

INSERT FIGURE 2.1

2.25 Under the NDS, the Commonwealth government has a dual role. It is responsible for providing national leadership in Australia's response to reducing drug-related harm, and it has responsibility for implementing its own policies and programs to contribute to the reduction of drug-related harm. The Department of Health and Ageing is the Commonwealth agency with overall responsibility for coordination of the NDS and related programs. Activities undertaken or administered by the Commonwealth Department of Health and Ageing can be categorised as:

- funding to state and territory governments and peak bodies under the NDS;
- prevention and early intervention;
- national responses to HIV / AIDS, hepatitis C and related diseases;
- treatment, including diversion to treatment;
- education and promotion of best practice;
- research, monitoring and evaluation;
- addressing the needs of specific populations;
- registration, availability and quality use of pharmaceutical products; and
- international activities. [27]

2.26 It is important to note, however, that a range of other Commonwealth government agencies have responsibility for policies and programs that may impact on the demand for, or supply of, tobacco, alcohol, and other drugs. These include:

- Commonwealth Department of Education, Science and Training - responsible for the development and implementation of the National School Drug Education Strategy;
- Commonwealth Attorney-General's Department - monitors adherence to international drug treaties and develops and implements policy in the area of crime prevention, money laundering, extradition and mutual assistance;
- Australian Customs Service – enforces the Commonwealth governments controls on illicit drugs and controlled substances;
- Australian Federal Police – primary responsibility for investigating offences associated with the importation of illicit drugs into Australia and for disrupting the international supply of illicit drugs;
- Australian Crime Commission – undertakes criminal intelligence collection and analysis, sets national criminal intelligence priorities,

27 Commonwealth Department of Health and Aged Care, sub 145, pp viii-x, 92.

conducts intelligence led investigations of national significance and exercises coercive powers to assist in intelligence operations and investigations;[28] and

- Australian Institute of Criminology.

2.27 It is difficult to estimate the overall funding by the Commonwealth for the NDS but since 1997 the Commonwealth government has allocated more than $1 billion for the National Illicit Drug Strategy[29].

2.28 State and territory governments provide leadership within their respective jurisdictions. They are responsible for policy development, implementation and evaluation and for the delivery of police, health and education services to reduce drug-related harm in the manner best suited to meet local circumstances. Other activities for which state and territory Governments are responsible under the NDS include:

- developing and implementing their own drug strategies from the perspective of law enforcement and population health and based on local priorities;
- controlling the supply of illicit drugs through both specialist drug law enforcement units and general duties police officers;
- enforcing the regulation of pharmaceutical drugs;
- enforcing laws regulating the consumption and availability of alcohol and developing and enforcing legislation relating to tobacco;
- implementing harm reduction strategies to prevent drink driving;
- providing public sector health services or funding community based organisations to provide drug prevention and treatment programs;
- regulating and administering the delivery of methadone services and needle and syringe programs;
- developing effective and comprehensive professional education and training, research and evaluation strategies, in close cooperation with other jurisdictions so as to achieve consistency;
- assessing measures that allow police to exercise discretion in diverting drug users away from the criminal justice system into appropriate treatment options; and
- establishing an appropriate public policy framework to deal with drug use and drug-related harm in areas such as housing,

28 Commonwealth Department of Health and Aged Care, sub 145, pp 85-86; Australian Crime Commission, viewed 6/8/03, <http://www.crimecommission.gov.au/index.html>

29 Commonwealth Department of Health and Ageing, sub 291, p 2.

> school-based drug education, criminal justice and juvenile justice and liquor licensing.[30]

2.29 The NDS was originally planned to run from 1998-99 to 2002-03. It has, however, been extended by one year to 2003-04 and will be evaluated in 2003 before the next stage of the strategy is developed.[31] More detailed strategies and action plans have been developed to address specific aspects of substance abuse, including illicit drugs, alcohol, tobacco, and school-based drug education. The plans specify priorities for reducing harm, strategies for taking action and performance indicators.[32] The National Drug Prevention Agenda is also being prepared.[33] Details on these policies are presented in later subject specific chapters.

2.30 Pragmatic and balanced is how the Australian approach to drug policy has been described in a recent overview by Fitzgerald and Sewards.[34] According to Fitzgerald and Sewards, an important feature of Australia's drug policy making has been 'the deliberate avoidance of electoral politics and public conflict by attempting to maintain consensus and accommodation through an extensive network of consultative machinery'.[35] The achievements of these policies are considerable. Falling tobacco and illicit drug use, the containment of HIV infections and extensive availability of treatment are among Australia's successes.

2.31 Notwithstanding these successes, much still remains to be done. Simply in economic terms, much expense could be avoided if more effective anti-drug policies and programs were introduced. Collins and Lapsley estimated that 62.1 per cent of total alcohol costs ($3,928.6 million) and 44.9 per cent of total tobacco costs ($9,467.2 million) were avoidable.[36] The challenge for governments is to put effective policies in place. This committee intends that this report will contribute significantly to this process.

The international context

2.32 While Australia is an island, it is not unique in the way drugs are used, abused and responded to. Patterns of drug use in Australia bear

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30 Commonwealth Department of Health and Aged Care, sub 145, pp 89-90.
31 Commonwealth Department of Health and Ageing, sub 238, p 14.
32 Commonwealth Department of Health and Aged Care, sub 145, p 77.
33 Commonwealth Department of Health and Ageing, sub 238, pp 14-18.
34 Fitzgerald JL & Sewards T, p vi.
35 Fitzgerald JL & Sewards T, p 26.
36 Collins DJ & Lapsley HM, p 61.

resemblances to and are influenced by what is happening overseas. Overseas events also affect how Australian governments, communities and individuals respond to the impact of drugs.

2.33 As one of the world's 'western' countries, Australia's pattern of drug use is likely to approximate most closely that of other similar nations. Close comparisons between countries is difficult, however, because of the differences in the way in which countries collect and present their national drug-related data.

2.34 The *2002 annual report on the state of the drugs problem in the European Union and Norway* commented that, after the sharp rises in drug use in the 1980s and early 1990s, 'the general picture seems now more similar to a stable "endemic" situation, with constant recruitment and exit rates'. The report's author, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), noted stability in cannabis use, problem drug use, HIV prevalence, and drug-related deaths. There is, however, considerable variation between countries. Prices of most drugs seem generally stable or decreasing, and cannabis remained the most widely used illicit drug across Europe.[37]

2.35 The 2001 US National Household Survey on Drug Abuse reported a significant increase from year 2000 in the recent use of cannabis, cocaine and the non-medical use of pain relievers and tranquillisers by Americans 12 years and older. The use of ecstasy tripled between 1998 and 2000. There were, however, no significant changes between 2000 and 2001 in heavy and binge drinking and tobacco use.[38]

2.36 The US survey also revealed ethnic and geographical differences in the US, with illicit drug use being highest amongst American Indians, Alaskan Natives and blacks, and higher in urban than in rural areas.[39]

2.37 The policies and programs in place in western countries vary in their emphasis on supply control as opposed to demand reduction and in how restrictive they are in tolerating substance use. Their approaches to drug problems reflect the nature of their experience with drugs and their cultural traditions. The US, for example, relies more heavily on law

37 European Monitoring Centre for Drugs and Drug Addiction, *2002 annual report on the state of the drugs problem in the European Union and Norway*, Office for Official Publications of the European Communities, Luxembourg, 2002, pp 5, 11, viewed 30/4/03, <http://annualreport.emcdda.eu.int/pdfs/2002_0458_EN.pdf>.

38 US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *2001 National Household Survey on Drug Abuse: Highlights*, pp 1, 3, viewed 28/4/03, <http://www.samhsa.gov/oas/nhsda/2k1nhsda/vol1/highlights.htm>.

39 US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, p 1.

enforcement to address drug problems than Australia and many European countries, and the approaches taken by European countries range from the more liberal in the Netherlands to more restricted in Sweden.

2.38 Evidence is accumulating that indicate how far supply control measures can be expected to impact on reducing drug abuse. For example, the 2002 report by the US Office of National Drug Control Policy on that nation's drug control strategy indicated significant progress in reducing the crime and violent consequences of drug trafficking, but progress towards demand reduction, prevention and reducing the quantity of illicit drugs available were described as 'off track' in reaching strategy targets.[40] At a recent United Nations' meeting, progress was reported on addressing the world's drug problems, including a new emphasis on prevention, advocacy and treatment as a UN operational priority. This new priority balances an earlier emphasis on supply control.[41]

2.39 The EMCDDA reported growing consensus among European countries about the measures to address some of the principal problems and evidence on their effectiveness.

> For example, the value of low-threshold services and the importance of access to sterile injecting equipment to reduce bloodborne infections are widely acknowledged. The protective effect of methadone maintenance on mortality and morbidity, the additional value of voluntary drug-free treatment and the role of medically-assisted treatment in reducing illegal drug consumption, risky behaviour and crime are now broadly recognised.
>
> The widespread recognition of the value of these measures is a contributing factor, perhaps, to the relative convergence of public policy in the areas of prevention and treatment in the European Union …[42]

2.40 The EMCDDA also noted prominent developments in the legislative area with moves:

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40 Office of National Drug Control Policy, *2002 final report on the 1998 National Drug Control Strategy: Performance measures of effectiveness*, ONDCP, no place, February 2002, pp ix-x, viewed 1/10/02, <http://www.whitehousedrugpolicy.gov/publications/policy/02pme/pmepdf/PME.pdf>.

41 United Nations Office on Drugs and Crime, *'Encouraging progress towards still distant goals': Progress report by the Executive Director as a contribution to the mid-term review of UNGASS [United Nations General Assembly Special Session]*, UNODC, 8 April 2003, p 9, viewed 30/4/03, <http://www.unodc.org/pdf/document_2003-04-08_2.pdf>.

42 European Monitoring Centre for Drugs and Drug Addiction, p 5.

> … to target substances regardless of their legal status, to widen the distinction between drug users and drug-law offenders, to reduce or remove penalties for personal use or possession of cannabis and to strengthen the legal framework for substitution treatment …[43]

The UK government, for example, planned to introduce legislation by July 2003 to downgrade the classification of cannabis, following recommendations from its Advisory Council for the Misuse of Drugs and the House of Commons Select Committee on Home Affairs. *The Government reply to the third report from the Home Affairs Committee session 2001-02 HC 318 The Government's drug policy: Is it working?* stated:

> The Government has taken into consideration this recommendation and the advice of the Advisory Committee for the Misuse of Drugs and intends to bring forward proposals to Parliament to reclassify cannabis from Class B to Class C under the Misuse of Drugs Act 1971 by July 2003. Reclassification will not mean cannabis is made legal. It is illegal and will remain illegal. [44]

However, by June 2003 the Home Office announced that the changes to the cannabis laws would not come into effect until January 2004 at the earliest. Difficulties in the passage of legislation were experienced.[45]

2.41 Australia's geographic position close to Asia means that it is impacted by drug use, production and policies in those countries. The United Nations Office for Drug Control and Crime Prevention noted that in 2000 opiate and cannabis abuse decreased in South East Asia but there were increases in the abuse of amphetamines and ecstasy, especially amphetamines.[46] Along with other countries, Australia has taken measures to increase international cooperation in reducing drug supplies. Fighting the diversion of chemical products and precursors into illicit drug production, international customs and police cooperation, and international tracking of financial transactions have grown in recent years.[47]

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43 European Monitoring Centre for Drugs and Drug Addiction, p 5.

44 *The* [United Kingdom] g*overnment reply to the third report from the Home Affairs Committee: The government's drugs policy: Is it working*, July 2002, pp 2-3, 12-13, viewed 14/5/03, <http://www.official-documents.co.uk/document/cm55/5573/5573.pdf>.

45 Travis A, Downgrading of cannabis put off till next year: Change to penalties depends on passage of crime bill, *The Guardian*, 23/6/03.

46 United Nations Office for Drug Control and Crime Prevention, *Global illicit drug trends 2002*, ODCCP Studies on Drugs and Crime: Statistics, UNODCCPP, New York, 2002, p 7, viewed 30/4/03, <http://www.unodc.org/pdf/report_2002-06-26_1/report_2002-06-26_1.pdf>.

47 Commonwealth Attorney-General's Department, sub 149, pp 20-21 and sub 259, p 12; European Monitoring Centre for Drugs and Drug Addiction, p 10.

3

Families and communities

Introduction

3.1 Tragically drug addiction can affect our children, peers, mothers, fathers, brothers, sisters, neighbours, work colleagues or friends. Families and individuals may then become witness to, and victims of, episodes of deceit, lies and crime that can come from this addiction.

3.2 A detailed account given to the committee described how families are affected:

> Families dealing with a drug addict are split. Mothers want to protect, fathers often react with anger, which is fear based, siblings want to ignore the problem and extended family members distance themselves because they are unable to relate to the pain and heartache that that particular family is experiencing … This anger is often directed at the system, the government and, eventually, their drug addicted child. The lack of support for parents and family members does little to correct the anger, and often drug users are thrown out of home because parents are at a loss as to what else they can do or how to cope with the behaviour.
>
> Many parents find themselves caring for their grandchildren on a permanent basis, and others are the victims of domestic violence perpetrated by their own children. This brings about a situation in which parents believe they deserve this treatment because they have failed their child or children. The verbal abuse that goes into physical abuse sinks in, as it does with any other form of domestic violence. Providing information and support to groups with such deep-seated shame and guilt requires care, because they are as

> vulnerable as the drug users themselves, if not more so, because they are actually living the effects of the substance abuse.[1]

3.3 The death of a family member from substance abuse is devastating.

3.4 The impact of addiction spreads beyond the family to the neighbourhood where people respond with fear when they learn of addicts in their midst. They discriminate against the addict and, as Mr Trimingham, of Family Drug Support, pointed out, both the addicts and their families feel the 'shame, stigma and isolation …'[2]

3.5 One family described this experience as it related to the death of their 22 year old son:

> We live next door to an elderly couple and their reaction to his death was predictable even though he was viewed by them as 'a nice young man'. Their reaction to the news that they had lived next door to a 'drug addict' was met with a look of horror and fear. We feel that they were genuinely frightened by the revelation. [But] Drug addicts are <u>not</u> all lazy, good-for-nothing people living in squats or in the gutter without aspirations or hope. Some, such as our son, have loving and supportive families with extended family networks, who care for each other …[3]

The fear of the local crime associated with drug abuse can have a profound effect on the attitudes and behaviour of the wider community as well.

3.6 This chapter is largely devoted to considering the family and local environmental factors that influence drug use, and what efforts the Commonwealth, state and territory governments should pursue to assist families and their communities. It also looks at the support needed by families affected by drug abuse. This task is all the more important given the observation of the former committee that, despite a recent, concerted effort by governments, there are still deficiencies in the help provided to families in relation to drug use.[4]

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1 Bressington A, transcript, 15/08/02, pp 1148-1149.

2 Trimingham T, transcript, 15/08/02, p 1147.

3 Riley family, sub 32, p 2.

4 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?- A discussion paper: Inquiry into substance abuse in Australian communities*, FCA, Canberra, September 2001, p 30.

Drugs: use, costs, accessibility and attitudes

3.7 Australians' use of the licit drugs alcohol and tobacco are higher than that of illicit drugs; the resultant damage of alcohol and tobacco use is also greater. Cannabis is the only illicit drug that compares with the rate of use of alcohol and tobacco. These points are illustrated in Table 3.1 from the National Drug Strategy (NDS) Household Survey which shows the numbers of Australians aged 14 years and older who reported having recently used drugs in 2001. Of these users, some have already become dependent on the drugs they use and others will do so at great cost to themselves and others.

Table 3.1 Estimated numbers of Australians aged 14 years and over who had recently[(a)] used drugs in 2001

Drug Type	Males	Females	Persons
Tobacco – daily smokers	1,677,200	1,431,700	3,072,900
Alcohol – daily & weekly	4,437,100	3,081,400	7,517,300
Marijuana/ Cannabis[(a)]	1,232,800	1,025,700	2,029,500
Amphetamines[(a)]	323,100	211,200	534,200
Ecstasy[(a)]	277,000	179,400	456,400
Heroin[(a)]	21,000	16,700	37,700
Any illicit drug[(a)(b)]	1,536,800	1,125,800	2,663,600

Note:
Based on 2001 National Drug Strategy Household Survey consumption pattern data.

(a) Recent – Used in the last 12 months.

(b) Any illicit drug: Illegal drugs, drugs and volatile substances used illicitly, and pharmaceuticals used for non-medical purposes. The survey asked questions on the following illicit drugs: painkillers/ analgesics*; tranquillisers/sleeping pills*; steroids*; barbiturates*; amphetamines*; marijuana/cannabis; heroin; methadone**; other opiates*; cocaine; LSD/synthetic hallucinogens; ecstasy and other designer drugs; any (injected)*. NB * for non-medical purposes; ** non-maintenance program.

Derived from Australian Institute of Health and Welfare. 2001 National Drug Strategy Household Survey: First results, AIHW, Canberra, May 2002, pp 13, 17, 20, 22, 24, 26, 28, 48-49.

3.8 Sickness and death due to substance abuse impacts on the activities which sustain families and contribute to community life. Collins and Lapsley estimated the financial cost of this impact on domestic activities, childcare, the purchasing of goods and services, and volunteer and community work. Alcohol is estimated to have cost $402.6 million worth of household labour in 1998-99, tobacco cost $6.9 billion, and illicit drugs $344.8 million. In so far as it is possible to attribute a cost suffered by individuals from loss of life, pain and suffering, alcohol can be said to have cost $2 billion. It was estimated that 63.2 per cent of this cost was avoidable, had fully

effective policies and programs been in place. Comparable figures for tobacco were $13.5 billion, of which 45.4 per cent was avoidable.[5]

3.9 Results from the 2001 NDS Household Survey revealed tobacco to be the second most accessible drug after alcohol. While the proportion of the population who smoked daily declined between 1998 and 2001, the proportion drinking alcohol daily remained stable. There were also no changes from 1998 to 2001 in the average ages at which smokers took up tobacco (15 years) and drinkers had their first full serve of alcohol (17 years).[6] Among the survey respondents, 42.5 per cent approved of the regular use of tobacco by adults and 81.4 per cent approved of regular alcohol consumption.[7]

3.10 The 2001 NDS Household Survey stated 'The most accessible illicit drugs were painkillers / analgesics and marijuana / cannabis - 38.4% and 21.0% of the population respectively were offered or had the opportunity to use these drugs.'[8] The average age at which new users first tried illicit drugs remained stable between 1998 and 2001 at 19 years of age.[9]

3.11 The 2001 NDS Household Survey looked at approval ratings for the use of drugs. 'Respondents were asked if they personally approve or disapprove of the regular use by an adult of a selected list of drugs.'[10] Of the illicit drugs, cannabis had an approval rating of 27.4 per cent by males (compared with a disapproval rating of 72.6 per cent) and an approval rating of 20.1 per cent for females (compared with a disapproval rating of 79.9 per cent) for its regular use by adults. 8.9 per cent of males and 6.8 per cent of females approved regular, non-medical use of prescription drugs but fewer accepted the use of other illicit drugs. Heroin was seen as the drug of most general concern to the community, ahead of tobacco and alcohol. Attitudes to the acceptability of illicit drug use were also reflected

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5 Collins DJ & Lapsley HM, *Counting the cost: Estimates of the social costs of drug abuse in Australia in 1998-9*, Monograph series no 49, Commonwealth Department of Health and Ageing, Canberra, 2002, pp ix-x, 29, 61.

6 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, Drug statistics series no 9, AIHW, Canberra, May 2002, p xiii.

7 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: Detailed findings*, Drug statistics series no 11, AIHW, Canberra, December 2002, p 8.

8 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, p xiv

9 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, p xiv.

10 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey, Detailed findings*, p 8.

in the low support for their legalisation and in approval of tougher penalties for their use.[11]

3.12 Australian parents are concerned about the use of drugs by young people. The Commonwealth Department of Health and Ageing indicated that recent research has shown that two in five parents (43 per cent) of 8–17 year olds believe that taking illegal drugs is the main social problem facing young Australians today. One in six (17 per cent) regard illegal drug use as totally out of control and three in five (58 per cent) saw underage binge drinking as a significant problem. There was also a widely held belief in the community that family breakdown was associated with drug use.[12]

3.13 Governments and non-government organisations around Australia have responded to parental and community concerns by fostering efforts to prevent or discourage smoking and the use of illicit drugs, and to encourage the responsible use of alcohol. They have also provided services for those families with members who are abusing substances.

Help for families and communities by governments and non-government organisations

3.14 The national strategies dealing with alcohol, tobacco and illicit drugs all contain elements that cover the provision of information to Australians and focus on the prevention of harm. Information campaigns are or have been run with funding from the Commonwealth Department of Health and Ageing for:

- tobacco (1997-present), comprising a number of strategy components and currently targeting smokers and recent quitters aged 16-40 years, with an emphasis on those of low socio-economic status;
- alcohol (2000-02) focusing on teenagers, their parents and young adults; and
- illicit drugs (2001-present), the first part of which targeted parents and carers of teenagers, aiming to enhance their skills in communicating with children about drugs in order to deter initiation or continuation of drug use – the second part of the campaign will target youth.[13]

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11 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: Detailed findings,* pp 5, 8, 95-96.

12 Commonwealth Department of Health and Ageing, sub 238, pp 12-13.

13 Commonwealth Department of Health and Ageing, sub 238, pp 19, 24, 26.

3.15 Other information, guidance and health promotion messages, provided with Commonwealth assistance, come from such sources as:

- the national drug information service run by the Australian Drug Foundation that disseminates information to the general community, parents and schools, as well as to health professionals and care facilities[14];
- community education promoted by the Alcohol Education and Rehabilitation Foundation;
- the National Health and Medical Research Council's 2001 Australian Alcohol Guidelines which provide advice on alcohol consumption[15];
- the National School Drug Education Strategy and the National Framework for Protocols for Managing the Possession, Use and/or Distribution of Illicit and Other Unsanctioned Drugs in Schools, which has been endorsed by all Australian governments[16]; and
- for school children, the Rock Eisteddfod and Croc Festivals, which are performing arts events.[17]

3.16 The Community Partnerships Initiative is a community grants program 'to encourage quality practice in community action to prevent illicit drug use and to build on existing activity occurring across Australia'. The initiative has received funding of $8.8 million over four years, and a further $14 million was provided in the 2002 budget. Examples of some of the programs supported under the initiative are given in Box 3.1. Future funding from the initiative will be directed towards early childhood and adolescence, based on a growing understanding that 'preventive investment in the early years of life pays off'.[18] In the 2003-04 federal budget $12 million was allocated over the four years 2003-04 to 2005-06. $4.4 million previously allocated was directed to higher priority National Illicit Drug Strategy initiatives.[19]

3.17 Further very early prevention efforts can be expected when the National Drug Prevention Agenda is completed, under the auspices of the Intergovernmental Council on Drugs' Prevention Expert Committee which is chaired by the Commonwealth Department of Health and

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14 Commonwealth Department of Health and Aged Care, sub 145, p 87.

15 Commonwealth Department of Health and Ageing, sub 238, pp 23-24.

16 Commonwealth Department of Education, Science and Training, sub 262, p 1 and sub 284, p 1; Commonwealth Department of Education, Training and Youth Affairs, sub 147, pp 1-3.

17 Commonwealth Department of Health and Ageing, sub 238, p 25.

18 Commonwealth Department of Health and Ageing, sub 238, p 28.

19 *Budget measures 2003-04*, Budget paper no 2, Commonwealth Department of Treasury, Canberra, May 2003, pp 174-175.

Ageing. At present a monograph is being prepared which consolidates international and national evidence for prevention in drug policy and action. The other elements of the agenda are a national prevention policy and action plan, agreed by all jurisdictions to guide prevention initiatives.[20] Workshops were held in all capital cities during March 2003 to discuss a prevention policy consultation document. The outcome of the consultations and the monograph's findings will guide the development of the action plan.[21]

Box 3.1 Examples of projects funded by the Community Partnerships Initiative

Cootamundra (NSW) Community Centre's anti-drug campaign provided education to families and the broader community, incorporating the How to Drug Proof Your Kids Program.

Knox (Victoria) Community Health Service Inc ran the SMART – Skills, Mentoring and Resilience Training project to build resilience and achieve cognitive change in the world view of young people, 10-17 years old.

DRUG-ARM's (Queensland) Brisbane West Youth Partnership project aims to build a partnership with community groups and individuals through youth roundtables, youth action teams and youth community forums.

Pika Wiya Health Service Inc (South Australia) ran the Young Peoples Program – Getting the Message Across involving an early intervention project using role models; developing posters, hand outs and impact messages; running youth camps and tapping into prison anger management courses.

Teen Challenge Perth Inc organised the Say No to Drugs Bike Marathon with teams of bike riders and speakers who travelled through many communities via Perth, Kalgoorlie and Esperance.

Alice Springs Youth Accommodation and Support Services seeded the establishment of a bush adventure project for 15-18 year olds at high risk of illicit drug use.

The Parents and Friends' Association and The Friends' School Inc (Tasmania) through its 'It's in our hands' project, aims to empower parents to respond effectively to drugs in a school-community partnership.

Source: Commonwealth Department of Health and Ageing, sub 290, appendix 2.

20 Commonwealth Department of Health and Ageing, sub 238, p 15.

21 Commonwealth Department of Health and Ageing, sub 295, p 2.

3.18 Under the National Illicit Drug Strategy, Commonwealth assistance is also provided to state and territory governments through the Commonwealth Department of Family and Community Services to support families with a young person coping with illicit drug use. Under this program, $11.3 million is being given over four years to community groups to support families with parent and group support programs, telephone referral services, family counselling and Indigenous drug services.[22] In addition, other, more general departmental programs, through their support for families, help to create environments in which drug abuse is less likely to occur than it might otherwise be. In the 2003-04 federal budget $3.2 million was provided for the National Illicit Drug Strategy – strengthening and supporting families coping with illicit drug use program. This program continues for another year while an evaluation of the benefits of the program is completed.[23]

3.19 Programs run by state and territory governments contribute to and expand on the programs outlined above. The former committee noted the large range of such programs during 2000 and 2001.[24] Recent submissions from state and territory governments indicated that new approaches are being examined[25], and implemented by these jurisdictions. The Victorian government, for example, reported a substantially increased emphasis on prevention and early intervention.[26]

3.20 Non-government agencies play a vital role in the delivery of services to families affected by substance abuse. From its contact with numerous such agencies, the former committee remarked that:

> … These agencies do more than bridge service gaps: they have the advantage of being run by people who have had similar experiences and who are, therefore, uniquely placed to offer a kind of 'wordless' understanding valued by many …
>
> All around Australia, non-government agencies are running telephone counselling services, referring families to treatment services, developing education kits for parents and families, running drug education courses, offering respite care and crisis accommodation, and working in advocacy roles to influence drug-

22 *Commonwealth Department of Family and Community Services annual report 2001-02*, vol 2, FACS, Canberra, October 2002, p 21.

23 *Budget measures 2003-04*, p 177.

24 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, pp 18-23.

25 Northern Territory government, sub 240, pp 1-2; South Australian government, sub 279, attachment, *Communique*, South Australian Drugs Summit 2002, Adelaide, 24-28 June 2002, pp 1-43.

26 Victorian government, sub 255, pp 1, 3.

> related policies and programs. Some NGOs receive funds from government agencies while others, church-affiliated organisations for example, are relatively self-sufficient. Most rely on the energy and commitment of volunteers to deliver their services …[27]

3.21 The committee agreed that resources and available funding for NGOs be examined in order to ensure the continued support of these valuable services.

The social context in which drug use and misuse develops

3.22 The family, school and neighbourhood can all be environments affecting drug use and misuse by young people. Professor Patton told the committee that:

> … [The] central point [is] the sense of connection, bonding and attachment between a young person and these core institutions of family, school and local neighbourhood. Where a young person is bonded – connected – to adults in that setting they are likely to adopt a set of healthy values and beliefs that, in turn, will lead on to healthy lifestyle choices and behaviours. Where that connection does not exist young people at the margins of school and family are going to connect to other young people in similar situations, and adopt their values and behaviours. Those are the routes to substance abuse.[28]

According to Kerr, these are also the routes to other aspects of social and individual disadvantage and dysfunction such as failure to complete school, unemployment, mental ill health, homelessness and crime.[29]

3.23 Spooner and her colleagues outlined a number of macro-environmental factors that impact on drug use by young people:

> … widening socioeconomic gaps have been associated with increased feelings of relative deprivation and decreased social capital, which negatively affect community life. Furthermore, low socioeconomic status, including unemployment, has been found to

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27 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, pp 23-24.

28 Patton G, transcript, 15/8/02, pp 1086-1087.

29 Kerr S, 'The place of prevention in drug policy', *Conference Papers Collection*, CD-ROM, 2nd Australasian Conference on Drugs Strategy, Perth, 7-9 May 2002, Alcohol & Drug Coordination Unit, Western Australian Police, 2002, p 3; Patton G, transcript, 15/8/02, p 1087.

> cluster within communities, creating environmental risk factors for children growing up within those areas …
>
> [The social environment is also important. For example] … the greater individualism and libertarianism of modern society have some benefits, but have also resulted in a lack of shared norms, values and feelings of belonging, resulting in youth alienation and a sense of powerlessness.
>
> [Furthermore] … The lack of leisure time for many working parents can be a problem when it results in a lack of supervision and boredom for children. Ethnic cultural influences … can have positive as well as negative impacts on drug use and social development. Drug and alcohol use cultures within work sites were identified as an issue of concern in relation to young people entering the workforce. [There are] in sum, multiple social and cultural influences on youth drug use …[30]

3.24 How the social environment influences young people to experiment with and pursue tobacco use was best illustrated for the committee at its roundtable discussions by Professor Hill. He said parental example, for instance, is one of the strongest predictive factors in the uptake of smoking. Places where young people congregate for entertainment are also significant with recent concerns focused on these venues for their role as 'nicotine classrooms' and as places where smoking and binge drinking go together. These are environments that encourage our young people to participate even if they are not yet committed to smoking. On a more positive note, the smoke-free workplace is increasingly common. Over the last decade, Australian workplaces have made huge advances in this respect. This means that young people are effectively going into workplaces that are often smoke-free zones.[31]

3.25 Detailed analyses of the factors influencing young people's use and abuse of drugs have identified more specific risk and protective elements than those outlined above. Healthy standards and attachments and good social skills are protective. Toumbourou pointed out that the risk factors are many, and apply to different developmental settings, as shown below.

- At the community level, the risk of drug abuse among young people is greater with availability of substances, extreme economic deprivation, transitions and mobility, high levels of neighbourhood disorganisation, and where it is regarded as normal behaviour.

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30 Spooner C, Hall W & Lynskey M, *Structural determinants of youth drug* use, ANCD research paper 2, Australian National Council on Drugs, Canberra, 2001, p ix.

31 Hill D, transcript, 15/8/02, pp 1083-1085.

- Among families, a family history of substance abuse, poor family management practices, family conflict, parental drug use and parental attitudes favourable towards drug use predict substance use.
- In the school environment, factors like failing academically, persistently difficult behaviour and low commitment to school can be predictors for substance use.[32]

3.26 Physical and sexual violence are among the background factors that are associated with drug use, according to a study of American adolescents by Kilpatrick et al. They found that adolescents who had been physically assaulted or sexually assaulted, who had witnessed violence, or who had family members with alcohol or drug use problems had increased risk for current substance abuse and dependence. Furthermore, post-traumatic stress disorder independently increased risk of marijuana and hard drug abuse and dependence.[33] The relationship between bodily and substance abuse is also apparent among the many women prisoners who abuse drugs. A New South Wales parliamentary committee found that most women inmates have experienced violence and abuse, including incest and sexual abuse, as children and have long-standing drug and alcohol addictions.[34]

3.27 According to Professor Patton, individual risk factors relate to anti-social behaviour, school dropout and suicidal behaviour. [35]

3.28 Information like that cited above provides a good guide to how to approach the vital tasks of prevention and early intervention. It clarifies that the home, workplaces and entertainment venues are important places to target and the importance of targeting messages about substance use and abuse to parents as well as young people. Above all, it underlines, as Professor Patton pointed out, the need to foster young people's connectedness to others around them by:

- creating opportunities for connection with adults in schools, local neighbourhoods and families;

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32 Toumbourou JW, 'Drug prevention strategies: a developmental settings approach no 2', September 2002, DRUG INFO clearinghouse, pp 2-3, viewed 14/3/03, <http://druginfo.adf.org.au/article.asp?id=3343>.

33 Kilpatrick DG, Acierno R & Saunders B, 'Risk factors for adolescent substance abuse and dependence: data from a national sample', *Journal of Consulting and Clinical Psychology*, vol 68, February 2000, p 19.

34 Select Committee on the Increase in Prisoner Population, New South Wales Legislative Council, *Interim report on inquiry into the increase in prisoner population: issues relating to women*, SCIPP, Sydney, 2000, pp xx, 7.

35 Patton G, transcript, 15/8/02, p 1087; Patton G, presentation to roundtable, Canberra, 15/8/02, exhibit 41, slide 4.

- promoting skills in young people and adults for making those connections; and
- getting young people actively involved in communities, families and schools in a way that is valued and recognised.[36]

3.29 Other sources stressed that prevention strategies require a holistic approach to life and living in the various environments that have marked impacts or influences on the pathways taken by our young people. Working with families is important.[37] Spooner and others pointed out that a long term approach is required as one-shot interventions are not effective.[38] The committee was told by Major Watters that attacking substance abuse alone is not sufficient, under-privilege and lack of employment must also be tackled. He also stressed that people problems, societal problems, and deeper issues in families must be dealt with.[39] Ms Bressington listed bonding with families, neglect and sexual abuse as some of the issues that need addressing.[40]

3.30 As the committee was told by Dr Wodak, there is overwhelming evidence that early intervention in the uptake of drug use and abuse is cost effective.[41] Furthermore, funding for early intervention that targets social factors was strongly supported in several submissions to the inquiry.[42] In this context the National Drug Prevention Agenda is potentially a significant step forward in terms of drug prevention. However, according to Alcohol and other Drugs Council of Australia (ADCA), 'insufficient funds have been allocated and the process is lacking urgency. There is a need to prioritise the development of the National Drug Prevention Agenda'.[43]

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36 Patton G, transcript, 15/8/02, p 1087.

37 Australian Family Association, sub 73, p 5; National Council of Women of Australia, sub 19, p 2.

38 Spooner C, Hall W & Lynskey M, p xi.

39 Watters B, transcript, 16/8/02, p 1249.

40 Bressington A, transcript, 15/8/02, p 1155.

41 Wodak A, transcript, 16/8/02, p 1248.

42 Riley family, sub 32, p 4; Toora Women, transcript, 21/5/01, p 954; Turning Point Drug and Alcohol Centre, sub 137, p 6.

43 Alcohol and other Drugs Council of Australia, *Federal Budget 2002-2003 submission*, p 4, viewed 14/3/03, <http://www.adca.org.au/policy/submissions/adcabudgetsubmission.pdf>.

Conclusion

3.31 Having considered the evidence, the committee:

- recognises that the impact of substance addiction spreads beyond the family, impacting on society as a whole and is evident across all sectors of the community;
- believes the National Drug Prevention Agenda should be urgently completed and action plans developed;
- agrees that the area of resources and available funding for NGOs be examined to ensure the continued support of these valuable services;
- believes that risk factors which may lead to substance abuse can include a family history of substance abuse, physical and sexual abuse, and inadequate family management practices, such as family conflict, parental drug use and parental attitudes favourable towards drug use;
- notes that parental example and supportive family relationships are the most conducive element in preventative and recovery strategies;
- agrees that concentrating on substance abuse alone is not sufficient and that creating opportunities for young people to actively engage in family, community and school activities would enhance early intervention and prevention outcomes; and
- expresses concern for the lack of support for parents in the complex interaction between mental health, drug abuse and suicide.

Recommendation 1

3.32 **The committee recommends that the Commonwealth government, in cooperation with the State and Territory governments, ensure that early intervention and prevention programs aimed at young people are expanded to**:

- **actively encourage and support young people to be involved in communities, families and with their peers in a way that is valued and recognised;**
- **create opportunities for them to connect with adults in schools, local neighbourhoods and families; and**
- **promote skills in young people and adults for making those connections.**

Recommendation 2

3.33 **The committee recommends that the Commonwealth, State and Territory governments work in cooperation to ensure that all early intervention and prevention programs aimed at young people are delivered in conjunction with programs targeting areas of disadvantage such as poverty, poor housing, ill health and poor school attendance.**

Recommendation 3

3.34 **The committee recommends that the Commonwealth government, in cooperation with the State and Territory governments, give the highest priority to the implementation of the National Drug Prevention Agenda and its ongoing evaluation.**

Schools

3.35 Schools are one of the places where young people spend many hours and, as such, they can be important in influencing attitudes towards drugs and their use. Schools can provide information to students about drugs to increase their awareness of all the issues surrounding use and abuse; they can also, encourage discussion and challenge attitudes. At a broader level, schools can provide an environment in which individuals feel they have a place and are valued; they can help in this way to build skills and resilience among the students. Schools can have a role in assisting those students who have already developed drug-related problems.

3.36 In May 1999 the National School Drug Education Strategy was launched. The goal of the strategy is 'no illicit drugs in schools'. The Commonwealth Department of Education, Science and Training advised that the Commonwealth has provided $27.3 million over four years for school drug education, of which $18 million is directed to enhancement of programs under the National School Drug Education Strategy (which supports state and territory activities and national strategic initiatives) and $9.3 million is allocated towards the management of drug related issues and incidents in schools by COAG's agreed measures. [44]

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44 Commonwealth Department of Education, Science and Training, sub 262, p 1; Commonwealth Department of Education, Training and Youth Affairs, sub 147, pp 1-2.

Schools' role in preventing the uptake of drugs

Formal drug education in schools

3.37 Mr Munro, Director, Centre for Youth Drug Studies, reported that formal drug education is a central component of every government drug strategy, whether at the Commonwealth, state or territory level. He said its usefulness has been demonstrated by research that shows that:

> … formal drug education through the classroom can impact positively on young people's drug use. Drug education can reduce young people's drug use; it can offset drug use or it can delay the initiation of drug use by young people and it can also reduce the amount of drug use that the person who is using drugs actually undertakes.[45]

The National Drug Research Institute stated that even relatively brief classroom interventions with respect to alcohol can produce change in young people's alcohol-related behaviour, particularly with respect to harmful use.[46] Furthermore, as indicated by Andrews and Wilkinson, with booster sessions in subsequent years the effectiveness of prevention programs is enhanced.[47]

3.38 Submissions to the inquiry from DRUG-ARM, Family Drug Support and National Drug Research Institute, supported the inclusion of drug education in the school curriculum[48], and suggested desirable features for this education. For example, as Mr Munro said, it should help young people to learn how to manage legal drug use, as well as encouraging them not to use illegal drugs.[49] This issue is also being looked at by the New South Wales parliamentary committee inquiry into the use of prescription drugs and over the counter medications in children and young people.[50] On the other hand, Mr Corcoran suggested, it should stop short of informing them of how to use illicit drugs.[51] Adopting a similar view, a Victorian parliamentary committee recommended that information about inhalants should not be given in the mainstream drug

45 Munro G, transcript, 15/8/02, pp 1136-1138.

46 National Drug Research Institute, sub 110, p 6.

47 Andrews G & Wilkinson D, 'The prevention of mental disorder in young people', *Medical Journal of Australia*, vol 177, 7 October 2002, p S98.

48 DRUG-ARM sub 199, p 21; Family Drug Support, sub 229, p 7, National Drug Research Institute, sub 110, p 38.

49 Munro G, transcript, 15/8/02, pp 1157-1158.

50 Parliament of New South Wales, Joint Statutory Committee on Children and Young People, Inquiry into the use of prescription drugs and over the counter medications in children and young people, Issues paper no 3, NSW Parliament, Sydney, May 2002, pp 7-8.

51 Corcoran J, sub 268, p 4.

education curriculum, only to regular users outside the classroom.[52] Further, the former Commonwealth Department of Health and Aged Care identified that school education programs on hepatitis C are not being addressed commensurate with the seriousness of the problem, nor the link between injecting drug use and acquiring hepatitis C.[53]

3.39 Mr Munro said as it is best to provide drug education before behavioural patterns are established, education in both late primary and secondary school is appropriate.[54] Another view was that starting even earlier was appropriate. According to Family Drug Support, there should be an age-specific program from school entry through to school leaving[55], with the curriculum targeting both the risk and protective factors.

3.40 The Australian Medical Association summit entitled *Party drugs: A new public health challenge* held in April 2002 noted that relying on young people to spread knowledge and skills among their peers can also be effective, particularly with the newer drugs, such as party drugs, wherein parents are not seen as the most credible source of information.[56] According to the Brisbane Youth Service, three-quarters of a sample of 51 young people supported the idea of peer-based education.[57]

3.41 Professor Patton explained that it is important to realise that education that simply provides knowledge about drugs does not work as a strategy; it needs to be complemented by attention to the broader setting.[58] Mr Munro indicated a whole of school approach ensures that school policies and practices complement drug education. For example, giving students every opportunity to be successful and develop high self-esteem means that they are less vulnerable to the risk of using drugs.[59] In its submission, the Toowoomba Drug Awareness Network said that resilience to drug use is also strengthened by activities that build social skills, such as providing mentors for interaction, role modelling, and preventing aggressive behaviour towards vulnerable children.[60]

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52 Parliament of Victoria, Drugs and Crime Prevention Committee, *Inquiry into the inhalation of volatile substance: Final report*, DCPC, Parliament of Victoria, Melbourne, September 2002, p xi.

53 Commonwealth Department of Health and Aged Care, *National Hepatitis C Strategy 1999-2000 to 2003-2004*, Commonwealth Department of Health and Aged Care, Canberra, 2000, pp 1, 32, viewed 4/3/03, http://www.health.gov.au/pubhlth/publicat/document/hepc_strat9900_0304.pdf>.

54 Munro G, transcript, 15/8/02, p 1157.

55 Family Drug Support, sub 229, p 7.

56 *Party Drugs – A New Public Health Challenge*, 2002 AMA Drug Summit, National Press Club, Canberra, 11 April 2002, Australian Medical Association, Canberra, 2002, p 6.

57 Brisbane Youth Service, sub 143, p 14.

58 Patton G, transcript, 15/8/02, p 1088.

59 Munro G, transcript, 15/8/02, pp 1137, 1152.

60 Toowoomba Drug Awareness Network, sub 273, p 6.

3.42 Graycar et al stated that few Australian drug education programs for illicit drugs have been evaluated[61]; yet, given the cost savings they can generate through prevention and harm reduction, evaluations would help to identify best practice elements for such programs.

3.43 In an oppossing view Spooner et al stated there is some evidence available, including a review of drug prevention strategies that concluded giving information about the risks and harms of drug use, and increasing self-esteem or social skills are relatively ineffective and may even be counterproductive.[62]

Conclusion

3.44 The committee agrees that:

- the school education system should include a process of evaluation that uses identified successful programs from throughout the education system ;
- it supports education programs which ensure all students are given every opportunity to be successful, including the development of high self esteem;
- as part of these programs schools should also educate and work with parents to encourage a home environment that facilitates development of high self-esteem and opportunities for success;
- policies should be developed and implemented to prevent school bullying as this can lead to vulnerability in children, putting them at risk of using substances to cope; and
- a comprehensive drug education program is fundamental in creating awareness of the dangers associated with substance abuse.

Involving schools, parents and the wider community

3.45 The protection against drug misuse that is provided by young people's connectedness to others in their community has already been addressed in Recommendation 1. An example of how this concept is being applied in some Victorian schools is provided by the Gatehouse Project. This project obtained reports from students about their relationships with their teachers, what their view of school work was, and what opportunities they had in their school settings. Professor Patton explained that the negative responses obtained from this process became the focus for preventive

61 Graycar A, McGregor K, Makkai T & Payne J, 'Drugs and law enforcement: actions and options', paper presented at *South Australian Drugs Summit 2002, Adelaide, 26 June 2002*, p 7.

62 Spooner C, Hall W & Lynskey M, p 56.

work through both the curriculum and what was 'happening in the schoolyard and on the sports field'.[63]

3.46 The National Drug Research Institute advised that incorporating parents and the community into school drug programs, alongside teachers and students, is a desirable approach.[64] The former committee was told:

> … Schools cannot be effective without parents. It is essential that we build the links ... We want parents to know what is happening at schools. We want parents to be comfortable. We want to assist them in knowing how to deal with these issues ...[65]

3.47 As documented by the former committee, a number of projects are underway across the country to involve families with schools and assist them in dealing with drug issues.[66] Other projects involve the local community as well. For example, local community drug 'summits' that link all these groups are being held across the country at present. School, parent and community partnerships are a focus of particular activity in states such as Tasmania, New South Wales and Western Australia.[67] In some schools, community support agencies, as represented by school nurses and chaplains, work closely with the school community.[68]

3.48 An evaluation of approximately 500 local 'summits' that had been held up to mid 2003 recorded very positive comments and feedback from them. The evaluation recommended that 'summits' continue to be supported and research be undertaken on how to expand 'the engagement of parents in local drug education and early intervention activities in a more targeted way'.[69]

Conclusion

3.49 The committee:

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63 Patton G, transcript, 15/8/02, pp 1087-1088.

64 National Drug Research Institute, sub 110, p 6.

65 New South Wales Department of Education and Training, transcript, 21/2/01, p 558.

66 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, pp 26-27.

67 Commonwealth Department of Education, Science and Training, sub 262, pp 2, 5.

68 Erebus Consulting Partners, *National school drug education: Innovation and good practice project*: *Draft final report*, unpublished, 14 May 2002, p 14.

69 Health Outcomes International Pty Ltd in association with Catherine Spooner Consulting, National Drug and Alcohol Centre & Turning Point Alcohol and Drug Centre, *Evaluation of Council of Australian Governments' initiatives on illicit drugs: Final report to the Department of Finance and Administration: vol 1: Executive summary*, Health Outcomes, St Peters SA, October 2002, pp 37, 39.

- strongly supports the involvement of parents and communities in school programs that assist in desirable mentoring benefits for children; and
- while recognising all children are at risk particular attention should be directed towards those children identified as being most at risk.

Adequacy of funding

3.50 At one stage unrealistically high expectations were held for the power of school drug education to minimise young people's substance use. As the committee was told by Mr Munro, one 'problem for drug education in schools is that it has traditionally been judged—and … is still judged—on whether it prevents drug use totally'.[70]

However:

> … there are very powerful impulses in society for drug use, and it is not just a matter of 'let's educate young people and solve the problem'. In the health and education fields in the past two decades, that has caused something of a loss of support for drug education in schools …[71]

3.51 Mr Munro reported that perhaps as a result of disappointment that school drug education was not more effective, it has suffered from 'stop-start' funding. He said:

> … a scare will occur in one state and then there will be money going in to drug education for one or two years. Just at the time when teachers have some decent training the tap will be turned off for three or four years. In three or four years time it will be turned on again. By that time the teachers who have been trained in drug education have stopped doing it or they have left …[72]

He stressed that providing longer term funding is essential if school drug education is to have a chance of delivering the benefits we know it can provide.[73]

Conclusion

3.52 The committee:

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70 Munro G, transcript, 15/8/02, p 1138.
71 Munro G, transcript, 15/8/02, p 1136.
72 Munro G, transcript, 15/8/02, p 1165.
73 Munro G, transcript, 15/8/02, p 1165.

- is disappointed to learn that school drug education has not been pursued as well as it might have been and believes that long term, adequate funding for education programs must be provided; and
- agrees consistent allocation of drug education funding in schools across all states and territories would assist teachers in continuous personal development in up-to-date training techniques.

Recommendation 4

3.53 **The committee recommends that the Commonwealth government in conjunction with State and Territory governments ensure that adequate funding is provided on a long term basis for comprehensive school drug education programs that are part of a whole of school and community approach to dealing with drug use. Programs must be evaluated for effectiveness across a range of criteria.**

Teacher training and experience

3.54 It is also essential that we have teachers with training and experience in delivering drug education. Yet, as mentioned above, this is not the case. In addition, as Mr Munro pointed out:

> … We are quite good at providing materials, although we do need more about illicit drugs. Where we fall down is in giving teachers the training. Many teachers feel ignorant and that these are very personal issues that they do not want to get involved in. I think from a government view down, we do need to be providing more support for teachers ...[74]

3.55 Guidance for teachers, pre-service and ongoing professional development (in service) and the provision of evidence-based resources were recommended by Murnane and others in a national review of effective implementation of school drug education. Guidance should also include coverage of their legal and pastoral responsibilities and how to identify and intervene appropriately where they believe students are using drugs.[75] In this context, it is encouraging that the current arrangements for pre-service teacher training in school drug education are being reviewed.[76]

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74 Munro G, transcript, 15/8/02, pp 1164-1165.

75 Murnane A, Snow P, Farringdone F, Munro G, Midford R & Rowland B, *National School Drug Education Strategy: Final report: Effective implementation practice in relation to school drug education*, Commonwealth Department of Education, Science and Training, Canberra, July 2002, pp 11-13.

76 Commonwealth Department of Education, Science and Training, sub 284, p 2.

Conclusion

3.56 The committee applauds the review for pre-service teacher training and recommends that the momentum to address training for teachers be maintained, as many teachers do not have the professional training required to identify and intervene in suspected substance abuse.

Recommendation 5

3.57 **The committee recommends that the Commonwealth government in conjunction with State and Territory governments ensure adequate numbers of:**

- **teachers receive ongoing professional development (in-service) in order to provide effective drug education; and**
- **trainee teachers are specifically trained (pre-service) to provide effective drug education.**

Schools' role in helping drug using students

3.58 Mr Munro told the committee that schools have an important role to play in the way they respond to drug taking by young people. For licit drugs which are found in many homes, this is relatively straightforward. Students using alcohol and tobacco can be helped to use these substances in a way that exposes them to the lowest possible risk,[77] and referred to more specialist help if needed.

3.59 An emerging problem with prescription and over-the-counter medications was identified by the New South Wales Joint Statutory Committee on Children and Young People. It found evidence of students selling, swapping and sharing medications. The Commission for Children and Young People in that state has suggested strategies for intervening in these practices.[78]

3.60 According to research reported by Mr Munro, dealing with illicit drug use in schools is very much harder. Traditionally, schools have responded with expulsion, an approach that has met with wide community support. This aggressive response has sprung from the stigma attached to such drug taking. The image of a school suffers greatly when the community

77 Munro G, transcript, 15/8/02, pp 1138, 1158.

78 New South Wales Parliament, Joint Statutory Committee on Children and Young People, pp 3-4.

learns that drug taking occurs there, despite the fact that every Australian school deals with drug use among their students every year.[79]

3.61 However, he went on to say exclusion from school brings with it the danger that the young person will drop out completely from pursuing an education, so joining the ranks of those who have not completed Year 12. He told the committee:

> Young people who leave school early—that is, before they have completed year 12—are at a much higher risk of acquiring not only drug problems but a whole host of other problems. It certainly can reduce their life chances; it reduces their chance of getting a decent job, having a career and going on to tertiary education.[80]

3.62 According to Mr Munro, it is now becoming clear that the traditional approach 'is not the recommended action for schools'. Rather discovering drug use among students is the perfect chance for a school to explore the reasons for this. Is it just the experimental action of an adolescent wanting to explore the world, or is it the mark of a potential drug problem? It could be related to stress, conflict at home, a more personal problem or even a mental health problem. Early intervention can short circuit the development of full blown problems and the need for much more costly intervention.[81] Spooner et al stated that research supports the view that schools should therefore have, or refer students to, counselling and cessation programs.[82] The Commonwealth Department of Education, Science and Training has developed a web site to assist schools, parents and others to refer students to relevant professional help.[83]

Conclusion

3.63 While recognising the problems presented to the whole school community by students who possess and use drugs, the committee:

- believes it is important for all schools (public and private) to face the substance abuse issue and acknowledge the need for an individual school-community response;
- agrees with current moves to keep students engaged with school and would urge schools where appropriate not to use expulsion as the first or only response;

79 Munro G, transcript, 15/8/02, p 1138.

80 Munro G, transcript, 15/8/02, p 1137.

81 Munro G, transcript, 15/8/02, p 1137.

82 Spooner C, Hall W & Lynskey M, p 57.

83 Commonwealth Department of Education, Science and Training, sub 262, p 5.

- believes that schools represent an ideal environment for identifying those at risk, providing them and their families with support and putting them in touch with professional help; and
- believes support services are required to ensure children identified as at risk of substance abuse can be successfully engaged in treatment programs.

Recommendation 6

3.64 **The committee recommends that the Commonwealth, State and Territory governments ensure that schools:**

- **are sufficiently resourced to provide comprehensive assistance to substance using students and their parents;**
- **have adequately trained staff to deliver this assistance;**
- **this resourcing must be sufficient to enable schools to effectively liaise with health and welfare agencies dealing with students at risk of substance abuse; and**
- **are urged where appropriate not to use expulsion as the first or only response.**

National initiatives and best practice

3.65 Some of the items listed above as desirable features for school drug education are contained in the national principles for drug education in schools which were developed in 1994. The inclusion of drug education in the curriculum was stressed together with the need for a whole of school approach and involvement of students, parents and the wider community.[84] These points also feature in the National Framework for Protocols for Managing the Possession, Use and/or Distribution of Illicit and Other Unsanctioned Drugs in Schools.[85]

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84 *National School Drug Education Strategy*, Commonwealth Department of Education, Training and Youth Affairs, Canberra, May 1999, p 7, viewed 11/2/03, <http://www.dest.gov.au/archive/schools/Publications/1999/strategy.htm>.

85 Commonwealth Department of Education, Training and Youth Affairs, *National Framework for Protocols for Managing the Possession, Use and/or Distribution of Illicit and Other Unsanctioned Drugs in Schools*, endorsed by the Council of Australian Governments and the Ministerial Council for Education, Employment, Training and Youth Affairs, Commonwealth Department of Education, Training and Youth Affairs, Canberra, June 2000, pp 6-7, viewed 11/2/03, <http://www.detya.gov.au/schools/Publications/2000/drugs/protocols.htm>.

3.66 A recent review of the principles by Midford et al reiterated the need for these features and flagged others mentioned in the last section of this chapter for inclusion, such as:

- initiating drug education before drug use starts and patterns of use are established;
- the use of interactive teaching techniques and trained peer leaders;
- adequate follow up; and
- drug resistance and social skills training.[86]

The Commonwealth Department of Education, Science and Training indicated that a nationally accepted, revised set of principles will be available in mid-2003.[87]

3.67 A recent review, by Erebus Consulting Partners, that investigated innovation and good practice in school drug education identified further educational elements that should be included. Among them were multi-faceted approaches that do not use a single initiative or rely only on formal classroom teaching, and creating and maintaining students' connectedness to schooling.[88] They said it is also important to realise that:

> Any learning that involves consideration of issues related to drugs is perceived by the great majority of students as fundamentally different from most other learning in the formal curriculum. For them, drug education involves personal and emotional considerations that are unlikely to arise in other learning areas …[89]

As a result drug education must engage students both cognitively and emotionally if it is to be successful.[90]

3.68 The National School Drug Education Strategy is being evaluated at present. The Commonwealth Department of Education, Science and Training reported that:

> Preliminary findings of the current evaluation, due for completion in April 2003, indicate that the Strategy has been successful in strengthening the provision of educational programmes and

86 Midford R, Munro G, McBride N & Snow P, *Review of the principles for drug education in schools: Final report*, Commonwealth Department of Education and Training, Canberra, June 2001, pp 24-25.

87 Commonwealth Department of Education, Science and Training, sub 284, p 2.

88 Erebus Consulting Partners, pp 9-10.

89 Erebus Consulting Partners, p 10.

90 Erebus Consulting Partners, p 10.

> supportive environments which contribute to its goal of 'no illicit drugs in schools'.
>
> …
>
> … the Strategy has made significant progress in achieving its objectives, particularly those addressing good practice in school drug education policies, programmes, curriculum and resources and enhancing State and Territory drug education strategies.[91]

3.69 In the 2003-04 federal budget the government continued funding of the National Schools Drug Education Strategy. An additional $1.8 million was allocated for the development of new Student at Risk and Parent Initiatives. A national resource kit to be developed for the Parent Initiative will help parents talk to their children about drugs, and a Student at Risk Initiative resource kit will assist schools to identify students most at risk of drug related harm. This brings total funding of the strategy to $5.3 million in 2003-04.[92]

3.70 Advice on best practice in handling drug-using students is also available. The National Framework for Protocols for Managing the Possession, Use and/or Distribution of Illicit and Other Unsanctioned Drugs in Schools noted, 'It is a significant challenge for schools to make judgements about appropriate responses to drug related incidents ...'[93] Because of the disadvantage associated with expulsion from schools, the national framework stresses that strenuous efforts should be made to retain those involved in drug related incidents within an education or treatment setting. At the same time:

> … It should be the clear perception and reality that unlawful and anti-social behaviours will, when identified, result in consequences for those involved based on fair, just and consistent actions which take into account individual circumstances.[94]

3.71 The framework outlines the key elements and components of any approach to dealing with drug-related issues. They include:

- identifying and supporting students at risk which, according to a recent review is an area where further work is needed to establish best practice;

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91 Commonwealth Department of Education, Science and Training, sub 284, p 1.

92 *Budget measures 2003-04*, p 178.

93 Commonwealth Department of Education, Training and Youth Affairs, *National Framework for Protocols for Managing the Possession, Use and/or Distribution of Illicit and Other Unsanctioned Drugs in Schools*, p 3.

94 Commonwealth Department of Education, Training and Youth Affairs, *National Framework for Protocols for Managing the Possession, Use and/or Distribution of Illicit and Other Unsanctioned Drugs in Schools*, p 3.

- action plans for dealing with incidents;
- communication with those not involved in the incident;
- formalised cooperative liaison and referral with other agencies;
- support for students involved in an incident, including those who have been excluded; and
- recording drug trends in the school and community and the effectiveness of interventions.[95]

Conclusion

3.72 The committee is pleased to learn that considerable efforts continue to be made to identify the best way to approach school drug education and to put in place appropriate strategies and supporting measures.

Recommendation 7

3.73 **The committee recommends that the Commonwealth, State and Territory governments continue to give a high priority to developing and maintaining effective school drug education programs.**

Strengthening families and communities

Empowering family and community groups

3.74 Much information is available to the community about substance use and abuse. It reaches people via mass media campaigns, via messages targeted at selected groups, via telephone support services and, for those with access to the internet, via web sites. Providing information of this kind was strongly supported in submissions to the inquiry.[96] Some of these sources of information are discussed further in Chapters 5, 6 and 7 in relation to alcohol, tobacco and illicit drugs respectively.

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95 Commonwealth Department of Education, Training and Youth Affairs, *National Framework for Protocols for Managing the Possession, Use and/or Distribution of Illicit and Other Unsanctioned Drugs in Schools*, pp 7-9; Murnane A, Snow P, Farringdone F, Munro G, Midford R & Rowland B, *National School Drug Education Strategy: Final report*, p 13.

96 Shortland Youth Forums, sub 223, p 3; Tablelands Alcohol & Drugs Service, sub 202, p 1; The Western Australian Network of Alcohol and other Drug Agencies, sub 91, p 10.

3.75 In addition to information, parents need to develop parenting and communication skills to guide their children in relation to drug use. Parents are demanding resources, assistance and empowerment as Mr Williams from Focus on the Family Australia, who works with parents, commented:

> … A lot of parents were feeling right out of their depth and saying: 'What can I do as a parent? I am afraid my child might be using drugs or is using drugs,'or 'I want to try and prevent my child from being hurt by drug use. What can I do to prevent that?' … The other thing was to try and look at overcoming the ignorance and misunderstanding that many parents had—and still have—parental fear and anxiety, and a lack of skills, which often leads to an inappropriate response.[97]

3.76 Several submissions indicated that the provision of programs to skill parents is important[98], and evaluations have shown that they appear to be particularly promising for at-risk families. However, as Spooner and others have said, 'They are problematic as a universal prevention strategy because of low participation, self-selection ('the worried well') and the high cost of such interventions …'[99]

3.77 Non-government groups have formed in a number of places and operate, with and without government support, to inform about drugs and drug use and to develop local initiatives to target drug use and abuse. For example, Mr Williams said the 'How to Drug Proof Your Kid Program' run by Focus on the Family Australia aims to equip and empower key influencers in communities to deliver programs to parents.[100] Another example is provided by the local drug action groups in Western Australia described by Ms Hanbury. They organise drug awareness events and develop solutions to local problems, such as forming family support groups and providing activities for young people. Some of the groups have been set up by young people.[101]

3.78 The strength of these programs lies in their ownership by the community which ensures that they can accommodate regional, cultural and language differences. Their effect is even greater if they are built into drug policy

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97 Williams G, transcript, 15/8/02, p 1141.

98 Arrowsmith B, sub 28, p 3; DRUG-ARM, sub 199, p 12; National Council of Women of Australia, sub 19, p 2; Toowoomba Drug Awareness Network, sub 273, p 6.

99 Spooner C, Hall W & Lynskey M, p 57.

100 Williams G, transcript, 15/8/02, p 1141.

101 Hanbury J, transcript, 15/8/02, pp 1139-1140.

and strategies, as pointed out in evidence by Ms Hanbury and Mr Williams.[102] Ms Hanbury advised:

> … We need ongoing commitment: there are always children coming through and always families there to deal with them. There needs to be support by existing infrastructure so that family education is something that is built in and it is not just one-off, with things happening here and there. It must be adequately resourced and serviced …[103]

However, both Ms Hanbury and Mr Williams indicated that these programs receive very slender, short term funding, so those attending training courses often have to contribute to the cost of the course.[104] Mr Trimingham advised the committee that programs that focus on the family are relatively new and require more sustainable long-term commitments.[105]

Conclusion

3.79 The committee:

- believes that appropriate efforts to skill, involve and empower parents should receive support;
- believes open and accessible family and parenting drug support and education programs are essential for successful outcomes in treating substance abuse;
- calls for more adequate, longer term funding of local initiatives; and
- agrees that as programs that focus on the family are relatively new, it is important that their effectiveness be assessed before additional funding is committed.

Recommendation 8

3.80 **The committee recommends that the Commonwealth, State and Territory governments work together to:**

- **evaluate the effectiveness of family and community-focused interventions in relation to:**

102 Hanbury J, transcript, 15/8/02, p 1140; Williams G, transcript, 15/8/02, p 1142.

103 Hanbury J, transcript, 15/8/02, p 1140.

104 Hanbury J, transcript, 15/8/02, p 1161; Williams G, transcript, 15/8/02, pp 1160-1161.

105 Trimingham T, transcript, 15/8/02, pp 1145, 1148.

- ⇒ **informing people about substance use;**
- ⇒ **providing people with the skills to be better parents and in particular to deal with substance use by family members and others; and**
- ⇒ **empowering communities to identify and implement appropriate local initiatives; and**

- **ensure programs found to be cost-effective prevention measures are funded on a more generous, longer term basis than at present.**

Providing alternative activities to drugs for young people

3.81 Providing activities in which young people can become involved gives them options for occupying themselves other than with drugs and develops other interests and with them skills and confidence. In evidence given before the committee, Professor Roche said:

> There is a whole range of strategies that communities can put in place to ensure that there are facilities for young people. One of the complaints you will hear in rural and remote areas and some outer suburban areas of most metropolitan cities is that young people have nowhere to go, that they do not have sufficient things to do and that they do not have enough supervision … [Hence] the value of sporting activities or any activities that will keep young people purposefully engaged in a safe environment under the supervision of older people, either responsible young adults or adults that they can bond with or form meaningful relationships with. We know—the evidence tells us—that those things provide a tremendous protection against a range of things including alcohol and other drugs but also juvenile crime and dropping out of school.[106]

3.82 There is, however, another less enthusiastic, more qualified view of the value of community-based recreational programs, as portrayed by Spooner et al:

> … They can be beneficial because they address the risk factors of alienation and association with antisocial peers, but they can also provide an opportunity for crime as victims and offenders interact. They can also provide an opportunity for socialisation with and between antisocial peers.[107]

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106 Roche A, transcript, 15/8/02, p 1125.

107 Spooner C, Hall W & Lynskey M, p 57.

Providing alternative activities, such as sports, arts, entertainment or business ventures, therefore:

> … tend to be not effective on their own, but could be an integral component of a larger intervention, particularly for high-risk youth, as it could provide opportunities for personal development and pro-social bonding.[108]

3.83 The committee is keen to see ample sporting and other activities available to young people in the context of a broader program to address other aspects of their lives.

Recommendation 9

3.84 **The committee recommends that the Commonwealth, State and Territory governments support the provision of out-of-school activities for young people:**

- **with particular attention to those areas where few such activities are currently available; and**
- **ensuring that these activities form one component of a larger intervention that addresses other problem aspects of these young people's lives.**

3.85 While sport has been looked on as a potentially good activity to help prevent drug misuse, some amateur and community-based sports clubs have undermined this promise. They have in fact contributed to alcohol abuse by accepting and promoting excessive drinking and providing inappropriate role models for young people. The Good Sports Program operates in Victoria and New South Wales as a partnership between the Australian Drug Foundation, sports bodies and the government sector. It assists and accredits sports clubs to manage alcohol responsibly, including putting in place practices and policies that enable clubs to develop a culture that attracts families and junior players. The program is expanding rapidly in Victoria and has started in New South Wales.[109]

3.86 The committee believes that it should go without saying that venues where activities are provided for young people should be safe and should not encourage unsafe substance use. The committee sees programs such as

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108 Spooner C, Hall W & Lynskey M, p 57.

109 Good Sports Program, Introduction, Australian Drug Foundation, viewed 17/3/03, <http://www.adf.org.au/goodsports/introduction.htm>.

the Good Sports Program with its accreditation and ongoing monitoring processes as a valuable stimulus to creating a healthy sporting environment for both younger and older people.

Recommendation 10

3.87 **The committee recommends that the Commonwealth, State and Territory governments ensure that the Good Sports Program or like programs are established and promoted in all jurisdictions.**

A comprehensive approach

3.88 Spooner et al reported from the evaluations of existing approaches to prevention, that it appears the best results would be obtained if a variety of strategies were used simultaneously. Ideally the needs of each community would be assessed and a comprehensive plan developed to match those needs. The plan would offer a combination of interventions suited to each individual community and aimed at individual, family and community level. Very few such projects have been undertaken so we do not know how well they would work. Furthermore, planning, implementing and evaluating them would be time consuming, costly and difficult.[110]

Conclusion

3.89 Recognising the difficulties outlined by Spooner et al, the committee would like to see efforts made to test comprehensive community prevention strategies like that described in the previous paragraph and recommends accordingly.

3.90 The committee agrees that while such strategies are costly, they can address more than just drug prevention and provide multiple benefits to the individual and society through minimising the development of other problems such as criminal behaviour. In that sense they may well be cost-effective.

Recommendation 11

3.91 **The committee recommends that the Commonwealth, State and Territory governments trial substance abuse prevention strategies that**

110 Spooner C, Hall W & Lynskey M, p 58.

combine school, family and community-focused activities which have been tailored to the needs of the individual local communities where they are implemented.

Families coping with substance abuse

3.92 Evidence given to the committee by Mr Trimingham said that families with a member who has drug problems face daily and 'ongoing trials and trauma':

> … They face health issues, they face communication issues, they face conflict and even violence issues within the home. They face lack of trust and, on top of that, they face the ever-present prospect of the criminal justice system and its impact.
>
> It is true that, if left unsupported, families who have members who are involved in drugs will disintegrate and over time disconnect from drug users. That is generally what happens. At the same time, human beings and families can be incredibly resilient. We have seen evidence … that, if given support, awareness and education, families not only survive but become vital and important tools for working towards successful outcomes …[111]

3.93 Mr Trimingham said we can see that families' need for help is great from the use made of the Family Drug Support's telephone support service. The weekly number of calls that it received each week doubled from 112 in 1999 to 280 in 2002. Calls lasted on average about 30 minutes and about half the calls were from the mothers of users.[112]

3.94 Working with families helps them to understand better the nature of the problems they face and how to cope with them. In evidence, Ms Bressington advised that family counselling and therapy may cover:

- knowing about the physical, physiological and emotional effects of mind altering substances and how slow recovering from addiction usually is;
- working out the origins of the addict's drug taking and how the family's behaviour affects it and needs to change to support the addict; and

111 Trimingham T, transcript, 15/8/02, p 1145.

112 Trimingham T, *Family Drug Support telephone statistics: 1 July 2001-30 June 2002 comparison of call patterns over the last four years*, unpublished, pp 1-2, presentation to roundtable, Canberra, 15/8/02, exhibit 23.

- developing strategies and skills to cope with their problems.[113]

3.95 Many submissions to the inquiry supported expanding services that inform, support, counsel and provide therapy to families.[114] In this context, the National Drug Research Institute indicated it is important to know what exactly parents need, and what factors influence their decisions to seek help and to remain in touch with that help.[115] Such information can help with the design of programs that are well-matched to the needs of the participants.

3.96 In addition, Families and Friends for Drug Law Reform (ACT) and Family Drug Support reported that engaging family members in the treatment process can be very helpful to the addict.[116] However, as the former committee reported, there has been a tradition of not involving families. Although family-friendly practices are now being promoted for alcohol and drug services, 'such facilities are rare, and their scarcity is a real obstacle for parents seeking treatment for drug dependency'. The shortages of family-friendly treatment options for women with children greatly reduces the chances of mothers attending detoxification and rehabilitation programs.[117]

Conclusion

3.97 The committee is concerned that:

- families of substance users are not being adequately supported in dealing with the drug-related problems they encounter;
- the lack of treatment facilities that are family friendly for parents and their children reduce the chances of successful rehabilitation;
- more must be done to meet this need and to involve families, where appropriate, in the treatment of the substance user; and

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113 Bressington A, transcript, 15/8/02, pp 1149-1150.

114 Alcohol and other Drugs Council of Australia, sub 61, pp 13-14; Alcohol and Drug Foundation Queensland, sub 200, p 3; Alcohol Awareness and Family Recovery, sub 203, p 3; Arrowsmith B, sub 28, p 4; Australian Medical Association, sub 133, p 3; Catholic Health Australia, sub 138, p 8; Hampson I, sub 103, p 7; Shortland Youth Forums, sub 223, p 3; The Western Australian Network of Alcohol and Other Drug Agencies, sub 91, p 10.

115 National Drug Research Institute, sub 110, p 7.

116 Families and Friends for Drug Law Reform (ACT), sub 65, p 1, and sub 266, p 1; Family Drug Support, sub 229, p 8.

117 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, pp 28-29.

- the effectiveness of these activities should also be evaluated with a view to establishing best practice.

Recommendation 12

3.98 **The committee recommends that the Commonwealth, State and Territory governments provide funding:**

- **for programs that support families dealing with substance abuse;**
- **for treatment regimes that allow families to be involved with the substance user's treatment; and**
- **to evaluate the success of these programs and regimes with a view to identifying best practice and disseminating information about that best practice.**

3.99 There are other practical details that may also need attention to assist access to treatment. For example, as the former committee reported, in some jurisdictions public housing tenants must continue to pay full or partial rent to maintain their hold on their housing when they go into residential treatment. Clearly, this financial burden could work as a disincentive to undertaking treatment.[118] In other cases, as the NSW Users & Aids Association and Mr Trimingham pointed out, supported accommodation for drug-addicted parents would be very helpful.[119] The Australian Intravenous League suggested including places where children can stay with their parents.[120]

3.100 In addition, the Alcohol and Drug Foundation Queensland and Mr Arrowsmith suggested changes to the financial assistance provided to drug-affected individuals and family units.[121] According to the National Drug Research Institute, increasing the funding for education and training for the most disadvantaged young people, for example, would be beneficial as it would put them in a better position to finish Year 12 and secure future training and employment.[122]

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118 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 29.

