

*Drugs*  
*and our*  
*Community*

REPORT OF THE PREMIER'S DRUG ADVISORY COUNCIL  
MARCH 1996

**Joint Departmental Information Centre  
Cataloguing-In-Publication entry**

Victoria. Premier's Drug Advisory Council  
Drugs and our Community: Report of the Premier's Drug Advisory Council/  
Premier's Drug Advisory Council, March 1996. Melbourne: Victorian Government, 1996.

164 p.; 30 cm

Bibliography.

ISBN: 0 7306 9227 2

Cover title.

1. Drug utilization - Social aspects - Victoria. 2. Substance abuse - Victoria.

I. Title.

362.2909945

Report designed and produced by **O'SHEA SAUNDERS PTY. LTD.** Tel: (03) 9583 8827

Cover designed and produced by **ROYCE COMMUNICATIONS PTY. LTD.** Tel: (03) 9820 3733

# CONTENTS

1

<b>ACKNOWLEDGMENTS</b>	<b>i</b>
------------------------	----------

<b>OVERVIEW</b>	<b>iii</b>
-----------------	------------

2

<b>BACKGROUND</b>	<b>1</b>
-------------------	----------

<b>1.1</b>	COUNCIL ACTIVITIES	<b>1</b>
------------	--------------------	----------

<b>1.2</b>	COMMISSIONED WORK	<b>2</b>
------------	-------------------	----------

<b>ILLICIT DRUGS: CONTEXT AND FACTS</b>	<b>3</b>
---	----------

<b>2.1</b>	NATURE AND EXTENT OF TRAFFICKING AND USE	<b>4</b>
------------	--	----------

<b>2.2</b>	DETECTING MANUFACTURE, SUPPLY AND DISTRIBUTION	<b>29</b>
------------	--	-----------

<b>2.3</b>	PREVENTING USE AND REDUCING HARM	<b>40</b>
------------	----------------------------------	-----------

<b>2.4</b>	AUSTRALIAN AND INTERNATIONAL EXPERIENCES	<b>59</b>
------------	--	-----------

3

<b>CHALLENGES AND CHOICES FOR VICTORIA</b>	<b>65</b>
--	-----------

<b>3.1</b>	INTRODUCTION	<b>65</b>
------------	--------------	-----------

<b>3.2</b>	CURRENT KNOWLEDGE	<b>66</b>
------------	-------------------	-----------

<b>3.3</b>	DEMAND AND SUPPLY TRENDS	<b>68</b>
------------	--------------------------	-----------

<b>3.4</b>	DIFFERENT RESPONSES TO DIFFERENT DRUGS	<b>72</b>
------------	--	-----------

<b>3.5</b>	INFORMATION AND HEALTH EDUCATION	<b>77</b>
------------	----------------------------------	-----------

<b>3.6</b>	SUPPORT AND TREATMENT SERVICES	<b>87</b>
------------	--------------------------------	-----------

<b>3.7</b>	LAW ENFORCEMENT AND POLICING IN A HARM MINIMISATION STRATEGY	<b>100</b>
------------	--	------------

<b>3.8</b>	THE LAW	<b>105</b>
------------	---------	------------

<b>3.9</b>	INFRASTRUCTURE	<b>115</b>
------------	----------------	------------

4

<b>RECOMMENDATIONS</b>	<b>119</b>
------------------------	------------

<b>APPENDICES</b>	<b>135</b>
-------------------	------------



## Acknowledgments

---

The Premier's Drug Advisory Council has benefited greatly from the advice and assistance of many people and organisations. The intelligence and generosity that distinguished many contributions has made it possible for Council to successfully complete its work.

Council members want to particularly acknowledge and thank the staff who supported their work. Staff work was of the highest quality and always delivered against extraordinary demanding timelines.

Acknowledgment and thanks has been earned by Mr Kelvin Frost, Manager, Library Services, Australian Drug Foundation. His ready response to frequent requests for information and publications ensured Council always had access to relevant research and commentaries.

In addition, the Council and its Secretariat wish to thank the following organisations and their staff for regularly supplying data and information:

- Addiction Research Centre
- Australian Drug Foundation
- Department of Justice
- Drug Strategy and Operations Unit, Health and Community Services
- Mr David Rose, Epistle Post Release Service
- National Drug and Alcohol Research Centre
- Turning Point Alcohol and Drug Centre

Many Government and non-Government organisations were also of great assistance, but are too numerous to identify individually. While their assistance ensured needed information was available to Council, responsibility for the use and interpretation of data rests with the Council.

Council also spoke with many drug users and their families about the realities of addiction. Their willingness to discuss extremely difficult and personal issues enriched Council's understanding of the complex and intractable problems drugs raise for us all.



# OVERVIEW

Victorians are justifiably concerned about widespread misuse of drugs in our community. Experimentation among young people is widespread. Use of drugs such as cannabis and amphetamines is high by international standards, despite prohibitionist laws and a strong commitment to law enforcement.

Concerns have become apparent about increasing adolescent initiation into heroin, and the proliferation of intravenous administration of amphetamines and the use of derivatives of this group such as Ecstasy. Use of multiple drugs is common as the same criminal source may offer a variety of drugs. There has been an increase in the number of deaths directly attributable to illicit drug overdose in the past three years. These are all reasons for re-evaluation of policies and programs.

The Council was charged by the Premier with undertaking an intensive public investigation into illicit drugs and advising on how Victoria should tackle the problem. Some of the eight Council members had wide familiarity with the field, while others brought different experience and skills. Together we have examined the considerable body of evidence currently available in Australia and overseas, have consulted widely in the Victorian community, reviewed over three hundred written submissions, and have taken initiatives to explore issues with special groups and authorities.

The Council is conscious of many firmly held and divergent views on particular issues about illicit drugs in our society. We are also fully aware that no simple solution will solve what are, by their nature, long-standing and intractable problems. The issues must be tackled as a whole, as the many facets are interrelated. There are no easy answers.

The Council has come to a common view that changes are necessary to policies, legislation and services if we are to effectively contain the problems, and have the capacity, in time, to reduce the harm being caused to our community by drugs. If society is unwilling to consider change, many more individuals and families will be adversely affected in the future.

We appeal to the community to consider all our recommendations, covering a wide range of interrelated issues. We hope that agreement will be gained to the adoption of a significantly fresh approach. The recommendations put forward are the unanimous view of the Council, and were dictated by consideration of the large body of information and carefully considered views that we had before us.

The damage done by illicit drugs is widespread. It includes:

- Lives that are controlled by drug dependency.
- Many deaths due to drug overdose.
- Disruption of families by bereavement or grief due to a family member's dependence on illicit drugs.
- Family tensions created for loving parents by demands for money or the consequences, in many cases, of commitment of drug dependent people to lives of crime or prostitution.
- Effects on the wider community of crimes of theft, burglary, and instances of violence.
- Ever-present danger of corruption in our society because of the huge sums of money involved in the drug trade.
- Spreading of diseases such as HIV/AIDS, and hepatitis B and C in the community by intravenous drug administration under unsafe conditions. Rates of hepatitis C among injecting drug users are very high. This is in spite of the implementation of needle exchange programs in Australia which have contained the spread of HIV/AIDS more successfully than almost any other country.
- The economic costs to society of law enforcement and imprisonment.

While the number of deaths attributable to alcohol or tobacco in any year is far greater than those due to illicit drugs, the problems of illicit drugs are feared and clouded, in many people's minds, by moral considerations. Many Victorians find it difficult to consider pragmatic approaches to measures designed to reduce the harm being caused. However, the Government's and Council's over-riding concern must be to reduce the harm drugs cause to people, to families and to our community.

Victoria and Australia have led most of the world in enlightened responses to the problems of abuse of alcohol and tobacco, but our approach to the illicit drugs has lagged in terms of innovation. Until the 1970s, public drunkenness was seen as a major community problem, but with the introduction of widespread school and public education, and changes in policing, major advances have been made. Public advertising and roadside testing for alcohol has achieved major improvement in the number of road deaths related to alcohol.

In contrast, the widespread use of marijuana, because it is illicit, has not been subject to any education programs to help people to distinguish use from misuse. Twelve per cent of all Victorians have used marijuana in the past year and the proportion is much higher among young people. Community concerns about the risks associated with driving under the influence of marijuana (and other drugs) supports development of education and law enforcement programs similar to drink driving campaigns and programs.

Deaths attributable to drug overdose now approach, in number, the deaths due to traffic accidents.

The use of agents that alter mood has a long history in human society. Records or evidence of use of the opium poppy, of marijuana and of alcohol go back over thousands of years. Concern over international trafficking in narcotics, (particularly those derived from opium, cocaine and cannabis) has resulted in the adoption of successive international treaties, the first of which was in the early years of this century. These were subsumed by the United Nations in 1949. Subsequent treaties have bound signatories to ensure that trafficking, possession, and use of stipulated drugs is treated as a criminal offence.

Australia has ratified acceptance of these treaties in 1953, 1967 and again in 1993. State by State, legislation has been enacted at various stages, although some differences have emerged over the past eight years, particularly in respect of marijuana. Italy and Spain have moved away from criminal sanctions for the use of all drugs in recent years. The Netherlands has not changed its laws, but it imposes no penalty for use or sale of marijuana.

The international community has attempted to curb production and trafficking in cocaine and opium (from which heroin is derived). However, evidence provided by United Nations agencies indicates that production of these drugs continues to increase and that it represents a major portion of the economies of a number of South East Asian and South American countries. Producers continue to search for new outlets through thriving international criminal networks that control a black market.

Contemporary Australian assessments indicate that law enforcement agencies, despite rigorous efforts, are having only a relatively small impact on the availability of drugs.

## THE ECONOMICS OF TRADE IN ILLICIT DRUGS

---

Estimates of global annual turnover in the illicit drug industry are of the order of \$US400 to 500 billion and approach 10 per cent of the total value of international trade! A report of the Parliamentary Joint Committee on the National Crime Authority in 1988 estimated the annual turnover in Australia for heroin, cocaine and cannabis alone to be \$2.6 billion. Despite their illicit status and vigorous efforts at law enforcement, drug seizures are simply responded to by the black market with replacement supplies and/or rising prices.

The cost to our economy of illicit drugs in Australia is estimated to be of the order of 0.5 per cent of GDP. In the USA, it has been estimated that the average economic cost to the community of a dependent heroin user was \$US43,000 per year. Incarceration costs \$45,000 per year; by comparison, residential care in a treatment facility costs \$16,500 per year, and methadone maintenance in the community \$3,500 per year. The costs in Victoria are similar in Australian dollars.

With goods and money moving more readily around the world every year as trade increases, there is no possibility that interdiction of supply will solve drug problems in our community. The Parliamentary joint committee cited above concluded:

*'Over the past two decades in Australia we have devoted increased resources to drug law enforcement, we have increased the penalties for drug trafficking and we have accepted increasing inroads on our civil liberties as part of the battle to curb the drug trade. All the evidence shows, however, not only that our law enforcement agencies have not succeeded in preventing the supply of illicit drugs to Australian markets, but that it is unrealistic to expect them to do so. If the present policy of prohibition is not working then it is time to give serious consideration to the alternatives, however radical they may seem.'*

Mr George Schultz, former Secretary of State in the USA, said in 1990, that the 'war against drugs', as then conceived, was doomed to fail and that '... we need at least to consider and examine forms of controlled legalisation of drugs' (*The Wall Street Journal*, October 27).

In an address to the recent international drug-related harm reduction conference, the Secretary General of Interpol, Mr Ray Kendall, said he was 'entirely supportive of the notion of removing the abuse of drugs from the penal realm in favour of other forms of regulation such as psycho - medical - social treatment'. He went on to state that 'the dollar you spend on demand reduction is seven times more cost effective than the dollar you spend on law enforcement'.

The General Accounting Office of the United States Government, in 1993, released a review entitled *Confronting the Drug Problem: Debate Persists on Enforcement and Alternative Approaches*. The study canvassed a wide range of possible approaches, including the establishment of a regulated market for marijuana, while continuing prohibition for other, more addictive, illicit drugs.

In 1994, a Commonwealth Department of Human Services and Health publication set out five legislative options for cannabis in Australia that ranged through the system of fines currently applicable in South Australia and the ACT, and decriminalisation of varying degrees, to regulated supply and free markets. Many are searching for solutions, few have been willing to adopt them.

Cannabis products are readily available in the community to those who choose to use them. The estimated turnover of this trade in Australia was \$1.9 billion in 1988. Victoria probably contributes between twenty to twenty five per cent of this figure.

Decriminalisation of cannabis cultivation for personal use, within the context of the home environment where a family chooses such a course, would diminish the link with other more damaging and addictive illicit drugs. However, any such change must be made in conjunction with the provision of appropriate education and public advice on the dangers of abuse of the drug, and appropriate penalties for dangerous use.

The Council is not of the view that we should lessen efforts to control trafficking, but rather that we should look afresh at strategies that might curb demand and reduce the harm caused in society by the use of illicit drugs. These entail:

- Mobilisation of virtually every sector of our community to gain a better understanding of the nature of the problems, and to improve collaboration at the local level between all involved in tackling the problem.
- Development of school based education programs about the misuse of licit and illicit drugs so that young people are encouraged to keep control of their own destinies and to protect their minds and bodies.
- Better understanding of the issues by parents so they can discuss them constructively with their children, while recognising that many young people may be subject to peer pressure to experiment with 'exciting' or 'dangerous' practices.
- New approaches in the country as a whole, and at the level of each local community to help young people who have never found employment, who see no long-term future for themselves as constructive contributors to society, and who are particularly vulnerable to the seductive 'excitement' associated with drugs.
- Further development of the services that are available to support people with drug dependency, particularly those that offer the possibility of removal from a life of frequent crime and unsafe intravenous drug administration and treatment that offers the possibility of escaping completely from dependency on drugs.
- Improvement in services for young people who have begun on the path to drug dependency, but for whom there is a real possibility of rehabilitation with appropriate support. To this end, Council proposes the establishment of a Youth Substance Abuse Service to support the important contribution of youth workers already in the community.
- Development of research and evaluation capabilities so that services for the care and rehabilitation of drug-dependent people are based on dispassionate assessment of their effectiveness. This should be achieved through establishing an Agency for Drug Dependency based on development of existing services and offering support to the many valuable voluntary sector agencies which provide support in this field.
- Improvement in the quality of advice to the courts and enhanced capacity to ensure treatment required by the courts is delivered by a competent organisation and with appropriate supervision. This would not diminish the obligations on the courts to deal with criminal offences on their merits.
- Acknowledging the achievements of the Victorian methadone program, which is recognised nationally and internationally to be effective. The program should be researched more fully and the means explored by which it can be improved.

- Development of proposals to trial new drugs that may offer other options in treatment, additional to methadone, in support of those with dependency and in the course of rehabilitation from dependency. This should not diminish the importance of the role of programs using non pharmacological means of rehabilitation.
- Elimination, as an offence, of personal possession and use of marijuana. This would enable police and court resources to be redirected to more effective community policing and law enforcement against drug trafficking across the range of illicit drugs, including other more potent cannabis products.
- Growing of up to five plants per household for personal use would also no longer be an offence. This should apply to a normal residence, but should not apply to schools, colleges or public institutions.
- Trafficking in marijuana and trafficking, possession and use of the more potent cannabis products and other currently illicit drugs should remain as offences.
- Regulation, by local authorities, of marijuana smoking in public places. Offensive behaviour, should it occur, would be dealt with by police under the current law.
- Ensuring police are able to deal with dangerous driving under the influence of drugs, including marijuana. Both P- and L-plate drivers, if convicted of driving dangerously, recklessly or carelessly while impaired by marijuana, should be automatically disqualified for an extended period and required to participate in education programs. Protocols should be drawn up to assist in the policing of these provisions.
- Research and development being funded to establish a test for short-lived metabolites of cannabis products in breath or in saliva. This would allow the introduction of roadside testing for cannabis in a manner comparable to alcohol breath testing.
- Reviewing sentencing patterns and levels of penalties to ensure trafficking penalties are appropriate to the crime.
- Recognising the achievements of practitioners, researchers and communities in the field of harm minimisation and related community development by the creation of an annual award.

The emphasis in this report is on reducing demand, encouraging treatment, support and rehabilitation where possible, and concentrating law enforcement resources to curb the supply of all illicit drugs in local communities and statewide. An appropriate balance between these aspects is essential if the harm being done to society is to be minimised, and the important achievements of the Victorian and National Drug Strategies of the past 10 years are to be built upon.

The recommendations for an escalating sequence of responses to possession and use of the remaining illicit drugs, commencing with a formal warning by police, are designed to foster education and the potential for rehabilitation rather than punishment. Our recommendations are closer to practice in Singapore and Sweden (where obligations to education, treatment and rehabilitation are handled outside the court system) than those in the USA. While there would be less rigorous supervision in our community in the first instance than in Singapore, for example, there would be sanctions for the courts to fall back on and more severe penalties if necessary.

Few people are currently committed to prison in Victoria for possession and use of illicit drugs alone, although many arrests and charges are brought before the courts on this basis. For the courts to be comfortable with the use of formal warnings by police and educational programs in the first instance, it will be necessary to expand facilities for treatment, supervision, counselling and rehabilitation in the community. Specialist assistance, monitoring, research and leadership will be provided through the new Agency for Drug Dependency.

The proposed changes to penalties largely reflect what is current practice with respect to sentencing in Victoria for possession and use of illicit drugs. However, they have the potential to make the processes for dealing with drug users far more effective, and reduce the court time devoted to these offences.

The proposed review of sentencing by the courts for offences of trafficking in illicit drugs should assist all the courts to focus more directly on this critical aspect of the State's response to illicit drugs.

In view of the intersectoral and interdisciplinary nature of the problems associated with drugs of dependence (which involve activities associated with Health and Community Services, Education, Police, Corrections, the courts, many voluntary agencies and a number of the professions), it is recommended that an expert reference group, akin to the current Council, play a role in advising the Premier, through a unit within his Department, during a period in which the Council's recommendations are being implemented.

A number of further recommendations are contained in the body of the report. The fact that they are not included in this overview in no way diminishes their importance. Those selected above give the sense of direction of the recommendations to guide debate and assist the reader in understanding the considerable volume of information contained in the report.

**David Penington** A.C.



The Premier's Drug Advisory Council was established in December 1995 to conduct an intensive public investigation into the trade and use of illicit drugs in Victoria. The terms of reference and membership of the Council are set out in appendices 1 and 2 of this report.

The Council was required to provide the Government with as detailed a picture as possible about the use of illicit drugs and the impact they are having, or could have, on Victorians. The Government has sought advice on ways to respond to the supply and demand for illicit drugs. These responses could include legislative and law enforcement as well as preventive, support and treatment initiatives. The Council was asked to put its advice about the current situation and its proposals for the future in the context of international and Australian experience.

## 1.1

### Council Activities

The Council undertook a range of activities to ensure that it maximised the opportunity for community and expert input. Major activities included:

- Advertisements calling for community and expert submissions to the Council were placed in the major metropolitan newspapers on 16 December 1995 and the deadline for written submissions was extended to 12 January 1996.
- Briefings were held with representatives from key government agencies.
- Eight public hearings were held in metropolitan Melbourne and regional Victoria during January 1996.
- An issues paper outlining key questions being considered by the Council was circulated at the public hearings and feedback was invited.
- Four specialist forums were conducted by organisations on behalf of the Council.
- The Council met with organisations involved in local community initiatives, local government representatives and individual drug users.
- Australian and international experts were consulted by the Council regarding prevalence of drug use, demand and supply of illicit drugs, legislation, law enforcement, treatment options, education and community development and international experiences.

An overview of the public hearing process is detailed in appendix 3. Some of the individuals and organisations that contributed to the Council's work asked for anonymity, or that their material be kept confidential. The Council has respected these requests and their contributions, while useful to the Council, are not acknowledged in this document. A list of submissions is provided in appendix 4.

## Commissioned Work

External bodies with specific expertise were commissioned by the Council to undertake work in selected areas. In brief, the work undertaken included:

### AUSTRALIAN INSTITUTE OF CRIMINOLOGY

- Preparing material outlining the current status of illicit drug use in Victoria and Australia, and analysing trends and comparing our situation to relevant overseas experience.
- Preparing material regarding policy options with regard to the range of supply management and law enforcement options.

### AUSTRALIAN DRUG FOUNDATION

- Reviewing existing education campaigns nationally and internationally, and designing a comprehensive and sustained strategy for consideration by the Council.

### SCHOOL OF PUBLIC HEALTH AND COMMUNITY MEDICINE, UNIVERSITY OF MELBOURNE

- Reviewing treatment options and their effectiveness. This work included any relevant contextual requirements and comment on their application in Victoria.

The Council's terms of reference require it to consider issues and options relating to illicit drugs. Figure 1 categorises and briefly describes a range of drugs, both licit and illicit. It is important to recognise that the illicit drugs are, in functional terms, the same as legal drugs. Alcohol and tobacco have a considerably greater health impact because of their widespread use.

**FIGURE 1** CATEGORISATION OF DRUG TYPE

CATEGORY	DESCRIPTION
<b>Depressants</b>	• Alcohol
	• Cannabis
	• Heroin (opiate and product of the opium poppy - along with opium, morphine and codeine)
	• Inhalants (and also volatile substances; for example petrol, glue, lighter fluid, textas)
	• Tranquillisers and sedatives (including benzodiazepines, e.g. Valium, Serapax)
<b>Stimulants</b>	• Amphetamines (speed)
	• Cocaine
<b>Hallucinogens</b>	• Cannabis
	• Ecstasy
	• Ketamine
	• LSD
	• Magic mushrooms
	• Mescaline (peyote cactus)
<b>Other Drugs</b>	• Anabolic steroids
	• Tobacco

Throughout the consultation process, the Council received comment about the use and dangers of inhalants, misuse of legal drugs (principally pharmaceuticals), and anabolic steroids. While recognising the importance of these problems and the overlapping issues regarding the causes of drug use, educational opportunities and treatment strategies, the Council has focused on five major drugs:

- Heroin
- Cannabis
- Amphetamines
- Cocaine
- Ecstasy and designer drugs

Council is also aware that misuse of inhalants is a problem with very young adolescents and can have seriously detrimental effects on their health. The misuse of legal substances legally available has not been a major focus of this inquiry.

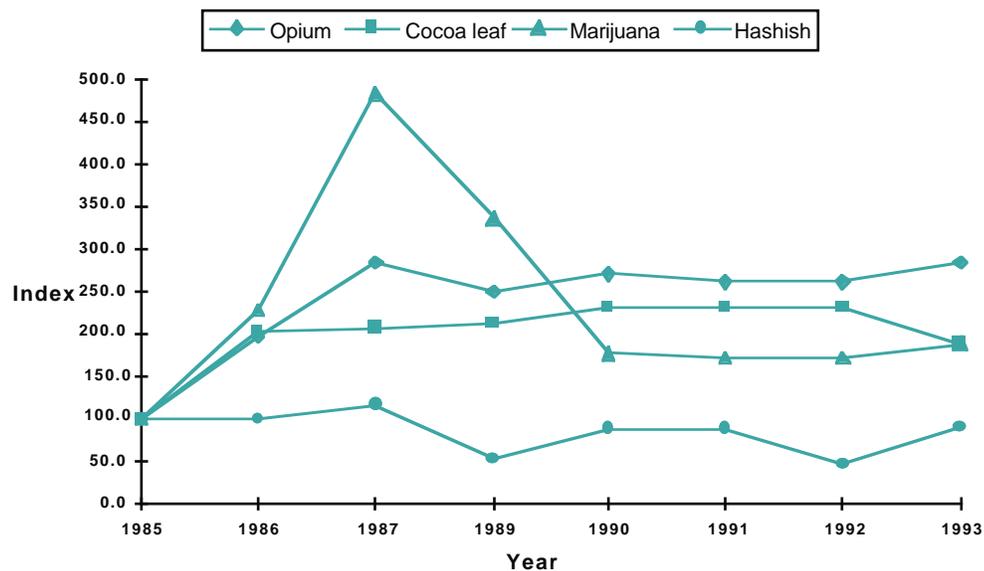
The Premier's Drug Advisory Council is not the first such body to address these issues in Australia. During the 1970s and 1980s in particular, there was a series of commissions and inquiries into drugs; the most relevant are listed in appendix 5. A number of common themes were addressed by these bodies, including investigation of the importation and distribution of illicit drugs, the consequences of illicit drug usage, law enforcement, and treatment options. In addition, most also examined the dimensions and consequences of licit drug use, in particular tobacco and alcohol.

## 2.1 Nature and Extent of Trafficking and Use

### 2.1.1 SOURCES OF ILLICIT DRUGS

In 1995, the United Nations (UN) Economic and Social Council's *Interim Report: Economic and Social Consequences of Drug Abuse and Illicit Trafficking*, commented that although there are no universally accepted figures on illicit drug production, trends indicate that worldwide production is expanding. The trends in global production from 1985 to 1993 are presented in figure 2. These data suggest that global coca and cannabis production, after rising dramatically in the 1980s, has levelled and decreased in the 1990s. In contrast, global production of opium (from which heroin is derived) is still rising.

**FIGURE 2 TRENDS IN GLOBAL PRODUCTION OF ILLICIT DRUGS, 1985–1993 (INDEX 1985 = 100)**



Source: United Nations Economic and Social Council, March 1995.

The overwhelming majority of illicit drugs consumed today are plant products, or plant products that have undergone some semi-synthetic processes. Illicit crop cultivation is concentrated in certain geographic areas, but it frequently shifts within, and sometimes between, continental subregions. Synthetic drug markets are, however, developing rapidly. The Australian Bureau of Criminal Intelligence (ABCI) details the major sources of illicit drugs in Australia in the *1994 Australian Illicit Drug Report*. The information is summarised in the following section. The 1995 report will be available in the later part of 1996.

## CANNABIS

Most of the world's cannabis is produced in Lebanon, Pakistan, Afghanistan and Morocco, which together in 1993 produced an estimated 1150 tonnes of cannabis resin (hashish). However, the vast bulk of cannabis consumed in Australia is grown locally in open-air plantations, or in indoor hydroponic nurseries. Supplies of concentrated cannabis products (hashish and oil) come mainly from South-East Asia. The most common importation method is by mail and larger quantities arrive as sea or air shipments. Smaller quantities are carried by individual couriers.

## HEROIN

The four main areas of opium production affecting Australia include:

- The 'Golden Triangle' (Burma, Laos and Thailand).
- The 'Golden Crescent' (Pakistan, Afghanistan and Iran).
- The Middle East (including Lebanon).
- The Andean Region (Colombia, Peru and Bolivia). Although Mexico and Colombia also produce opium, the ABCI reported in 1995 that there were no indications that this heroin has reached Australian markets (ABCI, 1995).

Worldwide production of heroin in 1993 was estimated to be 3699 tonnes. The Golden Triangle was the largest single producer at 2797 tonnes (UN Economic and Social Council, 1995). About 80 per cent of heroin seized in Australia can be traced to the Golden Triangle. There is evidence that suggests that much heroin now comes to Australia from Burma through China to Hong Kong, rather than via Thailand. In addition, Vietnam is also emerging as a transit country for heroin. Heroin is imported by a number of methods that include individual couriers, concealed in cargo and on ships disguised as fishing vessels, and on light aircraft using the northern Australian coastline.

## AMPHETAMINES

Amphetamines are generally locally produced in clandestine laboratories and only very small amounts are imported into Australia. Law enforcement strategies have targeted illegal laboratories that are sometimes found in rural areas. Twenty-nine clandestine laboratories were detected making amphetamines in Australia during 1994. In Victoria, nine laboratories were located in rural locations and two in suburban Melbourne (ABCI, 1995).

Amphetamine production requires the supply of essential chemical precursors that are available legally in Europe and the USA. Most jurisdictions in Australia have introduced legislation to control access to these chemicals. Interstate distribution is by truck, car or motorcycle, as well as by domestic air travel. Jurisdictions also report use of courier and postal services to distribute amphetamines. Evidence put to the Council suggests that some motorcycle gangs are involved in the manufacture and distribution of amphetamines throughout Australia, although it is clear that production and distribution also occurs through other channels.

## OTHER DRUGS

The world's supplies of cocaine are nearly all produced in South America. Level of importation of cocaine into Australia remains low compared with other illicit drugs. Cocaine reaches Australia mainly by being imported via the USA and/or Europe. This adds to the cost of the drug. LSD is produced in clandestine laboratories in the USA, United Kingdom and the Netherlands and there is no evidence of manufacture in Australia. It is easily imported because of its small form, usually tablet. There were a number of new developments in the illicit drug trade in Australia during 1994 with emerging drugs including Nexus, PMA, Cloud 9-Yohimbix 8, Ketamine, GBH. It has been suggested that the range of designer drugs is likely to increase.

### 2.1.2

#### PRICE AND PURITY

---

Due to its illegal nature, the quality, composition and purity of street drugs is unknown and can be highly variable. There is no mechanism for ongoing monitoring of prices and purity levels. Heroin purity is generally measured as the percentage of heroin in a given sample. In its pure form, heroin is relatively non-toxic to the body and causes little damage to body tissue and other organs. It is however highly addictive and, depending on dose, can arrest breathing. Street heroin is usually a mixture of pure heroin and other substances known as cutting agents such as talcum powder, baking powder, starch, glucose or quinine. These additives can be highly toxic and can cause chronic health problems. Their presence also contributes to accidental overdose and death as a result of users being unaware of the level of purity of the heroin they are using. Information provided to the Council indicates that heroin is currently readily available in Victoria at relatively low prices. Drugs seized by the Victoria Police are analysed to determine their purity, packaging and additives. This information is often used as evidence in contested court cases and is not generally available to the public.

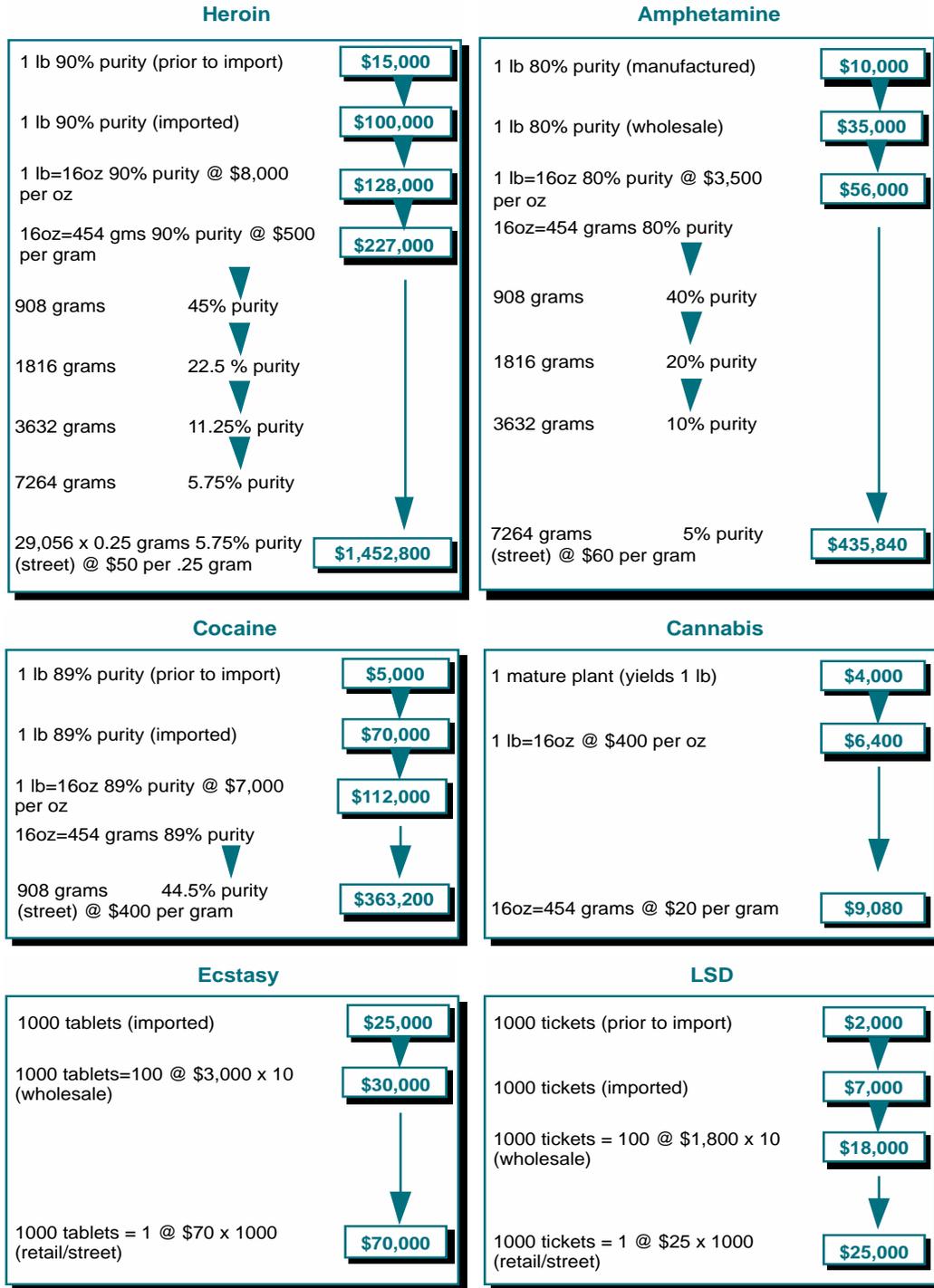
Purity levels are also variable in other types of illicit drugs. For example, the level of delta-9-tetrahydrocannabinol (THC), the primary psychoactive constituent in cannabis, can result in differing effects on the user. Hashish has a high level of psychoactive potency and more concentrated levels can have more extreme effects. Cannabis products available in an unregulated market will invariably have a range of THC levels. As a result, the majority of users will not be aware of the potency of the product and will therefore be at some degree of risk.

Amphetamines are also available in differing levels of purity and can be mixed or 'cut' with other substances. The quality of amphetamines varies slightly from state to state and, particularly at the street level, the level of purity is generally low. This suggests greater demand and the practice of adulterating the amphetamine to meet this demand (ABCI, 1995). The effect of controls on the necessary chemical precursors may also influence the level of purity, and results from a need to further 'cut' the product to maintain a constant supply. Very little is known about the level of purity of cocaine in Australia. As with heroin and amphetamines, cocaine is also available in varying levels of purity.

It has been estimated that more than 90 per cent of the value added (gross profit) of cocaine and heroin is generated at the distribution stage of the illicit drug industry (UN Economic and Social Council, 1995). Figure 3 charts the transaction profit of the major illicit drug types under review. It shows the value added to a given quantity of specific illicit drugs at each stage of the distribution

process. Prior to importation, one pound of 90 per cent pure heroin is worth approximately \$15,000. The value added to this quantity of heroin accumulates during the importation and distribution phases and, depending on the final level of purity, this original amount of heroin could be worth as much as \$1.4 million (based on 5.75 per cent purity and sold at \$50 per 1/4 gram). Heroin, cocaine and amphetamines generate the highest profits. This is largely due to the ability to mix or 'cut' with other substances, thereby reducing their level of purity.

**FIGURE 3** **ILLICIT DRUG TRANSACTION PROFIT CHART**



Source: Victoria Police.

Economic and social costs of drug use are considerable. In Australia, the costs of licit and illicit drug misuse were estimated to be equivalent to 4.6 per cent of gross domestic product (GDP) in 1992. Of this, illicit drug misuse was estimated to account for 0.5 per cent of GDP (UN Economic and Social Council, 1995). The largest part of this involves drug-related crime and law enforcement. A similar investigation conducted in the United Kingdom and commissioned by the European Community found that identifiable costs of drug trafficking and abuse amounted to 1.8 billion pounds sterling in the United Kingdom in 1988, and also accounted for some 0.5 per cent of GDP (UN Economic and Social Council, 1995).

The health costs of a drug-dependent person are estimated to be some 80 per cent higher than those of the average citizen in the same age group. Special concerns arise because drug use occurs most frequently in the 15–35 age group that includes young people entering or about to enter the workforce. Given current unemployment rates, entry into the workforce is a major problem. Abuse of illicit drugs reduces chances to enter or remain in the workforce, while frustration from failure to find employment favours drug consumption and creates a vicious circle (UN Economic and Social Council, 1995).

Social costs of drug misuse are less easily quantified; however, their impacts may be more insidious. Social integration and cohesion (at the family, community and even broader levels), are almost always compromised by an escalating drug problem. The lifestyle associated with that misuse can contribute significantly to destructive anti-social behaviour, violence and child abuse, loss of employment, financial hardship, dependency, and social marginalisation.

Data gaps and limitations make precise estimates of the cost of illicit drugs impossible. However, the authors of the most comprehensive and methodologically sophisticated Australian study to date indicate that a conservative estimate for Australia was in the area of \$1.44 billion in 1988 (Collins and Lapsley, 1991).

Collins and Lapsley include both tangible and intangible costs in their model that has been applied to alcohol and tobacco as well as illicit drugs. Major differences emerged between licit (alcohol and tobacco), and illicit drugs regarding the estimated proportion of tangible rather than intangible costs. Nearly three-quarters of total economic costs of illicit drugs were tangible compared to 12 per cent for tobacco and 53 per cent for alcohol. Major contributions to the economic costs of illicit drugs were the resources that would be available for other purposes if consumption of illicit drugs ceased, which accounted for about half of the total costs. Law enforcement costs accounted for a further 25 per cent of total costs and net production costs another 24 per cent. 'Net production costs' attempts to estimate the resources rendered unavailable for community consumption or investment as a result of loss of production due to mortality and morbidity.

Estimated total economic costs of illicit drug misuse as estimated by Collins and Lapsley for Australia in 1988 are set out in table 1. This model does not account for the costs of all use; rather it focuses on misuse of drugs. Using these figures as a base, a conservative estimate of the cost of abuse of illicit drugs in Victoria in 1995 is about \$458 million.

TABLE 1

## TANGIBLE AND INTANGIBLE ECONOMIC COSTS OF MISUSE OF ILLICIT DRUGS, 1988 AND 1995

	AUSTRALIA \$ MILLION		VICTORIA \$ MILLION
	1988	1995	1995
Tangible	1,042.4	1,330.1	331.2
Intangible	398.8	508.9	126.7
<b>TOTAL COSTS</b>	<b>1,441.1</b>	<b>1,839.0</b>	<b>457.9</b>

Source: Adapted from Collins & Lapsley, Estimating the Economic Costs of Drug Abuse in Australia, NCADA, Monograph Series No.15, 1991.

Note: Figures have been adjusted to produce Victorian estimates for 1995 on a per capita basis, by applying implicit price deflation adjustments from 1988. This follows the methodology of the recent Western Australia Task Force on Drug Abuse.

