# PROGRESS REPORT

FROM

# THE JOINT COMMITTEE

OF THE

# LEGISLATIVE COUNCIL AND LEGISLATIVE ASSEMBLY

UPON

# DRUGS

TOGETHER WITH

# THE MINUTES OF PROCEEDINGS

AND

# EVIDENCE

No. 308

1976–77–78

PARLIAMENT OF NEW SOUTH WALES

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# FOREWORD

In March, 1977, as Chairman of the New South Wales Parliamentary Committee on Drugs, I presented a Memorandum regarding Penalties for Drug Offences.

I now present a progress report on the Committee's deliberations. It is appropriate for me to explain that members of the Committee, who have worked assiduously and enthusiastically to investigate this most important feature of drug dependence in our modern-day society, have no illusions about the seriousness of the task allotted to them. They have adopted a very responsible attitude in formulating their recommendations.

We make no pretention to have investigated every aspect of this very complex matter. Parliamentary commitments of the members would alone preclude this. But the Committee has worked diligently to produce for the Parliament in reasonable time an honest appraisal of the present scene in New South Wales and where necessary recommended changes or innovations thought desirable.

Prior to his fatal illness, the Hon. H. J. A. Sullivan was a very active member of the Committee. I would like to record my appreciation of his valuable assistance.

I must especially thank Mr Gordon James, Clerk of the Committee, for great assistance to all the members and myself in particular. His unfailing humour helped to lighten many a serious moment in the preparation of itineraries, the hearing of evidence and marshalling of material. The value of his experience is evident in the Report itself.

Thanks are also due to our secretary, Mrs C. O'Regan, particularly for her patience in typing manuscripts and correcting proofs, to Hansard staff, members and staff of the Health Commission, the Federal Narcotics Bureau and the Commonwealth Department of Health, the staff of the Pharmacology and Pharmacy Departments of Sydney University, the State Laboratories at Lidcombe, the Police Department and staff of Parliament House.

Especial thanks are due to all the witnesses who gave evidence in public or in camera and to those who presented submissions, many of which gave the Committee highly valuable information.

In an Inquiry such as that conducted by this Committee it is inevitable that criticism must be made of certain aspects of the working of government departments. Where such has occurred the Committee feels that criticism is well-founded and positive recommendations have been made to effect improvement.

Finally may I repeat what I have said several times during the progress of our Inquiry. This is a Parliamentary Committee representative of all parties in both Houses of the New South Wales Parliament. The observations and recommendations contained in the Report are the views of that Committee. This Report is now presented to Parliament for its consideration. Executive Government has the power to implement those recommendations which the Committee feels should prove acceptable and practicable.

The members of the Committee feel that because of the magnitude of the task allotted to them they should continue their investigations and make a further Report to Parliament at a later date.

V. P. DURICK.

# SUMMARY OF RECOMMENDATIONS

The Committee recommends that—

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(1) A mixture of any two or more compounds of aspirin, caffeine, paracetamol, salicylamide, and their derivatives should be restricted to supply by a pharmacist on medical prescription only. (Schedule 4).

(2) Phenacetin should be restricted to supply by a pharmacist on medical prescription only. (Schedule 4).

(3) Aspirin, paracetamol, salicylamide and their derivatives, when combined with not more than 1 percent of codeine, packed in units containing not more than twenty-five tablets or twelve powders and supplied in strip packs or child-resistant closures, be available from a pharmacist provided the pharmacist believes that the substance is appropriate for the treatment of the person for whom it is being obtained. (Schedule 2).

(4) Aspirin, paracetamol and salicylamide and their derivatives should be available by open over-the-counter sale only when they are supplied as single substances not combined with any other therapeutically active substance; packed in units containing not more than twenty-five tablets or twelve powders; supplied in strip packs or in containers with suitable child-resistant closures.

(5) Sale of compound analgesics to the public, except by a pharmacist, be prohibited after the expiration of a period of six months from the application of 1 and 2 above.

(6) The supply to and sale of single analgesics (i.e., consisting of one analgesic only) by a diversity of retailers continue to be permitted.

(7) The packaging of all analgesics in conformity with the recommendations of the National Health and Medical Research Council be enforced.

(8) Continue investigation of and research programmes in analgesic dependence be supported.

(9) Widespread use of education programmes, including media shorts and leaflets, in the proper use of analgesics be encouraged.

(10) Additional renal units be established to afford greater convenience to people living in larger centres of population.

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(11) Consideration should be given to the inclusion of methaqualone (Mandrax) in Schedule 8 of the New South Wales Poisons Act, 1966 (as amended).

(12) Chloral hydrate should be examined urgently by the Drug and Alcohol Authority of New South Wales, in conjunction with the Poisons Advisory Committee, with a view to placing greater restrictions on its general availability to the public.

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(13) The controls on the components of amphetamines should be subject to stringent review.

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(14) Further consideration should be given to the Committee's previous recommendation in relation to forfeitures of money and goods seized in relation to drug offences.

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(15) Commonwealth authorities be requested to set up a feasibility study on the introduction of a programme similar to "Project DAWN" which is currently in use in the United States and that New South Wales authorities should give such a programme every support.

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(16) Because of the number of absconders from bail in cases of drug trafficking, early consideration should be given to a review of bail in such cases.

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(17) New South Wales should examine the methods adopted by the Australian Narcotics Bureau for the control and destruction of drug seizures with a view to their adoption in New South Wales.

(18) An early appraisal should be undertaken of the way in which dogs, possibly German Shepherds, might be usefully employed in drug detection by the New South Wales Police.

(19) Consideration should be given to police training in relation to experience in other countries, particularly in the United States and Europe. This should be by appropriate attachments to the law enforcement agencies in those countries.

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(20) Appropriate officials in New South Wales should initiate a review of existing laws and policies in relation to personal searches of incoming travellers.

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(21) The Health Commission of New South Wales should review its whole approach to its participation in the Commonwealth Health Department Drug Monitoring Scheme with a view to reporting the effectiveness of present systems; in particular, the staffing situation in the Therapeutic Goods Branch should be critically examined to provide more intensive and effective inspections within the State.

(22) Consideration should be given to improved means of checking the prescribing habits of doctors in relation to both Schedule 8 and Schedule 4 drugs.

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(23) The Pharmacy Guild of Australia should be given full support and encouragement in the efforts it is already making to bring about greater efficiency in pharmacy controls on the non-medical supply of all drugs.

(24) In view of the important role the pharmacist can play both in reducing demand and supply of drugs, the profession should have prominent representation in the management of health services provided in New South Wales.

(25) Sales of syringes should not be restricted by legislation but that special steps should be taken to remind pharmacists of their responsibility to maintain vigilance in the supply of syringes to confine supply as far as possible to those in genuine medical need.

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(26) The policies adopted in medical schools for teaching in relation to drug use should be reviewed.

(27) Prescribing guidelines should be developed in co-operation with the Australian Medical Association.

(28) Information on proper prescribing practices should be given more emphasis in medical schools.

(29) Refresher courses in drug education should be instituted for physicians through the Australian Medical Association and Health authorities.

(30) Consideration should be given to a "cheque book" system for prescriptions so that stolen pads might be traced more rapidly and easily.

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(31) Those responsible for the school curriculum should seek to galvanize present activity to accelerate the inclusion of education about the current use of drugs and the dangers of experimentation and misuse in the context of general health and social education in schools.

(32) Development of counselling services in schools.

(a) The Department of Education should encourage schools, in particular those which have not taken steps to providing counselling services, to review and define their policies and attitudes on such matters as:

(i) the development of a system of counselling designed to ensure a continuing awareness and concern for the welfare of the individual, bearing in mind that such a system requires the careful guarding of information obtained in confidence. The recipients of that information may sometimes need to get advice and help from relevant professionals;

(ii) the involvement both individually and collectively, and subject to the need to maintain confidences, of parents and guardians in such a system.

(b) The education authorities should consider the desirability, where necessary, of initiating co-operation with the other local statutory services, the police, and voluntary bodies concerned with the welfare of young people, and of ensuring that the support services available to the community at large are linked with the support services within the school. Such co-operation might best be achieved by the formation of liaison groups representing all the services involved to consider the problems of young people, including those associated with the misuse of drugs, and how they can be dealt with. Either through such liaison groups or through local education authorities themselves, the support services available to help young people while they are at school and when they leave should be made known to pupils, teachers and parents.

(33) Teachers should be trained to recognize and deal with the personal problems of pupils. Those responsible for the initial education and in-service training of teachers should continue to expand the opportunities for preparing teachers to be able to recognize and deal appropriately with the personal problems which beset the maturing young person. In so far as drug misuse may be a symptom of a problem, teachers should be kept informed of developments in this field.

(34) Basic teacher education courses in tertiary institutions should contain an adequate core strand (as well as electives or options for deeper study) for health education and personal development programmes.

(35) Personal development courses containing drug education should be compulsory in secondary schools.

(36) There should be training of other professional staff concerned with young people in trouble.

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(37) New initiatives in drug education in New South Wales should be taken.

(38) Specialist health education in regard to drug use should continue to be provided through the Health Commission of New South Wales.

(39) Programmes like the one already undertaken by the Hunter Community Addiction Service should be urgently evaluated with a view to their introduction in all Health Regions of New South Wales.

(40) Urgent consideration should be given to appropriate drug education through television and radio both at State and regional levels.

(41) Specialist drug education programmes at the personal level must be so structured as to provide adequate support for the more intensive demand for information and advice which can be expected to arise from global broadcasting and other media coverage.

(42) Specialist health education programmes should be carefully orchestrated with personal development programmes in the schools.

(43) In line with an overall aim to integrate drug education and drug treatment into strongly based community programmes, policies for specialist health education in relation to drugs must be closely integrated with the whole range of local drug programmes.

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(44) Immediate steps should be taken for the recently created Division of Drug and Alcohol Services within the Health Commission of New South Wales to commence operation.

(45) Action should be taken for the head of the Division of Drug and Alcohol Services to assume the principal executive function within the Drug and Alcohol Authority of New South Wales to provide for full cohesion in public policies and programmes.

(46) The Division of Drug and Alcohol Services should be provided with the necessary financial and manpower resources to undertake a full scale review for the design of an effective and efficient system of health care delivery for drug dependencies. Such a system should provide for optimum utilization of health care resources in the development and organization of services for drug-dependent populations.

(47) The methadone maintenance programme should remain the subject of stringent review, as recommended by the Division of Health Services Research in its findings "A Review of New South Wales Health Commission Treatment Services for Narcotic Persons".

(48) In the provision of drug treatment facilities, there should be recognition of the need to provide drug-dependent people in crisis with on-call help at all times of the day and night.

(49) Immediate attention should be given to the problems of multiple drug misuse. In particular there is a need to introduce machinery to monitor the number of drug-related admissions to casualty and emergency departments of general hospitals.

(50) Training of all medical and paramedical staff must recognize the growing and diverse problems being created within the community due to the misuse of drugs.

(51) The effect on drug treatment services of the regionalization policies of the Health Commission of New South Wales should be kept under careful review. The Committee's recommended provision of highly specialized treatment programmes, especially for narcotic dependency, will require strong central direction of such programmes.

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(52) The development of a State strategy for the long term rehabilitation of drug users.

(53) The introduction of Government policies to ensure that recovered drug abusers are not excluded from employment in the public and private sectors.

(54) A major Government review of all regulations to ensure that they do not impede employment and rehabilitation.

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(55) Full scale research should be implemented by the appropriate departments to determine the effect of all drugs on driving performance.

(56) To ensure that an immediate start is made on this, a departmental working party should be set up forthwith to investigate the dimension of the research required and to set the research parameters accordingly.

(57) A gas chromatograph-mass spectrometer should be provided as a matter of urgency for staff working for the Division of Analytical Laboratories. It would be used for the Division specifically for analytical work to determine the effects of drugs on driving and also for wider research and analytical work on drugs generally.

# SECTION 1

## CHAPTER 1

### INTRODUCTION

**Publication Note**

1. This Report of the Joint Committee of the Legislative Council and Legislative Assembly upon Drugs has been produced in book form at minimum reasonable cost so that it might be acquired and widely read by the public generally, particularly the people of New South Wales. Thus in reporting its findings the Committee has endeavoured to keep the narrative simple and to deal with the issues concisely in the hope of reaching as many of the population as possible.

2. The proceedings of the Committee and the evidence have been published separately and they are on sale at the Government Bookshop.

**The Committee and the Terms of Reference**

3. On 12th October, 1976, the Minister for Health, the Hon. K. J. Stewart, M.P., moved in the Legislative Assembly that a Joint Committee of Enquiry be appointed to investigate certain aspects of drugs of dependence (other than alcohol and tobacco) in common use in New South Wales.

4. Subsequently the Joint Committee was established with the following membership:

Mr V. P. Durick, B.A., M.P. (Chairman).

Legislative Council

The Hon. K. H. Anderson, M.L.C.
The Hon. M. A. E. Davis, M.L.C.
The Hon. C. Healey, M.L.C.
The Hon. H. J. A. Sullivan, M.L.C.

Legislative Assembly

Mr J. G. T. Jackett, M.P.
Mr B. McGowan, B.A., M.P.
Mr E. D. Ramsay, M.P.
Mr R. C. A. Wotton, M.P.

5. On 17th March, 1977, the late Hon. H. J. A. Sullivan, M.L.C., was discharged from the Committee and replaced by the Hon. F. M. MacDiarmid, O.B.E., M.L.C.

6. An investigation of drugs by a Joint Committee of both Houses had commenced in the previous Parliament. By a resolution of the Parliament the evidence taken by the earlier Committee has been made available to the Committee.[1]

7. The hearings of the earlier Committee were concerned with drugs of dependence in common use in New South Wales that are prohibited drugs, drugs of addiction and restricted substances within the meaning of the Poisons Act, 1966.

8. The Terms of Reference of the present Committee have been extended to cover all drugs of dependence, other than alcohol and tobacco, in common use in New South Wales. In detail these are:

(1) To review and report on available current scientific information concerning the pharmacological, psychological and social effects of drugs of dependence, other than alcohol or tobacco, in common use in New South Wales.

(2) To examine and report on available information on the incidence and trends of the use and misuse of such drugs in New South Wales.

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[1] Progress report from the Joint Committee of the Legislative Council and Legislative Assembly Upon Drugs together with Minutes of Proceedings and Evidence, March, 1976.

(3) To inquire into and report on—

(a) the adequacy of the control of the manufacture, distribution, possession and use of such drugs; and

(b) the adequacy and appropriateness of penalties for offences related to such drugs, the application of those penalties, and the distinction between penalties for offences relating to their use and penalties for offences relating to their manufacture and distribution.

(4) To inquire into and report whether in relation to the distribution, possession and use of such drugs the following are adequate and appropriate:

(a) general education for persons of all ages;

(b) special education for key groups responsible for education, treatment and counselling, detection and law enforcement; and

(c) preventive, counselling, treatment and rehabilitative services.

(5) To make such recommendations on terms (3) and (4) as the Committee sees fit.

**The Implications of the Terms of Reference**

9. The Terms of Reference which Parliament laid down for the Committee encompass virtually every aspect of the effects, use, supply and policy for dealing with all drugs of dependence in common use in New South Wales, except alcohol and nicotine.

10. This is a wide ranging task because the dividing line between appropriate use, misuse and abuse, both medically and non-medically, is not always clear and it is far from easy to define. The problems thus arising and the manner in which the Committee has approached them are matters which come later in this report. At this stage, however, it is appropriate for the Committee to deal with the vexed question of alcohol and nicotine which were excluded from the Terms of Reference of the Committee.

11. Although alcohol and nicotine are the two most widely used drugs in Australia today and are clearly drugs of dependence with psychoactive and mood-altering properties, their use and consequences were not included by State Parliament for study by the Committee. Whilst this is entirely a matter for Parliament to decide, the Committee believes that the decision was a justifiable one because public and social policy regarding alcohol and nicotine are significantly different from that regarding the other drugs of dependence under consideration. Alcohol and nicotine are legally obtainable and socially acceptable drugs whereas many of the drugs considered in this report are not legally obtainable, and in the case of those drugs which are, their non-medical use is not generally approved. The rights and wrongs of the place which alcohol and nicotine have in society today arise from deep historical antecedents and they are not matters which the Committee intends to debate.

12. As recently reported by the Senate Standing Committee on Social Welfare,[2] alcohol and nicotine are clearly *bona fide* substances of abuse whose use often creates significant and adverse social consequences. As such they should be dealt with along with other substances of abuse. The Committee recognizes this interrelationship and the need to integrate all elements of substance abuse into broader Government programmes.

13. It has become necessary, however, to focus attention on the other drugs of dependence because existing systems do not respond to the problem of hard drug addiction and other chronic drug abuse. In part this has been due to a reluctance on the part of society to come to grips with the issues surrounding the drugs of dependence other than alcohol and nicotine.

14. Consequently, unlike alcohol and nicotine, which have hitherto received the vastly predominant share of professional, government and public interest, *the other drugs of dependence have been much neglected,* notwithstanding the marked evidence in recent times that their growing misuse and abuse are creating serious social problems. This imbalance has in some degree been aptly demonstrated by the findings in the recent report of the Senate Standing Committee on Social Welfare. Having previously observed that the quality of submissions on the use of opiates in Australia was poor, the Senate Committee concluded that "the debate on opiate use should concentrate on the actual dangers of the particular drug rather than on the complicated folklore which surrounds drug-use. At present, sound information on the dangers of opiate use is being rejected by potential users as being biased and clothed in hypocrisy".

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[2] Drug Problems in Australia—an intoxicated society? Report from the Senate Standing Committee on Social Welfare, 1977.

15. That conclusion is perplexing when viewed against the grave warning given by the Senate Select Committee on Drug Trafficking and Drug Abuse in 1971[3] about the likely escalation of drug abuse in Australia to dangerous levels, its recommendations for avoiding such a situation, and the subsequent evidence of an almost total disregard for this warning at a time when there was growing evidence world-wide of an appalling increase in narcotic dependence, matched by an increasing amount of substantial evidence of the menace being created in Australia.

16. Much folklore there may be but the facts, although they are difficult to piece together, are far more appalling than any fiction and compel prominent attention in this report. The Committee makes no apology, notwithstanding the excessive use of alcohol by young people, for seeing narcotic dependence and associated multiple drug misuse amongst youth as the most serious social problem confronting New South Wales today. Accordingly, this aspect of the drugs issue has received foremost attention in the Committee's deliberations.

**The Nature of the Task**

17. The growing preponderance of drugs in our daily lives, the hazards which they create for old and young alike, have become increasingly evident in the past decade. No generation is untouched but the attendant danger for all of us in allowing this process to run unchecked seems to be very slow to sink in with most people.

18. When the Committee embarked on its task in November 1976, it was difficult to gauge the thinking below the surface. Drugs were making headline stories almost every day and certainly as far as many of the media were concerned, they would remain high on the list of public excitement. The attitude of the public towards drugs was not so readily apparent.

19. In the 1970's the unpalatable effects of inflation on our daily lives, and a growing uneasiness in the realization that Australia was not perhaps the lucky country, immune through distance from the shock waves of the troubled western economies, were the matters uppermost in people's minds. In short, worry about the standard of living, the security of the future, and rapid social change were probably foremost in people's minds.

20. That the increasing predominance of drugs in the headlines might be a facet of these changes in society was barely recognized by most people. For example, the intensive advertising for submissions by the earlier Parliamentary Committee on Drugs early in 1976 brought very little public response. Even allowing for the fact that this might have been partly due to a generally low level of public understanding of the use to be made of the democratic process, the vast majority of the people in the State would clearly have felt little motivation in making their views felt. The cause of this apparent apathy and lack of interest most probably arose from the sheer public ignorance about the true nature of the drugs problem.

21. Thus the Committee was faced with an uncertain situation. Practically a year had passed since the State Parliament had first instituted an enquiry into drugs. Reliable information was not readily available but the evidence suggested beyond doubt the narcotic dependence was spreading alarmingly. Sensational cannabis stories were daily in the news. The appointment of the Committee itself, with Terms of Reference embracing for the first time the minor analgesics, sparked off a burst of renewed media interest in the potential dangers of Bex and Vincents. The volume of national and international literature was mountainous and, as testified, for example, by the controversy surrounding the Eastland Report on Cannabis, much of it was either in direct conflict or was becoming outdated.

22. Commitments and the demands of the Parliamentary timetable restrict the availability of members of a Select Committee. At first the situation was largely a matter of guesswork and there was clearly a need to take evidence as widely as possible, especially within the State. Thus, because of the pace at which major problems were arising, the vast social ramifications in which the drugs problem is set, and the time factor, it was necessary to follow the key pointers.

23. Accordingly, the Committee resolved to focus its investigations on the machinery available within the State for dealing with drugs in order to assess the effectiveness of current drug programmes and policies and to determine whether priorities and organizational structures were appropriate to meet current and foreseen needs. Consequently, the main thrust of the Committee's enquiry has been through the principal government agencies—principally those responsible for health, law enforcement and education. Essentially this has been a matter of assessing the need for resources and deciding upon their allocation

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[3] Report from the Senate Select Committee on Drug Trafficking and Drug Abuse 1971—Parliamentary Paper No. 204.

through the public and voluntary sectors. To complement this process, the Committee set out to examine the situation on the ground through hearings and inspections within the Sydney metropolitan area and at selected regions throughout the State, and visits interstate. It was not expected that this somewhat selective exploration would provide a total and fully accurate assessment of the problem. It was, however, hoped that through such direct investigation the Committee would acquire an insight into local attitudes and expectations which could be measured against the projections in the central machinery of government.

24. Because of the profound social significance of drug use phenomena and of the importance of personal and public attitudes today, the Committee has attached particular importance to the public hearings. In order to encourage the participation of young people, it was decided to hold some of the hearings in more informal sittings than may have been customary for Select Committees in the past. In this regard the Committee's visit to the new community in the Nimbin area was of particular note.

25. In addition to the public hearings, the members of the Committee have collectively and individually held numerous private hearings with drug users, with experts in the field of drugs; and all have read extensively in the professional literature.

# CHAPTER 2

## THE CENTRAL QUESTION—WHAT IS DRUG DEPENDENCE AND WHY SHOULD WE WORRY ABOUT IT?

### The Importance of Understanding Terminology

26. The Senate Select Committee on Drugs found in 1971 that ". . . drug terms were frequently classified according to different criteria" and ". . . a great deal of confusion arising through the absence of mutually accepted and understood definitions. This confusion is not necessarily limited to those who lack technical competence but it is also to be found even within branches of the medical, legal and other professions." The situation the Senate Select Committee found in 1971 is not greatly different in 1977.

27. In finding out about drugs and if, and how, they present a problem, the Committee has been at some disadvantage. To marshal the world fund of present knowledge concerning the use of drugs of dependence would be impossible within the time and resources available to the Committee. It is essential, however, to establish the meaning of drug dependence and the proneness of the individual to it, in order to open the past to deciding the extent to which drug dependence matters. In this regard the views of the experts, and there are many of them, have to be studied first.

28. Wherever possible, the Committee has endeavoured to rely on the experts in New South Wales, not least because some of the best drugs research in the world is being undertaken in this State. That we do not properly capitalize on it is a matter of later comment in this Report.[1]

29. The characteristics of drug dependence have been a recurrent question in the hearings of the Committee. The subject is complex and terminology is important. This is not an easy matter for the ordinary citizen who generally has neither training in, nor great familiarity with, the language of medicine and the social sciences. But without some grasp of the clinical aspects of the various forms of the non-medical use of drugs, it is difficult to comprehend an appraisal of the priorities arising in relation to social cost, education, treatment, law enforcement and so on.

### Characteristics of the Major Forms of Non-medical Drug Use

30. It would break the thread of this Report to introduce into the main narrative at this stage a full exposition of the terminology and concepts of drug dependence. Accordingly, a description of the principal features of the drugs of dependence in common use in New South Wales is provided at Annexure "A" to this Report. The key points are:

> In line with the World Health Organization, the Committee has largely interpreted the issue as one concerning the non-medical use of drugs of dependence. Attention has been given to the medical use of drugs of dependence only in as far as medical use has a bearing on non-medical use. Drug dependence is not, however, strictly a matter of medicine. Sociology, anthropology, education, law and other disciplines are all at the heart of the matter.
>
> *Medical use* is defined as drug use for generally accepted medical reasons, whether under medical supervision or not; thus taking aspirin occasionally for headache or antacid tablets for indigestion is medical use.
>
> *Non-medical use* refers to use for not generally accepted medical reasons. Non-medical use can be either legal or illegal. To illustrate the point, reference must be made to alcohol whose use by adults is non-medical but legal; the use of cannabis, in contrast, is both non-medical and illegal.
>
> The treatment of any form of drug addiction requires skill and knowledge in handling the patient and the awareness of the psychological, physical and social complications of his dependency. In former years it was customary to refer to drug addiction instead of drug dependence. Addiction, however, proved to be hard to define because of the difficulty of distinguishing it from what was known as habituation. Nowadays, it is customary not to attempt to distinguish between addiction and

[1] Chapter 5, para. 134, chapter 13.

habituation but to refer to a single condition of drug dependence. This can exist in many forms and has been defined by the World Health Organization Expert Committee on Drug Dependence as "A state sometimes psychic and sometimes also physical resulting from the interaction between a living organism and a drug, characterized by behavioural and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects and sometimes to avoid the discomfort of its absence. Tolerance may not be present. A person may be dependent on more than one drug."

The World Health Organization has identified the following types of drug dependence:

(1) Morphine type.
(2) Barbiturate-alcohol type.
(3) Amphetamine type.
(4) Cocaine type.
(5) Cannabis type.
(6) Hallucinogenic type.
(7) Khat type.

The Committee has identified dependence on the minor analgesics as an additional phenomenon in Australia and in New South Wales especially. This is described as dependence of the aspirin type.

The following terminology needs to be broadly understood:

*A drug* is any substance that when taken into the living organism may modify one or more of its functions.

*Drug dependence* is the state of psychological or physical dependence or both on a drug arising in a person following administration of that drug on a periodical continuous basis.

*Drug abuse* is persistent and/or sporadic drug use inconsistent with or unrelated to acceptable medical practice.

*Psychological dependence* is the mental state characterized by the intensive desire to administer a drug on a continuous or periodic basis to obtain pleasure or to avoid discomfort, real or imagined. It is manifestation of the individual's reaction to the effect of a specific drug and varies with the individual as well as the drug.

*Physical dependence* is an adaptive state characterized by intense physical disturbance when the administration of the drug is stopped or counteracted by a specific antagonist. It is the inevitable result of the pharmacological action of some drugs administered in sufficient dosage over a sufficient period of time.

*Tolerance* is an adaptive state characterized by diminished response to the same quantity of drug or by the fact that a larger dose is required to produce the same degree of pharmacological effect and is produced by many of the drugs that induce dependence.

*Drug addict* is someone severely dependent on drugs.

*A psychoactive substance* is one which affects the central nervous system in either a desired or undesired manner.

*A psychotropic substance* is one which affects the central nervous system in a desired manner with a particular effect on mental activity.

*A drug trafficker* is one who supplies the drug for reason of profit, disregarding the health and welfare of the ultimate purchaser. He is the principal in the distribution chain and is unlikely to indulge in drug-taking or to be in direct contact with the users of drugs.

*A drug pusher* is one who seeks to establish a market for the distribution of illicit drugs.

*A drug pedlar* is the final link in the selling of small quantities of drugs to individual users. The pedlar quite frequently is involved in the selling of drugs merely to sustain his own drug habit.

(These last two definitions are in general currency. It is difficult to distinguish between them. The pusher or pedlar may be an addict who supplies to sustain his addiction.)

There is great difficulty in assessing how far the presenting personality of an addict is his basic personality or how far the picture is being modified by the psychic effects of the drug. An amphetamine addict, for instance, may present as a cheerful talkative individual whereas without the drug his basic personality may be quiet, anxious and withdrawn. The assessment of the previous personality prior to the onset

of drug-taking, is often impossible without the assistance of another informant, preferably a member of his family, who has known him for some time prior to the onset of drug taking. Drug dependence itself may be one expression of a personality disorder which, under stress or crisis lead to the misuse of drugs which are available.

Young drug addicts are often emotionally immature and inadequate individuals. They may fail to achieve their goals in life or may set their sights too low. Many have not been able to decide what to do with their lives. Younger addicts have often done badly at school, played truant or exhibited school phobic behaviour before taking drugs. Depression is not uncommon. In the home communication may have broken down completely. Young drug misusers tend to mix with members of their own age group also taking drugs or with other drug misusers irrespective of age.

Drug takers tend to be inconsistent in their feelings and critical of themselves but more commonly of others and established social modes and authority. There is a positive relationship between drug misuse and smoking, addicts being likely to be smokers and heavy smokers at that. There is often a history of mental illness, alcoholism or disturbed personality in the families of narcotic and other drug-dependent persons. Many of these factors are common to other forms of social deviancy but in the case of the young drug-abuser the onset of the drug abuse is at a formative period of development where the basic personality structure has not yet had time to mature. Drugs, often used to overcome normal anxieties and stresses of adolescence, may prevent or delay such personality maturation.

Although the large majority of drug-dependent persons of all age groups have marked personality problems the apparently normal person, particularly under periods of excessive stress, or depression, is not immune from the danger of dependence on drugs which may be prescribed or taken outside medical treatment, at such times.

Experimental and casual non-medical use of drugs is a growing feature of life amongst all age groups.

**Classification of Important Drugs used Non-medically**

31. These principal types of drug dependence are characterized by the fact that the drugs concerned within each group all affect the central nervous system and are taken to alter mood or perception, to cause stimulation, or to allay anxiety or psychic tension. Yet not all drugs that affect the central nervous system are used non-medically. The best examples are the "major tranquillizers" such as the phenothiazines.

32. Any drug used non-medically to such an extent that some personal or public harm results must possess, at least in the initial phases of its action, central nervous system effects perceived by the user as being stimulatory, even though the drug may be classed as a central nervous system depressant. For example, many people are familiar with the feeling of stimulation that occurs early in action of alcohol, although alcohol is a depressant.

33. A classification of drugs used non-medically which is not complete and which includes only those drugs of some importance is presented in the following table. (See page 17.) The drugs are divided into three major types: type I includes those substances that can cause severe physical as well as psychic dependence; type II includes those that cause only mild or questionable physical dependence but strong psychic dependence; and type III includes those that cause only psychic dependence. Type I drugs are further subdivided into subgroups IA, the morphine type, and IB, the alcohol-barbiturate type.

34. The practical importance of these classifications is that they give a broad but nevertheless valuable and easily recognizable indication of the likely personal and social cost of non medical use of the drugs concerned. Moderate to severe levels of physical dependence on types IA and IB drugs require withdrawal treatment, whereas those listed under types II and III do not. Furthermore, the drugs listed under types IA and IB are interchangeable *within* the subgroup, regardless of chemical structure, but type IA drugs are not interchangeable with drugs of type IB, and types II and III drugs are not interchangeable with type I drugs.

35. Thus, in type IA, the morphine type, methadone can be substituted for heroin, and morphine for meperidine, with satisfactory suppression of symptoms of abstinence of the opiate type. In type IB, the alcohol-barbiturate type, paraldehyde, chlordiazepoxide (librium), etc., can be substituted for alcohol, glutethimide for meprobamate. These facts are evidence of cross-tolerance and cross-dependence within the subgroups and can be interpreted as indicating that the drugs within the subgroups are pharmacologically related despite differences in chemical structure and some differences in pharmacologic action.

TABLE 1

**CLASSIFICATION OF IMPORTANT DRUGS USED NON-MEDICALLY***

I. Drugs causing psychic and severe physical dependence.

A. *Opiate or morphine type.* Physical dependence manifest by autonomic storm and central nervous system irritability on withdrawal. Very strong psychic dependence.

(1) Morphine and its congeners: codeine, diamorphine (heroin), hydromorphone (dilaudid), oxycodone (proladone, percodan), oxymorphone (numorphan).

(2) Morphinans: levorphanol (dromoran).

(3) Meperidines: diphenoxylate, pethidine (pethoid).

(4) Methadone and congeners: dextromoramide (palfium), methadone (physeptone).

B. *Alcohol-barbiturate type.* Physical dependence manifest by anxiety, tremors, insomnia, convulsions and delirium. Very strong psychic dependence.

(1) Ethyl alcohol.

(2) Barbiturates (all).

(3) Paraldehyde.

(4) Chloralhydrate.

(5) Meprobamate (equanil, miltown).

(6) Piperidinediones: gluthethimide (doriden, gludorm), methyprylone (noludar).

(7) Benzodiazepines: chlordiazepoxide (librium), clonazepam (rivotril), clorazepic acid (tranxene), diazepam (ducene, valium), flurazepam (delmane), lorazepam (ativan), nitrazepam (dormicum, mogadon), oxazepam (adumbran, serepax).

(8) Ethinamate (valamin).

(9) Ethchlorvynol (placidyl).

II. Drugs causing mild or questionable physical dependence.

A. *Opiate agonist-antagonist type.* Mild physical dependence, resembling physical dependence on opiates, mild to moderate psychic dependence.

(1) Morphine antagonists: nalorphine (lethidrone), naloxone (narcan).

(2) Morphinan antagonists: levallorphan (lorfan).

(3) Benzazocine antagonists: cyclazocine, pentazocine (fortral).

B. *Amphetamine type.* Physical dependence debatable but abstinence syndrome includes long sleep, hunger, apathy and depression (may be related to cocaine).

(1) Amphetamines: amphetamine (benzedrine), dexamphetamine (dexedrine), methylamphetamine (desoxyn, methedrine), phenmetrazine (preludin), diethylpropion (tenuate), etc.

(2) Piperidines: methylphenidate (ritalin), pipradrol (pipratone).

III. Drugs causing psychic dependence only.

A. Cocaine (may be related to amphetamines).

B. Hallucinogens of LSD type: lysergic acid (LSD-25) and congeners, psilocybin, mescaline, dimethyltryptamine, diethyltryptamine, hallucinogenic amphetamines (STP or DOM, TMA, etc.).

C. Volatile solvents: adhesives, thinners, ether, petrol, etc.

D. Cannabis: marihuana, hashish, tetrahydrocannabinols.

E. Nicotine: tobacco.

F. Caffeine: coffee, tea.

* Trade or popular names in parentheses following generic names.

36. In contrast, however, barbiturates, or any other member of type IIA, will not suppress abstinence from opiates and are of no specific value in withdrawing opiates. Likewise morphine and methadone will do nothing for abstinence of the alcohol-barbiturate type. These relationships between the drugs have marked implication for both treatment and also multiple drug abuse.

37. The drugs in type II cause only mild or questionable physical dependence, so that withdrawal treatment is not required.

Physical dependence on pentazocine (Fortral) may, however, represent a variant on opiate type dependence and may be misclassified here. Heavy intravenous use of amphetamines is associated with a definite sequence of symptoms (an abstinence syndrome) but, as yet, no specific distinctive pathologic neurophysiologic change has been demonstrated, so amphetamines might be classed with cocaine as central stimulants that do not cause physical dependence. Thus the type II classification is used to indicate the present uncertainties about these drugs.

38. Drugs of type III cause psychic dependence only and no withdrawal treatment is required.

39. All type IIIB drugs listed cause similar reactions and consumption of one dose daily leads to the development of a very high degree of tolerance which confers cross-tolerance to other members of the group (cross-tolerance to the hallucinogenic amphetamines has not been proved). No physical dependence on these compounds occurs. Psychic dependence on hallucinogens differs from psychic dependence on other drugs in that, except for initial experimentation, the drugs are not taken daily but occasionally. These drugs are particularly attractive to people who are in rebellion against the establishment. Those who become regular users take the drug in the hope of attaining transcendental mystic experiences which will give them greater understanding of themselves, the world and the universe. Frequently they become interested in and join the mystic religions of the Orient.

40. These compounds (except dimethyltryptamine and diethyltryptamine) are taken orally and rarely by injection. Dimethyltryptamine and diethyltryptamine must be smoked or injected. Generally, hallucinogens are taken in company with other persons in a setting utilizing garish colours, lights, strips of foil, etc. One or more persons usually abstain from the drug in order to observe and protect the others ("trip conductor or guide").

41. The various drugs differ chiefly in potency and time course. LSD causes a reaction lasting about 8 hours, whereas the effects of mescaline and DOM persist for 12 to 16 hours. Dimethyltryptamine and diethyltryptamine cause very rapid and very short "trips", lasting only an hour or two. The effects of these drugs are dose related.

42. No validated medical uses for these drugs have yet been shown. Some well-controlled studies have shown LSD useful for the treatment of persons dying of cancer and conflicting results have appeared with respect to the drug's usefulness in treating alcoholics, narcotic addicts and neurotics.

43. The degrees of psychic and physical dependence shown in Table 1 are important in an understanding of the potential threats and problems which the drugs of common dependence pose to the well-being of society. For example, the seriousness of dependence of the morphine type (especially involving the use of heroin) rests in the fact that, whilst it is restricted to a comparatively small number in the community, the ferocity of the addiction is such that it leads the users to anti-social behaviour which is either not present or much less evident in dependence of other types. The social and economic consequences of the various types of dependence are at the heart of the matter of deciding government policies and programmes. It is necessary, therefore, in this Report to examine the facets of each of the main types of dependence and their consequences. In this context, there is an underlying question—what makes people turn to non-medical use of drugs?

**(Note: A fuller description of the drugs of dependence is given in Annexure 'A' to this report.)**

# CHAPTER 3

## DRUGGISM—WHY PEOPLE TURN TO DRUGS TO AVOID FACING REALITY

### All Generations—Many Different Causes

44. Much has been written and said and there is undoubtedly much more in a similar vein to come about the drugs phenomenon which has erupted all over the world in the last twenty years or so. The Committee has had the benefit of access to many of the world's leading authorities in the drugs field during its visit to the 7th International Conference on Alcohol, Drugs and Traffic Safety in Melbourne in 1977, through evidence at formal hearings, from psychiatrists and academicians of world renown and through the literature. The very nature of modern mankind creates the risk of oversimplification in dealing with any of its problems. But the Committee has found one simple concept which appears to be incontrovertible. Nearly all of us living in advanced technological societies find the stress of contemporary existence too much to bear without recourse to soothing and relief in the form of some drug or other. This is as true of those who drink tea and thus find solace in its caffeine as it is of people who enjoy alcohol as a release from tension.

45. The Committee has heard much expert opinion about man's inadequacy in dealing with his problems and there is much on this subject to be found in the literatures listed in the bibliography to this Report. It will be self-evident from personal experience what an influential part alcohol, nicotine and caffeine play in the daily lives of the society we live in. The consequential costs to Australia have been fully described in the recent report from the Senate Standing Committee on Social Welfare chaired by Senator Baume.[1] It is another matter altogether whether the majority of smokers and drinkers give more than passing thought to the reasons why they smoke and drink. Clearly this is because they have been such permanent features of modern society for so long. Even young people have used alcohol and tobacco since time immemorial without their involvement being seen as a great social threat.

46. What then has happened to force non-medical use of drugs so dramatically to the forefront of public attention? The answer is inevitably as complex as the fabric of society itself. But in the centre stand quite clearly two mutually supporting influences. On the one hand, the increase in and availability of the number of chemical substances causing physical or psychological dependence and on the other hand any proneness of the individual to turn to drugs has been enhanced by the social developments of the technological age—greater leisure, media pressure and lack of identifiable personal purpose.

47. The Committee has received evidence to show that this greater reliance on drugs, both medically and non-medically used, is common to all the generations—the old, the middle aged and the very young. The increasing use of barbiturates, tranquillizers and sedatives amongst the middle aged is a greatly disturbing phenomenon. Notwithstanding these hidden problems of drug misuse amongst all the generations, the question undoubtedly causing greatest alarm in the minds of most people has been the development of drug use and experimentation amongst the younger generations, including children attending primary school.

48. In examining the issues surrounding the drugs of dependence, the Committee has paid particular attention to the question of drugs and young people.

49. On the available evidence, the Committee shares general public concern in this matter. It is the unanimous view of the Committee that the growing and diverse developments in non-medical drug usage amongst teenagers is by the very nature of the threat it poses to mature and responsible adulthood of the greatest single importance in the provision of health and education services. It must be emphasized, however, that in highlighting the problem as it affects the young, constant attention must be paid both to the relationship between the generations and also the inter-relationship of the drug-taking habits of the generations. This interplay, especially with regard to the conflicts arising over the legal status of the drugs of choice of the older generations as opposed to the illegal status of the drugs used by the young, has been a matter of repeated representation in evidence before the Committee. In this argument, use of alcohol, which is legal, and use of cannabis, which is illegal, are represented as strongly interwoven catalyst issues of the problem of drug dependence.

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[1] Drug Problems in Australia—An Intoxicated Society?—Australian Government Publishing Service Canberra 1977.

TABLE 2

**COMPARISON OF THE CHARACTERISTICS OF DRUGS OF DEPENDENCE**

| Drugs | Physical dependence | Tolerance | Overpowering need | Acquired desire | Psychic dependence | Psychotoxic | Psychotic on withdrawal | Legal control |
|---|---|---|---|---|---|---|---|---|
| Morphine-like | + | + | + | | + | | + | + |
| Barbiturates and other hypnotics | + | + | + | | + | + | + | |
| Cocaine | | | + | | | + | + | |
| Amphetamine | + | + | + | + | + | + | | + |
| Cannabis (marihuana) | | | | + | + | + | | + |
| LSD and other hallucinogens | | + | | + | + | + | | + † |
| Inhalation drugs | | ? | + * | + | + | | | |
| Aspirin | | ? | + * | + | + | + | | |
| Caffeine | | + | | + | + | | | |
| Nicotine | | + | | + | + | | | |
| Alcohol | + | + | + | + | + | + | + | + |

* Only a proportion of the users display the characteristic.
† Only partial control is exercised.

**Types of Users**

64. In essence, therefore, it is possible to define the "user" groups. Drawing on the work of Helen Nowlis, *Drugs Demystified* (Unesco Press, 1975), the South Australian Royal Commission divides users into four main groups, based on rate of usage, as follows:

- *"Experimental users,* who have tried the particular drug only once or twice. The experience satisfies curiosity and gains status with peers. The effects are not privately perceived as a benefit and so they are not privately regarded as worth the risks. We are told, though we have as yet no direct empirical evidence, that by far the greatest level of drug "use" among the young is of this kind.

- *Casual users,* who take the drug once or twice a month. Such users may use a drug only when others make it available in an acceptable social context. They tell us that they do not see such drug use as a very significant event in their lives; it is a form of social relaxation and amusement.

- *Regular users,* who use the drug weekly or several times a week. This rate of use implies at least psychological if not growing physical dependence on the drug—that is, failure to obtain the drug will engender significant disappointment if not actual "withdrawal symptoms". Here we see the edge of the "drug problem", and at this level of regular use much depends on the nature of the user's personality and of the drug being used. To elucidate the matter further, one may now ask the question: "What does this behaviour mean to this person?" as well as noting, for example, whether the drug is a depressant (such as alcohol, the barbiturates and certain opiates), a stimulant (such as caffeine, amphetamines and cocaine), a modifier of mood or perception (such as amitryptiline or cannabis), or whether it relieves pain (such as the opiates and non-narcotic analgesics).
- *Heavy users,* who use the drug daily. In the case of drugs known to produce physical addiction, daily use is very likely to bring this about sooner rather than later, which then often leads to bad health and social deterioration for various reasons. Numerous respondents have provided evidence that this is the core of the "drug problem"."

Describing the levels of usage, the Report "Some Responses" indicates that heavy use of drugs in Australia involves these categories:

- "Heavy use of alcohol, which is characteristic of the Australian community, and which, as the submissions make clear, is accepted by many groups as normal behaviour. Consequently, even very heavy alcohol use may not be regarded as reprehensible or deviant behaviour by most people, regardless of the devastating effects it may have on individuals and the community.
- Heavy use of tobacco among adults, which although it is now less acceptable in some quarters than it was, is still tolerated to a great extent. It is also currently tolerated among the young.
- Heavy use of analgesics, which is common particularly among middle-aged women, although the proportion of users suffering analgesic-induced kidney damage is not necessarily high.*
- Heavy use of sedatives and minor tranquillizers among middle-aged women, elderly men and women, and among small numbers of young people who may be taking other drugs as well. Such use is related to medical prescribing patterns and although still accepted, is a matter of increasing concern within the community but not necessarily of outright disapproval.
- Heavy use of opiates among small numbers of people in their late 'teens to early 20's, and a larger group using opiates experimentally. Estimates of just how many in either of the groups vary enormously. The discrepancy may result from a failure to differentiate between experimental, occasional and regular use.
- Heavy multidrug use involving some or all the drugs already referred to, together with other psychotropic drugs including barbiturates, other hypnotics and amphetamines."

65. Basically these conclusions correspond with the Committee's findings on non-medical drug use as it exists in New South Wales. This comparison provides confirmation of the Committee's opinion that drug use problems in New South Wales are by and large Australian problems. This underlines the need for national programmes and greater co-operation between the States.

66. The Committee believes, however, that its hearings and findings in New South Wales have produced evidence of a threat from growing narcotic dependence, and in particular a heroin menace, which has not yet been manifest to the same degree in any other State. Although in the view of the Committee the heavy use of minor analgesics, the barbiturates, sedatives and the minor tranquillizers are all matters of urgent concern in New South Wales, the heavy and growing use of opiates, and the alarming increase in deaths from heroin use within the State receives special prominence in this Report.

**Social Factors**

67. The availability of dependence producing drugs is a necessary but not sufficient condition for their use. As already described so far in this Report, a large number of personal and environmental variables have been suggested to explain why some persons initiate drug use and others do not, and why some stop or use drugs moderately while others progress to a state of drug dependence. It is obvious, however, while social acceptance, ready availability, poor environmental conditions and individual pathology may increase the probability of drug-

* This matter is examined comprehensively in Chapter 5, "Minor Analgesics".

use and dependence, they do not ensure that such behaviour will develop in a given person. The inability to specify a set of sufficient conditions for the occurrence of drug use is clearly a limitation in the search for preventive measures.

68. The social forces have an obvious importance in non-medical drug use. This specific area of the problem provides the bread and butter existence for countless numbers of professional people working in the medical, sociological and numerous allied fields. The related literature is an industry in itself. Frequently, the Committee has felt that looking at the drugs issue is like digging into an anthill: there is much frantic activity; all in some way part of the problem, few, if any, identifiably in control of it.

69. The Committee has been struck throughout by the quality of the findings of the Canadian Government Commission of Inquiry into the Non-Medical Use of Drugs (The Le Dain Reports) produced since 1970. It should be noted that the Health Commission of New South Wales made particular reference to these Reports in its first submission to the Select Committee in 1975.[4]

70. Whilst recognizing the need to take great care in translating experience in other parts of the world for application in Australia, since the social legal and political structures may be different, the Committee nevertheless believes that the Le Dain Reports provide the most readily comprehensive material on the framework in which the drugs phenomenon is set.

71. This is especially true of the Le Dain Commission assessment of the causes of non-medical drug use.[5] It is neither necessary nor appropriate to review these findings in detail in this Report. They did, however, crystallize for the first time in Western literature the larger social significance of the drug phenomenon—how it relates to various aspects of life today—family relations, education, work, institutions and conditions of life generally. In what way is it a response to the problems of modern living, what are its philosophical and spiritual implications? What does it say about our value structure? How does it reflect the way people think about the future?

72. Arising from this and all the evidence which the Committee has been able to gather within the State, in Australia and from experts from all over the world, the most disturbing single factor is the emergence of the crisis of confidence amongst so many young people. This is reflected in the outstanding difference between life in the technologically advanced nations in the first and second halves of this century. Whereas up to the mid-1950's the majority of children remained "drug free" at least until early adulthood, in the 1960's and the 1970's increasing numbers of young people have jeopardized their chances of reaching responsible adulthood by smashing their lives through a total dependence on drugs—any drug that they can get hold of. It is as if these young people have been brought by their early teens to the feelings of despair traditionally attributed to the middle-aged and the ageing and which is said to account for the excessive use of alcohol, sedatives and minor analgesics amongst those older generations.

73. The Committee does not believe that a great sense of worldly wisdom is needed to recognize the factors which may account for this crisis—the impact of television, with its intercontinental transmission of other people's lifestyles, the "spoiling" of everyone in our affluent society so that most days bring material gifts in the profusion which only 30 years ago were for most people a feature only of Christmas, the changes in social attitudes which have encouraged the "new look" in family life so that people take pride in not being attached to their children's bib strings without society having provided an adequate substitute for slack parental control and supervision. The list is long and much of it well rehearsed. Even to touch upon these issues will be seen by some as reactionary, old fashioned or perhaps hopeless.

74. Over and over again the Committee was told that the most important determinant of any form of non-medical use of drugs is the presence of a drug-taking group of the person's peers. Whilst recognizing the significance of peer pressure for people in all groups and at all ages, the Committee believes that it is important to ensure that it is not given undue prominence to mask inadequacies in other directions—especially in the willpower of society generally or the individual family to shoulder responsibility for the behaviour of its adolescents and young children. If, as is suggested in a recent report, many young children 10 years old in a Sydney suburb are frequently experimenting with soft drugs, this is a grave reflection on the adult responsibility being exercised by parents

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[4] Minutes of Evidence of the Progress Report of the Legislative Council and Legislative Assembly Upon Drugs, paras. 2-1, p. 2. March 1976.

[5] Chapter four "Some Causes of Non-Medical Drug-Use".

and bodies in that area. There are signs everywhere that these responsibilites are either not properly recognized or are being shirked. In this context the Committee perceives public enlightenment and personal development as a major priority at every level in the community. The needs in this direction are discussed more fully in Chapter 11.

**Psychological Factors**

75. Numerous factors have been postulated for the progression from experimental and casual to dependent use. No single "cause" has been found for initial or casual use. However, non-medical use of drugs of strong degree is nearly always associated with psychopathology. The psychiatric syndromes seen in drug abusers, however, are varied, not specific, and occur more frequently in non-users than in users. It has been explained to the Committee that although on the basis of life histories it is possible to demonstrate that psychopathology antecedes drug use it cannot be concluded that psychopathology is the sole cause of non-medical use. Additionally it is difficult to determine whether the psychopathology is not caused by the drug or the social consequences of becoming a member of a drug-using sub-culture. These uncertainties bedevil the fulfilment of successful treatment programmes and thereby deter containment of the growth in non-medical use of drugs.

# SECTION 2

## CHAPTER 4

### THE NON-MEDICAL USE OF DRUGS OF DEPENDENCE—THE CURRENT SITUATION IN NEW SOUTH WALES

**Why some drugs matter more than others**

76. The terms "drug abuse", "drug misuse" and "drug problem" mean different things to different people. For the purposes of its enquiry, the Committee has defined "drug abuse" as non-medical use of any drug in such a way that it adversely affects some aspects of the user's life, i.e. by inducing or contributing to criminal behaviour, by leading to poor health, economic dependence, impairment of physical capacity or by creating some other undesirable condition. Using this definition, the "drug problem" is seen as the total effect on society of these adverse effects of non-medical use of drugs.

77. These definitions assume especial importance in the context of measuring the wasteful effects of drug use because in taking numbers of users as a measure of the problem, four factors must be borne in mind.

(1) At any given level of consumption different drugs have different affects on the behaviour and condition of users.

(2) The magnitude of the drug abuse problem is related to the frequency and quantity and consumption. At high levels of consumption—particularly with intravenous administration—the user's behaviour and physical condition may deteriorate rapidly. For this user, a reduction in drug consumption is likely to significantly alter behaviour and therefore impact on the drug problem.

(3) The likelihood of advancing to chronic intensive levels of consumption differs from drug to drug and from individual to individual. Users of dependence-producing drugs such as heroin are more likely to advance to high levels of use than are users of non-dependence-producing drugs such as marihuana.

(4) An underlying and vastly influential feature of the drug problem is that drugs are often used in combination. This multiple drug use occurs for a variety of reasons. Beginners experiment in the quest for novel experiences; sometimes experienced users use combinations of drugs for the more intense combined effect; and frequently one drug is substituted for another which is unavailable. Multiple drug use is a key factor in the growing drug menace—young people especially who become heavily dependent on drugs will go in search of almost anything. The importance of this in compounding the explosion of non-medical drug use and illicit supply was stressed over and over again in the hearings of the Committee. This is a strong feature of dependence on narcotics but is just as marked amongst older people who use barbiturates and alcohol. It must be kept at the forefront of the mind when considering any of the drugs of dependence.

78. These complicated patterns of drug use make it difficult to estimate the true scope of the drug problem. For example, estimates of current abusers of different drugs do not give the true numbers, since an individual may be counted in different groups. Alternatively, one who should be included in more than one group may be counted in only one.

79. Thus in using estimates of numbers of drug users as an indicator of the drug abuse problem, it is important to distinguish among drugs being used, to recognize the variation of use patterns, and to predict how use patterns will vary over time. These factors determine the magnitude of the drug abuse problem.

80. With these considerations in mind, the Committee has examined the drugs principally in abuse in New South Wales on the basis of historical trends in use, availability and supply, and the current situations.

## HEROIN—A MODERN PLAGUE

### A Description of Heroin

81. Q. What sort of drugs was he using? A. The whole gamut, finishing of course on heroin, which is the queen of all drugs on the scene.[1]

82. Thus spoke a father who has suffered the ravages of opiate narcotics in the life of one of his children. His is a sad and increasingly familiar story.

83. As already described in chapter 2, dependence of the opiate or morphine type relates to the opiate narcotics. This term usually refers to opium and its derivatives and includes the most dependence-producing drug of all, heroin.

84. There is ample evidence that all derivatives of opium may be used by those who suffer from dependence of the opiate type or morphine type. It is beyond doubt, however, that heroin, which is a derivative of opium, is in a class all of its own. Heroin (the German heroisch, meaning "large" or "powerful") is currently a word with high emotional content. The mention of heroin brings visions to many of the most blatant moral and social degradation. It would not be an exaggeration to say that it has become a word with which almost everyone of us is now familiar, in itself a frightening revelation of the hold that this particular drug can gain within society in a relatively short period of time. Since this drug can bestow great benefits to mankind when used in certain medical circumstances, it is important to know something about it.

85. Structurally, heroin is diacetylmorphine hydrochloride. It is manufactured by the diacetylation of morphine. It is usually a white, odourless, crystalline powder that dissolves readily in water. Mexican heroin is brown. Pharmacologically, heroin is a highly effective narcotic analgesic. Developed by the Bayer Company in Germany in 1898, it was thought at first to be non-addicting and actually to be a cure for morphine addiction. Not until 1910 were the addictive properties of heroin noted.

86. Due to its marked euphoriant properties and rapid onset of action, the addictive potential of heroin is greater than that of any other drug. Heroin's properties are very similar to those of morphine and, in fact, much of its effect is due to conversion to morphine in the body. A user, who is known as a junkie, can however differentiate heroin from morphine given intravenously; the pleasurable effects come more rapidly and are more intense after a heroin injection. After subcutaneous or intramuscular injection ("skin popping"), however, he cannot distinguish between the two substances. Like morphine, heroin constricts the pupils. Heroin depresses respiration by its depressant action on the central nervous system, and respiratory failure and death may result from medullary paralysis.

87. Not uncommonly, respiratory rate is depressed to three or four breaths per minute. The greatest chance of accidental overdose and death occurs in the heroin-susceptible or non-tolerant individual. Included in this group is the beginner or someone who has been off the drug for a while, or the user who acquires a purer grade of heroin after using heroin which has been adulterated; or in the individual who concurrently injects or ingests a combination of respiratory depressant drugs (such as opiates, alcohol and barbiturates). The same effects may be produced by narcotic antagonists like nalorphine, levallorphan, or naloxone, which dramatically reverse the respiratory depression resulting from overdose of heroin or other narcotic substances.

88. Heroin depresses the respiratory centre and the cough reflex more effectively than morphine and is two to five times more efficient as an analgesic. Although heroin is an excellent rapid-acting reliever of postoperative pain, its medical use has been denied in New South Wales since it was banned in 1962.

89. Histamine release may be seen following heroin injection as may anaphylactic shock, collapse and death. The "itching nose" that is commonly seen is probably due to histamine release. "Cotton fever", marked by general shakes and collapse following injection of heroin, may be due either to an allergic phenomenon or to a septicemia secondary to an infected outfit or needle.

90. Constipation occurs after heroin use due to decreased propulsive activity throughout the gastrointestinal tract. Nausea and vomiting are not uncommon and are more likely to occur if the user is up and moving around.

91. Heroin is rapidly hydrolyzed by the liver and other body organs and tissues and is largely excreted in the urine as morphine and its chemical conjugates (this is the basis of the classic urine test). Heroin also appears as morphine in breast milk, in the sweat, and in saliva. It also readily crosses the placental barrier and may produce a narcotized and addicted foetus.

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[1] Minutes of Evidence, p. 4, para. 1840.

92. The foregoing description of heroin might provide some understanding of the classical quotation "it is so good, don't even try it once".

93. The description of "addicted" babies has been included because the number of children born to narcotically dependent mothers is becoming a marked feature of the drug problem. Recent reports indicate that 1000 narcotically dependent babies are born in New York each year.[2] There were 52 children born to addicted mothers in four inner metropolitan hospitals in Sydney during a period of two years.

94. Notwithstanding the dangers which clearly arise from the careless use of such a powerful drug, it has to be acknowledged that heroin obviously provides a human sensation which many people enjoy and that there is also a strong body of professional opinion which believes that good health and productive work are not necessarily incompatible with dependence on opiate narcotics, including heroin.