119 NSW Users & Aids Association, sub 128, p 3; Trimingham T, transcript, 15/8/02, p 1156.

120 Australian Intravenous League, sub 113, p 8.

121 Alcohol and Drug Foundation Queensland, sub 200, p 3; Arrowsmith B, sub 28, p 4.

122 National Drug Research Institute, sub 110, p 7.

3.101 The service provided by the staff at Centrelink and other community services also received comment from Mr Trimingham. Those staff were seen to be doing 'their best, but they are stretched to the limit' and underresourced.[123] Ms Bressington suggested a better service can be provided where individual officers specialise in dealing with local drug dependents and the agencies helping them.[124]

3.102 The Commonwealth Department of Family and Community Services commented that:

> Research findings and action learning from program delivery both point to the need for broad ranging coordination to create a comprehensive service system around individuals and families affected by substance abuse …[125]

Conclusion

3.103 The committee is attracted by the concept of coordinated, comprehensive services for drug-affected individuals and families in which issues, such as those discussed above, can be addressed. However, such services cannot be provided without adequate resources, so resource shortfalls must be rectified.

Recommendation 13

3.104 **The committee recommends that the Commonwealth, State and Territory governments implement adequately resourced, coordinated, comprehensive services for drug-affected individuals and their families.**

Database on available services

3.105 There are a number of information services to assist the community to know what services and treatment options for substance use and misuse are available. Such services include: the alcohol and drug service 24 hour hotlines in each state and territory; the National Drug & Alcohol Research Centre's Clients of Treatment Services Agencies - COTSA Census; the

123 Trimingham T, transcript, 15/8/02, p 1153.

124 Bressington A, transcript, 15/8/02, pp 1153-1154.

125 Commonwealth Department of Family and Community Services, sub 162, p 49.

AIHW Interactive Alcohol and other Drug Treatment Services Data; directories of services in various states, regions, suburbs, and by types of services etc. Another important information source is the Australian Drug Information Network (ADIN) website as a portal to web based alcohol and other drug information and resources. In the 2003-04 federal budget the government provided $1 million over four years to maintain ADIN.[126]

3.106 To further enhance access to treatment information in May 2001 the ANCD advised the former committee that it was seeking to commission a project which aims to provide information on Australia's drug treatment capacity through (in part) a mapping of location of services exercise. This was expected to provide a more complete picture of what treatment services are available, where they are located, the capacity and nature of the services and a discussion of formula-based funding allocation models for the establishment of future treatment services (type and location). In May 2003 advice to the current committee from the ANCD was that the project specification phase and selection of a consultant to undertake the work occurred between January 2001 and May 2002. The successful consultants commenced work with the project in July 2002 with an expected completion date of July 2003.[127] By July 2003 the project has reached a pilot stage. The ANCD also advised the committee that:

> It was acknowledged at the commencement of this consultancy that meeting this timeframe would be contingent upon time taken to obtain the relevant information from the Commonwealth, states and territories, which was difficult to anticipate accurately.
>
> … the ANCD is not in a position to compel the commonwealth, states and territories to provide the information sought. Accordingly, the ANCD has emphasised to the consultants the need to progress cautiously towards the collection of data …
>
> While this approach may mean the timeframe for the project extends beyond the desirable goal of twelve (12) months, the ANCD believes timeframe is of secondary importance to the actual conduct of the project.[128]

126 *Budget measures 2003-04*, p 176.

127 Australian National Council on Drugs, sub 289, pp 1-2.

128 Australian National Coucil on Drugs, sub 289, pp 1-2.

Conclusion

3.107 The committee remains dismayed and confounded at the apparent inability of the "system" to provide a comprehensive approach to the issue of practical support for people in our community with a substance abuse issue; whether as an abuser, addict, parent, service provider, child or friend.

3.108 The previous committee envisaged a comprehensive approach from the simplest first contact point for parent, adolescent, GP, police officer, schoolteacher, nurse and prison warder through to the availability of longer term treatment services. The availability of services urban and regional with the obvious gaps being identified and encouraging objective assessment and evaluation to be a key for the successful outcome of improved treatment and allocation of scarce taxpayer funds.

3.109 The committee believes that the provision of this information requires urgent attention. As a priority the ANCD provide an annual simple first stop guide for all Australians on how to best get help with a substance abuse matter.

3.110 The committee is pleased that, as noted earlier in this chapter, the Commonwealth Department of Education, Science and Training has developed a website to help parents, schools and others to refer students to professional help.

Recommendation 14

3.111 **The committee recommends that the Australian National Audit Office evaluate the Australian National Council on Drugs mapping exercise on Australian drug treatment capacity.**

Recommendation 15

3.112 **The committee recommends that any Commonwealth, State and Territory agency or body, or NGO, in receipt of Commonwealth funding for drug related programs, be compelled as a condition of funding, to provide to the Australian National Council on Drugs data and information required for the facilitation of the Australian National Council on Drugs database. The information is to be provided in a timely manner to enable the database to meet its objective of providing all Australians with advice on available services.**

Recommendation 16

3.113 **The committee recommends subject to the outcomes of the Australian National Audit Office evaluation, that the Australian National Council on Drugs mapping exercise:**

- **urgently complete the mapping of available alcohol and drug services across Australia;**
- **identify any gaps in the data assembled which are needed for planning purposes;**
- **ensure those data are collected; and**
- **regularly update the information contained in this database.**

Community attitudes and the media

3.114 As we observed at the beginning of this chapter, there is considerable stigma attached to substance abusers and their family. The same is true of others associated with them, for example, those health and other workers who deal with drug addicts. The former committee commented on the widespread lack of acceptance and understanding of drug abuse in the community, and drew attention to the role the media plays in providing information and influencing attitudes. This role, the former committee observed, was often a negative one. Media portrayal of drug issues is not always balanced and creates unnecessary levels of fear and division in the community.[129]

3.115 One solution to this problem, identified by the former committee was:

> … that governments and people employed in the alcohol and other drug (AOD) sector need to work harder at engaging the media to do what it can to promote reasoned debate in the community …[130]

129 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, pp 61-62.

130 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 62.

Recommendation 17

3.116 **The committee recommends that the Commonwealth, State and Territory governments and non-government organisations working in the alcohol and other drug sector constructively engage with the media to promote better informed, rational debate on drug issues.**

3.117 The former committee also flagged the possibility of developing voluntary media guidelines for the reporting of drug issues to improve the quality of general reportage. Such guidelines exist already for the reporting of suicides, particularly youth suicides.[131] The ANCD's website reports that it is pursuing the media reporting of drug and alcohol issues with the expectation of guidelines being developed.[132]

3.118 Although it has not been able to pursue this suggestion, the present committee believes that it deserves further attention and recommends accordingly.

Recommendation 18

3.119 **The committee recommends that the Commonwealth Department of Health and Ageing liaise with representatives of the media in order to develop a voluntary media code for responsible reporting of substance use and abuse similar to that in place for reporting youth and other suicides.**

131 Australian Press Council, General Press Release no 246(i)(July 2001), *Reporting of suicide*, viewed 23/6/03, <www.presscouncil.org.au/pcsite/guides/gpr246_1.html>

132 ANCD, 'ANCD media initiative', viewed 23/4/03, <http://www.ancd.org.au/current/current2.htm>.

4

Health care

Introduction

4.1 Addiction is now recognised as a chronic, relapsing disease. People who are dependent on drugs make demands on the health care system when they seek help to manage or kick their habit. When they become physically or psychologically ill as a result of their substance abuse, they also need medical care. The burden that they place on the health care system, as reflected in the numbers of drug-related deaths and hospitalisations, is considerable.

4.2 According to Collins and Lapsley, 19,429 Australian deaths in 1998-99 were attributable to tobacco smoking. As explained below in paragraphs 4.5 and 4.6, alcohol abuse both causes and averts deaths, so that overall in 1998-99, 2,744 net deaths were averted. Hospital beddays attributable to tobacco amounted to 965,433, while those attributable to alcohol were 138,974 net.[1] Smokers also spend longer in hospital than non-smokers.[2]

4.3 Collins and Lapsley did not provide data on deaths and hospital use due to illicit drug users. However, using a data set relating to 1998, the Australian Institute of Health and Welfare estimated that 1,023 deaths were attributable to illicit drugs, and in 1997-98 illicit drugs were responsible for 14,471 hospital episodes.[3]

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1 Collins DJ & Lapsley HM, *Counting the cost: Estimates of the social costs of drug abuse in Australia in 1998-9*, Monograph series no 49, Commonwealth Department of Health and Ageing, Canberra, 2002, pp 9, 11

2 English DR, Vu TVH & Knuiman MW, quoted by Collins DJ & Lapsley HM, p 30.

3 Australian Institute of Health and Welfare, *Statistics on drug use in Australia 2002*, Drug statistics series no 12, AIHW, Canberra, February 2003, pp 35, 36.

4.4 Substance abuse also influences the health and welfare of others in the community besides the abuser. For example, Donoghoe and Wodak reported that HIV spreads rapidly among injecting drug users and can be passed on through sexual contact to others.[4] According to the Australian National Council on AIDS, Hepatitis C and Related Diseases, an estimated 91 per cent of newly acquired hepatitis C cases in 2001 were related to injecting drug use.[5] Alcohol-related violence may cause harm and stress to an abuser's family, friends and colleagues, as may smoking tobacco. It is sometimes forgotten that drug use impacts on the unborn child as well as others. In fact, as Collins and Lapsley pointed out in relation to tobacco smoking, 'It has been demonstrated by Ricardo and Stevenson (2001) that, on current medical evidence, the overwhelming proportion of the morbidity attributable to involuntary smoking, as well as a high proportion of involuntary smoking mortality, is borne by the young'.[6]

4.5 Collins and Lapsley estimated that the health care costs of drug abuse in 1998-99 were $1,379.0 million. Of this sum 16.3 per cent was attributable to alcohol ($225.0 million) and 4.3 per cent to illicit drugs ($59.2 million). A much higher proportion (79.4 per cent or $1,094.9 million) is attributable to tobacco.

> … This is in spite of the fact that tobacco, because it produces a much higher level of premature mortality than the other drugs, produces substantial [health care] savings from these premature deaths …[7]

4.6 Although the proportion of people using alcohol greatly exceeds that of other drug users, it needs to be remembered, as Collins and Lapsley pointed out, that for some medical conditions alcohol consumption at moderate levels can have a protective effect, that is, it can reduce the risk of illness and death.[8] The National Health and Medical Research Council summarised the evidence for this effect when issuing the Australian Alcohol Guidelines in 2001.

> There is strong evidence that drinking alcohol reduces the risk of heart disease in people from middle age onwards. This protection

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4 Donoghoe MC & Wodak A, 'Health and social consequences of injecting drug use', in Stimson G, Des Jarlais, DC & Ball A, (eds) *Drug injecting and HIV infection*, World Health Organization, UCL Press, London, 1998, p 44.

5 Australian National Council on AIDS, Hepatitis C and Related Diseases, Hepatitis C Sub-committee, *Hepatitis C Virus Projections Working Group: Estimates and projections of the hepatitis C virus epidemic in Australia 2002*, National Centre in HIV Epidemiology and Clinical Research, August 2002, p 1, viewed 21/3/03, <http://www.ancahrd.org/pubs/pdfs/epidemic_02.pdf>.

6 Ricardo & Stevenson, quoted by Collins DJ & Lapsley HM, p 23.

7 Collins DJ & Lapsley HM, p 49.

8 Collins DJ & Lapsley HM, p 7.

> is achieved by drinking relatively small amounts of alcohol, with no additional benefit from drinking larger amounts. The benefit is largely attributable to alcohol *per se*, with other constituents of particular beverage types having little or no additional value. Protection is most closely associated with a consistent pattern of drinking small amounts of alcohol. More variable drinking patterns, especially involving large amounts of alcohol, may actually increase the risk of illness and death from heart disease.[9]

4.7 Collins and Lapsley estimated that, in 1998-99, alcohol caused 4,286 deaths but prevented over 7,029; alcohol-related disease consumed 394,417 hospital beddays but alcohol's protective effect avoided the need for 255,443 beddays. By contrast, few lives or beddays were saved by tobacco consumption.[10]

Role of government

4.8 As indicated in Chapter 2, the Commonwealth government provides national leadership in relation to the National Drug Strategy (NDS), as well as undertaking its own policies and programs. Action plans, agreed with state and territory governments, have been finalised for illicit drugs, alcohol and tobacco. These plans address both prevention and treatment and receive funding from Commonwealth, state and territory governments.

4.9 Commonwealth funding for prevention activities is directed to campaigns and services to provide information about drug use and to dissuade people from using drugs or, if they do, to use them in the least harmful way possible. For example, as detailed in Chapter 3, illicit drugs are targeted, by the National Illicit Drug Strategy (NIDS) through such initiatives as:

- the Community Partnerships Initiative to encourage community action to prevent illicit drug use;
- a national drug information service;
- the National Schools Drug Education Strategy and associated measures to manage drug-related incidents in schools; and

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9 National Health and Medical Research Council, *Australian alcohol guidelines: Health risks and benefits*, NHMRC, Canberra, October 2001, p 69, viewed 6/3/03, <http://www.health.gov.au/nhmrc/publications/pdf/ds9.pdf>.

10 Collins DJ & Lapsley HM, pp 9, 11.

- the National Illicit Drugs Campaign.[11]

4.10 The Commonwealth government does not directly provide treatment services but facilitates access to such services. In the case of treatment and rehabilitation of illicit drug users, for example, NIDS funds:

- the expansion and upgrading of non-government treatment services;
- the identification, evaluation, promotion and dissemination of best practice in the treatment of illicit drug dependence;
- the training of front line workers;
- the evaluation of alternative treatment modalities for illicit drug use and innovating with respect to prevention and treatment; and
- developing and introducing retractable needle and syringe technology.[12]

4.11 As part of the National Drug Diversion Initiative, by which illicit drug users are diverted from the criminal justice system into education and treatment, the Commonwealth government has funded assessment services and additional treatment places since 1999. This initiative has been supported by programs:

- to increase the number of pharmacies and other outlets distributing needles and syringes;
- to develop and disseminate cannabis cessation strategies; and
- to research the barriers and incentives to illicit drug users accessing and remaining in treatment.[13]

At the end of 2002 the Prime Minister announced continued funding for the National Drug Diversion Initiative for a further four years.[14]

4.12 The former Commonwealth Department of Health and Aged Care advised that treatment is also provided for people dependent on drugs by generalist health services, including general practitioners and hospital services. Commonwealth funding for these interventions is provided under Medicare, mainly in the form of:

- subsidies for prescribed medicines and private medical expenses;

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11 Commonwealth Department of Health and Aged Care, sub 145, p 87.

12 Commonwealth Department of Health and Aged Care, sub 145, pp 87-88; Commonwealth Department of Health and Ageing, sub 238, p 27.

13 Commonwealth Department of Health and Aged Care, sub 145, p 88.

14 Hon John Howard MP, Prime Minister, *Illicit Drug Diversion Initiative*, media release, 31/12/02, p 1.

- substantial grants to state and territory governments to contribute to the costs of providing access to public hospitals, at no cost to patients, and other health services; and
- specific purpose grants to State / Territory governments and other bodies.[15]

4.13 In addition, some medicines used to treat dependence are available under the Pharmaceutical Benefits Scheme. They are either subsidised, like acamprosate and naltrexone for alcohol addiction or, as for methadone, the cost is fully met by the scheme.[16]

4.14 Alcohol and tobacco dependencies are also targeted by the Commonwealth government with support for training of workers and promotion of best practice in relation to training, management, control, treatment and legislation.[17]

4.15 Research into issues raised by substance abuse is carried out at three national research centres that have been established to work on:

- the prevention of substance abuse: the National Drug Research Institute;
- treatment and rehabilitation: the National Drug and Alcohol Research Centre; and
- the education of professionals and non-professionals working with drug and alcohol addiction: the National Centre for Education and Training in Addiction (NCETA).[18]

Research is also carried out elsewhere, including with funds provided to the National Health and Medical Research Council and the Alcohol Education and Rehabilitation Foundation.[19]

4.16 The role of state and territory governments is to deliver services within the framework of the national strategy in such a way as best suits local health needs. The former Commonwealth Department of Health and Aged Care listed the following as activities undertaken by state and territory governments:

- provision of health care to drug addicts through the public sector health services and / or fund community-based organisations to provide drug prevention and treatment programs;

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15 Commonwealth Department of Health and Aged Care, sub 145, p 117.

16 Commonwealth Department of Health and Aged Care, sub 145, pp 115.

17 Commonwealth Department of Health and Aged Care, sub 145, pp 119-120.

18 Commonwealth Department of Health and Aged Care, sub 145, p 82.

19 Commonwealth Department of Health and Aged Care, sub 145, p 122-123; Commonwealth Department of Health and Ageing, sub 238, pp 23-24.

- regulation and administration of the delivery of methadone services and needle and syringe programs; and
- the development of effective and comprehensive professional education and training, research and evaluation strategies, in close cooperation with other jurisdictions so as to achieve consistency.[20]

Non-government organisations

4.17 The former committee noted that NGOs contribute substantially to the welfare of substance users and abusers, both through the provision of services and as lobby groups advocating change to government policies. Many of these organisations receive funding from state and territory governments or the Commonwealth government, or both.[21]

4.18 Non-government service providers run a range of mostly non-medical, residential and non-residential treatment services that are widely used by those who have already undergone detoxification in a hospital. The programs run by NGOs offer outreach services, counselling, and community education and referral, and vary in the approaches they take with respect to the treatment modalities they employ. As the former committee remarked, 'it is clear that governments rely very much on the dedication of this sector'.[22]

4.19 Among the larger lobby groups for drug-related issues is the Alcohol and other Drugs Council of Australia (ADCA), the peak body for the alcohol and other drugs sector in Australia. It develops, in consultation with its broad membership base and through a number of expert reference groups, comprehensive policy positions which it then advocates to governments, businesses and communities.[23] Another organisation through which the voice of NGOs is conveyed to government is the Australian National Council on Drugs (ANCD). The council is the peak advisory body to government on drug policy and programs.[24] Input to the drug debate is also provided by public health associations such as the Australian Medical Association (AMA) and the Public Health Association of Australia.

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20 Commonwealth Department of Health and Aged Care, sub 145, p 90.

21 House of Representatives Standing Committee on Family and Community Affairs, *Where to next? - A discussion paper: Inquiry into substance abuse in Australian communities*, FCA, Canberra, September 2001, p 42.

22 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 42.

23 Alcohol and other Drugs Council of Australia, sub 61, p 3.

24 Australian National Council on Drugs, sub 47, p 1.

Issues in providing health care

4.20 In its discussion paper, the former committee identified a number of key issues that require attention in relation to providing care for drug dependents. Many of the same points were also raised during the inquiry with the current committee.

Service delivery

Access to treatment

4.21 On the basis of a national stocktake of treatment facilities which it undertook, the former committee concluded that:

> Governments appear to be working hard to ensure that suitable treatment services are available to assist drug dependent people wanting to address their drug dependence problems. Despite this, the Committee heard from many sources that treatment services simply are not as available as they need to be to facilitate rehabilitation from drug abuse …
>
> …
>
> Detoxification from alcohol and other drugs is a pre-requisite for gaining entry into most treatment facilities, but there are few detoxification beds available, and hospitals appear to be pulling back from providing this relatively costly service. A lengthy waiting period may be involved before access is obtained, and then after a medically-supported withdrawal there might be another wait before access to a suitable, nearby rehabilitation facility is secured. These waiting periods are risky, and many opportunities for recovery are wasted as drug users drift back into their old, familiar, drug-using environments.[25]

4.22 The current committee was told that these problems still exist. Dr Wodak claimed that the mismatch between the demand for detoxification and the supply of places continues across the country.[26] Furthermore, according to Professor Webster:

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25 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, pp 51-2.

26 Wodak A, transcript, 16/8/02, p 1251.

> … if you went to most public hospitals, you would find virtually no drug and alcohol unit or not much of a drug and alcohol unit—if there is one, it might be a shed round the back …[27]

4.23 Participants at the committee's roundtable commented on the rehabilitation services available. Professor Webster pointed out that long-term, residential places give addicts the opportunity to 'learn to become a different person …'[28] Such places, according to Professor Mattick, are proven to give quite good outcomes.[29]

4.24 Professor Mattick pointed out that residential treatment does not appeal to everyone and is difficult for those undergoing treatment to incorporate with work and other responsibilities.[30] Mr Trimingham claimed that:

> … there is a need in Australia for day treatment: multidimensional services that take people wherever they are on the spectrum of need—and that includes families. This type of service would have assessment, pharmacotherapies, detox, rehab, counselling, dual diagnosis, impact on housing, child care, employment preparation, leisure, life skills—the lot, including clean needles. Moving people back to their own family on a daily basis, rather than taking up expensive residential beds, would be very cost effective. This system is widely used overseas, particularly in the United Kingdom …[31]

4.25 ADCA advised, however, that there was evidence of some improvement in the availability of treatment. The 2001 census of clients of treatment service agencies indicated an increased treated prevalence of alcohol and other drug problems among people over 15 years of age. The prevalence had increased from between 2.5 and 3.6 per 1,000 people in 1995 to between 3.4 and 4.6 per 1,000 in 2001. During the last 10 years the proportion of those in treatment who received that treatment in residential facilities has fallen as the proportion of outpatient interventions has grown.[32]

Conclusion

4.26 The committee:

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27 Webster I, transcript, 15/8/02, p 1113.

28 Webster I, transcript, 15/8/02, p 1127.

29 Mattick R, transcript, 15/8/02, p 1106.

30 Mattick R, transcript, 15/8/02, pp 1105-1106.

31 Trimingham, T, transcript, 15/8/02, pp 1146-1147.

32 Torres et al (1995) and Shand and Mattick (2001) quoted by the Alcohol and other Drugs Council of Australia, informal communication, 11/4/03.

- was concerned to learn of the continuing shortage of services that provide detoxification and / or rehabilitation;
- views that it is vital that places are available to assist those who need and want them. It is also important that treatment is provided in a variety of settings so that it is as readily available as possible to patients and can accommodate involvement of families in the treatment process;
- believes attention must also be given to ensuring an appropriate balance of residential and non-residential care; and
- recognises that Australia cannot expect to reduce the harm caused by addictions if the requisite health services are not there.

Recommendation 19

4.27 **The committee recommends that the Commonwealth, State and Territory governments must work together to substantially increase the number of places and access to detoxification, including rapid detoxification, and rehabilitation services that are critical to the successful transition from abuse to non-use.**

Recommendation 20

4.28 **The committee recommends that the Commonwealth, State and Territory governments, in order to achieve a substantial reduction in substance abuse, consult with non-government organisations to ensure that alcohol and other drug services offer a range of approaches to treatment and rehabilitation.**

Governments should consult with non-government organisations to ensure they are mindful of the need for an appropriate mix of residential and non-residential services, making provision for family involvement if desired.

4.29 In its discussion of factors that affect the accessibility of services to drug-dependent people, the former committee also highlighted three other issues:

- the particular disadvantage suffered by certain groups of Australians:

> … Access to drug treatment services … appears to be worse for people suffering from mental health as well as drug problems,

Indigenous Australians, young people, and people living in rural and remote parts of Australia[33];

- the difficulty of providing services in the face of community opposition to siting them where addicts can most easily travel to them: the former committee commented on the 'NIMBY' (Not In My Back Yard) factor[34]; and
- the cost of treatment for some drug users.

4.30 An example of this last point is provided by former heroin users who are on methadone maintenance programs. The former committee noted that, while some of these former users obtain their methadone free of charge through public programs, those who access it from pharmacies are required to pay. The former committee concluded that 'Other forms of treatment such as naltrexone programs [for heroin and methadone addicts] and rehabilitation clinics can cost thousands of dollars, an insurmountable obstacle for prospective clients without well-heeled connections'.[35]

4.31 The committee discusses this last matter further in Chapter 7 and the needs of disadvantaged groups later in this chapter. The difficulty posed by community attitudes to drug-dependent people is dealt with in Chapter 3.

Funding

4.32 The former committee pointed out in its discussion paper that, despite increased expenditure in recent years, adequacy of funding for drug-related health services remained an issue throughout Australia. The current committee was also told of underfunded services, for example, by Dr Wodak.[36] This is true not only of public institutions but of the non-government sector too. Professor Roche stated that 'Charitable organisations and the non-government sector, which Australia relies on tremendously for the provision of services and support in these areas, are traditionally underfunded'.[37]

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33 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 51. Prisoners are another relatively disadvantaged group as far as access to treatment is concerned, as discussed in Chapter 7.

34 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, pp 60-61.

35 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 52.

36 Wodak A, transcript, 16/8/02, pp 1246, 1254.

37 Roche A, transcript, 15/8/02, p 1116.

4.33 Funding inadequacies are reflected in lengthy waits and waiting lists for treatment, and pressure on resources can also affect the quality of service delivery. As the former committee reported, 'agencies feel they cannot afford, for example, to hire extra staff, diversify program offerings, evaluate services, or send staff off for training to upgrade their skills'.[38] Furthermore, as Professor Roche pointed out, under-resourced services employ the staff they can afford and often these are not the most well-qualified.[39]

4.34 Another area where the impact of inadequate funding on quality of treatment was very apparent to both the former and current committees was the way in which methadone treatment for heroin addiction is often managed. Both committees gained the impression that, once stabilised on methadone, some patients 'may not be getting the sort of help they need' in terms of counselling and education.[40] They appear to have been 'parked' in a situation without other options when, in fact, they would like or benefit from assistance to leave both heroin and methadone completely behind them. This issue is discussed further in Chapter 7.

Conclusion

4.35 The committee:

- believes that additional funds must be made available for alcohol and other drug treatment services. This may be achieved through the reallocation of existing resources;
- is convinced that only with adequate funding can enough facilities with the most qualified staff be secured to meet the treatment needs of drug-dependent people; and
- believes that increased funding is needed for ongoing medical, psychological and community support.

4.36 Later in this chapter, the committee identifies four groups of Australians whose particular needs are not always well-met by existing services: young people, Indigenous Australians, those living in remote and regional areas, and people who abuse substances and suffer mental ill-health. In the committee's view, support services for these groups require special attention, particularly those who are substance abusers and mentally ill.

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38 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 53.

39 Roche A, transcript, 15/8/02, p 1116.

40 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, pp 53-54.

Recommendation 21

4.37 **The committee recommends that the Commonwealth government, in consultation with State and Territory governments:**

- **provide additional funding for alcohol and other drug treatment so that the shortfall in services is eliminated and adequate numbers of appropriately qualified staff are employed to work in these services, with the ultimate objective being to obtain a drug free status for the client; and**
- **pay particular attention to the needs of people who abuse substances and suffer mental ill-health, including those in prison.**

Recommendation 22

4.38 **The committee recommends that the Commonwealth, State and Territory governments give priority to funding the ongoing medical, psychological and community support systems required for those users who have undertaken detoxification in order to provide the optimal chance of successful transition to an alcohol or a drug free state.**

4.39 The quality of treatment that non-government service providers are able to provide is impacted on by the insecurity of their funding over the long term. At intervals they must apply for further funding which is a very time-consuming process. The former committee reported:

> … Many NGOs complained of onerous grant application processes and the frustration of getting up good programs only to have these de-funded several years later. The National Aboriginal Community Controlled Health Organisation … argued that these processes appear to reward the quality of grant applications, rather than the relative merit of proposals. Some witnesses acknowledged that the competitive nature of submission-driven funding processes was divisive and meant that the NGO sector was not working as cohesively as it might.[41]

41 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 54.

Some of these same points were made to the current committee, for example by DrugBeat of South Australia.[42]

4.40 The Commonwealth government has introduced greater continuity into the funding of these NGOs and of the more than $65 million allocated to the NGO Treatment Grants Program in 2002-03, more than $46 million will be allocated to currently funded organisations, the balance being set aside for new treatment services that will fill gaps in service provision.[43]

4.41 The committee welcomes this initiative to provide greater security to NGOs which are demonstrating effective programs targeted at eventual cessation of substance abuse, rather than mere maintenance programs such as methadone parking.

Workforce recruitment and development

4.42 According to Professor Roche, there is a shortage of skilled workers in the alcohol and drug field. Many of the approximately 8,000 staff who work in about 550 specialist treatment services round Australia have minimum qualifications. In this respect:

> We know Australia lags very much behind North America – Canada and the United States. You are not required to have any kind of formal qualifications to work in this area; there is no formal accreditation system as there is for, say, counsellors in the addictions area in the United States … We have invested relatively little in providing training at the undergraduate and postgraduate level. Although Australia has made great strides forward in the last decade, we still lag substantially behind in the provision of professional training and upskilling in this area …[44]

4.43 The committee was told about steps that should be taken to improve the workforce.

- Professor Roche and Outcare suggested a better accreditation system.[45]
- Turning Point Alcohol and Drug Centre recommended 'proper career structures'.[46]

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42 DrugBeat of South Australia, sub 271, p 11.

43 Hon Trish Worth MP, Parliamentary Secretary to the Minister for Health and Ageing, *Allocation of funding under the Non-Government Organisation Treatment Grants Program*, media release, 1/12/02, p 1.

44 Roche A, transcript, 15/8/02, p 1117.

45 Outcare, sub 139, p 4; Roche A, transcript, 15/8/02, p 1117.

46 Turning Point Alcohol and Drug Centre, transcript, 23/11/00, p 502.

- The Catholic Women's League, NCETA and Professor Roche pointed out the need for more and better training that has been shown to be effective.[47]
- Professor Roche called for the provision of training on a nationally coordinated basis. At present each jurisdiction develops its own university and TAFE courses. To improve the training provided we need a better idea of what treatment services exist and what skills they require.[48]

4.44 Professor Roche also suggested that we require a means of transferring new knowledge to existing workers in the field. With the explosion of knowledge:

> … there is a major difficulty in how you translate that knowledge base into practice; how you get it into the hands and the minds of the clinicians and the other required workers in the area ... That translation of research into practice is a major dilemma for us.[49]

In addition, as Professor Roche pointed out, the drug scene is changing very rapidly and services need to change quickly to meet new demands. The increase in polydrug use and the uptake of drug use by ever younger people are two of the areas where new skills and ways of addressing problems are needed.[50]

4.45 Professor Roche pointed out that much is now known about the most effective mix of methods of transferring new knowledge to the workers who need it. Training and education are useful here, but should not stand alone. They should be supplemented by information tools such as internet-based clearing houses and journals that organise, synthesis and critique new information. Supportive workplace structures and policies are also important in encouraging the adoption of new approaches and practices.[51]

4.46 At present, according to Professor Roche, 'we have very little information about our [alcohol and other drugs] services … we know very little about who provides the services that are out there …' Professor Roche reported that NCETA is collecting information on the workforce of specialist alcohol and drug services, the skills requirements of these services and the

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47 Catholic Women's League, sub 75, p 26; National Centre for Education and Training, sub 208, pp 6-7; Roche A, transcript, 15/8/02, p 1117.

48 Roche A, transcript, 15/8/02, p 1117.

49 Roche A, transcript, 15/8/02, p 1117.

50 Roche A, transcript, 15/8/02, pp 1116-1118.

51 National Centre for Education and Training, sub 208, pp 5, 12, 20.

training needed to provide the requisite skills. Such information is needed to underpin systematic planning for workforce development.[52]

4.47 Professor Webster claimed that work in the alcohol and drugs arena is 'of poor status, poorly regarded and not … an area that professional people really want to work in'.[53] According to Professor Roche, the stigma attached to drug users extends to those who treat them.[54] These perceptions of work in the alcohol and drug field are one of the factors that contribute to the shortage of skilled workers in the field.

Conclusion

4.48 The committee agrees that:

- more attention needs to be given to developing the skills of Australia's alcohol and other drug workers through a variety of approaches that have been shown to be effective;
- there is a need to match the skills training provided to the requirements of the jobs in which workers are employed; and
- senior professionals have a responsibility to pass on their expertise with service training and acquaint themselves with the current standards and training of alcohol and other drug services which report to them.

Recommendation 23

4.49 **The committee recommends that the Commonwealth, State and Territory governments work with the alcohol and drugs sector, to improve the training available to workers in that sector by:**

- **supporting the development of a nationally agreed curriculum and accreditation system;**
- **providing adequate training opportunities to supply sufficient qualified staff, including ongoing access to new information and the implications of this new information for practice;**
- **sponsoring work on best practice in educating and training alcohol and drug workers; and**
- **encouraging senior professionals to inform themselves of the**

52 Roche A, transcript, 15/8/02, p 1117; Roche A, informal communication, 22/1/03.

53 Webster I, transcript, 15/8/02, p 1113.

54 Roche A, transcript, 15/8/02, p 1116.

needs of other drug and alcohol service providers and fully participate in that education and training.

Integration and coordination

Integration and coordination in the health care system

4.50 Links between different parts of the health care system are often needed to treat the complex problems that alcohol and drug addiction present. NCETA claimed that these complex problems need comprehensive, multi-sectoral responses.[55] Yet the previous committee reported hearing 'much about the "siloed" structure of government services and … lack of coordination …'[56]

4.51 The current committee learnt that there is often a failure to link the different phases of treatment that are needed to help addicts to manage their substance abuse and recover from it. Professor Mattick commented that 'Detox tends to be a bit stand alone … A better linkage would certainly be a very sensible thing, and that does not happen particularly well at the moment'.[57] After detoxification, drug-dependent patients must be supported by ongoing medical help as well as an enormous amount of psychological help, and this is often missing. Dr Currie from Westmead Hospital, Dr O'Neil in Perth and Mr Colquhoun of R&D Counselling and Therapy Group told the committee informally about the superior outcomes obtained in treating opioid dependent people using extensive counselling and family support.

4.52 In addition, as recovering addicts develop or re-establish the skills for living a more mainstream lifestyle, they often need assistance with training, employment and housing. To provide this requires linkages between health agencies and other government services and these too are often missing.

4.53 The lack of integration and coordination is also reflected in the multiplicity of services. As the Aboriginal Alcohol and Drug Council (SA) pointed out, some of these services duplicate one another and waste resources that could be better used.[58] Some governments, such as those in New South Wales and Western Australia, have attempted to better integrate the delivery of services by establishing offices with

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55 National Centre for Education and Training in Addiction, sub 208, p 11.

56 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 56.

57 Mattick R, transcript, 15/8/02, p 1106.

58 Aboriginal Alcohol and Drug Council (SA), transcript, 21/11/00, p 319.

responsibilities for coordination.[59] Another problem where service silos disadvantage patients is in the treatment of those with coexisting substance abuse and mental ill health.

Conclusion

4.54 The committee is concerned about reports of duplicated and uncoordinated services. It believes that better coordination and integration of services is critical in delivering improved health and other outcomes for drug-dependent people and in stretching scarce resources further. The committee is encouraged to hear of steps being taken to improve coordination and urges all parties that provide services to extend these efforts.

4.55 The committee acknowledges that support services including rehabilitation and detoxification are provided to those afflicted by illicit drugs by all levels of government and many NGOs. As a result of this good intention, considerable duplication has occurred, meaning valuable resources are diverted into administration and away from service delivery. The committee believes that more focussed allocation of resources to specialist services would result in more tangible outcomes.

4.56 In the committee's view, it is also critically important to improve the links between services provided by different parts of the health care sector and to provide adequate support to recovering addicts, both psychological and practical. On hearing and viewing evidence of the benefits of linked programs that are inclusive of family support, treatment options and post-treatment support services, the committee advocates urgent action to ensure linked services are available that can empower users to make a successful transition to non-user status. The committee has already recommended increased funding for adequate support in Recommendation 22 above. If a patient cannot move smoothly through the process of treatment, with ongoing help including with housing, training and employment if this is needed, his chances of recovery are considerably lessened.

Recommendation 24

4.57 **The committee recommends that the Commonwealth, State and Territory governments, working with the non-government sector, give priority to coordinating and integrating the many professionals and**

59 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 57.

agencies that serve substance-dependence people.

Attention should be given to:

- **improved links between different parts of the health care sector and between the health care sector and social service agencies such as those dealing with housing, training and education; and**
- **the funding for medical, psychological and community support services as recommended in Recommendation 22.**

Integration and coordination in disciplines and research

4.58 NCETA commented that:

> Not only are our administrative and functional responses to AOD [Alcohol and Other Drugs] issues constrained by 'silo-like' structures, so too are the knowledge and scientific bases which underpin these responses also contained within silos – albeit, discipline silos. Hence, it is not only integration of services that is often sought but also a better integration of knowledge domains … a shared knowledge and skill base is more pertinent here than perhaps in many other areas. A comprehensive understanding of these phenomena requires high level integration and synthesis.[60]

4.59 A similar point was made to the committee by Professor Patton in relation to the development of policy and programs that target drug use by young people.

> We need to be doing our research differently, for a start. We have tended to start with developing policies within silos, with doing our research within silos … if we can begin to do our research and our development of program work differently, with common objectives and common goals, then we can move to some common policies around this. And, moving to common policies across departments, we will then be moving to a situation where we are able to develop the infrastructure we need for doing prevention well.[61]

Conclusion

4.60 In view of the points raised in the last two paragraphs, it is clear to the committee that the better integration of services recommended above

60 National Centre for Education and Training in Addiction, sub 208, p 11.

61 Patton G, transcript, 15/8/02, pp 1097-1098.

must also be supported by similar efforts in the training and research that underpin the health services. The committee therefore recommends accordingly.

Recommendation 25

4.61 **The committee recommends that the Commonwealth, State and Territory governments, working with assistance from the non-government sector, in the training and research that underpin the health services, also ensure the integration of:**

- **knowledge from different disciplines to better train drug and alcohol workers so they can deliver the best possible services; and**
- **research efforts which will advise the development of new, more integrated policies and programs.**

Needs of special groups

4.62 As indicated earlier in this chapter, there are a number of Australians who have particular needs that are not always well-met by existing services. Drug addicts who are also mentally ill need treatment for both disorders and many services are not adequately equipped to do this. The conventional approach to dealing with drug addicts also fails to meet the needs of young people, many Indigenous people, and some groups of non-English-speaking Australians. In remote and regional Australia, with its small population, it is impossible to provide the full panoply of services that is required to deal with the range of drug-related problems that arise, and other means of delivering these services must be found. The challenge is to provide equitable access to services for all these groups.

Coexisting substance abuse and mental illness (comorbidity)

4.63 ADCA reported that an estimated 20 per cent of people with mental disorders also engage in harmful drug use, and three-quarters of all clients to alcohol and other drug services are mentally ill. Yet there are, according to ADCA, too few adequately trained workers to cope with complex multi problem cases.[62] As Gomes et al pointed out, services set up originally to treat one or the other condition have tended to pay inadequate attention to

62 Alcohol and other Drugs Council of Australia, sub 221, pp 7-8.

the coexisting condition.[63] As discussed in Chapter 8, prisons are another area where there are shortfalls in the provision of services for people suffering from both conditions. While there is growing recognition of the extent to which substance abuse and mental disorder occur together, there is still scope for improvement in the services provided to those suffering from comorbidity.

4.64 The National Comorbidity Project, funded by the Commonwealth Department of Health and Ageing, is developing a comprehensive evidence base to better inform those working in the field. It comprises the following resources:

- a monograph that reviews national and international evidence about comorbidity, including treatment and service provision ;
- a updated monograph on diagnostic screening; and
- scoping studies of:
  - ⇒ comorbidity in general practice and primary health care (which recommended research to establish what interventions work and 'are practically possible in the swamp of clinical reality …'[64]); and
  - ⇒ specialist treatment services for comorbid patients which describe the different characteristics of treatment services and help to identify best practice.[65]

4.65 While welcoming the National Comorbidity Project, ADCA called for 'a more concerted, strategic and adequately funded approach …' to comorbidity.[66]

4.66 In the 2003-04 federal budget the government provided $4.4 million over two years for the National Comorbidity Initiative.[67]

Conclusion

4.67 The committee:

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63 Gomes A, Robinos S & Pennebaker DF, 'Co-occurring mental illness and substance abuse: Poor service preparedness a significant issue', *Conference Papers Collection*, CD-ROM, 2nd Australasian Conference on Drugs Strategy, Perth, 7-9 May 2002, powerpoint presentation, slide 16.

64 McCabe D & Holmwood C, *Comorbidity in general practice: The provision of care for people with coexisting mental health problems and substance use by general practitioners*, Primary Mental Health Care Australian Resource Centre, Department of General Practice, Flinders University, Adelaide, revised July 2002, p 8, viewed 9/1/03, <http://som.flinders.edu.au/FUSA/PARC/comorbidityreportrevised2002.pdf>.

65 Commonwealth Department of Health and Ageing, sub 238, p 34.

66 Alcohol and other Drugs Council of Australia, sub 221, p 8.

67 *Budget measures 2003-04*, p 175.

- is pleased that the Commonwealth government is addressing the pressing issue of comorbidity, and agrees that it should be more vigorously pursued;
- is concerned at the lack of research available on the linkage between mental health, drug abuse and suicide; and
- expresses concern at the lack of support for parents and families coping with mental health, drug abuse and suicide.

Recommendation 26

4.68 **The committee recommends that the Commonwealth government, in consultation with State and Territory governments and all non-government stakeholders:**

- **evaluate the outcomes to date of the National Comorbidity Project;**
- **investigate the linkages between mental health, drug abuse and suicide; and**
- **identify from these outcomes and other sources what further steps must be taken to improve the treatment of and provision of services to people suffering from co-occurring mental ill health and substance abuse and their families and ensure their implementation.**

Indigenous Australians

4.69 Between 1997 and 2000, the former committee carried out an inquiry into indigenous health and recommended in relation to substance abuse that:

> The [then] Commonwealth Department of Health and Aged Care ensure that Commonwealth, state and territory substance misuse programs incorporate:
>
> - early and opportunistic intervention programs by health professionals;
> - diversionary and sobering-up shelters, including night patrols;
> - detoxification programs; and

- rehabilitation programs, including residential and family rehabilitation, and follow up after care programs.[68]

4.70 The Commonwealth government was able to accept this recommendation in principle only as it could not ensure the content of state and territory programs. However, it demonstrated in its response to the report, that it was addressing each element listed above.[69] Funding is provided annually to the Commonwealth Office of Aboriginal and Torres Strait Islander Health for the National Aboriginal and Torres Strait Islander Substance Misuse Program; in 2001-02, it amounted to $18.8 million.[70] An additional initiative, announced in May 2002, targeted $1 million at controlling tobacco use by Indigenous people.[71]

4.71 In addition, since 1999 the National Drug Strategy Reference Group for Aboriginal and Torres Strait Islanders has advised the Commonwealth government on Indigenous issues, and in 2001 the National Indigenous Substance Misuse Council was formed as the peak body for Indigenous Community Controlled Substance Misuse Services. The National Aboriginal Community Controlled Health Organisation, which is the peak body for community controlled primary health care services, also has a substantial interest in substance misuse. These three national bodies create a greater focus on Indigenous substance abuse than in the past. For example, according to the Commonwealth Department of Health and Ageing, the Reference Group has contributed to the development of an Indigenous drug strategy to complement the NDS.[72]

4.72 The Commonwealth Department of Health and Ageing is concerned that the health of Aboriginal and Torres Strait Islander people is significantly worse than that of the rest of the Australian population. The department also drew attention to the harmful effects of high tobacco use and excessive alcohol consumption among Indigenous drinkers.[73] An ANCD report on Cape York pointed out that, while Indigenous use of illicit drugs generally has been low, it appears now to be increasing.[74] Volatile

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68 House of Representatives Standing Committee on Family and Community Affairs, *Health is life: Report on the inquiry into Indigenous health*, FCA, Canberra, May 2000, p 92.

69 *Government response to the House of Representatives Inquiry into Indigenous Health – 'Health is Life'*, pp 29-30, March 2001, tabled 22/5/01.

70 Commonwealth Department of Health and Ageing, sub 292, p 5.

71 Senator the Hon Kay Patterson, *New package to tackle tobacco use in indigenous communities*, media release, 31/5/02, p 1.

72 Commonwealth Department of Health and Ageing, sub 238, p 11.

73 Commonwealth Department of Health and Aged Care, sub 238, p 10.

74 Australian National Council on Drugs, *ANCD Report: Cape York Indigenous issues*, 2002, p 4, viewed 23/12/02, <http://www.ancd.org.au/publications/pdf/cape_york_report.pdf>; Illicit Drugs Taskforce, *Illicit Drugs Taskforce Report 2002*, Northern Territory Department of Health and Community Services, pp 28, 52, viewed 23/12/02,

substance misuse by Indigenous young people in remote communities is also causing great concern.

4.73 Edwards et al reported that some Indigenous drug addicts have successfully used mainstream treatment and rehabilitation services, preferring them to their own community's services because of the shame they would feel when using the latter.

> … They think that everyone will know their business, or will think they or their whole family are bad people …
>
> [However] Other community members say that mainstream de-tox and rehab programs have not been much help to them, because the service is not very 'Aboriginal friendly'. They say the way mainstream services work does not fit in with Aboriginal lifestyle and culture. They say mainstream workers do not really understand how it is for Aboriginal people, even though some try.[75]

4.74 Professor Webster made a similar point when he commented to the committee, that Indigenous people have their own way of thinking about alcohol and drug problems which means that, even where they have access to mainstream services, they tend not to use them. In these cases, Indigenous people are best helped to address their problems in a culturally appropriate way by working through their own organisations.[76]

4.75 It is clear from the number of alcohol and drug projects that Indigenous people have initiated that this is something that they want to do. Gray et al pointed out that Indigenous people can be helped in this by being empowered 'to define the "problem" or "problems" and to determine appropriate solutions'.[77] This issue was also the subject of recommendations by others. Several organisations, both Indigenous and non-Indigenous, called for the creation of new and the maintenance of existing culturally specific programs for Indigenous citizens.[78]

<http://www.nt.gov.au/health/healthdev/aodp/illicit_drugs/Illicit_Drugs_Report_B.pdf>; Wilson S, Aboriginal Drug and Alcohol Council (SA), media release, 22/6/02, p 1.

75 Edwards G, Frances D & Lehmann TC, *Community report: Injecting drug use project*, Victorian Aboriginal Health Service Co-operative Ltd, Fitzroy Victoria, 1998, p 31.

76 Webster I, transcript, 15/8/02, p 1132.

77 Gray D, Sputore B, Stearne A, Bourbon D & Strempel P, *Indigenous drug and alcohol projects 1999-2000*, ANCD research paper 4, Australian National Council on Drugs, Canberra, 2002, p 44.

78 DRUG-ARM, sub 199, p 15; NACCHO, sub 122, p 2.

4.76 The committee:

- recognises that Indigenous-controlled organisations are better placed than mainstream services in some localities to maximise the reach of alcohol and drug programs; and
- believes that support for these organisations must be continued and expanded where needed.

Recommendation 27

4.77 **The committee recommends that Commonwealth, State and Territory governments continue to support and expand substance misuse programs that assist Indigenous planning processes to best achieve their objectives in delivering acceptable forms of treatment.**

4.78 As part of its undertaking to map all the drug and alcohol services available across Australia, the ANCD commissioned a national stocktake of the Indigenous alcohol and drug projects in operation in 1999-2000. It identified 277 such projects, 81.6 per cent of which were conducted by 177 Indigenous community-controlled organisations. The projects were both residential and non-residential and delivered:

- prevention through health promotion, community development and sporting and recreational activities;
- acute intervention by night patrols and the use of sobering up shelters; and
- other services such as support, referral, and program, staff and resource development.

4.79 In 1999-2000 $35.4 million was spent on these projects. Of this funding, all but $129,000 was provided by the Commonwealth, state, territory or local governments.[79]

4.80 The stocktake's authors, Gray and his colleagues, came to some important conclusions and indicated areas where future action might be focused. First, they pointed out that there is at present 'no comprehensive database

79 Gray D, Sputore B, Stearne A, Bourbon D & Strempel P, pp vii, 36-37. In 2001-02 the Commonwealth government contributed through the Office for Aboriginal and Torres Strait Islander Health's Aboriginal and Torres Strait Islander Substance Misuse Program to the operation of 65 community-controlled health organisations, of which 45 were devoted solely to substance abuse (Commonwealth Department of Health and Ageing, sub 238, p 36).

that would facilitate the identification and comparison of needs at regional levels' and help governments allocate resources to where they are most needed.[80]

4.81 Secondly, they drew attention to the considerable variation between regions and between states and territories in per capita expenditure. Per capita expenditure was highest in South Australia, followed by Victoria, Western Australia and the Northern Territory.[81] The stocktake's authors warned, however, that:

> … This information alone is not a sufficient basis upon which to recommend that additional funding, if it were to become available, be directed to [those regions with lower per capita expenditure]. It does, however, warrant further investigation into whether people in those regions are adequately serviced.[82]

4.82 Thirdly, Gray et al, while cautioning against the danger of dispersing funds too widely, suggested that an analysis of the data indicated where infusions of new funding were most needed. Some of the areas that require new funding were training for Indigenous workers and measures to address the increasing use of illicit drugs particularly in urban areas.[83] Submissions to the inquiry from DRUG-ARM and Wu Chopperen Medical Service also underlined the need for training for those working with Indigenous people.[84]

4.83 In the committee's view, the stocktake has usefully drawn attention to areas where work is required. It is important to know what alcohol and other drug services are needed by Indigenous people across Australia and whether adequate funding is available to provide those services.

Recommendation 28

4.84 **The committee recommends that the Commonwealth government, State and Territory governments and Indigenous organisations work together to:**

- **collect information on Indigenous needs for alcohol and other**

80 Gray D, Sputore B, Stearne A, Bourbon D & Strempel P, p 43.

81 Gray D, Sputore B, Stearne A, Bourbon D & Strempel P, p viii.

82 Gray D, Sputore B, Stearne A, Bourbon D & Strempel P, p 43.

83 Gray D, Sputore B, Stearne A, Bourbon D & Strempel P, p 44. A useful adjunct to training will be the information on best practice in Indigenous alcohol and drug programs that is to be assembled in the next phase of the Australian National Council on Drugs stocktake (p 1).

84 DRUG-ARM, sub 199, p 15; Wu Chopperen Medical Service, Cairns, sub 189, p 4.

drug services and how well those needs are currently being met;

- **direct existing resources to regions of greatest need and provide additional funding where required; and**
- **identify and, in the light of emerging trends, respond to new needs by ensuring access to appropriate programs.**

4.85 The committee also believes that the particular deficits identified by the stocktake should be addressed immediately. Accordingly the committee considers that attention be paid to Indigenous training needs and measures to combat the previously identified problem with increasing illicit drug use.

Recommendation 29

4.86 **The committee recommends that the Commonwealth, State and Territory governments institute programs to:**

- **combat increasing illicit drug use by Indigenous people; and**
- **provide improved training to Indigenous drug and alcohol workers.**

4.87 As with all Australians, it is important to look at the wider context within which substance abuse occurs and to address problem elements in the wider environment as well as the problems due specifically to substance abuse. Only in that way will prevention, treatment and rehabilitation be given the best chance of succeeding. The South Australian Drug Summit, for example, recommended that that state's government should pursue community development, housing and the employment of Aboriginal people in leadership positions in government organisations relevant to matters of substance abuse.[85] A previous and unrelated study of alcohol-related problems in Cape York recommended an integrated and coordinated approach: in such an approach demand reduction programs targeted at individuals, families and communities should be supported by wider structural support from government, for example, through

85 South Australian government, sub 279, attachment, *Communique*, South Australian Drugs Summit 2002, Adelaide, 24-28 June 2002, p 8.

legislation that limits alcohol supply.[86] Gray et al pointed out that 'Alcohol and other drug-specific interventions must go hand-in-hand with broader strategies to address Indigenous inequality …'[87] This issue has been addressed in the committee's Recommendation 24 above.

Australian Youth

4.88 ADCA claimed that 'The misuse of drugs is the sixth largest killer of young people, …'[88] However, according to both ADCA and Brisbane's Youth Substance Abuse Service, few services exist that are specifically designed to meet their needs.[89] Furthermore, as Professor Roche pointed out, many services exclude people under 18 years of age.[90] Professor Patton stated that:

> … the way in which we configure our health services for young people does not and has not worked … we need to be smarter in the way in which we make our services more accessible. Part of that is about the training of health professionals in responding appropriately to this age group. Part of it is also about looking at the way in which our services are structured and at how the younger group get to treatment, because they are not utilising the services as they currently are.[91]

4.89 This is a particularly important issue because, according to Professor Roche, people are starting to abuse drugs at younger and younger ages. Having had less opportunity to develop life skills than those who become drug dependent at older ages, young people need not only treatment for their drug habit but also substantial help in other aspects of their lives.[92] This last point has already been addressed in Recommendation 24; the

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86 *Advanced Copy: Cape York Justice Study Report: summary of brief in volume 2*, November 2001, p 18, viewed 15/1/03, <http://www.premiers.qld.gov.au/about/community/pdf/capeyork/summary.pdf>.

87 Gray D, Sputore B, Stearne A, Bourbon D & Strempel P, p 12.

88 Alcohol and other Drugs Council of Australia, sub 221, p 8. NB Australian Institute of Health and Welfare, Australia's health 2002: The eighth biennial health reports of the AIHW, AIHW, Canberra, May 2002, p 187 stated: In year 2000 drugs were responsible for 108 deaths of young people (83 males and 25 females). These accounted for 6 per cent of all deaths of young people aged 12-24 years. The rate of death related to drug dependence for young males in year 2000 was over three times that for young females.

89 Alcohol and other Drugs Council of Australia, sub 221, p 8; Youth Substance Abuse Service, sub 102, p 7.

90 Roche A, transcript, 15/8/02, p 1118.

91 Patton G, transcript, 15/8/02, p 1098. The same point was made by Ms Annie Madden about young Asian drug users' use of mainstream services (Madden A, transcript, 15/8/02, p 1134).

92 Roche A, transcript, 15/8/02, pp 1117-1118.

committee deals with the other points raised in this section as follows. The issue of compelling young people into treatment is covered in Chapter 8.

Recommendation 30

4.90 **The committee recommends that the Commonwealth government work with State and Territory governments and non-government organisations to:**

- **identify the best structures and practices to engage and retain young drug users in treatment;**
- **ensure that trained skilled health professionals are available to deal with young people who are substance-dependent; and**
- **ensure adequate support services are available to families and that families are getting the skills required as well as to cope with young people who are substance-dependent.**

Remote and regional Australia

4.91 Data from the NDS Household Survey showed that more people in regional areas reported smoking in 2001 than in urban areas (25.0 per cent and 22.5 per cent respectively). The reported use of alcohol, however, was similar in regional and urban areas (82.6 per cent and 82.5 per cent respectively), although there were more drinkers at risk or high risk in country areas (11.3 per cent compared with 9.3 per cent).[93] In addition, according to Gray and Chrikritzhs, alcohol use is substantially higher in the Northern Territory than in Australia as a whole.[94] The NDS Household Survey showed cannabis use in regional Australia approximated that in the city, but the use of other illicit drugs was less.[95] However, Graycar reported that illicit drug use is increasing in regional Australia.[96] In view of this situation, the shortfall of detoxification and rehabilitation places in regional Australia is particularly worrying.

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93 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: Detailed findings*, Drug statistics series no 11, AIHW, Canberra, December 2002, p 110.

94 Gray D & Chikritzhs T, 'Regional variation in alcohol consumption in the Northern Territory', *Australian and New Zealand Journal of Public Health*, vol 24, February 2000, p 35.

95 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: Detailed findings*, p 110.

96 Graycar A, quoted in the introduction to Williams P, 'Illicit drug use in regional Australia, 1988-1998', *Trends and issues in criminal justice*, Australian Institute of Criminology, no 192, February 2001, p 1, viewed 18/3/03, <http://www.aic.gov.au/publications/tandi/ti192.pdf>.

4.92 In 2000 the ANCD hosted consultations on addressing alcohol and drug use in rural and regional centres around Australia. The ANCD national report on rural and regional alcohol and other drugs consultation forum, reported the following conclusions and recommendations.

- It is important to recognise that rural and regional areas require their own strategies. It is not feasible to simply apply urban-based strategies to the rural and regional setting.
- With innovation, creativity and cooperation, good services can be delivered in rural and regional areas even though economic constraints preclude the provision of a full suite of services. Innovative approaches must be supported.
- With greater local government involvement, local issues are more effectively addressed and local drug action teams are more effective.
- Lack of transportation and housing are two specific factors which diminish the chances of successful treatment.
- The cost of providing services in rural and regional settings is more expensive than in urban areas, and funding bodies should recognise this. [97]

4.93 This latter dot point was also made by Gray et al in relation to Indigenous services: 'The more remote a location, the higher the cost of providing services'.[98]

4.94 The ANCD is pursuing improved funding for rural and regional services as a matter of high priority.[99] In the 2003-04 federal budget the government provided $4 million over four years to improve access to treatment and referral for illicit drug users in regional Australia.[100]

Conclusion

4.95 The committee believes that the shortfall in detoxification and rehabilitation places in rural and regional areas should be addressed as a matter of high priority. Furthermore, the matters outlined above should be pursued further with a view to identifying and disseminating information about best practice, and then making adequate funding available for its implementation.

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97 Australian National Council on Drugs, *Rural and regional alcohol and other drugs consultation forums*, pp 10-12.

98 Gray D, Sputore B, Stearne A, Bourbon D & Strempel P, p 43.

99 Australian National Council on Drugs, informal communication, 23/4/03.

100 *Budget measures 2003-04*, p 176.

Recommendation 31

4.96 **The committee recommends that the Commonwealth, State and Territory governments, in consultation with non-government organisations:**

- **ensure the needs for regional detoxification, treatment and rehabilitation facilities are met;**
- **assemble information on best practice options for providing alcohol and other drug services in remote and rural areas, and disseminate that information widely; and**
- **provide additional funding where needed to implement best practice.**

Management - Planning and evaluation

4.97 One of the issues raised earlier in this chapter is the lack of integration and coordination between different programs addressing substance abuse. This topic also is the subject of Recommendation 24. An additional concern in the planning of services is appropriately targeting them to those groups in the community that need them most. On this point the former committee commented, 'Where resources are not infinite, it is obviously critical to ensure these are dedicated in the most cost-effective ways and directed to areas of greatest need'.[101]

4.98 Evaluation is a useful tool in assessing the success of programs and indicating where fine tuning is required. The 1997 evaluation of the NDS recommended a significant increase in systematic evaluation of prevention and treatment programs and this is now happening.[102]

4.99 Among the elements that could drive planning processes and contribute to evaluations of service delivery are targets and performance indicators for alcohol and drug-related services. Yet, as the former committee noted, there is a dearth of them. The former committee explained that:

> Current national drug strategic planning processes are broadly consultative and provide for national leadership while allowing

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101 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 58.

102 The most recent submission to the inquiry from the Commonwealth Department of Health and Ageing (sub 238) refers to numerous evaluations of ongoing prevention programs and to the National Evaluation of Pharmacotherapies for Opioid Dependence.

> flexibility for States and Territories to ensure that plans developed to address drug problems are responsive to the needs and priorities of particular jurisdictions. National strategies and action plans do not provide, therefore, the specificity about outputs and performance indicators which is necessary to evaluate the effectiveness of national harm minimisation efforts …[103]

4.100 A number of key non-government agencies recommended to the former committee that governments should 'be more specific in their goal-setting – in short, set some hard targets'.[104] This call was repeated to the current committee by Professor Webster:

> … there should be targets put in place. In health care agreements you could put in expectations of performance and achievements that you would mark. For example, you could include the access of people with drug and alcohol problems to an appropriate level of services or you could ensure that a public hospital provided appropriate detoxification facilities. You could examine the extent to which … the proper standards of professional practice are incorporated into the work force …[105]

4.101 The committee is pleased that evaluations of drug-related programs are more routinely carried out now than they used to be. It believes, however, that evaluation and planning processes would be sharpened if more use was made of specific targets for each program. Performance against targets could also contribute to accountability arrangements for drug-related health programs.

Recommendation 32

4.102 **The committee recommends that the Commonwealth, State and Territory governments, in consultation with the non-government sector:**

- **establish targets for all drug-related health programs against which their outcomes can be judged;**
- **use this information to evaluate existing programs and plan new ones; and**

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103 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, pp 57-58.

104 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 58.

105 Webster I, transcript, 15/8/02, p 1129.

- **report annually to their parliaments on their performance against targets for each program.**

Information on service provision

4.103 The former committee commented on its disappointment that there was no available source of 'easily-accessible, coherent, basic information which could have supported deliberations on this Inquiry'. It reported that it had 'sought, for example, a comprehensive list of treatment service providers from the Commonwealth, only to discover that such a thing did not exist'. It commented too on its concern that there was also no consolidated national database to support workforce planning and that it was not possible 'to get a firm handle on national expenditure in the AOD arena'.[106] The committee has covered the issue of the list of treatment service providers project commissioned by the ANCD in Chapter 3.107 and has recommended accordingly.

Expenditure reporting

4.104 Commonwealth expenditure on substance abuse that is directly allocated for use, as in the case of Non-Government Organisation Treatment Grants, is more readily monitored than Commonwealth funding provided to state and territory governments. Commonwealth funds for the NDS are supplied to the states and territories under broadbanded bilateral Public Health Outcome Funding Agreements (PHOFA), along with the funds for eight other public health categories.[107] The PHOFAs are outcomes-based agreements, focusing on the achievement of agreed outcomes, and do not tie the states and territories to specific activities or matching of funding. The states and territories report on their performance against indicators on an annual basis.[108]

4.105 According to the most recent annual report on expenditure under the PHOFAs, the Commonwealth government spent $21.9 million to prevent hazardous and harmful drug use in 1999-2000, principally on:

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106 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 59.

107 Australian Institute of Health and Welfare, *National public health expenditure report 1999-00*, Health and expenditure series no 16, AIHW, Canberra, 2002, p xiii; Commonwealth Department of Health and Ageing, sub 238, p 31.

108 Commonwealth Department of Health and Ageing, 'Public Health Outcome Funding Agreements', pp 3-4, viewed 16/1/02, <http://www.health.gov.au/publhlth/about/phofa/phofa.htm>.

- preventing alcohol abuse ($5.2 million), mostly spent on the National Alcohol Strategy;
- addressing tobacco smoking ($3.4 million), almost totally focused on the National Tobacco Campaign; and
- preventing illicit drug use ($13.2), with the main items of expenditure being the Community Partnerships Initiative ($1.7 million), grants to non-government treatment organisations ($5 million) and the National Illicit Drugs Campaign ($3.2 million).[109]

4.106 The 1999-2000 annual report also indicated that state and territory expenditure of Commonwealth funds on prevention in 1999-2000 varied considerably from jurisdiction to jurisdiction. It is, however, difficult to make direct comparisons between jurisdictions as their financial reporting systems differ somewhat, as do their methods of recording comparable activities. The extent of the services provided in each jurisdiction is also affected by such factors as its population demographics and how far each, given its size, can pursue economies of scale. Notwithstanding the difficulty of making comparisons, some broad conclusions can be drawn: on the basis of a per person index, Victoria and New South Wales can be seen to have spent well below the average while Queensland spent more than the average.[110]

4.107 The PHOFA reporting system has been established only recently but will, with further refinement, allow the cost effectiveness and / or cost efficiency of public health interventions to be analysed.[111] In addition, the PHOFA report covers only part of the funds expended on drug-related harm. Information about funding for treatment and research would have to be sought from other, scattered sources. ADCA and Odyssey House claimed that it would be useful to have a consolidated report on all expenditure which would provide details of the amount of money spent on all alcohol and other drug programs and on the outcomes generated by this expenditure.[112] However, the committee was told by the Commonwealth

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109 Australian Institute of Health and Welfare, *National public health expenditure report 1999-00*, pp 19-20.

110 Australian Institute of Health and Welfare, *National public health expenditure report 1999-00*, pp 102-104. The index is (per person expenditure for the PHOFA category, prevention of hazardous and harmful drug use, in a particular state or territory) ÷ (per person expenditure for the PHOFA category, prevention of hazardous and harmful drug use, in all states and territories) x 100 (p 102).

111 Australian Institute of Health and Welfare, *National public health expenditure report 1999-00*, 2002, p 106.

112 Alcohol and other Drugs Council of Australia, sub 221, p 5; Odyssey House Victoria, sub 155, p 2.

Department of Health and Ageing that it would be time consuming and resource intensive to prepare such a report.[113]

Conclusion

4.108 The committee agrees that:

- despite the cost, the committee would like to see a comprehensive report on the nation's expenditure on health care for drug-related problems for accountability purposes;
- it has particular concerns about the accountability arrangements for research funding in the area of substance abuse. This issue is discussed in Chapter 11; and
- it accepts, however, that the resources needed to collect this information would be considerable and would be better directed to efforts to improve prevention and rehabilitation.

113 For example, in relation to research funds, Commonwealth Department of Health and Ageing, sub 293, p 1.

5

Alcohol misuse: prevention and treatment

Introduction

5.1 This chapter is the first of three that look in some detail at the misuse of specific substances. Chapters 5 and 6 deal with the licit drugs, alcohol and tobacco. Chapter 7 considers the use of drugs that it is illegal to possess, such as cannabis and heroin, and the misuse of otherwise licit substances such as sniffing petrol. With alcohol and tobacco we have two forms of substance abuse, on which much work has been done and for which effective treatment exists. However, we know far less about preventing the use of illicit drugs and have difficulty treating their abuse.

Use of alcohol by Australians

5.2 The 2001 National Drug Strategy (NDS) Household Survey revealed that of nearly 27,000 Australians over 14 years of age who were surveyed, 90.4 per cent had consumed alcohol at some time in their lives, and 82.4 per cent had done so in the previous 12 months. While most drinkers reported drinking weekly or less than weekly, 34.4 per cent of all persons had put themselves at risk of alcohol-related harm in the short term at least once in the previous 12 months, and 9.9 per cent were at risk of long term harm.[1] Risk was defined in terms of the advice provided in the National Health and Medical Research Council's guidelines for levels of

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1 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, Drug statistics series no 11, AIHW, Canberra, May 2002, pp 3-4, 15-16, 18-19.

drinking that 'minimise risks in the short and longer term, and gain any longer-term benefits'.[2]

5.3 Among 14-19 year olds, 73.6 per cent reported having used alcohol in the previous year, with people aged 20-29 years old being the most likely to expose themselves to long term risk of harm. The average age at which Australians first used alcohol was 17.1 years old. The majority of teenage drinkers consumed alcohol weekly or less than weekly (28.3 per cent and 44.9 per cent respectively) and female drinkers were more likely than males to consume at levels likely to expose them to long term risk of harm (14.6 per cent and 8.8 per cent respectively).[3]

Cost of alcohol misuse

5.4 According to the 2001 NDS Household Survey, 12.8 per cent of Australians had driven a motor vehicle in the previous year while under the influence of alcohol, and 4.9 per cent had been physically abused by someone under the influence of alcohol. Encouragingly, there had been a general decline between 1998 and 2001 in the level of potentially harmful activities undertaken by people under the influence of alcohol.[4]

5.5 Nevertheless, the Australian Institute of Health and Welfare reported that alcohol is a significant factor in motor vehicle fatalities and injuries, and is also associated with falls, drowning, burns, suicide and occupational injuries. The burden of harm is highest in the 15-24 age group, mainly due to road trauma.[5] Collins and Lapsley revealed that in 1998-99 alcohol misuse caused 4,286 deaths and in 1998-99 consumed 394,417 hospital beddays.[6]

5.6 As indicated in the introduction to Chapter 4, the National Health and Medical Research Council considers that strong evidence exists for a link between the consumption of alcohol in moderate amounts and reduced

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2 National Health and Medical Research Council, *Australian alcohol guidelines: Health risks and benefits*, NHMRC, Canberra, October 2001, pp 5-6, viewed 6/3/03, <http://www.health.gov.au/nhmrc/publications/pdf/ds9.pdf>.

3 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, pp 5, 16, 18.

4 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, pp 37-39.

5 Australian Institute of Health and Welfare. *Australia's health 2002: The eighth biennial health report of the AIHW*, AIHW, Canberra, May 2002, p 141.

6 Collins DJ & Lapsley HM, *Counting the cost: Estimates of the social costs of drug abuse in Australia in 1998-9*, Monograph series no. 49, Commonwealth Department of Health and Ageing, Canberra, 2002, p 9.

risk of heart disease in people from middle age onwards.[7] While alcohol use contributes to the costs of illness and premature death, it also protects against it. Collins and Lapsley estimated that in 1998-99 alcohol caused 4,286 deaths but prevented over 7,029; 394,417 hospital beddays were attributable to alcohol abuse but alcohol's protective effect avoided the need for 255,443 beddays.[8]

5.7 Collins and Lapsley estimated that health care for alcohol-related problems cost the Australian community $225.0 million in 1998-99. Collins and Lapsley claimed that $90.4 million of this expenditure could have been avoided, had effective anti-drug policies and programs been introduced. These estimates took into account alcohol's protective medical impact.[9]

5.8 Collins and Lapsley also pointed out that alcohol tax revenue in 1998-99 exceeded the total costs borne by governments for alcohol-related expenditures by $1.7 billion. Almost all this surplus accrued to the Commonwealth government.[10]

Response by governments

5.9 The National Alcohol Strategy's 'A Plan for Action 2001 to 2003-04' provides a broad, nationally coordinated approach to reducing alcohol-related harm. The strategy has primary aims:

- to reduce the incidence of premature alcohol-related mortality, and acute and chronic disease and injury;
- to reduce social disorder, family disruption, violence and other crime related to the misuse of alcohol; and
- to reduce the level of economic loss to individuals, communities, industry and Australia as a whole.[11]

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7 National Health and Medical Research Council, *Australian alcohol guidelines: Health risks and benefits*, p 69.

8 Collins DJ & Lapsley HM, p 9.

9 Collins DJ & Lapsley HM, pp x, 60.

10 Collins DJ & Lapsley HM, p 65.

11 *National Alcohol Strategy: A plan for action 2001 to 2003-04*, endorsed by Ministerial Council on Drug Strategy, Commonwealth Department of Health and Ageing, Canberra, July 2001, p 7, viewed 28/1/03, http://www.health.gov.au/pubhlth/nds/resources/publications/alcohol_strategy.pdf>.

It is structured around 11 key areas that comprehensively address the harms caused by alcohol while recognising the social and health benefits of drinking.[12] The action plan's key areas are shown in Box 5.1.

