EDUCATION AND HEALTH STANDING COMMITTEE

CHANGING PATTERNS IN ILLICIT DRUG USE IN WESTERN AUSTRALIA

Report No. 9
in the 38th Parliament

2011

Published by the Legislative Assembly, Parliament of Western Australia, Perth, May 2011.

Printed by the Government Printer, State Law Publisher, Western Australia.

Education and Health Standing Committee

Changing Patterns in Illicit Drug Use in Western Australia

ISBN: 978-1-921865-08-4

(Series: Western Australia. Parliament. Legislative Assembly. Committees. Education and Health Standing Committee. Report 9)

328.365

99-0

Copies available from: State Law Publisher
10 William Street
PERTH WA 6000

Telephone: (08) 9321 76880
Facsimile: (08) 9321 7536
Email: sales@dpc.wa.gov.au
Copies available on-line: www.parliament.wa.gov.au

EDUCATION AND HEALTH STANDING COMMITTEE

CHANGING PATTERNS IN ILLICIT DRUG USE IN WESTERN AUSTRALIA

Report No. 9

Presented by:
Dr J.M. Woollard, MLA
Laid on the Table of the Legislative Assembly
on 26 May 2011

COMMITTEE MEMBERS

Chairman	Dr J.M. Woollard, MLA Member for Alfred Cove
Deputy Chairman	Mr P. Abetz, MLA Member for Southern River
Members	Ms L.L. Baker, MLA Member for Maylands
	Mr I.C. Blayney, MLA Member for Geraldton (until 24 March 2011)
	Hon Dr G.G. Jacobs, MLA Member for Eyre (from 24 March 2011)
	Mr P.B. Watson, MLA Member for Albany

COMMITTEE STAFF

Principal Research Officer	Dr David Worth, PhD, MBA
Research Officers	Mr Michael Burton, BEc, BA (Hons) (from 21 June to 30 June 2010)
	Ms Renée Gould, BA, PGDip.A (PW) (from 1 July 2009 to 30 October 2009)
	Mr Timothy Hughes, BA (Hons) (until 27 May 2010)
	Ms Alice Jones, BA (Comm. St.) (Hons) (from 23 July 2010 to 3 August 2010)
	Mr John Pollard, BA (Hons) (from 5 August to 20 August 2010)
	Ms Lucy Roberts, BA (Hons), Grad Cert (Arts) (from 23 August 2010)

COMMITTEE ADDRESS

Education and Health Standing Committee
Legislative Assembly
Parliament House
Harvest Terrace
PERTH WA 6000

Tel: (08) 9222 7469
Fax: (08) 9222 7804
Email: laehsc@parliament.wa.gov.au
Website: www.parliament.wa.gov.au

TABLE OF CONTENTS

COMMITTEE'S FUNCTIONS AND POWERS

The functions of the Committee are to review and report to the Assembly on:

(a) the outcomes and administration of the departments within the Committee's portfolio responsibilities;

(b) annual reports of government departments laid on the Table of the House;

(c) the adequacy of legislation and regulations within its jurisdiction; and

(d) any matters referred to it by the Assembly including a bill, motion, petition, vote or expenditure, other financial matter, report or paper.

At the commencement of each Parliament and as often thereafter as the Speaker considers necessary, the Speaker will determine and table a schedule showing the portfolio responsibilities for each committee. Annual reports of government departments and authorities tabled in the Assembly will stand referred to the relevant committee for any inquiry the committee may make.

Whenever a committee receives or determines for itself fresh or amended terms of reference, the committee will forward them to each standing and select committee of the Assembly and Joint Committee of the Assembly and Council. The Speaker will announce them to the Assembly at the next opportunity and arrange for them to be placed on the notice boards of the Assembly.

INQUIRY TERMS OF REFERENCE

(1) To inquire into the adequacy and appropriateness of prevention and treatment services for alcohol and illicit drug problems in Western Australia, with particular reference to:

(a) the evidence base, content, implementation and resourcing (including professional training) for health education and other interventions on alcohol and illicit drugs for school-aged students;

(b) the evidence base, adequacy, accessibility and appropriateness of the broad range of services for treatment and support of people with alcohol and drug problems and their families, and the most appropriate ways to ensure integrated care; and

(c) the adequacy of the current education and training of medical and allied health professionals in the alcohol and drug field.

(2) To inquire into the impact on communities, and the social costs, of alcohol and illicit drug problems in Western Australia.

(3) To report to the House by 26 May 2011.

CHAIRMAN'S FOREWORD

This is the second interim report presented to the Parliament arising from the Committee's inquiry into the prevention, treatment and social costs of alcohol and illicit drug problems in Western Australia. This report focuses on the prevention, management and treatment of illicit drug use.

Illicit drug use

Illicit drug use is a serious public health problem with associated health, social and economic costs. Often illicit drug users are dependent on more than one drug. The use of illicit drugs may be related to previous or existing socio-economic problems such as unemployment, homelessness, mental illness, physical abuse and sexual abuse. Illicit drug use creates enormous problems for the user, their family and for the broader Western Australian community. In 2004-05 the direct and indirect cost to the State of illicit drug use was about $1 billion.

The prevention of illicit drug use requires sustained community awareness and participation in programs as well as deliberate action on behalf of government agencies, non-government agencies, and research bodies. This combined action has successfully led over the past decade to lower levels of the use of most illicit drugs in Western Australia.

The minimisation of the harm from illicit drugs is achieved by:

- **Disrupting the supply** of illicit drugs by organised crime and back-street laboratories.
- **Reducing the demand** for illicit drugs, primarily by prevention programs. Evidence-based research should guide campaigns to advise children, parents and families about substance misuse. The State Government must take a proactive stance towards the needs of the children of illicit drug users. Programs should occur from a prenatal, early childhood and childhood perspective. Ensuring all children have a supportive family and attend school on a regular basis will better position them for their life, including future employment.
- **Providing harm reduction programs,** such as secondary prevention measures and rehabilitation measures. This is particularly needed when drug users have dependent children who are often damaged by their parent's drug habits. Legislation should be introduced for the mandatory reporting, referral and treatment of minors using illicit drugs. School nurses and community health nurses should be trained to work closely with minors in families with illicit drug problems.

In terms of new issues, the Committee heard evidence that a serious problem in this State is that many people have become dependent on prescription opioid analgesics. The PBS cost of a morphine-based analgesic is about $60, while the street value of this pack might be $1,600. Increased funding for research, practice guidelines, and additional practitioners in pain management could assist in preventing the unsanctioned use of pharmaceutical opioids.

Children at harm from drug use

Every child should be supported at home, at school and in the community to achieve their potential. Parental drug use can cause harm to children from conception, where it can affect foetal growth, to adulthood. The number of children at harm will only fall when the number of parents using illicit drugs decreases. Reducing the harms to children from parental drug use must become a priority for all government departments. According to the age of the child, illicit drug use by parents may be exhibited by a child's failure to thrive emotionally, socially or academically.

Harms from inappropriate parenting practices may include poverty, inadequate supervision, domestic abuse, inappropriate adult behaviour, inadequate accommodation or frequent changes in accommodation, toxic substances in the home, social isolation and exposure to criminal activities such as drug dealing, stealing or robbery. Children with parents who are drug dealers may end up caring for parents who have drug and or mental health problems, and caring for younger children in the family. They may live with the additional burden of knowing they may be publicly exposed or separated from their family.

In a response to a recommendation from the UK Advisory Council's report *Hidden Harm: Responding to the needs of children of problem drug users* the government's proposed action was to ensure that "every family with a child under 5 years has a named Health Visitor". The Health Visitor was to be made aware of families resident in, visiting or moving to a local area. The equivalent role in Western Australia would be a community/child health nurse. In 2008 the State Government was made aware that there were 105 FTE child health nurse positions vacant, which have not yet been filled.

In Scotland, school nurses are actively involved in the planning, delivery, and evaluation of drug, alcohol and smoking preventative initiatives. School nurses provide advice, information and support to teachers, children, teenagers and their families. The State Government was informed in 2008 that there were 135 FTE school nurse positions vacant, which have not yet been filled.

The United Kingdom Government's Response to Recommendation 8 of the "Hidden Harm" report accepted that "all maternity units, social service and family teams routinely record drug or alcohol use by a pregnant mother or a child's parents" to improve service delivery for these families. In Victoria, the Department of Education and Early Childhood Development currently identifies whether there are "alcohol or drug related problems in the family" as part of its Primary School Nursing Program School Entrant Health Questionnaire. The results of this questionnaire are used by school nurses to identify and assist children who may be in need of additional assistance.

Drug dependence

Over the last decade new legislation was introduced to discourage Western Australians from using or dealing in illicit drugs such as cannabis, which remains the most prevalent illegal drug in this State. The Committee did not receive any submissions supporting the recent call by retired State judge, Mr Bill Groves, for illicit drugs to be decriminalised. The Commonwealth's 2007 National Household Survey showed that the vast majority of Australians do not want illicit drugs legalised– 95% of Australians opposed the legalisation of heroin, amphetamines and cocaine and 79% opposed the legalisation of cannabis.

The effect of drug use on families

Drug use may lead to unemployment or difficulties in the workplace, such as work related injuries or absenteeism. In the community, drug users may be homeless, may engage in antisocial behaviour, or in criminal activities. Drug dealers may be involved in people trafficking, money laundering or prostitution.

If families are aware a 'member' has a drug problem they will do their best to support them to seek help to enable them to break their habit. Drug dependency can cause family stress and breakdown when users require financial assistance to pay for their drugs. The cost of 'feeding' a drug habit may result in reduced money being available to purchase food and essential items for other family members. About a third of drug users are successful in quitting their drug habit, another third require life-long treatment and the remainder may die from their addiction.

Government collaboration

Key government departments work closely to prevent and deal with the problems associated with illicit drug use. These include the Police, Courts, Mental Health Commission, the Drug and Alcohol Office, the Departments of Health, Education, Child Protection, Community Services, and Local Government. The Department of Sport and Recreation should work closely with these agencies to ensure there are recreational facilities and services for young people to guide them away from illicit drug use.

Drug Courts

Western Australia has an adult and a youth Drug Court to help those convicted of drug-related criminal offences. The Court has an integrated approach to criminal justice, drug addiction treatment and social welfare programs. Its aims are to reduce drug use and criminal activity, reduce imprisonment rates and improve the health and social wellbeing of drug users to rehabilitate them back into the community. The lower cost of the Drug Court diversion programs augments the benefits of deferring the higher cost of incarceration, a decrease in recidivism and rehabilitation into the community. The New South Wales Bureau of Crime Statistics and Research compared 309 offenders one year after attending that state's drug court with a matched group and found that drug court attendees did better in terms of having a lower frequency of re-offending.

Programs in prison

About 50% of heroin users will at some time go to prison. Some illicit drug users are re-admitted to prison on a regular basis. Initiatives for prisoners who have drug problems can vary according to the geographical location of the prison. Some prisons provide methadone treatment for heroin addicts, others provide education, counselling services or anger management programs.

About two-thirds of offenders in prison have alcohol or illicit drug problems. Only about 10% of prisoners in 2005-06 who needed rehabilitation programs were able to obtain them. If imprisoned with a drug addiction, prisoners should be supported to become drug-free and be given follow-up care by DAO on release from prison to ensure they maintain a drug-free status.

Drug prevention strategies

Educational prevention strategies, such as health promotion in schools and in the community, have been found to be effective in altering the knowledge and attitude towards drugs. Some well-known programs such as SDERA, Dr YES and Teen Challenge target individuals or groups such as school children who are most at risk of trying illicit drugs. We need to ensure all health professionals, school teachers, TAFE and university lecturers as part of their basic curriculum are given the skills to diagnose symptoms of drug use. They should be provided with the skills to offer guidance and be encouraged, where appropriate, to work with specialists in this field.

Working with disadvantaged families

Family interventions by community nurses, skilled in alcohol and drug addictions, through home visiting programs have the potential to benefit the child, their family and the community. This is particularly important in the first two years after birth, but can also play a role with targeted follow up during early schooling and adolescence. Such visits may decrease maternal substance use and arrest, may prevent child abuse and neglect, and may ensure children are given an equal chance to participate in education thus preventing absenteeism from school, academic failure and subsequent employment difficulties.

Interventions to prevent the problems associated with drug use should commence in childhood. Prior to birth family home visiting could be made available to disadvantaged families to improve developmental outcomes for children in these families. From infancy to early childhood (0 to 4 years) family home visiting could be supported with parental education and school preparation programs to encourage physical and educational development. Family home visiting could continue for primary school children (5 to 11 years) in disadvantaged families.

For adolescents, some schools conduct programs to promote the prevention of alcohol and illicit drug use. These need to be evaluated along with other community programs in this area to ensure they are effective. Family interventions and preventative case management for high risk adolescents may prevent the commencement of using alcohol and illicit drugs and later reduce the consumption of them.

Drug demand reduction

In this area it is important that:

- Prevention occurs early and is included in the school curriculum as we know children are often targeted by drug dealers.
- Primary care workers are able to provide immediate brief interventions prior to referral to specialist treatment agencies.
- Treatment programs are based on guidelines which are evidence-based. They should include psychosocial and pharmacological treatments which have a goal of supporting drug users to become drug-free.

- Treatment programs take into consideration family and childcare support. Rehabilitation services, including therapeutic community settings, and other rehabilitation programs are provided throughout the State. They must be structured to cater for poly-drug users and vulnerable groups.

Drug supply reduction

The State's Police work hard to curtail drug related crime by reducing the production, trafficking and supply of illicit drugs. Western Australia has one of the highest usage rates in the world of amphetamines and the Police have been very successful at uncovering illegal backyard labs. As part of their annual report to Parliament DAO, in collaboration with DoH and the Police, should present the most recent emerging trends and patterns on drug use and drug markets. Much of the current public data is from surveys undertaken in 2007 or 2008.

Major illicit drugs

Cannabis

The use of cannabis remains a major problem in WA. The possession of cannabis is illegal throughout Australia. Legislation was introduced in WA to introduce prohibitions with civil penalties for minor cannabis offences, in 2003. The police commenced issuing infringement notices to individuals who had less than 30 grams in their possession, the first time they were found in possession of cannabis. As an alternative to paying an infringement notice, they were offered the opportunity to attend a Cannabis Intervention Scheme (CIN)- a specified cannabis education session at a community-based drug treatment centre.

The legislation was amended in 2010 by the current Government. There is still a prohibition scheme with a civil penalty. The payment of an infringement notice has been removed. For a minor cannabis offence, there is now a compulsory cannabis education session for those persons found possessing less than 10 grams of cannabis.

Use of cannabis by some school children may be related to earlier problems in their family, social or educational development. Cannabis use may damage an adolescent's brain (in particular dopamine receptors). Cannabis use in schoolchildren can lead to school absenteeism. This may cause later difficulties finding employment and possibly the involvement in criminal activities. People with, or who are predisposed to develop, mental illness may have more adverse effects from using cannabis. Approximately 10% of people who experiment with cannabis will develop a dependence, and undergo withdrawal symptoms when they try to stop using it.

While cannabis use in the State has decreased over the past decade, those who use cannabis appear to be using more (15 to 20 joints a day). These 'binge cannabis smokers' have an increased risk of health and social problems.

Further research is required to understand the biological mechanisms involved in cannabis addiction and to assess the association between cannabis and mental illness. This can guide future treatment, and determine the most appropriate way to deal with cannabis users. For example, in a

1996 study of cannabis offenders in Western Australia, it was found that almost 50% of those arrested for cannabis offences were not re-arrested up to 10 years later.

Cocaine

In 2007, about 2% of Western Australians used cocaine in the past 12 months. It is likely that the 2010 national survey will show that there has been a small increase in the use of cocaine.

Opioid/Heroin use

Heroin use is an international problem often associated with high morbidity and mortality. In Western Australia it is uncertain whether in recent years there has been an increase or a decrease in the use of this drug above the 2007 rate of 0.2%. There has been a substantial reduction from the 2000 usage rate of about 2%. Use in Western Australia appears to be sporadic and related to when a batch comes 'on the street'. When more heroin is in circulation more people may overdose or seek treatment. Alternatively, when availability decreases more people may seek assistance to counter the problems associated with withdrawal or move to other dugs.

About 3,000 heroin users are enrolled in community-based programs which provide substitution treatment and long-term care. Substitution treatment with psychosocial interventions has been shown to decrease criminal activity, risky behaviours, HIV transmission, overdoses and mortality. Used in a treatment program, these substitute drugs convince the brain that an addict had used an opiate recently and thus reduce their cravings and withdrawals.

Opioid replacement therapy is available under the Pharmaceutical Benefits Scheme, and includes:

- Methadone: available since the 1970s as methadone syrup and Biodone Forte.
- Subutex (buprenorphine): available since 2001.
- Suboxone (buprenorphine with naloxone): available since 2006.

Naltrexone is an opioid antagonist which blocks the effect of heroin and other opioids. Naltrexone was first developed in the 1970s by the US National Institute on Drug Abuse. Naltrexone implants are used in Western Australia but are currently not registered by the Therapeutic Goods Administration (TGA). It was reported that in 2008 the TGA ordered that these implants cease to be produced as, despite eight years of use in this State, they had not been assessed to ensure they met regulatory standards. This remains a controversial issue for the NHMRC, the TGA and the Pharmaceutical Benefits Advisory Committee. It is also of concern for the State Government which has continued to support the Fresh Start Recovery Programme since the late 1990s.

Amphetamines

Amphetamine is a generic term given to both amphetamine and methamphetamine which are central nervous system stimulants. Chronic use, or use with other substances such as alcohol, can lead to aggressive behaviour. The Australian Hotels Association puts the blame on the rise in violence in our community on the use of amphetamines. However, such binge drinking and

violence is now common overseas where the use of amphetamine is one-tenth (Germany) or even one-twentieth (France) that of Western Australia's rate. The common factor for all jurisdictions is the increase in risky drinking and 'determined drunkenness' by young people.

Prior to 2001, amphetamine (or 'speed') was reasonably available in Australia. Legislative controls which restricted the sale of the precursor chemicals in making amphetamine (ephedrine and pseudoephedrine) led to a decrease in the use of these drugs. While the use of amphetamine has dropped from 5.8% in 2000 to 4.1% in 2007 in Western Australia, the Police to their credit have discovered a record number of drug labs in the State in the past year.

Ecstasy and other 'party drugs'

Ecstasy is a synthetic substance chemically related to amphetamines. It is considered a 'recreational drug' by many users but is very harmful. In high doses it can require urgent medical attention and lead to a user's death. Western Australia has one of the highest usage rates of this 'party drug' in the world. Prevalence has remained about 4% over the past decade.

Legal highs

State agencies are currently monitoring and taking action to prohibit the sale of drugs on the Internet which are described as 'legal highs' or party drugs. Many of these substances have not been tested and so the immediate or long term damage from their use is uncertain. They include products from herbal mixtures (such as kronic) to synthetic 'designer' drugs or 'party pills' which can be smoked, snorted or ingested.

Future initiatives- Drug Awareness Day

June 26th is the international day for targeting drug trafficking and drug use. The State Government should co-ordinate a campaign for this day by providing the Police with funding to advise the community what to look for in relation to drug users, dealers, and on the detection of clandestine drug laboratories. As part of this campaign the community could be encouraged to call the Police with their concerns.

Biological tests and further research

When a person is taken into custody because of criminal, violent or antisocial behaviour, the State Government should give the Police the authority to request that biological samples are taken to establish whether their actions are in part due to illicit drug use. In addition, further research into drug use and abuse has the potential to prevent the initial use of illicit drugs and direct the treatment programs of illicit drug users so that they become abstinent.

The Committee has used data showing that most illicit drug use rates have dropped over the past decade, but no government agency or university body has undertaken research as to why. We have no real evidence as to which education, enforcement or treatment programs have been key factors in the sustained reduction in the usage of most illicit drugs in Western Australia.

Conclusion

I would like to thank the people and organisations who made over 40 submissions to this aspect of the Committee's work, and the nearly 120 people who appeared as witnesses. Many of these witnesses gave up valuable time to travel to meet the Committee during its five regional trips in Western Australia and its comprehensive overseas trip.

We have a serious problem with illicit drug use in this State. The cost to the State of illicit drug use has reduced thanks to the work of the Drug and Alcohol Office and the Police. In particular, I would like to thank the staff at DAO (especially Mr Neil Guard and Ms Julia Knapton) and Professor Steve Allsop at the National Drug Research Institute, Curtin University, who assisted the Committee make sense of the data on illicit drug use in the State.

I would like to thank the other Committee members for their enthusiasm and dedication to this inquiry and the preparation of this report. I would like to also thank Mr Ian Blayney, the Member for Geraldton, who worked with us for the most of this inquiry and recently moved committees.

Special thanks go to our principal research officer, Dr David Worth, for his dedication and commitment to the work of the Education and Health Standing Committee. Dave is greatly valued by all members of the Committee. His patience and guidance has helped steer the Committee in this valuable research over two years. In addition, I would like to thank the Committee's research officer, Ms Lucy Roberts, who joined us in 2010 and has contributed to the writing of this report and the planning of our recent research trip to Europe.

The Committee hopes this Report's recommendations will help the State Government further reduce the number of people who use, and require treatment for, illicit drug use in Western Australia. By helping these people, the Government will be helping protect their families, their children and the wider community from the direct and indirect damage caused by illicit drug use.

Janet Woollard

DR J.M. WOOLLARD, MLA

CHAIRMAN

ABBREVIATIONS

AA	Alcoholics Anonymous
ABS	Australian Bureau of Statistics
ACC	Australian Crime Commission
ADCA	Alcohol and other Drugs Council of Australia
AIHW	Australian Institute of Health and Welfare
ANZCA	Australian and New Zealand College of Anaesthetists
ATS	amphetamine-type stimulants
CATS	Court Assessment and Treatment Service
CINS	Cannabis Infringement Notice Scheme
CIR	Cannabis Intervention Requirement scheme
COAG	Council of Australian Governments
C-POP	Community Program for Opioid Pharmacotherapy
DAO	Drug and Alcohol Office
DCS	Department of Corrective Services
DoH	Department of Health
DoHA	Federal Department of Health and Ageing
DUCO	Drug Using Careers of Offenders
DUMA	Drug Use Monitoring in Australia
ECU	Edith Cowan University
GP	general practitioner
HAT	heroin-assisted treatment
HBV	hepatitis B virus
HCV	hepatitis C virus
HIV	human immunodeficiency virus
IDDI	Illicit Drug Diversion Initiative

IDU	injecting drug user
LAAM	levo-alpha acetyl methadole
LE	Life Education
MHC	Mental Health Commission
MODDS	Monitoring of Drugs of Addiction System
MSIC	Medically Supervised Injecting Centre- Sydney
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NCPIC	National Cannabis Prevention and Information Centre
NDA	University of Notre Dame Australia
NDARC	National Drug and Alcohol Research Centre
NDRI	National Drug Research Institute
NDS	Australia's National Drug Strategy 2010-15
NDSHS	National Drug Strategy Household Survey
NOPSAD	National Opioid Pharmacotherapy Statistics Annual Data
NSP	needle and syringe program
OST	opioid substitution treatment
PBS	Pharmaceutical Benefits Scheme
PSB	Pharmaceutical Services Branch of the Department of Health
RACP	Royal Australasian College of Physicians
RACWA	Royal Automobile Club of WA
RTO	registered training organisation
SDERA	School Drug Education and Road Aware
STI	sexually transmitted infection
TC	therapeutic communities
TGA	Therapeutic Goods Administration
THC	tetrahydrocannabinol (active ingredient in cannabis)
UNODC	United Nations Office on Drugs and Crime

UWA	University of Western Australia
WACOSS	Western Australian Council of Social Service Inc
WANADA	Western Australian Network of Alcohol and other Drug Agencies
WDR	World Drug Report of United Nations Office on Drugs and Crime

EXECUTIVE SUMMARY

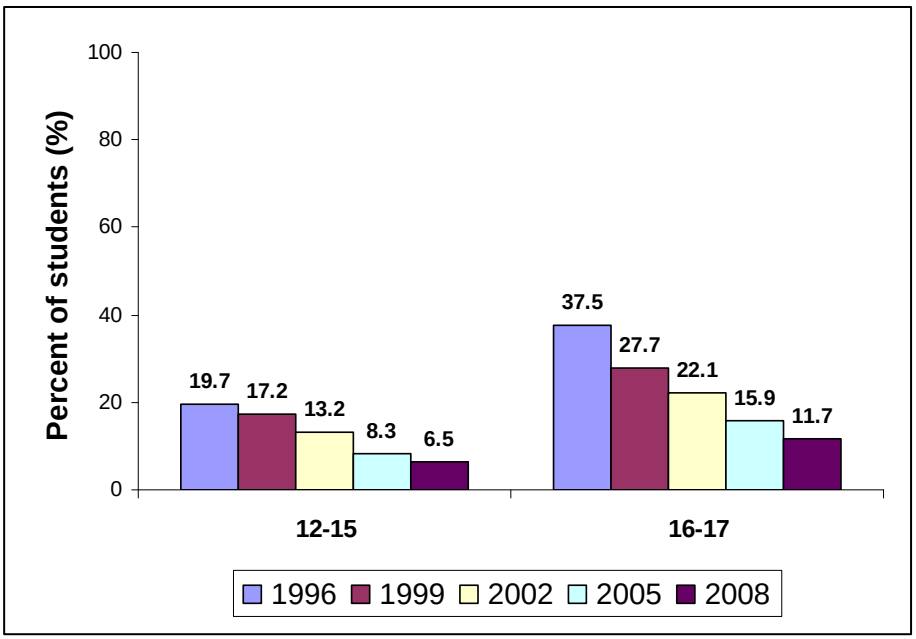
This interim report is the second of three produced as part of the Committee's *Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drugs in Western Australia*. The first interim report focused on the effectiveness of liquor restrictions in the Kimberley and was tabled on 17 March 2011. The Inquiry's final report will focus on the impact of alcohol in Western Australia. This report focuses on the impact of illicit drugs on the Western Australian community.

This report does not consider the possible use of legal drugs such as the ADHD stimulant dexamphetamine (Ritalin) that some claim may lead at a later stage to the misuse of illicit drugs.

Historically the State's community has been very concerned about the use of illicit drugs, despite the majority of drug-related ill-health and costs to the State Government arising from the consumption of legally-available tobacco and alcohol products. In fact there has been a substantial fall in the prevalence of the use of many illicit drugs since 1998 across Australia. In 2007 13.4% of Australians over the age of 14 years reported the recent use of an illicit drug, compared with 22% in 1998.

Between 1996 and 2008, the rate of self-reported cannabis use by older Western Australian school children had reduced by more than two-thirds.

Figure ES1- Cannabis use in the past month by Western Australian school children (1996-2008)



Drug use remains a problem

Despite a decline in the use of some illicit drugs, their use still has significant impacts for the Australian community. The Federal Department of Health and Ageing commissioned research to estimate the social cost of tobacco, alcohol and illicit drug abuse to the Australian community. Their estimates for 2004-05 found the total social cost of illicit drug abuse was $8.2 billion (or 15% of the total social costs of all drug use). Half of this cost was the cost to the community of crime associated with illicit drug use. The adverse health consequences accounted for a further $1.1 billion in costs.

The public continues to perceive heroin as a serious threat to the Australian community. In Western Australia, the heroin usage rate in 2007 was 0.2%, while cannabis usage was 10.8%, methamphetamine and amphetamine was 4.2%, ecstasy was 4.1% and analgesics were 2.5%. The Table below shows that in 2007 the usage rate for all illicit drugs had dropped from the 2001 rates, except for ecstasy and cocaine.

Table ES1- Drug use in the past 12 months in Western Australia

Drug	2001	2007
Cannabis	17.5%	10.8%
Meth/amphetamine	5.8%	4.2%
Ecstasy	4.0%	4.1%
Analgesics	3.9%	2.5%
Cocaine	1.5%	1.8%
Tranquillisers	1.7%	1.6%
Hallucinogens	2.0%	1.0%
Inhalants	0.6%	0.3%
Heroin	0.3%	0.2%
Methadone/Buprenorphine	0.1%	0.1%

While these reductions in usage rates are certainly a positive development, it remains the case that Western Australian usage rates tend to be higher than the Australian average. In addition, there are significant differences in the use of illicit drugs in the State's regions. Remote areas such as the Kimberley and the Goldfields have higher usage rates, especially of cannabis and methamphetamines, than others such as the metropolitan area.

Drug treatments

It was difficult for the Committee to obtain accurate data on the cost of the different treatment programs for heroin addiction, but a summary shows (in order of cost):

- a single treatment episode of naltrexone (which last about 150-300 days) by the Fresh Start Recovery Programme in Perth costs approximately $6,000 per patient;
- the average annual cost to the State of the methadone/buprenorphine program managed by Next Step per pharmacotherapy client is $2,859 per annum; and
- the cost to the State per community pharmocatherary client (managed by Corrective Service doctors and community GPs) is $308 per annum. The client also pays a dispensing fee of $5-$10 per day (or about $1,500 to $3,000 per annum) at their local pharmacy.

In Western Australia in 2008-09 the largest group of treatment clients were males aged 20-29 years, and the principal drug of concern for which people sought treatment was:

- alcohol accounted for 45.5% of treatment episodes;
- amphetamines for 19.8%;
- cannabis for 15.9%; and
- heroin for 8.5%.

The main forms of treatment provided in Western Australia are counselling, and withdrawal management. Western Australia offers counselling treatment episodes and rehabilitation treatments at rates 50% and 100% respectively more than other Australian jurisdictions. In addition, pharmacotherapy drug treatment is provided for heroin users who require it. Research has shown that pharmacotherapy drug treatment programs pay for themselves, with most of the benefits accruing from a decrease in the cost of crime. The ratio of benefits to costs across a number of studies ranges from 2:1 to 38:1.

Drug treatments in this State are provided under the Western Australian Drug and Alcohol Strategy, which is based on the principle of harm minimisation. This applies to both legal and illicit drugs and aims to balance three strategies:

- **supply reduction strategies** to police and disrupt the production and supply of illicit drugs and the control and regulation of legal substances;
- **demand reduction strategies** which prevent or delay the uptake of illicit drug use, including abstinence-oriented strategies and treatment to reduce drug use; and
- **harm reduction strategies** to reduce drug-related harm to individuals and the broader community.

The Mental Health Commission (MHC) presented evidence that showed that only 3% of the patients using their psychiatric services had used heroin in the past month, compared to 50% who had smoked cannabis in the past month and 32% who drank alcohol daily. Nearly half of their patients had poly-substance use.

Harm minimisation

As part of this inquiry, the Committee received submissions advocating that the government abandon the 'harm minimisation' approach in favour of 'abstinence' focused programs. Further research found significant differences in how the terms 'harm minimisation' and 'harm reduction' are interpreted and implemented. For some, 'harm minimisation' is taken to mean an overarching drug policy that focuses only on practical policies to reduce the harm of drug consumption. However, for others harm reduction strategies are simply one pillar of a broader policy, such as the Western Australian illicit drug strategy.

The World Health Organisation (WHO) told the Committee that there was considerable debate throughout the world as to what exactly 'harm minimisation' and 'harm reduction' should encompass. WHO considers 'harm reduction' to be only one of the three pillars of a country's drug policy (along with supply reduction and demand reduction).

The Committee found that Western Australia's overarching policy that focuses on all three pillars is an appropriate basis for the current levels of illicit drug use. While there will inevitably be debates over the relative resources devoted to each pillar, it is clear that all three are vital in the effort to address the problems of drug use.

Chapter outline

The Committee investigated each of the most prevalent illicit drugs in Western Australia.

Chapter One provides the background to this Inquiry and reviews illicit drug use patterns internationally, nationally and in Western Australia. The chapter shows that the term 'harm minimisation' has no internationally consistent definition.

Chapter Two addresses cannabis, the most prevalent illicit drug used in Western Australia. Details are provided on the reduction in cannabis use, new research findings of the medical impact of cannabis, and the recent legislative changes to address the consumption of cannabis and implement new education intervention sessions. The Committee found that even though the overall cannabis usage rate in Western Australia halved from 1998 to 2007, it remains a significant problem. The Committee looks forward to the 12-month review of the *Cannabis Law Reform Act 2010* as an opportunity to review the effectiveness of the changes, and especially their impact on young users.

Chapter Three examines the use of 'party type' stimulants such as cocaine and amphetamine-type substances (ATS). These substances include amphetamines, methamphetamines, ecstasy and other related drugs. Australia and New Zealand have some of the highest usage rates of these drugs in the world. Western Australia has seen a surge in the number of Police detections of clandestine ATS drug laboratories, rising from 30 in 2002 to 132 in 2010.

Western Australia's usage rates are considerably higher than the Australian average, with 4.2% of people over the age of 14 years reporting the use of methamphetamines (Australian rate of 2.3%) and 4.1% the use of ecstasy (Australian rate of 3.5%) in the past 12 months. The physical effects of amphetamine-type substances (ATS) create a range of challenges for Police, medical workers and drug treatment staff, and these challenges are discussed further in the chapter. The Committee also received evidence of ATS use by workers posing an increasing challenge for the State's mining industry.

A recent press report said that some mineworkers are now using a synthetic cannabis-like substance that impairs their ability to operate machinery but can not be detected by the existing drug and alcohol tests. 'Kronic' has been banned in 16 countries after being linked to deaths and is reported to be five to 10 times stronger than THC - the active substance in cannabis.

Chapter Four discusses opioids, benzodiazepines and inhalants such as butane. The misuse of prescription opioids is a growing problem throughout Australia, and the Committee heard evidence that in Western Australia this is in part caused by a lack of adequate pain management treatment. One witness described how prescription opioids replace heroin when the heroin supply dries up. This chapter addresses both the need for better pharmacy controls on prescription opioids to prevent doctor shopping, and for improved pain management treatments within the state.

Chapter Five addresses the issue of heroin use and treatment. Heroin has historically had a higher profile in Western Australia than other types of illicit drugs due to regular overdoses in the early years of the previous decade, and as such has a greater impact on the public's perception of the drug problem, and on the Government's response. The heroin usage rate is very low- 0.2% of the State's population in 2007. As an injected drug, heroin use carries with it the risk of HIV/AIDS and Hepatitis C infection, as well as significant risks of overdose.

The treatment programs for heroin users are discussed in detail, given the level of controversy that exists about some treatment options. Methadone prescription has been the 'gold' standard treatment for heroin addicts for many years, but overseas the practice of maintaining users on methadone for long periods has been criticised. In the United Kingdom (which has a heroin usage rate 10 times that of Western Australia) a recent shift in policy has seen an increasing emphasis placed on 'recovery' to abstinence rather than maintenance.

This chapter discusses in some detail Dr George O'Neil's Fresh Start Recovery Programme and the Naltrexone implant treatment trial. This program is subject to controversy, in part because it has not yet completed the approval process with the Therapeutic Goods Administration (TGA) and continues after more than a decade to run on a 'trial' basis. Despite this, it has received significant government funding from both the State and Federal governments and is supported by both sides of politics. The Committee finds that it is important that Fresh Start Recovery Programme and DAO meet the conditions for the additional grant received in 2009 from the State Government.

Chapter Six reviews how education and training programs are being used with school children as prevention measures. There is some debate about how effective education programs are. While it is clear that they increase children's knowledge, there is little evidence to suggest that alone they can achieve long term behavioural change. Experts have suggested that education programs need

to be one part of an overall, broad package of initiatives, rather than a stand-alone effort. One witness warned the Committee that a favourite tactic by representatives of the alcohol industry was to push for education programs, precisely for the reason that they do not on their own achieve behavioural change. The Committee was told of the need for broader educational programs that target whole families rather than just individuals or children at risk.

There is a need for additional training for medical, nursing and other allied health workers who work with people with drug issues. The Committee found that more funding is required from the State Government to:

- improve the availability of places for more health professionals to be trained within drug and alcohol services;
- improve pain management treatment; and
- give greater emphasis to drug and alcohol issues in university courses for medical students, nurses and allied health professionals.

Finally, **Chapter Seven** addresses in greater detail the provision of treatment programs in Western Australia. It focuses on the funding for treatment services, on government services provided by Next Step, and on some of the non-government service agencies working in this area. The chapter addresses the justice system and the opportunity for prisons to provide treatment services to people who may not normally come into contact with treatment services.

The Department of Corrective Services statistics suggest that the lack of treatment services for prisoners is an opportunity that is currently being missed. Greater provision of drug and alcohol treatment and rehabilitation services to people in the State's prisons is an urgent priority. The use of the Drug Court to steer individuals towards treatment is also a vital and under-resourced opportunity to intervene in the misuse of drugs.

FINDINGS

Page 11

Finding 1

Data from the 2007 National Drug Strategy Household Survey indicates that the level of use of most illicit drugs has reduced in both Australia and Western Australia since 1998.

Page 11

Finding 2

The consumption of alcohol and tobacco by Western Australians pose the greatest cost burden on the State's health system. The use of illicit drugs also imposes a significant cost burden on the health system, the user's family and the whole community.

Page 12

Finding 3

Publicly-available data on the use of illicit drugs in Western Australia can be up to four years old, limiting its usefulness in evaluating new policy options for government.

Page 21

Finding 4

Western Australia participates in the National Drug Strategy under the overarching framework of 'harm minimisation'. Harm minimisation is clearly defined in this Strategy to include demand, supply and harm reduction strategies. The term is interpreted in different ways by different stakeholders in the professional networks dealing with illicit drug users. Some use this term to just refer to reducing the risk and harm to an addict.

Page 35

Finding 5

Western Australia's overall cannabis usage rate halved from 1998 to 2007. However, data show that its use remains a significant health and justice issue, particularly in regions such as the Kimberley and the Goldfields. The Government expects that new cannabis laws will further lower the consumption of cannabis in the State, particularly among young users who access the cannabis intervention requirement (CIR) scheme education sessions.

Page 54

Finding 6

The high level of consumption of amphetamines and ecstasy by Western Australians over the past decade has created a significant demand on the State's health, Police and Justice systems. The State now has one of the highest amphetamine usage rates in the world.

Page 60

Finding 7

The misuse of prescription opioids has become a significant problem within Western Australia and the number of people misusing them is now at a similar level to the number consuming heroin.

Page 62

Finding 8

The Committee considers that the initiatives for the better management of pain medicine and monitoring of opioid prescribing proposed by Dr Visser might prove suitable to address the problem of the misuse of prescription opioids.

Page 77

Finding 9

There is a need for long-term follow-up on the effectiveness of all Western Australian opioid treatment programs.

Page 86

Finding 10

About 50% of people who are heroin dependent are incarcerated at some time.

Page 91

Finding 11

The Community Program for Opioid Pharmacotherapy in Western Australia focuses on a traditional treatment approach. The United Kingdom has adopted a new approach to treatment that gives emphasis to assisting 'users' to break their addiction and become drug-free.

Page 103

Finding 12

Two years after receiving an additional grant from the State Government to fund a range of services for clients accessing the Fresh Start Recovery Programme, two of the grant's three auditing conditions have not been completed by the Fresh Start Recovery Programme and the Drug and Alcohol Office.

Page 115

Finding 13

School education programs can provide useful information to young people on the prevention of using illicit drugs, and the harm done by their use. These programs may provide a baseline understanding so that broader community programs and strategies to lower the consumption of illicit drugs are more effective.

Page 118

Finding 14

Education programs that involve a child and their family may be more useful for altering young people's behaviour toward alcohol and other drugs, particularly for those children identified as being at risk.

Page 120

Finding 15

The State has trained insufficient doctors specialising in the alcohol and other drugs field in the past decade.

Page 123

Finding 16

It is important to the success of the State's illicit drug strategy that university courses increase their provision of drug and alcohol education to medical students, nurses and allied health professionals.

Page 149

Finding 17

The Drug Court diversion programs such as POP, IDP and STIR seem to have made a valuable contribution to lowering the amount of people being sent to prison for low-level drug infringements.

RECOMMENDATIONS

Page 12

Recommendation 1

As part of its annual reports, the Drug and Alcohol Office collate and publish the data on the use of illicit drugs in Western Australia for the preceding year.

Page 36

Recommendation 2

Given the dangers of young cannabis users being impacted by psychosis, the Minister for Police should ensure that the 12-month review of the *Cannabis Law Reform Act 2010* assesses in particular the impact of the legislation on young cannabis users aged up to 25 years of age.

Page 41

Recommendation 3

In the 2012-13 State Budget, the Minister for Health and the Minister for Mental health jointly fund additional specialist drug and alcohol counsellor positions and Clinical Nurse Consultants (such as that at Sir Charles Gairdner Hospital) specialising in drug and alcohol services in tertiary hospitals, and skilled drug and alcohol service nurses in secondary hospitals, in order to provide these services seven days a week, especially at peak times.

Page 54

Recommendation 4

The Minister for Mental Health ensure that funding for education and other demand reduction and treatment programs for amphetamines and ecstasy users is a priority in the State's illicit drug strategy, and appropriately funded in the 2012-13 State Budget.

Page 54

Recommendation 5

The Drug and Alcohol Office 2010-11 annual report include strategies to reduce the consumption of amphetamines and ecstasy in Western Australia.

Page 62

Recommendation 6

The Minister for Health fund a minimum of eight FTE pain medicine specialists and supporting staff across Western Australia in the State Budgets over the period 2012-14.

Page 63

Recommendation 7

The Minister for Health request the Department of Health to examine the need to expand the pseudoephedrine monitoring program to include both prescription opioids and benzodiazepines.

Page 66

Recommendation 8

By December 2011 the Minister for Mental Health table in Parliament a plan to deal with the use of inhalants by Western Australian school children aged 16 to 17 years of age.

Page 78

Recommendation 9

All opioid treatment programs need to provide to the Drug and Alcohol Office follow-up short and long-term (greater than five years) data on all patients to assist in evaluating the effectiveness of these programs, including rates of abstinence.

Page 86

Recommendation 10

The Minister for Corrective Services ensure that funding is available by December 2011 to enrol all opiate pharmacotherapy clients in Western Australian prisons in a 'road to recovery' program or a program promoting abstinence.

Page 91

Recommendation 11

The Minister for Mental Health should ensure that by December 2011 the Drug and Alcohol Office prepare guidelines for the six-monthly review of all illicit opioid drug treatment patients. When applying for a renewal of an authority to prescribe an opioid pharmacotherapy, prescribers should provide the Department of Health with an outline of the proposed treatment plan for each patient.

Page 91

Recommendation 12

Commencing in 2012, the Minister for Mental Health appoint a panel, including an Australian Medical Association-nominated addiction specialist, to conduct an annual random audit of 50 opioid pharmacotherapy patient treatment plans. The Drug and Alcohol Office include the results of these audits in their annual reports.

Page 103

Recommendation 13

The Minister for Mental Health ensure that the Fresh Start Recovery Programme and the Drug and Alcohol Office complete the requirements attached to the 2009-2010 funding agreement as a matter of urgency and prior to providing further State Government funding to the Fresh Start Recovery Programme.

Page 103

Recommendation 14

The Minister for Mental Health ensure that the Drug and Alcohol Office's 2011 annual report include an update on the progress of completing the auditing conditions of the Fresh Start Recovery Programme's additional grant, and any further requirements needed to apply for registration of naltrexone implants by the Therapeutic Goods Administration.

Page 104

Recommendation 15

The Minister for Mental Health should ensure that by December 2011 the Drug and Alcohol Office prepare guidelines for an annual review, including outcome data, of all naltrexone treatment patients. This outcome data should be included in the Drug and Alcohol Office's annual reports.

Page 104

Recommendation 16

At the conclusion of the current review, the Minister for Mental Health urgently seek funding to meet any further requirements needed to apply for the registration of naltrexone implants by the Therapeutic Goods Administration.

Page 116

Recommendation 17

The Minister for Mental Health should ensure that in the 2012-2013 State Budget, the new State-wide illicit drug strategy is funded to:

- encompass behaviour oriented programs that influence a student's self-image;
- prevent the use of illicit drugs;
- explain to the community the harms resulting from the use of illicit drugs; and
- ensure there are sufficient treatment programs for illicit drug users.

Page 118

Recommendation 18

The Minister for Mental Health ensure that the 2011 Drug and Alcohol Office annual report include details on how the prevention and treatment programs they fund include the whole family, particularly those families with children at risk.

Page 123

Recommendation 19

The Minister for Mental Health should ensure funding to the Drug and Alcohol Office includes additional time and resources for alcohol and illicit drug teaching as part of university courses (both lectures and clinical placements) for medical students, nurses, and other allied health professionals.

Page 123

Recommendation 20

The Minister for Mental Health seek funding by 2012 for the education and subsequent clinical placement of additional 'addiction medicine' or equivalent specialist positions for tertiary, secondary and community health care settings.

Page 137

Recommendation 21

By December 2011, the Department of Health introduce management guidelines with discharge planning for all patients who attend, or are admitted, to a tertiary or secondary hospital with alcohol and drug problems. The patient's discharge plan is to be provided to the Drug and Alcohol Office for follow-up.

Page 138

Recommendation 22

By December 2011, the Drug and Alcohol Office establish and fund a referral centre to plan the management for all patients who attend, or are admitted, to a tertiary and secondary hospital with alcohol and drug problems and to report on the operations of this centre in their annual report to Parliament.

Page 138

Recommendation 23

The Minister for Health by the end of 2011 mandate the relevant recording of disease and physical injury associated with alcohol and illicit drugs in discharge summary documentation.

Page 149

Recommendation 24

The Minister for Corrective Services and the Attorney General report to Parliament by December 2011 on what processes have been put in place to ensure the closer cooperation of the Courts and the Department of Corrective Services in managing the diversion programs offered to convicted children and adults in Western Australia.

MINISTERIAL RESPONSE

In accordance with Standing Order 277(1) of the Standing Orders of the Legislative Assembly, the Education and Health Standing Committee directs that the Minister for Mental Health, Minister for Police, Minister for Corrective Services, the Attorney General and the Minister for Health report to the Assembly as to the action, if any, proposed to be taken by the Government with respect to the recommendations of the Committee.

CHAPTER 1 INTRODUCTION

1.1 Illicit drugs and the Western Australian community

Western Australia over the past decade has moved in a similar policy direction as other Western countries - more strict in controlling illicit drugs, and more liberal in alcohol policy issues.[1] Illicit drugs policy is the only area of health where government mandates (often by laws) the approach of health officials to what individual treatment will be undertaken. This interim report focuses on illicit drug use in Western Australia and the final report for this Inquiry will report on alcohol.

The Committee explored in its previous interim report, on the alcohol restrictions in the Kimberley, the impact of advertising, accessibility and affordability as key factors in increasing the consumption of alcohol in Western Australia. In terms of illicit drugs, these are also key factors that restrict the use of these substances:

- *advertising*- given their illegal nature, these substances are not able to be advertised through normal channels but rely on word of mouth.
- *accessibility*- these substances can only be obtained through a limited range of outlets, with those manufacturing and selling them aware of the large penalties if they are caught by Police.
- *affordability*- illicit drugs such as heroin by their nature are more expensive than legal drugs such as alcohol, and this is a key limiting factor in their use.

Parliament was told that heroin is "one of the cruellest drug addictions known".[2] Illicit drug use deeply concerns Western Australians despite the majority of drug-related ill-health and costs to the State Government arising from the consumption of legally-available tobacco and alcohol products. In 2003, the abuse of cannabis, which is the illicit drug most widely consumed in this State, was estimated by the Australian Institute of Health and Welfare (AIHW) to account for the loss of 5,206 health years of life. This represents 0.2% of the total burden of disease in Australia (all illicit drugs accounted for 2.0%). Tobacco caused the loss of 204,788 life health years (39.3 times more than cannabis) and alcohol 61,091 life health years (11.7 times more than cannabis).[3]

It is clear that Western Australians remain highly concerned about illicit drugs even though the data in this report shows the consumption of most illicit drugs has reduced over the past decade. A recent survey of the State's school children aged 12-17 years old shows that the consumption of

---

1 Professor Jan Blomqvist, Research Professor, SORAD, Stockholm University, *Briefing*, 10 February 2011.

2 Mr Roger Cook, MLA, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 19 March 2009, p2210.

3 Australian Institute of Health and Welfare, 'The Burden of Disease and Injury in Australia 2003', 25 May 2007. Available at: www.aihw.gov.au/publication-detail/?id=6442467990, p76, p85 & p89. Accessed on 21 February 2011. The report measures mortality, disability, impairment, illness and injury arising from 176 diseases, injuries and risk factors using a common metric, the disability-adjusted life year (DALY).

cannabis has dropped by two-thirds between 1996 and 2008. Figure 1.1 below shows that the consumption at any time of any illicit drug (excluding cannabis) by 12-15 year olds has dropped by nearly half in this period and by one-third for 16-17 year olds. The decrease for usage of illicit drugs in the 'past month' is even more dramatic, with nearly a two-third drop for both younger and older age groups (see Figure 1.2).

Figure 1.1- Any consumption of an illicit drug (excluding cannabis) by Western Australian school children (1996-2008)[4]

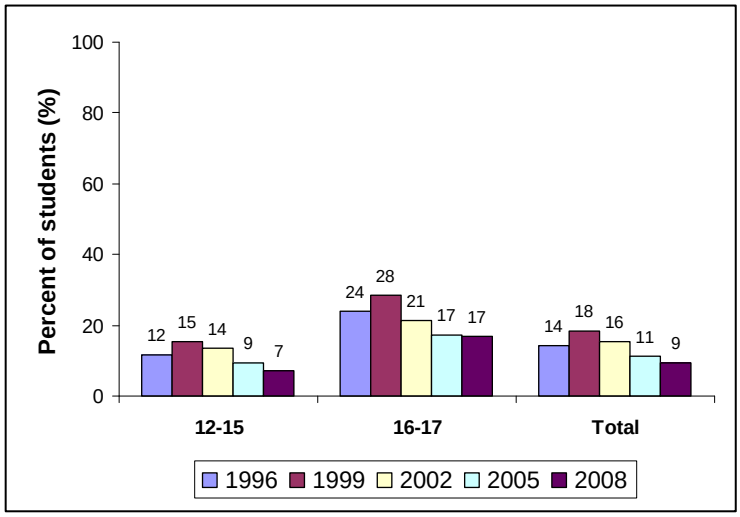
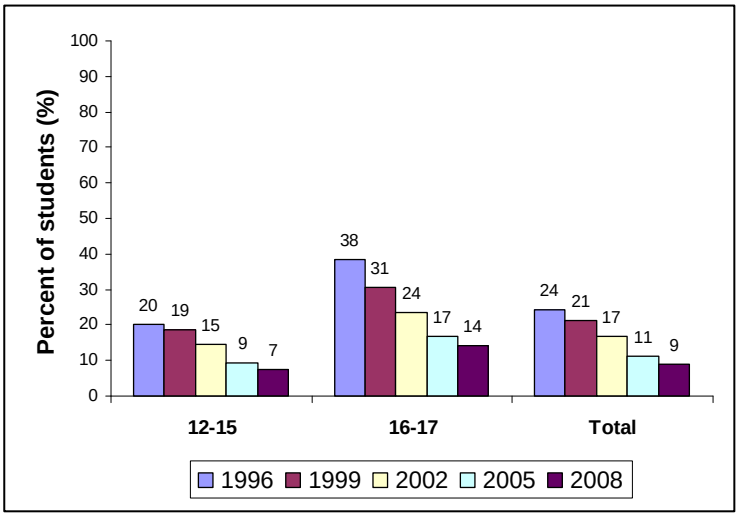


Figure 1.2- Consumption in the past month of any illicit drug by Western Australian School children (1996-2008)[5]



4 Ms Rebecca Haynes, 'Australian School Student Alcohol and Drug (ASSAD) Survey Results from 2008', 2010. Available at: www.dao.health.wa.gov.au/Publications/tabid/99/DMXModule/427/Default.aspx?EntryId=1217&Command=Core.Download, slide 35. Accessed on 22 March 2011.

5 Ibid.

As an example of the level of public concern about illicit drugs, the Australian Bureau of Statistics (ABS) *Crime Victimisation, Australia, 2009–10* reports that despite only 8.1% of Australians rating the taking or dealing of drugs as a social problem in their neighbourhood (the lowest by 50% of the 11 options offered to survey respondents), nearly 34% rate it is a major problem, compared to only 20.3% saying public drunkenness is a major problem.[6]

There have been previous inquiries into the impact of illicit drugs on Western Australians that helped shape the State's current range of treatment and education services:

- 1972 Williams Royal Commission into the treatment of alcohol and drug dependents;
- 1983 Legislative Assembly Select Committee into Alcohol and Other Drugs;
- 1995 Court Government's Taskforce on Drug Abuse;
- 1997 Legislative Assembly Select Committee review of the *Misuse of Drugs Act 1981* and report on health and education services to deal with illicit drugs;
- 2001 Community Drug Summit; and
- 2007 amphetamine summit.[7]

Cannabis is the illicit drug that is most heavily consumed in Western Australia. The results for the Police's *Operation Unification* in November 2010 saw 340 people ring Crime Stoppers with information about illicit drugs. Police seized only 38g of heroin and 58g of cocaine, but 5.5kg of cannabis.[8] In recognition of this status, the State Government tightened its laws in regard to the possession of cannabis in late 2010 with the passage of the *Cannabis Law Reform Act 2010*. More detailed data on the State's consumption of cannabis and other illicit drugs is given below.

1.2 The Inquiry

The Education and Health Standing Committee (EHSC) resolved to conduct an *Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia* on 13 May 2009. This Interim Report chiefly focuses on the Inquiry's term of references in terms of illicit drugs. An earlier report focused on the effectiveness and social costs of the alcohol restrictions and bans that have been in place in parts of the Kimberley and a later report will focus on the Inquiry's term of references in regard to alcohol.