The current estimated State Government outlays on illicit drug-related activities are presented in table 2. It is clear that the majority of expenditure in this area is spent in the area of law enforcement: approximately 74 per cent of the total outlays. It must also be noted that these figures do not include the expenditure of federal agencies (such as the Australian Federal Police, the National Crime Authority and the Australian Customs Service), that can be attributed to activities in Victoria. It should be noted that these figures are based on those police officers exclusively employed in drug law enforcement and therefore underestimate the numbers of police involved in drug-related work. Similarly, calculating court costs on those cases directly related to drug offences underestimates the number of crimes that are drug-use related (Marks, 1992). In addition, the capital and recurrent costs of housing prisoners charged with drug offences are substantial, although difficult to quantify, and are not included in this table. As a result, caution should be taken in assessing these figures.

TABLE 2

## ESTIMATED VICTORIAN GOVERNMENT OUTLAYS ON ILLICIT DRUG-RELATED ACTIVITIES

OUTLAYS	\$ MILLION
Support services (including specialist treatment services)	\$ 20.2
Prevention	\$ 1.6
Law enforcement	\$ 75.9
Research and training	\$ 2.0
Courts *	\$ 3.2
<b>TOTAL</b>	<b>\$102.9</b>

Sources: H&CS, Victoria Police, Department of Justice.

\* Based on average cost per primary criminal offender (excluding minor traffic offences) of \$403.50 by the number of defendants finalised in Victorian courts who had a drug offence as their most serious drug charge. Does not include defendants with drug offences in their list of answerable charges.

In Victoria, an estimated 285 people died from illicit drug-related deaths in 1995. In comparison, there were 378 fatalities on Victorian roads. It is interesting to note the significant difference in funding that is allocated for prevention programs addressing these issues. The high level of investment in road safety programs (approximately \$100 million per annum), has resulted in a marked decrease in road fatalities of about 45 per cent in five years.

ILLICIT DRUGS		ROAD SAFETY	
Drug-related deaths	285	Road fatalities	378
Expenditure:	\$ 1.6 million	Expenditure:	\$ 100 million
• Health prevention programs		• Mass media promotion	
• Drug education programs		• Targeted road engineering/ blackspot treatments	
		• Promotion of vehicle safety	
		• Targeted enforcement	
		• Community programs	
		• Education and safety management	

Sources: H&CS, Victoria Police, Vic Roads.

The Council notes that a large proportion of the costs attributed to road accidents actually relate to injury rather than fatalities, and that these injuries almost certainly will exceed those related to drug misuse.

#### 2.1.4

#### PREVALENCE RATES AND PATTERNS OF USE

The level of illicit drug use in Victoria, relative to licit drug use, is not high. However, indications are that the worldwide supply of some drugs, especially heroin, will impact on the levels and patterns of drug usage in Australia. Evidence presented to the Council indicated that high-purity heroin is more freely available, at lower prices, in Victoria than in the past. This raises a number of questions concerning increased initiation among young new users. In addition, the number of heroin-related deaths in Victoria increased significantly during 1995, and now accounts for half of all drug-related deaths reported to the State Coroner. This is addressed later in this chapter (see figure 7).

Population-based approaches, such as household surveys, aim to measure behaviour, knowledge, attitudes, beliefs and the relationships of lifestyle and other factors to drug use in a representative sample of the general population. It is argued that while they are the only way of obtaining relatively direct measures across the population as a whole, they are less valid with respect to the highly stigmatised nature of drug use. They also undersample or miss high-risk groups such as marginal populations, homeless people, or prisoners (Pompidou Group, 1994).

In Australia, the major sources of data on illicit drug usage are the Victorian Drug Household Survey and National Drug Household Survey. It should be noted that these are a general tool for gathering material on all drugs, not just those regarded as illicit. The Council has accepted advice that the nature of the surveys and their size is likely to lead to some understating of the prevalence of use in the community. They are, however, the only substantial and ongoing data-gathering tool available.

DUE TO THE NATURE OF HOUSEHOLD SURVEYS, HEROIN USERS ARE LIKELY TO BE UNDER-REPRESENTED. LEVELS OF REPORTED USE SHOULD BE SEEN IN THE CONTEXT OF A NUMBER OF FACTORS ADDRESSED LATER IN THIS REPORT INCLUDING:

- A significant increase in the number of heroin-related deaths since 1991, which accounts for half of all drug-related deaths in 1995.
- Eleven per cent of all calls to DIRECT Line over a two year period concerned heroin.
- A substantial increase in the number of people being prescribed methadone from 1989.
- An increase in the number of needles distributed by the Needle Syringe Exchange Program (NSEP), with over two million needles and syringes being distributed in 1995.

Table 4a and 4b show the level of substance use in Victoria in 1991, 1993 and 1995 as reported in the drug household surveys. These figures should be treated cautiously due to the small numbers reporting illicit drug use.

**TABLE 4A HOUSEHOLD SURVEY DATA ON USAGE OF LICIT AND ILLICIT SUBSTANCES (EVER TRIED)**

BASE: VICTORIANS AGED OVER 13	EVER TRIED		
	1991 (N = 404)	1993 (N = 1200)	1995 (N = 1200)
SUBSTANCE/DRUG	%	%	%
<b>LICITS</b>			
Alcohol	93	94	86
Tobacco	73	77	62
Tranquillisers	31	3(a)	4
Pain Killers/analgesics	81	80	(b)
<b>ILLICITS</b>			
Amphetamines	7	7	7
Barbiturates	5	3	1
Cocaine/crack	3	2	3
Hallucinogens	6	5	6
Heroin	2	2	2
Marijuana/hash	31	30	29
Ecstasy/designer drugs	2	2	2
Injected drugs	*	1	1
Illicit drugs (any)	36	34	32

\* Less than 1%.

# Substance added to 1993 VDHS.

(a) A change of definition in 1993 means that results cannot be directly compared to 1991.

(b) Use of pain killers/analgesics was not asked in the 1995 Victorian survey.

Source: 1991 National Drug Household Survey (Victorian component).

1993 Victorian Drug Household Survey Report, H&CS.

1995 Victorian Drug Household Survey (Draft) Report, AGB McNair/H&CS.

Although it would appear that the prevalence of heroin and cocaine use is similar, it is clear that heroin is regarded as a more severe social problem. There is some anecdotal evidence to suggest that cocaine users are more likely than heroin users to be sampled in such studies. Later in this section information is provided on drug offences by drug type (figure 13). These figures show that cocaine offences account for 0.1 per cent of all drug offences compared to heroin, which accounts for about 10 per cent.

The apparent overall prevalence of illicit substance use, according to the survey data, has slightly declined over these years with 32 per cent of Victorian adults having used at least one illicit drug in their lifetime in 1995 compared to 36 per cent in 1991.

Marijuana is by far the most common illicit drug ever used with 29 per cent in 1995 having used marijuana/hash, 7 per cent having used amphetamines, and 6 per cent hallucinogens. Only 2 per cent of the population surveyed indicated that they had used heroin at least once in their lifetime, and less than 1 per cent had used it within the past 12 months.

**TABLE 4B HOUSEHOLD SURVEY DATA ON USAGE OF LICIT AND ILLICIT SUBSTANCES (Used within 12 months)**

BASE: VICTORIANS AGED OVER 13	USED WITHIN 12 MONTHS		
	1991 (N = 404)	1993 (N = 1200)	1995 (N = 1200)
SUBSTANCE/DRUG	%	%	%
<b>LICITS</b>			
Alcohol	84	74	75
Tobacco	28	27	27
Tranquillisers	11	1(a)	1
Pain Killers/analgesics	73	2(a)	(b)
<b>ILLICITS</b>			
Amphetamines	3	2	2
Barbiturates	3	*	*
Cocaine/crack	1	*	1
Hallucinogens	2	1	1
Heroin	*	*	*
Marijuana/hash	12	12	12
Ecstasy/designer drugs	1	1	*
Injected drugs	*	*	*
Illicit drugs (any)	15	12	13

\* Less than 1%.

(a) A change of definition in 1993 means that results cannot be directly compared to 1991.

(b) Use of pain killers/analgesics was not asked in the 1995 Victorian survey.

Source: 1991 National Drug Household Survey, (Victorian component).

1993 Victorian Drug Household Survey Report, H&CS.

1995 Victorian Drug Household Survey (Draft) Report, AGB McNair/H&CS.

The use of illicit drugs is higher among males than females, with 38 per cent of those males surveyed having used an illicit drug at least once compared to 26 per cent of females in 1995. Illicit drug use is more prevalent among males than females for all types of drugs. In 1995, 35 per cent of males had used marijuana at least once in their lifetime, compared to 23 per cent of females.

TABLE 5

## EVER TRIED ILLICIT DRUGS BY SEX, VICTORIA 1991, 1993 AND 1995

	PER CENT					
	MALES			FEMALES		
	1991	1993	1995	1991	1993	1995
Marijuana/hash	37	35	35	21	25	23
Amphetamines	8	9	9	4	5	5
Hallucinogens	6	7	9	3	4	3
Ecstasy/designer drugs	3	2	3	1	1	2
Cocaine/crack	4	3	5	1	1	2
Heroin	2	2	2	1	1	1
Injected drugs	-	2	1	-	1	1
Illicit drugs (any)	37	38	38	28	30	26

## KEY TRENDS

- Males more likely to use illicit drugs than females.
- No significant change in patterns of use from 1991 to 1995.

Source: National Drug Household Survey and Victorian Drug Household Survey.

Illicit drug use was markedly higher for people aged less than 35 years of age than for older age groups.

TABLE 6

## EVER TRIED ILLICIT DRUGS BY AGE, VICTORIA 1993 AND 1995

	PER CENT							
	1993				1995			
	AGE GROUP				AGE GROUP			
	18-24	25-34	35-54	55+	18-24	25-34	35-54	55+
Marijuana/hash	45	48	30	3	47	53	25	2
Amphetamines	8	11	3	-	12	15	4	1
Hallucinogens	8	11	4	1	11	13	3	-
Ecstasy/designer drugs	2	5	-	1	2	6	1	-
Cocaine/crack	2	5	2	1	5	8	2	-
Heroin	2	2	2	-	1	3	3	-
Injected drugs	1	3	1	-	1	2	-	1
Illicit drugs (any)	48	50	32	5	49	54	30	3

## KEY TRENDS

- Slight increase in use among people aged 18-24 years from 1991 to 1995 for most categories of illicit drugs.
- About half of those aged 18-24 and 25-34 have used marijuana at least once in their lifetime.

Source: National Drug Household Survey and Victorian Drug Household Survey.

In 1995, 54 per cent of people aged between 25 and 34 had ever used an illicit drug, compared to 30 per cent of people aged between 35 and 54 years of age, and only 3 per cent of people aged over 55 years of age. The proportion of people aged between 25 and 34 who had tried marijuana increased from 48 per cent in 1991 to 53 per cent in 1995. There was also an increase in the proportion of this age group who had ever used amphetamines, rising from 11 per cent in 1991 to 15 per cent in 1995.

Younger people, those aged between 18 and 24, were less likely to have ever tried heroin than those in this age group surveyed in 1993. There was, however, an increase in the proportion who have ever used marijuana, amphetamines and hallucinogens. These figures should be treated cautiously because, due to their nature, household surveys are unlikely to pick up young heroin users whose parents do not know they are users, or young people not living in households.

The proportion of students who have used an illicit drug increases with each year level from 10.2 per cent (males) and 5.8 per cent (females) at Year 7, to 49.7 per cent (males) and 37.6 per cent (females) at Year 11. The proportions of students in Year 11 who have ever used illicit drugs are similar to those in the adult 18–24 age group.

**TABLE 7 SCHOOL STUDENTS EVER USED DRUGS BY YEAR LEVEL AND SEX, VICTORIA 1992**

DRUG TYPE	PERCENTAGE OF YEAR LEVEL					
	MALES			FEMALES		
	YEAR 7	YEAR 9	YEAR 11	YEAR 7	YEAR 9	YEAR 11
Marijuana	6.9	23.3	47.8	4.1	19.1	37.0
Hallucinogens	2.7	6.8	12.9	1.6	6.5	7.9
Amphetamines	2.4	5.1	9.7	2.4	6.2	7.5
Cocaine	2.9	5.0	4.5	2.7	4.9	3.3
Opiates	2.7	3.0	4.3	2.2	4.9	2.8
Steroids	2.9	3.8	3.7	0.4	1.2	0.5
Ecstasy	1.9	1.7	3.9	0.8	2.6	2.6
Used any illicit drug	10.2	25.7	49.7	5.8	22.3	37.6
Alcohol	47.0	69.0	89.0	36.0	72.0	87.0
Tobacco	50.0	65.0	79.0	43.0	67.0	77.0
Inhalants	27.0	22.0	22.0	22.0	27.0	21.0

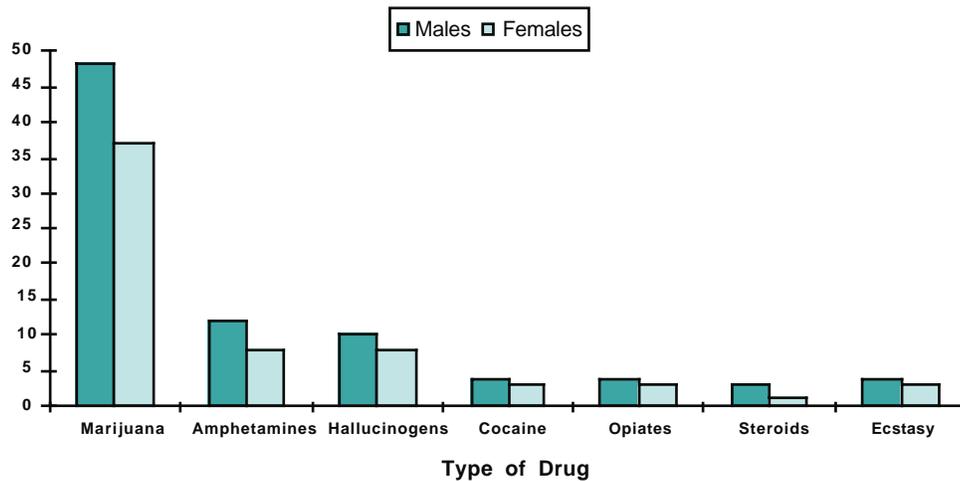
**KEY TRENDS**

- Male students are more likely to have used illicit drugs than female students.
- Almost half of male students in Year 11 reported that they had used marijuana at least once.

Source: 1992 Survey of Alcohol, Tobacco & Other Drug Use Among Victorian Secondary School Students, H&CS, 1993.

Use of inhalants, while not illicit, is high among school children, with over 20 per cent of boys and girls in Years 7, 9 and 11 having ever used inhalants. Illicit drug use among school students indicates similar trends to that in the adult population, with a higher prevalence of use among males compared to females. The most common illicit drug ever used was marijuana, having been used by 49 per cent of males and 37 per cent of females in Year 11. Hallucinogens and amphetamines were the next most common illicit drugs used by Year 9 and 11 students.

**FIGURE 4** PROPORTION OF YEAR 11 STUDENTS EVER USED ILLICIT DRUGS, VICTORIA, 1992



Source: 1992 Survey of Alcohol, Tobacco & Other Drug Use Among Victorian Secondary School Students, H&CS, 1993.

The Commonwealth Department of Human Services and Health has recently released a report titled *Review of Methadone Treatment in Australia*, which attempts to estimate the population prevalence of opiate dependence in Australia. Methodological difficulties notwithstanding, the report compared the estimated population prevalence of regular and irregular heroin use occurring in 1986 and 1990 and found statistically significant increases in both types of usage. The results of these calculations are presented in table 8.

**ESTIMATED POPULATION PREVALENCE OF REGULAR AND IRREGULAR HEROIN USE,  
AUSTRALIA 1986 AND 1990**

PREVALENCE	1986	1990
Regular heroin users	34,000	59,000
Prevalence per 1000	4.5	7.2
Irregular heroin users	75,000	113,000
Prevalence per 1000	9.9	13.8
Total heroin users	109,000	172,000
Prevalence per 1000	14.4	21.0
Population size <sup>(1)</sup> (15–44 years)	7,582,629	8,171,048

Source: Review of Methadone Treatment in Australia, CDHS&H, 1995.

(1) Australian Institute of Health and Welfare.

**KEY TRENDS**

- Almost doubling of the number of regular heroin users from 1986 to 1990.
- Fifty per cent increase in irregular heroin users from 1986 to 1990.

These calculations suggest that the estimated prevalence of regular heroin users (per 1000 of population) had increased from 4.5 in 1986 to 7.2 in 1990. The estimated prevalence of irregular heroin users had increased from 9.9 to 13.8 per 1000 population, while the estimated prevalence of all heroin users increased from 14.4 to 21.0 per 1000 population. The report states that these increases are statistically significant (CDHS&H, 1995). Current indications are that the number of heroin users has continued to grow since 1990.

**2.1.5**
**INTERNATIONAL COMPARISONS**

Examining international, Australian and Victorian trends in the patterns of illicit drug usage is central to assessing the effects changes may have at the local level. However, as outlined in the study undertaken by the Pompidou Group (1994), it is not easy to obtain valid information on phenomena that are often illegal, stigmatised and hidden. This continuing study began in 1983 and aims to improve the quality, usefulness and comparability of indicators of drug misuse, as well as monitoring and interpreting trends in drug misuse across a network of major European cities. The Pompidou Group stresses the difficulty in comparing countries or cities where there are important differences in definitions, traditions, legal and institutional arrangements, and perspectives on drug misuse, policies and interventions. The task of interpreting the data is therefore of central importance.

While acknowledging these difficulties, information on patterns and the extent of drug use provides the basis for which effective and strategic drug policy can be developed. Prevalence data from three overseas countries is compared to data from Victoria and Australia in table 9. The qualifications as detailed earlier in comparing prevalence rates between countries should be kept in mind when examining this information. The most recent data available to the Council is presented here.

Cannabis is by far the most widely used drug in all cases, although reported rates of prevalence in the United Kingdom are significantly lower than in other countries. Only 14 per cent of those surveyed in the United Kingdom in 1992 had ever used cannabis. Amphetamines are the second most used illegal drug in Victoria, Australia and the United Kingdom, and cocaine is the second most used drug in the USA and Amsterdam. As noted earlier, the apparent similarity in prevalence rates between cocaine and heroin use is likely to be a result of the nature of household surveys and under-representation of some members of the community.

**TABLE 9**      **COMPARATIVE PREVALENCE RATES OF ILLICIT DRUGS**

Drug Type	Victoria 1995 (a)		Australia 1993 (b)		Amsterdam 1994 (c)		United States 1994 & 1991 (d)		United Kingdom 1992 (e)	
	Ever Tried	Used in Last 12 Months	Ever Tried	Used in Last 12 Months	Ever Tried	Used in Last 12 Months	Ever Tried	Used in Last 12 Months	Ever Tried	Used in Last 12 Months
Cannabis	29%	12%	<b>34%</b>	<b>13%</b>	27%	11%	<b>34%</b>	9%	14%	5%
Heroin	<b>2%</b>	*	<b>2%</b>	*	1%	*	1%	*	*	*
Cocaine #	3%	1%	2%	1%	6%	2%	<b>12%</b>	<b>3%</b>	2%	*
Amphetamines	<b>7%</b>	2%	<b>8%</b>	2%	4%	*	7%	2%	4%	1%
Ecstasy	2%	*	<b>3%</b>	1%	2%	2%	N.A.	N.A.	2%	1%
Hallucinogens	6%	1%	7%	1%	4%	*	<b>8%</b>	2%	N.A.	N.A.

(a) 1995 National Drug Household Survey (base: Victorians aged 14+).

(b) 1993 National Drug Household Survey (base: All people aged 14+).

(c) Sandwijk, J.P., 1995 (base: people 12 years+).

(d) Figures for cannabis and heroin are from the 1994 United States National Household Survey on Drug Abuse (base: 12 years+). Remaining figures are from the 1991 United States National Household Survey on Drug Abuse (base: 12 years+).

(e) 1992 British Crime Survey (base: people 12–59 years).

\* Less than 1 per cent.

# Data for Australia and Victoria does not distinguish between crack and cocaine. The USA and UK surveys ask respondents if they have ever tried crack. In the USA, 3.6 reported that they had tried crack, and 1 per cent reported that they had tried it in the past year, while in the UK the figures were 0.3 per cent and 0.1 per cent respectively.

#### KEY TRENDS

- The Victorian drug use profile is similar to the Australian profile.
- In Victoria, Australia, the United Kingdom and the USA cannabis is by far the most widely used illicit drug.
- There has been an increase in cannabis use among high school children in recent years.
- Decriminalisation of the possession and personal use of cannabis in the Netherlands in 1976 did not lead to an increase in the use of cannabis among young people. The extent of use and trends remained similar to most other Western countries.
- In Victoria, Australia & the United Kingdom amphetamines are the second most widely used illicit drug.
- Household surveys suggest that heroin is used by a small number of people in the countries reviewed.
- Use of cocaine is far more prevalent in the USA than in Victoria, Australia or the United Kingdom.

The proportion of people who reported that they have ever tried amphetamines or hallucinogens was lower in Amsterdam compared to Australia and Victoria. In all countries examined, less than 1 per cent of those surveyed reported having used heroin within the last 12 months. Americans were more likely to ever have tried cannabis than Victorians, although a lower proportion reported that they had used in the last 12 months.

Drug users are generally divided into five major categories:

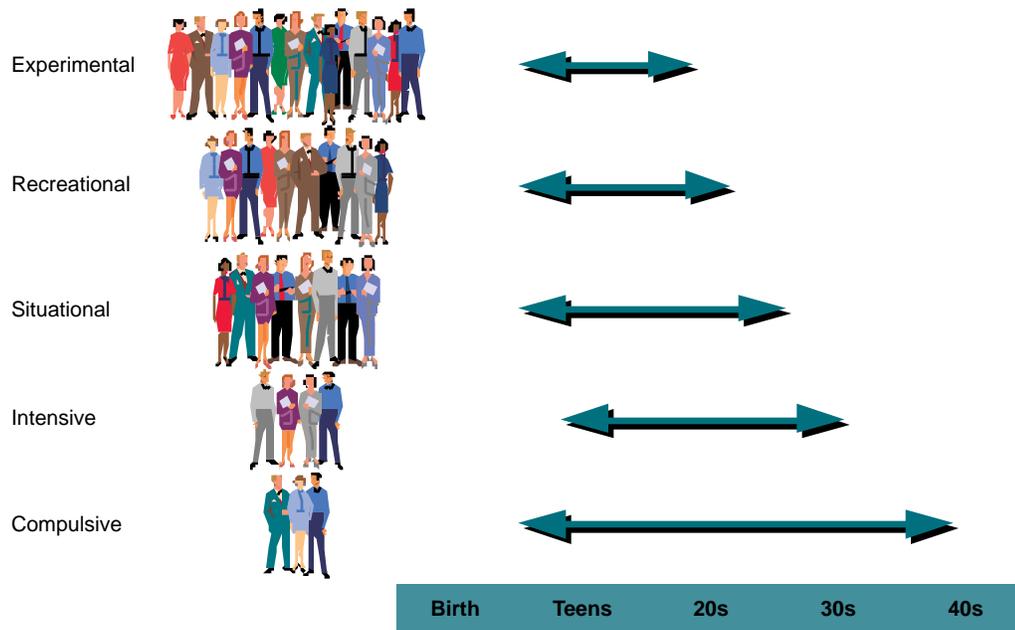
- Experimental users
- Recreational (or occasional) users
- Situational (or occupational) users
- Intensive (or binge) users
- Compulsive (or dependent) users

The majority of drug users do not progress from one group of use to another. However, of those that do, progression is generally related to:

- The route of administration: intravenous users are more likely to progress than oral users.
- Individual's characteristics: for example, those who use at a younger age are more likely to progress and a history of psychiatric problems is also associated with increased progression.

Most drug use is neither abusive nor problematic to the individual or the community and falls within the experimental and recreational patterns of use. The drug-using careers of these people is relatively short. Drug users in the intensive and compulsive categories are the least numerous, but on an individual basis, have the longest drug-use careers. Episodic abstinences and decreases in drug use appear to moderate the drug-using career. Lifestyle changes, such as employment and stable relationships, are correlated with cessation of drug use.

**FIGURE 5 DRUG-USING CAREERS TIME LINE**



## CANNABIS

The majority of cannabis use is experimental or recreational, and most people use the drug on a small number of occasions. They either discontinue their use, or use intermittently and episodically after first trying it. Among these people who continue to use cannabis over longer periods, the majority discontinue their use in their mid to late 20's. Only a small proportion of those who ever use cannabis use it on a daily basis over extended periods. Some 10 per cent of regular cannabis users develop dependence or complications from its use; a situation similar to that of regular users of alcohol. Daily users are more likely to be male and less well educated. They are also more likely to regularly use alcohol and have experimented with a variety of other illicit drugs.

## HEROIN USE

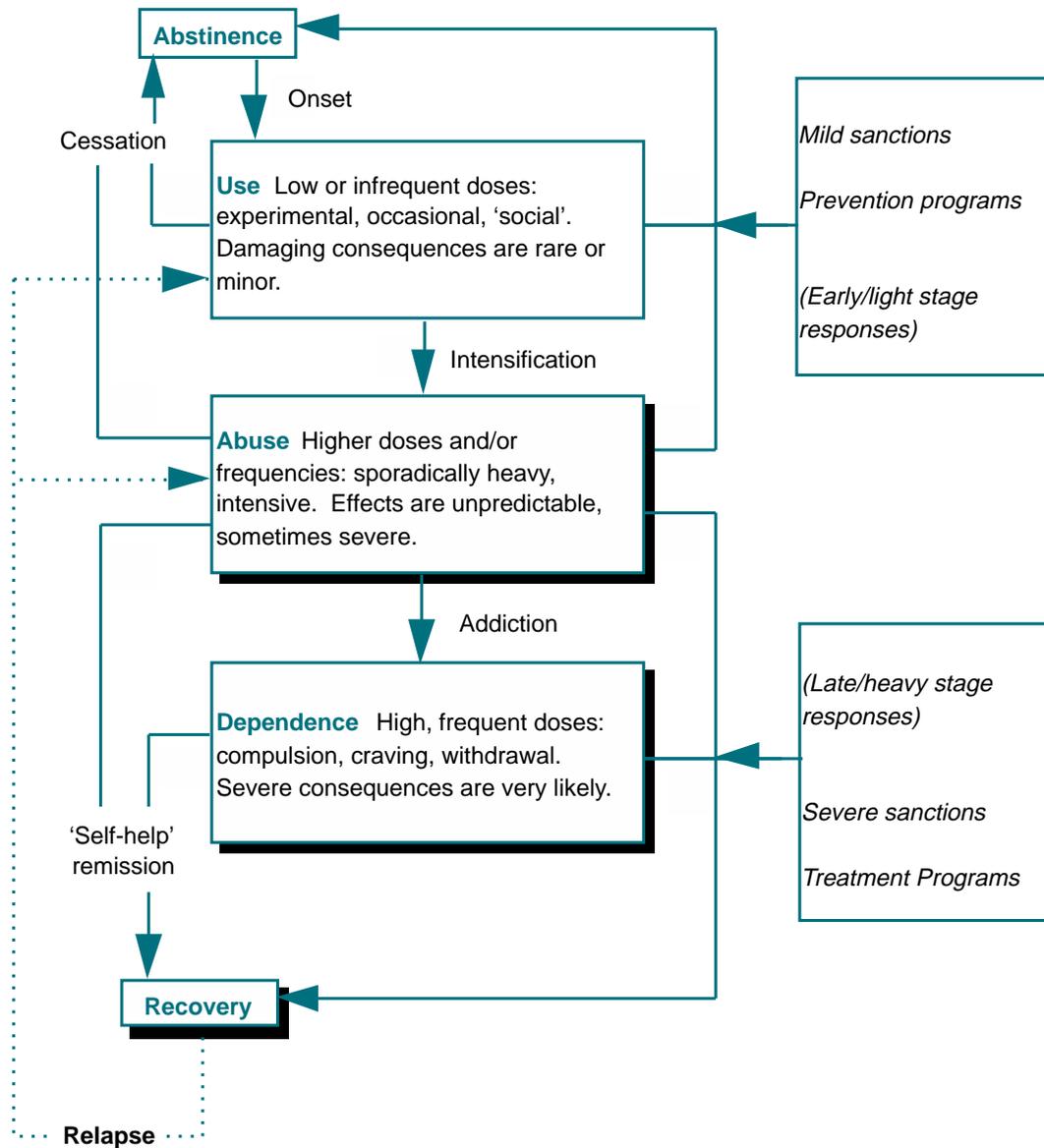
The peak period of initiation of heroin use usually occurs in the late teens. Many individuals who commence heroin use continue to do so for a relatively brief period (weeks or months). Among individuals who develop a regular pattern of heroin use, 10 per cent have stopped by the end of the first 12 months, and a steady 2 per cent to 3 per cent of people are commonly found to be abstinent in each subsequent year. At the end of the a 10-year follow-up, 40 per cent abstinence from heroin is a typical finding. The remaining 60 per cent are accounted for by active drug use, imprisonment and death. The death rate in these studies is typically of the order of 1–2 per cent per year. Follow-up studies indicate a high-level of polydrug use, especially alcohol, in the group that became abstinent from heroin 10 years after first use (Heather et al, 1989). Heroin can be injected, smoked or sniffed. Experience in Europe suggests that when the price is high and relative purity is low, users tend to inject heroin. As the price decreases, users tend to smoke or sniff heroin.

## AMPHETAMINES

Current trends indicate relatively high levels of experimental and recreational use of amphetamines among young people. There are also indications that experimentation with injecting as a route of administration is becoming more widespread (Hando and Hall, 1995). Amphetamines are also used by situational users such as long distance truck drivers, shift workers, and students who need to stay awake for long periods of time. Process workers may use amphetamines to relive the monotony of repetitive tasks. Athletes wishing to increase their energy, desensitise themselves from pain or even increase their aggressiveness may also use amphetamines (McAllister, 1991). Amphetamines can be injected or taken orally. Injecting amphetamines directly into the bloodstream increases the risk of harm to the user. These risks include a greater propensity of the user to succumb to bloodborne viruses.

## COCAINE

Until recently, cocaine use was thought to be restricted to upper socio-economic levels, but it is increasingly being evenly distributed throughout the community. Cocaine users tend to be unmarried and also polydrug users. A recent study in Sydney found that there were two main subcultures of cocaine use: casual or recreational use among high socioeconomic status intranasal users, and more compulsive, serious use among lower socioeconomic status injectors. Ages for both types of users ranged from the late teens to about 50 years of age, although the typical user was aged between 20 and 40. Initiation was generally through friends, partners or work colleagues (Hando, 1995).



Source: Adapted from Gerstein, D.R. and Harwood, H.R., 1990.

The above model shows the principal patterns or types of drug-taking behaviour. It groups them into common stages that, taken together, constitute a developmental pathway for individuals.

There are no reliable broadly based Australian studies that detail the social factors that contribute to illicit drug use. The relevance of international studies is limited as the social, cultural and political circumstances that prevail do not adequately relate to the Australian situation.

The factors which contribute to drug use are not clear. Many theorists suggest that psychological factors are the pre-eminent causes of drug use and abuse (West, 1991). Others have noted that the unemployed are over-represented in the numbers of those who have tried illicit drugs (Makkai, 1994). It is difficult to ascribe causal status in the development of drug abuse to socioeconomic factors. This is because not all people who have grown up in socioeconomically deprived circumstances go on to use drugs and commit crime. The reverse is also true: that some individuals from economically advantaged backgrounds have problems with substance abuse. However, the phenomena of youthful commencement leading to entrenched substance abuse often travels with a history of disordered relationships in the family of origin, socioeconomic disadvantage, and early and prolonged periods of homelessness (Spooner et al, 1995). The acceptability of drug use within any given society might also be a factor in determining the prevalence of drug use although evidence of a causal relationship is not to be found in the research literature.

Those who present to tertiary treatment centres or who become involved with the criminal justice system are usually economically impoverished and psychologically disordered. It is likely that those who come into treatment or the criminal justice system are there partly because the illicit nature of their addiction has led to, and maintained them in, a state of socioeconomic disadvantage. It is plausible therefore to suggest that substance abuse occurs within a matrix of socioeconomic disadvantage and emotional disorder. The origins of these substance abuse problems are often to be located in complex social and family risk factors and individual protective factors (Huba, Wingard, & Bentler, 1980; Sadava, 1987; Zucker & Gomberg, 1986).

Changes in the labour market, particularly as these affect young people first entering the job market, make a significant contribution to the sense of hopelessness many young people experience in relation to their future, as well as affecting their investment in society generally. Low-skilled jobs taken up by young people living on the fringes of society was historically an important means by which this group was integrated into society (Victorian Youth Affairs Council Submission, 1996). As greater emphasis is placed on the development of a highly skilled work force it is likely that these jobs are less available than has previously been the case.

The growth in the number of marginalised young people who comprise a chronic core of the young unemployed, almost certainly leads to an increasing probability that this group will initiate illicit drug use. If these factors are mediated by the influences of poor school achievement and diminished family support it is likely that emerging from this matrix of factors is a young person who has an increased likelihood of initiating and maintaining substance abuse (Ray & Ksir, 1990). The link between illicit drug use and crime means that this particular group of vulnerable young people are further marginalised.

The effects of use of any drug vary from person to person, and vary on different occasions for the same person. The situation in which they are used can also influence the experience of the drug, and the effect of some of the drugs can be more variable than others.

The experience of most of these drugs for most individuals, at least in the early stages of use, is positive. This is the main reason people continue to use drugs. At later stages, some use is self-medication, where the user takes the drug to treat a drug withdrawal effect. There are only a few users who do not enjoy their use.

The immediate effects of a drug can be influenced by the following factors:

- **The drug itself**

Most of the drugs under review have a specific effect on various areas of the brain which, for some of the drugs, determines the subjective effect. This is not the sole determinant of the experience for any of these drugs. Some drugs, such as cannabis, have a range of effects and might be classified variously as a depressant or a hallucinogen.

- **Drug strength**

The amount and intensity of the active substance taken is significant in determining the effect. In general, a higher dose is more likely to produce more extreme effects (but this is not always the case).

- **Drug purity**

There are two ways in which mixing drugs or substances can influence the effect or experience of using a drug. First, some effects of drugs are due to the mixers or cutting agents used in preparing the substances and these can be very dangerous (for example, the use of talcum powder in cutting heroin). Second, drugs can be mixed by consumption of more than one drug at a time or over time. The pattern of poly or multiple drug use is common. While some users are experienced and deliberate in their mixing of drugs to enhance the effect of one drug or reduce the side effects of another, most use a range of substances in response to market phenomena or unreliable supply, and to treat the long-term effects of chronic use. The use of licit drugs such as alcohol and tobacco, as well as prescription drugs is common among long-term heroin users for example.

- **Experience with the drug**

Where a person has developed a tolerance to the drug, the effect of using the same quantity will diminish. Some of these drugs have a greater capacity to induce tolerance with prolonged use than others. This is one reason why users tend to continue to increase their dose over time. In other words, they need to use more to achieve the same experience.

- **Route of administration**

While injecting is the most efficient way of administering some of these drugs to achieve maximum effect for the amount available (and one reason why those who inject do so), other drugs are equally effective when taken orally.

- **Expectations of the effect (sometimes known as 'set')**

The effect of most of these drugs can be influenced by the learned and socially or culturally determined reputation that the drug has. If the user is expecting it to make them 'high', this significantly increases the chances that this is one of the effects that will be reported on use. The effects experienced on use of these drugs have been described as highly suggestible.

- **Setting**

Drugs taken in settings where the user feels safe and secure are less likely to produce anxiety reactions than the same drugs taken in unfamiliar settings. In addition, the behaviours that are associated with the use of the drug can influence the way in which it is experienced (for example, taking a drug at a dance or 'rave' party will be a different experience to taking it at home, as it is likely to be associated with intense dancing and physical activity, heat and sometimes dehydration).

Table 10 outlines the immediate, acute and chronic effects of the major drugs under review by the Council. The effects of alcohol and tobacco are also presented here for comparison. Also included is the relative risk of addiction for these drugs, as outlined by Goldstein and Kalant (1995), on a five-point scale where 1 is the most severe. In this model, cocaine and amphetamines are seen as the most addictive of the psychoactive substances, and cannabis the least addictive. Falling between these in terms of addictiveness are the opiates (2), nicotine (2), alcohol (3) and hallucinogens (3).

A more detailed summary of the health effects of each drug type, including production, and mode of use, is provided in appendix 7. Also presented in appendix 7 is a comparative appraisal of the health risks of alcohol, tobacco and cannabis.