5.10 The strategy, endorsed by the Commonwealth, state and territory governments in 2001, was developed with the National Expert Advisory Committee on Alcohol playing a key role. This committee has a wide ranging membership including the alcohol beverages and hospitality industry, as well as representatives from public health, law enforcement, research, education, government, and community based service provision.[13]

5.11 The strategy lays out the roles and responsibilities of different levels of government. The Commonwealth government provides leadership in relation to policy development, establishing research needs, promoting work best done at the national level, fostering best practice, implementing public education programs, monitoring alcohol use, monitoring and reporting on outcomes, and through Food Standards Australia New Zealand (FSANZ) developing standards and regulations regarding labelling of alcohol products.[14]

5.12 Action by state and territory governments complements Commonwealth activities with respect to policy and program development. They focus on regulating the consumption and availability of alcohol, preventing drink driving, educating and informing the public, providing treatment, training the workforce, and monitoring and reporting on outcomes. Local governments are increasingly responding to local needs, for example, through local alcohol action plans and accords between police and local health authorities.[15]

12 Commonwealth Department of Health and Ageing, sub 238, p 22.

13 *National Alcohol Strategy: A plan for action 2001 to 2003-04,* p 1.

14 *National Alcohol Strategy: A plan for action 2001 to 2003-04,* p 20.

15 *National Alcohol Strategy: A plan for action 2001 to 2003-04,* pp 19-20.

Box 5.1 Key strategy areas and related actions in the National Alcohol Strategy Action Plan

Informing the community through information campaigns; public education on standard drinks labelling and the Australian Drinking Guidelines; community awareness of responsible serving provisions; complaints and appeals processes; awareness in schools, tertiary institutions, work places and the community; and awareness among parents and young people

Protecting those at higher risk, such as Indigenous people, pregnant women, prisoners and offenders, people with mental health disorders, older people and heavy drinkers

Preventing alcohol-related harm in young people by promoting mental health and parenting skills; educating and informing young people; and separating sporting activities and high risk drinking

Improving the effectiveness of legislation and regulatory initiatives in relation to liquor licensing, the availability of alcohol in local communities, numbers and types of licensed premises, further development of legislative frameworks and voluntary codes of practice, and underage drinking

Responsible marketing and provision of alcohol involving alcohol advertising codes, control of marketing strategies, and complaints mechanisms

Pricing and taxation through research and incentives to choose lower strength alcohol products

Promoting safer drinking environments focusing on licensed premises, public events, private homes, workplaces and the aquatic environment

Drink driving and related issues through public education, random breath testing, drink driving research, and a focus on pedestrians, road and automobile safety, and repeat offenders

Intervention by health professionals involving identifying those with alcohol-related problems, ensuring the availability of health care services to manage alcohol dependence, and providing services to remote areas

Workforce development across all sectors dealing with alcohol-related harm

Research and evaluation to develop the evidence base and involving dissemination of results.

Source: *Ministerial Council on Drug Strategy, National Alcohol Strategy: A plan for action 2001 to 2003-04, Commonwealth Department of Health and Aged Care, Canberra, July 2001, p 7, viewed 28/1/03, <http://www.health.gov.au/pubhlth/nds/resources/publications/alcohol_strategy.pd., pp 23-39.*

5.13 A number of activities undertaken recently in relation to some of the strategy's key areas indicate those areas in which the Commonwealth government has been active, as indicated below.

- The National Alcohol Campaign, comprising an initial phase followed by booster phases, is focused on 15-24 year olds and parents of 12-17 year olds. It has cost $9.6 million to date. Performing arts events, in the form of rock eisteddfods and croc festivals, are used to deliver the message to young people, supplementing print and electronic media.[16] A recent initiative is contributing $350,000 in sponsorship to the music industry to deliver messages to young people about choosing whether or not and how much to drink.[17]

- The National Alcohol Research Agenda has established a set of research priorities and principles to assist funding bodies and researchers to direct research at areas of greatest need and potential.[18] The agenda identified three areas as particularly in need of research; they are Indigenous issues, biomedical research, and law enforcement.[19]

- The Alcohol Education and Rehabilitation Foundation has been set up to give grants from funds provided by the Commonwealth government and the private sector to community and other organisations. The foundation's grants support community education, workforce development, and evidence-based treatment, rehabilitation, research and prevention programs in relation to alcohol and other licit drugs. Commonwealth funding is set at $115 million over four years (2001-02 to 2005-06).[20]

- In 2001, the National Health and Medical Research Council issued a revision of the Australian Alcohol Guidelines which provide advice on the consumption of alcohol. The target groups for the guidelines include everybody who drinks alcohol, people doing things that involve risk or a high degree of skill, and people responsible for private and public drinking environments.[21] A range of posters,

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16 Commonwealth Department of Health and Ageing, sub 238, pp 24-25.

17 Hon Trish Worth MP, Parliamentary Secretary to the Minister for Health and Ageing, *Federal government and Australian music industry to help spread responsible drinking messages*, media release, 26/11/02, p 1.

18 Commonwealth Department of Health and Ageing, sub 238, p 23.

19 *National Alcohol Research Agenda: A supporting paper to the National Alcohol Strategy: A plan for action 2001 to 2003-04*, Commonwealth Department of Health and Ageing, Canberra, March 2002, p 5.

20 Alcohol Education and Rehabilitation Foundation, About the Foundation, p 1, viewed 1/11/02, <http://www.aerf.com.au/about/about_index.htm>; Commonwealth Department of Health and Ageing, sub 238, pp 23-24.

21 Commonwealth Department of Health and Ageing, sub 238, p 23.

pamphlets and drinks coasters have been prepared for distribution at licensed premises and health care premises.[22]

- The National Excise Scheme for low alcohol beer was introduced in 2002 to replace existing state and territory subsidy schemes with a nationally uniform concession. It is funded jointly by state, territory and the Commonwealth governments and was expected to lower the price of low alcohol beers in some states.[23]

Issues in preventing and treating alcohol-related harm

5.14 Submissions to the inquiry and a number of recently published studies have identified for the committee several areas which should be targeted to reduce the harm caused by alcohol misuse. They are discussed below, starting with groups in the population who are at particular risk of alcohol misuse.

Australian youth

5.15 Concern has recently been expressed about binge drinking among young people. For Australians in general, the National Drug Research Institute found that 63.1 per cent of the alcohol consumed was on days when drinkers placed themselves at risk of injury and/or acute illness. For young drinkers aged 14-24 years, this figure was 80.9 per cent. While the overall consumption of alcohol in Australia has remained static over the last 10 years, heavy sessional drinking by young people has increased.[24]

5.16 The NDS stated we know that parental and peer pressures are among the important factors that influence young people's drinking. Young people are affected by their parents' attitudes to alcohol, the guidance they provide to their children, and the example they set in their own use of alcohol.[25] The 2001 NDS Household Survey revealed in 2001, 36.6 per cent of Australians thought that heroin was the most serious concern for the

22 Hon Trish Worth MP, Parliamentary Secretary to the Minister for Health and Ageing, *Knowing how much to drink the key to responsible alcohol consumption*, media release, 20/2/03, p 2.

23 Commonwealth Department of Health and Ageing, sub 238, p 24.

24 National Drug Research Institute, *Regular strength beer and spirits account for bulk of risky drinking by young people*, media release, 23/2/03, p 1.

25 *National Alcohol Research Agenda: A supporting paper to the National Alcohol Strategy: A plan for action 2001 to 2003-04*, pp 78-79.

general community, but only a fifth (20.0 per cent) nominated excessive drinking.[26]

5.17 Lum et al stated that evaluation of the National Alcohol Campaign launch and first booster phase showed that campaign activities had effectively communicated with their target audiences of young people and the parents of teenagers, and influenced awareness, attitudes and behaviour.[27] In addition, research for the most recent phase of the National Alcohol Campaign (June to September 2002) indicated that parents were seeking help in dealing with teenage drinking and teenagers were looking to their parents to set boundaries about alcohol consumption.[28] This is doubly important in view of the National Alcohol Campaign finding that a majority of teenagers, despite having experienced the negative aspects of high-risk drinking behaviours, drank to get drunk.[29]

Conclusion

5.18 The committee agrees that:

- there should be concern that the community views alcohol misuse as less significant than some other drugs when in fact it is responsible for a greater amount of harm;
- the attitudes of parents and young community members in the dangers of excessive consumption of alcohol need to be urgently addressed;
- parents play a pivotal role in setting boundaries for alcohol consumption; and
- lack of guidance can lead young people to use alcohol primarily to get drunk, resulting in misuse and abuse.

5.19 The committee believes campaigns to assist parents and young people to understand the nature of alcohol misuse and to reduce alcohol-related problems are therefore important.

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26 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: Detailed findings*, Drug statistics series no 11, AIHW, Canberra, December 2002, p 5.

27 Lum M, Ball J & Carroll T, *Evaluation of the booster phase of the National Alcohol Campaign: Research summary*, Commonwealth Department of Health and Ageing, Canberra, November 2002, pp 10-11, viewed 28/1/03, <http://www.health.gov.au/pubhlth/publicat/document/reports/alcbooster.pdf>.

28 Hon Trish Worth MP, Parliamentary Secretary to the Minister for Health and Ageing, *Parents encouraged to talk to their teenagers about drinking*, media release, 16/6/02, p 1.

29 Hon Trish Worth MP, Parliamentary Secretary to the Minister for Health and Ageing, *Teenagers drinking to get drunk at higher risk of harm*, media release, 26/6/02, pp 1-2.

5.20 The committee is impressed by the evidence of the effectiveness of public education campaigns. However, in the light of continuing concerns about young people's drinking, the committee believes that the campaign should continue. Future booster phases should address prevailing attitudes and awareness of alcohol-related issues in the light of emerging trends in alcohol use.

Recommendation 33

5.21 **The committee recommends that the Commonwealth government continue to:**

- **fund the National Alcohol Campaign;**
- **support the targeting of young people and parents of adolescents in future phases of the campaign; and**
- **evaluate the effectiveness of the campaign and use the results, together with other research, to determine the content for future campaign phases.**

5.22 Raising the legal age for drinking to 21 years was proposed by the National Woman's Christian Temperance Union as a way of reducing young people's drinking.[30] Forty-two per cent of respondents to the 2001 NDS Household Survey also favoured this approach.[31] The Public Health Association of Australia suggested more effective policing of present laws relating to underage drinking.[32]

Conclusion

5.23 The committee supports and recommends a greater focus on monitoring compliance by retailers with existing laws and penalising those who are found to have broken the law.

30 National Woman's Christian Temperance Union, sub 88, p 3.

31 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, p 35.

32 Public Health Association of Australia, transcript, 21/11/00, p 296.

Recommendation 34

5.24 **The committee recommends that the State and Territory governments must strictly police compliance laws regulating the supply of alcohol to minors and introduce harsher penalties against those found to be not complying.**

Pregnant women

5.25 The National Alcohol Strategy revealed that high risk drinking during pregnancy can contribute to a variety of problems for the unborn child, including fetal death, congenital malformation, growth retardation and behavioural deficits.[33] O'Leary reported that fetal alcohol syndrome (FAS) is regarded as the leading, preventable cause of non-genetic intellectual handicap; it is particularly common among Indigenous people. The prevalence of FAS in Western Australia, for example, was 0.02 per 1,000 for non-Aboriginal children and 2.76 per 1,000 for Aboriginal children and these may be underestimates.[34]

5.26 The dangers of excessive drinking during pregnancy are not as well known as they should be. O'Leary stated:

> … The knowledge of women, both in the general community and within high-risk groups, of the risks associated with alcohol consumption during pregnancy and of FAS in particular is limited. This lack of awareness is compounded by a lack of counseling by physicians on the risks associated with maternal alcohol consumption …[35]

O'Leary also reported that a recent Australian study, for example, showed that less than a third of recently pregnant women had been advised about their alcohol consumption.[36]

5.27 A course of action recommended to the committee by the Women's and Children's Hospital Adelaide during the committee's related inquiry into children's health and wellbeing was that there is clearly a need to provide the community, particularly adolescent girls and women of childbearing age, with the necessary knowledge to consume alcohol responsibly during

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33 *National Alcohol Strategy: A plan for action 2001 to 2003-04*, p 10.

34 O'Leary C, *Fetal alcohol syndrome: A literature review*, Prepared for the National Expert Advisory Committee on Alcohol, Commonwealth Department of Health and Ageing, Canberra, August 2002, pp 1-2, 19.

35 O'Leary C, p 2.

36 O'Leary C, p 26.

pregnancy or to decide on abstinence.[37] It was also suggested in evidence to the current inquiry from the Aboriginal Drug and Alcohol Council (SA) and the National Organisation for Foetal Syndrome and Related Disorders that public education campaigns should include warnings about the impact of alcohol on the unborn child, for example, by including information on this topic on labels on alcoholic drink containers.[38]

Conclusion

5.28 The committee agrees:

- with suggestions that more needs to be done to inform women about the consequences of heavy drinking during pregnancy; and
- that a campaign highlighting the risks to the unborn child associated with alcohol consumption during pregnancy should be a priority.

Recommendation 35

5.29 **The committee recommends that the Commonwealth, State and Territory governments work to ensure that effective information is widely circulated to female adolescents, women and their partners on the dangers posed to unborn children by heavy drinking during pregnancy.**

Indigenous people

5.30 The 2001 NDS Household Survey revealed that, although the proportion of Indigenous people who drink is lower than for non-Indigenous Australians, they are significantly more likely to put themselves at risk of short and long term alcohol-related harm than non-Indigenous people: 48.7 per cent of Indigenous people were exposed to risk or high risk of short term harm on at least one occasion over the previous year, compared with 34.3 per cent of non-Indigenous people. Comparable figures for long term harm are 19.9 per cent and 9.7 per cent respectively.[39] In some Indigenous communities heavy drinking is associated with violence that presents significant problems.

37 The Women's and Children's Hospital, Adelaide, sub 7 to the Inquiry into Improving Children's Health and Well Being by the House of Representatives Standing Committee on Family and Community Affairs, p 3.

38 Aboriginal Drug and Alcohol Council (SA), sub 181, p 12; National Organisation for Foetal Syndrome and Related Disorders, sub 51, p 7.

39 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: Detailed findings*, p 110; Commonwealth Department of Health and Ageing, sub 238, p 10.

5.31 Gray et al reported that Indigenous people have taken a number of steps to restrict the consumption of alcohol in their communities, including:

- establishing wet canteens to control the availability of alcohol and teach people to drink moderately;
- establishing dry areas where alcohol consumption is prohibited; and
- petitioning liquor licensing authorities to place increased restrictions on the availability of alcohol.

They also reported sobering up shelters and night patrols in Indigenous communities help to limit the harm that intoxicated people cause to themselves and others.[40] The importance of appropriate programs is recognised in Recommendation 27 in Chapter 4.

Advertising

5.32 The Distilled Spirits Industry Council of Australia reported that the advertising of alcoholic beverages is controlled in Australia by the Alcohol Beverages Advertising Code and Complaints Management System (ABAC). ABAC is a self-regulatory advertising code which has been in operation since 1998. It requires advertisements to present a balanced and responsible approach to consumption and 'must not have an evident appeal to children or adolescents'.[41]

5.33 The ABAC code is supported by an independent complaints panel and the Alcohol Advertising Pre-Vetting System (AAPS). The AAPS is also a code, in this case agreed between the industry and the Commonwealth Department of Health. Under the AAPS code, the independent panel vets advertisements at an early stage in their development to ensure that they do not contravene the spirit and letter of the ABAC. According to the Distilled Spirits Industry Council of Australia, few complaints are made each year about the advertising of alcohol.[42]

5.34 However, Jones and Donovan pointed out that the way in which some alcohol advertising has been conducted recently has been criticised for breaching the advertising guidelines.[43] The depiction of alcohol

40 Gray D, Sputore B, Stearne A, Bourbon D & Strempel P, *Indigenous drug and alcohol projects 1999-2000*, ANCD research paper 4, Australian National Council on Drugs, Canberra, 2002, p 6.

41 Distilled Spirits Industry Council of Australia, 'About DISCA: Community education – industry initiatives – affiliations – profiles', p 1, viewed 29/1/03, <http://www.dsica.com.au/sections/about/industry.html>.

42 Distilled Spirits Industry Council of Australia, 'About DISCA', pp 1-2.

43 Jones SC & Donovan RJ, 'Messages in alcohol advertising targeted to youth', *Australian and New Zealand Journal of Public Health*, vol 25(2), 2001, p 126.

consumption by attractive young people in situations characterised by excitement and sensuousness is seen as overstepping the limits and likely to influence drinking by young people, especially teenagers. Research by Carrol and Donovan has shown that exposure to some alcohol brands is higher for teenagers than for adults. Of particular concern is the alcohol industry's extensive marketing of alcohol over the internet where 'blatant breaches' of the advertising code have been found.[44]

5.35 Under instruction from the Ministerial Council on Drug Strategy (MCDS), the Intergovernmental Committee on Drugs is reviewing the effectiveness of the current self-regulatory system for alcohol advertising. The findings of the review will be reported to the MCDS in August 2003. In addition, the National Expert Advisory Committee on Alcohol has been asked to examine the marketing and promotion of ready to drink alcoholic products to minors. The latter review was stimulated by concern about the recent dramatic increase in the consumption of ready to drink products among underage drinkers, particularly given their popularity among girls.[45] Alcoholic flavoured milk is a recent product released on to the market.[46] In February 2003 it was banned by the Victorian government. Its ban was appealed by the manufacturers but on 17 April 2003 the Victorian Civil and Administrative Tribunal dismissed the appeal.[47] Since then it has been reported that all states, except South Australia, have banned or are set to ban such products.[48]

5.36 Among the suggestions on advertising, made to the committee in submissions to the inquiry, were banning the advertising of alcoholic drinks[49] in the same way as tobacco advertising is banned[50] and eliminating the sponsorship of sporting events by the industry.[51] Of the Australians over 14 years of age canvassed by the 2001 NDS Household Survey, 43.9 per cent also supported banning alcohol sponsorship of

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44 Carrol T & Donovan J quoted by Alcohol and other Drugs Council of Australia, 'What is shaping Australian perceptions on drugs', *ADCA News*, September-October 2002, p 4.

45 Hon Trish Worth MP, Parliamentary Secretary to the Minister for Health and Ageing, *Federal government concerned about marketing alcohol to young people*, media release, 19/9/02, p 1.

46 See Alcohol and other Drugs Council of Australia, *Peak body calls for a ban on flavoured alcoholic milk*, media release, 18/9/02, <http://www.adca.org.au/policy/media_releases/2002_sept18.htm>.

47 See Australian Drug Foundation, *Alcoholic milk too much to swallow*, media release, 17/4/03, p 1.

48 Anderson L, Now you can get drunk on milk, *The Advertiser*, 28/5/03.

49 Waters K, sub 46, p 1.

50 National Council of Independent Schools' Association, sub 167, p 2.

51 National Woman's Christian Temperance Union, sub 88, p 3.

sporting events. Seven out of 10 Australians (69.5 per cent) supported limiting alcohol television advertising to after 9.30pm.[52]

5.37 In the process of deciding on the best approach to regulating alcohol advertising, it is helpful to consider the evidence for advertising's impact on consumption. The Distilled Spirits Industry Council of Australia cited research showing that advertising has only a small role in shaping young peoples' attitudes and beliefs about drinking, compared to that played by parents and peers. It claimed that 'in fact, there is no compelling evidence of a correlation between advertising and either drinking patterns among young people, or rates of abuse'.[53]

5.38 However, Strasburger's recent, extensive review of the evidence relating to the impact of advertising on young people concluded that:

> Although the research is not yet scientifically "beyond a reasonable doubt," a preponderance of evidence shows that alcohol advertising is a significant factor in adolescents' use of this drug. For alcohol, advertising may account for as much as 10% to 30% of adolescents' usage …[54]

A further recent study by Synder et al confirmed a 'small and positive' effect on youth drinking for exposure to alcohol advertising.[55]

5.39 Martin said other research has shown that young people's beliefs, about how alcohol will affect them develop, before these youngsters have had direct experience with alcohol; their beliefs are strong predictors of intentions to use and actual, later consumption.[56] In other words, pre-adolescent children, as well as older people, may be affected by exposure to alcohol advertising.

5.40 Caswell reported that as evidence on the likely link between advertising and alcohol consumption has strengthened, public health considerations have assumed more significance.[57] The Australian Medical Association recommended that all alcohol advertising should encourage no more than

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52 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, p 35.

53 Distilled Spirits Industry Council of Australia, 'Alcohol advertising under attack', *National Liquor News*, September 2002, p 1, viewed 29/1/03,

54 Strasburger VC, 'Alcohol advertising and adolescents', *The Pediatric Clinics of North America*, vol 49, 2002, p 361.

55 Snyder L, Hamilton M, Fleming-Milici F & Slater MD, 'The effect of alcohol ads on youth 15-26 years old', *Alcoholism: Clinical and Experimental Research*, vol 26(6), 2002, p 902.

56 Martin SE, 'Alcohol advertising and youth: Introduction and background', *Alcoholism: Clinical and Experimental Research*, vol 26(6), 2002, p 900.

57 Casswell S, 'Does alcohol advertising have an impact on public health?', *Drug and Alcohol Review*, vol 14, 1995, p 395.

the level of consumption recommended in the national drinking guidelines.[58] Saffer pointed out that there is an increasing body of literature that suggests that alcohol counter-advertising is effective in reducing the alcohol consumption of teenagers and young adults.[59]

Conclusion

5.41 The committee agrees that the dramatic increase in the use of ready to drink products by young people is of great concern and all governments must address the issue of the targeting of young people through advertising campaigns.

5.42 The committee strongly supports the advertising code's guideline that advertising should not make drinking attractive to young people, and is therefore very concerned by allegations that the code has been breached. It welcomes the decision by the MCDS to review advertising practices in the alcohol industry. It believes that, if the voluntary code has been consistently and significantly breached, serious consideration should be given to legislative regulation of alcohol advertising. It is also important that significant counter-advertising is carried out.

Recommendation 36

5.43 **The committee recommends that the Commonwealth Department of Health and Ageing table in parliament the report on the review of the effectiveness of the current regulatory system for alcohol advertising as soon as possible so the parliament can consider the need for appropriate legislation for the regulation of the advertising of alcohol.**

Recommendation 37

5.44 **The committee recommends that the Commonwealth government implement requirements that all advertising of alcoholic beverages encourage responsible drinking, by including information on the National Health and Medical Research Council's Australian Alcohol Guidelines.**

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58 Australian Medical Association, sub 133, p 1.

59 Saffer H, 'Alcohol advertising and youth', *Journal of Studies on Alcohol*, Supplement no 14, 2002, p 173.

Labelling

5.45 FSANZ stated that labels on alcoholic beverages carry information on alcohol content and the number of standard drinks they contain.[60] According to the Australian Hotels Association, the concept of the standard drink has been one of the most effective public health promotions of recent years and should be maintained.[61] The suggestion in the 2001 NDS Household Survey that the size of the standard drinks label be increased in size was supported by 67.9 per cent of Australians over 14 years of age.[62]

5.46 In addition, the NDS Household Survey revealed that 71.0 per cent of survey respondents were in favour of adding the national drinking guidelines to containers.[63] A summary of the guidelines is shown in Table 5.1. These general guidelines are supplemented by 12 others specific to particular groups such as young people and women who are pregnant.[64]

5.47 The Australian Drug Foundation proposed that further label information could usefully cover how to use alcohol less harmfully, for example, in relation to binge drinking and drinking in unsafe contexts with messages such as:

- 'Swimming after drinking alcohol can be dangerous.'
- 'Drinking alcohol while pregnant may harm your unborn child.'[65]

60 Food Standards Australia New Zealand, *Australia New Zealand Food Standards Code*, Standard 2.7.1: Labelling of alcoholic beverages and food containing alcohol, Issue 61, Anstat, Melbourne, 2001, viewed 24/2/03, <http://www.foodstandards.gov.au/foodstandardscode/>.

61 Australian Hotels Association, transcript, 21/5/01, p 949.

62 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, p 35.

63 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, p 35.

64 National Health and Medical Research Council, *Australian alcohol guidelines: Health risks and benefits*, pp 5-17.

65 Australian Drug Foundation, 'ADF position on alcohol health warning labels', pp 3-4, viewed 31/1/03, <http://www.adf.org.au/inside/position/warning.htm>.

Insert Table 5.1 here

5.48 It has been suggested in US research by Greenfield, cited by Roche and Stockwell, that warnings on alcoholic beverages stand as a counterbalance to the overly enthusiastic assertions of health benefits that some in the alcohol industry are keen to include on labels.[66] However, the former Australian New Zealand Food Authority made the following point when it rejected an application for warning labels on alcoholic beverages.

> … simple, accurate warning statements, which would effectively inform consumers about alcohol-related harm, would be difficult to devise given the complexity of issues surrounding alcohol use and misuse, and the known benefits of moderate alcohol consumption.[67]

Furthermore

> Scientific evidence for the effectiveness of warning statements on alcoholic beverages shows that while warning labels may increase awareness, the increased awareness does not necessarily lead to the desired behavioural changes in 'at-risk' groups. In fact, there is considerable scientific evidence that warnings statements may result in an increase in the undesirable behaviour in 'at risk' groups.[68]

Conclusion

5.49 Of the two suggestions made about warning labels and the national alcohol guidelines, the committee accepts FSANZ's advice on warnings, but believes that adding the guidelines to beverage containers would be a useful move.

Recommendation 38

5.50 **The committee recommends that information from the National Health and Medical Research Council's Australian Alcohol Guidelines be included on alcoholic beverage container labels.**

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66 Roche AM & Stockwell T, 'Prevention of alcohol-related harm: Public policy and health' in *National Alcohol Research Agenda: A supporting paper to the National Alcohol Strategy: A plan for action 2001 to 2003-04*, Commonwealth Department of Health and Ageing, Canberra, March 2002, p 65.

67 Australia New Zealand Food Authority, 'Statement of reasons: Rejection of Application A359 – Requiring labelling of alcoholic beverages with a warning statement', 5/7/00, ANZFA, Canberra, 2000, p 1.

68 Australia New Zealand Food Authority, p 1.

Providing safe drinking environments

5.51 The way in which alcohol is served in licensed premises influences the extent of the harm caused by and to intoxicated persons. Several safer approaches were flagged with the committee, including such practices and activities as offering food with drinks, selling low alcohol beer, ensuring access to taxis or public transport[69], and installing breath testing machines.[70] The Commonwealth Department of Transport and Regional Services stated server intervention or responsible service programs can also assist, by educating servers about their legal rights and obligations, how to control alcohol consumption and how to manage intoxicated patrons.[71] According to the National Alcohol Strategy, 'responsible server programs from accredited course providers should be made available to all managers and licensees, and staff compliance with safe serving practices encouraged'. Other tourism and hospitality staff should also receive training.[72]

5.52 The Bureau of Crime Statistics and Research revealed that there is clear evidence that, at least in some parts of Australia, intoxicated drinkers continue to receive service even though it is against the law. More responsible service and enforcement of liquor laws could help prevent alcohol-related injury.[73] The National Drug Research Institute said to be fully effective, the policing of licensed premises must include elements of traditional enforcement as well as the development of voluntary codes of conduct such as accords.[74] There was strong support (by 85.0 per cent of respondents) from the 2001 NDS Household Survey for stricter laws against serving drunk customers.[75]

5.53 There are a number of other preventive measures that can be taken with respect to the sale of alcohol. Research by Chikritzhs et al in Perth has shown that licensed premises with extended trading hours have significantly more assaults than normally trading premises, and were more often the last drinking place of convicted drink drivers with blood

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69 Youth Substance Abuse Service, sub 102, p 7 also supported the provision of accessible public transport systems.

70 Aboriginal Drug and Alcohol Council (SA), sub 181, p 23 also supported the installation of coin-operated breath testing units in licensed premises.

71 Commonwealth Department of Transport and Regional Services, sub 164, p 3.

72 *National Alcohol Strategy: A plan for action 2001 to 2003-04,* pp 14, 17.

73 Bureau of Crime Statistics and Research, *Young adults' experience of responsible service practice in NSW*, media release, 26/7/02, pp 1-2.

74 National Drug Research Institute, sub 110, p 31.

75 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results,* p 35.

alcohol levels of more than 0.08.[76] Restricting late night trading hours is therefore useful, but only just over half the respondents to the 2001 NDS Household Survey (50.9 per cent) supported this measure, and even fewer, supported reducing the number of outlets (28.7 per cent) and reducing trading hours for pubs and clubs (32.4 per cent). However, 72.8 per cent of Australians favoured stricter monitoring of late night premises.[77]

Conclusion

5.54 For the reasons outlined, the committee favours the rigorous use and monitoring of responsible service practices in all licensed premises. Special attention should be paid to monitoring late night premises, both in relation to ensuring responsible service practices and in relation to patrons' behaviour when drunk. The readers' attention is also drawn to the recommendations specific to drink driving in Chapter 9.

Recommendation 39

5.55 **The committee recommends that the Commonwealth government, in consultation with State and Territory governments, ensure:**

- **the vigorous implementation of responsible service practices in licensed premises by adequately trained staff; and**
- **that legislation that penalises irresponsible service practices is in place and strictly enforced, particularly in premises that trade late into the night.**

Pricing and taxation

5.56 All alcoholic beverages attract 10 per cent GST. On top of that, additional charges apply.

- The Wine Equalisation Tax (WET) applies to wines and certain other alcoholic beverages at a rate of 29 per cent; this tax is applied irrespective of alcohol content.

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76 Chikritzhs T, Stockwell T & Masters L, 'Evaluation of the public health and safety impact of extended trading permits for Perth hotels and nightclubs', May 1997, *Conference Papers Collection*, CD-ROM, 2nd Australasian Conference on Drugs Strategy, Perth, Western Australia, 7-9 May 2002, p 1.

77 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, p 35.

- Excise is imposed on other domestically manufactured beverages, such as beer and spirits, generally according to alcohol content.[78] Thus, under the National Excise Scheme for low alcohol beer, the excise on light beers is less than that on full strength beers and provides incentives to both consumers and producers of beer to favour low alcohol beer.

5.57 Alcohol and other Drug Council of Australia (ADCA) is critical of the inconsistent treatment of different alcoholic beverages:

> … the WET results in the alcohol content of cheaper wine such as cask wine being taxed concessionally compared with all other alcoholic products. This encourages over-consumption of cask wine, which currently represents a high proportion of all wine sold. Australian studies have clearly shown that consumption of cask wine (and standard beer) is more closely associated with higher levels of violence, injury and illness than other wine and beer. At risk groups include younger persons who are so called 'binge drinking' and Aboriginal people.
>
> Consequently, present Commonwealth Government alcohol taxation policy promotes alcoholic beverages that cause most harm to individuals and the community.[79]

The Independent Winemakers Association argued in a similar vein in its submission to the inquiry.[80]

5.58 In its policy statement on alcohol taxation, ADCA pointed out that:

> … The majority of studies in various countries into the effects of changes in prices of alcoholic beverages on consumption levels have found that usually there are significant effects on overall consumption, with a price elasticity of 1 or less than 1. Few other policies have such clear evidence for effectiveness on overall consumption. There is considerable evidence that prices affect both levels of consumption and problem rates …[81]

5.59 ADCA also commented that while research is inconclusive about the impact of prices on the heaviest drinkers, prices are likely to have a greater impact on the less well-to-do, such as young binge drinkers and Indigenous people.[82]

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78 Alcohol and other Drugs Council of Australia, *Alcohol taxation policy statement*, 2002, p 6, viewed 29/1/03, <http://www.adca.org.au/policy/policy_positions/alcoholtaxationpolicystatement.pdf>.

79 Alcohol and other Drugs Council of Australia, *Alcohol taxation policy statement*, p 7.

80 Independent Winemakers Association, sub 158, pp 1-2.

81 Alcohol and other Drugs Council of Australia, *Alcohol taxation policy statement*, p 5.

82 Alcohol and other Drugs Council of Australia, *Alcohol taxation policy statement*, p 5.

5.60 A volumetric tax not only provides incentives to consumers and producers to favour low alcohol products, but is also rational and equitable. ADCA said current inequities are illustrated by the fact that a standard drink of cask wine attracts tax of about six cents while a standard drink of spirits containing the same amount of alcohol is taxed at about 71 cents.[83] Furthermore, the Distilled Spirits Industry Council of Australia stated that all pre-mixed spirits carry the same excise, regardless of strength, and more excise is paid on pre-mixed spirits than on beer of equivalent strength.[84]

5.61 ADCA advocated consistent taxing of all alcoholic beverages according to their alcohol content.[85] This call was supported by several other organisations in submissions to the inquiry[86], and ADCA's policy was endorsed by 18 others.[87] ADCA proposed that the tax should be set at a level that provides the highest net benefit to the community, that is, the benefits of the tax should be maximised while at the same time the costs to the community should be minimised. Any taxation changes should be introduced gradually to allow industry to adjust.[88]

5.62 The Winemakers Federation of Australia (WFA) has opposed changes to the current system for taxing wine on several grounds.

- Increasing the tax imposed on the industry would damage it.
  - ⇒ The Australian wine industry is already subject to higher levels of taxation than most other Australian industries and its international competitors. Not only does the current system distort resource allocation in the economy, but it threatens the continuing viability

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83 Alcohol and other Drugs Council of Australia, *A lost chance on alcohol taxation reform*, media release, 15/11/02, p 1.

84 Distilled Spirits Industry Council of Australia, *New low-alcohol excise rates applaude*d, media release, 15/5/02, p 1.

85 Alcohol and other Drugs Council of Australia, *Alcohol taxation policy statement*, p 1.

86 Drug & Alcohol Services Association Alice Springs, sub 198, p 1; National Drug Research Institute, sub 110, p 30.

87 The organisations supporting the Alcohol and other Drugs Council of Australia's policy for taxation based on alcohol content were the: Aboriginal Drug and Alcohol Council (SA); Alcohol and Drug Foundation (Queensland) ; Archbishop Peter Carnley, Primate, Anglican Church of Australia; Australian Catholic Health Care Association; Australian Council of Social Service; Australian Drug Law Reform Foundation; Australian Medical Association; Australian National Council on Drugs; DRUG-ARM Australia; Family Drug Support; Independent Wineries Association; National Indigenous Substance Misuse Council; NSW Alcohol and Drug Association; People against Drink Driving; The Salvation Army – Australian Southern Territory; Victorian Association of Alcohol and Drug Agencies; Wesley Mission – Drug Arm (New South Wales); The WA Network of Alcohol and Other Drug Agencies. They are mentioned in the Alcohol and other Drugs Council of Australia, *Alcohol taxation policy statement*, p 10.

88 Alcohol and other Drugs Council of Australia, *Alcohol taxation policy statement*, p 11.

of the industry in an increasingly competitive global economy. Rather than increase taxation, it should be decreased.

⇒ A volumetric tax would increase the cost of cask wine and drop that of premium wines, and cause wine consumption to fall. Writing in 2000, the WFA declared that 'a volumetric tax threatens 80% of wine sales in Australia'.

- Increasing the cost of wine is unlikely to influence the behaviour of 'the small number of individuals' who misuse it.

The WFA said, were a volumetric tax to be introduced, it would be necessary to take into account the health benefits of moderate wine consumption.[89]

Conclusion

5.63 In view of the harm caused by irresponsible alcohol consumption, particularly to more vulnerable Australians, the committee welcomes the introduction of excise on beer according to its alcohol content. In further recognition of alcohol's potential for harm, the committee believes that the social benefits of replacing ad hoc taxation on alcohol with an across the board regime based on alcohol content be investigated.

Recommendation 40

5.64 **The committee recommends that the Commonwealth government investigate the social benefits of replacing ad hoc taxation on alcohol with an across the board regime based on alcohol content.**

Early interventions and treatment

5.65 Interventions of various kinds have been shown to be successful in helping people with alcohol-related problems to become abstinent or control their drinking. Evidence suggested that these interventions include:

- self help strategies, particularly for younger, milder cases;
- screening and brief advice in general practice and hospital settings for those who drink excessively;

89 Winemakers Federation of Australia, sub 59, pp 25-28.

- pharmacological treatment to prevent relapse in alcohol-dependent people, using drugs such as acamprosate and naltrexone best accompanied with psychosocial therapy[90]; and
- a number of psychological interventions, such as cognitive behaviour therapy and 12 step programs like Alcoholics Anonymous.

Other evidence proposed further research is needed in some of these areas, among them the efficacy of using the internet for brief interventions and the relative effectiveness of different psychological therapies.[91]

5.66 The former Commonwealth Department of Health and Aged Care and Professor Saunders suggested although two effective pharmacological treatments (acamprosate and naltrexone) are available on the Pharmaceutical Benefits Scheme for treating alcohol dependence, only 1.5 per cent of alcohol-dependent people are currently receiving them.[92] Professor Webster pointed out one reason for this: the majority of people with alcohol-related disorders do not recognise that they have a problem and do not seek help.[93]

5.67 Another reason, Professor Webster said, for so few people being in treatment is that medical practitioners do not recognise the extent of the problem. General practitioners (GPs) tend not to associate problem drinking with younger people when in fact problem drinking is most prevalent among young people, especially 18-34 year olds.[94] Furthermore, Professor Saunders added that 'many medical practitioners are simply not aware of, or have no experience in the prescription of, these medications and, therefore, the treatment of patients with them'. Many alcohol and drug services are also not well linked with GPs.[95]

5.68 Professor Saunders also pointed out that to improve the uptake of treatment by those with alcohol-related problems, we need continuing education for GPs, improved coordination with alcohol and drug services

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90 Shand F, gates J, Fawcett J & Mattick R, National Drug and Alcohol Research Centre, The *Treatment of alcohol problems: A review of the evidence*, Prepared for the Commonwealth Department of Health and Ageing, NDARC, Sydney, June 2003, pp 70-71.

91 Saunders J, transcript, 15/8/02, p 1090; Teesson M, 'Does it work? Can it work? Is it worth it?' *CentreLines*, (9), National Drug and Alcohol Research Centres, December 2002, p 2; Teesson M & Proudfoot H, 'Interventions for alcohol dependence, abuse and excessive drinking', in National Drug Strategy, *National Alcohol Research Agenda: A supporting paper to the National Alcohol Strategy*, Commonwealth Department of Health and Ageing, Canberra, March 2002, pp 120-121; Webster I, transcript, 15/8/02, p 1112.

92 Commonwealth Department of Health and Aged Care, sub 145, p 115; Saunders J, transcript, 15/8/02, p 1090.

93 Webster I, transcript, 15/8/02, pp 1114-1115.

94 Webster I, transcript, 15/8/02, p 1114.

95 Saunders J, transcript, 15/8/02, p 1101.

and shared care arrangement of patients. Giving GPs incentives to provide brief interventions would also be useful.[96] The Commonwealth Department of Health and Ageing advised that clinical practice guidelines for GPs have been prepared and were made publicly available in June 2003.[97]

Conclusion

5.69 The committee believes that three of the issues outlined above should be supported and so recommends some further research, incentives for GPs to provide brief interventions, and education for medical practitioners and others engaged in primary health care. The committee agrees that education for GPs should include information to raise their awareness of prescription treatments available to treat alcohol abuse. Better links between different parts of the health care system are already covered by Recommendation 24 in Chapter 4.

Recommendation 41

5.70 **The committee recommends that the Commonwealth, State and Territory governments:**

- **ensure that primary health care providers receive adequate training to deal with alcohol dependence and other alcohol use problems;**
- **provide incentives for medical practitioners to provide brief interventions for alcohol problems; and**
- **fund research into new approaches to treating alcohol dependence, including:**
  - ⇒ **trialling new drugs; and**
  - ⇒ **filling gaps in knowledge, like the efficacy of using the internet for brief interventions and the relative effectiveness of different psychological therapies.**

96 Saunders J, transcript, 15/8/02, pp 1090, 1101.

97 Commonwealth Department of Health and Aged Care, sub 145, p 102; National Drug and Alcohol Research Centre, *Guidelines for the treatment of alcohol problems,* prepared for the Commonwealth Department of Health and Ageing, Commonwealth Department of Health and Ageing, Canberra, June 2003, x 200p.

5.71 The committee has already recommended in this chapter that educational campaigns should target young people and their parents, and women of child bearing age and their partners. In addition to these efforts, the committee believes that a strong campaign should be undertaken, that is aimed more broadly at the Australian population at large, and will assist in intervening early in the development of alcohol misuse and dependence. It is important that everyone is more aware, than they are at present, of the various kinds of alcoholic drinks that are associated with different degrees of risk and harm.

Recommendation 42

5.72 **The committee recommends that the Commonwealth, State and Territory governments work together to run education campaigns that raise awareness of and level of knowledge about the risks associated with:**

- **the disparity in alcohol content within various alcoholic drinks; and**
- **the different levels of intoxication during the process of alcohol consumption.**

6

Tobacco: prevention and cessation

> … Tobacco smoking is highly addictive: many users are unable to voluntarily cease use, even when aware of the harm tobacco causes.[1]

6.1 The statistics on tobacco availability, its use, public perceptions of the acceptability of its use, and the costs of smoking to the community are frightening.[2]

Prevalence

6.2 The National Drug Strategy (NDS) Household Survey revealed that in 2001 tobacco was the second most accessible drug to Australians. One in every two people aged 14 years or over had been offered tobacco or had the opportunity to use it in the previous 12 months (57.2 per cent).

6.3 Nearly a quarter of the Australian population aged 14 years or older were smokers in 2001 (23.2 per cent), more than a quarter were ex-smokers (26.2 per cent) and about half (50.6 per cent) had never smoked. Four out of five current smokers smoked on a daily basis. The proportion that smoked daily decreased slightly between 1998 and 2001 (from 21.8 per cent to 19.5 per cent).

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1 VicHealth Centre for Tobacco Control, *Tobacco control: a blue chip investment in public health – overview document*, Anti-Cancer Council of Victoria, Melbourne, June 2001, p 3.

2 The statistics in the next section of this chapter are taken from Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, Drugs statistics series no 9, AIHW, Canberra, May 2002, pp xiii, 3-6, 11-12, 14; Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: Detailed findings*, Drugs statistics series no 11, AIHW, Canberra, December 2002, pp xx, 20, 22-23, 24-26.

6.4 The 2001 NDS Household Survey reported that the mean age at which Australians reported having first used tobacco was 15.5 years; this figure had remained relatively stable from 1993 to 2001. In 2001 smoking rates peaked in the 20-29 years age group, 33.0 per cent of whom smoked. The lowest proportion of smokers was in the 60+ year age group with 9.7 per cent smoking. One in five teenagers (20.3 per cent) smoked tobacco with females slightly more likely (16.2 per cent) than males (14.1 per cent) to be daily smokers. For all other ages, males had higher smoking rates than females. However, a February 2002 study by McDermott, Russell and Dobson, entitled *Cigarette smoking among women in Australia,* revealed that 'Current figures suggest that within the next decade smoking will be more common among women than men'[3].

6.5 The mean number of cigarettes smoked per week by smokers in 2001 was 109.4 with the number increasing with age until the 50-59 age group (140.3 cigarettes). On average males smoked 111.8 cigarettes per week compared with 106.5 for females. Teenagers smoked on average 71.7 cigarettes per week. Recent smokers spent an average of $41.84 on tobacco weekly; manufactured cigarettes were the most commonly used form of tobacco.

6.6 In 2001 nearly half of all Indigenous Australians smoked (49.9 per cent), a proportion more than twice as great as non-Indigenous Australians smokers (22.8 per cent). The average number of cigarettes they smoked per week was also higher (125.4 compared with 108.3 respectively).

6.7 In the past 12 months a third of smokers (34.2 per cent) had reduced the amount of tobacco smoked per day. For both male and female smokers, cost and effect on health or fitness were the main motivators for change in smoking behaviour.

6.8 The VicHealth Centre for Tobacco Control (VCTC) noted tobacco smoking often goes hand in hand with other addictions.[4]

Costs

6.9 Canberra ASH Inc pointed out that 'Tobacco is harmful when used as intended …'[5] The Australian Institute of Health and Welfare (AIHW) has

3 McDermott L, Russell A & Dobson A, *Cigarette smoking among women in Australia,* National Tobacco Strategy 1999 to 2002-03 occasional paper, Commonwealth Department of Health and Ageing, Canberra, February 2002, p 11.

4 VicHealth Centre for Tobacco Control, *Tobacco control: A blue chip investment in public health – overview document,* p 3.

shown of all risk factors for disease, tobacco smoking is responsible for the greatest burden on the health of Australians. It is a major risk factor for various cancers, coronary heart disease, stroke, peripheral vascular disease and a number of other diseases and conditions.[6] McDermott et al pointed out that their projection that within the next decade smoking will become more common among women than men, has implications for women's health for many years to come.[7]

6.10 Collins and Lapsley found that in 1998-99, 19,429 deaths and 965,433 hospital beddays were attributable to tobacco smoking (both active and involuntary[8]). This was more deaths and beddays than were attributed to alcohol and illicit drug use combined. However, in recent years the number of deaths attributed to tobacco smoking has declined slightly, although the number of hospital separations has increased. Total hospital costs attributable to tobacco smoking were estimated to be $718.4 million in 1998-99.[9]

6.11 According to Collins and Lapsley, 224 deaths, 77,950 beddays and $47.6 million in hospital costs were attributable to involuntary smoking, and it was apparent that a high proportion of these costs were imposed on the young. Conditions attributable to involuntary smoking are antepartum haemorrhage, hypertension in pregnancy, low birthweight, premature rupture of membranes, SIDS, childhood asthma and lower respiratory illness (under 18 months). In 1998-99 the under 15s (the young) accounted for 45.7 per cent of deaths, 96.6 per cent of hospital bed days and 94.8 per cent of hospital costs attributable to involuntary tobacco smoking.[10] McDermott et al reported that 'women and their children remain at risk of exposure to ETS [Environmental Tobacco Smoke] at home'[11]. It is clear that smokers inflict great damage on their own and other's children.

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5 Canberra ASH Inc, sub 225, pp 1-2.

6 Australian Institute of Health and Welfare, *Australia's health 2002: The eighth biennial health report of the AIHW*, AIHW, Canberra, May 2002, p 134.

7 McDermott L, Russell A & Dobson A, p 11.

8 Collins and Lapsley disaggregate the costs of smoking into active and involuntary components. They use the term 'involuntary smoking' rather than passive smoking or sidestream smoke or environmental tobacco smoke. Medical conditions attributable to active smoking occur as a result of smokers inflicting adverse health effects on themselves. Conditions attributable to involuntary smoking occur when smokers inflict adverse health effects on others (including the unborn). Collins DJ & Lapsley HM, *Counting the cost: estimates of the social costs of drug abuse in Australia 1998-9,* Monograph series no 49, Commonwealth Department of Health and Ageing, Canberra, December 2002, p 23.

9 Collins DJ & Lapsley HM, pp 11, 50; Australian Institute of Health and Welfare, *Australia's health 2002,* p 134.

10 Collins DJ & Lapsley HM, pp 4, 51.

11 McDermott L, Russell A & Dobson A, p 12.

6.12 Collins and Lapsley estimated that in 1998-99 the cost of providing health care for diseases attributable to tobacco abuse was $1,094.9 million. This represented some 79 per cent of the total cost of providing health care for the abuse of all drugs examined ($1,389.1 million). It was also estimated that $472.8 million or about 43 per cent of the health care costs attributable to tobacco could have been avoided if effective anti-tobacco policies and programs had been in place.[12]

Perceptions of the problem and support of policy measures

6.13 The 2001 NDS Household Survey revealed that despite the above health facts, tobacco was primarily associated with a drug 'problem' by only 2.7 per cent of Australians aged 14 years or over (down from 4.2 per cent in 1998). Of the people surveyed, 39.7 per cent accepted the regular use of tobacco by adults. However, tobacco smoking was identified by 44.5 per cent of Australians as the main drug associated with mortality in Australia. It was the second most likely form of drug use to be nominated as a serious concern for the community.[13]

6.14 The 2001 NDS Household Survey also revealed that between 1998 and 2001, public support for measures to reduce the problems associated with tobacco remained strong and had increased. The greatest support (91.2 per cent of Australians aged 14 years or over) was for 'stricter enforcement of laws against supplying tobacco products to minors'. The greatest relative percentage increase in support was for 'banning smoking in clubs/pubs', which increased from 50.0 per cent in 1998 to 60.8 per cent in 2001. The lowest level of support, while still relatively high at 60 per cent, was for 'making it harder to buy tobacco in shops'. There was greater support for all these measures among females than males.[14]

12 Collins DJ & Lapsley HM, pp x, 60.

13 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, pp 7-8; Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: Detailed findings*, pp 5-7.

14 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, pp 34-35.

Government and non-government sectors working together

6.15 Given the health costs of tobacco smoking, it is widely recognised that tobacco control is a good investment for government. The National Tobacco Strategy stated 'Tobacco smoking … remains the single largest preventable cause of premature death and disease in Australia'.[15]

6.16 The current framework for national action on tobacco is the *National Tobacco Strategy 1999 to 2002-03*. It operates as part of the NDS and was endorsed by the Ministerial Council on Drug Strategy in June 1999. The National Tobacco Strategy provides a framework for the development and implementation of tobacco control activities at the national and jurisdictional levels. It is a 'national strategy' as opposed to a 'Commonwealth strategy' and aims to provide leadership while maintaining flexibility for each jurisdiction and non-government sector to ensure each group can respond to their needs and priorities. It builds on four decades of state, territory, Commonwealth, national and international experience with tobacco control initiatives.[16] The goals, objectives, key strategy areas and examples of action issues are set out in Box 6.1.

6.17 Under the strategy, state and territory governments have developed tobacco action plans, for example the Northern Territory has developed the 2000-2004 Tobacco Strategic Plan and Tasmania has the Tasmanian Drug Strategic Plan 2001-04.[17] The National Tobacco Strategy also allows for more detailed action plans for specific targeted population groups such as Aboriginal and Torres Strait Islander people, children and young people under 18 years of age, and pregnant women and their partners.[18]

6.18 Built into the strategy is an approach for developing an evaluation plan, an annual reporting system for state, territory and the Commonwealth governments, and performance measures to assess progress and the success of the strategy. A more detailed review by the Commonwealth government of the whole strategy will be undertaken in 2003-04.[19]

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15 *National Tobacco Strategy 1999 to 2002-03: A framework for actio*n, endorsed by the Ministerial Council on Drug Strategy, Commonwealth Department of Health and Aged Care, Canberra, June 1999, p 1.

16 *National Tobacco Strategy 1999 to 2002-03: A framework for action*, p 1.

17 Tasmanian Department of Health and Human Services, transcript, 14/6/01, p 1064; Northern Territory Health Services, sub 44, p 8.

18 *National Tobacco Strategy 1999 to 2002-03: A framework for actio*n, pp 2-3.

19 *National Tobacco Strategy 1999 to 2002-03: A framework for action*, pp 3-4.

Box 6.1 National Tobacco Strategy: Goals, objectives and key strategies

Strategy Goal

To improve the health of all Australians by eliminating or reducing their exposure to tobacco in all its forms.

Strategy Objectives

1. Prevent the uptake of tobacco use in non-smokers, especially children and young people.
2. Reduce the number of users of tobacco products.
3. Reduce the exposure of users to the harmful health consequences of tobacco products.
4. Reduce exposure to tobacco smoke.

Six Key Strategy Areas *(including examples of action issues)*

1. Strengthening community action

(*eg public education campaigns, school education programs, prevention programs, provision of public information on harm effects, health warnings)*

2. Promoting cessation of tobacco use

(*eg professional education to assist health professionals help smokers quit, resources and services to help and provide incentives for smokers to quit, cessation programs)*

3. Reducing availability and supply of tobacco

(eg reduction in affordability of tobacco products, reduction in illegal sale and supply to minors)

4. Reducing tobacco promotion

(eg reduction in advertising through legislation eg in films, TV, video clips, print; reduction of point of sale advertising; reduction in use of tobacco products as marketing tools; removal of tobacco sponsorship of sporting and cultural events)

5. Regulating tobacco

(eg disclosure of tobacco ingredients including additives, identification of cigarette yields, reduction of nicotine dependency)

6. Reducing exposure to environmental tobacco smoke

(eg establishment of smoke free environments; increasing public awareness and understanding of health risks)

Source: National Tobacco Strategy 1999 to 2002-03: A framework for action, endorsed by the Ministerial Council on Drug Strategy, Commonwealth Department of Health and Aged Care, Canberra, December 1999, pp 2, 12-15, 18-21, 24-25, 28-31, 34-35, 38-39.

6.19 The Commonwealth Department of Health and Ageing advised that responsibility for tobacco control is divided between the Commonwealth, state and territory governments.

- The Commonwealth government has direct responsibility under the National Tobacco Strategy for health warnings on tobacco packaging, tobacco taxation, measures against illicit trade, federal advertising and sponsorship restrictions, national social marketing effort, and policy leadership. It also schedules smoking cessation therapies.
- The states and territories are responsible for direct cessation services to smokers, regulation of retailers, passive smoking laws and preventing sales to minors. Some states also run their own social marketing campaigns in addition to their partnership in the National Tobacco Campaign, for example, the Victorian Smoking and Health Program (QUIT). Western Australia is recognised as a leader in public education campaigns that have targeted smoking through QUIT and other programs.[20]

6.20 The Commonwealth Department of Health and Ageing stated that Commonwealth funding for tobacco-related activity (including the National Tobacco Campaign) has been $5.14 million, $4.1 million and $5.1 million, respectively in the financial years 1999-2000, 2000-01 and 2001-02. That figure does not include the subsidy provided for Zyban under the Pharmaceutical Benefits Scheme, which was $29.1 million in 2001-02, according to Health Insurance Commission data. The Department also advised that, while there are no official estimates of the amounts spent by the states and territories, it is believed to be in excess of $10 million per year (not including funding to some non-government organisations such as health promotion foundations).[21]

6.21 The strategies for dealing with tobacco smoking continue to evolve. In June 2002 the Commonwealth Department of Health and Ageing reported the following recent initiatives:

- continued funding of the National Tobacco Campaign – according to the department, an evaluation indicated a decrease in smoking prevalence of 4.2 per cent among smokers aged 18 years and over between the commencement of the campaign in May 1997 and November 2001;
- amendment of the *Tobacco Advertising Prohibition Act 1992* to ban tobacco advertising at international sporting events from 1 October 2006;

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20 Commonwealth Department of Health and Ageing, sub 292, p 5; Victorian government, sub 166, p 3; Western Australian government, sub 115, p 2.

21 Commonwealth Department of Health and Ageing, sub 292, pp 4-5.

- in May 2002 initiation of a review of the Tobacco Advertising Prohibition Act;
- voluntary agreement with the three Australian cigarette manufacturers to disclose ingredients in Australian cigarettes;
- a review of health warnings on cigarette packets with new regulations expected to be in place in mid-late 2003;
- a review leading to the development of Australian smoking cessation guidelines for health professionals;
- from May 2002 establishment of a clearinghouse for information on Indigenous tobacco control, development of strategies aimed at Indigenous health workers and development of culturally appropriate tobacco control resources; and
- continuation of Australia's significant international role in the World Health Organisation's (WHO) Framework Convention on Tobacco Control and its support for the WHO Tobacco Free Initiative.[22] In late May 2003 all members of the WHO unanimously adopted the Framework Convention on Tobacco Control.[23]

Some future directions for prevention and treatment

6.22 From evidence to the committee it is clear that there is no room for complacency in dealing with this major health problem and that more remains to be done. For example, in June 2000 Alcohol and other Drugs Council of Australia (ADCA) sought an additional objective and strategies for the National Tobacco Strategy. The proposed objective was to improve consumer understanding of the health risks of tobacco smoke; to change individual and societal attitudes to smoking; and to reduce dangers posed by tobacco products through five strategies.[24]

6.23 Further, in June 2001 the VCTC issued a detailed practical agenda on tobacco control for consideration and action by Australian governments and all political parties. The agenda's objective was to markedly reduce the social costs of tobacco use in Australia. The agenda listed several new policies and programs, provided guidance for making some existing

22 Commonwealth Department of Health and Ageing, sub 238, pp 19-21.

23 The Hon T Worth MP, Parliamentary Secretary for Health and Ageing, *Australia welcomes world agreement on tobacco control*, media release, 25/5/03, 2p.

24 Alcohol and other Drugs Council of Australia, *Drug policy 2000: A new agenda for harm reduction*, ADCA, Canberra, June 2000, pp 58-59.

programs more cost effective, and estimated the costs and benefits to the community of the proposals. It suggested that the cost to the Commonwealth government of the proposed programs would be about $97 million per annum for three years, and provided options for financing the package.[25] The agenda was endorsed by 11 peak Australian health non-government organisations.[26]

6.24 In the following sections this committee has considered further actions for dealing with the problems of tobacco smoking under the six key strategy areas identified in the National Tobacco Strategy. As there is a close link between prevention and treatment activities for tobacco smoking, the discussion of these two matters is integrated.

Strengthening community action

6.25 Despite the success previously outlined of the National Tobacco Campaign, some groups sought further improvement of anti-smoking campaigns. Among their suggestions were that anti-smoking programs should target the whole community from adults through to infants, complemented by sustained efforts by community groups at a local level. These local initiatives should directly involve young people in developing and implementing appropriate strategies. Governments should continue to develop strategies for increasing awareness among young women of the effects of tobacco products.[27] The study by McDermott et al suggested that' The benefits to women in particular, of quitting smoking should be emphasised in mass media campaigns and their concern about weight gain taken into account.'[28] The VCTC stated programs should:

> … ensure that smokers and potential smokers from all age and social groups fully understand and appreciate all of the major risks associated with smoking – over 50 different diseases; the personal devastation caused to the families and friends of those who die from smoking-related diseases; the disability that can be caused by smoking related diseases, and the impact this has on quality of life;

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25 VicHealth Centre for Tobacco Control, *Tobacco control: A blue chip investment in public health – overview document,* pp 3-8.

26 The organisations are: Action on Smoking and Health Australia; Alcohol and other Drugs Council of Australia; Australasian Faculty of Public Health Medicine; Australian Council on Smoking and Health; National Asthma Campaign; National Heart Foundation; Public Health Association of Australia; The Cancer Council Australia; Australian Lung Foundation; Thoracic Society of Australia and New Zealand; and VicHealth Centre for Tobacco Control (VicHealth Centre for Tobacco Control, p 2).

27 Alcohol and other Drugs Council of Australia, sub 61, p 20; Hill D, transcript, 15/8/02, pp 1083, 1084.

28 McDermott L, Russell A & Dobson A, p 15.

> the addictiveness of tobacco; the various strategies that can be effective when giving up, and the help that is available.[29]

6.26 The VCTC stressed the need for commercially realistic funding for public education.[30] The National Heart Foundation (WA Division) stated that by comparison with other major public health problems, funding for public education campaigns has been 'woefully under-resourced', involving an expenditure of only 50 cents per head per annum.[31] The Public Health Association of Australia (PHAA) said it was estimated in year 2000 that for effective school tobacco education alone $7.12 per head was needed.[32] According to the Cancer Foundation of Western Australia, governments should devote a minimum of $10 per head of population to public education programs about smoking and governments should set targets for reducing the prevalence of use.[33]

6.27 Tobacco packaging and labelling have the potential to promote cigarette smoking. This potential can be reduced by requiring that the drawbacks of smoking be extensively and graphically listed on packaging. The National Tobacco Strategy background paper pointed out that in Australia there has been labelling of tar and nicotine levels on cigarette packages since 1982 with new and stronger warnings implemented in 1994.[34]

6.28 Currently there are six health warnings prescribed under the Trade Practices Legislation one of which appears on each cigarette packet. The warning is listed in large print on the front of the packet with a more detailed explanation in smaller typeface on the back of the packet and a contact number for more information. For example one warning is 'SMOKING CAUSES HEART DISEASE' and on the back of the pack the following words appear:

> SMOKING CAUSES HEART DISEASE Tobacco smoking is a major cause of heart disease. It can cause blockages in the body's arteries. These blockages can lead to chest pain and heart attacks. Heart attack is the most common cause of death in Australia. Smokers run a far greater risk of having a heart attack than people who don't smoke.

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29 VicHealth Centre for Tobacco Control, *Tobacco control: A blue chip investment in public health – overview document,* p 5.

30 VicHealth Centre for Tobacco Control, *Tobacco control: A blue chip investment in public health – overview document,* p 5.

31 National Heart Foundation of Australia (WA Division), sub 177, p 8.

32 Public Health Association of Australia, sub 159, p 10.

33 Cancer Foundation of Western Australia, sub 112, p 3.

34 *Background paper: A companion document to the National Tobacco Strategy 1999 to 2002-03*, endorsed by the Ministerial Council on Drug Strategy, Commonwealth Department of Health and Aged Care, Canberra, June 1999, p 14.

For more information, call 132130.

Government health warning

6.29 In its submission the Commonwealth Department of Health and Ageing advised that a review of the health warnings is being conducted.[35] More recent advice from the Commonwealth Department of Health and Ageing indicated the review is being undertaken jointly by the department and the Commonwealth Department of the Treasury with the assistance of the National Tobacco Strategy Technical Advisory Group.[36]

6.30 The first stage of the review was an evaluation of the existing six health warnings which confirmed the need to update the current warnings and include new consumer information on the health effects of tobacco. Following discussion with community and industry sectors, rigorous marketing testing of up to 16 new Australian health warnings is underway. This includes research into consumer reaction to a range of health warnings covering graphics and associated explanatory messages. When draft regulations and the Regulation Impact Statement are developed public consultation on new health warnings will occur. The department expects new regulations to be in place by mid 2004.

6.31 Several submissions to the committee also suggested that additional written and graphic health warnings be required on cigarette packets. For example, the Young Christian Women's Association of Perth supported the adoption of a pictorial graphic advertisement on cigarette packets (for example, a picture of lungs with cancer etc) as adopted in some other western countries.[37] The Cancer Foundation of Western Australia proposed legislation be introduced mandating all product information other than brand name be the responsibility of the Commonwealth government.[38] Canberra ASH Inc suggested that tobacco products be sold in plain packs with graphic health warnings which should be varied from time to time. It also sought cigars sold singly to carry a health warning and herbal cigarettes to carry a warning.[39]

6.32 A number of submissions to the inquiry also called for controls on the type of packaging allowed. They suggested plain, identical packaging for all

35 Commonwealth Department of Health and Ageing, sub 238, p 20.

36 Commonwealth Department of Health and Ageing, sub 298, p 2.

37 Young Women's Christian Association of Perth, sub 108, p 2.

38 Cancer Foundation of Western Australia, sub 112, p 3.

39 Canberra ASH Inc, sub 192, p 7.

brands of tobacco and cigarettes with only a registered brand number for identification.[40]

Conclusion

6.33 The committee is supportive of the evaluative work being undertaken on health warnings and of the need for updating the current warnings. The committee is concerned about the evidence that current figures suggest that within the next decade smoking will become more common among women than men and the associated health implications for women. The committee is particularly concerned about the increase in the number of young women taking up smoking.

Recommendation 43

6.34 **The committee recommends that the Commonwealth, State and Territory governments:**

- **run public education campaigns on the risks of smoking that target the whole community;**
- **continue to develop strategies for increasing awareness among school students, particularly young women, and older women of child bearing age and their partners, of the risks of tobacco smoking for reproduction and their children's health; and**
- **require updated more detailed written and graphic health warnings on cigarette packets.**

Promoting cessation of tobacco use

6.35 The Australian Medical Association (AMA) recommended that further research be conducted into why people commence smoking, methods to help smokers cease smoking, and the social and economic costs to the community of the ill-effects of smoking on health.[41] The committee notes Collins and Lapsley's contribution to estimating the social and economic costs of smoking, and that research is ongoing on methods of helping smokers come to grips with the problem. It is clear from Chapter 3 on families and earlier in this chapter that parental example is one of the strongest predictive factors in the uptake of smoking.

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40 Canberra ASH Inc, sub 192, p 7; Grantham G, sub 2, p 1; Ollquist R, sub 3, p 2; Public Health Association of Australia, sub 159, p 11; Thomas E, sub 16, p 1.

41 Australian Medical Association, sub 133, p 1.

Conclusion

6.36 The committee agrees that parental example is one of the strongest predictive factors in the uptake of smoking. While the committee is cautious in recommending further areas for research, it does believe much could be achieved in better understanding why people commence smoking.

Recommendation 44

6.37 **The committee recommends that the Commonwealth, State and Territory governments contribute funding for further research into why people commence smoking.**

6.38 The VCTC suggested the Commonwealth government force the pace towards greater investment in prevention of tobacco-related diseases by:

- including on the Medicare schedule items that:
  - ⇒ would enable appropriately trained general practitioners (GPs) to provide smoking cessation counselling; and
  - ⇒ would allow GPs to refer smokers to specialist tobacco dependence treatment services as was done in the past for patients with diabetes or mental health problems;
- limiting subsidies for pharmaceutical treatments for non life-threatening conditions, that would be improved by quitting smoking, until after cessation counselling has been attempted;
- requiring pharmacists to confirm that patients are enrolled in cessation programs before they fill prescriptions for subsidised tobacco dependence treatment products;
- making adoption of tobacco control policies and investment in tobacco cessation a condition of health care financing at state, territory and agency levels;
- including tobacco as a priority in all relevant national and state health strategies; and
- making tobacco dependence a national health priority.[42]

42 VicHealth Centre for Tobacco Control, *Tobacco control: A blue chip investment in public health – overview document,* p 4.

6.39 The Commonwealth Department of Health and Ageing recently advised that the development of best practice guidelines in smoking cessation is a priority task under the National Tobacco Strategy. It said it is based on sound evidence about the potential benefits of even brief intervention by general practitioners in achieving smoking cessation which is summarised in the literature review *Smoking cessation interventions: Review of evidence and implications for best practice in health care settings*[43]. The department further advised that the Australian guidelines are intended to:

- encourage general practitioners to intervene in smoking cessation and to do so in a consistent, evidenced-based manner;
- provide them with the latest evidence with respect to smoking cessation programs and therapies (including effective use of Zyban and other pharmacotherapies ;
- promote the integration of smoking cessation intervention and advice into the general practice setting, including records management; and
- provide a basic set of materials on smoking cessation for general practice that can be easily adapted to the needs of other professions, especially pharmacy, nursing and dentistry.[44]

6.40 The department also stated that General Practice Education Australia was awarded the contract for the development of *Australian best practice guidelines in smoking cessation for general practitioners and supporting resource material.* The department said stakeholder consultations are complete and they are now piloting the guidelines.[45]

6.41 Further, ADCA recommended that free or low cost smoking cessation services be made readily available throughout Australia, and the National Heart Foundation of Australia and the PHAA suggested that aids to cessation that are of proven efficacy, such as nicotine patches, be subsidised.[46] Another suggestion by the Women and Children's Hospital Adelaide was that, given that smoking during pregnancy is a clear risk factor for adverse birth outcomes, subsidies for nicotine replacement therapy is particularly important for pregnant women and their partners.[47]

43 Miller M & Wood L, *Smoking cessation interventions: Review of evidence and implications for best practice in health care settings: Final report*, National Tobacco Strategy 1999 to 2002-03 occasional paper, Commonwealth Department of Health and Ageing, Canberra, August 2001, viii 137p.

44 Commonwealth Department of Health and Ageing, sub 299, p 2.

45 Commonwealth Department of Health and Ageing, sub 299, p 2.

46 Alcohol and other Drugs Council of Australia, sub 61, p 20; National Heart Foundation (WA Division), sub 177, p 8; Public Health Association of Australia, sub 159, p 10.

47 The Women's and Children's Hospital, Adelaide, sub 7, Inquiry into Improving Children's Health and Well Being by the House of Representatives Standing Committee on Family and Community Affairs, p 3.

The work by McDermott et al stressed that 'Smoking cessation programs targeting pregnant women and their partners should become the key component of the national strategy to control tobacco smoke.'[48]

Conclusion

6.42 The committee agrees that:

- the development of the smoking cessation guidelines for general practitioners is important;
- there is considerable value in subsiding aids such as nicotine patches under the Pharmaceutical Benefits Scheme to better assist cessation of cigarette smoking; and
- in particular, subsidy of replacement therapies is important for pregnant women and their partners.

Recommendation 45

6.43 **The committee recommends that the Commonwealth, State and Territory governments:**

- **include tobacco as a priority in all relevant national, state and territory health strategies and make tobacco dependence a national health priority;**
- **promote attention to the status of tobacco as a national health priority by requiring the adoption of tobacco control policies and investment as a condition of health care financing at state, territory and agency levels;**
- **make free or low cost tobacco smoking cessation services and aids readily available throughout Australia particularly for pregnant women and their partners; and**
- **investigate the cost benefit analysis of subsidising aids such as nicotine patches under the Pharmaceutical Benefits Scheme to better assist cessation of cigarette smoking.**

6.44 The AMA recommended that life, sickness and disability insurance companies offer reduced premiums to non-smokers.[49] The committee,

48 McDermott L, Russell A & Dobson A, p 13.

49 Australian Medical Association, sub 133, p 1.

recognising the current climate of insurance, however believes that this suggestion should be given further consideration.

6.45 Canberra ASH Inc stressed that 'Treatment for illicit substance abuse and other addictions, to be successful and lasting, should include treatment for the primary drug addiction tobacco'.[50] The committee supports such an approach.

Reducing availability and supply of tobacco

6.46 The National Tobacco Strategy states that the availability of tobacco relates to two issues – accessibility and affordability.[51]

6.47 According to Collins and Lapsley, 'There is a great deal of persuasive evidence that the demand for tobacco is relatively unresponsive to changes in tobacco prices … the demand for cigarettes is price-inelastic ...'[52] However, Professor Hill told the committee that high prices does have the effect of reducing the amount of tobacco a person consumes.[53] In addition, the 2001 NDS Household Survey revealed that the cost of smoking was the most important motivator in changing people's use of tobacco; it was cited as a reason for change by 54.0 per cent of survey respondents.[54]

6.48 There is considerable support for pricing as a deterrent to smoking, in particular in relation to ensuring that cigarettes do not become affordable for children.[55] The VCTC agenda proposed achieving this by continuing the six-monthly indexation of tobacco excise and customs duty, regularly increasing duty in line with average weekly earnings and estimates of children's average weekly disposable pocket money, and minimising the evasion of customs and excise duty.[56] The AMA suggested that taxes on tobacco products be increased and those products not be allowed into Australia duty free.[57] Increasing taxes to pay for health education, treatment and to discourage smoking was supported by over 60 per cent

50 Canberra ASH Inc, sub 227, p i.

51 *National Tobacco Strategy 1999 to 2002-03: A framework for action*, p 22.

52 Collins DJ & Lapsley HM, pp 24-25.

53 Hill D, transcript, 15/8/02, p 1101.

54 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: Detailed findings*, p 23.

55 Hill D, transcript, 15/8/02, p 1101; Ollquist R, sub 3, p 2; Public Health Association of Australia, sub 159, p 7; Canberra ASH Inc, sub 192, p3.

56 VicHealth Centre for Tobacco Control, *Tobacco control: A blue chip investment in public health – overview document*, p 3.

57 Australian Medical Association, sub 133, p 1.

of respondents in the NDS Household Survey (64.3 per cent for health education, 67.0 per cent for treatment and 61.1 per cent for prevention).[58]

Recommendation 46

6.49 **The committee recommends a study of the price elasticity of tobacco and tobacco consumption in Australia be conducted to determine what is the minimum price increase that will stop large numbers of people smoking as a result of price alone.**

6.50 Selling cigarettes to a minor is illegal. However, the 2001 NDS Household Survey revealed that under age smokers most commonly obtained tobacco from a shop or retail outlet (82.6 per cent). The survey also indicated that public support was greater for 'stricter enforcement of laws against supplying tobacco products to minors' than for any of nine other measures to reduce problems associated with tobacco use; 93.3 per cent of respondents were in favour of this.[59] Stricter enforcement was also supported by others in evidence to the committee.[60]

6.51 The National Heart Foundation and the PHAA supported the licensing of tobacco retailers and wholesalers.[61] Given that nicotine is a highly addictive substance, it can be argued that its sale should be tightly regulated. It can also be argued that tighter regulation than occurs at present is urgently needed in the light of the evidence of widespread sale of cigarettes to minors.