95. Dr F. A. Whitlock, Professor of Psychiatry at the University of Queensland, writes[3]: "As far as opiates are concerned, there is abundant evidence that the illegal purchase and use of heroin is attended by heavy mortality and morbidity. The reasons for this are well-established; the injection of impure substances of unknown doses and an appalling indifference to elementary hygiene precautions. In contrast, more experienced and possibly more intelligent users of opiates appear not to suffer much harm. There is, in fact, abundant evidence that regular injection of opiates of known strength and purity have singularly little effect on health, unless the individual, who is by now physically and psychologically dependent, runs out of supplies. Hence, ironically, the more the authorities clamp down on the supplies of opiates the greater is the danger to the user in terms of death and disease."

96. It appears to be a fact that some people are able to function adequately, at least for a time, whilst using heroin. For example, Mr Gordon Gately, an acknowledged former heroin addict who is now undertaking voluntary work helping addicts on the South Coast, giving evidence before the Committee said: "While I was a practising narcotic addict I always worked but today I cannot get a job simply because people do not want to accept the fact that I can say I am a heroin addict but I do not use heroin any more. I tell them this and they check everything and are full of reservations; they do not want to know."[4] The point is, however, that Mr Gately felt compelled to give up heroin and it must remain debatable how long he would have continued to work adequately whilst heavily dependent on narcotics. As can be seen from a reading of the full evidence, drawing on his own experience as a narcotics user and also on his experience in rehabilitation work, Mr Gately provided a substantial picture of the misery which heroin use creates.

97. Based on the evidence of first-hand experience of this kind and the evidence of numerous discussions with addicts and workers in the drugs field during the Committee's visits throughout New South Wales and interstate, the Committee cannot see how any one, except perhaps in academic terms, could sensibly believe that heroin dependence, even of the purest and well controlled kind, does not raise grave risks for the physical well-being of the user. The question of controlled heroin dependence is an academic one because the problem confronting us is not how well the Chinese survived on opium, why certain doctors in Britain managed to stave off detection as heroin users in the early part of this century or why certain middle-class, middle-aged, predominantly female users of opium in nineteenth century America did not suffer much in the way of ill-effects. The problem of today is that many immature young people are turning to heroin and they cannot control its use. They are killing themselves in increasing numbers. Heroin is a dangerous drug. As will be demonstrated in ensuing discussion in this Report, there are vast diverse and complex problems relating to its use and control, not least because the drug has certain beneficial medical uses which have been the subject of several submissions. The Committee wishes it to be clearly understood that nothwithstanding certain problems arising from the prohibited status of heroin in Australia, it could not countenance a situation in which heroin might in any way achieve status as a "drug of choice" for some people.

**The Heroin Menace**

98. We are being flooded with heroin from so many different sources that it is almost impossible to cut off the supply. In order to investigate this aspect

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[2] New South Wales Police News, February, 1978.

[3] *Journal of Drug Issues*, Vol. 7, No. 4, p. 399.

[4] Minutes of Evidence, p. 158, para. 2991.

of the narcotics problem, the Committee was fortunate to be able to visit Canberra for discussions with officials of the Australian Narcotics Bureau (within the Department of Business and Consumer Affairs) which is responsible for the investigation of illicit drug matters at the national level. The Committee also visited Sydney Airport to inspect the work of the officers of the Bureau there and the special problems in controlling illicit drug supply through international airports. The Chairman of the Committee also inspected the work being done by the Bureau in Western Australia with special regard to the problem arising over the vast size of Australia's coastline.

99. Obviously, much of the information gathered by the Committee during these visits must by its nature remain confidential. The facts which the Bureau presented on the dimension of the heroin explosion, however, can be summarized as follows:

100. "Situation summary—Illicit-drug supply situation—Australia, 1970 to July 1976.

101. The opiates—Although opium has continued to be available on illicit markets in Australia during this period, demand for it is both reduced and inconstant when compared to the situation here earlier this century.

102. During the period there has been an increased consumer preference for diacetylmorphine, and a steady if low demand for morphine. Since 1970 at least, No. 3 heroin imported mainly from Thailand, Malaysia and Hong Kong has been readily available on the illicit markets of most major Australian cities. Prices at "street" and "pusher" levels have remained remarkably constant over the period. No. 4 heroin from similar South-East Asian sources has become increasingly available since towards the end of 1975. Opiates of other than South-East Asian origin are very scarce in Australia at present.

103. During 1975-76 three small heroin laboratories were seized in Australia; these illicit laboratories were engaged in producing heroin from the codeine phosphate present in proprietary analgesics such as "Codiphen". This was the first time that such a process had come to our attention.

104. Analysis of seizures and information from other sources indicate that during 1975 and 1976 there has been an increased illicit importation into Australia of low-grade No. 3 heroin consignments. In chemical composition some of these seizures have been so low-grade as to amount to little more than No. 2 or base heroin.

105. Apart from a steady and slightly increased incidence of pharmacy robbery and theft from doctors, there has been no significant diversion of licit opiate supplies onto the illicit market. There has been no diversion during the period from licit, Australian, opiate manufacture or production onto the illicit market.

106. As regards trafficking patterns, three distinct trends in heroin importation have emerged during the period.

107. In the first place, in the early part of the period Australian-Chinese importers, in Sydney in particular, started to increase the wholesaling of illicit heroin outside their own ethnic group; whereas previously they had tended to import mainly to meet the needs of their ethnic group in much the same way as they had earlier imported opium. This new trend has become particularly noticeable during the past 2 years, and we have become aware of regular importations of heroin, usually in from 1 to 5 kilogram consignments of low-grade No. 3 heroin, from ethnic-Chinese concerns in Malaysia and Hong Kong to their counterparts in Australia. Although Chinese-crewed commercial vessels are still a common means of such importation, we have also noticed a pattern of airline courier consignments which is similar to that reported in recent years by several Western European countries in respect of heroin importations from South-East Asia and Hong Kong.

108. Secondly, we have become aware of an increased number of small groups of heroin users who combine to send one or more of their number overseas to bring back 1 or 2 kilogram lots of heroin, usually in accompanied baggage or on the person. Such groups favour Malaysia or Thailand for their purchasing, and while they are there they often also arrange for a continuing supply of heroin to be sent to Australia in a succession of 20 to 25 gram consignments contained in first-class airmail covers addressed to a series of suburban post-office boxes which have been registered in false or different names.

109. Thirdly, and partly due to the small user groups mentioned above, the period has seen a marked increase in the number of mailed importations of small quantities of heroin, particularly from Thailand and Malaysia."

110. 1977 has seen a continuation of these trends. There are features of the Bureau's assessment which need to be stressed and which constitute a special threat to Australia. The first is the relative proximity of this country to the Golden Triangle and the Chinese connection.

111. The Golden Triangle is the lush 155 400 km² triangle covering the intersection of Burma, Laos and Northern Thailand. There each winter the tribesmen and their families move into the fields of the red and white opium poppies, split the green poppy bulbs and scrape off and collect the white sap. It is a simple, timeless process, and much of the opium is consumed by the tribesmen themselves. But the harvest, re-enacted through hundreds of Golden Triangle villages, results in an estimated yearly production of a little more than 700 tonnes of raw opium—a total similar to that produced by the old Turkey-Marseilles-New York "French Connection". The tribal families are the front line workers in a multimillion dollar commercial chain that is as complex as any multinational corporation.

112. The processing reduces the volume of the drugs to about a tenth of the raw opium and the relatively compact heroin is easily shipped through Bangkok to be smuggled by a countless variety of methods to Australia and elsewhere all over the world.

113. The opium is shipped to the Burma-Thailand border where it is refined into differing grades of heroin. As reported by the Narcotics Bureau, No. 3 grade heroin has been most frequently seen in Australia. However, members of the medical profession have reported in recent months that some very severe cases of heroin overdose suggest that much stronger grades of heroin are reaching the Australian market.

114. That the heroin entrepreneurs of the Golden Triangle are mounting a major supply effort into Australia is beyond question. Thus, for example, in evidence Dr Judianne Densen-Gerber told the Committee.[5] "How does this apply to Australia? It applies in two ways. I see here a ripe and fertile soil in your young people. I have brought along today a young man who will tell you a little of his experiences. Later we shall hear from a young woman. There is no difference between these children and the children that we saw in 1969 (in the United States of America). The second thing is that in 1975 we had a heroin war in the United States of America. The heroin war was between three major cartels, European, Mexican, and the Golden Triangle. The Mexicans and the Europeans have cornered the market. They have driven out to a great extent any of the Golden Triangle business. That leaves that particular group seeking a new market. I know it sounds funny to talk about marketing in the drug business, but you must understand that the forces against the stable society are well organized and highly interested in the almighty dollar, regardless of how they get it. They have good systems of supply. They need a market, Mr Durick, and your police here tell me that the heroin on your streets is Golden Triangle heroin. That tells me that they have analyzed the market, and found that Australia is affluent, with restless children here, and they are anxious to develop the market here."

115. Some recent Customs seizures have graphically demonstrated the ingenuity of the heroin smuggling chain. A notable example was the motor car imported into Perth with several million dollars worth of heroin concealed around the fuel tank. Yet another example in Western Australia was the capture in 1977 of two yachts which had been hired in Singapore for the purpose of smuggling both heroin and hashish in great quantities to Australia. In both cases, people of other nationalities as well as Australians were heavily involved. There is considerable evidence of strong trafficking links with people from the United States and New Zealand.

116. Another really disturbing development is the clear evidence that many young Australians not only are able to visit heroin outlet areas in close proximity to the Golden Triangle fairly easily on holiday but that there are a great number who are willing to undertake heroin smuggling commissions, particularly by importing heroin concealed on the body. An example is the two young women detected at Tullamarine Airport recently smuggling heroin internally.

117. In another case, the Committee was told in evidence[6] "7 years ago I got together $2,000. I got a girl to purchase an air ticket to Penang. It cost $720 return. I gave her the balance in cash and she came back with enough heroin, which she bought in Asia, to supply half of Bankstown for 6 months . . . all you have to do in Penang is get into a tricycle and ask the driver where you can buy heroin and you score heroin. You have it. It is as simple as that."

118. This is a facet of the heroin problem in Australia which is probably unique to this country compared say to the United States and Europe and accordingly it requires special emphasis.

119. The special vulnerability of Australia to the smuggling of illicit drugs from East Asia is a matter of serious concern. If this threat is to be overcome the public will have to contemplate the introduction of tougher measures to counteract

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[5] Minutes of Evidence, p. 17, para. 1924.

[6] Minutes of Evidence, p. 168, para. 3067.

the smuggling cartels and the individual undertaking small commissions, even at the expense of some infringement of civil liberties.

120. Whilst the Narcotics Bureau and the other law enforcement agencies grapple with the problem of heroin supplies, parliamentarians, doctors, sociologists all over the world are studying the question of demand.

121. Since the traffic in heroin is illegal, it is almost impossible to state definitely how many heroin addicts there are in New South Wales. Statistics collected through the formal government machinery must be generally regarded as incomplete and to provide underestimates. Moreover, the available official statistics are almost invariably about a year old and must be treated with caution as a gauge of current trends. There are marked inadequacies in monitoring non-medical use of drugs generally throughout the State which is a matter of fuller comment in chapter 9.

**Evidence of the Growth in Heroin Use**

122. However, the Committee has assembled the latest available information from the police, the Bureau of Crime Statistics, the Government Analyst, the Coroner's Court, the Health Commission of New South Wales and from certain other sources Australia-wide, from which it is possible to detect a marked upward surge in the use of heroin and other narcotics which amount to nothing short of an explosion. The statistics in relation to heroin are presented with those for other drugs in instances where trends can usefully be compared.

TABLE 3

**HEROIN SEIZURES (AUSTRALIAN NARCOTICS BUREAU)**

123.

| Year | Quantity kilograms | Percent increase on previous year |
|---|---|---|
| 1974 .. .. .. .. .. | 5 | |
| 1975 .. .. .. .. .. | 6 | 20 |
| 1976 .. .. .. .. .. | 15 | 150 |
| 1977 .. .. .. .. .. | 12 | 20 |

(Heroin when imported ranges in purity from 30 percent to 90 percent) 1 gram of heroin — 12 hits.

TABLE 4

**OFFENCES RELATED TO OPIATES (HEROIN, MORPHINE, OPIUM, ETC.)**

124. (Extracted from Court Statistics—Annexure (F)).

| Year | Lower Courts N.S.W. | Percent of total Drug Offences |
|---|---|---|
| 1971 .. .. .. .. .. | 265 | 30.2 |
| 1972 .. .. .. .. .. | 208 | 19.7 |
| 1973 .. .. .. .. .. | 167 | 12.4 |
| 1974 .. .. .. .. .. | 262 | 12.0 |
| 1975 .. .. .. .. .. | 516 | 13.1 |
| 1976 .. .. .. .. .. | 625 | 13.3 |

125. It will be noted that the number of drug convictions has continued to increase rapidly. The percentage decrease in the total of drug convictions in the lower courts is accounted for by the fact that offences in relation to cannabis have grown at a much greater rate in the same time frame, for example, 494 in 1971 to 3831 in 1976, compared with 265 in 1971 to 625 in 1976 for the opiates.

126. In the higher criminal courts in New South Wales there were 51 convictions for opiates in 1976 out of a total of 108 for all substances, representing 47 percent of the total. The comparable representation was 13 percent in 1975 and 18 percent in 1974.

127. Under Commonwealth legislation there were forty-three convictions relating to opiates (sixty-eight percent) compared to twenty for cannabis (thirty-one percent), the only other drug involved in 1976. In 1975, slightly more than half (sixty cases) of the Commonwealth cases involved opiates.

TABLE 5

**NEW SOUTH WALES POLICE DEPARTMENT DRUG DETECTIONS**

128. (Extracted from New South Wales Police Department Drug Statistics—Annexure (B)).

| Year | Narcotic Opiates (Heroin, Morphine, Opium, etc.) | Narcotic Synthetics (Illegal use of Methadone, etc.) | Detections Total Narcotic | Total Drug Detections |
|---|---|---|---|---|
| 1959 .. .. | 5 | 4 | 9 | 9 |
| 1960 .. .. | 5 | 3 | 8 | 11 |
| 1961 .. .. | 5 | 6 | 11 | 12 |
| 1962 .. .. | 4 | 8 | 12 | 13 |
| 1963 .. .. | 9 | 10 | 19 | 23 |
| 1964 .. .. | 3 | 8 | 11 | 14 |
| 1965 .. .. | 9 | 7 | 16 | 31 |
| 1966 .. .. | 28 | 11 | 39 | 98 |
| 1967 .. .. | 50 | 8 | 58 | 345 |
| 1968 .. .. | 50 | 14 | 64 | 501 |
| 1969 .. .. | 125 | 40 | 165 | 780 |
| 1970 .. .. | 215 | 92 | 307 | 914 |
| 1971 .. .. | 239 | 123 | 362 | 1151 |
| 1972 .. .. | 173 | 68 | 241 | 1291 |
| 1973 .. .. | 198 | 73 | 281 | 1646 |
| 1974 .. .. | 305 | 89 | 394 | 2403 |
| 1975 .. .. | 559 | 102 | 561 | 4734 |
| 1976 .. .. | 780 | 147 | 927 | 5433 |
| 1977 .. .. | 909 | 286 | 1195 | 6003 |

**Numbers entering New South Wales Methadone Maintenance Programme**

129. The drug methadone is used by the New South Wales Health Commission in the withdrawal and management of narcotic-dependent patients. Although methadone is the subject of comprehensive comment in chapter 12 the number of patients in methadone treatment programmes is a reflection of the trend in opiate narcotic use, including heroin.

130. The graph at Annexure C to this Report gives an indication of the demand for treatment and the extent to which the use of methadone maintenance has developed over the past seven years.

131. It will be seen that there is a strong and continuing growth in the numbers coming into the programme from single figures in 1970 to 1564 by mid 1977. The lowest curve shows the number of new clients admitted to the programme during each 2-month period, whilst the higher curve shows cumulative total of all addicts admitted to the programme since it commenced. The middle curve shows the number of clients currently on the programme at the end of each 2-month period. The lowest curve shows a rapidly growing increase in the numbers coming in each year up to 1977, the figures for 1974, 1975 and 1976 being as follows:

1974—138 1975—277 1976—388

132. But in 1977, however, there were only 260 new admissions to the programme.

133. There is no way of knowing exactly why this decline would come about from one year to the next. It might suggest that the incidence of opiate narcotic use has levelled out to a plateau for the time being, although this is not borne out by either the seizures, the number of cases arising in the courts, the

police figures, nor as will be seen in the ensuing paragraph, the number of deaths due to narcotics. It probably indicates a change in treatment procedures and an increasing reluctance by medical officers to prescribe methadone.

The peak in 1976 may be due to the fact that many narcotic-dependent persons saw the Government's methadone programme for the first time as a means of topping up their drug supply. This potential weakness in methadone maintenance programmes is a matter for further discussion in chapter 12.

**Fatalities**

134. A report "The Increasing Incidence of Fatalities Related to the Abuse of Narcotic Analgesic Drugs in N.S.W. and A.C.T. 1974-1976" by Mr M. J. Liddy of the Division of Analytical Laboratories, Health Commission of New South Wales is at Annexure D. This is an important research document. It provides a unique collection of information about narcotic deaths in the State (including some reference to the A.C.T. which has no significant bearing on the conclusions for New South Wales). The document is remarkable not only on account of the alarming picture it provides but also because it arose from the initiative and keen personal interest of the staff of the Division of Analytical Laboratories of the New South Wales Health Commission rather than as a component of any systematic review of drug casualties. This reflects a general weakness in the machinery for monitoring drugs within New South Wales which is the subject of further comment in chapters 9 and 12.

135. The paper at Annexure D sheds much light on the true nature of the potential threat of narcotic dependence and it should be studied closely. The main conclusions are:

"1. There has been a dramatic increase in the number of deaths resulting from the abuse of narcotic analgesic drugs:

| Year | 1974 | 1975 | 1976 |
|---|---|---|---|
| Deaths .. .. .. | 14 | 16 | 49 |

Morphine-associated deaths prior to 1974 were few in number. Additionally, a marked increase is evident in the total number of deaths of known drug addicts since 1974. (Table IV of the annexure.):

| Year | 1974 | 1975 | 1976 |
|---|---|---|---|
| Deaths .. .. .. | 9 | 10 | 16 |

These trends have been most pronounced since the winter of 1975.

2. Illicit opiates (principally heroin, also morphine and opium) were involved most frequently in the 113 deaths which followed abuse of narcotic analgesics during 1974-6. Methadone, alone or in combination with an opiate, was the other significant narcotic analgesic encountered in this survey.

3. Although the majority of these deaths occurred in the Sydney metropolitan area, an increasing incidence was observed for smaller urban centres.

4. The majority of deceased narcotic drug addicts and of others whose abuse of illicit narcotic analgesics was implicated in their death during 1974-6 were males less than 30 years old.

5. Deaths following the administration of narcotic drugs to the deceased by another person are becoming more frequent, and pose special problems for police, forensic toxicologists, and forensic pathologists in the criminal courts.

6. A few deaths during this period serve to highlight problems resulting from lack of hygiene amongst illicit intravenous drug users ("mainlining"), and from carelessness in the storage of prescribed methadone within reach of infants."

136. Based on cases being reviewed by the Division of the Government Analyst, those trends show no real signs of diminishing. Provisional figures are available for 1977. There were 41 deaths directly attributable to narcotic analgesics and 19 additional deaths of known narcotic addicts. This is a slight decline on 1976 but it should not be taken as a sign of a diminishing problem. The Committee has received evidence to suggest that deaths due to narcotics are being increasingly ascribed to other causes so as to protect the families of the victims. When this evidence was tested by the Committee before a prominent spokesman for the medical profession, he confirmed that it would be so. The coronial findings

do not, therefore, necessarily represent the full number of people dying prematurely from narcotic dependence. It is a fact, too, that narcotic dependence is killing people through illness such as hepatitis and renal failure and these deaths are not tabulated in any overall assessment of deaths arising from narcotic dependence. The numbers are possibly as great as those directly attributable to consumption of narcotics given that Dr Alan Freed, Director of Drug Dependent Services in Queensland, states that from his experience, both in Australia and in Britain, 50 percent of narcotic abusers have latent hepatitis.

**Surveys on the Extent of Use**

137. Since non-medical narcotic use is illegal, it is obviously difficult to get reliable information on the numbers in the population who might be experimental, casual or heavy users. Nevertheless it seems to the Committee that there is a dearth of effort in the collection of more reliable and accurate information on the use of narcotics. Only one document presented to the Committee in formal evidence[7] as containing information on the incidence of narcotic use in New South Wales dealt with the matter as follows:

TABLE 6

**RATES OF NARCOTIC USE**

| Year | Reference | Population | Age | Ever Used Percent | Current Users Percent |
|---|---|---|---|---|---|
| 1971 | Bell et al, 1975 | N.S.W. | 15-19 | 2.8 | 1.3 |
| 1971 | George, 1972 | Sydney suburb | 14 + | 0.9 | 0.5 |
| 1972 | Bell et al, 1975 | N.S.W. | 15-19 | 4.2 | 1.6 |
| 1972 | Graves, 1973 | Melbourne | 13-23 | 1.5 (oral) | 0.9 (oral) |
| | | | | 1.0 (intravenous) | 0.4 (intravenous) |
| 1973 | Bell et al, 1975 | N.S.W. | 15-19 | 4.5 | 2.1 |
| 1973 | Healy, 1975 | Sydney suburb | 14 + | 1.1 | 0.5 |
| 1973 | Irwin, 1975 | Canberra high school students | 12-17 | 1.4 | — |
| 1974 | Irwin, 1975 | As above | | 1.7 | — |
| 1974 | Turner and McLure, 1975 | Queensland school students | 11-17 | 2.3 (M) | 0.9 (M) |
| | | | | 1.4 (F) | 0.2 (F) |

[7] Monitoring Drug Use in New South Wales: Part 3, Correlation of Trends, Deviance and Attitudes—Exhibit presented by the Health Commission of New South Wales.

> "Most of the groups in this survey showed a low and stable level of narcotics consumption. The exception were the trade courses and prisoners groups in which the use of narcotics increased between 1971 and 1973. In the 1971 trade course sample, 1.5 percent claimed to be current users and in 1973 this figure increased to 4.7 percent. Among the prisoners sample the prevalence of use was 4.6 percent in 1971 and 14.9 percent in 1973."

138. The report further states "narcotics use also seems to be stabilizing, but the increased use by certain groups and the increasing permissiveness in all groups is a grim warning of future problems."

139. That warning has been fulfilled by the evidence of narcotics use in all the subsequent years to the present. The Committee has been particularly concerned to note that the young people in the trades show a marked prevalence in the survey reports of narcotics use. Equally there is quite conclusive evidence that narcotics are a heavy currency in the State's gaols. It is disturbing to note that in 1973, when the rates of narcotic use were said to be stabilizing, the prevalence of use among prisoners was 14.9 percent. Given the trends in other directions since then, the Committee must inevitably conclude that the problem in the gaols has magnified considerably. Evidence on oath from an ex-prisoner suggested that the drug trafficking in gaols had grown to shocking proportions.

140. Two further documents presented to the Committee in evidence by the Health Commission of New South Wales are of interest. They are "Some Recent Statistics on the Use and Abuse of Alcohol and Drugs in New South Wales" and "Drinking and Drug-taking Patterns of 23 000 Sydney Adults: A Comparison between Two Samples".

141. The first of these documents, "Some Recent Statistics on the Use and Abuse of Alcohol and Drugs in New South Wales," published in November 1976, is preponderatingly concerned with alcohol and largely has a cut-off point in 1974. It contains no information on incidence of use of narcotics resulting from community surveys of any kind.

142. The second, "A Comparison between Two Samples," reports on the drinking and drug-taking patterns of two samples of adults who voluntarily gave information through medicheck screening during 1975 and 1976. The total sample of 23 000 is by far the largest ever studied in Australia and is considered to have provided a reliable body of data. The findings relate exclusively to alcohol, the minor analgesics, sedatives, tranquillizers and anti-depressants. It is no way intended as a criticism of those who undertook this research nor of the merit of this research (which is cited as an example of monitoring which ought to be more extensively undertaken), to observe that the tenor of the report suggests a strong bias in the research process towards alcohol and other drugs mentioned. Whilst this may reflect absence in the sample of narcotics use or an unwillingness amongst those who were sampled to reveal their narcotic use, the Committee believes that it reflects a sluggishness in response to the narcotics problem. It is interesting to note that the survey was not in any case repeated in 1977. All told, the Committee has found it difficult to get anything like an accurate picture of the narcotics problem within New South Wales. Statistically the evidence summarized in the preceding paragraphs is about all there is to go on. The nature of narcotic drug dependence, especially in the case of those "hooked" on heroin, inevitably means that people involved are hard to track down. Nevertheless official record-keeping is poor. Within New South Wales, there are inconsistencies between the Regions and there is practically no follow-up work on people who have passed through government treatment programmes. Nobody seems to know or want to know very much what happens to those addicts who do not end up on the autopsy table. The Committee has already mentioned disquieting suspicions that many opiate deaths are not reported.

143. However, the foregoing statistics provide a useful pointer to the rapid upward trend in use of narcotics. The number of police detections has quadrupled between 1973 and 1977. The number of known morphine-related deaths has multiplied more than seven times in the same period and these deaths are accelerating at a most shocking rate. Seizures of heroin have risen in mammoth proportions in the same time. Whilst the court convictions for 1976 show a slowing down in the rate of increase of cases relating to narcotics coming before the courts, as the Director of the Bureau of Crime Statistics and Research pointed out in evidence[8] it is not possible to interpret this as either a downturn or a levelling off in the narcotics use. The police detections and continuing mortalities in 1977 suggest that the court statistics for 1976 more likely reflect a log jam in the numbers of cases which the courts were unable to deal with.

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[8] Minutes of Evidence, p. 252, para. 3852.

144. Even allowing for the fact that so many narcotic users are not "known" or "reported" and that hard data will always be difficult to acquire in this field, based on the foregoing evidence on trends and other pointers from the first-hand evidence during hearings and personal discussions with many people directly involved, the Committee judges that the extent of the problem to be much vaster than is even dimly perceived by the community generally.

145. In evidence before the Committee, the eminent pathologist, Dr Michael Baden, who is the Deputy Medical Examiner of the City of New York, which has the world's most disastrous heroin problem, explained the "Baden" formula for assessing the extent of heavy narcotic use.[9] In brief, this is that experience in the United States has shown that there are generally one hundred times the number of users who die from use of heroin or other opiate narcotics. Dr Baden recognized that the formula might not necessarily apply in New South Wales but he believed that on evidence he had seen, particularly during his later visit to Australia,[10] the formula would apply broadly in New South Wales. Based on the deaths related to opiate narcotics for 1977, this would suggest that there are at least 5000 people and perhaps as many as 7000 in New South Wales heavily involved in opiate narcotic use.

146. It is interesting to compare this finding with the results of the survey undertaken by Bell et al.[11] which showed that in New South Wales in 1972, in the 15-19 age group 4.2 percent "had used" narcotics and 1.6 percent were "current users". The total population within the State in that age group at the time was approximately 220 000. This would suggest that there were at least 3000 narcotic users in the State in that year alone—well before other indicators, such as police detections, the death rate amongst narcotic users, entries into the methadone programme and the heroin seizures, have suggested a massive upsurge in narcotic use in the mid-seventies which is still continuing.

**The Contagion Factor**

147. The Baden formula and the Bell findings assume an even more disturbing significance when viewed in relation to the fact that it is established beyond reasonable doubt that those who become severely dependent, especially on heroin, have no option but to seek new recruits to the scene in order to be able to afford to sustain their habit. Those in the scene all say that this is so. This "drug hunger" is the germinating force which spreads narcotic dependence like a contagion. In evidence Dr Judianne Densen-Gerber described the nature of heroin contagion thus: "We have to look at addiction both as an endemic disease and an epidemic disease. When it is endemic, the host susceptibility is extremely important, that is, how well and healthy a person is. If he is well and healthy he has a greater resistance to avoid the disease. When a disease becomes epidemic, more people are affected and there is more variation in susceptibility. When markets are developed in a country, it becomes epidemic. We have had two epidemics in the United States of America, the first from 1969 to 1972. Many of you will remember the famous statement of our Government in 1972 to the effect that we had a decrease. That meant we had a decrease in the rate of increase; we were still increasing but at a decreasing rate; it was not increasing as much as it was before. By 1975, we began the second wave of the epidemic or a second epidemic.

It is just like the 'flu. The best way of understanding addiction is very much the way we understand influenza or some similar epidemic in the community. In certain areas there are more drugs or more of the contagious element. We also estimate that about 7 percent of the children in some areas would take drugs if drugs were available. In epidemic areas it could go as high as a quarter of the population."[12]

148. It is vital to understand the problem in this way. Dr Alan Freed, Director of Drug Dependent Services, Department of Health, Brisbane, who was also prominent in Great Britain for his work in the city of Newcastle, has told the Committee, in his experience, a heavy user will deliberately recruit at least three users over a 2-year period. This compound effect probably accounts for the fact that in Great Britain, where addicts have to be notified once they come to official notice either medically or through the social services, the number of registered addicts has climbed from just a few hundred in the 1960's to nearly 2000 in 1976. It has been suggested that this rise can be directly attributable to the change in

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[9] Minutes of Evidence, p. 19, para. 1925.

[10] "The Drug Scene Today" Symposium, Sydney University, 5th November, 1977.

[11] Monitoring Drug Use in New South Wales, Part 3, Correlation of Trends, Deviance and Attitudes, p. 20.

[12] Minutes of Evidence, p. 20, para. 1927.

emphasis in British treatment programmes when official supply of heroin to the addict was changed to methadone management. In addition, the great heroin invasion all over Europe, in 1976 accounting for 325 deaths in the Federal Republic of Germany alone, has demonstrated dramatically the fierce nature of the heroin plague.

149. From such evidence that the Committee has been able to assess, therefore, it is not perhaps surprising to find that at one time officers of the Health Commission of New South Wales believed that 37 heroin users were living in a New South Wales South Coast town with a population of 600 people.[13]

150. It is the view of the Committee that it is beyond question there exists a growing narcotics crisis in New South Wales, with heroin at the centre. It is not possible to say how many people are involved. Taking the consensus of opinion in the treatment community, the number of deaths within the State directly attributable to narcotics, the narcotics seizures, court statistics, police detections and the views of the addicts, the Committee believes that there are almost certainly 7000 regular users, and possibly as many as 10 000, the vast majority mostly in their late teens and early twenties, at serious risk of becoming a loss to themselves, their families and society.

151. It will not end in disaster for everyone. The Committee heard about people who used heroin occasionally for a kind of "social" pleasure but never actually met anyone with such balance and sophistication. It did, however, meet many young people whose lives had been badly broken by a menace which was not inflicted on earlier generations. Many people who saw the film "Pure S", a film about heroin shown in this country in recent months, refused to believe that it provided a true picture of the inroads which heroin has made into the way of life of many young people. But from the evidence directly available to the Committee, scenes like those shown in "Pure S" are rapidly becoming part of the real life of this country. Let there be no mistake about it. This is no longer a case of something which happens in the ghettoes of New York or in Hamburg or in Kowloon. Increasingly the faces of young people in Sydney reveal the anxiety of drug hunger. And it is not just a matter, as seen by many, of a few drop-outs who float around Kings Cross. The staff at the Westmead Community Centre have told the Committee of an upsurge in recent months in the numbers of young people from the surrounding suburbs who have been using heroin and who arrive at the centre seeking treatment in panic. These young people are not psychopathic freaks or the traditional "no hopers" of the conventional Australian view. Some are going to work in the city every day, perhaps wearing a cardigan or keeping shirt sleeves rolled down if signs of intravenous injections are beginning to show. At the start they go on looking much the same as they always did, like the boy in the photograph in the insert, who was a heroin addict for 10 years before his death in 1977. He lost his left eye because he had reached a stage where he was injecting heroin into the veins behind his eye to achieve the greatest effect.

152. The photographs are published by the kind permission of his parents who want everyone to know what a disaster heroin can be. The disaster is not just a personal one. The causes and effects of the narcotic epidemic run deep in our society. The United States of America can be said to be in turmoil over it. The dollar cost in that country both in treatment and rehabilitation and through associated crime has amounted to billions.

**The Money Cost and Associated Crime**

153. If the number of heroin addicts cannot be fixed with certainty, it is just as difficult to estimate accurately the amount of heroin the average user needs daily to maintain his "high". The user may need as little as $20 a day or more than $150 a day. Most users the Committee met said that they needed at least $50 a day. Recent figures in the United States of America show that heroin users would need to earn in excess of U.S.$17,000 a year to acquire their drugs alone. The Committee knows of personal cases of young heroin users in Sydney who as well as using their earnings dissipated inheritances or savings of between $8,000 and $10,000 in a period of 6 months. Recently, in a Sydney suburban court, appeared a 20-year-old man who within 6 months had dissipated $12,000 awarded to him in a court action. He was found guilty of selling and using heroin in a local hotel in order to sustain his own habit. The magistrate in sentencing this young man said, "I am afraid that this young fellow, if he keeps using heroin, is not long for this world."

154. Combine the estimated minimum number of users in New South Wales with the average estimated daily cost of sustaining their habit, and it must be accepted that at least $50,000,000 a year is spent on illegal heroin use in New South Wales. The figure is probably significantly greater because the heroin is

[13] Minutes of Evidence, p. 99, para. 2397.

just the "core" problem in multiple drug use which requires extra cost by way of illicit prescription buying. Many multiple drug users said that they required roughly $10 to $20 a day as retainers for their regular suppliers of "topping up" drugs like valium, mandrax and so on.

155. It is apparent that the cost of heroin and multiple drug use becomes a matter of great concern. Obviously the great majority of users cannot conceivably earn anything like $50 a day legally so they have to turn to crime and enlist new users to pay for their habit. This is the very essence of the compounding effect of narcotic addiction and multiple drug-use—it eats into the society like a cancer. The rising crime rate is not just a matter of more chemist or doctors' surgery break-ins, or of the new technique of waylaying doctors on their way to bogus medical calls so as to steal their medicine bags, it is a matter of armed robbery and brutal murder. It is also a matter of general moral decay—of increasing male and female prostitution to pay for the drugs, or more and more professional people being prepared to accept payment for illicit supply of drugs and a quite miserable corrosion of relationships between families and friends because of the mistrust which arises from petty thieving and lie-telling.

156. The fact that drugs have become an economic as well as social problem has largely gone unnoticed. An economist in Sydney has suggested that drug running has reached the stage of being a factor in the balance of payments.

157. It is beyond doubt that street sales of imported drugs run into many millions of dollars. Not only does this mean that a great proportion of this money which originates within Australia leaves the country but it also must mean that all national and State economic calculations are founded on a strong element of uncertainty. The Committee has not been in a position to determine accurately the true nature of these hidden influences but believes that all governments in Australia should begin to take seriously the harmful effects of this underground activity in their calculations.

**Conclusion—A Situation of Deep and Growing Gravity**

158. The Committee found alarm and anxiety throughout the State over the nature and extent of heroin use and the accompanying commission of crimes amongst those who were directly affected by the problem—the parents, friends, the treatment community, law enforcement officers. It is clear to them that the heroin plight in particular is no longer something which happens to "other people" or to some unidentified citizens in the lower socioeconomic groups of our society. No single group in our society has a monopoly on either harm or injury due to crime arising from narcotic dependence. The problems are manifest at the centre of our cities, in the suburbs, on the beaches and in the country. It is moving into the life stream of the State and the Australian nation at a shocking rate. And the rate is shocking because the users are mostly very young and this has significant repercussions for the future of our society.

159. The situation is one of deep and growing gravity. Issues become confused and society becomes introspective. The prevalence of crime connected with drug-use and the even greater fear of crime combine to make rehabilitation far more difficult than would be the case in a climate of security for the public. Similarly, the fear of crime and violence and the accompanying geometric increase in heavy drug use which this in itself then creates has a divisive effect in many communities, fanning fear—often justified but sometimes widely exaggerated—and promoting hatred and mistrust. All these elements have become distressingly evident in New South Wales in a very short period of time.

160. Heroin is at the core of a problem which has wide ramifications beyond State borders at both the national and international level. Long-term planning and co-ordination is absolutely necessary. For too long, our response has been piecemeal and truncated. The problem cannot be solved overnight. Its parameters will not permit a regime of "stamp on" and "stamp out". Those who claim that such an immediate solution is possible are totally unrealistic and completely ignorant of the implications which have been allowed to develop.

161. Undoubtedly, to deal with the heroin trafficking problem on the scale on which it now exists demands more effective and efficient law enforcement. But heroin trafficking is only one limited aspect of the heroin addiction and accompanying crime problem. Law enforcement alone will not provide a solution. Our past reliance on such enforcement had led us into a state of self-delusion and allowed us the luxury of avoiding the compelling and unpleasant evidence underlying drug dependency. Disenchantment, unemployment, hopelessness, alienation are all facts contributing to the rise in multiple drug-use and increasing dependence on narcotics.

162. Understanding of cause and effect bedevils the problem of drug-use. There is much evidence to suggest that if all existing dangerous drugs could by some means be made to disappear, the human beings who feel the need to use such drugs would strive to find alternative substances of abuse, or would resort to other anti-social behaviour if nothing else was available to deal with the

problem. At the same time it is clear that the availability of dangerous drugs and addicting substances greatly accelerates the downward spiral into crime—and often death—for many who would otherwise serve lives useful to themselves, their loved ones and society. Thus the drug problem is both a symptom of deeper needs and an evil in itself.

163. Opportunities for jobs, a decent environment and communication with youth are all indispensable if we are truly concerned with eliminating the crisis. The young people who are turning to drugs must be offered a viable alternative. However, the devices of exhortation have failed miserably and we can no longer rely on them. To do so would be only to further alienate our young people and to solidify the divisions which already exist in our society.

164. We must recognize that application of predominantly punitive sanctions to treat drug dependence will only result in greater drug dependence and reaffirm the disenchantment and alienation of those young people who have become enslaved by murderous drugs. Concomitantly, we have denigrated respect for law and constituted authority by the continuing application of the arrest sanction to drug-users and consequently emasculated the deterrent effect of such a sanction. Thus the Committee believes in the urgent importance of more effective and enlightened law enforcement and the need to create conditions in which the crisis of drug-use amongst the young and associated crime can be overcome.

# CHAPTER 5

## MINOR ANALGESICS

165. *The Lone Hand Magazine 1907* "What the 'drink habit' is among men in Australia, the 'headache powder' is among women! Promiscuous consumption of these powders (acetanilide, phenacetin and caffeine) affect the heart and the alimentary canal as well as stopping women from finding out what caused their headaches."[1]

166. Seventy years later these problems are still with us. It is estimated that 60 percent of medical treatment in Australia is administered through self-medication. Much of this self-medication relates to the use of the minor analgesics. They are so described to distinguish them from the major analgesics—the opiate narcotics. They are frequently referred to simply as analgesics.

167. The dangers to health from the excessive use of minor analgesics has been frequently publicized in recent years. The consequential effects on the levels of consumption and on personal and total social cost to the community have been minimal.

168. The problem has been a matter of intense public scrutiny in the past year or so, both within the framework of the National Health and Medical Research Council and also in the recent report from the Senate Standing Committee on Social Welfare.

169. In medical research and use surveys in recent years, New South Wales, together with Queensland, has been shown to have the highest consumption of analgesics per head of population and the highest incidence of end stage disease due to analgesics not only in comparison with the rest of Australia but also in comparison with the rest of the world.

170. For these reasons, the Committee has paid special attention to the problem in its hearings. In particular, the Committee studied the problem in some depth in its visit to the Hunter Region where analgesic consumption and the problems arising from it have been well-documented through the specialist work of Dr R. S. Nanra and Dr J. M. Duggan at the Royal Newcastle Hospital. Furthermore, the Committee was fortunate in being able to take evidence from Dr J. H. Stewart on behalf of the Australasian Society of Nephrology and the Australian Kidney Foundation.

171. On the manufacturing side, the Committee heard evidence on behalf of the suppliers through representatives of the Proprietary Association of Australia.

172. The Committee would like to record its thanks to all those who presented arguments on all sides and for the diligence which went into their evidence which is borne out in the full Minutes of Evidence.[2]

### Definitions

*Preparation*

173. Analgesics include such substances as aspirin, phenacetin, paracetamol, salicylamide, codeine and caffeine. They are supplied either as single ingredients or combined or compounded as mixtures of two or more of each other, most commonly in tablet or powder form.

174. Two preparations of compound analgesics in widespread use contain caffeine, which is not an analgesic but a stimulant. These lines are Vincents APC (aspirin, salicylamide and caffeine) and Bex APC (aspirin, paracetamol and caffeine). Each contained phenacetin until 1967 and 1975 when this was replaced by salicylamide and paracetamol respectively.

175. All prescription drugs containing phenacetin have been withdrawn from the Australian Pharmaceutical Benefits Schedule.

*Availability*

176. Particularly in the form of tablets and powders, analgesics[3] have been freely available, without prescription by a registered practitioner, from pharmacies, grocery stores, milk bars, confectioners, tobacconists—in fact from any retailer who seeks to stock them.

177. They are also prescribed by medical practitioners.

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[1] Taken from Australia's Yesterdays 1974.

[2] Minutes of Evidence, Dr J. Stewart, pp. 29 to 50. Dr R. Nanra and Dr J. Duggan, pp. 67 to 78 and pp. 82-88. Proprietary Association of Australia pp. 265 to 297.

[3] Codeine preparations are available only from pharmacies.

*Medical Terms*

178. Nephro- or renal—relating to the kidney. Nephropathy—a disease of the kidney.

179. Medulla of the kidney—the anatomically and functionally distinct inner pyramids of the kidney where the urine is concentrated to conserve body water. During water conservation (hydropenia), salt, urea and a number of other chemical substances accumulate at high concentration in the renal medulla. The tip of the medullary pyramid, or renal papilla, projects into the pelvis of the kidney.

180. Renal pelvis—the uppermost part of the urinary tract, into which urine is discharged from the kidney.

181. Ureter—the tube connecting the renal pelvis with the bladder.

182. Renal papillary necrosis—the primary lesion occurring in the kidneys as a result of the toxic effects of analgesics. Tissue death (necrosis) appears first near the tip of the medullary pyramid, and extends to involve the whole of the distal half to two-thirds of the pyramid. This necrotic tissue obstructs the fine tubules of the kidney, resulting in their atrophy and in chronic inflammation in the surrounding (interstitial) tissue. Ultimately there is involvement of the glomeruli and blood vessels, causing chronic renal failure and hypertension. In addition, necrotic renal papillae are unduly susceptible to infection, which spreads to the surrounding healthy renal tissue, and to calcification (stone formation). They may separate to enter the renal pelvis and ureter, causing bleedings, severe pain and/or obtsruction to the kidney. The combination of obstruction and infection in the kidney results in a very serious illness, with acute renal failure and septicaemia (blood poisoning).

*Analgesic Dependence*

183. The composition of compound analgesics is such that they are used by many people habitually and for reasons other than the temporary relief of pain. In such cases abuse is said to occur.[4]

184. Abuse was defined for the Committee as "a patient who takes two kilograms of aspirin or phenacetin in the form of an analgesic mixture which is the equivalent of intake of three powders a day over 5 years; five powders a day over 3 years; one powder a day over 15 years or fifteen powders a day over 1 year."

*Analgesic Syndrome*

185. Although renal disease is the most dramatic consequence of analgesic abuse, Australian physicians appreciate that the majority of their patients suffer from a constellation of disorders which arise from the toxic effects of aspirin/phenacetin and/or caffeine and which has been named the analgesic syndrome.

186. Clearly recognized elements of the analgesic syndrome include peptic ulcer, anaemia, hypertension and recurrent headaches as well as nephropathy. To these should be added splenomegaly, haemostasis, complications of labour, carcinoma of the renal pelvis, and possibly occlusive arterial disease.

*Use*

187. Analgesics are used for the relief of pain.

188. As a guide to persons who choose to medicate themselves by way of first-aid for temporary on-set of pain, reputable manufacturers of analgesics include on their packages a warning concerning adherence to recommended dosage and that, in the event of pain persisting beyond a brief period, the advice of a medical practitioner should be sought.

189. The Australasian Society of Nephrology and the Australian Kidney Foundation state[4] that the only legitimate reason given for regular analgesic ingestion is arthritis or other chronic musculoskeletal pain. In Australia, this accounts for no more than one-fifth of the cases "of analgesic dependence".

190. Dr J. H. Stewart, Chairman of the Society's analgesic subcommittee, stated that it had been proven in experiments on a large group of patients with a chronic painful condition "that in terms of pain relief, or lowering of temperature, aspirin alone is as potent and as strong as a mixture of aspirin plus phenacetin, or aspirin plus paracetamol, or aspirin plus salicylamide".[5]

191. Dr R. S. Nanra, head of the Division of Nephrology at Royal Newcastle Hospital, supported this view that the treatment of medical ailments with a single analgesic could be just as effective as one containing two or three compounds.

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[4] Minutes of Evidence, p. 31 of Causes of Analgesic Dependence.

[5] Minutes of Evidence, p. 48, para. 2037.

He stated that "pharmacologically and scientifically aspirin on its own is an effective pain killer . . . I would contend that aspirin on its own is sufficient to deal with all ordinary pain, and for pain so severe that aspirin will not deal with it, perhaps the patient should see a doctor. Similarly panadol or paracetamol on their own are usually effective and if pain again is so severe that they are ineffective, it may be the person concerned should be seeing a doctor".[6]

192. On the other hand, The Proprietary Association of Australia, "representing some fifty manufacturers of over-the-counter proprietary medicines", regards the taking of one or two tablets of compound analgesics a day as acceptable use.[7] Professor K. J. Murton, one of the association's spokesmen, whose attention was drawn to the contention in a textbook by recognized authors Goodman and Gilman that "none of the mixtures of analgesic-antipyretics, including the traditional aspirin, phenacetin, caffeine combination, has been shown to provide significant advantage over medication with aspirin alone", said *inter alia:*

193. "I think the author is saying that the methodology that is used to measure pain has not shown significant increases in pain relief when these combinations of analgesics are to be put together . . . with analgesics, we have got to establish the treatment of cause and effect. Also we have to recognize the idiosyncratic response of some patients to certain analgesics; in other words, the type of analgesic which relieves your pain may not relieve[8] mine."

*Consumption*

194. On the submission of the Proprietary Association of Australia, which strongly supports home medication and existing marketing arrangements, the estimated consumption per head of aspirin in Australia is of the order of 25 percent more than Canada, 50 percent more than that of the United Kingdom, 160 percent more than that of Western Europe (including the United Kingdom) and 85 percent of that of the United States of America. It states that "in Western Europe, mild analgesics such as pyrazolones are used extensively, hence the lower aspirin usage".[9]

195. The Health Commission of New South Wales reported[10]:

"2.2.6 The evidence from surveys conducted in Australia of the high consumption of minor analgesics gives rise to concern about its adverse effects on health. For the year ended 30th June, 1974, New South Wales (with 35.7 percent of the national population) consumed 41.5 percent of minor analgesics."

196. The view is supported by evidence by numerous witnesses, by the findings of the Senate Select Committee on Drug Trafficking and Drug Abuse, 1971, and the Report from the Senate Standing Committee, 1977, "Drug Problems in Australia—an intoxicated society?"

197. The Committee must draw attention to the fact that the manufacturers have declined to provide data on total sales of analgesics throughout Australia. The Report of the Senate Standing Committee, however, contains the following data provided by Reckitts Pharmaceutical Division[11]:

*Proprietary Oral Analgesics*

TABLE 7

**PROPORTION OF NATIONAL SALES VOLUME BY OUTLETS**

| Type | Chemist shops | Food stores | Other outlets (a) | Proportion of total national sales |
|---|---|---|---|---|
| | percent | percent | percent | percent |
| Powders (packets of twelve) . . . . | 5.1 | 55.0 | 39.9 | 50.2 |
| Tablets (boxes of twenty-four) . . | 54.4 | 27.7 | 17.9 | 49.8 |

(a) Estimated volume through clubs, hotels, garages, milk bars, etc.

Source: Reckitts Pharmaceutical Division, a division of R. & C. Products Pty Ltd.

198. "This shows that 50.2 percent of all proprietary oral analgesics sold are powders. Altogether 94.9 percent of these powders are bought from food stores and "other" outlets and only 5.1 percent from pharmacies. Conversely, most tables (54.4 percent) are bought from pharmacies."

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[6] Minutes of Evidence, p. 73, para. 2207 and p. 85, para. 2311.

[7] Minutes of Evidence, p. 265, para. 3967.

[8] Minutes of Evidence, p. 288, para. 4028.

[9] Minutes of Evidence, p. 269 of "Appendix 1. Introduction and Use of Aspirin".

[10] Minutes of Evidence, p. 299, para. 4151.

[11] Report from the Senate Standing Committee on Social Welfare, pp. 111 and 112.

199. *Proprietary oral analgesics—sales related to State population.*

TABLE 8

**(NATIONAL CHEMIST AND FOOD STORES; OTHER OUTLETS NOT INCLUDED)**

| State | Proportion of national population | Proportion of national sales, tablets | Proportion of national sales, powders | Proportion of total national sales |
|---|---|---|---|---|
| | percent | percent | percent | percent |
| Queensland (including Northern Territory) .. .. | 15.0 | 17.2 | 34.5 | 24.5 |
| New South Wales (including Australian Capital Territory) .. .. | 37.2 | 38.0 | 52.8 | 44.2 |
| Victoria | 27.5 | 25.1 | 5.3 | 16.7 |
| Tasmania | 3.1 | 2.8 | 0.6 | 2.0 |
| South Australia | 9.2 | 9.8 | 4.0 | 7.3 |
| Western Australia | 8.0 | 7.1 | 2.8 | 5.3 |
| | 100 | 100 | 100 | 100 |

Source: Reckitts Pharmaceutical Division, a division of R. & C. Products Pty Ltd.

200. "This shows that whereas tablet sales clearly reflect the percentage of national population in each State, the sale of powders is very much a phenomenon of Queensland and New South Wales. The sales figures for these two States, which include those for the Northern Territory and the Australian Capital Territory respectively, account for 87.3 percent of the chemist and food shop sales of all proprietary analgesic powders but relate to only 52.2 percent of Australia's population. The excess powder consumption in New South Wales and Queensland could even be understated to a significant degree. It can be seen from table 7 that 39.9 percent of powders are sold in "other" outlets not included in table 8."

201. "Figures from pharmacy and food store sales suggest that aspirin—a single analgesic—is the analgesic most used in Victoria, Tasmania and Western Australia, whereas in Queensland and New South Wales, Vincent's is most commonly used, with Bex next most commonly used. Vincent's APC is in fact the analgesic most used in Australia. One can only speculate whether the brand preference for compound analgesics would be different if "other" sales outlets, such as factories, garages, etc., were taken into account."

202. The statistics contained in the evidence taken before the State Parliamentary Committee[12] and the reports mentioned give an indication of the extent of habitual use of compound analgesics, psychiatric malaise leading to dependence and addiction and the damage to health habitual consumers have suffered. These can best be summarized in the diagrammatic map of Australia. (Figure 1, page 44.)

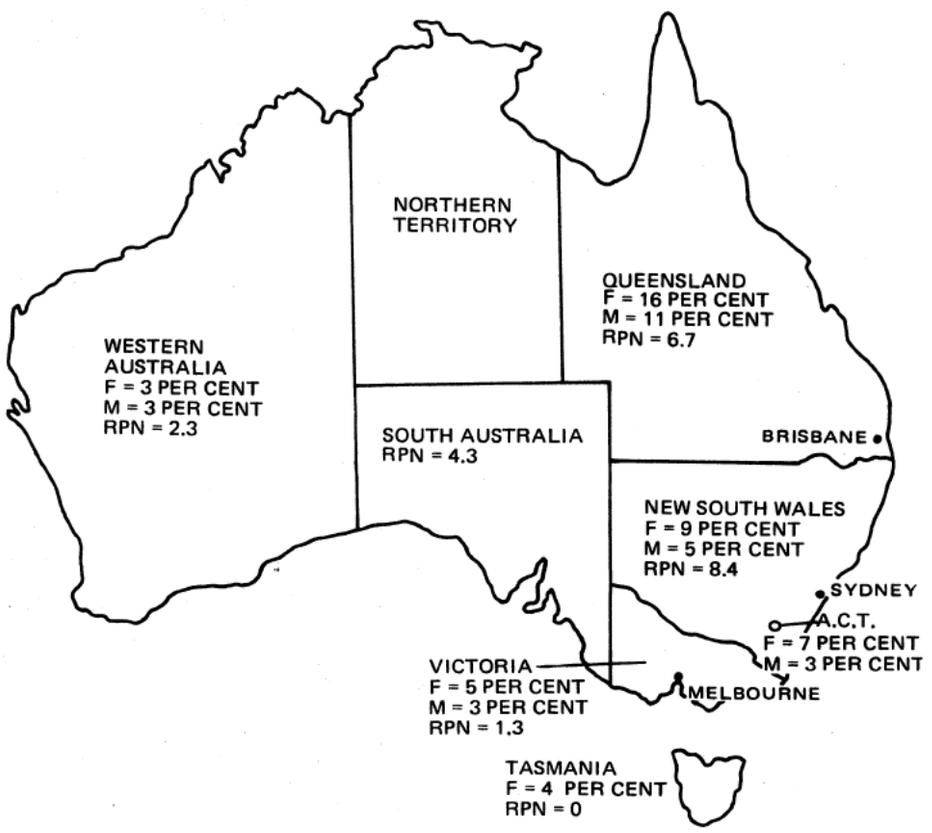
203. Commenting on these findings, Dr Stewart told the Committee[13]: "Some 16 percent of the adult female, and rather more than 10 percent of the adult male population of Queensland take analgesics every day. The rate of abuse falls, and the female preponderance disappears as one moves around Australia in a clockwise direction through New South Wales, the Australian Capital Territory, Victoria and Tasmania to Western Australia, where no more than 3 percent of the adult population of a provincial town were found to take analgesics regularly. No information is available from South Australia or the Northern Territory. Analgesic dependence is clearly less common in Christchurch and probably elsewhere in New Zealand than in the eastern Australian States.

204. "In the three most populous States, where surveys have been conducted both in capital cities and in country towns, no difference was apparent between metropolitan and rural populations.

[12] Minutes of Evidence, p. 31, para. 1974.

[13] Minutes of Evidence, p. 31, 4.3.1-4.3.5.

FIGURE 1




*The distribution of (a) regular analgesic consumption and (b) end-stage renal failure due to renal papillary necrosis throughout the six Australian States.* Beneath the name of each is shown separately the percentage of adult females (F) and males (M) who take one or more analgesic powders or tablets every day (data obtained from references 19-24, 26-38), and beneath that, the yearly rate (per million of total population) of entrance of patients with renal papillary necrosis (R.P.N.) into the maintenance dialysis/transplantation programme in each State (data abstracted from the twice-yearly reports of the Australian Kidney Foundation Maintenance Dialysis Survey covering the period 1971-6).

205. "The highest prevalence of analgesic abuse in any survey was found in the Aboriginal population of an "outback" country town in New South Wales. On the other hand, the habit of taking analgesic powders appears to be uncommon amongst non-British immigrant communities.

206. "Regular analgesic consumption may start during the teenage years but becomes more widespread during young adult life.

207. "Age-specific rates for regular analgesic consumption have shown a peak prevalence at about 50 years of age in Queensland and New South Wales. However, in communities where there is less habituation to analgesics, the prevalence of daily ingestion has been highest in old age when chronic painful complaints are most common. The Queensland and New South Wales data could be explained either by considerable excess mortality amongst analgesic addicts

during early middle age, or else by adoption of the analgesic habit in the first place by young adults, especially women, during or shortly after the Second World War. The evidence for this latter possibility now seems conclusive, particularly in respect of aspirin-induced gastric ulcer.

208. "In Queensland and New South Wales, those principally affected are housewives, unskilled workers and the poorly educated. In both sexes, usage increases with worsening socioeconomic status but there is no evidence that women who work are more liable to analgesic habituation than those who do not or that marital status is a significant factor."

209. "In the face of this evidence, however, the Proprietary Association of Australia regards the incidence of analgesic abuse as confined to a "very small portion of the community".[14]

210. There is no clear reason why New South Wales and Queensland should predominate. It might be due to more vigorous marketing by the suppliers or, as is suggested by some doctors, it might possibly be due to climate.

**Causes of Abuse**

211. In the submission of the Australasian Society of Nephrology and the Australian Kidney Foundation, Dr J. H. Stewart[15] indicated that—

- the reason most often advanced for regular daily ingestion of analgesics is headache;
- the first Bex or Vincent's powder generally is taken on rising to "clear the head" while further doses are taken to relieve the dull (caffeine withdrawal) headache or "let down" feeling which follows elimination of the drugs;
- habituation has been found more commonly amongst those with a history of domestic disharmony, neurosis or other psychiatric disease, association with tobacco smoking and possibly alcoholism;
- psychopathic traits, however, account for only a minority of cases of analgesic dependence particularly in populations where the habit is common. Other explanations need to be found for the demographic pattern and geographic distribution of abuse, particularly the female preponderance in abuse;
- widespread advertising and ready availability appear to have created a tradition of taking a powder for any minor complaint, a tradition handed down from mother to daughter (but which might not yet have become established in new Australian families whose mother tongue is not English).