Drug Type	Mode of Use	Severity of Addictiveness	Effects Directly Due to Drug	Possible Harmful Effects: Acute	Possible Harmful Effects: Chronic
<b>ILLICITS</b>					
<b>Depressants</b>					
Cannabis	Smoked, or eaten in food (hashish)	4	Feelings of self-confidence, wellbeing and relaxation, altered perception of time and space, heightened perceptions of taste, smell, touch and hearing, dissociation of ideas, difficulties with concentration and memory.	Anxiety, feeling unwell, impairment of thinking & performing skilled tasks, psychotic symptoms at high doses.	Chronic respiratory diseases, cannabis dependence syndrome, apathy, precipitation of psychotic tendency.
Heroin	Injected, smoked, inhaled	2	Intense pleasure and a strong feeling of wellbeing, pain relief, hunger and sexual urges are diminished.	At large doses (overdoses) breathing is suppressed and death can occur.	Constipation, impotence, infertility, collapsed veins (injectors), abscesses, damage to heart, liver, lungs and brain (due to contaminants).
<b>Stimulants</b>					
Amphetamines	Injected, taken orally, or inhaled	1	At low doses: sensations of wellbeing, enhanced self-awareness and self-confidence, increased visual awareness, heightened alertness, increased capacity for concentration, greater energy. Users become hyperactive, talkative, excited, irritable and restless. Reduction of appetite, increased breathing and heart rate.	Headaches, dizziness, blurred vision, irregular heart beat, stomach cramps, loss of coordination, dehydration. At high doses, amphetamine users may experience distortions & gross alterations in body image.	Chronic fatigue and exhaustion, paranoid psychosis, delusions, hallucinations, violent behaviour, depression, malnutrition, blockage of blood vessels leading to damage to kidneys, lungs and brain.
Cocaine	Inhaled, smoked, injected	1 (Crack, Cocaine)	Low dose effects include improved performance, increased confidence, increased energy, exhilaration, enhancement of physical and mental wellbeing, increased rate of respiration resulting in rapid shallow breathing, increased temperature, spasm of local blood vessels, enlarged pupils, cardiac arrhythmias, suppression of appetite, insomnia.	High dose effects include loss of coordination, tremors, dizziness, muscle twitches, severe agitation, confusion, paranoid symptoms, headaches, cold sweats, pallor, nausea & vomiting weak, rapid pulse, anxiety reaction.	Heightened reflexes, muscle twitching, loss of appetite, insomnia, chest pain, heart attacks. Cocaine psychosis: paranoid delusions, auditory and visual hallucinations, tactile hallucinations, violent or aggressive behaviour and decreased libido/impotence.
Ecstasy	Taken orally	Not included in 5 point scale	The effects of ecstasy are similar to those found with amphetamines, although it is reported that Ecstasy produces a more positive mood and sense of intimacy than amphetamines. A 1987 survey of MDMA users reported that they felt 'euphoric', more verbal and had a sense of closeness with other individuals'.	Jaw clenching, teeth grinding, hangover effect - painful jaw muscles, drowsiness and sometimes, depression, reduced ability to concentrate, dehydration.	Long term effects uncertain.
<b>Hallucinogens</b>					
LSD (lysergic acid)	Swallowed, injected, sniffed or smoked	3	The effects of LSD can include intense perceptual distortion including visual and auditory hallucinations. Low dose: alterations in mood and perceptions.	High dose: hallucinations, trembling, chills and nausea. Possible feelings of terror, depression, acute paranoia and panic.	Psychosis, and post-hallucination perceptual disorders (flashbacks).
<b>LICITS</b>					
Alcohol	Orally	3	A feeling of self-confidence and relaxation, social inhibitions are reduced, individuals become talkative. Low to moderate doses: increase or decrease in heart rate, lowering of body temperature.	Capacity to think, concentrate & perform tasks is impaired with increased likelihood of engaging in risky behaviour e.g., dangerous driving, unsafe sex. With increasing doses disorientation, confusion, slurred speech & blurred vision. At higher doses, stupor, coma & death.	High blood pressure, stroke, heart failure, gastritis, oesophagitis, pancreatitis, hepatitis, cirrhosis, bleeding from veins in the gullet, diarrhoea, malnutrition, brain damage, vitamin deficiency. Contributes to cancers in oesophagus, bowel and breast. Alcohol dependence syndrome.
Tobacco	Smoked	2	Initial inhalation of cigarette smoke can produce palpitations, dizziness, sweating, nausea & vomiting.	Palpitations and cough.	Chronic bronchitis, emphysema, vascular disease including heart attacks, gangrene of the legs, stroke, stomach ulcers, contributes to cancer of the lung, pharynx and larynx, stomach, bladder, breast, uterus and ovary. Nicotine dependence syndrome.

\* Adapted from Goldstein and Kalant, (1990) in United Nations Economic and Social Council, Economic and Social Consequences of Drug Abuse and Illicit Trafficking: An Interim Report, 1995.

In Australia, the vast majority of deaths caused by drugs were as a result of the use of licit drugs: tobacco and alcohol. This is clearly demonstrated in table 11. An extremely small proportion of deaths is related to the use of opiates, barbiturates and other illicit drugs.

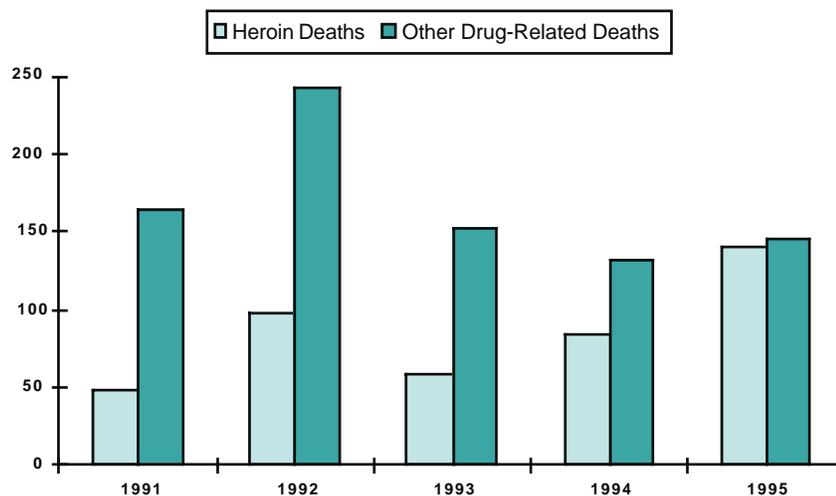
**TABLE 11** DRUG CAUSED DEATH RATES, DRUG INVOLVED PER 100,000 POPULATION, AUSTRALIA 1986–1992

DRUG	1986	1987	1988	1989	1990	1991	1992
Alcohol	39.9	40.7	40.9	40.4	38.7	37.6	37.6
Tobacco	111.4	111.7	112.7	113.9	106.0	103.9	108.5
Opiates	1.6	2.0	2.7	2.4	2.7	1.8	2.8
Barbiturates	0.6	0.5	0.4	0.3	0.2	0.2	0.1
Other Illicit	1.6	1.9	2.7	1.5	1.9	0.3	1.7
<b>TOTAL</b>	<b>155.1</b>	<b>156.8</b>	<b>159.4</b>	<b>158.5</b>	<b>149.5</b>	<b>143.8</b>	<b>150.7</b>

Source: Commonwealth Department of Human Services and Health, 1994.

Any certification of death where drugs are considered to be the main cause of death is required to be reported to the State Coroner. The Victorian Institute of Forensic Pathology (VIFP) has provided the Council with information on the prevalence of illicit drugs in sudden and unexpected deaths in Victoria. Deaths are classified as being drug-related if the cause of death is, at least in part, attributed to the toxic effects of drugs. In some cases, the drugs will have been used as part of a suicide rather than reflecting continued misuse of drugs. The number of heroin-related deaths reported to the State Coroner increased markedly in 1995 and accounted for half of all drug-related deaths.

**FIGURE 7** DRUG-RELATED DEATHS, VICTORIA 1991–1995



Source: Victorian Institute of Forensic Pathology, 1995.

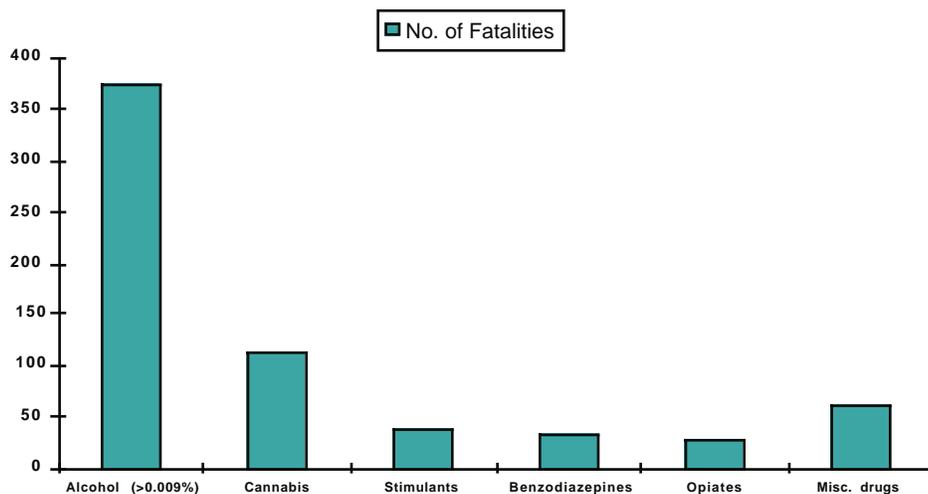
The proportion of all drug-related deaths that are heroin-related has increased over the last four years from 23 per cent to 49 per cent. This increase is a result of a decrease in non-heroin-related deaths, and a gradual increase in deaths attributed to heroin. The average number of heroin-related deaths per year is 86, or 1.9 per 100,000 population. Further statistics from the VIFP indicated that 78 per cent of heroin-related deaths are males, and that the mean age for males and females is 28 years. Only 15 per cent of all heroin-related deaths did not involve other drugs.

The prevalence of amphetamines in deaths reported to the Coroner has remained relatively steady in recent years. On average, 32 cases are detected each year involving amphetamines. Males account for 73 per cent of amphetamine-related deaths, and the mean age for males and females is 29 years. In Victoria, cocaine is rarely seen in deaths reported to the Coroner. Over the last five years there have been eight cases involving cocaine, four of which occurred in 1995. All cases were male and the mean age at death was 35 years.

Although marijuana is frequently detected in post-mortem specimens, its presence was not considered by the toxicologists as being a significant contributor pharmacologically to any death. However, its presence may contribute to the circumstances in which the death occurs; for example, in the case of fatal motor vehicle accidents.

A study by the VIFP analysed the drug content in the blood of over 1000 drivers killed in accidents in Victoria, Western Australia and New South Wales over the period 1990 to 1993. It concluded that alcohol was involved in 36 per cent of deaths, and other drugs involved in 22 per cent of deaths. Figure 8 indicates the major drugs involved. The most frequent drug involved was cannabis, which was detected in 11 per cent of fatalities. It should be noted that the presence of some drugs can be detected in the body for extended periods well after use. In the case of cannabis, although the effect of the drug may last for a number of hours, it can still be detected in the body for up to six weeks after use.

**FIGURE 8** PREVALENCE OF DRUGS IN ROAD FATALITIES, 1990-1993\*



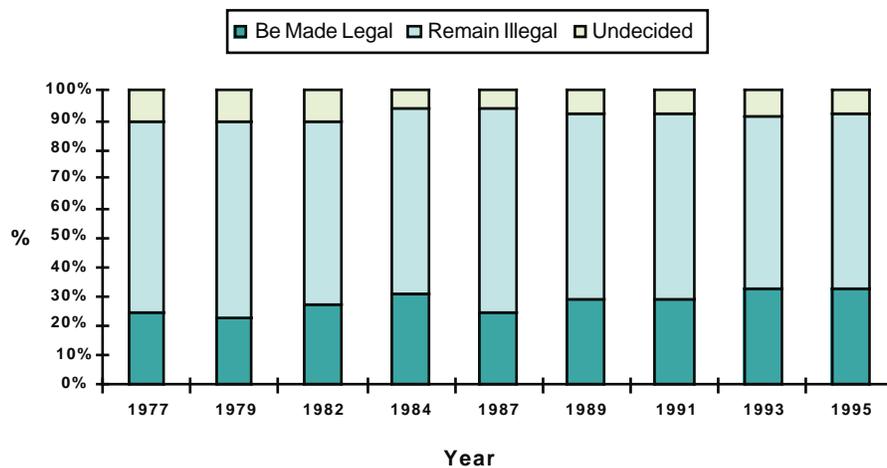
\* Some cases had two or more drugs detected.  
Source: Victorian Institute of Forensic Pathology, 1994.

Public knowledge about drugs and drug use, as well as public attitudes toward a range of drugs, is highly variable. The National Drug Household Survey and the Victorian Drug Household Survey seek to provide an insight into public opinion, knowledge and awareness of both licit and illicit drugs. In addition, other public opinion polls often seek information on the public's attitudes to the legalisation of certain drugs.

Many members of the community use the terms decriminalisation and legalisation interchangeably. Results from public opinion surveys should therefore be viewed cautiously.

Morgan Gallop Polls have regularly polled public attitudes to the legalisation of marijuana since 1977. In 1995, 33 per cent of Australians polled supported the legalisation of marijuana; an increase from 24 per cent in 1977. The highest levels of support came from those aged between 18 and 24 years (45 per cent), and 41 per cent of those aged 25–34 supporting legalisation. In Victoria, 31 per cent of those polled supported legalisation.

**FIGURE 9** SHOULD MARIJUANA BE LEGALISED?  
1977 TO 1995 (AUSTRALIA)

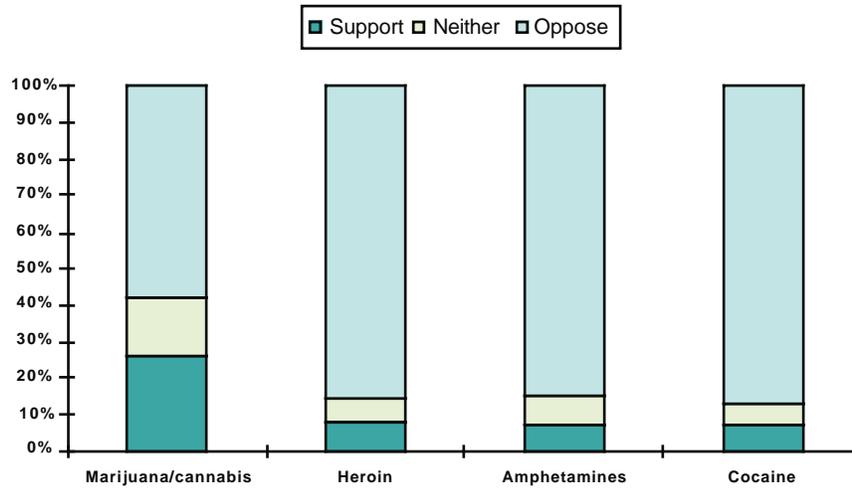


Source: Morgan Gallup Poll data.

The Victorian Drug Household Survey asked people if they supported the proposal to make personal use of specific illicit drugs legal. Figure 10 shows the level of support for the legalisation of personal use of illicit drugs of those surveyed in 1993. Approximately 26 per cent supported legalising personal use of cannabis, while only 8 per cent supported legal personal use of heroin.

FIGURE 10

SUPPORT FOR PERSONAL USE OF VARIOUS ILLICIT DRUGS BEING MADE LEGAL, VICTORIA, 1993

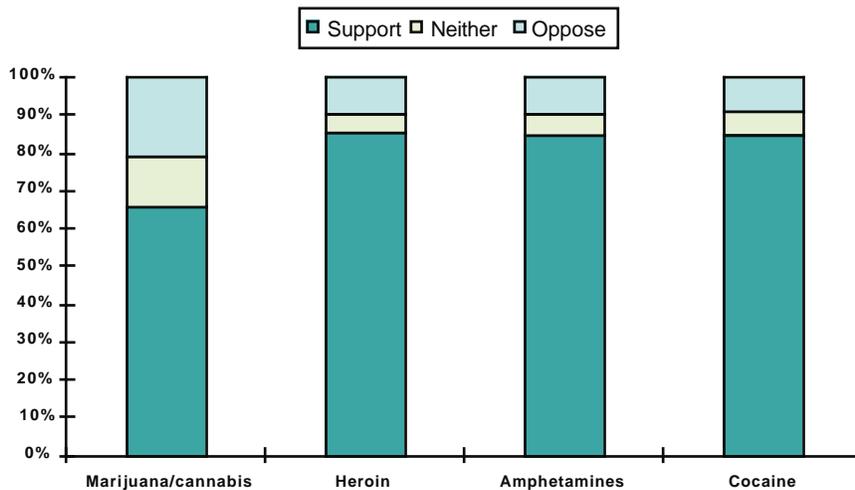


Source: 1993 Victorian Drug Household Survey.

In relation to penalties for the sale or supply of illicit drugs, support for higher penalties was high particularly in the case of heroin, amphetamines and cocaine. Approximately two-thirds of those surveyed supported increased penalties for the sale or supply of cannabis.

FIGURE 11

SUPPORT FOR INCREASED PENALTIES FOR SALE/SUPPLY OF ILLICIT DRUGS, VICTORIA, 1993



Source: 1993 Victorian Drug Household Survey.

The Australian Government is a signatory to a wide range of international treaties. Several of these relate to illicit drugs and are relevant to the work of the Council.

International treaties related to illicit drugs reflect the concerns of many nations about the impact of these drugs. They are also a recognition of the fact that controlling the supply of these drugs requires international cooperation. The extent and nature of the international treaties has evolved over many years. The first such agreement was the 1912 Hague Convention controlling the manufacture of opium.

A number of conventions were signed after 1912 and included:

- The 1925 International Opium Convention.
- The 1931 International Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs.
- The 1936 Convention for the Suppression of the Illicit Traffic in Dangerous Drugs.
- The 1946 Geneva Protocol that transferred functions exercised by the League of Nations under various narcotic treaties to the United Nations.
- The 1948 Paris Protocol that authorised the World Health Organisation to place under international control any dependence-producing drug, synthetic or natural.
- The 1953 New York Opium Protocol that limited the use of opium and international trade in it to medical and scientific needs.

The major treaties involving illicit drugs are:

- The 1961 Single Convention on Narcotic Drugs that Australia ratified in 1967. The convention defines the drugs covered (consistent with those that are the subject of the Council's terms of reference) and details the agreement that the trade and use of these drugs should remain illegal.
- The 1972 Protocol attaches to the 1961 Convention. The importance of this protocol is that it places greater emphasis on treatment, education and rehabilitation for abusers who commit minor offences as an alternative or adjunct to imprisonment.
- The 1971 Convention on Psychotropic Substances added synthetic hallucinogens, stimulants and sedatives to the list of banned drugs, and provided improved structures to distinguish medical use of drugs from other purposes.
- The 1988 Convention Against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances was ratified by Australia in 1993. This convention enhanced the provisions relating to inter-jurisdictional cooperation in the detection and prosecution of drug trafficking. It sets standards for signatories in such matters as dealing with possession and purchase of illicit drugs.

The impact of these conventions on legislation and policy are the subject of continuing debate in Australia and internationally. While there is clear international desire that all the specified substances remain controlled and that their use be diminished or contained, regimes for managing their use and the treatment of users vary widely.

In Australia and several other countries, there is concern about the impact of the treaties on policy flexibility. The debate on the legal status of cannabis and the most effective way to reduce its use and misuse is perhaps the most visible focus of concern. The discussions in Australia and elsewhere about

the merits of prescribing heroin would also test the requirements of the treaties. Discussion of these matters occurs in other sections of this report.

Legal opinions on these matters have been produced in the past. The opinions vary both because of the questions asked, and because the obligations arising from the treaties are capable of varying interpretations.

In the time available the Council did not seek any further legal opinions, nor was it seen as a necessary or appropriate course of action. This report details the legislative and policy directions that the Council believes are most appropriate. The Government will need to obtain advice on the specific options proposed.

### 2.2.2 STATE AND COMMONWEALTH LEGISLATION

---

Australian drug policy, prior to the 1960s, was largely determined by public servants and had bipartisan support. In general, drug use was condemned not only because of the perceived health risks involved, but also because of its lack of acceptance by the majority of the population. However, legislation enacted during the 1970s and 1980s reflected a major shift in focus, and the crime of possession was central to the structure of recent drug legislation (Manderson, 1992). Movements in legislation also reflected Australia's involvement in international treaties and conventions that became increasingly more important during the 20th century.

Manderson provides a useful history of drug legislation in Australia that is briefly summarised below:

- During the 19th century, the consumption of drugs (medical, quasi-medical and recreational) was largely a matter of personal choice.
- The Victorian *Poisons Act 1876* provided that, in general, poisons had to be sold by either a doctor or chemist and had to be labelled 'poison'. There were few controls on who could purchase them and for what purpose they were used. Self-prescription of opium and laudanum (an opiate) was prevalent. Around this time, Australia had the highest per capita consumption in the world of patent medicines, whose secret active ingredients were principally alcohol or opiates.
- The first drug laws in Australia were enacted at the turn of the century to prevent opium smoking. The laws were not based on a belief that addiction was unhealthy or immoral, but rather were racially based. At this time, the smoking of opium was a primarily Chinese habit and racism was an important element of political life in Australia.
- The first law prohibiting the smoking of opium was enacted in South Australia in 1895 and all other States had followed suit by 1908. This was linked to community attitudes to Chinese immigrants.
- In 1905, the Commonwealth proclaimed that the importation into Australia of opium in a form suitable for smoking was 'prohibited absolutely'. However, these laws did not deal with the opium contained in patent medicines, nor with its common and frequently habitual consumption in the form of laudanum.
- These laws formed the precedent for later laws that developed through the 1920s and 1930s and restricted the use of drugs such as heroin, morphine and cocaine. They were largely a response to international and bureaucratic pressures, rather than a conscious determination to create a comprehensive system of control over an ever-expanding range of drugs.
- The large number of treaties to which Australia became subject committed Australia to the prohibitionist approach advocated by the international community under the leadership of the USA. As a result of this pressure, the Commonwealth expanded the 1905 proclamation dealing with opium

in 1914 to deal with a range of other drugs covered by the Opium Convention of 1912. The importation of these substances was not prohibited absolutely, but was made subject to certain restrictions designed to ensure that they were used for 'medicinal purposes only'.

- State legislation also expanded to prohibit morphine, cocaine and heroin. In 1913, Victoria legislated that these drugs could only be available through a written prescription, or the order of a duly qualified medical practitioner. Regulations concerning various 'dangerous drugs' were introduced in 1922, and created a complex system of licences and authorisations. They penalised not only sale without a prescription but also possession. These laws were later put into the body of the Poisons Act.
- International pressure continued to expand the range of drugs that were legally available only with medical authorisation. Before and after the Second World War, Australia had very high levels of heroin consumption. By 1951 it recorded the highest per capita level of use in the world. Internationally, pressure for the complete prohibition of heroin grew.
- In 1953, the Commonwealth acted to prohibit absolutely the importation of heroin and began to pressure the States into enacting parallel legislation prohibiting manufacture, use and possession. As a result, all States prohibited the manufacture of heroin, although Victoria did not make the possession of heroin illegal, although heroin was legally unobtainable.
- Laws against cannabis were passed, although in the 1940s and 1950s its use in Australia was almost unknown. In 1940, the Commonwealth extended import controls over Indian Hemp, and its extract and tincture, to include preparations made using it. In 1956, the Commonwealth absolutely prohibited the importation of cannabis into Australia.
- In 1981, the *Drugs, Poisons and Controlled Substances Act 1981* (the act) replaced the Poisons Act in Victoria.

The Act sought to provide a framework for the protection of the public from the harm that could follow from the misuse or abuse of drugs and poisons that came under the control of the Act. The Act regulates the availability of drugs and poisons to those who need them and are equipped to handle them. With some substances, special facilities or training may be necessary for their safe use.

The Guide to the Drugs, Poisons and Controlled Substances Regulations 1995, published by the Department of Health and Community Services (H&CS), states that:

"The Act regulates the availability of drugs and poisons by:

- (a) classifying drugs and poisons via a Poisons Code into different schedules, each of which represents a different level of availability; and
- (b) establishing a system of authorising, licensing and permitting according to profession or activity; that is to say:
  - (i) authorising medical practitioners, pharmacists, veterinary surgeons and dentists to possess, use and supply;
  - (ii) licensing persons to manufacture and supply or to supply; and
  - (iii) permitting persons to possess and use for particular purposes, for example, industrial, educational or the provision of health services."

Maximum penalties for Victorian drug offences contained in the Act are outlined in table 12. As is the case with Commonwealth offences, the penalty range open to a sentencer is contingent upon certain statutory factors.

**APPLICATION OF PROVISIONS IN THE DRUGS, POISONS AND CONTROLLED SUBSTANCES ACT 1981 (VIC.)**

SUB-SECTION	STATUTORY FACTORS	MAXIMUM PENALTY
<b>TRAFFICKING</b>		
s.71(1)(a)	Commercial quantity	25 yrs and \$250,000 fine (NB: s.71(2) provides that where a commercial quantity is involved, imprisonment is mandatory)
s.71(1)(b)	Any other case	15 yrs and/or \$100,000 fine
<b>CULTIVATION</b>		
s.72(1)(a)	Cultivation unrelated to any trafficking purpose	1 yr and/or \$2,000 fine
s.72(1)(b)	Any other case	15 yrs and/or \$100,000 fine
<b>POSSESSION</b>		
s.73(1)(a)	Small quantity (see s.70(1)) of cannabis and offence not committed for any purpose related to trafficking	\$500 fine
s.73(1)(b)	Cannabis possessed for a purpose unconnected with trafficking	1 yr and/or \$3,000 fine
s.73(1)(c)	Any other case	5 yrs and/or \$40,000 fine
<b>CONSPIRACY</b>		
s.79(1)	(Specific to the particular offence)	Same punishment, pecuniary penalties and forfeiture as if offender had actually committed offence under ss.71, 72 or 73

Other pertinent Victorian legislation includes:

- *Bail Act 1977*
- *Crimes (Confiscation of Profits) Act 1986*
- *Road Safety Act 1986*
- *Sentencing Act 1991*
- *Summary Offences Act 1966*

Relevant Commonwealth legislation includes:

- *Crime (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990*
- *Customs (Prohibited Imports) Regulations*
- *Customs Act 1901*
- *Narcotic Drugs Act 1967*
- *Therapeutic Goods Act 1989*

The statutory factors and maximum penalties included in the Customs Act 1901 are detailed in table 13.

TABLE 13

## APPLICATION OF S.235 CUSTOMS ACT 1901 (CWLTH)

SUB-SECTION	STATUTORY FACTORS	MAXIMUM PENALTY
s.235(2)(c)(i)	Commercial quantity	Life imprisonment
s.235(2)(c)(ii)(A)	Trafficable quantity and previous conviction/s for Cwlth narcotic offence/s involving a trafficable quantity	Life imprisonment
s.235(2)(c)(ii)(B)	Trafficable quantity and finding by court that offender has at another time committed a Cwlth narcotic offence involving a trafficable quantity, without recording a conviction	Life imprisonment
s.235(2)(d)(i)	Trafficable quantity of narcotic substance other than cannabis	25 yrs and/or \$100,000
s.235(2)(d)(ii)	Trafficable quantity of cannabis	10 yrs and/or \$4,000
s.235(3)(a) & (b)	Trafficable quantity and no significant previous convictions for Cwlth narcotic offences and offence not committed for purpose related to sale or commercial dealing	2 yrs and/or \$2,000 fine
s.235(2)(e)	Any other case	2 yrs and/or \$2,000 fine

The trafficable quantities vary for each specific drug under Schedule VI of the Customs Act and are outlined in table 14.

TABLE 14

## DEFINITION OF TRAFFICABLE AND COMMERCIAL QUANTITIES, CUSTOMS ACT, SCHEDULE VI

SUBSTANCE	TRAFFICABLE QUANTITY (grams)	COMMERCIAL QUANTITY (grams)
Amphetamines	2.0	-
Cannabis	100.0	100.0
Cannabis resin	20.0	50.0
Cocaine	2.0	2.0
Opium	20.0	20.0
Heroin	2.0	1.5

A summary of key aspects of the *Crime (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990* is provided in table 15.

## (TRAFFIC IN NARCOTIC DRUGS AND PSYCHOTROPIC SUBSTANCES) ACT (Summary)

SUB-SECTION	STATUTORY FACTORS	MAXIMUM PENALTY
s.6(1) (a)-(g) 6(2)	Meaning of dealing in drugs	Definition only
s.9(a)-(d)	Possession of equipment	5 years (manufacture) 10 years (other)
s.15(2)	Cultivation of opium poppy and cocoa bush	More than 1000 plants—life Not more than 1000 plants but more than 20 cultivated—25 years Not more than 20 but more than 5 plants cultivated—10 years Not more than 5 plants—5 years
	Cultivation of cannabis	More than 1000 plants cultivated—life Not more than 1000 but more than 20 plants cultivated—10 years Not more than 20 but more than 5—5 years Not more than 5 plants—2 years
s.15(3)	Separation of opium from plant dealing	10 years
s.15(4)	Manufacture or possession for manufacture of narcotic drugs	Schedule 3 part (1)—10 years Schedule 3 part (2)—5 years
s.15(5)	Sale supply or possession for sale or supply <ul style="list-style-type: none"> <li>• Commercial quantity, or sold, supplied or possessed</li> <li>• Trafficable quantity, or sold, supplied or possessed</li> <li>• Less than a trafficable quantity sold, supplied or possessed</li> </ul>	Cannabis sold/supplied—life Any other cases—life Cannabis—10 years Any other cases—25 years Cannabis—2 years Any other case—5 years
s.15(6)	Importation, exportation or possession for import/export of a narcotic drug	As for sale of, supply/possession (above)
s.15(8)	Conspiracy	Punishable as if engaged in that conduct (see above)
15 A	Conversion	20 years
15 B	Conceal	20 years
	Knowingly acquire property from drug offence	20 years

Law enforcement measures are recognised as an important strategy in minimising the harmful effects of drugs on Australian society. Policing is one of several law enforcement measures used to reduce the level of use of illicit drugs. It ranges from the investigation of drug trafficking and importation by the Australian Federal Police and the Australian Customs Service to police activities at the community level dealing with problems arising from illicit drug use. The roles and functions of the major law enforcement agencies are outlined in appendix 8.

The Department of Justice, in its submission to the Council, advised that official police statistics on drug offences are dependent on the level of policing activity and the priority given to an area. For this reason, any increase or decrease in police recorded drug statistics is less likely to reflect changes in actual levels of drug use in the community than the priority given by police to drug-related offences and/or their efficiency in detecting and apprehending drug offenders. As a result, the Department of Justice advises that caution is taken in interpreting the police statistics for drug offences, as they are, like crime statistics generally, subject to a variety of influences, many of which are unrelated to the actual level of crime in the community.

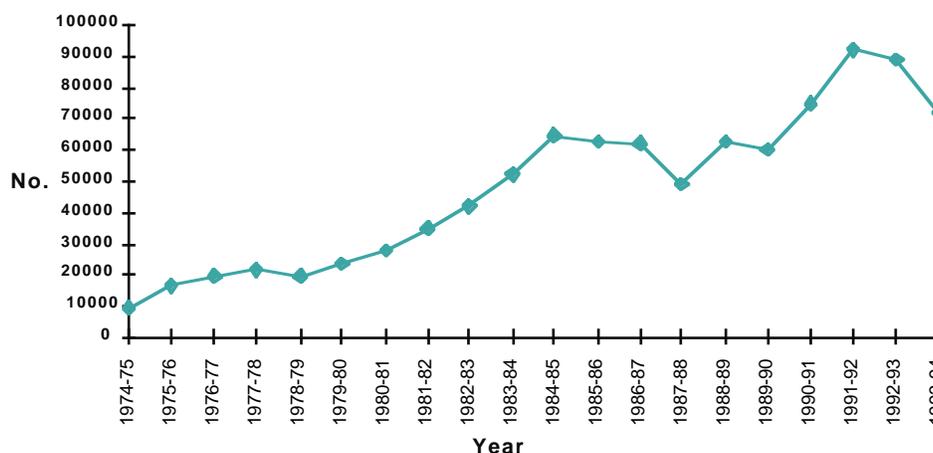
The number of drug seizures and the type and weight of drugs is one indicator of the availability of drugs. The Australian Customs Service reported to the Council that 6831 kilograms of illicit drugs were seized at the Australian border during 1994–95. These comprised 6520 kilograms of cannabis, 295 kilograms of heroin and 16.5 kilograms of cocaine. The amount of heroin seized constitutes a substantial increase on the amount seized in 1993–94 (54 kilograms) and 1992–93 (53 kilograms).

There has been a consistent decline in the number of drug seizures by federal agencies in Victoria, New South Wales and Western Australia since 1990–91. The decline in the number of seizures in Victoria is largely due to the reduction in cannabis-related seizures. All other categories of drugs have not shown a major change over this period in terms of number of seizures, although the weight involved has fluctuated.

In 1994–95, there were 9291 drug seizures by Victoria Police. Of these, 75 per cent were of cannabis, 12 per cent of amphetamines and a further 8 per cent of heroin. Smaller numbers of seizures were made for cocaine, LSD, Ecstasy and other drugs.

Police statistics indicate that the volume of recorded drug offences has increased over the last 20 years. The number of drug offences reported or becoming known to police throughout Australia from 1974–75 to 1993–94 is presented in figure 12.

1974-75 TO 1992-93



Note: Includes: use, possession, obtain unlawfully, receive, traffic, cultivate, manufacture, supply and import.  
 Source: Mukherjee and Dagger, 1990 updates. 1987-88 to 1992-93, Police Annual Reports for each jurisdiction.

It should be noted that many of the variations identified here reflect changes in enforcement practices as much as changes in patterns of drug supply and use. The trend over the same period for Victoria shows that number of drug offences per 100,000 population has also significantly increased. The rate of recorded drug offences has increased tenfold from 52.5 in 1974-75 to 542.0 in 1992-93.

Police record drug offences for statistical purposes in terms of two categories: those involving possession and use of the drug (drug consumption), and those involving the cultivation, manufacture and trafficking of drugs (drug provision). Key statistics were provided to the Council from the Victoria Police relating to provision and consumption offences. They are presented in table 16.

TABLE 16

PROVISION AND CONSUMPTION OFFENCES, VICTORIA,  
 1993-94 AND 1994-95

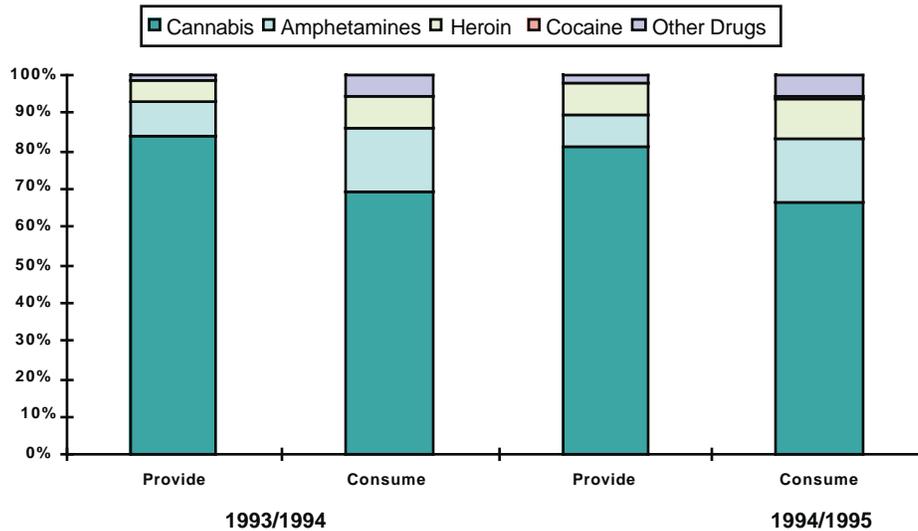
	1994-95		% CHANGE FROM 1993-94	
<b>Trafficking</b>	490	Heroin offences	86.3%	↑
	1286	Cannabis offences	13.4%	↓
	463	Amphetamine offences	23.6%	↓
	102	Drug of dependence offences	61.9%	↑
<b>Cultivation</b>	2587	Cannabis offences	3.8%	↑
<b>Possession</b>	603	Heroin offences	24.3%	↑
	5417	Cannabis offences	2.8%	↓
	1087	Amphetamine offences	11.7%	↓
	11	Ecstasy offences	57.1%*	↑
<b>Use</b>	526	Heroin offences	47.3%	↑
	1576	Cannabis offences	13.3%	↑
	378	Amphetamine offences	6.2%	↑

\* Based on small numbers.

Source: Victoria Police Statistics, 1995.

In terms of drug offences recorded by the police, cannabis is the overwhelming drug involved in drug provision (81 per cent in 1994–95) and drug consumption offences (68 per cent in 1994–95). Amphetamines accounted for approximately 8 per cent of provision offences and 14 per cent of consumption offences. Heroin also accounted for 8 per cent of consumption offences, and 11 per cent of provision offences.

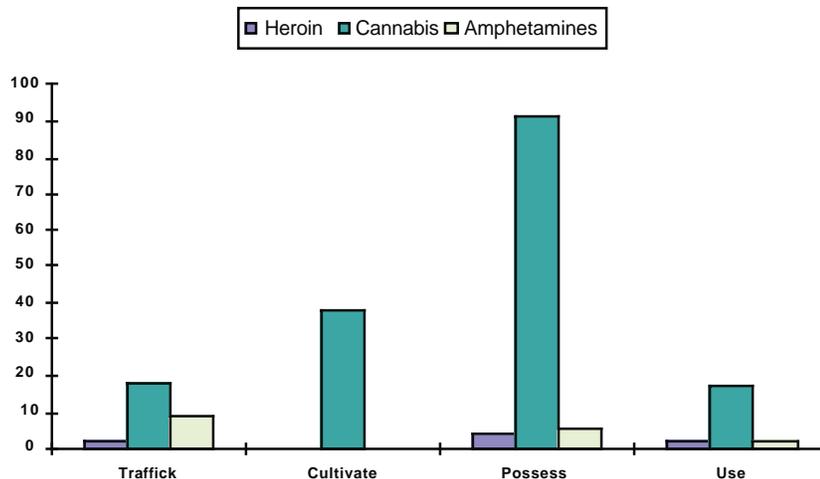
**FIGURE 13** TOTAL RECORDED DRUG OFFENCES BY DRUG TYPE, VICTORIA 1993–94 AND 1994–95



Source: Victoria Police Statistical Services Division.

Heroin offences, for provision and consumption, showed the only significant change between 1993–94 and 1994–95. In 1993–94, heroin offences accounted for 5 per cent of all provision offences and 8 per cent of all consumption offences. In 1994–95, the proportion of heroin offences increased to 8 per cent of all provision offences and 11 per cent of all consumption offences.

**FIGURE 14** DRUG OFFENCES BY DRUG TYPE IN A RURAL POLICE DISTRICT, 1995



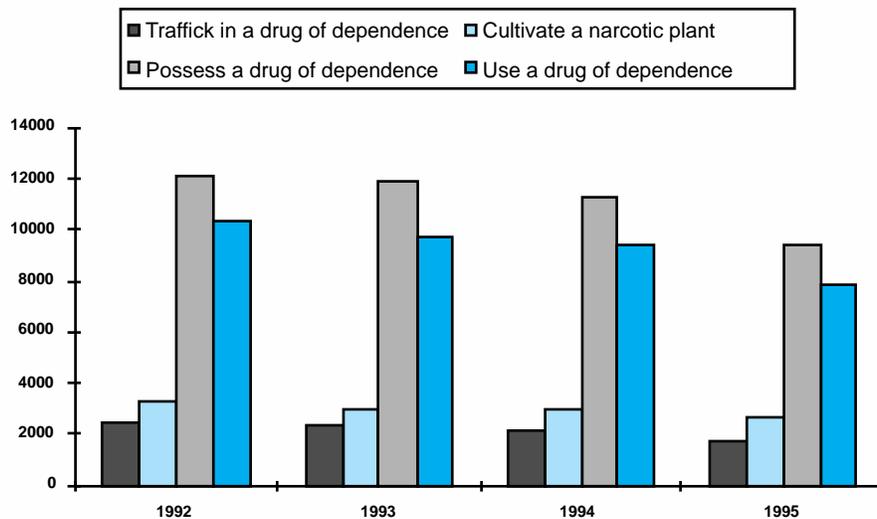
Source: Information provided to the Council by Victoria Police.

Drug offences for a typical rural police district in Victoria are outlined in figure 14. The vast majority of charges relate to cannabis offences and reflect law enforcement practices in many rural areas.