6.52 ASH Australia suggested regulation of the sale of tobacco products is best done under a fee-based registration system which would provide:

- information about all those businesses that retail tobacco products; and
- revenue that would finance the monitoring of compliance with the conditions attached to selling tobacco products.[62]

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58 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, p 34.

59 Australian Institute of Health and Welfare, *National Drug Strategy Household Survey: Detailed findings*, pp 92, 104.

60 National Heart Foundation of Australia (WA Division), sub 177, p 8; VicHealth Centre for Tobacco Control, *Tobacco control: A blue chip investment in public health – overview document*, p 4.

61 National Heart Foundation of Australia (WA Division), sub 177, p 6; Public Health Association of Australia, sub 159, pp 9, 11.

62 ASH Australia, informal communication, 6/3/03.

At present only two jurisdictions, the ACT and Tasmania, have fee-based registration systems.[63]

6.53 The Commonwealth Department of Health and Ageing has commissioned a report into the feasibility of introducing a national licensing scheme, which includes:

- identifying and reviewing the public health benefits of registration and/or licensing schemes for tobacco retail outlets and tobacco wholesalers;
- investigating the feasibility and justifiability of introducing registration and/or licensing schemes and the legality of imposing such a scheme/s, including any possible initiatives at the national level; and
- identifying the key elements of a best practice approach to the introduction of registration and/or licensing schemes.[64]

The report has not yet been released but is expected about July/August this year.

Recommendation 47

6.54 **The committee recommends that the Commonwealth, State and Territory governments work together to develop and legislate for nationally consistent regulations governing the registration and licensing of the wholesalers and retailers of tobacco products, which should include registration fees and an emphasis on heavier penalties for the sale of cigarettes to minors than apply at present.**

6.55 Illegal or chop chop tobacco can be sold more cheaply than legal tobacco, because no excise has been paid on it. The Australian Taxation Office said in 2002 it began an active compliance strategy in Australia's two main tobacco growing areas, Myrtleford in Victoria and Mareeba, Queensland. Over the last two years, work under that strategy has intercepted

63 *Public Health Act 1997*(Tas.), Part 4- Tobacco products, viewed 7/3/03, <http://www.thelaw.tas.gov.au/view/86++1997+GS74B@EN+2003030700>; *Tobacco Act 1927* (ACT), p 40, viewed 7/3/03, <http:www.legislation.act.gov.au/a/1927-14/current/pdf/1927-14.pdf>.

64 Commonwealth Department of Health and Ageing, sub 295, pp 2-3.

215 tonnes of illegal tobacco, preventing evasion of more than $54 million in excise.[65]

6.56 Apart from the evasion of excise, there are concerns about the impact of chop chop tobacco on the health of smokers. Bittoun reported chop chop tobacco may be fumigated with bleach and bulked up with additives.[66]

6.57 The committee believes that there should be more focus on elimination of the chop chop tobacco industry.

Reducing tobacco promotion

6.58 Tobacco companies still possess a number of avenues through which they can promote their products to the Australian public. Calls continue for legislation and other means of banning such advertising, and for expanding such bans to international broadcasting and the emerging electronic media.[67] The AMA suggested incidental product placement in television programs and movies should be acknowledged at the beginning of each program, and should receive a rating which does not allow the program to be shown when people under 18 years of age are able to view it.[68] The Cancer Foundation of Western Australia recommended legislation requiring tobacco manufacturers to reveal all their expenditures on any forms of promotion, marketing, public relations and incentives to retailers.[69]

6.59 As pointed out earlier in this chapter the Commonwealth Department of Health and Ageing advised that the *Tobacco Advertising Prohibition Act 1992* is being reviewed. More recently the department said that the review is looking to see if the Act is meeting its objectives, consider solutions to difficult provisions and the possibility of extending the objectives of the Act to take better account of new and emerging technologies and modes of advertising and promotion such as the internet. The department foreshadowed the release of a revised issues paper on the Act as soon as possible.[70]

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65 Australian Taxation Office, *Tax Office and Victoria Police to curb illegal tobacco in Melbourne and Sydney*, media release, 20/2/03, pp 1-2.

66 Bittoun R, '"Chop-chop" tobacco smoking', *Medical Journal of Australia*, vol 177(11/12), 2002, p 686.

67 Australian Medical Association, sub 133, p 1; Canberra ASH Inc, sub 192, p 7; Cancer Foundation of Western Australia, sub 112, p 3; Ollquist R, sub 3, p 2; Public Health Association of Australia, sub 159, pp 8-9; VicHealth Centre for Tobacco Control, *Tobacco control: A blue chip investment in public health – overview document*, p 4.

68 Australian Medical Association, sub 133, p 1.

69 Cancer Foundation of Western Australia, sub 112, p 3.

70 Commonwealth Department of Health and Ageing, sub 299, pp 2-3.

6.60 Misconduct by tobacco companies should be pursued. The PHAA recommended legislative provisions to penalise those making misleading public statements about tobacco.[71] The VCTC suggested litigation to expose the history of industry misconduct in failing to disclose the true nature of its product and to seek orders to prevent and address continuing and future misconduct.[72]

Recommendation 48

6.61 **The committee recommends the Commonwealth, State and Territory governments work together to ensure that all remaining forms of promotion of tobacco products be banned, including advertising, incentives to retailers, sponsorships and public relation activities.**

Regulating tobacco

6.62 According to the National Tobacco Strategy tobacco can also be regulated by disclosure by the tobacco industry of the contents of tobacco products and identification of appropriate interventions to regulate tobacco products.[73]

6.63 The National Tobacco Strategy reported a number of international developments regulating the tobacco industry such as in the Province of British Columbia, Canada's, legislation requiring companies to test and report on all ingredients and additives in their cigarettes, including chemicals used to treat papers and filters, and companies required to report on 44 selected poisons found in tobacco smoke. At the federal level in Canada, there have been proposals to amend the Tobacco Act, including expanding the reporting requirements to obtain data on more than 50 toxic constituents of tobacco and tobacco smoke and the reporting of ingredients used in the manufacturing process. Unlike the USA, there are no regulations in Australia that require the tobacco industry to report to government of the nature and extent of its advertising, promotion and marketing activities.[74]

6.64 In comparison, the National Tobacco Strategy stated, in Australia publicly available information about the contents of cigarettes is still limited.[75] This

71 Public Health Association of Australia, sub 159, p 11.

72 VicHealth Centre for Tobacco Control, *Tobacco control: A blue chip investment in public health – overview document,* p 3.

73 *National Tobacco Strategy 1999 to 2002-03: A framework for action,* p 32.

74 *National Tobacco Strategy 1999 to 2002-03: A framework for action,* p 32.

75 *National Tobacco Strategy 1999 to 2002-03: A framework for action,* p 32.

is despite the three Australian cigarette manufacturers voluntarily agreeing to disclose ingredients in Australian cigarettes. For example, one brand of cigarettes on the side of the packet stated:

> The smoke from each cigarette contains, on average:
> 1 milligram or less of tar – condensed smoke containing many chemicals, including some that cause cancer;
> 0.2 milligrams or less of nicotine – a poisonous and active drug;
> 2 milligrams or less of carbon monoxide – a deadly gas which reduces the ability of blood to carry oxygen.

6.65 During the course of the current inquiry, there were calls for similar initiatives to those being introduced overseas. Several groups suggested smoking can also be reduced by listing the ingredients of the tobacco products inside.[76] The VCTC recommended the strengthening of product label regulations to require disclosure and effective communication about:

- ingredients, including additives;
- maximum toxic output of products when smoked;
- any information relevant to potential acute and long term biological impact, and
- overall addictive potential and overall health risk.[77]

6.66 Further restrictions on tobacco that were suggested to the committee included:

- PHAA proposing removing nicotine's exemption from classification as a poison under state and territory Poisons Acts;[78] and
- ADCA suggesting a ban on manufacturing processes or additives that make tobacco more palatable to children.[79]

6.67 At present the Commonwealth's Standard for the Uniform Scheduling of Drugs and Poisons, No 18, effective date 1 May 2003[80], lists nicotine as a Dangerous Poison (Schedule 7) except when available as a Pharmacy Medicine (Schedule 2) or as a Pharmacist Only Medicine (Schedule 3), or as a Prescription Only Medicine (Schedule 4), or as a Poison (Schedule 6)

76 Canberra ASH Inc, sub 192, p 7; Cancer Foundation of Western Australia, sub 112, p 3; Young Women's Christian Association of Perth, sub 108, p 2.

77 VicHealth Centre for Tobacco Control, *Tobacco control: A blue chip investment in public health – overview document,* p 3.

78 Public Health Association of Australia, sub 159, p 10.

79 Alcohol and other Drugs Council of Australia, sub 61, p 20.

80 *Standard for the uniform scheduling of drugs and poisons, no 18, effective date 1 May 2003*, Commonwealth Department of Health and Ageing, Canberra, May 2003, pp 50, 59, 115, 202, 223, 291, 301, 307.

in preparations containing 3 per cent or less of nicotine when labelled and packed for the treatment of animals; or in tobacco prepared and packed for smoking. The Commonwealth's schedule classifies drugs and poisons into Schedules for inclusion in the relevant legislation of the states and territories. There is a high degree of compliance of the states and territories with the Commonwealth's scheduling. The committee understands that the matter of the removal of the nicotine exemption has been looked at in the past but believes it is timely for it to be examined again.

Recommendation 49

6.68 **The committee recommends that the Commonwealth, State and Territory governments investigate removing nicotine's exemption from classification as a poison under the Commonwealth's Standard for the Uniform Scheduling of Drugs and Poisons and in State and Territory Poisons Acts.**

Reducing exposure to environmental tobacco

6.69 The dangers of involuntary smoking were outlined earlier in this chapter. The National Tobacco Strategy report, *Environmental tobacco smoke in Australia* prepared by the VCTC in 2001, revealed that:

> … while most Australians are protected from exposure to ETS [environmental tobacco smoke] at work, over one quarter are still not protected in indoor workplaces, and many are inadequately protected in other places. We are still a long way from the point where no Australian is being involuntarily exposed to tobacco smoke toxins … Many smokers and non-smokers (in particular children and some of Australia's more disadvantaged communities) continue to experience very high levels of ETS exposure. Current patterns of ETS exposure are also a contributor to continuing inequality in health status between economically advantaged and disadvantaged groups.
>
> …

> … there is a need for a mix of legislation and public education to encourage smokers to be responsible about their smoking and not smoke around people who might be at risk – that is, anyone.[81]

6.70 Reducing involuntary exposure to toxic tobacco by-products in public places is strongly supported by the community and in evidence presented to the committee. The critical issue here is how public places are defined. Support was expressed in several submissions for a ban on smoking in such places as workplaces, shopping centres, restaurants and some outside areas, where there are doorways, restricted seating and airconditioning intakes. There is also growing support for banning smoking in pubs and clubs.[82] In the 2001 NDS Household Survey over 80 per cent of Australians agreed with smoking bans in workplaces, shopping centres and restaurants and a ban on smoking in pubs and clubs was favoured by three out of five people (60.8 per cent).[83]

6.71 The National Occupational Health and Safety Commission's 2002 position statement on environmental tobacco smoke recommended that exposure to such smoke should be excluded in all Australian workplaces. This exclusion should be implemented as soon as possible.[84] Various state and territory governments have already banned smoking in specified public places. For example since July 2001, smoking has been banned in Victorian restaurants and eateries, and from September 2002 Victorian licensed premises and gaming venues have been required to set aside more smoke free areas.[85]

6.72 The VCTC suggested that the Commonwealth government could provide education to build community support for such policies, and promote best practice regulatory drafting.[86]

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81 VicHealth Centre for Tobacco Control, *Environmental tobacco smoke in Australia,* National Tobacco Strategy 1999 to 2002-03 occasional paper, Commonwealth Department of Health and Ageing, Canberra, May 2001, pp 1-2.

82 Australian Medical Association, sub 133, p 1; Canberra ASH, sub 192, p 7; Grantham G, sub 2, p 1; VicHealth Centre for Tobacco Control, *Tobacco control: A blue chip investment in public health – overview document*, p 4.

83 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, p 34.

84 National Occupational Health and Safety Commission, *Position statement adopted by NOHSC concerning environmental tobacco smoke*, media release, p 1, 13/12/02, viewed 25/2/03, <http://www.nohsc.gov.au/NewsAndWhatsNew/MediaReleases/mr-13122002Position-ETS.htm>.

85 Victorian government, sub 255, p 5; Tasmanian government, sub 257, p 3; ACT government, sub 150, p 49.

86 VicHealth Centre for Tobacco Control, *Tobacco control: A blue chip investment in public health – overview document,* p 4.

6.73 The VCTC's *Environmental tobacco smoke in Australia* report also concluded that education and encouragement, perhaps accompanied by supportive structural change, is the preferred strategy for private environments such as homes for the foreseeable future.[87]

6.74 In addition, the VCTC's report stated that under some circumstances, exposure in unenclosed outdoor environments can be quite severe, for example when downwind of a smoker. Accordingly the report suggested that a comprehensive solution to the problem of involuntary exposure to environmental tobacco smoke will also need to include the widespread adoption of strategies by smokers to ensure non-smokers are not exposed to their smoke.[88]

Conclusion

6.75 The committee particularly notes that a smoke free workplace plays a valuable role in reducing tobacco consumption. It appears that there is much to gain by extending the smoke free requirements to other public places. The committee also supports efforts for education and encouragement to make private environments, such as homes, smoke free.

Recommendation 50

6.76 **The committee recommends that the Commonwealth, State and Territory governments:**

- **develop and deliver a program to build community support for a ban on tobacco smoking in public areas where exposure to involuntary smoking is likely; and**
- **develop a similar program to further discourage smoking in private environments, such as homes.**

Some funding options for future directions

6.77 In its June 2001 agenda for tobacco control the VCTC suggested a range of funding strategies whereby the tobacco industry could pay for existing and additional prevention and treatment activities. Options included:

87 VicHealth Centre for Tobacco Control, *Environmental tobacco smoke in Australia,* p 2.

88 VicHealth Centre for Tobacco Control, *Environmental tobacco smoke in Australia,* p 2.

- increases in tobacco excise and customs;
- the abolition of duty free tobacco sales;
- license fees to be paid by companies that import or sell tobacco products in Australia;
- a surcharge on tobacco company profits;
- a levy to help grow the market for tobacco dependence treatments; and
- a levy on each cigarette sold to finance measures to assist farmers leave the tobacco-growing industry.[89]

6.78 Others have also suggested using tobacco taxes to fund anti-smoking initiatives, more specifically that:

- tobacco taxes be made available to education and health services, to work collaboratively in delivering prevention[90]; and
- the link between tax revenue and expenditure on prevention activities be made.[91]

6.79 As Collins and Lapsley pointed out:

> … tobacco tax revenue does in fact exceed by a considerable margin the tobacco-attributable costs borne by the government sector. This fact is often interpreted to mean that "smokers pay their way".[92]

6.80 In looking at the budgetary impact of drug abuse, not drug consumption, Collins and Lapsley showed that:

> Tobacco tax revenue in 1998-99 exceeded tobacco-attributable costs borne by the public sector by almost $2.8 billion. The beneficiaries of this surplus were State Governments. The Commonwealth's tobacco-attributable outlays exceeded its tobacco revenue by $219m.[93]

6.81 However, how this applies at the present time has not been investigated so the committee is unable to draw conclusions on this matter.

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89 VicHealth Centre for Tobacco Control, *Tobacco control: A blue chip investment in public health – overview document,* p 6.

90 Australian Medical Association, sub 133, p 1; Patton G, transcript, 15/8/02, p 1108.

91 Hill D, transcript, 15/8/02, p 1102.

92 Collins DJ & Lapsley HM, p 24.

93 Collins DJ & Lapsley HM, p 66.

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Illicit drug use: prevention and treatment

7.1 This chapter deals with the issues raised for the health care system by illicit drug use. Heroin, cannabis, psychostimulants and injecting drug use are considered. The committee also examines the inappropriate use of licit substances such as inhaling solvents, glue, petrol or paint.

Prevalence and costs

7.2 Illicit drugs are used far less than licit drugs in Australia. Fewer than one in six Australians aged 14 years and over who were surveyed by the National Drug Strategy (NDS) Household Survey in 2001 had used illicit drugs in the previous 12 months. Over one-third had taken an illicit drug at some stage in their lives with males being more likely than females to have done so. Use of illicit drugs since the last survey in 1998 had fallen from 22.0 per cent of Australians to 16.9 per cent.[1]

7.3 The 2001 NDS Household Survey found that the illicit drug most commonly used in the last 12 months was cannabis; it was consumed by 12.9 per cent of Australians over 14 years of age. Other illicit drugs were much less frequently taken; the next most commonly used after cannabis were amphetamines, pain killers / analgesics and ecstasy / designer drugs, each taken by less than one person in 30 (3.4 per cent, 3.1 per cent and 2.9 per cent respectively).[2] However, according to the Australian Medical Association (AMA), the percentage of people over 14 years of age taking

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1 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, Drug statistics series no 9, AIHW, Canberra, May 2002, pp xiii-xiv, 3, 20, 31.

2 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, pp 3, 22.

ecstasy doubled in the seven years before 1998, and in 2002 appeared to be still on the increase.[3]

7.4 Heroin was the drug cited in the NDS Household Survey by the majority of Australians as being of greatest serious concern to the community[4], although it had been used at some stage in their lives by only 1.6 per cent of people aged 14 years and older.[5] Hall et al estimated the number of heroin users in Australia between 1997 and 1998 to be around 74,000.[6] The Household Survey showed that between 1998 and 2001, recent use of heroin dropped significantly.[7] No explanation was provided from the survey on why the usage dropped. However, in 2001 the Australian Drug Trends 2001 reported 'there was a marked and sustained reduction in the availability of heroin, which was manifest in decreased prevalence and frequency of use in all jurisdictions …'[8] Further evidence on decreased prevalence is outlined in Chapter 8.

7.5 27.7 per cent of teenagers (14-19 years age group) who were surveyed in the 2001 NDS Household Survey, had used an illicit drug in the previous 12 months, and 35.5 per cent of 20-29 year olds had also used an illicit drug in the last 12 months.[9] Cannabis was offered or available to 24.2 per cent of Australians surveyed, and to 48.3 per cent of 14-29 year olds. Curiosity, which was cited as the most common reason for trying illicit drugs, stood at 82.4 per cent, while peer pressure was also strong at 54.7 per cent.[10]

7.6 According to the Australian Institute of Health and Welfare (AIHW), illicit drugs are directly and indirectly a major cause of death and ill-health. Medical conditions associated with illicit drug use are overdose, HIV / AIDS, hepatitis C, low birth weight, malnutrition, infective

3 *Party drugs: A new public health challenge*, 2002 AMA Drug Summit, National Press Club, Canberra, 11 April 2002, Australian Medical Association, Canberra, 2002, p 4.

4 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: Detailed findings*, Drugs statistics series no 11, AIHW, Canberra, December 2002, p 5.

5 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, p 24.

6 Hall W, Ross J, Law L & Degenhardt L, 'How many dependent heroin users are there in Australia?' *Medical Journal of Australia*, vol 173[10], 20 / 11 / 00, viewed 26 / 11 / 01, http: / / www.mja.com.au / publicissues / 173_10_201100 / hall / hall.html>.

7 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, p 25.

8 Topp L, Kaye S, Bruno R, Longo M, Williams P, O'Reilly B, Fry C, Rose G & Darke S, *Australian drug trends 2001: Findings of the Illicit Drug Reporting System*, NDARC monograph no 48, National Drug and Alcohol Research Centre, Sydney, 2002, p 51.

9 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, p 20.

10 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: Detailed findings*, pp 15, 40.

endocarditis (i.e. inflammation of lining of the heart), poisoning, suicide and self-inflicted injury.[11] The AIHW also reported that illicit drugs were responsible for 1,023 deaths in 1998 (up from 781 in 1996 and 864 in 1997) and 14,471 hospital separations in 1997-98 (up from 11,057 in 1995-96 and 11,882 in 1996-97).[12] Australian Bureau of Statistics data, as reported by in the 2001 edition of Opioid overdose deaths in Australia, revealed opioid overdose deaths for 15-44 year olds varied from 347 deaths in 1988, 958 deaths in 1999, 725 deaths in 2000 and 306 deaths in 2001.[13] Collins and Lapsley estimated that the cost of health care for illicit drug-related problems in 1998-99 was $64.7 million.[14]

National Illicit Drug Strategy

7.7 The National Illicit Drug Strategy (NIDS) 'Tough on Drugs' is the current major focus of the NDS, and comprises both demand and supply reduction measures. The five priority demand reduction measures are:

- treatment of users of illicit drugs, including identification of best practice;
- prevention of illicit drug use;
- training and skills development for front line workers who come into contact with people who use drugs or at risk groups;
- monitoring and evaluation including data collection; and
- research.[15]

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11 Australian Institute of Health and Welfare. *Australia's health 2002: The eighth biennial health report of the AIHW*, AIHW, Canberra, May 2002, p 148.

12 Australian Institute of Health and Welfare, *Statistics on drug use in Australia 2002*, Drug statistics series no 12, AIHW, Canberra, February 2003, pp 35-36; Australian Institute of Health and Welfare, *Statistics on drug use in Australia 2000*, Drug statistics series no 8, AIHW, Canberra, May 2001, p 37.

13 Degenhardt L, *Opioid overdoses in Australia: 2001 edition: 2001 Australian Bureau of Statistics data on opioid overdose deaths*, National Drug and Alcohol Research Centre, Sydney, 2001, p 3, viewed 30/6/03, http://ndarc.med.unsw.edu.au/ndarc.nsf/c2fabb74f3f54c22ca256afc00097c53/4341b152e43d5786ca256b4b007a9146/$FILE/ABS%20DATA%202001.pdf

14 Collins DJ & Lapsley HM, *Counting the cost: Estimates of the social costs of drug abuse in Australia in 1998-9*, Monograph series no 49, Commonwealth Department of Health and Ageing, Canberra, 2002, p 58.

15 National Illicit Drug Strategy, 'Tough on Drugs', p 1, viewed 14/2/03, <http://www.health.gov.au/pubhlth/strateg/drugs/illicit/index.htm>.

7.8 Several of NIDS preventive measures have been discussed in Chapter 3 (the Community Partnership Initiatives, national drug information service and National School Drug Education Strategy). These are supported by the National Illicit Drugs Campaign designed to educate and inform the community about the dangers of illicit drug use. The first phase of the campaign, which was launched in 2001, targeted parents and included advice on their role in preventing illicit drug use by young people.[16] An evaluation of the campaign found that it had been successful in informing parents and prompting them to talk about illicit drugs with their children. Young people and other members of the community were also influenced by the campaign material.[17] The second stage of the campaign will target youth at risk.[18]

7.9 In addition to projects targeting specific dependencies, NIDS supports treatment through the Non-Government Organisation Treatment Grants Program (discussed in Chapter 4), and diversion of illicit drug users from the criminal justice system into education and treatment (covered in Chapter 8). Other NIDS measures include:

- increasing the number of needle and syringe outlets;
- research to investigate barriers and incentives to illicit drug users accessing and remaining in treatment;
- establishing best practice for therapeutic communities; and
- the National Health and Medical Research Council's program for research in prevention and treatment of illicit drugs.[19]

7.10 Of the three remaining NIDS priorities previously outlined, training and skills development for health care workers is covered in Chapter 4.

7.11 In the 2003-04 federal budget the government provided funding of $316 million over four years for a range of new and continuing measures to address illicit drug use in Australia.[20] Aspects of the package are noted in Chapters 4, 7 and 8. One component of this is that the government will provide $2.8 million over four years for interdisciplinary research into the prevention and treatment of illicit drug use, and to provide sufficient

16 National Illicit Drug Strategy, 'Tough on Drugs', p 4.

17 Bertram S, Worsley J & Carroll T, *Evaluation of the launch phase of the National Illicit Drugs Campaign: Chapter 1: Overview*, research report, Commonwealth Deaprtment of Health and Ageing, Canberra, January 2002, pp 14-15, viewed 19/3/03, <http://www.health.gov.au/pubhlth/publicat/document/reports/nidc_eval_1.pdf>.

18 National Illicit Drug Strategy, 'Tough on Drugs', p 4.

19 National Illicit Drug Strategy, 'Tough on Drugs', pp 3, 5- 6.

20 *Budget measures 2003-04*, Budget paper no 2, Commonwealth Department of the Treasury, Canberra, May 2003, p 168.

resources to attract new researchers to the field. Priority will be given to research into the interaction between mental health and substance abuse and psychostimulant use and for investigator-driven research.[21]

Prevention and treatment

7.12 Table 7.1 was presented to the committee at its roundtable by Professor Saunders; it summarises the extent of knowledge about the effects of different licit and illicit psychoactive substances, whether effective treatments for addiction to these substances exists and, where it does exist, whether it is widely available. It is clear from Table 7.1 and Professor Webster's presentation to the committee's roundtable that very little is known about effective, preventive approaches and ways to intervene early in the development of illicit substance use and misuse. With the exception of heroin, there is little effective treatment for dependence on illicit drugs. This stands in stark contrast with the treatments available for the licit drugs, particularly tobacco, and our knowledge about how to prevent their use.[22] Professor Mattick advised the committee that, while much has been done nationally and internationally over the last 20 years to address the deficits in knowledge and treatment of illicit drugs, investment in understanding cannabis, cocaine and amphetamines is now needed.[23]

Table 7.1 Summary of knowledge about and treatment for different drug dependencies

Drug	Fundamental Knowledge	Evidence of Effective Treatment	Widespread Availability of Treatment
Alcohol	✓	✓	0
Tobacco	✓	✓	✓
Cannabis	✓	0	0
Heroin & other Opioids	✓	✓	0
Psychostimulants	✓	0	0
Inhalants	0	0	0

Source: Saunders J, presentation to roundtable, Canberra, 15/8/02, exhibit 42, slide 6.

21 *Budget measures 2003-04*, p 175.

22 Saunders J, transcript, 15/8/02, p 1089; Webster I, presentation to roundtable, Canberra, 15/08/02, exhibit 53, slide 4.

23 Madden A, transcript, 15/8/02, p 1122; Mattick R, transcript, 15/8/02, p 1099.

Specific dependencies

Heroin

7.13 Research has shown that one-third of the people who try heroin become dependent[24], and half of all heroin users die before the age of 50 years.[25] Prevention and early intervention could therefore have a significant impact. However, early intervention to prevent the onset of heroin dependence among non-dependent users is difficult as, according to Professor Mattick, they do not recognise that they have a problem.[26]

7.14 Professor Mattick suggested that this problem could be addressed by more advertising by departments of health, outreach to vulnerable individuals and the involvement of a range of health professionals. However, there is considerable reticence on the part of some doctors and other health professionals in having 'anything to do with injecting drug users'.[27]

7.15 Nonetheless, as discussed in Chapter 5 in relation to alcohol-related problems, primary health care providers are in a good position to recognise the early signs of substance abuse.

7.16 Professor Saunders pointed out that there is considerable debate about the main goal in combating opioid dependence and its effects on both users and the wider community. The question is: 'Do we want to reduce opioid use completely, or do we want to reduce harm and deaths?'[28] According to Professor Mattick, only one-third of heroin addicts achieve and maintain abstinence. For the remainder, heroin dependence is a chronic, relapsing disease, and 'we have to talk about management, not cure'.[29] As Professor Webster observed, it is about 'trying to achieve an outcome where someone is socially functioning; we are trying to get them back to work and, presumably, back to their families …' [30]

7.17 The committee believes that once in this position, there may be a chance of moving on to abstinence.

7.18 Professor Saunders outlined for the committee the three main approaches currently in use for treating heroin dependence in Australia. Two involve the use of pharmacotherapies which have been shown to substantially

24 Mattick R, transcript, 15/8/02, p 1110.

25 Darke S, 'Suicide among heroin users: the silent killer', *CentreLines,* National Drug and Alcohol Research Centre, May 2002, p 3.

26 Mattick R, transcript, 15/8/02, p 1110.

27 Mattick R, transcript, 15/8/02, p 1110.

28 Saunders J, transcript, 15/8/02, p 1091.

29 Mattick R, transcript, 15/8/02, p 1093.

30 Webster I, transcript, 15/8/02, p 1124.

reduce heroin use as long as the patients remain in treatment, as demonstrated in the National Evaluation of Pharmacotherapies for Opioid Dependence (NEPOD) described as follows.[31]

- Antagonist substitutes are the current benchmark treatment for heroin dependence. They are substances that act on the brain in the same way as heroin. The most commonly used are methadone and buprenorphine which are available on the Pharmaceutical Benefits Scheme (PBS). Newer agonists such as LAAM (levo-alpha-acetylmethadol) have been trialled on a small scale.[32]
- Antagonist pharmacotherapies such as naltrexone block the brain's opioid receptors and remove the craving for heroin. Naltrexone is highly effective with about 5-10 per cent of opioid dependent people. As currently used, it is most suitable for highly motivated people with very good social support.
- Rehabilitation and supportive approaches are effective for some individuals but have a high attrition rate.[33]

Further examination of the outcomes of different types of treatment is being carried out in the Australian Treatment Outcome Study of heroin users.[34]

7.19 Dr Wodak pointed out that pharmacological approaches are effective in attracting and retaining people in treatment over reasonably long periods of time, and so provide important benefits across a range of health and social domains.[35]

Methadone and other agonist substitutes

7.20 Professor Mattick reported to the committee the results of a Swedish trial of methadone which showed its effectiveness in averting death and assisting addicts to become abstinent (Box 7.1). Professor Mattick advised that results such as these 'have been replicated in a number of trials

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31 NEPOD was carried out over three years, comprised 13 separate studies conducted by 250 clinical and research staff in six jurisdictions, cost $7 million and studied 1,425 patients (National Drug and Alcohol Research Centre, *National evaluation of pharmacotherapies for opioid dependence (NEPOD): Report of results and recommendations,* NDARC, Sydney, 6 July 2001, p 12).

32 In some overseas countries such as Switzerland, heroin itself is prescribed to addicts.

33 National Drug and Alcohol Research Centre, *National evaluation of pharmacotherapies for opioid dependence (NEPOD): Report of results and recommendations,* p 6; Saunders J, transcript, 15/8/02, p 1091.

34 National Drug and Alcohol Research Centre, 'The Australian treatment outcome study (ATOS): Heroin', viewed 31/1/03, <http://notes.med.unsw.edu.au/ndarc.nsf/website/Research.current.cp26>.

35 Wodak A, transcript, 16/8/02, p 1251.

internationally at different times, in different settings, with different investigators'.[36] A review by Professor Mattick and others concluded that methadone maintenance treatment (MMT):

- has been one of the best researched treatments for opioid dependence;
- is the only treatment for opioid dependence which has been clearly demonstrated to reduce illicit opiate use more than either no-treatment, drug-free treatment, placebo medication, or detoxification in clinically controlled trials; and
- is the most frequently prescribed pharmacotherapy in use globally for heroin dependence.[37]

According to NEPOD, MMT is also the most cost-effective treatment for opioid dependence available in Australia.[38]

7.21 There are also gains for the community from MMT. A review of the effectiveness of MMT showed that, for every dollar spent on methadone maintenance, the community benefits by $4-$5 in reduced health care, crime and other costs.[39] Hall et al summarised the results of randomised, controlled trials and observational studies of the impact of MMT on crime. These studies demonstrated that MMT reduced involvement in criminal activity and rates of imprisonment, and protected against HIV infection (but not against hepatitis B and C).[40] NEPOD found that MMT halved rates of property crime, drug dealing, fraud and violent crime.[41]

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36 Mattick R, transcript, 15/8/02, p 1096.

37 Mattick R, Breen C, Kimber J et al, 'Methadone maintenance versus no methadone maintenance for opioid dependence', *The Cochrane Database of Systematic Reviews*, vol (issue) 3, pp 1-2. The Cochrane Collaboration provides evidence-based, systematic reviews of available medical treatments.

38 National Drug and Alcohol Research Centre, *National evaluation of pharmacotherapies for opioid dependence (NEPOD): Report of results and recommendations*, NDARD, University of New South Wales, Sydney, 6 July 2001, p 9.

39 National Drug and Alcohol Research Centre, *A brief overview of the effectiveness of methadone maintenance treatment*, quoted by Commonwealth Department of Health and Ageing, sub 290, appendix 11, p 2.

40 Hall W, Ward J & Mattick RP, 'The effectiveness of methadone maintenance treatment 1: Heroin use and crime', in Ward J, Mattick RP & Hall W, *Methadone maintenance treatment and other opioid replacement therapies*, Harwood Academic Publishers, Singapore, 1998, pp 51-53; Ward J, Mattick RP & Hall W, 'The effectiveness of methadone maintenance treatment 2: HIV and infective hepatitis', in Ward J, Mattick RP & Hall W, *Methadone maintenance treatment and other opioid replacement therapies*, p 68.

41 National Drug and Alcohol Research Centre, *National evaluation of pharmacotherapies for opioid dependence (NEPOD): Report of results and recommendations*, p 41.

Box 7.1 Outcomes of methadone treatment for heroin addicts

The trial involved two groups of 17 heroin addicts, of which one received methadone for two years and the other none. The outcome after two years was as follows.

Received methadone (N=17)		*Received no methadone (N=17)*
12	Abstinent from heroin	1
5	Still using heroin	14
0	Dead	2

After two years, the 15 survivors of the group that received no methadone were given the choice of having methadone and followed for a further two years with the following results.

Chose methadone (N=8)		*Did not choose methadone (N=7)*
6	Abstinent from heroin	1
2	Still using heroin	4
0	Dead	2

Source: Mattick R, presentation to roundtable, Canberra, 15/8/02, exhibit 43, slides 21-24 summarising results from Gunne & Gronbladh's study published in 1981.

7.22 The 2001 NDS Household Survey showed that Australians generally support the use of pharmacotherapies for heroin dependence and 63.7 per cent approved the use of methadone, 65.8 per cent drugs other than methadone, and 75.2 per cent naltrexone.[42]

7.23 However, the proportion of dependent people in treatment is relatively low. According to Professor Mattick, about 45 per cent of dependent people are receiving treatment at present. He and Professor Saunders suggested that 80 per cent is what we should be aiming for if we want to reduce heroin-related harm and deaths.[43] One of NEPOD's conclusions was that 'A key challenge is to improve patient retention in all pharmacotherapies …'[44]

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42 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, p 36.

43 Mattick R, transcript, 15/8/02, p 1100; Saunders J, transcript, 15/8/02, p 1091.

44 National Drug and Alcohol Research Centre, *National evaluation of pharmacotherapies for opioid dependence (NEPOD): Report of results and recommendations*, p 6.

Conclusion

7.24 The committee agrees that much more should be done to raise the number of people receiving treatment and starting them on the road, to eventual freedom from their addiction.

7.25 The committee agrees that good treatment outcomes for patients are a stabilised, improved life style in the first instance that may put them in a position to move beyond maintenance medication to achieve abstinence.

Recommendation 51

7.26 **The committee recommends that, as a high priority, the Commonwealth, State and Territory governments:**

- **increase the proportion of heroin addicts in treatment from 45 per cent to 80 per cent of the total number of heroin dependent people in order to reduce heroin-related harm and deaths; and**
- **increase the target to include everyone who requests treatment, as resources permit.**

7.27 Although methadone is very effective in stabilising people dependent on opioids, there are strong criticisms of the way in which it is used. When methadone is used to treat heroin dependence, it simply substitutes one opioid for another and continues the addict's opioid dependence. Some people, such as Major Watters, believed that 'we have tended to take a mechanical or pharmacological approach …', and more effort should go into moving addicts towards abstinence through counselling and psychosocial support.[45] The committee was told by a former heroin addict, who now uses methadone, that the lack of assistance in this respect was disappointing:

> … One of the things that I have been disappointed about in relation to my own treatment, and I know that it is an issue for others, is never having had a treatment plan developed for me. I have just continued on and I happen to have the wherewithal to be able to make my own decisions now. I certainly would not necessarily have said that when I first went on the program, but I could just have easily have got lost in it all and I know people do. It saddens me a great deal to see people turning up and going each

45 Watters B, transcript, 16/8/02, pp 1249-1250.

> day [to collect their methadone doses] when no-one connects with them. I think there is so much lost potential there ...[46]

7.28 Professor Mattick advised the committee that more support should be provided to those receiving methadone. He commented, 'If you want these treatments to be effective, they need to be supported adequately in a number of ways …' He suggested that more ancillary services are required than are currently provided by state governments.[47] DRUG-ARM suggested that methadone programs should work towards 'a point of closure to ensure that clients' long term harms associated with long term exposure to methadone is minimised …'[48]

7.29 The disadvantages of methadone treatment were listed for the committee by Professor Mattick. They include methadone's side effects, the stigma attached to its use and the fact that it maintains dependence on opioids and is hard to withdraw from.[49] The need for daily dosing also places restrictions on the life styles of users.[50] Dr Currie and Mr Colquhoun of the R&D Counselling and Therapy Group pointed out how sharply methadone treatment impacts on an individual's capacity to lead a normal life in the community or hold down a job.[51] Others have suggested that it may also expose them to unpleasant encounters involving discrimination or being accosted by dealers.[52]

7.30 Evidence cited in the last paragraph illustrates the benefits of quitting to methadone dependent people. There are also benefits to the community in reduced costs, as indicated by the enormous health and crime costs associated with illicit drug abuse in paragraphs 7.6 and 8.4. Furthermore, as Dr Currie pointed out informally to the committee, moving people off methadone frees up places for those who need and cannot at present access it. Ms Madden told the committee that:

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46 Madden A, transcript, 15/8/02, p 1128.

47 Mattick R, transcript, 15/8/02, p 1095.

48 DRUG-ARM, sub 199, p 10.

49 Mattick R, presentation to roundtable, Canberra, 15/8/02, exhibit 43, slide 7; Mattick R, transcript, 15/8/02, p 1094.

50 Mattick R, Kimber J & Breen C, 'Buprenorphine maintenance verus placebo or methadone maintenance for opioid dependence', *The Cochrane Database of Systematic Reviews*, vol (issue) 3, p 2.

51 R&D Counselling & Therapy Group, sub 282, p 4; Currie J, informal communication, 25/9/02.

52 House of Representatives Standing Committee on Family and Community Affairs, *Where to next? A discussion paper: Inquiry into substance abuse in Australian communities*, FCA, Canberra, September 2001, p 61; R&D Counselling & Therapy Group, sub 282, p 4.

> … There are huge waiting lists all around the country. In some places, they do not even keep waiting lists any more because they are too demoralising for both the staff and patients.[53]

Conclusion

7.31 In the committee's view:

- the need to help people on MMT to move beyond it and on to abstinence is one of the most important issues to be addressed in relation to heroin addiction;
- it is very concerned about the inadequate resources available to help those who are ready and want to move on; and
- it is vital that opioid dependent people are not left in 'liquid handcuffs', 'parked' on methadone.

Recommendation 52

7.32 **The committee recommends that, when providing:**

- **methadone maintenance treatment to save lives and prevent harm to people dependent on heroin, the ultimate objective be to assist them to become abstinent from all opioids, including methadone; and**
- **in addition, comprehensive support services must be provided to achieve this outcome.**

Recommendation 53

7.33 **The committee recommends that the Commonwealth government, State and Territory governments provide funding to determine the extent of very long-term use of methadone, including dosage rates, by opioid dependent people and its effect on the user, including its impact on the user's workplace, community and family roles.**

53 Madden A, transcript, 15/8/02, p 1122.

7.34 Alternative agonist substitutes to methadone like buprenorphine are available in Australia. However, according to NEPOD, more research is needed to better understand how to use buprenorphine and LAAM.[54]

Naltrexone

7.35 Naltrexone is unlike other pharmacological treatments for heroin addiction which are opioid substitutes. Professor Mattick and Dr Currie told the committee that naltrexone blocks the opioid receptors from responding to opioids and so reduces craving for heroin and protects against its impulsive use.[55] As DrugBeat of South Australia noted, it is 'not a drug substitution treatment, but rather a treatment that promotes abstinence …'[56] Support for its use comes from those, like Festival of Light, who believe there should be greater opportunities for individuals to opt for abstinence rather than an opiate substitute like methadone[57], and from those who favour a range of treatments being available.

7.36 Drawing on NEPOD's results, Professor Mattick pointed out that orally administered naltrexone is safe and effective as long as patients remain in treatment but it is not well accepted by many who try it. Compared with the other pharmacotherapies evaluated, the study found that it is harder to retain patients in treatment with naltrexone, compliance is poorer, and the risk of death and overdose is higher when treatment is ceased or intermittent.[58] A review by Kimber et al for the Cochrane Collaboration of all 11 of the available, methodologically sound trials of oral naltrexone treatment confirmed NEPOD's finding of low retention rates. It also concluded that there was insufficient evidence to evaluate the efficacy of naltrexone.[59]

7.37 However, the committee learnt about others' experience of considerable successes with naltrexone treatment when patients are carefully selected for treatment and extensive social support is provided for them during their treatment. The committee was impressed during its visit to the Western Sydney Area Health Service Drug and Alcohol Services at

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54 National Drug and Alcohol Research Centre, *National evaluation of pharmacotherapies for opioid dependence (NEPOD): Report of results and recommendations,* p 11.

55 Currie J, informal communication, 25/9/02; Mattick R, presentation to roundtable, Canberra, 15/8/02, exhibit 43, slides 10, 11.

56 DrugBeat, sub 271, p 21.

57 Festival of Light, sub 256, p 7.

58 Mattick R, presentation to roundtable, Canberra, 15/8/02, exhibit 43, slide 11, quoting results from National Drug and Alcohol Research Centre, *National evaluation of pharmacotherapies for opioid dependence (NEPOD): Report of results and recommendations.*

59 Kirchmayer U, Davoli M & Verster A, 'Naltrexone maintenance treatment for opioid dependence', *The Cochrane Database of Systematic Reviews*, issue 3, 2002.

Westmead Hospital by the results reported by Dr Currie. Mr Colquhoun of the R&D Counselling & Therapy Group also reported favourably on the impact of naltrexone treatment coupled with strong support.[60] Dr O'Neil in Perth supplements his treatment regime with a network of primary and secondary caregivers for each patient to ensure their compliance with the regime. He claimed that 100 per cent success is assured with this regime.[61]

7.38 In addition, according to Professor Saunders, naltrexone implants provide a promising long-acting form of treatment. They are effective for between two and six months, which avoids the problems associated with oral administration. Both Professor Saunders and Mr Colquhoun of R&D Counselling & Therapy Group recommended further trialling of implants.[62] Professor Mattick advised that there has been little evaluation internationally of implant or depot or sustained release preparations. He suggested that there is a need for such an evaluation to be conducted, and Australia is in a position to carry out such work. The work would need to be foreshadowed or preceded by some attention to the release of the medication once it is implanted. It is normal to understand some aspects of the pharmacology and the activity or action of the medication implanted before attempting large scale trials. This would not preclude trials from proceeding, but is just a sensible first step.[63]

7.39 The Commonwealth Department of Health and Ageing said that a Commonwealth Expert Advisory Committee has been appointed to investigate the feasibility of a clinical trial of sustained release naltrexone, including the safety, quality and effectiveness of sustained release naltrexone, and the methodological and medico-legal issues of the trial. The committee comprises a range of recognised experts and is chaired by Professor Saunders. The Expert Advisory Committee met in May 2003 and will report its findings by the end of 2003.[64]

Conclusion

7.40 It is clear to the committee that there is a great need for more social support and counselling for opioid dependent people who are being treated with pharmacotherapies such as methadone and naltrexone. They need this help to successfully develop a more normal lifestyle and reach the point where they can move off these medications. These people should

60 R&D Counselling & Therapy Group, sub 282, p 2.

61 O'Neil G, *Understanding the treatment of heroin addiction: For patients and general practitioners*, Australian Medical Procedures Research Foundation, Subiaco, Western Australia, undated, p 8.

62 R&D Counselling & Therapy Group, sub 282, p 2; Saunders J, transcript, 15/8/02, p 1091.

63 Mattick R, informal communication, 9/4/03.

64 Commonwealth Department of Health and Ageing, sub 294, p 3.

be offered every opportunity to totally leave behind their dependence on opioids. The committee believes that greater emphasis should be given to expanding the use of naltrexone.

Recommendation 54

7.41 **The committee recommends that the Commonwealth, State and Territory governments ensure that sufficient funding is available to treatment services to provide comprehensive support to opioid dependent people who are receiving pharmacotherapy:**

- **for as long as it is needed to stabilise their lifestyle;**
- **if possible, to assist them to reduce or eliminate their use of all opioids, including methadone;**
- **support further research and trials of promising new medications and techniques;**
- **continue to fund research into pharmacotherapies for opioid dependence;**
- **make widely available as a matter of priority any treatments that are found to be cost-effective; and**
- **give priority to treatments including naltrexone that focus on abstinence as the ultimate outcome.**

Recommendation 55

7.42 **The committee strongly recommends as a matter of urgency that the Commonwealth government fund a trial of naltrexone implants, coupled with the support services required for efficacy.**

Therapeutic communities

7.43 Residential rehabilitation is another treatment option for opioid dependent people that impressed the former and current committee members who visited The Woolshed and Odyssey House. In addition, the current committee heard impressive evidence from Teen Challenge on their successes in residential rehabilitation. A review by Gowing et al of the limited research on residential rehabilitation showed that for those who completed the programs offered by therapeutic communities, drug

use and criminal behaviour reduced and legal employment increased. Gowing et al also found the need for at least three months of treatment to achieve change for clients and that good outcomes depend on progress with treatment, not just time in treatment.[65]

7.44 However, a survey of residential rehabilitation in Victoria and Gowing et al's review noted high drop out rates in the early stages of treatment in such communities.[66] Professor Mattick claimed that:

> If you take the 32,000 individuals who are currently in methadone treatment and try to put them into therapeutic communities, you will have a lot of difficulty … they do not have the desire.[67]

In addition, as indicated in Chapter 3, another difficulty with residential treatment for opioid dependent people is that clients may not be able to afford it while maintaining other commitments.

Conclusion

7.45 The committee:

- was impressed by the therapeutic community programs they visited and the efforts of the many voluntary organisations and individuals involved with them;
- agrees residential rehabilitation is a valuable treatment for substance abuse;
- expresses its concern that there are so few residential programs operating and that they lacked adequate funding and support from all levels of government;
- believes it is desirable that therapeutic communities are established throughout each state and territory and in particular in rural communities;
- believes successful outcomes depend on effective links with governmental agencies such as housing, health, education and employment; and
- believes there is a need to provide ongoing support services on leaving therapeutic communities.

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65 Gowing L, Proudfoot H, Henry-Edwards S & Teesson M, *Evidence supporting treatment: The effectiveness of interventions for illicit drug use,* ANCD research paper 3, Australian National Council on Drugs, Canberra, 2001, p xvii.

66 Gowing L, Proudfoot H, Henry-Edwards S & Teesson M, p xvii; McDonald P, 'Keynote speech to the World Therapeutic Communities Conference', *The World Federation of Therapeutic Communities: 21st World Conference,* Melbourne, 17- 21 February 2002, p 2.

67 Mattick R, transcript, 15/8/02, p 1106.

Recommendation 56

7.46 **The committee recommends that:**

- **the Australian National Council on Drugs urgently determine best practice models of residential rehabilitation in consultation with service providers;**
- **the Commonwealth, State and Territory governments ensure funding to establish these models throughout urban and rural areas;**
- **residential rehabilitation providers establish programs to instigate, where it is not already provided, ongoing support for those needing residential rehabilitation; and**
- **given the complexity of delivery of rehabilitation programs, responsibility and coordination should be undertaken by the Commonwealth Department of Family and Community Services.**

Heroin prescription

7.47 The prescription of heroin has been suggested as a useful further tool in stabilising the lives of heroin addicts. Overseas trials have shown that such prescriptions can improve the general health and social functioning of heroin dependent people, reduce their criminal behaviour and the amount of drugs they use.[68] According to Dr Wodak and Professor Saunders, it is a niche treatment useful for a small number of dependent people; it is prescribed for five per cent of heroin users in Switzerland and 3-4 per cent in the UK.[69] However, as Professor Mattick pointed out, it is at least three times more expensive than existing treatments and claims for its potential to 'remove the black market' and 'stop deaths' are overstated.[70]

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68 Van den Brink W, Hendricks VM, Blanken P, Huijsman IA & van Ree JM, *Medical co-prescription of heroin: Two randomized controlled trials*, Central Committee on the Treatment of Heroin Addicts (CCBH), The Netherlands, 2002, Chapter 12 Conclusions, p 4, viewed 16/9/02, <http://www.ccbh.nl/rapport_engels_html>; Ali R, Auriacombe M, Casas M, Cottler L, Farrell M, Kleiber D, Kreuzer A, Ogborne A, Rehm J & Ward P, External Evaluation Panel, *Report of the External Panel on the Evaluation of the Swiss scientific study of medically prescribed narcotics to drug addicts*, April 1999, p 4, viewed 16/9/02, <http://druglibrary.org/schaffer/library/studies/OVERALLS.htm>.

69 Saunders J, transcript, 15/8/02, p 1101; Wodak A, transcript, 16/8/02, p 1247.

70 Mattick R, transcript, 15/8/02, p 1100.

7.48 With 65.5 per cent of Australian's (aged 14 years and over who were surveyed) opposed, and 34.5 per cent in favour of a trial of prescribed heroin according to the 2001 NDS Household Survey[71], the Australian community predominantly opposed trials of heroin prescription as a useful approach to managing heroin dependence.

7.49 Individuals and organisations from both sides of the divide provided information and submissions to the committee. DRUG-ARM, for example, recommended that free heroin should not be provided to people dependent on heroin.[72] Supporters of trials included the Public Health Association of Australia (PHAA), the AMA and the Law Society of New South Wales.[73] Families and Friends for Drug Law Reform (ACT) recommended that, 'without delay the Federal Government facilitate a scientific trial of prescription heroin among severely dependent drug users for whom existing treatments are inadequate'.[74] Mr Tony Trimingham of Family Drug Support presented 339 petitions to the committee in favour of a trial[75], and the 2001 Western Australian Drug Summit also supported a trial.[76]

7.50 Professor Mattick commented to committee members that the discussion in the community about heroin trials was not well-informed.[77] Professor Saunders said that it was particularly unfortunate that the debate about the most appropriate way of treating as many addicts as possible had been highjacked by the attention given to heroin prescription.[78] DRUG-ARM suggested that a better approach in these circumstances would be to invest in alternative treatments, such as naltrexone, buprenorphine and hydromorphone.[79]

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71 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, p 36.

72 DRUG-ARM, sub 199, p 10.

73 Australian Medical Association, sub 133, p 2; The Law Society of New South Wales sub 39, attachment – copy of The Law Society of NSW submission to the NSW Parliamentary Drug Summit, Sydney, 17-21 May 1999, p 17; Public Health Association of Australia, sub 159, p 4

74 Families and Friends for Drug Law Reform (ACT), sub 266, p 4.

75 Trimingham T, 'Do you agree with a heroin trial? And the reasons for supporting a trial', personal petitions tabled at the committee's roundtable, Canberra, 15/8/02, exhibit no 25.

76 Government of Western Australia, *Community Drug Summit: Recommendations*, p 9, viewed 27/2/03, <http://www.wa.gov.au/drugwestaus/html/contents/publications/reports_official/summit/recommendations.pdf>.

77 Mattick R, transcript, 15/8/02, p 1093.

78 Saunders J, transcript, 15/8/02, p 1101.

79 DRUG-ARM, sub 199, p 10.

Conclusion

7.51 Noting that overseas trials of prescription heroin are occurring in some countries this committee has not been convinced of the value of this form of treatment for heroin dependence. However, the results of overseas trials of prescription heroin be closely monitored together with all other forms of treatment.

7.52 The committee also notes that laws, regulations and procedures governing the legality of a medical practitioner prescribing a drug of dependence for the treatment of a drug dependence are all state and territory laws.

Recommendation 57

7.53 **The committee recommends that trials of heroin prescription as a treatment for heroin dependence not proceed.**

Cost of treatment for opioid dependence

7.54 The Commonwealth government funds the wholesale cost of methadone and buprenorphine under the PBS. It spent $3.396 million on methadone in 2000-01, and $4.2 million on buprenorphine from the time it was listed on the PBS in August 2001 to May 2002. It also funds private methadone services and medical consultations through the Medicare Benefits Scheme. State and territory governments are responsible for methadone and buprenorphine programs within their jurisdictions.[80]

7.55 According to advice from the Commonwealth Department of Health and Ageing, in recent years there has been a substantial shift from the public to the private sector in the provision of methadone maintenance.[81] The Alcohol and other Drugs Council of Australia (ADCA) reported that in 1996 around 39 per cent of the approximately 19,500 people in Australia on methadone were treated through private providers, but by 2001 this figure had increased to about 67 per cent.[82]

7.56 According to ADCA, dispensing fees charged by pharmacists for methadone vary across Australia, ranging from $3.50-$7 per day. The cost can place a considerable financial burden on individuals, particularly

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80 Commonwealth Department of Health and Ageing, sub 290, appendix 11, p 1; Commonwealth Department of Health and Ageing, sub 238, p 35.

81 Commonwealth Department of Health and Ageing, sub 290, appendix 11, p 1.

82 Alcohol and other Drugs Council of Australia, informal communication, September 2002.

those who are already socially and economically disadvantaged.[83] The Pharmacy Guild of Australia recommended a Commonwealth subsidy for pharmacists who dispense and supervise methadone doses.[84] Reimbursing pharmacists who deal with young people on methadone programs was also recommended to the committee by the Youth Substance Abuse Service.[85]

7.57 The cost of naltrexone for opioid dependent people is also high because, although available on the PBS for treating alcohol dependence, it is not listed for heroin dependence. [86] At the time of writing, the dispensed price for heroin dependence for thirty 50mg tablets is approximately $167.00.

Conclusion

7.58 In the committee's view, it is absolutely essential that the cost of treatment be affordable so that those wishing to undertake treatment do not encounter hardship. Currently the cost of treatment can be prohibitive. It is important that a range of treatments are available and, as new treatments are found to be effective, they are rapidly made available at an affordable cost.

Recommendation 58

7.59 **The committee recommends that the Commonwealth government ensure that proven pharmacotherapies are available at low cost to all opioid dependent people undergoing treatment.**

Conclusion

7.60 As naltrexone has already been proved to be a cost-effective treatment, the committee believes that it should also be listed, as a matter of priority, for the treatment of opioid dependence.

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83 Alcohol and other Drugs Council of Australia, informal communication, September 2002.

84 Pharmacy Guild of Australia, sub 151, p 3.

85 Youth Substance Abuse Service, sub 102, p 10.

86 Pharmaceutical Benefits Schedule, 'Schedule of pharmaceutical benefits effective from 1 February 2003', p 1, viewed 2/4/03, <http://www.health.gov.au/pbs/scripts/search.cfm>.

Recommendation 59

7.61 **The committee recommends that the Commonwealth government list naltrexone on the Pharmaceutical Benefits Scheme for the treatment of opioid dependence, particularly for heroin and methadone dependence.**

7.62 It is interesting that, according to NEPOD, treatment for opioid dependent people may be provided more cost-effectively by GPs than in clinics. NEPOD suggested that this issue should be explored further.[87]

Conclusion

7.63 The committee notes that if the finding that treatment for opioid dependent people may be provided more cost-effectively by GPs than in clinics were to be confirmed, it would be possible for GPs to take a more prominent role in providing treatment. However as indicated above, some GPs might find this difficult because of their antipathy for managing injecting drug users.

Recommendation 60

7.64 **The committee recommends that the Commonwealth, State and Territory governments investigate the potential to deliver cost-effective treatment to opioid dependent people by the greater use of general practitioners.**

Cannabis

Medical use of cannabis

7.65 According to the National Drug and Alcohol Research Centre (NDARC), there are a number of obstacles to the medical use of cannabis. It lacks widespread public support because of cannabis' association with dependence and the use of other illicit drugs, and a feeling that allowing the medical use of cannabis would 'send the wrong message' about illicit drugs. In addition, regular smoking of cannabis is associated with increased risk of cancer, lung damage and poorer outcomes of pregnancy, and so would not be suitable medication for a chronic condition. NDARC suggested that an alternative way of delivering the active agent, which is

87 National Drug and Alcohol Research Centre, *National evaluation of pharmacotherapies for opioid dependence (NEPOD): Report of results and recommendations,* pp 9, 11.

tetrahydrocannabinol or THC, would need to be found, if cannabis were to be used for medical purposes.[88]

7.66 Notwithstanding these problems, ADCA supported the therapeutic use of cannabis[89], as did the AMA (NSW) and the Law Society of New South Wales. The latter advocated its use particularly for those who have failed to respond to conventional treatments.[90] Others, such as the Pharmacy Guild, cautioned that rigorous clinical trials of cannabis' efficacy should be carried out before any consideration is given to cannabis' use for medical purposes.[91] Further clinical trials and surveys were also recommended in a recent report commissioned by the New South Wales government.[92]

7.67 This report and the Victorian Drug Policy Expert Committee have both suggested leniency with:

- in New South Wales, recommendations that criminal sanctions not be imposed on those using cannabis for certain serious, debilitating conditions; and
- in Victoria, proposals for discretion by police and courts.[93]

7.68 On 20 May this year the New South Wales government announced that it was undertaking a trial of cannabis for the terminally ill. The trial will commence later this year and run for four years. The New South Wales government also said it is establishing a new Office of Medicinal Cannabis within the New South Wales Department of Health.

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88 National Drug and Alcohol Research Centre, 'The medical uses of cannabis', Fact sheet, pp 1-2, viewed 20/3/03, <http://ndarc.med.unsw.edu.au/ndarc.nsf/website/DrugInfo.factsheets>; Working Group on the Use of Cannabis for Medical Purposes, *Report of the Working Party on the use of cannabis for medical purposes: Volume 1: Executive Summary*, August 2000, pp 10, 15, 27, viewed 20/3/03, < http://www.druginfo.nsw.gov.au/druginfo/reports/canrep1.pdf>.

89 Alcohol and other Drugs Council of Australia, *Drug policy 2000: A new agenda for harm reduction*, June 2000, <http://www.adca.org.au/publications/Drug%20Policy%202000/65_cannabis.htm>.

90 The Law Society of New South Wales, sub 39, attachment – copy of The Law Society of NSW submission to the NSW Parliamentary Drug Summit, Sydney, 17-21 May 1999, pp 15-16. This recommendation is also contained in the attachment to that *submission Joint protocol between the Australian Medical Association (NSW) Ltd and The Law Society of New South Wales: Developing more effective responses to Australia's growing problem with illicit drug*, p 1.

91 Pharmacy Guild of Australia, sub 151, p 13.

92 Working Group on the Use of Cannabis for Medical Purposes, p 26.

93 Victorian Department of Human Services, Drug Policy Expert Committee, *Drugs:meeting the challenge*, quoted by Rickard M, *Reforming the old and refining the new: A critical overview of Australian approaches to cannabis*, Department of the Parliamentary Library, Research Paper no 6 2001-02, DPL, Canberra, 2001, p 14.

Conclusion

7.69 The committee believes that the medical use of cannabis is an important issue, but has not been able to collect sufficient information about it to reach a properly considered opinion and that further work should be done on this topic.

Recreational use of cannabis

7.70 One of the problems encountered in attempts to prevent and intervene early in cannabis use is the widespread belief, to which Australian Parents for Drug Free Youth referred, that cannabis is relatively harmless.[94] This belief was formed 20 or more years ago when, according to Professor Saunders, there were lower doses of the psychoactive ingredient in the cannabis used then and few serious health effects were evident. Current users receive a dose of the psychoactive agent, tetrahydrocannabinol (THC), which is, on average, 3.5 times greater than 20 years ago, and evidence is accumulating about the deleterious health effects of cannabis.[95] (A psychoactive substance is one that, when taken into the body, acts upon the central nervous system to affect behaviour, emotion and / or thought.[96]) Professor Saunders claimed that:

> … One could argue that cannabis use, as practised 20 years ago, was a relatively trivial form of substance abuse—that is not the case now. We are seeing an increasing number of people with cannabis dependence and the severe health effects of cannabis …[97]

7.71 Research by Hall and Swift reported in August 2000 stated that:

> There probably has been a modest increase in the THC content of cannabis, but changing patterns of cannabis use have probably made a larger contribution to any increase in rates of cannabis-related problems among young Australian adults.[98]

7.72 Hall and Swift stated that the more plausible explanation for the higher rates of cannabis-related problems among young Australian adults are: the more potent forms of cannabis ('heads') being more widely used ; and

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94 Australian Parents for Drug Free Youth, sub 267, p 1.

95 Saunders J, transcript, 15 / 8 / 02, p 1097.

96 Ryder D, Salmon A & Walker N, *Drug use and drug-related harm: A delicate balance*, IP Communications, Melbourne, 2001, p 281.

97 Saunders J, transcript, 15 / 8 / 02, p 1091.

98 Hall W & Swift W, The THC content of cannabis in Australia: Evidence and implications, *Australian and New Zealand Journal of Public Health*, 2000, vol 25 no 5, p 503.

cannabis users are initiating cannabis at an earlier age, thereby increasing the prevalence of harmful patterns of use.[99]

7.73 The Australian Drug Trends 2002 report stated that hydroponically grown cannabis is the predominant form of drug used, with over 70 per cent in all jurisdictions reporting hydroponic as the form most often used in the past six months.[100] The Australian Drug Trends 2001 report advised that 'The THC content of Australian cannabis has not been systematically tested, thus it is not possible to confirm whether the THC content has changed in recent years …'[101] The 2001 report also noted that there has been an increase in the use of 'bongs' or waterpipes that allow the more efficient smoking of the drug. They cool the smoke and therefore allow the smoker to hold the smoke in their lungs for a longer time so that absorption is maximised.[102]

7.74 In a recent review, Hall, Degenhardt and Lynskey summarised the acute and chronic effects of cannabis on the health and psychological status of users; these effects are shown in Box 7.2. Hall et al identified three groups as being at increased risk of experiencing adverse effects: pregnant women; adolescents with a history of poor school performance or who start using cannabis in their early teens; and people with pre-existing conditions such as cardiovascular or respiratory disease, schizophrenia, or dependence on other drugs.[103]

7.75 In addition, Rey and Tennant reported that there is growing evidence of an association between cannabis use and depression from US, Australian and New Zealand studies of adolescents who have been followed for seven or more years. There appears to be a dose-effect relationship between cannabis use and anxiety or depression, and this relationship is stronger for young women than young men.[104]

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99 Hall W & Swift W, p 503.

100 Breen C, Degenhardt L, Roxburgh A, Bruno R, Duquemin A, Fetherston J, Fischer J, Jenkinson R, Kinner S, Longo M & Rushforth C, *Australian Drug Trends 2002: Findings of the Illicit Drug Reporting System (IDRS)*, NDARC monograph no 50, National Drug & Alcohol Research Centre, Sydney, April 2003, p 9.

101 Topp et al, p 95.

102 Topp et al, p 95.

103 Hall W, Degenhardt L & Lynskey M, *The health and psychological effects of cannabis use*, Monograph series no 44, 2nd ed, Commonwealth Department of Health and Ageing, Canberra, 2001, pp xxv-xxvi.

104 Rey JM & Tennant CC, 'Cannabis and mental health', *British Medical Journal*, vol 325, 23/11/02, p 1183.

Box 7.2 Acute and chronic health and psychological risks of cannabis use

Acute effects

The major acute adverse psychological and health effects of cannabis intoxication are:

- anxiety, dysphoria, panic and paranoia, especially in naive users;
- cognitive impairment, especially of attention and memory;
- psychomotor impairment, and possibly an increased risk of accident if an intoxicated person attempts to drive a motor vehicle;
- an increased risk of experiencing psychotic symptoms among those who are vulnerable because of personal or family history of psychosis; and
- an increased risk of low birth weight babies if cannabis is used during pregnancy.

Chronic effects

The most probable health and psychological effects of chronic heavy cannabis use appear to be:

- respiratory diseases associated with smoking as the method of administration, such as chronic bronchitis, and the occurrence of histopathological changes that may be precursors to the development of malignancy;
- an increased risk of cancers of the aerodigestive tract, i.e. oral cavity, pharynx, and
- oesophagus; and
- development of a cannabis dependence syndrome, characterised by an inability to abstain from or to control cannabis use.

The following **possible** adverse effects of chronic, heavy cannabis use remain to be confirmed by further research:

- a decline in occupational performance marked by underachievement in adults in occupations requiring high level cognitive skills, and impaired educational attainment in adolescents; and
- subtle forms of cognitive impairment, most particularly of attention and memory, which persist while the user remains chronically intoxicated, and may or may not be reversed by prolonged abstinence from cannabis.

Source: Hall W, Degenhardt L & Lynskey M, The health and psychological effects of cannabis use, Monograph series no 44, 2nd ed, Commonwealth Department of Health and Ageing, Canberra, 2001, p xxv.

7.76 On the basis of their review, Hall et al concluded that there is also abundant evidence from surveys and longitudinal studies of an association between regular cannabis use and the use of other illicit drugs such as heroin and cocaine. A typical sequence has been observed among adolescents in several countries: they began using alcohol first, followed in order by tobacco and cannabis; they then moved on to hallucinogens, amphetamines and tranquillisers and finally to cocaine and heroin. In every case, it was younger and heavier users who were more likely to progress through this sequence. Such observations as these gave rise to the

hypothesis that cannabis is a 'gateway' drug. This hypothesis posits that, as Hall et al pointed out, 'adolescent cannabis use may increase the chance that young people will use other more dangerous illicit drugs, such as cocaine and heroin'.[105]

7.77 One explanation that has been advanced to account for the association between the use of cannabis and other illicit drugs is that cannabis has a direct pharmacological effect that predisposes users to the use of other illicit drugs. For example Nahas has hypothesised that 'the biochemical changes induced by marijuana in the brain result in a drug-seeking, drug-taking behaviour, which in many instances will lead the user to experiment with other pleasurable substances.'[106]

7.78 Hall et al claimed that the evidence for this effect was not compelling and concluded instead that:

> If there is a causal relationship between cannabis and other illicit drug use the explanation is more likely to be a sociological than a pharmacological one. The fact that cannabis use predicts an increased chance of using other illicit drugs reflects a combination of: (1) the selective recruitment to heavy cannabis use of persons with preexisting personality and attitudinal traits (possibly genetic in origin) that predispose to the use of other intoxicants; (2) their affiliation with drug using peers; (3) socialisation into an illicit drug subculture in which there is an increased opportunity and encouragement to use other illicit drugs; (4) increased access to opportunities to purchase and use other illicit drugs because of involvement in illicit drug markets as buyers and sellers; and possibly (5) a shared genetic vulnerability to use and become dependent on a range of different drugs.[107]

7.79 More recent reports have confirmed some of the above points and pointed to areas where further research is needed.

- Lynskey and others studied 311 same sex Australian twin pairs who shared the same genetic and family environment and among whom one twin from each pair had started using cannabis before the age of 17 years of age. Lynskey et al found an association between early cannabis use and the later use of other drugs and their abuse and dependence. They suggested that this association 'may arise from the effects of the peer and social context within which cannabis is used and obtained'. In addition, early access to cannabis and its use may reduce

105 Hall W, Degenhardt L & Lynskey M, pp 103-104.

106 Hall W, Degenhardt L & Lynskey M, p 107.

107 Hall W, Degenhardt L & Lynskey M, p 109.

perceptions of its harms and the barriers to other drug use. Early access to cannabis may also provide access to other drugs.[108]

- Drawing on a recent simulation of adolescent drug use in the US, Morral, McCaffrey and Paddock at the RAND Drug Policy Research Center claimed that a gateway effect is not needed to explain the observed association between the use of cannabis and other drugs. The association could be accounted for by differences in age at first use of these drugs and known variations in individuals' willingness to try any drugs.[109]
- Kandel observed that the best way to test the gateway hypothesis may be by experimentation with animals. One series of animal tests showed that exposure to one class of drugs increases consumption of other classes, a result that is consistent with the gateway hypothesis.[110]

7.80 As Kandel commented, whether or not there is a true causal link between cannabis and other drugs, the association between the two is well-established, and programs aimed at preventing the use of 'lower stage' drugs seemed to stop or reduce the use of 'higher stage' drugs.[111]

7.81 On the other hand, Dr Wodak and others suggested that:

> All drugs have risks. Cannabis is not harmless, but adverse health consequences for the vast majority of users are modest, especially when compared with those of alcohol and tobacco …
>
> It is time to acknowledge that the social, economic, and moral costs of cannabis control far exceed the health costs of cannabis use …[112]

7.82 The committee believes it appears that dispelling current misconceptions about cannabis by providing information about the dangers outlined above will help to prevent cannabis use.

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108 Lynskey MT, HeathAC, Bucholz KK, Slutske WS, Madden PAF, Nelson EC, Statham DJ & Martin NG, 'Escalation of drug use in early-onset cannabis users vs co-twin controls', *The Journal of the American Medical Association*, vol 289, 22/29 January 2003, pp 427, 432.

109 Morral AR, McCaffrey DF & Paddock SM, Drug Research Center RAND, 'Reassessing the marijuana gateway effect', *Addiction*, vol 97, issue 12, 2002, p 1493.

110 Kandel DB, 'Does marijuana use cause the use of other drugs?' *The Journal of the American Medical Association*, vol 289, 22/29 January 2003, p 283; RAND, *RAND study casts doubt on claims that marijuana acts as 'gateway' to the use of cocaine and heroin*, media release, 2/12/02.

111 Kandel DB, pp 282-283.

112 Wodak A, Reinarman C & Cohen PDA, Cannabis control: Costs outweigh the benefits, *British Medical Journal*, 324 (7329), 12 January 2002, p 108.

7.83 Swift et al suggested that the legal ramifications of breaking the law should also be pointed out and methods of reducing harm be brought to users' attention.[113] Swift et al warned, however, that:

> … It is important not to underestimate the benefits cannabis use is perceived to provide (e.g. relaxation, 'time out'), which may be powerful motivators for continued use despite the simultaneous recognition of cannabis-related problems …[114]

7.84 Professor Saunders stated that no pharmacological treatment currently exists to treat cannabis dependence. He suggested that:

- collaborative work with overseas research groups could usefully examine possible treatments; and
- although some psychological therapies have been trialled in Australia, more need to be carried out.[115]

The Commonwealth government is funding a number of cannabis cessation initiatives involving brief interventions and the provision of information to health professionals.[116] In the 2003-04 federal budget the Government advised that under the program designed to develop resources for cannabis-dependent adults and adolescents, resources had been successfully developed and distributed and it redirected remaining funds to new initiatives on illicit drugs contained in that budget. [117] Initiatives completed under this program to date include: adult intervention; adolescent intervention; nursing information sheets; update of National Drug Strategy Monograph No 25 on health and psychological consequences of cannabis use; indigenous research and intervention; and dissemination of cannabis education resource material designed for indigenous people.