---

6 Australian Bureau of Statistics, 'Crime Victimisation, Australia, 2009–10', 17 February 2011. Available at: www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/96D24600F95E026ACA257839000E060C/$File/45300_2009_10.pdf, p37. Accessed on 21 February 2011.

7 Submission No. 37- Part A from the Drug and Alcohol Office, 25 August 2009, pp41-42.

8 Mr Luke Eliot, '200 Charged after Drug Dob-in Push', *The West Australian*, 23 November 2010, p10.

An advertisement calling for submissions to the Inquiry was placed in *The West Australian* and *The Australian* on 27 June 2009 and was accompanied by a press release. Written invitations were sent to key stakeholder organisations. At the time of this Interim Report, the Inquiry had received nearly 80 submissions. The complete list of the Inquiry's submissions and hearing transcripts is available on the EHSC web site. Appendix One lists over 40 of these submissions that relate to illicit drugs.

Appendix Two lists the witnesses who gave evidence to the Committee on illicit drugs in Perth and regional areas, including during its 10-day trip to the Kimberley in late July 2010. The Committee took evidence on the use of illicit drugs in Merredin, Kalgoorlie, Albany, Katanning, as well as seven locations in the Kimberley. The Committee has heard from all the key government departments, non-government organisations as well as many Indigenous community corporations offering rehabilitation and treatment services.

Appendix Three includes briefings the Committee received from experts in other Australian jurisdictions and during its trip to Europe. The Committee attended the following conferences to gather information on illicit drugs:

- National Drug and Alcohol Research Centre (NDARC) Annual Symposium and Drug Trends Conference, in Sydney 28-29 September 2009;
- ANEX Australian Drugs Conference 'Drugs In Hard Times', in Melbourne 1-2 October 2009;
- Australasian Professional Society on Alcohol and other Drugs (APSAD) Conference 'Living on the Edge', in Darwin 1-4 November 2009; and
- Drug and Alcohol Office's 17th Western Australian Drug and Alcohol Symposium 'Hope, Hype or Hard Evidence', in Fremantle 31 August - 1 September 2010.

This Report places illicit drug consumption in Western Australia in context with that of other Australian and overseas jurisdictions. It is structured so that the chapter order reflects the size of the illicit drug consumption in this State, and thus commences with cannabis. This Report does not consider the possible use of legal drugs, such as the ADHD stimulant dexamphetamine (Ritalin), that some claim may lead at a later stage to the misuse of illicit drugs.[9]

The Report's recommendations have been proposed so that they will lead to a further reduction in Western Australians consuming illicit drugs. While most drug consumption levels have dropped, illicit drug use still poses considerable social harm. For example, a recent study by Victoria Police has found the incidence of drugs in the blood of drivers involved in non-fatal collisions has surpassed the incidence of alcohol in the blood of drivers in both fatal and non-fatal crashes.[10]

---

9 Mr Martin Whitely, MLA , Electronic Mail, 25 March 2011, p1.

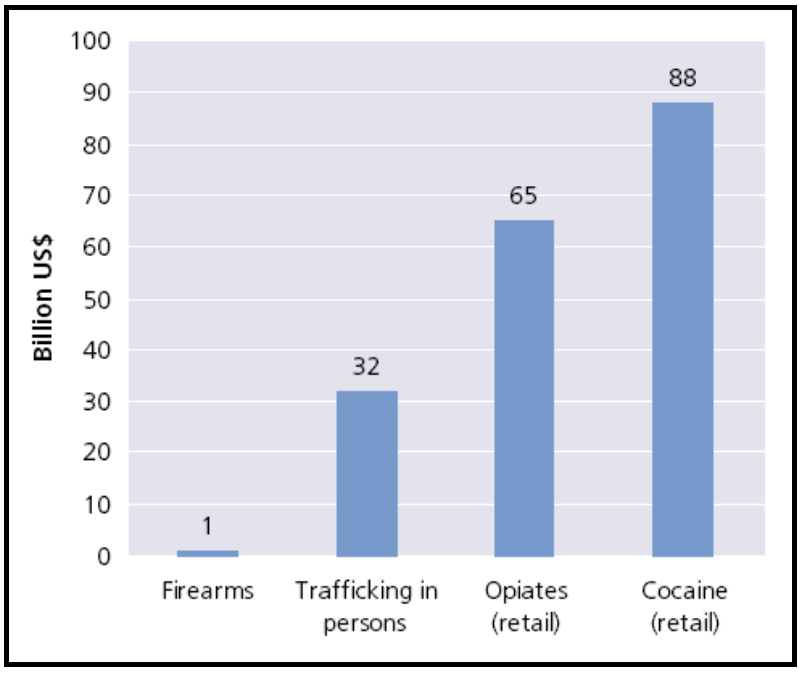
10 Australian College for Emergency Medicine, 'Emergency Medicine Conference Highlights for Thursday November 19', 19 November 2009. Available at: www.acem.org.au/media/media_releases/Motor_vehicle_and_drugs_191109.pdf. Accessed on 8 April 2011.

1.3 International levels of drug use

Public health is at the heart of the international illicit drug control system coordinated by various United Nations' agencies. The prevalence of illicit drug use around the globe is considered a key, though imperfect, indicator of the status of efforts by countries to lower the consumption of the main illicit drugs: cannabis, cocaine and heroin. Unlike the data presented below from Australia, internationally the consumption of illicit drugs has increased over the past decade. The United Nations Office on Drugs and Crime (UNODC) has reported that since the 1960s the international drug control system has been successful "in containing the spread of annual illicit drug use to around 200 million people, or 5% of the world population aged 15-64."[11]

In 1998 a special session of the UN General Assembly (UNGASS) decided to work towards the "elimination or significant reduction" of illicit drug production and abuse by 2008 and adopted a series of sectoral plans to reach that objective. While UNODC still does not have an accepted clear definition of what is meant by the expression the 'world drug problem',[12] its data does show that the trade in illicit drugs creates both serious public health issues in some countries as well as a criminal market larger than others, as shown in Figure 1.3 below.

Figure 1.3- Estimated annual value of some global criminal markets[13]



11 United Nations Office on Drugs and Crime, 'Introduction', 2011, Available at: www.unodc.org/documents/wdr/WDR_2010/1.0_Transnational_drug_market_analysis_Introduction.pdf, p33. Accessed on 1 March 2011.

12 Ibid, p31.

13 Ibid, p33.

Evidence given to the Committee by European witnesses on the international situation said the success or otherwise of a country's efforts at reducing the consumption of illicit drugs was often affected by its own history, culture and public policy. For example:

- in Sweden the success of its 'zero tolerance' approach was linked to the success of its earlier temperance movement in restricting the consumption of alcohol;[14]
- in 2001 Portugal decriminalised the consumption of illicit drugs (drug possession is still prohibited, but the sanctions fall under the administrative law, not the criminal law) with some reports saying this had led to a lower level of use of illicit drugs among teenagers;[15] and
- the newly elected government in the United Kingdom is moving away from a 'harm reduction' strategy to one of 'recovery', with efforts to have all heroin addicts treated to end their addiction, rather than remain on methadone.[16]

1.4 Drug use in Australia

Data from the National Drug Strategy Household Surveys show that self-reported use of any illicit drug increased in the first decade of Australia's National Drug Strategy from 1985-1995, but has fallen dramatically since 1998. Care should be taken in assessing trends as the different surveys had different sample sizes and survey methodologies. In 2007 13.4% of Australians over the age of 14 years reported the recent use of an illicit drug compared to 22% in 1998. The greatest use was of cannabis with 9.1% of Australians over the age of 14 years reporting recent use in 2007 compared to 17.9% a decade earlier.

Recent surveys have seen reductions in the use of most illicit drugs, or at least stable prevalence of their use. Only cocaine and tranquillisers show a recent increase, and the prevalence of their use is very low.[17] The 2007 National Drug Strategy Household Survey showed that alcohol and tobacco remained the most popular drugs for Australians (see Figure 1.4 below).

---

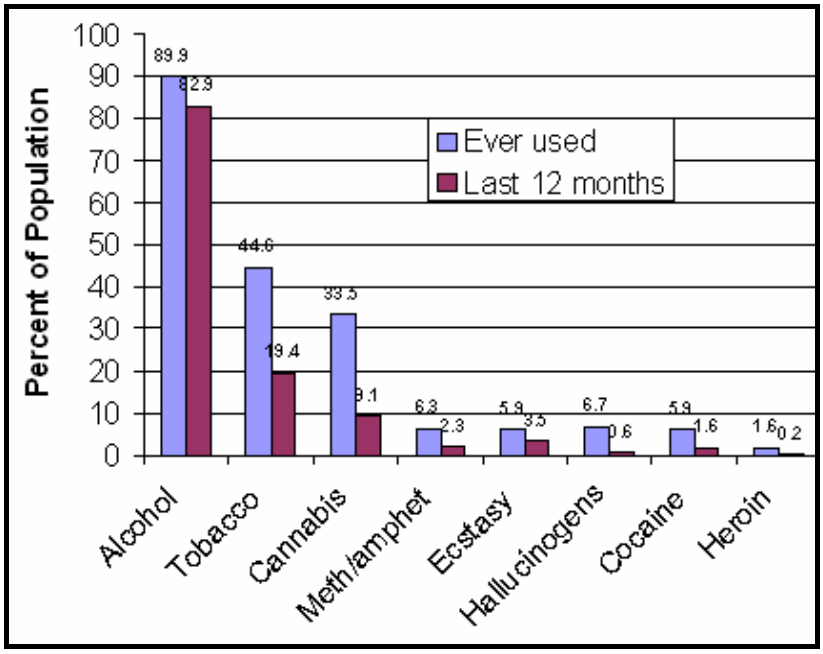
14 Dr Sven Andréasson, MD, Senior Consultant, Stockholm Center for Addiction, Karolinska University Hospital, *Briefing*, 10 February 2011.

15 Mr Glenn Greenwald, CATO Institute, 'Drug Decriminalization in Portugal: Lessons for Creating Fair and Successful Drug Policies', 2009. Available at: www.cato.org/pubs/wtpapers/greenwald_whitepaper.pdf. Accessed on 21 January 2011.

16 Professor Neil McKeganey, Director, Centre for Drug Misuse Research, University Of Glasgow, *Briefing*, 2 February 2011.

17 Siggins Miller (2009), *Evaluation and Monitoring of the National Drug Strategy 2004-2009: Final Report*. Available at: www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/consult-eval, Volume 1, Chapter 2, p7. Accessed 5 January 2011.

Figure 1.4- Prevalence of drug use in Australia (2007)



The Commonwealth Department of Health and Ageing commissioned research to estimate the social cost of tobacco, alcohol and illicit drug abuse to the Australian community.[18] Their estimates for 2004-05 found the total social cost of illicit drug abuse was $8.2 billion (or 15% of the total social costs of all drug use). Half of this cost was the cost to the community of crime associated with illicit drug use. The adverse health consequences of the interactions between alcohol and illicit drugs accounted for a further $1.1 billion in costs.[19]

Data shows that each birth cohort of Australians from 1940 to 1980 has used either certain illicit drugs or alcohol at a greater rate than previous cohorts, and that there was a higher prevalence of use by the age of 15 years for each succeeding cohort. However, Table 1.1 below shows that recent figures indicate the trend for these drugs may have abated.

---

18 Collins DJ & Lapsley HM (2008). *The Costs of Tobacco, Alcohol and Illicit Drug Abuse to Australian Society in 2004/05*. Monograph Series no. 64. Canberra: Commonwealth of Australia. Available at: www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/mono64.

19 Siggins Miller (2009), *Evaluation and Monitoring of the National Drug Strategy 2004-2009: Final Report*, Vol. 1, p12. Available at: www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/consult-eval. Accessed 5 January 2011.

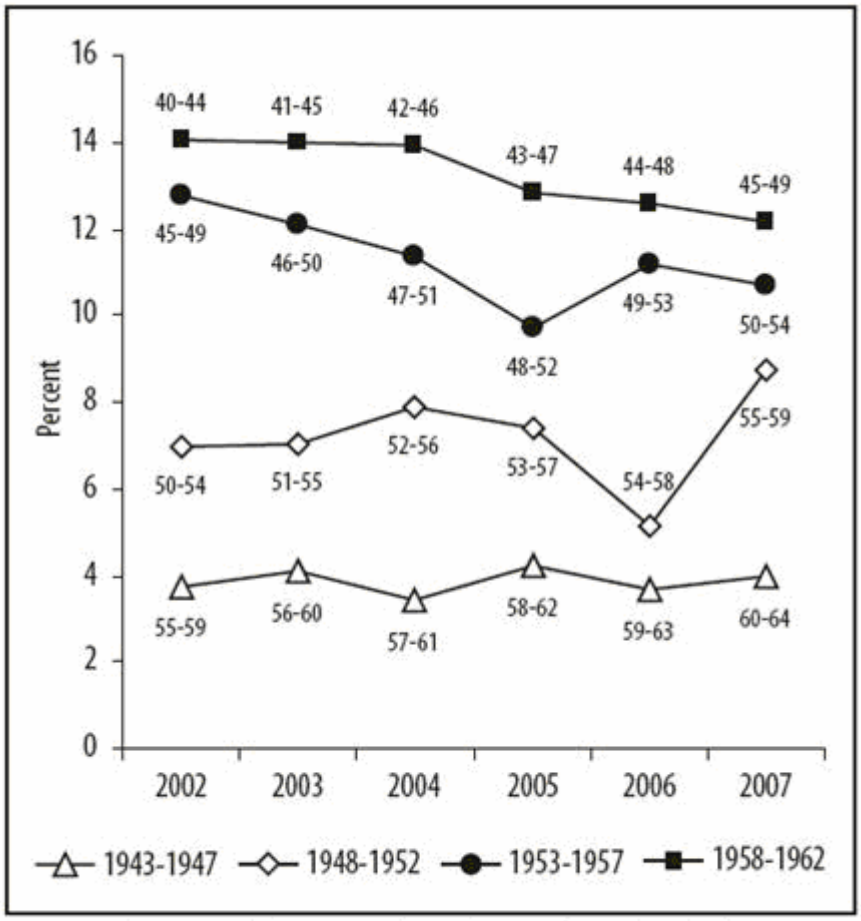
Table 1.1- Prevalence of drug use by Australian birth cohort (1940-1979, 2007)[20]

	Alcohol			**Cannabis**			**LSD**		
	Lifetime use	Prevalence by 15 yo	Av. Age first use	Lifetime use	Prevalence by 15 yo	Av. Age first use	Lifetime use	Prevalence by 15 yo	Av. Age first use
1940-44	97.6%	15.7%	18	13.9%	0.1%	30	1.2%	-	38
1945-49	97.8%	19.3%	18	24.3%	3.3%	26	3.2%	0.1%	23
1950-54	96.8%	20.3%	17	37.3%	0.7%	22	8.0%	0.1%	20
1955-59	95.9%	28.0%	17	50.5%	2.4%	20	11.9%	0.0%	19
1960-64	97.5%	34.5%	16	56.7%	6.8%	19	13.1%	0.7%	20
1965-69	97.2%	40.7%	16	61.5%	11.4%	18	13.7%	0.3%	21
1970-74	98.0%	45.9%	15	62.8%	13.0%	18	20.3%	0.6%	20
1975-79	97.2%	45.6%	15	62.8%	20.4%	16	22.5%	2.1%	18
2007	**89.9%**	**71.0% (by 19yo)**	**17yo**	**33.5%**	**12.9% (by 19yo)**	**19yo**	**6.7%**	**1.2% (by 19yo)**	**20yo**

There has been a similar increased use of illicit drugs at an earlier age in other developed countries, such as the United States of America (see Figure 1.5 below).

[20] Degenhardt, L., Lynskey, M., & Hall, W. 'Cohort Trends in the Age of Initiation of Drug Use in Australia'. Sydney: National Drug and Alcohol Research Centre, University of NSW, 2000. Available at: http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/resources/TR_23/$file/TR.083.pdf, p4, 7 & 10. Accessed on 15 December 2010; and Australian Institute of Health and Welfare, '2007 National Drug Strategy Household Survey- Detailed Findings', December 2008. Available at: www.aihw.gov.au/publications/phe/ndshs07-df/ndshs07-df.pdf, pxi. Accessed on 15 December 2010.

Figure 1.5- Any illicit drug use in the past year by selected birth cohorts (USA 2002-07)[21]



Note: The value near each data point indicates the age of the selected cohort in that survey year.

1.5 Western Australian data

The *Alcohol and Drug Authority Act 1974* (ADA) provides the legislative basis for the operation of the WA Alcohol and Drug Authority, which operates under the title of the Drug and Alcohol Office (DAO). The Act establishes the Board of the Authority and sets out its operation. DAO is responsible for coordinating drug and alcohol strategies and services in Western Australia, and is responsible to the Minister for Mental Health.

21 OAS Data Review, 'An Examination of Trends in Illicit Drug Use among Adults Aged 50 to 59 in the United States', August 2009. Available at: http://oas.samhsa.gov/2k9/OlderAdults/OAS_data_review_OlderAdults.pdf, p5. Accessed on 15 December 2010.

DAO collects statistics relating to drug and alcohol use in Western Australia. This data confirms that:

- the major 'drug' issues are from the consumption of alcohol and tobacco.
- the use of high-profile illicit drugs, such as cannabis and heroin, decreased between 2001 and 2007 (see Table 1.2 below).

Table 1.2- Western Australians who used illicit drugs in the past 12 months (2001-07)[22]

Drug	2001	2004	2007
Cannabis	17.5%	13.7%	10.8%
Meth/amphetamine	5.8%	4.5%	4.2%
Ecstasy	4.0%	4.1%	4.1%
Cocaine	1.5%	1.2%	1.8%
Heroin	0.3%	0.2%	0.2%
Inhalants	0.6%	0.5%	0.3%
Hallucinogens	2.0%	0.6%	1.0%
Methadone/Buprenorphine	0.1%	0.1%	0.1%
Analgesics	3.9%	2.7%	2.5%
Tranquillisers	1.7%	1.3%	1.6%

The Committee took no evidence from witnesses into the causes of this drop in usage of illicit drugs, other than that the decrease for the use of heroin began in about 2000 due to a 'drought' in its availability. It is likely that the education work undertaken by DAO and non government organisations (NGOs) has also had a positive impact in helping to lower usage rates.[23]

Within the State there are some dramatic regional differences in the consumption of illicit drugs, with the highest rates being in remote areas such as the Kimberley and the Goldfields, as shown in Table 1.3 below.

---

22 Submission No. 37- Part A from the Drug and Alcohol Office, 25 August 2009, p5.

23 Professor Mike Daube, Director, Mc Cusker Centre for Action on Alcohol and Youth, Curtin University, *Transcript of Evidence*, 20 October 2010, p2.

Table 1.3- Use of illicit drugs in Western Australia in the past 12 months, by region (2004)[24]

Region	Cannabis	Amphetamines	Ecstasy	Any Illicit Drug
Kimberley	30.2%	7.8%	3.8%	**35.9%**
Goldfields- SE coastal	22.5%	5.3%	7.7%	**25.3%**
Midwest- Murchison	14.0%	3.6%	4.1%	**18.4%**
North Metropolitan	14.4%	5.2%	4.9%	**18.3%**
Pilbara-Gascoyne	14.9%	2.5%	-	**16.7%**
South Metropolitan	12.4%	4.0%	4.1%	**16.1%**
South West	13.1%	5.7%	3.2%	**14.8%**
Great Southern	11.3%	2.4%	0.5%	**11.5%**
Wheatbelt	4.7%	-	-	**11.4%**
STATE AVERAGE	**13.7%**	**4.5%**	**4.1%**	**17.3%**

Finding 1

Data from the 2007 National Drug Strategy Household Survey indicates that the level of use of most illicit drugs has reduced in both Australia and Western Australia since 1998.

Finding 2

The consumption of alcohol and tobacco by Western Australians pose the greatest cost burden on the State's health system. The use of illicit drugs also imposes a significant cost burden on the health system, the user's family and the whole community.

(a) Usefulness of data

One of the difficulties the Committee faced in this inquiry was trying to understand the trends in the use of illicit drugs in this State while only having access to data that was nearly four years old. For example, the information provided to the Committee by DAO (and available on its web site to the public) and other witnesses was mainly based on the 2007 National Drug Strategy Household

[24] Submission No. 37- Part A from the Drug and Alcohol Office, 25 August 2009, p10.

Survey. The Committee was told that the national and State results from the 2010 NDSHS will be released in mid-2011 and the data will be made available to DAO in August 2011. A more comprehensive State report is then collated and will not be publicly available until early 2012.

While DAO has access to other more up to date sources from smaller surveys (eg Ecstasy Drug Reporting System Illicit Drug Data Report, Cannabis Infringement Notice scheme), the public is limited to data that might mask trends that have emerged since the NDSHS.[25] For example, the State Parliament was told in 2009 of a rise in the use of heroin in Perth.[26] This anecdotal evidence is supported by rises in the detection of heroin at Australia's borders and the amount seized by Police, but this trend is not reflected in the official data made available to the Committee.

One area of illicit drug statistics that is more current is the *National Opioid Pharmacotherapy Statistics Annual Data* (NOPSAD). In 1985, methadone maintenance treatment was endorsed as Australian policy, and national information on the numbers of pharmacotherapy clients was collected from 1986. NOPSAD was first published in 2005 and the results for 2010 should be available by mid-2011.[27]

Finding 3

Publicly-available data on the use of illicit drugs in Western Australia can be up to four years old, limiting its usefulness in evaluating new policy options for government.

Recommendation 1

As part of its annual reports, the Drug and Alcohol Office collate and publish the data on the use of illicit drugs in Western Australia for the preceding year.

1.6 Addiction as a chronic disease

Professor Jon Currie, a neurologist, and Director of Addiction Medicine at St Vincent's Hospital in Melbourne, gave evidence at a Perth seminar at the Fresh Start Programme in late 2010. He described how addiction is a chronic relapsing brain disease that over a long period creates a

25 Ms Julia Knapton, A/Director, Policy Strategy and Information, Drug and Alcohol Office , Electronic Mail, 15 December 2010, p1.

26 Mr Roger Cook, MLA, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 19 March 2009, p2210.

27 Australian Institute of Health and Welfare, 'National Opioid Pharmacotherapy Statistics Annual Data collection: 2009 report', May 2010. Available at: www.aihw.gov.au/publication-detail/?id=6442468365&tab=1. Accessed on 7 March 2011.

'reward pathway' in an addict's brain and may also create gene structure changes too.[28] To some witnesses this is a controversial proposal as their programs create long-term abstinence for their clients who learn new life skills that assist them in remaining off drugs. This can be seen as 'curing' their disease, so for them the term 'chronic disease' is not appropriate.

The World Health Organisation reports this approach to seeing addiction as a 'disease' is derived from advances in neuroscience. Research on substance dependence has facilitated the visualization of brain function in a living human, known as neuroimaging techniques (such as MRI and PET). Using these techniques, researchers can see what happens from the level of receptors to global changes in metabolism and blood flow in various brain regions of live addicts.[29]

Professor Petra Meier confirmed to the Committee that research showed that approximately one-third of addicts:

- managed to reach abstinence;
- came out of detox programs early but re-entered later; and
- got worse and were lost to programs and could not be followed up as they disappeared into the street market again.

For those heroin addicts who were not successful, she argued that their addiction could be seen as a chronic disorder and that it is unrealistic to expect all addicts to be weaned off their drug. Professor Meier proposed that in this case, the best approach for their treating medical practitioner is to maintain them on methadone, which has few side effects, so they can live their lives in society.[30] Other witnesses pointed out that providing methadone is simply substituting one addiction for another.[31]

A number of witnesses compared heroin addiction to other chronic diseases such as diabetes. However Dr Thomas McLellan, from the White House Office of National Drug Control Policy, compares it to alcoholism and the approach of programs such as Alcoholics Anonymous (AA). AA's 12-step program treats alcoholics as never being 'cured' but as 'recovering'. He classes

---

28 Professor Jon Currie, '2010 Recovery-focussed Drug Treatment Seminar', 21 August 2010. Available at: www.freshstart.org.au/information/2010-recovery-focussed-drug-treatment-seminar#click Currie. Accessed on 14 March 2011.

29 World Health Organisation, 'Neuroscience of Psychoactive Substance Use and Dependence: Summary', 2004. Available at: www.who.int/substance_abuse/publications/en/Neuroscience_E.pdf. Accessed on 14 March 2011.

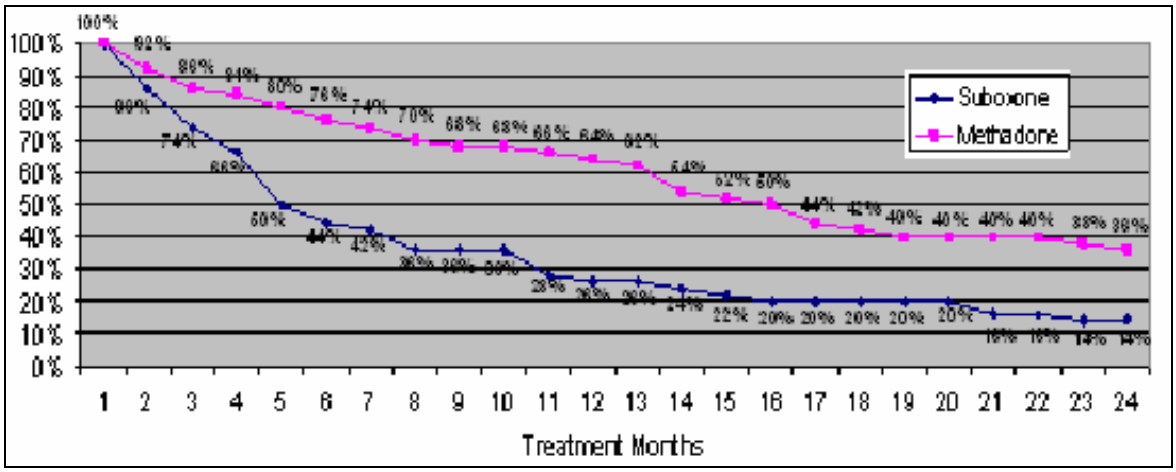
30 This is a similar proportion to that quoted by Associate Professor Richard Mattick above. Professor Petra Meier, Professor of Public Health, University of Sheffield, *Briefing*, 31 January 2011.

31 Professor Neil McKeganey, Director, Centre for Drug Misuse Research, University Of Glasgow, *Briefing*, 31 January 2011.

methadone maintenance as having "excellent outcomes and they have enduring outcomes" in terms of dealing with the chronic nature of heroin addiction.[32]

Data for Western Australian clients in Figure 1.6 shows a comparison of the low retention rates for two programs for heroin addicts. Just 36% of those on methadone maintenance and 14% of those on suboxone remained in the program after just 24 months.

Figure 1.6- Comparison of Retention of Patients on Methadone and Suboxone[33]



1.7 Harm minimisation

(a) Australian approach

The latest draft *National Drug Strategy 2010-2015*, the *National Cannabis Strategy 2006- 2009*, as well as individual jurisdictional policies, such as Western Australia's *Drug and Alcohol Strategy* and the Queensland *Drug Strategy 2006-2010*, are all based on the 'harm minimisation' approach.

These documents use the term 'harm minimisation' to mean a principle that encompasses both legal and illicit drugs and aims to balance three strategies:

- **supply reduction strategies** to police and disrupt the production and supply of illicit drugs and the control and regulation of legal substances;
- **demand reduction strategies** to prevent or delay the uptake of illicit drug use, including abstinence-oriented strategies and treatment to reduce drug use; and

[32] Dr A. Thomas McLellan, from the White House Office of National Drug Control Policy, 'Question and Answer Session', 2010. Available at: www.sree.org/conferences/2010/video/mclellanqa.php. Accessed on 14 March 2011.

[33] Mr Neil Guard, Executive Director, Drug and Alcohol Office, Letter, 1 March 2011, p3.

- **harm reduction strategies** to reduce drug-related harm to individuals and communities.

An independent evaluation of the earlier *National Drug Strategy 2004-2009* (NDS) noted that there was concern in the community about what was meant by 'harm minimisation'. The review found that managers and decision-makers within the NDS are comfortable with the term "using it as a convenient shorthand representation of a complex concept."[34]

However, the review found a perception existed that the term does not focus adequately on the prevention of drug use or the importance of abstinence-oriented interventions. The evaluation recommended replacing 'harm minimisation' with a term that explicitly highlights both the prevention and reduction of drug-related harm. It emphasised the importance of retaining the existing strategies of supply reduction, demand reduction and harm reduction.[35]

Family Voice submitted evidence to the Committee of "two comprehensive reports by committees of the House of Representatives" that called for the replacement of the harm minimisation policy. One House of Representatives report's recommendation included that the Australian Government:

> *replaces the current focus of the National Drug Strategy on harm minimisation with a focus on harm prevention and treatment that has the aim of achieving permanent drug-free status for individuals with the goal of enabling drug users to be drug-free.*[36]

Contrary to this Federal Committee's recommendation, the NDS and the Western Australian illicit drug programs have a high priority on harm prevention and treatment. This can be seen in the budgets allocated by the WA Police and DAO to these areas.

An Australian researcher outlined how difficult treatment programs are for heroin addicts, and how difficult it is for addicts to become abstinent:

> *There have been 20 and 24 year follow ups* [studies] *in the USA which found that about a third of people are prematurely dead. ... A third of them become clear of opiates, and the rest, that's about 40% cycle in and out of a number of treatments, and in and out of jail and in and out of heroin use. So about two-thirds of people either die, or don't overcome this problem, across a 20 year period.*[37]

Family Voice submitted that:

> *the Committee should recommend to the government that it cease all financial support for harm minimisation programs including needle exchanges, cannabis infringement notice*

---

34 Siggins Miller (2009), *Evaluation and Monitoring of the National Drug Strategy 2004-2009: Final Report*, Vol. 1, pp 30-32. Available at: www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/consult-eval. Accessed 5 January 2011.

35 Ibid.

36 Submission No. 14 from Family Voice Australia, 30 July 2009, p3.

37 Associate Professor Richard Mattick, 'Myths About Heroin Addiction', 15 October 2001. Available at: www.abc.net.au/rn/talks/8.30/helthrpt/stories/s391783.htm. Accessed on 2 December 2010.

schemes, and methadone substitution programs (unless these have as their goal a proven pathway to complete abstinence). The Committee should recommend that the government investigate the detailed operation of the successful Swedish drug policy and adopt it as a model for a new Western Australian Drug Strategy.[38]

(b) Other countries

World Health Organisation

The Committee heard from Dr Vladimir Poznyak, Head of Substance Abuse area of the World Health Organisation (WHO). He said that WHO, under Convention 61, plays an important role in recommending the level of international control on various psychoactive drugs. In 2009, during debate for a political declaration on harm minimisation at the Commission on Narcotic Drugs (CND), there was no agreement reached on the concept of, or a common policy on, harm minimisation. Even within EU countries there was no agreement.[39] The final declaration by representatives from 132 States, who were evaluating progress made since 1998 towards meeting the goals and targets established by the UN General Assembly, includes no mention of this term.[40]

Australia's National Drug Strategy includes supply reduction, demand reduction and harm reduction as parts of 'harm minimisation'. WHO considers supply reduction, demand reduction and harm reduction as the three pillars of any country's drug policy.[41]

'Road to Recovery' in the UK

The Committee heard of new policies and approaches being undertaken in Sweden and the United Kingdom (UK) based on 'recovery'. The UK has the highest usage rates of illicit drugs in the EU.[42] Over the past three years in the UK there has been a major change in the policy approach to illicit drugs. The new focus is on 'recovery' which means that treatment services must now focus their attention on enabling addicts to become drug-free.[43]

In Scotland the Committee was told the new 'Road to Recovery' strategy was supported in a bipartisan fashion and was needed as:

- there are 55,000 drug addicts in a population of 5 million people;

---

38 Submission No. No. 14 from Family Voice Australia, 30 July 2009, p5.

39 Dr Vladimir Poznyak, Head of Substance Abuse area, World Health Organisation, *Briefing*, 4 February 2011.

40 United Nations Office on Drugs and Crime, 'Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem,', March 2009. Available at: www.unodc.org/documents/commissions/CND-Uploads/CND-52-RelatedFiles/V0984963-English.pdf. Accessed on 14 March 2011.

41 Dr Vladimir Poznyak, Head of Substance Abuse area, World Health Organisation, *Briefing*, 4 February 2011.

42 Mr David Raynes, Drugs and Organised Crime Consultant, *Briefing*, 31 January 2011.

43 Professor Neil McKeganey, Director, Centre for Drug Misuse Research, University Of Glasgow, *Briefing*, 31 January 2011.

- Scotland has 550 drug deaths a year;
- over a six-year period, in only two years did the total quantity of seized heroin amount to more than 1% of the quantity that was being consumed that year;
- the socio-economic cost of drug use is £3-3.5 billion a year, and the cost of each user is £60,000 spread over the areas of health and justice; and
- there are 40-60,000 children who have a parent with a substance misuse issue.[44]

This change in the UK has been driven by several factors:

- there were over 320,000 addicts in 2006-07, nearly double the number in 1998;
- about 210,000 of these were in some form of treatment, mainly methadone;
- just 4,700 were in rehabilitation programs;
- less than 3% of those in treatment were recovering to abstinence each year; and
- the annual total cost of the program was about £750 million.[45]

Professor Neil McKeganey has been influential in the debate in the United Kingdom (UK) about the past reliance on methadone to treat heroin addicts and the need for a new approach. While acknowledging that the impact of alcohol in the UK overwhelms the use of illegal drugs, his passion for the change to a policy of 'recovery' is driven by his belief that illicit drug use has the future potential to threaten society in unforeseen ways.[46] He outlines this threat in his most recent book, *Controversies in Drugs Policy and Practice*, where he analyses the impacts of a scenario where the current 1- 1.5% of UK residents who are heroin addicts might rise to 4-5% over the next 10-15 years. He says that the UK is at a 'tipping point' and faces a challenge from illicit drugs which is as serious as the threat from global warming and terrorism.[47]

Neither in his book, or in his evidence to the Committee, does Professor McKeganey offer reasons why the rate of heroin addiction might double. Despite a drop of 24% in the number of UK heroin users in the 16-24 year age group since 1998, in later correspondence he proposes that this 'worst case' scenario will occur if there is:

- an increase in drug use amongst women, bringing their level of drug use closer to that of men;

---

44 Hon Mr Fergus Ewing MSP, Minister for Community Safety, *Briefing*, 2 February 2011.

45 Ms Kathryn Gyngell, Research Fellow, Centre for Policy Studies, *Briefing*, 31 January 2011.

46 Professor Neil McKeganey, Director, Centre for Drug Misuse Research, University Of Glasgow, *Briefing*, 31 January 2011.

47 McKeganey, N., *Controversies in Drugs Policy and Practice*, Palgrave McMillan, Hampshire, 2011, p10.

- a reduction in the age of onset of illegal drug use; and
- an increase in the level of illegal drug use in rural areas.[48]

Professor Neil McKeganey has been selected by the new Conservative-Liberal Government to convene a group to produce revised clinical guidelines in relation to methadone for the National Treatment Agency for Substance Misuse in England. These new policy approaches are already having an impact. The UK Department of Health has issued guidance to all prison-based doctors and health facilities that any prisoner who is on a sentence of longer than six months duration should not be on a maintenance dose of methadone. The Department of Health guidance is that this period is enough for any prisoner on methadone to start their journey to abstinence.[49]

In his evidence Professor McKeganey acknowledged the problem the UK Government now faces in delivering high-quality, recovery-oriented rehabilitation treatment programs to the large number of addicts they wish to help become abstinent. In his earlier book *Beating the Dragon,* he stated that getting addicts off drugs is a complex, resource-intensive and often a long-term process. It is not immediately amenable to hundreds of thousands of individuals. One suggestion that he made to ensure the success of such a large program helping addicts recover from their addiction was the use of regular random drug tests.[50]

Even those who are most vociferous in their opposition to the existing methadone maintenance programs acknowledge that there is a place for them to stabilise heroin addicts, but claim the gains are maximised within about the first eight months.[51]

Zero tolerance in Sweden

The Fresh Start Programme in Western Australia told the Committee that different approaches to harm minimisation operated in other countries, including in "Russia, medications like methadone have been made illegal because the treatments are known to prolong addiction." They recommended the 'Swedish model' which involves:

> *early detection and early intervention. In schools, police officers, social workers and school nurses work together to interview all students who show sudden changes in educational performance or family distress and drug screen them. This is followed for students who test positive for drugs with a compulsory intensive education programme consisting of six weeks of learning how to live, one year in a residential rehabilitation education programme and a second year during which they are allowed to go and live in*

---

48 Professor Neil McKeganey, Director, Centre for Drug Misuse Research, University Of Glasgow, Electronic Mail, 29 March 2011, p1. This information is expanded upon in: Neil McKeganey *et al.* 'Sociology and Substance Use', *Foresight Brain Science, Addiction and Drugs Project*, Office of Science and Technology, London, nd.

49 Professor Neil McKeganey, Director, Centre for Drug Misuse Research, University Of Glasgow, *Briefing*, 31 January 2011.

50 Ibid.

51 Ms Kathryn Gyngell, Research Fellow, Centre for Policy Studies, *Briefing*, 31 January 2011.

any town except their home town. The intensive education program costs US$10,000 per month.[52]

The Swedish approach to illicit drugs is unusual in Europe in that it is based on a zero tolerance policy. The Committee heard that this approach grew from the country's long history of temperance toward the consumption of alcohol that in 1922 saw a national referendum to ban alcohol just fail to reach a majority. Since then the sale of alcohol has been controlled by the Swedish Government and alcoholic products are only sold in government stores.[53] The Bratt system of rationing alcohol products was used between 1914 and 1955. Under the Bratt system, Swedes were granted the right to purchase only as much alcohol as they were deemed able to afford to buy. An immediate effect of this system was to limit alcohol sales among the country's women and poor.[54]

When the rise in illicit drugs swept western societies in the early 1960s, the Swedish political parties agreed that, based on their experience with alcohol, they would be made illegal. Since then the rates of illicit drug use have been generally lower in Sweden than in other European countries, but at not a significantly lower level (see Table 1.4 below). However, there has been a recent rise in use of illicit drugs that seems to be related to easier access to them through other EU countries, and a rise in the number of long-term unemployed.[55]

Table 1.4- Comparison of Swedish levels of illicit drug consumption with other selected countries, proportion of 15-64 yo (2010)[56]

Country	Cannabis use	Heroin use	Cocaine use	Amphetamine use
Sweden	2.1%	0.2%	0.6%	0.4%
Portugal	3.6%	0.5%	0.6%	0.2%
Germany	4.7%	0.2%	0.7%	0.5%
United Kingdom (England & Wales)	7.9%	0.8%	3.0%	1.1%
United States	12.5%	0.6%	2.6%	1.3%
Australia	**10.6%**	**0.4%**	**1.9%**	**2.7%**

52 Submission No. 30 from Fresh Start Recovery Programme, 31 July 2009, p4.

53 Professor Ted Goldberg, Professor of Sociology, University of Gävle, *Briefing*, 10 February 2011.

54 Answers.com, 'V&S Vin & Sprit AB', 2011. Available at: www.answers.com/topic/v-s-vin-sprit-ab-1. Accessed on 22 March 2011.

55 Professor Börje Olsson, SORAD Stockholm University, *Briefing*, 10 February 2011.

56 United Nations Office on Drugs and Crime, 'World Drug Report 2010- 4.2 Consumption', 2010. Available at: www.unodc.org/documents/wdr/WDR_2010/4.2_Consumption.pdf. Accessed on 22 March 2011.

Sweden has had a high rate of drug-related deaths. These have reduced since 2000 even with a recent rise in heroin use. This reduction in deaths was attributed in part to the greater use of methadone to treat addicts. The Committee was told that until recently, professionals in Sweden working in the illicit drug field were unable to freely use the term 'harm reduction' as it was equated to 'harm production'. The rise in drug-related deaths has led Sweden to re-assess the usefulness of harm reduction programs such as methadone.[57]

In 2011 the Swedish Government will adopt a new integrated strategy for alcohol, illicit drugs, and tobacco for the next five-year period. This is the first time that such an approach has been taken. It used to have a separate national strategy for both alcohol and for illicit drugs.[58]

Drug 'decriminalisation' in Portugal

In 2001 Portugal decriminalised the consumption of illicit drugs. Drug possession is still prohibited, but the sanctions fall under the administrative law, not the criminal law. Some reports say this development has led to a lower level of use of illicit drugs among teenagers[59] while others say it is too early to report on the impact of this change.[60] The Committee heard that the change in Portugal is not a decriminalisation of low-level possession of illicit drugs, but a 'de-penalisation' and remain similar to its neighbour, Spain.[61]. The new 'decriminalization' policy applies "to the purchase, possession, and consumption of all drugs for personal use (defined as the average individual quantity sufficient for 10 days usage for one person)."[62] In this new framework, drug usage and possession remain illegal and subject to police intervention but they are administrative violations that are processed in a non-criminal proceeding in special 'Commissions for the Persuasion of Drug Addiction' (CDT):

> *When a drug user is sent to a CDT for the first time they are just given a warning, the second time sanctions apply -- they include fines, the removal of drivers licence or passport, or a check-in with the police. Drug addicts are given the option of treatment.*[63]

A report of a recent meeting of the Global Commission on Drug Policy in Geneva called for an approach that, like Portugal's, treats drugs as a health problem and not a justice one.[64]

---

57 Ibid.

58 Ms Karin Nilsson Kelly, Dean of Section, Ministry of Health and Social Affairs, *Briefing*, 10 February 2011.

59 Mr Glenn Greenwald, CATO Institute, 'Drug Decriminalization in Portugal: Lessons for Creating Fair and Successful Drug Policies', 2009. Available at: www.cato.org/pubs/wtpapers/greenwald_whitepaper.pdf, p2. Accessed on 21 January 2011.

60 Dr Vladimir Poznyak, Head of Substance Abuse area, World Health Organisation, *Briefing*, 4 February 2011.

61 Professor Freya Vanderlaenen, Department of Criminal Law and Criminology, Ghent University, *Briefing*, 8 February 2011.

62 Mr Glenn Greenwald, CATO Institute, 'Drug Decriminalization in Portugal: Lessons for Creating Fair and Successful Drug Policies', 2009. Available at: www.cato.org/pubs/wtpapers/greenwald_whitepaper.pdf, p2. Accessed on 21 January 2011.

63 ABC -The Health Report, 'Portugal's Drug Laws', 24 August 2009. Available at: www.abc.net.au/rn/healthreport/stories/2009/2661510.htm. Accessed on 14 April 2010.

Belgium's mixed approach

The Committee heard that in Belgium there is a different approach taken to some drug policies in the northern Flemish area and the southern Wallon region. Researchers were unable to use the term 'harm minimisation' in their report to describe needle-exchange programs because of political differences. The more conservative Flemish region does not participate in programs such as the heroin prescription trial and nightclub pill-testing program that has been running for more than 20 years in the country's southern region.[65]

Conclusion

The range of differing approaches adopted by various governments towards illicit drugs reflect the differing cultures of each society and the history of their dealing earlier in the twentieth century with alcohol.[66] In this context, Australia's policy approach seems to chart a middle course.

Finding 4

Western Australia participates in the National Drug Strategy under the overarching framework of 'harm minimisation'. Harm minimisation is clearly defined in this Strategy to include demand, supply and harm reduction strategies. The term is interpreted in different ways by different stakeholders in the professional networks dealing with illicit drug users. Some use this term to just refer to reducing the risk and harm to an addict.

---

64 Dr Alex Wodak, 'Agony over Ecstasy is Helping No One', 1 February 2011. Available at: www.theage.com.au/opinion/society-and-culture/agony-over-ecstasy-is-helping-no-one-20110131-1ab3p.html. Accessed on 22 March 2011.

65 Professor Freya Vanderlaenen, Department of Criminal Law and Criminology, Ghent University, *Briefing*, 8 February 2011.

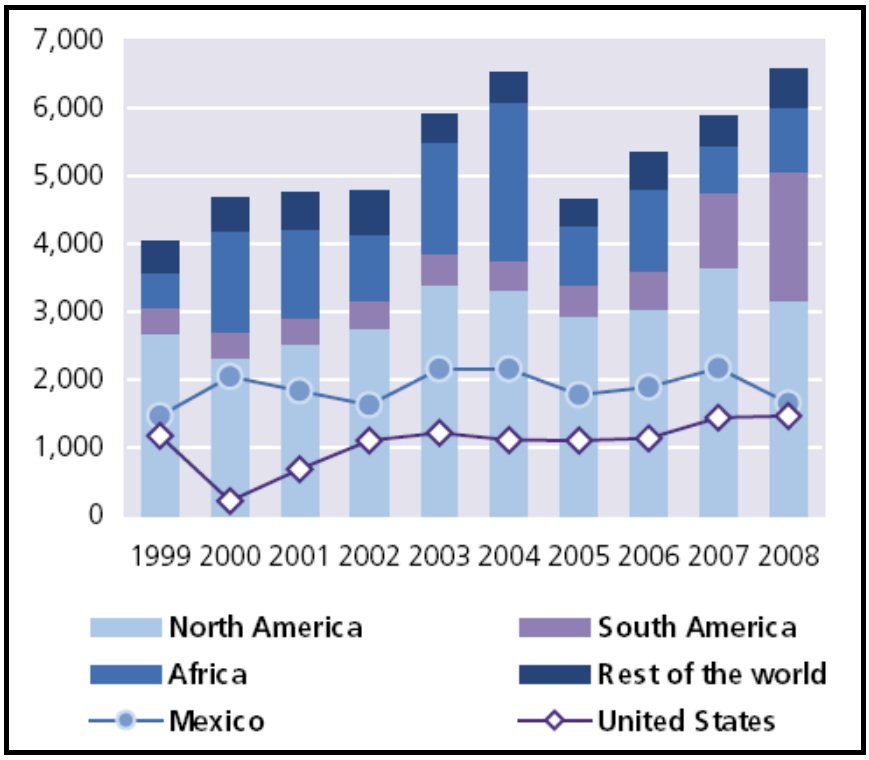
66 Professor Ted Goldberg, Professor of Sociology, University of Gävle, *Briefing*, 10 February 2011.

CHAPTER 2 CANNABIS

2.1 International situation

According to United Nations statistics "cannabis remains the most widely used illicit substance in the world." Globally, the number of people in 2008 who had used cannabis (also known as marijuana and ganga) at least once is estimated between 129 and 191 million, or 2.9-4.3% of the world population aged 15 to 64. Of the 147 countries for which United Nations Office on Drugs and Crime (UNODC) had data, 137 had seized one of the cannabis derivatives, 129 had made seizures of cannabis herb, 92 of cannabis resin, and 26 of cannabis oil. Based on 2003-2008 data, UNODC said "approximately one half of seizure cases related to all illicit drugs worldwide involved cannabis herb, resin or oil." [67] The *World Drug Report 2010* shows a generally increasing number of seizures of cannabis since 1999, as shown in Figure 2.1.

Figure 2.1- Global seizures of the cannabis plant (1999-2008)[68]



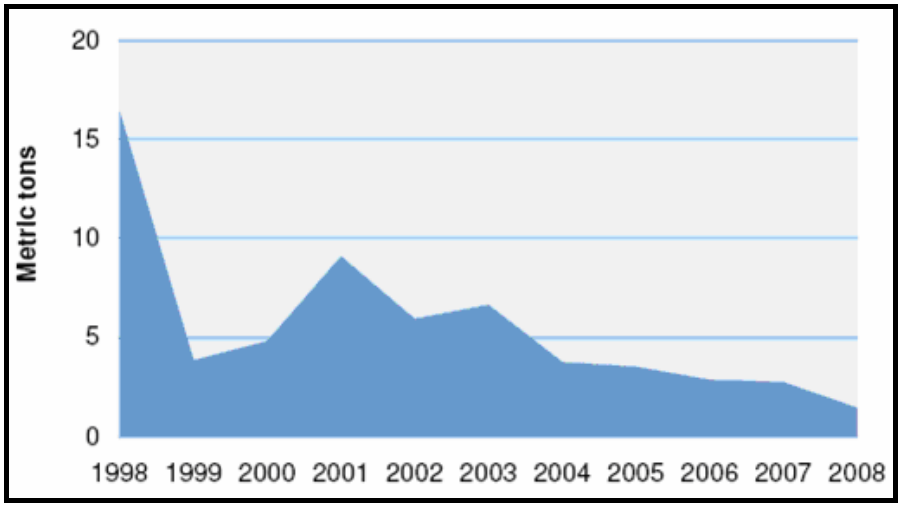
By contrast, the number of cannabis herb interceptions in the Oceania region (including Australia) has been in decline over the same period, particularly since 2001 (see Figure 2.2 below).

---

67 United Nations Office on Drugs and Crime, 'World Drug Report 2010', 2011. Available at: www.unodc.org/unodc/en/data-and-analysis/WDR-2010.html, p188 & 194. Accessed on 11 November 2010.

68 Ibid, p188.

Figure 2.2- Cannabis seizures in Oceania (1998-2008)[69]



Cannabis use in the United States and Canada has declined in the past few years, with a slight increase in the US in 2008. Between 2002 and 2007 "there was a significant decrease in the annual prevalence of cannabis use within the population aged 12 and over, from 11% to 10.1%" (in 2008 it rose to 10.3%).[70] In Canada, the annual prevalence among the population aged 15 and older decreased from 14.1% in 2004 to 11.4% in 2008.[71]

2.2 Australian situation

This declining trend in cannabis use in North America is reflective of an even greater reduction in Australia, where nationally the percentage of the population 14 and older who used cannabis in the previous 12 months had nearly halved: from 17.9% in 1998 to 9.1% in 2007.[72] These consumption rates in 2007 were as high as those in North America, and higher than most countries for which UNODC has data. The global average is between 2.9-4.3% for use in the past year by 15 to 64 year olds.[73]

---

69 United Nations Office on Drugs and Crime, 'World Drug Report 2010', 2011. Available at: www.unodc.org/documents/data-and-analysis/WDR2010/Cannabis-herb-seizures.pdf. Accessed on 11 November 2010.

70 United Nations Office on Drugs and Crime, 'World Drug Report 2010', 2011. Available at: www.unodc.org/unodc/en/data-and-analysis/WDR-2010.html, p195. Accessed on 11 November 2010.

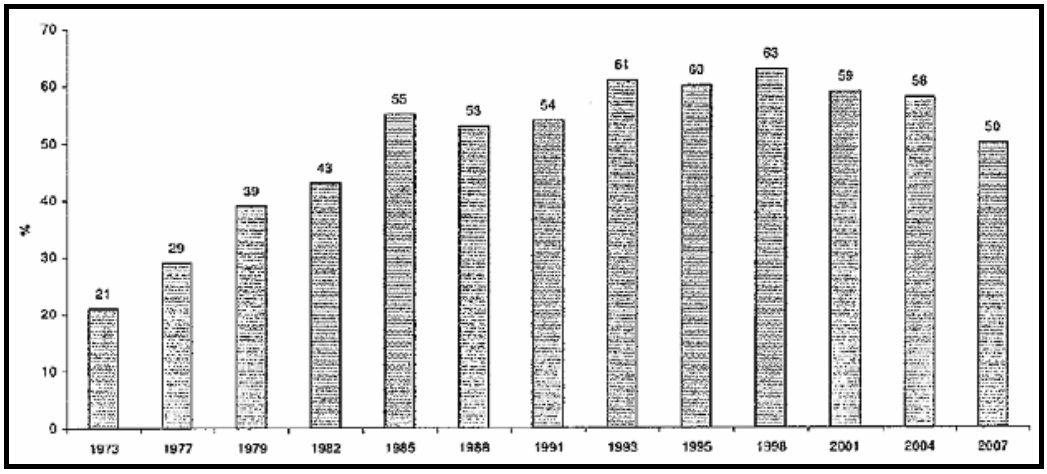
71 Ibid, p196.

72 Submission to the Queensland Social Development Committee No 60, from the National Drug Research Institute, May 2010. Available at: www.parliament.qld.gov.au/view/committees/SDC.asp?subarea=cannabis_submissions, p4. Accessed on 11 November 2010

73 United Nations Office on Drugs and Crime, 'World Drug Report 2010', 2011. Available at: www.unodc.org/unodc/en/data-and-analysis/WDR-2010.html, p194. Accessed on 11 November 2010.

The National Drug Research Institute (NDRI) reports that "lifetime cannabis use for Australians aged 20-29 (the age group with the highest prevalence of use) increased from the early 1970s to the early 1990s and recent data shows a decline since the late 1990s."[74] Figure 2.3 below plots the changes in consumption rates since 1973. It shows about half of Australians in this age group have consumed this drug at some stage. 'Lifetime use' data overstates the number of Australians who are regular users of cannabis as it includes those who may have had 'a few puffs on a joint'.

Figure 2.3- Lifetime cannabis use for Australians aged 20-29 (1973-2007)[75]



It is not clear exactly what has caused this decline. A Queensland parliamentary committee inquiry in 2010 into cannabis use suggested that the contributing factors included:

> ** the success of prevention and education messages;*
> ** a reduction in the number of people who are smoking generally;*
> ** factors related to global youth popular culture and the representation of cannabis in music, films and magazines;*
> ** an increasing awareness of the capacity of cannabis to cause harm;*
> ** the increased popularity of other drugs such as ecstasy; and*
> ** the shift towards more problematic alcohol use.*[76]

The greatest decline in usage rates in Australia over the decade 1998-2007 occurred in the 14 to 19 years age group. Usage rates for this group dropped from about 35% to 13% in this period (see Figure 2.4 below).