212. These findings are strongly endorsed by medical specialists. Dr R. S. Nanra, Head of the Division of Nephrology at Royal Newcastle Hospital and Convener and Chairman of the Analgesics Working Party of the Hunter Region, strongly supports the foregoing[16] particularly in respect of the caffeine withdrawal headache, traditional social acceptance of taking compound analgesic mixtures and "flagrant advertising". Likewise, Dr J. M. Duggan, Director of Medicine at Royal Newcastle Hospital, concludes that caffeine is probably the reason for abuse of analgesics.[17] He adds that he "found nothing to say it (caffeine) has any effect on pain . . . or in giving relief from pain". Dr P. J. O'Neill, Co-ordinator of Educational Services for the Hunter Health Region of the New South Wales Health Commission, unequivocally regards APC powders as drugs of physical and psychological dependence,[18] a view widely held throughout the world.

213. The Hunter District Medical Association attributes drug abuse in Newcastle to misleading advertising over many years in the news media.[19] The Association regards "stress in the area of interpersonal relationships within the family setting (as) undoubtedly the most significant and prevalent" factor in abuse.[20]

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[14] Minutes of Evidence, p. 250, para. 3703.

[15] Minutes of Evidence, pp. 31-32, para. 2280.

[16] Minutes of Evidence, pp. 69 and 71, paras 2183 and 2192.

[17] Minutes of Evidence, p. 76, para. 2275.

[18] Minutes of Evidence, p. 62, para. 2148.

[19] Minutes of Evidence, p. 79, para. 2279.

[20] Minutes of Evidence, p. 79, para. 2279.

214. Traditional loyalty to the ingestion of compound analgesics is endorsed by the comments of Mrs Cronin,[21] a victim of non-medical use of a proprietary preparation and a witness before the Committee. To quote:

> Q. When you went into the factory at the age of 15 did you take the powders because of the noise or did you take them to give yourself a lift, and did that apply to the other girls, or what was the reason?
>
> A. It was the noise too, but it was just a habit. Nearly everyone in the clothing factory takes powders. It is like having a glass of water; when you have a glass of water you take a Vincent's or a Bex. It is just the same as with a person who smokes or has a drink.
>
> Q. You thought the powders would fix your headache because you had read an advertisement somewhere saying that Vincent's or Bex would fix it?
>
> A. Yes. It says on the back of the powder to take only one or two and then to see your doctor. That is what we should have done but did not do. We would take one and it would give you a lift. There is something in the powders that gives people a lift. It sounds funny but it is true. If you have not taken them, you would not know. When the effect wears off you take another one. I got up to 15 a day and was having kidney fits and the doctors did not know what was causing them. Then Dr Nanra found out that I had kidney failure.
>
> Q. Was there a vending machine into which you put a coin and got out the powder?
>
> A. No, they were in a plain box, we just go and buy them. I worked in a factory last year and I told the girls there to take notice of what I went through. Their attitude was that it would not happen to them. Some of them would say, "I take only three a day". That is how I started and then it got up to fifteen a day.

215. The Proprietary Association, however, considers the incidence of analgesic abuse as confined to a "very small portion of the community".

216. The Proprietary Association believes that "there is a great deal of hearsay in the withdrawal headache"[22] and that "there is no factual foundation for the assertion that use of caffeine in mild analgesics tends to encourage overuse". [23] It also claims that advertising of analgesics dropped by 30 percent during the period 1972-76.[24]

217. The view taken by the Health Commission is that[25] "9.4.3 It is presumed that caffeine plays a significant role in dependence leading to analgesic abuse . . ." and Dr R. G. McEwin, its Chairman, did not agree with the Proprietary Association's claim that there was no scientific evidence to suggest that rebound headache occurs with the effects of caffeine.[26]

**Effects of Excessive Use—Abuse**

218. Dr J. H. Stewart, on behalf of the Australasian Society of Nephrology and the Australian Kidney Foundation, lists[27] the consequences of analgesic abuse as:

- renal or kidney disease
- a constellation of disorders arising from toxic effects of aspirin, phenacetin and/or caffeine (which has been named the analgesic syndrome), including—
  - peptic ulcer, anaemia—attributed to aspirin
  - hypertension
  - splenomegaly—attributed to phenacetin
  - defective haemostasis
  - complications of labour—attributed to aspirin
  - carcinoma of the renal pelvis—attributed to phenacetin
  - possibly occlusive arterial disease
  - recurrent headache—attributed to caffeine
  - organic dementia—due to aspirin or phenacetin intoxication

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[21] Minutes of Evidence, p. 74, para. 2232.

[22] Minutes of Evidence, p. 285, para. 4001.

[23] Minutes of Evidence, p. 287, para. 4018.

[24] Minutes of Evidence, p. 292, para. 4080.

[25] Minutes of Evidence, p. 304, 9.4.3.

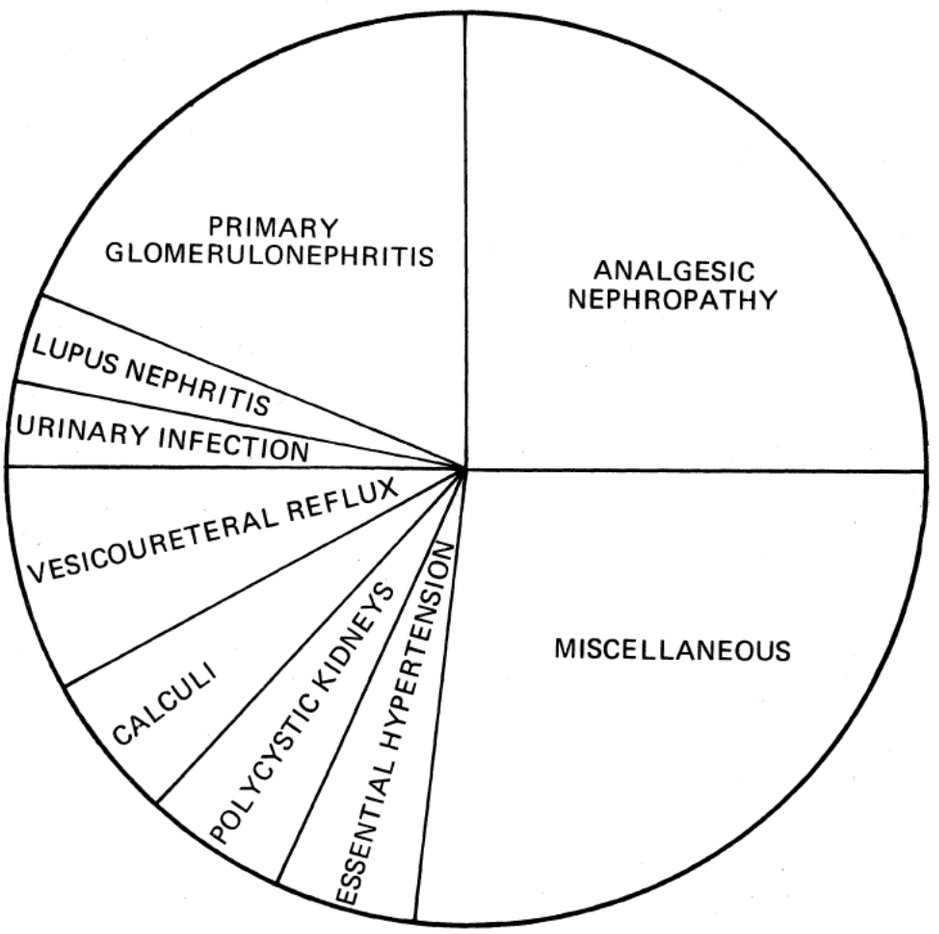
[26] Minutes of Evidence, p. 333, para. 4331.

[27] Minutes of Evidence, p. 32, "8.1 The Analgesic Syndrome".

219. The effects in kidney disease, in particular, peptic ulcers, hypertension, and premature ageing, are strongly supported by the evidence of Dr R. S. Nanra, head of the Division of Nephrology at Royal Newcastle Hospital.[28] Adverse effects may be caused to pregnant women.

220. The distribution of renal diseases found in 637 patients with non-terminal renal failure treated in the Sydney Hospital Renal Unit during the year 1976 was as follows:

FIGURE 2




221. Based on data provided by the Australian Kidney Foundation for 1976, the number of patients per year with end stage renal disease due to analgesics in New South Wales is 8.4 per million population. This compared with 6.4 in Queensland, 4.3 in South Australia, 2.3 in Western Australia, 1.3 in Victoria, and 0.0 in Tasmania. The position has worsened in New South Wales in 1977 since the number of end stage renal failures in the State has risen to 190 a year compared with 162 in 1976. The percentage due to analgesics has risen from 25 percent to 30 percent in the same period. Exact figures for the rest of Australia are not available for 1977 but it is certain that the number of cases has not diminished in other States.

[28] Minutes of Evidence, p. 67, para. 2183.

222. Currently the annual total cost of renal transplantation services in New South Wales would be in the order of $1 million (based on 120 transplant operations per year, and 400 patients at present with functioning grafts) and that of haemodialysis $2.5 million (based on 150 patients each on hospital—and home —dialysis). Of patients entering the dialysis/transplant programme in this State, 30 percent are suffering from analgesic nephropathy.

223. None of the above estimates take any account of the expense of providing health care for non-terminal renal failure, hypertension, urological disease, peptic ulcer and haematological disorders caused by analgesics, nor do they bear witness to the very real economic hardship and personal suffering endured by patients, especially those with papillary necrosis.

224. There is evidence that the existing resources are not enough. The Regional Director of Health in the Illawarra Region told the Committee[29] that there is no renal dialysis unit in Wollongong and that as a result thirty people were travelling from the area to Sydney three times a week for dialysis. The ambulances have to leave Wollongong at 3.30 a.m. to have the patients in Sydney by 9.30 a.m. The patient is picked up at 5.30 p.m. This is not only a tremendous burden to the patient but also a very costly system.

225. This is a regrettable state of affairs. It is cited both to underline the need to reduce the incidence of kidney disease and also to draw attention to the need to improve upon the establishment of dialysis facilities at the main centres of population throughout the State.

226. Whether one is more concerned with the human tragedy of unnecessary suffering and disability or the mounting cost of treating renal failure, much of it due to analgesics, the case for additional action is clear.

**Remedies Proposed or Implied**

227. Dr Stewart stated that "reference has been made by the Health Commission of New South Wales and others to the cost effectiveness of health programmes and the need for redetermination of priorities of impact". When Dr Nanra declared his whole-hearted support of the National Health and Medical Research Council's statement *(see p. 49)* and was asked whether the proposed special packaging of analgesics would increase their cost to the general public he said, "I suspect that it would. I have no expertise in this area but I think the price that one has to pay for them is readily offset by the fact that I have demonstrated that the significant morbidity and mortality related to the use of analgesics is such that it appears to be unrealistic on the part of the community on the one hand to support heavily financial programmes for the treatment of terminal kidney failure when it should be preventing terminal kidney failure."[30]

228. Dr Stewart also stated[31] that "in all publications claiming a substantial reduction in the number of new cases of analgesic nephropathy the change has followed and been attributed to the removal of phenacetin *(without substitution by paracetamol)"* from analgesics sold directly to the public. His submission continues that experimental evidence shows that the removal of phenacetin alone would be ineffective unless, at the same time, the rate of abuse of compound analgesic preparations was reduced.

229. The evidence continues—

> "10.2.3. A less drastic and perhaps no less effective alternative would be to control or prohibit advertising of these compound preparations and to allow their sale from pharmacies without prescription provided that the purchaser was attended personally by the pharmacist who would be charged with the responsibility of referring for medical advice, those customers who appeared to be dependent on analgesics.
>
> "10.2.4. It could not be argued seriously that restricting compound analgesic/stimulant preparations in the ways suggested would inconvenience ordinary people, the sick, doctors or pharmacists. Single drug analgesics and antipyretics would be freely available, as at present, for self-treatment of headaches, musculo-skeletal or menstrual pain, febrile illnesses and the like, and objective study has shown them to be little, if any less potent than the combination preparations. Moreover, being less addictive, single drugs undeniably are more appropriate than caffeine- or codeine-containing analgesics for unsupervised use . . ."

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[29] Minutes of Evidence, p. 103, para. 2457.

[30] Minutes of Evidence, p. 73, para. 2216.

[31] Minutes of Evidence, p. 35, para. 10.1.3.

230. The recommendations of the Australasian Society of Nephrology and the Australian Kidney Foundation are as follows[32]:

(a) Analgesic preparations containing more than one analgesic or including a stimulant or sedative be placed on Schedule 4 of the Poisons List.

(b) A prescription be not necessary for compound non-narcotic analgesics provided that the restrictions laid down in Schedule 3 of the Poisons List are applied and the pharmacist takes professional responsibility for dispensing of these drugs.

(c) All analgesic tablets and powders be packaged individually and sold in containers of less than a lethal dose.

(d) Information on the quantities of all analgesics imported, manufactured or sold in Australia be published annually.

(e) Comprehensive investigation of causes of analgesic dependence be undertaken by persons specializing in a diversity of fields of medicine and the social sciences.

(f) From such investigation an education programme in the proper use of home medication be devised.

(g) Detection of analgesic abuse be promoted through more widespread use of drug surveillance by urinary testing.

(h) Australian-based research into the mechanisms of analgesic-induced nephro-toxicity and carcinogenesis be extended.

231. The Health Commission of New South Wales stated—

"2.3. In the interests of prevention of human suffering, efficiency in disease management and reduction in costs of treatment programmes, the Health Commission would favour the allocation of greater effort towards prevention of analgesic abuse."[33]

232. The National Health and Medical Research Council issued a statement on 26th April, 1977, containing recommendations concerning the control and supply of analgesics.

233. The recommendations were as follows:

That aspirin, paracetamol and salicylamide and their derivatives should be available by open over-the-counter sale only when they are supplied as single substances not combined with any other therapeutically active substance; packed in units containing not more than twenty-five tablets or twelve powders; supplied in strip packs or in containers with suitable child-resistant closures.

That aspirin, paracetamol, salicylamide and their derivatives, when combined with not more than one percent of codeine, packed in units containing not more than twenty-five tablets or twelve powders and supplied in strip packs or child-resistant closures, be scheduled S2.

That a mixture of any two or more of aspirin, caffeine, paracetamol, salicylamide and their derivatives should be scheduled S4.

234. Dr R. G. McEwin, Chairman of the Health Commission, agreed with these recommendations, supported them strongly and believed "that it is very much in keeping with the health of the people of New South Wales that these recommendations should be supported by the Government".[34] He continued:

". . . The work we have done does not suggest it would be of great inconvenience to many people. The renal physicians have given opinions that it is possible to get people off compound analgesics without very much difficulty and without the people concerned having any problems. In fact, Mr Mewes has a paper here suggesting that only about 10 percent of such patients have any difficulties getting off compound analgesics."[35]

235. Mr R. M. Dash, the Commission's Co-ordinator of Scientific Services, drew an analogy with what happened with the bromureides.

". . . When bromureides were restricted to sale on prescription only their use practically died overnight. I would think there is a fair analogy

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[32] Minutes of Evidence, p. 36 of "11 Recommendations of the Australian Society of Nephrology and the Australian Kidney Foundation".

[33] Minutes of Evidence, p. 299, para. 2.3.

[34] Minutes of Evidence, p. 332, para. 4322.

[35] Minutes of Evidence, p. 314, para. 4324.

between what happened with bromureides and what we might expect to happen with compound analgesics."[36]

236. Taking a somewhat different view, Dr L. O. Darcy, Medical Superintendent, Morisset Mental Hospital, submitted:

"7. My proposal is that the use of caffeine in compound analgesics or substitution of it by any other stimulant be immediately prohibited, but that no regulations at all be introduced to ban the use of compound analgesics."[37]

237. The Proprietary Association of Australia in its submission and on the evidence of its representatives[38] strongly oppose the foregoing opinions—

". . . This association submits that misuse or excessive use will not be controlled by merely restricting outlets of distribution . . .

238. "In our view, to restrict the existing channels of distribution would substantially inconvenience the general public, increase the cost of mild analgesics, and in general, impair and impede the community health care system.

239. "In our view the Committee should not be unduly influenced by some clinicians, who look at analgesic misuse from a purely clinical viewpoint. Clinicians do not necessarily consider the wider public health issue outside their specialties, nor understand the broad ramifications of the recommendations they put forward.

240. "To restrict the availability of mild analgesics to pharmacies only, or to limit pack size, would we believe have virtually no effect on consumption habits of the determined user."

250. In essence, the manufacturers believe that the general public interest would best be served by greater education. The need for more vigorous education programmes about the dangers of non-medical use of drugs is a matter which receives fuller consideration later in this Report. Certainly public education about dangers to health of the excessive use of analgesics should continue to be a principal feature of programmes aimed at reducing analgesic abuse. The Committee is conscious of the need for great care in the design of such programmes so as to ensure that the result will serve the purpose rather than the reverse.

**Conclusion**

251. Having taken full account, however, of all the evidence, the Committee believes that education will not be enough.

252. It is reluctant to propose restrictions on producers, suppliers or the consumers who are the community at large. Nonetheless, having weighed the evidence and having regard for the care and economics of community health which must be the concern of government and citizens, the Committee is of the opinion that additional safeguards for the supply and use of compound analgesics must be taken. This conclusion is reached in full recognition that the single analgesics have been shown to be effective in dealing with the sort of pain not requiring professional medical treatment.

253. Whilst restrictions on the availability of minor analgesics are expected to bring about a reduction in the rate of renal failure and other illnesses associated with analgesic abuse, the incidence of abuse is so widespread in most age groups that it will be a long time before this reduction becomes apparent. There is a need for improvements in the services for the treatment of the adverse effects of abuse of minor analgesics, particularly in relation to renal diseases.

**Recommendations**

**254. The Committee recommends that—**

**(1) a mixture of any two or more compounds of aspirin, caffeine, paracetamol, salicylamide, and their derivatives should be restricted to supply by a pharmacist on medical prescription only. (Schedule 4);**

**(2) phenacetin should be restricted to supply by a pharmacist on medical prescription only. (Schedule 4);**

**(3) aspirin, paracetamol, salicylamide and their derivatives, when combined with not more than 1 percent of codeine, packed in units containing not more**

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[36] Minutes of Evidence, p. 340, para. 4405.

[37] Minutes of Evidence, p. 152, para. 2953.

[38] Minutes of Evidence, p. 265, para. 3967.

**than twenty-five tablets or twelve powders and supplied in strip packs or child-resistant closures, be available only from a pharmacist provided the pharmacist believes that the substance is appropriate for the treatment of the person for whom it is being obtained. (Schedule 2);**

**(4) aspirin, paracetamol and salicylamide and their derivatives should be available by open over-the-counter sale only when they are supplied as single substances not combined with any other therapeutically active substance; packed in units containing not more than twenty-five tablets or twelve powders; supplied in strip packs or in containers with suitable child-resistant closures;**

**(5) sale of compound analgesics to the public, except by a pharmacist, be prohibited after the expiration of a period of 6 months from the application of 1, 2, and 3 above;**

**(6) the supply to and sale of single analgesics (i.e., consisting of one analgesic only) by a diversity of retailers continue to be permitted;**

**(7) the packaging of all analgesics in conformity with the recommendations of the National Health and Medical Research Council be enforced;**

**(8) continued investigation of and research programmes in analgesic dependence be supported;**

**(9) widespread use of education programmes, including media shorts and leaflets, in the proper use of analgesics be encouraged;**

**(10) additional renal units be established to afford greater convenience to people living in larger centres of population.**

# CHAPTER 6

## BARBITURATES, TRANQUILLIZERS AND ANTI-DEPRESSANTS

### A group requiring greater attention

255. These drugs can be dangerous and require special attention because, unlike heroin, cocaine and cannabis, which are illegal, these categories of drugs are frequently prescribed by doctors for valid medical purposes. The existence of this legal market vastly complicates control problems and, as a consequence, procurement in the illicit market has tended to be easy and inexpensive.

256. These drugs are being prescribed more frequently and used more often by the general population. The Health Commission of New South Wales reported[1] that for the year ended 1974 New South Wales, with 37.5 percent national population, consumed 40.3 percent of the tranquillizers and 38.8 percent of the sedatives and hypnotics prescribed as N.H.S. drugs.

257. The officials of the Commission further reported[2] the following prevalence of the barbiturates, tranquillizers and antidepressants being used in Sydney.

| | Sedatives (or sleeping tablets) | Tranquillizers (e.g., Valium) | Anti-Depressants | Sedatives Tranquillizers and Anti-Depressants |
|---|---|---|---|---|
| | Percent | Percent | Percent | Percent |
| Male .. .. | 2.3 | 4.4 | 1.2 | 6.7 |
| Female .. .. | 6.3 | 10.1 | 3.2 | 16.1 |

258. These figures showed a slight drop on comparable figures for 1975. This decline may have been due to the 1976 regulation restricting repeat prescriptions of valium by general practitioners.

259. Throughout the Committee's hearings, witnesses, especially those from the treatment community, drew attention to the growing increase in the medical and non-medical use of these drugs and the dangers they were creating, especially when combined with alcohol.

260. Dr Chegwidden, Psychiatrist and Community Physician with the southern area of the North Coast Region of the Health Commission of New South Wales, provided some startling evidence in this regard.[3] To summarize, he stated that of the alcoholic admissions to Broughton Hall, one in four women were dependent on other drugs as well as alcohol and that one in ten men were also on prescribed drugs. A survey of prescriptions for valium over a 4-year period had shown that the prescriptions were in the first year five tablets for every man, woman and child in Australia. The next year it was seven, the next fourteen and then seventeen. Although there has been some decline, this is most likely due to the fact that valium is going out of fashion and has been replaced by serepax as the universal panacea of all ills.

261. Most barbiturate and tranquillizer use is under medical direction and controlled by prescription. There is, however, a certain amount of controversy amongst the medical profession as to the licence with which these drugs are prescribed. Thus in evidence[4] "A previous witness said, 'Thank God for valium'. Witness (a doctor responsible for health education services in the Hunter Region), 'It must have been a manufacturer'.

262. "No, it was a fully qualified medical practitioner. Does that statement surprise you? Witness, 'I regret to say no'."

263. And again in evidence Dr Densen-Gerber said, "I have spoken about children being vulnerable. There is another group that is tremendously vulnerable to drug abuse. It is that of the middle-aged woman. In 1914, when we passed our Harrison Act in the United States, there were 400 000 women on tincture of opium

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[1] *Drinking and Drug Taking Patterns of 23 000 Sydney Adults:* A Comparison between Two Samples—Reynolds et al.

[2] Joint Parliamentary Committee of the Legislative Council and Legislative Assembly Upon Drugs Progress Report, March 1976, Minutes of Evidence, p. 6, para. 7.3.4.

[3] Minutes of Evidence, p. 176, para. 3130; paras. 157 and 158, p. 180, para. 3169.

[4] Minutes of Evidence, p. 61, paras. 2135 and 2136.

because Lydia Pinkham's monthly magazine advised tincture of opium and alcohol. We laugh in the United States—perhaps with tongue in cheek—that the Act was the beginning of the end of American marriage because Mum, up to then, took the bottle of monthly medication, went and relaxed and had daydreams. What is happening in all countries now is that the woman goes to her doctor with problems of middle age. She is discontented. Her children are leaving and she has no place. She does not feel that she is worthwhile and she sits across the desk from a man who is facing exactly the same problem in his own home. He gives her a drug because he is threatened. When you tell me about a doctor who says 'Thank heavens for valium', I say he is having problems with his own wife. It may be that the woman is no longer a Racquel Welch and sexually attractive which is something which our society regards as of such importance. It may be that her children do not want her. She is going to be put out to pasture like a brood mare, she thinks. She does not need valium; she needs encouragement. She needs to be talked to and understood. We are making alcoholics and valiumics out of millions of women."[5]

264. The point is that many doctors use tranquillizers like valium as the least harmful way of treating people under stress and the best means of keeping them from drug dependence of a more damaging kind, especially alcohol. Others believe that their availability through overprescribing only serves to build up intensive drug use with high risk to the individual. There can be little doubt that uncontrolled non-medical use of the barbiturates and tranquillizers has grown during the period of increasing usage.

265. The Committee received much anecdotal evidence that non-medical use of these drugs has become widespread amongst youth. The Committee sees no reason to doubt this but there is a paucity of hard information which would provide a highly reliable indication of the pattern of use and the attendant dangers. Young people who have become totally dependent on drugs will "shoot up" anything and the barbiturates are in strong demand for intravenous use. These drugs are much more readily available in the illicit market than wholly illicit drugs like heroin. Their cost is comparatively low and it has been put to the Committee that a "night out on barbies" can be had for a tenth of the cost of a day on heroin.

266. The danger of the barbiturates and tranquillizers basically stems from the intoxicating effects they can have on the individual. Taken in conjunction with alcohol they can have devastating effects. In 1976, the Sydney City Coroner reported accidental deaths from these drugs as follows:

| | |
|---|---|
| Sedatives and Depressants (above)— | |
| Chloral Hydrate—Elix Nocte | 9 |
| Dormel | 5 |
| Barbiturates | 9 |
| Barbiturates and Diazepam | 1 |
| Methaqualone (Mandrax) | 2 |
| Total | 26 |
| Sedatives and Alcohol— | |
| Barbiturates | 7 |

267. The open findings and suicides for this group of drugs in the same year accounted for a further 55 deaths and 89 deaths respectively. All told, therefore, the barbiturates and tranquillizers accounted for 177 deaths in Sydney alone in 1976. The comparable figures for 1977 are not yet finalized but the indications are of a continuing rise in all cases.

The need for the development of facilities to deal with the casualties of the misuse of this group of drugs is discussed further in paras. 573 to 579.

**Two urgent problems**

268. Two of these drugs call for special comment—methaqualone (Mandrax) and chloral hydrate (Dormel and Elix Nocte).

*Methaqualone (Mandrax)*

Mandrax, which is a mixture of methaqualone and diphenhydramine, has been the subject of intense public concern and interest during recent months on account of growing evidence of its misuse and the number of accidental deaths which have resulted. Two deaths were reported in 1976 and the number rose to eleven in 1977.

270. In view of the adverse effects which are reported for this drug, the Committee believes that serious consideration should be given to its reclassification into Schedule 8 of the Poisons Act, 1966, as amended. In reaching this con-

[5] Minutes of Evidence, p. 22, para. 1932.

clusion it is necessary for the Committee to draw attention to the fact that during its meetings with Commonwealth Health Department officials it was pointed out that methaqualone itself was not dangerous and was only addictive in the Mandrax form. In evidence the Chairman of the Health Commission of New South Wales agreed that there is probably a synergistic effect between methaqualone and the extra chemical diphenhydramine in Mandrax, and that perhaps there is greater abuse potential with Mandrax than with methaqualone separately. He disagreed, however, that methaqualone on its own is not a drug of significant dependence.[6] These uncertainties should be a matter for special attention when the drug is being reviewed.

*Chloral Hydrate*

271. The rate of accidental deaths arising from chloral hydrate have been quite self-evident from publicly available statistics for some years and that there has been no action that the Committee is aware of to have the drug properly reviewed. This is all the more startling since the proprietary brands are freely available over the pharmacy counter. This apparent general slackness in the approach to drugs which are commonly available and the use of which can be extremely dangerous when unsupervised, is a matter which must be given prominent public attention at every opportunity. In this Report the Committee intends to hammer home this message at every appropriate opportunity even at the risk of becoming repetitive. The Committee makes no apologies for doing so.

**Recommendations**

**(11) Methaqualone (Mandrax) should be included in Schedule 8 of the New South Wales Poisons Act, 1966 (as amended).**

**(12) Chloral hydrate should be examined urgently by the Drug and Alcohol Authority of New South Wales, with a view to placing greater restrictions on its general availability to the public, in conjunction with the Poisons Advisory Committee.**

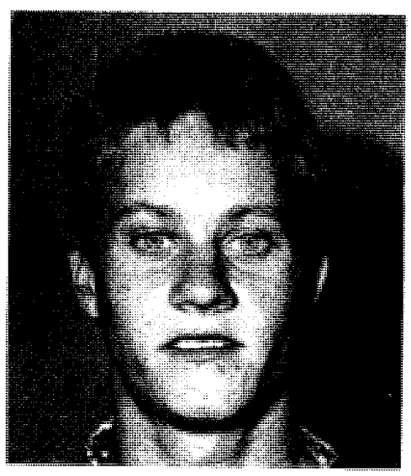
[6] Minutes of Evidence, p. 329, para. 4258.

**These photographs show a heroin addict who died in October 1977, at the age of 27. The photographs show a general decline in his physical health, including the loss of an eye from heroin.**

**BORN: 10.11.1950**

**19.2.1966**

**31.3.1967**



**6.11.1968**

**14.4.1972**

11.8.1975

25.9.1975

4.2.1976

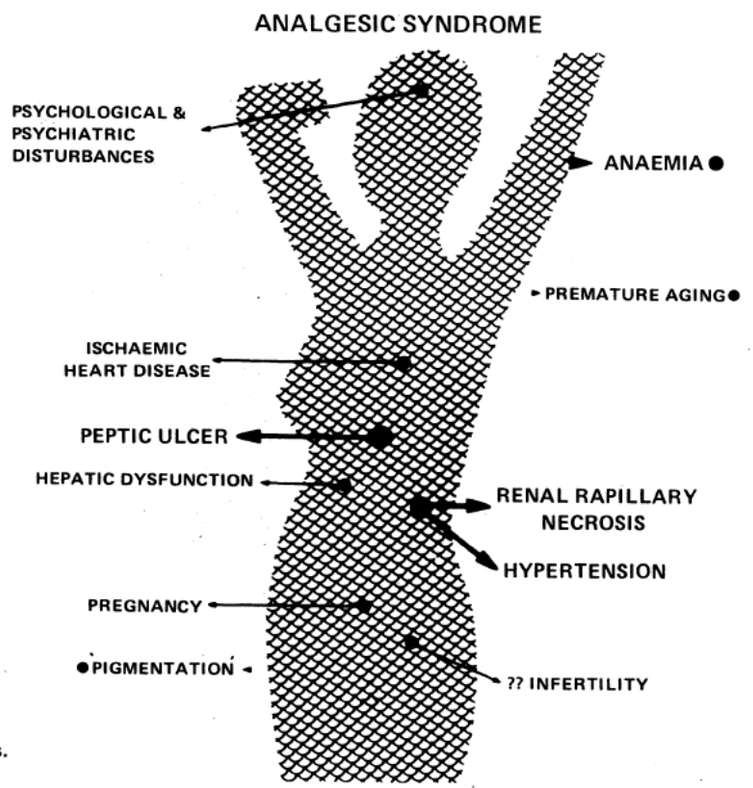
29.6.1976

1921 Advertisement

'20 ASPROS A DAY KEEPS A MAN'S PAIN AWAY'

'Recommended for relief of HEADACHES, NEURALGIA, MALARIA and SCIATICA'

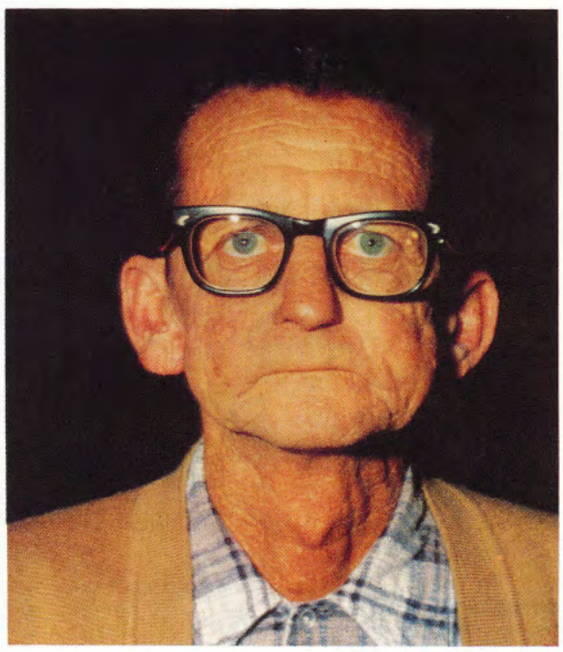
* Australia's Yesterdays, 1974




Outline of the human female body with indications of the various affects of headache powders.

A patient who had taken headache powders for 20 years at the rate of five or ten a day, and developed damage to the kidneys.

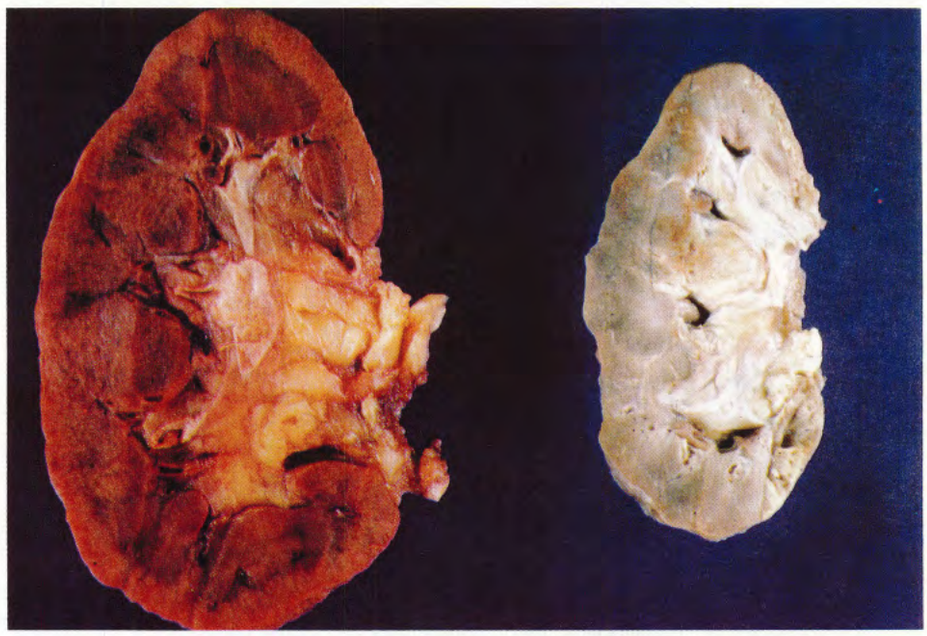
A man who died of a heart attack at the age of 39. His death was due to high blood pressure and kidney disease from excessive use of analgesics.



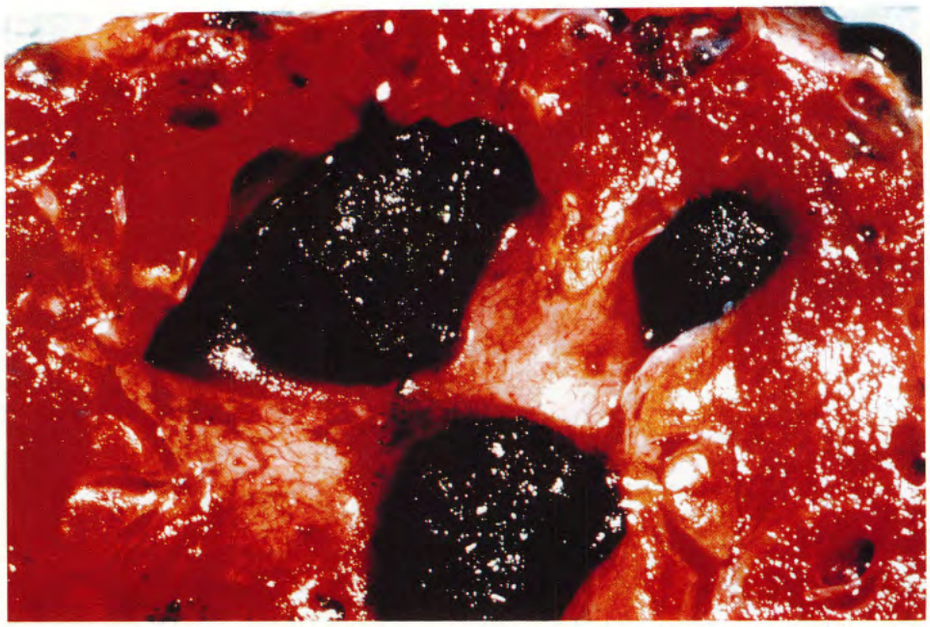
Both these photographs demonstrate premature ageing from kidney abuse.


Found in the hospital locker of a patient who at first denied taking headache powders.


Examples of sales promotion of compound analgesics.

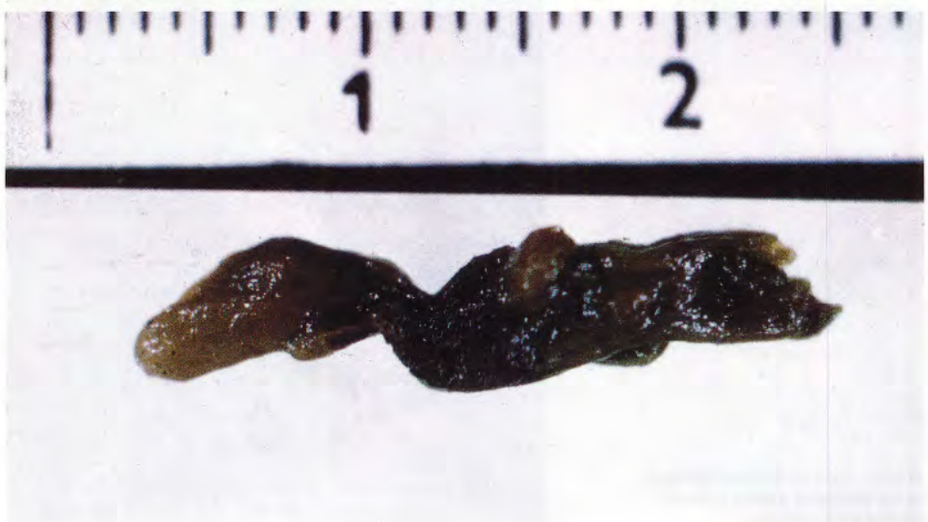


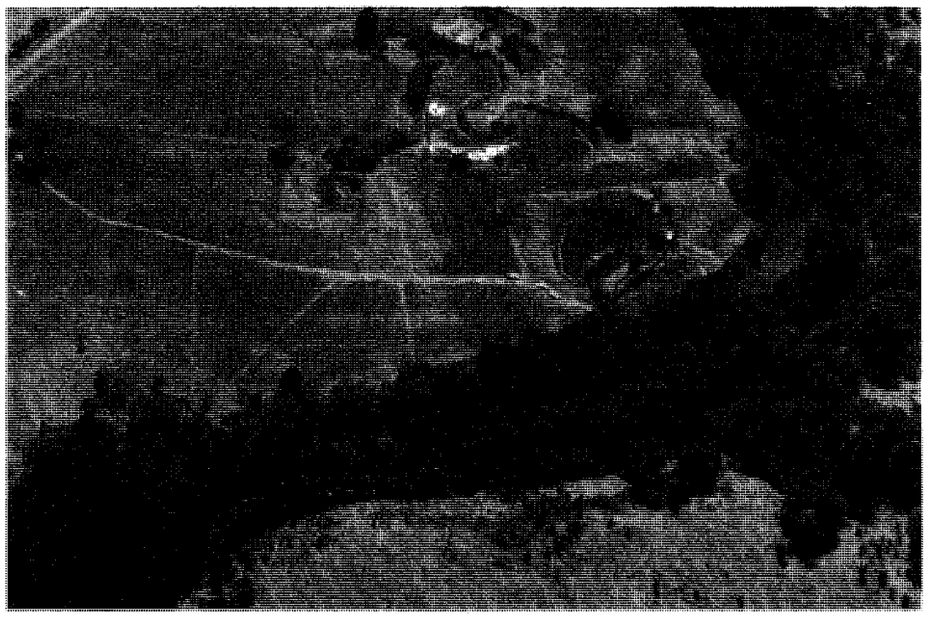
**The kidney on the left of the picture is healthy. The one on the right is taken from a patient who took three to four headache powders a day for 15 or 20 years; the kidney is small, shrunken and diseased, and it can no longer sustain proper health or life in that patient.**



Above: This is a kidney with black, dead areas of the inner part, called the medulla. This is known as papillary necrosis, or death of the inner part of the kidney, as the result of the abuse of the common headache powder. The change is characteristic and any nephrologist who saw it would know that it could have no other cause.

Below: Pieces of kidney which have rotted away and which can be identified in urine.





Above: A cannabis plantation discovered on the banks of a creek at Nabiac. The cannabis which can be seen growing on the bank between the trees and also amongst the corn demonstrates how easy it is to conceal the plantation.

Right: Also at Nabiac, some of these cannabis plants were in excess of 3 metres.

# CHAPTER 7

## AMPHETAMINES, HALLUCINOGENS, COCAINE, SOLVENTS

### Amphetamines

273. Amphetamines, when used non-medically, can be most dangerous drugs, not least, because strong psychotic disturbance can arise from abuse, especially where the drugs are used intravenously. New South Wales and Australia generally suffered a tremendous outbreak in illicit use of amphetamines a few years ago, in common with a similar outbreak throughout the Western world. As a consequence, the New South Wales Government, in common with all Australian authorities, took steps to classify amphetamines in Schedule 8 of the Poisons Act, 1966, and thereby implement a much stricter control on supply of the drug through licit channels for medical use. This virtually amounted to an almost total embargo on legal prescription of amphetamines or related compounds by medical practitioners. Written authority is now required in the two exceptional medical conditions for which this drug group can legally be prescribed—narcolepsy, and hyperkinesis in children.

274. It is the view of the Health Commission of New South Wales that the non-medical demand for the drug has subsequently diminished and that the former problem of amphetamine abuse is now minimal and under reasonable control.

275. The Committee does not dissent from this view in as much that it received no evidence to suggest that there had been any major breakdown in the control of supply at either wholesale or retail levels.

276. Yet there is evidence to suggest that amphetamines still have a strong attraction to young people who become strongly dependent on drugs and that there is a continuing high demand in the illicit market from people who use amphetamines non-medically to keep awake or as pep pills. Thus there is the incentive present for illicit manufacture. Several such laboratories have been detected in New South Wales.

277. The Committee received evidence about the manufacture of amphetamines which suggested that this would not be too difficult a process if sufficiently well-funded. In particular, phenylacetone, the basic ingredient of amphetamine, is fairly easy to import. The Committee believes instinctively that underground manufacture remains an objective for traffickers and that the present controls on the components of amphetamine should be subject to stringent review.

### Recommendation

**(13) The controls on the components of amphetamines should be subject to stringent review.**

### Cocaine

278. Cocaine, although available for many years, is the new "in" drug—stemming especially from the West Coast of North America.

279. The somewhat sparse data indicate that cocaine is used for the most part on an occasional basis; usually in the company of others, and is usually taken in combination with alcohol or marihuana, or some other drug. Cocaine is not physically addictive and current rates of usage do not yet result in serious social consequences such as crime, hospital emergency admissions or death.

280. However, the Committee has been concerned to learn from anecdotal evidence that the drug is establishing itself in Sydney as a "fun thing" amongst what might be described as the "socially trendy" set.

### L.S.D. and other Hallucinogens

281. Limited, non-medical use of L.S.D. has been a feature of the drug problem in New South Wales since the early 1960's. Today virtually all L.S.D. in New South Wales is produced illicitly and, because only very small amounts are needed to produce an effect, it is easily concealed.

282. Two types of hallucinogenic mushrooms are known to be deliberately used in Australia; both varieties grow along the East Coast, northwards from Newcastle. "Gold Tops" have been identified as *Psilocybe Cubensis;* the second variety, "Blue Meanies", is probably a type of *Panacolus.*

283. Both varieties grow out of cow manure and are dependent for growth on good rainfall. Hallucinogenic mushrooms are well-known to be used in New South Wales. The Committee was particularly disturbed to realize that they are freely available to schoolchildren. A doctor representing a community drug council in the Northern Region testified to a prevalence of "magic mushroom" use in schools and youngsters tripping on them in class. He even cited evidence of children taking "magic mushroom" sandwiches to sports day.[1]

284. Hallucinogens are very different from most other drugs. Addiction or even extended use is very unusual. Since a major reason why people use the drugs is to experience unusual mental effects, most users stop taking these drugs after the "trips" lose their novelty.

285. Surveys of hallucinogen use show that most who use them do so less than once a month, and that weekly use is very rare. None of the surveys support conclusively the widespread belief that these drugs are not as popular as they once were, but there appears to have been a definite decline in the number of hallucinogen-related problems.

**Solvents**

286. Very little is known about the pharmacology of solvents. Partial tolerance may develop, and the effects of these substances are intensified when used with other depressants, especially alcohol.

287. Data on solvents use are sparse. Volatile substance abuse occurs almost exclusively among the young, perhaps because solvents are often the most readily available intoxicants to children. Accordingly, maturing out of the inhalant habit is the general rule. Nonetheless, the adverse effects can be disastrous for the child and abuse must be monitored. The United States has suffered epidemics of "glue sniffing" following publicity about the dangers of solvents. Expert care is needed, therefore, in handling the subject in education programmes. It would also be helpful if influential sections of the media avoided coverage of "glue sniffing" incidents.

288. One simple counter measure might be to use unpleasant additives in the manufacturing process.

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[1] Minutes of Evidence, p. 239, paras. 3746-8.

# CHAPTER 8

## CANNABIS

### The Continuing Debate

289. The Memorandum which the Committee presented to Parliament in March, 1977,[1] dealt with cannabis and in particular the question of penalties relating to its use.

290. This Committee has not changed the views it expressed in the Memorandum regarding the nature of the controversy surrounding cannabis and the existing situation with regard to both its status throughout the world and related scientific research.

300. There are, however, some matters which require comment in this Report.

301. The Senate Standing Committee on Social Welfare has reported in some depth on cannabis in its recent report.[2] The Senate Committee commented[3]: "Of all the drugs our society chooses to use, cannabis has excited the widest range and quality of comment, research and protestation, and has given rise to a research literature varying enormously in quality and interpretation. Both denigrators and advocates of cannabis use have harangued, and continue to harangue, the public, lawmakers and law enforcers. The result is a most difficult tangle of half-truths, fact and fiction. Unfortunately for our society, this tangle has been partly brought about by some of the people in professions, on whom we have traditionally relied as providers of impartial and factual information, becoming emotive advocates for particular attitudes on the use and the dangers of cannabis.

302. The debate on cannabis needs to become relevant to everyone, including cannabis users. If the rhetoric continues to be partisan, biased and irrelevant, the credibility of those concerned about the use of drugs such as heroin will suffer. The lack of rational debate on the cannabis problem inhibits the development of rational methods of control of cannabis use, and also rational discussion and action in relation to the more serious problem of opiate use."

303. Conscious of these conflicts and the intense public interest in cannabis, the State Parliamentary Committee recognizes the need for cannabis to continue as the subject for rational debate.

304. The Committee decided to hold public hearings in the Northern Region of the State. A particular reason for this was that it had been represented to the Committee by local inhabitants in many walks of life that the region reflected a number of the issues arising from the drugs phenomenon. On the one hand it was cited as an area where rural, semi-urban and beach settings combined in such a way as to provide an ideal environment for those who wished to adopt a casual and drug-orientated life-style, particularly the many young people who had established new communities in and around Nimbin. It was also said to be a transit haven for migratory drug-users moving with the seasons from Sydney to Brisbane and further north. On the other hand, it was claimed in direct submissions to the Committee by representatives of the new communities that they had established an entirely balanced and meaningful life-style which brought renewed prosperity to the area as well as a resurgence of interest in lost local crafts but that their existence was subject to unwarranted harassment by the local authorities. Taking both sides of the argument, it is clear that the area is of special interest and importance in examining the drugs issue, particularly with regard to conflict between the old and the new.

305. During its visit to the area in July, 1977, the Committee held public hearings in Lismore, Mullumbimby, Casino and Tweed Heads. In addition to formal hearings the Committee held numerous informal discussions with representatives of all sections of the local communities. In particular, the Committee visited the new communities in the Nimbin area at Tuntable Falls, Main Arm, and Upper Arm, where it might be said the "alternative life-style" is well-established and has received wide publicity. The Committee would like to record publicly its great appreciation of the tremendous effort made by those responsible for organizing the visit to the region to make the visit a balanced and informative one.

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[1] Reproduced at annexure I.

[2] Drug Problems in Australia—an intoxicated society? Report from the Senate Standing Committee on Social Welfare, 1977. Chapter 5.

[3] *ibid*, p. 127.

**(Note: Marihuana and Health, the Sixth Annual Report to Congress by the U.S. Secretary of State for Health, Education and Welfare has been reproduced at Annexure "H" for general information.)**

306. A number of important matters arose—for example, the way in which the local pharmacists have organized themselves to provide effective surveillance of excessive non-medical use of drugs, which is a model which the Committee hopes to see adopted throughout the State;[4] the way that local communities can generate self-help groups to get young people "off the streets" and into something more workable as explained by witnesses from Woodburn;[5] the need for a much greater effort in informing the community about all drugs in isolated areas which are removed from the main centres of communication and whose existence is frequently taken for granted by the central branches of State Government.

307. Cannabis was, however, an issue of special significance. Equally strong representations were made for and against the liberalization of its use.

308. "The substances that I personally prefer are pure L.S.D. once every year or two for the purpose of spiritual inspiration, and the herb cannabis sativa or marihuana, which I have used regularly for about 10 years.

309. "The effects and uses of this herb are many. It can be used as a relaxant, helping one to be calm and more tolerant; it can help one to sleep or to stay awake; it inspires creative thinking and doing; it excels in easing the discomforts of influenza; and the plants, grown as a companion crop with brassicas, will repel the cabbage butterfly."

310. Thus spoke Martha Paitson, giving evidence in Lismore on 5th July, 1977.[6] There are many and varied views on cannabis but Ms Paitson has provided the Committee with the rarest. She exemplified by both her personality and her outlook on life the problems which arise in the conflicts between those who adhere strongly to society as we have traditionally known it and those who believe that there is a better life to be had in a return to collectivism on the land. This is the issue of the new life-style and those who support it believe genuinely that mild cannabis use is the least harmful of the socially therapeutic drugs available to man.

311. Many other witnesses in the Northern Region advanced arguments for greater liberalization of the law in regard to cannabis use, including people in the professions and the Public Service. The Committee also received evidence from a spokesman for the Cannabis Research Foundation advocating legalization of cannabis which would be controlled through a Cannabis Control Board.[7]

312. It is abundantly evident that there are a great number of sane, balanced and rational people, many exercising unquestionable adult responsibility, who are using cannabis, certainly in the milder marihuana form, without any obvious impairment to either themselves or to society. These people are to be found in all walks of life. Particularly notable have been the findings of Mr R. A. Brown, a senior lecturer in law at the University of New South Wales, who, in September and October, 1976, conducted a survey of drug-use among law students at three university law schools in New South Wales. This survey produced a number of important revelations about drug use amongst these students, not least that sixty were current users of opiates. In relation to cannabis, however, the survey shows that 511 respondents, just under half (49.3 percent) of the total sample claimed to have used or to be currently using marihuana. As Mr Brown points out, it is salutary to ponder that the group sampled,[8] in its socioeconomic make up, may be clearly unrepresentative of the State's total population, as lawyers their potential effect on law and social policy is disproportionately large relative to their numerical representation in the population. In particular, there are many lawyers employed in the Public Service.

There are no comparable surveys available amongst other students as a group, although it can be assumed with confidence that marihuana use would not be confined to law students and indeed the Committee received evidence to suggest widespread use among school teachers and students in the teacher-training establishments.

313. It is perhaps not surprising, therefore, to learn that in a recent survey of children in Fourth Year high school, 28 percent of the boys and girls sampled admitted to being current marihuana users, compared with 10 percent in 1971.

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[4] Minutes of Evidence, p. 197, para. 3295.

[5] Minutes of Evidence, p. 227, para. 3633.

[6] Minutes of Evidence, p. 198, para. 3317.

[7] Minutes of Evidence, p. 258, para. 3884.

[8] "A Preliminary Survey of Drug Use Among Law Students in N.S.W. *Journal of Drug Issues*, Fall 1977.

314. The Committee adheres strongly to the view it expressed in the Memorandum to Parliament in March, 1977, that scientific evidence is not yet sufficient to warrant the removal of the existing restriction on the use of any of the cannabis derivatives, particularly the stronger forms like hash oil. It would, however, be folly to ignore entirely the growing social stress which must be arising from the fact that a great many young adults, by indulging in a drug which they see as less damaging than alcohol, run the risk not only of involvement with the criminal law, but also have the prospect of ruined careers.

315. Indeed, it must be a matter for serious concern that so many of our potential lawyers, teachers and public servants are at risk in achieving employment if the existing law is followed through to the letter. We are presently in the process of spending vast sums on their education and training which will be wasted if they are dismissed for a first offence.

316. The Committee intends to give further consideration to this matter in its future deliberations.

**Forfeitures**

317. The Memorandum which the Committee submitted to Parliament in March, 1977, contained the following:

318. "In those cases where convictions for drug offences incur either fines and/or order for forfeitures of money and goods (not otherwise ordered to be destroyed), such money and proceeds of the sale of such goods should be transferred to a Special Deposit Fund to be used to support programmes for rehabilitation, education and research in the field of drug addiction.

319. "In setting up such a fund, it would be desirable to introduce a central register to record the details of the forfeitures."

320. The Committee notes that this recommendation was not considered when the Poisons (Further Amendment) Act, 1977, dealing with provision for more severe sentences for drug trafficking and the cultivation of prohibited plants, was introduced.

321. **Recommendation**

**(14) The Committee hopes that further consideration will be given to the previous recommendation in relation to forfeitures and that action will be taken for appropriate legislation.**

# SECTION 3

# WEIGHING THE OBJECTIVES—THE NEED FOR ACTION

## Part 1 Reducing Supply

## CHAPTER 9

### GENERAL

**Existing Machinery**

322. In recent years, the Federal Government of the United States of America has been faced with a fierce and, at times, seemingly overwhelming problem of drugs. Thus, the then Vice-President Rockefeller reported in 1975: "Drug abuse is one of the most serious and most tragic problems this country faces. Its cost to the nation is staggering: counting narcotics-related crime, health care, drug programme costs and addicts lost productivity, estimates range upwards of U.S.$17 billion a year. In addition to these measurable costs, the nation bears an incalculable burden in terms of ruined lives, broken homes and divided communities."

323. In this century, the United States can be said to have largely dominated world events and has frequently shown trends which are subsequently reflected all round the world. Above all, this is certainly now the case in the extent to which drug-use patterns are beginning to have a pronounced effect on the stability of society in Australia.

324. The United States Government has responded with a reinvigorated national effort in developing a strategy for containing the drug menace through the twin objectives of reducing both supply and demand.

325. This policy has already struck a strong chord in Australia with the Senate Standing Committee on Social Welfare, who recommend[1] "That all Governments in Australia adopt the seven declarations as the basis of the strategy for their approach to drug abuse.

> 1. Total elimination of drug-abuse is unlikely, but government action can contain the problems and limit their adverse effects. Control of drug abuse requires a long-term commitment within a publicly declared programme with clearly identified goals, and with time frame, monitoring procedures, financing arrangements and standards all specifically stated.
>
> 2. All drugs are not equally destructive. Control efforts should therefore concentrate on drugs having the most adverse public health effects, particularly where use puts others at risk. Programmes should give priority to individuals abusing high-risk drugs and to compulsive users of any drugs.
>
> 3. Efforts to reduce the supply of and the demand for drugs are complementary and interdependent, and Commonwealth programmes should be based on a balance between them.
>
> 4. Existing programmes aimed at reduction of supply and demand must be broadened. In the reduction of supply, a higher priority should be given to increasing international co-operation in preventing the illicit production of drugs. In the reduction of demand, increased attention should be given to prevention, constructive early intervention and better access to rehabilitation services.
>
> 5. Drug abuse is primarily a social/medical, not a legal, problem, though such abuse may have important legal consequences and aspects.
>
> 6. Management must be improved to ensure the maximum effect from resources committed to drug programmes. Better interagency co-ordination is required. More attention must be paid to the setting of priorities, with Commonwealth law enforcement efforts focused on high-level traffickers and Commonwealth resources focused on habitual users of high-risk drugs.

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[1] Report from the Senate Standing Committee on Social Welfare, 1977, pp. 20-23.

7. The Federal Government has particular responsibility for giving national leadership in coping with drug-abuse. The States have an equally important role, especially in the direct provision of services. No national control programme will be effective unless all governments co-ordinate their activities. The Commonwealth Minister for Health should have primary responsibility for Commonwealth action related to all forms of drug use and abuse."

The Parliamentary Committee generally endorses these seven declarations as providing the principles on which public policy in New South Wales should be broadly based.

326. The concept of a national programme with the full co-operation of all State Governments is not exactly new. As long ago as 1969 a meeting of Ministers of the Commonwealth and State Governments on drug-abuse directed that a National Standing Control Committee be formed, consisting of representatives of the Commonwealth Departments of Customs and Excise, Attorney-General, Health and Interior and of the departments in each State which were concerned with the problems of drug-abuse, under the chairmanship of the Comptroller-General of Customs. This National Standing Control Committee was directed to consider immediately the further steps that could be taken by the Commonwealth and States together to combat all aspects of the present drug problem in Australia including addiction, trafficking, and education; and to make recommendations to Ministers on legislation and administrative action which would be taken.

327. Very shortly after it was brought into being by the Meeting of Ministers in February, 1969, the National Standing Control Committee (N.S.C.C.) held its first two meetings and has continued to meet regularly since then. Its two main sub-committees are the Law Enforcement Working Party and The Drug-Education Sub-Committee.