Conclusion

7.85 The committee:

- believes that, in the absence of proven treatments for cannabis dependence and in view of the health and psychological harm that cannabis can cause, it is vital that information about the severe, negative effects of cannabis be made widely available;

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113 Swift W, Copeland J & Lenton S, 'Cannabis and harm reduction', *Drug and Alcohol Review*, vol 19, 2000, pp 104-107.

114 Swift W, Copeland J & Lenton S, p 104.

115 Saunders J, transcript, 15/8/02, p 1091; Table 7.1 in this chapter.

116 Commonwealth Department of Health and Ageing, sub 296, pp 3-4.

117 *Budget measures 2003-04*, p 174.

- is concerned about the serious dangers associated with regular cannabis use. The possible links between cannabis and opioid use, are not understood by the majority of Australian people;
- is alarmed that, according to the 2001 NDS Household Survey, cannabis was offered or available to nearly a quarter of Australians and to nearly half the 14-29 year olds surveyed;
- believes that it is particularly important to provide credible, accurate and comprehensive information about these dangers;
- notes the increasing concern about the nature of the link between the use of cannabis, mental health and opioid use. It believes that investigations of these links should be a priority;
- believes the body of evidence supports real concerns about the impact of cannabis use on: (i) mental health (ii) in conjunction with other drugs (polyuse) and (iii) as a gateway to addiction, and that immediate efforts to inform the community about these concerns be undertaken; and
- calls for definitive outcomes from research on treatment for cannabis dependence including the urgent development and dissemination of cannabis cessation strategies.

Recommendation 61

7.86 **The committee recommends that the Commonwealth, State and Territory governments:**

- **widely disseminate information to inform the Australian community about the levels of cannabis use including impacts on mental health and possible gateway to addiction and other drug use;**
- **evaluate the effectiveness of these information campaigns;**
- **trial innovative, preventive approaches to reduce the use of cannabis;**
- **develop consistent national policy and legislation which reflect the dangers of cannabis use; and**
- **in the interim monitor the effect of State and Territory specific legislation dealing with cannabis use and regularly report on the health, social and criminal outcomes for each State and Territory.**

Recommendation 62

7.87 **The committee recommends that the Commonwealth, State and Territory governments fund research into pharmacological and psychological treatments for dependence on cannabis.**

Recommendation 63

7.88 **The committee recommends that the Commonwealth, State and Territory governments give priority to funding research into the nature of the link between cannabis use, opioid and other drug use, and mental health.**

Psychostimulants

7.89 Psychostimulants include amphetamine-type substances (ATS), cocaine, nicotine and caffeine, but we are dealing here with only the first two. According to Professor Webster, very little is known about prevention and early intervention with cocaine and amphetamines.[118] However, the Commonwealth Department of Health and Ageing reported that they are, among the substances used as 'party drugs' which are emerging as an issue of concern.[119] An AMA summit entitled *Party drugs: A new public health challenge* held in April 2002 noted that prevention strategies aimed at "party drug users" would need to take into account that many of the users are highly educated and well-informed about the drugs they are using. There are also many subgroups of users in the community so a variety of approaches would be required.[120]

7.90 Research on treatment for psychostimulants has yet to yield positive results, according to published reports and Professor Saunders. Trials of pharmacological treatments for amphetamine dependence have shown little or no promise to date, and the same is true of cocaine.[121]

7.91 Given the growing use of ATS and the fact that far fewer ATS users than heroin addicts are in treatment, ADCA stressed that 'Investment in

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118 Webster I, presentation to rountable, Canberra, 15/8/02, exhibit 53, slide 4.

119 Commonwealth Department of Health and Ageing, sub 238, p 6. Party drugs include but are not limited to ecstasy (MDMA), liquid ecstasy (GHB), acid (LSD), ketamine (a veterinary, also known as special K) and speed (metamphetamine).

120 *Party drugs: A new public health challenge*, pp 4, 6.

121 Saunders J, transcript, 15/8/02, p 1092; Srisurapont M, Jarusuraisin N & Kittirattanapaiboon P, 'Treatment for amphetamine dependence and abuse', *The Cochrane Database of Systematic Reviews*, issue 3, 2002, p 2.

research into the treatment of ATS dependence is urgently required and should be a priority for the Commonwealth and State/Territory Governments'. ADCA therefore suggested that a trial comparable to the recent NEPOD be conducted.[122]

7.92 Professor Saunders recommended that research should also be conducted into psychological therapies for psychostimulants, including into those that have been proved useful for other forms of substance abuse and might be effective for ATS dependence as well.[123] The AMA summit *Party drugs: A new public health challenge* held in April 2002 called for a national party drugs research agenda.[124]

7.93 The Commonwealth government is currently funding an evaluation of cognitive-behavioural therapy for amphetamine use and the update of a monograph on intervention and care for psychostimulant users.[125]

7.94 In the 2003-04 federal budget it was announced that $2 million will be provided over two years to address problems associated with the increased availability and use of psychostimulants, in particular, evaluation of treatment options and development of guidelines for front line workers.[126]

Conclusion

7.95 In the committee's view, there is an urgent need to raise the public's awareness of the dangers associated with the use of psychostimulants. This is another area in which education is needed as a matter of priority.

Recommendation 64

7.96 **The committee recommends that the Commonwealth, State and Territory governments continue to fund research into pharmacological and psychological treatments for dependence on psychostimulants.**

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122 Alcohol and other Drugs Council of Australia, *Federal budget submission 2003-2004*, p 7, viewed 28/1/03, <www.adca.org.au/policy/submissions/federalbudgetsubmission03.pdf>.

123 Saunders J, transcript, 15/8/02, p 1092.

124 *Party drugs: A new public health challenge*, p 6.

125 Senate Community Affairs Legislation Committee, Examination of Budget Estimates 2002-2003, Additional information received, vol 3, Outcomes: Whole of portfolio, 1 & 2, Health and Ageing Portfolio, November 2002, p 61.

126 *Budget measures 2003-04*, p 175.

Recommendation 65

7.97 **The committee recommends that the Commonwealth, State and Territory governments, as part of the National Drug Strategy, urgently inform and warn the Australian community about the dangers of psychostimulant use.**

Managing harm associated with injecting drugs

7.98 Only a very small number of Australians are injecting drug users: in the 2001 NDS Household Survey, 0.6 per cent of over 14 year olds reported having injected an illicit drug in the previous 12 months and 1.8 per cent had injected at some stage in their lives.[127] The majority of these users injected at least once weekly (66.2 per cent) and 15.7 per cent did so daily.[128]

7.99 Injecting drug use is associated with major harms such as overdoses. Degenhardt using Australian Bureau of Statistics data reported that the numbers of opioid overdose deaths among 15-44 year old Australians each year in 1988, 1999, 2000 and 2001 were 347, 958, 725 and 306 respectively.[129] He suggested the dramatic decrease in deaths in 2001 is likely to be attributable to primarily the marked reduction in heroin supply in Australia in 2001; and likely to be attributable secondarily to the continued expansion of access to an increasing array of treatments for opioid dependence.[130] The 2001 National Heroin Overdose Strategy indicated that there were between 12,000 and 21,000 non-fatal overdoses each year.[131]

7.100 Data from the Illicit Drug Reporting System showed that the availability of heroin increased in 2002 and its cost fell. However, use had not returned

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127 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, pp 3-4.

128 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: Detailed findings*, p 83.

129 Degenhardt L, *Opioid overdose deaths in Australia: 2001 edition: 2001 Australian Bureau of Statistics data on opioid overdose deaths*, p 3.

130 Degenhardt L, *Opioid overdose deaths in Australia: 2001 edition: 2001 Australian Bureau of Statistics data on opioid overdose deaths*, pp 1-2.

131 *National Heroin Overdose Strategy: Summary*, endorsed by the Ministerial Council on Drug Strategy, Commonwealth Department of Health and Aged Care, Canberra, July 2001, p 3, viewed 30/1/03, <http://www.health.gov.au/pubhlth/nds/resources/publications/heroin_summary.pdf>.

to the levels seen before the heroin drought in 2000.[132] According to the ANCD, preliminary figures from Victoria suggested that, at least in that state, the number of overdose deaths in 2002 remained at the low level of the previous two years.[133]

7.101 The committee also heard evidence on another major harm related to injecting drug use, that being, the current epidemic of hepatitis C. The committee was told about 91 per cent of newly acquired cases in 2001 were estimated to be related to this practice. In addition, the longer a person has been injecting the more likely he or she is to test positive for the disease. Hepatitis C is the most common notifiable communicable disease in Australia, and 75 per cent of those who develop antibodies to it develop a chronic infection and the risk of subsequent serious disease. It was estimated that 16,000 new infections occurred in 2001, up from 11,000 in 1997.[134]

7.102 The committee notes that a number of measures have been put in place to minimise the harm experienced by injecting drug users and those associated with them. They include needle and syringe programs (NSPs) to reduce the spread of HIV/AIDS and hepatitis C, initiatives to prevent and manage overdoses, treatment for hepatitis C and AIDS, and education for injecting drug users. These initiatives are discussed in detail below.

Needle and syringe programs

7.103 In their report on NSPs, Health Outcomes International Pty Ltd (Health Outcomes), the National Centre for HIV Epidemiology and Clinical Research and Professor Drummond stated that:

> … NSPs are a public health measure funded to reduce the spread of blood borne viral infections such as HIV and hepatitis C among injecting drug users and are supported by the National Drug Strategy's harm reduction framework. They provide a range of services that include provision of injecting equipment and disposal facilities, education and information on reducing drug-related harms, referral to drug treatment, medical care and legal and other

132 Illicit Drug Reporting System, *Drug trends bulletin*, December 2002, p 4.

133 Major Brian Watters, ANCD, *Heroin: Flood or drought?*, media release, 26/2/03, p 2.

134 Australian Institute of Health and Welfare, *Australia's health 2002*, pp 94, 151; Australian National Council on AIDS, Hepatitis C and Related Diseases, Hepatitis C Sub-committee, *Hepatitis C Virus Projections Working Group: Estimates and projections of the hepatitis C virus epidemic in Australia 2002*, National Centre in HIV Epidemiology and Clinical Research, August 2002, p 1, viewed 21/3/03, <http://www.ancahrd.org/pubs/pdfs/epidemic_02.pdf>; Australian National Council on AIDS, Hepatitis C and Related Diseases, Puplick C, Chair, *New hepatitis C infections still increasing*, media release, undated, p 1, viewed 21/3/03, <http://www.ancahrd.org/media_releases/02/60ct.pdf>.

> services … The aim of providing sterile injecting equipment is to prevent the shared use of injecting equipment, which can lead to the transmission of blood borne viral infections … [135]

7.104 The report noted that the proportions of government and non-government run programs and the service model varies across jurisdictions. The service models used in Australia are: primary outlets (stand alone agencies specifically established to provide injecting equipment and sometimes with primary medical care), secondary outlets (needle distribution and exchange as one of a range of other health or community services), mobile services, outreach services and vending machines. To ensure their accessibility NSPs tend to be located in relatively public places. Generally the schemes provide 1ml syringes, which can be purchased, or, in NSW, exchanged free on return of a pack with used syringes.[136] In 1999 Dolan, Topp and MacDonald reported that there were over 3,000 NSPs in Australia and the service commenced in 1987.[137]

7.105 Details on expenditure and the number of needles distributed in 1999/2000 are shown at Table 7.2. Trends in expenditure on NSPs from 1990/91 to 1999/2000 are at Table 7.3. However there is no central register on the number of syringes distributed.

7.106 Health Outcomes reported that over 40 countries operate NSPs including Belgium, Brazil, Bulgaria, Canada, China, Croatia, Czech Republic, Denmark, Estonia, Finland, Germany, Greece, Hungary, India, Kazakhstan, Latvia, Luxembourg, Nepal, Netherlands, Norway, Philippines, Poland, Portugal, Slovak Republic, Salvador, Slovenia, Thailand, Ukraine, UK and USA.[138]

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135 Health Outcomes International Pty Ltd in association with the National Centre for HIV Epidemiology and Clinical Research and Professor Michael Drummond, Centre of Health Economics, York University, *Return on investment in needle and syringe programs in Australia: Summary report*, Commonwealth Department of Health and Ageing, Canberra, 2002, p 3.

136 Health Outcomes International Pty Ltd in association with the National Centre for HIV Epidemiology and Clinical Research and Professor Michael Drummond, Centre of Health Economics, York University, p 3.

137 Dolan K, Topp L & MacDonald M, *NSP: Needle & syringe programs: A review of the evidence*, Australian National Council on AIDS, Hepatitis C and Related Diseases, Sydney, 2000, p 8.

138 Outcomes International Pty Ltd in association with the National Centre for HIV Epidemiology and Clinical Research and Professor Michael Drummond, Centre of Economics York University, p 3.

Table 7.2 Expenditure and needles distributed by NSPs by State/Territory, 1999/2000(1)

	Government Expenditure ($'000)	Consumer Expenditure ($'000)	Total Expenditure ($'000)	Needles Distributed (000)
ACT	$531	$8	$539	593
NSW	$9,827	$463	$10,290	11,566
NT	n.a.	-	n.a.	604[2]
QLD	$1,678	-	$1,678	5,300
SA	$787	$43	$830	3,018
TAS	$484	$138[2]	$622	1,381[2]
VIC	$4,767	-	$4,767	6,177
WA	$1,227	$2,349[2]	$3,576	3,209
TOTAL[1]	**$19,673**	**$3,001**	**$22,674**	**31,848**

1 Data relates to government-auspiced NSPs only. Exclude expenditure on needle and syringes sold through pharmacies on a commercial basis.

2 Includes figures imputed from data provided by State/Territory health authorities.

Source: *Health Outcomes International Pty Ltd in association with the National Centre for HIV Epidemiology and Clinical Research and Professor Michael Drummond, Centre of Health Economics, York University, Return on investment in needle and syringe programs in Australia: Summary report, Commonwealth Department of Health and Ageing, Canberra, 2002, p 4.*

7.107 Details of seven Australian national and numerous state / territory based NSP projects to June 2002 are outlined in the *Evaluation of Council of Australian Governments' initiatives on illicit drugs.*[139] The evaluation revealed that the seven national projects[140] have 'developed and disseminated a range of resources and related materials that assist NSP workers and pharmacy workers in their interaction with people who inject drugs, and enhance their skills in this area.'[141] The evaluation also stated that reports

139 Health Outcomes International Pty Ltd in association with Catherine Spooner Consulting, National Drug and Alcohol Research Centre and Turning Point Alcohol and Drug Centre, *Evaluation of Council of Australian Governments' initiatives on illicit drugs: Final report to Department of Finance and Administration: Vol 3 – Supporting measures,* Health Outcomes, Kent Town, October 2002, pp 29-43 and *Appendix A – COAG-NIDS funded activities in needle and syringe programs in states and territories, 1999-2001,* 87p.

140 National projects to June 2002 are: National Hepatitis C Resource manual; National Needle and Syringe Worker Training Package; research into the availability, usage and quality of electronic information resources on HIV / AIDS, Hepatitis C and other blood borne viruses; National Illicit Drug Training Program for Pharmacists and Pharmacy Workers; National Forum on NSP Workers; Needle and Syringe Program Workers Information Resources Project; study of referral practices and outcomes; Return on investment in needle and syringe programs in Australia (see Health Outcomes International Pty Ltd in association with Catherine Spooner Consulting, National Drug and Alcohol Research Centre and Turning Point Alcohol and Drug Centre, *Evaluation of Council of Australian Governments' initiatives on illicit drugs: Final report to Department of Finance and Administration: vol 3,* pp 30-35).

141 Health Outcomes International Pty Ltd in association with Catherine Spooner Consulting, National Drug and Alcohol Research Centre and Turning Point Alcohol and Drug Centre,

on activities in the states and territories for 2000/2001 indicated 'there has been a considerable increase in both the capacity of NSPs and their workers, the development of wider networks of service providers, and improved communication between NSPs across all jurisdictions.'[142]

Table 7.3 Expenditure on NSPs, Australia, 1990-1991 to 1999-2000 ($'000) (Year 2000 prices)[1]

1990-1991	1991-1992	1992-1993	1993-1994	1994-1995	1995-1996	1996-1997	1997-1998	1998-1999	1999-2000	TOTAL
Overhead and Infrastructure Costs										
$441	$455	$530	$560	$541	$539	$714	$757	$841	$1,153	$6,531
Direct Operating Expenditure on Public NSPs										
$7,215	$7,730	$8,172	$8,710	$9,089	$10,251	$12,213	$13,250	$13,690	$15,243	$105,562
Subsidies to Community Pharmacies										
$826	$1,045	$1,129	$1,318	$1,497	$1,551	$2,079	$2,347	$2,975	$3,278	$18,045
Consumer Costs										
$1,091	$1,183	$1,608	$1,905	$1,865	$1,555	$2,043	$2,625	$2,930	$3,001	$19,807
Total Government Direct Expenditure										
$8,042	$8,774	$9,301	$10,028	$10,586	$11,802	$14,292	$15,597	$16,664	$18,521	$123,607
Total Government Expenditure										
$8,483	$9,230	$9,831	$10,589	$11,127	$12,341	$15,006	$16,354	$17,505	$19,673	$130,138
Total Expenditure										
$9,574	**$10,413**	**$11,438**	**$12,494**	**$12,992**	**$13,897**	**$17,048**	**$18,979**	**$20,435**	**$22,674**	**$149,944**

1 These data cover expenditure on NSPs operating within the programs managed by State and Territory health authorities. It excludes costs associated with the many retail pharmacies that also sell needles and syringes on a commercial basis, for which reliable data is not available on the number of needles sold or the level of expenditure by consumers.

Source: Health Outcomes International Pty Ltd in association with the National Centre for HIV Epidemiology and Clinical Research and Professor Michael Drummond, Centre of Health Economics, York University, Return on investment in needle and syringe programs in Australia: Summary report, Commonwealth Department of Health and Ageing, Canberra, 2002, p 11.

7.108 One of the projects funded at the national level was the Return on investment in needle and syringe programs in Australia which was undertaken by Health Outcomes in association with the National Centre for HIV Epidemiology and Clinical Research and Professor Michael

Evaluation of Council of Australian Governments' initiatives on illicit drugs: Final report to Department of Finance and Administration: vol 3, p 43.

142 Health Outcomes International Pty Ltd in association with Catherine Spooner Consulting, National Drug and Alcohol Research Centre and Turning Point Alcohol and Drug Centre, *Evaluation of Council of Australian Governments' initiatives on illicit drugs: Final report to Department of Finance and Administration: vol 3,* p 43.

Drummond of the Centre of Health Economics York University.[143] This evaluation looked at the effectiveness of NSPs in preventing transmission of HIV, and hepatitis C in Australia from 1991 (that is, from when NSPs were well established in all jurisdictions except Tasmania) to the end of 2000. The authors stated that the study highlighted that, in the 10 year period, the nearly $150 million invested in NSPs had saved between $2.4 billion and $7.7 billion and resulted in an estimated 25,000 cases of HIV and an estimated 21,000 cases of hepatitis C being avoided. It was also estimated that by 2010 over 5,000 lives would have been saved by NSPs. The authors stressed that the savings were conservatively estimated and stated the results reinforce original findings by Hurley, Jolley and Kaldor.[144]

7.109 One of the parties launching that evaluation, Major Watters, Chair of the ANCD, commented that:

> … the importance and value of NSPs has been more than demonstrated by the release of this report today. It is hoped that this will further enhance the public's awareness of the purpose and value of NSPs and help in overcoming the misunderstanding that these programs somehow condone or encourage the injecting of illicit drugs …[145]

7.110 In presenting the above results Health Outcomes noted that:

> It is not possible to separate the effects of the implementation of NSPs from the other HIV prevention strategies … In most settings, introduction of NSPs is one component of a broader harm reduction package to reduce the risk of transmission of blood-borne viruses and other harm associated with injecting drug use …[146]

7.111 An indication of the variation around the estimated benefits of NSPs is provided by the outcomes of the recent study by Jim Butler for the Commonwealth Department of Health and Ageing on public health programs to reduce HIV / AIDS reported in publication *Returns on*

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143 Health Outcomes International Pty Ltd in association with the National Centre for HIV Epidemiology and Clinical Research and Professor Michael Drummond, Centre of Health Economics, York University, p 21

144 Health Outcomes International Pty Ltd in association with the National Centre for HIV Epidemiology and Clinical Research and Professor Michael Drummond, Centre of Health Economics, York University, pp 10, 11, 15.

145 Australian National Council on Drugs, *National Council backs investment on needle programs*, media release, 23/10/02, p 1.

146 Health Outcomes International Pty Ltd in association with the National Centre for HIV Epidemiology and Clinical Research and Professor Michael Drummond, Centre of Health Economics, York University, pp 8-9.

investment in public health. This study looked at HIV only for the longer time period 1984-2010, and examined the main public health response to HIV covering securing the bloods; introducing NSPs for injecting drug users; and educating the population about the virus and the consequences of infection. Its authors estimated the number of HIV infections avoided due to the education and prevention programs was 6,973.[147]

7.112 In a presentation to the International Pharmaceutical Federation 61st World Congress in Singapore in 2001, Dr Helen Dodd, of the Karana Medical Centre Pharmacy in Queensland, reported that there is a lack of a register to report community needle stick injuries and as a result a lack of accurate data on the number of injuries in the community. For example she said the Queensland Injury Surveillance Unit reports injuries only from 14 Hospital Emergency Rooms with 154 needle stick injuries in community settings from 1998-2000 and that general practitioners in Australia do not report cases of community acquired needle stick injury.[148]

7.113 Dodd also stated that 'The risk of contracting HIV / AIDS is 0.4%, Hepatitis B is 5% and Hepatitis C is 3.5% after a needlestick injury.'[149] She went onto say:

- there is no effective vaccine available for Hepatitis C or HIV / AIDS;
- the cost of testing per person after a needle stick injury is $1100 paid for by Medicare;
- treatment with immunoglobulins is a standard procedure for hospital workers who have any exposure to blood;
- treatment costs for Hepatitis C is $100,000 - $150,000, paid for by health funds, Medicare or privately;
- treatment costs for HIV positive patient is $400,000; and
- compensation payments for maintenance workers – a maintenance manager in Shell Service Station in Albury NSW contracted HIV a year after he had received a needle stick injury while changing a toilet roll. He was awarded $429,000 compensation in November 2000.[150]

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147 Butler J, Public health programs to reduce HIV / AIDS, in *Returns on investment in public health: An epidemiological and economic analysis prepared for the Department of Health and Ageing,* Commonwealth Department of Health and Ageing, Canberra, June 2001, pp 61-62.

148 Dodd HJ, Karana Medical Centre Pharmacy, Karana Downs Qld, Solutions to a serious health problem through safer needle technology, presentation to *2001 Annual Congress of Pharmacy and Pharmaceutical Sciences, International Pharmaceutical Federation's 61st World Congress, on Combining practice and science to extend horizons, Singapore, 2-6 September 2001*, p 3.

149 Dodd HJ, p 4.

150 Dodd HJ, p 5.

7.114 Dodd also reported that HIV-1 is viable in syringes and can survive for over one month at 22°C; HIV-1 in blood remains viable after 60 minutes exposure to UV light laboratory conditions; and HIV remains viable for 28 days at room temperature.[151]

7.115 The committee notes that retractable syringes could assist in reducing the number of needle stick injuries. During the inquiry the committee received a demonstration of retractable syringe technology from Unitract. Duesman and Ross in a United States 12 months survey, in calender year 1997, of automated retractable syringes in 26 hospital facilities using 86,300 3mL syringes (Vanishpoint), demonstrated no accidental needle stick injuries documented over the 12 month period.[152]

7.116 The comparative cost of 1mL retractable needle syringes with a fixed needle syringe for community use are shown at Table 7.4.

Table 7.4 1ml Retractable needle syringes for community use

	Becton Dickinson	Retractable Technologies Inc	Occupational Medical Innovations	New Medical Technology Inc	Retractable Trading
Name	Fixed Needle	VanishPoint	Sharp Safe	NMT Syringe	Unitract
Needle type	Fixed Needle	Retractable Needle	Retractable Needle	Retractable Needle	Retractable Needle
Country	USA	USA	Australia	Scotland	Australia
Assembled components	6	10	7	16	>16
Price per Unit for 20 million	15c	40c	15-20c	70c	70c

Source: *Dodd HJ, Karan Medical Centre Pharmacy, Karana Downs Qld, Solutions to a serious health problem through safer needle technology,* presentation to *2001 Annual Congress of Pharmacy and Pharmaceutical Sciences*, *International Pharmaceutical Federation 61st World Congress, Singapore, 2-6 September 2001, p 7.*

7.117 In a move to address needle stick injuries, the Commonwealth government announced funding of $27.5 million over four years in the 2002-03 federal budget for an implementation strategy for the introduction of retractable needle and syringe technology.[153]

151 Dodd HJ, p 9.

152 Duesman K and Ross J, Survey of accidental needlesticks in twenty-six facilities using Vanishpoint (R) automated retractable syringe, *Journal of Healthcare Safety, Compliance and Infection Control,* 3/1/98, 6p.

153 *Budget measures 2002-03*, Budget paper no 2, Commonwealth Department of the Treasury, Canberra, 2002, p 119.

7.118 However, Ms Madden of the Australian Injecting and Illicit Drug Users League warned the committee that 'it is very likely that injecting drug users will not accept these devices' because 'people will not use different syringes'.[154] She also expressed considerable concern about 'the cost of retractable syringes compared with the very cost-effective current needles and syringes available through needle and syringe programs …'[155] Ms Madden suggested that a better approach than development and introduction of retractables to reduce publicly discarded injecting equipment would be to run broad community education campaigns which really has never been done before on this issue, and establish local networks to develop local solutions to the problem.[156]

7.119 According to the ANCD, injecting drug users who fear apprehension for self administration or possession of injecting equipment are more likely to toss away used needles than they would if the legislation targeted unsafe needle disposal instead.[157] The ANCD recommended that:

> … all governments, in consultation with appropriate community-based organisations, should consider the removal of legislative impediments to the proper disposal of used injecting equipment, specifically offences related to self-administration and possession of injecting equipment.[158]

Major Watters reiterated this point late last year.[159]

7.120 In the 2003-04 federal budget the following measures related to NSPs were addressed:

- due to the significant increase in the number of commercial providers developing retractable needle and syringe technology, the government redirected $8.7 million over two years from the introduction of needle and syringe technology to other initiatives in the illicit drugs area;
- continued to provide $17.5 million over three years to address community concerns about the risk of injury from needles discarded in public places through funding for the final phase of research and

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154 Madden A, transcript, 15/8/02, p 1119.

155 Madden A, transcript, 15/8/02, p 1120.

156 Madden A, transcript, 15/8/02, p 1120.

157 Australian National Council on Drugs, informal communication, 26/2/03.

158 Australian National Council on Drugs, *Needle and syringe programs: position paper*, ANCD, Canberra, undated, p 5, viewed 18/6/03 http://www.ancd.org.au/publications/pdf/pp_needle_syringe.pdf

159 Australian National Council on Drugs, *National Council backs investment on needle programs*, media release, 23/10/02, p 2.

development, including pilots of the technology in selected settings and the implementation of retractable technology across NSPs nationally;

- provision of $16.3 million over four years for the distribution of injecting equipment to illicit drug users through NSPs in an increased number of pharmacies and other outlets; and
- maintained funding ($22.4 million over four years) for education and counselling and referral services through community-based NSPs. [160]

Conclusion

7.121 The committee acknowledges the benefits of the two evaluations related to NSPs discussed. The committee also questions the increase in use of NSPs when data provided through the 2001 NDS Household Survey indicated that heroin use had dropped significantly. However, it is concerned that there is no easily available data on the number of needles distributed. This raises the question of the level of accountability of the needle and syringe programs. They also had concerns about the lack of data related to needle stick injury. The committee believes there is a need for a complete evaluation of all components of the NSPs including education and counselling and the impact on both HIV and hepatitis C. The committee is pleased that the effectiveness of retractable needle and syringe technology is being investigated. It believes that the technology merits examination to ensure its introduction is successful and cost-effective.

7.122 Of particular concern to the committee was the escalating incidence of HIV and hepatitis C despite the quantity of syringes distributed (not necessarily exchanged) nationally under this program.

Recommendation 66

7.123 **The committee:**

- **recommends that a complete evaluation of needle and syringe programs be undertaken by the Australian National Audit Office. Issues that should be assessed are distribution, inadequate exchange, accountability and associated education and counselling programs and the impact on both HIV and hepatitis C; and**
- **supports the recommendation of the Australian National**

160 *Budget measures 2003-04*, pp 174, 176 and 177.

Council on Drugs calling for the removal of legislative impediments to the proper disposal of used injecting equipment, specifically offences related to self administration and possession of injecting equipment.

Preventing and managing overdoses

7.124 The National Heroin Overdose Strategy, announced in July 2001, was adopted by all jurisdictions through the Ministerial Council on Drug Strategy. The strategy 'provides nationally agreed priority areas for reducing the incidence of heroin related overdoses in Australia and for reducing morbidity and mortality where overdose does occur.'[161] While entitled the National Heroin Overdose Strategy, it recognised a range of opioids are involved in overdose, including methadone and morphine, and encompassed them; and recognised that polydrug use plays a major role in overdose fatalities, particularly the use of central nervous system depressants such as alcohol or benzodiazepines in combination with opioids. [162]

7.125 Risk factors identified in the strategy are: polydrug use; resumption of opioid use following periods of reduced consumption or abstinence increases the risk of overdose; and drug users injecting alone decrease the chances of resuscitation in the event of an overdose.[163]

7.126 The Heroin Overdose Strategy suggested the strategies that might be adopted to prevent heroin related overdose include:

- provision of timely access to a diverse range of evidence based treatment services including pharmacotherapies;
- diversion of opioid users away from the criminal justice system to treatment;
- expanding provision of drug treatment services in prisons and ensuring those treatments are linked to community based services;
- education for families, friends, NSP workers, health workers, police who come into contact with opioid users regarding the factors which increase or reduce the risk of overdose; and

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161 *National Heroin Overdose Strategy: Summary*, p 2, viewed 30/1/03, <http://www.health.gov.au/pubhlth/nds/resources/publications/heroin_summary.pdf>.

162 *National Heroin Overdose Strategy: Summary*, p 2, viewed 24/6/03, http://www.health.gov.au/pubhlth/nds/resources/publications/heroin_summary.pdf

163 *National Heroin Overdose Strategy: Summary*, p 3, viewed 24/6/03, http://www.health.gov.au/pubhlth/nds/resources/publications/heroin_summary.pdf

- develop pre and post release education, information and support programs for prisoners and individuals completing detoxification programs.[164]

7.127 Strategies suggested to reduce overdose related to morbidity and mortality included:

- developing clinical protocols supported by training which addresses attitudes, knowledge and skills for accident and emergency workers to manage overdose; and
- developing local partnerships between police, paramedics, accident and emergency staff and specialist drug treatment services which encourage provision of information, referral and follow-up of opioid users who experience an overdose. [165]

7.128 The drop in overdose deaths in the last few years is very welcome and appears, according to the ANCD, to be due to a combination of factors including:

> … the disruption of key importers by Australia's law enforcement agencies at local, national and international levels; cyclical changes in drug use; the increased availability of residential and pharmacotherapy treatments; the introduction of a national diversion program for drug offenders and; the introduction of key peer based overdose reduction strategies.[166]

Safe injecting facilities

7.129 In its paper on safe injecting facilities (SIFs), the Drugs and Crime Prevention Committee of the Victorian Parliament defined such facilities as 'establishments whose specific and officially sanctioned purpose is to provide injecting drug users with a safe environment in which to inject their drugs'. It pointed out that clients inject drugs that they have acquired, no drugs are administered or distributed, and staff do not help clients to inject.[167]

7.130 According to the Victorian parliamentary committee:

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164 *National Heroin Overdose Strategy: Summary*, p 4, viewed 24/6/03, http://www.health.gov.au/pubhlth/nds/resources/publications/heroin_summary.pdf

165 *National Heroin Overdose Strategy: Summary*, p 5, viewed 24/6/03, http://www.health.gov.au/pubhlth/nds/resources/publications/heroin_summary.pdf

166 Major Brian Watters, *Heroin: Flood or drought?*, media release, 26/2/03, p 2.

167 Parliament of Victoria, Drugs and Crime Prevention Committee, *"Safe injecting facilities": Their justification and viability in the Victorian setting*, DCPC, Parliament of Victoria, Melbourne, undated, iii unpaged.

> … The safety of SIFs [safe injecting facilities] revolves primarily around their capacity to reduce the risk of fatal overdose, as well as the risk of blood-borne viral infections associated with unsafe injecting practices …
>
> SIFs should also play a secondary health and welfare role for users through
>
> - the provision of education and advice to users on safe drug use;
> - the provision of primary health-care and medical treatment …
> - the increased access to and availability of drug treatment and rehabilitation;
> - the increased access to advice and help with life-skill problems …[168]

7.131 The Victorian parliamentary committee drew attention to safe injecting facilities that have been established in Germany, Switzerland and the Netherlands. In cities with these facilities, public drug use and numbers of overdose deaths declined, as did the numbers of discarded syringes and complaints about public nuisance. Some clients entered treatment as a result of attending and, those who also attended life skills programs reduced their overall drug use.[169] It concluded that there were 'potentially strong advantages in having properly organised and operated SIFs …' but there were also 'possible disadvantages, as well, and there are dangers in viewing SIFs as a panacea for all the harms of street-based injecting …' [170] Some of the disadvantages cited by the Victorian committee were: SIFs need to be properly targeted and sensitively managed in the context of community consultation and education; have the potential to produce significant harms including the possibility of a further entrenched local drug market and related crime, perception of condoned drug use and entrenching drug injecting as the major route of administration; the need for full consideration and resolution of legal issues including criminal liability, observance of international treaties and civil liability; may not sufficiently remove the problems of public nuisance they are designed to overcome; and may not be able to effectively administer to the intended target group given the way SIFs are intended to operate.[171]

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168 Parliament of Victoria, Drugs and Crime Prevention Committee, *"Safe injecting facilities": Their justification and viability in the Victorian setting,* unpaged.

169 Parliament of Victoria, Drugs and Crime Prevention Committee, *"Safe injecting facilities": Their justification and viability in the Victorian setting,* unpaged.

170 Parliament of Victoria, Drugs and Crime Prevention Committee, *"Safe injecting facilities": Their justification and viability in the Victorian setting,* unpaged.

171 Parliament of Victoria, Drugs and Crime Prevention Committee, *"Safe injecting facilities": Their justification and viability in the Victorian setting,* unpaged.

7.132 While the Victorian government has not established a safe injecting facility, the New South Wales government, after extensive consultation, supported the establishment of the Kings Cross Medically Supervised Injecting Centre in Sydney, which opened in May 2001.

7.133 The preliminary findings of an evaluation by NDARC indicated that the centre had helped prevent overdose harm and fatalities. Among the 3,818 clients registered at the centre there were 424 drug-overdose related incidents that required clinical management during the 18 months covered by the evaluation. This was equivalent to a rate of 7 overdoses per 1000 visits.[172]

7.134 In addition, the evaluation found that:

- on approximately one in every four visits, a health care service was provided to the clients; and
- in one in every 41 visits clients were referred to other services, 43 per cent of which were for treatment for their drug dependence.[173]

7.135 However, the Kings Cross centre has been a controversial strategy. This was reflected in vehement opposition to it and to any extension of the trial in submissions to the inquiry, including those from Dr Santamaria and the Community Coalition for a Drug Free Society.[174] Among the concerns expressed were those of Mr Beswick:

> Official injecting rooms give the appearance of community acceptance of the behavior and will lead teenagers especially, unsettled and looking for 'something', to experiment with the crowds at such centres who apparently have found 'some thing' …[175]

7.136 DRUG-ARM said it:

> … does not support the provision of injecting rooms … DRUG-ARM will reassess its position on both of these strategies if the research and evaluation of proposed injecting room trials in Australia supports the stated goals of reducing the number of deaths, and the number of heroin overdoses of young people. This

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172 National Drug and Alcohol Research Centre, *Key findings from the 18-month report of the Medically Supervised Injecting Centre*, media release, 25/11/02, viewed 13/1/03, <http://ndarc.med.unsw.edu.au/ndarc.nsf/website/News.pressreleases.MSICNov.2002>.

173 National Drug and Alcohol Research Centre, *Key findings from the 18-month report of the Medically Supervised Injecting Centre*, media release, 25/11/02.

174 Community Coalition for a Drug Free Society, sub 251, p 1; Santamaria J, sub 231, p 11.

175 Beswick P, sub 42, p 3.

> change in policy position would occur only if DRUG-ARM members supported such a change.[176]

7.137 The final report of the evaluation by NDARC was released on 9 July 2003. The report concluded in summary that: it is feasible to operate the injecting centre in Kings Cross; there was no detectable change in heroin overdoses at the community level; the Medically Supervised Injecting Centre made referrals for drug treatment, especially among frequent attendees; there was no increase in risk of blood born virus transmission; there was no overall loss of public amenity; there was no increase in crime; and the majority of the community accepted the Medically Supervised Injecting Centre initiative. [177]

Conclusion

7.138 The committee believes that the most desirable way of dealing with injecting drug user problems is to get addicts into rehabilitation programs that lead on to longer term treatments, bolstered by a range of ancillary programs to give maximum support to individuals, rather than creating more safe injecting rooms.

Recommendation 67

7.139 **The committee recommends that the Commonwealth, State and Territory governments work to establish a wider range of detoxification and rehabilitation centres bolstered by a range of ancillary programs to give maximum support to individual drug users.**

Education

7.140 The committee notes that injecting drug users need advice on issues such as the safe disposal of injecting equipment and injecting practices that will minimise harm to themselves from blood borne disease and overdose. NSPs and safe injecting rooms are places where they can be targeted with advice. At the time of Warner-Smith et al's review of the situation, the quality of some of the information provided at NSPs was poor.[178] More recently, according to one of the review team, there has been an improvement in both the quality and quantity of the material available

176 DRUG-ARM, sub 199, p 10.

177 Kaldor J, Lapsley H, Mattick RP, Weatherburn D & Wilson A, MSIC Evaluation Committee, *Final report of the evaluation of the Sydney Medically Supervised Injecting Centre*, MSIC Evaluation Committee, Sydney, July 2003, p xvi.

178 Warner-Smith M, Lynskey M, Darke S & Hall W, p 42.

and injecting drug users' understanding of how to minimise harm to themselves.[179]

7.141 The former Commonwealth Department of Health and Aged Care reported that injecting drug use is a risk factor for the transmission of HIV and hepatitis C, and education about their transmission is a feature of the national strategies targeting both these diseases.[180] According to the AIHW, most cases of HIV infection result from sexual contact between men, with relatively little transmission (less than 20 per cent of cases diagnosed in 2000) from other sources.[181] However, as the National Hepatitis C Strategy points out that, approximately 90 per cent of newly acquired cases of hepatitis C are related to injecting drug use. Individuals can therefore play an important role in reducing the transmission of hepatitis C, for example by avoiding high risk behaviour such as injecting. Education and counselling are important in this respect, including peer education which has been shown to be effective among drug users.[182]

7.142 However, according to Ms Madden, a heroin user for 15 years and on MMT for eight:

> … although we have a fantastic national hepatitis C strategy—it is well written and it has some fantastic strategies and ideas in there—it is an unfunded strategy. If we have a great strategy but no funding to implement it, we simply cannot implement the strategy and get the runs on the board in relation to hepatitis C … so we have major work to do on that issue, and we cannot do it without adequate funding.[183]

7.143 The committee considers that it is also important to run education campaigns on an ongoing basis to ensure that new users are made aware of the health issues related to injecting drugs as early as possible in their using careers.

7.144 Ms Madden's comments about the lack of attention to this issue was therefore concerning:

> There has not been a major HIV prevention campaign with injecting drug users for many years now. Unfortunately—sadly—

179 Darke S, informal communication, 24/2/03.

180 Commonwealth Department of Health and Aged Care, *National Hepatitis C Strategy 1999-2000 to 2003-2004*, p 21; Commonwealth Department of Health and Aged Care, *National HIV/AIDSStrategy 1999-2000 to 2003-2004: Changes and challenges*, Commonwealth Department of Health and Aged Care, Canberra, 2000, pp iv, 12.

181 Australian Institute of Health and Welfare, *Australia's health 2002*, p 94.

182 Commonwealth Department of Health and Aged Care, *National Hepatitis C Strategy 1999-2000 to 2003-2004*, pp 21-22.

183 Madden A, transcript, 15/8/02, p 1123.

> when we talk to drug users on the ground they no longer say that HIV is the main health issue they think about …[184]

7.145 In the 1999-2000 federal budget the Government provided S12.4 million over four years ($1.5 million in 1999-00, $3.6 million in 2000-01, $3.6 million in 2001-2 and $3.7 million in 2002-03) for the Hepatitis C Education and Prevention Initiative. Funds were provided for improved education, prevention and health maintenance initiatives for those currently infected and those at risk of becoming infected to lower the current rate of transmission of hepatitis C in Australia.[185] Funding of a total of $15.9 million for the program was maintained in the 2003-04 federal budget for a further four years (that is $3.8 million in 2003-03, $3.9 million in 2004-05, $4.0 million in 2005-06, and $4.1 million in 2006-07).[186]

Conclusion

7.146 The committee believes that education programs on hepatitis C must be addressed in a way that is commensurate with the seriousness of the problems it creates.

Recommendation 68

7.147 **The committee recommends that the Commonwealth, State and Territory governments continue to give a high priority to funding education campaigns to:**

- **target the general population as well as at high risk groups; and**
- **inform high risk groups about HIV/AIDS and hepatitis C and, in particular how to prevent the transmission of these diseases.**

National Hepatitis C Strategy

7.148 The National Hepatitis C Strategy 1999-2000 to 2003-2004 aims to reduce the transmission of hepatitis C and to minimise the social and personal impacts of the disease.[187] While understanding of the hepatitis epidemic

184 Madden A, transcript, 15/8/02, p 1122.

185 *Budget measures 1999-2000*, Budget paper no 2, Commonwealth Department of the Treasury, Canberra, May 1999, p 107.

186 *Budget measures 2003-04*, p 187.

187 Commonwealth Department of Health and Aged Care, *National Hepatitis C Strategy 1999-2000 to 2003-2004*, Commonwealth Department of Health and Aged Care, Canberra, 2000, p 1,

has improved over the last decade, the Commonwealth government is continuing 'to pursue research and surveillance in order to improve the evidence base for the development of public policy programs'.[188] According to the Australian National Council on AIDS, Hepatitis C and Related Diseases (ANCAHRD), priorities for research have been identified, with three national research centres providing significant resources aimed at managing the epidemic.[189]

7.149 NSPs and education are important elements of the strategy and have been discussed in the last sections of this chapter. Improved treatment for hepatitis C infection and assistance to people affected by hepatitis C to maintain their health are among the priority areas for the strategy.[190] According to ANCAHRD, treatment has improved but 'a widely available and practicable cure for the virus eludes us'.[191] The former Commonwealth Department of Health and Aged Care regards the search for a cure as critical in view of the speed with which the disease is spreading and its association with a diminished quality of life, cirrhosis of the liver, and liver cancer.[192]

7.150 Core funding of $7.3 million was provided in 2001-02 for research into preventing the spread of HIV and hepatitis C infection, reducing harm from HIV, and improving the quality of life of people living with these two diseases.[193]

7.151 As foreshadowed in the National Hepatitis C Strategy the strategy was to be subject to an independent, external review mid-term of the strategy's implementation.[194] The Commonwealth Department of Health and Ageing indicated that the National Hepatitis C Strategy was reviewed in 2002, and the review will be considered by the Minister for Health and Ageing in the context of the 2003-04 federal budget.[195]

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188 Senate Community Affairs Legislation Committee, *Answers to estimates questions on notice: Health and Ageing Portfolio: Budget estimates 2002-2003*, 5 and 6 June 2002, p 40.

189 Australian National Council on AIDS, Hepatitis C and Related Diseases, 'Research', pp 1-2, viewed 3/4/03, <http://www.ancahrd.org/research/index.htm>.

190 Commonwealth Department of Health and Ageing, 'Commonwealth action on hepatitis C: the Australian response', p 2, viewed 3/4/03, <http://www.health.gov.au/pubhlth/strateg/hiv_hepc/hepc/response.htm>.

191 Australian National Council on Aids, Hepatitis C and Related Diseases, Puplick C, *New hepatitis C infections still increasing,* media release, undated, p 2.

192 Commonwealth Department of Health and Aged Care, *National Hepatitis C Strategy 1999-2000 to 2003-2004*, pp 6-7.

193 *Commonwealth Department of Health and Ageing annual report 2001-02*, Commonwealth Department of Health and Ageing, Canberra, October 2002, p 61.

194 Commonwealth Department of Health and Aged Care, *National Hepatitis C Strategy 1999-2000 to 2003-2004*, p 63.

195 Commonwealth Department of Health and Ageing, sub 297, p 3.

7.152 In the 2003-04 federal budget the Commonwealth government announced that it will maintain funding by providing $15.9 million over four years to continue the Hepatitis C Prevention and Education program that reduces the transmission of hepatitis C in the Australian community by providing education, prevention and health maintenance initiatives for those currently infected and those at risk of becoming infected with hepatitis C.[196]

7.153 In June 2003 there were newspaper articles drawing attention to a report, not yet publicly available, that was critical of the approach to hepatitis C and calling for: a national public awareness campaign; better partnerships with groups working with drug injecting users; action to boost prevention and safety; and more funds to deal with the problem. It was reported that 'A spokesman for Senator Patterson said part of the report would be released next month, while the Government had allocated $16 million to reduce transmission.'[197]

7.154 A media release by the Australian Hepatitis Council commenting on the above report stated:

> … the Australian Hepatitis Council, supports the assertion in the review that the national response for hepatitis C has been poorly implemented …
>
> The Australian Hepatitis Council maintains that a second National Hepatitis C Strategy must be accompanied by an implementation plan and funding from the Commonwealth Government or, despite its intentions, it will fail to address the discrimination, care, support and treatment needs of a quarter of a million Australians with hepatitis C.
>
> In the recent budget, the government allocated $15.9 million over four years for hepatitis C Education and Prevention. Whilst welcome support for existing hepatitis C initiatives, this money will not be able to meet the ever increasing needs of the sector …[198]

Conclusion

7.155 The committee welcomes the 2003-04 federal budget allocation of $15.9 million over four years to continue the hepatitis C prevention and education programme.

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196 *Budget measures 2003-04*, p 187.

197 Schubert M, Drug law blamed for hep C epidemic, *The Australian*, 13/6/03.

198 Australian Hepatitis Council, Wallace J spokesperson, *Time to act on Hepatitis C*, media release, 13/6/03, 1p.

7.156 The committee believes that:

- given the current hepatitis C epidemic, concerted efforts must be made to better understand the disease, how to contain and treat it, and how to assist those affected by it; and
- insufficient recognition has been given to the problems that hepatitis C sufferers experience, especially in rural areas.

Recommendation 69

7.157 **The committee recommends that the Commonwealth government evaluate the outcomes of the 2003-04 budget funding for the National Hepatitis C Strategy over the four year period to ensure that the issues outlined in 7.153 are being adequately addressed.**

Recommendation 70

7.158 **The committee recommends that the Commonwealth, State and Territory governments continue to fund research into the prevention and management of hepatitis C infection.**

Misuse of licit substances

7.159 The committee notes that a number of licit substances are misused in the sense that they are employed for purposes other than those for which they are supplied. The misuse is triggered by a desire to induce or enhance a drug experience, to enhance performance or for cosmetic purposes. Substances that are misused in this way include prescription and over-the-counter drugs, and volatile substances like petrol, solvents, glue and aerosols.

7.160 Table 7.5 shows some of the substances that are misused in this way. As can be seen from Table 7.5, which shows results from the 2001 NDS Household Survey, the proportion of Australians who reported in 2001 that they had misused such substances at some stage in their lives was relatively small. It varied from one in 17 for pain-killers / analgesics to three in 100 for steroids. The proportion of Australians that was misusing

these substances fell significantly between 1998 and 2001 for all substances except steroids and barbiturates.[199]

7.161 Nonetheless, the committee considers that the harm caused to those who misuse them is considerable and some of these substances are very addictive.

Table 7.5 Summary of drugs ever used and recently used: proportion of the population 14 years and over, Australia 2001

Drug/Behaviour	Ever used (per cent)	Recently used (per cent)
Pain-killers/analgesics	6.0	3.1
Tranquillisers/sleeping pills	3.2	1.1
Steroids	0.3	0.2
Barbiturates	0.9	0.2
Inhalants	2.6	0.4

Source: 2001 National Drug Strategy Household Survey: first results, Australian Institute of Health and Welfare, Canberra, May 2002, p 3, 4.

7.162 The committee received little evidence about the use of drugs in sport and the misuse of prescription and over-the-counter medication. There was also insufficient time to pursue them to the extent that would allow well-based decisions to be reached. The committee therefore decided not to consider these topics in this report. It proposes to deal here only with inhalants.

Inhalants

7.163 The practice of inhaling solvents and 'chroming' (specifically inhaling from an aerosol paint can) is a matter of concern to the committee. According to the AMA, inhaling volatile substances is 'highly dangerous'.[200] While inhaling appears to be relatively rare, the report from a recent forum on chroming indicated that there are some pockets of particularly disadvantaged people who become intensive users, for example in some Aboriginal communities. Elsewhere inhaling tends to occur among younger secondary students.[201]

199 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, pp 3-4.

200 Australian Medical Association, Position statement on 'Use and misuse of medicines and drugs', 1998, attachment to AMA sub 133.

201 Victorian Alcohol and Drug Association, *Chroming: Beyond the headlines: Final report*, April 2002, p 3, viewed 23/1/02, <http://www.vaada.org.au/Chroming%20Forum%20Report.htm>.

7.164 The use of inhalants recently received attention in several Australian states:

- in the inquests, carried out Coroner W C Chivell, into three deaths of Anangu Pitjatjantjara people who died as the result of inhaling petrol fumes[202];
- in an inquiry into the inhalation of volatile substances by the Victorian Parliament's Drugs and Crime Prevention Committee[203]; and
- by the Northern Territory Legislative Assembly Select Committee on Substance Abuse.[204]

7.165 Reports from the inquests, the Victorian inquiry and work by others summarised ways of addressing inhaling and suggested improvements to current efforts at prevention and treatment. For example, Coroner Chivell called for state, territory and Commonwealth action to urgently address petrol sniffing in Anangu communities; coordinated approaches are needed to 'avoid the fragmentation of effort and confusion and alienation of service-providers which are features of current service delivery'.[205]

7.166 The Victorian Drugs and Crime Committee stressed that responding to the problem of inhaling must be led at a national level, and recommended a national committee be formed to coordinate prevention and treatment policy and activities.[206]

7.167 The Victorian committee's report provided detailed discussion of many aspects of dealing with inhaling; some of the report's conclusions were as follows.

- The Victorian committee did not recommend that volatile substance use be criminalised as it felt that such a move would be unlikely to be

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202 *South Australia: Finding of inquest*, delivered by W C Chivell, Coroner, September 2002, paragraph 13.2.5, viewed 24/2/03, <http://www.courts.sa.gov.au/courts/coroner/findings/findings_2002/kunmanara_hunt.finding.htm>.

203 Parliament of Victoria, Drugs and Crime Prevention Committee, *Inquiry into the inhalation of volatile substances: Final report*, DCPC, Parliament of Victoria, Melbourne, September 2002, 662p.

204 Northern Territory Legislative Assembly, Substance Abuse Committee, *Seeking public input to the Substance Abuse Committee*, media release, 3/4/02, viewed 15/5/02, <http://www.nt.gov.au/lant/parliament/committees/substance/Termref.shtml>.

205 *South Australia: Finding of inquest*, Recommendations, delivered by W C Chivell, Coroner, September 2002, pp 79-80, viewed 24/2/03, <http://www.courts.sa.gov.au/courts/coroner/findings/findings_2002/kunmanara_hunt.finding.htm>.

206 Parliament of Victoria, Drugs and Crime Prevention Committee, *Inquiry into the inhalation of volatile substances: Final report*, pp v, viii.

effective and could be counter-productive. Instead, intoxicated persons should be detained and intoxicants seized.

- It did not support the introduction of age restrictions on the sale of certain volatile products. It recognised, however, that there was strong support for such a move among significant sections of the community. It recommended that the proposed national committee investigate this matter further.
- The Victorian committee recommended continuing work by government and private industry in developing safer spray paint products.[207]

Conclusion

7.168 The committee believes that the Commonwealth government should take a greater role than at present in relation to inhalants and could usefully lead a nationally coordinated response to the problem.

Recommendation 71

7.169 **The committee recommends that the Commonwealth government take a leading role as a matter of urgency in establishing a national committee to coordinate policy and programs to prevent the use of inhalants and treat dependent users.**

207 Parliament of Victoria, Drugs and Crime Prevention Committee, *Inquiry into the inhalation of volatile substances: Final report,* pp ix, x, xiii.

8

Crime, violence and law enforcement

The link between crime and substance abuse

8.1 In its discussion paper, the former committee explored the links between crime and substance abuse. The information that came to the committee from various sources pointed to the following conclusions.

- Much crime is alcohol or drug-related.
- Offenders are often illicit drug users and their drug habit may contribute to their offending. However, not all drug users are offenders.
- Alcohol-related verbal and physical abuse is common and consumes a very substantial part of local police time. However, consuming alcohol does not cause violence, rather it disinhibits and intensifies existing aggressive tendencies.
- When substance abuse coexists with a mental illness, violence is more likely than with mental illness alone.
- Although there are clearly strong links between drug taking (including alcohol) and crime, our understanding of these links is incomplete.[1]

8.2 Where newer information is now available it confirms and clarifies some of the findings mentioned above. For example, Dr Graycar and

1 House of Representatives Standing Committee on Family and Community Affairs, *Where to next? - A discussion paper: Inquiry into substance abuse in Australian communities*, FCA, Canberra, September 2001, pp 66-69.

his associates found that although illicit drug offenders make up a very small proportion of the offenders that police arrest each year, in a sample of 1770 offenders arrested in 2001, at least 70 per cent of those arrested for violence and traffic or property offences tested positive to an illicit drug.[2] Between 37 and 52 per cent of the offences for which a group of police detainees were arrested have been estimated to be related to alcohol or drug use[3], and about one-third of the offences committed by a group of male prisoners.[4]
Dr Weatherburn reported that about half of all assaults are alcohol-related[5] and, according to the Alcohol and other Drugs Council of Australia (ADCA), 34 per cent of offenders and 31 per cent of homicide victims were under the influence of alcohol at the time of the homicide. Alcohol-related violence is particularly prevalent among Indigenous people.[6]

8.3 Of the Australians questioned in the National Drug Strategy (NDS) Household Survey in 2001, 26.5 per cent reported that they had been verbally abused by a drunk person and 4.9 per cent had been physically abused. Fewer people reported having being harmed by illicit drug users, 11.3 per cent having experienced verbal abuse and 2.2 per cent physical abuse. Abuse by drunk persons appeared to have fallen since 1998 but there had been no change in abuse by illicit drug users.[7]

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2 Graycar A, transcript, 16/8/02, p 1215; Graycar A, McGregor K, Makkai T & Payne J, 'Drugs and law enforcement: Actions and options', paper given to the *South Australian Drug Summit 2002, Adelaide, 26 June 2002,* p 2.

3 Calculated from Makkai T & McGregor K, Appendix D, 'Drugs and crime: Calculating attributable fractions from the DUMA project', in Collins DJ & Lapsley HM, *Counting the cost: estimates of the social costs of drug abuse in Australia in 1998/9,* Monograph series no 49, Commonwealth Department of Health and Ageing, Canberra, 2002, p 111.

4 Williams P, 'Appendix C, Aetiological fraction estimates of drug-related crime', in Collins DJ & Lapsley HM, *Counting the cost: Estimates of the social costs of drug abuse in Australia in 1998-9,* Monograph series no 49, Commonwealth Department of Health and Ageing, Canberra, 2002, p 105.

5 Weatherburn D, transcript, 23/9/02, p 1258.

6 Alcohol and other Drugs Council of Australia, sub 80 to the Inquiry into Crime in the Community by House of Representatives Standing Committee on Legal and Constitutional Affairs, pp 7-9.

7 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results,* Drug statistics series no 9, AIHW, Canberra, May 2002, p 39.

Costs of drug-related crime

8.4 The cost of drug-attributable crime is very high. Estimates by Collins and Lapsley based on information from 1998-99 put the tangible cost of crime due to alcohol at $1.2 billion and that due to illicit drugs at $2.5 billion. Crimes committed by those who have taken both types of drugs together cost a further $582.3 million. According to Collins and Lapsley, these figures are likely to be underestimates as a substantial number of crimes are never reported to the police and so cannot be included when calculating these figures.[8]

8.5 Alcohol and drug-related crime has an impact far beyond the economic. It touches the every day lives of individuals, families and communities when they become victims of crime or find themselves providing support to those affected. Collins and Lapsley estimated that in 1998-99 the intangible cost of drug-attributable crime (reflecting loss of life-violence) totalled $501.7 million for alcohol-related costs, $492.5 million for costs associated with illicit drugs, and $574.6 million for both alcohol and illicit drugs.[9] In addition, as the former National Crime Authority (NCA) pointed out, through the involvement of organised crime in the drug trade, damage is done:

> … in a broader sense to the national interest by undermining public and private sector institutions, for example through fraud and corruption. This, too, ultimately affects every member of the community.[10]

Australia's response to licit and illicit drug-related crime

8.6 As previously outlined in this report, Australia's approach to its drug problems is driven by the NDS which has been based on the premise that efforts to reduce the supply of and demand for drugs are to be complementary and interdependent, and programs should be based on a balance between these. The National Alcohol Strategy, for

8 Collins DJ & Lapsley HM, pp x, 47-48.

9 Collins DJ & Lapsley HM, pp 47-48. Some component of crime costs is causally attributable jointly to alcohol and illicit drugs. It is not possible to indicate what proportion of these joint costs is attributable to either alcohol or illicit drugs individually.

10 National Crime Authority, transcript of the Inquiry into Crime in the Community by House of Representatives Standing Committee on Legal and Constitutional Affairs, 9/10/02, p 214.

example, seeks a balance between public health, law enforcement and educational strategies in its aim of reducing the incidence of social disorder, family disruption, violence, including domestic violence, and other crime related to misuse of alcohol.[11] The National Illicit Drug Strategy (NIDS) *Tough on Drugs* also provides a balanced and integrated approach to reducing the supply of and demand for illicit drugs and delivering education about drugs. [12]

8.7 The Commonwealth Department of Health and Ageing advised that of the more than $1 billion allocated to the NIDS since 1997, approximately $456 million are being spent on supply control measures, and $691 million for a range of demand reduction measures. Of the $691 million earmarked for demand reduction measures, approximately $659 million is for health and family measures and of this $325 million is for the diversion of users from the criminal justice system into education and treatment. The percentage of funding ($1 billion) allocated to law enforcement is 39.75 per cent ($456 million).[13]

Evaluation of law enforcement activities

8.8 Graycar et al pointed out that finding the best ways in which law enforcement efforts can reduce drug market activity and contribute to reducing the demand for drugs requires constant trialling and evaluation of new approaches, as well as evaluation of existing approaches. They suggested that successful strategies are built on local and international experience and research evidence; all the relevant stakeholders need to be involved in developing strategies; and cooperation among stakeholders is essential.[14] They also stressed it is important to realise that 'The complexity of all drug policy is that there is no 'one size fits all'…'[15]

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11 *National Alcohol Strategy: A plan for action 2001 to 2003-04*, endorsed by the Ministerial Council on Drug Strategy, Commonwealth Department of Health and Ageing, Canberra, July 2001, p 7, viewed 28/1/03, <http://www.health.gov.au/pubhlth/nds/resources/publications/alcohol_strategy.pdf>.

12 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 70.

13 Commonwealth Department of Health and Ageing, sub 291, p 2.

14 Graycar A, McGregor K, Makkai T & Payne J, 'Drugs and law enforcement: Actions and options', p 15.

15 Graycar A, transcript, 16/8/02, p 1225.

8.9 The Commonwealth government contributes funds for the development and assessment of new approaches. One such project that will be discussed is the Illicit Drug Diversion Initiative. Another is the National Drug Law Enforcement Research Fund. This fund promotes quality evidence-based practice in drug law enforcement to prevent and reduce the harmful effects of licit and illicit drug use in Australian society.[16] In commenting on the fund, Atherton noted that its current priorities include:

- approaches to curb alcohol-related violence and alcohol-related anti-social behaviour, particularly around licensed premises and public places;
- youth-related issues, particularly with respect to underage and binge drinking and other drug use;
- alternative criminal justice approaches to drug offences and drug offenders including community-based approaches;
- education and training for police in the use of diversion options; and
- promoting greater community cooperation in the provision of information to drug law enforcement agencies.[17]

8.10 Other research initiatives funded by the Commonwealth government are adding to our understanding of the links between substance abuse and crime which, as the introduction to this chapter point out, is incomplete. The Commonwealth Attorney-General's Department advised that the Australian Institute of Criminology's (AIC) projects on Drug Use Monitoring in Australia – DUMA - and the Drug Use Careers of Offenders – DUCO - are helping to answer the question of how much and in what ways crime is drug-related.[18] Graycar et al noted that the more we know about different groups of drug using criminals, the better able we will be to design appropriate law enforcement strategies for each group.[19]

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16 National Drug Strategy, 'National Drug Law Enforcement Fund', viewed 6/11/02, <http://www.health.gov.au/pubhlth/nds/igcd/ndlerf/>.

17 Atherton T, 'National Drug Law Enforcement Research Fund', *Conference Papers Collection*, CD-ROM, 2nd Australasian Conference on Drugs Strategy, Perth, 7-9 May 2002, p 3.

18 Commonwealth Attorney-General's Department, sub no 259, pp 14-16.

19 Graycar A, McGregor K, Makkai T & Payne J, 'Drugs and law enforcement: Actions and options', p 4.

8.11 Graycar et al commented that few if any evaluations of what works in law enforcement have been carried out.[20] According to the evaluation of the national illicit drug initiatives, best practice in law enforcement is an under-researched area and lacks best practice guidelines.[21]

8.12 Dr Weatherburn commented that:

> … the critical question in crime control is not whether a measure is effective but whether it is the most cost-effective way of achieving the result in question. To my knowledge there has only ever been one cost-effectiveness study in crime control policy in Australia, even though it is routine in every other area of government policy to ask for the alternatives, how much they cost and how much benefit you get from them.[22]

Family Drug Support and the Public Health Association of Australia noted that information about the cost-effectiveness of different approaches is critical in direct funding to the most appropriate supply and demand reduction measures among both law enforcement and other approaches.[23]

8.13 The committee believes that it is important that evaluations take a broad view and consider not only the immediate outcomes of particular law enforcement operations but their wider impact. For example, Dr Weatherburn pointed out that if a particular drug is targeted for attention, we need to know how this affects the consumption of other drugs that might be alternatives to the targeted drug. Targeting cannabis might push its price up and make more dangerous drugs like heroin, cocaine or amphetamines more attractive and so worsen rather than improve the overall situation.[24]

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20 Graycar A, McGregor K, Makkai T & Payne J, 'Drugs and law enforcement: Actions and options', p 4.

21 Health Outcomes International Pty Ltd, p 8.

22 NSW Bureau of Crime Statistics and Research, transcript of the Inquiry into Crime in the Community by House of Representatives Standing Committee on Legal and Constitutional Affairs, 9/10/02, p 254.

23 Family Drug Support, sub 229, pp 4- 5; Public Health Association of Australia, sub 159, pp 3-4.

24 Weatherburn D, transcript, 23/9/02, pp 1261, 1263.

Conclusion

8.14 The dearth of evaluation of law enforcement approaches to drug use needs to be rectified. The committee is therefore pleased to see that greater efforts have been made recently to evaluate diversion initiatives and efforts to prevent alcohol-related problems. It believes that evaluations should be carried out routinely and take a comprehensive approach.

8.15 The committee believes that finding the best ways of dealing with alcohol and drug-related crime will also be improved as we extend our understanding of the factors that protect individuals from using and abusing drugs and that build their resilience to abuse.

Recommendation 72

8.16 **The committee recommends that the Commonwealth, State and Territory governments build evaluation into all their law enforcement initiatives related to substance abuse and misuse.**

Controlling drug supplies

National initiatives

8.17 The committee notes that the key to controlling the availability of illicit drugs is understanding how the market works and hence where and how law enforcement activities should be targeted to have maximum impact. The Commonwealth government's focus in this context is on Australia's borders and beyond, and on the operation of the criminal syndicates which sell illicit drugs as an important part of their activities. Much of the law enforcement within Australia is the responsibility of state and territory police forces, operating on information collected locally, as well as on intelligence from other sources, including Commonwealth agencies.

8.18 Evidence from the former NCA and Federal Agent McDevitt of the Australian Federal Police (AFP) indicated that criminal syndicates are best seen as businesses run according to recognisable business principles. They are well informed and resourced and increasingly flexible, switching from one product to another and forming alliances

with one another to advance their business.[25] According to the former NCA, 'It is not unusual for criminal syndicates to be multi-jurisdictional, exploiting weaknesses in the ability of law enforcement agencies to effectively investigate across national and international borders'.[26]

8.19 A view of the market as shown in Figure 8.1 demonstrates where the supply chain is most vulnerable to intervention and can direct the attention and activities of law enforcement agencies. According to Federal Agent McDevitt, taking out facilitators for example, including in other countries can have an impact far greater than seizing large quantities of drugs at Australia's borders.[27] The former NCA pointed out that 'a narrow focus by law enforcement on the interdiction of drugs would not necessarily be successful in dismantling networks and prosecuting the Mr Bigs', because major figures in organised crime usually distance themselves from high-risk illegal activity.[28]

8.20 The NCA listed the capabilities needed to combat the 'Mr Bigs' as, among others:

- investment in knowledge;
- coordinated investigative and legislative responses;
- an attack on the drivers and motives of criminal syndicates;
- whole of government responses;
- an intelligence-led, proactive, integrated approach; and
- strategies to ensure resources are being allocated in the best way possible.[29]

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25 McDevitt B, transcript, 16/8/02, p 1220; National Crime Authority, transcript of the Inquiry into Crime in the Community by House of Representatives Standing Committee on Legal and Constitutional Affairs, 9/10/02, p 214; As of 1/1/03, the National Crime Authority, the Australian Bureau of Criminal Intelligence and the Office of Strategic Crime Assessments have been incorporated into the Australian Crime Commission.

26 National Crime Authority, transcript of the Inquiry into Crime in the Community by House of Representatives Standing Committee on Legal and Constitutional Affairs, 9/10/02, p 215.

27 McDevitt B, transcript, 16/8/02, p 1220; National Crime Authority, transcript of the inquiry into crime in the community by House of Representatives Standing Committee on Legal and Constitutional Affairs, 9/10/02, p 214.

28 National Crime Authority, transcript of the Inquiry into Crime in the Community by House of Representatives Standing Committee on Legal and Constitutional Affairs, 9/10/02, p 215.

29 National Crime Authority, sub 86 to the Inquiry into Crime in the Community by House of Representatives Standing Committee on Legal and Constitutional Affairs, pp 10-11.

INSERT FIGURE 8.1

8.21 The Commonwealth Attorney-General's Department advised that funding from the NIDS, a new legislative framework and international agreements have been pursued to improve Australia's capabilities in controlling the drug market. With increased funding, for example, the Australian Customs Service (Customs) and police overseas liaison networks and programs have been expanded and are providing information relevant to the increasingly globalised drug market. The National Heroin Signature Program is being expanded to include cocaine and amphetamines.[30] By identifying unique characteristics of samples seized, this program enables the drugs' source country to be identified and distribution networks traced.[31] In the 2002-03 federal budget additional funding has been provided for the AFP, the former Australian Bureau of Criminal Intelligence (ABCI) and Customs to combat terrorism and boost national security, and that will also contribute to reducing the supply of illicit drugs.[32]

8.22 On the legislative front, the Commonwealth Attorney-General's department stated powers conferred by the *Measures to Combat Serious and Organised Crime Act 2001* 'significantly enhance the capacity of Commonwealth law enforcement agencies to fight drug trafficking networks and prevent illicit drugs from reaching our community'.[33] The Department noted importantly, the profit motive in the drug trade is being attacked with the introduction of a system of civil forfeiture of the proceeds of crime. All jurisdictions, with the exception of the Australian Capital Territory, Tasmania and the Northern Territory, can now prosecute drug offenders under civil forfeiture legislation.[34]

8.23 The Attorney-General's Department said that at a meeting on 5 April 2002, Commonwealth, state and territory leaders agreed that a new national framework was needed to combat multi-jurisdictional crime as well as combating terrorism.

8.24 A significant initiative in relation to fighting multi-jurisdictional crime at an operational level was the establishment of the Australian Crime Commission (ACC) on 1 January 2003.[35] The commission was formed

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30 Commonwealth Attorney-General's Department, sub 259, pp 4, 9, 12.

31 Commonwealth Attorney-General's Department, sub 149, p 13.

32 Commonwealth Attorney-General's Department, sub 259, pp 4-5, 12.

33 Commonwealth Attorney-General's Department, sub 259, p 11.

34 Commonwealth Attorney-General's Department, sub 259, p 10 and informal communication, 17/2/03.

35 Commonwealth Attorney-General's Department, informal communication, 6/5/03.

by the amalgamation of the NCA, the ABCI and the Office of Strategic Crime Assessments.