The offences of possessing a drug of dependence and using a drug of dependence are the third and fifth most frequent specific charges in the list of the top 100 charges heard in the Magistrates' Court. When individual offences are broadly categorised into property, driving, drugs, personal crime and other, the drug offence category is third most frequent after property and driving offences. However, it should be noted that many property offences are drug-related, even though not recorded as such in the readily available statistics.

The four major drug charges heard in the Magistrates' Court are trafficking in a drug of dependence, cultivating a narcotic plant, possessing a drug of dependence, and using a drug of dependence. Figure 15 compares the number of drug charges heard for each of these categories from 1992 until 1995.

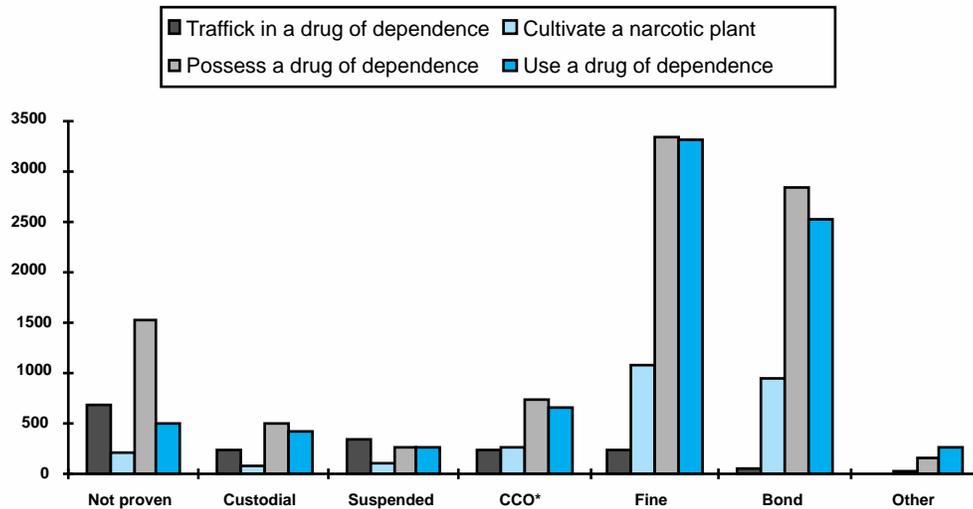
**FIGURE 15** DRUG CHARGES HEARD IN THE MAGISTRATES' COURT, VICTORIA, 1992-1995



Source: Magistrates' Courts Sentencing Statistics.

It is clear that the vast proportion of drug charges heard relates to possession and use of a drug of dependence, rather than trafficking or cultivation offences. Sentencing dispositions vary according to the type of charge heard. Possession, use, and cultivation of a drug of dependence are most likely to result in a fine or bond. Trafficking charges are more likely to result in a custodial or suspended sentence. A high proportion of trafficking charges is not proven. In 1995, 38 per cent of all trafficking charges were not proven in the Magistrates' Court.

**SENTENCING DISPOSITIONS FOR ALL DRUG CHARGES HEARD IN THE MAGISTRATES' COURT, VICTORIA, 1995**



\* Community Corrections Order.

Source: Magistrates' Courts Sentencing Statistics.

The majority of defendants convicted of a drug offence in the higher courts receive a term of imprisonment. This proportion has remained relatively stable from 1991 to 1995. Fines and bonds are used infrequently for drug offences finalised in the higher courts (whereas they are the most likely penalty to be imposed for drug offences in the Magistrates' Court).

When the expected sentence length is computed for each drug offender, prisoners with drug provision offences as their most serious offence serve approximately five years in custody. Prisoners with a drug consumption offence as their most serious offence serve approximately 3.6 years in custody. These figures should be treated cautiously because of the averaging process and the small numbers involved. The distribution of sentence lengths for drug providers has not changed significantly over the period from 1990-91 to 1992-93. However, there has been a decrease in the overall numbers of prisoners on drug consumption charges over this period, while the number on provision charges has increased. The number of prisoners serving sentences of over 10 years for drug consumption charges may reflect the tail end of earlier sentencing policy.

TABLE 17

**NUMBER OF PRISONERS ON DRUG CHARGES BY SENTENCE LENGTH, VICTORIA**

YEAR	DRUG OFFENCE	<1YEAR	<2YEARS	<5YEARS	<10YEARS	10+YEARS	LIFE	TOTAL	AVERAGE YEARS
1990/91	Provide	26	18	36	54	32	1	167	6.0
1991/92	Provide	34	20	44	45	30	2	175	5.5
1992/93	Provide	31	23	55	54	31	1	195	5.5
1990/91	Consume	8	4	6	1	3	0	22	3.5
1991/92	Consume	4	1	5	0	2	0	12	3.9
1992/93	Consume	3	2	0	1	1	0	7	3.6

Source: National Prison Census 1993, Australian Institute of Criminology.

A study of male and female sentenced prisoners in Victoria found that 69 per cent of those sampled were diagnosed as having a lifetime diagnosis of dependence on or abuse of alcohol, other psychoactive substances, or a combination of these (Herman, McGorry, Mills and Singh, 1991). In this context, a lifetime diagnosis refers to a diagnosis that has been sustained over time. Other studies have also found high levels of prior drug use among prisoners. Miner and Gorta (1987) found that 79 per cent of women prisoners in their sample reported prior drug use, and heroin was the drug most commonly mentioned.

## 2.3

## Preventing Use and Reducing Harm

### 2.3.1

### COMMUNITY EDUCATION AND INFORMATION

---

The Commonwealth, Victoria or any other State has not implemented a sustained effort to communicate with, inform or educate the community about illicit drugs. In Victoria, few resources have been allocated to the provision of community education and information programs in relation to drug use. Those that have been conducted have had a strong focus on licit drugs, especially tobacco, alcohol and prescription drugs. Table 2 indicates that of the \$103 million spent on addressing illicit drug issues in Victoria in 1995, only \$1.6 million was spent on prevention/education and information activities.

Key elements of community education strategies include information provision, media campaigns, sponsorships, school-based drug education, print resources and community development. There is very limited knowledge of which approaches to community education provision work. This is due to a lack of disciplined evaluations against which to judge the effectiveness of various strategies. These evaluations are in fact difficult to conduct. The overriding principle of drug education is that there is no one response to addressing the illicit drug problem through campaign information and education activities and that any strategic response must be multifaceted, integrated, coordinated and sustainable.

There are a range of audiences and target groups that might usefully be identified in thinking about drug information and education. They are:

- Members of the general community including specific subgroups that may warrant specific attention, such as people of other language and cultural groups and people from regional and rural Victoria.
- Community leaders, including religious leaders.
- Professionals to whom drug users and their families turn to for advice and support, including:
  - Generalist health and welfare professionals such as general practitioners, and nurses; those especially well placed to provide information, education and early interventions, such as youth workers.
  - Those whose work involves them being in contact with drug users, such as police and ambulance officers.
  - The law makers and those charged with its implementation, such as politicians, magistrates and those working in public administration.
  - Specialist alcohol and drug personnel.

- Parents and friends.
- Young people.
- Those contemplating using drugs.
- Users: those who are already experimenting with, or regularly using, various drugs.

## COMMUNITY INFORMATION

The community obtains information about drugs from a variety of sources; some are accurate, others are inaccurate. The mainstream media are prime providers of drug information to the community. They rank ahead of health, welfare and education services and personnel.

Analysis of content and style of reporting of legal and illegal drug issues was conducted by the Australian Drug Foundation in 1990 and replicated in 1994. In brief, this indicated that illicit drug matters were reported far in excess of their usage and 'harm levels'. Often this reporting was inaccurate and sometimes dangerous. It was usually sensationalised, particularly through headlines.

Strategically, it is crucial to maximise the reach and impact of the media as a source of drug information. At the same time it is important to understand the motives for the type of reporting of different drug issues.

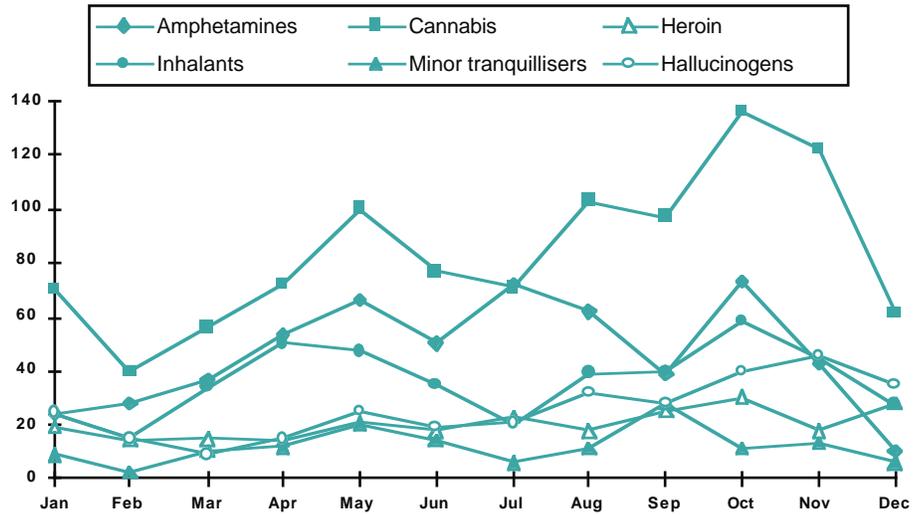
Drug use can be affected by media reporting. For example, research has shown a direct link between media reporting of inhalant use and increased usage among young people; especially where the report includes naming products that can be used or includes diagrams and symbols which show use.

To enhance the level of knowledge and to inform community debate, the availability of accurate information is essential.

Sources of drug information include the media, printed and other information at specifically targeted venues such as waiting rooms in health services, and information available at needle syringe exchange programs.

Where people actively seek information, initial contact is usually made by telephone. Written material can often be an adjunct to verbal advice, information, counselling or referral.

Figure 17 shows the number of general drug information calls received by the Australian Drug Foundation by drug type during 1995. Information requests for cannabis and heroin appear to have peaked around May and October, but care is needed in interpreting these figures.



\* Excludes counselling.

Source: Australian Drug Foundation.

Community information services are provided by the Australian Drug Foundation’s Info Service, which provides information to the general community about drugs and which is strongly linked to a comprehensive specialist alcohol and drug library. DIRECT Line 24 hour telephone information, counselling and referral service provides the general community with information about drug use, counselling and support services and referral to alcohol and drug services. The Drug and Alcohol Clinical Advisory Service (DACAS) provides general practitioners and other generalist health and welfare professionals with advice and information on the clinical management of alcohol and drug problems. DIRECT Line, DACAS and Drug Info provide for regional and rural residents through the provision of a Freecall (1-800) number. Each of the above services are well utilised by the general community, as well as by a range of professionals working in the alcohol and drug and allied fields.

Information received from DIRECT Line indicates that it receives an average of 41,000 calls per year. Seventeen per cent of these calls are from people living in regional and rural areas of Victoria. Calls to DIRECT Line from 1994 to 1996 by the main drug of concern are detailed in table 18.

TABLE 18

MAIN DRUG OF CONCERN: CALLS TO DIRECT LINE,  
1994–1996

	TOTAL NO.	% OF TOTAL CALLS
Heroin	7,853	11.2
Cannabis	6,633	9.5
Amphetamines	4,109	6.0
Methadone	2,884	4.1
Hallucinogens	409	0.6
Cocaine	180	0.3
Ecstasy	170	0.2
Other Illegal	50	0.1
Alcohol	14,938	21.3
Tobacco	2,316	3.3
All other calls <sup>2</sup>	30,633	43.6
<b>TOTAL CALLS</b>	<b>70,178<sup>1</sup></b>	<b>100.0</b>

<sup>1</sup> Excludes 10,886 Drink Drive calls.

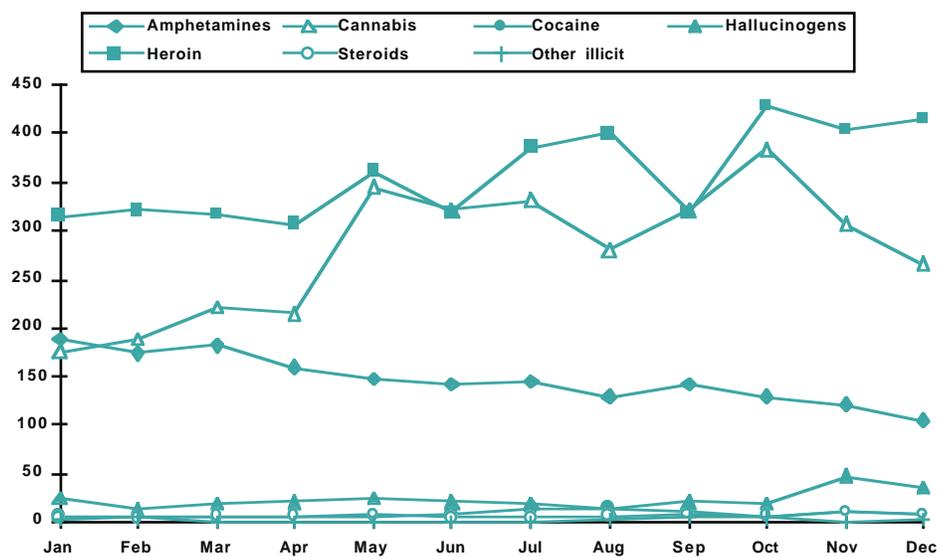
<sup>2</sup> All other calls include 6700 (9.5%) calls in which a drug not listed above was identified in addition to 23933 (34.1%) calls for which the main drug of concern was not identified or relevant (i.e. referral enquiry, informational enquires not specific to a drug (or one drug) such enquiries from parents and non-drug-related crises).

Source: Direct Line.

Figure 18 shows the prevalence of enquiries involving illicit drugs during 1995 to Direct Line. The number of calls relating to hallucinogens, steroids and other illicit drugs is relatively low and stable throughout the year, while calls about amphetamines declined. The majority of enquiries about illicit drugs relate to heroin and cannabis.

FIGURE 18

PREVALENCE OF ENQUIRIES INVOLVING ILLICIT DRUGS (1995)



Source: Direct Line.

A number of generalist telephone services, such as Life Line, who receive a total of 30500 calls a year and Aids Line, include calls about drug use. However, the way data is collected by these services makes calls relating to alcohol and drug issues difficult to quantify. Information about drugs is also freely available on the Internet from a variety of sources. There is currently no way of ensuring that the information provided is accurate.

## DRUG EDUCATION IN SCHOOLS

Schools are a natural site for drug education, as they offer access to the whole cohort of adolescents up to the school-leaving age of 15 years (and in many cases up to 17 years as the majority of students now complete Year 12).

The Drug Education Strategic Plan 1994–1999 guides the provision of drug education in Victorian schools. It was formulated under the aegis of the Directorate of School Education (DSE) in consultation with the Catholic Education Office, the Association of Independent Schools of Victoria, the Australian Drug Foundation, QUIT and Victoria Police. The plan seeks 'to enhance and sustain drug education in order to contribute to the minimisation of harm associated with drug use by young people'.

Over the past five years, a range of drug education materials and programs has evolved. These have been funded both from national and state government programs, and a range of community-based organisations and individuals. There appear to be no evaluations of the specific provision of information in Australia.

Evaluation of school drug education programs has been a focus overseas and elsewhere in Australia for some time. Evaluation results suggest that approaches which may appear appropriate to the lay person may not always be so. Evaluations of Victorian education programs have emerged particularly in the past five years. In the early 1970s efforts to dissuade young people from using drugs showed them the 'terrible troubles' that drugs could cause. These were the scare tactic campaigns. These programs sometimes included testimonials of ex-users describing their life when using drugs. Evaluation research found that many of these programs actually increased the likelihood of young people using drugs.

Moving away from this approach, the late 1970s saw drug education directed at personal development, such as enhancing self-esteem and decision making, and there was no mention of the drugs themselves. Evaluations of this approach produced varied results.

Findings from research and evaluation have helped improve knowledge about appropriate and effective drug education. It is likely that the educational approach to different drugs will vary according to a number of factors including their legal status. There is a suggestion that direct discussion of drugs that are legal and commonly available needs to be approached differently to the provision of information and education about illicit and rarely encountered drugs.

Consistent with guidelines suggested by the National Initiatives in Drug Education (NIDE) project, which aims to increase and improve drug education for school aged young people, the DSE has recently completed the development of *Get Real*. This package provides a resource that allows schools to respond to drug education from a policy, curriculum and welfare perspective within the health and physical education section of the curriculum, sequentially across the school years from Prep to Year 10. There is, however, no obligation on schools to undertake drug education or to use the resource material provided.

Council has been made aware of the efforts of some government and independent schools to provide drug education. During the consultations, representatives of some schools involved in the development of *Get Real* told Council how positively it had assisted their school.

Victoria Police also briefed the Council on its Police Schools Involvement Program (PSIP) in which 80 officers trained in harm minimisation work in schools across the State. Drugs and alcohol is one of seven modules delivered to students. A major role of the PSIP is on improving attitudes toward police. Australian Drug Foundation (ADF) research indicates that the program is effective with respect to alcohol and drugs if the officers have been trained and when their work is integrated into broader school programs.

Representatives of other schools and community groups with an interest in education talked about the efforts to provide drug education through visiting programs, and through written and other resource material. The Council has been provided with copies of some of this material. Some of these initiatives are large statewide programs one-off, visiting inputs, such as Life Education Centres. Others are local efforts initiated by concerned citizens. No detailed description of the extent and nature of these initiatives has been possible in the time available to the Council.

## PROFESSIONAL DEVELOPMENT

The potential role that health and welfare professionals can play in any drug strategy has long been recognised. Generalist health and welfare professionals are regularly responding to ongoing drug issues and related crises.

This group includes medical workers (GPs, hospital doctors and nurses), welfare personnel workers, employment officers, supported accommodation and assistance (SAAP) workers and youth workers. Their interaction with clients at a time when they are concerned or are experiencing problems with their health or lifestyle provides a unique opportunity to deliver information, and to educate the client and their family about illicit drug issues. It is also an invaluable opportunity to provide an early intervention.

A comprehensive, national report was prepared on the training needs of an extensive set of professional and other groups who are involved in delivering services to alcohol and drug users in 1986 (Commonwealth Task Force on Training, 1986 and 1987). A National Centre for Education and Training in Addictions (NCETA), has been established in South Australia and has links to Victorian organisations.

Some drug and alcohol specialist education opportunities are currently available and national courses offering distance education can be accessed, however, these cater for only a small number of students.

Police and teachers are also in a prime position to provide information, education and early interventions to young people. Preservice and ongoing professional development in current issues, policies and practice, contribute significantly to effectiveness.

In-service training and professional development of generalist health and welfare workers is currently minimal and ad hoc. The level of preservice training available to key professional groups is also variable. Under the current redevelopment of alcohol and drug services in Victoria, \$1 million has been allocated for the provision of training for generalist health and welfare workers, but this program is still in its early stages.

The Victorian Medical Post Graduate Foundation (VMPF) has also received funding from the Department of Health and Community Services (H&CS) to provide training for methadone prescribers through the Methadone training program and Prescriber Forums, in conjunction with the Turning Point Alcohol and Drug Centre. The training program aims to increase skills of methadone prescribers in identifying patients who are suitable for methadone, in assessing procedures for the safe prescribing of methadone, and in managing methadone clients within a context of long-term harm minimisation. Prescriber Forums are conducted every quarter and aim to meet some of the needs for ongoing prescriber education.

## MEDIA CAMPAIGNS

Few major media campaigns have been conducted that address illicit drug use. The two most recently conducted in Australia were the *Speed Catches Up With You* Campaign in 1993–94 and *Heroin Screws You Up* in 1987–88. Evaluations of these and other media campaigns have been equivocal at best. This is consistent with evidence relating to campaigns in other countries. Miller and Ware (1989) conducted a thorough review of the effectiveness of media campaigns and concluded that they have an important role to play in providing an information base that would predispose the community to be receptive to other drug control strategies. Mass media campaigns should be viewed as one plank in a platform of strategies required to effectively address the problems associated with alcohol and other drug use, and are probably less appropriate for illicit drugs than for licit drugs (Miller and Ware, 1989).

## COMMUNITY INVOLVEMENT

Drug issues are issues for the whole community. Community involvement strategies can aim to change structural, environmental, and social factors that contribute to drug use and drug harms. They often require the support of a dedicated worker who is skilled in working with divergent groups, and who has an understanding of community development principles and processes.

A small number of local councils are supportive of this approach and have provided submissions and verbal presentations to Council describing their current or proposed local projects. One example of community involvement is the St Kilda Project in the City of Port Phillip. This project has been in operation since 1991 and aims to reduce the negative impact of alcohol and other drug issues on the life of the St Kilda community through a process of community consultation, participation and education, and through the development of specific projects. Independent task groups and special project groups are developed to address specific issues in the community. A coordinated approach is encouraged through the interaction of task groups on activities and initiatives. This project is currently being evaluated.

The City of Greater Dandenong and the Victorian Department of Justice jointly fund a Safer Communities Project. This project aims to build partnerships between police, council, and the community to identify, develop and implement community safety initiatives. The strategy encompasses broad community safety and crime prevention issues (such as urban design and planning safer communities, violence prevention, community education), and interaction with educational institutions and youth specific drug and alcohol and health initiatives.

The Westgate Drug Task Force has been established to address the drug problem that has escalated in the western suburbs of Melbourne. The task force has representatives from regional Police Community Consultative Committees that include local community representatives and police. The task force's proposed strategies to address the drug issue in the western suburbs include, an integrated public education program, and a drug and violence assistance unit. It combines the resources of Victoria Police, local government and H&CS.

A small number of additional initiatives have been described to Council, including programs in country areas such as Benalla. To date, however, there has been no attempt at a coordinated local government effort in Victoria.

## DRUG USERS

Drug use affects all strata of society. Drug users are not a homogeneous group; there are distinct subcultures associated with the use of the various illicit drugs, and status of using (recreational, occasional, occupational, dependent and so on). There are also differences between age groups and ethnic backgrounds. The illicit status of these drugs can make the groups who use them difficult to reach.

Very limited resources or strategies currently exist that address the prevention and education needs of the using population. Information is currently provided by DIRECT Line, Victorian Intravenous Drug Users and AIDS Group (VIVAIDS), and at needle syringe exchange outlets.

Peer education has been used extensively among users of illicit drugs, including young offenders. Peer education is an education strategy that aims to change cultural norms from within the given culture. It is also referred to as peer information, support or counselling. Due to the illegality of their behaviour and the user's distrust of authorities, peer education is a principal means to access this group.

While specialist treatment services are vital to those with a drug dependency, treatment can be an inappropriate response for many people with non-dependent drug use. Young people and adults are unlikely to seek help or support from specialist treatment agencies until dependency is established. Information, education and practical support can be effectively provided by generalist workers in a range of contexts. The workplace can also be a site for the provision of drug education and information.

### 2.3.2 SUPPORT AND TREATMENT SERVICES

---

There are a variety of strategies and services to reduce the use of illicit drugs and deal with the resulting harms. They are provided through a wide range of government, non-government and local community organisations including generalist health services, acute health services, specialist alcohol and drug services, and services in the correctional system. These services and strategies have been developed by individual organisations in response to the problems that have arisen in the community as a result of alcohol and drug use. They have not, however, often been developed in a coordinated fashion across the range of government and non-government organisations. The result has been that treatment, support and prevention services are provided in an ad hoc and inconsistent fashion. The Council is concerned that there may be significant service gaps in all levels of the treatment system to cope with youth who develop physical, social or mental health problems associated with the increased initiation into illicit drug use, particularly 'at risk' young people.

## GENERAL SERVICES

People who have health-related problems that result from their drug use commonly consult their general practitioner, or use the services of a range of health and community services such as community health centres and non-government agencies that provide accommodation and support. No systematic data on the use of these services is available.

## ACUTE SERVICES

Victoria's acute medical hospitals and psychiatric services regularly provide services to people who have serious medical problems resulting from their drug use. Table 19 outlines the number of discharges from Victorian public hospitals where the principal diagnoses were related to drug use other than tobacco or alcohol. The most recent data available to the Council was for the period 1992–93. Females were treated in public hospitals in higher numbers than males, and a principal diagnosis related to drug use with females accounted for 59 per cent of these separations. These data provide a minimum estimate of services provided in the acute health sector.

TABLE 19

### DISCHARGES FROM VICTORIAN PUBLIC HOSPITALS WHERE THE PRINCIPAL DIAGNOSIS IS RELATED TO DRUG USE (Other than Tobacco and Alcohol), VICTORIA, 1992–93\*

DRUG TYPE	MALES					TOTAL	%
	<18	18-24	25-34	35-54	55+		
Amphetamines	6	10	9	0	0	25	2.2
Opiates	0	33	40	22	3	98	8.7
Benzodiazepines	34	70	126	140	37	407	36.0
Other tranquillisers	46	97	180	160	45	528	46.6
Other illicit drugs	8	30	19	6	11	74	6.5
<b>TOTAL</b>	<b>94</b>	<b>240</b>	<b>374</b>	<b>328</b>	<b>96</b>	<b>1132</b>	<b>100</b>
DRUG TYPE	FEMALES					TOTAL	%
	<18	18-24	25-34	35-54	55+		
Amphetamines	1	1	6	0	0	8	0.5
Opiates	6	16	24	14	5	65	4.0
Benzodiazepines	56	123	194	240	60	673	41.3
Other tranquillisers	80	173	245	272	80	850	52.1
Other illicit drugs	3	13	9	3	7	35	2.1
<b>TOTAL</b>	<b>146</b>	<b>326</b>	<b>478</b>	<b>529</b>	<b>152</b>	<b>1631</b>	<b>100</b>

Source: Prepared by the Addiction Research Institute using data from the Victorian Inpatient Minimum Database, H&CS.

\* (Discharges = separations).

Most separations for males and females had a principal diagnosis related to benzodiazepines or other tranquillisers. Together these accounted for 82.6 per cent of male separations and 93.4 per cent of female separations. Hospital separations with a principal diagnosis related to 'other' drugs occurred mainly in the 25–54 age group (62 per cent of both males and females). In 1994–95, about 4 per cent of separations from psychiatric services inpatient facilities related to drug and alcohol disorders.

## DRUG AND ALCOHOL TREATMENT SERVICES

A major redevelopment of specialist drug and alcohol services is underway and involves:

- Continuing the trend away from large government-run institutions toward smaller non-government services through the establishment of a statewide network of withdrawal and counselling services. These services will replace the formal government metropolitan institutions, Pleasant View and Heatherton which have closed (phase 1).
- Establishing a research and training centre, Turning Point Alcohol and Drug Centre, affiliated with the University of Melbourne and St Vincent's Hospital (phase 1).
- Establishing funds to support additional training for professionals working with people who need support and treatment for their drug and alcohol problem (phase 2).
- Reviewing and redeveloping the existing drug and alcohol services run by non-government organisations across the State (phase 3).

Maps showing the location of the new services being established in phase 1 are provided in appendix 9.

The major functions of these services are:

- Drug withdrawal services: residential drug withdrawal services are provided by 12 bed community residential withdrawal residential units. These allow an average stay of six days. Rural drug withdrawal services combine a short hospital stay if required with outpatient or home-based services. Home-based services assist those people able to stay at home while being supported in their withdrawal.
- Counselling and support services: these services employ specialist professionals who take responsibility for the management of clients with complex alcohol and other drug problems including suicidal people and those at risk to others. They are also responsible for the provision of supervision and training for other staff within the region, and have a role in the planning and development and evaluation of services.
- Turning Point Alcohol and Drug Centre leads therapeutic innovation, research, education, training and evaluation.

Stage two of the redevelopment involves the establishment of a Health and Welfare Training and Support Program. This will focus on the integration of alcohol and drug services with generalist health and welfare services. There will be an increased emphasis on early and brief interventions delivered through community health services, hospitals and general practitioners.

A range of additional services are currently provided to address alcohol and drug use issues by an additional 70 (approximately) non-government organisations funded by the Drug Strategy and Operations Unit of H&CS. The services provided include outpatient assessment, counselling and referral services, needle syringe exchange services and education and information services. A small number of residential services are also funded, including Odyssey House and the Windana Therapeutic Community. In the 1994–95 financial year, an estimated 44 per cent of clients registering with these services were seeking services primarily relating to the use of illicit drugs (Drug and Alcohol

Information System, H&CS). Table 20 shows new registrations by principal problem type for the period 1991–92 to 1994–95. The most common presenting problem is alcohol (52 per cent for males and 33 per cent for females). Of the illicit drugs, opiates, amphetamines and cannabis are the most common principal presenting problems.

**TABLE 20** **NEW REGISTRATIONS AT VICTORIAN ALCOHOL AND DRUG TREATMENT SERVICES BY PRINCIPAL PROBLEM TYPE (Percent), 1991–92 TO 1994–95**

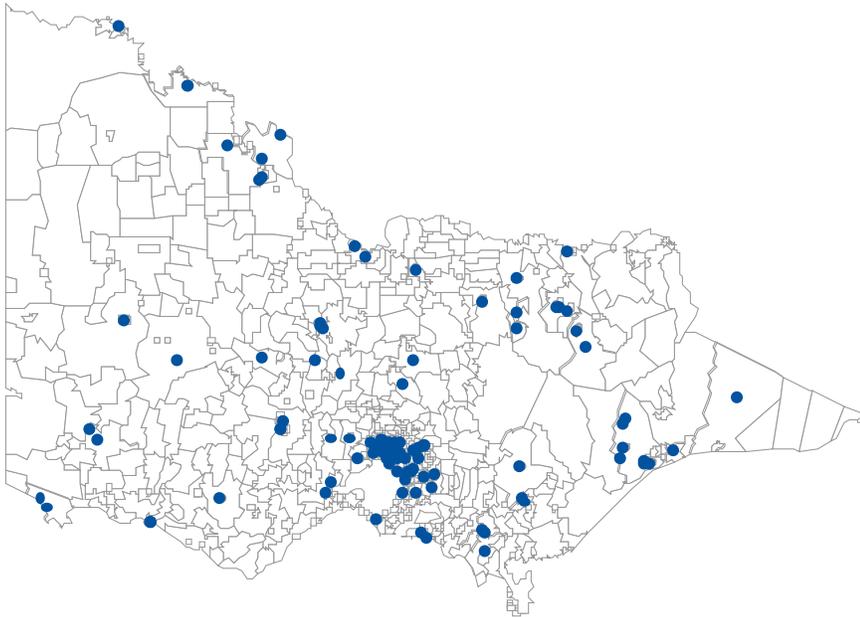
PRINCIPAL PROBLEM	1991–92		1992–93		1993–94		1994–95	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
	%	%	%	%	%	%	%	%
Alcohol	57.6	36.6	50.2	29.5	44.6	28.3	51.9	32.6
Amphetamines	8.5	12.0	10.0	13.6	10.9	14.0	9.9	11.7
Barbiturates	0.1	0.3	0.1	0.3	0.2	0.2	0.1	-
Benzodiazepines	2.2	10.8	2.6	11.6	2.6	9.4	2.0	8.6
Other tranquillisers	0.3	1.6	0.1	1.2	0.1	0.7	0.1	0.5
Cannabis	7.9	6.1	10.9	7.0	12.1	9.0	11.9	9.9
Cocaine	0.1	0.1	0.2	0.2	0.1	-	0.2	0.1
Hallucinogens	0.1	0.1	0.3	0.2	0.2	0.2	0.4	0.5
Opiates	11.9	18.2	14.9	24.0	14.6	20.8	16.3	24.1
Poly drug	4.0	5.7	5.2	6.7	7.2	7.6	5.0	6.3
Volatile substances	0.2	-	0.2	0.3	0.2	0.2	0.4	0.3
Other	6.9	8.6	5.2	5.5	7.1	9.4	1.8	5.3
<b>TOTAL PERCENT</b>	<b>100</b>							
<b>TOTAL NUMBER</b>	<b>6,154</b>	<b>2,045</b>	<b>6,313</b>	<b>2,206</b>	<b>5,480</b>	<b>2,066</b>	<b>4,460</b>	<b>1,724</b>

Source: DAISy Database, H&CS—data refers to new registrations at each funded service.

The information in table 20 shows an increase from 1991–92 to 1994–95 in the number of first registrations primarily due to opiate use (12 per cent to 16 per cent for males, and 18 per cent to 24 per cent for females). New registrations primarily for cannabis use have also increased slightly over this period.

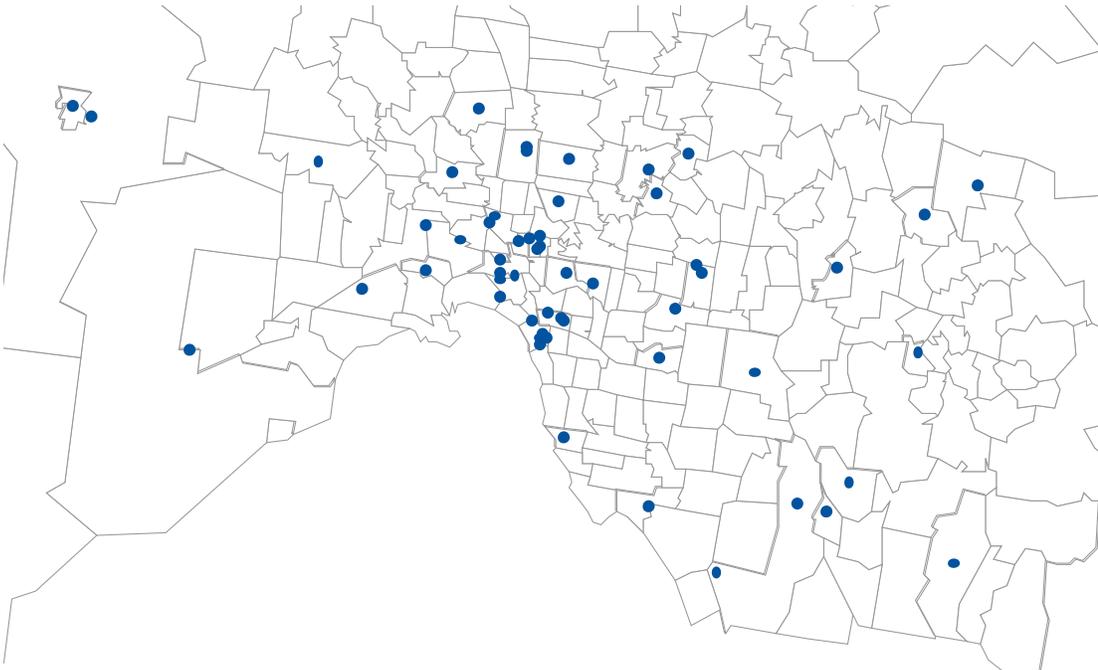
Most of these services have been in operation since the commencement of the National Campaign Against Drug Abuse in 1985. Previously these services have been funded on a historical basis. There have been no reliable monitoring and evaluation systems in place and H&CS does not therefore have detailed knowledge of how these services operate, what they provide, and how effective they are. The Council was informed that it is intended under the redevelopment to undertake a review of these services to establish a baseline of information that will assist in the planning of a more appropriate service mix. Maps 1a and 1b shows the location of these services.

LOCATION OF EXISTING ALCOHOL AND DRUG SERVICE PROVIDERS FUNDED BY H&CS,  
VICTORIA, 1995



Source: Public Health Branch, H&CS.

LOCATION OF EXISTING ALCOHOL AND DRUG SERVICE PROVIDERS FUNDED BY H&CS,  
MELBOURNE AREA, 1995



Source: Public Health Branch, H&CS.

## PEER SUPPORT

Many users do not wish to discontinue their drug use and therefore do not come into contact with specialist treatment agencies. As the drugs they take are illicit, they may come into contact with the criminal justice system which may result in stigmatisation. Contact with general health and welfare agencies is often marred by what users perceive to be judgemental and harsh attitudes. This may result in further alienating them from generalist health and welfare organisations. In these circumstances this group of users will often seek out the support of a peer-based service/s. Other users, who may be in touch with generalist or specialist services, may also seek the support of peer support groups for a sense of understanding and support some would argue only comes from talking to and being with those who have endured similar experiences. Peer-based services provide support, advocacy and education to users about safe injecting and drug-taking practices, and referral information and liaison. The relevance of these organisations to users who might otherwise not come into meaningful contact with primary, secondary and tertiary sector treatment services means that these services form a vital link for users to forms of support and education. The work of these organisations is crucial in providing a point of stability and continuity as the user comes into contact with other parts of the health and welfare, law enforcement and related systems.

In Victoria, a number of peer education and support organisations exist. Many of these have a broader membership than illicit drug users. The organisations that are solely concerned with providing peer support and education to illicit drug users are:

- Understanding and Support Society and the Self Help Addiction Resource Centre
- Victorian Intravenous Drug Users and AIDS group (VIVAIDS).

## SELF-HELP GROUPS

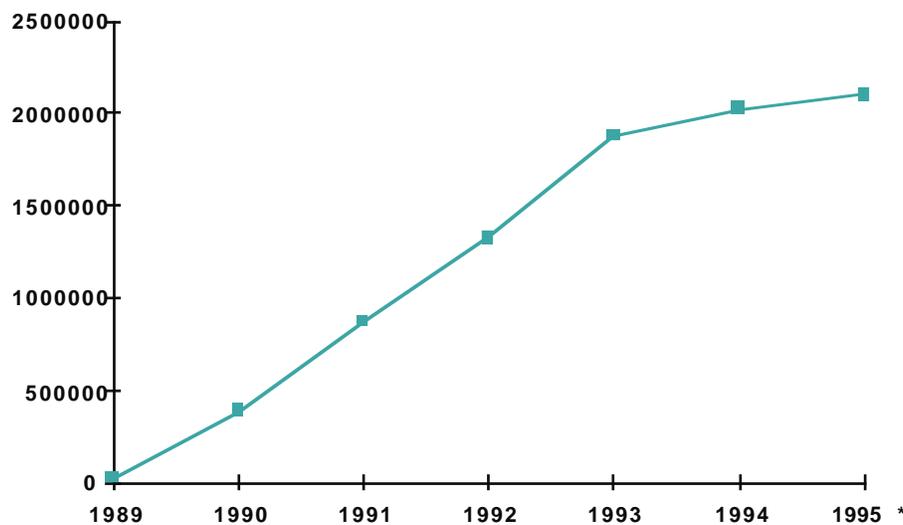
Self-help groups provide an alternative or an important adjunct to specialist services. Twelve- step programs such as Narcotics Anonymous have provided support based on an abstinence model first used in Alcoholics Anonymous. The Understanding and Support Society and the Self Help and Addiction Resource Centre has provided direct support to users and their self-help groups. Parents of drug users have also found the mutual aid offered by Drug Users Parents Association to be of enormous benefit. More recently, Women for Sobriety has also taken its place among self help groups available to users in Victoria. Other self-help groups include Adult Children of Alcoholics, CoDependents Anonymous, AlAnon, Alateen. While these groups ostensibly aim at relatives and significant others of alcoholics, they may well attract people concerned about the use of other drugs. Families Anonymous is open to family members experiencing a range of difficulties including drug use. These organisations are largely self-funding. They rely on contributions and support from their membership and often the good will of other services for the provision of meeting space. Smaller self-help groups often have a limited life span and this list is therefore not exhaustive.