328. The prime task of N.S.C.C., as laid down by the Meeting of Ministers, was the co-ordination of all Commonwealth and State efforts into a national effort to counter the drug problem. There had previously been Commonwealth/State Committee meetings in 1966 and 1967 at the instigation of the Prime Minister, with a view to ensuring that all Commonwealth, State and Territory legislation conformed with the requirements of the Single Convention on Narcotic Drugs, 1961. The N.S.C.C., however, was to become the first means by which continuous dialogue on the drug problem was established between the Commonwealth and the States, and between the specialist bodies dealing with various aspects of the problem. In this, N.S.C.C. has been and continues to be successful in a sensitive area involving both Commonwealth and State relationships and differing but strongly held community views.

329. From the outset, responsibility for Australia's obligations under the International Drug Conventions has been with the Customs Department. During recent reorganization of the Australian Public Service, that department has now become the Bureau of Customs within a large, new composite Department of Business and Consumer Affairs. Among its responsibilities in this field, the Department provides Australia's current membership of the United Nations Narcotics Commission; it also provides the N.S.C.C. with its secretarial support.

330. At its initial meeting in 1969, N.S.C.C. felt that certain of the duties of the then Department of Customs and Excise in relation to the control of the licit distribution of drugs might be more appropriately handled by health authorities. The Australian Department of Health has accordingly taken over control of all licit imports and exports of narcotics and dangerous drugs to and from Australia; it has also taken over control of the manufacture in Australia of narcotic drugs.

331. The Australian Department of Health is also responsible for assisting the State Governments in their control of the domestic licit trade in drugs of dependence within their respective States. Main assistance in this field is provided by means of a computer system operated by this Department which is used to monitor the movement of narcotic drugs, methaqualone and certain stimulants into, out of and within Australia. This monitoring system has, incidentally, attracted the interest of several overseas governments.

332. Legislation for and control of the domestic licit trade in narcotics and dangerous drugs rests with each State Government. The State Governments are also responsible for their own drug-education programmes, and they receive financial support in this field from the Australian Government by way of recommendations from the N.S.C.C.'s Drug-Education Subcommittee. In addition to recommending financial support for State drug-education programmes, the N.S.C.C.'s Drug-Education Subcommittee also acts as a co-ordinating body in this field. The Australian Department of Health provides the secretarial support for the N.S.C.C.'s Drug-Education Subcommittee.

333. Each State Government is also responsible for its own treatment and rehabilitation programmes in respect to drug-dependent persons. Such pro-

grammes do, however, attract Australian Government finance. This is provided through the Community Health Programmes of the Australian Department of Health which also provides an information service in respect to technical information on drug-related matters.

334. In the field of illicit-drug control, each State Government legislates against the illicit-drug trade within its State boundaries. In effect, this means that the Drug Squad of each State Police Force concentrates its efforts upon combatting the illicit use, possession and selling of prescribed drugs within that State.

335. Because their investigations often overlap State boundaries and because the illicit-drug problem in Australia is essentially a national one in both character and scale, close co-operation between the State Police Drug Squads and the Australian Narcotics Bureau is vital. The N.S.C.C. was aware from the first of this need for close co-operation between drug-law enforcement agencies; thus the chief of each State Police Drug Squad is a member of the N.S.C.C.'s law enforcement subcommittee which is known as the Law Enforcement Working Party.

336. The Australian Narcotics Bureau was formed as a branch of the former Department of Customs and Excise; at its inception in 1968 it was known as the Customs Narcotics Bureau. The Australian Narcotics Bureau provides the Australian Government with a single agency specializing in the investigation of illicit drug matters at the national level.

337. The headquarters of the Australian Narcotics Bureau is located in Canberra, as are its International Enforcement and Liaison subsection and its main Intelligence Unit. The Bureau maintains regional headquarters for its Northern, Eastern, Southern and Western Regions in Brisbane, Sydney, Melbourne and Perth respectively. The Bureau also maintains offices in other State and Territory capitals in Australia; it has one overseas post at present, in Kuala Lumpur.

338. The Committee does not wish to denigrate the work of the agencies which have been operating within the framework of the National Standing Committee. This is especially true of the work of the Australian Narcotics Bureau which has a record of proven success against illicit importation of drugs, notwithstanding evidence at times of a marked lack of public interest and sympathy in their endeavours. The Committee cannot conceal, however, a sense of disappointment that although at national level and within the State, whilst a machinery has existed for co-ordination of public effort in the control of non-medical use of drugs, this growth in machinery has not been matched by achievement.

339. It seems to the Committee that a fundamental cause of this lack of achievement has been a failure by administrations to set clear goals and objectives, notwithstanding the very clear lead given in this direction by the Senate Select Committee on Drugs in 1971. The residual powers in the States may perhaps be an inhibiting factor in this regard. The Committee feels obliged to observe, however, that there appears to have been a marked absence of drive and energy in public sectors which might have resulted in the generation of new programmes. This is especially true in the area of rehabilitation, where, for example, the State of Victoria has given a lead which might have been more vigorously followed in New South Wales.

340. The Committee must assume that this is not due to any sense of false pride in this State. There is sometimes a feeling to be detected in New South Wales that, because we have the biggest population, we must be best. There is little doubt that at the present rate of progress our drug habit taking patterns will show us up to be the worst (and in some cases, like the abuse of minor analgesics, worst compared with everyone else in the world). This might sound very unpalatable to those with closed minds but unfortunately it is true.

**The need to set priorities**

341. In the view of the Committee, public policy should be most concerned with those drugs which have the highest costs to both society and the user, and with those individuals who have chronic, highly intensive patterns of drug abuse.

342. In determining the social cost of a particular drug, it is necessary to take into account such things as the likelihood that a user will become a compulsive user, either physically or psychologically dependent on the drug; the ability of the drug to produce tolerance, requiring successively higher intake to achieve the same result; and the severity of adverse consequences of use, both to the individual and to society, in terms of criminal behaviour, health consequences; and the number of compulsive users who are currently suffering, or causing others to suffer, adverse consequences.

343. The direct consequences to the individual relate to illness or death, acute behavioural effects such as paranoia from amphetamines and L.S.D.; and

chronic behavioural impairment including apathy, depression asociated with long-term narcotic use, loss of productivity, and so on.

344. Amongst the indirect consequences to the individual—injury or death associated with impaired judgement, particularly in relation to driving, frequently occur, as do injury or death associated with conditions of use. Transmission of viral hepatitis from shared needles is a medical problem for users. Young people in the drug culture are particularly susceptible to pneumonia. Infections associated with use of unsterile needles may be fatal.

345. The adverse consequences to the individual from the use of drugs is society's loss, too. But there are also the more directly measurable costs to society, such as health care costs, property loss directly attributable to drug-related theft, and lost productivity. These costs are broadly reflected through the drug-users' appearances in the various institutions which deal with people in personal difficulty, principally the health care delivery, welfare and criminal justice systems. Drug-users often appear and may be identified as users. Thus the frequency of appearance provides one rough indicator of the magnitude of the social cost of drug abuse.

346. In New South Wales there is barely an elementary capability to monitor such appearances. Fragmentation has been such that the Health Commission of New South Wales reported to the former Parliamentary Committee Upon Drugs[2] in reference to opiate narcotics, "statistics referred to earlier suggest that the abuse of these drugs is presently being contained at comparatively low-levels; existing institutional and community treatment services are considered to be adequate and appropriate to meet established needs and the major emphasis at the present time is properly placed on prevention".

347. It is difficult to see the justification for that conclusion when an elementary reference to police detection rates in the court statistics in relation to narcotics should have sounded alarm bells loudly with all those with public responsibility for drug matters.

348. The Committee has not been able to draw upon, therefore, a systematic data collection to allow for a exposition of the drug priorities. It is possible, however, to rank the various drugs according to a broad balance between individual harm and social cost as set out in the following table:

TABLE 9

**DRUG PRIORITIES**

| | Dependence | Severity of Consequences | | Estimated number of intensive users |
|---|---|---|---|---|
| | | Personal | Social | |
| Heroin | High | High | High | 7000 |
| Minor Analgesics | High | High | Medium | 300,000 |
| Barbiturates | High | High | High | Medium |
| Tranquillizers | Medium | High | Medium | 300,000 |
| Amphetamines | | | | |
| Needle | High | High | High | Low |
| Oral | Low | Medium | Medium | Low |
| Cocaine | Low | Medium | Low | Low |
| Marihuana | Low | Low | Low | Low |
| Hallucinogens | Medium | Medium | Medium | Low |
| Inhalents | Medium | High | Medium | Low |

Note: The minor analgesics rate higher than barbiturates in Government programmes because steps can be taken immediately to restrict their supply.

349. Though these rankings are imprecise, a clear pattern emerges. Heroin, mixed barbiturates and minor analgesics rank high in three out of four categories. All the other drugs are less serious.

[2] Progress Report of the Joint Committee of the Legislative Council and Legislative Assembly Upon Drugs, p. 6, para. 7.4.

350. On the basis of this analysis, the Committee recommends that priority in efforts, both to reduce supply and demand, be directed toward those drugs which inherently pose a greater risk to the individual and society.

351. The Committee rates heroin first because of the rate at which dependence is accelerating, the severe consequences for both the individual and society, and the very special nature of the threat which heroin poses to the younger generation. Second, the minor analgesics, both on account of their widespread misuse and high personal cost to health. The availability of safer means of self-medication would permit early curtailment of their supply without jeopardizing genuine medical need and thereby eventually reduce associated demand on health funds.

352. Third, the barbiturates and tranquillizers, particularly their mixed use, because they are widely used and they kill at home, at work, and on the roads. In this regard they warrant attention and a major initiative is required to establish their real need and regulate their use and supply.

**Early Warning**

353. The Committee does not suggest that all efforts go into these high priority drugs—an early warning system is needed to monitor all drug use, both to keep them from exploding into major problems and also because there are individuals suffering severe medical problems from a low priority drug, such as a solvent.

354. In this regard the Committee has paid particular attention to the United States Drug Alertness Warning System.

355. Since 1972, the National Institute on Drug Abuse (NIDA) of the U.S. Public Health Service, and the Drug Enforcement Administration (DEA) have jointly sponsored a programme to provide data on drug abuse patterns in the United States. The programme is called the Drug Alertness Warning Network (DAWN).

356. Project DAWN is a nationwide programme utilized by NIDA and DEA for the purpose of gathering, interpreting and disseminating data on drug abuse from selected sites within the continental U.S.A. The DEA directs the information to its enforcement, compliance and scheduling programmes, whilst NIDA applies the information towards forecasting, education, prevention, treatment and rehabilitation programmes.

357. The original concept of the project was to provide information for:

(a) identification of drugs currently abused and/or associated with harm to the individual and society;

(b) determination of the existing patterns of drug-abuse in twenty-nine metropolitan areas, and nationwide monitoring of abuse trends, including detection of new abuse entities and new combinations;

(c) provision of current data for the assessment of the relative hazards to health, both physiological and psychological, and relative abuse potential for substances in human experience; and

(d) provision of data needed for rational control and scheduling of drugs of abuse, both old and new.

358. A private firm is employed to gather drug-abuse and drug death statistics from emergency rooms, inpatient units of general hospitals, country medical examiners/coroners and crisis intervention centres, in a defined sample of standard statistical areas.

359. It is reported that the DAWN system is proving to be a useful early indicator of medical and non-medical drug-taking patterns in the United States and in view of the paucity and fragmented nature of drug data in New South Wales and Australia, the Committee believes such a concept would have benefits in Australia. Ideally, the programme should be nationally based.

360. **Recommendation**

**(15) Commonwealth authorities should be requested to set up a feasibility study on the introduction of a programme similar to "Project DAWN" which is currently in use in the United States and that New South Wales authorities should give such a programme every support.**

# CHAPTER 10

## THE SUPPLY CHAIN

361. The Committee recognizes that total elimination of illicit drug supply would be an unrealistic goal. Man is endlessly inventive and there would be many seeking to undermine such an objective. Policies should be devised and vigorously implemented so as to achieve the greatest disruption of distribution systems of illicit supplies of drugs—to and for greater rationalization of supplies of drugs for genuine medical use—through enforcement, intelligence, international programmes, regulations (to restrict and prohibit use and supply), science and technology detection and education.

### Major trafficking

362. Very few can have failed to become aware of the dramatic developments in New South Wales and throughout Australia arising from the detections of huge quantities of illicit drugs in the past year or so. The seizures of heroin by the Narcotics Bureau are set out in table 3. The seizures of the cannabis derivatives are as follows:

TABLE 10

| | Cannabis (leaf and resin) | Cannabis (Oil) |
|---|---|---|
| | Kilograms | Kilograms |
| 1974 .. .. .. .. .. | 343 | 5 |
| 1975 .. .. .. .. .. | 886 | 33 |
| 1976 .. .. .. .. .. | 1230 | 45 |
| 1977 .. .. .. .. .. | 704 | 37 |

363. The figures are literally mind boggling when it is remembered that they are thought to represent only a small percentage of the total illicit supply.

364. The Committee received much evidence in camera about drug trafficking and the related problems. It must be clearly understood within the community that the level of drug trafficking in Australia, and especially New South Wales, where Sydney is acknowledged to be one of the leading "Drug Capitals" in the world, is reaching highly dangerous levels. There can be no doubt that very evil geniuses are involved. They must be detected and immobilized. They constitute an insidious threat to Australian society which has been unsurpassed in the country's history. This is a difficult message to convey because those who have not yet suffered disastrous consequences at first hand find it difficult to comprehend the nature of the threat. The Committee believes deeply from discussions with the family and friends of the man whose photograph appears in the insert, that he would have perhaps survived to live a useful life if heroin had not been available. There is no knowing for certain. But it is wrong, quite wrong, for people, and they are numerous, to shrug heroin off as the process of natural selection. If the process of natural selection means that young people should be physically maimed and emotionally wrecked, then it must be repelled by every means available to society. It would be an abrogation of every decent human principle to let this horror run its course. Some sections of society are outraged by the injection of myxomatosis in rabbits. The ravage of narcotics is just as terrible for many human beings.

365. Immobilizing the major trafficker in dangerous drugs requires the utmost priority. Accordingly, the Committee welcomes the Royal Commission in New South Wales into Drug Trafficking. The Committee is conscious of the need to avoid comment which might disturb the investigations of the Royal Commission. The Royal Commissioner and his colleagues are undertaking an important, delicate and difficult task. They deserve the fullest public support. By a resolution of the Parliament all evidence taken by the Committee, including submissions, has been made available to the Royal Commission.

366. There are, however, some general matters of principle in relation to the operation of the law dealing with drug trafficking on which the Committee believes it appropriate to comment.

### Penalties and Sentencing

367. The first relates to penalties and sentencing patterns. In the Memorandum presented to Parliament on 30th March, 1977, the Committee pointed

350. On the basis of this analysis, the Committee recommends that priority in efforts, both to reduce supply and demand, be directed toward those drugs which inherently pose a greater risk to the individual and society.

351. The Committee rates heroin first because of the rate at which dependence is accelerating, the severe consequences for both the individual and society, and the very special nature of the threat which heroin poses to the younger generation. Second, the minor analgesics, both on account of their widespread misuse and high personal cost to health. The availability of safer means of self-medication would permit early curtailment of their supply without jeopardizing genuine medical need and thereby eventually reduce associated demand on health funds.

352. Third, the barbiturates and tranquillizers, particularly their mixed use, because they are widely used and they kill at home, at work, and on the roads. In this regard they warrant attention and a major initiative is required to establish their real need and regulate their use and supply.

**Early Warning**

353. The Committee does not suggest that all efforts go into these high priority drugs—an early warning system is needed to monitor all drug use, both to keep them from exploding into major problems and also because there are individuals suffering severe medical problems from a low priority drug, such as a solvent.

354. In this regard the Committee has paid particular attention to the United States Drug Alertness Warning System.

355. Since 1972, the National Institute on Drug Abuse (NIDA) of the U.S. Public Health Service, and the Drug Enforcement Administration (DEA) have jointly sponsored a programme to provide data on drug abuse patterns in the United States. The programme is called the Drug Alertness Warning Network (DAWN).

356. Project DAWN is a nationwide programme utilized by NIDA and DEA for the purpose of gathering, interpreting and disseminating data on drug abuse from selected sites within the continental U.S.A. The DEA directs the information to its enforcement, compliance and scheduling programmes, whilst NIDA applies the information towards forecasting, education, prevention, treatment and rehabilitation programmes.

357. The original concept of the project was to provide information for:

(a) identification of drugs currently abused and/or associated with harm to the individual and society;

(b) determination of the existing patterns of drug-abuse in twenty-nine metropolitan areas, and nationwide monitoring of abuse trends, including detection of new abuse entities and new combinations;

(c) provision of current data for the assessment of the relative hazards to health, both physiological and psychological, and relative abuse potential for substances in human experience; and

(d) provision of data needed for rational control and scheduling of drugs of abuse, both old and new.

358. A private firm is employed to gather drug-abuse and drug death statistics from emergency rooms, inpatient units of general hospitals, country medical examiners/coroners and crisis intervention centres, in a defined sample of standard statistical areas.

359. It is reported that the DAWN system is proving to be a useful early indicator of medical and non-medical drug-taking patterns in the United States and in view of the paucity and fragmented nature of drug data in New South Wales and Australia, the Committee believes such a concept would have benefits in Australia. Ideally, the programme should be nationally based.

360. **Recommendation**

**(15) Commonwealth authorities should be requested to set up a feasibility study on the introduction of a programme similar to "Project DAWN" which is currently in use in the United States and that New South Wales authorities should give such a programme every support.**

# CHAPTER 10

## THE SUPPLY CHAIN

361. The Committee recognizes that total elimination of illicit drug supply would be an unrealistic goal. Man is endlessly inventive and there would be many seeking to undermine such an objective. Policies should be devised and vigorously implemented so as to achieve the greatest disruption of distribution systems of illicit supplies of drugs—to and for greater rationalization of supplies of drugs for genuine medical use—through enforcement, intelligence, international programmes, regulations (to restrict and prohibit use and supply), science and technology detection and education.

### Major trafficking

362. Very few can have failed to become aware of the dramatic developments in New South Wales and throughout Australia arising from the detections of huge quantities of illicit drugs in the past year or so. The seizures of heroin by the Narcotics Bureau are set out in table 3. The seizures of the cannabis derivatives are as follows:

TABLE 10

| | Cannabis (leaf and resin) | Cannabis (Oil) |
|---|---|---|
| | Kilograms | Kilograms |
| 1974 .. .. .. .. .. | 343 | 5 |
| 1975 .. .. .. .. .. | 886 | 33 |
| 1976 .. .. .. .. .. | 1230 | 45 |
| 1977 .. .. .. .. .. | 704 | 37 |

363. The figures are literally mind boggling when it is remembered that they are thought to represent only a small percentage of the total illicit supply.

364. The Committee received much evidence in camera about drug trafficking and the related problems. It must be clearly understood within the community that the level of drug trafficking in Australia, and especially New South Wales, where Sydney is acknowledged to be one of the leading "Drug Capitals" in the world, is reaching highly dangerous levels. There can be no doubt that very evil geniuses are involved. They must be detected and immobilized. They constitute an insidious threat to Australian society which has been unsurpassed in the country's history. This is a difficult message to convey because those who have not yet suffered disastrous consequences at first hand find it difficult to comprehend the nature of the threat. The Committee believes deeply from discussions with the family and friends of the man whose photograph appears in the insert, that he would have perhaps survived to live a useful life if heroin had not been available. There is no knowing for certain. But it is wrong, quite wrong, for people, and they are numerous, to shrug heroin off as the process of natural selection. If the process of natural selection means that young people should be physically maimed and emotionally wrecked, then it must be repelled by every means available to society. It would be an abrogation of every decent human principle to let this horror run its course. Some sections of society are outraged by the injection of myxomatosis in rabbits. The ravage of narcotics is just as terrible for many human beings.

365. Immobilizing the major trafficker in dangerous drugs requires the utmost priority. Accordingly, the Committee welcomes the Royal Commission in New South Wales into Drug Trafficking. The Committee is conscious of the need to avoid comment which might disturb the investigations of the Royal Commission. The Royal Commissioner and his colleagues are undertaking an important, delicate and difficult task. They deserve the fullest public support. By a resolution of the Parliament all evidence taken by the Committee, including submissions, has been made available to the Royal Commission.

366. There are, however, some general matters of principle in relation to the operation of the law dealing with drug trafficking on which the Committee believes it appropriate to comment.

### Penalties and Sentencing

367. The first relates to penalties and sentencing patterns. In the Memorandum presented to Parliament on 30th March, 1977, the Committee pointed

out[1] that "In considering the penalties for trafficking two things stand out from the court statistics. Firstly, the rate of trafficking has not diminished since the introduction of higher penalties in 1970. Secondly, the courts have not made use of the existing maximum sentences. For example, in 1975 of a total of 177 trafficking convictions under Commonwealth and State legislation, no sentence exceeded 8 years; and only 18 offenders received gaol sentences between 5 and 8 years".

368. The Committee has subsequently noted in the court statistics for 1976[2] that sentences of 9 years were passed and that the 4 to 9 years category rose to 35.2 percent of total convictions in the New South Wales Higher Criminal Courts compared with 11.3 percent in 1975.

369. His Honor Judge K. F. E. Torrington, a judge of the District Court of New South Wales and Chairman of Quarter Sessions, with much experience in dealing with drug trafficking offences, has provided a most useful assessment of sentencing of drug offenders.[3] In particular his Honor pointed out that every appeal against a sentence imposed for a drug distribution offence in New South Wales on the ground of severity has been dismissed by the State Court of Criminal Appeal. This suggests increasing recognition by the judiciary of the need for more severe sentences for drug trafficking.

370. In its Memorandum to Parliament in March, 1977[4], the Committee recommended that:

(i) The penalty for trafficking in the prohibited drug (heroin) and drugs of addiction listed in Schedule 8 of the New South Wales Poisons Act, 1966 (with amendments), should be increased to $50,000 fine and/or 15 years' imprisonment.
(ii) There should be provision for the attachment of property where the fine is not met.
(iii) In the case of cannabis in all its forms, the existing penalties for trafficking should remain unchanged pending a full-scale review of the Poisons Act.

371. Subsequently, action has been taken by the New South Wales Government in the Poisons (Further Amendment) Act, 1977, to increase the penalty for drug trafficking. For the prohibited drug (heroin), drugs of addiction listed in Schedule 8 of the New South Wales Poisons Act, 1966 (with amendments), including some offences relating to cannabis, the penalty was raised to $50,000 and/or 15 years imprisonment; in the case of offences relating to cannabis in leaf form, including cultivation of a prohibited plant of the genus cannabis, the penalty has been increased to $25,000 with the addition or alternative of the existing 10 years gaol sentence.

372. It has been suggested to the Committee frequently in informal evidence that inconsistencies abound within the judiciary and the magistracy in the application of sentences, especially in the question of bail. In particular, it has been represented that bail is often set at such a low-level as to make it possible for major traffickers to raise the money to abscond.

373. Certainly there was a time when this was so but as Judge Torrington has also pointed out, judges and magistrates had first to learn from experience of a new phenomenon. There has been considerable improvement arising from self-generated judicial education through conferences and seminars. The Committee welcomes these initiatives and believes they should be given strong Government encouragement.

**Recommendation**

**(16) Because of the number of absconders from bail in cases of drug trafficking, early consideration should be given to a review of bail in such cases.**

374. Increased penalties and more severe sentencing are not enough. The illicit supply of dangerous drugs is mounting. The campaign against traffickers must be intensified in all the areas of enforcement.

**Strengthening the Capabilities of the State Police**

375. The New South Wales Drug Squad has been considerably strengthened. Police education programmes throughout the force have undoubtedly improved

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[1] Memorandum from the Joint Committee of the Legislative Council and Legislative Assembly Upon Drugs, p. 7, para. 49.

[2] Bureau of Crime Statistics and Research Statistical Report No. 8, Series 2, p. 39, Table No. 6.12.

[3] *Journal of Drug Issues*, Vol. 7, No. 4, p. 346.

[4] Memorandum from the Joint Committee, p. 8, para. 54.

the success rate in detections. The Committee knows of many officials and citizens who are devoted to eradication of the worse effects of non-medical use of drugs. Obviously it would be impossible to list them all.

376. The Committee believes it right, however, to single out for mention Detective-Sergeant K. S. Astill, who has for many years inspired the efforts of the New South Wales Drug Squad. In addition to his evidence in public and in camera before the Committee, Detective-Sergeant Astill has been of immense value through his unparalleled knowledge of the drug scene in the State. His beliefs about the dangers posed by drugs, though not wholly shared by everyone, have brought him high regard in the community, not least amongst many young people involved in drug use who testify forcefully to Mr Astill's great personal integrity. He represents beyond doubt the finest traditions of public service.

377. The police have a considerable problem in controlling the security of drugs which they seize and also of ensuring total destruction so as to prevent the risk of illicit supply.

378. The Committee was able to hear and see at first hand the procedures adopted in this matter by the Australian Narcotics Bureau. The Committee is not in a position to divulge the details of such operations but considers that they merit study for use by the police in New South Wales.

379. The Australian Narcotics Bureau also demonstrated the use of German Shepherds in drug detection. The Committee judges that these dogs have a significant value and believes that their use by the police in New South Wales should be given early appraisal.

380. **Recommendations**

**(17) New South Wales should examine the methods adopted by the Australian Narcotics Bureau for the control and destruction of drug seizures with a view to their adoption in New South Wales.**

**(18) An early appraisal should be undertaken of the way in which dogs, possibly German Shepherds, might be usefully employed in drug detection by the New South Wales Police.**

**(19) Consideration should be given to training in relation to experience in other countries, particularly in the United States and Europe. This should be by appropriate attachments to the law enforcement agencies in those countries.**

**Intelligence**

381. In detailed discussions with Federal officials, the Committee was impressed by the part which intelligence and determined international co-operation must play in curtailing illicit drug supplies.

382. It was represented strongly to the Committee that good strategic intelligence on trends in drug-abuse, general levels of availability, sources of drugs, and capabilities of other Governments to control drugs is essential.

383. The Committee welcomes the efforts which have already been made in establishing a national narcotics intelligence system. As far as the Committee has been able to judge, co-operation between the Federal authorities and the New South Wales Police is well-established. The Committee found no evidence of undue competitive attitudes within and among the enforcement agencies which might have a negative impact on the sharing and use of operational intelligence.

384. The importance of a coherent and concerted national effort cannot be emphasized too strongly.

385. The need for effective intelligence has been aptly demonstrated by recent drug seizures all over Australia. There has been much public discussion about the self-evident problems in controlling illicit imports presented by the vastness of the Australian coastline and the availability of many deserted airstrips in the outback, particularly in the Northern Territory. The vastness of Western Australia, in which it would be possible to fit the state of Texas, the British Isles and Indonesia and still have room to spare, presents a daunting task in this regard.

386. At first glance it might seem that what is required is a maximum build-up of ground and air surveillance in these remote areas. Certainly there is a case for this, particularly in the use of aircraft with advanced technological surveillance equipment like antisubmarine aircraft. It was however pointed out to the Committee that surveillance projects can be disproportionately costly in terms of manpower and support costs. For example, patrol boats are not necessarily excessively costly, but since they would have to operate in remote areas, there is need to provide amenities for families and other expenditure which add immensely to cost. These are Federal matters and the Committee has delved into them only in as far as they present a global aspect on the situation in New South Wales. The difficulty, however, in providing truly cost effective coastal surveillance

strongly underlines the need for good intelligence. This is especially true, too, in regard to detecting couriers who are flooding in through the international airports, particularly at Sydney.

387. The Federal Government has already announced provision for legal telephone tapping by certain enforcement agencies and the Committee believes this to be a justifiable measure provided great care is taken in the exercise of this discretion.

388. There is, however, a limit to which intelligence gathering can be taken, and with so many illicit drugs flooding into Australia through personal couriers, the question of personal searches at airports must be confronted.

389. Under existing Federal law, there is provision for personal searches for smuggling on the person but the law is silent on the question of internal searches. Considerable amounts of heroin are being smuggled by these couriers internally and many couriers are young and female. Unless there is good intelligence, in the light of which a magistrate might decide to authorize an internal search, the Customs authorities have no legal basis on which to conduct internal searches on people strongly suspected of carrying drugs within their person.

390. This situation has particular significance for New South Wales because of the great volume of international passenger traffic through Mascot airport. The Committee visited the airport early one morning to inspect various customs and immigration authorities at the peak traffic time when aircraft arrive in great numbers in a short space of time after the night-flying curfew. Their task is a formidable one—both in relation to people and their baggage. It is enlarged by the great numbers of Australians who travel on holiday to distribution points of the drugs originating in the Golden Triangle. Undue impediment to the fulfilment of the task of the immigration authorities is not in the public interest.

391. In the opinion of the Committee, it is a matter of public necessity that the law should provide for greater freedom of search by the appropriate authorities of people entering Australia. This would include provision for internal searching on reasonable grounds of suspicion without recourse to court authority. This is a sensitive and delicate matter at the heart of the current public debate about privacy and civil liberties.

392. For the Committee, who have been privileged to acquire a strong insight into the magnitude of the scale on which drug importation is now being conducted, it is beyond question that encroachment on public freedom and greater personal sacrifice are called for if the menace of dangerous drugs is to be overcome. People have come to accept that international piracy in the air requires personal inconvenience through security checks which they would not have countenanced 10 years ago. This is because they perceive the direct threat of the hijacker to the individual. Similar solutions are needed to overcome the drugs problem. The public will be reluctant to back them until they grasp the seriousness of the problem. They must be carefully educated to do so.

393. The Committee believes therefore that the law should be drawn up in such a way as to minimize the risk of its abuse.

394. **Recommendation**

**(20) Appropriate officials in New South Wales should seek a review of existing laws and policies in relation to personal searches of incoming travellers.**

**International**

395. No matter how hard the problem of drug abuse is fought at home, we cannot make really significant progress unless Australia succeeds in gaining co-operation from foreign governments, because many of the serious drugs of abuse originate in foreign countries.

396. We can endeavour to achieve this through internationalization of the drug programmes, co-operative enforcement and vigorous control of raw materials.

397. These are national matters for the Federal authorities. The Committee has not been in a position (nor would it be entirely appropriate) to assess Australia's diplomatic efforts, particularly with regard to control of raw materials. However, the general observation can be made that since the root source of the supply of opiate narcotics to Australia is principally amongst the poorer communities of the Golden Triangle which depend on opium growing for sustenance, Australia should certainly support international efforts to produce alternative means of income for such communities.

398. The Golden Triangle poses a very special threat to this country. We should thus seek to take the initiatives. We cannot expect the rest of the world to solve the problem for us.

399. The alternative course of seeking to destroy by force the sources of the opium poppy has been canvassed on occasion, particularly when the United States were being assaulted by large imports of heroin from Turkey. The Committee could not foresee a time when this would become a realistic option but it does reflect the potential stress which might arise between nations as a result of the growing and widespread drugs problem. It also serves to highlight the importance of an all-out effort to disrupt and dismantle the trafficking syndicates.

**Regulation and Control**

400. The abuse of barbiturates, tranquillizers, sedatives and minor analgesics ranks with heroin as a serious social problem. In the case of both, a high proportion of the population are using them chronically and without medical supervision. Of course, the essence of home medication is self-aid without any assistance of the medical profession.

401. The Committee believes that regulation and control should play a vital role in the effort to control the illicit supply of prescribed drugs and to reduce the ready availability of the minor analgesics for which there are no controls whatever, except those arising from the marketing requirements of the manufacturing companies.

402. Diversion from legitimate production can occur at a variety of different points and in a variety of ways. Drugs can be diverted at the production stage, the prescribing and dispensing stage, or at the subretail level; for example, the family medicine cabinet. This diversion can occur as a result of thefts, accidental losses, fraudulent purchases or illicit sales.

403. Legislation and machinery for control of drug distribution and use in Australia is something of a bureaucratic nightmare. The Health Commission of New South Wales have provided the Committee with a compendium on international conventions and control, Federal legislation and control measures and co-ordination of State legislation and control measures.[5] It is not the Committee's intention to rehearse the complexities of these controls in this Report. Suffice to say that it embodies two international conventions—the Single Convention on Narcotic Drugs 1961 and Conventions on Psychotropic Substances 1971; three major Acts within Federal legislation—Customs Act 1901, Narcotics Drug Act 1967, Therapeutic Goods Act 1966, as well as the Customs (Prohibited Imports) Regulations; and within the State the New South Wales Therapeutic Goods and Cosmetics Act, 1972, and the New South Wales Poisons Act, 1966, as amended, supplemented by Poisons Regulations and a Poisons List. The other States have corresponding legislation of their own, in some instances in differing forms.

404. Co-ordination of Federal and State legislation and control measures is provided through the National Standing Control Committee on Drug Dependence, the National Health and Medical Research Council Poisons Schedule Subcommittee and the National Therapeutic Goods Committee.

405. The implementation of legislation and control measures is through a plethora of Committees at National and State level. The National Standing Control Committee on Drugs of Dependence, the National Health and Medical Research Council Poisons Schedule Subcommittee and the National Therapeutic Goods Committee, all operating nationally. At State level, the National committees are reflected through the operations of the Poisons Advisory Council of New South Wales. Thus the making of the laws for the control of drugs of dependence is decided between the Commonwealth and the six State Governments.

406. The Commonwealth Department of Customs and Excise controls the importation and exportation of drugs through the Customs Act and the Prohibited Import and Export Regulations made under that Act. It also administers the Narcotic Drug Act, which regulates the manufacture of narcotic drugs in accordance with the U.N. Single Convention on Narcotic Drugs, 1961. Through its Federal Narcotics Bureau the Department of Customs and Excise administers control at a Federal level to combat the illicit importation of drugs.

407. The Commonwealth Department of Health is responsible for the control and examination of all imported therapeutic substances to ensure adherence to purity, potency and safety standards.

408. Laws relating to distribution, handling of drugs and penal provisions for non-medical use are dealt with by the six State authorities and the Commonwealth. Within each State responsibility is divided between various agencies—such as Health and Police Departments.

409. The Commonwealth Police Force, through its Central Crime Intelligence Bureau, operates an information retrieval system on drug offences and the illicit market.

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[5] Progress Report of the Legislative Council and Legislative Assembly Upon Drugs, p. 30—Appendix 7.

410. In order to exercise control over the licit market the National Standing Control Committee on Drugs of Dependence in April, 1969, recommended a system to collect, collate and disseminate information on all interstate and intrastate movements of drugs covered by the U.N. Single Convention on Narcotic Drugs, 1961. Consequently the Commonwealth Department of Health has become responsible for National Computerized Drug Transaction Monitoring Scheme which provides computer facilities to monitor the licit movement of drugs of dependence within the Commonwealth. The system covers the narcotic drugs in the 1961 Convention and includes amphetamine, dexamphetamine, methylamphetamine, phenmetrazine and methylphenidate.

411. On paper, at least, it may appear that the effective control of the supply of drugs is well-catered for. Acts and regulations abound and there appears to be much provision for discussion and planning of them.

412. In particular, in relation to those drugs of dependence which have highest attraction in the illicit market—particularly the narcotics which require strict control—the Commonwealth Department operates the National Computerized Drug Transaction Monitoring Scheme. By a system of cross-matching of entries in order to ensure that goods supplied by one reporting authority are matched with an incoming entry for the receiving reporting authority, it provides the necessary surveillance to identify unusual peaks in ordering at all levels. In fact, the Committee was told by Commonwealth officials that the system, if properly followed through at State level, should be watertight.

413. It is the view of the Committee that controls through these existing systems at the production and wholesale distribution stages appear to be effective. Regrettably at all remaining stages the Committee has received evidence to suggest a serious breakdown in the chain. Failings in the Government machine, community irresponsibility, personal weakness and downright carelessness by many in a variety of professions and at all levels in the community are the causes.

**Controlling Retail Diversion**

414. Thefts from pharmacies, drug thefts from doctors, the evidence of readily available fradulent prescriptions and the ease with which they are fulfilled have been cited consistently throughout the Committee's hearings as evidence of the predominance of retail diversion in the provision of drugs in the illicit market. Hence a pharmacist in Lismore reported[6]: "One other thing that my colleagues and I have been worried about is the prescription by some medical practitioners of this area of drugs of addiction.

415. "Last year, I was on roster and I received a prescription for palfium tablets for a lady from one doctor not in Lismore. Someone brought the prescription in for this young lady. Next day, the same prescription for the same lady from another doctor also outside Lismore was brought in by a different person. That same night when I was on duty again I received a third prescription for the same young lady for the same tablets. I thought that this was rather funny, so I spoke to the president of our association. He suggested that we send a note around the block for starters to find out if the name had popped up regularly. The name did pop up regularly and, in fact, so regularly that she had got 700 tablets in the area within 3 months. That was a lot of palfium. Subsequently we inquired of other pharmacies at Ballina and at Byron Bay and Alstonville and found that she had obtained 1800 palfium tablets in 3 months. There was no problem about us giving them to her because the prescriptions were there and everything was quite legal. We think the medical practitioners should look at these Schedule 8 prescriptions closely. There is not enough control sometimes."

416. The Committee wants to bring out as forcibly as it can that situations like the one described are common. The Committee took in-camera evidence from young multiple-drug misusers who gave numerous examples of the length to which they went to deceive members of the medical profession into supplying excessive quantities of drugs. There is strong evidence that many members of the profession are either particularly gullible or lax in the exercise of their prescribing responsibilities. There is evidence of some who clearly abrogate these responsibilities for illicit gain. It is a matter of the gravest public concern that this situation goes unchecked.

417. There is a need for a drastic improvement in control of the chain of supply at the retail level. Within the Health Commission of New South Wales, participation in the Commonwealth monitoring scheme is the responsibility of the Therapeutic Goods Branch. In this regard the Commission reported, *inter alia*[7].

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[6] Minutes of Evidence, p. 197, paragraph 3295.

[7] Minutes of Evidence of the Legislative Council and Legislative Assembly Upon Drugs Progress Report, p. 303.

"6.4. A desirable inspection rate is considered to be each pharmacy in the State every 2 years and this level was achieved when the Poisons Branch, as it was then called, was formed in 1968, and five inspectors were able to devote the bulk of their time to routine inspections. Since then the rate of such inspection has progressively dropped as a result of new legislation (Therapeutic Goods and Cosmetics Act, 1972) coming within the Therapeutic Goods Branch's administration and the erosion of time available to inspectors because of the need to attend to matters of a more urgent day-to-day nature. The net result is that only two inspectors are available to carry out investigations under the Poisons Act and most of their time is devoted to investigations, leaving little time for routine inspections. When such investigations involve visits to pharmacies, the opportunity is taken to carry out a general inspection."

"6.5. Routine inspections of pharmacies serve not only to ensure that the requirements of the law are being met but, perhaps more importantly, provide valuable intelligence on drug use and abuse in general and facilitate the detection of problems at an early stage."

"The Health Commission would favour the regionalization of much of the work of the Therapeutic Goods Branch but staff limitations have prevented this from occurring so far."

418. It will be noted that the value of pharmacy inspections is highlighted at paragraph 6.5, whereas at 6.4 it was demonstrated that the rate of inspections has decreased due to manpower problems.

419. In evidence officials of the Health Commission explained some of the difficulties as follows[8]: "We can indeed monitor the prescriptions written by doctors in general practice because we have access in a limited way to the computer run by the Commonwealth Department of Health. However, this is a fairly sensitive area; it is a matter of privacy—the doctors' records, and their care of their patients. It is a thing that should be handled with great sensitivity. Mr Dash may wish to amplify that. (Mr Dash) There is a monitoring programme in which the States participate. It is a joint Commonwealth-State venture from manufacturers down to the level of supply of drugs from wholesaler to retail level, and the results from it tend to be 6 to 8 weeks late. It relies upon weekly returns from manufacturers and wholesale distributors. There is the coding of these, the running at 4-week intervals of all the coded data and then the printing out of reports. This system will highlight changes in usage in particular areas through increased purchases of drugs by individual pharmacies or hospitals. It then requires a physical follow-up to look at the records maintained at that hospital or pharmacy to find out what is the cause of the increase. Dr McEwin was referring to the records of prescriptions dispensed as pharmaceutical benefits, which is a very sensitive area. These are Commonwealth documents to which we do not have any right of access, as distinct from the documents which are obtained as part of the monitoring system of wholesale transactions."

420. The benefits of the Commonwealth Department of Health National Computerized Drug Transaction Monitoring Scheme for drugs of dependence in Schedule 8 will clearly be undermined if there is insufficient manpower in the State to undertake speedy follow-up checks and if doctors' prescribing habits for all drugs remain unscrutinized. The Chairman of the Health Commission explained in evidence that with regard to prescriptions under the pharmaceutical benefits scheme that the Health Commission of New South Wales does have informal lines of communication with the Commonwealth Department of Health and "sometimes we get information on these informal lines which allows us to recognize unusual patterns of prescribing".[9]

421. With regard to the registers of dangerous drugs which doctors are required to keep by law, the evidence revealed the following in the system:

"Q. Doctors are required to keep a book of dangerous drugs prescribed, by law, are they not? A. Not of dangerous drugs prescribed but supplied.

Q. And if they prescribe them? A. They are not obliged to keep a record.

Q. If they supply them they must keep a record? A. Yes.

Q. Are those books inspected regularly? A. I would not say regularly. (Second witness) Not on a regular basis because of the shortage of staff. We find it generally unprofitable to spend long periods waiting to see doctors. They usually keep little in the way of stock. Sometimes they keep records of prescriptions on patient record cards but it would be an enormous task to go through those cards to find out what had been

[8] Minutes of Evidence, p. 321, para. 4233.

[9] Minutes of Evidence, p. 334, para. 4308.

prescribed. If there is reason to believe that a doctor might be using more than the normal amount of drugs we would ask to see the drug register. (First witness) On the matter of communication, I have here copies of a recent *Newsletter for Medical Practitioners* which features the matter of obligations in respect of prescribing for addicts. I will make copies of the newsletter available to members of the Committee.

Q. Thank you. It was put to us that some doctors who had been visited, presumably by Commonwealth inspectors, had not made an entry in their books for more than 2 years. Would you find that exceptional?

A. No, I would not be entirely surprised if some doctors are not keeping records as they should. In most cases usage is confined to, say, ten ampoules of methadone or morphine per month. Some doctors are lax in keeping records.

Q. But legally they should do so? A. Yes."

422. A major problem in achieving effective control at this level is the sheer number of doctors and pharmacies involved. Manpower inspections cannot be effective if the Therapeutic Goods Branch is left at its present staffing level. This matter requires urgent appraisal within the Health Commission of New South Wales.

423. **Recommendations**

**(21) The Health Commission should review its whole approach to its participation in the Commonwealth Health Department Drug Monitoring Scheme with a view to reporting the effectiveness of present systems; in particular, the staffing situation in the Therapeutic Goods Branch should be critically examined to provide more intensive and effective inspections within the State.**

**(22) Consideration should be given to improved means of checking the prescribing habits of doctors in relation to both Schedule 8 and Schedule 4 drugs.**

## The Pharmacist

424. The Committee has paid particular attention to the role of the pharmacist. Undoubtedly, this profession has a leading role to play in the fulfilment of policies for properly controlled use of drugs within the community. The Committee has received much evidence from the profession, through the Pharmacy Guild and from individual pharmacies. There is much public discussion about weaknesses amongst some pharmacists in their approach to drug supply. This is obviously true in some cases. The Committee has, however, been impressed by the great sense of duty to the public which is manifest amongst many in the profession. Examples of initiatives taken by individual pharmacists or by groups of pharmacists in local monitoring and curtailment of excessive drug use recur throughout the Minutes of Evidence. The Pharmacy Guild is undertaking commendable efforts to strengthen the profession's role in the community awareness of sensible drug use and to introduce measures for the reduction in thefts and other means of illicit supply. The profession is seeking to ensure that people take not only the drugs they require but that they understand the effects and potential dangers of them. They deserve the greatest Government and public support in this regard.

## Sale of Syringes

425. The Committee has had complaints that many pharmacists too freely make available hypodermic needles for the use of addicts.

426. The Committee is of the same opinion as the Council of the Pharmaceutical Society of New South Wales who considered similar complaints regarding the abuse of hypodermic needles and syringes and the apparent haphazard sale in some instances of these items.

427. The Council concluded that the vast majority of pharmacists are acting properly in this matter but that it seemed appropriate that their members should be reminded of their responsibility in adequate surveillance of purchases of such equipment. They exhorted pharmacists to act in the best interest of the community so that abuse is discouraged and genuine users are spared unnecessary hardships when seeking to purchase the necessary item as part of their drug therapy.

428. Experience of members of the Committee suggests that drug addicts are very resourceful in fashioning implements that can be used for hypodermic injections even when needles and syringes are not available. For example, the Drug Squad at Police Headquarters has in its possession many items which had been used as substitutes by drug-users.

429. **Recommendations**

**(23) The Pharmacy Guild of Australia be given full support and encouragement in the efforts it is already making to bring about great efficiency in pharmacy controls on the non-medical supply of all drugs.**

**(24) In view of the important role the pharmacist can play in reducing the supply of drugs, the profession should have prominent representation in the management of health services provided in New South Wales.**

**(25) Sale of syringes should not be restricted by legislation but that special steps should be taken to remind pharmacists of their responsibility to maintain vigilance in the supply of syringes to confine supply as far as possible to those in genuine medical need.**

**The Medical Profession**

430. The Committee has already commented on the need to improve the capability within New South Wales to monitor and eradicate, as far as is reasonably possible, illicit drug supply through the medical profession. This is not however the main problem.

431. Doctors are subject to commercial pressure from the drug companies and requests from genuine patients suffering either physical illness or emotional stress. Doctors are only human and it is sometimes forgotten that they are just as prone to mistakes and misjudgement as the rest of society.

432. It should not be surprising, therefore, that evidence arises of over-prescribing and faulty prescribing. The Committee has not been able to get a totally accurate picture of the dimension of this aspect of non-medical use of drugs. But on the evidence of many representatives of the profession it is a significant factor in the apparently excessive use of barbiturates and tranquillizers, not least because there is a measure of conflict within the profession about the role such drugs should play. The Seventh International Conference on Alcohol, Drugs and Traffic Safety gave the Committee an opportunity to hear from an Australian doctor now practising in Canada of his experiences when he decided to return to good old-fashioned family doctoring. Although he had sufficient nursing staff to help in counselling, by taking his patients off valium the result was an almost catastrophic increase in the number of patients requiring proper psychiatric treatment at a neighbouring mental hospital. This experience is mentioned to demonstrate the complexity of the problem which can face the general practitioner.

433. Nevertheless, many doctors have told the Committee that they believe that teaching in the medical schools remains quite unsuited to the problems which the medical graduate meets in practice.

434. There has been a general consensus of opinion that vigorous efforts are required in the development of prescribing guidelines and the introduction of improved elements for teaching of proper prescribing practices in medical schools. In this latter regard, the Committee has been interested to note the principles to be adopted in teaching at the new medical school to be opened at the University of Newcastle.

435. Attention must be drawn also to the vulnerability of the doctor at home and in his consulting room and in particular the risk of stolen and forged prescriptions. The Health Commission of New South Wales abandoned a proposal for accountable prescription forms.[10] The Committee accepts that practical difficulties may arise on account of the volume but the Banks manage to overcome these difficulties in the use and control of cheque books. The Committee, therefore, looks for a greater show of willpower in tackling this problem.

436. **Recommendations**

**(26) The policies adopted in medical schools for teaching in relation to drug use should be reviewed.**

**(27) Prescribing guidelines should be developed in co-operation with the Australian Medical Association.**

**(28) Information on proper prescribing practices should be given more emphasis in medical schools.**

**(29) Refresher courses in drug education should be instituted for physicians through the Australian Medical Association and Health authorities.**

**(30) Consideration should be given to a "cheque book" system for prescriptions so that stolen pads might be traced more rapidly and easily.**

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[10] Progress Report of the Joint Committee of the Legislative Council and Legislative Assembly Upon Drugs Minutes of Evidence, p. 4, 4.28.

# Part 2 Reducing Demand

## CHAPTER 11

437. If the supply can be contained and reduced, illicit drugs will become more expensive, will be more difficult to find and buying them will be hazardous. As a result, fewer people will use drugs illicitly and those who do may reduce their consumption.

438. However, some drugs will continue to be available in the illicit market in varying quantities, since supply reduction efforts cannot be completely successful. Some people will continue to use drugs and others will experiment and perhaps become habitual users.

439. The effectiveness of the overall effort to combat drug abuse will depend on a proper programme to reduce the demand for drugs to complement the reduction in supply.

440. What efforts there have been in New South Wales in the demand-reduction area have been principally geared to providing treatment for drug-abusers. This emphasis on providing care for those in need is appropriate because of the acute nature of the problem and the Government's responsibility to provide treatment to those who seek it. The Committee has looked very carefully at the current state of the State's treatment programmes. The Committee's conclusions and recommendations are contained in Chapter 12.

441. Nonetheless, experience all over the world proves that "cures" are difficult to obtain. This is especially true if we define a cure as total abstinence from a drug. Relapse rates are high, and many narcotic addicts and multiple drug-users require treatment again and again. Even treatment which does not result in permanent abstinence is worthwhile from society's point of view, since for the period of treatment plus some time beyond, most addicts' lives are stabilized and most are better able to function as a valuable member of society. Perhaps the addict is able to hold a job, become an active member of the family or return to school. Certainly, even if not entirely successful, treatment is important.

442. But the treatment done is not enough. Once someone reaches the point at which he needs treatment, a serious problem has already begun and permanent improvement is extremely difficult. It is axiomatic that it is far better to prevent the problem before it develops.

443. Therefore, the Committee believes that greater emphasis must be placed on education and prevention efforts that promote the healthy growth of individuals and discourage the use of drugs as a way to solve (and avoid) problems. Experiences to date indicate that broad-based, community-centred programmes which must meet the needs of children and youth are the most effective, and future emphasis should be placed on this type of prevention and education programme.

444. At the same time that greater emphasis is being placed on prevention effort, it is also important that greater attention be paid to drug-users by the creation of rehabilitation programmes in order to provide them with marketable skills and jobs. Positive changes in an addict's life and self-esteem are needed to keep him from returning to drug-use. A job can do as much to accomplish this as anything else.

445. The Committee believes that the growing problem of non-medical use of drugs in New South Wales calls for vigorous programmes for education and prevention, treatment and vocational rehabilitation. These programmes will not materialize effectively without a corresponding reappraisal of this interface with the criminal justice system and properly structured support programmes for research, demonstration and evaluation. Above all, they must be set at a frontier where the community and governments stand together to remove the hideous face of wrongful drug use and supply through State, national and international efforts. Drugs may have some place for soothing amongst the aged and the dying. No way in the world should they have the place which they are taking in the lives of the younger generations. All our children deserve the best future we can provide for them. Adult society must take the full responsibility for seeing that this is so.

446. This is not pious rhetoric to be stored in the archives of Parliament House. This is a call to the people of New South Wales and Australia generally to wake up to the potential threat of the greatest social menace of modern times.

### EDUCATION AND PREVENTION

447. The desirability of expanding efforts in the education and prevention field is not a new concept. In 1971, the Senate Select Committee recommended

"1. Existing education programmes aimed at correcting drug-abuse are inadequate.

2. Any programme directed against drug-abuse in isolation would be ineffective.

3. Education programmes in schools should be designed as "education for living" as the best long-term preventive measures.

4. There is a need for specially planned programmes designed to reach specific age groups and these overall programmes should be co-ordinated by one national group which would:

- undertake curriculum research to establish guidelines for new school programmes in all States and Territories of the Commonwealth;
- be a National Resource Centre for the collection and dissemination of factual information;
- develop programmes for the training of teachers and counsellors; and
- support programmes, including seminars directed specifically to the adult population."

448. Throughout its hearings, the Committee in New South Wales found that the bases on which those recommendations were set are broadly the same as those being advanced today. It is interesting to note that "education for living" was a main theme at the Sydney Teachers' Training College half a century ago. In particular, the risk of creating an adverse effect from the one desired, and inciting interest in drug-taking, is the central problem. As a result, the policy of caution seems to have developed. Minutes of Evidence.[1]

Q. Do you think enough is being done to educate people about the dangers of drugs to health?

A. (Dr Storey): I think the answer to that question must inevitably be no. On the other hand, I add a note of caution that an education programme must be carefully conceived and implemented. Many so-called drug education projects can be counter-productive. (Dr Webb):

Your question contained the word "danger" which is commonly used by concerned people in the community. They say that if people are told that something is dangerous to their health or their life, they will behave appropriately.

We know for some other educational programmes that this is not so. About 10 percent of people behave appropriately if they are told something is dangerous; the other 90 percent behave according to their mood or how their peers are behaving. Informing people, particularly about dangers, could be counter-productive. The Americans coined a phrase about this. They said that peril is the lure. They have found that their drug education programme, into which they leapt with great enthusiasm and in respect of which they told people that some things were certain to lead to a bad future life, caused some personalities to take that risk.

Q. One of the things that has struck me is that witnesses can tell us what is not the right education programme, that it is counterproductive, but no one has been able to say what they think is the right programme. Has the Health Commission anything which it is prepared to say it thinks is the right approach and programme or that what it has done over all the years has been wrong?

Dr Webb: You are quite right: more people know about what not to do than what to do with drug education."

Australia is not alone in this. Dr Robert Willette of the United States National Institute in Drug Abuse told the Committee that follow-up on early education programmes in the United States showed increased drug usage even by increasing awareness or decreasing fear. At one time, there was even a moratorium on drug education programmes in the United States.[2]

449. In regard to the effectiveness or efficacy of the drug education services in this State, Dr Webb continued:

"Three years ago we were told that we were one year ahead of England and were possibly in the lead in the world. This was an international

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[1] Minutes of Evidence, p. 349, para. 4503; p. 358, para. 4602; and p. 355, para. 4577.

[2] Minutes of Evidence, p. 9, para. 1864.

conference. Where we failed I think is in penetration. The ideas, the techniques, what not to do, are all good and can all be defended. I do not think that enough Health Commission staff, Education Department staff, enough key community leaders and groups know what they should and should not be doing or even know the dangers of doing anything. So I should say that the quality is good but the delivery or penetration is poor."

450. The Committee found that generally there was a state of great uncertainty in the present formulation of health education within the sponsorship of the Health Commission of New South Wales and also in the programmes through the Department of Education in the schools.

In view of the evidence of growing misuse of drugs amongst children, the Committee has paid particular attention to this area of the education problem.

**The Size of the Problem in the Schools**

451. The extent of drug-use amongst schoolchildren has already been a subject of comment in this report. The Committee has been bedevilled throughout by the lack of up-to-date surveys on the extent of drug misuse. The Department of Education provided the earlier Parliamentary Committee with the most comprehensive survey of drug use in the schools available at the time.[3] An extract is as follows[4]:—

"(1) The most used drugs are:

painkillers—90+ percent;

alcohol—70-80 percent;

tobacco—33-43 percent.

(2) All other drugs are used by fewer than 20 percent of the sample.

(3) Statistically, changes of 1 percent and 2 percent are not significant, nor are readings of that magnitude.

(4) In the case of all the drugs so far named (except for tobacco, where there has been a rise of 1 percent since 1972 following a fall of 2 percent since 1971), the graph for sixth form shows a fall. The fourth form graph shows a rise of alcohol by 6 percent and of sedatives by 2 percent. (Sedatives are the substances available on prescription; painkillers are the substances available without prescription.)

(5) In the case of "illegal" drugs (those falling within the terms of reference for your enquiry), the graphs all show a sustained plateau or a fall except in the case of marihuana, where sixth form use increases to about 13 percent and fourth form to about 10 percent (increases of about 6½ percent and 4 percent approximately). Hallucinogens stabilize at about 3.3 percent and narcotics at 1.2, 2 percent.

(6) The fall in the use of stimulants from approximately 9½ percent to about 3½ percent (a fall of 6 percent) can probably be explained mainly by changes in the prescribing habits of doctors who became aware of the abuse of amphetamines by all age groups and came to question their efficacy in treating weight problems and reduced or ended their use for such purposes and for helping long-distance drivers and students to stave off sleep. Hence the substances were harder to acquire legally or from dispensaries and family cupboards.

(7) The high rate of painkillers may reflect a number of factors, such as menstrual pain (studies show women and girls are major abusers in this group), tension headaches associated with noise, fatigue and emotional stress, and the success of advertising campaigns which have made some phrases part of the language (e.g. a Bex; a cup of tea and a good lie down . . .; take Vincent's with confidence; it's your day, don't share it with a headache; take Vincent's . . .; Aspro is part of caring for your family—the implications of the last are particularly pernicious).

The "hidden messages" of stage, radio and television scripts are also significant; there, characters under stress frequently have recourse to sedatives or alcohol or both.

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[3] Progress Report of the Joint Committee of the Legislative Council and Legislative Assembly Upon Drugs 1976, pp. 159-190.

[4] Progress Report of the Joint Committee of the Legislative Council and Legislative Assembly Upon Drugs, page 160.

(8) For whatever reasons they are chosen, the high rate of use of pain-killers has been a consistent feature of Australian drug-abuse throughout all age groups for as long as any observations have been made.

(9) All countries represented at UNESCO and WHO conferences agree that alcohol abuse is the greatest of their drug abuse problems. These figures support that opinion.