8.25 Among the other measures being pursued are:

- reforming the laws relating to money laundering;
- legislation through model laws for all jurisdictions and mutual recognition for a national set of powers for cross-border investigations;
- legislation and administrative arrangements to allow investigation by the AFP into State and Territory offences incidental to multi-jurisdictional crime;
- modernising criminal laws in the areas of model forensic procedures (during 2002), model computer offences (during 2002) and model serious drug offences (pursued during 2003);
- ensuring adequate access to radio-frequency spectrum for an effective inter-operability between national security, police and emergency services;
- enhancing capacity in each jurisdiction for the collection and processing of samples to create DNA profiles and their uploading to the national DNA database; and
- priority work in law enforcement in: control over the illegal importation of criminal contraband specifically illicit drugs and firearms; extradition between States; recognition of expert evidence; identity fraud; gangs; etc [36]

8.26 In the 2003-04 federal budget, the government announced it is to:

- provide ongoing funding for four years (that is, $2 million each year from 2003-04 for the ACC and $1 million each year from 2003-4 for the AFP) to the ACC and AFP to continue programs to investigate illicit drug trafficking and other major crimes;
- continue to provide funding (that is, $2.1 million in 2003-04, $2.2 million in 2004-05, $2.2 million in 2005-06 and $2.2 million in 2006-07) to the AFP for the Law Enforcement Cooperation Programme to support offshore disruption to transnational criminal threats. This program facilitates cooperation with overseas law enforcement agencies to increase the flow of intelligence

36 Commonwealth Attorney-General's Department, sub 259, p 13.

information on activities that may adversely impact on Australian security;

- continue to provide funding (of $1.4 million in 2003-04 and $1.5 million in each of 2004-05, 2005-06 and 2006-07) to the AFP for the Overseas Liaison Network which supports Australia's drug law enforcement intelligence and participation in joint investigations with overseas law enforcement agencies to disrupt the supply of illicit drugs reaching Australia;
- continue to provide funding ($5.1 million over four years) for the connection of the AFP overseas posts to the national computer network AFPNET which allows overseas liaison officers to access real-time information on operations;
- provide funding of $4.3 million over four years to enable the AIC to continue the government's Drug Use Monitoring in Australia (DUMA) program which provides an ongoing national picture of drug use and crime in Australia by conducting interviews and urinalysis of police detainees; and
- provide additional funding of $2.3 million to enhance the Australian Transaction Reports and Analysis Centre's (AUSTRAC's) financial intelligence capability to identify illicit drug trafficking and related activities.
  - ⇒ Related to this is an additional $2 million over four years for AUSTRAC to provide law enforcement agencies with intensive training and support to better integrate financial intelligence into major drug and money laundering investigations; and
  - ⇒ also related is continued funding of $7.3 million over four years to AUSTRAC for the High-Risk Cash Dealer Strategy to ensure ongoing provision of high quality financial intelligence targeting organised criminal networks involved in drug trafficking and other forms of major crime.[37]

Conclusion

8.27 The committee:

- supports the development of this new national framework to deal with multi-jurisdictional crime, believing that it will contribute significantly to limiting the drug trade;

37 *Budget measures 2003-04*, Budget paper no 2, Department of the Treasury, Canberra, May 2003, pp 170-173.

- applauds the government's commitment to limiting drug trafficking and associated activities in the 2003-04 budget; and
- applauds all jurisdictions and agencies commitment to limiting drug trafficking and associated activities.

Recommendation 73

8.28 **The committee recommends that Commonwealth, State and Territory governments put in place as soon as possible all components of the new national framework to combat multi-jurisdictional crime.**

Local and state initiatives

Policing practices

8.29 The previous committee drew attention in its discussion paper to the very substantial amount of police time that is devoted to dealing with alcohol-related incidents.[38] Police target dangerous drinking with random breath testing of drivers and by monitoring compliance with the laws governing the sale of alcohol. These matters are discussed further later in the report in relation to road trauma (Chapter 9) and the prevention of alcohol abuse (Chapter 5).

8.30 Voltz stated supplies of illicit drugs can be controlled or made harder to access by targeting vulnerable points in the local drug and associated markets. This in turn depends on understanding the nature of the market, for example, whether it is a cottage industry or dominated by more organised groups.[39] Dr Weatherburn noted that experience has shown that police activity can disrupt open drug markets without simply shifting it to another area. Acquiring property to finance a drug habit can be made more difficult by proactive policing of problem areas and targeting the receivers of stolen goods and repeat offenders.[40]

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38 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 67.

39 Voltz D, 'Illicit market scans: The findings of two pilot studies examining the heroin and amphetamine markets in Queensland', *Conference Papers Collection*, CD-ROM, 2nd Australasian Conference on Drugs Strategy, Perth, 7-9 May 2002, slide 3.

40 Weatherburn D, transcript, 23/9/02, pp 1259-1261.

8.31 More proactive policing received support in many submissions to the inquiry. There were calls for:

- adequate[41] or more[42] policing, particularly in relation to removing dealers and drug affected individuals from the streets, schools, night clubs, pubs and other venues[43];
- improved liaison between police and family members[44] and the community[45], including the appointment of police liaison officers trained to help drug users, their families and communities[46]; and
- more attention to reducing the amount of stolen goods for sale, including from pawn shops.[47]

8.32 Some communities are facilitating proactive involvement between the police and the community. For example the Cabramatta Chamber of Commerce and Industry advised the Legal and Constitutional Affairs Committee as part of its inquiry into Crime in the community that initiatives it had undertaken included: a monthly business magazine with the majority of articles on policing issues; a Business Watch program to improve communication between business and the police; extending the hours and programs of the Police and Community Youth Club; raising funds to purchase equipment for the police such as pushbikes, personal alarms for distribution to the elderly etc.[48]

8.33 Graycar et al noted traditional police approaches to illicit drug crimes have included such activities as street sweeps, raids and surveillance. More recently, multi-agency approaches have been developed that recognise that police clients are often also clients of other agencies such as the health care and social security systems.[49] Williams et al stated there is an increasing emphasis on addressing the underlying

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41 Australian Family Association, sub 73, p 6.

42 Drug Advisory Council of Australia, sub 165, p 1; Shortland Youth Forums, sub 223, p 4.

43 Reece S, sub 180, p 10; Fairfield City Council, sub 83, p 14; National Council of Women of WA, sub 172, p 2.

44 Hampson I, sub 103, p 7.

45 Fairfield City Council, sub 83, p14.

46 Family Drug Support, sub 87, p 8.

47 Fairfield City Council, sub 83, p 14; Family Drug Support sub 87, p 8; Hampson I, sub 103, p 7.

48 Cabramatta Chamber of Commerce Inc, sub 44 to the Inquiry into Crime in the Community by the House of Representatives Standing Committee on Legal and Constitutional Affairs, pp 13-14.

49 Graycar A, McGregor K, Makkai T & Payne J, 'Drugs and law enforcement: Actions and options', p 13.

problems that cause crime and disorder, and this means that police work more with other agencies than in the past.[50]

8.34 One example of this, as discussed later in this chapter, is provided by the programs that divert drug using offenders to treatment. Another example is Operation Mantle which operated in Adelaide from 1997 to 1999. Williams et al said Operation Mantle aimed to disrupt local drug markets, using specialist and non-specialist police; it targeted low and middle level dealers and diverted them into treatment. During the operation, links were also forged with local government, government agencies and the local community to gain intelligence about local drug markets.[51]

8.35 According to the Police Federation of Australia, there is a case for a greater involvement by the Commonwealth government in local law enforcement. The Police Federation of Australia pointed to federal initiatives in the United States that substantially increased the police presence on the nation's streets. The Federation particularly pointed to the need for an investigation of the United States Violent Crime Control and Law Enforcement Act (VCCA) enacted in 1994 and the COPS MORE (Making Officers Redeployment Effective) program. It advocated that the Australian federal government follow this example and provide financial support for more community policing.[52]

Conclusion

8.36 The committee believes that more attention should be focussed on breaking the links between organisational dealers and substance-dependent dealers. This could involve police liaison officers working with families and communities to remove substance-affected dealers and individuals from areas of risk to interim safe havens.

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50 Williams P, White P, Teece M & Kitto R, 'Problem-oriented policing: Operation Mantle- a case study', Australian Institute of Criminology, *Trends and issues in crime and criminal justice*, no 190, February 2001, p 1.

51 Government of South Australia, 'Drugs: Together, South Australians can make a difference: A guide to community programs in South Australia', p 3, viewed 1/4/03, <http://www.ministers.sa.gov.au/Premier/others/Drug%20Booklet.pdf>; Williams P, White P, Teece M & Kitto R, 'Problem-oriented policing: Operation Mantle-a case study', p 3.

52 Police Federation of Australia, sub 58 to the Inquiry into Crime in the Community by the House of Representatives Standing Committee on Legal and Constitutional Affairs, pp 2-3.

8.37 The committee believes that the suggestion for greater involvement by the Commonwealth government in supporting local law enforcement bears further examination.

Recommendation 74

8.38 **The committee recommends that the Commonwealth, State and Territory governments urgently examine the need for Commonwealth initiatives, to supplement that available in the States and Territories, directed at supporting local community drug control initiatives.**

Sentencing practices

8.39 Sentencing practices also received attention. Tougher, severe penalties were favoured by some [53], including by respondents to the 2001 NDS Household Survey. The survey indicated that there was a high level of support for increased penalties for the sale or supply of illicit drugs (marijuana / cannabis 57.9 per cent, heroin 87.8 per cent, amphetamines / speed 84.7 per cent and cocaine 86.0 per cent). Support for a prison sentence as an action against those in possession of illicit drugs was: marijuana / cannabis 3.7 per cent, ecstasy / designer drugs 15.9 per cent, heroin 27.8 per cent and amphetamines / speed 21.2 per cent. 37.7 per cent of survey respondents thought that the possession of small quantities of marijuana / cannabis for personal use should be a criminal offence. [54]

8.40 However, the evidence for the effectiveness of severe penalties is mixed. Dr Weatherburn told the committee that US experience showed that increasing the level of imprisonment had a small effect on crime levels, but little on drug trafficking.[55] Coerced drug treatment of offenders was also suggested and is discussed further later in this chapter.

8.41 Less stringent sentencing practices were favoured by others.

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53 Community Coalition for a Drug Free Society, sub 251, p 3; National Council of Women of WA, sub 172, p 2; Riley family, sub 32, p 4; Toughlove South Australia, sub 236, p 1.

54 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: Detailed findings*, Drug statistics series no 11, AIHW, Canberra, December 2002, pp 965-100.

55 Weatherburn D, transcript, 23 / 9 / 02, p 1265.

- Sisters Inside advocated that the special needs of drug-dependent parents with dependent children be acknowledged and they be imprisoned only as a last resort.[56]
- Youth Substance Abuse Services suggested that the particular attributes of young offenders be recognised, including through the introduction of national guidelines for juvenile justice dispositions.[57]
- National Aboriginal Community Controlled Health Organisation suggested that Indigenous people are another group for whom alternatives should be sought to incarcerating them for offences related to substance abuse. According to ADCA, imprisonment simply compounds the grave social problems they already face.[58]

8.42 While the Commonwealth government does not have a primary responsibility for these matters, it does have an interest in sponsoring best practice, as well as promoting a nationally consistent approach to national problems.

Conclusion

8.43 The committee believes that the Commonwealth government should take a leadership role in pursuing consistency and best practice in sentencing practices through the ministerial councils responsible for policing, justice and corrective services and other means at its disposal. This ensures that there is not displacement to a jurisdiction with weaker sentencing laws.

Recommendation 75

8.44 **The committee recommends that the Commonwealth government play an active role through the ministerial councils on police, corrective services and justice in establishing best practice and promoting nationally consistent policies and practices in policing and sentencing as they relate to drugs.**

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56 Sisters Inside, sub 30, p 16.

57 Youth Substance Abuse Services, sub 102, p 5.

58 Alcohol and other Drugs Council of Australia, sub 80 to the Inquiry into Crime in the Community by House of Representatives Standing Committee on Legal and Constitutional Affairs, p 9; National Aboriginal Community Controlled Health Organisation, sub 122, p 16.

Issues in controlling drug supplies

Gathering and sharing intelligence

Resources

8.45 Federal Agent McDevitt, representing the AFP at the committee's roundtable, reported that as drug syndicates have become more sophisticated in their mode of operation, intelligence gathering has become more complex. Considerable effort is needed to identify emerging trends in the drug market and to understand their implications.[59] The committee notes that with such knowledge, appropriate, rapid responses to changing illicit drug use can be developed, enabling early intervention when epidemics of particular drugs are developing.

8.46 According to the AFP Association, investigating narcotic-related crime is very resource intensive and more funding is needed. Funds should be supplied for more human and technological resources, including local intelligence gathering capacity. The AFP Association claimed that the then ABCI and the Commonwealth Forensic Services (CFS) would also benefit from increased resources to expand the services they provide, that is, the then ABCI to provide more extensive access to data and the CFS to improve their technical capacity.[60]

Conclusion

8.47 The committee is convinced that the critical nature of intelligence gathering is of such importance that without adequate resources agencies charged with pursuing significant players in the drug market will be unable to do their job to the standard needed.

Recommendation 76

8.48 **The committee recommends that, with respect to the Australian Customs Service, the Australian Federal Police, the Australian Crime Commission and the Commonwealth Forensic Services, the**

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59 McDevitt B, transcript, 16/8/02, pp 1219-1221.

60 Australian Federal Police Association, sub 70 to the Inquiry into Crime in the Community by the House of Representatives Standing Committee on Legal and Constitutional Affairs, pp 33-35, 45, 76.

Commonwealth government:

- **undertake an independent external review by the Australian National Audit Office every three years of the adequacy and funding of these agencies' capacity to gather the intelligence about drug-related crime that is needed to intercept supplies; and**
- **funding levels recommended by the review be set as the minimum for the subsequent period.**

Consistency of data across jurisdictions

8.49 Predicting and understanding emerging changes in drug markets are important not only for law enforcement purposes but for other purposes as well, such as informing strategies to be used by other front line workers. This point is illustrated by the burgeoning market for amphetamine type stimulants (ATS). Federal Agent McDevitt reported that controlling ATS calls for different law enforcement strategies from other common drugs, because ATS are not sourced from crops but are manufactured from chemical precursors in South East Asia and increasingly in mobile clandestine laboratories within Australia.[61] Furthermore, the behaviour of offenders who are under the influence of ATS differs from that of other users: dealing with hallucinating, aggressive people presents a contrast for police and emergency and health workers more used to managing heroin users.[62] The committee notes that forewarning of emerging drug use epidemics enables front line staff who deal with users to be better prepared.

8.50 In its June 2000 submission to the inquiry, the former ABCI highlighted a number of deficiencies in the intelligence it collected from other agencies to provide national, regional and local views of the drug situation in Australia. Since then, progress has been made in standardising the data obtained from each jurisdiction,[63] but further improvements are needed. For example, the former bureau's data on the availability and street price of drugs are provided on a state by state basis only, not on a local level, and not always consistently for

61 McDevitt B, transcript, 16/8/02, pp 1222-1223, 1228; Australian Federal Police, sub 288, p 1.

62 McDevitt B, transcript, 16/8/02, p 1219.

63 Australian Bureau of Criminal Intelligence, sub 49, pp 2-3 and sub 261, p 1.

all states for all time periods. Graycar et al have said that if local information were available, it could be used to assess the success of local initiatives as well as guide street-level policing.[64]

8.51 Current police data on how crime is drug-related from different jurisdiction are not standardised. Graycar et al stated:

> … Both classification systems and offence names can differ across the country. Furthermore counting rules in police jurisdictions have changed over time, and what may have been counted once may not today, and vice versa.[65]

Conclusion

8.52 The committee believes that the lack of consistency of data across jurisdictions is an unsatisfactory situation that cannot be expected to adequately deliver the outcomes required.

Recommendation 77

8.53 **The committee recommends that the Commonwealth, State and Territory governments give high priority to:**

- **further standardising the drug-related data collected by different jurisdictions; and**
- **ensuring that such data is consistently collected and capable of being reported to reveal what is happening at the local, state and national level.**

Linking agency databases

8.54 Other agencies referred to the limitations imposed by different computer systems that are unable to communicate with one another and the need for greater cohesion. Federal Agent McDevitt stressed the need to link police, court and corrections databases.[66] The former NCA described other obstacles to cooperation, such as secrecy provisions in legislation and reluctance to share information when

64 Graycar A, McGregor K, Makkai T & Payne J, 'Drugs and law enforcement: Actions and options', pp 6-7.

65 Graycar A, McGregor K, Makkai T & Payne J, 'Drugs and law enforcement: Actions and options', p 5.

66 McDevitt B, transcript, 16/8/02, p 1228.

corruption within law enforcement agencies is feared. The former NCA referred to 'major steps forward' in the last five or six years in removing barriers to communication in a whole of government response to organised crime. It warned, though, that 'we still have a long way to go'.[67]

8.55 The committee notes there may also be difficulties in some jurisdictions with compatibility of computer systems because a particular jurisdiction is using a whole-of-government approach and law enforcement agencies therefore have no discretion on their jurisdiction's computer system which may not be compatible with the law enforcement computer system network.

8.56 In the committee's view, this is clearly another area that needs particular attention. The committee is mindful however of difficulties that some jurisdiction may face if they are operating on a computer system that applies to all government agencies in that jurisdiction.

Recommendation 78

8.57 **The committee recommends that the Commonwealth, State and Territory governments devote more resources to overcoming barriers to communication between jurisdictions and agencies dealing with drug-related crime, including barriers within information management systems.**

Interagency cooperation and collaboration

8.58 The AFP's Federal Agent McDevitt told the committee that:

> … the best results [from law enforcement efforts] are when there is active collaboration and cooperation between agencies. The AFP could not do it alone—there is no doubt about that at all. We have a very good and strong relationship with Customs; they are absolutely critical to our success. We have a very good relationship with the Australian Bureau of Criminal Intelligence … Intelligence is absolutely critical to all of us. I think there is a hell of a lot more sharing of

67 National Crime Authority, transcript of the Inquiry into Crime in the Community by House of Representatives Standing Committee on Legal and Constitutional Affairs, 9/10/02, p 220.

> intelligence and information between law enforcement agencies, both at a national level and at a Commonwealth level, than we have ever seen in the past.[68]

He went onto say one way of stimulating and tracking improvements in the level of cooperation and collaboration between agencies is the use of performance measures that assess these characteristics.[69]

8.59 In its 2000-2001 annual report the AFP notes the significant benefits of the continuing development of effective strategic alliances and enhanced coordination of the AFP with other Commonwealth law enforcement agencies, partner agencies and with international law enforcement agencies. It cites the Joint Asian Crime Group - JACG as an excellent example of cooperation between the Commonwealth and State law enforcement agencies. Agencies involved comprise representatives of Customs, the AFP, the former NCA, the NSW Crime Commission and the NSW Police. Another successful group is the Western Australia Joint management Group comprising the AFP, Western Australia Police Service and AUSTRAC. The AFP's vision statement – To fight crime together and win – reflects the priority given to agencies working together. [70]

8.60 The committee commends all law enforcement agencies involved for the effective efforts they are putting into collaboration and cooperation in intelligence sharing both at management and operational levels in agencies.

Recommendation 79

8.61 **The committee recommends that Commonwealth, State and Territory government agencies dealing with drug-related crime:**

- **extend the cooperation and collaboration between them; and**
- **develop performance measures to report on improvements in inter-agency cooperation and outcomes.**

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68 McDevitt B, transcript, 16/8/02, p 1228.

69 McDevitt B, transcript, 16/8/02, p 1228.

70 *Australian Federal Police- To fight crime together and win - Annual report 2001-02*, AFP, Canberra, September 2002, p 17.

Should illicit drug laws be changed?

Views for and against

8.62 A great range of views was expressed to the committee about existing drug laws, whether they should be changed, and how they might be altered to deliver a better outcome for the community.

8.63 Major Brian Watters pointed out that the current laws were introduced to counteract the harm caused by substance abuse. They deter drug use, he claimed, and provided the authority for interventions that limit harm; lives are saved and users are directed into treatment when they are unable to make decisions for themselves.[71] Studies by Jones and Weatherburn confirmed that prohibition does deter some young people from using cannabis.[72] For example, they also found that users reported that imprisonment or arrest would make them stop or reduce their use; more frequent users would, however, be less influenced by arrest and imprisonment than infrequent users.[73]

8.64 In evidence to the inquiry, opposition was voiced against changing drug laws[74], including those relating to cannabis.[75] Responses to the NDS Household Survey also indicated little support (less than one in 10 Australians) for legalising the personal use of heroin (7.6 per cent), amphetamines/speed (6.8 per cent) or cocaine (6.6 per cent), although legalising marijuana/cannabis was favoured by three in 10 people (29.1 per cent).[76]

8.65 Major Watters also said that among those who opposed changes to drug laws, it was seen as important that cannabis use remain illegal to retain the deterrent impact associated with that status.[77] Professor Saunders while having concerns about liberalisation of cannabis laws in general stated, that if further changes were being made, measures

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71 Watters B, transcript, 16/8/02, pp 1240-1241.

72 Weatherburn D and Jones C, 'Does prohibition deter cannabis use?', *Crime and Justice Bulletin*, NSW Bureau of Crime Statistics and Research, no 58, August 2001, 8p.

73 Jones C & Weatherburn D, 'Reducing cannabis consumption', *Crime and Justice Bulletin*, NSW Bureau of Crime Statistics and Research, no 60, November 2001, pp 1-2.

74 Drug Advisory Council of Australia, sub 165, p 1; Catholic Women's League, transcript, 21/5/2001, p 960.

75 Toowoomba Drug Awareness Network, sub 273, p 5.

76 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: Detailed findings*, p 95.

77 Watters B, transcript, 16/8/02, pp 1240-1242.

to prevent large scale cultivation and trafficking should remain in place.[78]

8.66 Specific recommendations were made in submissions to the committee regarding the regulation of hydroponics shops[79], the confiscation of drug-related paraphernalia[80], random drug testing at rock and dance concerts, and selected night clubs and pubs (known to be central points for drug trading in the drug subculture)[81], and the repatriation of immigrants who deal in commercial quantities of drugs regardless of how long they have been in the country.[82]

8.67 Dr Wodak noted that those who favour a more liberal regime argue that trying to reduce drug supply is 'expensive, relatively ineffective and quite often counterproductive'. Prohibition creates powerful market forces; prohibitionists ignore the importance of the profit motive. Dr Wodak also suggested that, in the case of cannabis, the least bad approach is to tax and regulate it to cut out criminals, corrupt police and motor cycle gangs.[83] Ms Daley suggested that if illicit drugs were legalised, they should be retailed by non-profit organisations.[84] Dr Rosevear suggested that taxes collected from the sale of illicit drugs could be spent on education, control, rehabilitation, disease prevention and alternative approaches to helping drug users.[85]

Current legislative framework

8.68 The nature of our drug laws is influenced by three international conventions to which Australia is signatory. They are the 1961 Single Convention, the 1971 Convention on Psychotropic Substances and the 1988 United Nations Convention (The Vienna Convention). Signatories are obliged to establish control systems that prohibit the availability of controlled drugs, except for scientific or medical use. The obligations of these treaties are given effect by three Commonwealth acts: the *Narcotics Drugs Act 1967*, the *Psychotropic Substances Act 1976* and the *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990*.

78 Saunders J, transcript, 15/8/02, p 1104.
79 Toughlove South Australia, sub 236, p 1.
80 Toughlove South Australia, sub 236, p 1.
81 Reece S, sub 180, p 10.
82 Community Coalition For A Drug Free Society (Vic), sub 251, p 3.
83 Wodak A, transcript, 16/8/02, pp 1244-1245, 1247.
84 Daley H, sub 63, p 5.
85 Rosevear W, transcript, 2/5/01, p 825.

8.69 Although interpretations of the international treaties differ, Lenton suggested there is general agreement that:

- the international treaties would be violated by free availability of illicit drugs;
- they would be violated by regulated availability of illicit drugs for recreational purposes;
- partial prohibition would only be consistent with the treaties if the laws against personal use were retained but not enforced; and
- prohibition with civil penalties does not violate the treaties; nor does prohibition with an expediency principle, in which the government agrees not to enforce the law under defined circumstances[86], such as use for scientific or medical purposes.

Recommendations that all drugs be legalised[87] are therefore very unlikely to be realised.

8.70 Traditionally it has been a matter for each state and territory government to determine its own approach to illicit drug control, within the limits of the Constitution. The Commonwealth government:

- has some legislation of its own relating to illicit drugs, for example, governing their import and export; and
- is bound by the international drug conventions listed above.

In addition, the Commonwealth government has an interest in promoting consistency with the national drug policy. It also provides extensive funding for research and program development, most recently for diversion initiatives which influence state and territory practices.

8.71 The states and territories differ somewhat in their legislative approaches to the use, possession, cultivation, manufacture and supply of illicit drugs. For example Rickard reported that all states have legislation that prohibits cannabis possession and supply for personal use and count them as offences that ought to be penalised. Each jurisdiction prohibits these offences with different degrees of coercive strength reflected in the different types of penalties they

86 Lenton S, 'Using prohibition with civil penalties to reduce harm on the supply side', *Conference Papers Collection*, CD-ROM, 2nd Australasian Conference on Drugs Strategy, Perth, 7-9 May 2002, slides 13, 14.

87 For example, Rosevear W, transcript, 2/5/01, p 825.

apply. The possession and use (and cultivation) of small amounts of cannabis (presumptively for personal use) in South Australia, the Northern Territory and the Australian Capital Territory incur civil penalties such as minor fines or similar forms of expiation. Criminal penalties apply to minor offenders in the other states, although diversionary cautioning allows first or second time offenders to be cautioned or provided with education or counselling instead of the normal court appearance.[88]

8.72 Rickard went onto say that these differences can have a downside because:

> … Within a federation of state jurisdictions with open geographical boundaries and easy transport, such as in Australia, it [is] important that legislative approaches to cannabis be as coordinated as possible to minimise counter productive effects.[89]

Conclusion

8.73 The committee does not favour any change to the general thrust of Australia's illicit drug laws. It strongly advocates that illicit drugs remain illicit. However, it believes that clear definitions of state laws must be determined regarding the quantities in drug possession that constitute a dealer and the levels of criminal offences of possession and supply. It also believes that the laws would serve the country better if there were greater consistency and coordination of legislative approaches between jurisdictions. In line with Recommendation 75 about greater consistency in policing and sentencing, the committee recognises that this is starting to happen under the model criminal code but makes a similar consistency recommendation in relation to legislation.

Recommendation 80

8.74 **The committee recommends that the Commonwealth, State and Territory governments work together to develop nationally consistent legislation relating to illicit drugs.**

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88 Rickard M, *Reforming the old and refining the new: A critical overview of Australian approaches to cannabis*, Department of the Parliamentary Library, Information and Research Services, research paper no 6 2001-02, DPL, Canberra, October 2001, pp 6-7.

89 Rickard M, p 22.

How effective are law enforcement efforts at controlling supplies?

8.75 According to the Commonwealth Attorney-General's Department, the detection and seizure of illicit drugs in Australia and overseas, either directly by Commonwealth agencies or in partnership with overseas agencies, have increased since the start of the NIDS in 1997.[90] Relative seizure rates compared with other nations have also increased. The AFP reported that between 1996 and 1998, the performance of the AFP in seizing heroin per head of population improved in the league table of 18 nations from 14th to second.[91] It also said drawing on its records of seizures and cost of operations, it has developed a measure of the harm that the seizures have prevented. Over the two years 1999-2001, five dollars of harm have been averted for every dollar spent on AFP and Customs operations which the AFP described as 'a good return on investment for the funds invested in it …'[92]

8.76 The committee notes that it is, however, difficult to assess the extent of the successes claimed without knowing what proportion of the total was seized. The former NCA estimated that 'Law enforcement has interdicted only a fraction of the illicit dugs circulating in the community …' The authority estimated that in 1999-2000, for example, just 12 per cent of the heroin brought into the country was intercepted.[93]

8.77 Evidence suggests that performance measures of the success or otherwise of law enforcement efforts should be qualitative as well as quantitative. More important than knowing how much is seized is the impact of the seizures on the market; a better indicator of success is whether criminal groups are dismantled and there is a lasting effect on the availability of drugs on the black market.[94] In late 2000 there was a sharp decline in the availability of heroin in Australia to which, according to the former ABCI and the United Nations Office for Drug

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90 Commonwealth Attorney-General's Department, sub 259, pp 7-8.

91 Australian Federal Police, 'Benchmarking heroin seizures', AFP research notes series, research note 1, p 2, 2002, viewed 10/12/02, <http://www.afp.gov.au/raw/publications/ResearchReports/Issue1/RN1.pdf>.

92 Australian Federal Police, 'Measuring the costs and benefits of AFP investigations', AFP research notes series, research note 2, 2002, p 2, viewed 10/12/02, <http://www.afp.gov.au/raw/publications/ResearchReports/Issue2/RN2.pdf>.

93 National Crime Authority, *NCA Commentary 2001*, p 22, viewed 6/11/02, <http://www.nca.gov.au/content/publications/NCA_Commentry_2001-28977.pdf>.

94 Families and Friends of Drug Law Reform (ACT), sub 266, pp 6-7; National Crime Authority, transcript of the Inquiry into Crime in the Community by House of Representatives Standing Committee on Legal and Constitutional Affairs, 9/10/02, p 215; McDevitt B, transcript, 16/8/02, pp 1218-1219.

Control and Crime Prevention, law enforcement operations contributed. The Commonwealth Attorney-General's Department noted that the shortage demonstrated:

> … Commonwealth law enforcement's success in dismantling established heroin trafficking networks and removing key players, and therefore the capability of syndicates to conduct further importations. A further factor was the contribution of State and Territory law enforcement with increasingly effective policing of domestic heroin markets.[95]

8.78 The committee believes that such an impact appears to be a good indicator of law enforcement's success. However, as Federal Agent McDevitt and the former NCA stated other factors may also have contributed to the shortage. For example, a drought in Burma where most of the heroin used in Australia originates which led to a reduction in supply, and/or a business decision by syndicates to switch to trafficking amphetamines.[96] The Commonwealth Attorney-General's Department advised that a project commissioned by the National Drug Law Enforcement Research Fund is investigating the causes and impacts of the heroin shortage and will report in late 2003.[97]

8.79 A number of improvements for assessing law enforcement's impact on drug supplies were suggested to the committee, including:

- Federal Agent McDevitt's suggestion that better measures of offshore seizures and benchmarking border seizures against overseas agencies[98]; and
- Families and Friends of Drug Law Reform's (ACT) (FFDLR) suggestion that making estimates of the annual consumption of drugs as a basis for measuring the effectiveness of supply control.[99]

Such moves could be part of a broader effort to develop national performance indicators for drug law enforcement. ADCA suggested

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95 Commonwealth Attorney-General's Department, sub 259, p 6.

96 McDevitt B, transcript, 16/8/02, pp 1218-1219; National Crime Authority, transcript of the Inquiry into Crime in the Community by House of Representatives Standing Committee on Legal and Constitutional Affairs, 9/10/02, p 218.

97 Commonwealth Attorney-General's Department, sub 259, p 9; Commonwealth Attorney-General's Department, informal communication.

98 McDevitt B, transcript, 16/8/02, p 1220.

99 Families and Friends of Drug Law Reform (ACT), sub 266, p 6.

that such indicators be developed by the Ministerial Council on Drug Strategy.[100]

8.80 An evaluation of the supply control activities of the National Illicit Drug Strategy concluded that:

> The current performance indicators for drug law enforcement sometimes make it difficult to judge the value of public investment in this area. The indicators that do exist are neither always drug-specific nor easily quantifiable …[101]

The evaluation recommended research and development of outcomes measures and suggested further performance indicators that might be used, such as perception among criminals that risks are higher and increased community awareness of, and involvement in, law enforcement efforts against drugs.[102]

Conclusion

8.81 The committee believes, as indicated above, that the development of performance measures to control the supply of drugs is fraught with difficulty. Such performance measures need more attention if they are to provide the most meaningful information possible.

Recommendation 81

8.82 **The committee recommends that Commonwealth, State and Territory governments cooperate to develop robust performance measures for supply reduction strategies of illicit drugs.**

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100 Alcohol and other Drugs Council of Australia, sub 80 to the Inquiry into Crime in the Community by the House of Representatives Standing Committee on Legal and Constitutional Affairs, p 24.

101 Health Outcomes International Pty Ltd in association with Catherine Spooner Consulting, National Drug and Alcohol Centre & Turning Point Alcohol and Drug Centre, *Evaluation of Council of Australian Governments' initiatives on illicit drugs: Final report to Department of Finance and Administration vol 1: Executive summary*, St Peters, SA, October 2002, p 44.

102 Health Outcomes International Pty Ltd, pp 44.45.

Amphetamine type stimulants

8.83 The Commonwealth Attorney-General's Department advised that the use of ATS has increased over recent years; arrests, seizures and surveys of drug users all point to this trend.[103] The AFP reported that in 1999 the United Nations Office of Drugs and Crime – UNDO reported that methamphetamine was the most commonly used ATS in North America and East Asia while amphetamine was dominant in Europe. In 2001 global trends had changed with East Asia and Oceania emerging with the highest prevalence amid patterns of stabilisation or decrease in the Americas and Europe. The AFP also reported that the UN Global Illicit Drug Trends 2002 shows annual prevalence of amphetamine abuse as a percentage of the population aged 15 years and over for all reporting regions. Thailand shows the greatest percentage (5.9 per cent) of any country and Australia second at 3.6 per cent. Although data is limited, the AFP said that China, Myanmar and the Philippines appear to be the main sources of the finished product with China the largest supplier of precursors for manufacturing ATS. [104]

8.84 In the face of the adverse consequences of ATS use, several measures have been suggested to control supplies. Foremost among them is making access to precursor chemicals more difficult. For example the AFP Association recommended this be done by mandatory reporting of theft or loss of precursors and / or listing them as prohibited imports in the *Customs Act 1901*.[105] Federal Agent McDevitt and Professor Saunders supported restricting, even banning, the sale of over-the-counter medicines containing precursors such as pseudoephedrine, and replacing them with other equally effective medicines for the relief of colds and flu.[106] Based on changes introduced by the pharmaceutical company Warner Lambert, the Pharmacy Guild of Australia suggested restricting access to pseudoephedrine could be achieved through agreed ceiling orders for retailers, agreed limitations of replacement by wholesalers, and close liaison between the police and the pharmaceutical industry over high-use customers.[107]

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103 Commonwealth Attorney-General's Department, sub 259, p 6.

104 Australian Federal Police, sub 288, p 1.

105 Australian Federal Police Association, sub 70 to the Inquiry into Crime in the Community by the House of Representatives Standing Committee on Legal and Constitutional Affairs, p 80.

106 McDevitt B, transcript, 16 / 8 / 02, p 1222; Saunders J, transcript, 15 / 8 / 02, p 1109.

107 Pharmacy Guild of Australia, sub 151, p 15.

8.85 At present the *1 May 2003 Standard for the uniform scheduling of drugs and poisons No 18* lists pseudoephedrine as a Schedule 4 Prescription Only Medicine except when included in Schedule 2 Pharmacy Medicine or Schedule 3 Pharmacist Only Medicine (there are nine exceptions in the later two schedules).[108]

8.86 Pfizer suggested a national coordinated approach to managing the sale of products containing pseudoephedrine.[109] On a more general level, a formal National Code of Practice for Supply Diversion into Illicit Drug Manufacture[110] has been developed to establish a common system of practice for Australian chemical manufacturers, importers, distributors, scientific equipment and instrument suppliers that are company members of the Plastics and Chemicals Industries Association and Science Industry Australia.[111]

8.87 A National Working Group on Diversion of Precursor Chemicals into illicit drugs was established in late 2002 with Commonwealth, State and Territory law enforcement, health and industry groups. In December 2002 following the first meeting of the working group the Minister for Justice and Customs and Parliamentary Secretary to the Minister for Health and Ageing stated that:

> The working group's primary aim is to identify a balanced and coordinated approach to stopping the diversion of precursor chemicals, such as pseudoephedrine found in cold and flu tablets, into the production of Amphetamine Type Stimulants (ATS) while ensuring that the public has appropriate access to legitimate products.[112]

8.88 The Ministers announced that the Working Group had decided to take a national approach to make it more difficult for illegal drug manufacturers to access pseudoephedrine and other chemicals. They also said:

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108 *Standard for the uniform scheduling of drugs and poisons: No. 18: 1 May 2003,* Commonwealth Department of Health and Ageing, Canberra, 2003, x, 382p.

109 Pfizer Pty Ltd, sub 276, pp 2- 3.

110 *Code of Practice for Supply Diversion into Illicit Drug Manufacture.* Prepared jointly by Chemical Sector of the Plastics and Chemical Industries Association and Science Industry Australia in consultation with government and law enforcement agencies. NSW Commissioner of Police, Sydney, June 2002, 20p.

111 Australian Bureau of Criminal Intelligence, sub 261, p 3.

112 Senator the Hon Christopher Ellison, Minister for Justice and Customs and the Hon Trish Worth MP, Parliamentary Secretary to the Minister for Health and Ageing, *National working group on diversion of precursor chemicals into illicit drugs,* joint media release, 4/12/02, p 1.

Key outcomes from today's meeting included:

- Recognition of the need to develop consistent penalties and offences across jurisdictions.
- Agreement that regulations and legislation should be improved nationally so that there were consistent controls of precursors, and methods to investigate clandestine laboratories.
- Support in principle for the implementation of a code of conduct for the Australian Self-Medication Industry (ASMI).[113]

8.89 In the 2003-04 federal budget, the government announced it will provide $4.3 million to implement programs targeting precursor chemicals used in the illicit manufacture of drugs. The budget papers stated that funds will provide for: a national forensic database on illicit drug laboratories; strategic research and analysis of current and emerging threats; partnership initiatives; and the raising of awareness amongst key sectors.[114]

Conclusion

8.90 The committee recognises that part of the difficulty in dealing with ATS is that the precursors can be varied slightly changing the substance and thus making it difficult to regulate. While you can regulate for the precursor today it may change tomorrow.

8.91 The committee welcomes the development of an industry code and the initiatives being followed up by the National Working Group on Diversion of Precursor Chemicals but believes that more needs to be done. Mandatory reporting of loss or theft of precursors, amendments to the Customs Act and restrictions on the supply of over-the-counter medicines containing pseudoephedrine all merit attention.

8.92 The committee believes that other options include registering an individual purchasers name and address or medicare card or medicare number at the time of sale should be investigated.

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113 Senator the Hon Christopher Ellison, Minister for Justice and Customs and the Hon Trish Worth MP, Parliamentary Secretary to the Minister for Health and Ageing, p 1.

114 *Budget measures 2003-04*, p 170.

Recommendation 82

8.93 **The committee recommends that legislation be introduced by governments at the Commonwealth, State or Territory level to:**

- **require that the loss or theft of the precursors of amphetamine-type stimulants be reported to the police;**
- **amend Schedule VI of the *Customs Act 1901* to include the precursors of amphetamine-type stimulants;**
- **restrict the supply of the precursors of amphetamine-type stimulants by:**
  - ⇒ **placing ceilings on orders by retailers;**
  - ⇒ **limiting replacements by wholesalers; and**
  - ⇒ **requiring the pharmaceutical industry to report high-use customers to the police.**

Recommendation 83

8.94 **The committee recommends that:**

- **the National Working Group on Diversion of Precursor Chemicals identify a way to make legislation sufficiently flexible to be able to regulate immediately the changing precursors that are found in amphetamine type stimulants;**
- **the Commonwealth government amend its *Standard for uniform scheduling of drugs and poisons* to make all substances containing pseudoephedrine a Schedule 4 Prescription Only Medicine; and**
- **State and Territory governments adopt the proposed legislative and scheduling proposals developed on pseudoephedrine, as outlined in the two dot points above, as soon as possible after their identification.**

Demand reduction

8.95 Earlier chapters of this report have detailed the role of the education and health sectors and non-government organisations in reducing

substance use and abuse through education, treatment and support for those affected by alcohol and drugs. The criminal justice system can also contribute to demand reduction by diverting those encountering the system into drug education and/or treatment. This can occur at any point along the chain from first contact with the police to post sentence in the courts.

Diversion from the criminal justice system

Rationale for diversion

8.96 Several studies have shown that, with treatment, some drug users will cease using altogether and stop their criminal activities. Even those who eventually relapse commit fewer crimes while in treatment and before relapsing than the untreated criminal. For example, Hall reported that:

> There is consistent evidence that MMT [methadone maintenance treatment] reduces heroin use and crime while heroin-dependent persons receive adequate doses of methadone in programs with a methadone maintenance treatment goal …[115]

Dr Weatherburn stated:

> The available evidence suggests that coerced treatment, if properly resourced, is no less effective than voluntary treatment in reducing drug use and drug related crime.[116]

Graycar et al stated:

> … Coerced treatment is based on two pieces of empirical work. The first is that the length of time a person spends in treatment is a significant factor in predicting success. The second is that there appears to be no difference in outcomes between people coerced into treatment and those who enter voluntarily. To effectively implement these two pieces of research evidence drug courts have been introduced …[117]

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115 Hall W, 'Methadone maintenance treatment as a crime control measure', NSW Bureau of Crime Statistics and Research, Report B29, 1996, p 14, viewed 26/9/02, http://lawlink.nsw.gov.au/bocsar1.nsf/pages/cjb29text

116 Weatherburn D, transcript, 23/9/02, p 1259.

117 Graycar A, McGregor K, Makkai T & Payne J, 'Drugs and law enforcement: Actions and options', p 10.

8.97 Furthermore, the cost of treating drug dependent offenders is less than the costs they impose on society through crime and the cost of dealing with them within the criminal justice system. For example, Ashton reported that estimates based on a large British study suggested that every £1 spent on treatment gains over £3 in cost savings from crime.[118] A US study showed that for ten US cities crime costs due to US cocaine addicts fell 78 per cent after long term residential treatment and 28 per cent after outpatient drug-free treatment.[119] In another US study by Gerstein et al it was reported that the cost of crime was found to have fallen 42 per cent from before to after treatment for the study group of women and men who relied on welfare income, had children, had parenting and custody issues or some combination of these.[120]

Conclusion

8.98 The committee believes that as well as reducing crime in the community and giving dependent drug users an alternative to prison and ultimately a better quality of life, it clearly makes financial sense to divert them away from the criminal justice system into treatment.

Australian programs

8.99 A very significant diversion effort is being made by the Council of Australian Governments through the Illicit Drug Diversion Initiative. The program started in April 1999. Eligible drug users are diverted from the criminal justice system into drug education or assessment, from where they are referred to a suitable drug education or treatment and support program to address their drug problems. They are given the incentive to identify and treat their problems and also avoid incurring a criminal record.[121] The Commonwealth Department of Health and Ageing advised that the Commonwealth government

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118 Ashton M, 'NTORS [National Treatment Outcome Research Study]: the most crucial test yet for addiction treatment in Britain', *Drug and Alcohol Findings*, issue 2, 1999, p 18.

119 Rajkumar A & French M, 'Cost and benefit of cocaine treatment', quoted in DATOS [Drug Abuse Treatment Outcome Studies] , viewed 29/10/02, <http://www.datos.org/adults/adults-cost.html>.

120 Gerstein D, Johnson R, Larison C, Harwood H & Fountain D, *Alcohol and other drug treatment for parents and welfare recipients: Outcomes, costs, and benefits: Final report*, US Department of Health and Human Services, Washington, January 1997, pp 1, 6, viewed 30/10/02, <http://aspe.os.dhhs.gov/hsp/caldrug/calfin97.htm>.

121 Council of Australian Governments, National Drug Strategy, *Illicit Drug Diversion Initiative*, 'About diversion', viewed 4/11/02, <http://www.nationaldrugstrategy.gov.au/nids/diversion/abtdiv.htm>.

has signed funding agreements with all the states and territories[122] and has provided $110 million over four years for the initiative.[123] At the end of 2002, the Prime Minister announced the provision of a further $215 million for 2003-07.[124] This continuation funding was reflected in the 2003-04 federal budget.[125]

8.100 A recent evaluation of Australian programs by Health Outcomes International Pty Ltd (Health Outcomes) found diversion occurring at pre-arrest, pre-trial, pre-sentence and post-sentence stages of the criminal justice system. Up to 31 March 2002, nearly 20,000 referrals to diversion had been estimated to have been made. Police diversions made up 90.3 per cent of these referrals. Not all states have court diversion programs yet (Health Outcomes lists Tasmania, Queensland and South Australia in this category). [126]

8.101 Another important diversionary mechanism is provided by the drug courts which have been established in all jurisdictions except Tasmania, the Australian Capital Territory and the Northern Territory. Freiberg noted that drug courts have a number of defining characteristics. They deal specifically with drug offenders and integrate drug treatment into the criminal justice case processing system. They employ a non-adversarial approach, a dominant and continuing role for the court judge, frequent drug testing, comprehensive treatment and supervision, and a system of graduated sanctions and incentives.[127]

8.102 Several submissions to the inquiry strongly supported the use of diversion and called for more of it.[128] Drug courts also received special mention by FFDLR and Dr Santamaria.[129] FFDLR stressed that diversion was seen as being especially appropriate for early

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122 Commonwealth Department of Health and Ageing, sub 238, p 26.

123 Commonwealth Department of Health and Ageing, fax, 12/9/02.

124 Hon John Howard MP, Prime Minister, *Illicit drug diversion initiative*, media release, 31/12/02.

125 *Budget measures 2003-04*, p 177.

126 Health Outcomes International Pty Ltd, *vol 1*, pp 17-18; Health Outcomes International Pty Ltd, *vol 2: Diversion initiatives*, pp 34-80.

127 US Department of Justice, quoted by Freiberg A, 'Australian drug courts: A progress report', *Conference Papers Collection*, CD-ROM, 2nd Australasian Conference on Drugs Strategy, Perth, 7-9 May 2002, p 3.

128 Drug Advisory Council of Australia, sub 165, p 1; Public Health Association of Australia, sub 159, pp 3-4.

129 Families and Friends of Drug Law Reform (ACT), sub 65, pp 1, 5; Santamaria J, sub 231, p 10.

intervention in a drug user's activities[130], and other groups stressed it is particularly useful for young people.[131] Dr Matthews reported that with really heavy drug users (that is, with an average of six previous incarcerations) as many as 40 per cent of offenders brought before the New South Wales drug court had never sought treatment for their drug habits. Diversion is therefore also a way of getting into treatment people who have never before received help for their problems.[132] Dr Matthews also noted that points of incarceration are also places where drug users can be diverted into treatment.[133]

Recommendation 84

8.103 **The committee recommends that the Commonwealth works collaboratively with all State and Territory governments to establish effective court diversion programs and drug courts in all States and Territories.**

Evaluation of diversion programs

8.104 Early indications from Australia's diversion programs suggested they were having a positive impact. For example:

- a significant drop off in participation from first to second and third cannabis offences pointed to a change of offender behaviour;
- the majority of a small sample of clients reported a positive effect, including reducing drug use and crime, the opportunity to obtain treatment and reflect on their lives; and
- some clients accessed a drug and alcohol service for the first time.

Relative to some overseas programs, Australian initiatives have done well in terms of intersectoral collaboration and the availability of treatment services for diverted clients.[134]

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130 Families and Friends of Drug Law Reform (ACT), sub 65, pp 1, 5.

131 Family Drug Support, sub 87, p 8; National Council of Women of WA, sub 172, p 2; Youth Substance Abuse Services, sub 102, pp 4-5.

132 Matthews R, transcript, 16/8/02, p 1238. The former committee's discussion paper, *Where to next?*, (p 83) supported diversion for young illicit drug users.

133 Matthews R, transcript, 16/8/02, p 1238.

134 Health Outcomes International Pty Ltd, *vol 1*, pp 20, 22.

8.105 Graycar et al noted that evaluations of overseas diversion programs have identified some of the elements that make such programs successful. They include:

- a proactive mode of work;
- a working style which wins the respect and trust of users;
- adequate resourcing;
- a capacity to provide ongoing support; and
- appropriate, adequately resourced treatment services to which to refer clients.[135]

8.106 However, evaluations have highlighted some pitfalls than we can learn from. Dr Graycar pointed out for example that:

> … An important factor is the different philosophical differences that different agencies bring to the table … Essentially the health care system is based on consent and in most cases voluntary participation; criminal justice agencies, including the police, operate in a coercive environment … A productive partnership needs to recognise and accommodate these differences. This can only be achieved in a supportive and trusting environment where there is respect for different views of the world ...[136]

8.107 The difficulties that can arise from the different perspectives of law enforcement and health care are illustrated in the former committee's work. It found that 'some members of the police service are uncomfortable with the sort of work they are doing with diversion'. The former committee considered that 'training ought to be provided to police, as much of the success of this initiative rests on their shoulders'.[137] The recent evaluation of Australian programs by Health Outcomes also concluded that, despite increasing support for diversion among police and court personnel, 'there is a need for ongoing support for and training of police, magistrates and court

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135 Graycar A, McGregor K, Makkai T & Payne J, 'Drugs and law enforcement: Actions and options', p 14.

136 Graycar A, McGregor K, Makkai T & Payne J, 'Drugs and law enforcement: Actions and options', p 14.

137 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, pp 79-80.

personnel to further develop and sustain their support for the program.'[138]

8.108 Family Drug Support suggested that this training should be targeted at all groups in the criminal justice system and cover the nature of drug abuse, its treatment, the services available, and avoiding discrimination against drug users.[139] Spooner et al showed it is important for the police to understand the wider role they can play in reducing harm compared with that delivered by traditional policing. They need to be more aware of how their actions can impact on community health. Greater collaboration with health workers is now happening but is not practised consistently at all levels of health and law enforcement.[140]

8.109 Other issues raised by Health Outcomes included indications that diversion programs were not engaging illicit drug users early enough in their drug-using activities. Clients in diversion programs were generally in their mid to late 20s and had longer, more problematic drug use than had been expected when the programs were established. This raised the question of how to engage younger users. Also needed are standard data about the programs and research, development and evaluation to further improve programs effectiveness.[141]

8.110 In an evaluation of Australia's first drug court, that in New South Wales, Lind et al said that this court was found to have been both effective and cost-effective, although not dramatically so. They believed further effort is needed to target better the offenders who are accepted into the court program and to fine tune the program's procedures.[142] In reviewing Australian drug courts Freiberg concluded that:

> Overall, my interim verdict is that the courts are a worthwhile innovation which deserves further support. Final judgement should be withheld until the results of the Queensland, South Australian, Western Australian and Victorian evaluations are

138 Health Outcomes International Pty Ltd, *vol 1*, p 6.

139 Family Drug Support, sub 87, p 8.

140 Spooner C, McPherson M & Hall W, 'The role of police in illicit harm minimisation: an overview', *Conference Papers Collection*, CD-ROM, 2nd Australasian Conference on Drugs Strategy, Perth, 7-9 May 2002, p 5.

141 Health Outcomes International Pty Ltd, *vol 1*, pp 6, 20, 28-29.

142 Lind B, Weatherburn D, Chen S, Shanahan M, Lancsar E, Haas M & De Abreu Lourenco D, *New South Wales drug court evaluation: Cost-effectiveness*, NSW Bureau of Crime Statistics and Research, Sydney, 2002, p vii-viii.

published and a further review is carried out of the New South Wales court in its mature and settled phase.[143]

8.111 Non custodial sanctions also received comment in evidence. Dr Weatherburn noted that in the past in most states they have generally not been actively supervised nor strongly enforced. Penalties have not always been strict. There is scope here to make the non custodial regime more effective by strengthening its operation and penalties.[144] In addition, Professor Freiberg advised the treatments that are provided to people on community based orders are 'derisory', 'the service delivery is intermittent, it is delayed and it is basically inadequate', and the support services are not really there.[145]

Conclusion

8.112 The committee is pleased by the Commonwealth and those State and Territory government's who continue to support the diversion of offenders away from the criminal justice system and into drug education and/or treatment. However, it:

- believes more effort should be put into training and support for those involved in providing diversion initiatives;
- supports work to develop best practice approaches to the different types of diversion programs and complementary interventions to engage drug users earlier in their drug using activities; and
- is concerned by the poor quality of non-custodial sanctions.

Recommendation 85

8.113 **The committee recommends that the Commonwealth, State and territory governments provide training and support for police, magistrates and court personnel to enable them to effectively refer offenders to proven diversion programs where outcomes can be measured.**

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143 Freiberg A, 'Australian drug courts: A progress report', *Conference Papers Collection*, CD-ROM, 2nd Australasian Conference on Drugs Strategy, Perth, 7-9 May 2002, p 26.

144 Weatherburn D, transcript, 23/9/02, p 1260.

145 Freiberg A, transcript of the Inquiry into Crime in the Community by House of Representatives Standing Committee on Legal and Constitutional Affairs, 9/9/02, p 33.

Recommendation 86

8.114 **The committee recommends that the Commonwealth, State and Territory governments fund research to:**

- **establish best practice in relation to existing diversion programs and disseminate the results widely; and**
- **explore strategies to identify drug users or young people at risk at an earlier stage through precursive or associated behaviour that may present to the criminal justice or welfare system.**

Recommendation 87

8.115 **The committee recommends that the Commonwealth fund a national evaluation of the drug courts to determine their success in achieving beneficial outcomes for offenders, their families and communities.**

Recommendation 88

8.116 **The committee recommends that better resourced, more efficient and effective systems be established to monitor non-custodial sanctions imposed on drug offenders.**

Coerced treatment for drug dependence in a diversionary context

8.117 In keeping with the committee's interest on a greater emphasis on treatment, it is singling out for particular comment the issue of coercing offenders into treatment. This is significantly related to diversion activities. As indicated above, coerced treatment can be as effective as voluntary treatment. Furthermore, coerced treatment for drug dependence was strongly supported in submissions to the inquiry[146], with penalties for refusing[147] or failing to remain in treatment.[148] Major Brian Watters told the committee that:

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146 Beswick P, sub 42, p 3; Catholic Women's League, sub 75, p 16; DRUG-ARM, sub 199, p 7; Robinson F, sub 5, p 1; Santamaria J, sub 231, p 10.

147 Hubbard C, sub 8, p 1;

148 Toowoomba Drug Awareness Network, sub 273, p 4.

> So many times, people – especially young people – have been sent to us or have come to us at a point of crisis and, after two or three days when they start to feel better and have been detoxed, have decided to leave, and I have had the families plead with me: 'Please don't let them go. They will go out there and get back into this and they are going to die.' In some instances, they have. I have been distressed along with the parents, as a parent and a grandparent myself. We did not have the means, and it was not our role, to incarcerate people and prevent them from leaving. But if there was some way that they could have been contained and constrained until they had gone through that further process of detoxification – and begun to be capable of thinking rationally and normally, begun to get some hope and to recognise that they are not bad people and that they are not useless and worthless people, begun to build up some of that sense of self-esteem, and, in the group work, begun to realise that they are not alone and that there are other people who are struggling with this and there are underlying issues we can help them with if we can get them through that early stage – then the possibility of their going on to successful completion of the program and remaining in a drug free state would be very high. [149]

8.118 Submissions suggested coercive treatment for addicted offenders who had committed serious crimes[150] and Toowoomba Drug Awareness Network suggested repeat drug offenders on a diversion order should enter into compulsory rehabilitation within the criminal justice system with the possibility of a non-recorded sentence[151]. DRUG-ARM also recommended that the government introduce compulsory treatment for those whose family has sought and received a court sanction for their family members to undergo a drug treatment option.[152]

8.119 One of the questions raised with the committee was whether methadone treatment should be mandatory for drug-dependent offenders in gaols. The argument put to the committee by Dr Matthews was that:

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149 Watters B, transcript, 16/8/02, p 1241.

150 Beswick P, sub 42, p 3; DRUG-ARM, sub 199, p 7; Santamaria J, sub 231, p 10.

151 Toowoomba Drug Awareness Network, sub 273, p 4.

152 DRUG-ARM, sub 199, p 7.

> … commencing any medication, particularly an S8 [Schedule 8 Controlled Drug] medication [which includes methadone] to which people get dependent, needs to be a decision made between doctor and a patient with all options considered and entered into voluntarily.[153]

Conclusion

8.120 Given that there is evidence that coerced treatment in diversionary programs can be successful, the committee believes that:

- it is necessary to see the issues relating to coerced treatment considered in more detail, particularly in relation to young offenders and repeat offenders;
- targeting these two groups could make a substantial difference;
- seeking early intervention for young people at risk (for example, those caught with cannabis for the first time) to ensure more significant drug problems do not arise is appropriate;
- intervening early in a drug user's activities minimises the damage done to the user as well as to the community;
- as repeat offenders are responsible for a significant proportion of alcohol and drug-related offences, treating them would greatly reduce the burden they place on the community;
- where appropriate social workers should be able to obtain a court sanction for a patient to undergo treatment; and
- as an alternative to the question of whether methadone treatment should be mandatory for drug-dependent offenders in gaols the committee notes that an order to use a non-addictive treatment such as a naltrexone implant (that is, a Schedule 4 Prescription Only Medicine) might well be ethically more acceptable.

Recommendation 89

8.121 **The committee recommends that Commonwealth, State and Territory governments examine the establishment of a regime that would highlight options of appropriate coerced treatment and rehabilitation programs for young offenders and repeat drug-dependent offenders.**

153 Matthews R, transcript, 16/8/02, p 1237.

The regime should include the use of good behaviour bonds and incentive sentencing as an option and sanctions for pulling out of the program.

Treatment for prisoners

8.122 At the outset it is important to recognise the existence of drugs in prisons. The treatment and rehabilitation of prisoners is easier when drugs are absent or in short supply. While all jurisdictions pursue strategies to reduce the flow of drugs into prisons, the committee strongly encourages them to make every effort to minimise every chance of drugs getting into prisons, either through contact visits or through the correctional system itself. If this isn't done, other strategies to assist drug affected prisoners won't work.

8.123 The former committee noted that as many as 75 per cent of prisoners have a drug or alcohol problem and a high proportion of these are repeat offenders.[154]

8.124 The committee agreed when offenders come into the prison system their drug use status should be assessed. The question is whether this should be mandatory or not and whether the staff in prisons should be drug tested as well.

8.125 Drug testing in the law enforcement system is occurring. In evidence the AFP reported that since July 2000 under the provisions of the Commissioner' employment powers pursuant to the *Australian Federal Police Act 1979* and the *Australian Federal Police (Disciplinary) Regulations* there is mandatory drug testing for employees. The AFP also tests its contractors and volunteers. From 1 July 2002 the Mandatory Targeted Testing was expanded to ensure that 100 per cent of the workforce was tested within a specified time frame – the 2002/03 financial year. The AFP does not conduct random testing for alcohol. [155]

8.126 The AFP also reported that NSW Police is the only other police jurisdiction in Australia to have implemented mandatory testing and this is limited to sworn members (section 211A, *NSW Police Act 1990*). Other jurisdictions are considering the introduction of mandatory drug testing programs.[156]

154 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 80.

155 Australian Federal Police, sub 288, pp 2-3.

156 Australian Federal Police, sub 288, p 3.

8.127 The committee is aware that a long-standing principle in prisons is to ensure first-time offenders are not mixed with hardened long-term offenders. The committee is of the view that a similar approach needs to be implemented in relation to the drug use status of inmates.

8.128 Dr Matthews pointed out that many drug dependent offenders have never previously accessed treatment while living in the community, so their incarceration represents an opportunity to get them into treatment.[157] As the former committee noted, treatment for prisoners is important because as highlighted above as many as 75 per cent of them appear to have a drug or alcohol problem and a high proportion of them are repeat offenders (for example, 51 per cent of those jailed for possession or drug use charges in the year 2000 had been inside jail before).[158] Dr Weatherburn said substantial benefits to the criminal justice system, the prisoner and the community can therefore be expected from successful treatment of this group that 'has caused the community most of the grief and … cost the community most of the money'.[159]

8.129 The committee is of the belief that repeat offenders should be treated. There is debate about whether this treatment should be mandatory or not as when an offender enters the criminal justice system this is a rare opportunity to intervene in drug taking and crime.

8.130 However, Dr Matthews stressed that 'rehabilitation, although a laudable aim, is not logistically possible in the correctional setting'; since most prisoners do not stay in one place for very long.[160] Research by the Victorian Alcohol and Drug Association into several overseas studies demonstrates that it is possible, though, to start prisoners on treatment which they continue after leaving jail, and this has been shown to be effective.[161] The South Australian Drug Summit recommended that this should happen.[162]

8.131 The committee believes that this should happen more extensively than it does at present.

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157 Matthews R, transcript, 16/8/02, p 1238.

158 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 80.

159 Weatherburn D, transcript, 23/9/02, p 1266.

160 Matthews R, transcript, 16/8/02, p 1231.

161 Victorian Alcohol & Drug Association, 'Tough on crime' versus drug treatment: a VAADA report', August 2002, pp 1, 4-5, viewed 30/0/02, <http://www.vaada.org.au/tough_on_crime.htm>.

162 South Australian Government, sub 279, attachment, *Communique*, South Australian Drugs Summit 2002, Adelaide, 24-28 June 2002, p 24.

Recommendation 90

8.132 **The committee recommends that the Commonwealth government encourage State and Territory governments to ensure that treatment is provided to all drug dependent prisoners.**

8.133 As for treatment on the inside, the former committee reported itself to be:

> … dismayed to discover that corrective service departments around the country are not dedicating sufficient resources to support the health and welfare needs of drug dependent prisoners …
>
> … [It declared that] Governments should invest more on the provision of health, education and welfare staff to help prisoners …'[163]

The committee also noted that, the former Commonwealth Department of Health and Aged Care stated that in 1999 as part of the national diversion initiative, Australian governments agreed to develop and trial diversionary programs in jails.[164] However, the Commonwealth Department of Health and Ageing stated informally that NIDS dollars are not generally available for drug prevention and treatment programs in prisons as many prisons are managed by the private sector.

8.134 Information available to the current committee confirmed that, while treatment services are provided in prisons, they fall short of what is needed. For example, a paper prepared for the 2002 South Australian Drug Summit reported that treatments involving opioid substitution therapies had been capped in that state at about 150 prisoners. As a result, some prisoners were being released back into the community

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163 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, pp 81-82.

164 Commonwealth Department of Health and Aged Care, sub 145, p 90.

before a place became available.[165] It is estimated that the program is meeting only 50 per cent of the demand for it.[166]

8.135 The joint protocol between the Australian Medical Association (NSW) and the Law Society of NSW recommended that the range and capacity of treatment services in prisons should be expanded so that services are available to all who seek treatment and are of the same standard as services in the community.[167] ADCA also called for the same quality and level of treatment for prisoners as is provided for the general public.[168]

8.136 Dr Matthews stressed that an appropriate range of treatments is needed and he and several non-government agencies suggested treatments including buprenorphine, methadone, naltrexone and other opioid pharmacotherapies, abstinence-based programs, needles and syringes, and therapeutic communities.[169] Dr Matthews also suggested that preserved places and residential communities which accepted clients undergoing pharmacotherapy would also be very helpful.[170]

Conclusion

8.137 The committee believes that:

- it is clear that, if treatment is to be effective, it must be of an adequate standard and offer a sufficient range of treatments to meet the diverse needs of the prison population;

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165 Department of Correctional Services, South Australia, 'Illicit drugs and correctional services', Issues paper, *South Australian Drugs Summit 2002, Adelaide, 24-28 June 2002*, p 5, viewed 24/4/03, <http://www.drugsummit2002.sa.gov.au/public/summit_themes/drugs_correctional_svcs.pdf>.

166 South Australian Government, sub 279, attachment, *Communique*, South Australian Drugs Summit 2002, Adelaide, 24-28 June 2002, p 24.

167 The Law Society of New South Wales, sub 39, attachment – copy of The Law Society of NSW submission to the NSW Parliamentary Drug Summit, Sydney, 17-21 May 1999, attachment *Joint protocol between the Australian Medical Association (NSW) Ltd and The Law Society of New South Wales: Developing more effective responses to Australia's growing problem with illicit drug,* p 1.

168 Alcohol and other Drugs Council of Australia, *Drug policy 2000: A new agenda for harm reduction*, ADCA, Canberra, June 2000, p 133.

169 Alcohol and other Drugs Council of Australia, sub 61, p 23; Family Drug Support, sub 87, p 8; Australian National Council on AIDS, Hepatitis C and Related Diseases, sub 111, p 5; Matthews R, transcript, 16/8/02; p 1238; Toowoomba Drug Awareness Network, sub 273, p 5; DRUG-ARM, sub 199, p 19.

170 Matthews R, transcript, 16/8/02, p 1238.

- prisoners should be assessed and treated in accordance with their individual needs. A database on prisoners and their treatment would assist this process;
- in addition, if the trial of naltrexone implants recommended in Chapter 7 proves them to be safe and effective in assisting opioid dependent people, serious consideration should be given to requiring the use of such implants with suitable heroin dependent prisoners; and
- a long-standing principle in prisons is to ensure first-time offenders are not mixed with hardened long-term offenders. The committee is of the view that a similar approach needs to be implemented in relation to the drug use status of inmates.

Recommendation 91

8.138 **The committee recommends that every prisoner should be assessed to determine their exposure to drug use and an appropriate drug-related treatment and management strategy should be implemented if substance abuse or risk thereof is determined.**

Recommendation 92

8.139 **The committee recommends that State and Territory governments ensure that they provide a range of treatments for drug-dependent prisoners to the standard to which they are available in the wider community.**

Recommendation 93

8.140 **The committee recommends that, as part of the trial recommended in Recommendation 55, naltrexone implants also be trialled to treat opioid dependent prisoners. Should the trial be successful, then the use of naltrexone implants be an ongoing treatment for opioid dependent prisoners. Participation in the trial must be voluntary and agreed between the doctor and patient.**

Recommendation 94

8.141 **The committee recommends that the Commonwealth government work with State and Territory governments to facilitate:**

- **the establishment of independent drug free units in correctional centres;**
- **drug free units should incorporate education programs including drug education;**
- **admission to the drug free unit should be on a voluntary basis by inmates who are assessed to be willing to achieve drug free outcomes;**
- **numeracy, literacy and life skills should form part of an education program in the unit;**
- **compulsory blood or urine tests should be undertaken during the time of the program to ensure participants remain drug free; and**
- **remissions should be offered as an incentive to become engaged in successful completion of the program.**

Recommendation 95

8.142 **The committee recommends all personnel employed in correctional facilities should be subject to mandatory random blood or urine tests.**

Recommendation 96

8.143 **The committee recommends that State and Territory governments promote best practice in drug treatment in prisons and recognise those organisations which achieve best practice.**

Needle and syringe programs in prisons

8.144 Needle and syringe programs (NSPs) in prisons have been suggested because of the benefits that they provide. However, as the Australian National Council on Drugs (ANCD) indicated:

> … the benefits to the community from NSPs … are clearly being undermined by a lack of progress in the prison system – the fact that needle sharing is a regular event in probably all our prisons is quite disturbing.[171]

8.145 The New South Wales Users and AIDS Association - NUAA told the former committee that such programs had been opposed by prison staff on the grounds that the danger of needles being used as weapons would increase.[172] However, according the South Australian Department of Correctional Services, there have been no reports of such incidents in the 19 NSPs operating in overseas prisons.[173] The NUAA suggested that the establishment of safe injecting rooms within prisons would help to ensure that the needles do not enter other parts of the prison.[174] The ANCD supported serious consideration of the proposal by the Australian National Council on AIDS, Hepatitis C and Related Diseases (ANCAHRD) for a trial of retractable needle and syringe technology in prisons.[175]

8.146 In terms of the link between injecting drug use and the transmission of hepatitis C, Dolan stated that if transmission is to be cut, 'the primary goal has to be to reduce drug injecting in prison'. She suggested this might be done by providing methadone maintenance treatment, imposing lesser punishments for the use of non-injectable drugs than for injectable drugs, and facilitating non-injecting routes of administration.[176]

8.147 The importance of reducing injecting drug use in prisons is underlined by two facts. First, according to Dr Matthews, 40 per cent of men and 66 per cent of women in New South Wales correctional centres are hepatitis C positive.[177] Secondly, Dolan reported in year 2000 that about a quarter of prisoners injected drugs while incarcerated.[178] The ANCAHRD advocated the 'Development and

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171 Australian National Council on Drugs, *National Council backs investment in needle program*, media release, 23/10/02, p 1.

172 New South Wales Users and AIDS Association, transcript, 21/2/01, p 655.

173 Department of Correctional Services, South Australia, p 6.

174 New South Wales Users and AIDS Association, transcript, 21/2/01, p 656.

175 Australian National Council on Drugs, *National council backs investment in needle program*, media release, 23/10/02, pp 1-2.

176 Dolan KA, 'Can hepatitis C transmission be reduced in Australian prisons?', *Medical Journal of Australia*, vol 174, p 378.

177 Matthews R, transcript, 16/8/02, p 1234.

178 Dolan KA, p 378.

implementation of Models of Care and Prevention of blood-borne viruses for people in custodial settings'.[179]

8.148 ADCA recommended that education about reducing the harm associated with drug use should be provided to prisoners, preferably within a peer-based structure arrived at in consultation with prison officers.[180] Education about hepatitis C should also be included.

Special needs of women and children in prisons

8.149 In evidence attention has been drawn to the special needs of women prisoners. The South Australian Department of Correctional Services pointed out that most current programs for women are adapted from those developed for male prisoners. As such they do not acknowledge the strong relationship between drug use and the child sexual abuse and other forms of violence that many women prisoners have experienced.[181] Based on its experience in Queensland, Sisters Inside recommended much greater coordination of drug treatment policy and programs for women prisoners so that the provision of counselling and treatment meet the needs of these women.[182]

Recommendation 97

8.150 **The committee recommends that the Commonwealth, State and Territory governments initiate specific programs for women and children to address drug treatments in prisons and make available support services post-release from prisons.**

Prisoners who have a mental illness / disorder

8.151 The committee notes that another group in need of particular attention are those with the comorbid condition of drug dependence and mental illness, which is common in the prison setting. Dr Matthews reported that the national mental health interview showed that 90 per cent of women and 78 per cent of men on arrival in prison were suffering from a mental disorder, and 63.3 per cent of men and 74.5 per cent of women were abusing or dependent on drugs

179 Australian National Council on AIDS, Hepatitis C and Related Diseases, sub 111, p 5.

180 Alcohol and other Drugs Council of Australia, *Drug policy 2000: A new agenda for harm reduction*, p 133.

181 Department of Correctional Services, South Australia, p 11.

182 Sisters Inside, sub 30, pp 2, 16.

or alcohol.[183] The Victorian Institute of Forensic Mental Health noted the considerable impact that substance abuse has on mentally disordered offenders and the need for continued research on overcoming the difficulties of dealing with and treating them. It also commented on the lack of experts working in this field in Australia, and emerging evidence of a relationship between coexisting substance abuse and mental disorder and a dramatic increase in the likelihood of violence.[184]

8.152 In Chapter 4, the committee recommended increased funding for alcohol and drug services, with particular emphasis on those for people suffering from mental illness and substance abuse, including those in prison. It now recommends increased efforts to understand the links between comorbidity, crime and violence.

Recommendation 98

8.153 **The committee strongly recommends that the Commonwealth, State and Territory governments:**

- **fund research into the nature of the links between coexisting substance abuse, mental illness, crime and violence; and**
- **ensure sufficient research workers with appropriate skills are available in Australia to carry out this work.**

Linking pre- and post-release treatment arrangements

8.154 Most importantly, evidence suggested that there must be good links between pre- and post-release treatment arrangements, and this is often not the case.[185] In addition, support services are needed in association with treatment, and sometimes such services are very inadequate. Professor Freiberg told the House Legal and Constitutional Affairs Committee in connection with its inquiry into crime in the community that:

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183 Matthews R, transcript, 16/8/02, pp 1233-1234; Mattthews R, presentation to roundtable, Canberra, 16/08/02, exhibit 49, slide 8.

184 Victorian Institute of Forensic Mental Health, sub 52, pp 4, 12.

185 Matthews R, transcript, 16/8/02, p 1236; South Australian Government, sub 279, attachment, *Communique*, South Australian Drugs Summit 2002, Adelaide, 24-28 June 2002, pp 24-25; Weatherburn D, transcript, 23/9/02, p 1260.

> … the major problems are not the drug problems: they are housing problems; they are employment problems; they are, if you like, personality and mental illness related problems and family problems. Unless you provide the package of services, you are not going to make a large difference.[186]

Recommendation 99

8.155 **The committee recommends that State and Territory governments ensure that:**

- **arrangements are put in place to provide closely coordinated pre-release and post-release treatment and support services for drug-dependent prisoners with the objective of assisting them to become drug-free; and**
- **in particular a strong focus on education and employment should form the basis of post-release support.**

Resourcing health services in prisons

8.156 The issue of resourcing health services in prisons was raised by Dr Matthews who pointed out that as prisons are a state responsibility, prisoners do not have access to Medicare.[187]

8.157 The present committee agrees with the former committee that more funding for such programs is clearly needed. The committee believes that in the absence of Medicare funding for prisoners, there is a case for Commonwealth funding for a program that promises equivalent benefits.