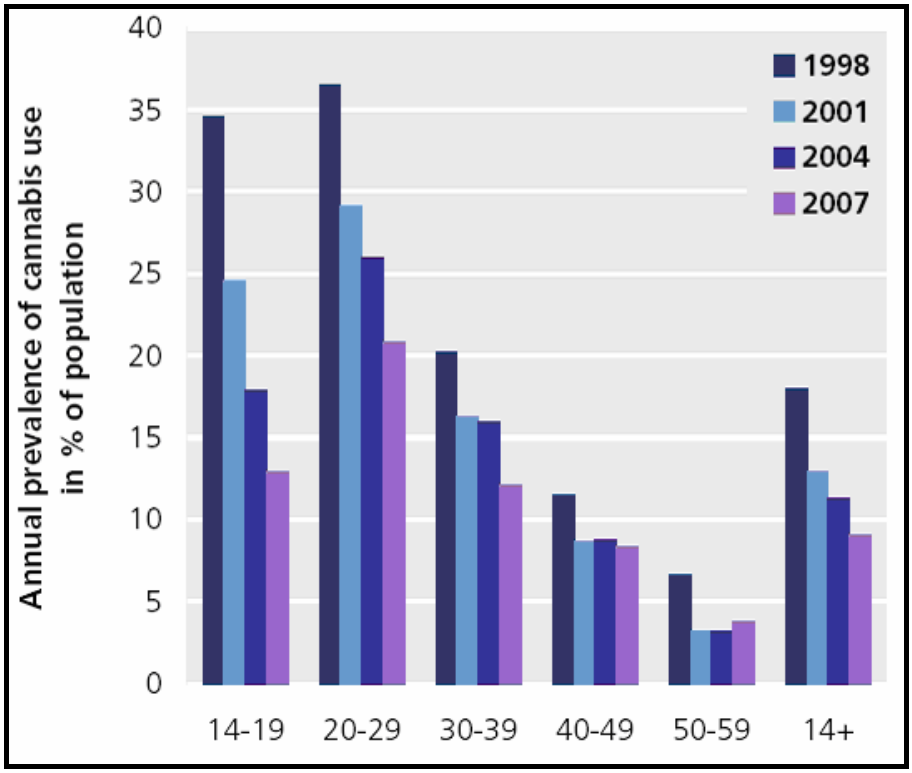
---

74 Submission to the Queensland Social Development Committee No 60, from the National Drug Research Institute, May 2010. Available at: www.parliament.qld.gov.au/view/committees/SDC.asp?subarea=cannabis_submissions, p4. Accessed on 11 November 2010.

75 Ibid.

76 Social Development Committee, *Inquiry into Addressing Cannabis-Related Harm in Queensland, Report 10* Government of Queensland, November 2010. Available at: www.parliament.qld.gov.au/view/committees/SDC.asp?SubArea=inquiries. Accessed on 22 December 2010.

Figure 2.4- Annual prevalence of cannabis use among Australians aged 14 and above (1998-2007)[77]



2.3 Western Australian evidence

In Western Australia, the overall cannabis usage rate more than halved over the decade 1998 to 2007: from 22.3% to 10.8% of the population having used it in the past 12 months. The State's usage rate has been consistently higher than the national rate. Despite the general decline in usage, cannabis use is still a significant health and justice problem in some sectors of the State's population. For example, according to the Drug and Alcohol office "cannabis was the most commonly reported illicit substance used [in the last 12 months] by Indigenous people in 2004-05 (23% versus 11% across the total State population)."[78]

The 2007 *Drug Use Monitoring in Australia* report found that at the East Perth Police lockup, 53% of males and 45% of females in detention tested positive for cannabis. Of the male detainees, whose most serious offence was one of violence, 63% tested positive for cannabis.[79]

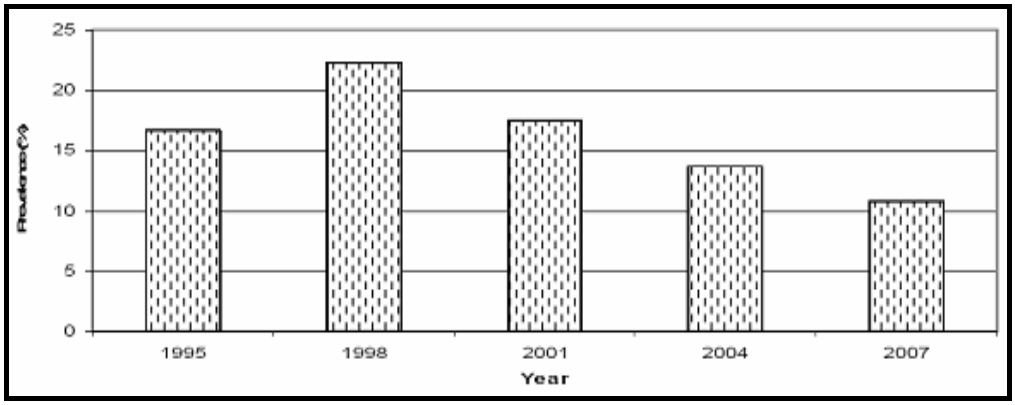
---

77 United Nations Office on Drugs and Crime, 'World Drug Report 2010', 2011. Available at: www.unodc.org/unodc/en/data-and-analysis/WDR-2010.html, p201. Accessed on 22 December 2010.

78 Submission No. 37- Part A from the Drug and Alcohol Office, 25 August 2009, p12.

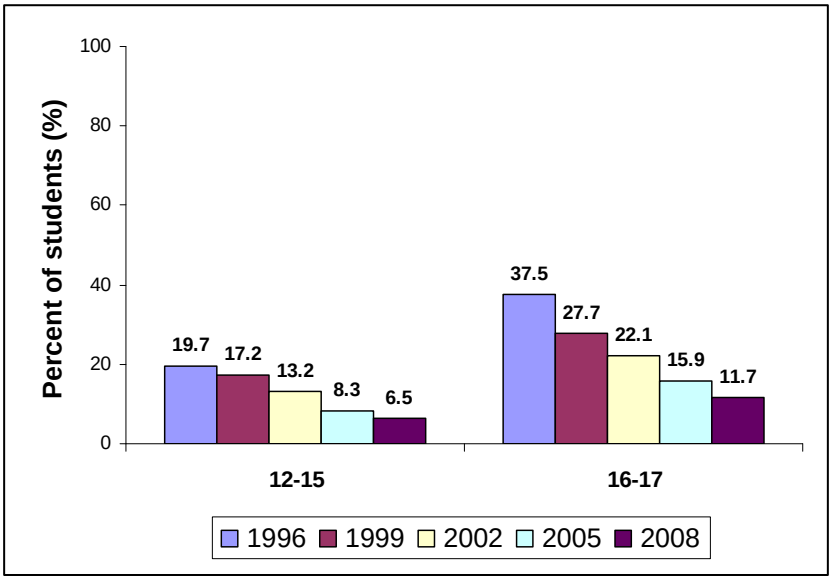
79 Ibid, p23.

Figure 2.5- Cannabis use in the past 12 months for Western Australians (1995-2007)[80]



One of the most significant indicators of the decrease in cannabis use was the most recent survey of Western Australian schoolchildren. Figure 2.6 shows a drop of nearly two-thirds between 1996-2008, for both the younger and older student age groups, who smoked cannabis in the last month. The survey highlighted the peer pressure felt by students to smoke cannabis. They were asked to estimate the proportion of students their own age who use cannabis at least once a week. Overall, students estimated that 25.8% of their peers used it at least once a week. This is a dramatic overestimate, as only 4.5% actually reported using cannabis in the previous week.[81]

Figure 2.6- Cannabis use in the past month by Western Australian school children (1996-2008)[82]



80 Submission No. 37- Part A from the Drug and Alcohol Office, 25 August 2009, p8.

81 Ms Rebecca Haynes, 'Australian School Student Alcohol and Drug (ASSAD) Survey Results from 2008', 2010. Available at: www.dao.health.wa.gov.au/Publications/tabid/99/DMXModule/427/Default.aspx?EntryId=1217&Command=Core.Download, slide 12. Accessed on 22 March 2011.

82 Ibid, slide 13.

(a) Regional differences

While the State-wide rate of cannabis consumption seems to have declined, the Committee heard evidence that it is far more widespread in remote regions such as the Kimberley:

> *It is incredibly widespread and it is debilitating. It diminishes people's motivation; they sit around more and it is a very widespread problem. It does not come to the attention of either the Police or medical services as much because they just sit around and do not cause any trouble, but it is part of the big overall problem that we have in the region. … an awful lot of people, when they talk to their doctor, admit to fairly large-scale cannabis consumption on a regular basis.*[83]

Statistics provided by DAO in Table 2.1 below highlight the regional differences within the State and the above average rate of use of cannabis in the Kimberley and the Goldfields.

Table 2.1- Proportion of Western Australian regional population using cannabis in the past 12 months (2004)[84]

Region	Cannabis	Any Illicit Drug
Kimberley	30.2%	**35.9%**
Pilbara-Gascoyne	14.9%	**16.7%**
Midwest- Murchison	14.0%	**18.4%**
Goldfields- SE Coastal	22.5%	**25.3%**
North Metropolitan	14.4%	**18.3%**
South Metropolitan	12.4%	**16.1%**
Wheatbelt	4.7%	**11.4%**
South West	13.1%	**14.8%**
Great Southern	11.3%	**11.5%**
STATEWIDE AVERAGE	**13.7%**	**17.3%**

In Fitzroy Crossing, the Committee was told by the Police that "we have an emerging trend towards cannabis. Three years ago, the cannabis use in town was fairly negligible, but it is now becoming more prevalent. It seems to be supplied by extended family members from Derby or

83 Dr David Atkinson, Acting Medical Director/Medical Educator, Kimberley Aboriginal Medical Services Council, *Transcript of Evidence*, 26 July 2010, pp7-8.

84 Submission No. 37- Part A from the Drug and Alcohol Office, 25 August 2009, p10.

Broome."[85] The claim that cannabis distribution in the Kimberley originated in Broome and Derby was confirmed by Mr Boke at Noonkanbah station.[86]

One of the reasons why cannabis usage is widespread but not heavy amongst the Indigenous population in the Kimberley is "there is not a lot of ready cash to go around to go and buy cannabis." Generally for residents it is cheaper to purchase alcohol as it is more readily available. Senior Sergeant Sears, OIC, Kununurra Police Station said:

> *is not as prevalent as what it might be if this were a mining town where people with very high incomes and a lot of available cash to spend on drugs of recreation, if you may like to call them. I do not like to call them recreation drugs because drugs are drugs at the end of the day. So, cannabis is not as prevalent in that aspect amongst the Indigenous people.*[87]

2.4 Health and other impacts

Evidence has emerged that the health impact of cannabis use may be more significant than previously thought. Earlier perceptions of the drug as relatively harmless have given way to a recognition that it carries with it risks associated with both acute and chronic use. For example, a recent 'meta analysis' of 83 scientific studies reported that "the age at onset of psychosis for cannabis users was 2.7 years younger than for nonusers".[88] Unfortunately the design of this study meant that it could not confirm that the use of cannabis caused a user's psychosis. The research has been criticised as it did not consider whether those cannabis users who developed psychosis may have been pre-disposed to it.[89]

However, it has been known for some time that cannabis use does lead to a wide range of psychological effects for many users. According to National Drug Research Institute (NDRI):

> *the most common acute harms associated with cannabis use include negative psychological effects such as anxiety and paranoia,…disrupting memory and other*

---

85 Senior Sergeant Ian Gibson, OIC, Fitzroy Crossing Police Station, WA Police, *Transcript of Evidence*, 29 July 2010, p2.

86 Mr Denis Boke, Yungngora (Noonkanbah) Community, *Transcript of Evidence*, 30 July 2010, p5.

87 Senior Sergeant Graham Sears, OIC, Kununurra Police Station, WA Police, *Transcript of Evidence*, 2 August 2010, p10.

88 Large, M. *et al.* 'Cannabis Use and Earlier Onset of Psychosis- A Systematic Meta-analysis', *Archives of General Psychiatry*, 7 February 2011, ppE1-7.
The report also found that alcohol use was not associated with a significantly earlier age at onset of psychosis.

89 Professor Wayne Hall and Professor Louisa Degenhardt, 'Adverse Health Effects of Non-medical Cannabis Use', *The Lancet*, vol. 374, 17 October 2009, p1388.

> *cognitive functions,…psychomotor impairment…and an increased risk of psychotic symptoms amongst vulnerable individuals.*[90]

In addition to these harms, cannabis intoxication is a significant risk factor for motor vehicle accidents due to its effect of impairing complex psychomotor functions. Research suggests that drivers killed in a motor vehicle crash that tested positive:

> *to any level of THC* [the active ingredient in cannabis] *alone were 2.7 times more likely to have been responsible for their accident and those at >5ng/ml (indicative of likely intoxication with the drug) were 6.6 times more likely to be culpable than drug-free drivers.*[91]

Evidence was given to Parliament that "cannabis use places a massive impost on our health system". Parliament was told that the number of Western Australians treated as outpatients in the State's psychiatric hospitals specifically for cannabis issues nearly doubled in five years, from 462 in 2001 to 804 in 2006.[92]

Chronic use of cannabis carries a range of risks for the user, including cannabis dependence. It is estimated that "around 10% of cannabis users become regular heavy users and risk long-term health consequences and dependence."[93] Adolescent users consuming cannabis daily appear to be more at risk of dependence than their older counterparts:

> *Young people are at higher risk of developing the adverse acute and chronic effects of cannabis, and in particular may be more at risk of dependence…Daily or near daily use by adolescents is the most risky pattern of use. One study found that 73% of Victorian students using daily were dependent compared to 13% of those using 1-2 days a week.*[94]

Heavy, chronic cannabis smoking poses risks to the user's respiratory system, contributing to respiratory disease. Some recent reviews and "case controlled studies of lung cancer suggest cannabis smoking is a risk factor," although the research is not conclusive at this point.[95]

---

90 Submission to the Queensland Social Development Committee No 60, from the National Drug Research Institute, May 2010. Available at www.parliament.qld.gov.au/view/committees/SDC.asp?subarea=cannabis_submissions, p6. Accessed on 11 November 2010.

91 Ibid.

92 Mr Peter Abetz, MLA, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 21 April 2010, p1937.

93 Submission No. 18 from National Drug Research Institute, August 2009, p3.

94 Submission to the Queensland Social Development Committee No 060, from the National Drug Research Institute, May 2010. Available at www.parliament.qld.gov.au/view/committees/SDC.asp?subarea=cannabis_submissions, p7 & p9. Accessed on 11 November 2010.

95 Ibid.

Recent research has provided new evidence of:

> *cannabis exposure-related structural abnormalities in the hippocampus and amygdla in a small sample of long term heavy users. …Subtle impairments among chronic cannabis users have been demonstrated in thinking ability - including memory, attention and the ability to handle complex information.*[96]

The Committee heard in the Kimberley that an additional problem created by the smoking of cannabis was the effect this has had on reducing the sexual inhibitions of young women. This has contributed to high rates of teenage pregnancies and sexually transmitted infections (STIs). The Committee was told that some pregnant girls continued to smoke cannabis during and after their pregnancies.[97]

However, the most well-known impact of cannabis use on young people is its link with psychosis:

> *In a nutshell the emerging evidence suggests that cannabis use roughly doubles the risk of psychosis (from 7 cases in 1,000 to 14 in 1,000)…The risk is greater for those who begin at an early age and daily or near-daily users…Thus, daily adolescent users were 1.6 to 1.8 times more likely than non-users to develop psychosis.*[98]

Some studies estimate that up to 10% of people who use cannabis more than once in their life experience cannabis related psychosis or delirium.[99] There is a discussion between experts and within the scientific literature around the role played by a person's vulnerability to psychosis and the interaction with cannabis use:

> *A well controlled laboratory study found a dose response relationship between THC and symptoms of psychosis in a sample of people in remission with a past diagnosis of schizophrenia again pointing to a link between cannabis use and psychotic symptoms in people with a demonstrated vulnerability…**It has been estimated that if all adolescent cannabis use could be stopped it would reduce the rate of schizophrenia by between 8% to 13%.***[100]

---

96 Ibid.

97 Mr Christopher Cresp, Chief Executive Officer, Palyalatju Maparnpa Health Committee, *Transcript of Evidence*, 27 July 2010, p13.

98 Submission to the Queensland Social Development Committee No 60, from the National Drug Research Institute, May 2010. Available at www.parliament.qld.gov.au/view/committees/SDC.asp?subarea=cannabis_submissions, pg7-8. Accessed on 11 November 2010.

99 Jan Ramstrom, *Adverse Health Consequences of Cannabis Use: A Survey of Scientific Studies Published up to and Including the Autumn of 2003*, National Institute of Public Health - Sweden, Sweden, 2004, p40.

100 Submission to the Queensland Social Development Committee No 60, from the National Drug Research Institute, May 2010. Available at www.parliament.qld.gov.au/view/committees/SDC.asp?subarea=cannabis_submissions, p8. Accessed on 11 November 2010.

Another area of discussion among experts is the relationship between cannabis use and anxiety and depression. A number of studies have found a link between these factors, but further research is needed to understand any causal relationship between them.[101] Another researcher said:

> *Cannabis use also poses a moderate risk for later depression, with heavy cannabis use possibly posing a small additional risk of suicide. While cannabis use and anxiety disorders co-occur at a rate greater than chance, the relationship appears to be largely mediated by factors other than cannabis use.*[102]

2.5 Legal reforms to the State's cannabis laws

(a) The *Cannabis Control Act 2003*

One of the outcomes of the 2001 Community Drug Summit was a review of, and amendment to, the legislation relating to the penalties for the possession and use of small quantities of cannabis. The *Cannabis Control Bill 2003* was developed by a Ministerial Working Party and was passed in Parliament on 24 September 2003. The *Cannabis Control Act 2003* came into effect on 22 March 2004.[103]

This Act introduced a new process known as the Cannabis Infringement Notice Scheme (CIN). This system of civil penalties meant that while the possession, use or cultivation of any amount of cannabis remained illegal in Western Australia, adults in possession of not more than 30 grams of cannabis, up to two non-hydroponic cannabis plants, or a used smoking implement could avoid a criminal conviction if they paid a fine or attended an approved education session.[104]

Parliament was told that the use of this scheme was quite low with as few as 135 people participating in the education sessions.[105] A review of CINS found that in the three years between 2004 and 2007 1,269 of the CINs (or 13%) were expiated by the attendance at education

---

101 Ibid.

102 Ms Joanne Ross, National Drug and Alcohol Research Centre, 'Illicit Drug Use in Australia: Epidemiology, Use Patterns and Associated Harm', 2007. Available at: www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/17B917608C1969ABCA257317001A72D4/$File/mono-63.pdf, pv1. Accessed on 2 March 2011.

103 The *Cannabis Control Act 2003* only applied to adults. The *Young Offenders Act 1994* continues to apply to juveniles. Drug and Alcohol Office, '2004 Cannabis Program', nd. Available at: http://www.dao.health.wa.gov.au/AboutDAO/Prevention/2004CannabisProgram/tabid/94/PageContentID/103/Default.aspx. Accessed on 21 March 2011.

104 *Cannabis Control Act 2003.* Available at www.slp.wa.gov.au/legislation/statutes.nsf/main_mrtitle_110_homepage.html. Accessed 20 December 2010.

105 Ms Lisa Baker, MLA, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 21 April 2010, p1938.

sessions.[106] The Albany Police reported they had been told they were one of the most prolific infringement areas, with 17 in one year, which reflects the lack of uptake of the discretionary, voluntary scheme.[107] In Kalgoorlie, it was reported that Centrecare had received only 10 referrals over four years, and in Merredin there were no cannabis infringement notices from the region within the nine month period immediately prior to the Committee's hearing.[108] Sergeant Daley in Merredin explained that this was not because cannabis was not a problem in the area, but that people caught with cannabis were carrying amounts too big to qualify for the CINS.[109]

A NDRI study in 2007 of public knowledge and attitudes to drug use reported on the then-Government's decriminalisation of cannabis under the *Cannabis Control Act 2003* and found that:

> *two-thirds of the general community who responded to the 2007 survey considered the …Cannabis Infringement Notice Scheme 'a good idea';* [and] *one-third of recent users believed users with a problem were more likely to seek help since the law changes.*[110]

However, the Minister for Police, Hon Rob Johnson, reported to Parliament that in 2009 "fewer than 5% of offenders who [were] given a cannabis infringement notice opt[ed] to attend the education session. Most offenders opt to pay the modified penalty attached to the cannabis infringement notice."[111]

(b) The *Cannabis Law Reform Act 2010*

The *Cannabis Law Reform Bill 2009* introduced by the Barnett Government repealed the *Cannabis Control Act 2003* and amended the *Misuse of Drugs Act 1981* and the *Young Offenders Act 1994*. Under the *Cannabis Law Reform Act 2010*, the option to pay a fine to avoid participating in an education session is removed. Instead, both adult and juveniles found in possession of 10 grams or less of cannabis are required to attend and complete a 90-minute Cannabis Intervention Requirement (CIR) scheme session within 28 days. If the person does not attend the intervention session, they will be prosecuted by Police for the original offence.

---

106 Drug and Alcohol Office, 'Statutory Review Cannabis Control Act 2003- Technical Report', November 2007. Available at: www.dao.health.wa.gov.au/Publications/tabid/99/DMXModule/427/Default.aspx?EntryId=935&Command=Core.Download, p44. Accessed on 21 April 2010.

107 Superintendent Dene Leekong, Great Southern District Office, WA Police, *Transcript of Evidence*, 11 September 2009, p11.

108 Ms Deborah Clark, Chairperson, Kalgoorlie Local Drug Action Group, *Transcript of Evidence*, 14 September 2009, p9, and Mr Luke Turner, Diversion Officer and Counsellor-Educator, Wheatbelt Community Drug Service Team, *Transcript of Evidence,* 7 September 2009, p5.

109 Sgt Michael Daley, Acting Officer in Charge, Merredin, WA Police, *Transcript of Evidence,* 7 September 2009, p5.

110 Submission No. 18 from the National Drug Research Institute, 5 August 2009, p6.

111 Hon Mr Rob Johnson, Minister for Police, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 14 October 2009, p8023.

The nature of the intervention session will be different to the original education sessions. The intervention session will be an individual therapeutic intervention. These changes are expected to significantly impact on the uptake rate for the intervention option. As the Minister for Police said, "Given the nature of the cannabis intervention session and the fact that the alternative is prosecution through the court, it is anticipated that a significant proportion of offenders will attend and complete this requirement."[112]

Other changes in the *Cannabis Law Reform Act 2010* include the eligibility of juveniles to access two CIRs, whereas adults are only eligible for one. Offenders will no longer be eligible for the diversion scheme if they are cultivating cannabis plants, are in possession of plants, or are in possession of cannabis resin or other derivatives. In addition, the sale or displaying for sale of cannabis smoking paraphernalia will be an offence.

The Government expects that the revised diversion program will attract about 3,500 clients a year– 1,000 juveniles and 2,500 adults. This will place a significant load on treatment agencies and so an additional $6 million has been allocated to DAO over the next four years to provide for treatment services and public education campaigns. This includes funding for ongoing treatment should clients require treatment beyond the mandatory first session. The funding for this scheme over the current Budget and out years is:

- 2010-11: $1.125 million;
- 2011-12: $1.72 million;
- 2012-13: $1.608 million; and
- 2013-14: $1.684 million.[113]

The Minister for Police committed to Parliament that the new legislative framework will be reviewed 12 months after its proclamation. This review will allow the Government to:

- ensure that the scheme is operating as envisaged;
- assess whether the funding provided for treatment sessions is sufficient;
- examine the efficacy of the intervention sessions;
- review the extent to which CIRs are available in regional and remote areas; and
- assess the effectiveness of treatment agencies delivering the intervention sessions.[114]

---

112 Ibid.

113 Hon Mr Rob Johnson, Minister for Police, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 12 August 2010, p5527.

114 Ibid.

The review will be an opportunity to analyse intervention data provided within the first year of operation. A review of Queensland's similar diversion program "found that 81% of people eligible for the scheme accepted the referral to the assessment and information session…Further research found some 60% of these were found to be cannabis dependent."[115]

Current Australian statistics on treatment uptake suggest that cannabis users do not often access treatment services. According to research by the National Drug and Alcohol Research Centre (NDARC), the 'treatment penetration rate' for cannabis use is only about 10%. This means that there are about 30,000 treatment episodes at any one time in Australia, compared with approximately 300,000 weekly users.[116] NDARC cited:

> *a recent NCPIC* [National Cannabis Prevention and Information Centre] *survey of 200 regular cannabis users revealed that only one quarter (26.5%) of the total sample was aware of the availability of specific cannabis treatments, although the majority (88.4%) believed that such treatment is important.*[117]

The Committee hopes that the new *Cannabis Law Reform Act 2010* will enable a greater awareness of the availability of treatment options for the State's cannabis users.

Finding 5

Western Australia's overall cannabis usage rate halved from 1998 to 2007. However, data show that its use remains a significant health and justice issue, particularly in regions such as the Kimberley and the Goldfields. The Government expects that new cannabis laws will further lower the consumption of cannabis in the State, particularly among young users who access the cannabis intervention requirement (CIR) scheme education sessions.

115 Submission to the Queensland Social Development Committee No 60, from the National Drug Research Institute, May 2010, available at www.parliament.qld.gov.au/view/committees/SDC.asp?subarea=cannabis_submissions, p17.

116 Submission No. 10 from National Drug and Alcohol Research Centre, 29 July 2009, p2.

117 Ibid, p3.

Recommendation 2

Given the dangers of young cannabis users being impacted by psychosis, the Minister for Police should ensure that the 12-month review of the *Cannabis Law Reform Act 2010* assesses in particular the impact of the legislation on young cannabis users aged up to 25 years of age.

CHAPTER 3 STIMULANTS AND 'PARTY DRUGS'

3.1 Introduction

This chapter deals with stimulant substances, such as cocaine and ecstasy. These are often referred to generically as 'party drugs' because they are distributed at 'raves' or parties where they are consumed as pills. The most popular of these types of substances are defined by the United Nations Office on Drugs and Crime (UNODC) as 'amphetamine-type stimulants' (ATS). These are "a group of synthetic substances comprised of amphetamine-group (primarily amphetamine and methamphetamine) and ecstasy-group substances (MDMA)."[118] Chemicals closely related to ecstasy (called 'analogues') include MDA and MDEA.[119]

3.2 Amphetamine-type stimulants

ATS are now the State's second most-commonly used illicit drug and their prevalence is considerably greater than heroin. Some of the street names for these drugs are set out below.

Table 3.1- Names of Amphetamine-type Stimulants[120]

Scientific name	**Street name** (most well-known names are in italics)
Amphetamine, dexamphetamine	*speed*, whiz, uppers, goey, louee, dexies, pep pills
Methylamphetamine	*meth, speed*, whiz, fast, uppers, goey, louee, pep pills
Methylamphetamine- paste	base, pure, wax
Methylamphetamine- liquid	oxblood, leopard's blood, red speed, liquid red
Methylamphetamine- crystal	*ice*, *meth*, d-meth, glass, *crystal*, batu, shabu
MDMA: 3,4-methylenedioxymethamphetamine	XTC, X, *ecstasy*, Adam, M&M, eccy, E, go, scooby snacks, hug, beans
MDEA: 3,4-methylenedioxyethylamphetamine	Eve
MDA: 3,4-methylenedioxyamphetamine	Love bug, crystal, P, window pane

118 United Nations Office on Drugs and Crime, 'World Drug Report 2010', 2011. Available at: www.unodc.org/unodc/en/data-and-analysis/WDR-2010.html, p95. Accessed on 11 November 2010.

119 The chemical name for ecstasy is 3, 4 methylenedioxymethylamphetamine, but it is usually abbreviated to MDMA. MDMA is closely related to another phenethylamine, MDA (3, 4-methylenedioxyamphetamine), and to mescaline. A third phenethylamine, MDEA (3,4-methylenedioxyethylamphetamine) is also known as MDE. See: *A Rough Guide to Ecstasy*, www.urban75.com/Drugs/e_guide.html. Accessed on 1 March 2010.

120 Australian Crime Commission, *Illicit Drug Data Report*, Commonwealth of Australia, Canberra, June 2009, p14.

(a) International situation

According to UNODC, the spreading use of ATS can be attributed to their attractiveness to both users and the criminal organisations, such as bikie gangs, who manufacture them:

> *They appeal to the needs of today's societies and have become part of what is perceived to be a modern lifestyle, both recreationally and occupationally. Their use is believed to enhance performance including sexual performance and their use is often initiated by mouth in 'convenient' and discrete pill form that avoids the dangers of injection or social stigma of smoking. They are affordable, often sold in single tablet units, which are often erroneously perceived as being less harmful than in other forms.*[121]

The *World Drug Report 2010,* while recognising the difficulties in estimating the prevalence of use of ATS substances, reports that:

> *past-year amphetamine-group and ecstasy-group users are estimated to be in the range of 14 to 53 million and 10 to 26 million, respectively. Thus the global number of ATS users likely continues to exceed the number of opiate and cocaine users combined.*[122]

New data suggests an increasing use in developing countries. The *World Drug Report 2010* finds that "ATS problem drug use represents the only class of drug use in the past decade which has increased significantly in every region of the world."[123] However, in developed ATS markets where regular assessments of drug use among the general population are carried out, UNODC says that the annual prevalence of amphetamine-group substances has stabilised or declined over the past seven years.[124]

Global usage estimates vary widely due to difficulties with data availability and analysis. The UN estimates that amphetamine-group substance users who used at least once in the preceding year equate to a global annual prevalence range of 0.3% to 1.2% of the population aged 15 to 64 years. For ecstasy-group users, the range is between 10.5 to 25.8 million people worldwide, or 0.2% to 0.6% of this age group.[125]

In the United States the annual usage prevalence rate of all stimulants among the population aged 12 and over was reported as 1.1% in 2008, a decline from 1.5% in 2006.[126] In Europe "between 2.5 and 3.2 million people aged 15-64 had used amphetamines-group substances at least once in the past year, and the annual prevalence is estimated at between 0.5% to 0.6%."[127]

---

121 United Nations Office on Drugs and Crime, 'World Drug Report 2010', 2010. Available at: www.unodc.org/unodc/en/data-and-analysis/WDR-2010.html, p95. Accessed on 11 November 2010.

122 Ibid, p100.

123 Ibid p103.

124 Ibid, p101.

125 Ibid, p214.

126 Ibid, p221.

127 Ibid, p217.

During its research in Europe, the Committee was told that these stimulants were popular in the United States. There was not a major problem of illegal backyard laboratories producing methamphetamine in the UK.[128] In France amphetamine use is rising, but the Committee heard that there is not much methamphetamine use as the French seemed to be not keen on synthetic drugs, but prefer the 'natural variety', such as cannabis.[129]

(b) Australian situation

UNODC data show that some of the highest prevalence rates in the world for both amphetamine-type and ecstasy-group substances are in Australia and New Zealand:

> *The prevalence of amphetamines use in New Zealand (2.1% among the population aged 16-64) in 2008 and Australia (2.7% among the population aged 15-64) in 2007 remains one of the highest in the world, though there are signs of a declining trend in recent years…The highest prevalence of 'ecstasy' use remains in Oceania (3.6%-4%)*[130]

According to the Australian Institute of Health and Welfare's *National Drug Strategy Household Survey 2007*, the Australian usage rates for the population aged over 14 years in the previous 12 months was 2.3% for meth/amphetamine (speed), and 3.5% for ecstasy. Western Australia's rates are considerably higher than the national rate – 4.2% for meth/amphetamine (speed) and 4.1% for ecstasy.[131] One illustration of the increase in usage of amphetamine in Australia over the past decade is the rapid rise in the discovery of clandestine drug labs, shown in Figure 3.1 below.

---

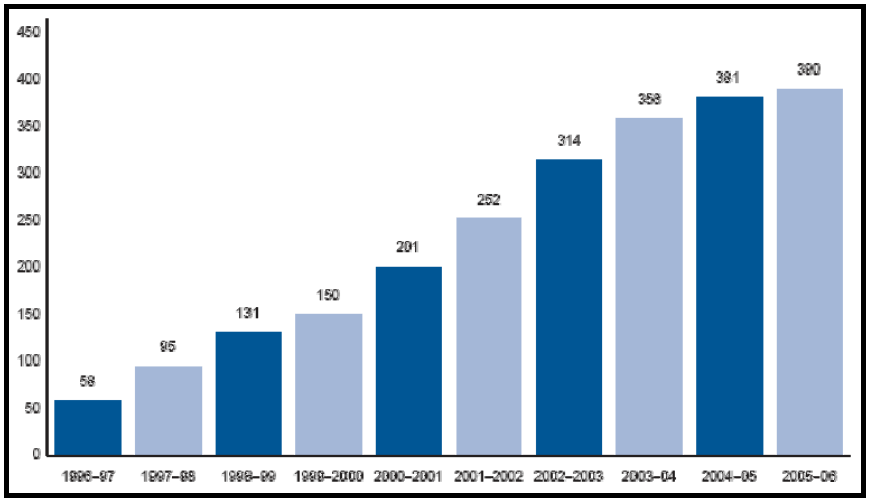
128 Professor Neil McKeganey, Director, Centre for Drug Misuse Research, University Of Glasgow, *Briefing*, 2 February 2011.

129 Mr Etienne Apaire, President, Mission Interministerielle de Lutte Contre la Drogue et la Toxicomanie, *Briefing*, 7 February 2011.

130 United Nations Office on Drugs and Crime, 'World Drug Report 2010', 2010. Available at: www.unodc.org/unodc/en/data-and-analysis/WDR-2010.html, pp222-223. Accessed on 11 November 2010.

131 Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2007 - First Results*, Available at: www.aihw.gov.au/publications/phe/ndshs07-fr/ndshs07-fr-no-questionnaire.pdf, p31&33. Accessed on 11 November 2010, and Submission No 18, National Drug Research Institute, August 2009, p3.

Figure 3.1- Discovery of Australian clandestine drug labs (1996-2006)[132]



(c) Western Australian evidence

(i) The West Australian Illicit Amphetamine Summit

Concern around the usage of amphetamines in Western Australia resulted in a summit in 2007, which was sponsored and co-chaired by the Police Commissioner and the Director General of the Department of Health. The summit aimed to identify and develop strategies to address illicit amphetamine use in WA.

In line with a recommendation of this summit, the Government provided funding through the Drug and Alcohol Office for new drug and alcohol nurse positions to be established in the three tertiary emergency departments in Perth "to provide assessment and engagement into treatment as well as support for families and information for emergency department staff."[133] These positions have become a significant resource for the tertiary hospitals in managing all drug and alcohol-related presentations.

---

132 Australian Institute of Criminology, 'Clandestine Drug Laboratories in Australia', October 2007. Available at: www.aic.gov.au/publications/current%20series/cfi/141-160/cfi160.aspx, p1. Accessed on 15 December 2010.

133 Drug and Alcohol Office, *Western Australia Illicit Amphetamine Summit July 2007: Government Action Plan*, Government of Western Australia, Perth, 2007, p34. Available at: www.dao.health.wa.gov.au/Publications/tabid/99/DMXModule/427/Default.aspx?EntryId=892&Command=Core.download. Accessed on 21 December 2010.

The Drug and Alcohol Office reported in mid-2009 on these nurse positions:

> *From the feedback we are getting, it is proving very successful, including follow-ups with people who they were not there with at the time but whose telephone numbers have been taken, or who have been given an opportunity to call for further advice and information.*[134]

The Committee heard evidence from both Sir Charles Gairdner Hospital (SCGH) and Royal Perth Hospital (RPH) that they would like to be able to expand the scope and hours of the drug and alcohol services they provide. SCGH currently provides a 6-days a week service and would like to move to 7-days a week.[135] RPH currently provides a 9am to 5pm weekday service and would also like to move to 7-days a week.[136] Further details regarding these treatment services and proposals to expand them are covered in Chapter 7.

Recommendation 3

In the 2012-13 State Budget, the Minister for Health and the Minister for Mental health jointly fund additional specialist drug and alcohol counsellor positions and Clinical Nurse Consultants (such as that at Sir Charles Gairdner Hospital) specialising in drug and alcohol services in tertiary hospitals, and skilled drug and alcohol service nurses in secondary hospitals, in order to provide these services seven days a week, especially at peak times.

(ii) Recent data

Police report that the number of clandestine drug laboratories detected and dismantled in Western Australia rose "by 421%, from 24 in 2008 to 125 in 2009."[137] By the end of 2010, the Police had detected 132 clandestine labs. The rapid rise in the detection of these labs since 2008 is shown in Figure 3.2 below.[138] Following an explosion in one of the labs, the Minister for Police, Hon Rob Johnson, announced the Government was "planning to increase criminal penalties for people caught manufacturing drugs where there were children at the property."[139]

---

134 Mr Neil Guard, Executive Director, Drug and Alcohol Office, *Transcript of Evidence*, 26 August 2009, p13.

135 Submission No. 12 from Ms Etza Peers, Clinical Nurse Consultant, Alcohol and Drug Service, Sir Charles Gairdner Hospital, 30 July 2009, p5.

136 Submission No. 42 from Dr Nigel Armstrong, Chairman Elect, Royal Perth Clinical Staff Association, 29 September 2009, p2.

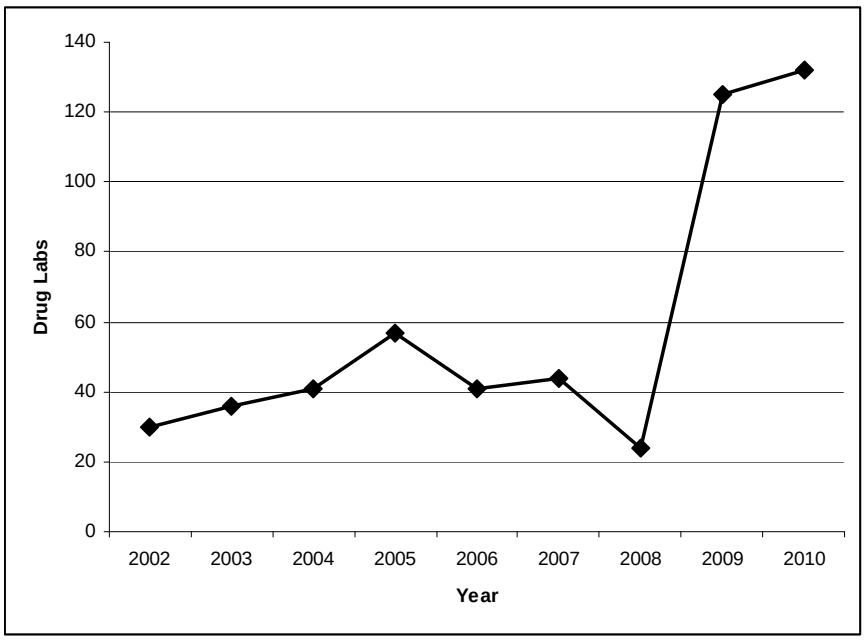
137 Western Australian Police, *Western Australian Police Annual Report 2010*, Perth, 2010, p21.

138 Ms Gabrielle Knowles, 'Drug Cooks Dice with Danger', *The West Australian*, 22 March 2011, p5.

139 Mr Daniel Emerson and Ms Natasha Boddy, 'Tougher Laws to Protect Children', *The West Australian*, 23 March 2011, p10.

It is likely that this rise is associated with the move of bikie gangs into the State. Detective Inspector McMurtrie told the media his officers were monitoring the movements of NSW bikie gangs Lone Wolf and Rock Machine. Western Australia's growing economy has made it "a fruitful prospect for eastern states bikie gangs wanting to expand their operations". The gangs are attracted here because there was more disposable cash and the street price of amphetamines was twice that in the eastern states.[140]

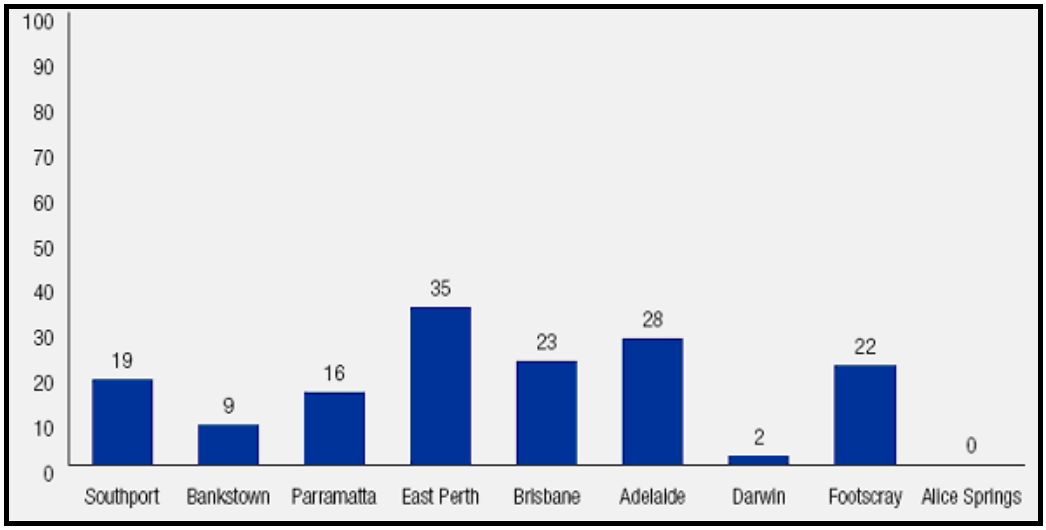
Figure 3.2- Number of Western Australian clandestine drug labs found by Police (2002-10)



The regular Drug Use Monitoring in Australia survey (DUMA), which monitors police detainees in various lock-ups around Australia, found the highest percentage of detainees who tested positive for amphetamine use in 2008 was at the East Perth site in Western Australia.

140 Ms Aja Styles, 'New Bikie Gangs Eye off WA's Lucrative Drug Market', 9 July 2010. Available at: www.watoday.com.au/wa-news/new-bikie-gangs-eye-off-was-lucrative-drug-market-20100709-1031p.html. Accessed on 22 March 2011.

Figure 3.3- Proportion of Adult Detainees who Tested Positive for Amphetamines (2008)[141]



While the State's prevalence rate in 2007 for amphetamine group consumption seems high at 4.1%, it is in fact a 25% reduction from the rates of the late-1990s and early-2000s. The Western Australian prevalence rate for amphetamine-type drugs in 2001 was 5.8%. The rate of ecstasy use has remained relatively stable over this decade with a rate of 4.0% in 2001 and 4.1% in 2007.[142]

As with cannabis, there are important regional differences associated with the use of ATS in Western Australia. Table 3.3 below shows the higher rates in remote regions such as the Kimberley, the Pilbara and the Goldfields, where the use of these drugs is often associated with mining projects. These regions also have a higher proportion of people using cannabis in the past 12 months and drinkers consuming alcohol at levels that are a high risk for their health.

141 Australian Institute of Criminology, 'Drug Use Monitoring in Australia: 2008 Annual Report on Drug Use Among Police Detainees', February 2010. Available at: www.aic.gov.au/en/publications/current%20series/mr/1-20/09.aspx, p16. Accessed on 16 November 2010.

142 Drug and Alcohol Office, WA, *2001 National Drug Strategy Household Survey- First Results for WA*, February 2003, Available at: www.dao.health.wa.gov.au/Publications/tabid/99/DMXModule/427/Default.aspx?EntryId=544, p11. Accessed 16 November 2010.

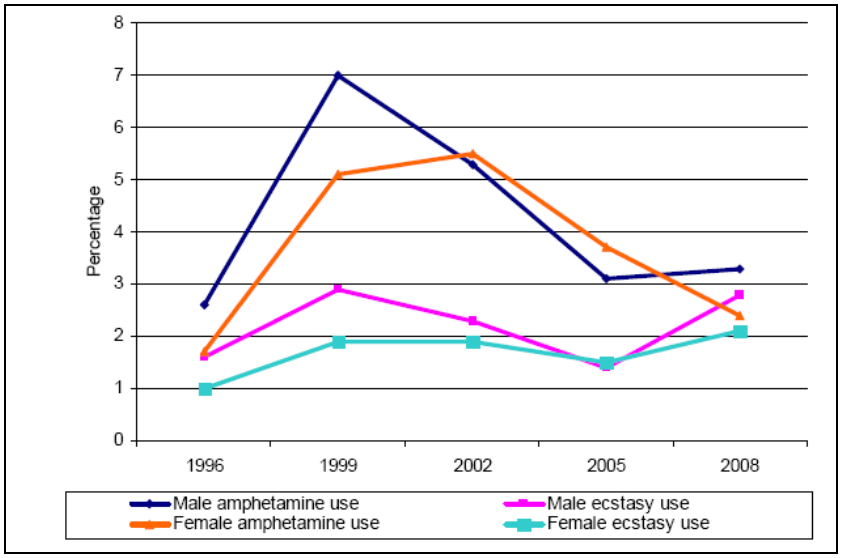
Table 3.3- Proportion of Western Australian regional population using ecstasy and amphetamines in the past 12 months, 2004[143]

Region	Amphetamines	Ecstasy	Any Illicit Drug
Kimberley	7.8%	3.8%	35.9%
South West	5.7%	3.2%	14.8%
Goldfields- SE Coastal	5.3%	7.7%	25.3%
North Metropolitan	5.2%	4.9%	18.3%
South Metropolitan	4.0%	4.1%	16.1%
Midwest- Murchison	3.6%	4.1%	18.4%
Pilbara-Gascoyne	2.5%	-	16.7%
Great Southern	2.4%	0.5%	11.5%
Wheatbelt	-	-	11.4%
STATEWIDE AVERAGE	**4.5%**	**4.1%**	**17.3%**

The prevalence of use by students of ecstasy has remained about the same over the past decade. The data in Figure 3.4 below from the 2008 ASSAD survey of the State's school students indicates that the use of amphetamines by students has halved in this time.

143 Submission No. 37- Part A from the Drug and Alcohol Office, 25 August 2009, p10.

Figure 3.4- Western Australian school students aged 12–17 years who reported using either amphetamines or ecstasy in the prior month (2008)[144]



(d) Health and other impacts of ATS

High rates of meth/amphetamine use can result in a range of negative health and social impacts. When used in combination with other drugs, these effects can be exacerbated. As the background paper for the *2007 Western Australian Illicit Amphetamine Summit* reported, amphetamine use often occurs concurrently with alcohol (87%), cannabis (68%), ecstasy group substances (MDMA) (49%) and tranquillisers (7.1%). Amphetamines, and the more potent version methamphetamine, act as central nervous system stimulants, and have a range of negative effects, the risk of which increases when the drug is injected or smoked. The common negative side effects associated with amphetamine use include:

> *agitation, anxiety, restlessness, disturbed sleep and loss of appetite. Both injectors and smokers of methamphetamine report experiencing problems including dependence and psychosis. Agitation and aggression, hallucinations, paranoid delusions and psychosis may occur.*[145]

A recent report from the Drug and Alcohol Office (DAO) found "a strong correlation between amphetamine-related indicators and crimes against the person", meaning that both the indicators of amphetamine use and assaults and other attacks on individuals rise at the same time.[146]

---

144 Drug and Alcohol Office, 'Annual Report 2009-10', 2010. Available at: www.dao.health.wa.gov.au/Publications/tabid/99/DMXModule/427/Default.aspx?EntryId=1186&Command=Core.Download, p10. Accessed on 15 December 2010.

145 Drug and Alcohol Office, *WA Illicit Amphetamine Summit July 2007 - Background Paper*, Government of Western Australia, Perth, July 2007, p2.

146 Drug and Alcohol Office, *Drug Trends and Crime Tracking: Relationships between Indices of Heroin, Amphetamine and Cannabis Use and Crime*, Government of Western Australia, Perth, November 2010, p43.

According to DAO, amphetamine use places significant strain on the State's medical and mental health services:

> *The impact of extremely agitated, psychotic methamphetamine users on accident and emergency and psychiatric units has been the subject of widespread media attention both nationally and in Western Australia. A… study in Western Australia found that 1.2% of emergency department presentations may result from amphetamine use and that these tend to be high impact cases.*
>
> *The proportion of mental health admissions to hospitals due to amphetamines was 1.7% in 2005-06 (448 of 25,855), having peaked at 2% in 2001-02 (580 of 29,274). …In 2006, 1.5% of outpatient episodes in mental health services (representing 560 of 36,890 unique individuals) were due to amphetamines. The number of outpatient episodes presenting at mental health services has substantially increased since 2001.*[147]

Based on the figures from 2007, an extrapolation of the 1.2% rate of amphetamine-related hospital presentations resulted in an expectation of "an approximate amphetamine presentation burden of 4,090 [emergency department] patients per year across the metropolitan area."[148]

This large number of presentations creates an obvious impact on frontline medical workers:

> *The degree of hostility exhibited by some users when they become psychotic presents a crisis situation for both Police and health workers, who often have to apprehend these people for their own safety and for the safety of bystanders.*[149]

The West Australian study found that amphetamine presentations at hospitals resulted in prolonged stays in the emergency department and required considerable staff resources. Half of the people presenting had previous amphetamine presentations, and 20% required some Police involvement. One-third of the presentations required sedation for agitation, more than one-third required psychiatric review, and their mean time in an emergency department was six hours.[150]

An additional complicating health factor of amphetamine use is co-morbid mental health issues. Research by DAO's Next Step alcohol and drug treatment services found that:

> *46% of methamphetamine dependent clients have a previously diagnosed psychological health problem with 30% of these cases requiring psychiatric hospital admission. Depression was also found to be present in 35% of methamphetamine dependent clients.*[151]

---

147 Drug and Alcohol Office, *WA Illicit Amphetamine Summit July 2007 - Background Paper*, Government of Western Australia, Perth, July 2007, p6.

148 Ibid, p6.

149 Ibid, p26.

150 Ibid, p27.

151 Ibid p24.

DAO also found that:

> *Trends in stimulant related hospital admissions related to mental disorders due to the abuse of stimulants for the period from 1999/2000 to 2005-06 show that stimulant related disorders typically constituted about one in 10 of all mental and behavioural disorders due to psychoactive drug use, except for 2001-02 and 2003-04 when such episodes made up about one in eight of all drug-related episodes.*[152]

A 2010 study by Royal Perth Hospital doctors found that about 20% of speed users treated in the RPH emergency department had a brain abnormality linked to memory loss, dementia and an increased risk of stroke. The average age of the patients was 29 years and none of them were aware of their brain abnormalities.[153]

The challenges of managing ATS users requiring health and mental health treatment are considerable. An additional problem is the perception of ATS users that drug treatment services are oriented to alcohol and heroin users. ATS users may find it difficult to seek assistance due to their paranoid and aggressive behaviour flowing from their amphetamine use.[154] Despite these barriers to treatment, DAO found that there had been "a marked growth in the number of quarterly [treatment] episodes concerning amphetamines from the March quarter 1999 (208 episodes) to the December quarter 2006 (1,018 episodes), a nearly five fold increase."[155]

The Drug Policy Modelling Program of NDARC carried out modelling to assess what proportion of drug users nationally are receiving treatment. For methamphetamine, with an estimated 81,600 people who used within the last week, there were 17,292 treatment episodes, suggesting about 21% of users are in treatment at any one point in time.[156]

In Western Australia:

> *the total annual number of* [treatment] *episodes where amphetamines was the principal drug problem increased by 325%, from 942 in 1999 to 4,006 in 2006. Amphetamines have become more frequent as a problem being managed by treatment services in WA, rising from one in 10 (9.6%) in 1999 to one in five (22.3%) of the total number of episodes for all types of drug problems at all specialist service providers in 2006.*[157]

---

152 Drug and Alcohol Office, *Statistical Bulletin, Amphetamine Type Stimulants, Western Australia*, Government of Western Australia, Perth, June 2007, p3.

153 Ms Cathy O'Leary, 'Brain Injuries Blamed on Amphetamines', *The West Australian*, 7 September 2010, p30.

154 Drug and Alcohol Office, *WA Illicit Amphetamine Summit July 2007 - Background Paper*, Government of Western Australia, Perth, July 2007, p11.

155 Drug and Alcohol Office, *Statistical Bulletin, Amphetamine Type Stimulants, Western Australia*, Government of Western Australia, Perth, June 2007, p3.

156 Submission No. 10 from the National Drug and Alcohol Research Centre, 29 July 2009, p2.

157 Drug and Alcohol Office, *Statistical Bulletin, Amphetamine Type Stimulants, Western Australia*, Government of Western Australia, Perth, June 2007, p3.

According to the *Alcohol and Other Drug Treatment Services in Australia 2008-09* report, there are significant differences in the principal drugs of concern reported by treatment agencies in other Australian jurisdictions. The principal drugs of concern are:

- alcohol as the first and cannabis as the second in New South Wales, Victoria, the ACT and the Northern Territory;
- heroin as the third in NSW, Victoria, South Australia and the ACT; and
- alcohol as the first, (45.5%), amphetamines as the second (19.8%), cannabis as the third (15.9%) and heroin as the fourth (8.9%) in Western Australia.[158]

3.3 Ecstasy group substances (MDMA)

Ecstasy is the street name for MDMA, a chemically-similar drug to the amphetamine group, which has similar stimulant and hallucinogenic properties to ATS drugs. It is included in this chapter as "it is sometimes referred to as a psychedelic amphetamine."[159] Ecstasy use has remained relatively stable in Western Australia since 2001.