(10) Case histories and studies of drug-abusers identify two significantly recurring factors—low-esteem and learnt patterns of behaviour in which home influences are especially strong. The latter observation has especial significance when studies also suggest that people who abuse common analgesics tend to be more likely to abuse other drugs. (Hence sedating oneself in front of one's children or sedating them in crisis or before travelling or when baby-sitters come may be efficiently teaching them how to depend on drugs.)"

452. There are already examples in the voluntary treatment centres of 12- and 13-year-olds using drugs dangerously, including heroin and hashish. It will not be long before the media deafen us with the news of a child of this age overdosing on heroin.

453. A look at the missing persons list in New South Wales does not make it extremist to ask whether perhaps this has not already happened.

454. It would clearly have been helpful for the Committee to have had more up-to-date information about the pattern of drug-taking among school-age children at the commencement of its hearings.

However, the difficulties of mounting a study on the scale that would have been required and which would have presented data within a reasonably short time meant that the Committee was obliged to rely on the experience of witnesses throughout the community for building up a picture of the situation at the present time.

455. The picture that emerged showed wide variations in the views held between different localities and between those responsible in schools in the same locality as to the degree of drug misuse current among boys and girls of secondary school age in this country.

456. The evidence taken by the Committee during its visit to the North Coast is an example of this. The Director of Education for the North Coast Region of the Department of Education said in evidence[5]: "I believe that in the North Coast Region we are very fortunate in that there is very little problem indeed in the schools so far as drugs are concerned. We do have some problem with alcohol and tobacco, but we have few problems as far as other drugs are concerned. I am in regular contact with the principals of the twenty-two high schools and of the seven central schools that have secondary pupils. I know that they are ever vigilant. During last week I rang every one of those principals so that I could be brought up to date with the position. The principals informed me that in the past 4 years as a group they are aware of only seven instances in which youngsters have been involved with the smoking of marihuana. None of those instances took place in the school.

457. "All the principals stated to me that they have no doubt that there is something of a drug problem in the North Coast Regions with post-school people. They have no doubt that marihuana can be obtained. They have regular discussions with their school pupils and the school pupils are not backward in stating that if they wanted marihuana they could get it. There may be cases other than the seven of which I am aware.

"Perhaps there are cases known to the police and to the Department of Youth and Community Services that have not been reported to the principals. I doubt whether there would be many.

458. "At one of our southern high schools there is a boy attending at the moment who was convicted of a drug offence last year involving marihuana. He was placed on a bond. After discussion with me the principal took the boy into school again; he was re-admitted. He is continuing in Year 12 this year. That is the policy that we would adopt; we would not ban a boy from school. This lad has been allowed to return. He is the only one in that category.

459. "Personal development courses are being offered in all but three of our secondary schools. In the three schools where these courses are not offered there are courses in health education. So drug education is being given in all the schools in the North Coast. At this moment I am certain that we have no serious problem. I only hope that it remains that way."

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[5] Minutes of Evidence, p. 182, para. 3195.

460. Yet a housewife at Woodburn, who had developed a community action group to deal with the growing misuse of drugs, reported[6]: "I am involved with the young people in Evans Head. At Christmas time in 1975, there was a great deal of pot smoking going on round the town, and I guess also the harder drugs, the barbiturates. At the court at Woodburn in 1976, some forty young people from the town appeared. It was almost all the male population under about 19. They appeared at the court for minor misdemeanours. This was a shock to me. If it had been one or two children I would have thought probably their family background had something to do with it, but when there were so many it caused me to ask what was the community doing for these young people?"

461. Giving evidence, a doctor in Tweed Heads[7] representing a community drug council operating from the North Coast Region to Brisbane told the Committee of children "tripping" on LSD and "magic mushrooms" in school, in class, in that area in recent times.

He told of one incident of youngsters with magic mushroom sandwiches to take to sports day.

The following extract from his evidence throws light on the problem in the schools:

> "Q. Does it surprise you that all the top people from the Education Department in the area state that there is no drug problem? A. It does not surprise me at all that they say that. I do not think they have any idea. I do not see how they could get an idea.
>
> Q. Surely if you were principal of a school you would have an idea? A. I think you would have no idea. They could be tripping in class. I shall not name this school now but there is a school in this area where eight of the thirty kids in a class were tripping on magic mushrooms during the day in class and I am sure that the teacher did not know because I saw these kids the same day and I did not know until they told me that they were as high as kites on magic mushrooms.
>
> Q. How did you know? A. I know the kids pretty well and they said later on—they had been talking to me for a while—they said, "Do you know that we are tripping?" I had another look at them. After looking back in retrospect, if you like, it was obvious but until they mentioned it, it had not occurred to me to look for those sorts of signs. They talked to me for half-an-hour before they said this and you could notice changes in their moods that goes with the sort of drug. I have seen several hundreds of people under the influence of LSD or magic mushrooms.
>
> Q. It seems strange that you would not detect the symptoms then? A. You would not, unless you were looking for it. I would not be able to detect a few people who had a half a dozen beers for lunch but if I am talking, in close conversation, I might be able to identify that they had.
>
> Q. Is there any other case you can add apart from that particular one? A. That was in one class at one time—quarter of the kids were tripping. There is the business of magic mushrooms in sandwiches to take to school lunches or sports programmes. (Second witness) We have had several cases, in the centre, of young people taking Mandrax through classes. When parents found out they came to us worried about it and we have talked to the children. They have admitted taking them in class. (First witness) It is impossible for the Director of Education to have any idea—and the school principals. I know a few teachers in the schools who say they can tell the kids that walk into the class stoned from marihuana or whatever and they do not do anything about it. They say that for a number of reasons. First, what will they do in the first place—suppose you do know the kid is smoking marihuana—you have to be able to prove it. Second, what right have you to do anything about it, anyway?
>
> Q. The teacher is *in loco parentis,* with a responsibility to the parents. A. Quite, but certain teachers, ones who smoke marihuana themselves, for instance, and eat magic mushrooms, have said to me, "I know the kids in my class who are stoned during class". He has said, "I do not mind a smoke myself now and again, so I am not going to do anything about it. I have told them on the quiet that they really should not do it at school". That is the sort of attitude you have to deal with. I do not think that a headmaster would know—or parents—if their kids were high at a particular time."

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[6] Minutes of Evidence, p. 227, para. 3633.

[7] Minutes of Evidence, p. 239, para. 3743-3755.

462. In another part of the State, the Regional Director of Education, Illawarra Region, told the Committee[8]: "As far as I am concerned, if you look at the incidence of drug-taking in schools, it is virtually impossible to get any reliable evidence. It is one of those things that is hidden. The students cover up and parents cover up and if it is reported to the medical practitioner obviously it is not going to be disclosed from that source. So, over the past 2 years I have been asking principals to feed as much information as they can and to seek it out in all manner of ways so we might get at some of the problems and remedy some of the situations, but invariably they point to the almost impossible task of getting evidence.

463. ***"I do not think that teachers, in the main, are really trained to identify the results of drug-taking in any case. They are more wise to it now than they were before, but in the main they would not even be aware that a student was in the habit of taking drugs, whatever form it takes.*** From just discussing this with principals they almost invariably maintain that alcohol is the most common drug that children take and they maintain that this is pretty widespread and that in quite a number of cases it is taken to excess. In fact, in quite a number of schools these days they are very worried at having school socials for that very reason, as it is difficult to keep alcohol and other drugs away from the scene.

464. "So far as marihuana is concerned, I have not had any reported smoking of marihuana on premises but I have no doubt that there must be some of it going on. It appears that marihuana is readily available around schools. Who is doing the supplying and who does the pushing is one of those things that cannot be identified, although it appears that in most instances the principals believe that it is the students themselves who are actually involved in the drug-pushing situation."

465. Viewed against this evidence, it is worth note that in 1976 the police drug arrest statistics for that area showed 51 cases between the ages of 14 and 16 years and a further 114 aged 17 or 18 years.[9] These figures would clearly not represent the total user population of school age. Throughout its hearings in Wollongong, the Committee heard from widely representative members of the community about the growing misuse of drugs amongst young people at secondary school. There is a marked degree of community concern in the region about the growing drugs problem in all ages in the community and this is demonstrated repeatedly through the evidence.[10]

466. The Committee has to report, therefore, a somewhat conflicting and confused view amongst the professional community about the extent of drug use amongst schoolchildren. This is not peculiar to New South Wales, it is apparent elsewhere in Australia. In the United Kingdom, recent official reports have suggested that general use of drugs amongst secondary school pupils might be on the decline, whereas the United States Strategy Council on Drug Abuse reported in November, 1976, that one of the most striking and worrisome findings of the most recent surveys of drug-using behaviour was the extremely high use rates amongst young people aged between 12 and 25.

467. The findings of Bell and Campion in 1973 have been updated in 1977. The findings are provisional at this stage but they reveal the following drug use trends amongst the pupils surveyed.

TABLE 10

**USE BY 15-YEAR-OLD SCHOOLCHILDREN**

| | 1971 | 1973 | 1977 | |
|---|---|---|---|---|
| | Percent | Percent | Percent | |
| Alcohol .. .. | 71 | 75 | 88 | Rise in regular weekly use. |
| Tobacco .. .. | 40 | 41 | 49 | Rise in regular weekly use (girls have now caught up with boys). |
| Marihuana .. | 6.5 | 10 | 27 | Biggest rise—300 percent. Use not up in weekly but in occasional. |
| Narcotics .. .. | 1.4 | 2 | 2.8 | |
| Stimulants .. | 9.1 | 6.4 | 5.6 | |
| Hallucinogens .. | 2.4 | 3.4 | 4.2 | |
| Sedatives .. .. | 15 | 17 | 10.2 | |
| Painkillers .. | 81.2 | 92 | 90 | |

[8] Minutes of Evidence, p. 134, para. 2762.

[9] Minutes of Evidence, p. 106.

[10] Minutes of Evidence, pp. 89 to 137.

468. The Committee must emphasize that these findings have yet to be properly assessed. Officials of the Health Commission of New South Wales confirm, however, that there is conclusive evidence from the survey that drug-taking amongst schoolchildren is growing and that it is happening in Year Ten high school and even earlier.

469. There are broadly three reasons why young people take drugs. They are the challenge to experiment in order to discover new feelings and sensations; the pressure to conform with others in their particular social groups in a recreational situation; and the desire to find escape from intolerable mental stress. On the basis of the figures in Miss Guthrie's evidence[11] it is difficult to judge the full extent of the likelihood of most children maturing out of drug-taking without taking opiates. The increasing numbers who do not are possibly mainly those in the third category who turn to drugs as a palliative to stress. The Committee has no doubt, however, that growing numbers of these young people are becoming increasingly involved in opiate use at ages 12 and 13, and that they come from a wide area of society. They represent young lower-income group boys and girls living in deprived areas, nearly all with delinquent histories and exhibiting the problems of poverty, overcrowding, poor education and lack of occupational opportunities; young middle-income group males and females from the affluent and less affluent suburbs, often drop-outs from higher education in conflict with parents whose values they have rejected and moving from "pad" to "pad", the casualties of rapid change; the institutionalized children from separated or single parents who have run away from their institution to hide in the anonymity of the city; and many more adrift from an early age due to family breakdowns, often vagrants from interpersonal stress.

470. The Committee has met many such young people who started their drug-taking at school. They and their peers to whom the misuse of drugs is quickly spread will continue to present problems for both children and their parents for the foreseeable future. It has to be recognized as a phenomenon which for many children presents grave difficulties along the road to maturity, and it is the schools that the society at large tends to regard as primarily responsible for helping children through such difficulties. The Committee believes that educationalists in this country accept that there is a responsibility upon the educational system to help them through the particular difficulties which beset them in adolescence, by encouraging them towards a better understanding of themselves and others so that they can develop their own beliefs, feelings and attitudes without coming into conflict with adult society.

**Department of Education Policy**

471. The Department of Education is responsible for government policy and drug education in the schools. A submission to the earlier Parliamentary Committee by the Staff Inspector, Pupil Welfare and Curriculum, Miss E. M. Guthrie, stated that, "In carrying out 'drug education', our views are[12]:

> "1. We are concerned with attitude formation and behaviour change, not merely giving information. We are therefore concerned with motivation for behaviour and long-term programmes are necessary.
>
> 2. As in any good education, we are concerned with principles, not rote learning . . .
>
> 3. Any education must be suited to the interests and understanding of those to whom it is directed. Though there will be some common elements, 'blanket' type campaigns directed to the whole range of the community do not serve the purpose.
>
> 4. Programmes must involve the person in exercising discrimination and making decisions about courses of action.
>
> 5. No programme on drugs as a separate and special problem is taking account of the nature of the problem, the meaning of drug-use or the scope and complexity of human behaviour. The problem is not the drug but the interaction of a person and a drug. The framework of a programme should be self-understanding and maintenance of good health and function in physical, psychological and social sense.
>
> 6. Emphasis should not be on negative warnings . . .
>
> 14. The school is not the sole nor the most influential educating agent. Its influence can achieve little if its efforts are not supported by, or in accord with, a number of the other agents among which are family, peers, others in the community with whom one mixes, 'heroes' or models, the media."

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[11] Paragraph 451 of this Report.

[12] Progress Report of the Joint Committee of the Legislative Council and Legislative Assembly Upon Drugs, 1976, p. 171, paras. 4.1.1-4.1.17.

472. Support must be canvassed for the central concepts of good education in mental and physical health if any 'drug education' (or any other) programme is to succeed."[13]

473. The same submission commented on the methods employed in drug education for teachers and pupils[14]

> "The films made to date have almost universally been bad. They suffer from the same disability as the casual lecture in not being able to cover the range of material, let alone accomplish the real purpose of drug education; clearly to establish attitudes and either modify or reinforce behaviour modifications obviously take time and discussion over an extended period to allow for gradual acceptance of new ideas and this cannot be achieved in a one-night stand or by film alone as these employ largely a one-way process.
>
> *"Looking at the number of teachers so far involved in Health Commission seminars, I can only say that the surface has barely been scratched."*

474. Miss Guthrie pointed out that the courses for teachers have been conducted mainly in inner-metropolitan areas and have not by any means covered the State. The difficulties in releasing teachers to undertake them because of industrial action, the limit to funds available to employ relevant teachers and the resultant spasmodic attendances rather than education efforts is largely useless[15]. The N.S.W. Government Budget papers, 1977, indicated 21 744 secondary teachers and 339 secondary schools; such workshops as have been conducted would have very little effect on the problem evident in the schools.

**The Views of the Education Community**

475. The Committee has tested attitudes to these general guidelines amongst those responsible for education at the regional level and also in the schools. There is evidence at regional and local levels that there is reluctance, in the absence of a local drug problem among young people, to lay any special emphasis in the school curriculum on the misuse of drugs in case this leads to experimentation by those who might not have thought of it. Some teachers feel that it would be equally wrong, as had happened in some schools, for a session to be inserted into the school curriculum because there had been a problem in the school or because the topic was receiving special media attention. They were opposed to "experts" being called in to conduct sessions on the subject. They were generally convinced, however, that teaching directed towards a proper appreciation of the use and misuse of drugs and stressing the commonsense view that an excess of anything can be harmful, should be included in the curriculum as part of the syllabus of health or social education and not specifically as drugs education. These views accord with the view of the delegates to a UNESCO Conference on the subject of Education in more developed countries to prevent drug misuse, held in Paris in December, 1972, that programmes of education for the prevention of drug misuse should be carried out as part of a broader programme directed towards education in human behaviour and healthy living in the full mental as well as physical sense, conducted in close co-operation with the various authorities which determined the quality of the environment.

476. It has been presented to the Committee that teaching about drugs could have both preventive and counter-preventive effects, and that in the long term it did not seem that particular effects were related to particular educational methods. Furthermore, although attitudes towards drugs might be changed through education, it did not follow that they would be maintained and hence immediate effects could not be regarded as indicative of the long-term consequences. Therefore, it is argued the preventive value of education could only be maximized by more intensive programmes based on defined goals and principles. This had led to the designing of drug education "packages" for schools which focus pupil's knowledge about drugs with the object of reducing the desire to experiment with them, so improving communication between teacher and pupil and development of the pupil's decision-making skills. The Committee would not deny the validity of this approach. They believe, however, that it needs to be carefully amalgamated with other programmes for education for life through the implementation of Personal Development courses in the schools. The success of such programmes presupposes a highly responsible and professional attitude on the part of the teacher involved.

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[13] Vide, Progress Report of the Joint Committee of the Legislative Council and Legislative Assembly Upon Drugs, 1976, p. 172.

[14] Progress Report of the Joint Committee of the Legislative Council and Legislative Assembly Upon Drugs, 1976, p. 172, paras. 4.2.4 and 4.2.5.

[15] Vide, ibid.

477. Some witnesses have suggested to the Committee it was not so much the educational aspects that authorities were most concerned about as the need to provide good supporting services and for good liaison with medical officers and the police which would help them to deal with individual problems. Some teachers emphasize the importance of effective systems of wider counselling in schools for helping children to overcome their problems and to become emotionally mature. Many children need an understanding adult in whom to confide and to whom they can turn in case of need. This role was often fulfilled by the teacher. The question has been raised as to whether children felt inhibited in going to someone they knew if they had a problem and whether it would not be better for them to have access to some independent agency. The evidence the Committee received suggested, however, that schools do not appear to regard this as a difficulty and are satisfied that pupils and, indeed, ex-pupils do go to them for help and advice on drugs and other personal problems. Parents also generally regard schools as places to which they can turn for consultation about their children's behaviour problems.

478. Schools are obviously better able to help children with drugs problems if they are kept well-informed of the local situations and know where they can turn for professional help and support if need be. It has been suggested that the schools, doctors, youth workers, the police, health education officers, social services representatives, probation officers, and any others concerned with young people in trouble of any kind, could share information. A group of this kind would also provide an invaluable and continuing link between schools and those agencies who are concerned with young people at risk when they leave school, and those working with school non-attenders.

479. The Committee recognizes that many teachers and indeed other professionals, especially those whose formal training occurred some years ago, are as yet inadequately trained for dealing with the many social problems, including drug misuse, which may now become part of their experience.

480. The New South Wales Department of Education and the Health Commission of New South Wales are sources of information and advice for teachers on health education within the curriculum. The proposed use of video tapes made at the residential course for teachers from government and non-government schools, at regional conferences of teachers with some of the key teachers and other experts participating, can give improvement to in-service education in this field.

**Conclusion**

481. The Committee feels, however, that this is an aspect of teacher education which requires to be considerably developed, particularly in initial teacher education, so that all teachers are equipped to be able to recognize children with personal problems, and with sufficient knowledge of how they should act when confronted by them. The Committee has been glad to be assured by the Department of Education that those responsible for teacher education are certainly not unmindful of the need for education for both counselling and health education and that it is the intention that attention will continue to be given to it.

482. So long, however, as drugs continue to play a prominent role as an escape from many of society's ills, no one can afford to become complacent about the misuse of drugs by young people at school. The Committee recognizes that a young person's experimentation with drugs cannot be viewed outside the context of adolescence and that in trying to deal with the problems that arise attention needs to be given to the nature of adolescence generally and the social conditions which predispose the young to using drugs or finding other ways of overcoming their personal difficulties. The Committee noted that some effort has been made in the field of education for helping young people who are involved with drugs or beset by other problems of growing up. The Committee feels, however, that its hearings have highlighted ways in which these services could be developed.

483. **Recommendations**

The following recommendations are intended as suggestions for fostering and encouraging those developments which the Committee has learned from those concerned with the education and care of children seem most likely to achieve success.

**(31) Those responsible for the school curriculum should seek to galvanize present activity to accelerate the inclusion of education about the current use of drugs and the dangers of experimentation and misuse in the context of general health and social education in schools.**

**(32) Development of counselling services in schools.**

**(a) The Department of Education should encourage schools in particular those which have not taken steps to provide counsel-**

**ling services, to review and define their policies and attitudes on such matters as:**

**(i) the development of a system of counselling designed to ensure a continuing awareness and concern for the welfare of the individual, bearing in mind that such a system requires the careful guarding of information obtained in confidence. The recipients of that information may sometimes need to get advice and help from relevant professionals;**

**(ii) the involvement both individually and collectively, and subject to the need to maintain confidences, of parents and guardians in such a system.**

**(b) The education authorities should consider the desirability, where necessary, of initiating co-operation with the other local statutory services, the police, and voluntary bodies concerned with the welfare of young people, and of ensuring that the support services available to the community at large are linked with the support services within the school. Such co-operation might best be achieved by the formation of liaison groups representing all the services involved to consider the problems of young people, including those associated with the misuse of drugs, and how they can be dealt with. Either through such liaison groups or through local education authorities themselves, the support services available to help young people while they are at school and when they leave should be made known to pupils, teachers and parents.**

**(33) Teachers should be trained to recognize and deal with the personal problems of pupils. Those responsible for the initial education and in-service training of teachers should continue to expand the opportunities for preparing teachers to be able to recognize and deal appropriately with the personal problems which beset the maturing young person. In so far as drug misuse may be a symptom of a problem, teachers should be kept informed of developments in this field.**

**(34) Basic teacher-education courses in tertiary institutions should contain an adequate core strand (as well as electives or options for deeper study) for health education and personal development programmes.**

**(35) Personal development courses containing drug education should be compulsory in secondary schools.**

**(36) There should be training of other professional staff concerned with young people in trouble.**

**The Adult Community**

484. There is a need to reach the adult community. It is beyond question that in New South Wales people have been left abysmally ignorant of an elementary comprehension of the nature of the uses and misuses to which drugs can be put, their potential benefits and hazards and, above all, help with self-understanding so that individuals can judge more adequately for themselves the potential personal dangers of their drug-taking habits. The experience world wide of the education campaigns about the effects of tobacco show that the public is slow to respond to the education process. The warnings about dangers which nicotine poses to health have frequently seemed dire, but people continue to smoke, and even at times have increased their consumption directly in proportion to the intensity of the campaigns against smoking. Nevertheless, there is evidence that general public education can work.

485. The State of Ontario in Canada has over a period of 25 years built up a major drug information service through the Addiction Research Foundation in Toronto. It is probably leading the world in the matter of drug education. The experience there has been that the public will respond to balanced education programmes about all drugs, including alcohol. When restrictions were placed on consumption of alcohol at sports meetings the public accepted them with little demur and demand for alcohol generally went down. It is a fact that in New South Wales the Government's recent ban on smoking in public transport has been readily accepted by the vast majority of the community, by smokers and non-smokers alike.

486. The Committee heard much in evidence about international drug conferences where delegates appeared to have spent much time discussing what was wrong with drug education and why it might not work. The Committee heard nothing officially about the work or the policies of the Government of Ontario which through the Addiction Research Foundation in Toronto achieved a considerable measure of success in containing the use of drugs.

487. The Health Commission of New South Wales tendered as evidence to the earlier Parliamentary Committee a report by the Assessment Team to Drug Education Subcommittee of the National Standing Control Committee on Drugs of Dependence.[16] This Report contained a survey by a group of experts on the state of education about drugs throughout Australia up to 1974. It is of value in as much that it gives some indications of the difficulties in providing drug education that is not counter-productive and of achieving a marked degree of community penetration. It revealed that the Drug Education Unit in the Health Commission of New South Wales was at that stage potentially capable of producing programmes which might create a lead in Australia.

488. As stressed by those directly responsible within the Health Commission, subsequent performance has been disappointing.[17]

489. Indeed, the Committee cannot escape the conclusion that in the provision of general health education about drugs for the community at large, the State effort in New South Wales is pitiful. There is a shortage of manpower, a lack of strong central direction and confusion about objectives. With a population of well over 1 million people, the Western Region of Sydney has only one health education officer specializing in drugs, as do the Hunter, Illawarra, and New England Regions. These regions might count themselves fortunate. The Inner-Metropolitan, Northern Metropolitan and North Coast have none.[18]

490. It is not surprising that the Committee heard so frequently from witnesses during inspections that the people who wanted to find out about drugs, through their interest or because of a developing family problem, had no idea where to turn for help.

491. The Committee has no doubt that the provisions of resources for health education about drug-use has to be augmented. The Committee has been told frequently that the drug problem is a people problem. That is true. But it is true in the sense not just that drug-use reflects personal stress and physical need, but that it is upon the quality and availability of the professional and voluntary people working in the health field that implementation of successful programmes ultimately depends.

492. There has been no shortage of expert opinion available to the Committee on the theory of drug education programmes. The Committee encountered a certain degree of frustration, however, in pinpointing the reasons why nothing very impressive has been achieved in practice.

493. Dr Robert Irwin of the Canberra College of Advanced Education, who is an acknowledged authority in drug education research, referred to programmes in other States which were achieving results. The Committee has paid some attention to these. The Committee has concluded, however, that health education services being provided in the Hunter Health Region of New South Wales are as good an example as any of what the right degree of enthusiasm and the right expertise can do. During its visit to the Region the Committee spent some time at the Hunter Community Addiction Service Centre. The co-ordinator, a medical practitioner, subsequently gave formal evidence.[19] The Committee does not suggest that the Hunter Region provides an absolute blueprint for health education about drugs but the Committee believes, however, that the work in that region gives a lead in the right direction. The Committee believes that its hearings in Newcastle demonstrated a co-ordinated and vigorous attempt by the medical profession especially to come to grips with the excessive use of drugs. This was amply demonstrated by the evidence of members of the Australian Medical Association who gave evidence before the Committee.[20] The co-ordinated link between the Regional Director of Health and his staff, the Hunter Community Addiction Service, the Royal Newcastle Hospital and the local medical profession was an encouraging sign of what might be achieved with community education, involvement and control. Those concerned in the Hunter would not claim to have more than scratched the surface. The Committee believes that they show what talent, drive and energy can achieve at local levels.

494. In citing the Hunter Region in this way, the Committee does not wish to imply invidious comparisons with the other Regions which the Committee visited. At Regional level, the Committee found that health staff in other Regions were greatly perturbed by the growing drugs problem and their lack of resources

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[16] Progress Report of the Joint Committee of the Legislative Council and Legislative Assembly Upon Drugs, 1976, p. 67 (Appendix 15).

[17] Minutes of Evidence, p. 356, para. 4577.

[18] Minutes of Evidence, pp. 316 to 318.

[19] Minutes of Evidence, p. 59, para. 2130.

[20] Minutes of Evidence, pp. 79 to 81.

to deal with it. The North Coast Region, for example, does not have provision for a special health educator in drugs use. It is perhaps little wonder that the local doctor who gave evidence formally before the Committee claims to have found primary schoolchildren "tripping" on LSD in class. As he pointed out, neither parents nor teachers know what they should look for.

495. The vexed question of allocation of greater resources for drug programmes generally is discussed in chapter 12. The Committee supports the need for vigorous implementation of health education programmes which pay particular regard to drugs. The community has a need for them, there is evidence that there is a growing demand for them amongst community groups and the community has every right to expect them.

**Health Commission Policy**

496. The senior psychiatrist in charge of the Drug Education Unit, Central Drug and Alcohol Advisory Service, Health Commission of New South Wales, tendered in evidence[21] a paper concerned with the prevention of narcotic or polydrug-abuse which discusses the productive and counter-productive educational techniques on the basis of research findings and international reports on the outcome of such programmes. Since this document represents the latest official thinking on drug education in New South Wales, its conclusions merit examination. The paper reads:—

**Commonly Used Counter-Protective Techniques in Drug-Abuse Prevention**

497. "It is unfortunate that the most common methods used to counter drug-abuse are almost invariably used in situations where they are counter-productive. It is regrettable that some well-meaning people and some 'ego trippers' present themselves as allies in so-called drug education programmes. Their communicatory methods positively provoke drug experimentation, either because of the precise information they give to the curious or because, in their zeal, they oversell, thus straining their own creditability.

498. "The following methods are to be regarded as potentially very dangerous to the health of the community and some have in fact been prohibited in America.

(1) *Media Warning Campaigns*—"The American Consumers' Association was able to trace glue sniffing, now endemic in the States, across the country from town to town where well-meaning media campaigns had been carried out to warn people of the dangers of this behaviour.

(2) *One Night Stands*—"It is not possible for people to grapple with their attitudes, values and future behaviours all in the course of one session. The nature of the session dictates that more harm than good is likely to be the outcome.

(3) *Giving Information on its Own*—"When information is given, usually on a one night stand basis, to the general public, it carries a high risk of counter-productiveness. Information by itself can often arouse curiosity, or it is not properly perceived by the receiver; its use without discussion and where it is not part of a continuing programme is counter-productive.

(4) *Ex-Addict Testimonials*—"This is a particularly contentious issue. The public enjoy them (voyeuristic gratification?), amateur educators use them as draw cards and some even believe that their use is productive. However, the powerful non-verbal message contained in the *ex* is a real danger. It fosters the delusion that 'he can give it up, so could I'. A glance at the treatment figures for narcotic dependency will confirm that there is only a miniscule chance of a permanent cure for narcotic dependency. This, of course, does not exclude the use of ex-addicts or addicts as counsellors in the *treatment* medium.

(5) *Finally, the Use of Fear is Counter-Productive*—"The Americans have coined the phrase 'the peril is the lure' and this is considered to be real. It is a challenge to gutsy youth; it is only the chicken who doesn't try. In the past many fear communications were associated either with untruths or part truths which acted against the credibility of the speaker and hence his message. Fear messages become associated with untrue messages. There is also a defensive mechanism which operates when fear is used in messages to the non-naive. Here the message is blocked by the receiver and, moreover, this blocking occurs on all subsequent occasions that

[21] Health Commission of New South Wales: Prediction and Prevention of Drug Abuse—Webb, et al, October, 1976.

the same topic is raised: the individual has in fact been rendered inaccessible to messages he might otherwise have listened to and acted upon.

499. "The use of these techniques alone or together will be likely to create drug experimentation and they have been named and prohibited in some countries. It is unfortunate that to date these counter-productive techniques are still being used (albeit innocently) and undoubtedly play their part in increasing both the incidence and prevalence of drug abuse in Australia."

500. The paper concludes, therefore, in relation to productive techniques, that:

*Productive Preventive Techniques*

Drug-abuse prevention is one of the few areas cursed with a rebound phenomenon, i.e. the behavioural outcome of drug abuse prevention can be, and often is, the opposite of the intention: it is not just a useless process, like some say typhoid vaccination is, but it will actually cause the disease it is intended to be preventing—drug dependency.

501. "Over the years, social scientists and educators have discovered that straightforward information-giving methods are ineffective in either establishing new attitudes and behaviour where none previously existed or in converting people from one to another.

Such an approach is effective with an audience that is predominantly rational, receptive, objective and well-adjusted. However, since only a minority could be thus described and since one is rarely in a position to compose one's audience in a deliberately selective fashion, one has to plan programmes for humbler, more typical mortals. It can also be added that even those who are rational, objective, etc., live in social networks and the prospect of any significant behavioural change will confront them with not-always-pleasant repercussions in other parts of their lives.

502. "Previous approaches seem to have been based on the above model of the ubiquity of rational man. An alternative model which seems to offer a more accurate and therefore more promising guide to action is based on the following assumptions:

(1) people need to sort out their basic values and aspirations;

(2) people need to grapple with all aspects of the problems and dilemmas confronting them;

(3) they need to do this with people they understand and who understand them and they need time to do all this;

(4) they need to learn experientially as far as is possible;

(5) any attitudinal or behavioural change needs to be reinforced and consolidated over time;

(6) a forewarning of the consequences which are attached to any decision regarding their future behaviour is not without value provided these consequences are seen as real and not as false.

503. "The following techniques are therefore commended as largely helpful to the community and in essence, the potentially productive techniques require some understanding of human behaviour, some skill in communicating and all are built round the concept of participation by the audience, clients or group.

*Group discussion*

504. "This should always follow a lecture. It allows for debate, consensual validation of opinions and for statements to be made on one's own position with regard to drugs.

*On-going programmes*

505. "These are always desirable where opinion, attitude or behaviour formation is concerned. A one night stand just does not allow time for even an internal debate to take place and certainly several sessions will be required before decisions will be made about one's behaviour.

*Values Clarification*

506. "This is a process whereby people are helped first to identify their values and later to understand how much this value means to them in terms of their own behaviour. The technique uses 'games' liberally and can demonstrate how each normal individual varies considerably from his normal neighbours; the technique can also be used to help people make personal or consensus decisions on future behaviour.

507. "The outcomes of value clarification exercises are interestingly similar to the stated objectives of some of De Bono's exercises. Both certainly require

people to think and inter-relate and both provide a non-threatening milieu in which possible major decisions can be made.

*Analysis of Pressures*

508. "The object here is to develop methods of resisting persuasive pressures, whether the pressures be those emanating from the media or from one's peers. Advertisements are analysed for their hidden message, how they appeal and how they are likely to affect behaviour. Peer pressures to conform with group behaviour are also examined in the light of retaining one's position in the group yet maintaining areas of independence.

*Super Peer Programmes*

509. "These are designed to give first year students at High School support in all areas in what is regarded as an 'at-risk' year. Fifth form volunteers can be trained in some facets of the personality and needs of a 12-year-old and are also trained in listening. The fifth-formers are backed by a teacher, counsellor or mental health worker and are instructed to meet their group of six youngsters on a weekly basis. Some thirty schools in Sydney have tried and are trying variations on this theme which results in personal growth of the fifth-formers whilst providing support and an identification point for the group of first-formers.

*Alternatives*

510. "These are much discussed as a solution to drug abuse but they have connotations of the old Christian system of keeping someone so busy and exhausted that he has no time to sin. Certainly, if playing rugby union is seen as an alternative it can't be said to be exactly successful as far as the drug alcohol is concerned. In fact, alcohol after the game is all part of the subculture surrounding football.

511. "Helen Nowlis, however, has spoken of dissonant behaviours, behaviours which are incompatible with the use of drugs and hence could be used as alternatives. Berzins et al, as noted above, have pointed out the presence of abusers who are escaping from stress and of others who are seeking hedonistic experiences.

512. "It is possible to provide alternatives suited to the actual need and not just alternatives which use up time and energy. These would be to foster an antisympathomimetic state for those seeking to escape and 'adrenalin highs' for those seeking excitement. All those techniques, which seem to rise and fall in popularity like the tide, that purport to teach relaxation, meditation or alpha wave generation, should satisfy the escape type abuser. In fact, some claim success for those techniques with actual addicts as a treatment medium, and not as a preventive alternative as is suggested here. Transcendental meditation, yoga, relaxation, bio-feed back, can be taught and can all be used by ordinary citizens as an alternative to drugs. As a preventive technique, and particularly where minor tranquillizer abuse is at risk, these methods of obtaining relaxation can be tried.

513. "Behaviours dissonant with stimulant drug use such as hang-gliding, mountaineering and car racing, would all provide an adrenalin high. The authors are unaware of any claims however made for these as viable alternatives to drugs, and suspect that the same criticisms as apply to rugby could also apply here.

514. "It is clear, however, that the activities themselves are dissonant with drug-use and do not have a culture connection with the overuse of alcohol. They are solitary and not team sports and perhaps it is only team sports which are associated with heavy alcohol use.

*Role Playing*

515. "A technique which requires skilful leadership, as it can be harmful if it is mismanaged. It is, however, a powerful tool in teaching understanding of others' behaviours and in teaching insights into one's own. It can be used in conjunction with the fish bowl technique, which considerably enlarges its sphere of influence.

*Psychological Inoculation*

516. "This is an experimental technique whereby an attempt is made to strengthen people's defences against anticipated risks such as being offered drugs. This has been shown to be possible in a laboratory setting but does not appear to have been attempted in the community. The technique is based on an analogy with the physical process of immunization. The antigen or the offer of drugs is presented in a modified form such as an instruction to refute in writing certain persuasive arguments to use drugs. Other techniques such as role playing or group discussion would probably be more potent immunizers than the cognitive exercise of writing and it is proposed to test this out very soon. This strategy, like physical immunization, would almost certainly be ineffective in the long run unless repeated at intervals.

*Anticipatory Guidance*

517. "A true preventive technique which uses forewarning about predictable crises. Here forthcoming crises such as operations or entry to a new school can be effectively defused by dissipating false fears and beliefs through prior discussion of the real elements of the crises.

518. "In crisis intervention the crisis and its psychological impact on the individual is used by the health worker to foster growth in that individual. It is claimed that the new skills acquired during the resolution of the crisis will generalize and that all subsequent crises will be handled successfully. Would this valuable skill be lost if the crisis was defused by anticipatory guidance? The authors think not. The predictable crisis still occurs but it is now divested of all its unhealthy psychological components such as fantasy and false fears. In fact a crisis which has been the subject of anticipatory guidance can well be seen as a genuine form of psychological immunization. A modified antigen has been presented to the person who has produced coping antibodies which have lasting benefits to the individual so affected."

519. The Committee is not in a position to decide upon the validity or otherwise of professional findings of this kind. The Committee is only concerned that such findings should not now rest in a pigeonhole or remain as esoteric fare for the delectation of delegates at international conferences. These findings are, at least, representative of the evaluation which is needed. The Committee wants to see them used to create positive programmes and realistic programmes. If some of the terminologies appearing in the professional reports find their way into education programmes, they are not likely to provide much public enlightenment or acceptance.

**The Situation within the Health Commission**

520. In the creation of positive or worthwhile programmes, the Committee has been concerned to note that regionalization within the Health Commission appears to be a strongly inhibiting factor in the provision of health programmes in relation to drugs.

521. Thus in evidence[22] "basically I think we are apt to and do attempt to collect from our own experience and all over the world what is going on in drug education and the results of various drug education programmes and then to see that Health Commission staff know about these techniques and the disastrous results of some of them. It fits in with what I was saying. To do that one has to consult, to meet and to run training workshops with Health Commission staff. In summary I should say that I see our main job as ensuring that as many Health Commission staff as are engaged in education, know the guidelines that we are putting out and how to do this job". Also

[23] Q. "Dr Webb, could you give the Committee some idea of your average working week and the type of work you would be engaged in? A. At this moment I should like to say that I am advisory rather than a doer, and I have been so since regionalization. It is mainly consultative work with education officers who either ring up or come in for resources material or for advice on what techniques to use with particular community groups, children or teachers or whoever it is. I would say that is a fairly large part of my duties. Another large part is attempting to collect on a mateship network, information about what is going on in the Region as *there is no obligation on them to report or to inform us as to what is happening.* This is mainly supporting work. There is another responsibility in training that is in running fairly continuous workshops for our Health Commission staff and we are asked to help Commission staff run workshops in their areas for other professions. For instance, yesterday the Inner-Metropolitan Health Region was running a teacher workshop and they asked three of us to help them out with this work. This would be a smaller part of the week's work but I would guess it would probably be the most important work in terms of doing things. Another part of the work is writing policy statements and submitting them. Meetings are held by the dozen. They would be meetings with our own people and with the Department of Education; there would be meetings also with other government department officials. There seem to be more of those in the form of committees and working parties or groups trying to make up policy statements between the Department of Education and the Health Commission. They are also trying to prepare a joint drug education programme. That is roughly the sort of work I am doing.

Q. "Would you spend much time visiting the various regions in the Health Department? A. Not very much. I prefer to be invited because of the peculiar position of being neither fish nor fowl, being advisory without the sort of authority to say that I am making a visit. We do visit but usually for a specific job rather than to see what is going on. It would be a visit to consult with them."

522. On the strength of this evidence it would appear that there is a lamentable breakdown in the management of drug education services within the

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[22] Minutes of Evidence, p. 355, para. 4575.

[23] Minutes of Evidence, p. 353, paras. 4553 and 4554.

Health Commission of New South Wales, at a time when there is overwhelming evidence of a rapidly growing social problem in relation to the misuse of drugs and marked community concern about it. It is a matter of the gravest public concern that officials of the Health Commission of New South Wales, either in the central services agencies or in the regions, should wonder whether they should talk to each other about the implementation of drug education programmes.

523. In the regions the Committee found no reluctance on the part of those on the staff who have been provided to deal with drug education, to seek advice and guidance and help with programmes. They showed a certain amount of desperation about the lack of support they were getting.

524. Clearly there is a serious organizational breakdown in this respect. It is perhaps aggravated by a somewhat confused view within the Health Commission of New South Wales at the highest levels about the role which education can play in regard to drugs.

525. Thus in evidence[24] Q. "It has been submitted to us that the answer to excessive usage of analgesics by a minority group in the community lies in consumer education rather than restrictive legislation. You would not agree with that opinion? A. (Dr McEwin) No, not really. I think it would be fine if we could educate people not to use analgesics, but I do not think that is a practical solution.

[25] Q. "We have been informed that interested parties are willing to co-operate with the Health Commission in any education programme designed to achieve an enlightened use of analgesics. Have any approaches been made to the Commission with regard to the production of such programmes in relation to non-opiate analgesics? A. Yes, we have had approaches from people concerned in the manufacture of these substances. We have not thought that that really is the best answer to solving the problem.

[26] Q. On 12th September the Chairman of the Health Commission said in answer to a question from me about analgesics that while he had some reservations about consumer education he felt legislation was far more effective. What is your reaction to that? A. (Dr Webb) My personal reaction is I am always pleased when chairmen of my Commission say that they believe in education. Our approach has not been to educate by drug but by behaviour. Dr Egger was saying it is a people problem. I would not like to mount an analgesic specific education programme. I would like to include analgesic abuse in part of the general education programme which looks at the reasons for the use of any drug, including analgesics.

Q. His opinion was that it would be fine if we could educate people not to use analgesics, but he did not think that was a practical solution. A. (Dr Storey) I think Dr Egger made the point this morning that analgesics are at the end of the spectrum, away from physical dependence. Therefore, probably—and in my view, certainly—the most effective way of dealing with this is by way of a legislative programme, backed up by the reasons why we are doing it, and trying to ease the problem for the very small minority who might be adversely affected by legislative action.

Q. Do you agree that the same criteria would apply to barbiturates? A. I think they would be half-way in between. We are moving across the spectrum now. (Second witness) With the compound analgesics we have an alternative that is just as effective in medical terms, that is, the single analgesic. The only property lacking is the addictive property. That is, the extra caffeine. With the barbiturates I think there is probably a case to be made for some of the more harmful ones being restricted, in the same way as the compound analgesics. There are still some benefits to be gained by certain of the barbiturates, the same as with single analgesics."

526. The Committee believes that in the above extracts Dr Storey hit the nail right on the head when talking about combined analgesics "that the most effective way of dealing with this is by way of a legislative programme, *backed up by the reasons why we are doing it* and trying to ease the problem for the very small minority who might be adversely affected by legislative action".

527. It seems to the Committee that, backed up by the reasons why we are doing it, the crux of the problem lies, for example, in explaining that consumption of analgesics at the rate of one APC a day can put the user's health at serious risk. Members of the Committee have found this information to be salutary. However, it has been argued that the danger warnings of a similar kind in relation to tobacco consumption have never worked. It seems to the Committee that programmes which suggest to people that they must find ways around their

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[24] Minutes of Evidence, p. 334, para. 4322.

[25] Minutes of Evidence, p. 334, para. 4326.

[26] Minutes of Evidence, p. 356, paras. 4578, 4579, 4580.

personal problems without recourse to drugs will not work unless they relate to accurate and reliable information about physical risk. For example, in the case of alcohol, which most adults use and more readily understand, the majority of people enjoy the relaxation it provides, even to the point of becoming drunk and possibly in some cases know of no better way of relaxing in the modern world. The only way of persuading them to reduce their consumption might be to convince them that if they go on at certain rates they will kill themselves prematurely either through tissue damage or sudden death on the roads. Looked at in this way it seems to the Committee that drug education programmes can only aim to contain consumption at certain levels whilst attempts are made through other means altogether to inform people of the killing drugs like heroin.

**The Need for a More Vigorous Approach**

528. The Committee recognizes that many experts and drug educators would not dissent from this general conclusion. Nevertheless, the Committee finds it difficult to understand why if the object is containing drug-use and a programme fulfilment to dissuade people from excessive use according to the spectrum Dr Egger referred to in his evidence that there should be such a marked reluctance to deal with drug education through the use of the broadcasting and television media.

529. During its visit to the Seventh International Conference on Alcohol, Drugs and Traffic Safety, the Committee heard from a drug education expert residing in New South Wales on the need to adopt the same professionalism in devising advertisements warning against the risk of excessive drug-use as many of the well-known drug manufacturers use in promoting their products. There are many who believe that in the private sector are experts capable of producing health education material for comprehensive media coverage which could be accurate and not counter-productive—a reason often cited for doing nothing in this regard. For example, reference was made to a well-known British Government sponsored advertisement concerning the health hazard of smoking. It showed a young man and woman in a romantic setting; the girl was smoking. As the boy leaned across the table in a amatory manner, the girl's face turned into a dirty ashtray filled with ash and cigarette butts. At this point a voice intoned solemnly, "How would you like making love to an ashtray?".

530. This advertisement was judged to have done more to educate young people away from smoking in one swoop than 20 years of intensive advertising of the risks of lung cancer. There may be purists in the drugs education field who would be aghast at this approach. The Committee believes that such initiatives should be assessed and evaluated for use within New South Wales. The Committee cannot believe that it is impossible to find education and advertisement styles which can be deployed to great effect through the mass media, particularly television. Such presentation would, of course, need to be compiled by experts, probably on a contract basis, and such compilation be subject to the direction and endorsement of persons well qualified in the disciplines, and subject to approval by educationalists knowledgeable and experienced in teaching a particular age group to which the programme is directed. The cost of presentation time or space would always have to be under review as to cost effectiveness for local and relatively restricted range and regional media. Such series might well be welcomed to make up time and space without charge.

531. The Committee believes that an immediate build-up of such programmes without the support of proper evaluation techniques could in the long run create counter-productive benefits and serious damage. The Committee, therefore, recommends that the Health Commission of New South Wales should, as a matter of urgency, decide what in its current education programmes is safe for use throughout the State and to provide full State coverage in the regions by the end of 1978.

532. This programme should proceed in tandem with urgent examination of pilot programmes for drug education through the media. The Committee hopes that such pilot programmes will be available for assessment by September, 1978. The Committee expects that bringing the media more directly into the matter of drug education would have the consequential benefit of more reliable information which could then correspondingly provide more accurate media coverage of drug stories as they appear in the daily news.

533. The Committee recognizes that reaching the adult community at large in this way presents practical difficulties with finance and manpower ceilings which arise from ever increasing competition for public resources. The Committee endorses, therefore, the Health Commission view that priority must be given to providing courses for influential community leaders and community groups. These are the techniques being deployed in the Hunter Region. This is not a new idea. The new initiative must relate to a renewed vigour in their continuing evaluation and their introduction throughout the State.

534. The potentiality of television and radio serves to underline the need for good back-up information services. It must be recognised that global coverage

on the air would most beneficially stir public interest and inquiry. Properly trained educators must be available to deal with general health and meet people's deeper personal needs in relation to drug-use and health and welfare.

535. In providing such back-up the Committee has been surprised to learn that nowhere in Australia is formal health education provided at any educational level. In the words of a witness,"If you need a health education qualification you have to go overseas to get one".

536. This is a remarkable state of affairs. It is a general inadequacy which the Committee believe exists generally in the provision of community health care delivery programmes. The Committee supports the concept which takes the matter of general health and social welfare back into the local community on a self-help basis.

537. **Recommendations**

**(37) New initiatives in drug education in New South Wales should be taken.**

**(38) Specialist health education in regard to drug use should continue to be provided through the Health Commission of New South Wales.**

**(39) Programmes like the one already undertaken by the Hunter Community Addiction Service should be urgently evaluated with a view to their introduction in all Health Regions of New South Wales.**

**(40) Urgent consideration should be given to appropriate drug education through television and radio, both at State and regional levels.**

**(41) Specialist drug education programmes at the personal level must be so structured as to provide adequate support for the more intensive demand for information and advice which can be expected to arise from global broadcasting and other media coverage.**

**(42) Specialist health education programmes should be carefully orchestrated with personal development programmes in the schools.**

**(43) In line with an overall aim to integrate drug education and drug treatment into strongly based community programmes, policies for specialist health education in relation to drugs must be closely integrated with the whole range of local drug programmes.**

have become the pushers. Up to the present moment we have had very little opportunity to offer any viable alternatives. One talks about preventive medicine but in point of fact it does not exist today until you start to look at alternative approaches like acupuncture, yoga, Ti-chee and herbology. You look at diagnostic means to find these out, like iridology and so forth. The point I try to make here is that we are still rooted very much in the past and we have not yet developed viable forms of treatment that would not cause as many harmful side-effects as we hope to cure. The attitude about this also, I cannot say that my hands are clean—we work with what we have. The fact is that what we have had to work with up to the present moment is grossly inadequate. But we keep on acting as though what we knew was all that there was to know about things so we keep on pushing these old methods of treatment.

547. "How successful was this experiment in Brisbane Street? I would say that of the 100 percent of the people who approached us for treatment some 50 percent dropped out, not because acupuncture did not work but because it did work. They were faced with the existential moment of truth when they found there was something that could help them. Looking back on it, of those 50 percent that walked out I think as a doctor and as a person enthusiastic about what he was doing, those patients were driven to treatment long before they were ready to accept it. Now we have to look at the whole problem of motivation. It seems to me in this area courts will make persons accept treatment long before they are ready and therefore all our efforts at healing them are in a way doomed to failure. That is an appalling negative thought but the fact is—and I think you could probably gather this from comments from various people in the profession and allied professions and from drug addicts themselves—they will come only when they feel the need to, not when we think they should. Of the 50 percent who did remain from treatment there was a 100 percent cure of them. The point here is that the motivation to cure a disease must come from the person concerned, not from people outside of them.

548. "I think there is going to be a lot of expensive waste of public moneys in driving people to a cure. I feel sorry that we are left in a position therapeutically where a person has to come along of his own volition and say that he wants out. I deplore that in a way but I have to respect that a person has a right to run his own life. I have to respect that public moneys are not to be wasted in this area. Some of the cases were interesting. I recall a patient who came in for treatment who was on a 100 milligram methadone plus a $120 a day habit—this was at the Brisbane Street Clinic. We took him off with "cold turkey" and he has been free of any addictive qualities since then. That was more than 18 months ago. I do not think that the Health Department is sufficiently aware of the fact that there are very beautiful healing techniques available and really they do not want to know about them because they are not in charge of it. We are drifting into an area of healing where the average medical practitioner does not have a clue about acupuncture and cannot really recommend it. Furthermore, a lot of healing in the area is drifting heavily away from the medical profession into the hands of what I should like to call healers. The people with whom I have been associated in healing areas in the past 4 years are not medically qualified but they pay an intellectual respect to learning their new techniques and they have a feeling for people. We know that that has disappeared from the medical profession. The Committee should look at the fact that a lot of valid healing is done outside the medical profession. These people have intellectual integrity, sensitivity and compassion for the people they treat."

549. Dr H. Freeman, a private psychiatrist who is also employed by the Health Commission of New South Wales on a private basis, offered a further view.[5] "I am most concerned about prescribed drugs and about opiates and the way they are used. In my capacity as a psychiatrist I guess I see quite a few of the people who get into difficulties both with prescribed drugs and with opiates. My opinions about opiates are those that I gave to you before but I want to reaffirm that. I believe that opiates should be prescribable by any doctor. I do not think there is any way of dealing with the problem of addiction to opium or the opiates other than to make them readily available but only when prescribed by a doctor. I think in this way you can effectively bore most people out of using the opiates, providing you can reliably educate the doctors who prescribe them not to do so without ensuring that a lot of talking goes on between the doctor and the patient getting them. I believe that the use of opiates should be decriminalized as has been done in some countries. I cannot see that criminalizing the use of them is doing anything but increasing the likelihood that they will have people pushing to use more.

550. "As far as prescribed drugs are concerned, you will hear more about those from Rod Richardson later on. I agree with him that we now have in the community a climate, and I am referring to doctors, nurses and all sorts of people who are responsible, that is saying that good health is something that you can only get at the hands of experts and probably only experts who have access to

[5] Minutes of Evidence, p. 206, para. 3419.

drugs and technology. That is disastrous. Good health should be something we should all have access to by virtue of our own labours, beliefs and actions. The more we believe that good health can only be gained by regular access to professional people, drugs and high technology, the more we will have an uncontrollable juggernaut with regard to health through our delivery services. I believe that is a serious problem. I believe doctors overuse virtually all drugs. They are merely reflecting and reinforcing the attitude that health is a thing that you do not get merely by leading the right sort of life. So long as they do that we have a quarter that says the introduction of foreign substances into the body is O.K. That is a problem. It is not really O.K. and we should not believe that. Those are the attitudes I want to present to you. So far as marihuana is concerned, later on I would like to talk about that."

551. It is salutary to reflect that these disparate views represent extreme diversity in practice in one health region alone, although they are representative of the evidence which the Committee found throughout its hearings.

552. Against the background of so wide an attitudinal spectrum the Committee has had to consider its approach to treatment with care. If we subscribe to the belief that those who become heavily dependent on drugs are in need of the best care and attention the community can offer, the fact that they should be allowed to roam in a system with such divergent approaches as demonstrated by the foregoing extracts of evidence is a matter to which the Committee must at once draw attention as one of great disquiet. It immediately raises the question whether existing treatment systems are more the creation to satisfy the preconceived notions of the treatment community than the inspiration to provide for the needs of the individuals.

553. Treatment of drug dependence has presented the Committee with the most daunting part of its task. Conceptually the subject is a massive one. The Committee found it difficult to get a clear idea of the place which the treatment of drug dependence has in the overall policy framework of the Health Commission of New South Wales.

554. The Central Drug Advisory Unit is the responsibility of the Commissioner for Personal Health Programmes who, amongst other things, is responsible for State psychiatric services and community health programmes. The exercise of this dual function somewhat reflects the ambivalence, confusion and conflict in the evidence the Committee has received from within the treatment community as to where the treatment of drug dependence should be placed within the health structure.

555. On the one hand, witnesses have claimed that dependence is a complex medical-social problem though not of itself a mental illness or strictly a mental disorder. Psychiatrists have, however, taken the lead not only in treating the psychiatric and personality problems often found to accompany dependence, but also exploring approaches to treatment of dependence itself. Mental health institutions have thus frequently become the focal point of referral and treatment. The development of this process can be traced back to the emergence in the last century of the highly industrialized society when society looked at its technological and entrepreneurial accomplishments and reasoned that the same skills should be able to respond with equal success to human and social needs. Thus the mentally ill were taken out to the backrooms of the communities that did not understand them, where in special environments skilled professionals could prepare them to re-enter the community as useful and productive citizens.

556. On the other hand, it is said that drug dependence and abuse present problems which run wider than that, and differ in several important respects from those presented by mental illness. The scope for prevention is broader. One may attempt to influence the availability of, and the attitudes of society to the "agent", as well as tackling the problems of the individual and the stresses placed on him by his environment. Physical medicine and the general hospital services have a part to play in the physical complications—liver disease, overdoses, withdrawal symptoms, and malnutrition. Moreover, it is argued that the great interaction of agents other than mental disorder, call for the delegation of rehabilitation of people dependent on drugs to the immediate community through co-operation between health, education, social services, law enforcement authorities and the voluntary bodies working in the field. The growth of this approach is in one way demonstrated by the fact that community services are provided in New South Wales for treatment of drug dependence to a far greater extent than for the mentaly ill by voluntary effort.

557. These divergencies are reflected in the extracts of evidence quoted at the beginning of this chapter. The Committee heard and read about 101 ways to deal with drug dependence. There is no clearly defined State Health policy and the voluntary organizations have many differing views.

558. The Committee has broadly detected two distinct approaches in New South Wales best described as medical maintenance and self-help abstinence. This represents a broad division evident in other parts of the world.

559. The medical maintenance approach is founded on the combined use of drugs and other rehabilitative services to help the dependent person, known as the "patient" or in more recent times the "client", back to a useful life with a need in some cases for life-time medication.

560. The abstinence approach is founded on the principle of drug-free treatment programmes, usually operated with the help of "ex-addicts" who are responsible for therapeutic communities functioning in a highly structured setting which emphasizes individual vulnerability to drugs and provides group settings in which common experiences are shared and abstinence is reinforced.

561. The New South Wales Health Commission has adopted the maintenance approach through the methadone maintenance programme begun in New South Wales in 1971.

562. Generally speaking, the voluntary organizations in New South Wales, notably WHOS Fellowship, the William Booth Clinic, and more recently Odyssey House enforce drug-free programmes.

563. **The Committee *wishes it to be clear that it has unlimited admiration for the many people whom it has met, both in government employment and in the voluntary organizations, who are working selflessly in the care of people in trouble from the use of drugs and in the quest for effective means of prevention.* However, the Committee must report that its review of the present treatment situation reveals—in as far as they exist—a cluttered, disjointed, overlapping, unco-ordinated set of public and private programmes that are opportunistic and responsive primarily to an immediate personal crisis or community tension. Lacking is a purposeful and continuing system that approaches the problem at both the individual and community levels, that is able to bring together current resources effectively and that is responsive to changes in the population served. If this is not quickly reversed, there can be no question that society in New South Wales will continue to perpetrate immeasurably harmful, self-inflicted damage.**

**Public Programmes**

*The General Position*

564. It is necessary for the Committee to draw attention to the fact that, alcohol apart, progress in establishing the required treatment capacity for drug-dependent persons in New South Wales has been singularly unimpressive. Such minimal facilities as do exist are concentrated almost exclusively on the treatment of narcotic dependent persons through the Methadone Maintenance Programme. Moreover, this programme has not achieved the beneficial results expected of it. The programme has been the subject of stringent review[6] within the Health Commission of New South Wales in which it has been shown to have serious shortcomings.