Recommendation 100

8.158 **The committee recommends that the Commonwealth government make equivalent medicare benefit funding available to corrections health services to enable the level of treatment described in previous recommendations to be provided to eligible drug-dependent prisoners.**

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186 Freiberg A, transcript of the Inquiry into Crime in the Community by House of Representatives Standing Committee on Legal and Constitutional Affairs, 9/09/02, pp 33-34.

187 Matthews R, transcript, 16/8/02, pp 1236-1237.

8.159 Dr Matthews urged the Commonwealth government to take a lead in establishing minimum standards of health care for people in custody across the country and an ideal framework for delivering these services.[188]

8.160 The committee agrees that such standards and advice on best practice would be helpful.

Recommendation 101

8.161 **The committee recommends that the Commonwealth government, in consultation with State and Territory governments, establish minimum standards for the health care of people in custody and the best practice in the delivery of health care.**

8.162 The ANCD has commissioned the National Drug and Alcohol Research Centre to conduct an overview of the drug-related strategies employed by all Australian jurisdictions to reduce the supply of and demand for drugs in correctional services. Among the data being sought is information on the types of programs in operation, their cost and any evaluations of them.[189]

188 Matthews R, transcript, 16/8/02, p 1236.

189 Australian National Council on Drugs, 'Review of correctional services responses to reduce the initiation, level and impact of drug use within Australian prisons', viewed 24/4/03, <http://www.ancd.org.au/current/current11.htm>; National Drug and Alcohol Research Centre, 'Current project: title: 'Review of correctional services responses to reduce the initiation, level and impact of drug use within Australian prisons', viewed 1/4/03, <http://notes.med.unsw.edu.au/ndarc.nsf/website/Research.current.cp46>.

9

Road trauma

The contribution of substance abuse to road trauma

9.1 From July 2001 to June 2002, 1746 people were killed on Australia's roads[1], and abuse of alcohol and other drugs was among the factors that contributed to this toll. In a 10-year study (1990-99) of 3,398 drivers killed in Victoria, New South Wales and Western Australia, Professor Olaf Drummer of the Victorian Institute of Forensic Medicine estimated that 28 per cent of road trauma was caused by alcohol, and eight per cent by other drugs.[2] His more recent data covering 2000 and 2001 from Victoria suggest that the contribution of drugs to fatalities is probably double that figure (16 per cent) and the proportion of fatalities due to alcohol may be falling.[3]

9.2 The cost of road trauma is huge. According to Collins and Lapsley, alcohol-related accidents alone are estimated to have cost $3.4 billion dollars in 1998-99, of which 56 per cent were tangible costs. Illicit drugs were less costly at $531.6 million.[4]

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1 Australian Transport Safety Bureau, untitled document, June 2002, p 2 (Road fatalities for state/territory for month, year to date, and 12 months), viewed 20/3/03, <http://www.atsb.gov.au/road/stats/pdf/mrf062002.pdf>.

2 Drummer O, transcript, 23/9/02, p 1276; Drummer's study quoted by Swann P, transcript, 16/8/02, p 1195.

3 Drummer O, 'Briefing paper on the role of drugs and alcohol on road trauma', unpublished, while at Victorian Institute of Forensic Medicine, October 2002, p 2.

4 Collins DJ & Lapsley HM, *Counting the cost: Estimates of the social costs of drug abuse in Australia in 1998-9*, Monograph series no 49, Commonwealth Department of Health and Ageing, Canberra, 2002, pp 54-55.

9.3 According to Professor Drummer there has been a change over recent years in the proportion of dead drivers detected with alcohol and other drugs in their blood. The proportion testing positive for alcohol has decreased from 33 to 27.7 per cent during the 1990s, but in the late 1990s other drugs were found in a higher proportion, up from 22.2 per cent in the early nineties to 30.1 per cent.[5]

Role of the government

9.4 Under the Australian Constitution, the states and territories are largely responsible for regulating road use and enforcement. However, the Commonwealth government is working with the states and territories on a regulatory reform agenda. The National Road Transport Commission was formed in 1991 to drive the reform process by proposing uniform arrangements for vehicle regulation and operation and overseeing the implementation of agreed reforms. The commission reports to the Commonwealth, state and territory transport ministers in the Australian Transport Council. The council also includes an observer from local government.

9.5 National coordination on road transport issues that include matters relating to drink and drug driving is also provided by:

- the Australian Transport Safety Bureau which coordinates, monitors and reviews the National Road Safety Strategy and related plans, compiles and analyses road safety statistics and funds and coordinates research; and
- Austroads, the association of Australian and New Zealand road transport and traffic authorities whose projects include road safety and the production of recommendations for national adoption, guidelines and codes of best practice.[6]

National Road Safety Strategy

9.6 The National Road Safety Strategy 2001–2010 and action plans for 2001 and 2002 and for 2003 and 2004 have been adopted by the Australian Transport Council. The strategy provides a framework which complements the strategic road safety plans of state, territory and local

5 Drummer O, sub 277, pp 2-3.

6 Information sourced through the web site of the Commonwealth Department of Transport and Regional Services, viewed 21/10/02, <http://www.dotrs.gov.au/transreg/str_rtrhome.htm>; Australian Transport Safety Bureau, informal communication, 17/2/03.

governments and other stakeholders in road safety. The strategy's target is to reduce road fatalities by 40 per cent per 100,000 population between 1999 and 2010, and the action plans target measures relating to drink and drug driving that will help to achieve this.

9.7 The 2003 and 2004 action plan identifies an increased emphasis on deterring drink driving as one of the measures likely to have the most substantial impact on road fatalities. The activities to be pursued under this plan are:

- maintaining and increasing resources for enforcement and public education;
- developing national guidelines on best practice in drink driving enforcement, for example, achieving the best combination of general deterrence and effective targeting of particular locations and times;
- focusing on developing more effective programs to reduce drink driving in rural areas; and
- implementing and monitoring alcohol interlock and rehabilitation programs to change the behaviour of repeat offenders.

The action plan specifies for drug driving deterrence, measures are to be developed and evaluated.[7]

Reducing drink driving

Random breath testing

9.8 The former committee noted in its discussion paper that the incidence of drink driving fell substantially with the introduction of random breath testing (RBT) in the 1980s.[8] However, Mr King and Dr Swann advised that road trauma caused by drink driving has remained constant for some years since then.[9] According to the 2001 National Drug Strategy (NDS) Household Survey, 12.8 per cent of Australians aged 14 years and over had driven a motor vehicle during the previous 12 months while under

7 Australian Transport Council, *National Road Safety Action Plan 2003 and 2004*, pp 12, 18, viewed 20/3/03, < http://www.dotars.gov.au/atc/actionplan_2003-04.pdf>.

8 House of Representatives Standing Committee on Family and Community Affairs, *Where to next? - A discussion paper: Inquiry into substance abuse in Australian communities*, FCA, Canberra, September 2001, pp 87-88.

9 King M, transcript, 16/8/02, p 1191; Swann P, transcript, 16/8/02, p 1195.

the influence of alcohol.[10] In addition, Poyser et al reported that in a sample of 555 people arrested for traffic offences at four police stations from 1999 to 2001, 38 per cent reported having used alcohol shortly before being arrested.[11]

9.9 In the view of the Commonwealth Department of Transport and Regional Services, there was 'still some scope for further enhancement of RBT efficiency and effectiveness (and increased intensity in at least some jurisdictions)'.[12] Mr King also said that RBT is 'a technique which needs to be constantly renewed to make sure that it remains effective, otherwise it wears out'.[13] For example, research by Abelson has shown a higher rate of accidents in New South Wales when enforcement efforts declined.[14] Constant reinvigoration of enforcement is now recognised best practice in RBT, said the Australian Transport Safety Bureau.[15] According to the National Road Safety Action Plan 2001 and 2002, extending integrated publicity and enforcement could reduce fatalities by at least one per cent.[16]

9.10 In the committee's view, it is vital that RBT should be maintained and improved.

Recommendation 102

9.11 **The committee recommends that the Commonwealth government, in consultation with State and Territory governments, continue to strengthen random breath testing practices and maintain and improve this process.**

9.12 One place where RBT seems to be less effective in curbing drink driving is in rural areas. The former committee reported that country people have

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10 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, Drug statistics series no 9, AIHW, Canberra, May 2002, p 37.

11 Poyser C, Makkai T, Norman L & Mills L, *Drug driving among police detainees in three states in Australia*, Monograph series no 50, Commonwealth Department of Health and Ageing, Canberra, August 2002, p x.

12 Commonwealth Department of Transport and Regional Services, sub 164, p 2.

13 King M, transcript, 16/8/02, p 1191.

14 Abelson P, 'Road safety programs and road trauma', in Applied Economics, (eds), *Returns on investment in public health: An epidemiological and economic analysis prepared for the Department of Health and Ageing*, Commonwealth Department of Health and Ageing, Canberra, 2003, p 106, viewed 9/4/03, <http://www.health.gov.au/pubhlth/publicat/document/roi_eea.pdf>.

15 Australian Transport Safety Bureau, informal communication, 17/2/03.

16 Australian Transport Council, *National Road Safety Action Plan 2001 and 2002*, p 3, viewed 17/10/02, < http://www.dotars.gov.au/atc/actionplan.pdf>.

fewer alternatives than city people for getting home after a night out, and news on the whereabouts of the booze bus spreads faster, enabling drivers to evade the bus by taking back roads. Testing may in fact increase rather than reduce the number of crashes when country drivers travel home on the more dangerous back roads.[17]

9.13 Austroads recently has examined ways in which the effectiveness of random breath testing might be improved in rural areas. It trialled three enforcement programs in two rural communities in Victoria and South Australia, and made a number of recommendations which focused on:

- using smaller, mobile testing units;
- reducing the usual blitz-like approach and predictability of location and time;
- moving activities to times that impact early in the chain of decision to drink; and
- increasing the number of offenders punished.

It said it is also possible that covert operations would have a greater effect, as might public education strategies that emphasise community values and the opinions of others.[18]

Conclusion

9.14 In the committee's view, these recommendations could form the basis for different approaches to the use of testing in country areas. In addition, there is concern by the committee that an unintended consequence of these approaches may be a negative impact of social isolation in country areas. To guard against this there is a need for additional strategies by local rural communities to prevent social isolation and promote social interaction. Responsible driving behaviour could include neighbouring properties having an alternating designated driver who doesn't drink on social occasions. It was also suggested a "safe house" scenario, where drivers can test their alcohol content levels prior to driving. If the level is too high then they can wait at a safe location within the community until such time as they have legal levels of alcohol in their test. Individual communities need to work together to develop the most appropriate strategy for them.

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17 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 89.

18 Austroads, *Drink driving and enforcement: Theoretical issues and an investigation of the effects of three enforcement programs in two rural communities in Australia*, Austroads Inc, Sydney, 2001, in Executive summary unpaged.

Recommendation 103

9.15 **The committee recommends that the Commonwealth government, in consultation with State and Territory governments:**

- **modify the conduct of random breath testing in country areas to:**
  - ⇒ **use smaller, mobile testing units;**
  - ⇒ **reduce the usual blitz-like approach and predictability of location and time; and**
  - ⇒ **move activities to times that impact early in the chain of decision to drink; and**
- **ensure that there is consistency of approach in random breath testing between country and city areas.**

Penalties

9.16 One of the more striking findings in the 2001 NDS Household Survey was the level of support for more severe penalties for drink driving; they were favoured by 87.2 per cent of the almost 27,000 survey respondents.[19] There is certainly proof from the Australian Transport Council that imposing penalties commensurate with the danger posed by serious drink driving offences is beneficial.[20]

9.17 Details of penalties are noted in the former committee's report.[21] The Australian Drug Foundation said of particular concern are drink drivers who repeatedly offend and are undeterred by current penalties. In Victoria, for example, such drivers are responsible for five per cent of the annual road toll.[22] The Salvation Army saw referral to treatment and rehabilitation programs as an essential component of the penalties imposed for drink driving[23], as did Austroads Working Group on Drugs and Driving.[24]

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19 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, p 35.

20 Australian Transport Council, *National Road Safety Action Plan 2001 and 2002*, p 3.

21 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, pp 88-90.

22 Australian Drug Foundation, 'ADF position on ignition interlocks', p 2, viewed 20/3/03, <http://www adf.org.au/inside/position/interlocks.htm>.

23 Salvation Army (Southern Territory), sub 43, p 5.

24 Austroads, *Drugs and driving in Australia*, Austroads, Sydney, 2000, p v.

9.18 The Commonwealth Department of Transport and Regional Services advised that it appears from overseas experience that the compulsory installation of alcohol ignition interlocks is a promising approach with repeat offenders.[25] An interlock is a breath-testing device fitted to a vehicle ignition which prevents the vehicle starting if the driver is over the legal limit for alcohol.[26] The Australian Transport Council stated that, if used as a sentencing option and/or administrative sanction, alcohol ignition interlocks could reduce fatalities by one per cent. Promoting their voluntary installation would also be a useful move.[27]

9.19 The Australian Transport Council reported that during the National Road Safety Action Plan 2001 and 2002, most states laid the groundwork for alcohol interlock schemes to target serious drink driving offenders. Enabling legislation was introduced in South Australia, Victoria and New South Wales.[28] Mr King said use of interlocks is being linked to a driver education program in Queensland[29] and Mr Gaudry said it is linked to access to counselling in New South Wales.[30] The Commonwealth Department of Transport and Regional Services reported that the devices seem to be more effective when their installation is linked to a requirement that the offender undertake rehabilitation.[31] Mr King suggested that as use of these devices increases, attention will need to be paid to the administrative impediments to managing them across state borders.[32]

Conclusion

9.20 The committee also favours having alcohol ignition interlocks as a standard feature of new cars; this would further reduce drink driving and should be pursued. The committee's support is subject to the ignition locks being practical for everyday use.

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25 Commonwealth Department of Transport and Regional Services, sub 164, p 3.

26 Victorian government, 'Alcohol interlocks in Victoria', p 3. http://www.arrivealive.vic.gov.au/downloads/Alcohol_Interlocks_Report.pdf>.

27 Australian Transport Council, *National Road Safety Action Plan 2001and 2002,* p 3.

28 Australian Transport Council, *National Road Safety Action Plan 2003- 2004*, p 4.

29 King M, transcript, 16/8/02, p 1192.

30 Gaudry B, transcript, second reading speech, *Debates,* New South Wales Legislative Assembly, 28/6/02, p 4164.

31 Commonwealth Department of Transport and Regional Services, sub 164, p 3.

32 King M, transcript, 16/8/02, p 1193.

Recommendation 104

9.21 **The committee recommends that the Commonwealth government, in consultation with State and Territory governments, ensure the imposition of more severe penalties for repeat drink driving offenders than are currently in place.**

Recommendation 105

9.22 **The committee recommends that the Commonwealth government, in consultation with State and Territory governments**:

- **impose the use of alcohol ignition interlocks on repeat drink driving offenders; and**
- **promote the voluntary installation of alcohol ignition interlocks.**

Recommendation 106

9.23 **The committee recommends that all new cars made in, or imported into, Australia be fitted with alcohol ignition interlocks by 2006.**

Drug driving

Prevalence and risks

9.24 Professor Drummer advised that after alcohol, the most common drugs found in fatally injured drivers around the world have been cannabis, benzodiazepines, amphetamine-like stimulants and opioids. The same is probably true for Australia.[33] He went on to say of these drugs, cannabis and stimulants are of most concern as drivers using them have been found to increase their risk of a fatal accident over that of drug-free drivers by 2.7 and 2.3 times respectively. There is an even greater risk of fatal accidents when higher drug concentrations are present. For example, when the active form of cannabis (tetrahydrocannabinol) is present at blood concentrations of 5ng / mL or more the risk rises to 6.6. This is the

33 Drummer O, sub 277, p 1.

same level of risk as is experienced by drivers with blood alcohol concentrations between 0.5 and 0.1 per cent. Furthermore, when more than one drug, or alcohol and another drug, are present, risk of fatality is also increased.[34]

9.25 An alternative viewpoint was put by one researcher at Turning Point in Melbourne when the committee visited them in mid 2002. The committee was surprised when the researcher presented material that indicated that driving capacity was not greatly impaired by the use of cannabis.

9.26 Evidence given by Dr Graycar indicated that drug taking is also found among traffic offenders. About three-quarters of a group of people arrested for such offences in 2001 returned a positive result when tested for illicit drugs, 57 per cent being positive to cannabis.[35] Data from the Drug Use Monitoring in Australia (DUMA) project 1999-2001 collection showed that 47 per cent of traffic offenders were positive to drugs other than cannabis and 37 per cent showed evidence of having taken more than one drug.[36]

9.27 These drugs may have contributed to their offending. Austroads stated that there is evidence, for example, from laboratory and road driving tests undertaken by people who have been given cannabis that the drug is a potential cause of impairment.[37] Professor Drummer told the committee that:

> … it would be fair to say that there is really no dispute that cannabis, if used in other than very trivial amounts, has a great capacity to impair a range of functions that are required for safe driving. For example, hand-eye coordination, lane control—staying in the right lane, not going over the white lines or off the edge of the road—perception of time and space, perception of traffic around oneself, vigilance and awareness of what is happening on the roads and particularly cognition; in other words, the way you respond to visual signals and translate them into some sort of function and thought process.[38]

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34 Drummer O, sub 277, p 3; Drummer O, transcript, 23/9/02, p 1275; Drummer O, 'Briefing paper on the role of drugs and alcohol on road trauma', unpublished, while at Victorian Institute of Forensic Medicine, October 2002, p 1.

35 Graycar A, presentation to roundtable, Canberra, 16/8/02, exhibit 47, slide 13.

36 Graycar A, presentation to roundtable, Canberra, 16/8/02, exhibit 47, slide 24.

37 Austroads, *Drugs and driving in Australia*, p ii.

38 Drummer O, transcript, 23/9/02, p 1273.

Reducing drug driving

Drug testing

9.28 Random breath testing for alcohol provides a powerful deterrent to drink driving; according to Dr Graycar 89 per cent of 155 people arrested for traffic offences thought they were likely to be caught if they were drink driving. By comparison, as many as 73.5 per cent thought that they would not be caught driving while using cannabis. Drivers using amphetamines, heroin and cocaine were also seen as unlikely to be detected.[39]

9.29 People know much less about the effects of drugs on driving than they do about alcohol. Some of their generally held assumptions are wrong. For example, Dr Graycar reported that 63.5 per cent of 155 traffic offenders arrested in 2001 in the DUMA project viewed cannabis as having no effect on driving skills and 14.3 per cent perceived a beneficial effect on driving.[40] Yet, Professor Drummer said cannabis can have a significant effect on driving skills for up to two hours[41], with Dr Swann noting maximum impairment being apparent between 40 minutes and one hour after consumption.[42]

9.30 Although a variety of roadside screening devices are available for detecting all the critical drugs that impair driving, there are, as yet, no simple, cheap tests for drugs comparable to those used in random breath testing, according to Dr Swann.[43] Dr Swann advised that saliva testing is one of the new devices considered for roadside drug driving testing. Two drops of saliva, 0.3ml can be collected by the person themselves with virtually minimum health risks. It is easily conducted by wiping the device across the tongue or mouth and obtain an indication within one and a half minutes. It would take another 10 minutes for the process of negative and positive calibration to be carried out. Tetrahydrocannabinol (THC) is detectable in saliva for the first hour of impairment and in regard to truck drivers, amphetamines have always been easy to detect in saliva.[44]

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39 Graycar A, presentation to roundtable, Canberra, 16/8/02, exhibit 47, slide 28.

40 Graycar A, presentation to roundtable, Canberra, 16/8/02, exhibit 47, slide 27. The impression that cannabis has limited effects is derived from the results of earlier tests that measured metabolites of the active form rather than the active form itself (Swann P, transcript, 16/8/02, p 1194).

41 Drummer O, transcript, 23/9/02, p 1273.

42 Swann P, transcript, 16/8/02, p 1197.

43 Swann P, transcript, 16/8/02, p 1199.

44 Swann P, transcript, 16/8/02, pp 1197-1198

Several jurisdictions, including Victoria, are testing roadside screening devices, or considering doing so.[45]

9.31 Professor Drummer told the committee there are problems with these devices. They do not yield reliable results and any positive tests must be confirmed to an evidentiary standard by lab tests. It is likely that it will take some time for the manufacturers to validate the devices and the devices will probably be considerably more expensive than breathalysers.[46] In addition, Mr King reported at present we do not know the level at which to set the legal limit for driving with drugs other than alcohol in the blood.[47]

9.32 Some European countries have addressed this last point by making it illegal to drive when any drug is present. According to Professor Drummer, in Australia:

> … as in Europe, it should be an offence to drive while using a drug … As soon as we say that having half a joint or a weak joint of cannabis is safe then we come up against questions such as how much you inhale of a joint … The variability of absorption is such that we really cannot define a safe level and therefore any usage must be seen as unsafe. Any use of amphetamines, cocaine or heroin and driving should be seen as unsafe. It should be avoided at all costs.[48]

9.33 Professor Drummer talked about another approach to drug driving being in use overseas[49] and in some states. It focuses in the first instance on detecting driver impairment rather than the presence of drugs. Boorman reported that under legislation in force in Victoria, for example, it is only after impairment has been established in two standard tests that a blood sample is taken:

> … A driver is presumed to be driving while impaired by a drug when a drug is found to be present in a driver, the behaviour of the driver is consistent with the behaviour usually associated with a person who has used the drug found, and the behaviour usually associated with a person who has used that drug would result in the person being unable to drive properly …[50]

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45 Victorian government, 'Victoria's Road Strategy: 2002-2007: Drugs and driving', viewed 7/2/03, http://www.arrivealive.vic.gov.au/c_drugsAD.html.

46 Drummer O, transcript, 23/9/02, p 1277.

47 King M, transcript, 16/8/02, pp 1207-1208.

48 Drummer O, transcript, 23/9/02, p 1279.

49 Drummer O, transcript, 23/9/02, p 1278.

50 Boorman M, 'Drug impaired driver enforcement Victoria', *Conference Papers Collection*, CD-ROM, 2nd Australasian Conference on Drugs Strategy, Perth, 7-9 May 2002, p 2.

Further, he said there is a 97.5 per cent agreement between impairment and blood test results.[51]

9.34 A recently available report by Poyser et al sets the above discussion in a clear framework - options for developing a legislative framework to drug driving. They say that in Australia there are currently three legislative approaches, namely 'driving under the influence' statutes, impaired-based statutes (which are often difficult to distinguish from 'driving under the influence') and per se statutes. Most jurisdictions use the 'driving under the influence' approach. Key issues for legislative approaches may include: defining the drugs, the cut-off level and impairment. In terms of strategies for dealing with drug driving which may also impact on legislative developments there is a need for roadside screening, random testing and compulsory blood testing. In looking at this issue states and territories commented to Poyser et al that harmonisation of legislation is desirable but difficult to achieve. A way forward may be to see what legislative model is most effective as different approaches in different jurisdictions operate and then adopt a best practice national approach. Poyser et al do not evaluate the success or otherwise of the various approaches.[52]

9.35 It is clear, as the Australian Medical Association pointed out to the former committee, that we do not yet fully understand the connection between the action of different drugs and the effect they have on driving skills, and that further work is needed here.[53] The Salvation Army said we need to work towards reaching consensus on a definition of a drug for the purpose of legislation describing drivers under the influence of a drug.[54]

9.36 The Australian Transport Council reported that continued research on the relationship between drugs and crashes and enactment of legislation to test and prosecute drug-impaired drivers were among the 107 possible measures suggested in the National Road Safety Action Plan 2001 and 2002.[55]

Conclusion

9.37 The committee:

- questions some of the research on the effect of cannabis on drivers that was presented by Turning Point to the committee during the inquiry;

51 Boorman M, 'Drug impaired driver enforcement Victoria', p 4.

52 Poyser C, Makkai T, Norman L & Mills L, pp xi, 38-56.

53 Australian Medical Association, sub 133, p 3.

54 Salvation Army (Southern Territory), sub 43, p 5.

55 Australian Transport Council, *National Road Safety Action Plan 2001 and 2002*, p 4.

- believes in the light of evidence of increasing drug use much needs to be done to develop quick, simple and reliable roadside drug tests;
- favours the position that it should be an offence to drive whilst using any illicit drug; and
- is persuaded of the value of saliva testing as a roadside drug testing method.

Recommendation 107

9.38 **The committee recommends that the Commonwealth, State and Territory governments give high priority in the National Road Safety Action Plan to:**

- **work towards all States and Territories making it an offence to drive with any quantity of illicit drug present within the system;**
- **have all States and Territories enacting legislation to test and prosecute drug drivers;**
- **fund and coordinate roadside drug testing with a model similar to that of alcohol random breath testing; and**
- **continue research into the relationship between drugs and driving impairment.**

Reducing stimulant use by long distance truck drivers

9.39 A special case of substance abuse is seen among long distance truck drivers who use stimulants to enable them to remain alert on long journeys. Professor Drummer has estimated that stimulant use among truck drivers increases their risk of a fatal accident by 8.8 times that of a drug-free driver. Twenty-three per cent of the dead truck drivers in his study had been using stimulants.[56] Dr Swann said that if stimulant use were eliminated, the road toll could be reduced by up to 4.6 per cent.[57]

9.40 Several ways of limiting the use of stimulants have been suggested. Dr Swann suggested that one would be to make available to truck drivers substitute drugs that do not damage sleep architecture and are not addictive.[58] Other approaches that do not involve drugs would be

56 Drummer O, transcript, 23/9/02, p 1275; Swann P, transcript, 16/8/02, p 1196.

57 Swann P, transcript, 16/8/02, p 1196.

58 Swann P, transcript, 16/8/02, p 1204.

preferable. For example, vehicle sanctions imposed on drivers who test positive could be extremely effective; the committee was told by Dr Swann that:

> … from a road safety perspective, if you deregister a truck, even for 24 hours, when the driver tests positive to a stimulant, … you would go a very long way to changing this culture of occupational drug use.[59]

9.41 As stimulants are used by drivers in response to pressures within the workplace, the broader context within which this work-related substance abuse is occurring should be addressed. A drug-free workplace policy for the transport industry, associated with mandatory drug testing, was among the recommendations of a House of Representatives committee inquiry into fatigue in the transport industry.[60]

9.42 Another option is better management of fatigue among drivers. This topic has been extensively reviewed by the National Road Transport Commission (NRTC), and a draft policy for regulating driving practices has been developed in consultation with industry and issued for comment. The NRTC said the policy focuses on creating improved opportunities for drivers to sleep and shifts the emphasis for fatigue management to management practices and better control of the precursors of fatigue. It places greater responsibility on parties in the transport chain whose decisions may influence driver fatigue and emphasises enforcing compliance.[61]

Conclusion

9.43 The committee:

- supports the emphasis of greater responsibility and penalties on parties in the transport chain which may encourage driver fatigue by their company policy and actions; and
- considers the NRTC draft policies for regulating driving practices is extremely important and should be believes that this is an important initiative that should be pursued.

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59 Swann P, transcript, 16/8/02, p 1196.

60 House of Representatives Standing Committee on Communications, Transport and the Arts, *Beyond the midnight oil: Managing fatigue in transport*, CTA, Canberra, October 2000, p 122.

61 National Road Transport Commission, 'Heavy vehicle driver fatigue: summary of draft policy proposal', Update fact sheet, October 2002, viewed 25/10/02, <http://www.nrtc.gov.au/publications/content/factsheets/HeavyVehicleDriverFatigueOct2002.pdf>.

Recommendation 108

9.44 **The committee recommends that the Commonwealth, State and Territory governments work with industry to complete and implement the new policy for managing fatigue among heavy vehicle drivers that is currently being coordinated by the National Road Transport Commission.**

9.45 The NRTC reported that it is proposed that legislation to support the policy will contain a general duty to manage fatigue that will bear on all parties in the transport chain including employer operators, drivers, consignors and receivers. In June 2002, the commission issued a draft Commonwealth, state and territory Road Transport Reform (Compliance and Enforcement) Bill that will ensure that those who are in a position to influence a decision to breach the road transport regulations are held accountable for their actions. The Bill's provisions will enhance enforcement powers, sanctions and penalties.[62] The Australian Transport Safety Bureau said following extensive public consultation, the draft bill will be revised and submitted to transport ministers in the middle of 2003.[63] The NRTC said that if approved by them, it will be enacted in all jurisdictions. The legislation will apply to all vehicles over 4.5 tonnes[64], and builds on experience with chain of responsibility legislation already in place in Queensland, New South Wales, Victoria and South Australia.

9.46 The committee notes that the NRTC oversees the implementation of agreed road transport reforms and reports on this in its annual report.

9.47 The committee believes that this legislation will make an important contribution to reducing drug driving. The Commonwealth government should therefore continue to encourage and monitor the implementation of this legislation.

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62 National Road Transport Commission, 'Heavy vehicle driver fatigue: summary of draft policy proposal', p 6.

63 Australian Transport Safety Bureau, informal communication, 17/2/03.

64 National Road Transport Commission, 'Compliance and Enforcement Bill', Update fact sheet, June 2002, viewed 21/10/02, <http://www.nrtc.gov.au/publications/content/factsheets/CandEBill.pdf>.

Recommendation 109

9.48 **The committee recommends that the Commonwealth government continue to vigorously promote the implementation of chain of responsibility legislation applying to the road transport industry.**

Education on the impact of drugs on driving

9.49 It is clear to the committee that more comprehensive and accurate information must be made available to drivers, not only about cannabis but about other drugs too. Some of the areas nominated for attention in submissions to the inquiry included:

- expanding driver education programs to cover information about drugs[65] and the dangers of combining them[66], and
- providing information to health professionals about the effect on driving of some legal medications.[67]

9.50 One of the possible measures identified by the National Road Safety Action Plan 2001 and 2002 was public information campaigns 'to alert drivers to the effects of some drugs and medications have on the ability to drive safely'.[68] Austroads Working Group on Drugs and Driving suggested discouraging driving while under the influence of drugs, and promoting the therapeutic use of drugs that do not impair driving performance in lieu of those that do.[69]

Recommendation 110

9.51 **The committee recommends that the Commonwealth government, in consultation with State and Territory governments, develop and run campaigns to inform drivers about the dangers of driving while using illicit and licit drugs.**

Conclusion

9.52 In view of the significant contribution of drink and drug driving to road trauma, the committee believes that the Commonwealth government

65 Shortland Youth Forums, sub 223, p 5.

66 Fairfield City Council, sub 212, p 3; Swann P, transcript, 16/8/02, p 1211.

67 Fairfield City Council, sub 212, p 3.

68 Australian Transport Council, *National Road Safety Action Plan 2001 and 2002*, p 4.

69 Austroads, *Drugs and driving in Australia*, p v.

should continue to promote all those measures with proven efficacy in reducing drink and drug driving, and research and evaluate new approaches where existing approaches need improvement.

9.53 It is also the committee's view that, at the end of each National Road Safety Action Plan, a report should be compiled on the nationwide outcomes of implementing the plan's measures. This report should be made public for accountability purposes.

9.54 The committee concludes that, if the effort to reduce road trauma due to alcohol and drugs is to be cost effective, the contributing factors of alcohol and other drugs must be reflected in the effort directed at reducing them. The introduction to this chapter makes clear that drink driving causes greater damage than drug driving but that the incidence of drug driving is increasing.

Recommendation 111

9.55 **The committee recommends that the Commonwealth government, in consultation with the State and Territory governments, continue to vigorously promote the drink and drug driving reduction strategies of the National Road Safety Action Plan.**

Recommendation 112

9.56 **The committee recommends that the Commonwealth government, in consultation with State and Territory governments**:

- **ensure that the effectiveness of the measures adopted in the National Road Safety Action Plan are evaluated and research carried out on promising new approaches;**
- **contribute funding if necessary to ensure that evaluation and research proceed leading to the direct introduction of effective measures; and**
- **produce a publicly available report on the nationwide results of implementing measures in the National Road Safety Action Plan.**

Recommendation 113

9.57 **The committee recommends that the Commonwealth government work with the State and Territory governments to ensure that drug and drink driving are targeted for deterrence and prevention.**

10

Workplace safety and productivity

Introduction

10.1 Many of the physical and psychological effects of drugs diminish the safety and efficiency with which alcohol and other drug users perform their every day tasks. Not only does substance abuse reduce employees' on-the-job productivity, it contributes to absenteeism and low morale, and when illness leads to premature retirement or death, it reduces the size of the available workforce. In addition, as flagged in Chapter 3, drug use also impacts on the productivity of unpaid workers, those who perform domestic activities, care for children and perform voluntary work.[1]

10.2 Workplaces are faced with the challenge of providing a healthy and safe environment for their employees. This means that employers must pay attention to the problems that substance abusers bring into the workplace, and that interfere with their effective functioning and the general well being of their colleagues as well as impacting on business productivity. Employers must also be aware of the conditions within the workplace that may predispose workers to use or abuse drugs.

10.3 While there is not a great deal of research that has been done about the impact of substance abuse in the workplace, there are costs involved in the impact and the states, territories and the Commonwealth government have responsibilities collectively in this area.

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1 See Collins DJ & Lapsley HM, *Counting the cost: Estimates of the social costs of drug abuse in Australia in 1998-9*, Monograph series no 49, Commonwealth Department of Health and Ageing, Canberra, 2002, pp 27-28, 29.

Use and impacts

Consumption of alcohol and other drugs by workers

10.4 The consumption of alcohol and other drugs by workers has been examined in a number of studies and has been found to generally mirror consumption in the community at large. While relatively little information is available for illicit drugs in the workplace, recent data have been summarised by Phillips for alcohol. He showed that around seven per cent of workers drink at harmful levels and about 15 per cent drink above the low-risk level, as defined by the National Health and Medical Research Council.[2]

10.5 As Phillips commented, however:

> … it is not clear what relevance alcohol and drug consumption data have unless they are related to employment. Even the consumption of harmful and hazardous levels of alcohol, for example, may not be indicative of harm or hazard at the workplace.[3]

10.6 Surprisingly little work has been undertaken to estimate the prevalence of intoxication or being drug-affected at work. One of the few studies carried out is by Sargaison and it found that 0.8 per cent of a sample of coalminers had a blood alcohol level greater than 0.05 per cent when at work.[4] Another indication of the extent to which people work when drug-affected is available from the 2001 National Drug Strategy (NDS) Household Survey. Among survey respondents 4.3 per cent reported having gone to work during the past 12 months when affected by alcohol, and 2.3 per cent went to work under the influence of other drugs.[5]

Impact of substance misuse on productivity and safety

10.7 Even though we know that using tobacco, alcohol and illicit drugs affects the health, safety and productivity of workers, making a precise

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2 Phillips M, 'The prevalence of drug use and risk of drug-related harm in the workplace', in Allsop S, Phillips M & Calogero C, (eds), *Drugs and work: Responding to alcohol and other drug problems in Australian workplaces*, IP Communications, Melbourne, 2001, p 22.

3 Phillips M, p 26; National Health and Medical Research Council's guidelines for low risk drinking can be found in National Health and Medical Research Council, *Australian alcohol guidelines: Health risks and benefits*, NHMRC, Canberra, October 2001, p 5.

4 Sargaison J, *Report of the survey of substance abuse programs in the Queensland coal mining industry*, Queensland Mining Council, Brisbane, 1993, quoted in Phillips M, p 24.

5 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, Drug statistics series no 9, AIHW, Canberra, May 2002, p 37.

assessment of their impact is difficult. For example, ethical constraints make it impossible to conduct definitive controlled studies on the relationship of drug use and occupational accidents. Normand and others pointed out that the impact of drug use on work must be inferred from studies conducted in the laboratory and the field:

> Laboratory studies provide evidence regarding the effects of controlled, short-term exposure to specific drugs on the performance of specific tasks. Field studies provide evidence regarding the links between drug use (either self-reported or detected through other means) and a number of work behaviours, but they lack the controls needed to allow researchers to isolate specific drug effects.[6]

> … finding consistent relationships between relatively rare events such as alcohol and other drug abuse and accidents requires a carefully designed study with a large sample size and reliable measures - a difficult task indeed …[7]

Even if consistent relationships are found, the committee notes that it can be difficult to demonstrate causality.

10.8 The Australian Coal Association, which has collected 'the only high quality, industry wide Australian data', highlighted the fact that:

> … there is no proven link between the presence of a drug and impairment and, most importantly, that post accident the presence of a drug should not be assumed to be the root cause of the accident without significant further evaluation ...[8]

Dr Gardner noted fatigue, shift design and rostering may all contribute as well.[9]

10.9 Despite the difficulties of establishing relationships, some objective evidence exists of the link between fatalities and drug use and estimates of impacts have been made. The most comprehensive Australian study of work-related fatalities, which was undertaken by the National Occupational Health and Safety Commission (NOHSC), examined coroners' reports for a large number of workplace deaths between 1989 and 1992. Of the 1235 deaths for which blood alcohol information was

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6 Normand J, Lempert R & O'Brien C, (eds), *Under the influence? Drugs and the American workforce*, Committee on Drug Use in the Workplace, US National Research Council and Institute of Medicine, National Academy Press, Washington DC, 1994, p 119.

7 Normand J, Lempert R & O'Brien C, p 159.

8 Gardner I, transcript, 15/8/02, p 1173.

9 Gardner I, transcript, 15/8/02, p 1173.

available, 'Raised blood alcohol appeared to have contributed to at least … 5.3 % of working deaths …'[10]

10.10 When both drugs and alcohol were detected together, at least 5.2 per cent of working deaths 'probably occurred in part because of one or both of these groups of substances'.[11] A similar result was found in a study of US fatal occupational injuries for the period 1993-94, by Greenberg and others.[12] According to Phillips, NOHSC's study also found that:

> Drugs appeared to contribute to 2 per cent of the working deaths, but information on drug levels was available in only about one-third of working deaths. The type of drugs found to have contributed to the fatal incidents included amphetamines, cannabis, barbiturates and narcotics ...[13]

10.11 In relation to workplace accidents, the evidence on the links with alcohol and drug use is less firm than that for fatalities. The International Labour Organization reported that:

> Over recent years, studies have shown that … in many workplaces, 20-25 per cent of accidents at work involve intoxicated people injuring themselves and innocent victims.[14]

However, no supporting evidence for this statement was provided and its accuracy was questioned by Dr Ian Gardner when he spoke to the committee. He reported the conclusion of a US National Research Council and Institute of Medicine report regarding the magnitude of the impact of alcohol and other drug use at work:

> Many of the effects found, although statistically significant, are small to moderate. Indeed, the available research, taken as a whole, should soften the concern about employee alcohol and other drug use often found in the popular media.[15]

10.12 Dr Gardner's view is shared by others. Phillips pointed out that the estimates of the contribution of alcohol to occupational injuries and fatalities:

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10 National Occupational Health and Safety Commission, *Work-related traumatic fatalities in Australia, 1989 to 1992*, Commonwealth of Australia, Canberra, December 1998, pp 50-51.

11 National Occupational Health and Safety Commission, *Work-related traumatic fatalities in Australia, 1989 to 1992*, p 51.

12 Greenberg M, Hamilton R & Toscano G, 'Analysis of toxicology reports from the 1993-94 census of fatal occupational injuries, *Compensation and working conditions: Fall 1999*, viewed 27/6/02, <http://www.bls.gov/iif/oshwc/cfar0032.pdf>.

13 Phillips M, p 28.

14 International Labour Organisation, InFocus Programme on Safety and Health at Work and the Environment. *Drug and alcohol abuse - an important workplace issue*, viewed 21/6/02, <http://www.ilo.org/public/english/protection/safework/drug/impiss.htm>

15 Gardner I, transcript, 15/8/02, p 1176.

> … are considerably lower than the figures presented by many commentators. For illegal drugs, the evidence base is much weaker and the estimates lower … The evidence suggests that costs are incurred as a result of drug-related accidents at work, but these are a small proportion of the overall costs arising from workplace accidents.[16]

10.13 Estimates have also been made of the impacts of drug use on absenteeism. Bush and Wooden found that smokers have been found to be 1.4 times more likely to be absent from work than those who have never smoked and ex-smokers 1.3 times more so. For those who engage in harmful drinking, the likelihood of being absent is 1.2 times that of other drinkers and non-drinkers.[17] Dr Gardner reported that positive results in pre-employment tests for marijuana among US postal workers was associated with greater numbers of accidents and injuries, more absenteeism and discipline problems and higher labour turn over.[18]

Impact of the workplace on substance abuse

10.14 The contribution of the workplace to alcohol and drug use is sometimes overlooked, according to Reilly. Workplace factors that may affect workers' drug and alcohol consumption include long working hours, poorly managed shiftwork, stress, workplace conflicts, negative managerial styles, bullying, harassment and peer pressure.[19] The Alcohol and other Drugs Council of Australia (ADCA) reported that isolation and boredom are other factors that may influence alcohol and drug use.[20]

10.15 The Employee Assistance Service NT stated that corporate entertaining and a workplace culture of drinking may also contribute to substance misuse.[21] NOHSC reported from its study of workplace fatalities that:

> The alcohol has been consumed at least partly in connection with work in 39% of these deaths. The alcohol had been consumed either at work during normal duties or at work-sponsored functions.[22]

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16 Phillips M, pp 40-41.

17 Bush and Wooden quoted by Collins DJ & Lapsley HM, pp 28-29.

18 Gardner I, transcript, 15/8/02, p 1172.

19 Reilly D, *Over the limit*, CCH's Australian Occupational Health and Safety, March 1999, p 24.

20 Alcohol and other Drugs Council of Australia, *Drug policy 2000: A new agenda for harm reduction*, ADCA, Canberra, June 2000, p 164.

21 Employee Assistance Service NT, transcript, 20/4/01, p 683.

22 National Occupational Health and Safety Commission, *Work-related traumatic fatalities in Australia: 1989 to 1992: Summary report*, p 18.

10.16 In commenting on the complexity of the relationship between drug use behaviour and the workplace Allsop and Pidd stressed that:

> … it is evident that the development and maintenance of drug-related harm in the workplace are the outcome of an apparently wide array of factors, including individual resilience and vulnerability, cultural and sub-cultural influences, and the way in which work is structured, supervised, and rewarded ...[23]

Costs imposed by substance abuse in the workplace

10.17 The loss of national productive capacity in the paid workforce that results from drug-attributable sickness and death is considerable. According to Collins and Lapsley, it comprises losses from absenteeism, reduction in the size of the workforce and reduced on-the-job productivity. The loss due to the first of these two factors in 1998-99 was estimated by Collins and Lapsley to have been $5.5 billion. Absenteeism accounted for 25.6 per cent of this sum and the rest to reduction in the workforce. As the losses from reduced on-the-job productivity could not be quantified, the actual loss is even larger. Tobacco was responsible for 46.1 per cent of the costs to national productivity in the paid workforce, followed by alcohol (35.7 per cent) and illicit drugs (18.2 per cent). [24]

Limits to knowledge about the impact of substance abuse on the workplace

10.18 Evidence suggested that it is clear that we have inadequate information available to guide our understanding of the relationship of substance abuse to performance in the workplace and its impact.[25] On the basis of an examination of 400 documents that comprised all published and unpublished literature in Australia between 1980-96, Associate Professor Allsop concluded that:

> … in terms of available information in Australia we actually have a dearth of information on which to judge the best approaches that we can take, whether or not there is a problem and what responses we should actually make.[26]

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23 Allsop S & Pidd K, 'The nature of drug-related harm in the workplace', in Allsop S, Phillips M & Calogero C (eds), Drugs and work: Responding to alcohol and other drug problems in Australian workplaces, IP Communications, Melbourne, 2001, pp 17-18.

24 Collins DJ & Lapsley HM, pp 27, 29, 53.

25 Alcohol and Drug Foundation Queensland, sub 200, p 5; Allsop S, transcript, 15/8/02, p 1168, 1171; Gardner I, transcript, 15/8/02, p 1174.

26 Allsop S, transcript, 15/8/02, p 1168.

10.19 In addition, according to Associate Professor Allsop, what information we have is more than 10 years old, and painting a national picture of the situation is difficult because the data needed are not collected in a standard manner across different jurisdictions.[27] Furthermore, reported Dr Gardner, the existing Australian standards for recording workplace accidents and their causes may in fact inhibit the collection of data that accurately reflects the impact of substance abuse on workplace safety. So too may workplace practices which encourage early return to work after accidents.[28] Dr Gardner also said, the standards for recording lost time injury and their unintended consequences for managing injured workers should be examined.[29]

10.20 It is important that we fill the gaps in our knowledge about the prevalence of substance abuse among employed persons and the relationship between substance abuse and workplace safety and productivity. A study of the prevalence of substance abuse in the workplace, coordinated by the NOHSC, could go some way to filling these gaps. It might consider not only the impact of substance abuse on impairment in the workplace but other impacts as well, such as the characteristics of the working environment and non-occupational factors such as mental ill-health, prescription drug use and chronic medical conditions. [30]

Conclusion

10.21 The committee believes that a study such as outlined above would be valuable, especially in relation to establishing workplace policies and programs to combat alcohol and drug-related harm. Such a study is also significant in relation to the issue of alcohol and drug testing in the workplace which is discussed later in this chapter.

10.22 The committee also believes that collection of data in a nationally standardised manner is a prerequisite for the study recommended above and must be pursued.

Recommendation 114

10.23 **The committee recommends that the Commonwealth, State and Territory governments, with input from unions and industry, fund a well-designed study coordinated by the National Occupational Health**

27 Allsop S, transcript, 15/8/02, pp 1169-1170, 1185.

28 Gardner I, transcript, 15/8/02, pp 1172-1173.

29 Gardner I, sub 287, p 6.

30 Gardner I, sub 287, p 5.

and Safety Commission to investigate:

- **the prevalence of substance abuse in Australian workplaces; and**
- **the relationship of substance abuse to impairment, harm and lost productivity, in the context of other factors that also impact on workplace safety and productivity.**

Recommendation 115

10.24 **The committee recommends that the Commonwealth government, through the National Occupational Health and Safety Commission:**

- **promote the development of standard methodologies for collecting data relating to workplace harm;**
- **ensure the standards developed encourage safe practices; and**
- **work with State and Territory governments and other stakeholders to ensure that these data are collected in all jurisdictions.**

Role of government

Commonwealth, state and territory governments

10.25 The states and territories have responsibility for making laws about workplace health and safety and for enforcing those laws. With the exception of Tasmania and South Australia, workplace alcohol and drug issues are generally not addressed in the principal occupational health and safety legislation (OHS) in Australian jurisdictions. In most jurisdictions, legal obligations to address substance abuse problems in the workplace arise through:

- duty of care provisions that require employers to take all reasonable steps to ensure the health and safety of all workers as outlined by the NOHSC[31]; and

31 National Occupational Health and Safety Commission, 'Duty of care', viewed 18/12/02, <http://www.nohsc.gov.au/OHSLegalObligations/DutyofCare/dutycare.htm>.

- other legislation that makes specific provision for alcohol and drug consumption, for example, in connection with safety in mines, reported Dr Gardner.[32]

10.26 State and territory OHS agencies have developed guidance on dealing with alcohol and drugs in the workplace. All emphasise the need to involve employers and workers in designing a comprehensive program, and tailoring policy to fit the needs of particular industries or workplaces.[33]

10.27 The Commonwealth government has an interest in workplace issues both as a large employer and in its role of coordinating, stimulating and leading national action on significant matters. The *Occupational Health and Safety (Commonwealth Employment) Act 1991*, administered by the Commonwealth Department of Employment and Workplace Relations, aims 'to secure the health, safety and welfare at work of employees of the Commonwealth and of Commonwealth authorities'. The Act requires Commonwealth agencies to put in place a policy of employer-employee cooperation in promoting and developing measures to ensure the employees' health, safety and welfare at work, and adequate mechanisms for reviewing the effectiveness of the measures.

10.28 The NOHSC provides a forum for the Commonwealth, state and territory governments, employer organisations and trade unions to develop national approaches to OHS matters. In regard to OHS legislation, the commission has the power to declare national OHS standards and codes of practice. These are developed to provide national consistency but are not legally enforceable unless state and territory governments adopt them as regulations or codes of practice under their principal OHS Acts.[34]

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32 Gardner I, transcript, 15/8/02, p 1182.

33 Guidelines for drugs and alcohol and the workplace are provided in WorkCover New South Wales, *Drugs, alcohol and the workplace: A guide to developing a workplace drug and alcohol policy*, WorkCover NSW, Sydney, 1995; WorkCover Corporation of South Australia, *Guidelines for drugs, alcohol & the workplace, Adelaide: WorkCover S.A., 2001*; WorkSafe Western Australia: *Guidance Note: Alcohol and other drugs at the workplace*, viewed 28/6/01, <http://www1.safetyline.wa.gov.au/pagebin/pg000055.htm>; and, for Queensland, Workplace Health & Safety, *Brochure 034: Alcohol and drugs and the workplace*, viewed January 2001, <http://www.whs.qld.gov.au/brochures/bro034v1.pdf>; Work Health Authority, Northern Territory, *Developing an alcohol policy and getting help*, Bulletin No. WH 15.01.04, Department of Industries & Business, Northern Territory, September 2000.

34 National Occupational Health and Safety Commission, 'Regulatory framework', viewed 18/12/02, <http://www.nohsc.gov.au/OHSLegalObligations/RegulatoryFramework/regulatoryframework.htm>.

National Occupational Health and Safety Strategy

10.29 The National OHS Strategy 2002-2012 was developed by the NOHSC and released in May 2002 with the endorsement of the Workplace Relations Ministers' Council. The strategy lays out the national priorities for government, industry and employees to improve OHS and sets minimum national targets for reducing the incidence of workplace deaths and injuries. Progress will be reported annually to the ministerial council.[35]

10.30 The strategy identifies nine areas requiring national action which include comprehensive OHS data collections, a coordinated research effort, a nationally consistent regulatory framework, and OHS awareness and skills development. Activities in these areas underpin the five national priorities, one of which is to strengthen the capacity of government to influence OHS outcomes.[36]

Promoting health and safety in the workplace

10.31 Calogero and others have stated that workplaces have responded to the threat of drug-related harms by developing a variety of strategies, some of which date back to the 1940s. These approaches to reducing the risk of harm from drug use include policies using control strategies, disciplinary measures, drug testing, prevention and treatment.[37]

Policies and programs

10.32 According to Dr Gardner, national and international OHS agencies all support the development of clearly laid out workplace policies and programs to address alcohol and drug issues.[38] Duffy and Ask stressed, when developing policy, three broad principles must be incorporated: the emphasis must be on prevention, policies must be rooted in the culture of the workplace, and they should complement assistance to employees with drug-related problems. That assistance may consist of counselling, advice

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35 National Occupational Health and Safety Commission, *New national OHS strategy endorsed by ministers*, media release, 29/5/02, viewed 17/6/02, <http://www.nohsc.gov.au/NewsAndWhatsNew/MediaReleases/mr-29052002.htm>.

36 National Occupational Health and Safety Commission, *National OHS strategy 2002-2012*, pp 6-8, viewed 18/12/02, <http://www.nohsc.gov.au/nationalstrategy/Strategy2sep.pdf>.

37 Calogero C, Midford R & Towers T, 'Responding to drug-related harm in the workplace: The role of prevention, counselling, and assistance programs', in Allsop S, Phillips M & Calogero C, (eds), *Drugs and work: Responding to alcohol and other drug problems in Australian workplaces*, IP Communications, Melbourne, 2001, p 88.

38 Gardner I, transcript, 15/8/02, p 1172.

and/or links with external treatment agencies[39], and is best provided when it is fully integrated with the workplace OHS setting and policies[40] and Dr Gardner said has significant input from those who know and understand the workplace.[41]

10.33 Evidence to the committee stated one of the ingredients needed to develop good policies to address drug-related harm is the use of extensive consultation between employers, workers[42] and other stakeholders.[43] Duffy and Ask listed some of the other factors that make for good policy. Policies must:

- apply to all employees regardless of status;
- be organisation-specific and comprehensive;
- include instructions and procedures for responding to drug-related incidents; and
- consider drug testing as a potential and complex option that can be applied only to limited domains.[44]

10.34 They also stated that implementing policies in a pragmatic, effective way is best done through:

- gradual and informed change;
- publicising the policy in an appropriate and equitable way;
- engendering employee compliance through the definition of roles and responsibilities, and education and training; and
- evaluating the implementation process.[45]

OHS practices have the best chances of succeeding when supported by good supervision and performance management.

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39 Duffy J & Ask A, 'Ten ingredients for developing and implementing a drug and alcohol policy in your workplace' in Allsop S, Phillips M & Calogero C, (eds), *Drugs and work: Responding to alcohol and other drug problems in Australian workplaces*, IP Communications, Melbourne, 2001, p 78.

40 Alcohol and other Drugs Council of Australia, *Drug policy 2000: A new agenda for harm reduction*, p 165; Public Health Association of Australia, sub 159, p 17.

41 Gardner I, transcript, 15/8/02, p 1175.

42 Alcohol and other Drugs Council of Australia, sub 61, p 19; Gardner I, transcript, 15/8/02, p 1172; The Western Australian Network of Alcohol and other Drug Agencies, sub 91, p 11.

43 Alcohol and other Drugs Council of Australia, *Drug policy 2000: A new agenda for harm reduction*, p 165.

44 Duffy J & Ask A, pp 79-82.

45 Duffy J & Ask A, pp 82-84.

10.35 An example of a successful workplace program is that run for the building industry by the Building Trades Group of Unions Drug and Alcohol Committee. This program:

- was developed by workers for workers working from the bottom up;
- uses peer education strategies;
- raises awareness in the workplace;
- employs a harm reduction approach;
- emphasises the need for workers to take responsibility for their own and others' safety; and
- informs workers with drug and alcohol problems of available treatment options.

Mr Sharp reported that the program is now operating in four states.[46] Dr Gardner said that overseas programs also provide useful insights into successful approaches.[47]

10.36 From programs such as these one we can learn more about designing and implementing effective interventions to add to existing knowledge. Associate Professor Allsop advised we also know that:

> ... there are a number of industries that are well protected from harm. We can learn a lot by looking at those industries that have low levels of harm and by finding out why that is. … we will [probably] find that those companies that have good occupational health and safety, good levels of supervision and good safety records are likely to be the industries that have lower levels of alcohol and drug related harm. We need to identify effective interventions … [48]

10.37 In commenting to the committee on the current approach to dealing with drug use in the workplace, Dr Gardner identified seven elements that characterise this approach:

- legislative compliance;
- fitness for duty testing;
- employee and supervisor education;
- provision of employee assistance program programs delivered in the workplace;

46 Sharp T, transcript, 15/8/02, p 1177.

47 Gardner I, transcript, 15/8/02, p 1175.

48 Allsop S, transcript, 15/8/02, p 1171.

- limited support of residential treatment facilities;
- performance appraisal and counselling; and
- disciplinary proceedings including dismissal.[49]

Dr Gardner suggested that all of these elements need further consideration to ensure they best meet current working conditions.[50]

Recommendation 116

10.38 **The committee recommends that the Commonwealth, State and Territory governments fund a study coordinated by the National Occupational Health and Safety Commission to:**

- **investigate existing workplace policies and interventions to reduce the impact of drugs on workplace safety and productivity, with the aim of identifying best practice and areas that need change;**
- **trial innovative approaches to reducing the impact of drugs in the workplace;**
- **disseminate widely the best practice findings of these investigations and trials; and**
- **recommend any legislative changes deemed necessary to promote the adoption of best practice.**

10.39 Little information is available on the extent to which organisations have put in place workplace policies that address drug-related harm. ADCA reported that in many workplaces there are no formal policies[51], particularly the Employee Assistance Service NT said among small companies[52] and, Dr Gardner noted that on the basis of experience in the United States, small companies are the ones where drug abuse appears to be more prevalent.[53]

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49 Gardner I, transcript, 15/8/02, p 1174.

50 Gardner I, transcript, 15/8/02, p 1174.

51 Alcohol and other Drugs Council of Australia, *Drug policy 2000: A new agenda for harm reduction*, p 165.

52 Employee Assistance Service NT, transcript, 20/4/01, p 683.

53 Gardner I, transcript, 15/8/02, pp 1173, 1182.

10.40 ADCA has called for 'national guidelines and appropriate legislative frameworks for the implementation and monitoring of workplace alcohol and other drug policies' in all medium and large workplaces.[54]

> There should be a national impetus for workplaces to develop alcohol and other drug policies. Every Australian workplace should have an alcohol and drug policy as part of their broader occupational health and safety requirements, and as part of their insurance arrangements. The provision of best practice policy guidelines could significantly improve the quality of individual workplace alcohol and drug policies and practices. This role of encouraging and monitoring the development of alcohol and drug policies should be a national initiative, supported at both a state / territory and local agency level.[55]

Conclusion

10.41 The committee supports the need to further investigate effective interventions to reduce drug-related harm in the workplace. The committee believes that workplace alcohol and drug policies need to have a higher profile and supports ADCA's suggestion that every Australian workplace have an alcohol and drug policy under Occupational Health and Safety requirements and as part of their insurance package. Insurance companies could be encouraged to offer premium incentives to businesses who adopt this practice.

Recommendation 117

10.42 **The committee recommends that the Commonwealth, State and Territory governments promote the implementation and monitoring of workplace alcohol and other drug policies by developing national guidelines and appropriate legislative frameworks.**

Drug and alcohol testing

10.43 Dr Gardner reported that drug and alcohol testing is carried out routinely in some workplaces, and is a legislative requirement for certain defined hazardous industries, such as coal mining. In other cases, employers have interpreted their duty of care obligations to provide a safe working

54 Alcohol and other Drugs Council of Australia, sub 61, p 19.

55 Alcohol and other Drugs Council of Australia, *Drug policy 2000: A new agenda for harm reduction*, pp 165-166.

environment to include testing of employees.[56] Recent press reports suggest that the use of testing is spreading, for example in the transport industry and the Victorian building industry.[57]

10.44 Testing may be carried out randomly or targeted at particularly high risk individuals or areas of work; it is also used in recruiting workers and after accidents. The tests used may employ breathalysers and urine, blood, hair and saliva sampling. Alternatively they may test for impairment. Some submissions to the inquiry stressed that tests should focus on impairment rather than on the presence of drug metabolites in body fluids.[58]

10.45 Alcohol and drug testing not only safeguards employees and those with whom they come in contact, it also identifies those who need help. The Western Australian Network of Alcohol and other Drug Agencies maintains that it is important that testing programs be part of comprehensive workplace alcohol and drug policies.[59] In conjunction with workplace education, counselling, treatment and rehabilitation, testing allows for earlier intervention in the using career of affected workers than might otherwise be the case and improves these workers' contribution to the workforce. According to the Salvation Army (Southern Territory) the proactive use of screening devices and drug recognition techniques is useful in industry-based occupational safety initiatives.[60] In addition, Jackel's work showed testing produces a cultural shift in attitudes to drinking and drug taking, as the NSW police found when drug testing was instituted.[61]

10.46 Corry reported a number of secondary benefits have also been identified from testing, for example, it could reduce theft and the likelihood of blackmail, and foster public trust of organisations.[62] The last two points are of particular importance for public agencies, such as the police.

10.47 Workplace testing received support in some submissions to the inquiry, for example, mandatory testing for people in authority whose work

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56 Gardner I, transcript, 15/08/02, p 1182.

57 'Workers face workplace drugs tests', *Australian Associated Press*, Melbourne, 04/6/02.

58 Allsop S, transcript, 15/8/02, p 1171; NSW Users and AIDS Association, sub 128, p 6.

59 The Western Australian Network of Alcohol and other Drug Agencies, sub 91, p 11.

60 Salvation Army (Southern Territory), sub 43, p 5.

61 Jackel G, 'Workplace drug and alcohol policy and testing – the NSW police experience', *Conference Papers Collection*, CD-ROM, 2nd Australasian Conference on Drugs Strategy, Perth, Western Australia, 7-9 May 2002, p 5.

62 Corry A, 'Controls on drug use' in Allsop S, Phillips M & Calogero C, (eds), *Drugs and work: Responding to alcohol and other drug problems in Australian workplaces*, IP Communications, Melbourne, 2001, p 113.

involves making drug law and policy and contact with drugs and drug users.[63]

10.48 According to Dr Gardner, the evidence base does not support a requirement that drug screening programs be part of a test of fitness for duty. Only where considerations of public safety are concerned, such as airline and heavy vehicle operations, should testing be undertaken.[64] The ADCA, while opposing workplace drug testing in principle, also supported the view that it was reasonable to test for drugs where there was a risk to public safety and security.[65]

10.49 There are a number of further concerns with testing that were outlined in evidence:

- it is seen by some as an invasion of privacy[66] and legislative changes may be needed to adequately safeguard privacy where testing is carried out following injury;
- Dr Gardner said apart from being fraught with interpretational difficulties, problems arise in relation to considerations of chain of custody issues and false positive test results;
- he also said testing distracts attention from the contribution of other personal factors and workplace characteristics to workplace harm;
- Dr Gardner also suggested the efficacy of the computer screen-based tests that are widely used in sections of Australian industry to test impairment is unproven by large scale published studies[67]; and
- NSW Users and AIDS Association reported testing may not be as cost-effective as alternative approaches to reducing drug-related harm.[68]

Conclusion

10.50 The committee notes that although workplace testing offers benefits and received some support, it is also a contentious issue. As we saw earlier in this chapter, very little is known about the extent to which people go to

63 Catholic Women's League of Australia, transcript, 14/6/01, p 1018; Community Coalition for a Drug Free Society, sub 251, p 3; Festival of Light, sub 100, p 1.

64 Gardner I, transcript, 15/8/02, p 1176.

65 Alcohol and other Drugs Council of Australia, *Drug policy 2000: A new agenda for harm reduction*, p 166.

66 Australian Medical Association, transcript, 21/5/01, p 904; NSW Users and AIDS Association, sub 128, p 6; Nolan J, 'Employee drug testing: Some recent legal developments', in Allsop S, Phillips M & Calogero C, (eds), *Drugs and work: Responding to alcohol and other drug problems in Australian workplaces*, IP Communications, Melbourne, 2001, pp 62-63.

67 Gardner I, transcript, 15/8/02, pp 1172, 1174.

68 NSW Users and AIDS Association, sub 128, p 6.

work when intoxicated or drug-affected. Nor do we know, with the exception of alcohol, precisely what relationship there is between a positive result and impaired performance.

10.51 The committee is concerned about the flimsy basis on which drug testing has been built, given that we have inadequate information at present on the relationship of drug use to impairment, and large scale studies to validate the tests have not yet been carried out. The committee has already recommended further research on the relationship of substance abuse to workplace impairment, safety and productivity. It now also recommends that a better basis for the tests be established and guidelines for best practice in testing developed. It is important that privacy issues be addressed as well. Until all these steps have been taken, the committee believes that it is premature to recommend that all workplaces should be required to implement testing.

Recommendation 118

10.52 **The committee recommends that the Commonwealth, State and Territory governments, with input from unions and industry, fund a large-scale study to assess the efficacy of devices that purport to measure workplace drug use and impairment.**

Recommendation 119

10.53 **The committee recommends that the Commonwealth, State and Territory governments identify the privacy concerns relating to drug testing in the workplace, examine the need for legislative changes to address these concerns, and enact any needed changes.**

Recommendation 120

10.54 **The committee recommends that, following finalisation of the studies recommended in Recommendations 114, 116 and 118, the Commonwealth, State and Territory governments develop guidelines for best practice implementation and use of workplace drug testing.**

Implementing the recommendations

10.55 In order to reinvigorate efforts to curb the impact of substance use on the workplace, Dr Gardner suggested that a national summit should be held to focus attention on the issues involved. The summit's aims should be:

- to review existing knowledge, including international experience, so that a way forward can be identified; and
- to make plans the implementation of suggested changes, including the funding and conduct of necessary research.[69]

The committee agrees that such a summit would be a useful move in reactivating national approaches to improving workplace safety and productivity. It would contribute to the national OHS priority of strengthening the capacity of government to influence OHS outcomes.

Recommendation 121

10.56 **The committee recommends that the Commonwealth government:**

- **convene a national summit on the issues relating to reducing the impacts of alcohol and other drugs on workplace safety and productivity that will;**
- **involve all stakeholders and relevant international speakers; and**
- **develop proposals for the further development of the initiatives recommended in Recommendations 114-120 in this chapter.**

69 Gardner I, transcript, 15/8/02, p 1174.

11

Final comments

Introduction

11.1 Australia's National Drug Strategy (NDS) was originally planned to run until 2002-03 but has been extended to 2003-04. The Commonwealth Department of Health and Ageing advised that the strategy is currently being independently reviewed in consultation with key stakeholders under the management of the Intergovernmental Committee on Drugs. The evaluation will be reviewed by the Ministerial Council on Drug Strategy at its meeting in August. The terms of reference for the review are as follows:

1. Assess the impact of the National Drug Strategic Framework (NDSF) on reducing supply, demand, and harm to individuals and the community;

2. Based on that assessment, propose any required changes to the NDSF, including related action plans and strategies, in the context of evidence on the most effective strategies for supply, demand and harm reduction.

In fulfilling these terms of reference, the evaluator will be required to:

(a) identify current and emerging trends in drug problems from existing sources;

(b) propose any changes to existing performance indicators for effective monitoring and evaluation of a national strategy;

(c) identify deficiencies or gaps in available data collections to support monitoring and evaluation of a national strategy;

(d) review the processes by which national action plans have been developed, maintained and implemented and evaluate the impact of the national action plans in terms of outputs, intermediate outcomes and cost effectiveness; and

(e) consider the appropriateness of the structures and governance arrangements to implement a national strategy.[1]

11.2 In this chapter the committee examines a number of the broader issues relating to the strategy with a view to making recommendations that will assist in the formulation of the next stage of the National Drug Strategy.

Harm minimisation

11.3 In a recent review, Fitzgerald and Sewards pointed out that the principle of harm minimisation has been one of the key principles of Australia's drug strategy since its inception in 1985.[2] In stressing harm minimisation, the strategy recognises that, as the 1977 Senate committee inquiry into drugs observed, total elimination of drug abuse is unlikely, but government action can contain the problem and limit the adverse effects.[3] The strategy's aim from the outset has been to reduce the harmful effects of drug use in Australian society, and to improve the health, social and economic outcomes for the individual and the community. As set out in the National Drug Strategic Framework, both licit and illicit drugs are targeted through a balanced combination of:

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1 Commonwealth Department of Health and Ageing, informal communication, 1/4/03, p 1.

2 Fitzgerald J & Sewards T, *Drug policy: The Australian approach*, ANCD research paper 5, Australian National Council on Drugs, Canberra, 2002, p vi.

3 Senate Standing Committee on Social Welfare, *Drug problems in Australia - an intoxicated society?*, Commonwealth Government Printer, Canberra, 1977, p 1.

- supply reduction strategies designed to disrupt the production and supply of illicit drugs;
- demand-reduction strategies designed to prevent the uptake of harmful drug use, including abstinence-oriented strategies to reduce drug use; and
- a range of targeted harm-reduction strategies designed to reduce drug-related harm for individuals and communities.[4]

11.4 According to Fitzgerald and Sewards, a feature of Australia's drug policy making has been 'the deliberate avoidance of electoral politics and public conflict by attempting to maintain consensus and accommodation …'[5] The National Drug Strategic Framework is intended to bring together in a consensual way the people who are dealing with drug issues.[6] Harm minimisation, or harm reduction as it was originally defined, was the banner under which people came together.

11.5 Among the supporters of harm minimisation policy was Turning Point Drug and Alcohol Centre which claimed that harm minimisation was seen as a way of recognising that drug use is a continuum from no use to dependent use, and allowing for 'a sound balance of practical responding which is, at the same time, humane'.[7] The Australian Association of Social Workers claimed that harm minimisation approaches, which include abstinence, are the best ways to achieve positive, cost-effective outcomes.[8] The Public Health Association of Australia (PHAA) also saw harm minimisation as of proven effectiveness[9], and Alcohol and other Drugs Council of Australia (ADCA) 'remains strongly supportive of harm minimisation as the key principle underpinning the National Drug Strategy'.[10]

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4 *National Drug Strategic Framework 1998-99 to 2002-03: Building partnerships: A strategy to reduce the harm caused by drugs in our community*, prepared by Joint Steering Committee of the Intergovernmental Committee on Drugs and the Australian National Council on Drugs, endorsed by the Ministerial Council on Drug Strategy, MCDS, Canberra, November 1998, p 1.

5 Fitzgerald J & Sewards T, p 26.

6 Fitzgerald J & Sewards T, p 44.

7 Turning Point Drug and Alcohol Centre, sub 137, p 3.

8 Australian Association of Social Workers, sub 104, p 13.

9 Public Health Association of Australia, transcript, 21/11/00, p 290.

10 Alcohol and other Drugs Council of Australia, Submission to the National Drug Strategy evaluation, March 2003, p 9, viewed 14/4/03, <http://www.adca.org.au/policy/submissions/ndsf_eval_sub.pdf>.

11.6 The Australian Medical Association (AMA) stressed that it is vital that harm minimisation measures are supported by evidence of their effectiveness.[11]

11.7 According to Dr Foy of Newcastle Misericordiae Hospital:

> It is not enough … that the measures are *designed* to avoid harm, they must be shown *actually* to reduce harm and not to do more harm in the process. Good intentions are not enough, actual evidence of benefit is required. In Australia, the evidence is not conclusive for all the measures that have been used.[12]

11.8 Others were also critical of harm minimisation approaches. The Drug Advisory Council of Australia claimed that some harm minimisation policies had facilitated and exacerbated the use of illicit drugs[13], and the proponents of the policy had failed to recognise this. The Festival of Light cited needle and syringe programs as an example of a failed harm minimisation approach[14] (although, according to the Australian National Council on Drugs, the evidence of gains in terms of lives saved and sickness avoided is considerable[15]).

11.9 The Community Coalition for a Drug Free Society said, 'When ordinary Mums and Dads understand what harm minimisation really is, **they do not want it**'.[16] Restrictive policies are preferred to harm minimisation by such groups in the Australian community as Keep Our Kids Alive.[17]

11.10 According to the AMA, terms such as harm minimisation, while they may have been useful in drawing people together in the past, now appear to be polarising them instead.[18] Fitzgerald and Sewards in their analysis of Australia's drug policy noted that there has been much debate both nationally and internationally about the meaning of terms such as harm minimisation and harm reduction. They also noted that confusion has arisen as harm minimisation has been used

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11 Australian Medical Association, transcript, 21/5/01, p 892

12 Foy A, Newcastle Mater Misericordiae Hospital, sub 196, p 1.

13 Drug Advisory Council of Australia, sub 165, p 1.

14 Festival of Light (SA), sub 100, p 10.

15 Australian National Council on Drugs, *National Council backs investment on needle programs*, media release, 23/10/02, p 1.