## NEEDLE AND SYRINGE EXCHANGE

The Needle Syringe Exchange Program (NSEP) commenced in Victoria in 1987 and expanded rapidly. At the end of 1995, 160 NSEPs were approved for operation throughout metropolitan and country Victoria. A variety of settings were chosen: community health centres, alcohol and drug agencies, shopfronts, hospitals, pharmacies, youth services, university student health services, municipal councils, aboriginal cooperatives and a sexual health service.

NSEPs provide drug users with free sterile equipment to inject with, and education to reduce the likelihood that their injecting or sexual behaviour will increase the spread of blood-borne viruses such as HIV. During 1995, over two million needles and syringes were distributed and just under one million used needles and syringes were returned. The number of needles distributed through the program from 1989–1995 is depicted in figure 19.

**FIGURE 19** NEEDLES DISTRIBUTED BY THE NEEDLE SYRINGE EXCHANGE PROGRAM 1989–1995



\* Based on Jan–Sep 1995.

Source: Victorian Needle and Syringe Exchange Program: Annual Reports, AIDS/STD Unit, H&CS.

The success of NSEPs is measured in the rates of intravenous drug users who succumb to HIV infection. In 1994, the proportion of HIV diagnoses attributable to heterosexual intravenous drug users was 2.8 per cent which represented a 1.5 per cent decrease from 1993. The estimated seroprevalence for intravenous drug users has stabilised below 2 per cent, which is a low rate when compared with other countries.

## METHADONE

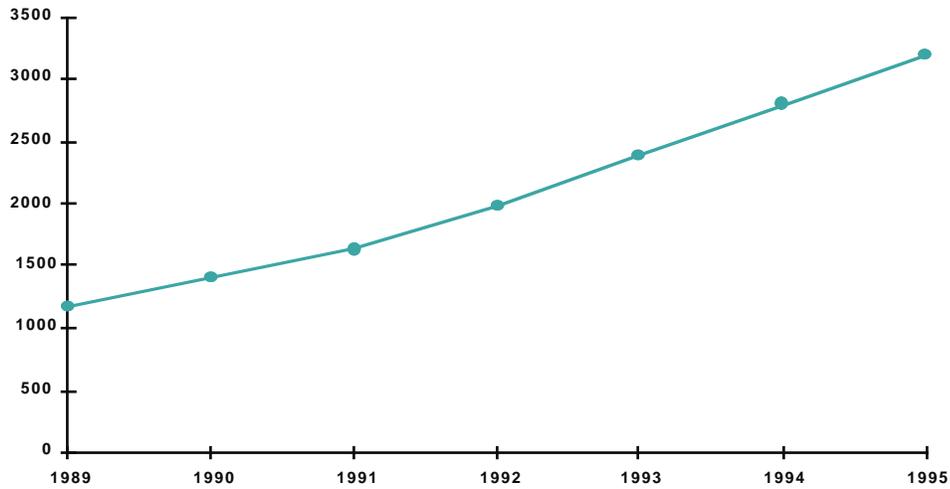
Methadone maintenance programs aim to reduce the harms associated with illicit opiod dependence by prescribing and dispensing methadone (a substance that acts by reducing the desire to use other opiates). Methadone is also an addictive opiate; however it differs from heroin and other opiates used in medicine in that its effects last longer and thus it only has to be given once daily. Methadone is a legal and regulated drug. It can only be prescribed to an opiate-dependent person by a registered

medical practitioner who is an approved prescriber, and who has obtained a permit for each patient from the Victorian Department of Health and Community Services. Methadone used in such programs is usually diluted in a fruit juice cordial and taken orally.

Methadone for the treatment of opiate dependence was first prescribed in Australia in 1969. It is considered by most drug specialists to be a cost-effective treatment of heroin dependence, and successful in reducing heroin use, criminality, needle sharing and preventing the spread of blood-borne viruses, in particular HIV in intravenous drug users (Ward, Mattick & Hall, 1992). The number of persons who are prescribed methadone has dramatically increased, particularly since 1989 as depicted in figure 20.

FIGURE 20

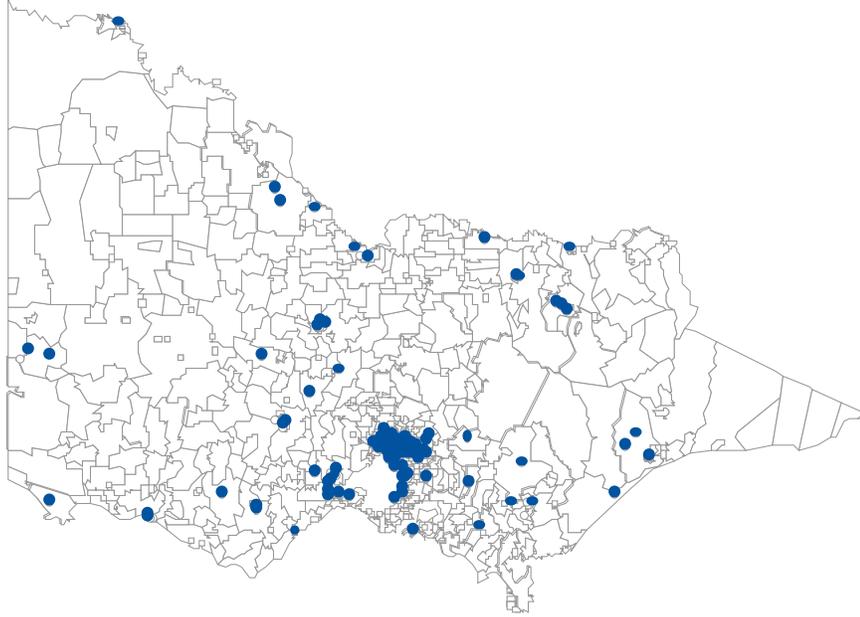
NUMBER OF PERSONS PRESCRIBED METHADONE IN VICTORIA, 1989–1995



Source: Public Health Branch, H&CS.

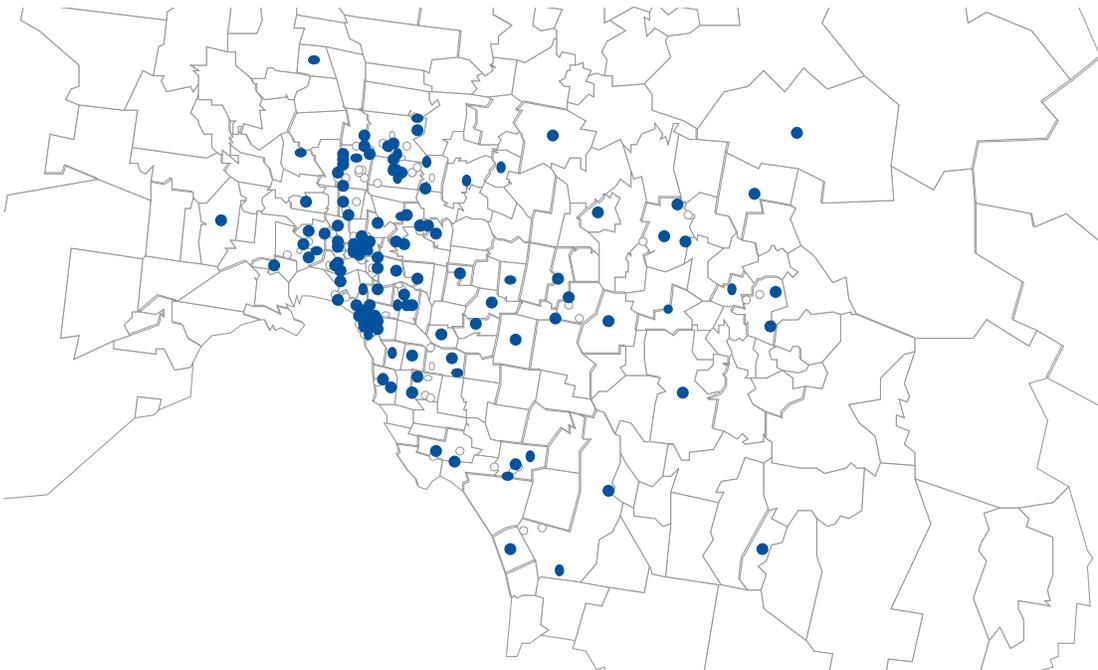
Currently 3193 Victorians are on a methadone program and more than 90 per cent of these people are under the care of general practitioners. They collect their daily doses at local pharmacies. Some clients require more intensive treatment and specialist management. To cater for these clients, specialist methadone services have been established in the metropolitan Melbourne area at Footscray and Fitzroy. A further two services are to be established in Melbourne. The following maps depict the location of methadone prescribers and pharmacies on 20 September 1995.

**METHADONE PRESCRIBERS ON 30 SEPTEMBER 1995,  
VICTORIA**



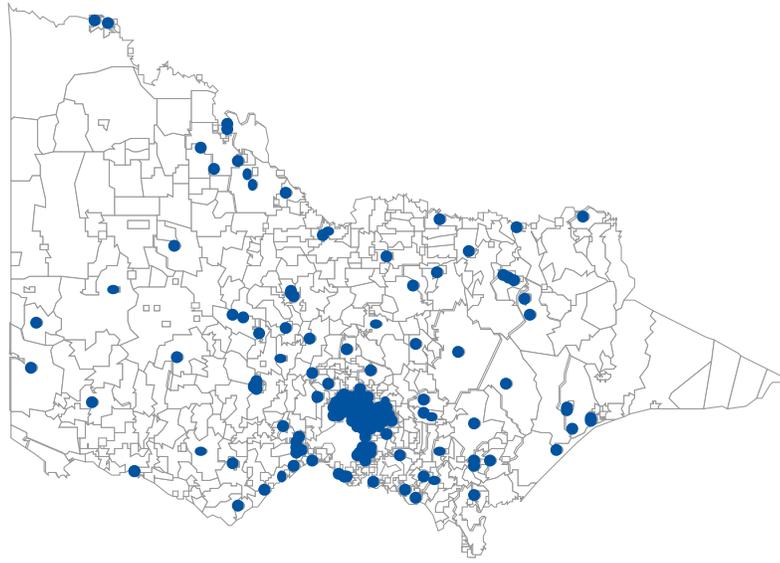
Source: Public Health Branch, H&CS.

**METHADONE PRESCRIBERS ON 30 SEPTEMBER 1995,  
MELBOURNE AREA**



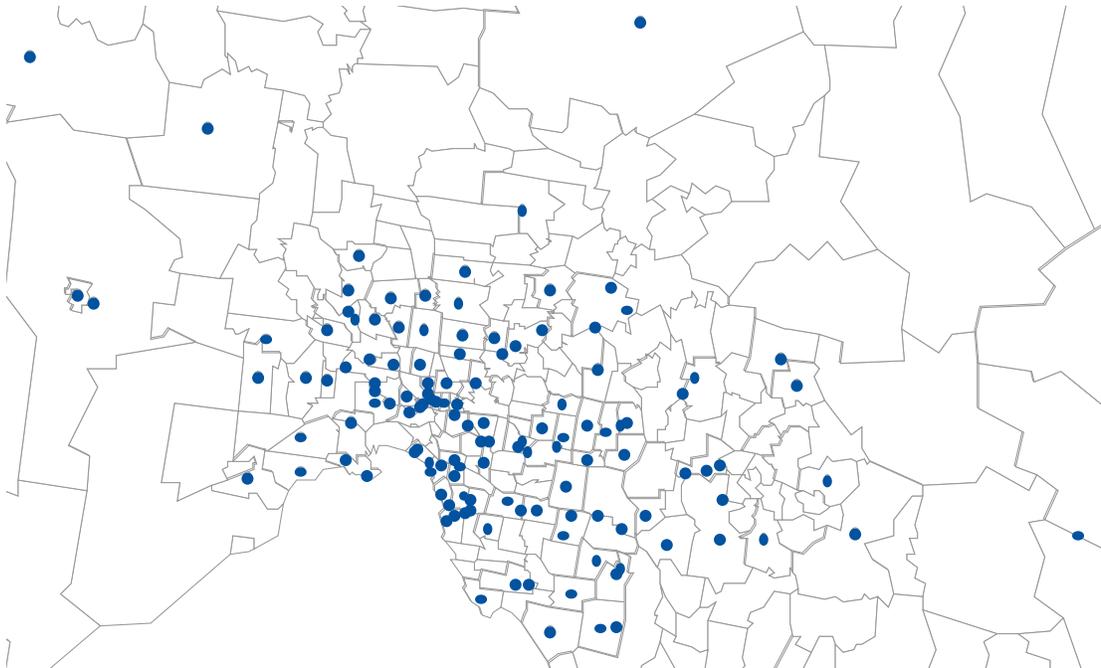
Source: Public Health Branch, H&CS.

**METHADONE PHARMACIES ON 30 SEPTEMBER 1995,  
VICTORIA**



Source: Public Health Branch, H&CS.

**METHADONE PHARMACIES ON 30 SEPTEMBER 1995,  
MELBOURNE AREA**



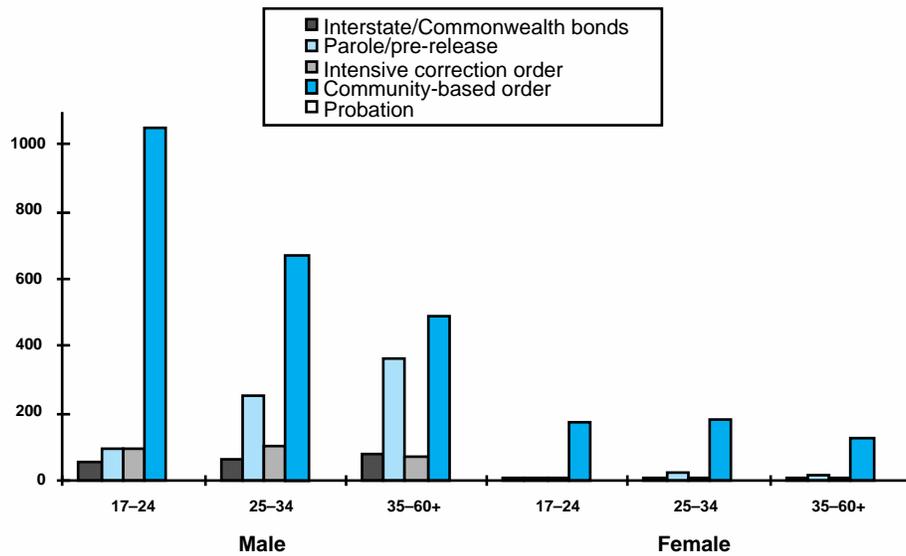
Source: Public Health Branch, H&CS.

Correctional Services are responsible for containing in prisons, and supervising people subject to community-based dispositions. Many men, women and young people who have committed offences also have concurrent substance abuse problems.

Currently there are 2236 persons in male prisons and 182 in female prisons. Figure 21 indicates the number of people by age and type of community-based disposition. It should be noted that these figures exclude those people who have unpaid fines converted to a community-based order. Therefore, the graph only shows those people subject to community-based dispositions who have supervision, and/or testing, and/or assessment and/or treatment conditions attached to their disposition.

FIGURE 21

#### COMMUNITY BASED CORRECTIONS OFFENDERS BY AGE, SEX AND PROGRAM TYPE AT 30 JUNE 1995



Note: Excludes fine conversion community-based orders.  
Source: Department of Justice.

There are on average 118 young people in youth training centres and 1140 young people on parole and other orders being supervised at youth supervision centres.

As noted previously, there is evidence to suggest a high prevalence of substance abuse in correctional populations: in community-based corrections and prisons, and the juvenile justice system (Herrman et al, 1994; Youth Parole Board Report, 1995). Contact with the criminal justice system is often a time of crisis for individuals and an important window of opportunity to address problems with substance abuse and associated family, vocational and other problems. This is true of adult and youth correctional populations. Research literature indicates that treatment, even if compulsory, with correctional populations can be effective provided it is adequately resourced (Hall, 1995; Platt, Buhlinger, Kaplan, Brown, Taube, 1988).

People with a substance abuse disorder who are in contact with the criminal justice system usually have a range of social needs (such as housing, general support and troubled family relationships) that also need to be addressed if specific treatment for substance abuse is to be successful. Voluntary sector

organisations, such as the Victorian Association for the Care and Resettlement of Offenders, Brosnan Centre, and Epistle Post Release Centre provide accommodation and support to young people and adults in contact with the criminal justice system and their families. All are significant in addressing these broader needs.

In Victoria, magistrates and judges have the capacity to sentence people to community-based dispositions. The aim of these dispositions is to combine retributive and rehabilitative intentions by ordering unpaid community work and, where necessary, assessment and treatment of any psychological, psychiatric or social factors that may have contributed to the offences being committed. The Victorian Adult and Youth Parole Boards are able to grant parole orders that may require individuals to receive treatment and, in the adult correction system, perform unpaid community work. Community-based dispositions and parole orders and the special conditions attached to them, are used by the court and parole boards to compel individuals within adult correctional services and the juvenile justice system to receive treatment for substance abuse issues.

H&CS administers treatment services for people with drug problems ordered by the courts under section 28 of the Sentencing Act 1991. There are currently 219 people receiving treatment under these orders.

## TREATMENT AND SUPPORT SERVICES IN ADULT CORRECTIONS

The Correctional Services Division (CSD) of the Department of Justice also provides support and treatment for people in prisons both sentenced and on remand. Community Based Corrections staff provide supervision of people subject to community based dispositions and administrative functions on behalf of the Adult Parole Board. Services provided, either directly by CSD or contracted through agencies by CSD, are:

- **Community Based Corrections**

- Education for people unmotivated for treatment and not at a high risk of reoffending.
- Drug and Alcohol Monitoring Program (DAMP) delivered by the Western Region Centre for Alcohol and Drug Dependence (WESTADD).
- Referral to a special drug and alcohol treatment agency.

- **Prisons**

- Peer education provided to prisoners by other prisoners on reception into prison.
- Gradual withdrawal of methadone for people serving sentences over six months and methadone maintenance program for prisoners serving sentences under six months or who are pregnant or on remand. Council was advised that policy guidelines could be altered according to clinical need (Forensic Health Services, H&CS).
- A therapeutic community with a capacity for 20 male prisoners.
- Fairlea Prison for women provides an Intensive Treatment Program targeted at prisoners with a recognised significant substance abuse problem and has a focus on relapse prevention strategies.

The corrections prison-based treatment services are currently the subject of review by an external consultant. Some programs within community based corrections are currently being evaluated.

In Australia, two important initiatives at the national level set the scene for Victorian harm minimisation strategies and initiatives: the National Drug Strategy (formerly the National Campaign Against Drug Abuse) and the National Anti-Crime Strategy. Harm minimisation is the guiding principle for the State and National Drug Strategies and aims to reduce the adverse health, economic and social consequences of drug use for individuals and society. It does not necessarily imply the goal of prohibiting or eliminating drug use. Prohibition may be part of a harm minimisation policy, but only if it can be demonstrated to contribute to the overall aim of reducing the harms associated with drug use.

In Australia, harm minimisation has been the accepted strategy for more than a decade. The foundation of the National Campaign Against Drug Abuse (NCADA) in April 1985 was the principal vehicle through which this strategy was to be developed. Victoria's Drug Strategy followed suit in the same year. Current drug strategies federally and in Victoria have since remained firmly within the framework of harm minimisation. The specific form taken by harm minimisation strategies depends partly on the drug-related harms identified as most significant. In the Victorian Drug Strategy these are clearly laid out to be:

- Illness and disease
- Accidents and injuries
- Family and social disruption
- Violence and crime
- Workplace problems.

Legal and illicit drugs are the focus of the harm reduction strategy. As the concern is with harms, the strategy is concerned with alcohol and tobacco as well as illicit drugs. Indeed, it is clear that the legal drugs together create a far greater amount of harm than do illegal drugs. However, the status of illicit drugs creates specific problems that follow from their illegality. These include significant harms created by the high potential for corruption among public officials. This potential, added to the fact that law enforcement frequently cannot prevent widespread use of illicit drugs, has the further effect of diminishing respect for the law. Other problems include such matters as the difficulties of reconciling the sometimes conflicting goals of enforcing the law and minimising harms to drug users. Harm minimisation is a goal or a philosophy, not a method, and involves several types of strategies:

**Demand reduction:** education and prevention.

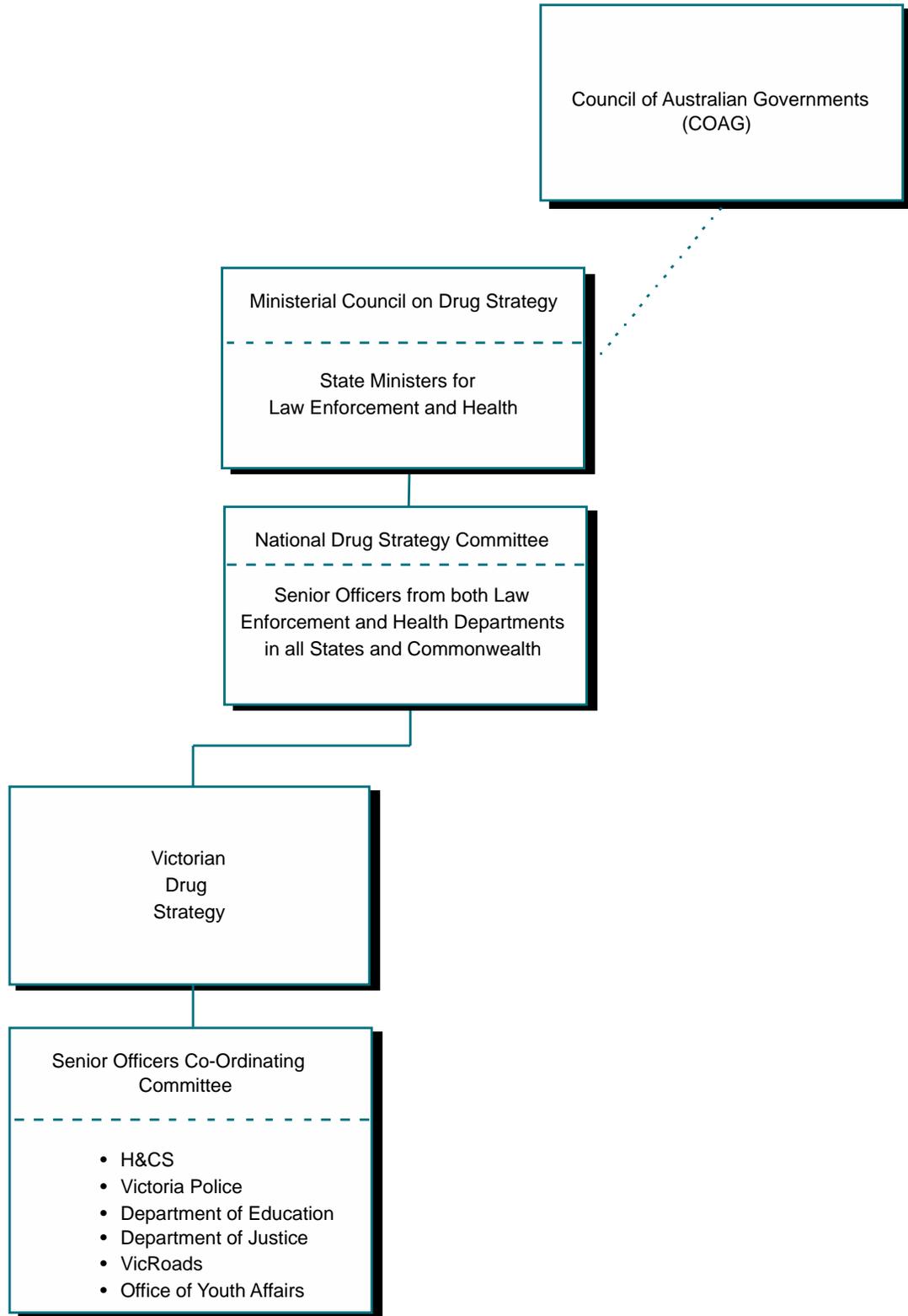
**Supply control:** legalisation and regulation.

**Harm reduction:** helping people to use drugs as safely as possible.

It also includes measures that aim to prevent or reduce specific problems associated with drug use by recognising, but not condoning, illicit use or harmful levels of licit drug use. Table 21 presents an overview of the relevant strategies.

STRATEGY	GOALS/ISSUES
<p><b>NATIONAL DRUG STRATEGY</b></p> <p>Established: 1985</p> <p>Strategic Plan Published: 1992</p>	<ul style="list-style-type: none"> <li>• To minimise the harmful effects of drug use on Australian society.</li> <li>• Key policy approaches include: harm minimisation, social justice, drug control, an intersectoral approach, international cooperation, evaluation and accountability.</li> </ul>
<p><b>NATIONAL ANTI-CRIME STRATEGY</b></p> <p>Established: 1984</p>	<ul style="list-style-type: none"> <li>• Addressing the issue of demand, as well as supply, of drugs.</li> <li>• Examining the complex relationship between drug dependency and crime.</li> <li>• Developing counselling and education programs tailored to different age groups.</li> <li>• Targeting of government resources to higher level drug crime.</li> </ul>
<p><b>VICTORIAN DRUG STRATEGY</b></p> <p>Established: 1985</p> <p>Strategic Plan Published: 1993</p>	<ul style="list-style-type: none"> <li>• To minimise the level of illness, injury, and death associated with the use of alcohol, tobacco, and other drugs in Victoria.</li> <li>• To minimise the level of drug offences and other alcohol and drug-related crime committed in Victoria.</li> <li>• To minimise the social disruption and loss of productivity attributable to alcohol and other drug use in Victoria.</li> </ul>

The National Drug Strategy is a cooperative venture between all governments and the non-government sector with the common aim 'to minimise the harmful effects of drugs on Australian society'. The National Drug Strategic Plan 1993–1997 sets out the aims and issues associated with the strategy and the goals and objectives to be achieved in the next five years. Individual States and Territories have developed their own strategic plans to fall within the broad framework set by the National Drug Strategy. The Victorian Drug Strategy Strategic Plan 1993–98 sets out the overall policy context for action on all alcohol and drug issues at a State level.



A comparison of international drug policies demonstrates the different ways in which a number of countries control the use of prohibited drugs. The drug policies of several countries, including Australia, are compared in table 22 using a number of variables raised by MacCoun et al. (1993). The criteria selected roughly place various industrialised countries along a continuum from more to less tolerant policy, or alternatively from nations that emphasise 'harm reduction' to nations that emphasise 'use reduction'. Selected policies are outlined in more detail below. MacCoun's original table has been adapted to include information on Australia, Sweden and Singapore.

**TABLE 22** **COMPARISON OF INTERNATIONAL DRUG POLICIES ON A HARM-REDUCTION/USE-REDUCTION CONTINUUM**

	LEGAL DISTINCTION BETWEEN HARD/SOFT		POSSESSION FOR PERSONAL USE NOT PENALISED		TREATMENT OFFERED IN LIEU OF PENAL SANCTION		REGULAR USE OF METHADONE IN TREATMENT		SYRINGES AVAILABLE/RETAIL EXCHANGE	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
Netherlands	✓		✓			✗	✓		✓	
Spain	✓		✓		✓			✗	✓	
Italy (pre '90)	✓		✓		✓		✓		✓	
UK		✗		✗		✗	✓		✓	
Canada		✗		✗		✗	✓		✓	
France		✗		✗	✓			✗		✗
Norway		✗		✗		✗		✗	✓	
Germany		✗		✗	✓			✗	✓	
USA		✗		✗		✗	✓			✗
Australia		✗		✗	✓		✓		✓	
Sweden		✗		✗	✓		✓		✓	
Singapore		✗	✓		✓			✗		✗

Source: Psychoactive Drugs and Harm Reduction: From Faith to Silence, Heather, N., Wodak, A., Nadelmann, E., and O'Hare, P. (eds.), Whurr Publishers, London, 1993.

Note: Table adapted from the above source.

### THE NETHERLANDS

The current Netherlands drug policies were established in 1976. They are characterised by a policy of 'normalisation' in which efforts are made to avoid stigmatising and marginalising drug users. This reflects the philosophy that the society as a whole must shoulder at least part of the responsibility for people experiencing harmful drug use, as poverty and limited life opportunities are risk factors for harmful drug use. The policy separates drugs into those that carry 'acceptable risks' (cannabis in all its forms) and those that carry 'unacceptable risk' (the so-called hard drugs: heroin, cocaine, amphetamines and so on). The Dutch legislative principle of 'inexpediency' has been applied with the result that prosecutorial guidelines mean that people are generally not arrested and charged with the

possession of small quantities of drugs, as it is inexpedient to do so. It is not an offence to use cannabis but it is to possess the drug for the purposes of use. Linked with these strategies is active education of all children in the Netherlands about drugs and their dangers.

Some 2500 'coffee shops' operate openly throughout the nation permitted to sell various kinds of marijuana and hashish but no other illegal drugs. In 1995, the Government released a new national drug strategy, titled *Drug Policy in the Netherlands: Continuity and Change*. It emphasises continuity in the philosophical and legislative underpinnings of the policy, along with modifications reflecting the changes Europe is experiencing. The new initiatives include reducing from 30 g to 5 g the amount of cannabis one can possess without police intervention, reducing drug-related 'nuisance', aggressively detecting and deporting drug tourists, and increasing law enforcement efforts against trafficking. Notwithstanding the legal sale of cannabis products, their consumption by the Dutch community is at a lower level than that in Australia.

### THE UNITED KINGDOM (UK)

The UK has recently adopted the 1995–1998 English Drug Strategy, using the slogan *Tackling Drugs Together*. The title reflects the strategy's focus on addressing supply and demand reduction initiatives. It has three main strategic goals: increasing community safety from drug-related crime, helping young people to resist drugs and reducing the health risks of drug misuse. It emphasises the need for structures and resources to enable the overall strategy to be implemented locally (at the municipal level). No mention is made in the new strategy of the former 'British System', under which doctors prescribed drugs such as heroin, to dependent people for maintenance purposes as a treatment intervention. As it is written, the new strategy moves away from the heavy law enforcement bias of earlier British drugs policy.

### THE UNITED STATES OF AMERICA (USA)

The USA national drug policy is heavily focused toward a law enforcement and prohibition model. The *1995 National Drug Control Strategy* specifies 14 goals with the overarching goal being 'to reduce the number of drug users in America'. Other goals are in the areas of demand reduction (particularly through criminal justice system programs), domestic law enforcement, and international activity. The strategy is managed nationally through the Office of the National Drug Control Policy within the Executive Office of the President.

Action plans for 1995 included:

- Reducing the demand for illicit drugs.
- Reducing crime, violence and drug availability.
- Enhancing domestic drug program flexibility and efficiency at the community level.
- Strengthening interdiction and international efforts aimed at disrupting the production and flow of drugs into the USA.

The implementation of the USA drug strategy in recent years has led to the criminalisation of high numbers of young Afro-American males and a substantial increase in the size of the prison population. By contrast, Victoria has nationally and internationally low rates of imprisonment per capita. However, within the Victorian prison population there is a high proportion of people with substance abuse problems.

## SINGAPORE

Prior to 1988, drug abuse was regarded as a medical problem in Singapore. Drug abusers were treated as patients, and programs and services were designed and provided on the basis of this philosophy. However, since 1988 drug abuse is viewed as a social and behavioural problem.

The strategy to tackle drug abuse in Singapore remains as a two-pronged approach of supply reduction and demand reduction. Measures to reduce supply are coordinated through government agencies such as the Central Narcotics Bureau, police and the custom service. Severe penalties exist for trafficking. Measures to reduce demand include preventive education, treatment and rehabilitation, supervision, and aftercare services.

Under the Misuse of Drugs Act 1973 (Singapore) the Director of the Central Narcotics Bureau has the power to commit drug-dependent persons, arrested or voluntarily surrendering, to drug rehabilitation centres for treatment and rehabilitation. Under this approach, the court system is bypassed and drug abusers are not criminalised by a court conviction or further stigmatised by a criminal record. The second major reason for this approach is to check the spread of drug abuse by ensuring that drug abusers are removed from bad influences and treated in a drug-free environment (Teck Hong and Isralowitz, 1996). Despite these measures, dependency on heroin remains a problem in Singapore.

## SWEDEN

Sweden is often cited as a country with an effective drug policy. In 1968, the Government laid the foundations of the current Swedish drug policy that aimed to produce a close interaction between preventive measures, control policy, and treatment of drug abusers. Penalties for drug offences were increased and residential treatment centres and outpatient units were established.

In 1977, the parliament passed a bill aimed at producing a drug-free society. In 1982, new legislation was introduced to allow coercive care for young and adult abusers placed within social services. A report released in 1982, titled *Offensive Drug Abuser Care*, placed emphasis on outreach activities, efforts to motivate drug abusers for treatment, and cooperation between the social services, the police, prisons and probation authorities. Since 1986, drug abuse care centres have increased in number.

To the Council's knowledge no evaluation of the effectiveness of these programs has ever been published. Survey data indicates that Sweden, along with West Germany (which has similar policies on cannabis and heroin) has an almost identical prevalence of cannabis and 'hard' drug usage to the Netherlands that has a more liberal policy on drugs (Reuband, 1995).

## Introduction

The significant information and facts about illicit drugs that have informed Council's investigations are outlined in chapter 2.

Council's terms of reference required it to provide the State Government with recommendations regarding the response that should be made to illicit drug use in the community. Council has reached conclusions about the most appropriate strategy, and this chapter outlines the major issues considered and the rationale for Council's recommendations.

As a result of its investigations, Council has many significant concerns about illicit drug use in Victoria. These concerns focus on the harmful effects that drugs can have on the users, their families, friends and the community. More broadly, the Council is concerned that as a community we have a poor understanding of the impact that drugs have on society and the mixed consequences that their legal status generate.

The drugs under consideration in this inquiry are illegal. Licit drugs are available but are subject to varying levels of regulation and restriction. The differing legal response to drugs is a result of complex social and political forces not a statement about the intrinsic status of these drugs. The community is increasingly aware of the risks of misuse of drugs and has accepted greater regulation when dangers are clear. The section of this chapter on the law outlines and assesses a range of legal options.

Reducing drug use and misuse is critical in the light of Council's concerns about the impact of drugs. Prohibition can contribute by containing supply and reducing demand. A wide range of other strategies also prevent use and misuse and deserve attention. Important among these options are education and information strategies. In this area, Victoria is well placed because of its successful health promotion and education strategies, particularly in relation to alcohol and tobacco.

Providing support and treatment to people with serious drug use problems may prevent the development of further problems and will, in some instances, reduce use. Effective support and treatment must be flexible to respond to the diverse needs and situations of drug users. Treatment services need to focus on those with serious problems, and to respond to the harms produced and the context in which misuse occurs.

Since 1985, and particularly since effective responses were developed to HIV/AIDS, Australia has pursued a drug policy goal of harm minimisation. Council believes available evidence lends strong support to current Victorian and Australian approaches. None of the evidence received by Council has argued that there is a set of policies or strategies capable of eliminating drug use from our society in the foreseeable future. On the contrary, considerable concern has been expressed about the social causes of drug use and the likelihood that trends will be towards increased rather than decreased use.

Victoria's response to illicit drugs requires clear objectives that enable evaluation of existing activity and assessment of the likely impact of alternative approaches. The objectives need to be framed in the knowledge that the health consequences of misuse are substantial and that any law enforcement, prevention and treatment approach can have positive and unintended negative consequences.

Council believes the objectives for Victoria's response to drugs should be:

- Minimising the harms caused by the misuse of psychoactive drugs.
- Minimising the use of psychoactive drugs.

Chapter 2 provided a brief description of what is meant by harm minimisation (2.4). The overall objectives through which minimisation of drug-related harms are to be achieved have been spelt out by the National Campaign Against Drug Abuse (NCADA—now the National Drug Strategy) as:

- *Promoting greater awareness and participation by the Australian community in confronting the problems of drug abuse.*
- *Achieving conditions and promoting attitudes whereby the use of illegal drugs is less attractive and a more responsible attitude exists toward those drugs and substances which are both legal and readily available.*
- *Improving both the quantity and quality of service provided for the casualties of drug abuse.*
- *Directing firm and effective law enforcement efforts at combating drug trafficking, with particular attention to those who control, direct and finance such activities.*
- *Supporting international efforts to control the production and distribution of illegal drugs.*
- *Seeking to maintain, as far as possible, a common approach throughout Australia to the control of drug use and abuse.*

The Council had eleven weeks to conduct its inquiries. It has had the benefit of input from written submissions, public hearings, specialist hearings and discussions with experts from Australia and overseas. Approaches that will improve Victoria's approach to illicit drugs have been distilled from these extensive and generous contributions.

Material presented in this report raises a wide range of policy and operational issues. While Council has developed a strategy that underpins its recommendations, it acknowledges that many matters require further consideration, informed public debate and careful reform.

Council has attempted to develop an approach to Victoria's drug problems that, above all else, minimises the harm caused by misuse. This chapter provides the building blocks that give substance to Council's aspirations.

## 3.2

### Current Knowledge

Council heard many inaccurate, false, and misleading assertions during its investigations. Illicit drugs and their effect on the community, and especially on the young, seem to promote views that are not always well grounded in factual information. This tendency is not confined to the general public as many people claiming to be expert in the area of illicit drugs are not always well-informed.

It is likely that the lack of well-informed public debate about illicit drugs is in part due to the fear they inspire in the community, their low prevalence relative to other drugs such as alcohol and tobacco and a lack of concerted public education.

Community understanding of the consequences of alcohol and tobacco misuse is relatively high. This level of understanding probably results from the extensive public education efforts made in recent years. The same does not exist for illicit drugs. While it is fortunate that use of illicit drugs, other than

cannabis, is not widespread, efforts to provide the community with information have been limited, partly because of their illegal status. Prohibition has not helped to engage the community in efforts to reduce the harms of illicit drugs or reduce overall usage.

There are many important gaps in the data required to confidently formulate policy, design programs, and monitor service effectiveness. This has affected the shape of proposals put by Council.