Drugs sold as ecstasy "may contain a variety of drugs mixed with MDMA, or may contain no MDMA at all. Tablets have been detected containing various combinations of substances including ephedrine, ketamine, MDA and methylamphetamine." According to the Australian Crime Commission "nearly half of the detainees who self-reported MDMA use in the previous 48 hours did not test positive to this drug, with 34% of these actually testing positive to methylamphetamine."[160]

Ecstasy is perceived by some as a relatively harmless party drug, used by a different group of people to the drugs more commonly recognised as dangerous, such as heroin. Ecstasy users tend to self-identify as festival goers, clubbers and social users.[161] They are "commonly perceived as a more affluent user group than, for example, injecting drug users…(and) are typically young people engaged in either university study and/or employment."[162] An additional group of users are "professionals, in highly paid positions or from affluent backgrounds, who have a disposable income and may tend to binge on weekends or at special events, rather than use frequently."[163]

---

158 Australian Institute of Health and Welfare, *Alcohol and Other Drug Treatment Services in Australia: Report on the National Minimum Data Set*, Australian Government, Canberra, December 2010, p22.

159 Drug Aware, 'Drug Information: Ecstasy'. Available at: www.drugaware.com.au/Drug%20 Information/Ecstasy.aspx. Accessed on 14 December 2010.

160 Australian Crime Commission, *Illicit Drug Data Report 2007-08*, Commonwealth of Australia, 2009, p27.

161 National Drug and Alcohol Research Centre, *West Australian Trends in Ecstasy and Related Drug Markets 2009: EDRS*, NDARC Technical Report Number 52. NDARC, University of New South Wales, Sydney, 2010, pxi.

162 Ibid, pxix.

163 Ibid, p5.

(i) Health impacts of ecstasy

Despite this perception of ecstasy as being relatively harmless, it has some significant negative physical effects. The short-term physical effects of ecstasy use include nausea; sweating; hot and cold flushes; jaw clenching; teeth grinding; feeling of well being; anxiety; increased pulse rate; increased blood pressure; high body temperature; exaggerated confidence; dry mouth; insomnia; and poor concentration. Higher doses can result in irrational behaviour; agitation; convulsions; dehydration; urinary retention; vomiting; hallucinations; excessive thirst; and muscle meltdown.[164]

Over the longer term, ecstasy use can lead to depression; drowsiness; muscle aches; loss of appetite; insomnia; loss of concentration and irritability. Ecstasy use can cause anxiety, depression, paranoia and psychosis in those people who have a vulnerability to mental health problems. Regular use can also lead to tolerance and dependence, with increased risk of overdose. Ecstasy overdose can result from the body overheating and becoming dehydrated, causing possible death from major organ failure (kidneys, liver and/or cardiovascular failure).[165]

Overdose from ecstasy usually results from the body overheating and becoming dehydrated, causing muscle meltdown (rhabdomyolysis) and possible death from the failure of major organs. Overdose may result from excessive water consumption and retention, causing cells in the body to swell, resulting in brain damage and death.[166]

The death of a young Western Australian man on New Year's Day this year from a tablet sold as ecstasy[167] follows the ecstasy overdose of young woman in 2009 at a Big Day Out music festival,[168] and demonstrates the high risk to users of this drug.

3.4 Cocaine

Cocaine is derived from the coca leaf and is the most potent natural stimulant. Administration of the drug—either by snorting, injecting or smoking—creates an almost instant rush of euphoria and exhilaration. Users become energetic and talkative and, often experience an increase in their sex drive, coupled with a loss of inhibition. Adverse health effects include the perforation of nasal membranes and loss of smell. Injecting cocaine can lead to the collapse or blockage of veins,

---

164 Australian Crime Commission, *Illicit Drug Data Report 2007-08*, Commonwealth of Australia, 2009, p13.

165 Ibid.

166 Drug Aware, 'Drug Information: Ecstasy'. Available at: www.drugaware.com.au/Drug%20 Information/Ecstasy.aspx. Accessed on 14 December 2010.

167 Mr Luke Eliot, 'Police Probe overdose Death', *The West Australian*, 20 January 2011. Available at: http://au.news.yahoo.com/thewest/a/-/wa/8684390/police-probe-overdose-death. Accessed on 2 March 2011.

168 Ms Aja Styles, 'Teenager Dead after Drug Overdose at Big Day Out', 2 February 2009. Available at: www.watoday.com.au/wa-news/teenager-dead-after-drug-overdose-at-big-day-out-20090202-7v9v.html. Accessed on 2 March 2011.

ulcers and abscesses. Heavy cocaine users can also experience a number of psychological and social problems.[169]

The risk of cocaine overdose is high, since the strength and mix of street cocaine is usually unknown. An overdose of cocaine can result in increased heart rate and body temperature, seizures, heart attack, brain haemorrhage, kidney failure, stroke and repeated convulsions. All of these can lead to coma and death.[170]

(i) International and national situation

International situation

United Nations Office on Drugs and Crime (UNODC) reports that Colombia, Peru and Bolivia are the largest producers of cocaine, with 158,800ha under cultivation in 2009. Following a significant increase over the period 2002-05, global cocaine seizure totals have been stable at about 710 metric tonnes and concentrated in the Americas and Europe. The past two years have seen more seizures in the South American source countries with clandestine laboratories which process the coca.[171]

UNODC estimates that the prevalence of cocaine use worldwide in 2008 ranged from 0.3% to 0.4% of the adult population, or between 15 and 19 million people who had used cocaine at least once in the previous year. The highest prevalence of cocaine use in the world remains in the US, at 2.6% of the adult population aged 15 to 64. In 2009, 3.4% of older high school children in the US had used cocaine that year, down from the highest usage rate of 6.6% in 1999.[172]

Australia's experience

Cocaine was first imported into Australia in the late 1800s and used as a local anaesthetic and treatment for morphine and alcohol addiction, fatigue and depression. It was also included in some patent medicines and beverages. Throughout the 1920s and 1930s, until a ban on selling cocaine without a prescription, Australia's per capita consumption of cocaine was the highest in the world. Since then the use of cocaine in Australia has traditionally been low but the Australian Institute of

---

169 Australian Institute of Criminology, 'Cocaine Use Among a Sample of Police Detainees', May 2004. Available at: www.aic.gov.au/documents/4/E/0/%7B4E0606AF-D692-42A7-B3B4-F2F3129DC122%7Dtandi276.pdf, p2. Accessed on 22 March 2011.

170 DrugInfo Clearinghouse, 'Cocaine', 21March 2007. Available at: www.druginfo.adf.org.au/druginfo/drugs/drugfacts/cocaine_info.html. Accessed on 22 March 2011.

171 United Nations Office on Drugs and Crime, 'World Drug Report 2010', 2010. Available at: www.unodc.org/documents/wdr/WDR_2010/2.3_Coca-cocaine.pdf, p161 & p166. Accessed on 22 March 2011.

172 Ibid, p173 & p175.

Criminology suggests that its use has increased, especially among high-risk groups, during the recent heroin shortage. The main entry point into Australia is Sydney.[173]

UNODC data shows that the annual prevalence rate in Australia grew from 1.0% in 2004 to 1.6% in 2007.[174] Cocaine was one of only two drugs that showed such a significant increase, the other being tranquillisers/sleeping pills used for non medical purposes (from 1.0% to 1.4%).[175]

A recent news report said that there has been a surge in cocaine use in Australia that was fuelled by the Sinaloa drug cartel in Mexico. This proposition follows the interception of 240kg of cocaine in July 2010. The NSW Bureau of Crime Statistics says recent data on cocaine arrests are 'unprecedented' and at 'record levels'.

In June 2010 the Australian Crime Commission (ACC) approved the use of coercive powers to investigate cocaine and the cartels behind its importation to Australia. Much of the interest in Australia as an export destination seems to be driven by the higher price of cocaine in this country. The ACC said a kilogram of cocaine:

- in Columbia is worth $2,100;
- imported to Mexico is worth $12,500;
- imported to the US is worth $28,500; and
- imported to Australia is worth $146,000.[176]

(ii) Western Australian data

The 2007 National Drug Strategy Household Survey showed Western Australia having a rate of 1.8% of the population having used cocaine in the past year, compared to rates of 2.0% in NSW and 1.6% in Victoria.[177]

One of the main user groups for cocaine in this State are people who are using other drugs. Data from the Ecstasy and Related Drugs Reporting System (EDRS) indicate over the past decade an increase in cocaine use in Western Australia. The EDRS shows that cocaine use among regular

---

173 Australian Institute of Criminology, 'Cocaine Use Among a Sample of Police Detainees', May 2004. Available at: www.aic.gov.au/documents/4/E/0/%7B4E0606AF-D692-42A7-B3B4-F2F3129DC122%7Dtandi276.pdf, p1. Accessed on 22 March 2011.

174 United Nations Office on Drugs and Crime, 'World Drug Report 2010', 2010. Available at: www.unodc.org/documents/wdr/WDR_2010/2.3_Coca-cocaine.pdf, p180. Accessed on 22 March 2011.

175 Australian Institute of Health and Welfare, '2007 National Drug Strategy Household Survey: Detailed Findings', 18 December 2008. Available at: www.aihw.gov.au/publication-detail/?id=6442468195. Accessed on 22 March 2011.

176 ABC News, 'Mexican Drug Cartel Infiltrates Australia', 15 September 2010. Available at: www.abc.net.au/news/stories/2010/09/15/3011870.htm. Accessed on 22 March 2011.

177 Australian Institute of Health and Welfare, '2007 National Drug Strategy Household Survey: State and Territory supplement', August 2008. Available at: www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442459903, p8. Accessed on 22 March 2011.

ecstasy users had increased from 17% in 2003 to 26% in 2010. The State's figures for cocaine use by ecstasy users are the lowest for any jurisdiction and the rise over the seven years is not as high as the national figures, which show an increase from 23% to 48% in the same period.[178]

Similar research for the State's injecting drug users (IDU) show 59% reported the lifetime injection of cocaine and 71% the lifetime snorting of cocaine at some stage during their use of illicit drug by injection. Of this sample, 12% reported a use in the last six months of cocaine, which was substantially down from 19% in 2005 and 32% in 2001. The total sample of the EDRS survey in Western Australia is about 100 users, with only 12 injecting drug users.[179]

In a recent development, a Police search of a BMW and homes in Wanneroo and Inglewood led them to seize more than 200g of cocaine worth $250,000 which seems to have been directly imported from South America. Organised crime squad detectives allegedly discovered the cocaine in block form and bearing the unique identifying stamp of a South American drug cartel.[180]

3.5 Illicit drug use in the mining industry

An area of special concern regarding the use of amphetamine-type substances in Western Australia is their use by workers in the mining industry. The Committee heard from two of Australia's largest mining companies, BHP Billiton and Rio Tinto, with regard to their drug and alcohol testing regimes. Both companies had similar programs aimed at preventing workers from operating on the mine sites while under the influence of either illicit drugs or alcohol.

Mr Watson from BHP Billiton said that workers in both Perth and on-site in the Pilbara are given a "blow-in-the-bag–type test for alcohol and a urine test for drugs".[181] BHP Billiton has an education program on alcohol and drugs and provides assistance to workers who test positive. Workers are given 'two-strikes' while some BHP Billiton contractors have a 'one-strike' policy. Mr Watson said:

> *The purpose of the testing program is to deter. It is not to catch people. We just want to deter people from turning up under the influence. We recognise that people have their own particular pastimes. We just want them to turn up at our site not under the influence of alcohol or drugs.*[182]

---

178 National Drug and Alcohol Research Centre, *Key Findings: Ecstasy and Related Drug Reporting System*, Australian Drug Trends 2010 Conference. University of New South Wales, Sydney, 2010, p30.

179 National Drug and Alcohol Research Centre, *West Australian Trends in Ecstasy and Related Drug Markets 2009: EDRS*, NDARC Technical Report Number 52. NDARC, University of New South Wales, Sydney, 2010, p56.

180 Mr Luke Eliot, 'Major Drug Cartel Suspect Arrested', 2 April 2011. Available at: http://au.news.yahoo.com/thewest/a/-/breaking/9121894/major-drug-cartel-suspect-arrested/. Accessed on 4 April 2011.

181 Mr Robert Watson, Manager Health and Safety, BHP Billiton, *Transcript of Evidence*, 22 September 2010, pp4-5.

182 Ibid, p2.

BHP Billiton has a target of "a minimum of … four tests per person, per year for drugs. We … use the Australian standard testing process. We have random testing as people come to work." The scale of testing by these large companies seems to be extensive and rigorous:

> *Last month we did 43,000 alcohol tests and we did about 4,300 drug tests. We have different regimes for each. We have a target range of less than 2% positives. That is really a public health number of what we expect. For alcohol, positive tests are consistently under 1% and on a long-term average we run between 0.5-1% positives.*[183]

Rio Tinto has a similar 'two-strikes' policy. During the first 10 months in 2010 over 5,000 tests were conducted and five staff were terminated as a result of positive testing. Staff who test positive:

> *go through a counselling process not only with their leaders but also through the employee assistance program group, which will help them. They are psychologists we employ through a contract. It is very comprehensive.*[184]

According to BHP Billiton, the problems encountered with people who repeatedly test positive tended not to be alcohol-related, instead "they mainly tested positive to cannabis and amphetamines."[185] Evidence from Rio Tinto's General Manager of Climate Change, Water and Environment, Mr Allan Jackson, concurred with BHP Billiton's perspective on amphetamine-related problems:

> *The big issue around drugs, in my view, is changing over the years. Alcohol is becoming less of a problem. The problem that is emerging is more around THC, which is cannabis, and/or methylamphetamine, the party drug. We are starting to see an emergence of that. The problem with the party drug is that people can partake on their rostered days off and then be pretty clean when they come to work*…[But] *They are fatigued. They could be very much fatigued.*[186]

A recent press report said that some mineworkers are now using a synthetic cannabis-like substance that impairs their ability to operate machinery but can not be detected by the existing drug and alcohol tests. 'Kronic' has been banned in 16 countries after being linked to deaths and is reported to be five to 10 times stronger than THC - the active substance in cannabis. The State

---

183 Ibid, pp2-3.

184 Mr Allan Jackson, General Manager Climate Change, Water and Environment, Rio Tinto, *Transcript of Evidence*, 13 October 2010, p2.

185 Mr Robert Watson, Manager Health and Safety, BHP Billiton, *Transcript of Evidence*, 22 September 2010, pp2-3.

186 Mr Allan Jackson, General Manager Climate Change, Water and Environment, Rio Tinto, *Transcript of Evidence*, 13 October 2010, p2.

Government's ChemCentre has developed technology capable of detecting the substance but most companies did not use this service because it was too costly.[187]

The ChemCentre is compiling a report on Kronic to help Government agencies determine whether the product should be banned after its testing found "about 10% of samples show positive for drugs like kronic, on some [mine] sites though that rate is as high as 30% of random drug testing."[188]

Finding 6

The high level of consumption of amphetamines and ecstasy by Western Australians over the past decade has created a significant demand on the State's health, Police and Justice systems. The State now has one of the highest amphetamine usage rates in the world.

Recommendation 4

The Minister for Mental Health ensure that funding for education and other demand reduction and treatment programs for amphetamines and ecstasy users is a priority in the State's illicit drug strategy, and appropriately funded in the 2012-13 State Budget.

Recommendation 5

The Drug and Alcohol Office 2010-11 annual report include strategies to reduce the consumption of amphetamines and ecstasy in Western Australia.

187 Ms Kim MacDonald, 'Drug Invisible to Mine Site Tests', 13 April 2011. Available at: http://au.news.yahoo.com/thewest/a/-/newshome/9184524/drug-invisible-to-mine-site-tests/. Accessed on 13 April 2011.

188 ABC, 'Call for Kronic Smokers to be Sacked', 12 May 2011. Available at: www.abc.net.au/news/stories/2011/05/12/3215252.htm?site=perth. Accessed on 12 May 2011.

CHAPTER 4 PRESCRIPTION DRUG DIVERSION AND INHALENTS

4.1 Opiate diversion- International situation

The diversion of prescription opiates for non-medical use is recognised as an increasing problem in many countries. The United Nations Office on Drugs and Crime (UNODC) reports that the problem is most notable in North America, but also exists in other regions.[189] According to the *World Drug Report 2010:*

> *Significantly increasing trends in the use of prescription and over-the-counter drugs, including oxycodone and hydrocodone among teens, is reported. From 1999 to 2006 the number of fatal poisonings involving opioid analgesics more than tripled from 4,000 to 13,800 deaths. In Canada, while the overall prevalence of opiate use is 0.3% of the population, heroin use has also been overshadowed by abuse of prescription opioids.*[190]

4.2 Australian situation

According to the Drug and Alcohol Office (DAO) in Western Australia:

> *a recent trend has been an increase in the misuse of prescription opioids such as MS Contin and Oxycontin. Drug treatment agencies across Australia are also seeing an increase in the number of people seeking treatment with problems from prescription opioid dependence.*[191]

This evidence for Western Australia is consistent with reports from other Australian jurisdictions. According to the Drug Prevention Network diverted "prescribed opioids (mostly MS Contin and OxyContin) accounted for almost half the drugs used by IDU [injecting drug users] in the Medically Supervised Injecting Centre in Kings Cross" in New South Wales.[192]

Evidence given to the Committee in South Australia suggests that the problem of prescription drugs is a major issue there. However, rather than a deliberate misuse of the drug, poor pain management practices have resulted in patients developing a dependency on them. This was

---

189 United Nations Office on Drugs and Crime, 'The Non-Medical Use of Prescription Drugs, Policy Direction Issues', 2010. Available at: www.unodc.org/unodc/en/drug-prevention-and-treatment/non-medical-use-prescription-drugs.html. Accessed on 11 November 2010.

190 United Nations Office on Drugs and Crime, 'World Drug Report 2010', 2010. Available at: www.unodc.org/unodc/en/data-and-analysis/WDR-2010.html, p156. Accessed on 11 November 2010.

191 Submission No. 37- Part B from the Drug and Alcohol Office, August 2009, p3.

192 Dr Malcolm Dobbin, The Drug Prevention Network, 'Prevention of Pharmaceutical Drug Misuse: Non-Medical Use of Pharmaceutical Drugs', December 2008. Available at: www.druginfo.adf.org.au/newsletter.asp?ContentID=non-medical_use_of_pharmaceutical_drugs1. Accessed on 1 November 2010.

termed 'iatrogenic dependence' or a dependence created by the prescribing patterns of medical practitioners for morphine, pethidine and MS Contin.[193]

The South Australia Drug and Alcohol Service recognised that this dependence on prescription drugs was not only an escalating future problem but was a current problem. There had been a large increase in the number of people who need to be managed through drug dependence programs. They had moved from having to deal with pain to having pain plus a dependence on the drugs that they were given to manage the pain.[194]

According to the Australian Institute of Health and Welfare, medically prescribed opioids are the third most prevalent illicit drug of abuse after cannabis and stimulants such as ATS.[195] The Royal Australasian College of Physicians' (RACP) *Prescription Opioid Policy* says there has been a significant increase in prescription opioid use in Australia in recent years: "there was a 40-fold increase in oral morphine supply between 1990 and 2006, and a nearly 4-fold increase in oxycodone supply between 1990 and 2003."[196]

Pharmaceutical Benefits Scheme figures show the number of opioid prescriptions almost tripled, from around 2.4 million in 1992 to seven million in 2007.[197] The RACP estimates that between 5-10% of these opioid prescriptions are being misused for either addiction or diversion for illicit sale.[198] It suggests that this is in part due to:

- increasing numbers of people suffering from chronic pain (estimated to be as high as 20% of the population); and
- advances in the safety and effectiveness of opioids to treat pain, which has resulted in an increase in the willingness of the medical profession to prescribe them.[199]

The misuse of prescription opioids creates particular challenges for the medical community:

> *we as pain management specialists and indeed all medical and healthcare practitioners, particularly the GPs I must say, are in the increasingly difficult position of balancing the*

---

193 Mr Keith Robert Evans, Executive Director, Drug and Alcohol Services South Australia, South Australia Health, *Briefing*, 28 September 2009, p4.

194 Ibid.

195 Dr Eric Visser, Pain Medicine Specialist and Anaesthetist, Immediate Past Chair, Faculty of Pain Medicine, ANZCA, *Transcript of Evidence*, 2 September 2010, p2.

196 The Royal Australasian College of Physicians, 'Prescription Opioid Policy: Improving Management of Chronic Non-Malignant Pain and Prevention of Problems Associated With Prescription Opioid Use,' Sydney 2009, p5.

197 Medical Observer, 'The New Face of Drug Addiction', 3 July 2009. Available at: www.medicalobserver.com.au/news/the-new-face-of-drug-addiction. Accessed on 5 April 2011.

198 Dr Eric Visser, Pain Medicine Specialist and Anaesthetist, , Immediate Past Chair, Faculty of Pain Medicine, ANZCA, *Transcript of Evidence*, 2 September 2010, p2.

199 Ibid.

need to use opioids legitimately to treat chronic non-cancer pain; and on the other hand trying to minimise the potential for individual and community harm in terms of addiction, which is a healthcare issue; and also diversion, which is probably more of a criminal issue.[200]

The RACP identifies two main causes of the unsanctioned use of prescription opioid use:

- the use of pharmaceutical opioids (both prescription and over the counter) by patients with chronic non-malignant pain; and
- the use of prescription opioids by individuals dependent on illegal opioids such as heroin, partly as a result of substantial unmet demand for treatment of opioid drug dependence.[201]

The RACP's suggested solutions to this problem include:

- Improving the clinical management of chronic non-malignant pain by:
  - improved and integrated primary care and specialist services for managing chronic non-malignant pain, including enhanced multidisciplinary care and access to specialist pain and addiction medicine services;
  - clinical guidelines for managing chronic non-malignant pain in individuals with problem drug use and/or aberrant drug behaviours; and
  - universal precautions in opioid prescribing by improving the capacity of medical practitioners and other health professionals such as pharmacists to identify and manage patients at risk of developing opioid dependence and related behaviours, and/or aberrant drug behaviours (diversion).
- Regulatory controls and monitoring the use of prescription opioids:
  - prescription monitoring programs to enable doctors to identify patients with problematic behaviours, and to receive feedback about their own prescribing practice relative to other doctors;
  - use of data collection systems that provide real-time information for doctors and pharmacists, safeguard privacy for patients, and establish an audit trail of information access; and

200 Ibid, p3.

201 The Royal Australasian College of Physicians, *Prescription Opioid Policy: Improving Management of Chronic Non-Malignant Pain and Prevention of Problems Associated with Prescription Opioid Use*, Sydney 2009, p6.

– better training and engagement of pharmacists with the issue of opioid control. Pharmacists should be recognised as key stakeholders in a multidisciplinary group to implement and evaluate policy.

A final proposal suggested by the RACP was the need for better access to Opioid Substitution Treatment (OST) such as methadone:

> *Limited access to good quality, affordable and attractive Opioid Substitution Treatment for heroin-dependent persons may be contributing significantly to the increasing diversion of opioids by increasing the price of black market prescription opioids. It is important to minimise unmet demand for opioid substitution therapy by increasing the range of treatment options for heroin and prescription opioid-dependent people and providing OST as attractively as possible.*[202]

4.3 Western Australian evidence

In Western Australia, several treatment agencies reported significant recent increases in the number of patients presenting with problems related to prescription drugs. The King Edward Memorial Hospital Women and Newborn Health Service reported to the Committee a recent increase in diverted prescription drug problems for their female patients,[203] as did DAO's Next Step drug treatment service. Dr Quigley, the Director of Clinical Services at Next Step, reported that this:

> *has been a major area of growth for us in the last three to five years. We were for a period of time seeing as many people with prescription drug opiate problems as we were with illicit drug opiate problems.*[204]

According to DAO statistics, treatment for heroin addiction has been in steady decline in Western Australia since 2000 (from 3,816 treatment episodes in 2000-01 to 2,056 in 2007-08) whereas others, such as prescription opioids, have increased steadily from 443 episodes in 2000-01 to 1,237 in 2007-08.[205]

The problem of prescription opioids is by no means limited to the Perth metropolitan area, with regional witnesses raising this problem with the Committee.

---

202 The Royal Australasian College of Physicians, 'Prescription Opioid Policy: Improving Management of Chronic Non-Malignant Pain and Prevention of Problems Associated With Prescription Opioid Use,' Sydney 2009, p7.

203 Dr Amanda Frazer, Executive Director, Women and Newborn Health Service, King Edward Memorial Hospital, *Transcript of Evidence*, 8 June 2010, p4.

204 Dr Allan Quigley, Director of Clinical Services, Next Step, Drug and Alcohol Office, *Transcript of Evidence*, 2 September 2010, p10.

205 Submission No. 37- Part C from the Drug and Alcohol Office, 18 September 2009, p106.

In Kalgoorlie it heard that:

> *Health providers in the area, particularly pharmacists would go to a local hotel to watch what is happening with the drug deals…They will issue a prescription - I am talking about prescribed medications in particular - and then the pharmacist will go to the hotel and have a few quiet beers only to see them being on-sold.*[206]

Several witnesses emphasised the extent to which prescription drugs are a substitute for heroin:

> *When it* [heroin] *is not there it does not matter much, because the OxyContin the doctors are supplying have kept their* [drug dealers] *business going because pensioners with back pain sell OxyContin for $100 a tablet. That business flourishes whenever the heroin supply dries up, so the number of people detoxing each week has not changed much over the past 10 years. The brand changes from government-supplied opiates to Afghanistan-supplied opiates. It is just a change in brand, but the numbers coming through stay pretty much the same.*[207]

The Committee heard from several witnesses that the extent of the problem in Western Australia is considerable, with estimates that each GP in the State may have as many as 10 patients with problematic opioid use.[208] If this estimate is correct, the State's 2,189 GPs have a case load of approximately 22,000 patients with problematic opioid use.[209]

According to DAO, the total prescriptions for oxycodone in Western Australia increased 13% in 2008, with nearly 131,000 scripts filled. In the first 5 months of 2009, 59,888 scripts were filled, an increase of about 1,000 scripts a month.[210] By November 2010, approximately 156,000 scripts had been processed for oxycodone in Western Australia.[211] The Pharmaceutical Services Branch (PSB) of the Department of Health said that:

> *The increase*[ing] *use of prescription opioids may be due to a number of factors including:*
>
> *(i) the increase*[d] *prevalence of chronic pain, and*

---

206 Ms Rosemary June Hunt, Executive Manager, CentreCare, Kalgoorlie, *Transcript of Evidence*, 14 September 2009, p9.

207 Dr George O'Neill, Medical Director, Fresh Start Recovery Programme, *Transcript of Evidence*, 16 June 2010, p12.

208 Associate Professor Nicholas Lintzeris, Policy Committee, Chapter for Addiction Medicine, Royal Australasian College of Physicians, *Briefing*, 30 September 2009, p9, and Dr Eric Visser, Pain Medicine Specialist and Anaesthetist, *Transcript of Evidence*, 2 September 2010, p2.

209 Australian Institute of Health and Welfare, 'AIHW Bulletin No 82: Medical Labour Force 2008', 2008. Available at: www.aihw.gov.au/publications/aus/bulletin82/tables/12016_primary-care-practitioners.xls. Accessed on 8 November 2010.

210 Submission No. 37- Part C from the Drug and Alcohol Office, 18 September 2009, p119.

211 Drugs of Dependence Section, Pharmaceutical Services Branch, Public Health Division, Department of Health, Electronic Mail, 24 March 2011, attachment.

> *(ii) development of pharmaceutical opioid formulations including sustained release tablets and transdermal patches which have enhanced safety and efficacy of opioids for legitimate patients to achieve pain relief…*[212]

Doh's PSB maintains a Monitoring of Drugs of Addiction System (MODDS) which

> *provides a prescription history of all patients prescribed Schedule 8 medicines in WA* [including oxycodone]. *Each pharmacy is required by legislation to record Schedule 8 medicines dispensed to each patient, and these records are provided to Pharmaceutical Services…on a monthly basis. These data are matched to the authorisations issued for the prescription of Schedule 8 opiates for greater than 60 days and for the prescription of medicines to a registered addict. Schedule 8 medicines dispensed can then be matched to authorisations, and patients' compliance with the authorisation can be assessed, as can prescriber compliance with legislative requirements.*[213]

A recent media report said that seven Western Australian doctors were being investigated by Medicare as part of a nation-wide review for over-prescribing narcotic painkillers such as OxyContin.[214] Dr George O'Neil of the Fresh Start clinic estimated that "about half of his detoxification patients were painkiller addicts". In addition, Australian Medical Association WA Vice-President Dr Steve Wilson said that "he personally had been assaulted in his clinic" by patients seeking these painkillers.[215]

The Committee was told that addressing the problems posed by prescribed opioids requires a close working relationship between pain specialists, GPs, DAO, pharmacists, nursing and other healthcare professionals.[216]

Finding 7

The misuse of prescription opioids has become a significant problem within Western Australia and the number of people misusing them is now at a similar level to the number consuming heroin.

---

212 Ibid.

213 Ibid.

214 Mr Andrew Millet, *The West Australian*, 'GPs Under Scrutiny for Misuse of Painkillers', 7 March 2011. Available at: http://au.news.yahoo.com/thewest/a/-/breaking/8961562/gps-under-scrutiny-for-misuse-of-painkillers/. Accessed on 8 March 2011.

215 Ibid.

216 Dr Eric Visser, Pain Medicine Specialist and Anaesthetist, , Immediate Past Chair, Faculty of Pain Medicine, ANZCA, *Transcript of Evidence*, 2 September 2010, p3.

(a) Proposal for an improved State pain management process

One of the issues raised with the Committee in regard to the misuse of prescription opioids was the length of time patients have to wait to access a specialist pain practitioner or pain management clinic. Waiting times can be 12 months in the public tertiary hospital system and six months in the private system. Even using technological innovations such as the Department of Health's *Telehealth* system leaves waiting times of four to five months for many patients. While patients wait for specialist appointments, general practitioners are under pressure to prescribe opioids:

> *For a quarter of patients it is appropriate; for three-quarters of patients using opioid medication to treat their pain for various reasons it is inappropriate…So, whilst they are waiting, of course, there is this pressure to do something, they start on opioids, and then there will be that percentage who get out of control with addiction and the other percentage that we do not know about with regard to diversion.*[217]

Dr Visser, Immediate Past Chair of the ANZCA Faculty of Pain Medicine, told the Committee that there are currently approximately 20 full time equivalent pain medicine specialists working in Perth, spread across the public and private systems. In order to adequately provide for the State's population, he estimated that this staffing level would need to double.

A detailed submission to the Committee sets out the workforce and funding requirements to adequately meet the State's pain management needs and totalled about $10 million per annum (see Appendix 10). The proposal should allow the development of multi-disciplinary pain medicine centres at tertiary and general hospitals statewide. Additional staff proposed included:

- 8 FTE pain medicine specialists;
- 4 FTE pain medicine training positions;
- 8 FTE clinical psychology positions;
- 8 FTE physical therapists;
- 8 FTE nurse practitioners;
- 2 FTE psychiatry or other medical specialties;
- 2 FTE drug and alcohol specialists; and
- 8 FTE administrative staff.[218]

---

217 Dr Eric J. Visser, Pain Medicine Specialist and Anaesthetist, Immediate Past Chair, Faculty of Pain Medicine, ANZCA, *Transcript of Evidence*, 2 September 2010, p5.

218 Submission No. 74 from Dr Eric Visser, Pain Medicine Specialist, 19 October 2010, pp5-6.

The submission highlights the need for expanded *Telehealth* services, and for a real-time, computerised monitoring system for opioid prescribing and dispensing (similar to the pseudoephedrine monitoring system currently operating in pharmacies).

Finding 8

The Committee considers that the initiatives for the better management of pain medicine and monitoring of opioid prescribing proposed by Dr Visser might prove suitable to address the problem of the misuse of prescription opioids.

Recommendation 6

The Minister for Health fund a minimum of eight FTE pain medicine specialists and supporting staff across Western Australia in the State Budgets over the period 2012-14.

4.4 Benzodiazepines

Benzodiazepines are tranquillisers that are usually in a tablet form, and are prescribed for stress and anxiety management, to relax muscles and to induce sleep. Some well known brand names include Valium, Serepax, Temaze, and Diazepam. Like prescription opioids, benzodiazepines can be subject to tolerance, dependency and withdrawal-related problems, or can be diverted into the illicit drug market.[219]

According to the 2007 National Drug Strategy Household Survey (NDSHS) survey, fewer than 2% of Australians aged over 14 years reported using tranquillisers or sleeping pills, including benzodiazepines, in the previous 12 months for non-medical purposes. This survey found usage rates in Western Australia of 1.6% of the population over 14 years.[220]

The health problems posed by these tranquillisers may be on the decrease as the Australian Crime Commission (ACC) reported that "in 2008-09, Customs and Border Protection detected 186 unauthorised importations of benzodiazepine pharmaceuticals at the Australian border. This is a decrease from 377 detections in 2007-08 and 612 detections in 2006-07."[221] However, the ACC's

219 Drug and Alcohol Office, *About Benzodiazepines*, Drug and Alcohol Office, Perth, 2002.

220 Submission No. 37- Part A from the Drug and Alcohol Office, August 2009, p5.

221 Australian Crime Commission, *Illicit Drug Data Report 2008-09, Other Drugs*, 2010. Available at: www.crimecommission.gov.au/publications/iddr/index.htm, p84. Accessed 16 December 2010.

Drug Use Monitoring survey of 2008 shows that 23% of adult detainees in police lock-ups tested positive to benzodiazepines.

Being a depressant, benzodiazepines carry risks of overdose, particularly when used in conjunction with other depressants such as alcohol, codeine, or heroin. While rarely fatal when used on their own, use of benzodiazepines in combination with other drugs can have very serious consequences, including death. The ACC said "research has indicated that the combination of benzodiazepine, heroin and alcohol consumption is a key factor in heroin overdose."[222] As benzodiazepines decrease alertness and impair the ability to judge time, space and distance, their use can create serious risks related to the driving of vehicles and operating machinery.[223]

According to the Australian Institute of Health and Welfare (AIHW), 67% of treatment episodes for people using benzodiazepines reported the concurrent use of other drugs, most commonly cannabis (19%).[224] The AIHW said the treatment for people using benzodiazepines showed the median age of persons receiving treatment was 35 years and proportionally more women received treatment for benzodiazepines compared with other drugs.[225]

While the misuse of benzodiazepines would not appear to be as serious a problem in Western Australia as the misuse of prescription opioids, it contributes to the need for the more effective control of prescription drugs. Any new control system, such as expanding the current Project STOP, may have substantial costs for pharmacists who will have to enter this data.[226]

Recommendation 7

The Minister for Health request the Department of Health to examine the need to expand the pseudoephedrine monitoring program to include both prescription opioids and benzodiazepines.

4.5 Butane and other inhalants

In 2008, Coroner Mr Alistair Hope conducted an inquiry into the death of Ms Dayle Koch. Ms Koch was a young woman who died from inhaling butane. The Coroner recommended that the sale of butane to minors should be prohibited by legislation as there had been at least a dozen

222 Ibid, p82.

223 Drug and Alcohol Office Western Australia, *Benzodiazepines: About Benzodiazepines*, Government of Western Australia, Perth, 2002.

224 Australian Institute of Health and Welfare, *Alcohol and Other Drug Treatment Services in Australia: Report on the National Minimum Data Set*, Australian Government, Canberra, December 2010, p34.

225 Ibid.

226 The Pharmacy Guild of Australia, 'Project Stop', 2007. Available at: www.projectstop.com.au/. Accessed on 5 April 2011.

deaths in the State between 1997 and 2008 from butane use. In September 2009 the Opposition introduced the *Butane Products Control Bill 2009* (based on the legislative framework provided by the Tobacco Products Control Act) to try to reduce the ill-effects of butane inhalation, such as asphyxiation or ventricular fibrillation.[227] Evidence was provided that 3% of Australians over 14 years of age admitted to having used inhalants in their lifetimes, and more than 10% of 12-17 year olds in Western Australia (or 18,120) admitted to having used them.[228]

The Barnett Government did not accept that legislation was the most appropriate approach to dealing with this issue as:

- a wide range of products contain butane, such as cigarette lighters; cigarette lighter refills; and butane gas cartridges for camping stoves and portable cooking devices;
- these sources of butane are freely available;
- 70% of the Retail Traders Association of WA members are complying with a voluntary code of conduct to not sell butane fuel products to minors, to remove products from the reach of minors, and to display signs indicating the retailer's right to refuse the sale; and
- the level of butane abuse is very low.[229]

The Government defeated the Bill on 23 February 2011. While the Bill was defeated, the Government should address the issue of inhalant use as the latest survey of illicit drug use by the State's older school children aged 16-17 years shows that the use of inhalants, such as butane, is one of the few areas of drug use that is on the rise in the State (see Figure 4.1 below). The inhalant data included in this figure do not include the sniffing of pens and textas or white-out.

227 Mr Roger Cook, MLA, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 16 September 2009, p7204.

228 Ms Janine Freeman, MLA, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 23 February 2011, pp1006-1007.

229 Hon Dr Kim Hames, Minister for Health, and Hon Dr Graham Jacobs, MLA, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 23 February 2011, pp1011-1012.

Figure 4.1- Inhalant use in the past month by Western Australian school children (1996-2008)[230]

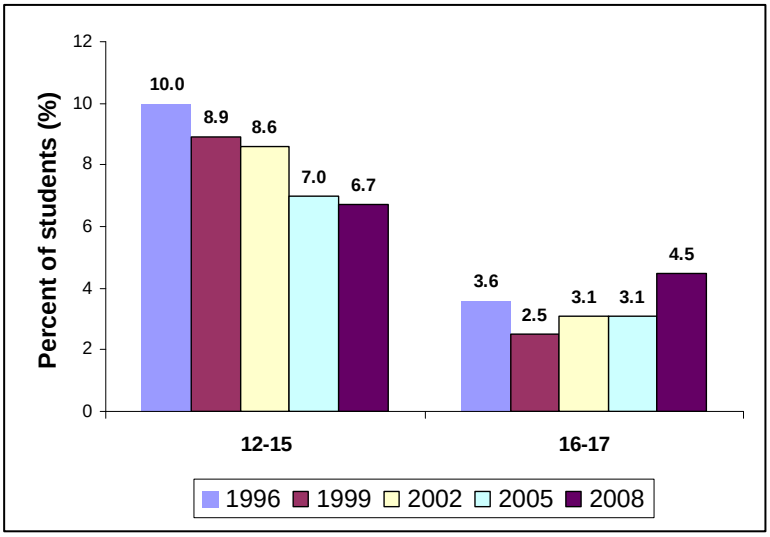
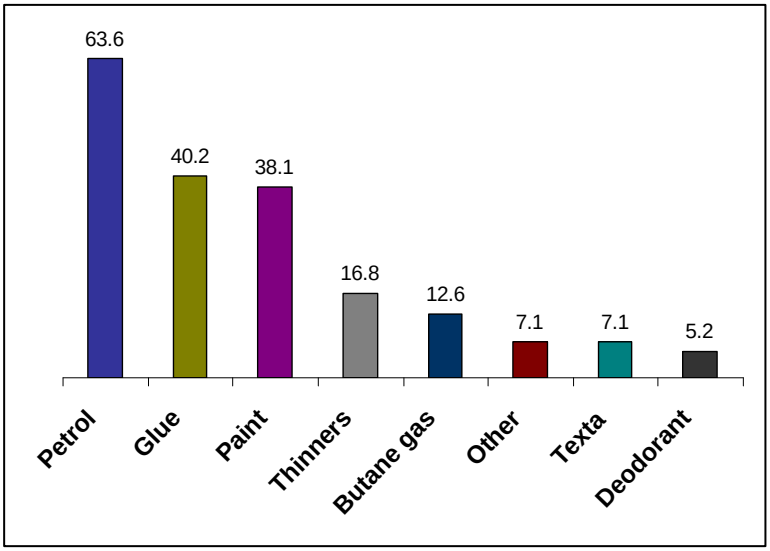


Figure 4.2 below shows that about 13% of students who had sniffed different inhalants in the past year had sniffed a butane product, compared to 40% who had sniffed glue and 64% petrol.

Figure 4.2- Most frequently inhaled substances in the past year by Western Australian school children (2008)[231]



230 Ms Rebecca Haynes, 'Australian School Student Alcohol and Drug (ASSAD) Survey Results from 2008', 2010. Available at: www.dao.health.wa.gov.au/Publications/tabid/99/DMXModule/427/Default.aspx?EntryId=1217&Command=Core.Download, slide 18. Accessed on 22 March 2011.

231 Ibid, slide 17.

The State Government is taking action on petrol sniffing in remote areas. The Premier told the Parliament this year that:

> *The Australian Government, in collaboration with Western Australia, South Australia and the Northern Territory is implementing a whole-of-government Petrol Sniffing Strategy in response to the devastating effects of petrol sniffing in some Indigenous communities. The Petrol Sniffing Strategy (PSS) aims to reduce the incidence and impact of petrol sniffing and other forms of substance abuse amongst Indigenous youth and communities in specific areas. These include* [in Western Australia] *the Ngaanyatjarra Lands and the East Kimberley region.*[232]

Recommendation 8

By December 2011 the Minister for Mental Health table in Parliament a plan to deal with the use of inhalants by Western Australian school children aged 16 to 17 years of age.

232 Hon Mr Colin Barnett, Premier, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), Questions on Notice, 17 March 2011, p1675.

CHAPTER 5 HEROIN

5.1 Background

The 2004 National Drug Strategy Household Survey (NDSHS) reported that heroin was nominated by 39% of Australians aged 14 years and older as the drug most associated with a 'drug problem'.[233] It has been estimated that in Australia in 2004-05 the government expenditure spent on tackling the problems of illicit drug use was about $2.7 billion with 92% of this expenditure related to law enforcement, 7% to health, and 1% to other issues such as road crashes and fires.[234] Western Australia's proportion of these estimated costs is approximately $300 million.

Data from the 2007 NDSHS shows that only about 0.2% of Australians were users of heroin or opium in the past 12 months, and that this rate has stayed flat for about 15 years.[235] The rate in Western Australia was also 0.2%. One witness warned the Committee that "we spend lots of money trying to gather data about illicit drug consumption. It is very hard because it is a hidden behaviour."[236]

Globally, more heroin users die each year from problems related to its use, and more are forced to seek treatment for addiction, than for any other illicit drug.[237] The Drug and Alcohol Office gave evidence that "generally, illicit drug use has been declining in Western Australia since 1988 ... The prevalence of heroin use is remaining relatively low and stable".[238]

While prevalence rates have dropped, the cost of treating addicts in hospital has risen. In 2001, the cost of the 4,605 illicit drug-related hospital admissions in Western Australia resulted in about 20,400 bed days of inpatient treatment at a cost of around $10 million.[239] By 2008, the direct cost of the 4,827 illicit drug-related hospital admissions in Western Australia resulted in 20,427 bed days of impatient treatment at a cost of approximately $22 million.[240] While these hospital

---

233 Australian Institute of Health and Welfare, 'Perceptions and Acceptability of Drug Use', June 2005. Available at: www.aihw.gov.au/publications/phe/ndshsdf04/ndshsdf04-c01.pdf, p4. Accessed on 2 December 2010.

234 Submission No. 37- Part B from the Drug and Alcohol Office, 25 August 2009, pv.

235 Australian Institute of Health and Welfare, 'National Drug Strategy Household Survey 2007 - First Results', 2008. Available at: www.aihw.gov.au/publications/phe/ndshs07-fr/ndshs07-fr-no-questionnaire.pdf, p4. Accessed on 2 December 2010.

236 Professor Steve Allsop, National Drug Research Institute, Curtin University of Technology, *Transcript of Evidence*, 11 May 2010, p11.

237 United Nations Office on Drugs and Crime, 'World Drug Report 2010', 23 June 2010. Available at: www.unodc.org/documents/wdr/WDR_2010/1.2_The_global_heroin_market.pdf, p34. Accessed on 2 December 2010.

238 Mr Neil Guard, Executive Director, Drug and Alcohol Office, *Transcript of Evidence*, 26 August 2009, p2.

239 Ibid.

240 Ms Julia Knapton, A/Director, Policy Strategy and Information, Drug and Alcohol Office, Electronic Mail, 11 March 2011, p1.

admission costs have doubled over the past decade, they are of a far smaller scale than the total direct cost of alcohol to Western Australia, which is estimated at over $1.5 billion per annum.

A witness told the Committee of the media impact of heroin overdoses:

> *government policies have come and gone. Drug and alcohol funding is often subject to whether there has been a spate of heroin overdoses, particularly in middle-class families, and then the policy changes—it* [overdoses] *goes off the radar again and something else happens and it becomes flavour of the social policy month.*[241]

5.2 International situation

The *World Drug Report 2010* (WDR 2010) states that each year more than 15 million people consume illicit opiates (opium, morphine and heroin). The majority of illicit drug opiate users consume heroin (the most lethal form). Global opium production greatly expanded in the first decade of the twenty-first century until 2007 but then declined over the next two years (from 8,890 to 7,754 tonnes), though remaining significantly above the estimated global demand of about 5,000 tonnes (as measured by consumption and seizure figures).[242]

Figure 5.1 below shows the change in the global opium production over the past 15 years. Heroin is the most lucrative of the illicit opiates and has an estimated annual market value of US$55 billion. Its supply source is concentrated in three areas:

- Afghanistan (about 90% of illicit global production);
- South-East Asia (mostly Myanmar); and
- Latin America (Mexico and Colombia).[243]

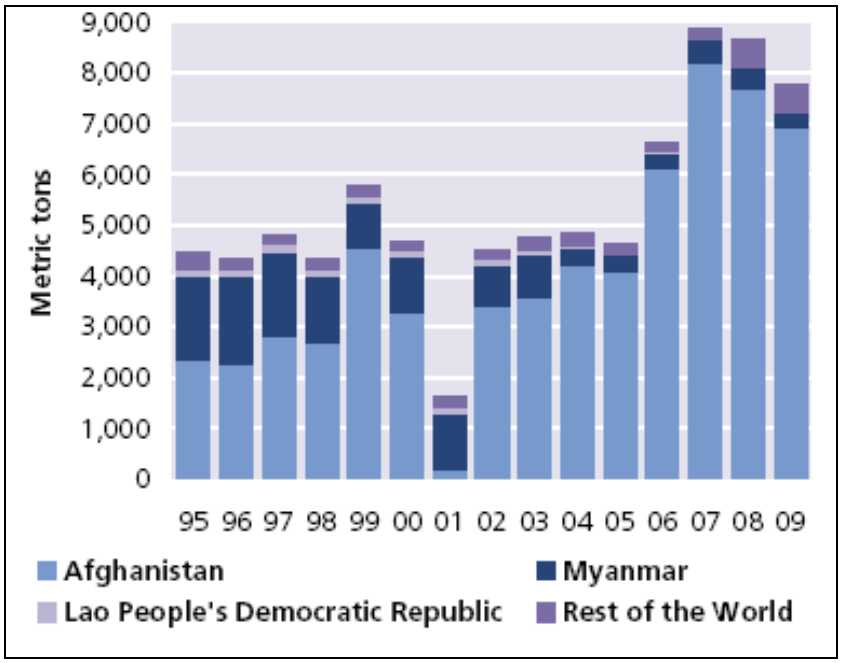
---

241 Hon Ms Sheila McHale, Chief Executive Officer, Palmerston Association Inc, *Transcript of Evidence*, 16 June 2010, p7.

242 United Nations Office on Drugs and Crime, 'World Drug Report 2010', 23 June 2010. Available at: www.unodc.org/documents/wdr/WDR_2010/1.2_The_global_heroin_market.pdf, p37 & p42. Accessed on 2 December 2010.

243 Ibid, p20.

Figure 5.1- Global opium production (1995-2009)



There are an estimated 4 million people who consume opium worldwide (mainly concentrated in Asia) and 11.3 million heroin users consuming about 340 tonnes of the drug.[244] Two markets, Europe and the Russian Federation, account for nearly half of the heroin consumed around the world. The Russian Federation is estimated to have the highest national level of consumption and consumes about 20% of the heroin sold on world markets.

Approximately 33% of those who have ever tried heroin will become addicted, compared to about 10% of those who have tried cocaine. The reason that rehabilitation programs need to consider all drugs is that about 70% of heroin addicts are also addicted to other drugs such as cocaine. In the United States:

> *the majority started their drug abuse history with cocaine. … and what we find is that the long-term cocaine abuser will turn first to prescription medications like benzodiazepines then will turn to alcohol in excess, but ultimately … they go on to become heroin addicted.*[245]

Heroin is the drug the public most associates with injection. Injections are associated with a host of acute and chronic health problems, including the transmission of blood-borne diseases such as HIV/AIDS and Hepatitis C. In many countries injecting opiates is linked to nearly 60-70% of all

244 Ibid, p40.

245 Professor Mary Jeanne Kreek, 'Myths About Heroin Addiction', 15 October 2001. Available at: www.abc.net.au/rn/talks/8.30/helthrpt/stories/s391783.htm. Accessed on 2 December 2010.

HIV infections.[246] With heroin, the difference between a recreational dose and a fatal one is small, and variations in street drug purity result in many overdoses. The mortality rate for dependent heroin users is between six and 20 times that expected for those in the general population of the same age and gender.[247]

A US study conducted a 33-year follow-up of 581 heroin users admitted to a Californian treatment program from 1962 to 1964. They found that, although five years of heroin abstinence considerably reduced future relapse, as many as 25% of patients experienced a relapse even after 15 years of abstinence.[248]

5.3 Heroin treatment programs

This section considers some of the wide range of treatment approaches to heroin addiction. A separate description of the Fresh Start Recovery Programme's naltrexone implant treatment offered in Western Australia is included later in the chapter. The treatment methods for heroin addiction fall into four broad categories: opioid prescription therapy, psychosocial treatments, residential rehabilitation programs and the opioid blocker naltrexone-based treatment. Some advocates of each treatment approach consider the other approaches inferior and this generates controversy among those involved in providing treatment and in the wider community.

(a) Self-initiated abstinence

Abstinence is a clear measure of the effectiveness of any drug treatment program and one that was stressed by a number of witnesses and submissions. Given the chronic relapsing nature of heroin dependence and its complexity, including the need to address the social and psychological dimensions of an addict, the achievement of abstinence is a lengthy and difficult process for many. Key factors in the achievement of abstinence by an addict are the severity and length of their addiction, the social support they have (particularly from their family) and their long-term retention in treatment programs. The implementation of the new 'road to recovery' strategy in the UK is outlined above in Chapter One.

(b) Opioid prescription therapies

'The most widely used treatment regime around the world for heroin addiction is opioid substitution therapy, which involves switching a user from heroin to a medically prescribed form

246 United Nations Office on Drugs and Crime, 'World Drug Report 2010', 23 June 2010. Available at: www.unodc.org/documents/wdr/WDR_2010/1.2_The_global_heroin_market.pdf, p34. Accessed on 2 December 2010.

247 Ibid, p47.

248 BNET, 'Relapse Rate High Despite Long-Term Heroin Abstinence', July 2001. Available at: http://findarticles.com/p/articles/mi_hb4345/is_7_29/ai_n28856791/. Accessed on 16 May 2011.

of a longer-acting opioid. The controversy around the use of methadone and other opioid substitutes centres on the substituting of one addiction for another.[249]

When heroin is consumed on a regular basis, physiological changes occur in the brain and the nervous system which result in a person needing to consume more heroin simply to feel normal. If a person ceases to use it, they experience severe withdrawal symptoms which may include vomiting, diahorea and severe cramps and pain. Opioid prescription or substitution therapies make use of less dangerous, and longer-acting opiods that can be taken orally. If a person moves from heroin to a longer-acting opioid, such as methadone, they generally do not experience such severe symptoms.

(i) Methadone maintenance

Methadone is the most widely-used replacement for heroin in medically-supported maintenance or detoxification programs. Many addicts stay on methadone for long periods, but some people gradually reduce the dose and come off illicit drugs altogether. Methadone is "a potent synthetic opioid agonist, which is well absorbed orally and has a long plasma half life and is taken as a daily oral dose."[250] It is used under two different prescribing regimes. The most common approach has been to prescribe a daily amount that prevents the patient experiencing withdrawal symptoms. This is described as a 'maintenance dose'. The patient can be on this same level of methadone for many years.

In some countries some heroin addicts have been on methadone maintenance programs for several decades. The Netherlands has the most geriatrics on methadone in Europe and has a retirement home catering exclusively to the needs of elderly drug addicts who have been unable to break their addiction.[251]

The second approach is to provide the patient with a decreasing amount of methadone over a pre-determined period, with a view to moving the patient to drug-free status.[252] For methadone to be a genuine treatment for addiction, the goal must be to gradually reduce the dose to work toward a patient's abstinence from opioids. However, the Australian Government recognised the danger that "forced abstinence may result in clients relapsing and losing gains already achieved while on methadone maintenance therapy."[253]

---

249 Dr Holger-Ortwin Lux, Board Member, International Federation of the Blue Cross, *Briefing*, 3 February 2011.

250 Drug and Alcohol Office, *Clinical Policies and Procedures for the Use of Methadone and Buprenorphine in the Treatment of Opioid Dependence*, DAO, Perth, October 2007, p12.

251 Radio Netherlands Worldwide, 'Woodstock: A Home for Aging Addicts', 18 February 2011. Available at: www.rnw.nl/english/article/woodstock-a-home-aging-addicts. Accessed on 14 March 2011.

252 Mr J. MacIntosh & Professor Neil McKeganey, *Beating the Dragon: The Recovery from Dependent Drug Use*, Pearson Education Ltd, Essex, 2002, p132.