16 Community Coalition for a Drug Free Society, sub 251, p 2.

17 Keep Our Kids Alive, sub 197, p 1.

18 Australian Medical Association, transcript, 21/5/01, p 839.

by different parties to justify quite contradictory strategies.[19] In addition, others, such as Single and Spooner, have commented on the confusion in the use of the term.[20] A particular problem to which the Cabramatta Chamber of Commerce referred was the apparent contradiction between harm minimisation and the 'Tough on Drugs' message.[21]

11.11 In the course of their study, Fitzgerald and Sewards interviewed policy advisers, bureaucrats, researchers and service providers in Australia. They reported that among these groups:

> There was particular discontent across all jurisdictions with the current status of harm minimisation as a key term to encompass supply reduction, demand reduction and harm reduction in the NDS … the term 'harm minimisation', has lost a lot of meaning … [and] can no longer provide strategic direction for drug policy. Without agreement over the meaning of key terms, the framework can no longer hold people together as it once did.[22]

11.12 There is clearly widespread unease about the effectiveness of the term harm minimisation at encapsulating and guiding the nation's response to substance abuse. Under these circumstances, Fitzgerald and Sewards suggested that 'the time may be ripe for considering a new consensus-building policy framework' that will bring people together[23] and better capture the community's sense of what direction drug policy should take.

11.13 As indicated above, drug-free and restrictive policies are among the suggestions made to the committee for a more appropriate focus for drug policy. Prevention was also proposed by several groups and individuals such as the Australian Family Association and Reverend

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19 Fitzgerald J & Sewards T, pp 16-17.

20 Single E, 'Achievements, shortcomings and lessons learned from Australia's National Drug Strategy', *Conference Papers Collection*, CD-ROM, 2nd Australasian Conference on Drugs Strategy, Perth, Western Australia, 7-9 May 2002, p 5; Spooner C, 'The role of police in illicit drug harm minimisation: an overview', *Conference Papers Collection*, CD-ROM, 2nd Australasian Conference on Drugs Strategy, Perth, 7-9 May 2002, p 3.

21 Cabramatta Chamber of Commerce, transcript of the Inquiry into Crime in the Community by House of Representatives Standing Committee on Legal and Constitutional Affairs, 9/10/02, p 197.

22 Fitzgerald J & Sewards T, p 43.

23 Fitzgerald J & Sewards T, p 44.

Robinson.[24] In addition, Drug Free Australia urged 'the introduction of a Federal policy of HARM PREVENTION whereby community expectations are supported by a Federal government focus on effective and comprehensive prevention of harm …'[25] On the basis of their consultations, Fitzgerald and Sewards reported that:

> There have been a number of alternative drug policy frameworks proposed based on different rhetorical positions. One such framework discussed by many during the course of the study is the prevention framework. Given the disquiet over the capacity of harm minimisation to bring people together, a number of groups suggested that discussion should centre on a new framework based on the broad strategy of prevention of harm and drug use ...[26]

11.14 Fitzgerald and Sewards warned that, were a prevention framework to be adopted, it is important that the framework is inclusive and:

> … cast in terms greater than simply prevention of illicit drug use. Prevention from its earliest use in 1985 has focused on the prevention of problems and harms as well as prevention of illicit drug use. Maintaining this broad definition of prevention will be a key element to a prevention framework.
>
> When prevention is cast only in terms of prevention of use, some members of the policy community could be excluded. Drug user groups, who are so central to the Australian approach, may suffer if prevention of drug use is a central priority.[27]

Conclusion

11.15 It will be clear from the earlier chapters in this report that the committee believes that much more effort needs to go into both preventing the uptake of smoking and illicit drug use and providing treatment that leads to abstinence and, in the case of alcohol,

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24 Australian Family Association, transcript, 23/11/00, p 545; Robinson M, transcript, 21/2/01, p 665.

25 Drug Free Australia, sub 283, p 6.

26 Fitzgerald J & Sewards T, p 44.

27 Fitzgerald J & Sewards T, p 44.

responsible use. Many of the committee's recommendations throughout the report are designed to achieve this.

11.16 Like many of those cited above, the committee is also confused by the use of the term, harm minimisation, particularly its relationship to the tough on drugs approach. The committee is concerned about the way in which the term harm minimisation may appear to encourage the maintenance of a drug habit and give rise to the idea that taking drugs is alright. The divisions in the community over the meaning of the term and the impact of these divisions on drug policy making and program implementation undermine one of the strengths of Australia's past, relatively united approach to its drug problem. There is a need to embrace terminology that clearly and inclusively conveys the government's policy with substance abuse and misuse in all its forms.

11.17 The committee believes that a prevention framework for the National Drug Strategy would capture better than harm minimisation the community's sense of the best approach to substance abuse and bring people together more effectively. Harm prevention and treatment should be considered as a focus for the new phase of the NDS, and the review of the current phase should include a consideration of the changes in policy and practice that might be needed in the move from a harm minimisation to a harm prevention and treatment approach.

Recommendation 122

11.18 **The committee recommends that the Commonwealth, State and Territory governments replace the current focus of the National Drug Strategy on harm minimisation with a focus on harm prevention and treatment of substance dependent people.**

11.19 In its submission to the evaluation of the NDS, ADCA commented on 'the inadequacy of any effective communications strategy to promote, inform and educate …' about the strategy's principles, directions, policies and programs. This inadequacy was also identified as a deficiency in the 1992 and 1997 evaluations.[28] ADCA suggested that:

28 Alcohol and other Drugs Council of Australia, Submission to the National Drug Strategy evaluation, p 4.

> … it is essential that the next NDS develop strategic approaches to promotion, education and information dissemination, to better engage both the AOD [alcohol and other drugs] and the broader health, welfare, law enforcement and judicial sectors.[29]

11.20 The committee believes that more effort should be put into explaining the basis of Australia's drug policy so that it is better understood by all.

Recommendation 123

11.21 **The committee recommends that the Commonwealth, State and Territory governments strengthen and better communicate the principles, policies and programs of the National Drug Strategy to both the general public and the alcohol and other drugs sector.**

Balance of effort

11.22 One of the features of the National Drug Strategy is its balanced approach. Balance is sought between supply reduction, demand reduction and harm reduction and between prevention, training and research. Fitzgerald and Sewards reported that:

> … balance is also sought between emphases on strategies targeted at licit and illicit substances, between funding for government and non-government sectors, and between [abstinence-based and non-abstinence-based] philosophies underpinning drug policy …'[30]

ADCA saw the NDS' balanced approach as one of its strengths which has contributed to placing Australia 'at the forefront of drugs policy internationally'.[31]

11.23 The balance between these different elements also received attention during the inquiry. The former committee noted:

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29 Alcohol and other Drugs Council of Australia, Submission to the National Drug Strategy evaluation, p 5.

30 Fitzgerald J & Sewards T, p 19.

31 Alcohol and other Drugs Council of Australia, Submission to the National Drug Strategy evaluation, p 3.

> … an imbalance in the amount of effort and resources going into prevention and treatment areas. While there is obvious merit and economies to be gained by investing in prevention, treatment services have usually received the lion's share of resources … [However] there is a recent burgeoning of interest and expenditure in the prevention of drug problems, and the Committee applauds this development.[32]

11.24 It is a development that appears in keeping with community sentiments as revealed by the 2001 NDS Household Survey. The survey showed that when respondents were asked to allocate $100 of a drugs budget across the three areas of education, treatment and law enforcement, education typically received the greater proportion of the allotted $100.[33]

Conclusion

11.25 As indicated in Chapter 3, the committee fully supports prevention initiatives as a very important adjunct to other approaches to reducing substance abuse. The committee is particularly excited by the possibilities offered by very early intervention in children's development and efforts to engage them with family and community. It has therefore recommended in Chapter 3 that work on the National Drug Prevention Agenda be expedited. The committee's support for prevention initiatives targeted at specific dependencies is reported in Chapters 5, 6 and 7.

11.26 Furthermore, the current committee concurs with the former committee's observation that:

> While the Committee sees the merit of placing a greater emphasis on prevention, it would not like to see this achieved at the expense of a diminution of resource allocation for treatment.[34]

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32 House of Representatives Standing Committee on Family and Community Affairs, *Where to next? - A discussion paper: Inquiry into substance abuse in Australian communities*, FCA, Canberra, September 2001, p 60.

33 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: Detailed findings*, Drugs statistics series no 11, AIHW, Canberra, December 2002, p 94.

34 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 60.

Recommendation 124

11.27 **The committee recommends that the Commonwealth, State and Territory governments ensure that any additional funding for the prevention of drug use and abuse is not provided at the expense of expenditure on treatment.**

11.28 Another point noted by members of the former committee was the preponderance of interest and activity directed at illicit drugs. They observed how numerous agencies had:

> … expressed their dismay at how a preoccupation with illicit drugs has resulted in relative inattention to the social and economic costs associated with the abuse of alcohol and tobacco, which accounts for the vast majority of social harms …[35]

As with the balance between prevention and treatment, the former committee remarked that there were also signs that the overwhelming emphasis on illicit drugs was waning. Increasing attention was being paid to licit drugs.[36]

11.29 Several submissions to the inquiry commented on the balance between law enforcement and health care in dealing with drugs. The Brotherhood of St Laurence, and joint protocol from the AMA (New South Wales Branch) and the Law Society of New South Wales to that state's Drug Summit stressed that substance abuse is primarily a social and health issue rather than a criminal one.[37] The PHAA stated in relation to illicit drugs, 'There is little evidence to support an overemphasis on law enforcement'.[38] The Families and Friends of Drug Law Reform (ACT) (FFDLR) suggested that more funding be put into treatment than into law enforcement.[39] As outlined in

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35 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 60.

36 House of Representatives Standing Committee on Family and Community Affairs, *Where to next?*, p 60.

37 Brotherhood of St Laurence, sub 76, p 3; Australian Drug Law Reform Foundation, transcript, 21/2/01, p 630; *Joint protocol between the Australian Medical Association (NSW) Ltd and the Law Society of New South Wales: Developing more effective responses to Australia's growing problem with illicit drug*, p 2, attachment to the submission by The Law Society of New South Wales to the NSW Parliamentary Drug Summit, Sydney, 17-21 May 1999.

38 Public Health Association of Australia, transcript, 21/11/00, p 292.

39 Families and Friends for Drug Law Reform (ACT), sub 65, p 2.

Chapters 8 and 4 respectively, increasing efforts are being made to divert drug users from the criminal justice system into treatment and the number of treatment places has increased in recent years. Of the more than $1 billion since 1997 provided for the National Illicit Drug Strategy, $456 million has been for supply control measures and $691 million for demand reduction measures.[40]

11.30 In relation to research activities and service provision the committee was told by Dr Wodak that funding:

> … is predominantly weighted to service provision by a large factor of 40:1 or 50:1—it is of that order. We do need research because we need to keep investing in what we should be doing in five, 10 and 15 years time. Also, we need research because, frankly, we do not have answers to problems that are very big issues now and that are looming —such as the increasing use of amphetamines in Australia.[41]

Research, monitoring and evaluation

11.31 Several submissions, for example, those from DRUG-ARM, FFDLR and the National Centre for Education and Training on Addiction, called for an evidence-based approach to program development, based on sound research and evaluation.[42] Evidence-based practice is one of the planks of the National Drug Strategy:

> … All supply-reduction, demand-reduction and harm-reduction strategies should reflect evidence-based practice, which is based on rigorous research and evaluation, including assessment of the cost-effectiveness of interventions …[43]

11.32 According to ADCA, however, one of the NDS's shortcomings with respect to its evidence base is that a national research strategy has not been produced. ADCA also pointed out that the usefulness of some of the data collections used for monitoring the NDS could be improved

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40 Commonwealth Department of Health and Ageing, sub 291, p 2.

41 Wodak A, transcript, 16/8/02, p 1255.

42 DRUG-ARM, sub 199, p 3; Families and Friends for Drug Law Reform, sub 65 (ACT), p 1; National Centre for Education and Training in Addiction, sub 208, p 3.

43 *National Drug Strategic Framework 1998-99 to 2002-03: Building partnerships: A strategy to reduce the harm caused by drugs in our community*, p 18.

so that the possibilities for service delivery and planning at national, jurisdictional, regional and local are less limited.[44]

11.33 The committee was interested in the NDS research effort from two points of view. It wished to assess whether the right balance between funding for research and the provision of services had been achieved, particularly in relation to health care. It also wanted to form a view on the nature of the research projects funded.

11.34 The committee sought information about funding for substance abuse-related research in Australia. It was advised by the Commonwealth Department of Health and Ageing that funding for health-related research into substance abuse provided by it and its agencies included:

- $4.0 million allocated in 1998 to the Strategic Research and Development Committee of the National Health and Medical Research Council to undertake the research component of the National Illicit Drug Strategy which aims to reduce health-related harm from illicit drug use, examine social issues, and inform national health policy. The Strategic Research and Development Committee identifies important areas in Australian health care where research is currently under-developed or where there are gaps in current effort and allocates grants;
- $12,779,957 over 2000-02 contributed by the National Health and Medical Research Council for grants for research into drug use;
- $11,531,713 over 2000-01 to 2002-03 for the three NDS research centres to support their core programs of research into drug treatment, prevention and workforce development;
- $1.303 million for the National Evaluation of Pharmacotherapies for Opioid Dependence; and
- $0.252 million for research into barriers to treatment.

None of the department's research budget is passed on to the states and territory governments for allocation to research projects.[45]

11.35 The committee was concerned that the department was unable to provide the committee with information about the expenditure on

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44 Alcohol and other Drugs Council of Australia, Submission to the National Drug Strategy evaluation, pp 3, 11.

45 Commonwealth Department of Health and Ageing, sub 292, pp 1, 5- 6 and sub 293, p 2 and attachment 1, p 1.

research by the states and territories. The funding mechanisms between the Commonwealth and state and territory governments in relation to addressing drug issues do not generally stipulate the provision of funds for specific purposes like research. Furthermore the department commented that the information provided by the states and territories to the Commonwealth does not identify the relative allocation of funds, nor how they define what is included within the parameters of 'research'.[46]

11.36 The department also advised that it did not have access to information about expenditure on research on other aspects of managing substance abuse by the portfolios that deal with customs, law enforcement, veterans' affairs, education and transport. Considerable time and extensive resources would have been required to assemble this information.[47]

11.37 During the inquiry, committee members heard much about substance-abuse-related research projects. It learnt that, while some of Australia's research into substance abuse was clearly yielding valuable outcomes, a number of projects appeared to lack accountability. The committee also heard that there is some duplication among the research being carried out, including by government departments with overlapping spheres of interest.

Conclusion

11.38 Whilst the committee has been hesitant about benefits of some research during this report it does believe that it is essential to use research and evaluation to identify cost-effective approaches to dealing with substance abuse and to develop good policy and programs. It is also the basis for judging the relative cost-effectiveness of different approaches within the National Drug Strategy.

11.39 The committee is therefore concerned about the lack of an overarching NDS research agenda and deficient data collections. It is also disappointed that it was unable to establish more exactly the amount of public moneys spent on research, even for health care. One such example was the significant discrepancies in evidence on the number of methadone users in Australia. The committee also judged

46 Commonwealth Department of Health and Ageing, sub 292, p 1 and sub 293, p 1.

47 Commonwealth Department of Health and Ageing, sub 292, p 1 and sub 293, p 1.

that some of the research projects about which it heard were unlikely to contribute substantially to efforts to reduce substance abuse. Given the lack of readily available information about expenditure on research and the committee's reservations about the usefulness of some of the research being performed, the committee believes that research expenditure should be more closely monitored and accountable than it is at present.

Recommendation 125

11.40 **The committee recommends that the Commonwealth, State and Territory governments:**

- **ensure that the programs and policies of the National Drug Strategy continue to be evidence-based;**
- **establish an overarching national drug research strategy;**
- **examine the national drug-related data collections with a view to improving their value for monitoring and planning purposes; and**
- **establish a reliable and consistent data methodology in conjunction with the Australian Bureau of Statistics.**

Recommendation 126

11.41 **The committee recommends that the Australian National Audit Office undertake a performance audit of the research element of the National Drug Strategy by:**

- **compiling a list of funded research programs;**
- **identifying duplication;**
- **investigating the cost-effectiveness of the research performed; and**
- **assessing the efficiency with which the evidence base is incorporated into policies and programs.**

Recommendation 127

11.42 **The committee recommends that the Commonwealth, State and Territory governments make proven benefits of research to those affected by substance abuse and misuse a prerequisite for continuing and new funding of projects.**

Responsiveness

11.43 The National Drug Strategy has been criticised for its lack of responsiveness to emerging problems in substance use and abuse. Problems, such as the increased use of amphetamine type stimulants and the risky use of alcohol by young people, have been identified, but in ADCA's view, 'the system has failed to react in a timely manner with the development of strategic policy, program, research and monitoring responses'.[48]

11.44 Both ADCA and Fitzgerald and Sewards commented on the complex governance structure of the NDS. ADCA referred to the many expert advisory committees and subcommittees which, while ensuring access to extensive expertise, reduce the responsiveness of the NDS. Issues may be passed between committees 'for some time, with little resolution'.[49] Fitzgerald and Sewards warned that the NDS' network of advisory structures may become 'an impediment to innovation'.[50] The importance of acting swiftly is obvious, as nipping an incipient problem is often much less costly of time, effort and expense than dealing with a full-blown one.

11.45 ADCA was also critical of the national action plans developed under the NDS. It pointed out that, while being comprehensive and evidence-based and providing 'a useful point of reference in terms of broad principles and goals', the action plans lack 'clear statements of what actions will be taken, by whom and by when'. ADCA suggested that jurisdictions:

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48 Alcohol and other Drugs Council of Australia, Submission to the National Drug Strategy evaluation, pp 7-8.

49 Alcohol and other Drugs Council of Australia, Submission to the National Drug Strategy evaluation, p 15.

50 Fitzgerald J & Sewards T, p 47.

> … develop their own action plans (as opposed to strategies) that are consistent with the overarching national framework and specify actions, timelines, resources and responsible agencies to address key jurisdictional priorities across all drug types (and including identified target groups) …[51]

11.46 The committee believes that it is critical that the NDS is as responsive as possible to emerging drug issues. This should be addressed in the formulation of the next stage of the NDS, with consideration being given to such matters as the role of the governance structure that supports the NDS and the usefulness of detailed jurisdictional action plans.

Recommendation 128

11.47 **The committee recommends that the Ministerial Council on Drug Strategy ensure that steps be taken to improve the effectiveness of the National Drug Strategy to dealing with the changing nature of substance use and abuse.**

Kay Hull MP
Chair

7 August 2003

51 Alcohol and other Drugs Council of Australia, Submission to the National Drug Strategy evaluation, p 13.

Clarifying statement – The Hon Alan Cadman MP, Mrs Trish Draper MP, Mr Peter Dutton MP, Mr Chris Pearce MP and Mr Barry Wakelin MP

By its very nature this Inquiry drew a vast range of opinions from Committee Members. During the report consideration stage, in a spirit of cooperation and with the aim of achieving a uniform position, Committee Members, whilst respecting fellow members' views, compromised and reached consensus on the recommendations.

Despite this final consideration and agreement the Committee was then advised that a dissenting report was to be submitted. After that advice, and in light of the compromises made, we took the decision that it was necessary to make the following Statement:

> With particular reference to sections 7.69 and 7.138 we do not condone or support in any way the trialling or experimental procedures in which illicit drugs are used. Neither should any finding, observation or statement in this report be construed to imply that we would support injecting rooms or the use of cannabis or any process whatsoever that involves the use of illicit drugs. We agree with the rejection by the American Medical Association and the British Medical Association of the therapeutic use of raw cannabis.

Signatories to the qualifying statement on the previous page are:

The Hon Alan Cadman MP

Mrs Trish Draper MP

Mr Peter Dutton MP

Mr Chris Pearce MP

Mr Barry Wakelin MP

Dissenting report – The Hon Graham Edwards MP and Mrs Julia Irwin MP

General Comments

As members of the committee since the inquiry began 3 years ago, we have no objections to the conduct of the inquiry. The range of submissions and evidence of witnesses allowed the committee the fullest opportunity to address the inquiry's terms of reference. The most valuable part of this report is in fact the submissions received by the inquiry, the volumes of testimony given by witnesses before the inquiry and in the forums conducted as part of the committee's information gathering process.

However, the consideration of evidence, the conclusions reached and the recommendations made must be seen as coloured by the personal views of committee members (including ourselves). This can be a strength of the political process. After all, elected representatives should be a sounding board for the views of the electorate. What are seen as socially acceptable recommendations can be expected to prevail.

But in reaching conclusions and making recommendations which reject the findings of scientifically based studies and by using assumptions and anecdotal evidence to support its recommendations, the committee's report loses credibility.

In many ways the report is not an objective assessment of the facts but a one sided argument in favour of a predetermined outcome. Surely the lives of thousands of young Australians should be above politics. Indeed the Australian people deserve an honest and open appraisal of drug policy. In the interests of redressing some of the shortcomings in the report, the following conclusions and recommendations of the committee's report are dissented from.

Recommendation 21

The committee recommends that the Commonwealth government, in consultation with the State and Territory governments:

- **provide additional funding for alcohol and other drug treatment so that the shortfall in services is eliminated and adequate numbers of appropriately qualified staff are employed to work in these services, *with the ultimate objective being to obtain a drug free status for the client;* and**
- **pay particular attention to needs of people who abuse substances and suffer mental ill-health, including those in prison.**

The inclusion of the clause ***with the ultimate objective being to obtain drug free status for the client;*** is opposed.

The clause is not essential to the main point of the recommendation which is the call for increased funding. By adding the rider that "the ultimate objective being to obtain drug free status for the client", funding authorities may take this to mean that priority in funding should be given to agencies that include this specific objective in their funding submissions.

This may skew funding to ends or outcome oriented services at the expense of front end services such as contact points and referral services. Services with objectives of stabilising the lifestyle of target groups may be excluded or limited in funding if the "ultimate objective" approach is used to determine funding.

Funding should be based on demonstrated need and the effectiveness of the service to meet a range of agreed objectives.

Recommendation 52

The committee recommends that, when providing:

- **methadone maintenance treatment to save lives and prevent harm to people dependent on heroin, the ultimate objective be to assist them to become abstinent from all opioids, including methadone; and**
- **in addition, comprehensive support services must be provided to achieve this outcome.**

The recommendation is opposed.

By including the requirement that "the ultimate objective be to assist them to become abstinent from all opioids, including methadone;" the committee ignores the advice of Professor Mattick (7.16)

> only one-third of heroin addicts achieve and maintain abstinence. For the remainder, heroin dependence is a chronic, relapsing disease, and 'we have to talk about management not cure'.

Professor Saunders (7.16) posed the question,

> Do we want to reduce opioid use completely, or do we want to reduce harm and deaths.

The committee has opted for the first alternative contrary to Recommendation 51 which calls for an increase in the number of addicts in treatment.

The evidence of Professor Webster (7.16) states:

> it is about 'trying to achieve an outcome where someone is socially functioning; we are trying to get them back to work and, presumably back to their families…

This is misinterpreted when the report leaps to the conclusion (7.17)

> The committee believes that once in this position, there may be a chance of moving on to abstinence.

While evidence was given outlining the disadvantages of methadone treatment, no evidence was given of success rates in weaning clients off methadone.

The danger of the recommendation is that it places pressure on methadone treatment facilities to move people off methadone long before complete abstinence has been achieved.

This is suggested by Dr Currie (7.30) when he,

> pointed out informally to the committee, moving people off methadone frees up places for those who need and cannot at present access it.

When taken with the evidence of Ms Madden (7.30) which pointed to the "huge waiting lists (for methadone treatment) all around the country." It is clear that funding pressures influence access to methadone maintenance treatment. There is a great risk that funding methadone maintenance treatment which requires a measurable outcome of patients becoming abstinent may simply become a revolving door with patients returning for further treatment at a later time.

Recommendation 54

The committee recommends that the Commonwealth, State and Territory governments ensure that sufficient funding is available to treatment services to provide comprehensive support to opioid dependent people who are receiving pharmacotherapy:

- **for as long as it is needed to stabilise their lifestyle;**
- **if possible, to assist them to reduce or eliminate their use of all opioids, including methadone;**
- **support further research and trials of promising new medications and techniques;**
- **continue to fund research into pharmacotherapies for opioid dependence;**
- **make widely available as a matter of priority any treatments that are found to be cost effective; and**
- **give priority to treatments including naltrexone that focus on abstinence as the ultimate outcome.**

The final Dot Point is opposed:

Give priority to treatments including naltrexone that focus on abstinence as the ultimate outcome.

While some medical evidence in support of naltrexone was received, its appeal appears to be from other groups, (7.35).

> As DrugBeat of South Australia noted, it is 'not a drug substitution treatment, but rather a treatment that promotes abstinence…' Support for its use comes from those, like The Festival of Light, who believe there should be greater opportunities for individuals to opt for abstinence rather than an opiate substitute like methadone, and from those who favour a range of treatments being available.

Medical evidence however raised some concerns (7.36).

> Professor Mattick pointed out that orally administered naltrexone is safe and effective as long as patients remain in treatment but it is not well accepted by many who try it. Compared with other pharmacotherapies evaluated, the study found that it is harder to retain patients in treatment with naltrexone, compliance is poorer, and risk of death and overdose is higher when treatment is ceased or intermittent.

The report (7.36) also notes findings that conclude "that there was insufficient evidence to evaluate the efficacy of naltrexone." But the committee sees naltrexone as a magic bullet, it concludes; (7.40), "The committee believes that greater emphasis should be given to expanding the use of naltrexone."

Clearly there is a need for further research into the effectiveness of naltrexone before recommending that priority be given to its use in treatments. This is the case in Recommendation 55 which calls for Commonwealth funding for a trial of naltrexone implants. Support for the use of naltrexone should be based on medical evidence not moralistic preference based on its promotion of abstinence.

Recommendation 56

The committee recommends that:

- **the Australian National Council on Drugs urgently determine best practice models of residential rehabilitation in consultation with service providers;**
- **the Commonwealth, State and Territory governments ensure funding to establish these models throughout urban and rural areas;**
- **residential rehabilitation providers establish programs to instigate, where it is not already provided, ongoing support for those needing residential rehabilitation; and**
- **given the complexity of delivery of rehabilitation programs, responsibility and coordination should be undertaken by the Commonwealth Department of Family and Community Services.**

Dot Point 4 of Recommendation 56 is opposed.

Residential rehabilitation must be considered as part of the overall treatment of addiction. It is essentially a health issue. Outcomes must be measured against health criteria. (See Recommendation 125). While some difficulties with access to social security support may exist, many services offer counselling and referral for clients in residential rehabilitation.

Responsibility for residential rehabilitation should remain the responsibility of The Department of Health and Ageing.

Recommendation 57

The committee recommends that trials of heroin prescription as a treatment for heroin dependence not proceed.

The recommendation is opposed.

The report concludes (7.51) "Noting that trials of prescription heroin are occurring in some countries this committee has not been convinced of the value of this form of treatment for heroin dependence."

Evidence presented to the committee (7.47) pointed to the results of overseas trials showing improvement of general health and social functioning, reduction in criminal behaviour and the amount of drugs used. Heroin prescription was described as a niche treatment, useful for a small number of dependent people, noting that it is prescribed for 5% of heroin users in Switzerland and 3-4 % in the UK. Professor Mattick gave its cost as 3 times more expensive than existing treatments.

The following alternative recommendation is preferred:

That the results of overseas trials of prescription heroin be closely monitored by government agencies and that, should a state or territory adopt a policy to conduct a trial, then the arguments in support of the trial be put to the Commonwealth government and that trial should be approved or disapproved on the strength and relevancies of the argument put forward based on the most current evidence available.

Conclusion (7.138) (Safe injecting facilities)

The committee believes that the most desirable way of dealing with injecting drug user problems is to get addicts into rehabilitation programs that lead on to longer term treatments, bolstered by a range of ancillary programs to give maximum support to individuals rather than creating more safe injecting rooms.

The Conclusion is not agreed with.

The longer term objective of getting addicts into detoxification programs overlooks the immediate health issue of preventing overdose deaths and bringing injecting drug users into contact with referral and treatment agencies.

It should be noted that policy decisions on safe injecting rooms are the responsibility of the States and Territories.

The following conclusion is preferred:

State and Territory governments should closely monitor the performance of the Kings Cross safe injection room trial and assess the suitability of injecting rooms based on those results.

Conclusion 8.27

The committee:

- **supports the development of this new national framework to deal with multi-jurisdictional crime, believing that it will contribute significantly to limiting the drug trade;**
- **applauds the government's commitment to limiting drug trafficking and associated activities in the 2003-2004 budget; and**
- **applauds all jurisdictions and agencies commitment to limiting drug trafficking and associated activities.**

We believe this to be a cheap attempt by government members of the committee to take credit for itself where credit is not due. The fact that the latter part of this inquiry was conducted during a period of 'heroin drought' caused in the main by factors external to Australia.

Instead of congratulating itself we believe the Government would better serve Australia if it gave recognition and greater support to the many parents, grandparents, carers, volunteers and front line drug workers who do most to assist those caught up in the horror and trauma of substance abuse.

Recommendation 93

The committee recommends that, as part of the trial recommended in Recommendation 55, naltrexone implants also be trialled to treat opioid dependent prisoners. Should the trial be successful, then the use of naltrexone implants be an ongoing treatment for opioid dependent prisoners. Participation in the trial must be voluntary and agreed between the doctor and patient.

The Recommendation is opposed.

While supporting drug treatment services for prison inmates, as a fundamental human rights concern, pharmaceutical trials should not be undertaken in a prison environment whether voluntary or not.

The report notes (7.36) in relation to naltrexone that:

> it is harder to retain patients in treatment with naltrexone, compliance is poorer, and the risk of death and overdose is higher when treatment is ceased or intermittent.

And that there is,

> considerable success with naltrexone treatment when patients are carefully selected for treatment and extensive social support is provided for them during their treatment.

The report Conclusion (8.137) offers the caution "if the trial of naltrexone implants recommended in Chapter 7 proves them to be safe and effective in treating opioid dependent people," not "as part of the trial" as stated in the recommendation.

The Conclusion (8.137) goes on to state "serious consideration be given to **requiring** the use of such implants with suitable heroin dependent prisoners." This is hardly "voluntary and agreed between doctor and patient."

We note the comments of the head of the NSW Prison Medical Service, Dr Mathews, (8.130) that "rehabilitation, although a laudable aim, is not logistically possible in the correctional setting"; since most prisoners do not stay in one place for very long.

These concerns should make prison trials of naltrexone inadvisable.

It should also be noted that as the states and territories meet the full cost of all medical treatment for prisoners, the high cost of naltrexone treatment would be carried by the states alone.

Recommendation 95

The committee recommends all personnel employed in correctional facilities should be subject to mandatory random blood or urine tests.

Recommendation opposed:

Industrial relations and privacy issues should preclude this proposal. There is no mention of any submission to the committee calling for this measure. No reasons are given for the proposal unless we make the assumption that persons who have used an illicit drug would be more likely to smuggle contraband into prisons.

Recommendation 106

The committee recommends that all new cars made in, or imported into Australia be fitted with alcohol ignition interlocks by 2006.

Recommendation opposed.

This would represent a high additional cost which is unnecessary for the great majority of motorists.

The alternative recommendation is made:

That motor vehicle third party insurers be encouraged to offer discounts where vehicles are fitted with alcohol ignition interlocks.

Recommendation 107

The committee recommends that the Commonwealth, State and Territory governments give high priority in the national Road Safety Action Plan to:

- **work towards all States and Territories making it an offence to drive with any quantity of illicit drug present within the system;**
- **have all States and Territories enacting legislation to test and prosecute drug drivers;**
- **fund and coordinate roadside drug testing with a model similar to that of alcohol random breath testing; and**
- **continue research into the relationship between drugs and driving impairment.**

With the exception of the last Dot Point, the recommendation is opposed.

The suggested offence outlined specifies "any quantity of illicit drug" without reference to any relationship between drugs (and their level in the system) and driving impairment as has been established for alcohol and for which further research is called for in Dot Point 4.

While this recommendation may be aimed at illicit drugs it will inevitably be extended to cover licit substances under a policy of 'zero tolerance' with the main target being alcohol. The legal limit for alcohol in Australia is 0.05 and the committee was presented with no evidence to say that a change to a zero level would be workable or practical.

Recommendation 122

The committee recommends that the Commonwealth, State and Territory governments replace the current focus of the National Drug Strategy on harm minimisation with a focus on harm prevention and treatment of substance dependent people.

Recommendation opposed:

The report discusses in detail the background and development of "harm minimisation" as one of the key principles of Australia's drug strategy. While some submissions supported the concept, (11.5),

> Turning Point Drug and Alcohol Centre which claimed that harm minimisation was seen as a way of recognising that drug use is a continuum from no use to dependent use, and allowing for 'a sound balance of practical responding which is, at the same time, humane'.

Fitzgerald and Sewards (11.11), claimed:

> the term 'harm minimisation', has lost a lot of meaning…[and] can no longer provide strategic direction for drug policy. Without agreement over the meaning of key terms, the framework can no longer hold people together as it once did.

At (11.4) Fitzgerald and Sewards make the observation that:

> a feature of Australia's drug policy making has been 'the deliberate avoidance of electoral politics and public conflict by attempting to maintain consensus and accommodation…' The National Drug Strategic Framework is intended to bring together in a consensual way the people who are dealing with drug issues.

While the AMA (11.10), warns that:

> terms such as harm minimisation, while they may have been useful in drawing people together in the past, now appear to be polarising them instead.

The report mentions the criticism by The Festival of Light of needle and syringe programs (11.8), and preference for restrictive policies over harm minimisation by such groups as Keep our Kids Alive (11.9). The term "harm prevention" which this recommendation (122) seeks to replace harm minimisation, came from the submission of Drug Free Australia.

But Fitzgerald and Sewards warned (11.14) that:

> were a prevention framework to be adopted, it is important that the framework is inclusive and: '…cast in terms greater than simply prevention of illicit drug use. Prevention from its earliest use in 1985 has focused on the prevention of problems and harms as well as prevention of illicit drug use. Maintaining this broad definition of prevention will be a key element to a prevention framework.
>
> When prevention is cast only in terms of use, some members of the policy community could be excluded. Drug user

> groups, who are central to the Australian approach, may suffer if prevention of drug use is a central priority.

The report ignores this advice and concludes (11.15):

> It will be clear from the earlier chapters in this report that the committee believes that much more effort needs to go into both preventing the uptake of smoking and illicit drug use and providing treatment that leads to abstinence and, in the case of alcohol, responsible use.

The wording of the recommendation which calls for governments to: **replace the current focus of the National Drug Strategy on harm minimisation with a focus on harm prevention and treatment of substance dependent people**, does not attempt to explicitly include what is understood to be harm minimisation as one of the key principles of harm prevention.

Even allowing for the inclusion of "**and treatment of substance dependent people",** without the explicit inclusion of the key principles of harm minimisation, the recommendation cannot be supported. Since Conclusion (11.15) specifically endorses only treatments that lead to abstinence, it does not go far enough to include all key principles of harm minimisation.

It is believed that the term **harm prevention** will rapidly become understood to mean zero tolerance. The consensus referred to by Fitzgerald and Sewards (11.4) would quickly be destroyed and the polarisation warned of by the AMA will become a reality (11.10)

The adoption of this recommendation by governments will place the majority of health professionals working in this field outside the ambit of the National Drug Strategy and put at risk the coordinated and cooperative approach developed over more than a decade.

The Hon Graham Edwards MP

Mrs Julia Irwin MP
Deputy Chair

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Dissenting report – Mr Harry Quick MP

I agree with the Hon Graham Edwards MP and Mrs Julia Irwin MP dissention on Recommendations 21, 52, 54, 56, 57, 93 and 122 and Conclusion 7.138.

I don't support their dissention on Recommendations 95, 106 and 107.

Mr Harry Quick MP

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Dissenting remarks – Ms Jennie George MP

In terms of the content of the Report I have been guided by the belief that prevention and treatment of substance abuse should be enhanced. It was particularly disturbing to find lack of data on the current availability of treatment services on a national basis. The lack of detoxification and rehabilitation places was particularly evident in the Committee's deliberations. People seeking treatment are far too often in a position of not being able to access assistance when needed.

As heroin dependence is a chronic, relapsing disease it is necessary to understand the need for ongoing support and treatment and that the issue is a medical not legal matter. Saving lives of people who are opioid dependent is an essential component of any program, which aims at achieving a drug free status.

There is an urgent need for further research into the use of Naltrexone given that many people are now 'parked' on methadone maintenance programs. It appears that Naltrexone treatment is most effective when patients are carefully selected for treatment and extensive social support is provided. In that regard, Naltrexone trials should not be introduced into the prison environment until such time as the efficacy of the trials has been proven. As noted by Dr Matthews, the head of the NSW Prison Medical Service "rehabilitation, although a laudable aim, is not logistically possible in the correctional setting…" Accordingly Recommendation 93 is opposed.

I oppose Recommendation 95 as the issue of random blood and urine tests is a matter that should be appropriately considered in an industrial context.

Finally, in supporting a greater emphasis on harm prevention and treatment, this does not equate to a strategy of zero tolerance. Addiction is a medical condition. Dependence on licit and illicit substances is not something that can be wished away. As a society we have an obligation to provide the necessary

support for people seeking to break their dependency, recognising that opioid dependency is a chronic, relapsing disease. In that process saving lives and minimising harm will continue to be part of an overall compassionate strategy.

Ms Jennie George MP

A

Appendix A – List of submissions

Submission No.	Individual/Organisation
39th Parliament	
1	Mr John Edge
2	Mr Geoffrey Grantham
3	Mr Ross Ollquist
4	Mr M Heuston
5	Mr Frank Robinson
6	Mr Dean Dowling
7	Mr Phillip Dawson
8	Ms Carole Hubbard
9	Mr Martin Wurzinger
10	Mr Steve Liebke
11	CONFIDENTIAL
12	Mr Brian Clarke
13	CONFIDENTIAL
14	Mr Jim Sheedy
15	E D Webber
16	Mr Evan Thomas
17	Dr J Quinlivan

18	Mrs Beverley Hellyer
19	National Council of Women of Australia Inc Ltd
20	Ms Sherron Dunbar
21	Tablelands Alcohol & Drugs Service
22	CONFIDENTIAL
23	Ms Denise Mullan
24	MOFFLYN: A Caring Agency of the Uniting Church
25	Country Women's Association of NSW
26	Dr Wendell Rosevear
27	Mr Duane Stanfield
28	Ms Betty Arrowsmith
29	Dr Andrew Byrne
30	Sisters Inside
31	Ms Bronwyn Barnard
32	The Riley Family
33	Holyoake Tasmania Inc
34	Mrs Pauline Whieldon
35	Australian Drug Law Reform Foundation Inc.
36	CONFIDENTIAL
37	Ted Noffs Foundation
38	Australian Drug Foundation
39	The Law Society of NSW
40	CONFIDENTIAL
41	CONFIDENTIAL
42	Mr Peter Beswick
43	The Salvation Army
44	Territory Health Services, Northern Territory Government
45	Mr Stephen Kendal

46	Ms Kathleen Waters
47	Australian National Council on Drugs
48	Dr Michael Dawson
49	Australian Bureau of Criminal Intelligence
50	Intergovernmental Committee on Drugs
51	National Organisation for Foetal Alcohol Syndrome & Related Disorders
52	Victorian Institute of Forensic Mental Health
53	Australian Federation of AIDS Organisations
54	Mental Health Council of Australia
55	Australian Olympic Committee Inc
56	Senator the Hon John Herron, Minister for Aboriginal and Torres Strait Islander
57	The Victorian Healthcare Association Ltd
58	Ms Lyn Roberts
59	Winemakers Federation of Australia
60	Number not assigned
61	Alcohol and other Drugs Council of Australia
62	Teen Challenge and InTouch Medical Centre
63	Ms Helen Daley
64	Toughlove (NSW) Inc
65	Families and Friends for Drug Law Reform (ACT) Inc
66	Mr Bruce Taggart and Mrs Michelle Taggart
67	Mr Trevor Barker
68	Number not assigned
69	Ms Rebecca Muldoon
70	Mr Strider
71	Number not assigned

72	National Drug and Alcohol Research Centre, University of NSW
73	The Australian Family Association
74	City of Monash
75	Catholic Women's League of Australia Inc
76	Brotherhood of St Laurence
77	Toughlove South Australia Inc
78	People Against Drink Driving Inc
79	Mr Ben Heinecke
80	Pharmacists Branch, Association of Professional Engineers, Scientists and Managers Australia
81	Mr Owen Phillips
82	Mr Rick Langtree
83	Fairfield City Council
84	CONFIDENTIAL
85	Mr Paul Carew
86	Family Council of Western Australia
87	Family Drug Support
88	National Woman's Christian Temperance Union
89	St. Mary's Convent
90	Mr Geoff Page
91	The Western Australian Network of Alcohol and other Drug Agencies
92	Caroline Chisholm Centre for Health Ethics Inc
93	AL-ALON Family Groups (Australia) Pty Ltd
94	Office of the Lord Mayor, Brisbane
95	Number not assigned
96	SANE Australia
97	Society without Alcoholic Trauma Inc

98	Health Insurance Commission
99	Mr Michael Blackwell
100	Festival of Light (South Australia)
101	Focus on the Family Australia
102	Youth Substance Abuse Service
103	Dr Ian Hampson
104	Australian Association of Social Workers
105	Australian Healthcare Association
106	'Anxiety & Panic Hub'
107	Inner Eastern Melbourne Division of General Practice Ltd
108	Young Women's Christian Association of Perth (Inc)
109	Mr Rick Langtree
110	National Drug Research Institute, Curtin University of Technology
111	Australian National Council on Aids, Hepatitis C & Related Diseases
112	Cancer Foundation of Western Australia Inc
113	Australian Intravenous League
114	Number not assigned
115	WA Drug Abuse Strategy Office
116	Dr Mal Washer MP
117	Dr Rodger Brough
118	Management Committee, The Care and Prevention Programme, Department of General Practice, Adelaide University
119	The Anti-Violence Project
120	Australian Association of Christian Schools
121	Number not assigned

122	National Aboriginal Community Controlled Health Organisation
123	Mr D Crosbie; Professor T Stockwell; Dr A Wodak and Ilse O'Ferrall, Curtin University of Technology
124	Philip Morris Ltd
125	Health Consumers' Council WA (Inc)
126	Assisting Drug Dependents Inc
127	The Society of Hospital Pharmacists of Australia
128	NSW Users and AIDS Association
129	CONFIDENTIAL
130	Divisions National Consortium for the Quality Use of Medicines in General Practice
131	Hon John Della Bosca MLC, Special Minister of State, NSW
132	Tranquilliser Recovery and New Existence Inc
133	Australian Medical Association Ltd
134	Ms Judy Aulich
135	HEMP SA Inc
136	Western Australian Government
137	Turning Point Alcohol & Drug Centre Inc
138	Catholic Health Australia
139	Outcare Inc
140	Ms Sarah Roberts, T Flanders and C C Williams
141	Ms Jennifer Nosovich
142	The Australian Associated Brewers Inc
143	Brisbane Youth Service
144	Australian Hotels Association
145	Commonwealth Department of Health and Aged Care
146	Australian Nursing Council Inc

147	Commonwealth Department of Education, Training and Youth Affairs
148	Tasmanian Government
149	Commonwealth Attorney-General's Department
150	ACT Government
151	The Pharmacy Guild of Australia
152	Australian Institute of Criminology
153	Australian Drug Law Reform Foundation Inc (Supplementary)
154	Granville Central
155	Odyssey House Victoria
156	South Australian Government
157	Australasian Faculty of Rehabilitation and Medicine
158	Independent Winemakers Association
159	Public Health Association of Australia
160	Reverend Michael Robinson
161	City of Newcastle
162	Commonwealth Department of Family & Community Services
163	W F Toomer
164	Commonwealth Department of Transport & Regional Services
165	Drug Advisory Council of Australia Inc
166	Victorian Government
167	National Council of Independent Schools' Associations
168	Dr John Gladstones
169	National Aboriginal Community Controlled Health Organisation (Supplementary)
170	City of Perth
171	Ms Peta Blackford

172	National Council of Women of WA
173	Independent Winemakers Association (Supplementary)
174	Mr Michael Stojanovic
175	Ms Sandy Moran
176	Ms Sandy Moran (Supplementary)
177	National Heart Foundation of Australia, WA Division
178	Mr Ron Natoli
179	Accelerated Inner-Mind Healing Centre
180	South City 7-Day Family Medical Centre Pty Ltd
181	Aboriginal Drug & Alcohol Council (SA) Inc
182	CONFIDENTIAL
183	Drug Advisory Council of Australia Inc (Supplementary)
184	Pilot Project for Parenthood
185	Ms Jennifer Rosewood
186	Mr Grant Cassar
187	Dr Les Drew
188	Ms Songsri Shinn
189	Ms J Robinson-McMahon, Wu Chopperen Medical Service, Cairns
190	Drug Advisory Council of Australia Inc (Supplementary)
191	The Western Australian Network of Alcohol and other Drug Agencies (Supplementary)
192	Canberra Ash Inc
193	Australian Drug Law Reform Foundation (Supplementary)
194	NSW Users and AIDS Association Inc (Supplementary)
195	The Australian Associated Brewers Inc (Supplementary)

196	Dr Aidan Foy
197	Keep Our Kids Alive
198	Drug & Alcohol Services Association Alice Springs Inc
199	DRUG-ARM Australia (Drug-Awareness & Relief Movement)
200	Alcohol and Drug Foundation Queensland
201	Associate Professor David Kavanagh
202	Tablelands Alcohol & Drugs Service (Supplementary)
203	Alcohol Awareness & Family Recovery
204	Mr John Brodie JP
205	Jawoyn Association
206	Centre for Accident Research and Road Safety: Queensland, Queenland University of Technology
207	Sisters Inside (Supplementary)
208	National Centre for Education and Training on Addiction, Flinders University of South Australia
209	Distilled Spirits Industry Council of Australia Inc
210	Mr David Huggonson
211	Northern Territory University
212	Fairfield City Council
213	Ms Patricia Johnson
214	Health Department of Western Australia (Supplementary)
215	Drug and Alcohol Services Council (Supplementary)
216	Tasmanian Department of Health and Human Services (Supplementary)
217	ACT Department of Health, Housing and Community Care
218	Victorian Department of Human Services
219	Territory Health Services, Northern Territory Government (Supplementary)

220	The Pharmacy Guild of Australia (Supplementary)
221	Alcohol and other Drugs Council of Australia (Supplementary)
222	NSW Department of Health (Supplementary)

40th Parliament

223	Youth Forums held on 10 & 13 September 2001 in the Shortland Electorate, NSW
224	People Against Drink Driving Inc (Supplementary)
225	Canberra ASH Inc (Supplementary)
226	Mr Stephen Kendal (Supplementary)
227	Canberra ASH Inc (Supplementary)
228	CONFIDENTIAL
229	Family Drug Support (Supplementary)
230	Mr John Brodie JP (Supplementary)
231	Dr Joe Santamaria
232	Alcohol and other Drugs Council of Australia (Supplementary)
233	Ms Jennifer Rosewood (Supplementary)
234	Cancer Foundation of Western Australia Inc (Supplementary)
235	Ms Helen Daley (Supplementary)
236	Toughlove South Australia Inc (Supplementary)
237	Mr Rick Langtree (Supplementary)
238	Commonwealth Department of Health and Ageing (Supplementary)
239	Dr D J Daly
240	The Hon Jane Aagard, Minister for Health and Community Services, Northern Territory Government
241	National Woman's Christian Temperance Union (Supplementary)

242	Australian Associations of Christian Schools (Supplementary)
243	People Against Drink Driving Inc (Supplementary)
244	Pilot Project for Parent Education (Supplementary)
245	Drug Advisory Council of Australia Inc (Supplementary)
246	National Council of Independent Schools' Associations (Supplementary)
247	The Salvation Army (Supplementary)
248	The Australian Family Association (Supplementary)
249	Ms Yvonne Tilley
250	Coalition Against Drugs (WA)
251	Community Coalition for a Drug Free Society (Vic)
252	National Organisation for Foetal Alcohol Syndrome & Related Disorders (Supplementary)
253	Mr Collis Parrett
254	National Aboriginal Community Controlled Health Organisation (Supplementary)
255	Victorian Government (Supplementary)
256	Festival of Light (Supplementary)
257	Tasmanian Government (Supplementary)
258	CONFIDENTIAL
259	Commonwealth Attorney-General's Department (Supplementary)
260	National Council of Women of WA Inc (Supplementary)
261	Australian Bureau of Criminal Intelligence (Supplementary)
262	Commonwealth Department of Education, Science and Training (Supplementary)

263	The Pharmacy Guild of Australia (Supplementary)
264	National Council of Women of WA Inc (Supplementary)
265	AL-ALON Family Groups (Australia) (Supplementary)
266	Families and Friends for Drug Law Reform (ACT) Inc (Supplementary)
267	Australian Parents for Drug Free Youth
268	Mr Jim Corcoran
269	Hon Trish Worth MP, Parliamentary Secretary to the Minister for Health & Ageing
270	Mr Rod MacQueen
271	DrugBeat of South Australia
272	Commonwealth Department of Defence, Defence Personnel, Defence Health Service Branch
273	Toowoomba Drug Awareness Network Inc
274	CONFIDENTIAL
275	Dr Don Weatherburn
276	Pfizer Pty Limited
277	Professor Olaf Drummer
278	Mr Merv Rolph
279	South Australian Government (Supplementary)
280	Australian Federal Police
281	CONFIDENTIAL
282	R & D Counselling & Group Therapy Pty Ltd
283	Drug Free Australia
284	Commonwealth Department of Education, Science and Training (Supplementary)
285	R & D Counselling & Group Therapy Pty Ltd (Supplementary)

286	Australian Medical Association Limited (Supplementary)
287	Dr Ian Gardner
288	Australian Federal Police (Supplementary)
289	Australian National Council of Drugs (Supplementary)
290	Commonwealth Department of Health and Ageing (Supplementary)
291	Commonwealth Department of Health and Ageing (Supplementary)
292	Commonwealth Department of Health and Ageing (Supplementary)
293	Commonwealth Department of Health and Ageing (Supplementary)
294	Commonwealth Department of Health and Ageing (Supplementary)
295	Commonwealth Department of Health and Ageing (Supplementary)
296	Commonwealth Department of Health and Ageing (Supplementary)
297	Commonwealth Department of Health and Ageing (Supplementary)
298	Commonwealth Department of Health and Ageing (Supplementary)
299	Commonwealth Department of Health and Ageing (Supplementary)

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B

Appendix B – List of exhibits

1 *Tough on drugs: Information for parents on the National School Drug Education Strategy,* Commonwealth Department of Education, Training and Youth Affairs. (Related to Commonwealth Department of Education, Training and Youth Affairs, sub 147)

2 *National School Drug Education Strategy: May 1999,* Commonwealth Department of Education, Training and Youth Affairs. (Related to Commonwealth Department of Education, Training and Youth Affairs, sub 147)

3 *National framework of protocols for managing the possession, use and/ or distribution of illicit and other unsanctioned drugs in schools,* Commonwealth Department of Education, Training and Youth Affairs. (Related to Commonwealth Department of Education, Training and Youth Affairs, sub 147)

4 ---

5 *Needle and syringe programs,* Commonwealth Department of Health and Aged Care. (Related to Commonwealth Department of Health and Aged Care, sub 145)

6 *Pathways to Prevention: Developmental and early intervention approaches to crime in Australia,* Commonwealth Attorney-General's Department. (Related to Commonwealth Attorney General's Department, sub 149)

7 Confidential

8 Confidential

9 ----

10 *Caring for the kids in our community*, Commonwealth Department of Education, Training and Youth Affairs. (Related to Commonwealth Department of Education, Training and Youth Affairs, sub 147)

11 *Information package: Action plan 1999-2001 and key initiatives*, WA Drug Abuse Strategy Office. (Related to WA Government Agencies [WA Drug Abuse Strategy Office – Coordinator], sub 115)

12 *The grog book: Strengthening Indigenous community action on alcohol*, Dr Maggie Brady.

13 *Using rapid assessment methodology to examine injecting drug use in an Aboriginal community*, Aboriginal Drug & Alcohol Council. (Related to Aboriginal Drug and Alcohol Council, sub 181)

14 *On the threshold: The future of private rooming houses in the City of Yarra*, Brotherhood of St Laurence. (Related to Brotherhood of St Laurence, sub. 76)

15 *Getting back on your feet: An evaluation of the Community Support Program*, Brotherhood of St Laurence. (Related to Brotherhood of St Laurence, sub. 76)

16 *A proposed drug policy for Australia*, Commissioned by Endeavour Forum Inc in conjunction with the Family Council of Victoria Inc and the Drug Advisory Council of Australia Inc, Endeavour Forum Inc, Melbourne, Nov 2001, 23p. (Provided by Endeavour Forum Inc)

17 VicHealth Centre for Tobacco Control, T*obacco control: A blue chip investment in public health: The economic case and a detailed proposal for greater investment in tobacco control in Australia*, Melbourne, VicHealth Centre for Tobacco Control, Melbourne, Sept 2001, 160p. (Provided by Professor David Hill)

18 Australian Injecting and Illicit Drug Users League, *Issues relating to retractable needles and syringes from the injecting drug user perspective*, Unpublished, nd, 3p, presented at Rountable, 15/9/02. (Provided by Ms Annie Madden)

19 Australian Injecting and Illicit Drug Users League, *Public liability insurance and needle & syringe programs*, Unpublished, nd, 1p, presented at Rountable, 15/9/02. (Provided by Ms Annie Madden)

20 Australian Injecting and Illicit Drug Users League, *Hydromorphone trial,* Unpublished, nd, 1p, presented at Rountable, 15/9/02. (Provided by Ms Annie Madden)

21 Australian Injecting and Illicit Drug Users League, *Submission to the Review of the 4th National HIV/AIDS Strategy,* Unpublished, May 2002, 42p, presented at Roundtable, 15/9/02. (Provided by Ms Annie Madden)

22 Australian Injecting and Illicit Drug Users League, *Submission to the Review of the 1st National Hepatitis C Strategy,* Unpublished, May 2002, 47p, presented at Roundtable, 15/9/02. (Provided by Ms Annie Madden)

23 *Family drug support telephone statistics,* Unpublished, nd, 3p, presented at Roundtable,15/9/02. (Provided by Mr Tony Trimingham)

24 Trimingham T, *Family drug support: A guide to coping with (problematic drug use).* Unpublished draft, Aug 2002, 28p. (Provided by Mr Tony Trimingham)

25 339 personal petitions on 'Do you agree with a heroin trial? And the reasons for supporting a trial'. (Provided by Mr Tony Trimingham)

26 Wilson L, *A stakeholder's view: Evaluation of the DrugBeat of South Australia Programme,* Unpublished, July 2001, 3p, Prepared for Ann Bressington, Administrator, ADTARP Inc., The DrugBeat of South Australia Programme. (Provided by Ms Ann Bressington)

27 Thompson C, *Drugs and law reform,* Unpublished, 15p. (Provided by Major Brian Watters, ANCD)

28 Reece S Dr, *Critique of drugs and dominant "harm minimization policy": British Medical Journal response,* June 2002, 10p. (Provided by Dr Stuart Reece)

29 Reece S Dr, *Critique of drugs and dominant "harm minimization policy": Medical Journal of Australia reply,* June 2002, 10p. (Provided by Dr Stuart Reece)

30 Makkai T & McGregor K, *Drug use monitoring in Australia: 2001 annual report on drug use among police detainees,* Robey Pty Ltd, Canberra, 2002, 73p. Australian Institute of Criminology

Research and Public Policy Series No. 41. (Provided by Dr Adam Graycar)

31 Graycar A, McGregor K, Makkai T & Payne J. Drugs and law enforcement: Actions and options, *Paper presented to South Australian Drugs Summit 2002, Adelaide, 26 June 2002,* Unpublished, June 2002, 20p. (Provided by Dr Adam Graycar)

32 National Occupational Health and Safety Commission. *Drug and alcohol use and occupational health and safety: background information for the committee.* Unpublished, 2002, 13p. (Provided by National Occupational Health and Safety Commission)

33 Roche AM, *Workforce development issues in the AOD field,* National Centre for Education and Training on Addiction, Adelaide, May 2002, 15p. (Provided by Professor Ann Roche)

34 Roche AM & McDonald J (eds), *Systems, settings, people: Workforce development challenges for the alcohol and other drugs field,* National Centre for Education and Training on Addiction, Adelaide, 2001, x 197p. (Provided by Professor Ann Roche)

35 Spanswick B, Premier's drug room exposed, *The Canterbury Suburbia*, Wednesday 31 July 2002. (Provided by Border Watch Australia)

36 *Proceedings report: 2002 AMA Drug Summit: Party drugs: A new public health challenge,* National Press Club, Canberra, 11 April 2002, 2002 AMA Drug Summit: Party drugs: A new public health challenge, AMA, Canberra, 2002, 49p. (Provided by Mr Jonathon Kruger, AMA)

37 Gray D, Saggers S, Atkinson D, Carter M, Loxley W & Hayward D, *The harm reduction needs of Aboriginal people who inject drugs,* National Drug Research Institute, Curtin University of Technology, Perth, Sept 2001, x 105p. (Provided by Ms Annalee Stearne, National Drug Research Institute, Curtin University of Technology)

38 Gray D, Sputore B, Stearne A, Bourbon D & Stempel P, *Indigenous drug and alcohol projects 1999-2000,* Australian National Council on Drugs, Canberra, 2002, viii 88p. Australian National Council on Drugs Research Paper no. 4. (Provided by Ms Annalee Stearne, National Drug Research Institute, Curtin University of Technology)

39 Brooks AW, Moss JR & White JM, *The South Australian Methadone Program: An economic evaluation.* University of Adelaide, Adelaide, 1997, i 50p, A University of Adelaide Research Report. (Provided by Mr Graham Strathearn)

40 Hill D Prof, Director, Cancer Council of Victoria and Chair, National Expert Advisory Committee on Tobacco, *Prevention and early intervention – tobacco,* Presentation, Roundtable, 15/9/02, 9p. (Provided by Professor David Hill)

41 Patton G Prof, *Prevention and early intervention,* Presentation, Roundtable, 15/9/02, 10p. (Provided by Professor George Patton)

42 Saunders J Prof, Centre for Drug and Alcohol Studies, Department of Psychiatry; School of Medicine, University of Queensland; and Alcohol and Drug Services of the Royal Brisbane Hospital and The Prince Charles Hospital Health Districts, *Current and new treatment options,* Presentation, Roundtable, 15/9/02, 8p. (Provided by Professor John Saunders)

43 Mattick RP Prof, National Drug and Alcohol Research Centre, University of NSW, *Evidence on effective treatment,* Presentation, Roundtable, 15/9/02, 18p. (Provided by Professor Richard Mattick)

44 Hanbury J, *Prevention: support and education for families,* Presentation, Roundtable, 15/9/02, 4p. (Provided by Ms Julie Hanbury)

45 King M, *Drink and drug driving - Queensland perspective,* Presentation, Roundtable, 16/9/02, 6p. (Provided by Mr Mark King)

46 Swann P Dr, *Drink and drug driving,* Presentation, Roundtable, 16/9/02, 25p. (Provided by Dr Philip Swann)

47 Graycar A Dr. *DUMA, Drug Use Monitoring in Australia: Pilot program,* Presentation, Roundtable, 16/9/02, 16p. (Provided by Dr Adam Graycar)

48 McDevitt B, Federal Agent, General Manager National, Australian Federal Police, *Controlling the supply of illicit drugs,* Presentation, Roundtable, 16/9/02, 12p. (Provided by Mr Ben McDevitt)

49 Matthews R Dr, CEO NSW Corrections Health Service, *Drug use in prisons,* Presentation, Roundtable, 16/9/02, 9p. (Provided by Dr Richard Matthews)

50 Colquhoun R, *An ethical framework for research on naltrexone implants,* Unpublished, nd, 11p. (Provided by Mr Ross Colquhoun)

51 Colquhoun R, *Rapid opiate detoxification using naltrexone: Advances in medical protocols,* Unpublished, nd, 15p. (Provided by Mr Ross Colquhoun)

52 *Young Offenders Act 1997 No 54.*
Young Offenders Amendment Act 2002 No 69.
Drug Misuse and Trafficking Act 1985 No 226.
Cannabis cautioning scheme guidelines.

(Provided by Superintendent Frank Hansen, Commander, Local Area Command, NSW Police Service)

53 Webster I Prof, Presentation, Roundtable, 16/9/02, 23p. (Provided by Professor Ian Webster)

C

Appendix C - Public hearings, roundtable, informal consultations & visits

(Includes list of witnesses and people the committee met with during the 40th Parliament)

Public Hearings

39th Parliament

Monday 14 August 2000, Canberra

Wednesday 13 September 2000, Perth

Tuesday 21 November 2000, Adelaide

Thursday 23 November 2000, Melbourne

Wednesday 21 February 2001, Sydney

Friday 20 April 2001, Darwin

Wednesday 2 May 2001, Brisbane

Monday 21 May 2001, Canberra

Thursday 14 June 2001, Hobart

40th Parliament

Monday 23 September 2002, Canberra

Roundtable

40th Parliament

Thursday 15 August 2002, Canberra

Friday 16 August 2002, Canberra

Informal Consultations

39th Parliament

Friday 9 June 2000, Canberra

Wednesday 11 October 2000, Canberra

Wednesday 22 November 2000, Melbourne

Wednesday16 December 2000, Canberra

Wednesday 7 March 2001, Canberra

Wednesday 4 April 2001, Canberra

Tuesday 1 May 2001, Brisbane

Wednesday 6 June 2001, Canberra

Wednesday 27 June 2001, Canberra

Wednesday 8 August 2001, Canberra

40th Parliament

Wednesday 15 May 2002, Canberra

Wednesday 19 June 2002, Canberra

Wednesday 26 June 2002, Canberra

Wednesday 28 August 2002, Canberra

Wednesday 25 September 2002, Canberra

Wednesday 23 October 2002, Canberra

Wednesday 4 December 2002, Canberra

Wednesday 11 December 2002, Canberra

Visits / Inspections

39th Parliament

Wednesday 9 August 2000, Melbourne

Thursday 10 August 2000, Melbourne

Monday 11 September 2000, Perth

Tuesday 12 September 2000, Perth

Monday 20 November 2000, Adelaide

Monday 19 February 2001, Goulburn

Tuesday 20 February 2001, Sydney

Thursday 22 February 2001, Newcastle

Wednesday 18 April 2001, Darwin

Thursday 19 April 2001, Katherine

Thursday 13 June 2001, Hobart

40th Parliament

Tuesday 23 July 2002, Melbourne

Wednesday 24 July 2002, Adelaide

Wednesday 27 November 2002, Sydney

List of witnesses and people the committee met with during the 40th Parliament

39th Parliament

For details of the witnesses and people who met with the committee in the 39th Parliament see the committee's website for the inquiry for:

- the former committee's *Where to next?: a discussion paper* at <http://www.aph.gov.au/house/committee/fca/subabuse/discpaper.pdf>; and/or
- the transcripts of the public hearings at <http://www.aph.gov.au/hansard/reps/commttee/r-commaf.htm>.

40th Parliament

Public Hearings

Monday 23 September 2002, Canberra

Dr Don Weatherburn, Director, NSW Bureau of Crime Statistics and Research

Roundtable

Thursday 15 August 2002, Canberra

General presentation

Major Brian Watters, Chair, Australian National Council on Drugs

Health care presentations

Professor David Hill, Director, Cancer Control Research Institute and The Cancer Council of Victoria; Chair, National Expert Advisory Committee on Tobacco

Ms Annie Madden, Executive Officer, Australian Injecting & Illicit Drug Users League

Professor Richard Mattick, Director, National Drug and Alcohol Research Centre, University of New South Wales

Professor George Patton, Centre for Adolescent Health, Murdoch Children's Research Institute, Royal Childrens Hospital, Melbourne

Professor Ann Roche, Director, National Centre for Education and Training on Addiction, Flinders University of South Australia; Member, National Expert Advisory Committee on Illicit Drugs

Professor John Saunders, Professor of Alcohol and Drug Studies, University of Queensland; Member, Australian National Council on Drugs

Professor Ian Webster, President, Alcohol and other Drugs Council of Australia

Presentations on families

Ms Ann Bressington, Chief Executive Officer, DrugBeat of SA; Member, Australian National Council on Drugs

Ms Julie Hanbury, Coordinator, HELP (Helping Empower Local Parents), Local Drug Action Groups Inc. (Western Australia-based); Member, Australian National Council on Drugs

Mr Geoff Munro, Director, Centre for Youth Drug Studies, Australian Drug Foundation

Mr Tony Trimingham, Founder and Chief Executive Officer, Family Drug Support

Mr Glenn Williams, Executive Director, Focus on the Family Australia

Presentations workplace safety and productivity

Dr Steve Allsop, Acting Director, Practice Development, Drug and Alcohol Office, WA and Associate Professor in International Health, Centre for International Health, Curtin University of Technology, WA

Dr Ian Gardner, Immediate Past President and Councillor, Australasian Faculty of Occupational Medicine

Mr Trevor Sharp, National Project Officer, The Building Trades Group of Unions Drug and Alcohol Committee; Chief Executive Officer, The Construction Industry Drug and Alcohol Foundation; Member, Alcohol and other Drugs Council of Australia's Workplace Reference Group

Friday 16 August 2002, Canberra

Presentations on road trauma

Mr Mark King, Principal Adviser (Road User Policy), Road Safety Policy and Advanced Technology, Land Transport and Safety Division, Queensland Transport

Dr Philip Swann, Manager, Drugs and Fatigue, Road Safety Department, VicRoads

Presentations on crime, violence and law enforcement

Dr Adam Graycar, Director, Australian Institute of Criminology

Dr Richard Matthews, Chief Executive Officer, Corrections Health Service, NSW

Mr Ben McDevitt, General Manager, National Operations, Australian Federal Police

General presentations

Major Brian Watters (appearing in a private capacity)

Dr Alex Wodak, President, Australian Drug Law Reform Foundation

Informal Consultations

Wednesday 15 May 2002, Canberra

Department of Health and Ageing

Ms Sue Gordon, Director, Alcohol, Substance Misuse and Injury Prevention Section

Ms Sue Kerr, Branch Head, Drug Strategy and Health Promotion Branch

Ms Mary Murnane, Deputy Secretary

Wednesday 29 May 2002, Canberra

Department of Health and Ageing

Dr Tom Carroll, Adviser to the Population Health Social Marketing Unit

Ms Sue Gordon, Director, Alcohol, Substance Misuse and Injury Prevention Section

Ms Mary Murnane, Deputy Secretary

Ms L Van Veen, Director, Population Health Social Marketing Program

Wednesday 19 June 2002, Canberra

National Aboriginal Community Controlled Health Organisations (NACCHO)

Ms Bridget Carrick, Policy Officer

Ms Glenda Humes, Deputy Chief Executive Officer

Mr Tony McCartney, Board Member, NACCHO; Chief Executive Officer, Victorian Aboriginal Health Services

Wednesday 26 June 2002, Canberra

Alcohol and other Drugs Council of Australia

Professor Ian Webster, President

Ms Cheryl Wilson, Chief Executive Officer

Wednesday 28 August 2002, Canberra

Professor David Collins, Adjunct Professor, Department of Economics, Macquarie University

Ms Helen Lapsley, Senior Lecturer, Public Health and Community Medicine, School of Health Services Management, University of NSW

Unitract

Mr Stephen Allan, Communications Manager

Mr Alan Shortall, Managing Director

Wednesday 25 September 2002, Canberra

Dr Jon Currie, Director, Western Sydney Area Health Service Drug and Alcohol Services, Westmead Hospital

Wednesday 23 October 2002, Canberra

Teen Challenge

Mr Kevin Brett, Executive Director

Mr Malcolm Feebrey, Program Manager

Wednesday 4 December 2002, Canberra

Mr Ross Colquhoun, Director, R & D Counselling & Group Therapy Pty Ltd

Dr George Kassar

Wednesday 11 December 2002, Canberra

Ms Marie Byrne, Director, Aisling Group, Ireland

Mr Gerard Thompson, President, Keep Our Kids Alive

Visits / Inspections

Tuesday 23 July 2002, Melbourne

Odyssey House, Lower Plenty

Mr Eric Allan, Director of Residential Services

Ms Lee Coonie, Director of Community Services

Mr David Crosbie, Chief Executive Officer

Turning Point Drug and Alcohol Centre, Fitzroy

Dr Adrian Dunlop, Senior Medical Officer

Professor Margaret Hamilton, Director

Dr Alison Ritter, Head of Research

Mr Eric Tyssen, Manager, Telephone Services

Youth Substance Abuse Service, Fitzroy

Mr Andrew Bruun, Manager, Education and Training

Mr David Murray, Chief Executive Officer

Mr Peter Wearne, Manager, Residential Unit and Day Program

Victorian Aboriginal Health Service, Fitzroy

Ms Bridget Carrick, Policy Officer, NACCHO

Mr Tony McCartney, Chief Executive Officer

Wednesday 24 July 2002, Adelaide

Salvation Army Sobering-up Centre, Adelaide

Mr Glen Williams, Manager

Mr John Wright, Director, 'Towards Independence'

Warinilla, Norwood

Mr Graham Strathearn, Chief Executive Officer, Drug and Alcohol Services Council (DASC)

Professor Jason White, Head, Maintenance Pharmacotherapies Unit

Mr Scott Wilson, State Director, Aboriginal Drug & Alcohol Council (SA Inc) (ADAC)

Kalparrin Community Inc, Murray Bridge

Mr Scott Wilson, State Director, ADAC

Mr Vic Wilson, Chief Executive Officer

The Woolshed, Ashbourne

Mr Paul Mazdon, Acting Manager, The Woolshed

Mr Graham Strathearn, Chief Executive Officer, DASC

Wednesday 27 November 2002, Sydney

Western Sydney Area Drug and Alcohol Service, Westmead and Cumberland Hospitals

Dr Jon Currie, Medical Director

Mrs Julie Esposito, Nursing Unit Manager, Inpatient Detoxification Ward /D3b

Ms Lorraine Gaunt, Nursing Unit Manager, Ambulatory Detox and Abstinence Maintenance and Intake, Triage, Assessment

Mrs Alison Zecchin, Associate Director of Nursing, Abstinence Maintenance and Intake, Triage, Assessment

A number of the services' clients who had been successfully treated with naltrexone.

Members of the Cabramatta Community

Mr Vincent Doan, Service Development Manager, Open Family

Mr Mark Hankin, Coordinator, Cabramatta Youth Team

Superintendent Frank Hansen, Commander, Cabramatta Local Area Command, NSW Police Service

Councillor Maria Heggie, Fairfield City Council (appearing in a private capacity)

Ms Lindsay Langlands, Drug and Alcohol Worker, Cabramatta Youth Team

Mr Phil O'Grady, retired Cabramatta pharmacist; Vice President, Fairfield City Chamber of Commerce (appearing in a private capacity)

Mr Michael Robinson, Managing Director, Drug Free Australia

Mr Ross Treyvaud, President, Cabramatta Chamber of Commerce

Detective Chief Inspector Deborah Wallace, Crime Manager, Cabramatta Local Area Command, NSW Police Service

Mr Hankin, Mr Doan and Mr Treyvaud accompanied committee members on a walk through the Cabramatta CBD.