565. In October, 1975, the Health Commission of New South Wales Report,[7] in regard to abuse of analgesics, tranquillizing, sedative and hypnotic drugs, stated: "The abuse of analgesic, tranquillizing, sedative and hypnotic drugs is second only to the abuse of alcohol in terms of incidence, personal and social cost, use of hospital resources and significant damage to physical and mental health.

566. "The resources of the Health Commission have so far been focused primarily on treatment of the physical consequences of the abuse of these drugs, and this almost exclusively through the general hospital system.

567. "Little has been achieved in relation to prevention in this area of drug-abuse, and little has been accomplished in providing specific assistance for these persons through the community health services. However, now that the provision of services for the treatment of alcohol abuse is well-advanced, a significant shift of emphasis from that area to the area of analgesic and sedative abuse is planned. This shift of emphasis in planning implies a major involvement of education and preventive resources in this area."

568. With regard to opiates, stimulants and hallucinogens the Health Commission of New South Wales reported[8]: "Statistics referred to earlier suggest that the abuse of these drugs is presently being contained at comparatively low-levels; existing institutional and community treatment services are considered to be adequate and appropriate to meet established needs, and the major emphasis at the present time is properly placed on prevention.

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[6] Minutes of Evidence, p. 309, para. 7.6.

[7] Progress Report of the Joint Committee of the Legislative Council and Legislative Assembly Upon Drugs, 1976, p. 6, 7.3.1.-7.3.3.

[8] Progress Report, 1976, p. 6, 7.4.1. and 7.4.2.

569. "Constant attention is given to the need to extend the range of treatment options at our disposal, and to improve the quality of services offered. Constant attention is now being given by the Health Commission to the monitoring of trends in the abuse of illicit drugs."

570. The Committee believes that these statements of policy represent confusion in objectives and misunderstanding of the situation which are hindering the fulfilment of more effective drug-abuse treatment programmes in the State. The Committee strongly endorses the stated commitment to education and prevention. To believe, however, that successful education and prevention programmes might now be achieved through a shift in resources from treatment is a distortion of actuality which, if not properly recognized now, will lead to continuing disappointment and failure in the realization of government programmes to combat the harmful personal and social consequences of drug misuse. Notwithstanding the improvements claimed in relation to services for treatment of alcohol abuse, the Committee has found serious shortcoming in the provision of treatment facilities for drug dependency generally. Such facilities are virtually non-existent and they do not therefore provide resources which can be shifted into primary intervention through education.

571. Such a shift in emphasis would hardly seem practical, for example, in the Illawarra Region, where the Regional Director drew attention to the difficulties presently being encountered in the provision of treatment for renal failure arising from the non-medical use of compound analgesics[9]. "We have no renal dialysis unit in Wollongong yet. We have one hopefully coming. We are also aware that there are thirty people travelling from this area to Sydney three times a week for dialysis. This is a very expensive system in terms of transportation. There is a patient from Shoalhaven Heads. The ambulance has to leave very early in the morning to take that patient to Sydney by 9.30 a.m. It leaves from Wollongong. There is some difficulty about using one from Nowra. I think the number of vehicles is not adequate. An ambulance wagon leaves here about 3.30 a.m. to have that patient in Sydney by 9.30 a.m. That picks up the patient, of course, at 5.30 p.m. It is a tremendous added burden to the patient. I cannot give you any idea at the moment of the number of patients who are on home dialysis machines. They are issued from Sydney and we are not told who they are, which is also awkward. So there are many people on home dialysis machines and there are thirty people travelling between Wollongong and Sydney three times a week."

572. These shortcomings in the provision of treatment of dependence on the minor analgesics are serious. They are equally prevalent in the provision of treatment for dependence on the major analgesics—the opiate narcotics. In the Sydney metropolitan area the only in-patient service for narcotic dependence is provided at Wistaria House and Jacaranda House, which form part of the Parramatta Psychiatric Hospital. The Committee can only commend the staff in those two treatment units for the valiant efforts they have made to cope in daunting surroundings. The physical facilities existing in both at the time of the Committee's first visit to them in February, 1977, made a mockery of the spirit of rehabilitation in a compassionate society. They stand as a hallmark of the failure of existing systems to respond to the evidence of the continuing, serious and rapidly worsening problem of drug dependence.

573. The Committee is concerned that some of the statistical evidence, for example, the slackening in the rate of increase in the number of drug convictions in 1976, the marked emphasis on the rate of increase in the use of alcohol amongst young people, the decline in the number of those seeking entry to the methadone programme, a growing familiarity with drug misuse stories from media exposure, might lull some people into a feeling that the drug problem might be on the point of diminishing. The drug problem is not in fact diminishing; it is changing. The main changes are that the numbers of those dependent on narcotics continue to grow and there is an increasing core of young misusers who because of the limited treatment facilities available, are having difficulty in finding appropriate help rapidly. Furthermore, there is evidence from clinics and accident and emergency departments of a growth in multiple drug misuse (the misuse of two or more drugs at one time), which has become the major drug problem of the seventies, although there has been no corresponding and appropriate development of treatment facilities. In addition, services for overdosed patients are frequently overburdened and inadequate and it is difficult for those who wish to stop using drugs to find suitable assistance. Finally, there is a lack of choice in rehabilitation facilities, both adequate and suitable, for those withdrawn from drugs in prison, undergoing treatment whilst on probation, and those multiple drug misusers who have survived an overdose episode.

**Development of Multiple Drug Misuse and the Need to Respond to It**

574. Despite the increase in the number of opiate addicts, and the preponderant emphasis on the provision of treatment through the Methadone

[9] Minutes of Evidence, p. 103, para. 2457.

Maintenance Programme, use of narcotics is not necessarily the largest part of the problem. There is considerable evidence that multiple drug misuse is presenting an even greater problem and yet provision for multiple drug misusers, especially those who are not opiate users, is largely lacking both at treatment centres and in general psychiatric services.

575. The Committee is particularly concerned about the situation at the accident and emergency departments of the Sydney metropolitan hospitals, where there is often severe pressure on services from drug misusers, many of whom are picked up from the streets suffering from overdoses.

576. The Committee has not had access to any systematic gathering of information based on surveys at accident and emergency departments. The figures available indicate that on average Sydney accident and emergency departments alone are probably dealing with as many as 500 cases of drug overdosing a week and the size of the problem must itself give cause for alarm. In January, 1978, the number of admissions to a major Sydney Hospital emergency department numbered seventy. The corresponding number for January in the previous year was fifty-two. Not all those admitted for the treatment of overdoses would of course be dependent on drugs, many would be admitted as potential suicides. However, it has been suggested to the Committee in evidence that patients considered to be dependent on drugs accounted for more than 25 percent of drug-related incidents. These drug dependent patients are thought far more likely to have taken mind-altering substances and to have taken two or more drugs. There is also a likelihood of their having mixed drugs and alcohol. Secondly, they are likely to have an impaired level of consciousness and they probably behave aggressively in accident and emergency departments; they are also more likely to have had a history of previous overdose.

577. Accident and emergency departments are on the whole not equipped to deal adequately with the drug dependence of patients and often find them difficult to deal with, partly at least because of their non-co-operative and frequently aggressive manner which leads to the disruption of the treatment of other patients. As a result, although few drug dependent patients are unlikely to be discharged without medical advice, many discharge themselves, and many reappear at accident and emergency departments within a short space of time, if not on the same day. Such people must inevitably continue to impose a compounding load on accident and emergency departments, because there are very few places to which they can be referred.

578. Those referral centres which do exist tend to be equipped to deal with alcohol or opiate misusers and do not generally have appropriate facilities for dealing with either users of other drugs or multiple-drug misusers, although staff, frequently at their wits end, appear to try to do their best. As a result, it can be difficult to obtain continuing treatment and the barbiturate misusers in particular frequently appear in accident and emergency departments following a further overdose. Continual overdosing may lead to death of the misuser and in 1977 there were 119 deaths in New South Wales caused by overdosing in cases where the patient was stated by the Coroner to be dependent on drugs. The Committee believes there would be many others whose dependence was not noted and also have died from overdoses.

579. There is a need to find some way of helping these very disturbed and self-destructive people who are represented in all age groups. At the very least, accident and emergency departments should have some specialist help on call to deal with follow-up and after-care of these cases. The Committee recognizes, of course, that accident and emergency departments are inappropriate in the on-going treatment of drug misusers, especially those dependent on barbiturates, who frequently have complex personal and social problems. The Committee stresses that it is necessary to establish much stronger links between the accident and emergency departments and the general psychiatric treatment facilities, which are themselves in need of considerable expansion in order to decrease, as far as possible, the situation of addicts repeatedly taking overdoses, necessitating repeated treatment in accident and emergency departments.

580. Thus, many of these misusers need both specialist and general health care and at present they are falling between the services provided with no specific provision being made for them.

581. The Committee has noted, however, the attempts in some regions to deal with the problems of these people. The Committee recognizes that there is considerable uncertainty about effective methods of treatment for drug treatment generally and wishes to avoid making specific recommendations which would seem to limit innovation. However, the Committee must stress that the needs of multiple-drug misusers, as well as those opiate misusers, should be regularly assessed and taken into account by health and social service authorities in their balance to provide adequate and appropriate treatment and services in their areas.

**Pressure on Resources**

582. Problems are increasing with the diversity of competing demands on public expenditure and the personal health services are not immune from the consequent restrictions. The Committee has noted particularly that in common with all Public Service departments the Health Commission of New South Wales has been required to operate within reduced staff ceilings imposed in 1976. Thus to the extent that the provision of services depends on the availability of additional resources it will often be possible only after savings or improvements in efficiency on other services have been effected. At the same time, the economic situation is to some extent affecting the availability of the private sources of funds for the voluntary bodies who now look to government financial support for increasing help in continuation of their activities. The Committee has borne these difficulties in mind when making recommendations and it is concerned to emphasize that a determined effort must be made to improve upon current services by better use of existing resources, although there is no escape from a need for new allocations in the drug treatment field.

**Inadequacy of services in the Sydney metropolitan area and elsewhere throughout the State**

583. The Health Commission of New South Wales has been functioning since April, 1973. The boundaries of the health regions outside the Sydney metropolitan area were determined by the former Government's definition of common regions which have been adopted for administrative and developmental purposes by all State departments and authorities. These are:

| | Areas | Regional Office |
|---|---|---|
| Region 1 .. .. .. .. | North Coast | Lismore |
| Region 2 .. .. .. .. | New England | Tamworth |
| Region 3 .. .. .. .. | Orana | Dubbo |
| Region 4 .. .. .. .. | Far West | |
| Region 5 .. .. .. .. | Murray | Albury |
| Region 6 .. .. .. .. | Riverina | Wagga Wagga |
| Region 7 .. .. .. .. | Central West | Bathurst |
| Region 8 .. .. .. .. | South-Eastern | Goulburn |

584. The Sydney metropolitan area was not included in the Government's scheme for common regions and separate action was taken to define six regions within Region 9. These are:

| Areas | Regional Office |
|---|---|
| Hunter | Newcastle |
| Illawarra | Wollongong |
| Northern Metropolitan | Chatswood |
| Southern Metropolitan | Kogarah |
| Western Metropolitan | Parramatta |
| Inner Metropolitan | Rozelle |

585. The consultative document "Regionalization and Management Structure of the Health Commission of New South Wales" presented by the Minister for Health in April, 1977, described the promotion of unattractive services thus: "Prior to the formation of the Health Commission, it was largely the responsibility of the "State hospitals" administered by the Public Service and financed directly from State revenues to provide such services as psychiatry, alcoholism treatment, drug addiction treatment, geriatrics and the care of the mentally handicapped. As a result of the work of the regional offices, many of these previously unattractive services are now being taken up by various parts of the public hospital system. There is in many of the regions a growing awareness that health and illness must be viewed as a totality and that it is the responsibility of each community to provide a full range of services for the people living within that community. There have been some very favourable examples of public hospitals taking up the responsibility for the care of the aged, for the rehabilitation of the chronically disabled and for the treatment of alcoholism. There is already a widespread acceptance by public hospitals of the need to provide psychiatric services. There is not yet the same degree of acceptance of responsibility for the mentally retarded, but there are several promising experiments being entered into in co-operation with public hospitals." And in relation to Community Health Programmes the Consultative Document continues:

586. "Prior to the formation of the Health Commission and the establishment of the regions, community health services of both a preventive and therapeutic kind were falling well behind the growth rate of the State. A serious deficiency had developed over a number of years in such areas as baby health, child health, school medical services, day centres for the aged, immunization programmes and community and district nursing. With the infusion of Commonwealth funds, the value of regionalization has been clearly demonstrated by the ability of the regions to plan and implement a comprehensive community health programme in the short space of 3 years. This is not to say that all the decisions made are necessarily sound ones, but the region is in a better position to relate services to local needs, to monitor and evaluate the effectiveness of those services, and to make sure that the best value is obtained for the money expended. For the first time, there are now statewide programmes available in child health and child guidance, dental health, mental health, alcoholism and drug addiction services, mental retardation and geriatrics.

587. "The question is, would all these benefits have been realized under the old system of divided and centralized administration? It is the view of the Task Force that while some improvements obviously would have been effected, nowhere near as much would have been achieved as has been under regionalization. The presence of a regional administrative arm of the Health Commission is very positively viewed by the people in the regions. The greater personal involvement of people in their health services has value in promoting social cohesiveness. Decisions are prompter and more relevant."

588. The Committee welcomes the part which regionalization and the on-going development of community health programmes are expected to play in the growing enhancement of the provision of treatment facilities for drug dependent people, but the Committee regrets that the available evidence suggests that as yet there has been little progress in putting policy into practice.

589. The Committee has not been able to visit all the Regions. It has concentrated on those at the seaboard and in the Sydney metropolitan area because hitherto they have tended to show the greater prevalence in drug misuse, particularly in the narcotics. The findings there do not necessarily reflect the situation everywhere in the State but the Committee believes firmly that its hearings and visits of inspection provided a clear pointer to patterns which have been allowed to develop throughout the State.

590. Whilst there was a wide divergence of view within the treatment community about the approach to be adopted, a broadly common theme could be detected. This is that treatment and rehabilitation is seen very much as a single process. Treatment is regarded primarily as a clinical responsibility; and the drug dependent person is regarded as having a medical problem which is probably best treated by a consultant psychiatrist with a special interest in drug dependence.

591. Generally speaking, treatment services are at present ill-conceived, unco-ordinated and fragmented. In as far as they exist, there is a marked emphasis on narcotic dependence with a gradual awakening in awareness to cater for the need for multiple-drug use. Government sponsored treatment for narcotic dependence has been based almost entirely on the use of methadone maintenance, prescribed through treatment centres attached to hospitals, in some cases through community health centres or otherwise by general practitioners.

592. Treatment may take the form of withdrawal altogether from drugs, as is the policy of the Health Commission's consultant psychiatrist in Wollongong, or "maintenance" therapy where the objective is to stabilize the addict and enable him to function normally in the community. The approach is multi-disciplinary and although most addicts have to be treated on an out-patient basis through lack of in-patient facilities, especially in the Sydney metropolitan area, more consideration should be given to in-patient treatment or rehabilitation in a residential unit. In Sydney, only two in-patient facilities exist—Wistaria House and Jacaranda House. They have already been the subject of comment from the Committee. In the country areas, the provision of in-patient treatment varies from region to region. Some psychiatric hospitals, for example, the one at Morriset, have addiction wards, and some general hospitals, depending on local inclination, endeavour to provide some form of in-patient care. Without exaggeration, the system can only be described as one of hit and miss. In Lismore the Committee was told that in the period 1st July, 1976, to 24th June, 1977, of the 219 cases admitted to the psychiatric acute admission centre (Richmond Clinic) 30 were cases relating to opiates. The local authorities felt some sense of resentment that these 30 were mostly not of local origin and had moved from either Sydney or the bigger cities. This would not be surprising given the dearth of adequate treatment facilities within the bigger cities.

593. The Committee frequently heard about the migratory habits of people dependent on narcotics, as if it were a part of their psychopathic need for drugs. This may well be so, but the Committee cannot escape the conclusion that many young people remain on the run with their dependence on narcotics and multiple-

drug use because we are failing so lamentably in establishing therapeutic treatment programmes which are designed to rehabilitate and not to remilitate. Each region is doing its own thing, some better than others, all revealing alarm and anxiety about the state of existing programmes.

**Methadone Maintenance**

594. The gravity of this situation is exemplified in the findings of the Division of Health Services Research in its report, "A Review of New South Wales Health Commission Treatment Services for Narcotic Dependent Persons, December, 1976". The overall conclusions and recommendations were:

595. "The enormous increase in the number of clients entering the methadone programme over the past 2 years, combined with the apparent poor prognosis of clients entering the programme, and the difficulties experienced by many prescribers and counsellors in providing adequate care and after-care, highlight the urgent need for the Health Commission of New South Wales to make such changes as are necessary to provide more effective narcotic treatment services. The main changes suggested are:

(1) Reduction in the number of clients entering the methadone programme.

(2) Adequate staffing of resources for narcotic dependence services.

(3) The provision of appropriate accommodation for narcotic dependence services.

(4) Ready access to appropriate in-patient and residential facilities.

(5) Development of therapeutic techniques and programmes without the use of methadone.

(6) Co-ordinated research programmes.

596. In more detail the findings are:

(1) *The need to reduce numbers*—There is an obvious need to reduce the number of clients entering the methadone programme, in order to enable more effective management of future and existing clients. This reduction in methadone clients would necessarily imply the diversion of some clients into alternative programmes (see 5 below). The reduction in the numbers of clients entering the methadone programme could be partly achieved by more critical assessment of clients before they are prescribed methadone. More critical assessment should also ensure that *only* clients who are physically dependent on opiates are prescribed methadone. A further reduction in numbers could be achieved by adherence to the additional requirements that alternative forms of therapy must have been shown to have failed with each client before methadone is prescribed for that client. However, it is recognized that this latter requirement may be reviewed upon subsequent improvements in the methadone programme.

(2) *Adequate staffing and resources to narcotic addiction services*—It is important that the Health Commission provide adequate staffing and resources for narcotic addiction services. It should be recognized that opiate dependence is a difficult area in which to work, and consequently the conditions and resources should be of a high standard in order to attract and retain skilled and enthusiastic staff. Because this is a relatively new area in Australia, there is a need for initial and continuing staff training for prescribers and counsellors. The staffing numbers and conditions should be such as to enable full flexibility of working hours (for increased accessibility of services to clients), thorough development of new programmes and comprehensive follow-up of all clients.

(3) *Better accommodation*—Attention should be paid to providing appropriate accommodation for narcotic dependence services. It appears that such accommodation should be located within general Community Health services in order to discourage the continuation of the addict subculture. Large concentrations of addicts at any one centre should be avoided.

(4) *Outpatient and residential facilities*—Community narcotic dependency services must have ready access to appropriate in-patient and residential facilities. These facilities should be accessible and attractive to patients, and should thus help counsellors to deal with patients who are in a state of crises. Drug-free withdrawal should at least be encouraged at some of these facilities.

(5) *The need for alternative programmes*—High priority should be given to encouraging and assisting staff in the development of therapeutic techniques and programmes which do not necessarily involve methadone. Such techniques and programmes should be sufficiently attractive to clients so that methadone is not the only incentive for treatment.

(6) *Co-ordinated research*—There is a need for a co-ordinated research programme which will evaluate all aspects of narcotic addiction treatment services, with particular emphasis on monitoring the psycho-social functioning of clients. Adequate documentation of all stages of the treatment process, including follow-up, will be required in order to achieve this comprehensive evaluation. If urine testing is to be used as an objective means of assessing drug "use" by clients, and as a means of ensuring that clients use methadone as an alternative to illegal opiates and not as an addition to illegal opiates, then a proper sampling methodology should be employed."

597. The Committee generally endorses these findings. The Committee received overwhelming evidence that the methadone programme has been allowed to get woefully out of control. In its present form, it has become an alternative means of drug dependence to many, it has lent itself to abuse by both users and prescribers, it has not been matched by back-up vocational rehabilitation programmes and it has stifled initiative in exploring alternative means of treatment to meet the needs of the individual.

598. The Committee would like to see its use phased out altogether. This is a clinical problem as much as a social one. Clearly its immediate abandonment would run the risk of wholesale mental crisis amongst drug-dependent people who have come to lean on it. The Committee cannot endorse a health policy which seeks almost entirely to replace one form of drug dependence with another. It is possibly a comparatively cheap and straightforward way out. Methadone may have saved lives and it may have to continue as a mental crutch for some. In the view of the Committee, it nevertheless discourages the search for alternative drug-free treatment programmes.

599. In examining the current use of methadone in New South Wales, the Committee has received a wide range of evidence on the so-called British system which was originally based on the free supply of heroin to registered addicts. In essence, through this approach it was hoped to contain the contagious nature of heroin addiction because those with the habit would not need to recruit and deal in the drug to sustain their addiction.

600. The Committee has not had an opportunity to study the British system at first hand. Four points can, however, be made about it. Methadone has largely replaced heroin as the drug used in maintenance. The number of addicts entering programmes has risen to 2000. There is a growing amount of illicit heroin available. Although all heroin users who come to notice are supposed to be compulsorily notified by the medical profession, it is estimated that the actual number of addicts is far greater (possibly as many as 10 000) than those formally on the registers.

601. The Committee cannot draw valid conclusions from the present situation in Britain. It might well be that the changed emphasis from heroin to methadone maintenance has simply forced the earlier users to return to heroin trading with a consequential upsurge in street use through the contagion factor. It might be that the increasing numbers of users reflect world patterns of supply and demand. The comparatively small numbers of heroin users per head of population, particularly compared with the United States and New South Wales, may reflect serious underestimates in Britain or that the change to methadone has not yet had its full consequential effect on heroin demand. With these uncertainties in mind, the Committee has not seen fit to recommend the introduction of heroin in maintenance programmes in New South Wales. To do so would mitigate against the improvements required in the control of the existing methadone maintenance programmes.

**Working Methods and Staffing**

602. Drug treatment is one of the less rewarding areas of health care. Drug misusers as a group do not as yet command wide public sympathy, they are particularly vulnerable in the competition for scarce public resources. The attention of the Committee has been called to various possible and undesirable effects on the present system of drug treatment programmes. From the Committee's hearings and inspections it has been made aware of the problems of providing effective treatment and rehabilitation services for drug misusers, and much dissatisfaction among staff on the limited success of their efforts with opiate addicts. Given these feelings and the added complication in the growth of multiple-drug misuse, which the rather poverty-stricken existing services are in any case ill-equipped to deal with, the Committee has not been surprised to learn it is difficult to maintain morale in the field.

603. Possibly the biggest single source of complaint to the Committee amongst the staff was that they were not allowed to provide a 24-hour service without recourse to sacrifice of their personal time outside normal working hours. For this reason many people work enthusiastically at the beginning and either get to a point where they refuse to deal with the patients after hours, which is in itself demoralizing for them, or otherwise leave. This is not only a problem of morale but of training and good management, because there is no time for either of these.

604. Accordingly, the Committee paid particular attention to this matter in its hearings with senior officials of the Health Commission of New South Wales[10]. It has become quite obvious to the Committee that this issue is a particularly vexing one. In common with all State departments and instrumentalities, the Health Commission of New South Wales is required to operate within budgetary and staff ceilings imposed by the Treasury and the Public Service Board. These are global ceilings and departments have thus to find the means of providing the most effective overall service they can within them. They can be said to provide a spur to a more efficient and cost-effective use of manpower.

605. This is not a special problem for the Health Commission or indeed the Public Service generally. It arises in all major undertakings in both the public and private sectors.

606. In examining the problem of providing a 24-hour service for the treatment of drug misusers, the Committee has considered whether as a general principle this is both necessary and right. There is an almost unanimous view amongst the treatment community that for many drug misusers the crisis occurs in the night and the early hours of the morning and that this is the time when they most need help. This is a widely held view amongst those working both in the public and voluntary organizations, and also amongst drug misusers themselves.

607. Whilst recognizing that it has been a tradition and a matter of professional pride amongst those working in the medical field that "clock watching" does not feature prominently in the care of patients, the Committee believes that it is another matter altogether to provide treatment services to cater for the growing crisis of drugs misuse on the basis of a 5-day week, 9 a.m. to 5 p.m., which is generally the case amongst the Health Commission specialist drugs services at present.

608. It is beyond question that there is a compelling need to extend the hours of the daily service and to provide for service at weekends. In reaching this conclusion the Committee is conscious of the pressures arising from a tightening of public resources. The facts however have to be faced. The present drug treatment services have been neglected and subjected to damaging "stop, go" policies in the provision of money and manpower. At present approximately 4 percent of the State's Health budget is spent on drug and alcohol services. A breakdown within this percentage between alcohol and drugs is not available but it is not disputed that alcohol is taking the greatest share.

609. It has been represented to the Committee by senior officials of the Health Commission that, whilst they recognize that there is a need for a greater shift of resources into drug treatment services, it is difficult, given the growing restraints on public spending and the constraints of the machinery of public accountability, to bring about an early shift of emphasis in favour of drugs programmes.

610. The Committee believes that to overcome a crisis, if there is a will, there must be a way. The appalling reality of the health and social crisis in the State arising from the misuse of drugs is upon us. The community needs, expects and is demanding more reliable information about drugs and better facilities for dealing with people who are either currently in personal strife over use of drugs or soon to be so.

611. Except for the methadone maintenance programme, it has not been possible to either locate or review every individual treatment programme operating throughout the State. As will be clear from the quotations of evidence at the outset of this chapter, there is disparity and conflict about the right approaches within the medical fraternity.

612. There has been virtually no rationalization for maximum utilization of health resources in dealing with problems throughout the State. General hospitals, psychiatric hospitals and community health centres are all used in different ways and drugs services vary according to a multitude of local factors.

613. The Health Commission of New South Wales has attempted to strengthen regional drug services by the provision of the following drug education, counselling and treatment staff. This is shown in Tables 11 and 12.

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[10] Minutes of Evidence, pp. 321-361.

TABLE 11

**HEALTH COMMISSION STAFF AVAILABLE FOR AND ENGAGED IN DRUG EDUCATION, COUNSELLING AND TREATMENT PROGRAMMES IN NEW SOUTH WALES**

| | Health Education Staff | | | Drug and Alcohol Councilling and Treatment Staff | | | Total |
|---|---|---|---|---|---|---|---|
| | Full-time | Part-time | Not filled | Narcotic Dependency Programme | Training Officer | Planning Officer | |
| CENTRAL STAFF: | | | | | | | |
| 1. Central Drug and Alcohol Advisory Service | 4 | .. | .. | 4 | 1 | 1 | 10 |
| 2. Division of Health Education .. .. .. | 1 | 1 | 2 | .. | .. | .. | 4 |
| Total .. .. .. .. | .. | .. | .. | .. | .. | .. | 14 |

TABLE 12

**STAFF AVAILABLE FOR AND ENGAGED IN DRUG EDUCATION, COUNSELLING AND TREATMENT PROGRAMMES IN N.S.W.**

| | Health Education Officers | | Drug and Alcohol Counselling and Treatment Staff | | | Total |
|---|---|---|---|---|---|---|
| | Specialist | Generalist | Full-time | Part-time | Not filled | |
| REGIONAL STAFF | | | | | | |
| I INNER METROPOLITAN | | | | | | |
| 1. Bellevue Street .. .. .. .. | .. | .. | 3 | .. | .. | 3 |
| 2. Bourke Street<br>3. Brisbane Street .. .. .. | .. | .. | 14 | .. | .. | 14 |
| 4. Burwood .. .. .. .. .. | .. | .. | 1 | .. | .. | 1 |
| 5. Campsie .. .. .. .. .. | .. | 1 | .. | .. | .. | 1 |
| 6. Glebe .. .. .. .. .. .. | .. | 1 | 1 | .. | .. | 2 |
| 7. Kalparin .. .. .. .. .. | .. | .. | 1 | .. | .. | 1 |
| 8. Marrickville .. .. .. .. | .. | 1 | 1 | .. | .. | 2 |
| 9. Rozelle .. .. .. .. .. | .. | 1 | .. | .. | .. | 1 |
| Total .. .. .. .. .. | .. | .. | .. | .. | .. | 25 |
| II SOUTHERN METROPOLITAN | | | | | | |
| 1. Advisory Service .. .. .. | 2 | .. | 3 | .. | 1 | 6 |
| 2. Bondi Junction .. .. .. | .. | 1 | 4 | .. | .. | 5 |
| 3. Boronia .. .. .. .. .. | .. | .. | 1 | .. | .. | 1 |
| 4. Botany .. .. .. .. .. | .. | .. | 1 | .. | .. | 1 |
| 5. Caringbah .. .. .. .. | .. | .. | 3 | .. | .. | 3 |
| 6. Cronulla .. .. .. .. .. | .. | .. | 1 | .. | .. | 1 |
| 7. Hurstville .. .. .. .. .. | .. | 1 | 2 | 1 | .. | 4 |
| 8. Lakemba .. .. .. .. .. | .. | 1 | .. | .. | .. | 1 |
| 9. Maroubra .. .. .. .. .. | .. | 1 | 2 | .. | .. | 3 |
| 10. Miranda .. .. .. .. .. | .. | 1 | .. | .. | .. | 1 |
| 11. Redfern House .. .. .. | .. | 1 | 1 | .. | 1 | 3 |
| 12. Rockdale .. .. .. .. .. | .. | 1 | 1 | .. | .. | 2 |
| 13. Sutherland .. .. .. .. | .. | 1 | 2 | .. | .. | 3 |
| Total .. .. .. .. .. | .. | .. | .. | .. | .. | 34 |

**STAFF AVAILABLE FOR AND ENGAGED IN DRUG EDUCATION, COUNSELLING AND TREATMENT PROGRAMMES IN N.S.W.—*continued***

| | Health Education Officers | | Drug and Alcohol Counselling and Treatment Staff | | | Total |
|---|---|---|---|---|---|---|
| | Specialist | Generalist | Full-time | Part-time | Not filled | |
| III NORTHERN METROPOLITAN | | | | | | |
| 1. Chatswood | .. | 1 | 5 | 1 | .. | 7 |
| 2. Dee Why | .. | .. | 4 | .. | .. | 4 |
| 3. Gosford | .. | 2 | 1 | .. | .. | 3 |
| 4. Manly | .. | .. | 3 | 2 | .. | 5 |
| 5. Prevention Team | .. | .. | 7 | .. | .. | 7 |
| Total | .. | .. | .. | .. | .. | 26 |
| IV WESTERN METROPOLITAN | | | | | | |
| 1. Bankstown | .. | 1 | 3 | .. | .. | 4 |
| 2. Blacktown | .. | .. | 1 | .. | 1 | 2 |
| 3. Campbelltown | .. | 1 | .. | .. | 1 | 2 |
| 4. Fairfield | .. | 2 | .. | .. | 1 | 3 |
| 5. Granville | .. | 3 | 2 | .. | .. | 5 |
| 6. Katoomba | .. | 1 | .. | .. | .. | 1 |
| 7. Liverpool | .. | 3 | 1 | .. | .. | 4 |
| 8. Mt Druitt | .. | 1 | 1 | .. | .. | 2 |
| 9. Parramatta | .. | 3 | .. | .. | .. | 3 |
| 10. Penrith | .. | 1 | 1 | .. | 1 | 3 |
| 11. St Marys | .. | .. | 1 | .. | .. | 1 |
| 12. Westmead | 1 | .. | 9 | 1 | 1 | 12 |
| 13. Wistaria House | .. | .. | 11 | .. | .. | 11 |
| Total | .. | .. | .. | .. | .. | 53 |
| V NORTH COAST | | | | | | |
| 1. Grafton | .. | 1 | .. | .. | .. | 1 |
| 2. Lismore (Richmond Clinic) | .. | .. | 1 | 1 | .. | 2 |
| 3. Port Macquarie | .. | .. | 1 | .. | .. | 1 |
| Total | .. | .. | .. | .. | .. | 4 |
| VI NEW ENGLAND | | | | | | |
| 1. Armidale | .. | .. | 1 | .. | .. | 1 |
| 2. Inverell | .. | .. | 1 | .. | .. | 1 |
| 3. Moree | .. | .. | 1 | .. | .. | 1 |
| 4. Narrabri | .. | .. | 1 | .. | .. | 1 |
| 5. Tamworth | 1 | .. | 2 | .. | .. | 3 |
| Total | .. | .. | .. | .. | .. | 7 |
| VII ORANA | | | | | | |
| 1. Dubbo | .. | .. | 2 | .. | .. | 2 |
| 2. Mudgee | .. | .. | 1 | .. | .. | 1 |
| Total | .. | .. | .. | .. | .. | 3 |
| VIII FAR WEST | | | | | | |
| 1. Broken Hill | .. | .. | 2 | .. | .. | 2 |
| Total | .. | .. | .. | .. | .. | 2 |
| IX MURRAY | | | | | | |
| 1. Albury | .. | 1 | 1 | 3 | .. | 5 |
| Total | .. | .. | .. | .. | .. | 5 |

**STAFF AVAILABLE FOR AND ENGAGED IN DRUG EDUCATION, COUNSELLING AND TREATMENT PROGRAMMES IN N.S.W.—*continued***

| | Health Education Officers | | Drug and Alcohol Counselling and Treatment Staff | | | Total |
|---|---|---|---|---|---|---|
| | Specialist | Generalist | Full-time | Part-time | Not filled | |
| X RIVERINA | | | | | | |
| 1. Griffith | .. | .. | 2 | .. | .. | 2 |
| 2. Narrandera | .. | .. | .. | .. | 1 | 1 |
| 3. Wagga Wagga | .. | 1 | 2 | .. | .. | 3 |
| Total | .. | .. | .. | .. | .. | 6 |
| XI CENTRAL WEST | | | | | | |
| 1. Orange | .. | 1 | .. | 5 | .. | 6 |
| Total | .. | .. | .. | .. | .. | 6 |
| XII SOUTH EAST | | | | | | |
| 1. Goulburn | .. | 2 | 2 | .. | .. | 4 |
| 2. Narooma | .. | .. | 1 | .. | .. | 1 |
| 3. Queanbeyan | .. | .. | 1 | .. | .. | 1 |
| Total | .. | .. | .. | .. | .. | 6 |
| XIII HUNTER | | | | | | |
| 1. Maitland | .. | 1 | .. | .. | .. | 1 |
| 2. Nelson Bay | .. | 1 | .. | .. | .. | 1 |
| 3. Newcastle | 1 | .. | 5 | .. | .. | 6 |
| 4. Windale | .. | 1 | .. | .. | .. | 1 |
| Total | .. | .. | .. | .. | .. | 9 |
| XIV ILLAWARRA | | | | | | |
| 1. Corrimal | .. | 1 | .. | .. | .. | 1 |
| 2. Port Kembla | 1 | .. | .. | .. | .. | 1 |
| 3. Warrawong | .. | 1 | .. | .. | .. | 1 |
| 4. Wollongong | .. | 2 | 6 | .. | .. | 8 |
| Total | .. | .. | .. | .. | .. | 11 |
| | | | | | Total Drug and Alcohol Staff | 197 |

614. Nowhere is it likely that this staff provision is adequate. For example, in the Illawarra Region (No. XIV) there is a total of 11—4 of whom are general health educators, 1 of whom is a specialist drug educator, which leaves only 6 full-time counselling staff, all in Wollongong. The Director in the region estimates that there are 1000 narcotic addicts in central Wollongong alone. There is no provision for staff or other resources at Bowral, Moss Vale and Nowra, all of which are judged to be problem areas.

615. The North Coast (No. V in the table) has a total of 4 staff for a widely scattered population of 251 000, running geographically in a coastal strip approximately 600 km x 100 km overlapping with the Gold Coast to the north and Port Macquarie in the south. In this region, the Committee heard evidence of a girl who acquired 1800 palfium tablets in 3 months, of an elderly lady admitted to hospital for drug intoxication with a bag containing 53 medicine bottles comprising 32 drugs, singly and of differing constitutions, and that about a third of the admissions to the Richmond Psychiatric Hospital relate to drugs.

616. In the Sydney Metropolitan Region the staffing ratios were better at first sight but in those regions visited by the Committee, the staff were uniformly of the view that many more were needed. In the Western Metropolitan Region (No. IV in the table), for example, full-time counselling and treatment staff are spread very thinly throughout a population of 1.2 million people. The concentration of twenty-three in the Westmead area is attributable to the provision of the eleven staff at Wistaria House providing the only specialist in-patient treatment for drugs users and alcoholics in the State. The staff at Westmead are continuously dealing with patients from all over the State. This in itself demonstrates how meagre resources elsewhere are. In the Northern Region, the Regional Director made the similar observation.

617. Whilst it must be recognized that these examples are not intended as a definitive evaluation of the problem, they point to the inescapable conclusion that present services are both undermanned, fragmented and incoherent. The number of unfilled vacancies is in itself a matter for considerable concern. Blacktown stands out in this regard. It is perhaps not surprising that the area has received considerable recent publicity for its drugs problems.

**The New Division of Drug and Alcohol Services, Health Commission of New South Wales.**

618. The Committee has noted that the Health Commission of New South Wales has already recognized the shortcomings in its provision for drug and alcohol services by the creation of a new division within the Health Commission. This new division is to be headed by a senior psychiatrist with experience in the drugs and alcohol field. In evidence the Chairman of the Health Commission expressed the hope that the division would have overriding authority to advise the Commission and the Minister[11].

619. The Committee notes that this new appointment is to be the source of reassessment of the programmes for drug and alcohol treatment and the Committee does not wish to make hard and fast recommendations in regard to treatment types or suggested staff levels which might inhibit the flexibility of the first incumbent. These are in any case highly professional matters to be decided within the broader framework for the development of policies and strategies for the purpose of improvement of methods of intervention. The Committee emphasizes, however, that it is desirable for this post to be filled by a person of outstanding quality, especially from the point of view of leadership, in an area where staff are already demoralized. The appointee should preferably be someone of high international standing and must certainly be greatly experienced in the treatment of drug dependence. It must clearly be recognized that this appointment is central to the whole strategy for containing the drugs problem. It is a managerial post of the utmost importance in the medical field.

**Drug and Alcohol Authority of New South Wales**

620. In its Interim Memorandum[12], the Committee recommended that early consideration be given to the best way to provide greater co-ordination so that the resources available and developed by Government and the voluntary organizations might be used in the most efficient and effective way. Subsequently in August, 1977, the Government created the Drug and Alcohol Authority of New South Wales, which will advise on education and treatment in the fields of drug and alcohol dependence. The State's Chief Stipendiary Magistrate is the Chairman of this new body and the Authority has in addition seven part-time members widely experienced in drug and alcohol treatment and education in both government and voluntary organizations. There is a small permanent professional staff headed by a principal executive officer responsible directly to the Authority.

621. This new initiative was designed to help people overcome drug and alcohol dependence and return to normal lives within the community. It is intended that the Authority with specialist resources will tackle the growing and disturbing problem of drug and alcohol dependence. It will especially look at ways of

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[11] Minutes of Evidence, p. 324, par. 4206.

[12] Memorandum from the Joint Committee of the Legislative Council and Legislative Assembly Upon Drugs, 30th March, 1977.

steering potential users of drugs away from dependence. It will help voluntary bodies already working in this field and set the guidelines for treatment and education to co-ordinate their work and that of official services aiding the addicted.

622. The specific functions of the Authority are:

- to keep under review all aspects of alcohol and drug problems in New South Wales and their relation to similar problems interstate and overseas;
- to advise on appropriate policy in relation to prevention, community education, early diagnosis and intervention, treatment and rehabilitation;
- to advise on priorities for resource allocation which would meet the policy objectives determined;
- to encourage data collection, research and evaluation in the field of alcohol and drug dependency;
- to co-ordinate and where necessary direct the activities of government and non-government agencies working in this field;
- to receive submissions from voluntary organizations, determine funding priorities and make recommendations on the allocation of funds to voluntary organizations; evaluation, co-ordination and accountability will be essential conditions of receipt of such funds;
- setting of minimal standards for treatment and rehabilitation services;
- to advise in the field of social policy, specifically on the influence of existing socioeconomic and cultural influences on alcohol and drug dependency problems and to recommend appropriate policy including necessary legislative changes.

623. It is the intention that the Authority will work in close association with the new Division of Drug and Alcohol Services being set up within the Health Commission to streamline and improve treatment programmes for drug dependent people.

**Possibility of Conflict**

624. The Committee has paid particular attention to the establishment of the Drug and Alcohol Authority and the proposals for the Division of Drug and Alcohol Services within the Health Commission. In this regard the Committee has looked closely at the comparable organizational structure in other States and the legislation which has given rise to them. There is no uniformity in other States. For example, in South Australia and Western Australia, broadly speaking, provision is made for dealing with all aspects of drugs and alcohol by statutory bodies with special legislation and separate from legislation dealing with other health matters, whereas in Victoria and Queensland, drugs and alcohol programmes are within the ambit of the States' Health Departments. In South Australia, the present division between the Health Department and the Drugs and Alcohol Board is under review and it is conceivable that drugs and alcohol will be remerged with the Health Department.

625. The Committee welcomes steps to improve the efficiency in the implementation of policies and programmes in relation to drugs and alcohol, particularly by a strengthening in the co-ordination process. The Committee has expressed particular concern in this Report about the paucity of effort and general weakness in information gathering and early monitoring of trends in drug-use within the State. In this regard the augmentation of data collection within the Drugs and Alcohol Authority should achieve improvements. As a policymaking and advisory body and separate from the managerial encumbrances so frequently arising in major departments, the Authority should be well-placed to bring about many of the improvements in the machinery for dealing with drugs which the Committee has stressed throughout this Report.

626. Nevertheless, the Committee must express strong misgivings about the potential threat to the effective coherence in the Government's effort deriving from the division between the independent Authority on the one hand and the all-important Division of Drug and Alcohol Services located within the Health Commission of New South Wales on the other. Efficiency in Government is frequently marred by a proliferation of competing bureaucracies. There has been much evidence in New South Wales in relation to drugs that whilst there are numerous Departments having direct interest in the problem—Police, Health, Education, Youth and Community Affairs—all recognizing their individual responsibilities and fulfilling them to effectiveness in varying degrees, there has been a breakdown in the cohesion between them notwithstanding the existence of a considerable amount of interdepartmental machinery for co-ordination of programmes.

627. The Committee does not wish to suggest that the Drug and Alcohol Authority, being widely representative of both government and voluntary bodies, is not inherently capable of exercising a vigorous oversight of policy and programmes in the drugs field. The Committee believes, however, it will be important to significant achievement for the Division of Drug and Alcohol Services within the Health Commission of New South Wales to have a clear and unambiguous lead in the creation of new initiatives in the treatment field.

628. In evidence[13] the Chairman of the Health Commission said that he would not expect any organizational impediment from the split between the Authority and the Division of Drug and Alcohol Services provided that the man in mind to head the new Division could be recruited. In other words, that personalities would be important. The Committee recognizes the importance of compatible personalities for effective performance at top management level and there have been notable disasters on occasions when the occupants of such positions have changed. In the view of the Committee such a risk might be avoided if the Director of the Division of Drug and Alcohol Services were to assume the senior executive role within the Drug and Alcohol Authority. If this were effected, it should provide the basis for strong overall co-ordination of the officials working in the research, evaluation, education and treatment areas and also provide the part-time Chairman and advisory members of the Authority and the Health Commission of New South Wales with a single coherent and vigorous channel of advice and executive implementation.

**Rationalization of Treatment**

629. The somewhat meagre and fragmented nature of the resources which have hitherto been devoted to drug dependency within the health care systems are to a marked degree reflected in the place presently held by the Central Advisory Service on Drugs and Alcohol within the Health Commission organization and structure. The Central Advisory Service still is a small one and it has not been well-placed to make a marked impact on the better provision of drugs programmes within the Regions.

630. It is not surprising therefore that there has been an absence of a thoroughgoing rationalization of the maximum use to be made through existing health services, particularly the hospitals.

631. There are a variety of treatment types—detoxification, which gradually eliminates physiological dependence; methadone maintenance, which provides the medication to satisfy the craving for narcotics in dependent individuals so that they can take advantage of rehabilitation services and maintain a more normal lifestyle; and drug-free treatment, which provides counselling and structured activities to help the individual to regain his place in society.

632. Each of these, in turn, is offered in a variety of settings which have different costs: In-patient in hospital; prison; residential, including half-way houses and therapeutic communities; day care, out-patient at a hospital.

633. There is no readily available data on the numbers of drug-dependent patients in the State entering each of these programmes, nor on the comparative costs of each. The Committee has not, therefore, been in a position to judge the cost effectiveness of these choices nor to make a general appraisal of the required balance between them. Such a review is badly needed and the Committee believes that it should become a priority task for the new Division of Drug and Alcohol Services.

634. There are, however, certain broad criteria which the Committee believes emerge as pointers for a more effective use of existing facilities.

635. It can be assumed that hospital in-treatment costs would be many times more than the costs of out-patient services. The Committee recommends the latter type of treatment be utilized wherever possible. For example, opiate detoxification can be accomplished on an out-patient basis.

636. In general, in-patient detoxification should only be used when drug-abusers are physically dependent on a drug and when life-threatening medical, surgical, psychiatric or obstetric complications justify hospitalization. This option should also be considered in cases of mixed addictions such as opiates and the barbiturates requiring two withdrawal regimes.

637. On the other hand, the possibility of effectively treating compulsive abusers of high-risk drugs on an out-patient basis is questionable. People abusing opiates and barbiturates generally need either medication or the supervision provided in either day-care or residential programmes.

638. These are elementary principles and they have been stated simply so as to give a lead to the assessments which need to be made. They do not

[13] Minutes of Evidence, p. 324, para. 4208.

necessarily hold hard and fast for every patient, especially those who suffer from mixed addictions and clearly must be treated with great care.

639. The quality of treatment is thus of underlying importance. To the degree that its effectiveness is improved the relapse rate should decline, thereby reducing the longer term demand for treatment services.

640. In this Report the Committee has commented on the shortcomings of the methadone maintenance programme and the in-patient and out-patient facilities at present offered through the health care systems. In some cases voluntary organizations offer treatment services which will provide a most suitable alternative in many individual cases. Many such voluntary programmes are based on drug-free regimes of varying kinds which an individual might not necessarily elect to join. Whilst, therefore, the Committee entirely supports the endeavours of the voluntary organizations, and government financial support for them, the Committee believes it proper for the Government to provide treatment programmes which cater for the full range of known drug dependencies. There should be no question of leaving it to the voluntary organizations.

641. Providing the right treatment for the individual at the right time is at the crux of the problem.

642. Given the present degree of disarray, the probability that a particular patient would receive the sort of treatment uniquely suited to his needs is of a low order indeed. If this did occur, it would be due more to patient initiative and/or natural selection, both quite inefficient and costly processes, and not to the efforts of treatment staff who are not geared to cross referral. Such factors as geographic proximity, access to routes of public transportation and the operation of local treatment biases are more powerful determinants of the type of treatment an individual receives than he actually needs. It seems patients presenting for treatment of drug dependency are generally faced with a single option, Hobson's choice; that or none. Since there is evidence that the probability of a successful outcome is directly proportional to the number of treatment options, this is a most unfortunate state of affairs.

**Addicted Pregnant Women, and the Addicted Mother and Her Child**

643. A submission to the Committee from the Obstetric Social Workers' Group in the Inner-Metropolitan Area is at annexure E. It deals with the growing problem of narcotic addiction in pregnant women and mothers and the need for specialist treatment facilities to deal with it. The Committee draws this to notice as a matter requiring early attention.

**Conclusion**

644. The Committee believes that there is a need for a fundamentally different approach to the treatment of psychoactive substance abuse, based on the following broad principles:

(1) That persons having difficulties in relation to psychoactive drugs are more different than they are alike.

(2) That, as a result of these differences, different patients may require different kinds of treatment.

(3) That current service delivery arrangements do not systematically take such differences into account; and therefore that a system which consistently takes patients' differences into account should be designed and tested.

645. Taking these principles into account, the Committee hopes that in the Division of Drug and Alcohol Services, leadership will be provided in the design of an effective and efficient system of health care delivery for drug dependencies. There should be optimal utilization of health care resources in the development and organization of services for drug-dependent populations. Given the wide variability among patients who come for treatment, there is a clear need to match patients to specific treatment programmes to make optimum and most economic use of specialized health care resources.

646. **Recommendations**

**(44) Immediate steps should be taken for the recently created Division of Drug and Alcohol Services within the Health Commission of New South Wales to commence operation.**

**(45) Action should be taken for the head of the Division of Drug and Alcohol Services to assume the principal executive function within the Drug and Alcohol Authority of New South Wales to provide for full cohesion in public policies and programmes.**

**(46) The Division of Drug and Alcohol Services should be provided with the necessary financial and manpower resources to undertake a full-scale review for the design of an effective and efficient system of health care delivery for drug dependencies. Such a system should provide for optimum utilization of health care resources in the development and organization of services for drug-dependent populations.**

**(47) The methadone maintenance programme should remain the subject of stringent review, as recommended by the Division of Health Services Research in its findings, "A Review of New South Wales Health Commission Treatment Services for Narcotic Persons".**

**(48) In the provision of drug treatment facilities, there should be recognition of the need to provide drug-dependent people in crisis with on-call help at all times of the day and night.**

**(49) Immediate attention should be given to the problems of multiple drug misuse. In particular, there is a need to introduce machinery to monitor the number of drug-related admissions to casualty and emergency departments of general hospitals.**

**(50) Training of all medical and paramedical staff must recognize the growing and diverse problems being created within the community due to the misuse of drugs.**

**(51) The effect on drug treatment services of the regionalization policies of the Health Commission of New South Wales should be kept under careful review. The Committee's recommended provision of highly specialized treatment programmes, especially for narcotic dependency, will require strong central direction of such programmes.**

### Role of Voluntary Organizations

647. Voluntary work based principally on charitable contributions has in this century played a major part in the care of people in personal trouble. Charitable organizations have traditionally played a major role in the voluntary field in the principal areas—care of alcoholics and the protection of destitute and orphaned children. The blind, deaf and those maimed either in war or in natural disaster have also traditionally attracted voluntary support and welfare. In recent times this has been extended to people suffering from rare infirmities; for example, muscular dystrophy.

648. Whilst alcoholism, therefore, has attracted public concern and private compassion, this has not been true of other drug dependencies. This is not to overlook the valiant work that has been undertaken by some organizations in New South Wales in the last ten years or so. The Way Back Committee, the William Booth Clinic (run by the Salvation Army), We Help Ourselves (WHOS), the Wayside Chapel, the Richmond Fellowship of New South Wales and the Association of Drug Referral Centres have all endeavoured to provide shelter and support for people in trouble with drugs and to enlist public sympathy and support for their programmes. The Committee believes that all voluntary organizations concerned with the plight of drug dependent people deserve the utmost public admiration. They have all shown an awareness of a serious and growing problem and have struggled to maintain their services at a time when the community generally has been slow to respond to the problem and on occasions has even shown hostility.

649. At a time when there is a marked degree of uncertainty throughout the world about the best means of treatment for drug dependent people, the Committee is reluctant to pass judgement on the various programmes being tried within the voluntary organizations. The people operating them represent a mixture of the professionally trained and the dedicated voluntary worker without special training of any sort, including in many cases people who have themselves been in trouble over drugs and believe their experiences can be of help to others who are suffering in the same way. It has been difficult to acquire data on success rates, although all the organizations which the Committee was able to visit believed that they were getting worthwhile numbers back to productive lives without recourse to drugs. It must be assumed, and it is almost certainly a fact, that most people working voluntarily in this field would not have survived in some of the straightened circumstances which they have had to face in recent years were it not for a great conviction that they had something to offer to people in trouble.

650. A significant development in the voluntary field has been the establishment in Australia at the end of 1977 of the first Odyssey House. The significance rests in the fact that the Odyssey drug-free rehabilitation concept, started in the United States as recently as 1969, has demonstrated an interesting success rate for this type of treatment in North America.

651. The Committee believes that for the foreseeable future there is a strong place for the voluntary organizations in the structure of drug treatment

rehabilitation services in New South Wales. The Drug and Alcohol Authority of New South Wales has already announced the provision of government subsidies for those organizations which it has judged to merit support. Clearly the Drug and Alcohol Authority has an important role to play in the general oversight of both voluntary and Government treatment programmes to ensure the maximum utilization of community resources. Nevertheless, the Committee must make it clear that drug-dependent people have as important a right to health care through health services provided by the Government as any other members of the community suffering from either mental or physical illness. It would be wrong for any misconception therefore about the lead which the Committee believes that the Health Commission of New South Wales and the Drug and Alcohol Authority should play in making sure that public services are available for those drug-dependent people within the community who seek them. The voluntary organizations may provide valuable backup; they should not become a substitute for services which it is the responsibility of the Government to provide.

**Vocational Rehabilitation**

652. Vocational rehabilitation is a vital part of the treatment process, since society's objective of altering the drug-using life-style of a former addict is clearly linked to his ability to find and hold a job. A job not only enables self-support, it enhances the dignity of self-reliance that people need to be responsible members of society.

653. Treatment services are an important first step in interrupting the abuse of drugs. To complete the process and insure against the likelihood of return to drug-abuse, it is necessary to provide the abuser with the emotional stability and technical skills needed for survival. At present, the rehabilitation needs of drug-abusers are not being met.

654. The Committee heard from many witnesses about the difficulties which people with former histories in dependence encountered in obtaining employment solely on the basis of their drug histories. The Committee was especially perturbed by what appears to be a policy of discrimination exercised in the employment of public servants. Hence, in evidence, the Committee was told[14] whilst the Regional Director of Health in the Illawarra Region had wished to employ a former heroin addict in counselling work, the Public Service employment rules had prevented it.

655. There is a strong case to be made for employment of former addicts in counselling. They should not be debarred from work in the public health field on grounds arising solely from their former drug dependence, even where this might have involved infringement of the criminal law.

656. The Committee recognizes their former criminal records militate against Public Service employment. In the case of drug dependency special factors may apply and each case needs to be treated on its merits. It is significant that Odyssey deliberately employs former addicts as part of its policy for rehabilitation. The rules need to be flexible. This is a matter calling for urgent review of present procedures.

657. Generally the story of rehabilitation is distressing; there is no discernible improvement in the employment and educational status of patients during their period of treatment. Throughout our system we are missing an important opportunity. We must do better. At a time of economic difficulty and general unemployment the problems assume special magnitude. The answer will not be found in despair. There is a need to build into our system effective co-operation, collaboration and co-ordination between treatment, rehabilitation and employment service agencies.

658. **Recommendations**

**(52) The development of a government strategy for the long term rehabilitation of drug users.**

**(53) The introduction of government policies to ensure that recovered drug abusers are not excluded from employment in the public and private sectors.**

**(54) A major government review of all regulations to ensure that they do not impede employment and rehabilitation.**

**Interface with the Criminal Justice System**

659. A great many non-medical users of drugs have a history of repeated involvement with the criminal justice system. This involvement may be arrested for possession or "habit supporting" crime such as pharmacy break-in. Whatever the reason, these drug-users are prime candidates for treatment since their involvement with "the law" provides an opportunity to detect and monitor their drug use behaviour and to encourage their participation in a treatment pro-

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[14] Minutes of Evidence, p. 163, para. 3011.

gramme. The Committee believes that the development of systematic links between the treatment and criminal justice system is critical to combating the contagious spread of opiate and multiple drug misuse.

660. Ideally this link would embrace everyone who comes into contact with the criminal justice system for any significant period of time and would operate from the time of detection until final discharge from the correctional system. The beginnings have been made through the Drugs Diversionary Programme introduced in New South Wales in March, 1977.

661. This is an innovative programme for treatment and assistance for people with severe drug dependency, particularly dependence involving narcotics. The programme is conducted by the Health Commission in association with the Court of Petty Sessions. It is a voluntary programme, initially limited to the Inner-Metropolitan Area and available to all addicts who plead guilty or are convicted of offences relating to heavy narcotics.

662. The Committee notes that it has since been extended to the Western Suburbs. Whilst in no way wishing to discourage initiative in any area of the drugs problem, given the paucity of and fragmentation of drug-treatment services generally available within the Sydney metropolitan area, the Committee must call into question the advisability of too rapid an augmentation of these programmes without proper evaluation of their success. On the evidence available to the Committee it would be immeasurably harmful for the authorities in the courts to encourage drug addicts to seek government treatment if they are encountering the present services which treatment staff locally are obliged to concede barely meet minimal standards. If the Drugs Divisionary Programme is to be extended it must be on the basis of evaluation and concurrent build-up in treatment services. The Committee believes that the drug situation on the streets has deteriorated to a level where the drug-abuser who is in default of the law, especially the heavy narcotic addict who will frequently have been involved in widespread criminal activity to sustain his addiction, will be greatly reluctant to trust any system which poses even minimal risk of a gaol sentence. The nature of the present drugs underworld in New South Wales appears to be such that the drug addict fraternity has no faith in society or its forces of law and order. It is a fact that the relationship between the treatment and criminal justice agencies is impeded by mutually shared suspicions at all levels—suspicions of corruption in some areas, of procedural obstacles and of inadequate co-ordination.

663. The Committee believes, therefore, that there is a need for a continuing review in producing a workable identification and referral programme for abusers of heavy narcotics.

664. The concept being developed so far is that the arrestees are brought before the courts and, in conjunction with the probation services, recommendations are made to place the defendants under supervision for treatment. The probation service can then assist the defendants in seeking any necessary drug treatment, employment help, medical or legal services.