253 Australian Government, 'Response to Road to Recovery: Report on the Inquiry into Substance Abuse in Australian Communities', July 2006. Available at: www.aph.gov.au/house/committee/fca/subabuse/gresponse.pdf, p24. Accessed on 13 May 2011.

In a Cochrane study[254], methadone appeared "statistically significantly more effective than non-pharmacological approaches in retaining patients in treatment and in the suppression of heroin use as measured by self report and urine/hair analysis, but not statistically different in criminal activity."[255]

An Australian researcher outlined how difficult any treatment and rehabilitation program is for heroin addicts:

> *There have been 20 and 24 year follow ups* [studies] *in the USA which found that about a third of people are prematurely dead. ... A third of them become clear of opiates, and the rest, that's about 40% cycle in and out of a number of treatments, and in and out of jail and in and out of heroin use. So about two-thirds of people either die, or don't overcome this problem, across a 20 year period.*[256]

Professor Mattick's study found that methadone was the most cost-effective intervention for the management of heroin dependence available in Australia. Six months after beginning their therapy, only 4% of those being treated with oral naltrexone remained in the treatment program while for the other pharmacotherapies (such as methadone and buprenorphine) the retention rate was 44%.[257] A similar study from Italy of 1,503 heroin users found the retention rate after one year was 40% for methadone, 18% for oral naltrexone, and 15% in drug-free treatment.[258] Some of those no longer in treatment may have returned to their dependence, while some may be abstinent.

One of the three pioneers of methadone treatment is Professor Mary Jeanne Kreek from Rockefeller University in New York. She considers methadone to be a treatment for a 'chronic disease' that deals with a biochemical deficiency in the same way that insulin does in a person with diabetes. Professor Kreek has published evidence that heroin is capable of inducing near-permanent changes to addicts' brains, and that these changes are what helps turn the problem into a long-term relapsing physical condition. In addition she found that "up to 54% of heroin addictions seem to be on a genetic or a heritable basis".[259] Research suggests a genetic pre-disposition coupled with risk taking behaviour could increase the likelihood of addiction.

---

254 The Cochrane Collaboration, 'What is a Cochrane Review', nd. Available at: www2.cochrane.org/reviews/revstruc.htm. Accessed on 5 April 2011.

255 Professor Richard Mattick *et al.*, 'Methadone Maintenance Therapy Versus No Opioid Replacement Therapy For Opioid Dependence', 19 February 2009. Available at: www2.cochrane.org/reviews/en/ab002209.html. Accessed on 2 December 2010.

256 Associate Professor Richard Mattick, 'Myths About Heroin Addiction', 15 October 2001. Available at: www.abc.net.au/rn/talks/8.30/helthrpt/stories/s391783.htm. Accessed on 2 December 2010.

257 Ibid.

258 Submission No. 37- Part B from the Drug and Alcohol Office, 25 August 2009, p10.

259 Professor Mary Jeanne Kreek, 'Myths About Heroin Addiction', 15 October 2001. Available at: www.abc.net.au/rn/talks/8.30/helthrpt/stories/s391783.htm. Accessed on 2 December 2010.

In 1997, neuroscience research proposed a view of drug addiction as a chronic disease:

> *virtually all drugs of abuse have common effects, either directly or indirectly, on a single pathway deep within the brain. This pathway, the mesolimbic reward system,… Not only does acute drug use modify brain function in critical ways, but prolonged drug use causes pervasive changes in brain function that persist long after the individual stops taking the drug. … That addiction is tied to changes in brain structure and function is what makes it, fundamentally, a brain disease.*[260]

The diabetic–insulin comparison does not take into account the human 'choice' element. Many people go on to 'beat' their addiction and live a drug-free lifestyle.

While methadone is a cheaper treatment option than others it does cause some side effects such as constipation, drowsiness, respiratory depression, sweating, headaches and dry mouth.[261] Higher doses can result in a client being unable to think clearly. Evidence shows that over 70% of people on methadone 'top up' with either heroin or other opioids, and very few are able to hold down a job.[262]

(ii) Buprenorphine maintenance

Buprenorphine is a long-acting opioid which is usually taken every two or three days. It has less side effects than methadone and was developed in the 1970s as an analgesic, as a post-operative pain killer in hospitals.[263] In Australia it has been used and funded under the Pharmaceutical Benefits Scheme as a heroin addiction treatment since 2001. In Western Australia buprenorphine is offered in the Community Program for Opioid Pharmacotherapy under the names of Subutex and Suboxone. Both Subutex and Suboxone are tablets that dissolve under a client's tongue.

Subutex contains only buprenorphine. Suboxone contains two ingredients, buprenorphine and Naloxone, in a 4-1 ratio.[264] Naloxone is added so that in the event the medication is re-directed into the illicit market, the 'high' the injecting user experiences is significantly reduced.[265]

---

260 Mr Alan Leshner *et al.,* 'Addiction Is a Brain Disease, and It Matters', *Science*, Vol. 278, No.45, 1997, p46.

261 Drug and Alcohol Office, *Clinical Policies and Procedures for the Use of Methadone and Buprenorphine in the Treatment of Opioid Dependence*, DAO, Perth, October 2007, p12.

262 Ms Kathryn Gyngell, Research Fellow, Centre for Policy Studies, United Kingdom, *Briefing*, 31 January 2011.

263 Associate Professor Richard Mattick, 'Myths About Heroin Addiction', 15 October 2001. Available at: www.abc.net.au/rn/talks/8.30/helthrpt/stories/s391783.htm. Accessed on 2 December 2010.

264 Hubpages Inc, 'Buprenorphine, Suboxone or Subutex – Which Do You Need?', 2011. Available at: http://hubpages.com/hub/Buprenorphine--Suboxone-or-Subutex--Which-Do-You-Need. Accessed on 5 April 2011.

265 Drug and Alcohol Office, *Clinical Policies and Procedures for the Use of Methadone and Buprenorphine in the Treatment of Opioid Dependence*, DAO, Perth, October 2007, p18.

In some countries, such as France, there is a more liberal policy to buprenorphine prescribing and it is more commonly used than methadone maintenance, with ten times the number of patients treated with buprenorphine than methadone. Buprenorphine is described by drug users as facilitating 'more normal' levels of daily activity compared to methadone, and leaving them more clear-headed and able to make decisions.[266] 'Coming off' buprenorphine is generally more comfortable for recovering addicts than 'coming off' methadone. People on reducing doses of methadone are sometimes switched to buprenorphine for the last phase of withdrawal.[267]

Buprenorphine is more costly than methadone, but is now regarded as a safer option to methadone as it is relatively easy to withdraw from and there are relatively few overdose deaths, except in combination with benzodiazepines.[268]

(iii) Other opioid prescription treatments

There are two other pharmacotherapies for the management of heroin dependence: levo-alpha acetyl methadole (LAAM), and prescribed heroin (diacetylmorphine).

LAAM

LAAM is similar to methadone but acts for a longer duration. It was first registered for use in the USA and Europe in the 1990s. A Cochrane review found LAAM is more effective than methadone in reducing heroin dependence, but there was not enough evidence from the trials regarding its safety. However, its registration is now suspended in Europe and restricted in the USA due to life-threatening concerns regarding cardiac problems it creates for patients.[269]

Prescribed heroin

The prescription of heroin as a maintenance treatment is based on the rationale of reducing associated risks to society (such as increased crime) from its illegal use. Heroin maintenance treatment is not available in Australia and conditions under which heroin can be prescribed are controlled by two international treaties.[270] About 200 clinicians are specially licensed in the UK to prescribe heroin to treatment-resistant addicts.[271]

Swiss voters in a 2008 referendum approved a measure that made permanent its pilot heroin-assisted treatment program (HAT). The HAT program began as a trial in 1994 and it showed that the lives of the addicts in treatment at government-run centers improved dramatically and their

---

266 Submission No. 37- Part B from the Drug and Alcohol Office, 25 August 2009, pp13-14.

267 Drug and Alcohol Office, *Clinical Policies and Procedures for the Use of Methadone and Buprenorphine in the Treatment of Opioid Dependence*, DAO, Perth, October 2007, p18.

268 Associate Professor Richard Mattick, 'Myths About Heroin Addiction', 15 October 2001. Available at: www.abc.net.au/rn/talks/8.30/helthrpt/stories/s391783.htm. Accessed on 2 December 2010.

269 Ibid, 19.

270 Ibid.

271 Mr David Raynes, Drugs and Organised Crime Consultant, *Briefing*, 31 January 2011.

dependence on crime as a source of income dropped from 70% to 10% after 18 months. The legal provision of heroin is limited to 21 outpatient clinics and two prisons. Distribution is tightly controlled by prescriptions and given only to addicts who have been unsuccessfully treated in other programs.[272]

Each year between 180 and 200 patients discontinue their participation in HAT. Of these patients, 35-45% are transferred to methadone maintenance and 23-27% to abstinence-based treatment. The average cost per patient-day at outpatient treatment centres in 1998 was about CHF50 (about AUD $55 in 2011). After the deduction of program costs, the net benefit of HAT was found to be CHF45 per patient-day (about AUD$50 in 2011).[273]

Programs such as HAT are now available for treatment-resistant addicts in England, Germany, Denmark, Switzerland and the Netherlands. A majority vote of the German Bundestag in 2009 decided to allow HAT to become available as a therapeutic option for severely-dependent heroin users who had not benefited from any previous treatment.[274]

(c) Psychosocial treatments

According to the Drug and Alcohol Office, there is currently insufficient evidence for the effectiveness of psychosocial treatments for opioid dependence on their own. Based on eight studies, a recent Cochrane review found psychosocial interventions were beneficial in combination with pharmacotherapies, and maintenance treatments such as methadone. Psychosocial treatments include counselling, social work, family therapy and regular medical care. Studies indicate that the skills and approach of the therapist is an important factor in determining the success of psychosocial treatments such as counselling.[275] The Committee felt that Teen Challenge use of therapeutic communities is an example of a successful non government psychosocial treatment program operating in Western Australia.

(d) Residential rehabilitation programs

Long-term residential rehabilitation is a costly method of assisting patients, but far less costly than incarceration. For example, the cost per resident per year in Teen Challenge's 45-bed facility in Esperance is about $25-30,000.[276] The Committee quoted in its earlier interim report that incarceration may cost over of $100,000 per inmate per year. Evaluations of the program show

---

272 Tere Miller-Sporrer, 'Switzerland Voters Approve Permanent Heroin Assisted Treatment Program', 1 December 2008. Available at: http://jurist.law.pitt.edu/paperchase/2008/12/switzerland-voters-approve-permanent.php. Accessed on 2 December 2010.

273 Federal Office of Public Health, Switzerland, 'Heroin-assisted Treatment (HAT)', nd. Available at: www.bag.admin.ch/themen/drogen/00042/00629/00798/01191/index.html. Accessed on 2 December 2010.

274 Dr Alex Wodak, 'Germany has Just Approved Heroin Assisted Treatment- Should We?', 1 June 2009. Available at: http://blogs.crikey.com.au/croakey/2009/06/01/germany-has-just-approved-heroin-assisted-treatment-should-we/. Accessed on 2 December 2010.

275 Submission No. 37- Part B from the Drug and Alcohol Office, 25 August 2009, pp23-24.

276 Mr Malcolm Smith, Executive Director, Teen Challenge WA, *Transcript of Evidence*, 11 August 2010, p.

that about 70-80% of the residents who graduate from the Teen Challenge residential rehabilitation program remain drug-free five years after completing the one-year program.[277]

Professor Meier told the Committee that rehabilitation programs have a good record of helping addicts become abstinent, but like most types of programs, there are no long-term research studies that show the status of addicts more than five years later.

A key aspect of the success of rehabilitation is if there is a key worker with whom clients can form a 'therapeutic alliance'. A relationship of this type is an important part of keeping clients in rehabilitation. The longer an addict stays in rehabilitation the greater their chance of reaching abstinence. However, 50-60% of clients entering a rehabilitation program do not complete it. Once people stay in a long-term program and get to the stage of entering a halfway house, or supported living arrangement, they have a good chance of recovering.[278]

Professor Vanderplasschen in Belgium confirmed the evidence of Professor Meier that the longer addicts stay in a rehabilitation treatment, the better their results in reaching abstinence. He confirmed that having a contact person within the program who monitors their progress and who motivates them can improve a client's retention and treatment.[279]

(e) Opioid-blocking therapy

Currently the only recognised opioid-blocking therapy is the use of naltrexone. Naltrexone was initially only available in tablet form, and the dependent user needed to take it daily in order for the blocking effect to be maintained. It is an opiate antagonist that blocks the effects of opioids and has been used as a withdrawal treatment and a relapse prevention treatment for both heroin and alcohol dependency. Various trials have shown benefits from using the tablet form but a persistent problem with the tablet is that addicts do not comply with their treatment.[280] This then makes them more sensitive to heroin and in greater danger of overdose.

In October 2010 the Food and Drug Administration in the USA approved Vivitrol to treat patients with opioid dependence who have undergone detoxification treatment. Vivitrol is an extended-release formulation of naltrexone administered by intramuscular injection once a month. Trials over six months show that 36% of the Vivitrol-treated patients were able to stay in treatment without using drugs, compared with 23% in the placebo group. However, the FDA warn of 'serious side effects' from this treatment, including "reactions at the site of the injection, which can be severe and may require surgical intervention, liver damage, allergic reactions such as hives,

277 Ibid, p5.

278 Professor Petra Meier, Professor of Public Health, University of Sheffield, United Kingdom, *Briefing*, 31 January 2011.

279 Professor Wouter Vanderplasschen, Researcher, Ghent University, Department of Orthopedagogics, *Briefing*, 2 February 2011.

280 Dr K. Chan, 'The Singapore Naltrexone Community-Based Project for Heroin Addicts Compared with Drugfree Community–Based Program: First Cohort', *Journal of Clinical Forensic Medicine*, 1996, vol. 3, pp87-92.

rashes, swelling of the face, pneumonia, depressed mood, suicide, suicidal thoughts, and suicidal behaviour."[281]

A later section of this chapter provides more detail on the efforts of Dr George O'Neil here in Western Australia to develop successful naltrexone implants to overcome the problem of users not complying with their tablet treatment. Dr O'Neil claims his implants are effective at blocking the effect of heroin for up to 180 days. These implants are not yet registered by the Australian Therapeutic Goods Administration (TGA), but similar implants are registered in Russia and used in China.[282]

Long-lasting naltrexone implants, if they prove to be reliable and safe, have the potential to displace methadone and buprenorphine as the standard pharmacological treatment for opioid addiction. They would enable a person to live an opioid-free lifestyle. This potential is what has motivated the State Government to engage a medical specialist to review the research on the implants to see what more needs to be done before an application for TGA registration can be made.[283]

(f) Lack of follow-up studies

For many of these programs for treating heroin addiction there is a lack of randomised control trials on their effectiveness. There is also a lack of trials extending beyond more than 2-3 years after a patient has commenced treatment. This is not unexpected for such public health interventions. Therefore the results of the specific treatments can be noted, but any success in keeping clients off heroin is not able to be scientifically verified for a particular program until these long-term and randomised trials have been completed.[284]

Finding 9

There is a need for long-term follow-up on the effectiveness of all Western Australian opioid treatment programs.

281 Food and Drug Administration, 'FDA Approves Injectable Drug to Treat Opioid-dependent Patients', 12 October 2010. www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm229109.htm. Accessed on 13 May 2011.

282 Hon Dr Graham Jacobs, Minister for Mental Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 19 March 2009, p2214.

283 Ibid.

284 Professor Wouter Vanderplasschen, Department of Orthopedagogics, Ghent University, *Briefing*, 2 February 2011.

Recommendation 9

All opioid treatment programs need to provide to the Drug and Alcohol Office follow-up short and long-term (greater than five years) data on all patients to assist in evaluating the effectiveness of these programs, including rates of abstinence.

(g) Health issues of repeated detoxification

The Committee heard that, as well as the difficulty of detoxing addicts from their heroin addiction, there were additional health challenges for addicts from undergoing multiple detox and rehabilitation programs. A witness in the UK said that it is not healthy for an addict to go from methadone into abstinence (and maybe back onto street drugs) and then through multiple rounds of detox programs as it may cause serious brain damage if they detox too many times. Professor Meier told the Committee that this medical effect was created by gradual detoxs as well as quick ones (which were more dangerous). Every time an addict came off heroin and then restarts, it does damage to their bodies. Deaths can occur because usually addicts restart at too high a level of heroin and risk overdosing.[285]

This health impact seems to be similar to that suffered by alcoholics "undergoing alcohol detoxification [who] are more likely to experience seizures if they have undergone previous episodes of detoxification. Prior research has indicated that multiple withdrawals may lead to changes in brain functioning."[286] These findings highlight the importance of giving a recovering addict adequate support to effectively re-enter main stream society, thereby reducing the likelihood of a relapse or overdose.

5.4 Australian situation

The *World Drug Report 2010* says that in Australia "there is no indication of heroin use returning to the levels of use seen prior to the 2001 heroin shortage." Australia's annual prevalence rate is reported by UNODC as 0.4%, about the same as in Canada and France, two-thirds the rate in the USA, a third of New Zealand's and a quarter of that in the UK.[287]

Other Australian data shows that the maximum level of heroin use was in 1998 with 0.8% of the population over 14 years reporting having used heroin in the past year. This rate dropped to 0.2%

---

285 Professor Petra Meier, Professor of Public Health, University of Sheffield, *Briefing*, 31 January 2011.

286 About.com, Alcoholism, 'Repeated Detox Can Impair Cognitive Function', 15 October 2003. Available at: http://alcoholism.about.com/cs/dementia/a/blacer031014a.htm. Accessed on 14 March 2011.

287 United Nations Office on Drugs and Crime, 'World Drug Report 2010', 23 June 2010. Available at: www.unodc.org/documents/wdr/WDR_2010/1.2_The_global_heroin_market.pdf, p157. Accessed on 2 December 2010.

in 2004.[288] Heroin-related overdose cases are often reported in the media and non-medical use of opioids (including methadone, buprenorphine, morphine and oxycodone) remain common.

Toward the end of 2000 Australia experienced an unprecedented reduction in the supply of heroin. Dr Don Weatherburn said the price of heroin rose from around $220 a gram to nearly $400 while the purity of 'hits' on the street fell from 60% to 20%. Dr Weatherburn says:

> *To that point many people thought that if heroin became more expensive, dealers' profits would increase and heroin users would commit even more crime to fund their purchases of heroin. What happened was that heroin use and crimes, such as theft and robbery, fell like a stone*.[289]

Dr Weatherburn said the national robbery rate fell 30%; the national burglary rate fell 93%; and the national motor vehicle theft rate fell 116%. In 2009, the burglary and motor vehicle theft rates in NSW were lower than they were in 1990. Heroin overdoses in NSW are now just one-sixth of what they were a decade ago. He says most heroin addicts "stopped using it; some used it much less frequently; some switched to other products (both legal and illegal)." Dr Weatherburn suggests governments not focus on whether the heroin shortage is ending but on the drug problems that have become worse, such as the increase in the use of cocaine, amphetamine and the abuse of pharmaceutical opioids, such as oxycodone.[290]

The Australian Crime Commission's (ACC) latest data shows that the number of heroin border detections in 2007-08 were 283, a decrease of 27% from 2006-07, while the weight of detections increased from 81.7 kilograms to 99.3 kilograms, an increase of 22% (see Figure 5.3 below). The ACC said "these figures are historically low when compared with the previous decade."[291]

---

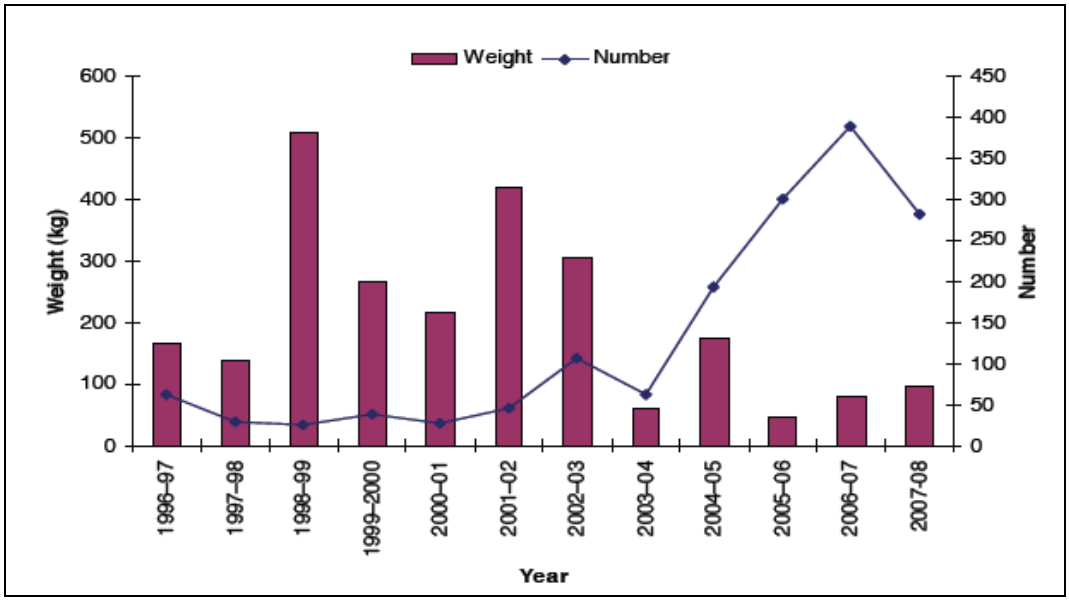
288 Australian Institute of Health and Welfare, 'Statistics on Drug Use in Australia 2006', April 2007. Available at: www.aihw.gov.au/publications/phe/soduia06/soduia06.pdf, p24. Accessed on 2 December 2010.

289 Dr Don Weatherburn, 'What Really Happened to the Heroin Drought', *Sydney Morning Herald*, 22 June 2009. Available at: www.smh.com.au/opinion/what-really-happened-to-the-heroin-drought-20090621-csik.html. Accessed on 2 December 2010.

290 Ibid.

291 Australian Crime Commission, 'Illicit Drug Data Report 2007 – 08: Heroin', 19 November 2010. Available at: www.crimecommission.gov.au/publications/iddr/_files/2007_08/04heroin200708.pdf, p50. Accessed on 3 December 2010.

Figure 5.3- Number and weight of heroin detections at Australia's borders (1997–98 to 2007–08)[292]



In 2007–08, the number of seizures of heroin shipments decreased in Western Australia, with the weight of heroin seized dropping by 65% to just 1.5kg. Similarly, the number of heroin and other opioid arrests in the State dropped by 12% to 131. Across Australia, the seizure numbers and arrests increased marginally in 2007-08. The number of arrests for using or providing heroin in 2007-08 were 2,280, or just 16% of what they were in 1998-99.[293]

(a) Treatment of opioid dependence in Australia

In January 2007, the Federal Department of Health and Ageing released the *National Pharmacotherapy Policy for People Dependent on Opioids*. This policy provides a framework for the policies and guidelines of Australian jurisdictions providing treatment of opioid dependence with methadone, buprenorphine or naltrexone. This policy says that the treatment of opiate dependence should be administered within a framework which includes pharmacotherapy treatment as well as social and psychological treatment.

There are three main types of treatment available:

- withdrawal treatment - generally for those seeking further treatment (such as rehabilitation) after initial pharmacotherapy to maintain abstinence;
- substitution/maintenance treatment - generally sought by those seeking to cease or substantially reduce their illicit use; and

292 Ibid, p51.

293 Ibid, pp56-58.

- relapse prevention treatment to block the effects of opioids.[294]

The Australian Government funds the provision of pharmacotherapy drugs via the Pharmaceutical Benefits Scheme (PBS). Treatment itself is provided directly by government providers or via other providers approved by state and territory governments. The pharmacotherapies currently recommended in Australia for the treatment of opioid dependency and available on the PBS are:

- **methadone hydrochloride**: taken orally on a daily basis. It has a low incidence of side-effects; however, there is a risk of overdose;
- **buprenorphine:** is a long-acting opioid that blocks the effects of other opioids such as heroin. It is available in tablet form for withdrawal management (detoxification) and maintenance purposes- available on its own or in combination with naloxone; and
- **naltrexone**: is not an opioid but an opiate antagonist that blocks the effects of opioids. Oral naltrexone in tablet form was registered in 1998 but its use has now reduced and is subsidised by the PBS only for the treatment of alcohol dependency. To improve treatment outcomes, slow-release implants are being investigated.[295]

(b) Alternative therapies

The Committee visited the controversial Sydney Medically Supervised Injecting Centre (MSIC) in Kings Cross, NSW. This centre is one of over 70 supervised injecting facilities around the world and opened in May 2001. This followed the NSW Drug Summit in 1999 and the passing of the *Drug Summit Legislative Response Act* in 1999 by the NSW Parliament which allowed for one MSIC to be opened in that state for an 18 month trial period.[296]

Commissioner Wood in his *Final Report on the Royal Commission into the New South Wales Police Service* had earlier presented evidence that illegal 'shooting galleries' were operating in Kings Cross, often with the approval of the police. The New South Wales Parliament acted in response to Commissioner Wood's recommendation and established a Joint Select Committee Upon Injecting Rooms in June 1997.[297]

---

294 Australian Government, 'National Pharmacotherapy Policy for People Dependent on Opioids', January 2007. Available at: www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/pharmacotherapy. Accessed on 3 December 2010.

295 Submission No. 37- Part B from the Drug and Alcohol Office, 25 August 2009, ppiii-iv.

296 Dr Ingrid van Beek, 'The Medically Supervised Injecting Centre- the First 7 Years', 2008. Available at: www.sydneymsic.com/__data/assets/powerpoint_doc/0003/29433/MSIC_NDARC_07.ppt#311,2,Background. Accessed on 3 December 2010.

297 Sydney Medically Supervised Injecting Centre, 'Report on the Establishment or Trial of Safe Injecting Rooms', 2008. Available at: www.sydneymsic.com/Bginfo.htm/report_on_the_establishment_or_trial_of_safe_injecting_rooms. Accessed on 3 December 2010.

The NSW Government recently announced it will remove the 'trial status' of the Medically Supervised Injecting Centre (MSIC) after nine years and formalise its operations. The MSIC provides syringes but not heroin to IDUs. New legislation will guarantee the continued stringent monitoring of the MSIC and ensure that it will remain the only legalised injecting centre in NSW. It will undergo regular statutory evaluations every five years, an independent evaluation after four years, and NSW Health will continue to conduct routine inspections.[298] Some organisations, such as Drug Free Australia, argue that the MSIC has been ineffective and should be closed.[299] The Committee heard no evidence that such a facility be developed in this State.

5.5 Western Australian evidence

The current State Government strategy is driven by a policy prepared by the Drug and Alcohol Office (DAO) that is now two years out of date – *The Western Australian Drug and Alcohol Strategy 2005 - 2009*. This document makes no mention of specific drugs such as heroin, but reflects the National Drug Strategy and "embraces the concept of harm minimisation, which encompasses the core functions of supply reduction, demand reduction and harm reduction."[300] The State's strategy is now driven by the draft *Interagency Strategic Framework 2010-15*.

(a) Injecting drug users

The 2007 National Drug Strategy Household Survey (NDSHS) indicated that in Western Australia about 3,400 people (0.2%) had used heroin in the past 12 months and around 20,600 (1.2%) had used it within their lifetime. Data from the National Drug Research Institute (NDRI) Illicit Drug Reporting System for a small sample of the State's injecting drug users (IDUs) in 2009 show:

- the mean age of first injection was 19 years;
- the mean age of IDUs was 35 years;
- men comprised approximately two-thirds of IDUs;
- less than 0.4% of the sample of IDUs reported that they were Indigenous;
- about one-third reported currently being in drug treatment;
- one-half reported a prison history;

298 Hon Ms Carmel Tebbutt, NSW Health Minister, 'Medically Supervised Injecting Centre to Remain Open', 15 September 2010. Available at: www.nswalp.com/blog/1096/medically-supervised-injecting-centre-to-remain-open. Accessed on 3 December 2010.

299 Drug Free Australia, 'The Kings Cross Injecting Room: The Case for Closure', nd. Available at: www.drugfree.org.au/fileadmin/Media/Reference/DFA_Injecting_Room_Booklet.pdf. Accessed on 26 April 2011.

300 Drug and Alcohol Office, 'The Western Australian Drug & Alcohol Strategy 2005 - 2009', nd. Available at: www.dao.health.wa.gov.au/Publications/tabid/99/DMXModule/427/EntryId/449/Command/Core.Download/Default.aspx, p8. Accessed on 3 December 2010.

- 37% reported no tertiary education; and
- unemployment was reported by 71% of IDUs.[301]

A survey of 222 Western Australians participating in the needle and syringe program (NSP) in 2009 provides a snapshot of illicit drug injecting which suggested a rise in use of heroin over the past five years. Recent NSP data is included in Table 5.1 below.

Table 5.1- Proportion of NSP respondents by last drug injected and injecting behaviour (2005-09)

	2005 Proportion (%)	2007 Proportion (%)	2009 Proportion (%)
Last drug injected			
Heroin	28	25	33
Methamphetamine	34	31	19
Pharmaceutical Opioids	14	21	17
Subutex/Buprenorphine	11	6	7
Methadone	4	4	5
Cocaine	0	0	1
Anabolic steroids	0	0	<1
More than one	2	5	5
Places injected last month			
Own home	80	93	91
Friend's home	35	49	50
Car	30	42	35
Public toilet	14	19	28
Street, park, beach	15	23	24
Dealer's home	17	32	23
Squat	1	8	9

301 National Drug Research Institute, Curtin University of Technology, 'WA Drug Trends 2009- NDARC Technical Report No. 43', 2010. Available at: http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/resources/IDRSJurisdictionalReports/$file/WA_IDRS_2009.pdf, p9. Accessed on 6 December 2010.

Table 5.2 provides information of the State's NSP injecting drug user participants and their involvement in treatment programs.

Table 5.2- Proportion of Western Australian NSP respondents by treatment for drug use (2008-09)

	2009 Proportion (%)	2008 Proportion (%)
Any treatment/therapy for drug use		
Yes	71	71
No	26	28
History of methadone maintenance treatment		
Currently	24	20
Previously	23	28
Never	50	51
History of buprenorphine (Subutex®) treatment		
Currently	12	11
Previously	19	30
Never	67	57
History of buprenorphine-naloxone (Suboxone®) treatment		
Currently	11	9
Previously	13	12
Never	74	76

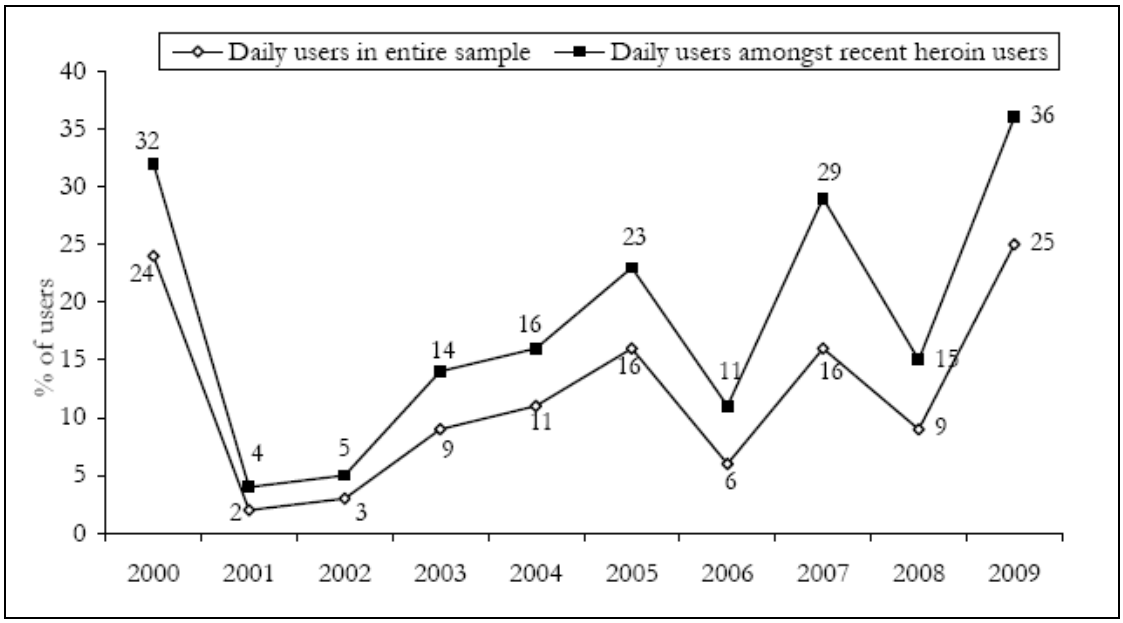
Of concern was data from the NDRI Illicit Drug Reporting System that showed a recent increase in the frequency of injections in Western Australia by IDUs, with 50% reporting injection once a day or more (compared to 30% in 2008). This survey uses a small sample of IDUs. In 2009, heroin surpassed methamphetamine as the drug most often injected in the last month (50% versus 34%) and as the most recent drug injected (46% versus 30%).

There was also an increase in the proportion of IDUs nominating heroin as the drug of choice: from 49% in 2008 to 58% in 2009. The average days of heroin use in the last six months significantly increased to 103 in 2009, from 61 days in 2008.

The NDRI data show that the proportion of daily heroin users had increased to 36% in 2009, from 15% in 2008, as shown in Figure 5.4 below.[302] Additionally, ambulance data indicate that the number of callouts to narcotic overdoses in Western Australia has significantly increased in the last two years. These factors may be due to an increase in heroin availability, a decrease in heroin price or an overall increase in the number of people using heroin daily.[303]

Evidence to the Committee in 2010 from Royal Perth Hospital Emergency Department staff that "we have now entered a real crescendo phase of heroin presentations just in the last few months" also suggests a recent increase in heroin use in Western Australia.[304]

Figure 5.4- Proportion of daily users among Western Australian IDUs (2000-09)



(b) Western Australian heroin treatment options

For clients seeking government-funded treatment services in 2006-07 in Western Australia, 10.5% presented for heroin and other opioids (oxycodone and morphine). This is substantially lower than the 1999 prevalence rate of 25.0%. About 58% of clients in 2007-08 were multi-drug users and many had co-occurring mental health and physical problems as well.[305]

As at June 2008, there were 2,908 people in Western Australia (or 7% of the Australian total) who were receiving methadone and buprenorphine pharmacotherapy. About 69% of the Western Australian clients were receiving methadone. The main pharmacotherapy prescribers are:

302 Ibid, p31.

303 Ibid, p9 and p15.

304 Dr David McCoubrie, Royal Perth Hospital Emergency Department, *Transcript of Evidence*, 8 June 2010, p10.

305 Submission No. 37- Part B from the Drug and Alcohol Office, 25 August 2009, pp1-2.

- GPs;
- DAO's Next Step service;
- Australian Medical Procedures Research Foundation (operating as the Fresh Start Recovery Programme); and
- Department of Corrective Services.[306]

The Community Program for Opioid Pharmacotherapy (C-POP) has operated since 1997 and is administered by DAO in partnership with the Department of Health's Pharmaceutical Services Branch.

Under C-POP, pharmacotherapies are prescribed by an addict's general practitioner and pharmacists dispense the pharmacotherapy. C-POP provides services to over 3,600 opioid-dependent clients through 160 GPs and 285 pharmacies trained and authorised to prescribe and dispense pharmacotherapies.[307] The 2010 Australian NSP Survey National Data Report showed that about 36% of illicit drug users (IDUs) obtain their syringes from C-POP providers, 60% from the Needle and Syringe Program, and 20% from their friends.[308]

All of Western Australia's 11 prison services provide opiate maintenance services to prisoners. As at August 2009 there were 240 opiate pharmacotherapy clients in the State's prisons.[309]

Finding 10

About 50% of people who are heroin dependent are incarcerated at some time.

Recommendation 10

The Minister for Corrective Services ensure that funding is available by December 2011 to enrol all opiate pharmacotherapy clients in Western Australian prisons in a 'road to recovery' program or a program promoting abstinence.

306 Submission No. 37- Part B from the Drug and Alcohol Office, 25 August 2009, pvi.

307 Ibid, pvi.

308 National Centre in HIV Epidemiology and Clinical Research, 'Australian NSP Survey National Data Report: 2005-2009', June 2010. Available at: www.nchecr.unsw.edu.au/NCHECRweb.nsf/resources/NSP_Complete2/$file/ANSP.NDR.2005_2009.pdf, p157. Accessed on 9 December 2010.

309 Ibid.

(i) Cost of the C-POP program

Methadone and buprenorphine are provided under the Pharmaceutical Benefits Scheme, for heroin users, at no cost to the State Government. The cost to the State of the C-POP program relates to the services provided through DAO and the Department of Health's Pharmaceutical Services Branch. DAO estimates that about 81% of Next Step's outpatient services and 50% of its pharmacy annual budget support for methadone and buprenorphine pharmacotherapy. This totalled $4,005,639 for 2009-10. DAO estimates that, based on Next Step managing about 35% of the total 3,919 authorised clients (about 1,370) shown in Table 5.3 below, the annual cost for their pharmacotherapy patients is $2,921 per annum.

Additionally, $704,160 of Next Step's budget is allocated to the Community Pharmacotherapy Program (C-POP) to manage the State-wide network of GPs and pharmacies involved in the C-POP program. This program includes the Clinical Advisory Service and a 24/7 telephone service that provides advice and information to doctors and health professionals. The Department of Health pharmaceutical services branch allocates one position to manage this program, estimated to cost $97,150 per annum.[310] Based on 65% of the total number of authorisations in October 2010 for opioid pharmacotherapy, the cost per patient for Next Step to manage these clients in the community was $1,226 per annum.

The cost to the State per community pharmacotherapy (C-POP) patients managed by doctors within Corrective Services (about 10% of patients) and GPs in the community (about 55% of patients) is $308 per annum.[311] Community patients also pay a daily dispensing fee of between $5-$10 (or about $1,000 to $3,600 per annum) at their local pharmacy.

Costs of buprenorphine versus methadone

The administrative costs above indicate they are the same for a C-POP client receiving either buprenorphine or methadone. The administrative costs are paid by the State Government for public patients and through Medicare for GP's patients.

The drug costs are:

- **Methadone**– costs $33.20 per 1 litre bottle containing 500mg of methadone. An average dose is 60ml and is taken daily. The average daily cost of methadone is $0.39 (about $140 per annum paid by PBS).
- **Buprenorphine**– costs $132.44 per 28 x 8mg of tablets. An average dose is 13mg per day, or $7.68 (about $1,370 per annum paid by PBS).

The retention of patients in treatment for buprenorphine is significantly less than for methadone and there is a slightly higher cost for clinical management, as there are more re-admissions.

---

310 Mr Neil Guard, Executive Director, Drug and Alcohol Office, and Dr Tarun Weeramanthri, Executive Director, Public Health, Department of Health, Letter, 1 March 2011, p3.

311 Ibid.

A move to buprenorphine would be cheaper for the patient, but increase the overall PBS cost of the drug doses to the Federal Government. Buprenorphine can be taken daily or as a double dose every second day. About 50% of patients take it every second day. These patient's dosing fees are reduced as they only have to pay every second day.[312]

(c) Trends in pharmacotherapy authorisations

The Committee heard in the United Kingdom that the move to a 'recovery' focus was in part driven by the large number of methadone clients who stay on their program and do not become abstinent. The Committee therefore sought data from DAO on the situation in this State and this data is shown in Appendices Five to Nine, and summarised in Table 5.3 below.

Table 5.3- Western Australian opioid pharmacotherapy treatment authorised clients (1 October 2010)

	Number of clients	Median dose	Median dosing months for clients on prescription for four years
Methadone	2,678	53.0mg	47.0 months
On methadone for 10 years or longer	(1,062)		
Buprenorphine (Subutex)	171	12.0mg	47.0 months
Buprenorphine (Suboxone)	1,315	14.0mg	51.1 months
TOTAL	**3,919**		

The average doses shown in Appendix Five may be affected by the movement of patients between Subutex (introduced in 2001), Suboxone (introduced in 2006) and methadone. The Department of Health said:

> *With the introduction of Subutex in 2001, authorised C-POP prescribers treating patients with methadone had the choice of pharmacotherapy. Patients who were on a reducing regime of methadone, when at a lower dose were transferred and continued in treatment on Subutex/Suboxone. ... Since 2003-04 patients weaning and on the lower doses of maintenance therapy may be on buprenorphine instead of methadone. This would have the effect of increasing the methadone statistical average.*[313]

312 Mr Neil Guard, Executive Director, Drug and Alcohol Office, Email, 16 May 2011, p1.

313 Ms Joy Knight, Department of Health , Electronic Mail, 10 March 2011, p1

In 2010 there were 2,367 patients receiving one of these three drugs (as shown in Table 5.4 below). This was an increase from the 765 patients in 1997 when statistics were started to be collected by DoH, and a decrease from a high of 3,122 patients in 2006. C-POP authorisations last for two years and some patients who continue in the program are not reflected in the categories listed in Table 5.4

Table 5.4- Western Australian C-POP client types (2010)#[314]

	Methadone	Buprenorphine (Subutex)	Buprenorphine (Suboxone)
New Admission	171	11	205
Re-Authorisation	587	63	344
Renewals	640	44	302

New Admission - Number of patients who are admitted into C-POP for the first time in a calendar year.
Re-Authorisation - Number of existing patients where there has been a change in prescriber or drug or a break in treatment in a calendar year so a re authorisation is required.
Renewal - Number of existing patients whose authorisation expires in the calendar year, and are renewed by DoH.

In response to questions from the Committee, DAO advised that in Western Australia there are no set targets for the movement of methadone and buprenorphine patients to an opioid-free status. DAO's program recommends that patients be encouraged to stay in treatment for at least 12 months (and preferably 24 months) before undertaking withdrawal. DAO's experience is that patients who tend to drop out of treatment early, tend to relapse to illicit drug use and then re-present for further treatment.

Table 5.5 shows the changes in dosing patterns for long-term C-POP patients (those who had dosed for more than 12 months) and who received a methadone or buprenorphine dose in both June 2009 and June 2010. Less than 30% of patients increased the level of their dose over 2009-10, with nearly 40% reducing it.

Table 5.5- Changes to patient doses for long-term C-POP patients (June 2009 and June 2010)[315]

	Increased Dose	Reduced Dose	No Change
Methadone	529	718	514
Subutex	20	26	32
Suboxone	145	192	246
TOTAL	**694**	**936**	**792**

314 Ibid, attached spreadsheet (ii).

315 Ibid, attached spreadsheet (viii).

DAO said there is no single optimal duration of treatment, but that the outcomes of methadone and buprenorphine maintenance improve with a client's increasing time in treatment. It provided evidence that arbitrary restrictions on the length of time in treatment often leads to poor treatment outcomes for most patients.[316]

DAO told the Committee that each client is reviewed while on the C-POP program by their treating doctor in the following fashion:

Methadone patients

- the day of the first dose;
- every 2 - 4 days until stabilisation;
- every week during the following 4 - 6 weeks;
- every 2 weeks during the following 4 - 6 weeks; and
- monthly reviews thereafter.

Buprenorphine patients

- the day, or the day after the first dose;
- every 2 - 4 days until stabilisation;
- every week during the following 4 - 6 weeks;
- every 2 weeks during the following 6 - 8 weeks; and
- monthly reviews thereafter, although the prescriber may wish to extend reviews to up to three months for stable patients.[317]

Clients with continuing high-risk patterns of drug use and associated medical, psychiatric or social problems may require more frequent reviews by their doctors.

Auditing of Community Pharmacotherapy Program providers

DAO told the Committee that the frequency or content of medical reviews conducted by community prescribers is not formally audited by either them or the DOH pharmaceutical services branch. It said:

> *that it is usual for patients managed by GPs to be seen on a monthly basis. At Next Step long term stable patients are reviewed by their doctor once every three to six months.*

316 Ibid, p8.

317 Ibid, p5.

> *These patients are seen for counselling and support more regularly by their case manager.*[318]

DAO said the training program to become an authorized prescriber includes information on medical reviews. The C-POP runs regular educational events for them and holds an annual conference where the latest evidence-based practice is presented. Registration as an authorized prescriber requires renewal every three years.[319] In 2010 there were 93 approved prescribers (not including DAO and Next Step staff) in 239 active sites across the State. The distribution of these prescribers and active dosing sites by area health district is shown in Appendix Five.[320]

Finding 11

The Community Program for Opioid Pharmacotherapy in Western Australia focuses on a traditional treatment approach. The United Kingdom has adopted a new approach to treatment that gives emphasis to assisting 'users' to break their addiction and become drug-free.

Recommendation 11

The Minister for Mental Health should ensure that by December 2011 the Drug and Alcohol Office prepare guidelines for the six-monthly review of all illicit opioid drug treatment patients. When applying for a renewal of an authority to prescribe an opioid pharmacotherapy, prescribers should provide the Department of Health with an outline of the proposed treatment plan for each patient.

Recommendation 12

Commencing in 2012, the Minister for Mental Health appoint a panel, including an Australian Medical Association-nominated addiction specialist, to conduct an annual random audit of 50 opioid pharmacotherapy patient treatment plans. The Drug and Alcohol Office include the results of these audits in their annual reports.

318 Ibid, pp5-6.

319 Ibid, p6.

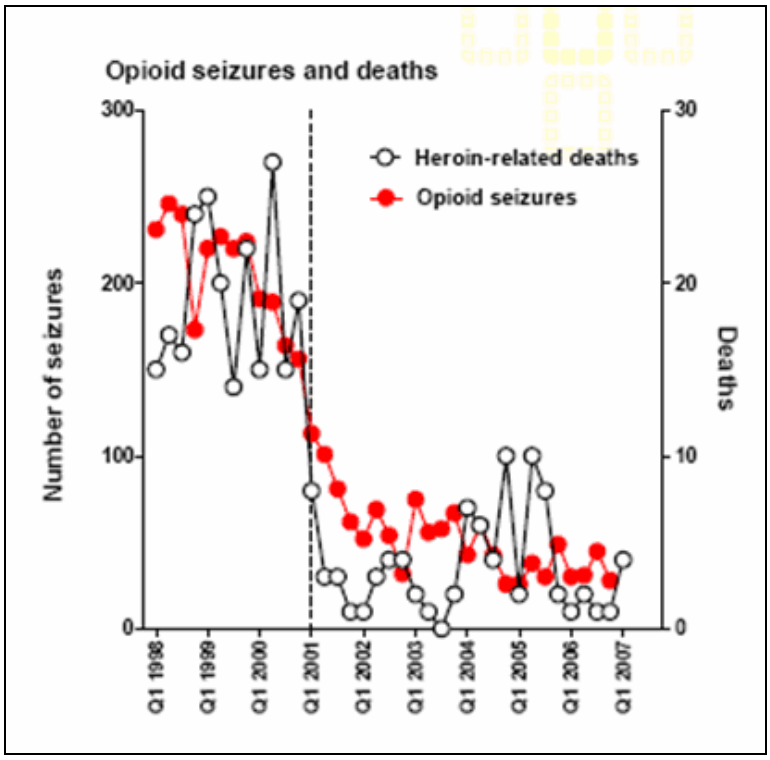
320 Ibid, attached spreadsheets (x) and (xi).

(d) Harms from heroin addiction

(i) Deaths

Australian Bureau of Statistics (ABS) data show that over the past decade about eight to 13 Western Australians die each year from unintentional poisoning by, and exposure to, narcotics and hallucinogens and even fewer from the intentional use of these drugs for suicide. In 2008 there were 17 deaths.[321] This decline from highs in 1998 is graphically shown in Figure 5.5 below from data presented at the DAO 2007 Conference.[322]

Figure 5.5- Western Australian opioid seizures and deaths (1998-2007)



However, NDARC provides different data for 2009. Their data from a small sample of illicit drug users (IDUs) show a lifetime history of heroin overdose was reported by 45% of IDUs and 11% reported an overdose in the last 12 months. According to their data the number of accidental

321 Australian Bureau of Statistics, '3303.0 Causes of Death, Australia, 2008- Table 6.2 Underlying cause of death, All causes, Western Australia, 1999–2008', 31 March 2010. Available at: www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/F04794356298C8CECA2576F60013375C/$File/3303.0_6%20underlying%20causes%20of%20death%20(western%20australia).xls#'6.2'!B9. Accessed on 2 December 2010.

322 Ms Laura Santana *et al.*, Working Out What Works 2007 - 16th Western Australian Drug and Alcohol Symposium, 'Heroin Trends Tracking Project- The Relationship Between Heroin Trends and Crime in WA'. Available at: www.dao.health.wa.gov.au/Publications/tabid/99/DMXModule/427/Default.aspx?EntryId=968&Command=Core.Download, p6. Accessed on 3 December 2010.

deaths due to opioids among those aged 15 to 54 years in WA in 2009 was 22: comprised of 17 males and five females.[323]

(ii) Viral infections

The vast majority of IDUs reported that they had not used a needle after someone else in the last month. Hepatitis C virus (HCV) continues to be more commonly notified than the hepatitis B virus (HBV). The prevalence of human immunodeficiency virus (HIV) among those people who inject drugs in Australia has remained stable at relatively low rates over the past decade, with HCV more commonly reported.[324]

The Western Australia Viral Hepatitis Committee submitted that the needle and syringe program (NSP) was introduced in Western Australia in the late 1980s and that the *Poisons Act 1964* was amended in 1994 to provide a legislative framework for this program to be coordinated by the Department of Health (DoH). In 2008, four million needles were distributed throughout the State, with about 10% provided by rural hospitals and health services. Vending machines in rural towns such as Kalgoorlie, Esperance, Busselton, Geraldton and Nickol Bay provide after-hours access to sterile needles at a small cost.

About 1,100 new cases of HCV are notified to DoH each year with about 90% estimated to be due to unsafe injecting practices, such as shared needles. Australia-wide data shows that the Federal Government spent about $140 million between 1991-2000 on the NSP. One study estimated substantial savings in treatment costs for viral infections from NSP programs.[325] Another report found it was not clear that these programs were solely responsible for these benefits.[326]

(iii) Mental health

The Mental Health Commission (MHC) presented evidence to the Committee that showed that only 3% of the patients using their psychiatric services had used heroin in the past month, compared to 50% who had smoked cannabis in the past month and 32% who drank alcohol daily. Nearly half of their patients had poly-substance use.[327]

---

323 National Drug Research Institute, Curtin University of Technology, 'WA Drug Trends 2009- NDARC Technical Report No. 43', 2010. Available at: http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/resources/IDRSJurisdictionalReports/$file/WA_IDRS_2009.pdf, p12. Accessed on 6 December 2010.

324 Ibid.

325 Submission No. 13 from Western Australia Viral Hepatitis Committee, 4 August 2009, pp1-2.

326 Institute of Medicine of the National Academies, 'Preventing HIV Infection among Injecting Drug Users in High Risk Countries: An Assessment of the Evidence', 15 September 2006. Available at: www.iom.edu/Reports/2006/Preventing-HIV-Infection-among-Injecting-Drug-Users-in-High-Risk-Countries-An-Assessment-of-the-Evidence.aspx, p149. Accessed on 16 May 2011.

327 Submission No. 53 from Mental Health Commission, 9 June 2010, p5.

Mental health problems were reported by 37% of IDUs in 2009 with the most commonly reported problems being depression and anxiety. Of those that self-reported a mental health problem, 78% reported consulting a professional in relation to the problem.

The MHC suggests in their submission to the Committee that there is a strong link (co-morbidity) between mental health and the use of alcohol and other drugs because:

- mental illness predisposes to a positive reinforcing effect provided by the illicit substance;
- mental illness causes people to be hypersensitive to the effects of drugs;
- the social vulnerability of mental illness brings people into contact with the substance abusing population; and
- substance use facilitates social contact and assists those with a mental illness 'cope with people'.[328]

Beyond blue provided information that 30-50% of people with a drug dependence have associated mental health disorders. The main reason for drug users to obtain professional assistance was for depression (69%), anxiety (34%), schizophrenia (12%), panic (8%), drug-induced psychosis (6%), and manic depression (5%).[329] The Department of Health's Mental Health Division reported that "55 - 75% of clients of AOD services have experienced a mental illness."[330]

(iv) Social harms

Data from a presentation at the DAO 16th Western Australian Drug and Alcohol Symposium show a stronger correlation between the increasing number of amphetamines seized by the Police over the past decade in Western Australia to crimes against the person, than to opioid seizures (see Figure 5.6).[331]

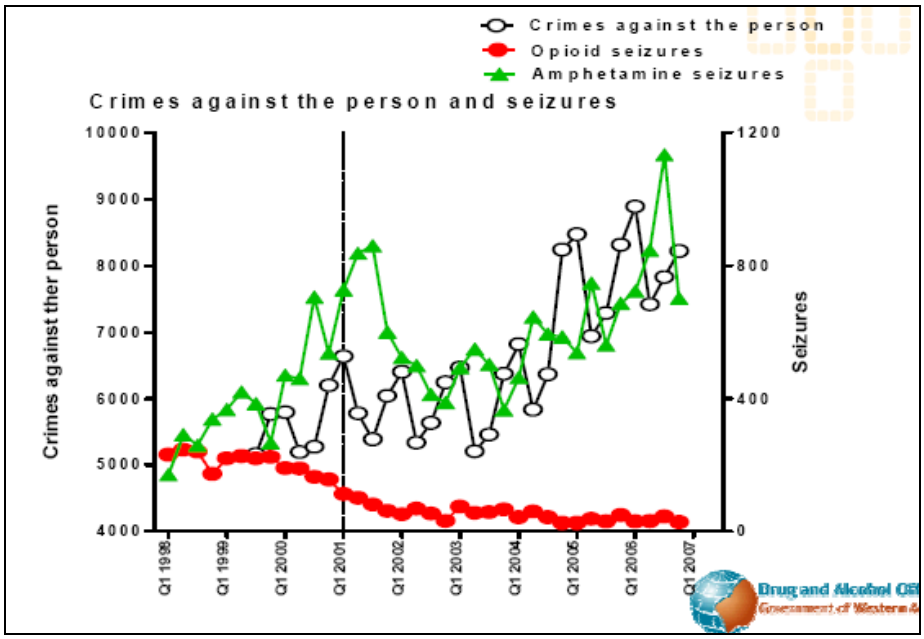
328 Ibid, p15.