Qualifications have been placed on much of the data included in chapter 2. Examples of problems are:

- Information on the level of use, particularly dependent and problematic use, is limited and almost certainly understates the position. The data is collected through small-scale household surveys (National and Victorian Household Surveys). Such surveys, because of the nature of the sample, are likely to underestimate the numbers using illicit drugs (Sutton et al, 1995).
- Very few of the preventive and educational initiatives that have been undertaken have been subject to critical evaluation. Some of the completed evaluations were not available to Council as they were regarded as confidential by the organisations that commissioned the work. Evaluations that can be used to predict future behaviours are difficult and costly to conduct. Results are sometimes not available for years, by which time most programs have already changed. This limits the applicability of the results.
- There are gaps and inadequacies in the international data that limit comparisons and analysis (Reuband, 1995). This includes any systematic analysis of the impact of various legislative regimes.
- Few evaluations of treatment services address illicit drug use in any substantive or authoritative manner. Those that exist are equivocal about the effectiveness of various service types or lack of consideration of costs (Pead, 1996).
- Treatment data to describe the patterns of use of services, and the clients of these services, have been inconsistent and unreliable.
- Data gathered by police, the courts and corrections systems are often not comparable, nor is it easy to integrate the data for purposes of evaluation or research. There is virtually no way to track a person's movement through the systems or to assess the impact of the process. Counting methods and definitions constrain comparisons and reliance on longitudinal data.
- Information sharing is not common across services and systems, with data often collected for different purposes and in different formats.
- Researching behaviours that are illegal is difficult. Users are understandably reticent about participating in research and providing reliable answers. Information which includes admissions of illegal activity poses ethical and possible legal impediments to the conduct of useful research since there can be no guarantee of confidentiality.

In this context, advice about reform options should be cautious. Council has heard on several occasions about the risk of 'unintended consequences' of action in this area (Wardlaw, oral submission 1995; Sutton, oral submission, 1996). This is an area where the consequences of action are significant, and where public support and understanding are important. Uncertainty about the consequences of reform and the level of support for any policy option indicates that an incremental and carefully monitored approach is required. Specific action will be required to engage and inform the community, and to better inform policy and program design and operational practice.

Confident policy making and program implementation in this area will require:

- **A broadly based research agenda involving collaboration between the Commonwealth, states, academic and service organisations.** Research on the impact of various policy initiatives and comparisons across jurisdictions is a potentially significant source of data for monitoring and future planning. It is important that research is initiated and co-coordinated in a national context although there are matters which require research support directly at state level. Commonwealth Government support for drug and alcohol research through two national research centres and an annual grant program has generated important information. Similarly, the State Government has supported some research and has established Turning Point Alcohol and Drug Centre. It has been funded to undertake research and provide clinical services and training. There remain large areas where research could have rapid and direct benefit. Council wants to encourage further research and, to this end, urges ongoing and enhanced support from the National Research Into Drug Abuse program. While integrated funding through bodies such as the National Health and Medical Research Council should also be encouraged, current specific targeted funding remains appropriate.
- **Consistent databases across the State Government agencies that have responsibilities in this area.** As noted earlier, some data systems within police, courts and correctional services are incompatible. A project to remedy these problems is underway. The Department of Health and Community Services is developing a new database designed to monitor the performance of treatment services. The Coroner maintains a database that is also likely to undergo development as part of a national initiative. Agreement to common definitions, core data and system compatibility is a prerequisite to improving the certainty and confidence of future decision making. Council believes that poor program design and management difficulties often result from inconsistency and gaps in data systems.
- **Introduction of local early warning/monitoring systems.** Many effective responses to illicit drug use need to operate at the local or street level. A particular need is early warning about changes in the types of drugs and patterns of use in different parts of Victoria. At this stage there are no structures designed to support and coordinate action in local areas, communicate with users, and develop relevant local strategies that minimise harms. A local early warning information system would also provide baseline data that could be linked to broader data systems and then reported back to local areas for comparative purposes. This matter is discussed further in sections on support and treatment and infrastructure.
- **Evaluation of the effectiveness of programs.** Victoria spends some \$100 million annually in law enforcement, education and treatment resulting from illicit drug use. The investigation conducted by Council demonstrates that, in most areas, these funds are applied without the benefit of a strategic framework based on current knowledge about what works in varying situations. The introduction of clear outcome indicators and integrated evaluation processes would provide significant improvements to the current situation. There is a strong reason to believe that targeted evaluations could pay significant dividends in better focused and more effective service provision.

### 3.3

## Demand and Supply Trends

Assessment of the existing and projected scale and patterns of drug supply and demand was an important baseline for Council's deliberations. A wide range of data and perspectives was provided through submissions, consultations and expert hearings.

Key issues raised relating to **demand** were as follows:

- Our community accepts, and in some cases values, drug use. Alcohol is a central part of many people's lives. Medicinal drugs are widely used and vital to the health of our community. They are sometimes misused. Illicit drugs are currently used for their psychoactive properties, but potentially some could be used for medicinal purposes (for example, cannabis and heroin).
- Defining some drugs as 'illegal' and 'demonising' the users has not eliminated their use. Illegal drugs are used by tens of thousands of Victorians. In excess of 30 per cent of our community has used an illicit drug at some time (see chapter 2). These people come from all walks of life and all parts of our State. Some users suffer serious health or other problems as a result of their drug use.
- There is some evidence that problematic and harmful drug use most often occurs where people are vulnerable or lack self-esteem (McAllister et al., 1991). The illegal status of the drugs and the stigma attached to users further entrenches their marginalisation. Provision of information, support and treatment is made more difficult in these circumstances.
- There are potentially serious health consequences that arise from misuse of illicit drugs (table 10). The level and nature of the consequences varies between drugs and is, to some degree, dependent upon the circumstances of their use.
- Use of the major illicit drugs has a direct effect on a very small percentage of the population. However, compared to other countries, the rate of intravenous use of heroin and amphetamines in Australia and Victoria is high and consequently is a problem for users and their associates (see section 2.1.5).
- Data from the National Drug Household Surveys and the Victorian Drug Household Surveys does not indicate that there has been a significant increase in the proportion of people acknowledging use of illicit drugs between 1991 and 1995. The data does, however, suggest that the overall proportion of 18–24 year olds admitting to using illicit drugs has increased slightly from 1993 to 1995. In terms of specific drugs, increases have been recorded for marijuana, amphetamines, hallucinogens and cocaine. Usage rates for other illicit drugs have remained stable or declined.
- The difficulty with extrapolating from this information is that household surveys, due to their nature, are less reliable in obtaining information on highly stigmatised patterns of drug use, such as dependence or intravenous drug use. In particular, they often under-represent high-risk groups such as marginal populations (Pompidou Group, 1994).
- Estimates from the recent review of methadone treatment suggest that there has been a significant increase in number of regular and irregular heroin users in Australia. This review suggests that between 1986 and 1990 there was a 73 per cent increase in the number of regular users, and a 51 per cent increase in the number of irregular users (section 2.1.4). Increasing deaths that appear to be related to using a mix of substances, including alcohol and benzodiazepines, do indicate greater misuse and are a sign of a growing problem.
- Variations in reported prevalence rates make it difficult to estimate the impact increased availability of illicit drugs would have in Victoria. Notwithstanding the difficulties associated with interpreting the available data, a number of comments can be made:
  - Males are more likely to use illicit drugs than females, although evidence put to Council suggests that amphetamine use is becoming popular among young women.
  - Young males in particular form a large proportion of the drug using population.
  - There appear to be lower rates of illicit drug use among employed and married people.
  - Prison populations show a high rate of drug use.

Designer drugs, including Ecstasy, appear to be increasingly available. While these are currently at low levels and used among small sub-groups, it is possible that this class of drugs will be increasingly available in the future. It is difficult for Council to predict the future demand for these drugs and it is impossible to predict the harms of barely known substances. It was suggested to Council that increasing interest in quite specific psychoactive effects might contribute to increased demand for this group of drugs.

Key issues raised with Council relating to **supply** were:

- Global production in illicit drugs appears to be increasing and, despite significant international cooperation, international supply of illicit drugs will continue to grow, possibly at an increasing rate.
- Although not certain, it seems inevitable that some of the increased supply will reach Australia. It is, however, unclear whether increased supply will contribute directly to overall demand. Increased supply can, and almost certainly will, lower the price of some drugs but the consequences of this are hard to predict.
- The Australian Bureau of Criminal Intelligence suggests that increased supply may not have a significant impact in Australia. Heroin is currently widely available throughout Australia at high purity levels and reduced prices, suggesting that sufficient quantities are being supplied to the market.
- Law enforcement agencies throughout Australia have reported that the harder illicit drugs and cannabis were generally readily available throughout 1994.
- Occasional price fluctuations and temporary shortages may indicate either a disruption in the supply or an increase in demand for specific drugs (ABCI, 1995).
- In the case of shortages, when supplies of one drug are limited, there is often a shift to other drugs. There is some evidence to suggest that increased seizures and intensified enforcement efforts can temporarily interrupt established patterns of drug use and sources of supply. This may have the effect of moving users to substitutes or to poly-drug use.
- It is difficult to argue that the quantities of drugs seized are directly proportional to the supply of drugs. Seizure rates are estimated to be low, between 3 to 10 per cent, and seem to exert little influence on heroin price, purity or availability (Weatherburn and Lind, 1995).

During its deliberations the Council was alerted to the problem of inadequate data on illicit drug production.

The United Nations Economic and Social Council comments in its 1995 interim report, *Economic and Social Consequences of Drug Abuse and Illicit Trafficking*, that:

*'Assessing the economic and social consequences of illicit drug abuse and trafficking implies, first that some measure of the magnitude of the problem is available, and secondly, that there is some conceptual clarity about the nature of the consequences themselves. Estimates of the extent of illicit drug production, distribution and consumption vary enormously, and are often contingent upon the methodology and political orientation of the observer'.*

The UN report, while acknowledging that there are no universally accepted figures, supports the view that on the global aggregate, illicit drug production is expanding. This is consistent with advice received by Council from a number of national and international experts (Wardlaw, oral submission, 1995).

The overall relationship between price and escalating demand is not clear. There is a question as to whether the consumption of illicit drugs, like other goods and services, decreases in response to rising prices and increases in response to falling prices. A number of studies suggest that, although small, price elasticities do exist. However, the addition of another variable, such as a successful preventive

education campaign, may reduce demand and thereby cause prices to fall, without the falling prices resulting in more consumption (UN Economic and Social Council, 1995).

On the basis of evidence available to it, Council has concluded that greater emphasis should now be placed on measures to reduce demand for drugs (such as education and health promotion) while maintaining law enforcement as an important control on supply.

Council does not condone drug taking. Nevertheless, it recognises that there will be those who, through ignorance, or other reasons, will misuse drugs whatever the consequences. The major goal of drug policy must be to ensure that people do not take drugs or if they do, that it occurs in ways that minimises the harms caused.

For people who use drugs, information and services aimed at reducing risks should be provided because this may save lives. Information provision should include unambiguous messages that abstinence from drugs is the only totally risk-free option.

Council does not believe that focusing on prevention of use and misuse represents an easy or soft option. Prevention requires multiple approaches and difficult decisions regarding targeting, and the integration of effort across the agencies involved. Minimising unintended consequences requires careful planning and implementation.

Harm reduction as a policy accepts that people use drugs on occasions. The challenge for services which come into contact with drug users is to minimise the harms associated with misuse.

Council's framework to deal with drug availability, drug use and associated problems includes the following elements:

- Commitment to reducing harm caused by drugs.
- Greater attention to harms and patterns of use of specific drugs.
- Effective control mechanisms that emphasise prevention and variation between drugs and client groups.
- Innovative and up-to-date demand management strategies.
- Emphasis on drug use as a public health problem rather than a crime problem.
- Focus on the drug user as a prime target with intervention designed to reduce emotional, social and physical harm and stigma associated with misuse.
- Collaborative efforts between police, health and other relevant agencies.
- Legislation and law enforcement that is consistent with harm minimisation principles.
- Strong and effective responses to illicit drug trafficking, including heavy penalties.

Council's approach incorporates a variety of strategies to reduce demand including:

- Information that is accurate, up-to-date and widely disseminated.
- Education that strengthens people's capacity to make reasonable decisions about drug use.
- Drug treatments that recognise different treatments will work for different people and that most drug dependent people will experience difficulty in stopping use.
- Community action that helps maintain drug users' links with supportive networks of families and friends.
- Advertising and sponsorship standards that ensure drugs are not seen as fashionable.
- Treatment targeted to high risk adolescents and adult offenders.
- Education, training and work opportunities targeted to young people at significant risk of drug abuse.

Drugs share many characteristics, in particular risk associated with misuse. However, there are important differences between individual substances. In some cases, these differences appear significant enough to justify varied responses (McCoun et al., in press). Table 23 summarises some of the characteristics that affect response options considered by Council. Analysis and debate revolve around how the production, distribution and consumption of a drug relates to its social harmfulness, and the likelihood of effective control under existing laws.

Use, prevalence and health risks associated with the use and misuse of individual drugs were outlined in chapter 2. Council also considered a range of other information about the most commonly used drugs in Victoria (marijuana, amphetamines and heroin) to assess whether different responses are appropriate for different drugs. Although cocaine is certainly available in Victoria, it was not considered in any detail by Council. Few submissions identified it as an issue and there are almost no problem users presenting at drug treatment services.

### 3.4.1 HEROIN

In the minds of most Victorians, heroin represents the drug problem at its worst. The prohibition of other, demonstrably less harmful drugs was justified in many submissions on the grounds that their use might lead to heroin. In terms of social cost, heroin dependence under current law is a significant contributing cause of crime, and closely associated with the serious risks of hepatitis B and C and HIV infection.

However, heroin also illustrates the central paradox of drug prohibition: use of criminal law and law enforcement for the protection of public health and morals results in an increase in associated crime and costs to the criminal justice system. Council's discussion with heroin users highlighted the fact that current heroin prices mean most users face the choice of prostitution, theft or trafficking to finance their habit. A constructive linkage between law enforcement goals and treatment is demonstrated by the methadone maintenance program that achieves a measurable reduction in crime and reduced health risks (Goldstein & Smith, 1995).

While many submissions advocated legalisation of heroin, the case for prohibition remains strong. However, Council also acknowledged the costs of prohibition, including increased misery of those who become dependent. To these are added community costs such as the spread of disease, user crime, and the expenditure of scarce law enforcement resources.

A practical response to heroin hinges on maximising the contribution of various programs designed to:

- Discourage initiation into heroin use.
- Control predatory drug trafficking.
- Contain the spread of disease among heroin users.
- Provide easy access to a range of programs that enable dependent users to manage the dependency with a reduced reliance on heroin, or to stop using.

Practical responses also involve the provision of support and treatment to drug dependent people willing to use such services. These are discussed in more detail in other parts of this chapter.

Special attention needs to be given to well-targeted action to prevent initiation. Available evidence suggests general anti-drug messages are of limited value in preventing heroin dependence because those at greatest risk of trying heroin and of becoming dependent are least likely to pay attention to messages from schools or the mass media. Special problems for anti-heroin messages are that only a tiny fraction of any identified population is likely to start using heroin. Thus, if messages have any 'advertising' effect, the number of new users inadvertently attracted could outnumber the number of new or potential users deterred. Consequently, anti-heroin messages need to be targeted very carefully. Current heavy users are likely to be enormously resistant to messages. The prospects of telling them something they do not already know are small and negative messages sometimes contradict their own experiences. To the extent that recently recruited heroin users can be identified by health workers or police, there seems some benefit in making them targets of 'secondary prevention' efforts designed to prevent progression to heavy and dependent use (Kleiman, 1992).

### 3.4.2

### AMPHETAMINES

---

After cannabis, amphetamines are the most widely used illicit drugs in Victoria. Advice from Victoria's Drug Squad suggests that there is a risk of substantial growth in use of these drugs. Local production continues to provide a readily available supply, despite police success in detecting and closing an average of one amphetamine laboratory a month.

While data remain patchy, there are indications from research studies and official statistics that amphetamine use increased among young Australian adults during the mid 1980s. This was probably because of their widespread availability, their lower cost by comparison with heroin and cocaine, and their relatively benign reputation. Amphetamines appear to be primarily used for recreational purposes in social settings where young people gather to 'party' and have a good time (Hando & Hall, 1995).

Concerns about growth in amphetamine use focus on several issues:

- Australian amphetamine users are more likely to inject the drug than users in other parts of the world. Reasons are unclear, but the apparent increase in the prevalence of injecting amphetamines generates a number of public health concerns. Large individual doses can be fatal. Chronic heavy use can lead to dependence and paranoid psychosis. There is also a high risk that following treatment some users may relapse. In addition, users can become aggressive and violent (Hall & Hando, 1993).
- There are increased risks of motor vehicle and other accidents arising as a result of intoxication from amphetamines and alcohol (Hall, 1993), both of which may lead to aggressive and dangerous driving.
- Many young people do not consider amphetamines to be dangerous. These young people often frequent nightclubs or 'rave' parties and take the drug for the extra energy that allows all night dancing.
- Better organised criminal groups are moving into amphetamine production as a growth market without the inherent risks associated with importation (ABCI, 1995).
- Much production is relatively primitive and there are significant risks of impurities and contaminants in products, adding to health risks for users.
- Withdrawal from amphetamines appears to be more difficult than, for example, heroin.

Practical responses to amphetamines include:

- Legislation to restrict the supply of chemicals necessary for manufacture, law enforcement, and improved national intelligence exchange concerning clandestine laboratories. While significant progress has been made, particularly in developing national legislation relating to precursor chemicals, supply and availability of drugs has not been reduced except for short periods.
- Reducing risks associated with injecting, by improving access to needle exchanges and discouraging unsafe sexual practices among amphetamine injectors.
- Improving information for health professionals about the range of amphetamine related health problems for which young people may seek medical care. In accident and emergency contexts, amphetamines mixed with alcohol contribute to accidental injury and assault. In psychiatric settings, amphetamine psychoses may be present in young adults with acute psychotic symptoms that remit with minimal treatment over several days (Hall and Hando, 1993). In general practice, concern should be aroused by young adults who come seeking medication to deal with insomnia or who show features resembling a depressive illness.
- A comprehensive training package (From Go to Whoa) has been developed in Victoria for the Commonwealth Department of Human Services and Health and Council urges its promulgation and use.
- Development of effective amphetamine-specific treatment. While replacement programs are now being tested, numbers of dependent users involved are very small. Alternative approaches also need to be explored.

Council's attention was also drawn to a number of initiatives in the Netherlands to minimise harm associated with amphetamine use. These included publication of guidelines for safe organisation and conduct of 'raves' or dances and special facilities to identify, via rapid chemical analysis, the likely content of substances purchased by young people. Both initiatives appear practical approaches to reducing the risks young people face in consuming these drugs.

**Ecstasy** is a widely used derivative of amphetamines. Ecstasy is probably the best known of a range of so called 'designer drugs'. These drugs can be manufactured to produce a range of different effects on the brain. Council has been advised that the range of such drugs may expand in the next few years. The appearance of such drugs on the market raises new, largely unknown risks to users and uncertainty for health services.

As with amphetamines, usage is likely to occur primarily at 'rave' parties or similar. However, it is possible that as the range of drugs expands, usage patterns may also change. The early warning information service proposed by Council will be vital in monitoring the extent and pattern of use of these drugs.

Although there is evidence of an increase in the use of drugs such as amphetamines and Ecstasy, users of these drugs are only now beginning to appear for treatment. Careful monitoring of new and emerging drugs should be accompanied by development and trialing of appropriate responses which may be similar to existing programs, or new and different interventions.

Marijuana is the most widely used illicit drug. Twelve per cent of Victorians have used marijuana in the past year, and this is considerably more than all other illicit drugs combined. Evidence provided to Council regarding a rural police district indicated that more than 90 per cent of police work was drug related. Of this, around 65 per cent related to cannabis, and most of this to use and possession. Use and possession charges also constitute a significant proportion of all charges heard in the Magistrates' Court. Yet marijuana does not loom large among drug problems in terms of observable and measurable harm done to users or to others. It is undoubtedly a powerful intoxicant and can generate a number of serious problems if abused. To decide how large a problem marijuana poses requires judgement of fact and value.

Even if marijuana posed few health risks itself, it would still represent a problem if it tended to lead to the use of other more dangerous substances. Dutch experience indicates that marijuana is not a 'gateway' to heroin. While marijuana is available throughout Dutch cities, there are very low rates of heroin initiation. The most careful study to date, conducted during the 1970s in the United States, explored the marijuana-heroin link among the largely minority-group adolescent population of Manhattan (Clayton & Voss, 1981). Its findings confirmed a relationship between heroin and marijuana, but with an unexpected twist. Heavy marijuana smokers did appear at greater risk of becoming heroin users, but the mechanism did not seem to involve the drug experience itself. Rather, heavy marijuana use appeared to generate involvement in drug selling, either as a way of paying for the marijuana consumed or simply by association with drug sellers. Drug selling, in turn, gave adolescents access to heroin and the money to buy it. This suggests marijuana was a gateway for these adolescents because it was illicit (Kleiman, 1992).

A number of cross-national reviews indicate that response to cannabis would be more effective if it was clearly distinguished from more dangerous drugs. In particular, current levels of marijuana use are more likely to be reduced through education and persuasion than appears likely for other illicit drugs. Marijuana is already widely used and therefore less exotic than other drugs. Therefore there is less risk that discussion in school will create an awareness and curiosity that would otherwise have been absent. By the same token, the target efficiency of the messages—the probability that any given recipient would have seriously considered using the drug now or in the future—is higher for marijuana than any other illicit substance. Benefits of carefully developed education to discourage marijuana misuse seem to outweigh risks (Kleiman, 1992).

During its investigations, Council was made aware that some Victorians may experience significant problems as a consequence of cannabis abuse. Development of a trial treatment service for cannabis users is recommended in chapter 4. Provision of information and support for parents responding to their children's marijuana use was also raised as a significant issue. This is discussed further in the next section. Law enforcement and legislative responses to marijuana are also discussed later in this chapter.

TABLE 23:

## COMPARING MARIJUANA, HEROIN, ECSTASY AND AMPHETAMINES (SPEED)

CATEGORY	FACTORS THAT INCREASE THE SOCIAL HARMFULNESS OF A DRUG	MARIJUANA	HEROIN	ECSTASY	SPEED	FACTORS THAT HINDER EFFECTIVE PROHIBITION OF A DRUG	MARIJUANA	HEROIN	ECSTASY	SPEED
<b>PRODUCTION</b>	Potency changes under different production conditions	Yes	No	No	No	Can be produced without special chemicals or skills	Yes	No	No	No
						Easy to produce in a private residence without special equipment	Yes	No	No	No
						Easy to expand supply by lacing with inert substance	Yes	Yes	Yes	Yes
<b>DISTRIBUTION</b>	Violence in markets	Yes	Yes	Yes	Yes	Easy to hide or disguise	Yes	Yes	Yes	Yes
	Large scale trafficking organisations	Yes	Yes	Yes	Yes	Users make infrequent purchases	Yes	No	Yes	Yes
	Quality is highly variable	No	Yes	Yes	Yes	Widely available and accessible	Yes	Yes	Yes	Yes
	Toxic adulterants are common	No	Yes	Yes	Yes	Inexpensive	No	No	No	Yes
						Available for legitimate uses	No	No	No	Yes
<b>CONSUMPTION</b>	High current prevalence of use	Yes	No	No	No	High current prevalence of use	Yes	No	No	Maybe
	Addictive	Low	High	Med.	Med. (1)	Widespread social acceptability	Yes	No	No	No
	Promotes aggression	No	No	Maybe	Yes	Health risks and harms to others perceived to be low	Yes	No	Yes	No
	Impairs cognitive, psychomotor functioning	Yes	Yes	No	Yes	Price elasticity of demand is low	Yes	No	Yes	Yes
	High potential for overdose	No	Yes	No	Yes	Generally consumed in private settings	Yes	Yes	No	No
	Used intravenously	No	Yes	No	Yes	Presence hard to detect for driving	Yes	Yes	Yes	Yes
	Often used with other intoxicants	Maybe	Maybe	Maybe	Maybe					
	No effective maintenance substitute	No	Yes	-	Maybe					
	Antagonist/antidote available	No	Yes	No	No					
	Effective treatment methods are unknown or costly	Yes	No	Yes	Yes					
High post-treatment relapse rate	No	Yes	Maybe	Yes						

Source: Adapted from McCoun, Reuter & Schelling (forthcoming).

Note: (1) Speed is highly addictive if injected.

Lack of information and inaccurate information are disturbing features of the Victorian community's knowledge about illicit drugs. While these shortcomings are widely acknowledged, there is less agreement about how information, health promotion and education become active and effective components of Victoria's response to illicit drugs. There has been little planning for a comprehensive, coherent and coordinated information and education approach to illicit drugs in Victoria.

Council believes that prevention must be one of the foundations of Victoria's long-term drug strategy. Dissemination of accurate information, and providing education about drugs within a health promotion framework, is a major component of the Council's proposed strategy.

Health education and information dissemination should always occur within supportive environments. Passive provision of information, even if accurate and well done, will have little or no impact. Information provision in the form of pamphlets, telephone services or curriculum should also take account of relationships between young people's mental status and attitudes to authority—two factors strongly related to drug use.

For legal drugs, primarily alcohol and tobacco, strategies to prevent misuse occur in a health promotion framework. There is now considerable experience in Australia and elsewhere about the effectiveness of health promotion that includes information and education about alcohol and tobacco.

A health promotion approach is likely to make a significant, long-term contribution to reducing use and misuse of illicit drugs. However, the combination and significance of strategies and settings for communicating health messages will be different from those used for legal drugs.

Total population approaches are likely to be more appropriate for drugs that are used by a large segment of the population. The increased prevalence of marijuana use suggests that a health promotion strategy similar to that used with alcohol and tobacco deserves attention.

Focussed strategies regarding the more dangerous drugs are required. Greater attention will need to be paid to ensuring that messages and support services are targeted to user populations and their networks, rather than the general public.

Detailed development of Council's strategy will require considerable community and expert input. An effective framework will require identification of:

- Groups that are the targets of the information.
- Drug(s) to be addressed.
- Behaviours to be targeted (for example, 'safe' use—injecting practices, sharing needles and equipment).
- Means to disseminate the information.
- Desired outcomes (these might include attitudes, knowledge and skills, intended behaviour and actual behaviour with regard to illicit drugs).

Given that the community receives most of its drug information from mainstream media sources, it is important to facilitate accurate and appropriate reporting as far as possible. The media liaison service that the Australian Drug Foundation offers is an important resource. The media should be encouraged to include information about other targeted services as part of its reporting, such as telephone numbers for further information or advice. The use of community announcements to advertise services might have a role.

The most important specific vehicles for disseminating accurate information to the general community are telephone information and printed materials. However, information provision without other reinforcing activity is unlikely to increase young people's capacity to resist drugs.

Existing specialist alcohol and drug telephone services provide different kinds of information. DIRECT Line provides specific information about the nature and effects of drugs. This information is targeted to those who are contemplating using drugs and their families, and is provided where counselling and referral to specific services is possible. DRUG Info provides a broad base for general information about drugs to the community, and back-up written materials on request. The two services are able to automatically transfer calls where a person's needs can best be met by the other service. Both receive calls from throughout Victoria, but calls from regional and rural Victoria are fewer than expected based on population figures.

Joint promotion of these two services should be encouraged, and opportunities for increased integration explored. Improved data regarding the use of these services is also required for future planning purposes.

Specific strategies are required to address the needs of people from diverse cultural and language groups, and regional and rural communities. Ethnic communities may be better informed through linkages with existing 24-hour interpreter services, recorded messages in languages other than English, recruitment of bilingual staff, and by using ethnic radio and press. Joint promotional efforts would increase the effective use of DIRECT Line and DRUG Info by people from these communities.

The National Drug Strategy has funded development of much printed material over the past ten years. While there have been repeated calls for coordination, printed material continues to be developed in isolation. Pamphlets and other printed materials are most useful when used in conjunction with other broad-based or specific information strategies. Information about illicit drugs, in particular, is likely to be of little or no value on its own.

Council believes that printed materials should be reviewed, and where appropriate for use in conjunction with other information dissemination activities, be translated into languages other than English.

Libraries are an important source of detailed information for the general public. Council has not explored the issue of drug information in general libraries, but notes the value of the comprehensive, specialist alcohol and drug library and information services at the Australian Drug Foundation.

Young people often experiment with drug use, licit and illicit. For a small number, use is chaotic and at problematic levels. Many young people's interest in information is high, particularly where it relates to the functioning of their bodies. Young people are one of the major audiences of mainstream media (particularly television and radio) where they receive information about drugs and lifestyle issues. A range of strategies is required in terms of information provision and education depending upon their developmental stage and social situation and cultural background. Public information is particularly important to assist parents to discuss these issues with their children.

Council believes that efforts to prevent young people using and misusing illicit drugs should be given a high priority.

A hierarchy of approaches exists for responding to young people's drug use. These include broad-based prevention strategies, closely linked to personal and mental health promotion, that aim to prevent the use of drugs when most young people are considering experimentation. This type of program, delivered as an integrated part of the school curriculum, will be all that most young people will need.

Some young people are at a particularly high risk of illicit drug use. It is important to note that these same young people are vulnerable to other health risks, including psychiatric illness, self-damage or mutilation, youth suicide, nutritional disorders, and the broad cluster of problems that are often associated with social disadvantage such as homelessness, family disruption and unemployment. Youth unemployment is strongly correlated with substance misuse (Ray and Ksir, 1990).

To prevent these marginalising circumstances, efforts to support young people are important. Efforts to reintegrate or provide resources and opportunities, such as training programs are likely to be very important drug prevention activities, although detailed consideration of these is beyond the scope of Council.

Council was particularly concerned about the suggestion that there is a lost generation of young people who are using illicit drugs in a destructive way and who, as a consequence, are alienated from mainstream society and are beyond help. This pessimistic view, and variants of it, were put to Council at community and expert forums and in written submissions. Others who spoke to Council had significantly more hope that more could be achieved, first in preventing young people from commencing problematic drug use and second, in intervening to reduce the harms associated with some young people's drug use. This latter view has informed Council's thinking. Council believes very strongly that no young person should be abandoned by the community, no matter how difficult or seemingly intractable many of their problems may be.

Opportunities to provide information exist at youth-specific venues, but it is inappropriate that materials relating specifically to illicit drugs should generally be placed in such venues because of the potential 'advertising' effect for non-users. An exception might be where those at high risk of hazardous and harmful drug use congregate, and the use of peer education approaches to reach those especially marginalised. Case management services provide important links for this group.

Response to, and support for, this group of young people are included in later discussions of community involvement, and support and treatment services.

Schools have a critical role to play in informing and educating young people about the role of drugs and their use and misuse in our society. Submissions strongly supported greater priority in this area. Views about when and how this education should be provided were more diverse.

Council heard about efforts of all school systems (government, independent and catholic), individual schools and community bodies to provide school-based drug education. These efforts have primarily concentrated on legal drugs and have produced a number of resources and materials addressing alcohol and tobacco use issues. Much of this effort is positive and deserves support.

However, Council is concerned that some current, widely supported activity does not accord with sound educational principles. Council is aware of the international literature that shows that drug education which is intensive and 'one off' can be ineffective or, in some cases, counterproductive, in fact increasing the likelihood of use. Recent Victorian research confirms these findings (Hawthorne, 1995). Council believes that drug education must be built into the normal structures of education.

Problems arise because the State has had no systematic and formal structure into which drug education fits, and has not equipped schools with the skills and resources to educate students effectively. The absence of a framework has allowed a range of ad hoc initiatives to develop (Hawthorne et al., 1994).

Recent activity has been directed at the development of resources including curriculum guidelines and materials. The principal outcome is the *Get Real* package developed by the Directorate of School Education (DSE), in consultation with a wide range of relevant organisations. These products are of high quality and deserve support.

Principles to guide school drug education should include:

- Education policy and programs should be consistent across the school environment and developed in conjunction with broader school policy about drugs, and student welfare. School ownership of policy and programs is vital.
- Objectives should be linked to the overall goal of harm minimisation.
- Programs should have sequence, progression and continuity over time throughout schooling and provide consistent and coherent messages.
- Drug education is best included within the health strand of the curriculum, but may also be appropriate to include in other areas such as science.
- Drug education should be delivered by teachers of the subject in which it is included. The teacher should retain responsibility for materials and any other resources used including outside programs.
- Programs should take account of research-based evidence supporting what is effective, and recognising that what seems like common sense can sometimes be counterproductive.

Success at school levels will also need to ensure that the following issues are addressed:

- Policy development: Schools must develop policies that deal directly and appropriately with the full range of issues about legal and illegal drugs.
- Curriculum space: While Council has not been able to assess the impact on existing curriculum, it believes drug education, incorporating licit and illicit drugs, should be part of core curriculum. While endorsing the need to commence drug education in primary school, Council believes that material relating to illicit drugs should be introduced in the late primary or early secondary curriculum.
- Curriculum content and materials: Further work is required to develop curriculum materials dealing with illicit drugs, particularly cannabis.

- Trained teachers: Council was advised consistently of the importance of ensuring that teachers are pivotal to drug education. Teachers must select and deliver the curriculum and materials appropriate to young people's level, needs and context using the principles outlined above. To deliver this, teachers need to be confident of their competence regarding drug education. This is not currently the case.

Teachers will require enhanced professional development and in-service training opportunities and resources if comprehensive drug education initiatives are to be successful.

Council received some evidence suggesting the presence of illicit drugs in Victorian schools. Given the reported use of drugs by school-age adolescents, this is hardly surprising. Council received no evidence, however, of illicit drug use within school hours.

Schools confront illicit drug use in many ways; drug education within the curriculum, policies relating to drugs and the possible use of drugs at school, and pupil welfare that can involve liaison with parents and community services. The preparedness, capacity, resources and responsiveness to these issues varies widely.

Council heard that some schools had moved to develop strong welfare responses and links to community services, especially those dealing with young people. Other evidence suggested that some schools actively discouraged young people with problems or, at best, provided little support. This leads to an apparent differentiation of schools into what is informally known as 'good' schools (those less likely to retain troubled youth) and 'bad schools' (those schools which worked to retain young people in schools). Further work is required to assess and minimise the long-term damage caused by such differentiation.

Within the school community, there is a small group of young people who are vulnerable to developing serious and lifelong substance use problems. It is important that strenuous efforts be made to retain this group within the school system to enhance their skills, knowledge and preparation for the workplace, and to prevent or delay their labelling and experience of unemployment. Additional resources are needed for this to be effective.

In instances where young people are using drugs, it is important to involve parents where possible, and community-based services in the provision of early intervention or treatment to address drug use issues. This collaboration could be arranged by school pupil welfare coordinators or other appropriate persons.

If the young person leaves school, careful case management into the community and linkage with other facilities and resources could reduce the impact of the sudden lack of support and connectedness to the general community, which makes young people particularly vulnerable to increased and harmful drug use.

*'While alcohol and other drug problems are relatively common, the majority of human service providers do not receive education and training on how to effectively respond. Consequently, many staff and organisations do not perceive that they have the knowledge, skills, confidence or legitimacy to respond to alcohol and drug related harm. However, a substantial literature has demonstrated that a broad range of human service providers such as general practitioners, nurses and police can have a significant impact on the reduction of alcohol and drug related harm at an individual and societal level.'* (Allsop, S., 1996, p.2)

Submissions, expert witnesses and commissioned work brought Council's attention to the role of a wide range of people whose jobs bring them into contact with current and potential drug users. Many of these are professionals in contact with drug users at a time when they may be motivated to change their behaviour.

While specialist services are important to drug users, treatment can be an unnecessary or inappropriate response for some people. Young people and adults are unlikely to seek help or support from specialists until dependency is established and social problems arise. Information, education and practical support can be effectively provided by generalist workers in a range of contexts.

These workers have a potentially critical impact on the provision of information and education about drug use and related issues as part of their principal role. They also have the potential to develop sustainable linkages across the range of health and welfare, law enforcement, and other support services and organisations within the community. This would assist communities to pool their resources and efforts, and provide an integrated response to drug issues.

Incorporating alcohol and drug training in undergraduate courses, and providing ongoing skill development in drug-related issues, has been given relatively little attention, at least partly because of the legal status of many drugs. Making harm minimisation principles relevant to the practice of many professionals can significantly enhance the preparedness and effectiveness of general health and welfare service providers who have an opportunity to intervene with drug users.

An effective strategy to reduce drug use and misuse will, in part, be dependent upon enhancing the knowledge and skills of people like police, doctors, teachers, nurses, welfare staff and youth workers about drugs and a harm minimisation approach. For some of these groups, integrating these matters into existing professional development and training structures is required, and in others, innovative action is needed. Planning in these areas will need to take into account opportunities to make this training part of, or consistent with, accredited educational courses so that participants can gain some professional recognition.

Although there is some shared training between Victorian programs and the National Centre for Education and Training in Addictions in Adelaide, Council believes this is not adequate to address the extent of the need.

There are currently three specific drug-related postgraduate courses available in Victoria. There are also some in other states, including at least one that can be accessed through distance education.

Providing enhanced educational and training opportunities at all levels is important. Council received submissions indicating that there was only a small pool of expert alcohol and drug personnel in Victoria

currently and that staff recruitment to specialist programs was difficult. Career opportunities were limited in this relatively small specialist field which indicates that educational opportunities might best be located within broader based undergraduate and postgraduate programs. Council did not examine the current courses with regard to the illicit drug curriculum specifically but believes there are insufficient drug and alcohol educational programs at tertiary levels.

Consistent training for all workers in direct contact with drug users, or people at risk of drug use, would enable better linkages to be made across service systems. Extensive work on development of protocols between specialist drug and alcohol services and other general and specialist services has commenced in some areas, such as child protection and psychiatric services. Some of these are still in their infancy and are currently underutilised. Some remain at draft stage and may lack commitment and resources to implement them.

Council agrees that there is a need to build a core of people from a variety of disciplines who have specialist expertise in substance abuse issues. Building and diversifying the expertise base will also require a long-term investment in higher degrees and research. This is particularly relevant in the professions involved in public health.

Council believes that a strategy for providing education and training is urgently required. This strategy should enable the development of an integrated approach to the provision of drug education across services and organisations.

#### 3.5.4 COMMUNITY INVOLVEMENT

---

Local government bodies and local communities presented to Council either through submissions, specialist forums or at public hearings. They described initiatives to address specific alcohol and drug issues in their communities. Some of these have been in place for a sustained period, but there has been little attempt at a coordinated local government effort in Victoria.

Advice from groups meeting with Council highlighted the impact of drug use. Advice also highlighted the fact that communities can play a positive role in reducing the harm caused by drugs. Council accepts that there is neither an easy nor consistent way to engage communities whether they be local communities or communities of interest. Fostering positive 'health-oriented' community involvement is likely to be an important ingredient in prevention, education, and reducing the harm caused by drugs.

Communities vary in their level of concern. All share a hope that drugs will not cause problems either directly through use, or indirectly through disruptive behaviour and illegal activity, such as the theft and burglary associated with illicit drug use. Some communities experience heightened concern from time to time that is related to an apparent increase in drug problems or drug-related incidents. The media plays an important part in influencing this level of concern.