665. This system is in its infancy and there are limited treatment and organizational facilities as yet available to back it. Whilst it is too early to judge its true efficacy, there are potential limitations. The activity applies only to those arraigned and pending trial, and does not deal with others who voluntarily come into contact with the system through investigation or arrest and release.

666. The fact has to be grasped that the number of heroin users in New South Wales has grown vastly. They form the base of a pyramid which is built on the aggressive and ferocious nature of the narcotic addiction. This pyramid will not be shaken if a means cannot be found of encouraging the users out of the scene. Many are frightened and confused. Many are becoming criminals against their nature because the drugs which have overtaken them cannot be made available legally without risk to even greater public disorder than now exists.

667. The fundamental philosophy of the non-punitive approach is however that it is non-punitive. There is a need for a new approach which would facilitate law enforcement to encourage the addicts into treatment and remove the conflict which presently exists between the addicts and society generally.

668. The major trafficker must be immobilized by every means possible. The user, captive in the machinations of those who feed their greed on drugs trafficking, must be encouraged to understand and trust in community care. Unless a break-through of mutual trust can be established, the division will continue to deepen and harden. In this concept a start would be made by the Police who, when the addict comes to notice, could provide him or her with an opportunity to seek treatment. Once in treatment the Health authorities and the law enforcement officers would work together to provide a welfare surveillance on patients to monitor potential relapse. Clearly this would be a long process of fulfilment and magic results would not be achieved overnight.

669. Frustrations, disappointments and distressing relapse can all be expected. Police, doctors, parents, friends would all suffer set-backs. Personal tragedies will continue. The goal must be a reduction.

# Part 3 A Special Problem

## CHAPTER 13

### DRUGS AND DRIVING

**The position with alcohol**

670. The present generation has witnessed enormous growth in technology throughout the Western World. Australia has not been insulated from these changes. Nowhere have these changes been more pronounced than in the field of transport.

671. It was announced recently that within the space of a few years the number of motor vehicles on Australian roads has doubled. It can truly be said that Australia is now on wheels.

672. High speed vehicles are today in the hands of virtually everybody of driving age. Impaired driving dramatically raises the risks we each face daily—not only the risks inherent in our own driving performance but those which result from the performance of other drivers.

673. Concurrent with this advance in machine technology has been the development in chemical fields so that today there is a veritable "Pandora's Box" of old and new mind-altering drugs. In recent years there has been a clear recognition of the part played by alcohol in traffic accidents. Within the last decade the epidemic of drug use has added a further complication to the question of road safety.

674. The role of alcohol in the causation of traffic accidents has been thoroughly researched and documented. Such work has enabled governments to legislate that it is an offence to drive a motor vehicle whilst there is a prescribed concentration of alcohol in the blood.

675. Under section 5 of the N.S.W. Motor Traffic Act it is an offence to drive, or occupy the driving seat, of a motor vehicle while under the influence of alcohol ***or a drug.***

676. Where a breath analysis test shows that the driver's blood alcohol concentration is below 80 mg percent limit, but the arresting officer has reason to believe that the consumption of a drug may be the cause of a traffic offence, there is at present no objective method of determining whether the offender has indeed drugs present in his body sufficient to affect his driving judgement.

677. It is interesting to study the Queensland history of breath and blood testing of suspected drinking drivers.

678. During the first 6 years of compulsory breath and blood tests in that State, only authorized medical practitioners were empowered to operate the Breathalyzer or take blood specimens.

679. During this period many thousands of clinical observations were made on impaired drivers. It was established that a number of persons whose driving behaviour was not explained by a low alcohol concentration were affected by some other drug or by drug-alcohol interaction. Yet no effective legislative means existed to prove this opinion in a court of law.

680. In 1974, the law was amended to provide that a suspected driver may be required to provide a specimen of his breath and/or blood and/or urine for analysis.

681. Now a person suspected of driving under the influence of alcohol and/or a drug is required to provide a specimen of his breath for analysis on a Borkenstein "Breathalyzer". Should his blood alcohol concentration be 80 mg percent or above, he is charged with that offence. However, should his B.A.C. be so low as to be incompatible with his behaviour pattern, he is questioned by police as to possible drug ingestion. He may admit to the use of a known therapeutic drug, to the use of an unnamed therapeutic drug, or deny the use of any drug at all.

682. The medical officer's duty is to take as full a history as possible, to make careful observations of the person's behaviour and to conduct a physical examination if the person consents to this. A prime function of the medical officer is to ensure that the person is not suffering from a pathological condition other than alcohol and/or drug affectedness; or, if the latter, to determine the best place for his immediate care—hospital or police station. In any case, the law requires the person to provide a specimen of his blood and/or urine for analysis.

683. The urine specimen is screened by thin-layer chromatography. When a drug is shown to be present in urine, the blood sample is analyzed for content of the drug and will be used as evidence in a court hearing. Urine is used strictly for screening and not for evidentiary purposes.

684. The charge of driving under the influence of alcohol and/or a drug is heard by a magistrate. The evidence placed before the court comprises—

- The driving behaviour of the person prior to his detention by police.
- Certified evidence as to his blood alcohol concentration.
- Certified evidence as to the presence of a drug in his blood, and/or its concentration.
- The clinical findings of the examining medical officer.
- Opinion evidence as to the consistency of the person's behaviour with the blood concentrations of alcohol and/or the drug, as certified, educed from the medical officer.

**Some U.S. findings on other drugs**

685. The Committee was fortunate to have as a witness Dr Robert E. Willette of the National Institute of Drug Abuse, Washington, D.C.

686. Dr Willette is no stranger to Australia, having worked at the Australian National University (for 2 years) on a post-graduate fellowship and for a further period with CSIRO before returning to the United States about 10 years ago.

687. In March, 1977, Dr Willette edited a publication from the NIDA (Research Monograph No. 11)—*Drugs and Driving.* The monograph is an edited version of the presentations on various aspects of this problem by a panel of nationally recognized experts on the behavioural effects of drug usage.

688. Each expert on the panel prepared an individual summary review and critique of a portion of the available literature from all parts of the world.

689. These drug impairment reviews covered anaesthetics, tranquillizers, opiates, sedatives, stimulants, hallucinogens, marihuana and other drugs in general use, some of which are well known in Australia.

690. In his introduction to this publication, Dr Willette states:

> "Evidence has been accumulating that licit and illicit drug-use causes impairment of driving and other complex human performance. This use is believed responsible for accidents and deaths from traffic collisions. Some studies have shown a correlation between drug-dose and performance decrements. Assays measuring the presence of drugs in fatally injured drivers have suggested drug-use as a significant factor in many of these deaths. Although alcohol alone and combined with other drugs predominates, a high rate of marihuana use among drivers indicates it could be a factor in traffic accidents and fatalities."
>
> "Primarily for these reasons, the National Institute on Drug Abuse (NIDA) undertook to sponsor a critical review of this research literature, to see how much we know and we still need to know."
>
> "The review was conducted by a panel of nationally recognized experts on the behavioural effects of drug-usage. Each expert on the panel prepared an individual summary review and critique of a portion of the literature."

691. Dr William Pollin, Director of the Research Division of NIDA, quotes the results of a recent survey in the Boston area. This study of 300 fatal car accidents indicates "that 39 percent involved driver use of alcohol or a combination of alcohol and other drugs. An additional 9 percent involved other drugs (marihuana, barbiturates, etc.) without alcohol. Of the total drivers, 16 percent admitted to being under the influence of marihuana at the time of the crash. In other limited surveys from 60 to 80 percent of marihuana users indicated they sometimes drive while cannabis-intoxicated. ***To some significant but as yet quantitatively uncertain degree, widely used drugs other than alcohol contribute to the toll levelled by alcohol".***

**A recent report in New South Wales**

692. We would be foolish to think that our own country does not reflect to some degree the situation in the United States. In November, 1975, the Traffic Accident Research Unit of the New South Wales Department of Motor Transport issued the findings[1] on the conclusions from a study on the interactive effect of single therapeutic doses of drugs and social doses of alcohol on human sensory cognitive and motor performance.

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[1] "Alcohol, Drugs and Accident Risk"—by the Traffic Accident Research Unit (4/75).

693. The report stated: "Currently, literature reviews on alcohol, prescription and over-the-counter drug-use in both North America and Europe suggest that:

(1) Between 35 percent and 50 percent of the general population risk driving after drug-use at least once a year.

(2) A conservative estimate of at least 7 percent of drinking drivers have also taken a psychotropic drug.

(3) Between 11 percent and 15 percent of accident-involved drivers had taken a psychotropic drug prior to their accident.

(4) Psychotropic drugs are most likely to be found in fatally injured drinking drivers. These drugs do not present a substitute for alcohol but an additional element frequently found in combination with alcohol.

(5) At least some psychomotor impairment in drivers with low or non-existent blood alcohol levels may be attributed to the use of psychotropic drugs. This implies that some highly impaired drivers are likely to be missed by present alcohol screening procedures.

694. "In Australia, information on drug-usage in the population is scanty and research on the effects of individual drugs and their combination with alcohol on human performance has been minimal. Questionnaire surveys in Sydney and Canberra indicated that about 11 percent of the population were daily users of analgesics. One Sydney study showed that about 10 percent of males and 24 percent of females were taking sedatives and tranquillizers, whilst the Canberra survey revealed that about 3 percent of males and 7 percent of females were receiving daily medication with these drugs.

695. "Although the number of people who risk driving on psychotropic or other drug medication in Australia has yet to be determined, some insight into the problem can be gained from the findings of Milner.[2] As a result of a study on 4584 general practice and psychiatric patients in Perth, Western Australia, it was estimated that of the 15 percent of the patients for whom psychotropic drugs were prescribed, 57 percent of the men and 35 percent of the women would be likely to both drink and drive whilst receiving medication. It is interesting to note that of the 10 000 drivers chosen at random from a sample of drivers who were breathalyzed in New South Wales during the period 1972-73, over 25 percent admitted to have been taking drugs concurrently. A classification was made of the drugs said to have been taken, from which it is evident that the non-narcotic analgesics and tranquillizers were most frequently involved. Valium alone accounted for nearly 50 percent of the tranquillizers used, although this figure perhaps only reflects the market share for this compound.

696. "Studies of drug-usage to date have given some indication of the nature of the drug-alcohol-driving problem. The seriousness of the problem besetting students of traffic safety is camouflaged by the lack of really adequate information on the effects and risks involved."

The main conclusions from the study were:

697. "It is clear from the studies on the tranquillizers that patients receiving diazepam (valium) should be warned of the dangers of operating complex machinery, especially driving a motor vehicle. They should be made aware of the drug and alcohol combination which produced detrimental effects that are greater than the additive effects of the individual drugs. Although it is difficult to be precise with regard to chlordiazepoxide (librium), certainly potential dangers exist but they are not as great as with diazepam.

698. "The studies reported to date give some indications of the combined effects of alcohol and other drugs on human performance. However, the extent of the role played by a combination of alcohol and other drugs in traffic accidents in Australia has yet to be established. Because the use of drugs is a part of the life-style of our urban society, continuing research into the effects of individual drugs and, most importantly, the combination of alcohol and other drugs on human performance is essential.

699. "Laboratory investigation on alcohol should be extended to include the effects of different alcoholic beverages taken under various conditions so as to reflect the various patterns of social drinking in which the blood alcohol levels may vary with the type of beverage, situation and drinking pattern. In addition, further study is necessary to establish—

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[2] Milner, G. Drinking and Driving in 753 General Practice and Psychiatric Patients on Psychotropic Drugs. *British Journal of Psychiatry,* 1969, 115, 99-100.

(a) whether or not intellectual functions are more susceptible than motor functions to the depressant effects of alcohol;

(b) the rate of recovery of various functions after alcohol.

700. "Controlled field experiments should use actual driving performance which permits an analysis of change in driving behaviour resulting from the intake of alcohol and/or other drugs under various traffic situations. This is likely to yield a better insight of the findings from laboratory studies in real life situations.

701. "For the assessment of the role which alcohol and drugs play in traffic accidents, a study of accident-involved and non-accident-involved drivers investigated under similar conditions is essential. Data concerning the involvement of alcohol and drugs from such a controlled study would almost certainly shed light on the risks involved of drinking drivers in the drug users population and the population at large.

702. "A study on hospitalized drivers who have been involved in road accidents to determine the presence of alcohol and other drugs by blood tests should be given a high priority. Together with the data on the type, severity, etc., of accidents, and sociological data of such drivers, the study will be invaluable to traffic safety management.

703. "If traffic safety education is to succeed in its role to ameliorate the road toll, it must equip itself, amongst other things, with adequate research information."

704. Dr Robert du Pont, Director of NIDA, states: "We know that marihuana intoxication produces severe deterioration in driving performance. We are left to guess at the impact of marihuana use on highway safety—and our best guesses are frightening. No less of a concern is the problem of prescription drug use and the problem of multiple simultaneous drug-use".

705. But the critical question is to determine the degree of impairment in driving. Once this is determined sanctions could be invoked.

706. Long before the introduction of breath analysis machines to determine a driver's concentration of alcohol, police charged the driver with being under the influence of alcohol, and testified to the court as to his condition.

707. Today the situation is the same with regard to drugs. The arresting officer may suspect that a driver is under the influence of a drug other than alcohol, but failing a confession from the defendant, has no way of determining whether his opinion is correct.

**The need for further research and greater use of available technology**

708. The Committee has had the good fortune to inspect a gas-chromatograph with mass spectrometer at Sydney University School of Pharmacy. This machine, linked with a computer, identifies drugs in a sample within minutes. At present the memory bank of this particular computer will identify 450 drug and drug metabolites and about 350 pesticide and pesticide metabolites spectra from its file. It is intended shortly to take in the *Aldermaston File* which has about 50 000 reference spectra of organic compounds.

709. In Brisbane, a similar machine without the computer identification and print-out is located in the forensic laboratories. Specimens supplied to them, including those covered by traffic offences, are subjected to analysis but the identification from the print-out is performed by experienced and talented operators.

710. With the computer attached the comparison of the unknown spectra with the reference spectra is carried out automatically, providing *in order* a list of the best fit of the unknown with ten reference spectra.

711. A brief explanation of the theory of the gas-chromatograph with mass spectrometer is supplied by courtesy of Professor T. R. Watson in annexure G. Accompanying the article is a print-out identifying valium and some of its metabolites in the urine of a patient who had taken an overdose of that drug.

712. We must take cognisance of the situation which has developed in other parts of the world. Having done so, we must then determine whether we will provide the means for traffic officers to enforce the law with some degree of certainty. There is no machine available to any government department to test such samples as may be required by amendment to the Motor Traffic Act. The appropriate place should be the government laboratories.

713. The influence of alcohol on the risk of a driver being involved in a road accident has been well-documented. In comparison with many other drugs, alcohol is comparatively straightforward both in terms of its effects on the driving performance of various individuals and in the ease with which its presence in the human body can be detected and quantified. But the variety and range of effects

of other drugs and the diversity of their effects on different individuals are vast, and identification and quantification of them in the human body can be extremely complex. Moreover, these "other drugs" are often taken for the relief or ease of symptoms which themselves may impair the driving function. There is therefore very little reliable information available about the effects of taking other drugs on the risk of being involved in a road accident; furthermore, there is little information available concerning the types and usage of drugs by drivers.

714. **Recommendations**

**(55) Full-scale research should be implemented by the appropriate departments to determine the effect of all drugs on driving performance.**

**(56) To ensure that an immediate start is made on this, a departmental working party should be set up forthwith to investigate the dimension of the research required and to set the research parameters accordingly.**

**(57) A gas-chromatograph with mass spectrometer should be provided as a matter of urgency for staff working for the Division of Analytical Laboratories. It would be used for the Division specifically for analytical work to determine the effects of drugs on driving and also for wider research and analytical work on drugs generally.**

ANNEXURE A

## MAIN FEATURES OF DRUG DEPENDENCE

**Non-medical use—the approach to the problem**

The World Health Organization has adopted the term "drug dependence" in place of "addiction" or "habituation" because it was found to be impractical and scientifically unsound to support a single definition of habituation. In this report, the Committee has followed the example of Canada[1] in interpreting the issue as one concerning the non-medical use of drugs of dependence. Accordingly attention has been given to the medical use of drugs of dependence only in as far as medical use has a bearing on non-medical use. It must be remembered, however, that it is wrong to see drug dependence in strictly medical terms. Sociology, anthropolgy, education, law and other disciplines are also all at the heart of the matter.

Although the issue is viewed, therefore, in a concept of "non-medical use" of drugs for brevity the terms "drug dependence" is generally used in this Report. The older terms "addiction" and "habituation" (habit) are sometimes used where appropriate.

*Medical use* is defined as drug-use indicated for generally accepted medical reasons, whether under medical supervision or not; thus taking an aspirin occasionally for headache or antacid tablets for indigestion is medical use. *Non-medical use* refers to use for not generally accepted medical reasons. Non-medical use can be either legal or illegal. To illustrate the point a reference must be made to alcohol whose use by adults is non medical. but legal; the use of marihuana, in contrast, is both non-medical and illegal.

Although this distinction between medical and non-medical use of drugs provides the most intelligible way to an understanding of the potential threat imposed by drugs, such an approach requires a comprehension of the nature of drug dependence which is the force behind non-medical use.

A wide range of drugs can be described as drugs of dependence. A characteristic common to most of the drugs which cause dependence is that they are taken initially because the individual taking them believes that a desirable pharmacological effect will result. This effect may be only indirectly related, or not related at all, to the therapeutic action for which they are normally prescribed. Drug dependence is defined as a state arising from repeated administration of a drug on a periodic or continuous basis. Its characteristics will vary with the agent involved and this must be made clear by designating the particular type of drug dependence in each specific case. Drug dependence of the morphine type, of the cocaine type, of the aspirin type, of the barbiturate type and so on. The universal characteristic of non-medical use that goes beyond occasional casual experimentation is *physic dependence,* which may be defined as a compulsion, arising from repeated ingestion of a drug, to continue use of the drug to obtain pleasure and avoid discomfort, either physical or psychological. Psychic dependence is difficult to define with precision, since it implies a quantitative judgement that degree and frequency of use have passed beyond casual use. Operationally psychic dependence is recognized by such phenomena as taking the drug becoming one of the individuals chief means of adapting to life situations, obsession with obtaining and maintaining supplies of the drug and a continuation of drug-taking despite conscious acknowledgement that drug-use is causing significant harm to health, social functioning, and family relationships, and by relapse after voluntary or involuntary cessation of drug taking. This is especially true of dependence on opiate narcotics and is a key factor in the growing heroin crisis.

Physical dependence refers to an altered physiologic state brought about by repeated ingestion of a drug which requires continued administration to prevent the appearance of a characteristic illness, called an abstinence syndrome. Physical dependence was once regarded as the one true criterion of "addiction", since it was objectively demonstrated and measureable. This notion led to some confusion because the only known form of physical dependence was associated with the opiates, yet both international and national law, place opiates in the same category as other drugs, for example cocaine and marihuana, neither of which cause physical dependence, with resultant confusion that has been a source of much misunderstanding about drugs which still exists.

Physical dependence could be regarded as a medical complication of non-medical use of drugs since, in moderate to severe cases, it requires treatment. Its importance, however, is far greater than a mere complication since its presence forces the individual into *continual* rather than intermittent drug use. Furthermore, the relief of abstinence by taking drugs tends to induce the user to invest the drug with magic qualities and conditioning of abstinence symptoms occurs, so that they recur if the proper stimuli—such as seeing another user present, and can lead to relapse. Thus physical dependence may have greater psychological importance than physiologic. This is of particular significance in relation to the contagious nature of non-medical use of the opiates however, despite its psychologic importance, physical dependence is a real physiologic disturbance involving the central nervous system that is not psychogenic, and is a self-limited, reversible process that will disappear if the drug is taken away. In lay terms this means that a non-medical user who is severely drug dependent can be "dried out". This does not mean that the craving will go away, especially if the drug victim is not removed from the stimuli of the drug scene. Keeping people drug free is the critical question at the heart of the drug crisis.

Tolerance refers to development of body or resistance leading to repetition of the same dose of a drug, or conversely, to a need to increase the dose to attain the initial degree of effect. Unlike physical dependence, its presence is discerned only when taking the drug.

Where the tolerance develops rapidly and almost completely, as with L.S.D., the user is forced to discontinue drug taking after 4 or 5 days until the tissues regain their prior responsiveness to it (thus it prevents continuous daily abuse).

Where the drug tolerance develops slowly and the drug also produces physical dependence (e.g. heroin and alcohol), the increased dose requirement accelerates and intensifies the development of physical dependence (one gets "hooked") as well as the monetary cost of indulging the habit.

Psychotoxicity is a characteristic common to all dependence producing drugs. It may be acute or chronic, or develop as one characteristic of the abstinence syndrome when the drug is withdrawn. Psychotoxic effects appear as disturbances in the normal behaviour patterns. The type and degree of these effects vary with the type of drug which is being used and are influenced by the psychological make up of the individual.

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[1] The Le Dain Commission of Inquiry into Non-medical Use of Drugs.

## Types of drug dependence and the drugs involved

The World Health Organization definition of drug dependence states that the characteristics of this state vary with the agent involved and that the phenomena associated with each drug must be clearly described and the particular type of drug dependence must always be specified; for example, drug dependence of the morphine type, the amphetamine type, etc. The WHO specified that drug dependence, which is here translated into non-medical use of drugs, is a general term selected for its applicability to all types of drugs and carries no connotation of the degree of risk to public health or the need for any or a particular kind of legal control. Thus, caffeine in the form of coffee and tea is a drug of dependence but causes no significant behavioural toxicity, so no legal control is required. Amphetamines, on the other hand, when taken intravenously, not only have catastrophic consequences to the health of the individual but the psychotoxicity of the amphetamines, when taken in this way endangers the public, so legal control is required.

However, it is important to bear in mind that drug dependence is a complex phenomenon relating not only to the pharmacological properties of the drug but also the characteristics of the user and his environment. Merely to use a drug once, even heroin, is not in itself capable of producing compulsive dependence. On the other hand the minor analgesics (the headache powders) clearly have enormous dependence potential for some users.

Nor is drug dependence likely to become a matter of finite scientific definition. Whilst recognizing these factors, the Committee nevertheless believes that the findings of the World Health Organization bring together international expertise and research of high standing. The Committee concludes, therefore, that the position adopted by the agencies of the World Health Organization in defining the main forms of drug dependence provides the foundation on which an assessment of the drugs problem in New South Wales should be based.

The World Health Organization has defined the following types of drug dependence as

(1) Morphine type.
(2) Barbiturate-alcohol type.
(3) Amphetamine type.
(4) Cocaine type.
(5) Cannabis type.
(6) Hallucinogenic type.
(7) Khat type.

Apart from Khat, which is largely encountered in the Arabian Peninsula and not generally found elsewhere, all the forms of drug dependence defined by the World Health Organization are to be found in New South Wales.

In addition, the Committee has been able to discern another form of drug dependence in this State relating to the use of compound minor analgesics.

## The Role of the Needle

In order to gain a proper comprehension of the significance of many of the differing types of drug dependence, the importance of the role of the needles must also be understood.

With respect to the physical health of the non-medical drug user, injection of drugs, particularly intravenous injection, is as important a factor as the toxicity of the drug itself. The kind of drug matters little. Opiates, amphetamines, cocaine and barbiturates are all equally bad if injected intravenously or even subcutaneously. This practice causes the infectious complications of non-medical drug use—hepatitis, tetanus, bacterial endocarditis, and other complications which are responsible for many deaths.

The personal human disasters arising from intravenous drug taking are perhaps the most appalling feature of the drugs epidemic.

The drugs are classified in Table 1 of the Report (page 17). Reference is made to the classifications shown in the table.

## Dependence of the Opiate or Morphine Type

The representative drugs are those listed in IA of the table—opium, its derivatives codeine, morphine and heroin, and the synthetic drugs. Medically these drugs are mainly used to relieve pain, cough, diarrhoea and as a preanesthetic medication.

The spectrum of non-medical use of opiates varies widely, ranging from the casual experimenter who takes one or two doses and stops to the strongly "hooked" individual, whose whole life is devoted to obtaining and taking the drug. Non-medical use of opiates is characterized by strong psychic dependence, marked physical dependence (depending on dose), and the tremendous grades of tolerance.

Except for the occasional individual who becomes dependent on opiates because of a chronic painful disease, the vast majority of non-medical users begin the drug quite early in life because of association with and social pressure from their peers.

The initial effects of opiates consist of mild psychic stimulation followed by easing of tension, relaxation and drowsiness. Aggressive or psychotic behaviour does not occur as a direct effect of opiates. A very marked degree of tolerance can be developed to opiates—cases are on record of persons taking up to 5 g of morphine in 16 hours. The tolerant opiate user is able to function very well as long as he has his drug and if he is motivated to do so. There is a marked tendency, however, for opiate users to become non-productive, to lead a parasitic existence, and to neglect personal and family responsibilities. The worst thing about the opiates is not the pharmacologic effects of the drug but the fact that they are injected, usually intravenously, leading to the complications of the needle, especially hepatitis, and accounting for most of the high death rates.

If the individual takes opiates regularly for a month or more, he not only becomes tolerant but has to take the drug continuously to prevent the appearance of the opiate abstinence syndrome. In short, he is physically dependent—"hooked". Physical dependence on opiates is a real physiologic but reversible disorder in the central nervous system.

Briefly, abstinence from opiates has two phases: the acute, which is over in a few days and which is easily treatable, and the protracted, which persists for 2 to 6 months, depending on the dose, and which is not readily treatable. Acute abstinence from opiates is characterized by central nervous system irritability manifest by anxiety, insomnia, and muscle twitching. Concomitantly, disturbances in both divisions of the autonomic nervous system occur, leading to pupillary dilation, sweating, rhinorrhoea, gooseflesh, nausea and vomiting. Acute abstinence from opiates is quickly reversed by a sufficient dose of any of the type IA drugs, and acute abstinence can be precipitated with any of the opiate antagonists.

Acute abstinence from opiates is not dangerous to life, convulsions and delirium do not occur, and treatment is simple. All that is required is a drug-free environment plus reduction of the dose of the drug of dependence over a period of a few days. Although any of the type IA drugs can be used for this purpose, methadone has found favour for two reasons: it is very effective orally and it has a long duration of action. For these reasons, substitution of methadone for whatever opiates or opioids the patient has been taking followed by reduction of the methadone over a period of days is now the most widely used method of withdrawing opiates. The method essentially exchanges a somewhat protracted mild illness for an acute, stormy one. There is no way that all withdrawal distress can be prevented, and there is no cure for the phase of protracted abstinence except time.

Taking away the opiate is the easiest and the only simple part of the treatment of an opiate dependent, and must be followed by a long period of after-care. Relapse is common and must be accepted as a part of a long-continuing illness. Currently, there are two general forms of management of opiate dependents: (1) total abstinence and social rehabilitation; (2) maintenance on opiates with social rehabilitation being the goal. These are subject to more detailed consideration in Chapter 12.

The threat posed by heroin is the subject of Chapter 4.

**Dependence of the Barbiturate—Alcohol Type**

Type IB—This type includes the hypnotics—the barbiturates (the major tranquillizers) and the non-barbiturates (the minor tranquillizers).

**Barbiturates**

Representative of this group are pentobarbital (nembutal), necobarbital (seconal), amobarbital (amytal), glutethimide (doriden), tuinal (combined ambobarbital and necobarbital) and chloral hydrate.

Medically these drugs are used primarily to induce sleep, reduce anxiety (to tranquillize), to control chemically induced convulsions, and occasionally as an aid in the diagnosis of psychiatric disorders.

As already explained, the drugs in group IA are placed together since they all, in high doses, cause a similar kind of intoxication and a similar form of physical dependence, and cross-tolerance and cross-dependence occur between all members of the group. Interchangeability is a feature of the type IB drugs.

Heavy non-medical use of the alcohol-barbiturate type is characterized by strong psychic dependence, moderate but limited tolerance, and a severe kind of physical dependence, characterized by anxiety, insomnia, tremulousness, convulsions, and delirium, if the drugs are withdrawn abruptly from persons who have been ingesting them in large amounts for long periods of time. This type of physical dependence, in contrast to the opiate type, is dangerous to life and must be prevented or treated vigorously.

As is the case with other drugs, there is a spectrum ranging from occasional light use to continuous high-level intoxication. The drugs may be taken occasionally, in "binge" fashion for a few days, or continuously for weeks or months. Some persons take one sleeping pill each night, others remain constantly intoxicated for months. Usually the drugs are taken orally; occasionally opiate or amphetamine dependents take them intravenously. Quite commonly, they are used in conjunction with central nervous system stimulants.

The effects of these drugs vary with dose and require little description, since basically all cause effects similar to those of alcohol. In sufficient dose, all cause, after an initial excitant phase, central nervous system depression ranging from mild sedation to hypnosis to stupor and coma. In sufficient dose, all cause impairment of judgement, loosening of behavioural controls, and psychomotor ataxia. All can cause traffic accidents.

The sociologic factors in dependence of the alcohol-barbiturate type are quite different from those associated with the opiate type. The position of alcohol provides the key to an understanding of the nature of dependence of the alcohol-barbiturate type. Since moderate use of alcohol is an accepted part of Western culture, the all-important peer group is very large and occurs in all strata of society. Alcoholics are generally introduced to alcohol in social situations. The alcohol dependent differs from the social drinker in that he loses control and drinks excessively. He may drink moderately for years before excessive drinking becomes a problem. Usually persons with alcohol dependence are middle aged rather than being young, as is the case with most opiate and amphetamine dependents.

Individuals who use sedative and hypnotic drugs to excess most frequently have had these drugs prescribed for relief for anxiety, insomnia, etc. They may be alcoholics but just as frequently are non-alcoholic neurotics. Such neurotic patients frequently see several physicians and may obtain a different prescription for a different sedative or hypnotic drug. They faithfully take all their medications as directed but do not stop the old ones because they are not told to do so. There is evidence of people who take 10 to 15 kinds of sedative medication, all as prescribed. The result in such cases is dependence of the barbiturate type resulting from several drugs.

*Abstinence Syndrome.* When drugs of this type are abruptly withdrawn from individuals strongly dependent on them, the patients first sober up and appear improved. Increasing anxiety, tremors, weakness, nausea, sweating and postural hypotension then appear. The patients may then have one or more grand mal convulsions. Following the convulsions, they may develop delirium tremens, with confusion, disorientation, and hallucinations. Usually the syndrome is self-limited, but death can occur because of injuries received during a convulsion, from exhaustion, dehydration, electrolyte imbalance, or a rapidly-rising temperature unassociated with infection. Like the morphine abstinence syndrome, the severity of the alcohol-barbiturate abstinence syndrome is dose-and-time dependent. At least four hypnotic doses of barbiturates or equivalent drugs daily for a month are required to create mild dependence, and eight or more doses daily are needed to induce severe physical dependence of this type. In the case of alcohol, ingestion of a quart of whiskey daily for a month is required.

Like abstinence from opiates, physical dependence of the alcohol-barbiturate type is due to a central nervous system derangement and is not psychogenic.

Since the type IB drugs are interchangeable, any of them can be used for withdrawal.

The dose of whatever drug is used must initially be sufficient to maintain a mild degree of intoxication (the stabilization dose). This dose must be determined individually by trial and error. Once the stabilization dose is known, it is reduced cautiously over a period of 3 to 21 days, depending on the amount of the stabilization dose and response. Any drug in group IB could be used, but ethyl alcohol is a poor choice because of its narrow margin of safety and its hepatoxotoxicity. Paraldehyde is a classic drug and is effective, although unpleasant. Chlordiazepoxide and diazepam are currently popular and effective. Barbiturates are also effective, if handled properly.

If the patient has had a convulsion or is delirious, he needs to be reintoxicated rapidly with one of the group IB drugs to a degree sufficient to induce sleep, after which the stabilization dose is determined and gradual reduction carried out as before.

As with the opiates, withdrawal of drugs of the alcohol or barbiturate type is the easiest, and only the initial step in the treatment of the alcohol-barbiturate type of dependence. Unlike dependence on opiates, maintenance on the drug of dependence or an equivalent drug is not pharmacologically rational because tolerance to alcohol and depressants is limited, so that the dependent individual can always become intoxicated by taking sufficiently large amounts of these drugs.

Total abstinence from alcohol and central nervous system depressants must be the therapeutic goal.

**Non-Barbiturates (the Minor Tranquillizers)**

Type IB—The representative drugs in this group are meprobamate (miltown, equanil), chlordiazepoxide (librium), diazepam (valium). The medical uses are anti-anxiety, sedative, muscle relaxant, anti-convulsant.

These drugs are similar to the barbiturate-hypnotics in most actions, but tend to be more relaxant to skeletal muscles, most selective in the relief of anxiety, less hypnotic, and less prone to produce inco-ordination of movement or to impair judgement. They also are less likely to produce coma, respiratory failure and death from overdosage (except for meprobamate), and are less (moderately) prone to produce psychologic dependence. Physical dependence has been reported for meprobamate within or only slightly above the therapeutic dose range; it has been established for chlordiazepoxide at higher dose levels, and is likely to occur with all members of this class of drugs (though to a lesser degree than with alcohol or the hypnotics).

The main dangers are similar to those seen with barbiturates, but reduced in intensity. It is difficult to commit suicide with chlordiazepoxide (librium) and diazepam (valium).

**Dependence of the Opiate Agonist-Antagonist Type**

Type IIA—It is now known that the narcotic antagonist, nalorphine, levallorphan, and cyclazocine, have morphine-like (agonistic) actions as well as antagonistic effects. All three drugs will, when given chronically, create a mild type of physical dependence similar to but not identical with abstinence from morphine. Pentazocine is a relatively potent agonist and hence an effective analgesic, but a weak antagonist. The result is that pentazocine is a drug of dependence.

**Dependence of the Amphetamine (Central Stimulant) Type**

The representative drugs are any of those in type IIB—amphetamine (benzedrine), dexamphetamine (dexedrine), methylamphetamine (desoxyn, methedrine), phenmetrazine (preludin), diethylpropion (tenuate), etc.

Medically they are used as anorexiants for the treatment of obesity, although the usefulness of stimulants for reducing appetite has been strongly challenged in many medical and research circles. Paradoxically the other proven medical use for these drugs is to reduce the overactivity and distractibility of hyperactive children.

Dependence of the amphetamine type is characterized by strong psychic dependence, marked tolerance, and the development (if large doses are taken) of a questionable sort of physical dependence. Dependence of the amphetamine type has a strong resemblance to dependence on cocaine, which is also a central nervous stimulant.

All are potent central nervous system stimulants, causing elation, alleviation of fatigue, insomnia, alertness, arousal, talkativeness, restlessness, pleasurable sensations and reduced appetite. Larger doses may produce irritibility, aggressiveness, anxiety, suspiciousness, excitement, adulatory hallucinations and paranoid fears. Stimulants also dilate the pupils, increase sweating, quicken breathing, raise blood pressure and produce tremors of the hands.

The spectrum of abuse of central stimulants is very wide, and ranges from the weight watcher who uses 10 mg of dextroamphetamine daily to the "speed freak" who injects the drug intravenously. Characteristically, amphetamine abuse tends to be mixed with dependence on opiates, hypnotics, or alcohol.

As long as the daily dosage is low (40 mg or less of dextroamphetamine or the equivalent amount of another drug), little harm results. If the dose is increased, the chief danger is the development of a psychotic state resembling paranoid schizophrenia, which clears when the drug is stopped.

Intravenous use of amphetamines was epidemic in Japan after World War II and was responsible for hospitalization of 50 000 persons with psychotic episodes. The Japanese epidemic was controlled by imposition of strong legal controls.

Intravenous use of central stimulants has spread rapidly in most Western countries within the last 10 years. The problem in Australia is subject to separate comment in chapter 7. The "speed freak" is typically a young adult who has experimented with marihuana, opiates, and other drugs. Intravenous use tends to occur in binges, called "runs". The amphetamine abuser begins a run by injecting an amphetamine intravenously. The intravenous injection causes a "flash"—an orgiastic sensation of tremendous elation, a feeling of great efficiency, omnipotence, etc. The effect lasts only an hour or two, so the "speed freak" repeats his injection every 2 or 3 hours. He does not eat, does not sleep, and tends to engage in senseless perseverative activity, such as repeatedly sorting nuts and bolts, shining shoes over and over, etc. Tolerance develops rapidly, so that the intravenous abuser may take several hundred milligrams at a dose. Finally the "freak" begins to feel that people are watching him and trying to harm him. Only rarely, however, does the amphetamine abuser take action on his paranoid ideas. The "run" finally terminates after a few days, either because of exhaustion or the development of a psychosis. Cessation of the run is called "crashing". The heavy

amphetamine abuser may attempt to reduce excessive central nervous stimulation by taking central nervous depressants.

A definite sequence of symptoms ensues when heavy amphetamine use is terminated. First, the patient falls into a deep sleep, lasting for a day or two. During this period, rapid eye movement (REM) sleep, which is associated with dreaming and which was suppressed by amphetamines, occurs in large amounts. The rebound in REM sleep has been interpreted as indicating that true physical dependence on amphetamines develops, but this phenomenon is non-specific, occurs during withdrawal of opiates, central nervous depressants, or after a period of sleep deprivation involving no drug. After the period of sleep, the "freak" is ravenously hungry and eats tremendous amounts of food. A period of apathy and depression then follows, during which suicide may occur, or the depression is likely to initiate another "run".

Heavy intravenous amphetamine abuse has to be ranked along with alcoholism and intravenous use of opiates as one of the most catastrophic forms of drug-abuse. Damage to the individual's health, personal relationships, and ability to function in society are clear from the description given above. To this must be added the "complications of the needle", including infections and sudden death.

*Treatment.* Withdrawal treatment is not necessary. If the patient is psychotic, the phenothiazine tranquillizers may be given, but usually all that is required is to protect the patient and let the syndrome run its course. The typical apathy and depression are especially difficult to handle and anti-depressants may be useful. A long period of aftercare with strict supervision and rehabilitative measures is necessary.

**Dependence of the Cocaine Type**

Type IIIA—Cocaine dependence, represents one of the oldest types of drug-abuse, and was the original central stimulant as well as the original local anaesthetic. The spectrum of non-medical use ranges from the chewing of coca leaf with lime by South American Indians living in the Andes, to alleviate hunger or fatigue, to its increasing casual use in Western Society as a "fun" drug used for "kicks". It is a favourite drug of sociopaths who take it intravenously, frequently in combination with heroin ("the speedball"), for its central stimulating effect. The clinical manifestations are similar to those of intravenous amphetamines, but the development of the paranoid psychotic state is more rapid. In addition, tolerance to cocaine is not thought to occur. The treatment required is withdrawal of the cocaine followed by the usual rehabilitative measures.

Too little is known about current use of cocaine in Australia.

**Dependence of the Hallucinogenic (LSD) Type**

The representative drugs are those listed at IIIB of the table—lysergic acid (LSD-25) and congeners, psilocybin, mescaline, dimethyltryptamine, diethyltryptamine, hallucinogenic amphetamines (STP or DOM, TMA, etc.).

All type IIIB drugs listed cause similar reactions and consumption of one dose daily leads to the development of a very high degree of tolerance which confers cross-tolerance to other members of the group (cross-tolerance to the hallucinogenic amphetamines has not been proved). No physical dependence on these compounds occurs. Psychic dependence on hallucinogens differs from psychic dependence on other drugs in that, except for initial experimentation, the drugs are not taken daily but occasionally. These drugs are particularly attractive to people who are in rebellion against the establishment. Those who become regular users take the drug in the hope of attaining transcendental mystic experiences which will give them greater understanding of themselves, the world and the universe. Frequently they become interested in and join the mystic religions of the Orient.

These compounds (except dimethyltryptamine and diethyltryptamine) are taken orally and rarely by injection. Dimethyltryptamine and diethyltryptamine must be smoked or injected. Generally, hallucinogens are taken in company with other persons in a setting utilizing garish colours, lights, strips of foil, etc. One or more persons usually abstain from the drug in order to observe and protect the others ("trip conductor or guide").

The various drugs differ chiefly in potency and time course. LSD causes a reaction lasting about 8 hours, whereas the effects of mescaline and DOM persist for 12 to 16 hours. Dimethyltryptamine and diethyltryptamine cause very rapid and very short "trips", lasting only an hour or two. The effects of these drugs are dose-related. Doses of 0.5 $\mu$g/kg of LSD (or equivalent doses of the others) cause principally euphoria, apprehension, and mild sensory distortion; doses of 1 $\mu$g/kg of LSD cause euphoria, marked sensory distortion, and, occasionally, optical hallucinations; doses of 2 $\mu$g/kg or more are disagreeable, frightening; hallucinations nearly always occur as does alteration in body image. Thus a "bad trip" will always occur if the dose is sufficiently large.

All these compounds cause signs of adrenergic stimulation, such as increased temperature, dilated pupils, increased blood pressure, and increased concentrations of free fatty acids in serum. No cross-tolerance between the hallucinogens and the non-hallucinogenic amphetamines exists.

The mental effects include elation, euphoria, difficulty in thinking, and distortion of taste, touch, hearing, smell, and particularly vision. Sounds seem louder, colours brighter, and sounds may be perceived as throbbing pulses of colour (synesthesia). Visual distortions are particularly spectacular and consist of kaleidoscopic changes in distance, size, shape, colour and form. The individual's own body may seem altered (depersonalization). He may feel large or small, his face may melt to that of a gargoyle if he looks in a mirror; his hands may appear like the paws of an animal. He may feel that he can see the blood and bones in his own hands. Hallucinations, both elementary or entoptic (flashing lights and colours without definite shape) and formed (definite pictures), are common. Most users retain insight and realize that the effects are due to the drug.

Serious acute psychiatric reactions can occur, and include panic reactions, depression with suicidal tendencies, paranoid ideas of reference and control, etc. LSD can trigger psychotic episodes lasting days to weeks and some persons have remained permanently psychotic after ingesting LSD. While these people may have been predisposed or actually psychotic before taking the drug, LSD seems to have made them worse or destroyed their limited ability to compensate. The other phenomenon is the "flashback" or recurrence of sensations under the drug at a later time when no drug is ingested. This phenomenon must be psychologic in origin but it can cause a panic reaction.

The physician is most likely to be involved in cases of "bad trips". These are usually readily handled by placing the patient in a quiet darkened room, and giving him quiet sympathetic support; for example, "talk him down". The presence of a friend is of great help. If any drug is used, a phenothiazine tranquillizer is the most rational choice.

**Dependence of the Khat Type**

For centuries Khat has been used in the Arabian Peninsula and its use has spread to the Horn of Africa. Usually the leaves are chewed and produce stimulation of the central nervous system with euphoria. When the effects of the drug have worn off, apathy, depression and loss of appetite occur.

Khat is unlikely to be encountered in Australia and it is not considered further in this Report.

**Dependence of the Cannabis Type**

Type IIID—The World Health Organization Expert Committee has defined the characteristics of dependence of the cannabis type as:

(1) A desire (or need) for repeated administration of the drug on account of its subjective effects, including the feeling of enhanced capabilities.

(2) Little or no tendency to increase the dose since there is little or no development of tolerance.

(3) A psychic dependence on the effects of the drug related to subjective and individual appreciation of these effects.

(4) Absence of physical dependence so that there is no definite and characteristic abstinence syndrome when the drug is discontinued.

Cannabis is the subject of continuing controversy and debate. On the matter of penalties, the Committee made certain recommendations in its Memorandum presented to the State Parliament on 30th March, 1977.

In subsequent public hearings, the Committee has received much further evidence on the whole issue of cannabis use. The Committee's findings on this evidence appear in chapter 8.

**Dependence on the Minor Analgesics**

The minor analgesics include such substances as aspirin, phenacetin, paracetamol, salicylamide and codeine. They are supplied either as single ingredients or combined or compounded as mixtures of two or more of each other, most commonly in tablet or powder form.

The Committee has received disturbing evidence about the widespread use of the minor analgesics in New South Wales and the damage which they can cause to people who, through their reliance on them, overindulge in their use. The Committee's findings on this dependence and the issues thus arising are to be found in chapter 5.

**Volatile Solvents**

Type IIIC—Although not strictly classified as drug dependence, a social phenomenon exists in the desire of a number of very young people to inhale any material containing a volatile solvent. This is commonly known as "glue sniffing".

Usually the solvent is contained in a plastic bag and the vapour inhaled. A wide range of materials can be "sniffed". All of these solvents are in effect general anaesthetics and cause excitation and drunkenness. The chief danger is suffocation by the inhaler slumping face down into the plastic bag. "Glue sniffing" is limited almost entirely to young boys and girls and, generally, is a phenomenon that passes as the child matures. It may, however, be a symptom of a serious behavioural disorder and on any account its occurrence is a cause for concern and counter action.

ANNEXURE B

**Table 1**

**NEW SOUTH WALES POLICE DEPARTMENT DRUG STATISTICS—DRUG ABUSE**

| Type of Drug | 1959 | 1960 | 1961 | 1962 | 1963 | 1964 | 1965 | 1966 | 1967 | 1968 | 1969 | 1970 | 1971 | 1972 | 1973 | 1974 | 1975 | 1976 | 1977 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Narcotics (Opiates) .. | 5 | 5 | 5 | 4 | 9 | 3 | 9 | 28 | 50 | 50 | 125 | 215 | 239 | 173 | 198 | 305 | 559 | 780 | 909 |
| Narcotics (Synthetics) .. | 4 | 3 | 6 | 8 | 10 | 8 | 7 | 11 | 8 | 14 | 40 | 92 | 123 | 68 | 73 | 89 | 102 | 147 | 286 |
| Cocaine .. .. .. | 1 | .. | .. | .. | .. | .. | .. | 2 | 2 | 28 | 19 | 14 | 19 | 11 | 10 | 15 | 21 | 22 | 30 |
| Cannabis .. .. .. | 2 | 1 | 1 | 4 | 3 | 15 | 57 | 104 | 193 | 324 | 365 | 505 | 807 | 1 173 | 1 838 | 3 737 | 4 091 | 4 300 | |
| Hallucinogens .. .. .. .. .. .. .. .. .. | | | | | | | | | 24 | 21 | 44 | 60 | 175 | 154 | 129 | 87 | 164 | 152 | 67 |
| Amphetamines .. .. .. .. .. .. .. .. .. | | | | | | | | | 131 | 172 | 148 | 84 | 48 | 26 | 32 | 24 | 25 | 36 | 36 |
| Barbiturates .. .. .. .. .. .. .. .. .. | | | | | | | | | 26 | 23 | 80 | 84 | 42 | 18 | 10 | 5 | 12 | 8 | 51 |
| (Other) .. .. .. .. .. .. .. .. .. | | | | | | | | | .. | .. | .. | .. | .. | 34 | 21 | 45 | 114 | 197 | 324 |
| Totals .. .. | 9 | 11 | 12 | 13 | 23 | 14 | 31 | 98 | 345 | 501 | 780 | 914 | 1 151 | 1 291 | 1 646 | 2 403 | 4 734 | 5 433 | 6 003 |

**Table 2**

**NEW SOUTH WALES POLICE DEPARTMENT DRUG STATISTICS—AGE GROUP AND SEX BREAKDOWN**

| Age Group | Sex | 1959 | 1960 | 1961 | 1962 | 1963 | 1964 | 1965 | 1966 | 1967 | 1968 | 1969 | 1970 | 1971 | 1972 | 1973 | 1974 | 1975 | 1976 | 1977 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 19 years and under .. .. | Male | .. | .. | .. | .. | .. | .. | 3 | 6 | 107 | 147 | 270 | 280 | 374 | 419 | 531 | 882 | 1 830 | 2 063 | 2 064 |
| | Female | .. | .. | .. | .. | .. | 1 | 1 | 7 | 73 | 112 | 153 | 168 | 164 | 115 | 114 | 149 | 305 | 302 | 364 |
| 20-34 years .. | Male | 3 | 3 | 4 | 4 | 6 | 3 | 10 | 56 | 98 | 153 | 257 | 358 | 509 | 652 | 860 | 1 210 | 2 239 | 2 617 | 3 035 |
| | Female | .. | 2 | .. | .. | 2 | 1 | 4 | 14 | 56 | 55 | 83 | 85 | 86 | 77 | 102 | 125 | 288 | 347 | 424 |
| 35-49 years .. | Male | 2 | .. | 4 | 5 | 6 | 4 | 7 | 12 | 8 | 12 | 9 | 19 | 8 | 19 | 31 | 24 | 54 | 90 | 88 |
| | Female | 2 | 4 | 1 | 3 | 3 | 3 | 5 | 2 | 2 | 5 | 2 | 3 | 1 | 5 | 4 | 8 | 4 | 8 | 11 |
| 50 years and over | Male | .. | 2 | 2 | 1 | 5 | 1 | .. | 1 | 1 | 11 | 21 | 1 | 9 | 4 | 2 | 5 | 13 | 6 | 15 |
| | Female | 2 | .. | 1 | .. | 1 | 1 | 1 | .. | .. | 6 | 5 | .. | .. | .. | 2 | .. | 1 | .. | 2 |
| Totals .. .. .. | | 9 | 11 | 12 | 13 | 23 | 14 | 31 | 98 | 345 | 501 | 780 | 914 | 1 151 | 1 291 | 1 646 | 2 403 | 4 734 | 5 433 | 6 003 |
| Recidivists .. .. .. | | .. | .. | .. | .. | .. | .. | .. | .. | 42 | 63 | 99 | 93 | 66 | 58 | 63 | 104 | 271 | 6 | .. |
| Grand totals .. .. .. | | .. | .. | .. | .. | .. | .. | .. | .. | 387 | 564 | 879 | 1 007 | 1 217 | 1 349 | 1 709 | 2 507 | 5 005 | 5 439 | 6 003 |

ANNEXURE B—*continued*

**Table 3**

**NEW SOUTH WALES POLICE DEPARTMENT DRUG STATISTICS—DRUG ROBBERIES, LOSSES, ETC.**

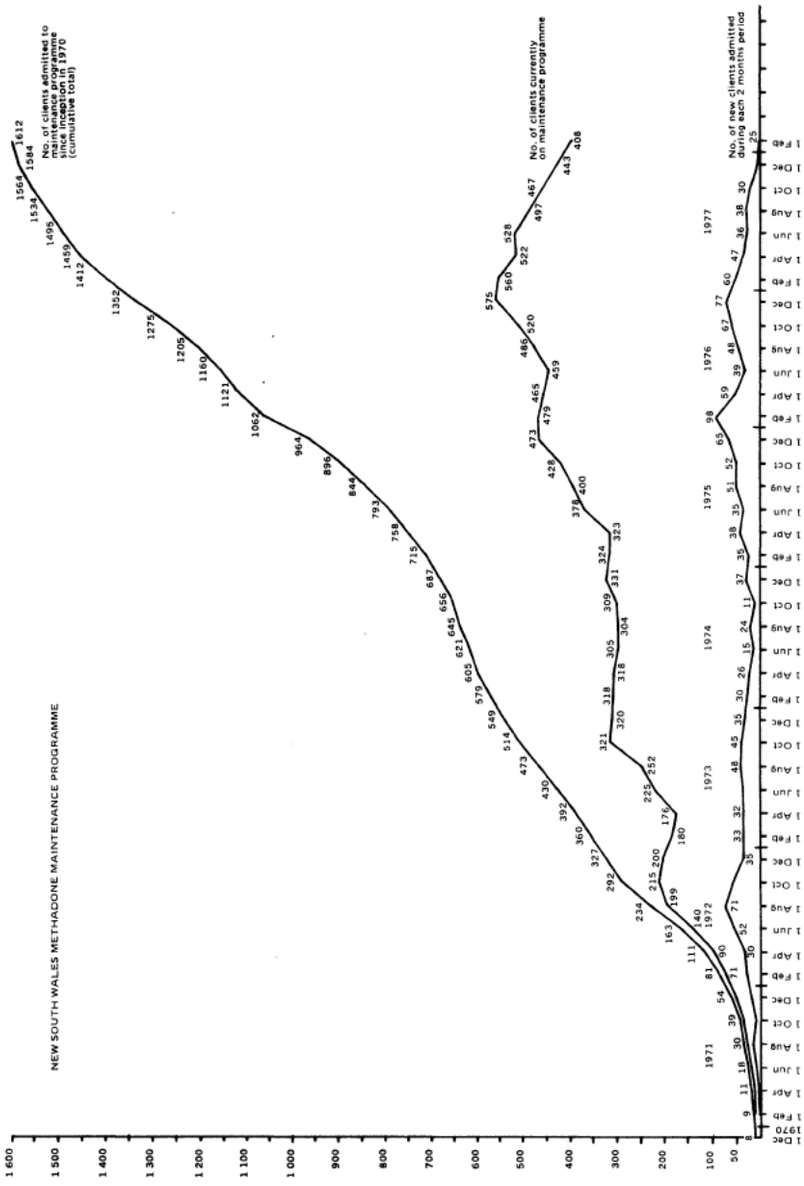
| Offence | 1967 | 1968 | 1969 | 1970 | 1971 | 1972 | 1973 | 1974 | 1975 | 1976 | 1977 | 1978 | 1979 | 1980 | 1981 | 1982 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pharmacy break and enters .. .. | 17 | 31 | 142 | 380 | 227 | 112 | 71 | 124 | 100 | 24 | 119 | .. | .. | .. | .. | .. |
| Dr's surgeries, cars, etc. .. .. .. | 25 | 31 | 46 | 47 | 88 | 166 | 90 | 51 | 115 | 32 | 109 | .. | .. | .. | .. | .. |
| Lost, stolen, missing drugs .. .. | 22 | 38 | 19 | 17 | 16 | 12 | 28 | 23 | 2 | 5 | 3 | .. | .. | .. | .. | .. |
| Hospital dispensaries, etc. .. .. | 5 | 2 | 3 | 4 | 23 | 11 | 11 | 12 | 9 | 8 | 6 | .. | .. | .. | .. | .. |
| Armed robberies .. .. .. .. | .. | .. | 1 | 4 | 44 | 42 | 23 | 44 | 16 | 4 | 41 | .. | .. | .. | .. | .. |
| Warehouses .. .. .. .. .. | 3 | 3 | 3 | 6 | 1 | 1 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Totals .. .. .. .. .. | 72 | 105 | 214 | 458 | 399 | 344 | 223 | 254 | 242 | 73 | 278 | .. | .. | .. | .. | .. |

**Table 4**

**NEW SOUTH WALES POLICE DEPARTMENT DRUG STATISTICS**

| Classification | 1968 | 1969 | 1970 | 1971 | 1972 | 1973 | 1974 | 1975 | 1976 | 1977 |
|---|---|---|---|---|---|---|---|---|---|---|
| Drug detections (including recidivists) .. | 564 | 881 | 1 007 | 1 230 | 1 382 | 1 709 | 2 507 | 5 005 | 5 439 | 6 003 |
| Drug charges preferred .. .. .. .. | 251 | 333 | 471 | 2 105 | 2 465 | 4 600 | 4 439 | 9 047 | 9 994 | 11 268 |
| Female offenders .. .. .. .. .. | 177 | 227 | 252 | 236 | 192 | 217 | 280 | 588 | 723 | 850 |
| Juveniles (under 18) .. .. .. .. .. | 135 | 184 | 194 | 190 | 199 | 227 | 382 | 782 | 945 | 924 |
| Offenders born overseas .. .. .. .. | 80 | 110 | 138 | 226 | 287 | 339 | 427 | 781 | 933 | 985 |
| Pedlars (all drugs) .. .. .. .. .. | 28 | 70 | 134 | 105 | 185 | 185 | 218 | 522 | 456 | 651 |

## ANNEXURE C


NEW SOUTH WALES METHADONE MAINTENANCE PROGRAMME
No. of clients admitted to maintenance programme since inception in 1970 (cumulative total)
No. of clients currently on maintenance programme
No. of new clients admitted during each 2 months period

ANNEXURE D

# THE INCREASING INCIDENCE OF FATALITIES RELATED TO THE ABUSE OF NARCOTIC ANALGESIC DRUGS IN N.S.W. AND A.C.T. 1974-1976

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Health Commission of New South Wales

Lidcombe, March, 1977.

## CONTENTS



## 1. SUMMARY

1.1 It is shown that there has been a dramatic increase in the number of deaths in New South Wales and the Australian Capital Territory, especially since mid-1975, in which abuse of narcotic analgesic drugs is implicated in the cause of death.

1.2 Illicit opiates (principally heroin, also morphine and opium) were involved most frequently in the 115 deaths which followed abuse of narcotic analgesics during 1974-76. Methadone, alone or in combination with an opiate, was the other significant narcotic analgesic encountered in this survey.

1.3 Although the majority of these deaths occurred in the Sydney metropolitan area, an increasing incidence was observed for smaller urban centres.

1.4 The majority of deceased narcotic drug addicts and of others whose abuse of illicit narcotic analgesics was implicated in their death during 1974-76 were males less than 30 years old.

1.5 Deaths following the administration of narcotic drugs to the deceased by another person are becoming more frequent, and pose special problems for police, forensic toxicologists, and forensic pathologists in the criminal courts.

1.6 A few deaths during this period serve to highlight problems resulting from lack of hygiene amongst illicit intravenous drug users ("mainlining"), and from carelessness in the storage of prescribed methadone within reach of infants.