329 Submission No. 17 from beyondblue, 31 July 2009, p3.

330 Submission No. 35 from Department of Health, 18 August 2009, p3.

331 Ms Laura Santana *et al.,* Working Out What Works 2007 - 16th Western Australian Drug and Alcohol Symposium, 'Heroin Trends Tracking Project- The relationship between heroin trends and crime in WA', . Available at: www.dao.health.wa.gov.au/Publications/tabid/99/DMXModule/427/Default.aspx?EntryId=968&Command=Core.Download, p11. Accessed on 3 December 2010.

Figure 5.6- Crimes against people and drug seizures (1998-2007)



5.6 Naltrexone debate

The Committee heard a great deal of evidence on heroin use in Western Australia and its relationship to the treatment of addicts by naltrexone implants at the Fresh Start Recovery Programme. This program is unique to Western Australia and is supported by both major political parties. A recent parliamentary debate highlighted that government support stretched back to the Court Government in the 1990s.[332]

The Drug and Alcohol Office said that the 2008 Cochrane review of naltrexone found that "there was insufficient evidence from randomised trials to evaluate the effectiveness of sustained-release naltrexone". Six ongoing studies are underway and the review concluded that naltrexone should be considered an investigational drug.[333]

In 2007 over 80% of Western Australians supported the use of naltrexone to deal with heroin addiction, compared to around 73% for needle exchange and methadone maintenance programs.[334]

---

332 Hon. Mr Eric Ripper, MLA, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 19 March 2009, p2212.

333 Submission No. 37- Part B from the Drug and Alcohol Office, 25 August 2009, pv. For more on the Cochrane review, see: http://onlinelibrary.wiley.com/o/cochrane/clsysrev/articles/CD006140/frame.html. Accessed on 27 April 2011.

334 Australian Institute of Health and Welfare, '2007 National Drug Strategy Household Survey: State and Territory Supplement', August 2008. Available at: www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442459903, p12. Accessed on 23 March 2011.

(a) Fresh Start Recovery Programme

The Fresh Start Recovery Programme (trading as Australian Medical Procedures Research Foundation Ltd since 1996) and Go Medical Industries Pty Ltd (who manufacture the 'O'Neil Long-Acting Naltrexone Implant' and the 'Springfusor infusion device')[335] are associated with the work of Dr George O'Neil. Dr O'Neil said there was a large personal cost to running Fresh Start "we are carrying a $6 million load in costs of just treating whoever is coming. We put a sign up outside 10 years ago to say that we will treat anybody, whether they can pay or not."[336]

Fresh Start argue that their approach is different to a 'harm minimisation' one that in Western Australia has seen "the number of government-subsidised opiate dependent patients (methadone, morphine, buprenorphine and others) [increase] from 1,000 in 1985 to more than 50,000 [sic]." The Fresh Start approach assumes that all addicts who wish to escape from opiate dependence should immediately be assisted and that the majority of these individuals present with a dream of reuniting with their family. The most profound difference between maintaining opiate dependence, via replacements such as methadone, and correcting it is the reaction of mothers and other family members who become committed to supporting a family member's drug-free lifestyle.[337]

The Fresh Start Recovery Programme CEO said that a single naltrexone implant treatment costs $6,000 and less than 2% of clients paid this fee up front:

> *the Fresh Start Recovery Programme, which is a not-for-profit program operated by an independent board and which agrees to treat patients for addiction, whether they can pay at the time or not. We currently have several hundred people on our books paying us $20 a week out of their social security to cover that treatment cost. If that is all they can pay, which it often is, it will take them up to six years to pay for the cost of one treatment.*[338]

The naltrexone implant works differently to methadone and buprenorphine by blocking receptors in an addict's brain which stops them from getting a high from using heroin and takes away the craving for the drug.[339] Naltrexone induces "a rapid and uncomfortable detoxification for heroin users" so Fresh Start Recovery Programme tends to use a light sedation for the first 24 to 48 hours after the implant. These effects will be least severe for those who have managed to stop their opiates for about four days beforehand.[340]

The Fresh Start Recovery Programme CEO advised that the program has treated 6,700 people in the past decade, with about half treated with the earlier oral tablet. Fresh Start currently has about 3,000 active patients and treats between 700-800 patients per annum and "including the implant

---

335 Submission No. 30 from Fresh Start Programme, 31 July 2009, p6.

336 Dr George O'Neil, Director, Fresh Start Programme, *Transcript of Evidence*, 16 June 2010, p8.

337 Submission No. 30 from Fresh Start Programme, 31 July 2009, p3.

338 Mr Jeff Claughton, CEO, Fresh Start Programme, *Transcript of Evidence*, 16 June 2010, p9.

339 ABC 7.30 Report, 'Authorities Debate Naltrexone Use to Break Drug Addiction', 13 January 2006. Available at: www.abc.net.au/7.30/content/2006/s1547424.htm. Accessed on 15 December 2010.

340 Submission No. 30 from Fresh Start Programme, 31 July 2009, p9.

cost, the surgeon's cost, the GP costs, the nurses and administration costs, the rehabilitation and follow-up cost, is about $8 million per year."[341] Dr O'Neil told the Committee the implant program operates every second week as "we cannot find the money to make the implants" to operate every week.[342]

However, this program is controversial in the medical science world and was criticised by Dr Wodak who said the Western Australian Government had "provided at least $8 million to Go Medical over eight years to assist the naltrexone implants program". He said another $500,000 was provided in 2009 for a company with "multiple and long standing breaches of the Therapeutic Goods Act, and despite documented cases of serious complications published in a respected, peer reviewed medical journal which have also been observed by many other clinicians."[343]

Dr Wodak told the Committee that his chief criticisms of the naltrexone implants were:

- other pharmacotherapies used in drug treatment programs are required to be registered and show they are effective, safe and cost effective. Naltrexone implants have not yet met these standards;
- the implants are not registered anywhere in the world for the treatment of heroin dependence;
- evidence had been published of significant harm coming to addicts who have had naltrexone implants; and
- heroin addicts being implanted in Perth under the category A of the Special Access Scheme were not 'terminally' ill and allowing them to have implants was in violation of the special access rules.[344]

Fresh Start Recovery Programme submitted that the 12 deaths in Sydney of patients with naltrexone implants referred to by Dr Wodak was misleading as "neither the Fresh Start detox protocols nor the Go Medical implants were used" in these cases. The suspect implants were imported from China.[345] Another witness provided glowing support for Dr O'Neil's naltrexone program and criticised Dr Wodak as "one of the world's most vociferous proponents of the legalization and decriminalization of all addictive drugs" and "the doyen, architect and principal exponent of the harm minimization movement".[346]

---

341 Mr Jeff Claughton, CEO, Fresh Start Programme, *Transcript of Evidence*, 16 June 2010, p9.

342 Dr George O'Neil, Director, Fresh Start Programme, *Transcript of Evidence*, 16 June 2010, p11.

343 Submission No. 7 from Dr Alex Wodak, 20 July 2009, p11.

344 Dr Alex Wodak, Director, Alcohol and Drug Service, St. Vincent's Hospital, NSW, *Briefing*, 30 September 2009. Dr O'Neil clarified that Go Medical (a business) has never received funding from the State Government but AMPREF, a charitable organisation trading as Fresh Start, did.

345 Submission No. 30A from Fresh Start Programme, 16 June 2010, p3.

346 Submission No. 40 from Dr Stuart Reece, 22 August 2009, p1.

Debate focuses on the effectiveness of naltrexone implants versus the 'gold standard' methadone treatment. People supporting each approach claim that the other's treatment is deleterious to drug addicts and less effective at stopping an addict's addiction to heroin.[347]

Dr O'Neil told the Committee that the implants were now effective for about 300 days, but that most of the publications on their trials here in Western Australia of the implants were for an operation of about 150 days. He said "if the work is properly funded and you give me another two years, I would expect to see us getting to 600 days or longer". He estimated that there were about 3,000 heroin addicts with implants provided by Fresh Start and "about 300 for amphetamines and about 300 for alcohol [addiction]".[348] Fresh Start's patient data suggests that after three years post-implant, of those still in contact with Fresh Start, 50% have had no relapse and 90% were drug-free.[349]

The process for a typical heroin addict with an implant for 300 days was described as:

> *At the end of 300 days, 50% of patients come back and have* [another] *implant. The other 50% say "I am fine", "I am living with my mum" or "I have a good husband". They go quite well until they crash. When they crash, they need a quick repair job. … In a typical five-year period, people use* [heroin again] *for 10 or 20 days and they come for their repair job within a week or so. The repair job is necessary and appropriate. ... It is a different program from a methadone program where you come every day.*[350]

Dr O'Neil reported on the side-effects of naltrexone:

> *With oral naltrexone a very high percentage is broken down in the liver straightaway. Nausea is on the list of side effects. With the implant, you are using a lower dose and it is delivered directly into the blood stream, so it bypasses the liver. You do not see the same level of nausea-type side effects. I think out of the 7,000 or 8,000 procedures, we would have removed a couple* [of implants] *from nausea and a couple for chronic pain. People often go through a period of being stressed and they just want to go back to heroin. Some of those people change their minds and ask for their implant to be removed.*[351]

(b) The funding of Go Medical and Fresh Start Recovery Programme

Go Medical Industries Pty Ltd is an O'Neil family company with 15 staff of which Dr O'Neil is a director. It has manufactured naltrexone implants since 2005 under a Therapeutic Goods Act (TGA) manufacturing licence restricting their use to clinical trials in accordance with Annex 13 of the Australian Code of Good Manufacturing Practice for Medicinal Products. The *Therapeutic Goods Act 1989* has allowed Dr O'Neil to undertake the personal manufacture of naltrexone

347 Ibid, pp1-3.

348 Dr George O'Neil, Director, Fresh Start Programme, *Transcript of Evidence*, 16 June 2010, p4.

349 Submission No. 30 from Fresh Start Programme, 31 July 2009, p13.

350 Dr George O'Neil, Director, Fresh Start Programme, *Transcript of Evidence*, 16 June 2010, p6.

351 Ibid, p7.

implants for many years under an exemption in the Therapeutic Goods Regulations which allows a medical practitioner to manufacture therapeutic goods for his or her own patients.[352]

Fresh Start's CEO told the Committee of its relationship with Go Medical, which provides:

> *about 2,000 implants a year and we pay it maybe $300,000 to $400,000 for that. Dr O'Neil provides two days of surgery—they are typically 12-hour days—each week and does not charge us for that surgery time. In addition, we have 46 volunteers on our books who contribute their time free of charge. That makes up around $500,000 worth of contributed services. We get other contributions of goods and services to make up about $1 million worth of cost and we get about $1 million a year in donations. Basically, we run an $8 million program on about $4 million in cash, of which the State Government contributes $1.2 million.*[353]

Fresh Start Recovery Programme does not pay Go Medical the full cost of the implants but transfers the funds paid by the patients for their implants, and that "typically, amounts to about 15% or maybe 20% of the value of the implants that are being supplied."[354] For 2009-10, the Fresh Start Recovery Programme Financial Report shows income of $5.7 million and expenses of $5.2 million. The balance sheet's surplus of $500,000 reflects an expected increase in the recovery of fees from the Programme's treated clients, although these funds may not be made for some years (or ever) by the debtors.[355]

Commonwealth funds

The Australian Government has provided over $4.6 million to support the work carried out by Dr O'Neil and Go Medical Industries Pty Ltd/ Fresh Start Recovery Programme. Recognising that naltrexone implants may be an effective treatment for opioid dependence the Australian Government, through the National Health and Medical Research Council (NHMRC), provided approximately $570,000 for a clinical trial of the naltrexone implants. The trial commenced in November 2005. About a further approximately $500,000 was provided to Professor Gary Hulse and the University of Western Australia for five projects assessing the safety and efficacy of naltrexone implants.[356]

The Australian Government support includes recent Department of Health and Ageing funding of:

- $618,180 to Fresh Start Recovery Programme under the Non Government Organisation Treatment Grants Program (NGOTGP) for the period 2008-11 to

---

352 Senator Hon Mr Joe Ludwig, Special Minister of State and Cabinet Secretary, The Senate, *Parliamentary Debates* (Hansard), Question on Notice, 20 August 2009, pp5689-5690.

353 Mr Jeff Claughton, CEO, Fresh Start Programme, *Transcript of Evidence*, 16 June 2010, p9.

354 Ibid, p11.

355 Mr Khim Harris, Executive Officer, Fresh Start Recovery Programme, e-mail, 14 December 2010.

356 Australian Government, 'Response to Road to Recovery: Report on the Inquiry into Substance Abuse in Australian Communities', July 2006. Available at: www.aph.gov.au/house/committee/fca/subabuse/gresponse.pdf, p23. Accessed on 13 May 2011.

employ a counsellor, occupational therapist, social worker and psychologist to support the recovery of clients post detoxification, by providing a range of services including professional counselling, education and training, and information and referral to other services that will offer support to the client's re-entry into the community.

- a further $160,000 under the Australian Government's Amphetamine Type Stimulants (ATS) Grants Program to June 2009 for the Fresh Start Recovery Programme for the development and implementation of staff training to better equip the program to meet the needs of ATS users.[357]

The Australian Minister for Health and Ageing said, while these grants supported staff training and the detoxification of patients, "neither of these grants provides funding for the use of naltrexone implants."[358]

State Government funds

Parliament was told that the Fresh Start Recovery Programme in late 2008 approached the State Government for an additional grant of $1 million, on top of its annual recurrent funding of more than $1.2 million.[359] The then-Minister for Mental Health, Hon Graham Jacobs, originally offered an additional sum of $50,000.[360] After a Matter of Public Interest Debate in Parliament, the Western Australian Government committed an additional $500,000 in May 2009 to Fresh Start with three conditions:

> *Dr O'Neil has been asked to agree to the appointment of an independent and qualified researcher with relevant drug and alcohol treatment expertise, to undertake a comprehensive review of the available records and data to confirm the quality, validity and applicability of the research material.*[361]

---

357 Senator Hon Mr Joe Ludwig, Special Minister of State and Cabinet Secretary, The Senate, *Parliamentary Debates* (Hansard), Question on Notice, 20 August 2009, pp5689-5690.

358 Hon Ms Nicola Roxon, Minister for Health and Ageing, House of Representatives, *Parliamentary Debates* (Hansard), Question on Notice, 10 November 2008, p10461.

359 Fresh Start Programme's annual grant was $1,201,306 in 2008-09 and $1,227,168 in 2009-10. Hon Dr Kim Hames, Minister representing the Minister for Mental Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), Question on Notice, 1 February 2011, p3.

360 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 19 March 2009, p2217.

361 Hon Dr Graham Jacobs, Minister for Mental Health, '$500,000 boost for treatment of heroin dependency in Western Australia', 5 May 2009. Available at: www.mediastatements.wa.gov.au/Pages/default.aspx?ItemId=131790&page=3. Accessed on 6 December 2010.

The Minister for Health, Dr Kim Hames, acknowledged in the 2009 debate about the additional funds for the Fresh Start Programme, that when he was a minister in the Court Government in 1997:

> *we were debating long and hard about funding for George O'Neil's naltrexone program. The issues then were the same as they are now, namely, the accountability of funding, reporting and recording, and seeking peer approval and recognition of his work.*[362]

In March 2011, the Minister for Mental Health, Hon Helen Morton, announced additional funding for Fresh Start Recovery Programme. Unlike Federal funding which is not for individual implants, this WA funding of $1.5 million was provided over the 2010-11 and 2011-12 financial years so that Fresh Start could provide services to another 244 patients.[363]

(c) Therapeutic Goods Administration registration process

Then-Minister Jacobs said in May 2009 that "the ultimate goal of this additional Government funding is for Dr O'Neil's implants to achieve Therapeutic Goods Administration (TGA) registration".[364] During this parliamentary debate, Mr Peter Abetz, MLA, said that the "vast majority of the trial work had been completed" and that the completed experimental work required for the registration of the naltrexone implants would "take two specialist medical writers six to nine months" to put it into a form that was acceptable to the TGA.[365]

Mr Abetz said that if successful, the registration by the TGA would see about $1.2 million in Federal funds from the Pharmaceutical Benefits Scheme flow to Fresh Start Recovery Programme, based on "the current rate of use of naltrexone implants".[366] This would allow Fresh Start to achieve 'financial independence.'[367]

Dr O'Neil told the Committee in June 2010 that the process would take two and half years once the TGA received the application for registration, and that he hoped if he could focus on registration process, optimistically to have the application submitted by November 2010.[368] The TGA told the Committee in December 2010 that it "had not received an application from the Fresh

---

362 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 19 March 2009, p2216.

363 Ms Cathy O'Leary, 'Program for Addicts Gets Additional $1.5m Funding', *The West Australian*, 23 March 2011, p28.

364 Hon Dr Graham Jacobs, Minister for Mental Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 19 March 2009, p2214.

365 Mr Peter Abetz, MLA, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 19 March 2009, p2218.

366 Ibid.

367 Hon Dr Graham Jacobs, Minister for Mental Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), Ministerial Statement, 5 May 2009, p3275.

368 Dr George O'Neil, Director, Fresh Start Programme, *Transcript of Evidence*, 16 June 2010, p7.

Start Recovery Programme, Dr George O'Neil or Go Medical Industries Pty Ltd for the full registration of naltrexone implants."[369]

The TGA confirmed that no naltrexone implants had been approved for marketing in Australia. Go Medical is the only manufacturer of these implants in Australia. Its implants are licensed for use in medical trials and for use in the treatment of patients under Category A of the Special Access Scheme. Such seriously ill patients must be months from death or are reasonably likely to have a premature death in the absence of early treatment.[370] These patients must be informed:

- that the product is not approved in Australia;
- the possible benefits of treatments and any risks and side effects that are known;
- the possibility of unknown risks and late side effects; and
- any alternate treatments using approved products which are available.

From December 2009, Go Medical has had approval to export its implants to the United Kingdom on "a limited scale for clinical trial use." They are not to be used commercially or by the general public in the UK.[371]

Dr O'Neil answered criticism that he had not yet applied to the TGA for approval of naltrexone implants by saying "this is an enormous job that normally costs $8 billion and 15 years, and I have got there with $50 million inside 10 years". He compared his program with that of the US Government to develop Vivitrex, an injectable form of naltrexone, which cost US$3 billion to develop but is only effective for about 28 days. He said some patients were flying to Perth from the US to access the implants as they were a more effective treatment for their addiction, and cost less than the $14,000 annual cost of Vivitrex.[372]

(d) Future plans

Fresh Start proposed to the Committee that the "Australian Commonwealth government provides full funding for opiate replacement services."[373] In outlining his future plans, which are reliant on greater government funding, Dr O'Neil said that he had "gone to the business meetings with at least eight companies, including the people making Vivitrol, and negotiated with them and the US government." However, these pharmaceutical companies had "made deliberate decisions to not

369 Mr Pio Cesarin, Head, Office of Medicines Authorisation, Therapeutic Goods Administration, Letter, 1 December 2010.

370 Therapeutic Goods Administration, 'Special Access Scheme', 25 August 2010. Available at: www.tga.gov.au/hp/sas.htm. Accessed on 5 April 2011.

371 Ibid.

372 Dr George O'Neil, Director, Fresh Start Programme, *Transcript of Evidence*, 16 June 2010, p13.

373 Submission No. 30 from Fresh Start Programme, 31 July 2009, p5.

work with us because they know that 95% of my patients will be non-paying and that it will take years to convince governments to join us."[374]

Fresh Start is looking to the State or Federal Governments for:

> *$1 million a year would be survival money and $3 million a year would mean that I could pay the sort of people that I need to put into place to ensure that we run a First World service, rather than a service that I am constantly told looks like a Third World service.*[375]

Fresh Start Recovery Programme told the Committee this additional assistance would "allow the treatment of additional addicts who are currently costing the State Government about $8,000 for a week's detoxification or about $100,000 per annum to be kept in prison."[376]

Finding 12

Two years after receiving an additional grant from the State Government to fund a range of services for clients accessing the Fresh Start Recovery Programme, two of the grant's three auditing conditions have not been completed by the Fresh Start Recovery Programme and the Drug and Alcohol Office.

Recommendation 13

The Minister for Mental Health ensure that the Fresh Start Recovery Programme and the Drug and Alcohol Office complete the requirements attached to the 2009-2010 funding agreement as a matter of urgency and prior to providing further State Government funding to the Fresh Start Recovery Programme.

Recommendation 14

The Minister for Mental Health ensure that the Drug and Alcohol Office's 2011 annual report include an update on the progress of completing the auditing conditions of the Fresh Start Recovery Programme's additional grant, and any further requirements needed to apply for registration of naltrexone implants by the Therapeutic Goods Administration.

374 Ibid, 14.

375 Mr Jeff Claughton, CEO, Fresh Start Programme, *Transcript of Evidence*, 16 June 2010, p13.

376 Dr George O'Neil, Director, Fresh Start Programme, *Transcript of Evidence*, 16 June 2010, p13.

Recommendation 15

The Minister for Mental Health should ensure that by December 2011 the Drug and Alcohol Office prepare guidelines for an annual review, including outcome data, of all naltrexone treatment patients. This outcome data should be included in the Drug and Alcohol Office's annual reports.

Recommendation 16

At the conclusion of the current review, the Minister for Mental Health urgently seek funding to meet any further requirements needed to apply for the registration of naltrexone implants by the Therapeutic Goods Administration.

CHAPTER 6 EDUCATIONAL AND TRAINING PROGRAMS

6.1 Introduction

This chapter reports the evidence the Committee received to the Inquiry's two terms of reference dealing with education and training:

- a) the evidence base, content, implementation and resourcing (including professional training) for health education and other interventions on alcohol and illicit drugs for school-aged students;
- (b) the adequacy of the current education and training of medical and allied health professionals in the alcohol and drug field.

The majority of witnesses supported the Government providing further resources to school education programs as "prevention is absolutely critical and as part of that activity we need to focus more on the area of public education."[377] Similarly, a Magistrate from Albany told the Committee that these educational activities should begin "as early as you get children in an educational setting" as the threat from illicit drugs and alcohol was such that children "have no protective powers if they do not have an education."[378]

Further, illicit drug education was seen by many witnesses as an important part of the demand-reduction strategies for illicit drugs, particularly around what are societal norms so that young people do not presume that the consumption of illicit drugs is a 'normal' activity.[379] The Committee was told that school education programs needed to be part of a broader community education package as there is no evidence as to their being effective on their own in changing the drug-taking behaviour of young people.[380]

The Committee was told in several European countries that, despite governments highlighting the need for drug prevention and educational programs, budget allocations instead usually focussed on the justice system and treatment programs.[381]

---

377 Mr Eric Dillon, Acting Executive Director, Drug and Alcohol Office, *Transcript of Evidence*, 11 May 2010, p7.

378 Ms Elizabeth Hamilton, Magistrate, Department of the Attorney General, *Transcript of Evidence*, 20 August 2010, p4.

379 Mr Bruno Faletti, Manager, School Drug Education and Road Aware, *Transcript of Evidence*, 9 June 2010, p2.

380 Dr David Foxcroft, Psychologist, Oxford Brookes University, *Briefing*, 31 January 2011.

381 Professor Neil McKeganey, Director, Centre for Drug Misuse Research, University Of Glasgow, *Briefing*, 2 February 2011 and Professor Freya Vanderlaenen, Department of Criminal Law and Criminology, Ghent University, *Briefing*, 8 February 2011.

6.2 School education programs

(a) Government programs

Department of Education

The Department of Education's School Drug Education and Road Aware (SDERA) program is the main school drug education program in Western Australia. Its annual funding in 2009-10 was "$1,023,000 from the Drug and Alcohol Office, specifically for State-funded drug education. … about $380,000 from the Commonwealth Government to implement national drug strategy initiatives and then we receive some road safety funding." Its Board consists of a representative from the:

- Catholic Education Office;
- Association of Independent Schools of Western Australia;
- Department of Education and Training;
- Road Safety Council; and
- Drug and Alcohol Office.[382]

To date SDERA has had an involvement with 81% of all government schools, 73% of all Catholic Education Office schools and 62% of all independent schools. In 2009 it delivered courses to 1,900 participants. SDERA packages its alcohol and drug programs together and runs professional training for teachers with "specific drug-related workshops and specific road safety-related workshops, … [and] teaching and learning strategy workshops where we provide teachers with some very interactive strategies to teach either drug or road safety education in those contexts."[383]

SDREA has consultants in the major regional areas of the State who try to embed its program in the community and develop networks and partnerships. In remote regions with high Indigenous populations such as the Kimberley, SDERA "piggyback with other services that are out there", such as the DAO-funded community drug service teams.[384]

Edith Cowan University has been commissioned to prepare a proposal for the monitoring and evaluation of SDERA programs between 2008 and 2011. The evaluation will investigate the dissemination of SDERA material as well as its impact on primary and secondary students in

382 Mr Bruno Faletti, Manager, School Drug Education and Road Aware, *Transcript of Evidence*, 9 June 2010, p3.

383 Ibid, pp3-4.

384 Ibid, p6.

urban and rural Western Australia. This evaluation will build on the work completed in 2005 and 2006 by the Child Health Research Unit.[385]

A frustration for SDERA is that it is up to a school community to decide whether or not to participate in drug education programs. Sometimes schools choose not to, and instead get "someone they know who used to use drugs or a bikie and talk, as an example, which is not always evidence based."[386]

Western Australian Police

The Western Australian Police's most well-known school drug education program is *Constable Care.* The Police Commissioner told the Committee that it had "taken over most of the work that the Police ever did in primary schools." Over the past 20 years a community police section provided talks to primary school children. Now, *Constable Care* is used by the police and the community police section closed as financial "pressure has [a]risen to do a lot of other things". The program provides an interactive and fun approach, particularly for young children, on a range of issues such as protective behaviours.[387]

Constable Care was established in 1984 by a member of the New South Wales Police Force and was set up as a non-profit organisation in Perth in 1989. Its programs reach more than 157,000 young Western Australians every year and the *Constable Care* character is central to a range of fun puppet shows and plays for two to 12-year-olds learning to do the right thing when it comes to road safety, drugs, bullying, graffiti, going to school, making friends and staying healthy.[388]

The Commissioner told the Committee of the Police's work with the Education Department and some metropolitan senior high schools that were considered 'higher risk schools':

> *We used officers who were from local PCYCs to outreach into those schools to work with those kids. It is early days yet. … its being run down at Rockingham for young men mostly from the Kwinana–Rockingham area who have got into trouble with the justice system* [for drugs and alcohol]*…and who consequently do not fit into the school system very well. The Police down there have, with the support of BHP, put them through a metal fabrication program and got them a trade certificate and got them into some employment. Our review of that program has shown that 80% of the young men who go into that program do not reoffend, whereas I think that the recidivism rate before that program was in place was quite high.*[389]

---

385 Department of Education, 'Evaluation', 2010. Available at: www.det.wa.edu.au/sdera/detcms/navigation/for-schools/about-sdera/evaluation/#toc1. Accessed on 15 December 2010.

386 Ms Jill Rundle, Executive Director, WA Network of Alcohol and Other Drug Agencies, *Transcript of Evidence*, 25 August 2010, p5.

387 Dr Karl O'Callaghan, Commissioner, WA Police, *Transcript of Evidence*, 26 May 2010, p12.

388 WA Police, 'Constable Care', nd. Available at: www.police.wa.gov.au/Youngpeople/ConstableCare/tabid/1577/Default.aspx. Accessed on 15 December 2010.

389 Dr Karl O'Callaghan, Commissioner, WA Police, *Transcript of Evidence*, 26 May 2010, p12.

(b) Non-government programs

There are a range of education programs offered across the State by non-government organisations.

Life Education Australia

In 1974 the Life Education Centre was set up by Rev. Ted Noffs at the Wayside Chapel in Kings Cross.[390] Life Education WA is the State's largest non government provider of drug and health education to primary school children and an important part of this work focuses on prevention programs. The Committee heard it is now "being approached by preschool and kindergartens because our focus is in the early stages—teaching children about respecting themselves and their bodies."[391]

Across Australia each year Life Education delivers its program in 100 mobile learning centres to almost 700,000 children using 120 trained educators who have a degree in education, health or physical sciences. It provides "children with interactive opportunities and videos. In our newest program, called *Mind Your Medicines*, we teach children in grades 4 and 5 about medications in the home and how to value them, respect them and how to use or not use them".[392]

Life Education (LE) evaluation efforts go back to 1996. The Committee were informed that 94% of schools invited LE back. The Committee heard:

> *some people in the bureaucracy and in academic circles say that education does not work with drug and health education. However, as a colleague of mine has said, if education does not work, try ignorance.*[393]

In Western Australia Life Education focuses on pre-primary and primary schools, while in other jurisdictions secondary school programs are also offered. Life Education has 10 modules for primary and preschool children and "until very recently, Western Australia was the only state that let illicit drugs be talked about in primary school". Alcohol and illicit drugs are part of modules from grade one to seven.[394] These modules incorporate the topic of illicit drugs through activities which assist students to:

- explore the potential harms from illicit drug use;
- assess the rules, laws and policies in relation to the use of illegal drugs;

---

390 Life Education Australia, 'History of Life Education Australia', 2010. Available at: www.lifeeducation.org.au/about-life-education-australia/history. Accessed on 16 December 2010.

391 Mr Jay Bacik, Chief Executive Officer, Life Education Australia, *Transcript of Evidence*, 11 August 2010, p2.

392 Ibid.

393 Mr Bernard Foley, Executive Officer, Life Education WA (Inc), *Transcript of Evidence*, 11 August 2010, p4.

394 Ibid, p11.

- access and assess information products and services in relation to illicit drugs;
- describe the short and long term effects of illicit drug use in the community; and
- identify skills and strategies for dealing with group-related illicit drug use harm.[395]

The previous Gallop-Government withdrew funding of $175,000 from Life Education in 2003, a year during which 35,000 Western Australian students heard its message. The program now continues with the support of the national office and a contribution from parents of children who attend the programs. Life Education WA delivered its programs to 23,300 students in 2008 and has a need for additional paid staff to allow it to provide its programs in regional areas such as the Mid-West, Goldfields, Esperance, Bunbury, Warren-Blackwood, Albany, Midlands, Narrogin, Pilbara and Kimberly where there is a continued demand from schools. Life Education is seeking an investment by the State Government of $1.1 million over four years to allow its programs to reach about 65,000 students throughout the State.[396]

Dr YES

One of the largest school-based programs run by NGOs in Western Australia is *Dr YES,* which was established in 1996 and is run by the Australian Medical Association (WA) Foundation. The AMA Foundation has focused on the health needs of adolescents as they negotiate the transitional period into adulthood. The Committee was told that adolescents are often extremely reluctant to seek help when faced with health-related issues. This, combined with the propensity for risk taking, makes them highly vulnerable, especially if they are under the influence of alcohol or other drugs. The Committee heard that the Dr YES program is unique to Western Australia and has operated for 10 years:

> *YES stands for Youth Education Sessions—is a school-based program designed to meet these principal areas of need. The program is led by medical students who are trained to act as peer group facilitators. Their primary role is to empower young people to make informed and healthy choices...*[397]

The AMA claims that the Dr YES program is successful because the coordinators are medical students who are not much older than the participating high school students and the program incorporates drama, role-playing and small group discussions to engage students. The program is designed to complement the school health curriculum for students aged 14 to 17 years and covers the areas of drugs and alcohol, sexual health and mental health. Each session involves up to 12 medical students with class sizes between 60 and 100 students.

Dr YES is supported by the medical faculties of the University of Western Australia and the University of Notre Dame Australia and more than 100 medical students volunteer their time as

---

395 Submission No. 43 from Life Education WA (Inc), 30 October, p10.

396 Ibid, p5, 14 & 23.

397 Dr Rosanna Capolingua, Medical Director, Australian Medical Association (WA) Foundation, *Transcript of Evidence*, 2 September 2010, p1.

coordinators.[398] Each year the AMA is funded by the Department of Health (DoH) to deliver the program to 2,000 metropolitan high school students and 1,000 regional students in 60 schools throughout the State, including remote areas such as the Pilbara, East and West Kimberley. With additional sponsorship funds and resources from the AMA, it reaches between 7-10,000 students each year.[399]

The Dr YES model is seen by the AMA (WA) as a cost-effective way of promoting youth health. This is based on leadership, ownership and commitment by the volunteer medical students who are taught communication skills, group facilitation skills and content. Before a medical student sits on their own with a group of up to 12 children, they are mentored by another volunteer who has had more experience. This model is "sustainable in the longer term because of the annual intake of young medical students with new ideas and knowledge of changing youth culture and behaviour—in other words, we stay contemporary!"[400]

The Dr YES Coordinator told the Committee that the main drug that is discussed in every session is alcohol "because a lot of kids will not think of alcohol as a drug, because 'drug' seems to be in their culture things like ice, speed, marijuana, that sort of thing." Then the program will discuss cannabis, amphetamines, ecstasy, and "depending on how much information they have had at school on tobacco, we will discuss tobacco use as well."[401]

The Committee heard how a Dr YES facilitator would discuss an illicit drug:

> *we will take ice for an example, and we will run through ice, because that is quite a big one at the moment. We talk about the specifics of the drug; that it is an amphetamine. We are not going to explain to the kids what an amphetamine does and how that affects receptors in the brain, because that is pitched above their level and they do not understand that. So we will generally be discussing things in terms of what the feelings are that the kids will get, what dependency is, what tolerance is, what addiction is, because they do not understand the concept of tolerance, and addiction and tolerance go hand in hand.*[402]

Dr YES also provides information to teenagers on the signs of dependency, such as irritability, erratic behaviour, being antisocial, paranoid, and having work and social problems. Then the program finishes with students talking about the possibilities of overdose with each drug. The program needs to discuss alcohol because it is so widely accessible to school students. Dr YES Coordinators "have heard of students turning up to school with hangovers". In the sessions:

> *kids will tell us that they are going out to parties on the weekend and that in some instances there are people drinking to excess and having hangovers the next morning.*

---

398 Ibid, p2.

399 Mr Paul Boyatzis, Executive Director, Australian Medical Association (WA), Letter, 3 November 2010.

400 Dr Rosanna Capolingua, Medical Director, Australian Medical Association (WA) Foundation, *Transcript of Evidence*, 2 September 2010, pp3-4.

401 Mr Thomas Bartlett, Dr YES Coordinator, Australian Medical Association (WA) Foundation, *Transcript of Evidence*, 2 September 2010, p4.

402 Ibid.

> *Essentially, I would call that unsafe behaviour, but we provide them with quick tips to make the night safer. We stress to the kids that it does not have to be less fun, because* ***initially they think that less alcohol means less fun*** [emphasis added]; *we provide them with tips to make drinking safer on their body.*[403]

Other practical advice given to students includes explaining that it is risky when they leave a friend unconscious at a party. Coordinators were told that students "will not contact an ambulance because they believe that the Police are attached to the ambulance service." Dr YES explains that "St John Ambulance and the Police have a contract where they will not speak to one another if an ambulance goes to a party where it is all underage drinkers." Other information is provided about GPs and their confidentiality requirements. This compliments the work of the AMA Foundation through its Youth Friendly Doctor (YFD) program.[404]

The Future of Dr YES

The Committee was told that the Dr YES program is underpinned by the AMA (who covers most of the costs), the medical student volunteers and a small grant from the State Government. The AMA Foundation provided the Committee with a comprehensive proposal to expand both the Dr YES and the YFD programs. The Health Department has supported the AMA Foundation since its inception and has allocated $281,600 for the period 2009-12, which is an annual allocation of $94,600 for both programs. To expand the current Dr YES program's reach of 7-10,000 students to 10-15,000, as well as expand the training of doctors in the YFD program by 50%, the AMA Foundation would require an annual grant of $325,000.[405]

Palmerston Association Inc

The Palmerston Association's Transformers program works with primary and early high school children of parents who are illicit drug users to try to give them coping mechanisms so that they do not get into the cycle of use themselves.[406]

The Committee heard that Palmerston has another program aimed at young adults aged from the late teens to the early 20s "who had very poor interpersonal skills and very low self-esteem. … [and] had modelled from a very young age, the use of substances to manage difficult situations."

This program has led Palmerston to develop courses for primary and high school students aimed at non-drug users to:

> *provide them with a range of skills that they could use to address some of the more difficult issues they might encounter in their lives; … We focused on interpersonal skills and we worked with small groups. We worked with the schools and we got very small groups of*

403 Ibid, p5.

404 Ibid, p6.

405 Mr Paul Boyatzis, Executive Director, Australian Medical Association (WA), Letter, 3 November 2010.

406 Hon Ms Sheila Mc Hale, Chief Executive Officer, Palmerston Association Inc, *Transcript of Evidence*, 16 June 2010, p5.

> *children identified as at risk of being drug users in the future because of their family backgrounds. We worked with them in small groups to teach them those skills.*[407]

Their work has provided evidence that improving the two areas of self-esteem and interpersonal skills could be a protective factor against student trying drugs in the future. This program was funded through the State Government 'proceeds of crime grant'. One of the positive spin-offs from the program "was that it encouraged more families to come seeking assistance from us as a family".[408]

Teen Challenge WA

Teen Challenge WA was established in 1985 and is best known for its work with young drug-dependent people through its residential facility located in Esperance.[409] This centre is one of seven in Australia and one of 1,100 centres in 90 different nations of the world that have operated for over 50 years.[410] Teen Challenge offers two prevention programs to about 10,000 people per annum— one for schools and one for families. The first program is a one-hour presentation in schools and "it is a simple "Say NO to Drugs—Stay Free". Teen Challenge said "people think that is simplistic, but the idea of "Say NO to Drugs—Stay Free" is the message for the young person who has not started using drugs". This program is presented by former drug addicts who have completed its residential course.[411]

The second part of the schools program is a 10-week presentation to young people at risk. A group of about 25 young people undertake the one-hour school lecture and Teen Challenge staff mentor them for 10 weeks, "we go along and we teach them a lot of things that we teach at our training centre in Esperance. It is a values system and it is about understanding family."[412]

The Teen Challenge family program is called *Solutions for Families* and is for families who think that their child is using drugs. This is a two-hour one-off presentation which teaches parents:

> *what is happening in their family when a child hits 13 or 14 years of age up to 19 years of age—the teenage years. … The first part of our family solutions seminar is to teach them about the dynamics of family because if you do not teach your children correctly, even if you think your are but you are still running a dictatorship and not a democracy where you are teaching your children to take control of their life and to become the masters of their own destiny, you will drive them into the arms of the drug dealer...*[413]

---

407 Mr Bram Dickens, Manager, Palmerston Association Inc, *Transcript of Evidence*, 16 June 2010, p5.

408 Ibid.

409 Teen Challenge, 'Teen Challenge in WA', 2010. Available at: www.teenchallengewa.org.au/welcome. Accessed on 16 December 2010.

410 Mr Malcolm Smith, Executive Director, Teen Challenge WA, *Transcript of Evidence*, 11 August 2010, p1.

411 Ibid, p2.

412 Ibid.

413 Ibid.

A finding of Teen Challenge's work is that "95% of all the kids who get involved with drugs … at the wrong time in their life in their early teenage years chose the wrong friends; they chose to run with the wrong people."

Residential program

Teen Challenges' 45-bed residential rehabilitation facility in Esperance has a three to four-month waiting list of young people waiting to be accepted into it. It has accommodation for 45 young people and 15 staff. The facility houses young people from 16 years and over from across the State and government agencies often send their 'uncontrollables' to it, who are sometimes as young as 14 or less.[414]

Royal Automobile Club of WA

As part of its community education program, the Royal Automobile Club of WA has staff that visit about 300 schools a year. They offer a road safety presentation to about 20,000 students:

> *a key part of that lecture is, in fact, the issue of alcohol and drugs and driving. … What are the impacts on driving ability of alcohol and drugs? More importantly, what are the social consequences of road trauma caused by drink and drug driving?*[415]

(c) Evaluation of school education programs

Some witnesses offered words of caution about school education programs. A witness who briefed the Committee about activities in Victoria saw limitations to what impact a school education campaign could have as children are exposed to many different role models and influences while they are developing.[416] An expert from Scotland, while supporting school programs, warned that they needed to realistically deal with drugs as otherwise "you just fall for the oldest trap in the world with kids of 'do as I say, not as I do'."[417]

Another witness suggested that current drug and alcohol education strategies are adult-based ones that have been adapted for youth and adolescents and often are not in a language that they understand.[418] The Committee felt that the SDERA, Life Education, Teen Challenge and Dr YES programs do not appear to fit this perception.

A number of witnesses questioned the efficacy of external programs in affecting actual behaviour. The Committee heard that Drug and Alcohol Services South Australia (DASSA) do not fund

---

414 Ibid, pp4-5.

415 Mr Matthew Brown, Head of Member Advocacy, Royal Automobile Club of WA, *Transcript of Evidence*, 11 May 2010, p2.

416 Mr Todd Harper, Chief Executive Officer, VicHealth, *Briefing*, 30 September 2009, p3.

417 Professor Gerard Hastings, Director, Institute for Social Marketing, University of Stirling, *Transcript of Evidence*, 12 August 2010, p11.

418 Mr Richard Bostwick, Lecturer in Nursing, Edith Cowan University, *Transcript of Evidence*, 25 August 2010, p2.

external providers to deliver programs in schools. While students may think the visiting speakers are interesting and have an impact on them, DASSA said there is no evidence to suggest that in the long term these programs alter the consumption of alcohol and illicit drugs.[419]

Another specialist in this area told the Committee that there is no evidence that these educational programs, especially one-off talks on the dangers of drugs, are an effective strategy.[420] The Heart Foundation said that it was a favourite strategy of alcohol industry representatives to campaign predominately for more education programs as "the reason they do that is they know it does not work. In isolation, it is useless."[421]

An expert in drug rehabilitation and treatment told the Committee that the benefits of the education of school-aged children are small and transitory. He said that numerous studies of these programs, in the United States, showed fairly small gains that did not last very more than several of months.[422] He quoted a major study that showed that the few sound evaluations available had a pooled effect size of 0.037, that is just "3.7% of young people who would use drugs, delay their onset of use or are persuaded to never use".[423]

Confirmation of this evidence is provided by research into the effectiveness of primary school programs delivered by Life Education Victoria. This evaluation "found that while the program conforms to most of the … curriculum advice available, it has its origins in the *knowledge/attitude* and *values/decision-making* drug education models of the late 1970s." The evaluation found that students had significant knowledge gains on these topics but the evaluation failed to show significant reductions in actual drug use.[424] The report quotes other research that suggests that these education programs:

> *appear to serve functions other than just the prevention of drug abuse, such as the reassurance of parents that the schools are at least trying to control substance abuse among students.*[425]

Similarly, an evaluation of a well-known community program in the United States to reduce youth alcohol consumption rates found that the curriculum provided between Grade 6 to Grade 9

---

419 Mr Keith Evans, Executive Director, Drug and Alcohol Services South Australia, SA Health,, *Briefing*, 28 September 2009, p10.

420 Associate Professor Nicholas Lintzeris, Policy Committee, Chapter for Addiction Medicine at the Royal Australasian College of Physicians, *Briefing*, 30 September 2009, p5.

421 Mr Maurice Swanson, Executive Officer, Heart Foundation, *Transcript of Evidence*, 19 May 2010, p8.

422 Dr Alex Wodak, Director of the Alcohol and Drug Service, St Vincent's Hospital, NSW, *Briefing*, 30 September 2009, p5.

423 White, D. and Pitts, M. 'Educating Young People About Drugs: A Systematic Review', *Addiction*, Vol. 10, October, 1998, p1484.

424 Centre for Health Program Evaluation, Monash University, 'Primary School Drug Education: An Evaluation of Life Education Victoria', nd. Available at: www.buseco.monash.edu.au/centres/che/pubs/rr02.pdf, p6. Accessed on 15 December 2010.

425 Ibid, p23.

demonstrated lower rates of alcohol use, but these effects tended to decline in the following years, so that by Grade 12 there were few significant effects.[426]

A non-government information sheet for teachers suggests that to be successful, secondary school education programs should offer more than just information. They should focus on 'social influences', and include components such as peer education, parent education and interactive strategies. The 'social influences' approach has a view that young people begin to use drugs because of their negative self-image or because of social pressures. It aims to empower students with the knowledge and skills to make informed choices about drug use, and has been shown to be successful with students known to be 'at risk' of harmful drug use.[427] This view is supported by evidence the Committee heard from Teen Challenge and the Blue Cross in Geneva.[428]

The Australian Government's *Principles for School Drug Education* purports to be based on "emerging needs and outcomes of research in drug education and curriculum practice". It suggests that "schools and teachers cannot 'drug proof' young people but they can use educational interventions that will support the minimisation of drug-related harm."[429]

Finding 13

School education programs can provide useful information to young people on the prevention of using illicit drugs, and the harm done by their use. These programs may provide a baseline understanding so that broader community programs and strategies to lower the consumption of illicit drugs are more effective.

426 Australian Drug Foundation, 'Drug Education Approaches in Secondary Schools', November 2002. Available at: www.druginfo.adf.org.au/downloads/Prevention_Research_Quarterly/REP_No3_02Nov_Drug_education.pdf, p5. Accessed on 15 December 2010.

427 Australian Drug Foundation, 'Drug Education in Secondary Schools', 2010. Available at: www.druginfo.adf.org.au/druginfo/fact_sheets/drug_education_approaches_in_s/drug_education_in_secondary_sc.html. Accessed on 15 December 2010.

428 Dr Holger-Ortwin Lux, Board Member, International Federation of the Blue Cross, *Briefing*, 3 February 2011.

429 Department of Education, Science and Training, 'Principles for School Drug Education', 2004. Available at: www.det.wa.edu.au/redirect/?oid=com.arsdigita.cms.contenttypes.FileStorageItem-id-1815156&stream_asset=true, p23. Accessed on 15 December 2010.

Recommendation 17

The Minister for Mental Health should ensure that in the 2012-2013 State Budget, the new State-wide illicit drug strategy is funded to:

- encompass behaviour oriented programs that influence a student's self-image;
- prevent the use of illicit drugs;
- explain to the community the harms resulting from the use of illicit drugs; and
- ensure there are sufficient treatment programs for illicit drug users.

6.3 Adult and family education programs

Programs for families

A common complaint made to the Committee by many witnesses was the lack of emphasis on adult education programs, especially for families who have teenagers. SDERA recommended to the Committee that this was an area needing further resources. SDERA suggested that "while we encourage schools to run events for parents, the whole notion of parents coming in after hours and engaging parents after work has always been a difficult one for schools."[430] Teen Challenge is one organisation which addresses this need with its 'Solutions for Families' seminars.[431]

The reason these programs are important is that research has shown that what occurs within a teenager's home is probably more important, in terms of their behaviour toward alcohol and drugs, than what is happening at school. The Committee heard that children who are in loving families where they can talk about alcohol and drugs will have lower usage rates of alcohol and illicit drugs than children who are not. Children with parents who say it is a taboo subject tend to not do as well. The Committee was also told that children who are connected to a church or a faith have lower rates of illicit drug use.[432]

430 Mr Bruno Faletti, State Manager, School Drug Education and Road Aware, Department of Education, *Transcript of Evidence*, 9 June 2010, p3.

431 Mr Malcolm Smith, Executive Director, Teen Challenge WA, *Transcript of Evidence*, 11 August 2010, p2.

432 Mr Keith Evans, Executive Director, Drug and Alcohol Services South Australia, SA Health, *Briefing*, 28 September 2009, p11.

Another reason to undertake programs within a family context is to prevent second and third-generation drug taking. The Committee was told "If you can work with the parents, and family and friends … you can, hopefully, prevent some of those things being replicated."[433]

This is a similar approach to that being taken with women affected by foetal alcohol syndrome (FAS) who are pregnant. The results of the Salvation Army's work during *Alcohol Awareness Week* on FAS "were startling and really quite frightening. … But it is not just Indigenous women— it was significantly high across the board." They told the Committee:

> *kids learn behaviour. It is in front of us every day. … They learn how to solve their problems by watching adult behaviour and parent behaviour and they learn how not to solve them. Often using alcohol and substances is one of the ways they learn how to deal with issues.*[434]

In the current economic environment where many parents work seven days a week it "is an even bigger ask to get families involved in their kids' environment and to engage in their kids' activities, but somehow or other we have to find ways to do that." In trying to assist children learn what is a good behaviour and what is not, "working with parents has to be part of that. You cannot look at the family in isolation." The Salvation Army is an organisation that tries to take 'a whole-of-family approach' as:

> *there is no point running a really good healthy lifestyle program in a sporting club or a crèche or a primary school or a high school, when kids go home to see dad come in from a stressful day and deal with it by having a drink and having another one and steadily getting drunker as the night goes on, and mum taking three or four pills in order to sleep, because they are getting two messages and they are mixed.*[435]

The Salvation Army employ a family counsellor on their substance abuse program. The Committee was told:

> *For a lot of the people we work with, it is not uncommon for some to have picked up their first substance at six, seven or eight years of age. It is often in a party context; that is, they have been at parties where they have picked up the cans of beer at the end of the party, because that is the normality of what happens for them where they are.*[436]

Adult education

Other adult education programs run by non government organisations include the Cancer Council's lectures at universities. These include alcohol and drug issues, along with their better-

---

433 Ms Carol Daws, Board Member, WA Network of Alcohol and Other Drug Agencies, *Transcript of Evidence*, 25 August 2010, p5.

434 Major Jenny Begent, Divisional Social Programme Secretary, The Salvation Army, *Transcript of Evidence*, 25 August 2010, p2.

435 Ibid, pp3-4.

436 Mr Kenneth Smith, Minister of Religion, The Salvation Army, *Transcript of Evidence*, 25 August 2010, p4.

known cancer prevention programs such as *SunSmart*.[437] Similarly, SDERA provide assistance to lecturers at university and work with the final year student teachers at university before they are placed into schools.[438]

Finding 14

Education programs that involve a child and their family may be more useful for altering young people's behaviour toward alcohol and other drugs, particularly for those children identified as being at risk.

Recommendation 18

The Minister for Mental Health ensure that the 2011 Drug and Alcohol Office annual report include details on how the prevention and treatment programs they fund include the whole family, particularly those families with children at risk.

6.4 Training of medical and allied health professionals

(a) Government sector

The Committee heard that in the State's alcohol and other drugs sector, workforce development is a significant part of the activities of the Drug and Alcohol Office. DAO said it provides support:

> *both to the drug and alcohol sector and to other human services agencies and the broader community, to … expand access to professional education and training, workforce organisation support and resource development in the alcohol and drug area. Next Step also offers clinical training and placement for undergraduate and postgraduate health professionals.*[439]

DAO is a nationally acknowledged Recognised Training Organisation (RTO) that provides strategic support and planning for treatment and prevention programs. It is obtaining Federal Government funding for the next three years to build on the existing Certificate 3 program and

437 Mr Tony Slevin, Director, Education and Research, Cancer Council WA, *Transcript of Evidence*, 23 June 2010, p5.

438 Mr Bruno Faletti, Manager, School Drug Education and Road Aware, Department of Education, *Transcript of Evidence*, 9 June 2010, p5.

439 Mr Neil Guard, Executive Director, Drug and Alcohol Office, *Transcript of Evidence*, 26 August 2009, p15.

develop a Certificate 4 one that will include an additional focus on mental health and alcohol issues.[440]

The Committee were told there should be a greater focus on mental health co-morbidities particularly in tertiary training programs. The Committee was told that this training needed "the inclusion of co-morbidity drug and alcohol and mental health treatment frameworks that are consistent, predictable, evidence-based, best practice and based on what-works". Staff needed to be able to have a "model about 'stage of change' and 'motivational interviewing' and then be able to develop a plan as a result of using those processes with a client."[441]

Professor Allsop told the Committee that Western Australia "used to be in the position of having the best workforce development, many would have said, in the country." He thought that the falling away in standards was not due to DAO's efforts, nor in continuing education, but in the fall in the tertiary education sector, "of students enrolled in what I might call broadly, addiction studies." He said the notable exception was Edith Cowan University, which has a very large number of students enrolled in addiction studies.[442] One of the reasons given for this drop at universities was competition for space in the curriculum of nursing and medicine degrees, as well as a lack of resources to teach alcohol and drug topics.

Professor Allsop said that in the past substantial core funding came from the Department of Health and DAO to Curtin University and Edith Cowan University, and some Federal funding went into the University of WA (UWA). He said that it was critical to:

> *ensure that we get addiction studies front and foremost in nursing and medicine. After all, if you are going to be working as a GP, if you are going to be working as a nurse in the emergency department, you are going to see a large number of alcohol and drug-related cases…*[443]

A problem was that in some of the university curricula there are "a lot of bits of alcohol and drug stuff going on but no individual has responsibility—even on a part-time basis—to coordinate that". He suggested some modest resources were required to create leverage within university faculties to work with professional groups to ensure that addiction studies are part of a student's professional development. Another problem that Professor Allsop identified, compared to other jurisdictions, is that "medical trainees do not go through our [hospital] alcohol and drug services". He thought that it was important to expose more medical and nursing staff to alcohol and drug treatment so that this specialisation was seen as a viable career option and a legitimate part of their role.[444]

---

440 Ibid.

441 Ms Melinda Misson, Team Manager, Mental Health, WA Country Health Service-Great Southern, Department of Health, *Transcript of Evidence*, 11 September 2009, p13.