The absence of readily available guidelines and well-publicised resources contributes to considerable duplication of effort and frustration. Systematic and reliable information about patterns of drug use and associated harms is usually not readily available at a local level and makes planned responses difficult. This needs to be addressed in an overall effort at enhancing data collection and dissemination.

The involvement and collaboration of major service sectors at the local level are also vital. Council noted examples where this was working well, and others where the different orientation of some sectors contributed to confusion and inconsistent approaches. Intersectoral linkages might occur through a variety of existing structures, such as local government, or sector-specific consultative mechanisms such as Police Community Consultative Committees. Council is not confident that any one of these is necessarily appropriate or working well across all communities.

Current efforts to bring together, document and evaluate these efforts and the subsequent production of guidelines for local action should be supported.

Council noted that the involvement and collaboration of major local service sectors is particularly crucial in establishing strategies and initiatives that address the issues of drug use and misuse among young people. Such strategies and initiatives may include:

- The development of stronger linkages between local services and organisations including schools, youth services, police, sporting and service clubs.
- The establishment of a range of local activities for young people. Young people should be involved in the development of these activities.
- Improving the local public transport service where required to allow young people access and safer travel to entertainment venues within and outside the local area.
- Providing information about drugs and their effects that are appropriately targeted to reach young people where they congregate, or through other appropriate media such as radio and television programs.

Strategies to provide additional support to young people who are particularly 'at risk' and those who have an established drug use problem, may include:

- Providing information about drugs in settings where they congregate, and through appropriate media such as radio and television programs.
- Ensuring access to stable housing.
- Providing assistance in seeking and obtaining employment.
- Re-establishing linkages with their families.
- Providing access to a range of relevant support and treatment services if and as required.

### 3.5.5

### PARENTS

---

Parents are a critical influence on drug use by young people. This occurs through general care, welfare and provision of guidance and resources, as well as through their own drug use, and their values and opinions on drugs. Parents and peers act as role models and provide information about drugs. A major concern is that misinformation can often take the place of facts.

Parents have stronger influence on younger age groups. While peers become more influential during adolescence, parents remain important and can provide vital stability.

While there were general calls for the provision of information about drugs to parents, there was no clear evidence that parents actively seeking this information had not been able to obtain it.

Many parents of those already using drugs expressed frustration at the lack of information about drug use and related services. Parents with a child who is actively using drugs and sometimes already

experiencing severe problems need targeted help. Council heard many distressing stories from parents of drug users. These people were consistently seeking compassion and support and none sought controls or penalties. Many sought assistance for themselves and spoke of the inconsistent advice they received from a range of sources. Some of this advice suggested they 'reject' their child, which they found unacceptable. These parents told stories describing their role in supporting their children that suggested they experienced considerable fear, anger, distress and a sense of impotence. These parents came from all strata of the community.

This group needs specific assistance to deal with their own reactions and to support their child. Where possible counselling should involve interaction between the child, parents and those able to provide support. Council recognises the often complex family relationships associated with drug use and believes that this group might benefit from self-help and other peer support and information initiatives. This was not explored further by Council.

Parents should be encouraged to utilise those whom they ordinarily turn to for support and assistance in their community. This might be a friend, community member, or someone located in a specific service. For those who feel they do not have these resources available, the DIRECT Line telephone service can provide advice, counselling and referral. DRUG Info can assist with information about the drugs that their children are using and printed materials.

Council received advice that in many communities, including ethnic communities, parents often approach religious or community leaders as a first port of call to request information and assistance on drug issues. These parents or religious and community leaders may not be fully aware of resources available. The development of strategies to ameliorate the situation, including those outlined in section 3.5.1, need further consideration. Council's attention has been drawn to the recent seminars organised by the Ethnic Liaison Unit of Victoria Police and involving the Centre for Adolescent Health and Odyssey House on 'Drugs in the Greek Community'. These seminars aimed to disseminate relevant information to Greek-speaking parents on drugs from the medical, legal treatment, and policing perspective. Further such initiatives should be encouraged and supported.

Improved knowledge and skills relating to drugs and their use could be acquired by parents through increased involvement in schools and promotion of community information services. Information about drugs could also be included in courses or workshops provided for parents (such as parenting skills workshops) by local community organisations. The training of generalist health and welfare workers (including general practitioners, nurses and other health and welfare workers) would increase their ability to provide parents with information and to direct them to appropriate services as required. Schools may also contribute to the knowledge and skills of parents by involving them in issues and activities relating to the provision of drug education within the school.

### 3.5.6

#### DRUG USERS

---

Council was made aware that the provision of prevention and information services to drug users or potential drug users is difficult to achieve, primarily because the illegality of drug use and their mistrust of authorities make them a difficult group to contact. Education targeted to users must therefore be non-judgemental and aimed at harm reduction and safe use. Any insistence on abstinence may impede efforts to disseminate information. Referral to treatment services should be offered on request by the user.

The limited resources or strategies currently addressing the prevention and education needs of drug users concerns Council. Information is currently provided by DIRECT Line, VIVAIDS and at needle syringe exchange outlets.

Drug users are at high risk of suffering the harmful acute and chronic effects of drug use, including HIV/AIDS, hepatitis B and C, as well as the risk of overdose and death. Peer education is likely to be one of the most effective ways of reducing these harms. Drug users who met with Council supported the use of peer-based education. However, Council has also been informed that conventional peer education has not been effective for certain ethnic user groups, and that for these groups outreach services are more effective.

It is clear that hepatitis C is more readily transferred than HIV within the intravenous drug using population. There is a need for further research to determine why this is the case. There is a need to develop targeted education programs aimed at intravenous drug users if the success in controlling HIV spread in the Australian intravenous drug using population is to be replicated for hepatitis C.

### 3.5.7

#### MEDIA CAMPAIGNS

---

Council received many written and oral submissions requesting a major media campaign to address the issue of illicit drugs in Victoria. Evaluations of such campaigns conducted nationally and internationally indicate that while they are useful in preparing the community for proposed changes to policy and drug control strategies they have not been successful in convincing users to change their using behaviour. They have also not been successful in stopping use once established. Evidence for their effectiveness in preventing drug use is missing. More dangerously, such campaigns if not very carefully developed, as part of a comprehensive strategy, have the potential to attract some people to illicit drug use.

Major media campaigns are only likely to be used effectively when advertisements are one component of a broader strategy. Evaluation of Victoria's successful campaign to reduce alcohol-related road fatalities has clearly demonstrated the importance of police activity (including speed cameras, booze buses, targeted sponsorships and education) in delivering the impact of key messages in television advertisements.

Council believes that media campaigns should only be used to communicate major changes to policy and arrangements in Victoria: where appropriate, this should be in cooperation with the Commonwealth Government.

Illicit drugs differ from other issues commonly dealt with in media campaigns because they effect a small percentage of the community. Messages targeted at this group run the risk of communicating unintended messages to non-users. They would also have a poor cost benefit return.

Council urges ongoing liaison between journalists and those in the drug and alcohol sector, particularly those involved in information provision. While various efforts could be made to develop appropriate codes of conduct, Council recognises the difficulty of consistently implementing these. This is an area that may warrant future attention.

## Support and Treatment Services

A wide range of problems and issues confront many people who use drugs. The services available to assist them range from the informal through to highly specialised drug and medical services. During its deliberations, Council received wide-ranging input about support and treatment for drug misuse. At times, the same information was used to draw widely divergent conclusions about support services for drug users. The same services were highly praised by some submissions and heavily criticised by others.

Council has not endeavoured to be comprehensive but has examined identified problems and searched for achievable solutions. Council believes that the problems of youth deserve special attention and it has accordingly considered these issues in a separate part of this section. Similarly, the issues for drug users who come into contact with the criminal justice system warrant increased attention and a specific discussion of these issues is included.

Council is aware that there are other vulnerable groups who use illicit drugs; for example, opiate-dependent women with young babies. Many of the issues surrounding this group relate to the absence of adequate family support and general welfare services. Shortages of these services work against these often fragile families gaining the necessary skills to meet the developmental and survival needs of vulnerable young babies and children. This, in turn, may lead either to tragedy, or the precipitous and repeated engagement of child protection services. Solutions to these problems do not lie in the expansion of specific drug and alcohol services but rather a stronger and more able generalist health and welfare sector capable of responding without prejudice to the medical, dental and other care and support needs of opiate or other drug dependent women and their families.

Homeless people are another vulnerable group who experience difficulties in accessing services in the general health and welfare system. Such people are often living on the fringes of society and this increases their chances of having a range of problems, including illicit drug misuse.

Chronic pain sufferers constitute a special group of opiate-dependent people. Issues surrounding this group are, however, not discussed in detail.

Council believes that proposals developed in respect of treatment and support services, although not directly addressing the needs of these groups in detail, will benefit them.

The community and professionals working in all support, treatment and related sectors need to be aware of the importance of illness prevention approaches with illicit drug users. These may include provision of information and education as well as counselling and, for some, substitute drug therapies.

Information and advice about the prevention of spread of blood-borne infections, improvements in nutrition, and sexual health are especially important. Council notes that the needs of injecting drug users require special attention. It may be appropriate that injecting drug users be encouraged to use in less harmful ways, such as inhaling, smoking or snorting.

The provision of secondary consultation by the Drug and Alcohol Clinical Advisory Service is an important means by which the capabilities of generalist health and welfare professional are strengthened to deal effectively with clients who have substance use problems.

It should also be noted that people who take illicit drugs usually take more than one drug simultaneously, although they might have a drug of preference. This phenomenon is described as poly-drug abuse and commonly increases the harms associated with drug use.

### PEER SUPPORT AND SELF-HELP GROUPS

Many drug users have had negative experiences that have resulted in an enduring sense that they are alienated from the community and not able to access services. In this context, they have found the support and advocacy offered by peer support groups invaluable. Council has also formed the view that these organisations are vital. Their potential as a link into other services and legal systems is currently underdeveloped. For example, organisations offering peer-based support are successful in delivering family and other support services that have credibility and relevance to users, but also take account of the needs of user's children (McGregor, 1994).

Council urges that these services should be consulted extensively about their role with a view to developing more sophisticated use of the expertise.

### NEEDLE SYRINGE EXCHANGE PROGRAMS (NSEP)

Needle exchange programs (NSEP) play a critical role in reducing rates of infection and safer injecting practices, be they provided by outreach services or at fixed locations usually in health centres. Council also acknowledges the important role NSEPs play in providing education to users and, where requested, referral to treatment agencies. Many pharmacies also provide needles, syringes and, where appropriate, advice to users.

Growth in the number of needles/syringes distributed in recent years is evidence both of the demand and support for these programs. Council heard several descriptions of positive and collaborative efforts to maintain individual services. One example involved police and local health services in St Kilda.

The NSEP program remains contentious for some people and examples of local community reluctance to accept these services was apparent. There are important planning decisions that need to be considered, including the harms that result to users and others from unsafe injecting practices. Long delays in establishing NSEPs have hidden and potentially significant costs for the community that must be actively balanced with local issues.

Council was advised that injecting drug use continues in Victoria's prisons despite vigorous attempts to eliminate drugs. In the absence of provision of clean injecting equipment, intravenous drug use in this environment is likely to be high risk. Council accepts that management of this situation requires careful consideration.

### ACUTE SERVICES

---

Individuals experiencing problems with illicit drug use may develop problems that require emergency care. Currently, help may be sought in the emergency rooms, the psychiatric care system, from general medical practitioners and the ambulance service. These services are an important link in the acute care system that supports and treats people with drug problems.

Council was advised that the ambulance service plays a vital role in responding to drug use, particularly

in the case of overdose or suspected overdose. Ambulance officers are able to provide general health care and, in the case of a heroin overdose, administer a drug (Narcan) which rapidly counteracts the effect of heroin.

Council was advised that some young drug users believe that the ambulance service will notify either their parents or the police if called. As a result the ambulance service is not called to some overdose situations, dramatically increasing the risk of death. Council believes this issue should be addressed through policy and practice guidelines and protocols.

### 3.6.3 SPECIALIST DRUG TREATMENT SERVICES

---

#### SERVICE REDEVELOPMENT

Victoria has been a leader in the development of many drug and alcohol services over the past thirty years. Council noted, for example, the respect that a number of experts from elsewhere in Australia and from overseas have for the Victorian Methadone Program. This program is delivered largely through general practitioners and community pharmacies rather than specialist clinics.

While most drug users access general health and welfare services when they need assistance for problems, they will often seek specialist support for issues directly associated with their drug use. In addition, they also seek support from specialist agencies to change their drug using or to reduce the harms of drug use. Similarly, general service providers often refer such people to specialist services.

The Victorian drug and alcohol service system is being redeveloped with a view to encouraging general service providers to retain overall management of such clients while the drug and alcohol sector provides specialist backup and treatment (see 2.3.2).

The range of specialist treatments includes thorough assessment, withdrawal programs, counselling and therapy, support or self-help services, and substitute pharmacotherapies such as methadone. Some of these services can be residential, although most are now provided as outpatient services. Some services offer highly specialist long-term residential therapy. Research evidence suggests that this is likely to be appropriate for a quite small number of people and the cost per client is high, relative to other treatment options although more economic than imprisonment.

Council believes that the rationale underpinning the program redevelopment is sound. Council accepts that it is important to develop services which are based on research evidence on what works and to ensure that there is a fair distribution of services across the State. Council does have concerns about a number of transition issues and about the capacity of the service system to deal with the existing level of demand.

Council heard many concerns expressed by current drug service providers, drug users, providers of community services and members of the community about the current provision of specialist drug treatment services in Victoria. Key issues were associated with the transition toward a service system in which drug and alcohol services back up generalist services. Views expressed included challenges to the conceptual basis of this program shift, suggestions of apparent gaps in services and claims that the funding provided for new services is insufficient to provide a professional service.

Council understands that a number of services approved by Government as part of the redevelopment have not commenced operation. The State Government gave approval for the establishment of a range of services following a formal tender process in early 1995. Most of these services are now operating, some on an interim basis. Several others have not commenced and urgent action is required to ensure that these services are established.

A range of other concerns have been raised regarding the still new withdrawal services, residential and home-based. Council accepts that these are relatively new services and that further discussion with service providers and interest groups is required to assess whether the concerns result from the newness of the services or service specifications. An issue requiring consideration in this process is the capacity of the withdrawal services to meet the needs of particular groups (for example, women with children and the homeless).

Redevelopment is not yet completed and elements of both the former and new system exist. This appears to be causing some difficulties for service providers and clients. It is difficult for Council to assess the longer term impact of changes, but current disquiet suggests that ongoing review and evaluation are essential.

There has been considerable input to Council suggesting that there are not enough specialist services to meet the needs of people with serious drug problems. Service providers persistently claimed that clients approaching the specialist drug and alcohol sector are increasingly complex and difficult to manage and include many with psychiatric illness and severe social problems. The data available did not enable Council to assess these claims. It is clear that if the claims are accurate and reflect a sustained shift in demand, the field will be dealing with a more demanding and resource intensive group of clients. A review of client trends and consequent funding requirements may be justified.

Data provided to Council indicates that Victoria, relative to other states, underinvests in specialist drug treatment services (Alcohol and Other Drugs Council of Australia (ADCA), written submission, 1996). ADCA undertook a national survey in 1995. The survey gathered data on:

- Revenue raised through taxes on drugs.
- Outlays in specialist drug and alcohol services by State and Commonwealth Governments.
- The views of people working in the drug and alcohol field about the overall performance of the service system in their State.

Figures for both revenue and expenditures were provided to ADCA by the relevant authority. The performance assessment was based upon responses to a questionnaire.

The report indicates that Victoria spent \$4.94 per head of population at the time of the data collection (December 1993). The national average was \$8.93. Council believes that the survey figures should only be used as a guide to the general magnitude of expenditures made by all governments.

Various groups have argued that there is a serious lack of post-withdrawal support and counselling services across the State. The need for residential and non-residential post-withdrawal support has been expressed, with an emphasis placed on the need for residential services.

The current approach of the Victorian Government is to provide outpatient, rather than inpatient, rehabilitation services. The Government's approach is based on research that indicates that it is likely that well-designed non-residential services, backed-up by accessible acute services linked with other

primary care services, can provide better and more affordable treatment for drug problems and allow greater needs to be met (Pead, 1996). It may be that at this stage of the redevelopment, insufficient linkages have been made and that this is exacerbating concerns. While Council has been unable to conduct a detailed assessment of need, there do appear to be insufficient post-withdrawal services available in Victoria.

## SUBSTITUTE PHARMACOTHERAPIES

There is a range of substitute medications available internationally that are used to assist withdrawal, and for ongoing supportive management in the treatment of drug dependence. These are appropriate where the person has a long-standing and entrenched dependence on particular drugs.

There are good reasons to offer such therapies to dependent drug users early in their regular use as a harm reduction strategy. The benefits of early commencement on substitute pharmacotherapies include reducing the chances of severe illness to the user and reducing the spread of infectious diseases within the community.

In Victoria methadone is the only currently available substitute maintenance program that is safe, reliable and enables people to maintain normal lifestyles.

## METHADONE SERVICES

Current evidence suggests that the methadone program removes a substantial number of heroin users from crime, trafficking and prostitution to support their dependency. Participation in the program is associated with improvements in nutritional status and a significant lessening of the hazards of intravenous drug use.

Council is persuaded, on the basis of empirical evidence, that methadone is regarded by many users and their doctors as a desirable and appropriate service. Council also heard considerable comment about the problems that some people face and acknowledges that methadone will not attract and retain all heroin users.

Methadone is a restricted and potentially dangerous substance. There are risks both to the person on the program and others if methadone were to be easily accessible in the community. Council supports an ongoing regulatory regime to minimise the risks of misuse. Victoria has made significant innovations surrounding methadone maintenance programs and careful monitoring remains important for the individuals on the program and the broader community.

People continue to have difficulty gaining access to the methadone program in some rural areas. In part, these problems have arisen because of difficulties in recruiting and retaining medical practitioners and pharmacists in rural areas. Council supports further action by the Commonwealth Government and the Royal Australian College of General Practitioners to encourage general practitioners to work in rural areas to undertake public health functions such as methadone prescribing. The Department of Health and Community Services should continue to work with the Pharmacy Guild of Victoria to expand pharmacy coverage.

Council accepts that some groups with special needs (such as young people, persons from minority groups and opiate-dependant persons in prisons) are under-represented in the methadone program. Council is concerned that efforts to develop specialist methadone programs have been delayed and believes that efforts should be made to expedite service development and include unrepresented groups. Council is also of the view that many opiate-dependent persons on methadone programs benefit from counselling on a non-compulsory basis.

Victoria has led Australia in the training of prescribers of methadone. The Victorian Methadone Program guidelines for providers are a significant advance in the training of prescribers and have been developed in consultation with clinicians, trainers and researchers. In Council's view providers, recipients and regulators of methadone would benefit from the establishment of a peer review group to supply advice to the Department of Health and Community Services, to comment on the results of the monitoring process, and to guide the introduction of best practice innovation in this field.

Current and former users of the methadone program complained about the cost and indicated that for some people the cost is an impediment to involvement. Methadone users are required to meet the prescribing costs incurred in the community pharmacy. Council did not address the matter in any detail.

Council believes continuing improvement can be made in this important program, and that it should be subject to rigorous ongoing evaluation.

#### OTHER DRUGS FOR USE IN TREATMENT

A range of other substitute and antagonist drugs has been tried internationally in the treatment of opiate dependence. The drugs available include LAAM, Buprenorphine and Naltrexone. The roles these drugs perform differ but they all act to substitute for, replace the effects of, or reduce the craving for, opiates.

Council has not been able to ascertain in detail the cost and benefit of these drugs. Discussion with international experts (Strang, oral submission, 1996) confirms the potential benefit of one or more of these drugs.

Careful assessment is required of these drugs, and others that may be available. Intergovernmental discussions as well as liaison with the pharmaceutical companies is required to ensure trials can proceed expeditiously.

Council is of the view that Victoria has established itself as a leader in setting standards in the methadone therapy. It has the clinical and research capabilities to lead Australia in the development of programs utilising alternatives to methadone such as LAAM and Buprenorphine, and in establishing the place of Naltrexone in treatment programs during drug withdrawal.

Careful assessment will be required to determine which of these drugs has the greatest potential to supplement methadone in providing a range of treatment options for dependent drug users. The reason to broaden options is that some drug users are not attracted to methadone or find it unacceptable. Council supports the development of any potential treatment that would bring dependent users into regular contact with treatment services and reduce the harm associated with current drug use.

## HEROIN PRESCRIBING

Heroin can be used as an alternative pharmacotherapy for dependent drug users. Heroin has been available to dependent people on a prescription basis in the United Kingdom for many years. One expert consulted by Council indicated that it is now losing popularity.

Council received numerous submissions supporting provision of replacement heroin to dependent users in a medically controlled manner. Many of these submissions indicated that the social, emotional and health harms of heroin are largely a result of heroin's illicit status. These submissions argued that if heroin were available to dependent users in a controlled manner, more dependent users would be attracted into treatment. Heroin prescribing would also reduce dependent users' involvement with the criminal justice system and enables controls of both the quality of the product and its administration.

The National Centre for Epidemiology and Population Health and the Australian Institute of Criminology have been responsible for planning the research, scientific design and evaluation of the following question: *'Should a carefully controlled and rigorously evaluated trial be conducted to determine whether or not the prescription of pharmaceutical heroin (diacetylmorphine) is a useful addition to current maintenance treatment for dependent heroin users?'* (Stage 2 Feasibility Research into the Controlled Availability of Opioids, 1995).

Dr Gabriele Bammer, Fellow, National Centre for Epidemiology and Population Health at the Australian National University has been responsible for overseeing the project and was asked to give evidence. Council was impressed by the level of attention to detail, the scientifically rigorous design of the preceding and ongoing research and the proposed design of the pilot projects. The ACT Heroin Trial represents one attempt to develop sound research based experience of the effect of offering heroin in a controlled manner to heroin dependent clients.

Council is of the view that the trial is justified on research grounds and should be supported by the Commonwealth. The trial will assist in determining if there are groups of heroin dependent users for whom the availability of a heroin treatment option is more effective and cost-effective than offering methadone alone. Individual and social outcomes, and attraction and retention rates in treatment, will be examined.

The trial involves three sequential stages. It is proposed that there be two pilots conducted in the ACT followed by a multi state clinical trial. The decision to implement each stage is contingent on the successful completion of the earlier stage. This approach is appropriately cautious.

The proposers of the trial acknowledge that the organisation and administrative requirements of a controlled heroin prescribing service are necessarily complex. Council is also concerned that these difficulties may only be surmountable at considerable cost, or reduction in the relevance of the service to potential users. Council believes that a careful assessment of the outcomes of each pilot and the final trial is required. Council accepts that, on the basis of evidence collected in each of the three stages, heroin prescribing may appropriately be considered for inclusion in the range of pharmacotherapies.

Council has concluded that Victoria should seek to further develop its methadone program and develop proposals for clinical trials of new drugs which may offer additional benefits as alternatives to methadone or in support of withdrawal programs. In Council's view, priority should be given to the

development of new drug trials. It could be appropriate that Victoria be involved with the formal heroin trial in order to undertake comparative assessment of the alternative drug choices. A judgement on this matter may be required if the formal trial proceeds and work on trialing other options is sufficiently advanced in Victoria.

## HARMFUL CANNABIS USE

Council has also been concerned about the level of cannabis use that occurs in our community. Some people who use cannabis persistently become dependent on it, and seek treatment to change their patterns of use. Council notes that very little is known about effective treatment approaches for cannabis dependence. Council believes there is a need to develop and evaluate appropriate, responsive treatments for this group.

### 3.6.4 YOUNG PEOPLE

---

Youth are a heterogeneous group most of whom will experiment with licit and illicit substances, most notably tobacco, alcohol and cannabis. Drug dependence is usually a long term and damaging process. Preventing young people commencing use or reducing the levels of misuse is one of the potentially most significant initiatives that could emerge from this investigation.

The vast majority of young people who try illicit drugs are simply experimenting, primarily with cannabis, and will not develop a dependency on this or other illicit substances.

Council is concerned about the situation of young people from diverse cultural and/or linguistic backgrounds who have problems with illicit drug use. While many schools and services are endeavouring to provide appropriate support, many other organisations appear unable to cope with cultural diversity coupled with illicit drug use. This can occur because the organisation is too 'stretched', or through a lack of knowledge in dealing with a culturally diverse clientele. This, in turn, may lead to a lower level of utilisation of services by these groups and poorer information about the harms caused by drug usage.

With respect to substance use it is possible to conceptualise young people as belonging to the following categories:

- At 12–14, people who may begin with some experimental use of drugs.
- At 15–17, experimental use continues but becomes interspersed with 'binge' use.
- At 18–20, any problematic use of substances begins to become integrated into the young persons life.
- At 21–24, problematic use of substances becomes entrenched (McDonald, 1996).

The risk of young people developing serious problems with drug use is more likely if other areas of their lives have been disrupted. Disordered family relationships, social disadvantage and early and prolonged periods of homelessness are predictive of serious problems with substance abuse as a young person and in later adult life (Chamberlain, MacKenzie, 1985; Spooner, Mattick & Howard, 1995).

Polydrug use (particularly amphetamines, alcohol, Ecstasy, inhalants and abuse of prescription drugs) is also a feature of problematic adolescent drug use (Spooner et al., 1995; McDonald, 1996).

On the basis of substantial advice, Council is concerned about the capacity of services to respond to young people with drug problems. Service gaps are seen in the primary, secondary and tertiary intervention sectors.

Council received many representations about the lack of alcohol and drug withdrawal facilities for youth. There are also few other services able to deal with young people whose health and wellbeing are seriously affected by drug misuse.

Council's commissioned work on treatment concluded that youth rarely experience clinical dependence. They do, however, experience distress after episodic abuse of illicit drugs, particularly within the context of crises and significant disruptions to their lives.

As with adults, many young people in contact with the justice system have drug problems.

Council agrees that there are large gaps in the network of services able to support young people, particularly those with serious drug abuse and related problems. Initiatives in the following areas, implemented in an integrated fashion, would address many of these deficiencies.

**Outreach:** Workers who have the capacity to provide:

- Secondary consultation to agencies who come into contact with youth who are experiencing problematic drug use.
- Direct service to young people who are in need of specialist assessment and support, or referral to a residential service.
- Case management and support with other matters likely to be of concern to the young person such as family issues, accommodation and linkage to a range of local services.

**Training, professional supervision and consultation:** Training should be provided to outreach and other key youth workers, to build the skill base and knowledge of the field. This training would need to be provided as part of the broader training proposed in section 3.5.3. Council is also convinced that professional supervision and consultation is required to maintain focus and enhance the skills and training expertise of youth workers in the community and correctional systems.

**Intensive supportive care:** The most effective way to support young people is within the networks and services where they feel most comfortable. Serious drug problems and the behaviours that can, from time to time, accompany them exceed the capacity of these services and young people are evicted or rejected. Council believes that with periodic and highly skilled support these services can be supplemented and assisted to retain their caring role through these crises. This support would have to be very flexibly provided given the range of different situations in which it may be required. There also needs to be a new residential treatment service linked to this outreach support. This facility, with a small number of beds, should be associated with an acute hospital because of the possible need for emergency medical and psychiatric services. Access to this facility would have to be carefully managed and linked to the outreach support services, and supported by a specialist drug and alcohol agency.

**Research and evaluation:** There is little systematic, research based knowledge about young people who have specific problems with drug use. There is even less evaluation of models of care that could form a basis for further development of youth services. Victoria has not had a systematic, clear service system for these young people. Various sectors including education, health, welfare and correctional services are involved in the care and management of young people who have problems with drug use.

Council believes that Victoria requires appropriate research in adolescent health and harmful drug use to support the design, implementation, practice and evaluation of a system of care and specific services.

**Monitoring:** Throughout this report the volatility of the drug market has been highlighted. Comment has been made in public hearings and expert consultations about the importance of having current and local knowledge about the drugs being used, particularly by young people, and their quality. A database is required which is both current and able to provide direct feedback to people in contact with users about the drugs. This database will also facilitate informed policy making at a state and regional level. The database will require resources in terms of pathology expertise and data collection, analysis and dissemination.

Council believes this model or approach is likely to engage youth who are 'hard to reach' and who may be involved or at risk of being involved with the juvenile justice system. It also aims to retain the young person in their usual social environment and thus has the capacity to address the variety of other problems that beset young people who use drugs.

### 3.6.5

## CRIMINAL JUSTICE SYSTEM

---

### PEOPLE IN POLICE CUSTODY

People held in police custody who have problems with illicit drugs are vulnerable, particularly with regard to withdrawal. Their withdrawal could be from an illicit drug or prescribed methadone. Unsupervised withdrawal can be medically dangerous. Police face a difficult task in recognising that someone is at risk from withdrawal, and in providing an appropriate service. In the time available to Council it was not possible to investigate this issue in detail. As concern has been expressed to Council which accepts the importance of the issue, Council believes a review of standing orders and current police practice is justified.

### THE COURT SYSTEM

A significant number of people who have serious drug problems come into contact with the court system and subsequently the corrections systems (see section 2.2.3).

Some people are motivated to change their behaviour as a result of contact with these systems. The courts have the power to require people to access information and treatment as part of their disposition. The experience of imprisonment can also contribute to a person's willingness to utilise treatment services, particularly if doing so contributes to earlier release through parole. This means that, either directly or indirectly, the corrections system can play a critical role in facilitating contact with treatment services within the community, or by providing these services within the prison.

Council believes that the state can better capitalise on these opportunities and the infrastructure that currently exists. Utilisation of the opportunity will depend upon courts and the Parole Board having confidence in using treatment as part of their disposition. They will also depend upon community understanding the potential harm reduction benefits of treatment rather than other punitive options for many drug offenders.

## COURT SERVICES

Council has received comment from judges and magistrates that 'on the spot pre-sentence expert advice' about the availability and suitability of treatment services, as well as a specialist assessment about the nature and extent of an individual's drug problem, is inadequate. In Council's view the court system would be well served by the establishment of a specialist court drug advice service.

This service would include specialist assessments that may facilitate improved judgements regarding possible and effective treatment options which can be put before the judge or magistrate. The benefit of such an initiative is likely to be better targeting of community based orders and diversion of more drug offenders from prison. Council is not suggesting that drug offenders should receive more lenient sentences than other offenders. Rather it is suggesting that the damage done in a prison environment can be significant, and the offender and the community could benefit if offenders can be safely supervised and treated effectively in the community. This is particularly true for first offenders who may be diverted from a life of continuing criminal activity.

## COMMUNITY-BASED CORRECTIONS

Victoria has a significant number of people subject to community based dispositions. Many of these people have a treatment condition attached to their order (see section 2.3.3). The Department of Justice has recently established a specialist treatment service targeted at younger offenders. The Department of Health and Community Services, which administers treatment required under section 28 of the Sentencing Act 1991, provides funding to ensure treatment is provided for some of these people. The department also coordinates the administration of services required by people ordered to attend an assessment centre under section 11 of the Alcoholics and Drug-dependent Persons Act 1968. These arrangements need to be reviewed because they are inefficient. All others required to receive treatment are referred to existing specialist treatment services that are expected to accept these referrals in the normal manner.

Council supports the principle that people required to receive treatment should be assisted in exactly the same way as those who use services on a voluntary basis; however, Council believes current arrangements are deficient in at least three ways. Most specialist treatment services lack the capacity to deal effectively with forensic clients and those attending on a voluntary basis. There are no arrangements that ensure that people referred by the courts gain the preferential access to services required to meet the requirements of the court. Thus, there is a high likelihood that inadequate or no services will be provided despite a court order. Secondly, there are few guidelines or protocols to guide community corrections staff or the agencies in managing these clients and fulfilling their obligations to the courts. Finally, there is almost no training provided for staff of treatment agencies regarding their forensic obligations to clients and community corrections staff. The reverse is also the case. Community corrections officers often have case loads which comprise a variety of client problems leading to diffusion of expertise. Council believes community-based corrections staff's management of people with substance abuse problems could be improved if at least two staff in each community corrections office were required to develop expertise in the substance abuse field, and form positive liaison relationships with local and statewide specialist drug and alcohol services.

Council believes that it is possible to improve arrangements to better manage the decision making and referral process which ensure that the network of treatment agencies is supported to meet its obligations. This can be achieved by enabling the proposed specialist court advice service to purchase treatment services from drug and alcohol services. As well as providing more people, dealt with by the courts, with the opportunity to receive adequate treatment, the new arrangements are likely to free up service capacity in these agencies for other people. Similar working arrangements are also likely to assist more effectively the Adult Parole Board in its decision making and post-release supervision.

## PRISONS

The prison system attracts a population with substance abuse problems of a serious and lifelong nature. Some studies suggest up to 78 per cent of persons within adult prisons have a substance abuse disorder (Taylor & Gunn, 1993; Herrman, McGorry, Mill & Singh, 1989). This is particularly true of women in prison (Pathé, 1993; Hurley & Dunne, 1991; Miner & Gorta, 1987).

The prison environment is simultaneously a difficult environment in which to deal with drug issues, and a valuable opportunity for people to confront their drug use, provided adequate treatment and support is available.

Council has been advised that while the frequency of illicit drug use by people in prison is low, the harms done are substantial.

Council has also been advised that prison-based treatment services are currently subject to review. This review is very important as Council has substantial concerns regarding the adequacy and appropriateness of existing services. While Council wished to explore this area in greater detail, the current review provides a means for urgent and broadly based input to future development. Council urges that the information and advice flowing from this review be considered by a wide range of groups, including people involved in operating community and support services. Participation by these kind of groups will help to ensure that treatment options and standards replicate those in the community.

Council assumes that the discussion and planning proposed following the current review will inform requirements in specifications for any privatisation of prisons.

### 3.6.6

## INTERSECTORAL ISSUES

---

People who have problems with illicit substances commonly face multiple problems. Further, many people with substance abuse problems also live in family groups caring for young children. There is a known interaction between substance abuse, child abuse and neglect, the criminal justice system, mental health, and the disability fields. This represents an opportunity to address the delivery of services across health and community services and the criminal justice system in a manner that genuinely endeavours to address the problems of people with multiple needs (Scott & Campbell, 1994). Such an approach requires services to forget their traditional boundaries and work together for the benefit of clients and their families requiring multiple services.

In contrast, services are generally organised and provided by specialist services with tight eligibility criteria. The drug field, in common with others, is grappling with ways to provide effective and integrated services. It should be an active partner in enhancing several services' capacity to assess and manage people with drug problems.

Council has been told of an ongoing issue between drug and alcohol services and psychiatric services concerning a number of clients who do not appear to fit readily within either service. Tensions have arisen in crisis situations, usually in the context of agencies in one of the service systems refusing to assess or accept people who are both intoxicated and apparently suffering an acute psychiatric episode. Council has been advised that attempts are being made to better manage these tensions by developing in-service protocols. Council supports these efforts.

The Department of Health and Community Services is currently developing or upgrading a range of protocols between key program areas. Protocols are being developed with Child Protection, Psychiatric Services and Supported Accommodation and Assistance Program. Protocols aim to establish a model of collaboration between services to assist people requiring the services of both programs. H&CS is also funding a small number of integrated service models. These initiatives are being monitored to assess their usefulness as models of integrated care.

Potential exists to increase the confidence and backup needed for health and welfare practitioners working in generalist settings, such as general medical practice and accommodation and community health centres. Council believes that shared care models of service and secondary consultation should be actively explored as a means of making more creative use of specialist and generalist services.

The Departments of Justice and H&CS are collaborating on the development of aspects of the community corrections system. These initiatives, while important, may not provide an effective response to current need. Proposed developments in the support systems for people with drug problems should be integrated rather than divided between departments.

### 3.6.7

### CONCLUSION

---

Council believes that the proposals outlined in this section could have significant impact upon the range and quality of support and treatment services in Victoria. The impact will be maximised as the training, research and service evaluation initiatives also begin to take effect. Consistent leadership and coordination of these activities will be required. Many organisations, some prominent in the field, others newcomers, will need to be involved and to share the responsibility for the leadership and coordination tasks.

Drug law enforcement is a national concern. Considerable public resources are invested in enforcing existing drug laws. In the time available to Council, only a limited and general assessment of the effectiveness of law enforcement has been possible. Law enforcement in this area is necessarily complex and the strategies, priorities and operational details are often confidential. Council has had the benefit of advice from senior officers in Commonwealth and State law enforcement agencies. It has also had the benefit of access to several, very recent analyses and reviews commissioned by law enforcement agencies. Council has been reliant, to a substantial degree, on the material provided by these sources.

As detailed in section 2.2.3, law enforcement includes policing, the courts and corrections system and it consumes the vast bulk of the State's investment in responding to illicit drug use. The direct costs relate to cases where formal drug offences were the most serious charge. These costs account for 10.6 per cent of all offenders processed by police (monthly Criminal Justice Statistics November 1995). They also account for 8.5 per cent of all charges in the Magistrates' Court and 5 per cent of matters dealt with in higher courts. Some 6.5 per cent of people in the correctional services system also have drugs as the most serious charge (monthly Criminal Justice Statistics November 1995).

These figures, while significant, understate the case. They exclude matters where drug offences were committed but were not the most serious charge. They also exclude a range of offences committed as a consequence of drug use, most commonly burglary and theft committed to support a drug habit. They also exclude crimes of violence committed as part of the drug trade, or as a consequence of a marginalised lifestyle. Council has heard that informed estimates indicate that some 70 per cent of burglary and theft offences are committed as a consequence of drugs.

Enforcing the drug laws and dealing with crime, arising from drug use and trafficking, is a major priority for the police, courts and corrections system. It will clearly remain a priority for the foreseeable future. The issues before Council relate to defining strategies that gain maximum benefit and more effective use of existing resources.

### 3.7.1

#### SCOPE FOR EFFECTIVENESS

---

Estimates of the rate of detection and seizure of heroin entering the country vary from 1 per cent to 10–15 per cent (Royal Commission into Drug Trafficking, NSW, 1979). Australian Customs Service barrier examination rates are fairly low (9 per cent of passengers searched and 1 per cent of containers 1992–93) (ACS, 1993). The drugs, whether domestically made or imported, are often relatively easily concealed. Finding them is essentially a very difficult task. There are clear limits to the capacity of even the most efficient enforcement arrangements (Reuter, 1993).

The best evidence available indicates that all law enforcement bodies achieve relatively limited success with regard to reducing supply. While regrettable, Council accepts the reality and believes that this information needs to inform the community's expectations regarding performance of law enforcement agencies. Reorganisation, and a change of strategies, tactics and priorities can help reduce demand and

contribute to harm reduction. This would enhance the overall performance of law enforcement. Expanding the attempts of law enforcement to significantly reduce supply will achieve only marginal gains.