442 Professor Steve Allsop, Director, National Drug Research Institute, Curtin University, *Transcript of Evidence*, 11 May 2010, p3.

443 Ibid, p4.

444 Ibid, p5.

Next Step

A witness from Next Step (a treatment centre funded by DAO) agreed that there was a gap in the relationship between it and the State's tertiary hospitals. He said "I think it would probably be a good thing to have a closer relationship with the tertiary hospitals … in South Australia; there are better links there with placements and so forth." One way to improve this relationship would be to have a higher rotation of medical staff working in the alcohol and drug field so that more people become familiar with this area. Next Step does have some limited placements:

> *We have general practice registrar six-month placements …. We get two a year—that is, two six-month placements … we have medical students coming for half-day placements at our different sites at East Perth, Fremantle and Warwick.*[445]

Dr Quigley agreed with Professor Allsop that the university medical curriculum is crowded and getting drug and alcohol modules into the existing curriculum was difficult. The doctors from Next Step have some input into undergraduate medical education, but at UWA and at the University of Notre Dame Australia (NDA) it is limited to just two one-hour lectures in the whole course. He agreed with Professor Allsop that "if there were drug and alcohol consultants in hospitals, medical students would get more exposure to drug and alcohol issues as part of their teaching-hospital experience".[446]

Finding 15

The State has trained insufficient doctors specialising in the alcohol and other drugs field in the past decade.

Pain specialists

In terms of the legal use of opioids for pain relief, the Committee heard that there are currently just four training positions per year for pain specialists in metropolitan hospitals—two at Sir Charles Gairdner, one at Royal Perth and one at Fremantle. In 2010 there were only two trainees filling those positions. Trainees are usually from anaesthesia specialists, but general practice or any division of medicine is appropriate. It costs about $130,000 per annum to train one specialist as a senior registrar equivalent. The Committee was told that to cope with current demand, the State needed to train between 6-8 specialists per annum.[447] Chronic pain affects about 20% of Western

---

445 Ms Susan Alarcon, Director of Operations, Next Step, Drug and Alcohol Office, *Transcript of Evidence*, 2 September 2010, p2.

446 Dr Allan Quigley, Chair, Australasian Chapter of Addiction Medicine, WA Branch, *Transcript of Evidence*, 2 September 2010, p4.

447 Dr Eric Visser, Pain Medicine Specialist, Faculty of Pain Medicine, Australia and New Zealand College of Anaesthetists, WA Regional Committee, *Transcript of Evidence*, 2 September 2010, p5.

Australians, of whom a substantial proportion have alcohol and drug related problems, including prescription opioid abuse.[448]

Department of Health

The Department of Health (DoH) provides annual training for staff working on needle and syringe programs. A one or two-day training is combined with education programs on sexually transmitted diseases. DoH brings rural workers to Perth for this training. The Committee was told that the training "is very good… it is probably sufficient" for people who have minimal contact with drug users.[449]

(b) Non-government sector

University nursing courses- Edith Cowan University

The Committee was told that the Edith Cowan University (ECU) undergraduate nursing course has about 450 students who commence their studies each year. The course has 24 units. Mental health is a core unit and includes issues of illicit drugs and alcohol. Over a 12-week term, students have 12 two-hour lectures and 12 two-hour tutorials on mental health. In addition they have an 80-hour practical placement in mental health services. Issues that the students cover on illicit drugs include:

> *everything from how we legislate and the legal aspects of substance abuse, right through to the costs around chronic disease and the costs to society around domestic violence, work-related injuries, and impact on families and the community—so a whole range of things around substance misuse.*[450]

ECU nursing students undertake their 80 hours of clinical experience in tertiary mental health settings: for example at Fremantle, Armadale, Bentley, Graylands or Joondalup hospitals. They have an option of doing a two-week elective in their third year in a community care setting. This could include either a community mental health service or a community-driven alcohol service. The Committee was told that ECU's is one of only eight curricula in Australia rewritten in the last 18 months to match the national framework for mental health within the undergraduate nursing curriculum. It is the only university in Western Australia that conforms to these standards.[451]

---

448 Submission No. 74 from Dr Eric Visser, Pain Medicine Specialist, Faculty of Pain Medicine, Australia and New Zealand College of Anaesthetists, WA Regional Committee, 21 October 2010, p2. For more information on this 'hidden epidemic', see ABC 4 Corners, 'Oxy: The Hidden Epidemic', www.abc.net.au/news/video/2010/09/27/3023252.htm. Accessed on 15 December 2010.

449 Dr Carruthers, Viral Hepatitis WA, *Transcript of Evidence*, 2 September 2010, p6.

450 Mr Richard Bostwick, Lecturer in Nursing, Edith Cowan University, *Transcript of Evidence*, 25 August 2010, p11.

451 Ibid, p12.

University nursing courses- University of Notre Dame, Australia

The University of Notre Dame Australia (NDA) nursing course is unique in Western Australia in that it offers a mental health major for its students, with eight identified units in the standard nursing curriculum. The compulsory mental health unit for all nursing students is in the third year of the course. All NDA third year students undertake a 120 hour compulsory clinical practicum. This covers acute mental health areas, community areas, and includes drug and alcohol placements. The Committee heard that "drug and alcohol placements are quite difficult to get, and we would probably only get two or three placements each semester."[452]

The Drug and Alcohol Office (DAO) provide three two-hour lectures to NDA's second year students. NDA students undertake their placements at DAO's Next Step facility. At the completion of their compulsory mental health unit, third year NDA students are able to do an extra two weeks of clinical practicum, which is another 80 hours in a mental health setting. This practicum could include a drug and alcohol placement.[453]

NDA has about 160 students in its third year. It also has a Broome campus and teaching "up there has a different emphasis because the Kimberley has really quite a high percentage of people with drug and alcohol issues."[454] Students undertaking the mental health major have grown to nearly 30 in less than three years, with many undertaking the postgraduate mental health course. NDA is rewriting its nursing curriculum for introduction by 2012. It is considering ideas from the Mental Health Nurse Education Taskforce, which includes incorporating drug and alcohol content right through the curriculum, "starting from semester one and going through each semester and scaffolding that learning."[455]

Australian Medical Association (WA)

The Australian Medical Association (WA)'s youth-friendly doctor (YFD) training program is modelled on its Dr YES program (described above). Doctors are trained in seeing young people and dealing with drugs and alcohol, sexual health, mental health, ethics, young people and the law, and issues around confidentiality and treating a minor. The AMA (WA) has a website with the youth-ready trained doctors listed on it so that the teenagers participating in the Dr YES program, particularly from regional areas, can access it. YFD's aim is to try to get doctors to learn the language of young people and understand contemporary issues affecting their patients.[456]

---

452 Ms Wendy Scapin, Senior Lecturer, University of Notre Dame Australia, *Transcript of Evidence*, 25 August 2010, p2.

453 Ibid, p3.

454 Ibid, p4.

455 Ibid, p8.

456 Dr Rosanna Capolingua, Medical Director, Australian Medical Association (WA) Foundation, *Transcript of Evidence*, 2 September 2010, p9.

St John Ambulance

The St John Ambulance trains its staff on alcohol and drug issues during its degree training program for paramedics. In the first year of the program there is a unit on the social environment. This includes the social impact of alcohol and drugs, and communication skills such as persuading people affected by drugs that they need to go to hospital.[457]

Finding 16

It is important to the success of the State's illicit drug strategy that university courses increase their provision of drug and alcohol education to medical students, nurses and allied health professionals.

Recommendation 19

The Minister for Mental Health should ensure funding to the Drug and Alcohol Office includes additional time and resources for alcohol and illicit drug teaching as part of university courses (both lectures and clinical placements) for medical students, nurses, and other allied health professionals.

Recommendation 20

The Minister for Mental Health seek funding by 2012 for the education and subsequent clinical placement of additional 'addiction medicine' or equivalent specialist positions for tertiary, secondary and community health care settings.

457 Ms Deborah Walley, Manager Ambulance Education, St John Ambulance, *Transcript of Evidence*, 8 June 2010, p7.

CHAPTER 7 OVERVIEW OF TREATMENT PROGRAMS

7.1 Overview of the State's treatment programs

The Committee was told that "for better or worse, people with alcohol and drug problems are marginalised in our community. That is one of the biggest barriers we have to provide adequate care."[458]

Chapter Five provided detailed information on treatment programs available for heroin addicts, as these are often controversial. One such program dealt with in that chapter was the naltrexone implant program provided by the Fresh Start Recovery Programme.

In Table 7.1 below is an overview of the drugs of concern for treatment episodes in 2008-09, with a comparison between the national and State figures.

Table 7.1- Principal drug of concern for treatment episodes (2008-09)#[459]

Principal Drug	Australia	Western Australia	WA treatment episodes
Alcohol	45.8%	45.5%	**7,088**
Amphetamines	9.2%	19.8%	**3,076**
Cannabis	22.5%	15.9%	**2,477**
Heroin	10.3%	8.5%	**1,323**
Methadone	1.5%	2.1%	**328**
Benzodiazepines	1.5%	0.8%	**124**
Ecstasy	1.0%	0.7%	**107**
Cocaine	0.3%	0.2%	**29**
Other drugs	2.6%	5.1%	**795**

Excludes data on those seeking treatment in relation to the drug use of others.

Alcohol remains the most common drug for which Australians seek treatment. It made up almost half of all drug and alcohol related treatment episodes in 2008–09. The number of treatment

458 Professor Steve Allsop, Director, National Drug Research Institute, Curtin University, *Transcript of Evidence*, 11 May 2010, p5.

459 Australian Institute of Health and Welfare, 'Alcohol and Other Drug Treatment Services in Australia 2008–09', December 2010. Available at: www.aihw.gov.au/publications/hse/92/11500.pdf, p22. Accessed on 10 December 2010.

episodes for alcohol has risen in each of the past four years, according to a report released by the Australian Institute of Health and Welfare (AIHW).

Around 143,000 alcohol and other drug treatment episodes were provided in Australia in 2008-09, with most of the treatment episodes (96%) for clients seeking treatment for their own drug use. The largest group of clients in treatment were males aged 20–29 years.[460]

The proportion of treatment episodes for heroin addicts in Australia has nearly halved over the past six years, to 10% of all treatments in 2008–09 compared with 18% in 2002–03. The proportion of treatment episodes for cannabis use has remained stable at about 22% while amphetamine treatment episodes have declined to 9%.[461] The proportion of closed treatment episodes where there was more than one drug of concern was 55% and 98.6% of treatment episodes have another drug of concern reported.[462]

An Australian study of cannabis users looked at why low numbers of dependent cannabis users entered treatment programs. It confirmed previous research findings that the typical cannabis user believes treatment is unnecessary, that they are ready to stop using and would feel stigmatised when accessing treatment.[463]

(a) National and State treatment frameworks

In Western Australia, the *Western Australian Drug and Alcohol Strategy 2005-2009* is the framework for approaches to the prevention, treatment, law enforcement and other initiatives such as workforce development, quality improvement, research, evaluation and monitoring activity.[464] It has now been superseded by the State's draft *Interagency Strategic Framework 2010-15*.[465]

The *National Drug Strategy* (NDS) and its forerunner, the National Campaign Against Drug Abuse (NCADA), have provided a national policy framework to inform the development of drug-related policies and programs in Australia since 1985. Approaches to treatment programs in each jurisdiction are informed by the NDS and its advisory structures, such as the Ministerial Council on Drug Strategy (MCDS), the Intergovernmental Committee on Drugs (IGCD) and the

460 Ibid, pviii.

461 Ibid.

462 Ibid, p20.

463 Mr Peter Gates *et al*., National Cannabis Prevention and Information Centre, 'Barriers and Facilitators to Cannabis Treatment', 2009. Available at: http://ncpic.org.au/static/uploads/files/barriers-and-facilitators-to-cannabis-treatment.pdf, piii. Accessed on 5 April 2011.

464 Drug and Alcohol Office, 'Western Australian Drug and Alcohol Strategy 2005 - 2009', 2005. Available at: www.dao.health.wa.gov.au/Publications/tabid/99/DMXModule/427/EntryId/449/Command/Core.Download/Default.aspx. Accessed on 22 December 2010.

465 Drug and Alcohol Office, 'Draft Interagency Strategic Framework for Western Australia 2010-15', nd. Available at: www.dao.health.wa.gov.au/Publications/tabid/99/DMXModule/427/Default.aspx/EntryId/1191/Command/Core.Download/. Accessed on 27 April 2011.

Australian National Council on Drugs (ANCD). The Strategy for 2010-15 was approved by the Ministerial Council on Drug Strategy in February 2011.[466]

(b) Types of drug treatment

Illicit drug treatments include a range of formal interventions that try to engage dependent users and lead them to more health-enhancing behaviours. Treatment can include informal social methods, such as support from friends, family, peers and the broader community. It can include the process where people give up their problematic drug use themselves. The Committee heard in Sweden that 'untreated recovery', self-change or unassisted recovery is by far the most common way out of alcohol addiction and that this is probably also true for narcotics. Professor Blomquist said that his studies showed about three-quarters of former addicts have never been in treatment.[467]

In Australia, treatment is mainly provided through government-funded services. The majority of services are free of charge and clinicians providing the services may include nurses, psychologists, social workers, counsellors, doctors and welfare workers. The World Health Organisation (WHO) has identified nine key principles for the development of services for treatment of alcohol and drug dependence. The principles are:

- availability and accessibility of treatment;
- screening, assessment, diagnosis and treatment planning;
- evidence-informed alcohol and drug treatment;
- drug treatment, human rights and patient dignity;
- targeting special subgroups and conditions;
- addiction treatment and the criminal justice system;
- community involvement, participation and patient orientation;
- clinical governance of drug dependence treatment services; and
- treatment systems: policy, strategic planning and coordination of services.[468]

---

466 Australian Government, 'National Drug Strategy', 25 March 2011. Available at: www.nationaldrugstrategy.gov.au/. Accessed on 5 April 2011.

467 Professor Jan Blomqvist, Research Professor, SORAD, Stockholm University, *Briefing*, 10 February 2011.

468 United Nations Office on Drugs and Crime, 'Principles of Drug Dependence Treatment', March 2008. Available at: hwww.unodc.org/documents/drug-treatment/UNODC-WHO-Principles-of-Drug-Dependence-Treatment-March08.pdf. Accessed on 5 April 2011.

Range of treatment options

While just a few drugs, such as alcohol, cannabis and amphetamines, provide the greatest demand for treatment programs in Western Australia, a diversity of services is required to respond to the wide range of problems faced by different clients. These treatment options include:

- brief interventions;
- inpatient and outpatient withdrawal management;
- pharmacotherapies;
- outpatient counselling; and
- residential rehabilitation, including therapeutic communities (TCs).[469]

Other treatment options include peer support, couples counselling, family therapy and self-help groups. Support services, harm reduction programs, case management and diversion programs are required within a treatment system. The treatment program that is best for a person depends on the individual's needs and takes account of their level of dependency, the goal of treatment, the drug or drugs used, their cognitive ability and motivation to change. Other broader factors include their family situation, housing, education and the availability of social supports.[470]

The United Nations Office on Drugs and Crime (UNODC) states that there is no single treatment appropriate for all clients and that differentiated and targeted treatment interventions respond best to the specific needs of each case. As with other jurisdictions, in Western Australia there is a range of treatment interventions provided to people with a drug problem.[471]

Table 7.2 below lists the main treatment types for both Western Australia and nationally. Counselling (37.4% of episodes) and withdrawal management (detoxification) (16.4% of episodes) were the main treatments provided across Australia. Western Australia's rate of counselling treatment episodes is 50% higher than the Australian rate and the rate of rehabilitation treatments twice as high.[472]

469 Submission No. 37- Part C from the Drug and Alcohol Office, 25 August 2009, p75.

470 Ibid.

471 Ibid, p76.

472 Australian Institute of Health and Welfare, 'Alcohol and Other Drug Treatment Services in Australia 2008–09', December 2010. Available at: www.aihw.gov.au/publications/hse/92/11500.pdf, p38. Accessed on 10 December 2010.

Table 7.2- Main treatment type (2008-09)#

Main Treatment	Australia	Western Australia	WA treatment episodes
Counselling	37.4%	56.4%	**9,539**
Rehabilitation	6.7%	13.8%	**2,326**
Withdrawal/detoxification	16.4%	10.2%	**1,731**
Assessment only	14.7%	7.6%	**1,283**
Information only	9.2%	3.6%	**611**
Support only	8.9%	3.1%	**529**
Other	6.6%	5.3%	**896**

Excludes data from agencies whose sole activity is to prescribe methadone or other opioid pharmacotherapies.

Between 2005 and 2009, treatments for alcohol, cocaine and ecstasy increased for Indigenous and non- indigenous clients while other drugs stayed steady or decreased (see Table 7.3 below).

Table 7.3- National trends in treatment, by indigenous status (2005-09)[473]

	2005-06		2008-09		Change 2005-09
Principal Drug	**Indigenous**	**Non-indigenous**	**Indigenous**	**Non-indigenous**	**Indigenous (↑)/ non-indigenous (↑)**
Alcohol	44.9%	37.8%	53.7%	44.8%	↑ ↑
Amphetamines	9.9%	11.2%	7.5%	9.6%	↓ ↓
Cannabis	24.9%	24.7%	23.4%	22.3%	↓ ↓
Heroin	9.6%	14.3%	6.1%	10.9%	↓ ↓
Methadone	1.3%	1.7%	1.3%	1.6%	→ →
Benzodiazepines	0.9%	1.9%	0.6%	1.6%	↓ ↓
Ecstasy	0.1%	0.7%	0.3%	1.1%	↑ ↑
Cocaine	0.1%	0.3%	0.2%	0.4%	↑ ↑
Other drugs	5.5%	3.6%	3.2%	2.4%	↓ ↓

473 Ibid, p59.

(c) Costs of different treatment programs

It was difficult for the Committee to obtain accurate data on the cost of the different treatment programs for heroin addiction, but a summary of what it was able to collect shows:

- the average cost per client for a six-month rehabilitation program in the United Kingdom is about £12,000 (or about $19,500), but clients are often limited to a 8-12 week program due to the high cost;[474]
- a single treatment episode of naltrexone (which last about 150-300 days) by the Fresh Start Recovery Programme in Perth costs approximately $6,000;[475]
- the average annual cost to the State of the methadone/buprenorphine program managed by Next Step per pharmacotherapy client is $2,859 per annum;[476] and
- the cost to the State per community pharmocatherary client (managed by Corrective Service doctors or community GPs) is $308 per annum.[477] The client also pays a dispensing fee of $5-$10 per day (or about $1,500 to $3,000 per annum) at their local pharmacy.

(d) Treatment programs pay for themselves

In Australia the cost of a Therapeutic Goods Administration-registered pharmacotherapy drug for heroin treatment programs is covered by the Pharmaceutical Benefits Scheme (PBS) but most clients pay a dosing fee to the pharmacist to cover their costs. The fee set by the PBS for this is $8.15. It is estimated that 80% of clients in Australia pay dispensing fees. Within Western Australia there is a wide range for the daily dispensing fee set by a pharmacy, and it varies between $5 and $10 per day. Patients using the State Government's Next Step facility are not charged a fee.[478]

The literature on the costs and benefits of pharmacotherapy treatments claim that treatment programs pay for themselves, with most of the benefits accruing from a decrease in the cost of crime (estimated at about $4 billion per annum in Australia in 2004-05). The available cost-benefit research similarly concludes that the costs of providing methadone maintenance are significantly lower than the accrued socio-economic benefits. Both methadone and buprenorphine have been demonstrated to be highly cost-effective relative to detoxification alone, or residential

474 Ms Kathryn Gyngell, Research Fellow, Centre for Policy Studies, *Briefing*, 31 January 2011.

475 Mr Jeff Claughton, Chief Executive Officer, Fresh Start Recovery Programme, *Transcript of Evidence*, 16 June 2010, p9.

476 Mr Neil Guard, Executive Director, Drug and Alcohol Office, Letter, 1 March 2011, p3.

477 Ibid.

478 Mr Neil Guard, Executive Director, Drug and Alcohol Office, and Dr Tarun Weeramanthri, Executive Director, Public Health, Department of Health, Letter, 1 March 2011, p2.

rehabilitation programs, although about 70% of clients on these programs are likely to be using other drugs or alcohol as well.[479]

The ratio of benefits to costs across a number of studies ranges from 2:1 to 38:1. The wide range of the cost-benefit ratios is understandable given the diversity of drug clients, including their level of dependency as well as the differences in their treatment programs. It is also difficult to assign monetary costs to some factors such as family burdens related to substance use, the community's fear of crime, drug use and injecting behaviour.[480]

Drug and alcohol treatment is an essential service that many studies have shown provides a good return on the cost of the treatment. Treatment 'works' and is cost effective in terms of a person's health care and broader social costs, such as crime cost reductions. The Drug and Alcohol Office (DAO) provided evidence that the benefits of providing drug and alcohol treatments in Western Australia are estimated to outweigh costs by a factor of between 4:1 and 7:1. The majority of this return on investment is realised through reductions in levels of crime.[481]

The benefits of treatment are optimised when programs are readily accessible, entry into treatment is prompt, retention in treatment is high and services are able to address the multiple needs of an individual.

Measuring outcomes

Outcome effectiveness is most commonly measured by a reduction or cessation in a person's use of a drug. The most common indicators of successful treatment outcomes are:

- decreased drug and alcohol use;
- increased employment or self-support;
- reduction in deaths from overdose;
- reduction in criminal involvement;
- improvements in a person's physical and mental health; and
- improvements in family and social relationships.[482]

479 Professor Mary Jeanne Kreek, 'Myths About Heroin Addiction', 15 October 2001. Available at: www.abc.net.au/rn/talks/8.30/helthrpt/stories/s391783.htm. Accessed on 2 December 2010.

480 Submission No. 37- Part B from the Drug and Alcohol Office, 25 August 2009, pp25-26.

481 Ibid.

482 Submission No. 37- Part C from the Drug and Alcohol Office, 25 August 2009, p78.

Therapeutic relationship

The Committee was told that the importance of the therapeutic relationship to treatment outcome is clear in both the general psychotherapy and the drug and alcohol literature. For example, research shows that a client's perceptions of their therapist's regard and expertise helped predict the outcome of treatment. The strength of this relationship and the interpersonal skills of the clinician are consistently predictive of positive treatment outcomes. Effective counsellors establish a therapeutic alliance quickly, and apply their knowledge about how to manage the relationship once it has been established.[483]

Treatment matching

Matching a client with the most appropriate treatment is critical. The behavioural change for a drug user is a definitive process. People attempting to change their behaviour move through stages of change. Interventions tailored to a person's stage of change can significantly enhance treatment outcomes.

The degree of drug dependence is a major factor in selecting a treatment type. Some heavily dependant people need withdrawal management and may choose pharmacotherapy maintenance for a longer term. Other factors in treatment matching include the presence of co-occurring problems such as mental health conditions or pain management.[484]

Withdrawal management

Withdrawal from drug dependence may involve various dramatic physical and psychological reactions experienced as the client adjusts to no longer having a drug present in their body. Although withdrawal is an important stage in any person's treatment, it does not in itself, change drug-seeking behaviour. Withdrawal from a heavy dependence on drugs such as alcohol and benzodiazepines can be dangerous and potentially life threatening.[485] The Committee was told "an outpatient opiate detox is not a complicated procedure from a doctor's point of view and does not have the potential risks that an alcohol detox has. Alcohol detox is much trickier."[486]

Cannabis withdrawal symptoms are not as dramatic as those associated with withdrawal from opioids or alcohol, but are still significant to users. In general, these symptoms do not warrant a pharmacological intervention, but information about what to expect during withdrawal, as well as providing supportive counselling to allay anxiety, may be helpful to maintain abstinence.

---

483 Ibid, p79, and Professor Wouter Vanderplasschen, Department of Orthopedagogics, Ghent University, *Briefing*, 2 February 2011.

484 Submission No. 37- Part C from the Drug and Alcohol Office, 25 August 2009, p80.

485 Ibid, p81.

486 Dr Allan Quigley, Chair, Australasian Chapter of Addiction Medicine, WA Branch, *Transcript of Evidence*, 2 September 2010, p5.

Withdrawal may be managed at home, as an outpatient, or in an inpatient setting. It can be with or without medication, depending on the severity of dependence and client choice. Home-based withdrawal is more suitable for adults and young people experiencing mild to moderate withdrawal symptoms and for clients with a single-substance dependence who have family members or friends to provide support.[487]

Therapeutic communities and residential rehabilitation

A therapeutic community (TC) is a treatment facility in which the community itself, through self-help and mutual support, is the principal means for promoting and supporting personal change. Residents and staff participate in the management and operation of the whole community. In a TC the community helps to heal individuals and support the development of positive behaviours, attitudes and values of healthy living. A Cochrane review of TCs found that they did not offer any significant benefit in comparison to other residential treatment programs, however a prison-based TC may be better than prison on its own to prevent re-offending post-release.[488]

Those with higher levels of drug and alcohol involvement and less-developed living skills are likely to benefit more from a residential rather than a non-residential program. There is evidence that residential TC programs are more effective when a broad range of treatments and interventions are involved. These can include access to medical care, individual and group counselling, life skills training, employment opportunities and recreation options. For residential rehabilitation, historically three months of treatment was required to achieve positive change. Recently short-term residential rehabilitation programs have emerged.[489]

Social support

There is growing evidence showing that treatment programs should focus on social support and link clients to additional services (for example, medical screening, housing assistance, parenting classes and employment services). These enhanced programs are significantly more effective than traditional services. Clients treated in enhanced programs showed significantly less substance use, fewer physical and mental health problems and better social functioning.[490]

7.2 Drug and Alcohol Office funded services

(a) Overview

The WA Alcohol and Drug Authority was established in 1974 following the Williams Royal Commission into the Treatment of Alcohol and Drug Dependents. The functions of the Authority are set out in the *Alcohol and Drug Authority Act 1974* and focus significantly on the provision of

487 Submission No. 37- Part C from the Drug and Alcohol Office, 25 August 2009, p82.

488 Ibid, p83.

489 Ibid, pp83-84.

490 Ibid, p84.

treatment services. The Drug and Alcohol Office (DAO) provides government services in WA and acts as a conduit for funding other government and non-government drug and alcohol services. In recent years the Federal Government has become an increasingly significant funder of drug treatment services in Western Australia.[491]

The number of treatment episodes in Western Australia has been gradually increasing since 2005-06, as shown in Table 7.4 below. Over the past decade there has been a significant growth in the number of clients seeking treatment for alcohol and amphetamines addiction and a drop in those seeking help for heroin and other opioids. There has been a small reduction in the number seeking treatment for cannabis use. Many clients use more than one drug (58% in 2007-08).

Table 7.4- Comparative principal drug of concern for Western Australian clients in treatment (2000-2008)[492]

Drug Type	2000-01	2007-08
Alcohol	25%	39%
Amphetamines	16%	23%
Opioids (Heroin and all others)	27%	19%
Cannabis	16%	13%

Table 7.5 shows that Western Australian rates of drugs of concern when a client is being treated are similar to the national average for alcohol, but higher for amphetamines, and lower for cannabis and heroin.

Table 7.5- Comparative principal drug of concern for treatments (2006-07)[493]

Drug Type	Western Australia	Australia
Alcohol	40%	42%
Amphetamines	26%	12%
Cannabis	16%	23%
Heroin, Methadone and Morphine	10%	14%

Of the closed (or completed) treatment episodes, the percentage successfully completed has averaged between 62-64%, with higher rates for younger clients (see Table 7.6 below). Clients had

491 Ibid, p91.

492 Ibid, p105.

493 Ibid.

attended an average of seven service occasions per closed episode and about 20% failed to attend a booked session. Comparative analysis of treatment services across Australian jurisdictions in 2006-07 indicates that successful completion rates varied from 61% to 80%, with a median rate of 69%.[494]

In 2006-07, 90% of Australians seeking treatment did so in relation to their own drug use and 9.5% in relation to the drug use of someone else. In 2007-08, approximately 62% of clients seeking treatment were men and 38% women (with no difference in these proportions between the Indigenous and non-indigenous populations). Of the 22,604 episodes open in 2007-08, 3,271 (14.5%) were for Indigenous clients. Since 2005-06, a total of 22,778 episodes of care have been provided to young people experiencing problems with drugs and/or alcohol. Of these episodes, 4,635 (20%) have been provided to young Indigenous people.[495]

Table 7.6- Successfully completed treatment outcomes for closed episodes (2005-07)[496]

Age Group (years old)	2005-06	2006-07
0-17	73%	75%
18-24	58%	64%
Over 24	60%	61%

(b) Funding of treatment services

The Western Australian and Federal Governments provided $51.2 million in 2008-09 for operating costs associated with the State's dedicated public alcohol and drug treatment services, excluding Medicare costs.[497] A small proportion of the general government health funds going into hospital and GP services benefits clients who have alcohol and drug problems. Furthermore, specialist drug and alcohol treatment services receive donations and sponsorship from fund raising activities and income from charges levied on users (usually for residential services).

Of the $51.2 million of direct government funds, 61.4% was from the State Government and 38.6% from the Commonwealth. About 65.7% of the total funding was allocated to metropolitan services and 34.3% to country ones.[498]

494 Ibid, p104.

495 Ibid.

496 Ibid, p105.

497 Ibid, p102.

498 Ibid.

Of the total funds spent in the State, approximately $16.2 million (31.6%) was allocated to services dedicated to Indigenous clients. Of the $17.5 million provided to regional areas, the approximate allocation was:

- Kimberley- 44.5%;
- Goldfields- 14.1%;
- Pilbara- 12.9%;
- Midwest/Gascoyne- 12.3%;
- Great Southern- 6.9%;
- South West- 5.1%; and
- Wheatbelt- 4.2%.[499]

Trends in funding

DAO data shows that drug and alcohol funding has increased from $35.1 million in 2006-07 to $51.2 million in 2008-09. Of this increase, approximately $6 million (38.7%) came from the State Government and $10.1 million from the Federal Government. In regional areas of the State the increases were:

- Kimberley- $3.4 million;
- Goldfields- $1.0 million;
- Pilbara- $0.6 million;
- Midwest/Gascoyne- $0.7 million;
- Great Southern- $0.5 million;
- South West- $0.3 million; and
- Wheatbelt- $0.4 million.[500]

499 Ibid.

500 Ibid, p103.

(c) Services provided

Next Step

DAO's Next Step service is the State Government's specialist clinical medical drug and alcohol service. Its purpose is to provide leadership and excellence in clinical care, professional training and research. Next Step is staffed by addiction medicine consultants, nurses, clinical psychologists, pharmacists and social workers. Patients are referred to Next Step from GPs, hospitals, mental health services and the non-government sector.

The clinical services provided include outpatient clinics across the Perth metropolitan area, an inpatient withdrawal service, a pharmacy and support for the Community Program for Opioid Pharmacotherapy (C-POP). Next Step also provides undergraduate and post-graduate education and clinical placements for doctors, nurses, pharmacists and psychologists and undertakes clinical research.[501]

New tertiary services needed

Dr Quigley from Next Step proposed that what was missing from the State's current services were some inpatient drug and alcohol beds at hospitals, an outpatient service and "a consultation liaison service across the hospitals" as is done in other jurisdictions, including Victoria. The Chapter of Addiction Medicine in its workforce development submission to the Committee acknowledges that the State has 13 consultants at present but there is a need for about 20 positions. All of the current consultants are located in the Perth metropolitan area—seven at Next Step, one in postgraduate psychiatry at Graylands Hospital and the others are in private practice.[502] Dr Quigley told the Committee that the major Perth hospitals should have at least one Addiction Medicine consultant, at an approximate annual cost of $350,000.[503]

Recommendation 21

By December 2011, the Department of Health introduce management guidelines with discharge planning for all patients who attend, or are admitted, to a tertiary or secondary hospital with alcohol and drug problems. The patient's discharge plan is to be provided to the Drug and Alcohol Office for follow-up.

501 Ibid, p92.

502 Dr Allan Quigley, Chair, Australasian Chapter of Addiction Medicine, WA Branch, *Transcript of Evidence*, 2 September 2010, p5.

503 Ibid, p7.

Recommendation 22

By December 2011, the Drug and Alcohol Office establish and fund a referral centre to plan the management for all patients who attend, or are admitted, to a tertiary and secondary hospital with alcohol and drug problems and to report on the operations of this centre in their annual report to Parliament.

Recommendation 23

The Minister for Health by the end of 2011 mandate the relevant recording of disease and physical injury associated with alcohol and illicit drugs in discharge summary documentation.

Rehabilitation services[504]

A number of residential rehabilitation services are located throughout the State. These are funded by State and Commonwealth agencies, or public donations.

Metropolitan area (178 adult beds)

- Rick Hamersley Centre (40 mixed gender beds) operated by Cyrenian House at Gnangara.
- Saranna (14 cottages for women and their young children) is also operated by Cyrenian House at Gnangara.
- Palmerston Farm, with 32 mixed gender beds of which three are transition beds, operated by Palmerston Association at Wellard south of Perth.
- Serenity Lodge with 26 mixed gender beds at Rockingham.
- Harry Hunter Centre with 45 mixed gender beds operated by the Salvation Army in Gosnells.
- Bridge House rehabilitation service with 21 mixed gender beds located at Highgate, which prepares clients for entry to the Harry Hunter facility in Gosnells.

504 Submission No. 37- Part C from the Drug and Alcohol Office, 25 August 2009, pp93-94.

Regional and remote (56 adult beds)

- Rosella House, with 12 mixed gender beds operated by Drug Arm in Geraldton.
- Milliya Rumurra, with 22 mixed gender beds (including capacity for 4 children), located in Broome.
- Ngnowar Aerwah with 22 mixed gender beds and with capacity for 12 children, located near Wyndham.

Additionally, a residential facility of between 12-20 beds is planned for construction by the Federal Government in South Hedland.

Young people (56 beds):

- The Drug and Alcohol Youth Service (Yirra Program) has 10 mixed gender beds, and is operated by Mission Australia in conjunction with Next Step as an integrated service located at Carlisle. Mission Australia is seeking Federal funding to establish six transition units at Carlisle and will use recurrent funding provided by DAO to staff them.
- Teen Challenge, has a 46 bed mixed-gender facility for 16 to 35 year olds, located in Esperance.

Sobering-up centres[505]

Sobering-up centres (SUCs) were implemented in Western Australia as a response to recommendations from the 1988 Interim Report of the Muirhead Royal Commission into Aboriginal Deaths in Custody.[506] They provide a safe, supervised place for people found intoxicated in public to be cared for overnight. Clients are provided with a shower, clean bed-clothes, their own clothes are washed overnight, and a breakfast and clean clothes are provided before their discharge. SUCs are aimed at reducing the harms caused by intoxication by providing a more appropriate care environment than a Police lock-up.

There are 12 sobering-up centres in Western Australia with a total bed capacity of 210 beds. Anawim (five beds) is exclusively for women and is located in Perth. The others are at Highgate (nine beds), Geraldton (18 beds), Roebourne (18 beds), South Hedland (16 beds), Broome (32 beds), Derby (19 beds), Halls Creek (21 beds), Kununurra (20 beds), Wyndham (16 beds), Kalgoorlie (20 beds) and Wiluna (16 beds).

505 Ibid, pp94-95.

506 Justice J. Muirhead, *Interim Report of the Royal Commission into Aboriginal Deaths in Custody*. Australian Government Publishing Service, 1988, Canberra.

Young people's programs[507]

Drug and Alcohol Youth Service (DAYS) is a partnership between Mission Australia and DAO's Next Step service providing a comprehensive range of drug and alcohol services for young people aged 12 to 18 years old (with some flexibility up to the age of 21 years). The service provides an inpatient withdrawal and respite unit, a residential rehabilitation facility, and various outpatient services. The seven-bed inpatient unit is based in East Perth and offers 24-hour supervised care. It offers a two to three week program providing a physically and emotionally safe place for young people to withdraw from drugs.

The ten-bed residential rehabilitation facility is based in Carlisle and provides a 12 week program for young people to engage in treatment and transition back to the community.

The Drug Arm WA Inc *Street Van Outreach Program* operates as a mobile referral, aid and crisis support centre. The program operates from 8pm to 2am on Thursday, Friday and Saturday evenings. The focus of this service is to identify, assist and refer young people, aged between 10 and 24 years, at risk of or involved in drug and alcohol related problems.

The Street Van Outreach Program operates in:

- Armadale to Victoria Park;
- Fremantle;
- City/Northbridge; and
- Rockingham.

Drug Arm WA Inc also operates the *Street Van Outreach Program* in Geraldton and Albany through non-DAO funding sources.

The National Affordable Housing Agreement (NAHA) provides services to young people and NGOs. These agencies funded by DAO to provide drug and alcohol support include:

- Joondalup Youth Support Service;
- Swan Emergency Accommodation;
- Anglicare (Chesterfield House);
- Anglicare (Armadale);
- Anglicare (Spearwood); and
- Mission Australia (South East Metro).

507 Submission No. 37- Part C from the Drug and Alcohol Office, 25 August 2009, pp96-102.

The NAHA funding allows for a dedicated drug and alcohol worker to be available to work with high risk populations, the majority of whom have substance use issues. Preventing drug taking behaviour becoming entrenched is a high priority for these young people.

The On-Track service is located in central Perth and operated by Mission Australia. It is funded by the Federal Government and offers a place of safety for intoxicated or vulnerable youth in crisis. On-Track links with its sister service Making Tracks for follow up and support of the young people referred from On-Track. It works closely with the WA Police and the Department for Child Protection.

Telephone information and counselling service[508]

The Alcohol and Drug Information Service (ADIS) provides free, confidential and anonymous telephone counselling 24 hours a day, every day of the year to anybody in Western Australia concerned about their own or somebody else's drug and alcohol use. Trained drug and alcohol counsellors are available to provide information, referral, assessment and counselling. Counsellors can provide ongoing call backs to people living in isolated situations or in situations where it is difficult to access a face to face counselling service.

ADIS operates three services, the:

- ADIS line;
- Parent Drug Information Service (PDIS) line; and
- Quitline for smokers.

PDIS provides a unique peer support service to parents by telephone, so that parent callers have the opportunity to talk to a counsellor or a specially trained parent volunteer who has experienced their own child's drug or alcohol use. PDIS has a network of 30 parent volunteers. In addition, PDIS attends the Perth Drug Court (adult), and the Children's Court.

The three services received an average of 19,938 calls a year over the last five years. In 2010 there were 2,099 calls to the PDIS line, 4,912 for Quitline and 13,551 for ADIS.[509] Approximately 65% of callers are concerned about their own substance use, 25% concerned about someone else's substance use and 10% from health professionals seeking information. Counsellors also provide interim call backs for people recently discharged from hospital or recently detoxed from substance abuse.

Most calls received through the ADIS and PDIS lines relate to alcohol use (57%) followed by amphetamine use (6%) and cannabis use (5%). The age group with the largest number of callers concerned about their own drug or alcohol use is 30-39 years (28%). However, parent callers are

508 Ibid.

509 Ms Julia Knapton, A/Director Policy Strategy and Information, Drug and Alcohol Office, Electronic Mail, 11 May 2011, p1.

most often concerned about their children in the 20-29 age group (28%) and 10-19 age group (27%).

7.3 Treatment within the justice system

The prison environment offers a unique opportunity to address the drug and alcohol misuse of prisoners, and their associated problems within the wider community. Where it is offered, drug and alcohol treatment improves outcomes for offenders and has beneficial effects for the general public's health and safety. Effective treatment can:

- decrease future drug and alcohol use and drug-related criminal behaviour;
- improve the individual's relationships with his or her family; and
- improve an individual's prospects for employment.[510]

(a) International situation

The Committee heard of a close relationship between illicit drugs and the justice system, and that drug-taking in overseas prisons was very common. For example:

- the prevalence of drug use in Belgium's prisons is somewhere between 40-50% of the prison population but only two of the country's 30 prisons offer treatment programs;[511]
- about 60% of Swedish prisoners have a drug problem but they are not allowed to be given methadone in prison;[512] and
- relapse rates in San Diego following one year of incarceration without treatment for drug-related offenders was 74%.[513]

Scotland is one example of countries that separate the responsibilities for illicit drugs and legal ones such as alcohol. The Committee heard from the Minister for Community Safety that the Justice Department deals with Scotland's drug strategy while the Health Department deals with alcohol issues.[514]

---

510 Submission No. 26 from Department of Corrective Services, 11 August 2009, p1.

511 Professor Freya Vanderlaenen, Department of Criminal Law and Criminology, Ghent University, *Briefing*, 8 February 2011.

512 Dr Jessica Storbjörk, Researcher, SORAD, Stockholm University, *Briefing*, 10 February 2011.

513 Dr A. Thomas McLellan, from the White House Office of National Drug Control Policy, 'Question and Answer Session', 2010. Available at: www.sree.org/conferences/2010/video/mclellanqa.php. Accessed on 14 March 2011.

514 Hon Mr Fergus Ewing MSP, Minister for Community Safety, *Briefing*, 2 February 2011.

(b) Australian situation

The *National Drug Strategy* quotes research from 2009 which shows:

- 81% of prison entrants were current smokers and 74% smoked daily;
- 52% of prison entrants reported drinking alcohol at levels that placed them at risk of alcohol-related harm;
- 71% of prison entrants had used illicit drugs in the 12 months prior to their incarceration; and
- 35% tested positive for hepatitis C.[515]

(c) Western Australian situation

The Department of Corrective Services (DCS) told the Committee that the "direct relationship between drugs and crime is difficult to accurately quantify, but self-reports by offenders suggest that up to 35% of offences may be directly related to drug use." DCS' own data show that most of the State's prisoners who need treatment programs for their drug addictions do not receive assistance.[516]

DCS provided additional information that:

- The Department of Justice Profile of Women Prisoners in 2003 indicates that of all women prisoners surveyed in 2003, 78% of respondents reported they had frequently used drugs and alcohol in the six months prior to their arrest;
- The 2005 Drug Use Careers of Offenders (DUCO) study indicates 67% of juveniles in detention use a substance regularly. This equated to 630 juveniles in 2005-06 requiring a service;
- DUCO identifies that approximately 62% of prisoners have alcohol and other drugs problems, which equates to 4,874 prisoners needing a service in 2005-06. However 4,440 did not receive a service; and
- Department for Corrective Services incurs significant and growing costs resulting from the connection between drug use and crime.[517]

---

515 Ministerial Council on Drug Strategy, 'The National Drug Strategy 2010–2015: Consultation Draft', December 2010. Available at: www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/E3AAD7FA931F0998CA2577DD0006E36C/$File/ndsdraft.pdf, p10. Accessed on 22 December 2010.

516 Submission No. 26 from Department of Corrective Services, 11 August 2009, p1.

517 Ibid.

During 2008-09, 1,625 prisoners were assessed by DCS for substance use offending of which 1,480 were recommended to engage in a substance use program. Overall, 54.3% of the prisoners recommended for a program were non-Indigenous (744 male and 60 female) and 45.7% were Indigenous (617 male and 59 female).

DCS data of all adults on a community order identified that 53% (6,500) had an alcohol or other drug problem. Services provided by the non-government sector show that only about 3,500 of these people received a service in 2005-06.[518]

A 2007 national survey showed that 56% of Western Australian prison entrants were injecting drug users and 21% had the Hepatitis C virus. Drug and alcohol dependence contributed to 9.6% of the principal causes of post-release mortality of Western Australian prisoners.[519]

Current addiction-offending program delivery

The Committee was told that treatment programs provided by the Department of Corrective Services (DCS) for drug using offenders must often address a complex array of personal issues and behaviour. DCS' Offender Services provides a range of program options to assist adult offenders in custody and the community to address their substance using behaviours. All programs delivered are suitable for poly-drug users and are aimed toward reducing their risk of relapsing into illicit substance use. Programs offered range from medium intensity to intensive, where more therapeutic processes are involved.[520]

DCS Health Services deliver brief educational and self-awareness courses and health promotion advice in addition to a pharmacotherapy program. All programs encourage harm reduction in drug use behaviours and include referral information about community-based agencies. Programs target each stage of motivation and risk of relapse in order to encourage change in addictive behaviour.

All DCS addiction offending programs have a cognitive behavioural focus with therapeutic group work as the principal model of intervention. Group work concentrates on challenging beliefs where drug use and offending behaviours have been legitimised. Programs are available to offenders in custody and the community either through direct service delivery, via departmental staff or more recently, through contracted non government providers.

These programs include:

- High Intensity programs: Moving on From Dependencies (MOFD) and Pathways; and

518 Ibid.

519 Department of Corrective Services, 'Offender Drug and Alcohol Strategy', 2010. Available at: www.correctiveservices.wa.gov.au/_files/rehabilitation-services/drug-strategy.pdf, p8. Accessed on 5 April 2011.

520 Submission No. 26 from Department of Corrective Services, 11 August 2009, p3.

- Medium Intensity programs: Indigenous Men Managing Anger/Substance Use (IMMASU), Aboriginal Educational Preventing And Managing Relapse Program (Acacia Prison), Women's Substance Use Program and Breaking Out.[521]

Pathways is a 120 hour intensive program offered by DCS. It is otherwise known as *Criminal Conduct and Substance Use Treatment: Strategies for Self Improvement and Change - Pathways to Responsible Living*. It is an evidence-based treatment program for adults with a history of criminal conduct and alcohol or other drug use problems. This program has recently been evaluated and demonstrates a moderate to strong effect, and has been adapted for delivery to women and for adolescents. Training for the delivery of the program took place in July 2009, with Pathways due to replace the MOFD programs as they are completed. Pathways is currently running in three of the State's prisons.[522]

In 2008-09, 403 prisoners were enrolled to one of the above programs, with 378 actually completing the program. Projections for 2009-10 have forecast an increase of 85% in delivery of these programs to prisoners.

In 2007-08, 546 patients were registered on the prison pharmacotherapy program. This comprised 455 registered on the methadone program, 70 on the Suboxone program and 21 on the Subutex program. Patients are prescribed medication to assist in their withdrawal from opioid, stimulants and sedative drugs. In 2007-08 there were 417 prisoners issued specialist opioid withdrawal medications, 137 individuals issued with amphetamine management medications and 351 individuals issued with alcohol withdrawal medications.[523]

Drug and Alcohol Throughcare Service (DATS)

The Drug and Alcohol Throughcare Service (DATS) was introduced by DCS in January 2009 and is contracted to Holyoake and Cyrenian House, both community treatment agencies. It provides a through-care service from prison to the community. The program aims to increase prisoner engagement with treatment upon their release, by commencing counselling in prison. DATS replaced the Prison to Parole Program (PPP).[524]

Drug Court and the Court Assessment and Treatment Service (CATS)

Community Justice Services' Court Assessment and Treatment Service (CATS) is an integral part of the Western Australian Drug Court. CATS case manages participating offenders, assesses and monitors them, and links them to specialist drug treatment and rehabilitative service providers. The Committee was told that CATS was established in December 2000 as a pilot of the Perth Drug Court.[525] The Drug Courts and other court and Police diversion services or programs "were

521 Ibid.

522 Ibid.

523 Ibid, p4.

524 Ibid, p5.

525 Ibid.

born out of a COAG agreement in 1999 reflective within the national drug strategy and the national illicit drug diversion initiative (IDDI)".[526]

CATS advises the Drug Court on the progress of participants. It also provides intervention services to defendants referred by metropolitan and regional criminal courts who use illicit drugs but are not involved with the Drug Court. In these cases, CATS refers participants to appropriate treatment, monitors their progress and provides pre-sentence advice to the referring courts. In 2008-09, 191 offenders were placed on court orders (59 females, 132 males) and case-managed by CATS. The Committee was told that CATS is very intrusive for the participants in terms of drug testing. DCS utilise external agencies "that we pay a fee for service for drug testing and things like that. That happens up to three times a week."[527]

Not all DCS clients with drug or alcohol problems participate in treatment programs. In these cases DCS is "limited to those who are acknowledging that they have committed an offence and are prepared to plead guilty and are willing to engage in a program or service." DCS relies heavily on existing community services from NGOs, especially for "community-based offenders, [we] try to engage people in services that exist in their community. They are not in jail. They are in the community."[528] One of the complicating issues for CATS is that offenders may not be appearing before a court for a drug or alcohol-related offence but "it may be stealing, assault or whatever, but that it has been identified as being drug-related actually puts it into that [CATS] mandate."[529]

Department of Corrective Services Drug Strategy

The Department of Corrective Services (DCS) developed its first Drug Strategy in 2003. The plan focused on providing equity and access to quality treatment services for offenders and tried to 'develop a holistic approach to Indigenous alcohol and drug use.' Major strategies implemented since the strategy commenced include:

- drug-free units at Bandyup and Albany Prisons;
- increased drug testing in all WA prisons;
- drug detection dog teams at three regional prisons;
- a comprehensive prison pharmacotherapy program across all WA prisons; and

526 Mr Steve Robins, Assistant Commissioner Adult Community Corrections, Department of Corrective Services, *Transcript of Evidence*, 25 August 2010, p2.

527 Ibid.

528 Ibid.

529 Ibid, p7.

- expansion of intensive addiction offending programs for high risk recidivist offenders.[530]

A new strategy was finalised in 2010. It aims to meet the multiple needs of drug users by:

> *maximising treatment gains through the provision of links to health, social care and other services. The success of this strategy will be underpinned by the success of the collaborative relationships between DCS and its treatment providers, particularly the non-government sector.*[531]

Members of the Western Australian Network of Alcohol and other Drug Agencies (WANADA) state that the workload associated with DCS clients is significantly higher than for clients in the general community with drug-related problems. The importance of these NGOs to the successful operation of the DCS diversion programs was made clear to the Committee:

> *we are obliged to fulfil the orders of the court, or to work within the orders of the court. Quite often those orders may place requirements or impositions that are very difficult for us to deliver on. … Sometimes the court places conditions that say this person has to attend a program or be given a certain sort of intervention, and the program or intervention does not exist. It puts our staff in an untenable position because they are either required to try and do something, and they make referrals that are a waste of space, or they are breaching the person because the person cannot comply with that sort of requirement because it does not exist.*[532]

Table 7.8- Illicit drug diversion options in Western Australia[533]

Level of Diversion Programs	Diversion Program
Police	Diversion Cannabis Education Sessions All Drug Diversion Young Persons Opportunity Program (YPOP)
Magistrates' Court Diversion	Pre-sentence Opportunity Program (POP) Indigenous Diversion Program (IDP) Supervised Treatment Intervention Regime (STIR)
Specialist Court Diversion	Drug Court Regime Drug Court Regime (Children's Court)

530 Department of Corrective Services, 'Offender Drug and Alcohol Strategy', 2010. Available at: www.correctiveservices.wa.gov.au/_files/rehabilitation-services/drug-strategy.pdf, p3. Accessed on 5 April 2011.

531 Submission No. 26 from Department of Corrective Services, 7 August 2009, p6.

532 Mr Steve Robins, Assistant Commissioner Adult Community Corrections, Department of Corrective Services, *Transcript of Evidence*, 25 August 2010, pp13-14.

533 Crime Research Centre, University of Western Australia, 'WA Diversion Program – Evaluation Framework (POP/STIR/IDP) Final Report', May 2007. Available at: www.dao.health.wa.gov.au/Publications/tabid/99/DMXModule/427/Default.aspx?EntryId=754&Command=Core.Download, p12. Accessed on 22 March 2011.

The key drug diversion program programs offered by DCS in Table 7.8 include:

- **Pre-Sentence Opportunity Program**- POP provides an early intervention program for low-level, often first-time, offenders with some low-level drug use issues. POP clients could normally expect to receive a Community Based Order or a fine upon a plea of guilty;

- **Supervised Treatment Intervention Regime**- STIR is a Commonwealth-funded program aimed at more entrenched drug use by moderate-level offenders. It targets individuals with more extensive criminal and drug use histories than are included in POP. STIR clients could normally expect to receive a Community Based Order or Intensive Supervision Order upon a plea of guilty;

- **Young Person's Opportunity Program**- YPOP has operated in the metropolitan area since 2004 and aims to increase the number of young offenders accessing drug education and treatment services; and

- **Indigenous Diversion Program**- IDP is a regional early intervention drug diversion program for Aboriginal or Torres Strait Islanders facing minor offences related to illicit drug use.[534]

People charged with sexual, drug trafficking, or high-level violent offences and those facing a mandatory prison sentence are excluded from the POP, YPOP, IDP and STIR programs.[535]

Offenders can only access court-ordered drug services such as POP, STIR and YPOP if they plead guilty. Many offenders do not understand that by ensuring they plead guilty, DCS is actually trying to help them rather than trying to trap them into going to prison. A remaining challenge for DCS is to support the judiciary service to make appropriate determinations that may not involve imprisonment, but may involve some aspects of community work (or other intervention in the community) that will give DCS staff the opportunity to work closely with offenders to address their illicit drug problems.[536]

In late 2008 a new pilot program was implemented by the Children's Court Drug Court with the assistance of the Drug and Alcohol Office. The Youth Supervised Treatment Intervention Regime (YSTIR) is targeted at young people (10–18 years of age) who are moderate level young offenders with an illicit drug use problem. These young people would normally receive a six to 12 month Community Based or Intensive Supervision Order upon conviction. YSTIR is a voluntary program

534 Ibid, pp41-87.

535 Ibid.

536 Mr Steve Robins, Assistant Commissioner Adult Community Corrections, Department of Corrective Services, *Transcript of Evidence*, 25 August 2010, p13.

with a therapeutic focus and the time dedicated by the young person in the program is taken into account at their sentencing on conclusion of the program.[537]

Finding 17

The Drug Court diversion programs such as POP, IDP and STIR seem to have made a valuable contribution to lowering the amount of people being sent to prison for low-level drug infringements.

Recommendation 24

The Minister for Corrective Services and the Attorney General report to Parliament by December 2011 on what processes have been put in place to ensure the closer cooperation of the Courts and the Department of Corrective Services in managing the diversion programs offered to convicted children and adults in Western Australia.

537 WANADA, 'Drugs Speak', December 2008. Available at: www.wanada.org.au/Download-document/58-Drugspeak-December-2008.html, p1. Accessed on 22 March 2011.

APPENDIX ONE

SUBMISSIONS RECEIVED

List of Submissions received for the Inquiry.

Date	Name	Position	Organisation
27 June 2009	Mr Matthew Allen		
3 July 2009	Mr Kevin Moran	Executive Member	Justice First Inc
16 July 2009	Dr Eric Visser	Chair	Western Australian Regional Committee of the Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists
20 July 2009	Dr Alex Wodak	Director, Alcohol and Drug Service	St. Vincent's Hospital, NSW
28 July 2009	Mr David Perrin	Executive Officer	Drug Advisory Council of Australia
29 July 2009	Dr Alison Ritter	Acting Director	National Drug and Alcohol Research Centre
30 July 2009	Ms Etza Peers	Clinical Nurse Consultant, Alcohol and Drug Service	Sir Charles Gairdner Hospital
30 July 2009	Dr David Phillips	National President	FamilyVoice Australia
31 July 2009	Associate Professor Moira Sim		
31 July 2009	Mr Bruno Faletti	Manager	School Drug Education and Road Aware
31 July 2009	Ms Yvette Pollard	Manager, Research and Policy	beyondblue
31 July 2009	Dr Allan Quigley	Chair	Australasian Chapter of Addiction Medicine (WA Branch)

31 July 2009	Professor Gary Hulse	Professor of Addiction Medicine	University of Western Australia
31 July 2009	Mr Ross Kyrwood	WA State Director	Mission Australia
31 July 2009	Mr Mark Porter	MST Program Manager, South Metro Area Health Service	Department of Health
31 July 2009	Mr Luke van Zeller	Operations Manager	Western Australian Network of Alcohol and Other Drug Agencies
31 July 2009	Mr Jeff Claughton	Chief Executive Officer	Fresh Start Recovery Programme
4 August 2009	Dr Susan Carruthers	Chair	Western Australia Viral Hepatitis Committee
5 August 2009	Professor Steve Allsop	Director	National Drug Research Institute, Curtin University
5 August 2009	Ms Ann Deanus	Chief Executive Officer	Women's Health Services
7 August 2009	Dr Steve Patchett	Chair, Inter-agency Executive Committee	People with Exceptionally Complex Needs Project
7 August 2009	Ms Kathrin Stroud	Strategic Communications and Policy Officer	Alcohol and other Drugs Council of Australia
7 August 2009	Hon Ms Sheila McHale	Chief Executive Officer	Palmerston Association Inc
11 August 2009	Mr Ian Johnson	Commissioner	Department of Corrective Services
11 August 2009	Mr Steve Parry	Acting Deputy Director General	Department of Housing
12 August 2009	Ms Sharyn O'Neill	Director General	Department of Education and Training
18 August 2009	Dr Peter Flett	Director General	Department of Health
22 August 2009	Dr Stuart Reece		

24 August 2009	Ms Sue Ash	Chief Executive Officer	Western Australian Council of Social Service Inc
25 August 2009	Mr Neil Guard	Executive Director	Drug and Alcohol Office
28 August 2009	Ms Alison Sinclair	State Manager SA/WA	Quality Management Services
30 October 2009	Mr Jay Bacik	Chief Executive Officer	Life Education Australia
5 March 2010	Mr John Ryan	Chief Executive Officer	ANEX
10 May 2010	Mr Greg Swensen		
8 June 2010	Mr Neil Guard	Acting Commissioner	Mental Health Commission
15 June 2010	Mr Jeff Claughton	Chief Executive Officer	Fresh Start Recovery Programme
23 June 2010	Mr Tony Slevin	Director, Education and Research	Cancer Council WA
13 July 2010	Mr Jeff Claughton	Chief Executive Officer	Fresh Start Recovery Programme
20 August 2010	Major Jenny Begent	Divisional Social Programme Secretary	The Salvation Army
25 August 2010	Mr Steven Robins	Assistant Commissioner, Adult Community Corrections	Department of Corrective Services
2 September 2010	Dr Rosanna Capolingua	Dr YES program	Australian Medical Association (WA) Foundation
19 October 2010	Dr Eric Visser	Pain Medicine Specialist	Faculty of Pain, ANZCA
19 October 2010	Professor David Clark		Wired In

APPENDIX TWO

HEARINGS

List of Hearings held for the Inquiry.

Date	Name	Position	Organisation
26 August 2009	Mr Neil Guard	Executive Director	Drug and Alcohol Office
	Mrs Myra Browne	Director, Policy, Strategy and Information	Drug and Alcohol Office
	Mr Eric Dillon	Director, Client Services	Drug and Alcohol Office
11 September 2009 Merredin	Mr Eric Nordberg	Regional Manager	Holyoake Australian Institute for Alcohol and Drug Addiction Resolutions
	Mr Luke Turner	Holyoake Diversion Officer and Counsellor-Educator	Wheatbelt Community Drug Service Team
	Sgt Michael Daley	Acting Officer in Charge, Merredin	WA Police
11 September 2009 Albany	Ms Marcelle Cannon	Manager, Mental Health, WA Country Health Service-Great Southern	Department of Health
	Ms Melinda Misson	Team Manager, Mental Health, WA Country Health Service-Great Southern	Department of Health
	Superintendent Dene Leekong	Great Southern District Office	WA Police
	Mr Bryan Taylor	Palmerston-Great Southern Community Drug Service Team	Palmerston Association Inc
14 September 2009 Kalgoorlie	Miss Deborah Clark	Chairperson	Kalgoorlie Local Drug Action Group
	Ms Rosemary Hunt	Executive Manager	Centrecare

21 September 2009 Katanning	Ms Claire Heffernan	Manager, Community and Youth Justice	Department of Corrective Services
	Mr Carl Beck	Deputy Chief Executive Officer and Manager of Community Services	Shire of Katanning
	Mr Gregory Crofts	Police Officer, Katanning	WA Police
10 November 2009	Dr Peter Flett	Director General	Department of Health
16 February 2010	Mr Kim Snowball	Acting Director General	Department of Health
11 May 2010	Mr Eric Dillon	Acting Executive Director	Drug and Alcohol Office
	Ms Myra Browne	Director, Policy, Strategy and Information	Drug and Alcohol Office
	Mr James Hunter	Project Manager, Policy	Drug and Alcohol Office
	Mr Gary Kirby	Director, Prevention and Workforce Development	Drug and Alcohol Office
	Professor Steve Allsop	Director, National Drug Research Institute	Curtin University
12 May 2010	Mr Tim Brown	Vice-President	WA Night Clubs Association
19 May 2010	Ms Jo-Anne Hodson	Drug and Alcohol Service Manager	Womens Health Services
26 May 2010	Dr Karl O'Callaghan	Commissioner	WA Police
8 June 2010	Dr Amanda Frazer	Executive Director, King Edward Memorial Hospital	Department of Health
	Mr Neil Guard	Acting Commissioner	Mental Health Commission
	Mr Wynne James	Manager Policy and Strategy Directorate	Mental Health Commission
	Dr David McCoubrie	Emergency Department	Royal Perth Hospital
	Dr Roger Swift	Emergency Department	Sir Charles Gairdner Hospital

	Ms Deborah Walley	Manager, Ambulance Education	St John Ambulance
9 June 2010	Mr Bruno Faletti	Manager, School Drug Education and Road Aware	Department of Education
	Mr Stephen Kinnane	Researcher	Nulungu Centre for Indigenous Studies, Notre Dame University
16 June 2010	Dr George O'Neil	Director	Fresh Start Recovery Programme
	Mr Jeff Claughton	Chief Executive Officer	Fresh Start Recovery Programme
	Hon Ms Sheila McHale	Chief Executive Officer	Palmerston Association Inc
	Mr Bram Dickens	Manager, South Metro Community Drug Team	Palmerston Association Inc
16 June 2010	Major Dennis Rowe	Divisional Commander	Salvation Army
23 June 2010	Ms Jackie Tang	Deputy Commissioner	Department of Corrective Services
	Mr Mark Glasson	Director of Offender Services	Department of Corrective Services
26 July 2010 Broome	Mr Alan Clements	Acting Superintendent, Broome Prison	Department of Corrective Services
	Ms Rebecca Ross	Regional Programs Development Officer	Department of Corrective Services
	Mr Norm Smith	Manager	Department of Corrective Services
	Ms Gaelyn Shirley	Team Leader, Youth Justice	Department of Corrective Services
	Ms Jennifer Evans	Curriculum Manager, Kimberley District Education	Department of Education and Training
	Mr Bruno Faletti	State Manager, School Drug Education and Road Aware	Department of Education and Training

	Dr David Atkinson	Acting Medical Director/Medical Educator	Kimberley Aboriginal Medical Services Council
	Mr Robert Goodie	Regional Manager	Kimberley Mental Health and Drug Service
	Ms Sally Malone	Regional Coordinator	Kimberley Community Drug Service Team
	Mr Christopher Bin Kali	Director	Milliya Rumurra Aboriginal Corporation
	Ms Leonie Kelly	Director/Chairperson	Milliya Rumurra Aboriginal Corporation
	Ms Mary Martin	Board Member	Milliya Rumurra Aboriginal Corporation
	Cr Graeme Campbell	Shire President	Shire of Broome
	Mr Kenneth Donohoe	Chief Executive Officer	Shire of Broome
	Mr Kim Darby	Operations Manager, Broome Hospital	WA Country Health Service, Kimberley
	Dr Suzanne Phillips	Senior Medical Officer, Broome Hospital	WA Country Health Service, Kimberley
	Ms Kerry Winsor	Regional Director	WA Country Health Service, Kimberley
	Inspector James Cave	Kimberley District Office	WA Police
	Senior Sergeant Robert Neesham	OIC, Broome Police Station	WA Police
	Sergeant Thomas Stafford	Broome Police Station	WA Police
27 July 2010	Mr Peter Hunter	Councillor	Ardyaloon Inc
Beagle Bay/ One Arm Point	Ms Rowena Mouda	Chairperson	Ardyaloon Inc
	Ms Veronica Yue		Ardyaloon Community
	Mr Brian Lee	Chairperson	Djarindjin Aboriginal Corporation

	Mr Daniel Howard		Djarindjin Aboriginal Corporation
	Ms Maria Lombardi	Manager, Beagle Bay Clinic	Kimberley Aboriginal Medical Services Council
	Senior Sergeant Neville Ripp	OIC, Dampier Peninsula Police Station	WA Police
	Sergeant Jane Korculanic	Dampier Peninsula Police Station	WA Police
	Sergeant Noel Howie	Dampier Peninsula Police Station	WA Police
27 July 2010 Balgo	Mr Christopher Cresp	Chief Executive Officer	Palyalatju Maparnpa Health Committee
	Mr Bede Lee	Chairman	Palyalatju Maparnpa Health Committee
	Sergeant David Risdale	Balgo Police Station	WA Police
28 July 2010 Derby	Mrs Margaret D'Antoine	Manager	Garl Garl Walbu Alcohol Association Aboriginal Corporation
	Ms Olwyn Webley		Kinway-Anglicare WA, Broome
	Ms Zoe Evans	Coordinator of Standby Suicide Response Service, West Kimberley	Kinway-Anglicare WA, Broome
	Mr Stephen Austin	Chief Executive Officer	Mowanjum Community
	Mr Eddie Bear	Chairman	Mowanjum Community
	Mr Vincent Bear	Elder and Councillor	Mowanjum Community
	Mr Gregory Spinks	Coordinator	Numbud Patrol
	Ms Elsia Archer	President	Shire of Derby - West Kimberley
	Mr Peter McCumstie	Councillor	Shire of Derby - West Kimberley
	Mr Paul White	Deputy President	Shire of Derby - West Kimberley

	Dr Brian Collings	Senior Medical Officer	Royal Flying Doctor Service, Western Operations
	Hon Mr Ernest Bridge	President	Unity of First People of Australia
	Ms Jeanny Catlin	Project Coordinator/ Nurse	Unity of First People of Australia
	Senior Sergeant Michael Wells	OIC, Derby Police Station	WA Police
29 July 2010 Fitzroy Crossing	Mr Joe Ross	FaHSCIA Contractor	
	Mr Shayne Stewart	General Manager	Crossing Inn
	Mr Geoffrey Brooking	Chairman	Kimberley Aboriginal Law and Culture Centre
	Mr Neil Carter	Cultural Heritage Officer	Kimberley Aboriginal Law and Culture Centre
	Mr Wes Morris	Coordinator	Kimberley Aboriginal Law and Culture Centre
	Ms Hayley Diver	Regional Training Coordinator	Kimberley Mental Health and Drug Service
	Ms Sally Malone	Regional Coordinator	Kimberley Community Drug Service Team
	Mr Patrick Green	Director	Leedal Pty Ltd
	Mr John Rodrigues	Chief Operations Manager	Leedal Pty Ltd
	Ms Emily Carter	Chairperson	Marninwarntikura Women's Resource Centre
	Ms Patricia Dick	Mobile Playgroup Worker	Marninwarntikura Women's Resource Centre
	Ms Christine Gray	Manager, Family Violence and Prevention Unit	Marninwarntikura Women's Resource Centre

	Ms Lisa Brough	Team Leader, Women's Shelter	Marninwarntikura Women's Resource Centre
	Ms Maggie Kirby	Administrative Assistant	Marninwarntikura Women's Resource Centre
	Ms Bridget Miller	Art Therapy Coordinator	Marninwarntikura Women's Resource Centre
	Ms Tammy Munroe	Mobile Playgroup Worker	Marninwarntikura Women's Resource Centre
	Mr Paul Miller	Manager, Community Garden	Marninwarntikura Women's Resource Centre
	Mr Billy Surprise	Certificate II student	Marninwarntikura Women's Resource Centre
	Mr Matthew Waye	Certificate II student	Marninwarntikura Women's Resource Centre
	Ms Maureen Carter	Chief Executive Officer	Nindilingarri Cultural Health Services
	Ms Sharyn Burvill	Area Manager	Shire of Derby - West Kimberley
	Dr Ralph Chapman	Acting Senior Medical Officer, Fitzroy Valley Health Services	WA Country Health Service, Kimberley
	Mrs Carol Erlank	Director of Nursing, Fitzroy Crossing Hospital	WA Country Health Service, Kimberley
	Mrs Rosalie Lupton	Community Health Nurse Manager, Fitzroy Crossing Hospital	WA Country Health Service, Kimberley
	Mr Brian Wilson	Acting Operations Manager, Derby-Fitzroy Health Services	WA Country Health Service, Kimberley
	Ms Joanne Wraith	Child and Adolescent Mental Health Professional, KMHDS	WA Country Health Service, Kimberley

	Senior Sergeant Ian Gibson	OIC, Fitzroy Crossing Police Station	WA Police
30 July 2010 Fitzroy Crossing	Mr Paul Jefferies	Principal	Fitzroy Valley District High School
	Mr Heath Sanderson	Manager	Fitzroy Valley Men's Shed
30 July 2010 Noonkanbah	Mr Denis Boke		Yungngora (Noonkanbah) Community
	Mr Dickey Cox	Community Elder	Yungngora Community
	Ms Francine Cox		Yungngora Community
	Mr Malcolm Skinner		Yungngora Community
	Mr John Smith		Yungngora Community
1 August 2010 Broome	Ms Jillian Coole	Clinical Team Leader	Milliya Rumurra Aboriginal Corporation
	Ms Maria Lovison	Chief Executive Officer	Milliya Rumurra Aboriginal Corporation
2 August 2010 Wyndham	Ms Lesley Evans	Chief Executive Officer	Ngnowar-Aerwah Aboriginal Corporation
	Ms Ruth Bath	District Director of Nursing	WA Country Health Service, Kimberley
	Ms Wendy McKinley	Acting Operations Manager, Halls Creek and Wyndham Hospitals	WA Country Health Service, Kimberley
	Ms Monica Frain	Acting Director, Population Health	WA Country Health Service, Kimberley
	Sergeant Bradley Warburton	OIC, Wyndham Police Station	WA Police
2 August 2010 Kununurra	Ms Emma White	District Director	Department for Child Protection
	Ms Sally Malone	Regional Coordinator	Kimberley Community Drug Service Team
	Ms Edna O'Malley	Deputy Chair/Member	Miriuwung Gajerrong Ord Enhancement Scheme

	Ms Anna Moulton	Program Manager	Miriuwung Gajerrong Ord Enhancement Scheme
	Mr Graeme Cooper	Chief Executive Officer	Ord Valley Aboriginal Health Service
	Mr Gary Gaffney	Chief Executive Officer	Shire of Wyndham - East Kimberley
	Cr Fred Mills	President	Shire of Wyndham - East Kimberley
	Dr Erik Beltz	Senior Medical Officer	WA Country Health Service, Kimberley
	Mr Terry Howe	Registered Nurse, Kimberley Mental Health and Drug Service	WA Country Health Service, Kimberley
	Mr David Williams	Acting Operations Manager, Kununurra	WA Country Health Service, Kimberley
	Ms Kerry Winsor	Regional Director	WA Country Health Service, Kimberley
	Sergeant Scott Moyle	Kununurra Police Station	WA Police
	Senior Sergeant Graham Sears	OIC, Kununurra Police Station	WA Police
	Mr Ralph Addis	Chief Executive Officer	Wunan Foundation
	Mr Ian Trust	Executive Chair	Wunan Foundation
11 August 2010	Mr Michael Mc Auliffe	Chairman	Life Education WA (Inc)
	Mr Jay Bacik	Chief Executive Officer	Life Education WA (Inc)
	Mr Bernard Foley	Executive Officer	Life Education WA (Inc)
	Pastor Lance Macormic	WA State Officer	Family Voice Australia
	Mr Richard Egan	National Policy Officer	Family Voice Australia
	Reverend Malcolm Smith	Executive Director	Teen Challenge
18 August 2010	Ms Michelle Scott	Commissioner	Commissioner for Children and Young People WA

	Mr Terry Murphy	Director General	Department for Child Protection
	Professor Gary Hulse	Director of Research and Education in Alcohol and Drugs	University of Western Australia
20 August 2010 Albany	Justice Elizabeth Hamilton	Magistrate	
	Mr Anthony Bourne	Manager	Palmerston Association Great Southern
	Ms Karina Bateman	Team Leader, Yarning and Parenting Program	Palmerston Association Great Southern
25 August 2010	Ms Jill Rundle	Executive Director	Western Australian Network of Alcohol and Other Drug Agencies (WANADA)
	Ms Cheryl Davenport	Chair	WANADA
	Mr Wayne Flugge	Aboriginal Services Manager	WANADA
	Ms Carol Daws	CEO Cryenian House	WANADA
	Mr Steve Robins	Assistant Commissioner Adult Community Corrections	Department of Corrective Services
	Mr Adrian Robinson	Director North Adult Community Corrections	Department of Corrective Services
	Mr Richard Bostwick	School of Nursing	Edith Cowan University
	Ms Wendy Scapin	College of Nursing	University of Notre Dame
2 September 2010	Dr Rosanna Capolingua	Dr Yes Program	Australian Medical Association (WA) Foundation
	Mr Thomas Bartlett	Medical student	Australian Medical Association (WA) Foundation
	Dr Allan Quigley	Chair	Australasian Chapter of Addiction Medicine, WA Branch

	Ms Susan Alarcon	Director of Operations, Next Step	Drug and Alcohol Office
	Dr Susan Carruthers	Chair	WA Viral Hepatitis Committee
	Ms Cherie Toovey	Tour Presenter, Parliamentary Education Office	Parliament of Western Australia
	Dr Eric Visser	Chair	WA Regional Committee for the Faculty of Pain Medicine of the Australian and New Zealand College
	Mr Peter Fry	Volunteer	Alternatives to Violence Project
	Mrs Sally Herzfeld	Volunteer	Alternatives to Violence Project
	Ms Jo Vallentine	Activist	Alternatives to Violence Project
	Associate Professor Ted Wilkes	National Drug Research Institute	Curtin University
22 September 2010	Mr Rob Watson	Manager Health and Safety	BHP Billiton Iron Ore (WA)
13 October 2010	Mr Allan Jackson	General Manager Climate Change, Water and Environment	Rio Tinto

APPENDIX THREE

BRIEFINGS HELD

List of Briefings held for the Inquiry.

Date	Name	Position	Organisation
29 September 2009	Mr Keith Evans	Executive Director, Drug and Alcohol Services South Australia	SA Health
	Dr Marianne Jauncey	Medical Director	Medically Supervised Injecting Centre- Sydney
30 September 2009	Dr Alex Wodak	Director, Alcohol and Drug Service	St. Vincent's Hospital, New South Wales
	Associate Professor Nicholas Lintzeris	Policy Committee, Chapter for Addiction Medicine	Royal Australasian College of Physicians
4 November 2009	Mr Chips Mackinolty	Policy and Strategy Manager	AMSANT, Northern Territory
31 January 2011	Mr David Raynes	Consultant	United Kingdom
	Ms Kathy Gyngell	Chair, Addictions Policy Forum	Centre for Policy Studies, United Kingdom
2 February 2011	Professor Neil McKeganey	Founding Director, Centre for Drug Misuse Research	University of Glasgow
3 February 2011	Dr Anthony Kasozi	Deputy Secretary General	International Federation of the Blue Cross, Switzerland
	Ms Christine Aebli	Communication Officer	International Federation of the Blue Cross, Switzerland
	Dr Holger Lux	Board Member	International Federation of the Blue Cross, Switzerland

	Dr Riaz Khan	Médecin adjoint, Suppléant du chef de service	Service d'addictologie, Geneva
	Dr Yves-Alexandre Kaufmann		Service d'addictologie, Geneva
8 February 2011	Professor Freya Vander Laenen	Director, Institute for International Research on Criminal Policy	University of Ghent, Belgium
	Ms Charlotte Colman	Department of Criminal Law and Criminology	University of Ghent, Belgium
	Ms Despina Spanou	Principal Adviser, Health and Consumers Directorate-General (SANCO)	European Commission, Belgium
	Mr Timo Jetsu	Policy Officer, Health and Consumers Directorate-General (SANCO)	European Commission, Belgium
	Professor Wouter Vanderplasschen	Department of Orthopedagogics	University of Ghent, Belgium
10 February 2011	Ms Karin Nilsson- Kelly	Section Head	Ministry of Health and Social Affairs, Sweden
	Professor Börje Olsson	Director, Centre for Social Research on Alcohol and Drugs (SoRAD)	University of Stockholm, Sweden
	Professor Jan Blomquist	Researcher, Centre for Social Research on Alcohol and Drugs (SoRAD)	University of Stockholm, Sweden
	Dr Jessica Storbjork	Researcher, Centre for Social Research on Alcohol and Drugs (SoRAD)	University of Stockholm, Sweden
	Professor Sven Andreasson	Director, Alcohol and Drugs Division	National Institute for Public Health, Sweden
	Professor Ted Goldberg	Professor of Social Work	University of Stockholm, Sweden

APPENDIX FOUR

LEGISLATION

List of Legislation used in the Inquiry.

Legislation	State (or Country)
Alcohol and Drug Authority Act 1974	Western Australia
Alcohol And Drug Authority Repeal Bill 2005	Western Australia
Butane Products Control Bill 2009	Western Australia
Cannabis Control Act 2003	Western Australia
Cannabis Law Reform Act 2010	Western Australia
Cannabis Law Reform Bill 2009	Western Australia
Drug Summit Legislative Response Act 1999	New South Wales
Misuse of Drugs Amendment Bill (No. 2) 2010	Western Australia
Poisons Act 1964	Western Australia
Young Offenders Act 1994	Western Australia

APPENDIX FIVE

NUMBER OF PATIENTS WITH VALID C-POP AUTHORISATION AND DOSING IN A CALENDAR YEAR (1997-2010)#538

Year	Methadone	Subutex	Suboxone	TOTAL
	No of Patients	No of Patients	No of Patients	No of Patients
1997	384	N/A	N/A	**384**
1998	1,328	N/A	N/A	**1,328**
1999	2,015	N/A	N/A	**2,015**
2000	2,196	N/A	N/A	**2,196**
2001	1,940	255	N/A	**2,109**
2002	1,732	1,139	N/A	**2,662**
2003	1,966	1,436	N/A	**3,149**
2004	2,867	1,937	N/A	**3,407**
2005	2,438	1,447	N/A	**3,637**
2006	2,403	1,137	804	**3,528**
2007	2,469	276	1,062	**3,531**
2008	2,595	229	1,200	**3,726**
2009	2,756	189	1,359	**3,974**
2010	2,678	171	1,315	**3,919**

A patient may be counted more than once in a calendar year if authorised and dosing during that year with more than one C-POP medicine. Dosing data from community participating pharmacies for 1997 and 1998 was not complete.

538 Ms Joy Knight, Department of Health, Electronic Mail, 10 March 2011, p1.

APPENDIX SIX

COMMUNITY PHARMACOTHERAPY OPIOID PROGRAM-APPROVED PRESCRIBERS (1997, 2003, 2010)# [539]

Area Health Service	Area Health District	1997	2003	2010
North Metro AHS	Oceanic	4	15	21
	Stirling SEC	2	5	5
	Joondalup	2	3	1
	Wanneroo	0	2	1
	Bayswater-Bassendean	0	3	3
	Valley and Hills	0	1	5
	Kalamunda	0	1	0
	Stirling Coastal	0	1	0
	Armadale	1	1	4
South Metro AHS	Bentley	1	5	4
	Fremantle	5	7	5
	Peel	1	4	8
	Rockingham-Kwinana	3	3	1
WA Country HS	Blackwood	0	0	1
	Bunbury	1	5	5
	Busselton	2	4	3
	Central Great Southern	0	0	0
	East Pilbara	0	1	2
	Eastern Wheatbelt	0	0	0
	Gascoyne	0	2	1
	Geraldton	1	1	10
	Kimberley	0	0	1
	Leeuwin	0	1	1
	Leschenaults	0	0	0
	Lower Great Southern	2	2	4
	Midwest	1	0	0
	Murchison	0	0	0
	Northern Goldfields	0	2	1
	South East Coastal	0	2	3
	Southern Wheatbelt	0	0	1
	Warren	0	0	0
	Wellington	0	0	0
	West Pilbara	0	2	1
	Western Wheatbelt	0	0	1
	Total	**26**	**73**	**93**

Some towns such as Geraldton show a large jump in number of prescribers but DoH said that this is due to "a prescriber is counted at each medical practice they work from, if they treat patients at more than one practice then they will be counted at each site."

[539] Ms Joy Knight, Department of Health, Electronic Mail, 10 March 2011, p1.

APPENDIX SEVEN

APPROVED C-POP DOSING SITES BY AREA HEALTH DISTRICT (1997, 2003, 2010)#540

Area Health Service	Area Health District	1997		2003		2010	
		Total	*Active*	Total	*Active*	Total	*Active*
North Metro AHS	Oceanic	3	***3***	18	***11***	37	***23***
	Stirling SEC	6	***3***	16	***16***	23	***19***
	Joondalup	3	***2***	8	***8***	15	***11***
	Wanneroo	2	***1***	4	***4***	14	***12***
	Bayswater-Bassendean	5	***2***	8	***7***	1-	***9***
	Valley and Hills	3	***1***	1-	***7***	14	***1-***
	Kalamunda	-	***-***	4	***3***	7	***3***
	Stirling Coastal	4	***3***	6	***6***	12	***11***
	Armadale	6	***1***	11	***1-***	15	***11***
South Metro AHS	Bentley	3	***1***	14	***12***	26	***2-***
	Fremantle	4	***2***	18	***13***	33	***27***
	Peel	4	***3***	6	***4***	11	***1-***
	Rockingham-Kwinana	4	***3***	8	***8***	17	***1-***
WA Country HS	Blackwood	1	***-***	3	***1***	5	***1***
	Bunbury	2	***1***	3	***2***	7	***6***
	Busselton	1	***-***	2	***2***	6	***6***
	Central Great Southern	-	***-***	2	***2***	2	***2***
	East Pilbara	1	***-***	2	***1***	4	***3***
	Eastern Wheatbelt	-	***-***	2	***1***	6	***3***
	Gascoyne	1	***-***	2	***1***	2	***2***
	Geraldton	-	***-***	1	***1***	4	***4***
	Kimberley	1	***-***	4	***3***	5	***4***
	Leeuwin	-	***-***	1	***1***	3	***3***
	Leschenaults	-	***-***	3	***3***	3	***2***
	Lower Great Southern	4	***2***	7	***6***	8	***7***
	Midwest	-	***-***	2	***1***	4	***2***
	Murchison	-	***-***	-	***-***	-	***-***
	Northern Goldfields	2	***1***	4	***3***	6	***5***
	South East Coastal	1	***-***	3	***3***	5	***1***
	Southern Wheatbelt	-	***-***	1	***1***	5	***2***
	Warren	2	***1***	4	***2***	5	***2***
	Wellington	-	***-***	1	***1***	1	***1***
	West Pilbara	-	***-***	4	***3***	5	***1***
	Western Wheatbelt	-	***-***	1-	***7***	13	***6***
	Total	**63**	***3-***	**192**	***154***	**333**	***239***

540 Ms Joy Knight, Department of Health, Electronic Mail, 10 March 2011, p1.

APPENDIX EIGHT

C-POP MEDIAN DOSES (1997-2010)[541]

Year	Methadone Dose (mg)	Subutex Dose (mg)	Suboxone Dose (mg)
1997	54.0	N/A	N/A
1998	46.0	N/A	N/A
1999	45.0	N/A	N/A
2000	44.0	N/A	N/A
2001	42.0	8.0	N/A
2002	41.0	15.0	N/A
2003	45.0	15.0	N/A
2004	46.0	14.0	N/A
2005	48.0	14.0	N/A
2006	49.0	14.0	12.0
2007	50.0	10.0	12.0
2008	52.0	10.0	12.0
2009	54.0	12.0	14.0
2010	53.0	12.0	14.0

541 Ms Joy Knight, Department of Health, Electronic Mail, 10 March 2011, p1.

APPENDIX NINE

CURRENT C-POP AUTHORISATIONS#542

No of Years	Methadone		Subutex		Suboxone	
	No of Patients	Median dosing months	No of Patients	Median dosing months	No of Patients	Median dosing months
<1	226	2.0	14	2.0	336	1.0
1	231	11.0	14	10.0	233	11.0
2	191	23.0	6	28.5	149	24.0
3	124	35.0	3	37.1	154	36.0
4	127	47.0	7	47.0	373	51.1
5	126	60.0	13	59.0	N/A	N/A
6	139	72.0	12	74.0	N/A	N/A
7	116	83.0	10	84.1	N/A	N/A
8	96	95.1	31	97.1	N/A	N/A
9	82	109.1	15	104.1	N/A	N/A
10	211	120.1	N/A	N/A	N/A	N/A
11	192	132.1	N/A	N/A	N/A	N/A
12	257	144.1	N/A	N/A	N/A	N/A
13	377	155.1	N/A	N/A	N/A	N/A
14	25	162.1	N/A	N/A	N/A	N/A

There might be a break for the patient in treatment during these years. The data presented does not include patients who may have been in treatment prior to 1997. This table does not include those patients transferred from Subutex to Suboxone in 2006.

542 Ms Joy Knight, Department of Health, Electronic Mail, 10 March 2011, p1.

APPENDIX TEN

PAIN PROPOSAL[543]

Dr Visser was requested to prepare a five-year business case for the resources required to optimise the pain services available in Western Australia. He indicated:

- an additional $4.97 million per annum was required if Western Australia was to match Queensland's population-based budget for pain services; and
- an additional $9.78 million per annum was required if Western Australia was to have an optimal pain service system.

The proposal outlines the following needs and approximate costs:

- develop four multidisciplinary tertiary pain medicine centres ('hubs') at Fremantle Hospital/Fiona Stanely Hospital, Sir Charles Gairdner Hospital, Royal Perth Hospital, and Joondalup Health Campus, and 'spoke' services at Rockingham General Hospital, Midland Health Campus, Armadale Health Service, Osborne Park Hospital and Bentley Health Services. The staffing requirements to do this would include: 8 pain medicine specialists, 4 pain medicine training positions, 8 clinical psychology positions, 8 physical therapists, 8 nurse practitioners, 2 psychiatry or other medical specialties, 2 Drug and Alcohol specialists and 8 administrative staff. **Staffing budget cost of $6,940,000 per annum**.
- fund introductory patient-centred pain education programs in addition to established comprehensive pain management programs. **Cost $1,400,000**.
- enhance and expand services to rural and remote patients with chronic pain and drug and alcohol problems by expanding *Telehealth* and outreach programmes to patients and health care professionals. **Salary costs of $200,000 per annum and one-off infrastructure costs of $100,000**.
- establish a combined pain medicine and drug and alcohol management programme for the timely and comprehensive review of complex patients with chronic pain and substance abuse problems. **Cost $400,000 per annum**.
- develop a real-time, computerised monitoring system for opioid prescribing and dispensing (similar to the pseudoephedrine monitoring system currently operating in pharmacies); real time access to 'doctor shopping' hotlines and DoH Department of Pharmaceutical Services (monitoring of schedule 8 drugs). **Not costed**.

---

543 Submission No. 74 from Dr Eric Visser, Pain Medicine Specialist, 19 October 2010, pp1-10.

- Enhance the Community Programme for Opioid Pharmacotherapy (C-POP), making it more accessible and totally *cost free* for patients who require supervised dispensing of opioids for pain or substance abuse. **Not costed**.

REFERENCES

Australian Broadcasting Corporation. (2011) 'Call for Kronic Smokers to be Sacked'. Available at: www.abc.net.au/news/stories/2011/05/12/3215252.htm?site=perth. Accessed on 12 May 2011.

Australian Broadcasting Corporation. (2010) 'Oxy: The Hidden Epidemic', *4 Corners.* Available at: www.abc.net.au/news/video/2010/09/27/3023252.htm. Accessed on 15 December 2010.

Australian Broadcasting Corporation. (2006) 'Authorities Debate Naltrexone Use to Break Drug Addiction', *7.30 Report*. Available at: www.abc.net.au/7.30/content/2006/s1547424.htm. Accessed on 15 December 2010.

Australian Bureau of Statistics. (2011) *4530.0 Crime Victimisation, Australia, 2009–10*. Available at: www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/96D24600F95E026ACA257839000E060C/$File/45300_2009_10.pdf. Accessed on 21 February 2011.

Australian Bureau of Statistics. (2010) *3303.0 Causes of Death, Australia, 2008- Table 6.2 Underlying cause of death, All causes, Western Australia, 1999–2008*. Available at: www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/F04794356298C8CECA2576F60013375C/$File/3303.0_6%20underlying%20causes%20of%20death%20(western%20australia).xls#'6.2'!B9. Accessed on 2 December 2010.

Australian Crime Commission. (2010) *Illicit Drug Data Report 2008-09, Other Drugs*. Available at: www.crimecommission.gov.au/publications/iddr/index.htm. Accessed 16 December 2010.

Australian Crime Commission. (2009) *Illicit Drug Data Report 2007-08*. Available at: www.crimecommission.gov.au/publications/iddr/_files/2007_08/04heroin200708.pdf. Accessed on 3 December 2010.

Australian Drug Foundation. (2010) *Drug Education in Secondary Schools*. Available at: www.druginfo.adf.org.au/druginfo/fact_sheets/drug_education_approaches_in_s/drug_education_in_secondary_sc.html. Accessed on 15 December 2010.

Australian Drug Foundation. (2002) *Drug Education Approaches in Secondary Schools*. Available at: www.druginfo.adf.org.au/downloads/Prevention_Research_Quarterly/REP_No3_02Nov_Drug_education.pdf. Accessed on 15 December 2010.

Australian Government. (2006) *Response to Road to Recovery: Report on the Inquiry into Substance Abuse in Australian Communities*', Canberra.

Australian Institute of Criminology. (2010) *Drug Use Monitoring in Australia: 2008 Annual Report on Drug Use Among Police Detainees*. Available at: www.aic.gov.au/en/publications/current%20series/mr/1-20/09.aspx. Accessed on 16 November 2010.

Australian Institute of Health and Welfare. (2010) *Alcohol and Other Drug Treatment Services in Australia 2008–09.* Available at: www.aihw.gov.au/publications/hse/92/11500.pdf. Accessed on 10 December 2010.

Australian Institute of Health and Welfare. (2010b) *Alcohol and Other Drug Treatment Services in Australia: Report on the National Minimum Data Set*, Australian Government, Canberra.

Australian Institute of Health and Welfare. (2008) *2007 National Drug Strategy Household Survey: State and Territory Supplement.* Available at: www.aihw.gov.au/publication-detail/?id=6442468144. Accessed 23 December 2010.

Australian Institute of Health and Welfare. (2008b) *National Drug Strategy Household Survey 2007 - First Results*, Available at: www.aihw.gov.au/publications/phe/ndshs07-fr/ndshs07-fr-no-questionnaire.pdf. Accessed on 11 November 2010.

Australian Institute of Health and Welfare. (2008c) *2007 National Drug Strategy Household Survey- Detailed Findings.* Available at: www.aihw.gov.au/publications/phe/ndshs07-df/ndshs07-df.pdf. Accessed on 15 December 2010.

Australian Institute of Health and Welfare. (2008d) *AIHW Bulletin No 82: Medical Labour Force 2008*. Available at: www.aihw.gov.au/publications/aus/bulletin82/tables/12016_primary-care-practitioners.xls. Accessed on 8 November 2010.

Australian Institute of Health and Welfare. (2007) *The Burden of Disease and Injury in Australia 2003*. Available at: www.aihw.gov.au/publications/index.cfm/title/10317. Accessed on 21 February 2011.

Australian Institute of Health and Welfare. (2007b) *Recent Patterns of Alcohol, Tobacco and Other Drug Use*. Available at: www.aihw.gov.au/drugs/ndshs/recentuse.cfm. Accessed on 2 December 2010.

Australian Institute of Health and Welfare. (2007c) *Statistics on Drug Use in Australia 2006*. Available at: www.aihw.gov.au/publications/phe/soduia06/soduia06.pdf, p24. Accessed on 2 December 2010.

Australian Institute of Health and Welfare. (2005) *Perceptions and Acceptability of Drug Use.* Available at: www.aihw.gov.au/publications/phe/ndshsdf04/ndshsdf04-c01.pdf. Accessed on 2 December 2010.

Australian Institute of Health and Welfare. (2005b) *2004 National Drug Strategy Household Survey, State and Territory Supplement*. Available at:

www.aihw.gov.au/publications/phe/ndshs04sts/ndsh04sts.pdf. Accessed on 2 December 2010.

Centre for Health Program Evaluation, Monash University. (–) *Primary School Drug Education: An Evaluation of Life Education Victoria*. Available at: www.buseco.monash.edu.au/centres/che/pubs/rr02.pdf. Accessed on 15 December 2010.

Chan, K. (1996) 'The Singapore Naltrexone Community-Based Project for Heroin Addicts Compared with Drugfree Community–Based Program: First Cohort', *Journal of Clinical Forensic Medicine*, 1996, vol. 3, pp87-92.

Collins, D. & Lapsley, H. (2008) *The Costs of Tobacco, Alcohol and Illicit Drug Abuse to Australian Society in 2004/05*. Monograph Series no. 64. Commonwealth of Australia, Canberra.

Commonwealth of Australia. (2010) *National Drug Strategy*. Available at: www.nationaldrugstrategy.gov.au/. Accessed on 22 December 2010.

Commonwealth of Australia. (2007) *National Pharmacotherapy Policy for People Dependent on Opioids*. Available at: www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/pharmacotherapy. Accessed on 3 December 2010.

Degenhardt, L., Lynskey, M., & Hall, W. (2000) *Cohort Trends in the Age of Initiation of Drug Use in Australia*. National Drug and Alcohol Research Centre, University of NSW, Sydney.

Department of Education. (2010) *Evaluation*. Available at: www.det.wa.edu.au/sdera/detcms/navigation/for-schools/about-sdera/evaluation/#toc1. Accessed on 15 December 2010.

Department of Education, Science and Training. (2004) *Principles for School Drug Education*. Available at: www.det.wa.edu.au/redirect/?oid=com.arsdigita.cms.contenttypes.FileStorageItem-id-1815156&stream_asset=true. Accessed on 15 December 2010.

Dobbin, M. (2008) *Prevention of Pharmaceutical Drug Misuse: Non-Medical Use of Pharmaceutical Drugs*. Available at: www.druginfo.adf.org.au/newsletter.asp?ContentID=non-medical_use_of_pharmaceutical_drugs1. Accessed on 1 November 2010.

Drug and Alcohol Office. (2010) *Drug Trends and Crime Tracking: Relationships between Indices of Heroin, Amphetamine and Cannabis Use and Crime*, Government of Western Australia, Perth.

Drug and Alcohol Office. (2010) *Annual Report 2009-10*. Available at: www.dao.health.wa.gov.au/Publications/tabid/99/DMXModule/427/Default.aspx?EntryId=1186&Command=Core.Download. Accessed on 15 December 2011

Drug and Alcohol Office. (–) *The Western Australian Drug & Alcohol Strategy 2005 - 2009*. Available at: www.dao.health.wa.gov.au/Publications/tabid/99/DMXModule/427/EntryId/449/Command/Core.Download/Default.aspx. Accessed on 3 December 2010.

Drug and Alcohol Office. (2007) *WA Illicit Amphetamine Summit July 2007 - Background Paper*, Government of Western Australia, Perth.

Drug and Alcohol Office. (2007b) *Western Australia Illicit Amphetamine Summit July 2007: Government Action Plan*. Available at: www.dao.health.wa.gov.au/Publications/tabid/99/DMXModule/427/Default.aspx?EntryId=892&Command=Core.download. Accessed on 21 December 2010.

Drug and Alcohol Office. (2007c) *Statutory Review Cannabis Control Act 2003- Technical Report*. Available at: www.dao.health.wa.gov.au/Publications/tabid/99/DMXModule/427/Default.aspx?EntryId=935&Command=Core.Download. Accessed on 21 April 2010.

Drug and Alcohol Office. (2007c), *Statistical Bulletin, Amphetamine Type Stimulants, Western Australia*, Government of Western Australia, Perth.

Drug and Alcohol Office. (2007d) *Clinical Policies and Procedures for the Use of Methadone and Buprenorphine in the Treatment of Opioid Dependence*, Government of Western Australia, Perth. Government of Western Australia

Drug and Alcohol Office. (2005) *Western Australian Drug and Alcohol Strategy 2005 - 2009*. Available at: www.dao.health.wa.gov.au/Publications/tabid/99/DMXModule/427/EntryId/449/Command/Core.Download/Default.aspx. Accessed on 22 December 2010.

Drug and Alcohol Office. (2003) *2001 National Drug Strategy Household Survey- First Results for WA*. Available at: www.dao.health.wa.gov.au/Publications/tabid/99/DMXModule/427/Default.aspx?EntryId=544. Accessed 16 November 2010.

Drug and Alcohol Office. (2002) *About Benzodiazepines*, Government of Western Australia, Perth.

Drug Free Australia. (–) *The Kings Cross Injecting Room: The Case for Closure*. Available at: www.drugfree.org.au/fileadmin/Media/Reference/DFA_Injecting_Room_Booklet.pdf. Accessed on 26 April 2011.

Eliot, L. (2011) 'Major Drug Cartel Suspect Arrested', *The West Australian*, 2 April, p17.

Eliot, L. (2011b) 'Police Probe Overdose Death', *The West Australian*, 20 January, p10.

Eliot, L. (2010) '200 Charged after Drug Dob-in Push', *The West Australian*, 23 November, p10.

Emerson, D. and Boddy, N. (2011) 'Tougher Laws to Protect Children', *The West Australian*, 23 March, p10.

Federal Office of Public Health, Switzerland. (–) *Heroin-assisted Treatment (HAT)*. Available at: www.bag.admin.ch/themen/drogen/00042/00629/00798/01191/index.html. Accessed on 2 December 2010.

Gates, P. *et al*. (2009) *Barriers and Facilitators to Cannabis Treatment*, National Cannabis Prevention and Information Centre, University of New South Wales, Sydney.

Hall, W. & Degenhardt, L. (2009) 'Adverse Health Effects of Non-medical Cannabis Use', *The Lancet*, vol. 374, 17 October, pp1381-91.

Institute of Medicine of the National Academies. (2006) *Preventing HIV Infection among Injecting Drug Users in High Risk Countries: An Assessment of the Evidence*. Available at: www.iom.edu/Reports/2006/Preventing-HIV-Infection-among-Injecting-Drug-Users-in-High-Risk-Countries-An-Assessment-of-the-Evidence.aspx. Accessed on 16 May 2011.

Jacobs, G. (2009) *$500,000 Boost for Treatment of Heroin Dependency in Western Australia*. Available at: www.mediastatements.wa.gov.au/Pages/default.aspx?ItemId=131790&page=3. Accessed on 6 December 2010.

Jones, C. (2011) 'Drug Laws Debate Call Wins Support', *The West Australian*, 17 January, p17.

Knowles, G. (2011) 'Drug Cooks Dice with Danger', *The West Australian*, 22 March, p5

Large, M. *et al.* (2011) 'Cannabis Use and Earlier Onset of Psychosis- A Systematic Meta-analysis', *Archives of General Psychiatry*, 7 February, ppE1-7.

Leshner, A. *et al.* (1997) 'Addiction Is a Brain Disease, and It Matters', *Science*, Vol. 278, No.45, p46.

Life Education Australia. (2010) *History of Life Education Australia*. Available at: www.lifeeducation.org.au/about-life-education-australia/history. Accessed on 16 December 2010.

MacDonald, K. (2011) 'Drug Invisible to Mine Site Tests', *The West Australian*, 13 April, p3.

MacIntosh, J. & McKeganey, N. (2002) *Beating the Dragon: The Recovery from Dependent Drug Use*, Pearson Education Ltd, Essex.

McKeganey, N. (2011) *Controversies in Drugs Policy and Practice*, Palgrave McMillan, Hampshire.

McKeganey, N. *et al.* (–) 'Sociology and Substance Use', *Foresight Brain Science, Addiction and Drugs Project*, Office of Science and Technology, London.

Mattick, R. *et al.* (2009) *Methadone Maintenance Therapy Versus No Opioid Replacement Therapy For Opioid Dependence*. Available at: www2.cochrane.org/reviews/en/ab002209.html. Accessed on 2 December 2010.

Mattick, R. & Kreek, M. (2001) *Myths About Heroin Addiction*. Available at: www.abc.net.au/rn/talks/8.30/helthrpt/stories/s391783.htm. Accessed on 2 December 2010.

Miller-Sporrer, T. (2008) *Switzerland Voters Approve Permanent Heroin Assisted Treatment Program*. Available at: http://jurist.law.pitt.edu/paperchase/2008/12/switzerland-voters-approve-permanent.php. Accessed on 2 December 2010.

Millet, A. (2011) 'GPs Under Scrutiny for Misuse of Painkillers', *The West Australian*, 7 March. Available at: http://au.news.yahoo.com/thewest/a/-/breaking/8961562/gps-under-scrutiny-for-misuse-of-painkillers/. Accessed on 8 March 2011.

Ministerial Council on Drug Strategy. (2010) *The National Drug Strategy 2010–2015: Consultation Draft*. Available at: www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/E3AAD7FA931F0998CA2577DD0006E36C/$File/ndsdraft.pdf. Accessed on 22 December 2010.

Morton, H. (2011) *$1.5million Grant for Treatment of Alcohol and Other Drug Dependency*, Statement of Minister for Mental Health. Available at: www.mediastatements.wa.gov.au/Pages/WACabinetMinistersSearch.aspx?ItemId=138165&minister=Morton&admin=Barnett. Accessed on 22 December 2010.

National Centre in HIV Epidemiology and Clinical Research. (2010) *Australian NSP Survey National Data Report: 2005-2009*. Available at: www.nchecr.unsw.edu.au/NCHECRweb.nsf/resources/NSP_Complete2/$file/ANSP.NDR.2005_2009.pdf. Accessed on 9 December 2010.

National Drug and Alcohol Research Centre. (2010) *West Australian Trends in Ecstasy and Related Drug Markets 2009: EDRS*, NDARC Technical Report Number 52. NDARC, University of New South Wales, Sydney.

National Drug Research Institute. (2010) *WA Drug Trends 2009- NDARC Technical Report No. 43*. Available at: http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/resources/IDRSJurisdictionalReports/$file/WA_IDRS_2009.pdf. Accessed on 6 December 2010.

O'Leary, C. (2011) 'Program for Addicts Gets Additional $1.5m Funding', *The West Australian*, 23 March, p28.

O'Leary, C. (2010) 'Brain Injuries Blamed on Amphetamines', *The West Australian*, 7 September, p30.

Ramstrom, J. (2004) *Adverse Health Consequences of Cannabis Use: A Survey of Scientific Studies Published up to and Including the Autumn of 2003*, National Institute of Public Health, Sweden.

Ross, J. (2007) *Illicit Drug Use in Australia: Epidemiology, Use Patterns and Associated Harm*, National Drug and Alcohol Research Centre. Available at: www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/17B917608C1969ABCA257317001A72D4/$File/mono-63.pdf. Accessed on 2 March 2011

Royal Australasian College of Physicians. (2009) *Prescription Opioid Policy: Improving Management of Chronic Non-Malignant Pain and Prevention of Problems Associated With Prescription Opioid Use*, Royal Australasian College of Physicians, Sydney.

Santana, L. *et al.* (2007) *Working Out What Works 2007 - 16th Western Australian Drug and Alcohol Symposium*, 'Heroin Trends Tracking Project- The Relationship Between Heroin Trends and Crime in WA'. Available at: www.dao.health.wa.gov.au/Publications/tabid/99/DMXModule/427/Default.aspx?EntryId=968&Command=Core.Download. Accessed on 3 December 2010

Siggins Miller. (2009) *Evaluation and Monitoring of the National Drug Strategy 2004-2009: Final Report*. Available at: www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/consult-eval.

Social Development Committee. (2010) *Inquiry into Addressing Cannabis-Related Harm in Queensland, Report 10,* Government of Queensland. Available at: www.parliament.qld.gov.au/view/committees/SDC.asp?SubArea=inquiries. Accessed on 22 December 2010.

Styles, A. (2009) 'Teenager Dead after Drug Overdose at Big Day Out', *WA Today*, 2 February, Available at: www.watoday.com.au/wa-news/teenager-dead-after-drug-overdose-at-big-day-out-20090202-7v9v.html. Accessed on 2 March 2011.

Sydney Medically Supervised Injecting Centre. (2008) *Report on the Establishment or Trial of Safe Injecting Rooms*. Available at: www.sydneymsic.com/Bginfo.htm/report_on_the_establishment_or_trial_of_safe_injecting_rooms. Accessed on 3 December 2010

Tebbutt, C. (2010) *Medically Supervised Injecting Centre to Remain Open*. Available at: www.nswalp.com/blog/1096/medically-supervised-injecting-centre-to-remain-open. Accessed on 3 December 2010.

Teen Challenge. (2010) *Teen Challenge in WA*. Available at: www.teenchallengewa.org.au/welcome. Accessed on 16 December 2010.

United Nations Office on Drugs and Crime. (2011) *World Drug Report 2010*. Available at: www.unodc.org/unodc/en/data-and-analysis/WDR-2010.html, p188 & 194. Accessed on 11 November 2010.

United Nations Office on Drugs and Crime. (2010) *The Non-Medical Use of Prescription Drugs, Policy Direction Issues*. Available at: www.unodc.org/unodc/en/drug-prevention-and-treatment/non-medical-use-prescription-drugs.html. Accessed on 11 November 2010.

van Beek, I. (2008) *The Medically Supervised Injecting Centre- the First 7 Years*. Available at: www.sydneymsic.com/__data/assets/powerpoint_doc/0003/29433/MSIC_NDARC_07.ppt#311,2,Background. Accessed on 3 December 2010.

WA Police. (–) *Constable Care*. Available at: www.police.wa.gov.au/Youngpeople/ConstableCare/tabid/1577/Default.aspx. Accessed on 15 December 2010.

Weatherburn, D. (2009) 'What Really Happened to the Heroin Drought', *Sydney Morning Herald*, 22 June. Available at: www.smh.com.au/opinion/what-really-happened-to-the-heroin-drought-20090621-csik.html. Accessed on 2 December 2010.

White, D. & Pitts, M. (1998) 'Educating Young People About Drugs: A Systematic Review', *Addiction*, Vol. 10, October, p1484.

Wodak, A. (2009) *Germany has Just Approved Heroin Assisted Treatment- Should We?.* Available at: http://blogs.crikey.com.au/croakey/2009/06/01/germany-has-just-approved-heroin-assisted-treatment-should-we/. Accessed on 2 December 2010.