In considering police effectiveness, Council noted that inquiries held in many countries and in other states of Australia have confirmed that some degree of corruption is an almost inevitable consequence of the existence of prohibition. However, the investigation of this matter in Victoria is beyond the resources available to Council. While Council was presented at public hearings and in submissions with a range of information and comment relating to police effectiveness, it has neither sought nor received indications of systematic corruption in the Victoria Police with respect to illicit drugs.

### 3.7.2

#### PRIORITIES

---

Data available to Council indicates that drug use and possession charges considerably exceed those for trafficking and related charges (Figure 15). Council understands that most prosecutions relating to possession and use of drugs do not arise out of proactive drug law enforcement. Most charges concerning use and possession of small quantities of illicit drugs result from their discovery, incidentally, during enforcement that is related to other matters. Surprisingly, there is a considerable number of people charged where possession or use of drugs is the only, or the most serious, charge pursued by police. The numbers of people whose most serious charge relates to possession or use of cannabis is five times that whose most serious charge relates to trafficking.

There are substantial cost and other consequences in using the criminal law to deal with personal use or possession of any drug. In the context of a harm minimisation strategy, it is unlikely that this response will further reduce harm or represent the most cost-effective approach. There is also limited scope for 'deterrence' if the chances of detection are low and unpredictable.

Council has heard that it is not current police policy to pursue drug users. Concerns were expressed to Council that this policy is not uniformly carried through to the community level.

According to advice received by Council, a major emphasis of law enforcement strategies in recent years has been on prosecuting major and large-scale participants ('Mr Bigs') in the financing, importing and trafficking aspects of the drug trade. Evidence suggests that strategies employed have not been particularly successful. Information about the proportion of matters relating to use or possession, as distinct from trafficking, is an indicator of poor targeting. A further indicator is that a high proportion of trafficking charges is not proven. In 1995, 38 per cent of trafficking charges were not proven, over three times the proportion for possession and use charges.

It was suggested to Council that the relative lack of success in pursuing large-scale traffickers, financiers and importers may reflect the relative absence of major funders and controllers in the Australian drug market. Council has also heard that low levels of success are a consequence of the high resource costs and risks of the enforcement operations involved. It was made aware of real limitations in the extent to which drug enforcement agencies can demonstrate their effectiveness in this regard (ABCI, 1995). It was also argued that restricted powers available to police, particularly with respect to search and seizure, have hindered their ability to move against large-scale and sophisticated traffickers. Council is not in a position to adequately assess all of these comments and explanations.

According to some reports, experience in the USA is similar and there has been a long-term move away from focussed pursuit of large traffickers on the grounds that success rates have been very poor.

It is clear that the complexity, scale and volatility of the market for illicit drugs presents major challenges to large and traditional organisations such as the police. Council is aware that apparently inescapable tensions between drug law enforcement and harm minimisation place police in a difficult position. Even operations directed at the seizure of drugs and disruption to supply can contribute to a range of unintended consequences.

There is some inconsistency between the stated priorities of police and the data about the patterns of arrests that result from police activity. This suggests there is a need for on-going priority setting, policy communication, training, and implementation management.

Active policing can contribute to reduced demand and reduced harm through misuse of drugs. Council has heard evidence that indicates that three broad areas deserve priority.

### COMMUNITY POLICING

Council has heard a good deal about community policing as a potentially useful approach to the drug problem at a local level. While not having time to develop a sophisticated definition, Council believes community policing to mean that police engage the public in problem solving, and consider their input in determining and evaluating operational policy and procedures.

Community police involvement can disrupt drug markets and increase the difficulty with which buyer and sellers can get together. It has potential benefits and costs, particularly where vigorous activity in one area simply displaces drug dealing to another area or to another drug type. Council believes that the goal should be to maintain a constant presence and pressure that discourages low level dealers and novice users. These activities can form an important element of an area-based harm minimisation strategy, particularly where they are developed and implemented in association with local community health, and community service organisations. Senior police have confirmed their commitment to working with local communities on issues such as drugs.

Council has heard considerable comment about effective street level enforcement and engagement with local agencies, and some strong criticisms about police practice. Council was provided with evidence of high-quality internal collaboration at operational levels. There was also information that indicated difficulties occur with respect to the sharing of information about patterns of drug availability, use and trafficking, and the utilisation of this information to formulate comprehensive strategic responses. If this advice is correct, steps should be taken to improve strategic planning and cooperation within the Force, particularly between the Drug Squad and specialist district support groups, and also in collaboration with community agencies and the community.

Street level enforcement also provides information and intelligence that will contribute to the pursuit of major participants in the trade.

## MAJOR TRAFFICKING

As noted earlier, State and Commonwealth agencies have a role in pursuing people with a significant stake in the illicit drug industry. Council has heard about the sophisticated operations that are involved. It has also been advised that the trade is diverse and flexible. It has a rapidly changing structure that law enforcement agencies find difficult to tackle in anything other than a reactive way.

Council has heard that working relations between State and Commonwealth agencies have improved in recent years. It is clear that improved collaboration is a prerequisite to enhanced effectiveness in charging and convicting the major players. Council believes that this area deserves continued emphasis, in particular to ensure coordination and cooperation to enhance enforcement efforts.

Some advice suggested that dealing effectively with the big players in the drug trade requires different expertise than is commonly available in police forces around Australia. Council was impressed with the multidisciplinary task force models used by the National Crime Authority, Australian Federal Police and groups investigating white collar crime.

## THE MONEY TRAIL

There is international recognition that the profits from the drug trade are large and that tracing money movements may assist in the apprehension of major figures in the trade. Tracking of this kind is a necessary precondition to any asset confiscation arrangement. There is international agreement about the need for nations to establish legislation to control and report on funds movement. Australia has acted on this agreement.

Council has received evidence and submissions which show that Australia has some of the most effective laws and administrative machinery (AUSTRAC) for monitoring national and international money movements. Council has been told that police may be able to make more effective use of the data from the Australian tracking system (Wardlaw, oral submission, 1995).

Council has been advised in submissions that the effectiveness of this approach may be improved by broadening the definitions of transactions and the number of agencies required to report. If obstacles exist in identifying beneficial ownership of investments, attention should be given to identifying means by which these can be overcome in retrieving the proceeds of trafficking. The potential benefits to be accrued may be significant and Council believes that further investigation of this area is justified.

## DEVELOPING THE INFRASTRUCTURE TO ENHANCE POLICING

Council agrees that police make important contributions to harm minimisation. For some officers this is through work outside hours of duty but it could be seen, increasingly, as central to community policing. Council wishes to enhance that contribution.

Council has been made aware of the problems that can emerge when police activity is undertaken in the absence of impact and outcome-related data. This is especially the case regarding regional data that are most important for shaping and assessing harm minimisation activities at the local level. This data relates to:

- Consumption patterns.
- Health consequences.
- Violence associated with trafficking.
- The impact of law enforcement on use and supply.
- Crimes committed in relation to the consumption of drugs. These data are required for planning and implementing law enforcement within a harm minimisation strategy.

Comment has been made on the inherent difficulty for police, particularly those working at street level, to meet the goals of a harm minimisation approach. This suggests the need for more training in harm reduction strategies and their implications for police work. Any such training would need to have a practical, as well as theoretical, aspect. Council believes training is a crucial element of its strategy and makes reference to this matter in more detail in section 3.5.3 on professional development. Police are a priority group in this context.

Comment was also made earlier about the importance of ensuring police engagement with, and encouragement of local community involvement in responses to drugs. During Council's consultation, it became apparent that levels of commitment to and involvement in drug-related community work varied considerably between local areas. In part, this appeared to reflect the ability and enthusiasm of particular officers. In other cases, much depended on success of local police-community liaison initiatives such as Police Community Consultative Committees. While these initiatives are valuable, there is need for a more systematic and sustained program of community policing and inter-agency cooperation with respect to drug use, particularly at local and district level.

Council does not believe that any single model for community development would be appropriate in this respect, as the variability of local problems, resources and appropriate vehicles needs to be recognised. It is proposed that further development of police strategies in this field provide increased guidance and support for police-community initiatives aimed at reducing the harms associated with illicit drug use. The issue of community involvement in drug issues is dealt with in the discussion regarding information and education (see section 3.5.4).

Council was made aware of the important contributions made by many police officers at the community level, including work in educational, welfare and recreational contexts. It was indicated on a number of occasions that such work is not highly valued in the Force, and that officers involved received neither adequate career recognition nor sufficient resourcing for their efforts. Council has heard of the approach to community policing being developed in Amsterdam and was impressed with its positive and preventive approach.

In view of the potential contribution of such activity to harm minimisation, Council believes that the resources available to support this work, and career recognition provided to officers involved, should be investigated and that appropriate responses to identified deficiencies be developed as a priority.

Council's assessment that law enforcement is relatively ineffective in controlling the supply and use of illicit drugs is not a criticism of the agencies involved. The time and data available to Council has not enabled any detailed judgement regarding the performance of any of the law enforcement agencies. The criticism is largely based on the structural difficulties of the task in the circumstances, and the limited amount of evaluative data available.

Overall, the contribution of law enforcement to the management of illicit drug use in Victoria needs to be more closely integrated with harm reduction strategies currently endorsed by the Victorian and Commonwealth Governments. Structural and process reforms should focus particularly on four major tasks:

- Ensuring that a clear, comprehensive and coordinated strategy and operational guidelines on drug activities are in place within the Victoria Police.
- Developing an appropriate monitoring and evaluative mechanism, with clear, well-defined success indicators.
- Increasing operational integration between police, and health and community agencies, that is designed to ensure collaboration on harm minimisation strategies and priorities at all levels, particularly in responding to users within local communities.
- Improving training on policing in a harm minimisation framework.

## 3.8

### The Law

Reform of Victoria's drug-related legislation was one of the recurring themes in submissions to Council. A range of groups and experts alerted Council to perceived weaknesses, contradictions, dilemmas and tensions with current laws; other submissions argued strongly that current prohibitions should remain.

Legislation considered by Council included:

- *Drugs, Poisons and Controlled Substances Act 1981.*
- *Crimes (Confiscation of Profits) Act 1986.*
- *Road Safety Act 1986.*
- *Sentencing Act 1991.*

### 3.8.1

#### LEGISLATIVE OPTIONS

---

Legislative options were classified by Council using a framework developed by the South Australian Royal Commission into the Non-medical Use of Drugs (Sackville, 1978). Available options are:

- Total prohibition.
- Prohibition with civil penalties.
- Partial prohibition.
- Regulation.
- Free availability.

Under a system of **total prohibition**, the use, possession, cultivation, importation, sale and distribution of any amount of a specified drug is treated as a criminal offence. Current Victorian legislation and legislation in most other states reflect a policy objective of total prohibition. Despite significant resources directed toward achieving this goal, widespread use and trafficking occurs in illegal drugs.

Under the **prohibition with civil penalties** option, penalties for possession and use of small amounts of drugs for personal use are dealt with by penalties such as a fine, rather than criminal sanctions including imprisonment. Criminal sanctions still apply for possession, manufacture and trafficking of larger quantities of drugs. Examples are the South Australian Cannabis Expiation Notice Scheme,

introduced in 1987, the similar scheme introduced in the Australian Capital Territory in 1992, and the scheme to be introduced in the Northern Territory later in 1996. In the USA during the first half of the 1970s, criminal penalties for marijuana possession were removed in 11 States, which cover one-third of the nation's population.

**Partial prohibition** seeks to maintain controls on the production and trafficking of drugs while eliminating offences for possession and personal use and, in the case of cannabis, cultivation of plants for personal use. A number of countries (for example, Spain) have followed this model (McDonald et al., 1994).

Government **regulation** would broadly reflect current arrangements for tobacco, alcohol and many pharmaceutical products where Government, to a greater or lesser extent, controls production distribution and sale. Regulatory structures generally provide controls not only over purchase, but also over quality, standards and marketing. In respect of cannabis, the Netherlands exhibits some elements of the regulatory model. **Free availability** would mean the absence of any legislative or regulatory restrictions on a drug's production, sale or use.

The alternative legal responses to drugs form a continuum. The practical policy decisions regarding a particular drug involve who should be allowed to use it, under what circumstances, for what purposes, with what restrictions, and what sanctions are to be applied to violations of those rules, rather than simply whether the drug should be called 'licit' or 'illicit'.

### 3.8.2 CHOOSING BETWEEN OPTIONS

---

Differences between supporters of existing law and those advocating alternative approaches revolve around three key issues:

- Assessment of benefits and costs of current laws, and whether a different policy mix would achieve greater benefit at an acceptable cost.
- The projected impact of changes to existing laws on demand and use.
- The health risks of the different illicit drugs. Issues include whether risks associated with a particular drug are serious enough to justify current sanctions, and how the known risks compare with well-documented consequences of misusing alcohol or tobacco.

Evidence relating to each of these issues is canvassed in this section. Other views, including a moral perspective that drugs are evil, were advanced in several submissions.

#### BENEFITS AND COSTS

A comprehensive assessment of benefits and costs of different responses to drugs concludes that drugs are a community problem for which there is no solution—only better or worse outcomes (Kleiman, 1992; Reuter & Caulkins, 1995). Each available policy regime increases some harms and reduces others. Victoria's current laws, for example, mean that prohibition and law enforcement, rather than drug use, generate the overwhelming proportion of direct costs and arguably most of the harms arising from drug misuse. At each step along the chain of production, distribution and consumption, illicit drugs divert law enforcement time, energy and resources away from other responsibilities with little apparent impact on either drug supply or use.

The fact that prohibitionist drug laws and law enforcement cannot eradicate, or even significantly reduce drug abuse is not necessarily a reason to change. Current laws aim, and arguably succeed in deterring many people from trying drugs and restrict their availability. However, these achievements must be balanced against not only the direct costs of law enforcement but a range of health and community costs, including the isolation of many drug-dependent people from health services.

Many submissions drew Council's attention to consequences of the failure of current legislation to support the harm minimisation objectives of the Victorian and national drug strategies. These include:

- Constraints on effective drug education, particularly by grouping cannabis with more harmful drugs, rather than alcohol and tobacco.
- Increased health risks when addicts are reluctant to call for emergency medical assistance (Zador et al., 1996).
- Corruption of enforcement agencies (Fitzgerald 1989, Wood 1996).
- Alienation of young people from the police and courts required to enforce prohibition.
- Individual and community costs caused by reduced educational, employment and other opportunities as a result of convictions for possession and use (Sackville, 1979; McDonald & Atkinson, 1995).

A recent attempt was made to consolidate available information about the various harms associated with drug use and whether they arise from drug use itself, laws or law enforcement. This information is presented in table 24 and suggests that prohibitionist laws and their enforcement create more harms and costs for a community than the known harms of drugs themselves. However, any overall assessment of whether harms are greater than benefits is constrained by the following factors:

- There is an absence of relevant empirical evidence of many of the harms that are at least quantifiable in principle.
- Many of the quantifiable harms cannot be easily translated into monetary terms.
- Many of the harms are inherently intangible and subjective.
- It is easier to perceive the presence of harms than their absence; in other words, policy may be blamed for harms that it allows or creates, but gets no credit for harms it reduces or prevents.

Three important conclusions emerge from McCoun, Reuter & Schelling's assessment of different legislation and law enforcement responses to drugs:

- Until better data is available, few confident assertions can be made about what will work more efficiently.
- Preference for a particular legislative response to drugs is often guided by a moral or ideological perspective rather than by significant disagreement about the findings of available evidence.
- Legislative responses can vary among different drugs depending on the level of harm they pose to society, and whether laws can be enforced in ways that achieve objectives at an acceptable cost.

CATEGORY	HARM	USERS	DEALERS	INTIMATES	EMPLOYERS	NEIGHBOUR HOOD	SOCIETY	PRIMARY SOURCE OF HARM
HEALTH	Health care costs (drug treatment, other)	X		X			X	Use
	Suffering due to physical or mental illness (acute, chronic)	X		X				Use
	Addiction	X		X				Use
	HIV/other disease transmission	X		X			X	Use, Illegal status
	Prevention of quality control	X						Illegal status
	Inhibition of voluntary pursuit of treatment	X		X				Enforcement
	Restriction on medicinal uses of drug						X	Illegal status
SOCIAL AND ECONOMIC FUNCTIONING	Reduced performance, school	X		X	X		X	Use
	Reduced performance, family	X		X		X	X	Use
	Reduced performance, workplace	X		X	X		X	Use
	Influence on others' using			X	X	X	X	Use
	Harm to self-esteem associated with use	X						Use, illegal status
	Harm to reputation associated with use	X						Use, illegal status
	Harm to employability associated with use	X		X			X	Use, illegal status
	Elevated dollar price of substance	X		X			X	Enforcement
SAFETY AND PUBLIC ORDER	Infringement on personal liberty	X	X		X	X	X	Enforcement
	Accident victimisation (work, road, etc)	X		X	X	X	X	Use
	Property/acquisitive crime victimisation			X	X	X	X	Use, enforcement
	Violence, psychopharmacological	X	X	X	X	X	X	Use
	Violence, economic compulsive	X	X	X		X	X	Enforcement
	Sense of public disorder and disarray				X	X	X	Use, enforcement
	Observably widespread violation of law						X	Illegal status
CRIMINAL JUSTICE	Increased police costs						X	Enforcement
	Increased court costs						X	Enforcement
	Increased incarceration costs						X	Enforcement
	Court congestion and delay						X	Enforcement
	Police invasion of personal privacy	X	X	X		X		Enforcement
	Corruption of legal authorities						X	Enforcement
	Demoralisation of legal authorities						X	Enforcement
	Violation of the law	X	X				X	Illegal status
	Devaluation of arrest as moral sanction						X	Enforcement
	Fines	X	X	X				Enforcement
	Time and income lost (in court in prison)	X	X	X	X			Enforcement
	Legal expenses	X	X	X			X	Enforcement
Stigma of criminal record, prison record	X	X	X				Enforcement	
Fear of apprehension	X	X	X				Enforcement	

Source: adapted from McCoun, Reuter & Schelling (in press).

## IMPACT OF LEGISLATIVE CHANGE ON DEMAND

While analysis of the impact of changes to existing laws is significantly constrained by a lack of reliable data in respect of heroin, amphetamines and cocaine, more comprehensive and reliable data is available to enable assessment of the likely impact of changes in respect of cannabis. Available data indicates:

- Cannabis use is not significantly constrained by current law. An estimated 30 per cent of Victoria's population have used it and it is the most widely used psychoactive drug after alcohol and tobacco (table 4A).
- Removing criminal penalties for minor cannabis offences in South Australia, the USA and Europe has had little impact on consumption (Atkinson & McDonald, 1995; Reuter & MacCoun, 1995; Korf, 1995; Reuband, 1995).
- Removing all penalties for minor cannabis use and possession offences in the Netherlands also appears to have little impact on consumption (Korf, 1995).
- Small changes in legislative provisions on cannabis also appear to have little impact on patterns of use, although the evidence is less clear in this area (Atkinson & McDonald, 1995).
- More generally, a recent cross-European comparison of drug use and drug law (Reuband, 1995) concluded that there is no clear-cut relationship between drug law and drug use. For example, while cannabis is readily available through the Netherlands' 2500 coffee shops, drug use by adults and youth is basically the same as in Germany where no such availability exists (Reuband, 1995).

## HEALTH RISKS

Existing knowledge of health risks associated with use and misuse of existing drugs is considered in chapter 2. While there are excellent reasons why use and misuse of all illicit drugs should be discouraged, prohibition, particularly in relation to marijuana, has not achieved this result. Council believes an alternative approach should be considered in an effort to minimise use over the long term. More generally, if minimising harm from drug use remains the primary policy goal, early intervention and treatment should be developed as the first level response to drug abuse. Health risks associated with imprisonment for drug-related crime reinforce the current role of prison as a last resort for offences involving only drug use and possession. Information available to Council supports advice from police, magistrates and judges that current law enforcement practice means that almost no Victorians are jailed when the only offence is drug use. Council believes this practice should be made explicit and strengthened with earlier and better diversion to assessment and treatment services.

### 3.8.3

## APPROACHES TO CANNABIS LAW REFORM

In its 1994 report, Cannabis and the Law in Queensland, the Criminal Justice Commission (CJC) assessed three legal options for dealing with cannabis: legalisation, retention of existing laws; and the introduction of an expiation notice scheme. In summary, its conclusions were:

- There is an overwhelming case for modifying the existing Queensland offence and penalty structure for dealing with minor cannabis offences.
- An expiation notice scheme should not be adopted in Queensland.
- The current Victorian model of adjourned bonds provides a useful starting point for developing a statutory scheme for Queensland.

The CJC arguments against the expiation option, along South Australian lines, are:

- The levels of penalties under the South Australian arrangements are too low.
- The South Australian scheme relies on the threat of a criminal conviction to induce expiation.
- In practice, the South Australian system seems to have caught up a larger number of people than would have been charged under earlier laws.
- There is no hierarchy of penalties for repeat offenders.

The Queensland CJC was attracted to Victorian provisions for a sentencing option for first-time cannabis offenders of an adjourned bond as:

- It allows for more substantial penalties to be imposed on second and subsequent offenders.
- The bond constitutes a formal denunciation on behalf of the community of drug use as unacceptable behaviour.

Arguments for and against different approaches revolve around issues such as whether any realistic regime will significantly deter consumption, what penalties best reflect the level of community concern about the health and other risks associated with marijuana use, and whether the costs of enforcing the law can be justified against competing demands for law enforcement resources. While the South Australian scheme was devised to reduce court costs, higher than projected failure to expiate fines has created additional court work and associated costs. Current Victorian arrangements reduce no police or court costs. The Queensland Criminal Justice Commission estimates of the cost to Queensland of apprehending and prosecuting people possessing cannabis was, on average, around \$320 a case. If Victorian costs were broadly comparable, prosecution of cannabis possession and use would cost the criminal justice system at least \$6.5 million a year.

Council also considered a range of related issues in assessing options for legislative reform relating to cannabis. These included:

- The possibility of different legal responses to different forms of cannabis. For example, should the same restrictions apply to marijuana as to other cannabis products?
- Whether adults should have less constrained access to marijuana, with tighter restrictions remaining for young people.
- Whether drug use posed sufficient risks in operating work-based equipment or driving cars to justify specific restrictions and testing procedures.
- If possession and use were decriminalised, should the drug be able to be sold openly? In Amsterdam, for example, not only is marijuana able to be used without risk of penalty, but it is sold openly in the 'coffee shops'.

Council's conclusions on these issues are identified in its recommendations.

### 3.8.4

#### IMPACT OF INTERNATIONAL TREATIES

---

Any changes to existing legislation and/or penalties will need to take account of obligations entered into by the Australian Government under international treaties. The drug conventions ratified by Australia (see section 2.2.1) oblige the Commonwealth Government to ensure domestic laws are consistent with conventions. While State Governments are not directly prevented from passing or retaining laws that are inconsistent, they generally abide by the obligations. However, where a law is inconsistent, it is open to the Commonwealth Government to override the state law (Criminal Justice Commission, 1994).

The Single Convention on Narcotic Drugs 1961 codified all existing conventions and obligations of the nations that were parties to the convention. It also introduced an international prohibition in relation to cannabis. Within the various conventions, cannabis is listed alongside more dangerous substances. This labelling has arguably contributed to the confusion and misinformation about cannabis and its effects (Criminal Justice Commission, 1994). Certainly on available evidence, the association of cannabis with more dangerous and addictive drugs such as heroin is difficult to justify.

While there are diverging legal opinions about what the conventions require, the Queensland Criminal Justice Commission concluded that legalising possession of cannabis for personal use would be outside convention terms (Criminal Justice Commission, 1994). However, there is less agreement about what the conventions require in terms of severity and types of sanctions. A former President of the New South Wales Court of Appeal, the Hon. A.R. Moffitt, QC, has argued in a paper submitted to Council that the expiation schemes in South Australia and Australian Capital Territory breach the international conventions. Another view is that the combined effect of the conventions preclude only one option: legalisation or total deregulation of drugs (Woltring, 1990). An opinion obtained from the Commonwealth Attorney General's Department by the Queensland Criminal Justice Commission, concluded that the South Australian approach is consistent with the 1961 and 1988 Conventions (Criminal Justice Commission, 1994).

Internationally, parties to the conventions have a variety of approaches for dealing with cannabis ranging from 'administrative' decriminalisation in the Netherlands, to decriminalisation at different times in Italy and Spain. Council is not aware that any action has been taken against these regimes.

The most recent convention (1988) also provides, *'in appropriate cases of a minor nature, the Parties may provide, as alternatives to conviction or punishment, measures such as education, rehabilitation or social interpretation, as well as, when the offender is a drug abuser, treatment and aftercare'* (UN Convention 1988, Article 3, section 4).

### 3.8.5 SENTENCES AND PENALTIES FOR DRUG OFFENCES

---

Drug offences constitute a significant proportion of the current workload in Victoria's courts. In 1994, possession and use of a drug of dependence were respectively the third and fifth most frequent charges heard in the Magistrates' Court. Of the 26,077 drug offence charges finalised in the Magistrates' Court during 1994, nearly 80 per cent were for consumption-related offences, rather than provision and trafficking. In Victoria's higher courts, 5 per cent of total charges finalised were for drug offences, although, more serious cases were heard in higher courts. Around 90 per cent of all charges related to drug provision rather than drug consumption.

While data provided to Council did not allow offences to be distinguished between different drugs or first from subsequent offences, imprisonment is the penalty in only a small minority of drug consumption cases. Just over 2 per cent of individuals convicted of 'drug consumption' in Magistrates' Courts were sentenced to gaol, and nearly 91 per cent received a fine or a bond. Drug provision (including trafficking) offences were dealt with more severely in Magistrates' Courts, with more than 21 per cent of those convicted receiving a custodial (7.8 per cent) or suspended custodial (13.7 per cent) sentence. In the Children's Court, trends over the 1991-94 period indicate greater use of community-based supervisory orders as well as fines or good behaviour bonds.

While large numbers of Victorians are in prison for drug-related offences, correctional services figures confirm the small number of people in prison for drug consumption. At 30 June 1995, a total of 22 prisoners were incarcerated for drug consumption offences. Australian Institute of Criminology 1993 Prisons Census data also indicated that Victoria's rate of drug consumers in custody, per 100,000 population, was 0.2 compared to 1.9 in NSW and 0.9 in Queensland.

While Victoria's figures for 'drug providers' in custody remained well below the New South Wales rate, they were more than double that of Queensland. At 30 June 1995, a total of 259 Victorians were in prison for 'drug provision' offences. While 1994-95 data on sentence length were not available to Council, average 'drug provision' sentences were around five years between 1990-91 and 1992-93.

The Council is aware also that the Attorney General is considering introducing into the Sentencing Act 1991 the concept of a 'serious drug offender', with consequences similar to those for serious sexual and violent offenders (see s.3 Sentencing Act). If persons are convicted of a serious drug offence (that is, importing, cultivating, manufacturing or trafficking in commercial quantities) and have two or more convictions for similarly serious nominated drug-related offences in the past for which they have received a sentence of imprisonment, they could become a 'serious drug offender'. When classified as a serious drug offender, certain sentencing consequences could be attached (see s.10 of the Sentencing Act). Taking into account the fact that the abolition of remissions would no longer apply, sentences would also be cumulative, and the sentencing principle of proportionality would not apply.

Maximum penalties are already severe under the Drugs, Poisons and Controlled Substances Act 1981, with trafficking attracting a penalty of up to 25 years and a fine of \$250,000. However, such sentences are rarely imposed and a number of submissions to Council argued that some penalties did not reflect the seriousness of the offence. Other submissions to Council suggest that any changes proposed to the Sentencing Act to create a category of serious drug offender should seek to distinguish addicts trafficking at street level to support their addiction from larger scale traffickers. Council was not able to explore in detail reasons for variations in current penalties. However, further investigation is required of the levels and patterns of sentences actually imposed by courts for drug trafficking. Review findings should inform government decisions about whether penalties imposed by courts are appropriate.

### 3.8.6

#### DIRECTIONS FOR REFORM

---

After careful consideration of evidence available to it, Council concluded that some changes should be made to existing provisions of the Drugs, Poisons and Controlled Substances Act 1981. Proposed amendments are part of a much broader strategy developed by Council, and have been guided by Council's conclusions that:

- Some existing laws have created harms and costs greater than those that result from the drugs themselves.
- Criminal law and criminal sanctions will continue to fail to reduce supply of illicit drugs and will have little impact on use.
- Many young Victorians' lives are seriously damaged by the consequences of a combination of their drug use and their community's response to it.
- Respect for laws can be undermined when a significant portion of the population is committed to

doing something that the government makes illegal. While community views and behaviour strongly support existing laws relating to heroin, amphetamines and cocaine, they are more divided on cannabis.

Council has also concluded that changes to laws relating specifically to marijuana will enable more effective education and health promotion. The broadly comparable risks of tobacco, alcohol and marijuana should be explained to young people free of the ignorance, misinformation and confusion that now differentiates learning about licit and illicit drugs. Resources currently devoted by police and courts to detecting and prosecuting marijuana offences will be available for other responsibilities. Recommended changes to cannabis cultivation laws may also weaken links between marijuana consumption and trafficking in drugs such as heroin and amphetamines.

### 3.8.7 ROAD SAFETY

---

One of the principal concerns arising from the short-term effects of cannabis use is its intoxicating effect, and the consequent impairment of motor skills and the ability to perform complex tasks, like operating machinery and driving. Submissions to the Council raised serious concerns about the risk to the community posed by drivers under the influence of drugs. Widely reported current use of cannabis highlights this concern.

Council is aware that this issue is being considered in detail by the Victorian Parliamentary Road Safety Committee. The committee is expected to report on the issue of drugs and road safety in May 1996. Implementation of Council's recommendations on road safety should be considered alongside the Parliamentary Committees report.

Evidence available to Council indicated that drugs other than alcohol were present in significant proportions of drivers killed in road accidents, although the contribution of an individual substance to the accident was unclear. The major drug types present in such drivers were cannabis, amphetamines, benzodiazepine, minor tranquillisers, heroin and methadone. Evidence concerning the impact of cannabis use on driving is equivocal. Hall, Solowij & Lemon hold that cannabis use in isolation increases the risk of a driver being involved in a road crash, while Chesher, in a study for the Parliamentary Road Safety Committee, suggests that risks are increased only by the use of cannabis in conjunction with alcohol (Chesher, 1994).

While driving a motor vehicle under the influence of any drug is prohibited under the Road Safety Act 1986, significant research and development work is required before police action could match current responses to alcohol and driving. This would include a test to detect short-lived metabolites of cannabis products in saliva and breath. When developed, this would allow the introduction of roadside testing for cannabis in a manner comparable to alcohol breath testing.

Driving dangerously, recklessly or carelessly are already offences under the Road Safety Act. Council believes that learner and provisional permit drivers found guilty of such an offence, and determined to be under the influence of marijuana, should automatically be disqualified from driving for an extended period, and required to participate in education programs. Protocols should be developed to assist the policing of these offences.

Amendments to the Crimes (Confiscation of Profits) Act 1986 were also advocated to Council. The Justice Department's submission described the current Act as unnecessarily complex and difficult to implement, and it had not provided an adequate procedural structure for decision making. Particular attention was drawn to the lack of any body with general responsibility for operation of the scheme. Presumably in response to these acknowledged weaknesses, the Attorney General established a working party in August 1994, chaired by Mr Peter Faris, QC, to review the Act. While Council has been advised that the working part submitted a preliminary report in October 1994 and its final report in December 1995, copies of neither report were available until after Council had considered this issue.

Legislation to enable confiscation of profits of drug trafficking is widely regarded as an important tool in efforts to control drug crime. However, international experience suggests that the translation into legislation requires careful scrutiny and a realistic assessment of the likely benefits. Experience to date suggests that whatever benefits legislation has in depriving individuals of profits and providing government with additional funds, it has had little impact on deterring the supply of illegal drugs. Any wider reforms recommended by Mr Faris's report should be considered carefully to ensure they will achieve the legislation objectives at an acceptable cost. In the interim priority should be given to ensuring the objectives and intent of the current Act are able to be met, and administrative arrangements are in place to operate Victoria's confiscation of profits scheme as effectively as possible.

Council's attention was also drawn to American experience with 'drug courts'. Although there are a number of distinct models in the more than 100 courts currently in operation, they all share four characteristics: defendants are diverted by the courts to drug treatment shortly after arrest; judges are closely involved in monitoring the defendants' progress; judges, prosecutors, defence lawyers, treatment providers and probation staff run the court as a team; and relapses are accepted as part of the treatment process and not considered an indication of failure.

Council has discussed elsewhere in this report ways to strengthen court access to specialist advice and expertise about appropriate responses to drug offenders. Development and implementation of protocols, and improved working liaison between courts and treatment services offer the prospect of improved outcomes for all parties. With such reforms in place, the additional benefits of specialist drug courts within Victoria are unclear. However, evaluation of the American experience should be monitored and if appropriate, easily adopted aspects integrated into Victoria's arrangements.

A diverse range of government agencies and community organisations are necessarily involved in responding to illicit drug use and misuse. The potential for inconsistency, service gaps and unintended consequences across these sectors is considerable. The consequences of service system failures for potential and current users are significant.

The need for a structure to manage drug policy has been recognised in Victoria and Australia. Council's observations in relation to structural arrangements in the area of illicit drugs are:

- Australia is recognised worldwide for the enlightened pursuit of harm minimisation policies. Within Australia, Victoria is recognised as having played a lead role in the development of a range of multifaceted harm minimisation initiatives that are now taken for granted. These have often involved the regulation of legal drugs. Less has been achieved regarding illicit drugs.
- The harm minimisation policy framework and many associated structures and programs at both national and State level are sound, although there are opportunities for significant improvement.
- There is widespread support for attempts to manage and coordinate efforts to address illicit drug issues and reduce the harms of drug use. This provides an important base that can be used to develop agreed strategies for action. However, there is considerable debate about how this should be achieved.
- There is strong and well informed support for harm minimisation policies at senior levels of the relevant departments. Council considers this is a sound foundation for future efforts.
- Council has been made aware of possible structural and functional weaknesses in the current arrangements. The current structures seem to have emphasised cooperation at the expense of leadership. The intersectoral approach inherent in the delivery of the State Drug Strategy, with its multiple portfolio approach, has potential weaknesses:
  - Opportunities for unintended consequences and gaps in delivery may develop and go unchecked.
  - Shared responsibility may lead to shared priorities but not high levels of ownership in any one portfolio or across portfolios. Illicit drugs is an important, but small, issue confronting large State government departments.
  - There are difficulties in maintaining momentum on many initiatives because agencies work at different rates and have levels of effort and emphasis without review or critical scrutiny.
  - Government departments are not always well equipped to manage the tension created by conflicting community views, particularly where there is no strong evidence to support a particular course of action.

While Council has had limited time and scope to address this issue in depth, there is broad agreement that effective action in response to drugs:

- Needs public engagement and support.
- Involves a wide range of government departments and community agencies.
- Requires coordinated work at state, regional and local levels.
- Depends on integrated government, community and family responses.
- Needs strategic leadership to maintain and gain momentum.

The Council has received direct criticisms of the current Victorian arrangements, including comment that the current structure coordinating the Victorian Drug Strategy is bureaucratic and cannot sufficiently engage with the range of community interests and the public to advance policy. Also, it does not ensure integrated harm minimisation strategies are implemented in a strategic and coordinated way.

Representation on the senior officer committee has been downgraded from senior management to middle management reducing the direct leadership of change role envisaged for this group.

The National Ministerial Council on Drug Strategy is a significant body and, appropriately, reflects the importance of drug issues. Council has been advised about concerns regarding the National Drug Strategy Committee (NDSC) that supports the Ministerial Council. Concerns have been raised regarding

membership, out of session inactivity, slow and ad hoc policy development, and overemphasis on licit drugs. The lack of investment in prevention programs and dominance by health departments that marginalise law enforcement interests has been highlighted. The Commonwealth Department of Human Services and Health also commented on the reluctance of states to take sufficient financial and organisational responsibility for the operation of the NDSC. Council understands that a review of the NDSC is underway. Council is not in a position to comment, in any detail, on national structural issues. The national significance and the cross-jurisdictional issues, however, demand effective collaboration if responses to drug issues are to be consistent and effective.

A review of national and international approaches to the management and coordination of drug policy has demonstrated to Council that other places face similar problems and dilemmas to those in Victoria. Council was not presented with any existing model appropriate for Victoria (McDonald, 1996).

Council recognises the need for Victoria to have a set of structural arrangements that has the potential to lead debate and coordinate drug issues and policies. Council has used the following principles in suggesting improvements.

**Interagency Coordination:** Drug abuse is a problem that affects many portfolios. There is a need to have the capacity to integrate the roles and efforts of the various agencies when appropriate, in a whole government approach.

**Leadership:** Ongoing and high profile leadership is essential. The leadership needs the capacity to engage the public in this area and draw together the diverse strands of government and non-government service provision.

**Information:** Any structural arrangement must have an appropriate data and research capacity to inform policy and practice. Databases and intelligence must provide a responsive flow of strategic information to and from planners and practitioners to increase the effectiveness of services, and to support policy developments.

**Policy and Monitoring:** Any structural arrangement must have the capacity to develop quality policy outputs, and the ability to closely monitor program developments. Long- and short-term monitoring and evaluation models must be in place to explain what works, what doesn't, and why.

**Early Warning:** A critical matter, related to issues identified above, is the need to construct a system that alerts and warns the key stakeholders of movements and shifts in local activity that could necessitate refocussing of policy or practices and the timely reallocation of resources.

**Community and Practitioner Input:** A key element of any model would be to provide an avenue for engaging the community and receiving feedback in a simple and immediate manner. Advice is required from many groups to inform the policy and implementation processes, and to inspire ownership at community level.

**Training and Support:** Participants in the delivery of drug abuse programs need to be up to date with trends and quality practice. Structural arrangements must allow for the support and professional development of key participants and other relevant groups.

**Recognition:** Many people and organisations make outstanding contributions to minimising the harms illicit drugs cause in our community. In order to further promote high quality practice, the Council supports the introduction of a high profile award scheme to recognise:

- Quality work which provides leadership to the field.
- Exemplary practice, particularly in community projects.
- Outstanding contributions to research, evaluation and clinical practices.

The award scheme should have a high level of sponsorship and be presented and celebrated regularly, as an integral part of the implementation process as the reforms proposed in this report.

**National Coordination:** Given the nature of the drug problem, all relevant jurisdictions should be engaged on a national basis in the most effective way possible.

Other significant elements recommended in design of an administrative structure are:

- Minimal, but effective central bureaucracy.
- A focus on quality service provision.
- Simple and accessible structures.
- The harm minimisation approach promoted and complemented.