## 2. INTRODUCTION

Mortality due to overdosage of heroin and other narcotic analgesic drugs has increased dramatically since the mid-1960's in the U.S.A., United Kingdom, and Europe.[1-8] Between 1972 and 1976 in New South Wales there has been an increase in the number of narcotic drug addicts presenting themselves for treatment in an authorized methadone maintenance programme. Before 1972, only 82 such addicts were known, whereas by December, 1976, 2 300 addicts were registered for this treatment.[9]

The explanation of the pathophysiology of death from intravenous administration of narcotic analgesic drugs has been hindered in the past by the small number of fatal cases reported annually in those areas with coronial or medical examiner jurisdictions (incorporating forensic pathologists and forensic toxicologists) and by relatively insensitive toxicological methods. A widespread and dramatic increase in deaths attributed to intravenously-administered narcotics, together with improved and sensitive methods for the identification and quantitation of the major metabolites of heroin in post mortem tissues and body fluids, has provided medico-legal scientists with more suitable criteria for the presumptive diagnosis of acute narcotism.[10]

On injection into the body, diamorphine (heroin) is rapidly metabolized to morphine, which is then excreted from the body. Bile, urine, liver and blood are the specimens of choice, and it is the presence of morphine (not heroin) which is reported by the forensic toxicologist. Consequently, toxicological analysis is unable to distinguish between injection, inhalation, or ingestion of heroin, morphine or opium. If other exhibits—syringes, spoons, powders—are found in the possession of the deceased by the Police, these exhibits may be submitted to the Laboratory for analysis.

Two non-barbiturate sedative/hypnotics are sometimes used by narcotic drug addicts—"mandrax" and chloral hydrate. The active ingredients of "mandrax" are methaqualone and diphenhydramine. Chloral hydrate is available from pharmacists without a doctor's prescription.

This report presents demographic and statistical data concerning deaths apparently due to overdosage of heroin and other narcotic analgesic drugs, and concerning deaths of persons known to police as narcotic drug addicts, during the period January, 1974, to December, 1976. Data are presented in relation to 113 deaths occurring in the State of New South Wales (population at 31st December, 1975: 4 819 100) and in the Australian Capital Territory (population at 31st December, 1975: 201 200).[11] Special reference is made to the methadone treatment programme controlled by the Health Commission of N.S.W.

## 2.1 TOXICOLOGICAL ANALYSIS

The Forensic Toxicology Section of the Division of Analytical Laboratories performs analyses of post mortem specimens (stomach and contents, liver, blood, urine, bile) collected at autopsy in cases of unexplained or suspicious death, or in cases of known or suspected previous drug abuse by the deceased. Specimens are received from coroners throughout the State of New South Wales and from the Australian Capital Territory. This is the only laboratory in this State authorized to perform forensic toxicological analyses. Details of the analytical methods employed for morphine, the levels detected in post mortem specimens, and the significance of these levels will be submitted for publication.[12]

Each set of specimens is accompanied by a report of the police officer investigating the death, which report may include details of the suspected cause of death and any past history of drug abuse. The results of toxicological analysis are reported to the coroner and the police. Arrangements exist with the senior coroner by which this laboratory is furnished with a copy of the findings of the coronial inquest in the case of deaths within the Sydney metropolitan area. Such arrangements do not yet exist with coroners in the country or in the Australian Capital Territory.

## 3. DATA

The attached tables comprise data compiled from the results of cases analyzed by the Forensic Toxicology Section between 1974 and 1976.

Table I: Classification of toxicological results, 1974 and 1975 (taken from the Annual Reports of the Division of Analytical Laboratories for 1974-75 and 1975-76). The data for 1976 cannot be classified until mid-1977, since they rely heavily upon the findings of coronial inquests—which may not be completed until several months after the death. However, the totals for 1976 have been added for comparison.

Table II: Deaths involving morphine, 1974-76.

Table III: Deaths involving metadone, pethidine, and dextromoramide, 1974-76.

Table IV: Deaths of known narcotic drug addicts in which drugs other than morphine, methadone, pethidine, or dextromoramide were involved, 1974-76.

Table V: Age and sex distribution for deaths involving narcotic analgesic drugs, 1974-76 (i.e., taken from tables II and III).

Table VI: Age and sex distribution for deaths of known narcotic addicts, 1974-76 (irrespective of cause of death, i.e., taken from tables II-IV).

A small number of cases were submitted for analysis representing those in which morphine and/or pethidine were administered by a medical practitioner solely for their therapeutic analgesic effect; these are not included in this survey. In none of these cases could death be attributed to drug overdosage or abuse.

Several qualifications should be made concerning the data contained in the tables.

Table I: The 1974 and 1975 statistics only list cases in which the narcotic drugs were found in concentrations likely to have caused death. Information is not yet available to allow the results for 1976 to be classified as for 1974 and 1975. The 1976 data include only those cases in which the narcotic drug(s) was likely to be a contributory cause of death.

Tables II-IV:

(i) Known narcotic addicts: this information is obtained from the report of the police officer which accompanies the specimens for toxicological analysis. At this early stage in the police enquiries it is not always possible to establish the past history or drug convictions of the deceased. Another problem is that drug addicts frequently use aliases, and so police files may be incomplete. Undoubtedly, these tables underestimate the true incidence of addiction in deaths occurring during 1974-1976.

(ii) Methadone treatment programme: only six cases are recorded in which it was learned from the report of the investigating police officer that the deceased was a registered heroin addict undergoing treatment in an authorized methadone treatment programme. For the reasons stated above, the true incidence of such deaths is undoubtedly underestimated in the tables.

## 4. CONCLUSIONS AND DISCUSSION

Certain conclusions can be drawn from the data contained in the tables.

(a) As shown in table V, there has been a dramatic increase in the number of deaths resulting from the abuse of narcotic analgesic drugs:

| Year: | 1974 | 1975 | 1976 |
|---|---|---|---|
| Deaths: | 14 | 16 | 49 |

Hodda[13] has shown that morphine-associated deaths prior to 1974 in New South Wales were few in number. A sharp increase is also evident in the total number of deaths of known drug addicts since 1974 (table I). These trends have been most pronounced since winter 1975. Based on cases being received in the Forensic Toxicology Section, these trends show no signs of diminishing during 1977.

(b) Deaths involving narcotic analgesics during 1974-1976 (total: seventy-nine cases) occurred most frequently in males aged 18-21 years (thirty-one cases), 22-25 years (twenty cases), and 26-30 years (six cases).

(c) Deaths of known narcotic addicts during 1974-76 (total: seventy-eight cases) occurred most frequently in males aged 22-25 years (thirty cases), 18-21 years (twenty-four cases), and 26-30 years (eleven cases).

(d) Of the narcotic analgesic drugs involved in 79 deaths during 1974-1976, the opiates (heroin, morphine, opium) alone were the most frequently encountered (37 cases), followed by methadone alone (18 cases). Pethidine or dextromoramide alone accounted for 1 case each. The predominance of opiates amongst the deaths here reported resulting from narcotic abuse is consistent with American experience.[3, 5, 7, 8, 10] However, in one study in Washington, D.C.,[14] methadone alone was encountered in 39 out of 109 acute narcotic overdose deaths, and in combination with heroin in a further 21 deaths.

(e) Combinations of the following narcotics were also present amongst the 78 deaths involving narcotic analgesics:

opiate + methadone—2 cases.

opiate + pethidine—3 cases.

opiate + dextromoramide—1 case.

The remaining sixteen deaths involved narcotics in combination with other drugs or carbon monoxide.

(f) The incidence of deaths resulting from the abuse of an opiate together with methaqualone ("mandrax", "mandies") increased from one case in 1974 to six cases in 1976.

(g) Although alcohol is involved in approximately one-third of all deaths in which drugs are a factor,[13] its incidence in deaths following abuse of narcotic analgesics, or in deaths of narcotic addicts is lower (about 21.5 percent and 11 percent respectively, for the period 1974-76).

(h) Whilst the majority of deaths involving opiates and methadone during 1974-76 occurred in the Sydney metropolitan area (sixty-three out of seventy-seven such deaths), smaller urban centres—Newcastle, Canberra, Wollongong, Gosford, Armidale—are increasingly experiencing this problem.

(i) Only four deaths resulted from pethidine abuse, and these all occurred in 1976; three of these cases involved the abuse of an opiate in combination with pethidine. These deaths occurred most frequently in women, and in the 41-50 years age group.

(j) The drugs most commonly encountered in narcotic drug addicts dying from causes other than narcotic analgesic overdosage or acute narcotism during the period 1974-1976 were the following sedative/hypnotic drugs:

| | Percent of cases |
|---|---|
| Barbiturates | 32 |
| Chloral hydrate | 16 |
| Methaqualone | 13 |

(k) During 1975-76, the Police Drug Squad informed this laboratory of allegations that some illicit heroin in Sydney was being "cut" with strychnine, a highly poisonous alkaloid. The analytical methods employed are capable of detecting sublethal levels of strychnine in visceral specimens. However, strychnine has not been detected in any case in which morphine was detected by this laboratory.

Other adulterants such as quinine have been alleged to cause cardiac irregularities which may be a mechanism for sudden death in addicts.[15] Quinine was not detected in any of the cases here reported.

### 4.1 FORENSIC IMPLICATIONS

In the past, death from drug overdosage has been by accidental or suicidal self-administration. Rarely have such deaths resulted in criminal charges being laid because of alleged administration of a poison to the deceased by the accused acting with felonious intent, or as a consequence of a criminally negligent act.

However, in 1975 and 1976, manslaughter charges followed the deaths of at least five persons as a result of morphine or methadone overdosage. In each instance, those accused were alleged to have been criminally negligent in having administered a harmful substance to the deceased. If the deceased is addicted to heroin, the levels of morphine found in the visceral specimens as a result of toxicological analysis in most instances are significantly lower than the levels found following the death of a non-addict due to fatal heroin overdosage. Interpretation of low levels in such cases places an onerous burden on the forensic toxicologist when appearing as an expert witness at the trial in the criminal courts.

A further difficulty is experienced by forensic pathologists when a person dies following heroin or morphine self-administration. Respiratory collapse and coma which precede death may cause alarm to companions of the deceased, who may attempt resuscitation. Lack of success of these efforts causes the companions to panic in some instances: the body is left until the following day, when the death is reported to the police as having occurred during the night unknown to the companions, who claim that they only discovered the body when they awoke. Unknown to the "unsuspecting" companions, signs of attempted resuscitation of a dead body may be evident during autopsy. The dilemma facing the forensic pathologist and police is whether to prosecute the companions for having failed to seek proper medical treatment, knowing that the patient was seriously ill. Additionally, the question of attempted concealment of death arises.

### 4.2 METHADONE TREATMENT PROGRAMME

As mentioned earlier, there has been a dramatic rise in the number of narcotic drug addicts who have registered for treatment in Sydney with methadone as part of a programme conducted by the Narcotic Dependence Service of the N.S.W. Health Commission. A recent review of this programme concluded that—as with similar studies in other countries—licit methadone supply has not markedly solved or alleviated the opiate addiction problem. The death of a 2-year-old child in 1974 by self-administration of methadone supplied to the child's mother to treat her addiction is a poignant reminder of the hazards of drugs left within the reach of infants and children.

Up to 50 percent of methadone clients were found[9] to be using illicit opiates (chiefly heroin) whilst on methadone treatment (as determined by random toxicological analysis of client's urine specimens). Abuse of other analgesic (e.g., dextropropoxyphene) and sedative/hypnotic (e.g., methaqualone, barbiturates) drugs was frequently observed. There was an apparent poor prognosis (in terms of becoming opiate-free) for clients entering the methadone treatment programme.

### 5. ACKNOWLEDGEMENTS

The permission of the N.S.W. Government Analyst to publish this report is appreciated. The author is grateful to Mrs J. Turner and Mr J. Beedham for their assistance in data compilation.

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TABLE I

Classification of toxicological results, 1974 and 1975, with 1976 totals added for comparison.

The table lists the results of visceral examinations for the calendar years 1974 and 1975. Only those cases have been listed in which the narcotic drugs found were of such concentration that it is likely that they were the cause of death. The column headings have the following meanings:

*Coronial findings:* Cases are listed in these columns when the finding of the coronial inquiry has been received.

*No coronial findings:* In those cases where no record of a coronial finding has been received, a tentative classification of results has been made based on the information available.

"A". The concentration of the compound found was such that it was considered to be the cause of death.

"B". The concentration of the several compounds found were such that together they were considered to be the cause of death.

"C". The concentration(s) of the compound(s) present, together with a significant concentration of alcohol, were considered, in total, to be the cause of death.

*Total:* The sum of the results in other columns.

| Compound | Year | Coronial finding | | | No coronial finding | | | Total |
|---|---|---|---|---|---|---|---|---|
| | | A | B | C | A | B | C | |
| Dextromoramide* .. | 1974 | 1 | 1 | .. | .. | .. | .. | 2 |
| | 1975 | .. | 1 | .. | .. | .. | .. | 1 |
| Methadone .. .. .. | 1974 | 4 | .. | .. | 2 | 1 | .. | 7 |
| | 1975 | 2 | 1 | 1 | 1 | .. | .. | 5 |
| | 1976 | .. | .. | .. | .. | .. | .. | 11 |
| Morphine .. .. .. | 1974 | 3 | .. | .. | 2 | .. | .. | 5 |
| | 1975 | 3 | 2 | 2 | 3 | .. | .. | 10 |
| | 1976 | .. | .. | .. | .. | .. | .. | 36 |
| Pethidine* .. .. .. | 1976 | .. | .. | .. | .. | .. | .. | 4 |
| | 1974 | Known narcotic drug addicts (amongst deaths reported to this laboratory, irrespective of the cause of death). | | | | | | 15 |
| | 1975 | | | | | | | 17 |
| | 1976 | | | | | | | 45 |

Note: * No case in other years.

TABLE II

**DEATHS INVOLVING MORPHINE, 1974-76**

| Case No. | Locality (a) | Age (years) | Sex | Addict (b) | Alcohol (c) | Other drugs found | Coronial findings or other comments |
|---|---|---|---|---|---|---|---|
| | | | | | | 1974 | |
| 1012 | C | 20 | M | .. | .. | | |
| 1283 | S | 18 | M | .. | .. | | Morphine poisoning. |
| 1297 | S | 22 | M | x | .. | Methadone | |
| 1363 | S | 21 | M | .. | .. | | Morphine poisoning. |
| 1577 | S | 21 | M | .. | 0.120 | | Acute intravenous morphine poisoning. |
| | | | | | | 1975 | |
| 1713 | C | 18 | M | .. | .. | | Heroin O/D. |
| 1846 | S | 18 | M | x | .. | | Morphine poisoning. |
| 1984 | S | 21 | M | x | .. | | Heroin and dextromoramide O/D. |
| 2143 | S | 25 | M | x | .. | CO, methaqualone | CO/morphine/methaqualone O/D. |
| 2149 | S | 25 | M | x | .. | Methadone | Undergoing methadone treatment; methadone + morphine O/D. |
| 2267 | S | 19 | M | .. | 0.030 | | Manslaughter conviction. |
| 2296 | S | 29 | F | .. | 0.110 | Acetaldehyde | Acetaldehyde poisoning + morphine and alcohol. |
| 2297 | S | 20 | M | .. | .. | | Manslaughter charges pending. |
| 2337 | S | 23 | M | x | 0.150 | | Morphine poisoning + alcohol. |
| 2351 | C | 19 | M | .. | .. | Codeine | |
| 2360 | S | 21 | M | .. | .. | | No morphine detected, but death found to be due to morphine poisoning. |
| 2400 | S | 26 | M | .. | 0.170 | | Morphine poisoning. |
| 2413 | S | 27 | M | x | 0.030 | Methadone, codeine | Poisoning by morphine, methadone, codeine, alcohol. |
| | | | | | | 1976 | |
| 2452 | S | 41 | F | .. | .. | Pethidine | Poisoning by morphine + pethidine. |
| 2532 | S | 21 | M | .. | .. | Phenobarbitone | Morphine poisoning. |
| 2574 | A | 20 | M | x | .. | | Manslaughter charge dismissed. |
| 2611 | S | 26 | M | .. | .. | | Injected with ½ cap of heroin by brother; died 15 min. later; no morphine detected. |

| Case No. | Locality (a) | Age (years) | Sex | Addict (b) | Alcohol (c) | Other drugs found | Coronial findings or other comments |
|---|---|---|---|---|---|---|---|
| 2632 | S | 23 | M | x | 0.110 | | Morphine intoxication + alcohol. |
| 2687 | S | 49 | F | .. | .. | Pethidine | Medical practitioner. |
| 2668 | S | 18 | M | x | .. | Methaqualone | |
| 2712 | S | 17 | M | x | .. | | Acute narcotism. |
| 2783 | S | 20 | M | x | .. | | Acute intravenous narcotism. |
| 2827 | S | 29 | F | x | 0.020 | | |
| 2838 | S | 20 | M | x | .. | | Morphine poisoning. |
| 2848 | C | 22 | M | x | .. | | |
| 2896 | S | 22 | M | x | 0.105 | | |
| 2930 | S | 19 | M | .. | .. | | Acute narcotism. |
| 2996 | S | 22 | M | x | .. | | Heroin O/D. |
| 3047 | C | 23 | M | x | .. | Methaqualone, Diphenhydramine | |
| 3078 | S | 21 | M | x | .. | | Morphine poisoning. |
| 3091 | S | 22 | M | .. | .. | | Morphine poisoning. |
| 3102 | S | 21 | M | .. | 0.145 | | Acute narcotism. |
| 3109 | S | 25 | M | x | .. | Pentobarbitone | |
| 3122 | S | 20 | F | .. | .. | Methaqualone | |
| 3129 | S | 25 | F | .. | .. | | |
| 3158 | S | 21 | M | x | 0.060 | Pethidine | |
| 3173 | S | 23 | M | x | .. | Methaqualone, Diphenhydramine | |
| 3203 | S | 21 | M | x | .. | | Heroin poisoning. |
| 3205 | S | 25 | M | x | 0.045 | | |
| 3231 | S | 20 | M | x | .. | Methaqualone, Diphenhydramine | |
| 3256 | S | 34 | M | x | .. | | |
| 3267 | S | 23 | M | x | .. | | |
| 3273 | S | 31 | M | .. | .. | Methaqualone | |
| 3300 | S | 22 | M | x | 0.145 | | |
| 3304 | S | 23 | M | x | .. | | |
| 3309 | C | 21 | M | .. | .. | | |
| 3317 | S | 20 | M | x | 0.070 | | |
| 3335 | S | 22 | M | x | .. | | |
| 3338 | C | 18 | F | .. | .. | | Manslaughter charges pending. |
| 3366 | S | 19 | M | x | .. | | |

TABLE III

**DEATHS INVOLVING METHADONE, PETHIDINE, AND DEXTROMORAMIDE, 1974-1976**

| Case No. | Locality (a) | Age (years) | Sex | Addict (b) | Alcohol (c) | Other drugs found | Coronial findings or other comments |
|---|---|---|---|---|---|---|---|
| (a) **METHADONE** | | | | | | 1974 | |
| 997 | C | 20 | M | x | .. | | |
| 1069 | S | 2 | F | .. | .. | | Mother registered addict undergoing methadone treatment. Child died by self-administered methadone poisoning. |
| 1100 | C | 19 | F | .. | .. | | |
| 1131 | S | 22 | F | x | .. | | Bronchopneumonia following methadone overdose. |
| 1162 | S | 17 | M | .. | .. | | Methadone poisoning. |
| 1192 | S | 48 | M | .. | .. | | Bronchopneumonia following poisoning by methaqualone and nitrazepam. |
| 1232 | S | 36 | F | .. | .. | | |
| 1297 | S | 22 | M | x | .. | Morphine | |
| 1558 | S | 19 | M | x | .. | | Acute narcotism. |
| | | | | | | 1975 | |
| 1745 | S | 25 | M | .. | .. | | Methadone O/D. |
| 1836 | C | 27 | M | .. | 0.040 | | |
| 2149 | S | 25 | M | x | .. | Morphine | Undergoing methadone treatment; methadone + morphine O/D. |
| 2251 | C | 21 | M | x | .. | | |
| 2413 | S | 27 | M | x | 0.030 | Morphine, codeine | Poisoning by morphine, methadone, codeine, alcohol. |
| (c) **DEXTROMORAMIDE** | | | | | | 1974 | |
| 1588 | S | 31 | M | x | 0.070 | | Dextromoramide poisoning whilst undergoing methadone treatment. |
| | | | | | | 1975 | |
| 1984 | S | 21 | M | x | .. | | Heroin and dextromoramide O/D. |

Key to tables II and III

(a) S—Sydney metropolitan area.
C—New South Wales country area.
A—Australian Capital Territory.

(b) Addict: x—denotes that the deceased was known by the investigating police officer to be a narcotic drug addict.

(c) Blood alcohol: nil, unless otherwise stated;
units: gram of alcohol per 100 ml of blood.

(d) Ingredients of a proprietary cough syrup, a large quantity of which was consumed by the deceased.

O/D—overdosage.
CO—carbon monoxide.
Dextromoramide—"Palfium", a narcotic analgesic.

TABLE IV

**DEATHS OF KNOWN NARCOTIC DRUG ADDICTS IN WHICH DEATH DID NOT INVOLVE MORPHINE, METHADONE, PETHIDINE OR DEXTROMORAMIDE, 1974-76**

| Case No. | Locality (a) | Age (years) | Sex | Alcohol (b) | Drugs found | Comments and coronial findings |
|---|---|---|---|---|---|---|
| | | | | | 1974 | |
| 899 | S | 43 | M | 0.080 | None | Undergoing methadone treatment; suffocation due to hanging. |
| 978 | S | 21 | M | .. | Cocaine | Death due to injection of cocaine contaminated with dirt. |
| 986 | S | 31 | F | .. | Chloral hydrate; Pentobarbitone | Hallucinating in street, dropped dead. |
| 1199 | S | 22 | M | .. | None | Empty syringe on table, together with opium, methadone, morphine "Palfium", and "Dicodid"; cause of death could not be established. |
| 1281 | S | .. | M | .. | None | Died in psychiatric centre; cause of death not known. |
| 1377 | S | 37 | M | .. | Chloral hydrate; Pentobarbitone | |
| 1382 | S | 22 | F | .. | Pentobarbitone; Amylobarbitone; Quinalbarbitone. | Barbiturate overdose. |
| 1394 | C | 25 | M | .. | None | Conveyed to hospital, frothing at mouth following ?methadone overdose; cause of death not known. |
| 1410 | S | 37 | M | .. | Methaqualone | Methaqualone overdose. |
| 1445 | C | 30 | F | .. | Chloral hydrate | |
| | | | | | 1975 | |
| 1739 | S | 53 | M | .. | Proxyphylline; Caffeine | Registered for treatment with "Proladone" to relieve pain due to Potts disease. |
| 1780 | S | 21 | M | .. | None | Methadone tablets found on bed. |
| 1833 | S | 24 | M | 0.115 | None | |
| 1937 | S | 23 | F | .. | Amylobarbitone; Quinalbarbitone | Self-injected barbiturate overdose. |
| 2072 | S | 27 | M | .. | Ethinamate, Pentobarbitone, Paracetamol, Codeine. | Died 3 days after overdose. |
| 2076 | S | 26 | F | .. | Methaqualone, Pentobarbitone | |

TABLE IV—*continued*

**DEATHS OF KNOWN NARCOTIC DRUG ADDICTS IN WHICH DEATH DID NOT INVOLVE MORPHINE, METHADONE, PETHIDINE OR DEXTROMORAMIDE, 1974-76**

| Case No. | Locality (a) | Age (years) | Sex | Alcohol (b) | Drugs found | Comments and coronial findings |
|---|---|---|---|---|---|---|
| 2134 | C | 18 | M | .. | None | Died after severe coughing bout. |
| 2180 | S | 25 | M | .. | Methaqualone, Caffeine | Undergoing methadone treatment; collapsed and died after meal. |
| 2339 | S | 21 | F | .. | Chlorpromazine | Collapsed and died in prison. |
| 2343 | S | .. | M | 0.145 | None | Heroin capsule found near body. |
| | | | | | 1976 | |
| 2489 | C | 21 | M | .. | None | Found hanged in police cell. |
| 2624 | S | 29 | F | .. | Pentobarbitone | |
| 2641 | S | 32 | M | .. | None | Treated for Pethidine addiction. |
| 2767 | S | 30 | M | 0.135 | Amylobarbitone, Diazepam | |
| 2782 | C | 24 | M | .. | Methaqualone, Diphenhydramine | Struck by car whilst wandering in centre of road. |
| 2902 | S | 29 | M | .. | Cocaine | |
| 2919 | S | 23 | F | .. | Chloral hydrate | |
| 2981 | S | 18 | M | .. | None | Syringes and spoon found near body. |
| 2990 | S | 23 | M | .. | Diazepam | |
| 3075 | S | 19 | M | .. | Chloral hydrate | |
| 3123 | S | 26 | M | .. | Methaqualone | Found immersed in bath. |
| 3154 | S | 23 | F | .. | Quinalbarbitone, Phenytoin | Found in bed in burnt-out flat. |
| 3157 | S | 23 | F | .. | None | Addicted to both heroin and dextromoramide. |
| 3179 | S | 32 | F | .. | Amylobarbitone, Quinalbarbitone | |
| 3200 | S | 23 | M | .. | Amylobarbitone | Jumped into path of train. |
| 3241 | S | 24 | M | .. | Pentobarbitone | |

**Key:**

(a) S—Sydney metropolitan area.
C—New South Wales country area.
A—Australian Capital Territory.

(b) = (c) in Key to tables II and III (i.e., blood alcohol).

"Dicodid"—dihydrocodeinone. "Proladone"—oxycodone.

TABLE V

**AGE AND SEX DISTRIBUTION OF DEATHS INVOLVING NARCOTIC ANALGESIC DRUGS 1974-76.**

| Year | Age | < 18 | 18-21 | 22-25 | 26-30 | 31-40 | 41-50 | Total |
|---|---|---|---|---|---|---|---|---|
| 1974 | .. .. .. .. .. | 2 (1) | 7 (1) | 2 (1) | Nil | 2 (1) | 1 (nil) | 14 (4) |
| 1975 | .. .. .. .. .. | Nil | 8 (nil) | 4 (nil) | 4 (1) | Nil | Nil | 16 (1) |
| 1976 | .. .. .. .. .. | 1 (nil) | 21 (4) | 17 (2) | 4 (1) | 2 (nil) | 4 (3) | 49 (10) |
| Total | .. .. .. .. .. | 3 (1) | 36 (5) | 23 (3) | 8 (2) | 4 (1) | 5 (3) | 79 (15) |

The number of deceased who were females is shown in parentheses.



TABLE VI

**AGE AND SEX DISTRIBUTION OF DEATHS OF KNOWN ADDICTS, 1974-76 (IRRESPECTIVE OF CAUSE OF DEATH).**

| Year | Age | < 18 | 18-21 | 22-25 | 26-30 | 31-40 | 41-50 | > 50 | Not known | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| 1974 | .. .. .. .. | Nil | 3 (nil) | 5 (2) | 1 (1) | 4 (1) | 1 (nil) | Nil | 1 (nil) | 15 (4) |
| 1975 | .. .. .. .. | Nil | 6 (1) | 6 (1) | 3 (1) | Nil | Nil | 1 (nil) | 1 (nil) | 17 (3) |
| 1976 | .. .. .. .. | 1 (nil) | 15 (nil) | 19 (4) | 7 (2) | 3 (1) | 1 (nil) | Nil | Nil | 46 (7) |
| Total | .. .. .. .. | 1 (nil) | 24 (1) | 30 (7) | 11 (4) | 7 (2) | 2 (nil) | 1 (nil) | 2 (nil) | 78 (14) |

The number of deceased who were females is shown in parentheses.

ANNEXURE E

## COMMENTS FROM THE OBSTETRIC SOCIAL WORKERS GROUP IN THE INNER-METROPOLITAN AREA TO THE JOINT COMMITTEE OF THE LEGISLATIVE COUNCIL AND LEGISLATIVE ASSEMBLY UPON DRUGS.

The following information and points have been drawn up by Social Workers from Obstetric Hospitals in the Inner-Metropolitan Regions of Sydney and are quoted basically with relevance to the obstetrical environment. Attempts have been made to fit this information within the terms of reference set out by the Joint Committee of the Legislative Council and Legislative Assembly upon Drugs.

**Under the first point of the Terms of Reference**

Social effects of the addicted pregnant woman, and the addicted mother and her child is of particular concern to those working in the obstetric field and would therefore be appropriate for point 1 of the terms of reference, i.e., the social effects of drugs of dependence.

(1) Basically there are a wide range of outcomes, ranging from the situation being "satisfactory", particularly if there is outside suitable support, e.g., family, boyfriend, husband, to the intolerable, e.g., baby having to be taken from mother's care under various acts of the Department of Youth and Community Services to neonatal death at 36 weeks or various degrees of child abuse.

(2) Generally the situations demand reliable on-going follow-up support and supervision. The situation is frequently unstable with the mother making an unrealistic appraisal of her ability to cope with the stress involved in caring for a child and the temptation that she will face to escape in her usual manner. The mother's personal strengths are likely to be extremely poor, which is likely to be the reason for her addiction in the first place.

(3) It appears to be fairly common that where a mother is not returning to her family she moves frequently so the child is constantly adjusting to a new environment. At the Royal Hospital for Women at least two addicted mothers have spent periods in jail within 12 months of confinement. Despite the usual procedure of notifying the Department of Youth and Community Services when a known user is taking custody of a child, their ability to follow up is affected by:

(a) heavy case loads and;

(b) constant moves of the mother.

Even where the mother reverts to use of drugs the authorities are reluctant to take action unless the child is physically affected, e.g., abandoned or bashed. Should an officer of the Department of Youth and Community Services take a case before the court he is aware that the alternatives may be:

(a) The child is left in the care of the mother who may become hostile towards the Department thus making further supervision difficult.

(b) The child may be a ward of the State. This would mean institutional or foster care for the child. Faced with the possibility of an unstable future for the child, the officer may be reluctant to act.

(4) There is frequently a lack of ante- and post-natal care, as a result of irregular attendance for medical appointments. Addicts are often unaware how far their pregnancy has progressed, they tend to discharge themselves from hospital early and generally fail to turn up for post-natal care. Their frequent changes of address and/or hostility to authority figures makes it difficult to follow-up even if purely for one post-natal check-up.

(5) The addicted mother appears to have more mothercraft difficulties, e.g., the general policy of obstetric hospitals is to put the child in the intensive care unit for observation in case of withdrawal, which unfortunately, affects the mother/child bonding relationship. Because of her addiction the mother may be very vague or forgetful about the feeding routines or bathing the baby. This obviously causes staff concern for the baby after discharge and mothers may resent what they see as authoritarian interference. Generally, addicts have difficulty fitting into any system, e.g., hospitals.

**Psychological Elements**

(1) Due to the dependency on drugs the mother/child relationship is affected—when the mother is so much in need herself, she has great difficulty in giving to the child.

(2) Her mothering ability is affected, e.g., drowsiness from the drugs and the patients' low tolerance to stress as exhibited by frustration aroused by even simple hospital procedures.

(3) The patients are frequently not in touch with reality of the situation due to the immediate effect of the drugs or from withdrawal.

(4) The obstetric staff may display distrust, hostility and anger to drug addicts, causing distress and aggression from the addicted mothers. The early separation from the mother e.g., because the child is placed in I.C.U. increases the difficulty in bonding between mother and child.

(5) Many addicted mothers experience guilt feelings realizing the physical difficulties of withdrawal for herself and assumes that it is an even more unpleasant experience for her child.

(6) During pregnancy those who have used drugs usually express concern about the effect of the drugs on the baby. Most of the girls who have regular ante-natal care try to stop or limit their intake of drugs during pregnancy. Some totally succeed, some partially, i.e. they go off and on. The length and severity of the usage seem to determine the mother's ability to withdraw.

**In assessing the risk of sending an infant home with its mother the following factors need to be considered**

(1) *Age of Mother*—Less than 18 years or more than 30 years of age represent a high risk.

(2) *Length of Drug Use*—The shorter the period of time the mother has used drugs, the less is the risk.

(3) *Presence in a Drug Programme*—Participation in a drug programme reduces risk factors.

(4) *Reason for Entering Drug Programme*—Voluntary entry—good. High risk if the woman enters a programme under court order.

(5) *Drug Usage while on Methadone*—The lowest risk is the woman who uses no drugs while receiving methadone.

(6) *Home Interaction*—The lowest risk is the woman living with older family members, none of whom is using drugs.

(7) *Ability to Raise Other Children*—The lowest risk is the woman who has raised other children without problems.

(The above table was compiled from: *Born with a habit—infants of drug addicted mothers,* Peter Rothstein and Jeffrey B. Gould. Paediatric Clinics of North America Vol. 21, No. 2, May 1974.)

Under point 4 of the Terms of Reference the following comments and recommendations are thought to be appropriate:

(1) It would seem worthwhile to have better control of sale of drugs, e.g., Mandrax, which can be responsible for beginning of drug-usage among many teenagers. Is there any point in controlling marijuana when amphetamines and alcohol are easily obtained?

(2) Education of parents to take more responsibility re accessibility to drugs in the house particularly if they themselves deal with problems by drug relief.

(3) Education at schools re implications of drug taking not just for the consumer, but to the child they produce. This could be covered in a course incorporating issues of social responsibilities.

(4) Education of medical staff re effects particular drugs have on the pregnant mother and her child, and the appropriate form of treatment required.

(5) If a drug addicted woman is placed on a drug programme, attention should be paid to the new lifestyle this offers, e.g., family planning, as the reproductive system is now regulated making pregnancy more likely if no precautions are taken.

**Incidence of Drug Abuse in Obstetric Hospitals**

(1) *Royal Hospital for Women*

Twelve mothers in 2 years were known drug addicts. Of these, thirteen children were produced. Of the twins, one died and the other had to have surgery for bowel malformation. Five babies were premature.

Of the twelve mothers, two were barbiturate and alcohol abusers, one used LSD and nine were heroin addicts. One girl submitted her child for adoption and several weeks later was admitted to a psychiatric hospital for attempted suicide. Another of these women overdosed on heroin and later died. Her 2-year-old son was placed for adoption but because of his extremely unstable background is a very disturbed child.

(2) *The Women's Hospital, Crown Street*

In 2 years at the Women's Hospital, Crown Street, twenty-five patients were known heroin/methadone users. Of the twenty-five patients, eighteen were single, three married, one was married and separated and three were in *de facto* relationships. All were Australian. Out of these patients' babies, one child was adopted out, one baby was still-born at thirty-six weeks, seventeen babies were kept by their mothers and four babies were taken into care or fostered because of the following reasons:

(a) Child was "dropped" following keeping—child was fostered through Dr Barnardo's (State ward).

(b) Child was initially kept, at first with a good prognosis. Child was taken into care because baby was abandoned at the Prince of Wales Hospital after mother admitted baby with bruises.

(c) Baby was removed because of drugs, and a psychiatric background and a State ward.

(d) The child was taken from patient's care whilst in hospital following confinement, due to continual marihuana smoking, no money, accommodation was bad, and there was an inappropriate response and care of the child.

On five occasions the patients' mothers and/or putative fathers were involved, the patients' prognoses being better than those without support. Three baby health centres were involved with patients. One patient had a drug conviction and two putative fathers were in gaol.

The age group of these patients ranged from 16 to 28 years of age, with the majority of the women being in their 20's.

(3) *St Margaret's Hospital for Women*

At St Margaret's Hospital for Women, there were nine known users of drugs aged between 19 and 27, with the majority being in their early 20's. Of these one patient adopted out her child and one child was still born. Three women were known heroin users, one woman being supplied by her husband with no interest in a drug programme. One woman was married, six were single and two patients were in *de facto* relationships.

(4) *King George V Hospital*

King George V Hospital had five patients who were drug-abusers in 2 years.

It should be noted that these are the figures of known drug-abusers at four inner-city obstetric hospitals. Figures of drug abusers presenting at outer-suburban hospitals such as Bankstown, Blacktown, Canterbury are not known. It is also not known how many patients present at hospitals as "dried out", only to return to taking drugs once out of sight of people who could be seen as authority figures.

From observations, many social workers suspect that a proportion of termination of pregnancy patients are drug-abusers, a fact which can be difficult to substantiate, due to limited contact.

**Statistics from Royal North Shore Hospital**

The Royal North Shore Hospital had three addicted patients in the same 2 years

period. One patient who makes very heavy demands on community resources and had family support managed to care for herself and her baby adequately. A second girl, wary of authority figures such as hospital staff or government officers, has also managed satisfactorily. Both these girls were on methadone programmes when they became pregnant, and have maintained themselves satisfactorily on these programmes. A third patient kept her child, was a heroin addict and her prognosis is poor.

**List of Articles on Methadone and Neo-Natal Addiction**


(1) "Neo-natal narcotic abstinence; effects of pharmacotherapeutic agents and maternal drug usage on nutritive sucking behaviour".
Reuben E. Kron, Mitchell Litt., Marianne D. Phoenix and Loretta P. Finnegan.
*Journal of Paediatrics* 1976, Vol. 88, No. 4, Part 1, pp. 637-645.

(2) "A study of factors that influence the severity of neonatal narcotic withdrawal".
Enrique M. Ostrea, Cleofe J. Chavez, Milton E. Strauss.
*Journal of Paediatrics* 1976, Vol. 88, No. 4, Part 1 pp. 642-645.

(3) "Neonatal addiction: a two year study". Cyril M. Ramer and Ann Lodge. Childrens Hospital, San Francisco.

(4) "The effects of maternal drug abuse on the foetus and infant". Michael Heffernan, *Australian Family Physician,* August, 1975, FMP Supplement.

(5) "Neonatal narcotic addiction—comparative effects of maternal intake of Heroin and Methadone". Carl Jeson, Sook Ja Lee and Marie Cassalino.

(6) "Effect of prenatal drugs on the behaviour of the neonate" T. Berry Brazelton. *American Journal of Psychiatry,* 126 (9) 1261-1266 March 1970.

(7) "Drug abuse in pregnancy; its effects on the foetus and newborn infant". Lois L. Neumann. Drugs and Youth; The Challenge of Today, Pergamon Press Inc. 1973, pp. 1-32.

(8) "Fetal complications of maternal heroin addiction; abnormal growth infections and episodes of stress". Richard R. Naeye *The Journal of Paediatrics,* **83**, (6), 1055-1061 December 1973.

(9) "Methadone withdrawal in newborn infants". B. K. Rajegowda. *Journal of Paediatric Research,* **81**, (3) 532-534 September 1972.

(10) "Delayed presentation of neonatal methadone withdrawal" Stephen R. Kandell, *Paediatric Research,* **7**, (4), 320/92 April 1973.

(11) "Fetal stress from methadone withdrawal" Frederick P. Zuspen, James A. Gumpel, Alfonso Mejia-Zelaya, John Madden and Royal Davis. *American Journal of Obstet. & Gynae.* May 1975 Vol. 122 No. 1.

(12) "Infant of the addicted mother". Carl Zelson *Medical Intelligence—Zelson* Vol. 288 No. 26

(13) "Born with a habit—infants of drug addicted mothers". Peter Rothstein and Jeffrey B. Gould. *Paediatric Clinics of North America* Vol. 21 No. 2 May 1974.

(14) "Methadone withdrawal in newborn infants". B. K. Rajegowda, Leonard Glass, Hugh E. Evans, Graciella Maso, Donald P. Swartz and Wiemer Leblanc.

(15) "Drug addiction and the newborn". Dr. Betty L. Priestly. *Proc. Roy. Soc. Med.,* Volume 65, October 1972.

(16) "Summary of developmental findings with infants born to mothers on methadone maintenance". Ann Lodge.

(17) "Results of 313 consecutive live births of infants delivered to patients in the New York City Methadone maintenance treatment program". Robert G. Newman, Sylvia Bashknow and Doris Calko. *American Journal Obstet. & Gynae.* 15th Jan., 1975. Vol. 121 No. 2.

(18) "Methadone and children". Commentaries *Paediatrics August 1971,* Vol. 48, No. 2.

(19) "Dr Judi; Helping addicts, their babies". Elaine Tait. *Philadelphia Inquirer,* December 14th, 1975.


**List of Articles on Methadone and Pregnancy and Addiction**


(1) "Casework with pregnant women on methadone maintenance". Arthur Maglin. *Social Casework,* March 1975.

(2) "Narcotics Dependence in pregnancy". Loretta P. Finnegan. *Journal of Psychedelic Drugs,* Vol. 7 (No. 3) July-Sept., 1975.

(3) "Abstract—Clinical Observations on Methadone—Maintained Pregnancies". Roy C. Davis, John N. Chappel, Alfonso Mejia-Zelaya and John Madden.

(4) "Narcotic dependency in pregnancy—methadone maintenance compared to use of street drugs". Barry Stimmel, Karlis Adamsons. *JAMA,* March 15, 1976, Vol. 235, No. 11.

(5) "Pregnancy in Narcotics addicts treated by medical withdrawal". George Blinick, Robert C. Wallach, Eulogio Jerez. *American Journal of Obstet. & Gynae.* Vol. 105, No. 7, December, 1969.

(6) "Narcotic withdrawal in the newborn". Leonard Glass and Hugh E. Evans. *American Family Physician,* **6**, (1), 75-78 July, 1972 Vol. 2.

(7) "Comprehensive care of the pregnant addict and its effect on maternal and infant outcome". Loretta P. Finnegan, James F. Connaughton, John P. Emich *et. al.*
*Contemporary Drug Problems* 1 (4), 795-809 Fall, 1972.

(8) "Drug dependence and pregnancy—A review of the problem and their Management". Roger Newberg. *Journal of Obstet. & Gynae. of the British Commonwealth,* 77, 1117-1122, December, 1970.

(9) "Methadone maintenance of pregnant addicts". Rules and Regulations, Federal Register Vol. 40, No. 158, Thurs. August 14, 1975.

ANNEXURE F

## PART I—OFFENCES UNDER PARTS III AND IV OF THE N.S.W. POISONS ACT, 1966, AS AMENDED

### Introduction

As with drink/drive offences the analysis of our drug statistics is made on the basis of the number of "distinct persons" appearing before the courts, classified by principal offence.

When reading this section of the report it should be noted that the Bureau's figures differ from those of the Police Department which include all drug related offences brought before the courts. Hence the police figures include both back-up charges and multiple offences committed by a person during the year.

Parts III and IV of the N.S.W. Poisons Act, 1966, as amended, provided for the offences of: manufacture, sell, distribute, administer, use, possess and forge and utter in relation to a large number of drugs of addiction. Any person who commits one of these offences may be convicted in the summary jurisdiction of a Court of Petty Sessions either before two justices of the peace or a stipendiary magistrate. The maximum penalty that can be imposed for these offences is 2 years imprisonment and/or a two thousand dollar fine.

The drugs of addiction which may be subject to the above provisions of the N.S.W. Poisons Act are specified in Schedule 8 of the N.S.W. Poisons List. As this list contains about 110 drugs we have grouped these under the headings listed below.

OPIATES (Heroin, Morphine, Opium, etc.)

CANNABIS (Indian Hemp, Marihuana and Hashish)

HALLUCINOGENS (L.S.D., Mescaline, Psilocybin (Gold Top Mushrooms), etc.)

STIMULANTS (Methedrine, Benzedrine, Dexadrine, etc.)

SEDATIVES (Mandrax, Barbiturates, Valium, etc.)

COCAINE

### Overall Picture

In 1976 there were 5 238 appearances under parts III and IV of the N.S.W. Poisons Act finalized before Courts of Petty Sessions in N.S.W. Findings of guilt were recorded against 4 707 people, which represented an increase of 19.6 percent over the 1975 figures.

TABLE 6.1

**Number of persons convicted**

| | 1976 | 1975 | 1974 | 1973 | 1972 | 1971 |
|---|---|---|---|---|---|---|
| Number .. .. .. .. .. .. | 4 707 | 3 937 | 2 174 | 1 352 | 1 058 | 897 |
| Percentage Increase over previous year . .. .. .. .. | 19.6 | 81.0 | 60.7 | 27.8 | 20.4 | 36.4 |

It is impossible to come to a firm explanation of the reasons for the slowing down of the increase in drug convictions from 1975 to 1976 based solely on the information in table 6.1. It is important to note that these figures do not precisely reflect trends in the behaviour of drug use in the community, but rather reflect the activity of the police in this area. Therefore the interpretation of these figures should be made by taking into account factors such as the following:

- There was not an increase in the size of the Drug Squad during 1975 and 1976.
- The intense state-wide education programme which was introduced in 1974 to improve drug investigative potential among local police was continued during 1975 and 1976.
- Some authorities have suggested that following an intensive education programme such as this the number of police arrests may reach a plateau which is limited by manpower and activity levels.
- A further explanation may be that there has been a pattern of rapid increase in the growth of usage levels of drugs and that the increase has levelled off to a plateau as the saturation of the likely community of users is completed.

### Type of Substance

Since 1971, when the Bureau started collecting these statistics the majority of cases involved cannabis. From 1971 to 1973 there was a rapid increase in the proportion of cases involving cannabis which has levelled off to about 80 percent.

TABLE 6.2

**TYPE OF SUBSTANCE**

| | 1976 | | 1975 | | 1974 | | 1973 | | 1972 | | 1971 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | No. | Per-cent | No. | Per-cent | No. | Per-cent | No. | Per-cent | No. | Per-cent | No. | Per-cent |
| Cannabis .. | 3 831 | 81.4 | 3 226 | 81.9 | 1 824 | 83.9 | 1 079 | 79.8 | 733 | 69.3 | 494 | 56.2 |
| Opiates .. | 625 | 13.3 | 516 | 13.1 | 262 | 12.0 | 167 | 12.4 | 208 | 19.7 | 265 | 30.2 |
| Hallucinogens | 104 | 2.2 | 138 | 3.5 | 72 | 3.3 | 98 | 7.8 | 114 | 10.3 | 110 | 12.5 |
| Stimulants .. | 33 | 0.7 | 20 | 0.5 | 28 | 1.2 | 20 | 1.5 | 24 | 2.3 | 52 | 5.9 |
| Sedatives .. | 171 | 3.6 | 108 | 2.7 | 55 | 2.5 | 24 | 1.8 | 29 | 2.7 | 51 | 5.8 |
| Cocaine .. | 15 | 0.3 | 22 | 0.6 | 14 | 0.6 | 6 | 0.4 | 13 | 1.2 | 14 | 1.6 |
| Other .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 2 | 0.2 |

NOTE: Because multiple drugs were used this table adds up to more than 100 percent.

**Type of Offence**

Since 1972, there has been a gradual increase in the proportion of persons found guilty for whom the principal offence was illicit possession of drugs of addiction. This figure rose from 38.5 percent in 1972 to 50.8 percent in 1976. While there has not been a corresponding increase in the other "Using" offences (use and administer), the overall increase in these offences has been from 76.2 percent in 1972 to 91.8 percent in 1976.

The increase in "Using" offences has been accompanied by a significant drop in the percentage of "Pushing" offences (distribute and sell) and illegal procurement of drugs (forge and/or utter prescriptions, manufacture). In 1972 these offences accounted for 14.4 percent and only 8.2 percent in 1976.

TABLE 6.3

**TYPES OF OFFENCES**

| | 1976 N=4707 | 1975 N=3937 | 1974 N=2174 | 1973 N=1352 | 1972 N=1058 |
|---|---|---|---|---|---|
| | No. | Percent | Percent | Percent | Percent |
| Possess | 2 394 | 50.8 | 50.1 | 48.5 | 47.8 | 38.5 |
| Use (i.e., take orally) | 1 603 | 34.1 | 35.0 | 36.1 | 33.2 | 37.6 |
| Administer (i.e., intravenously) | 326 | 6.9 | 6.3 | 7.6 | 6.8 | 9.5 |
| Distribute | 50 | 1.1 | 0.7 | 1.0 | 1.8 | 2.4 |
| Sell | 220 | 4.7 | 5.0 | 4.5 | 4.5 | 6.5 |
| Forge and/or utter prescriptions | 33 | 0.7 | 2.0 | 1.3 | 2.5 | 4.5 |
| Manufacture | 81 | 1.7 | 0.9 | 1.0 | 1.3 | 1.0 |
| | 4 707 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

**Type of Offence by Substance**

For all categories of drugs, most findings of guilt related to "Using" offences. Caution should be taken when viewing stimulants and cocaine in view of the small sample sizes.

TABLE 6.4

**TYPE OF OFFENCE BY SUBSTANCE**

| | Cannabis | | Opiates | | Hallucino-gens | | Stimulants | | Sedatives | | Cocaine | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | No. | Per-cent | No. | Per-cent | No. | Per-cent | No. | Per-cent | No. | Per-cent | No. | Per-cent |
| "Push" | 217 | 5.2 | 58 | 7.9 | 18 | 14.6 | 4 | 11.4 | 6 | 3.0 | 4 | 21.1 |
| "Use" | 3 945 | 94.8 | 678 | 92.1 | 105 | 85.4 | 31 | 88.6 | 191 | 97.0 | 15 | 78.9 |
| | 4162 | 100.0 | 736 | 100.0 | 123 | 100.0 | 35 | 100.0 | 197 | 100.0 | 19 | 100.0 |

**Court Action**

Between 1971 and 1976, the proportion of persons found guilty for whom the penalty imposed was a fine, rose from 27.1 percent in 1971 to 58.1 percent in 1976. During the same period proportionately fewer persons were sentenced to terms of imprisonment. This decrease has been consistent for all groupings of terms of imprisonment.

The proportion of persons who benefited from the provisions of section 556A of the Crimes Act rose from 0.9 in 1971 to 6.7 in 1976.

TABLE 6.5

**COURT ACTION**

| | 1976 N=4707 | | 1975 N= 3937 | 1974 N= 2174 | 1973 N= 1352 | 1972 N= 1058 | 1971 N= 879 |
|---|---|---|---|---|---|---|---|
| | No. | Per-cent | Per-cent | Per-cent | Per-cent | Per-cent | Per-cent |
| Offence proved, discharged/recognizance S.556A with/without probation | 313 | 6.7 | 9.4 | 9.7 | 9.3 | 10.9 | 0.9 |
| Fine in default, rising of the court | 10 | 0.2 | 0.5 | 0.6 | * | * | * |
| Admonished and discharged | 95 | 2.0 | 0.7 | 1.5 | * | * | * |
| Fine | 2 736 | 58.1 | 54.3 | 50.0 | 44.5 | 37.7 | 27.1 |
| Recognizance with/without fine | 1 206 | 25.6 | 28.2 | 30.2 | 34.5 | 39.2 | 53.1 |
| Committed to the care of institution | 40 | 0.9 | 0.7 | 1.1 | 0.9 | 0.9 | 2.0 |
| IMPRISONMENT | | | | | | | |
| Periodic detention | 16 | 0.3 | 0.4 | 0.2 | 0.1 | .. | .. |
| Less than 1 month | 15 | 0.3 | 0.4 | 1.0 | 0.8 | 0.6 | 0.6 |
| 1 month, less than 6 months | 120 | 2.6 | 2.2 | 2.6 | 3.6 | 3.8 | 4.4 |
| 6 months, less than 1 year | 94 | 2.0 | 1.9 | 1.9 | 4.1 | 4.0 | 6.7 |
| 1 year to 2 years | 62 | 1.3 | 1.3 | 1.2 | 2.0 | 2.8 | 5.0 |
| Not specified | .. | .. | .. | .. | 0.2 | 0.1 | 0.2 |
| Total | 4 707 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

**Court action, offence, drug**

In order to gain a better understanding of the sentencing patterns in Courts of Petty Sessions we analyzed the action taken for the offences of "push" and "use" in relation to cannabis, opiates and other drugs.

For each of the substance categories there was a higher proportion of "pushers" sent to prison than "users". It was interesting to note that there was a substantial increase in the proportion of opiate "pushers" who were sent to prison in 1976 (27 of 50) compared to 1975 (11 of 48).

TABLE 6.6

**ACTION TAKEN, OFFENCE, DRUG**

| | Opiates | | | | Cannabis | | | | Other Substances | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Push | | Use | | Push | | Use | | Push | | Use | |
| | No. | Per-cent | No. | Per-cent | No. | Per-cent | No. | Per-cent | No. | Per-cent | No. | Per-cent |
| 556a Dismissal .. | 0 | 0.0 | 31 | 5.4 | 0 | 0.0 | 258 | 7.1 | 2 | 7.7 | 24 | 8.1 |
| Recognizance fine | 3 | 6.0 | 107 | 18.6 | 61 | 31.6 | 2 473 | 68.0 | 7 | 26.9 | 105 | 35.4 |
| Rising of court .. | 0 | 0.0 | 1 | 0.2 | 0 | 0.0 | 6 | 0.2 | 0 | 0.0 | 3 | 1.0 |
| Admonished and discharged .. | 0 | 0.0 | 1 | 0.2 | 0 | 0.0 | 87 | 2.4 | 0 | 0.0 | 7 | 2.4 |
| Probation with/ without fine or recognizance .. | 20 | 40.0 | 334 | 58.1 | 76 | 39.4 | 680 | 18.7 | 8 | 30.8 | 124 | 41.7 |
| Institution .. .. | 0 | 0.0 | 4 | 0.7 | 7 | 3.6 | 27 | 0.7 | 1 | 3.8 | 4 | 1.3 |
| Prison .. .. | 27 | 54.0 | 97 | 16.8 | 48 | 25.4 | 108 | 2.9 | 8 | 30.8 | 30 | 10.1 |
| Total .. .. .. | 50 | 100.0 | 575 | 100.0 | 193 | 100.0 | 3 639 | 100.0 | 26 | 100.0 | 297 | 100.0 |

**Offender characteristics**

*Age and sex*

As in previous years the vast majority of guilty persons were males (88.2 percent). Similar trends were recorded in relation to drink/drive offences (94.5 percent) and petty sessions offences (78 percent).

More than half (57.5 percent) of the guilty persons were less than 21 years of age.

TABLE 6.7

**AGE AND SEX OF OFFENDERS**

| Age | Total | | Male | Female |
|---|---|---|---|---|
| | No. | Percent | No. | No. |
| 7-11 .. .. .. .. .. .. .. .. | 1 | 0 | 0 | 1 |
| 12-17 .. .. .. .. .. .. .. .. | 869 | 18.5 | 756 | 113 |
| 18-20 .. .. .. .. .. .. .. .. | 1 836 | 39.0 | 1 621 | 215 |
| 21-24 .. .. .. .. .. .. .. .. | 1 224 | 26.0 | 1 076 | 148 |
| 25-29 .. .. .. .. .... .... .. | 522 | 11.1 | 473 | 49 |
| 30-34 .. .. .. .. .. .. .. .. | 129 | 2.7 | 112 | 17 |
| 35-39 .. .. .. .. .. .. .. .. | 42 | 0.9 | 38 | 4 |
| 40 and over .. .. .. .. .. .. | 35 | 0.7 | 31 | 4 |
| Not known .. .. .. .. .. .. | 49 | 1.0 | 45 | 4 |

**Occupation**

The results of many sociological studies have suggested that occupational prestige, the relative social status which the Australian public attributes to different occupations, is an effective indicator of variations of life-style and opportunities associated with the concept of "class". In order to measure the class distribution of the guilty persons occupational categories were used which ranged from A (high) to D (low).

The proportion of findings of guilt recorded against persons in the four groups has remained almost constant since the Bureau started collecting this data in 1972. As it is shown in table 6.8 the "C" and "D" groups contributed to the vast majority of offences.

The number of persons who were unable to be classified on the occupational scale consisted of 269 students, 39 pensioners, 75 housewives, and 1 031 unemployed persons. It was interesting to note that there has been an increase in the number of unemployed offenders in the past 2 years which may largely be attributed to a corresponding increase in the number of unemployed persons in the population.

TABLE 6.8

OCCUPATION

| | | 1976 N=4707 | | 1975 N=3937 | 1974 N=2174 | 1973 N=1352 | 1972 N=1058 |
|---|---|---|---|---|---|---|---|
| | | No. | Percent | Percent | Percent | Percent | Percent |
| Professional/ managerial .. .. .. | A | 11 | 0.2 | 0.2 | 0.1 | 0.5 | 0.3 |
| Semi-professional/ middle management .. | B | 89 | 1.9 | 2.4 | 3.5 | 3.8 | 3.5 |
| Sales, small business, clerical, skilled trades . | C | 1 474 | 31.3 | 36.6 | 41.1 | 41.7 | 36.5 |
| Unskilled .. .. .. | D | 1 616 | 34.4 | 33.4 | 38.3 | 37.0 | 42.0 |
| Student .. .. .. .. | | 269 | 5.7 | 4.6 | 7.4 | 6.4 | 7.6 |
| Pensioner .. .. .. .. | | 39 | 0.8 | 0.8 | 0.4 | 0.1 | 0.3 |
| Domestic .. .. .... .. | | 75 | 1.6 | 1.7 | 1.2 | 1.6 | 2.2 |
| Unemployed .. .. .. | | 1 031 | 21.9 | 17.9 | 6.6 | 6.4 | } 7.6 |
| Not known .. .. .. .. | | 103 | 2.2 | 2.4 | 1.4 | 2.5 | |
| | | 4 707 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

* The number of unemployed persons was not obtained in 1972 and is included in the not known category.

## PART II—DRUG CONVICTIONS IN N.S.W. HIGHER CRIMINAL COURTS

In addition to those sections of parts III and IV of the N.S.W. Poisons Act which enable persons to be prosecuted for drug offences in the summary jurisdiction of a Court of Petty Sessions, offenders may also be committed for trial on indictment for the offences of selling or supplying drugs of addiction, under s. 45A of the N.S.W. Poisons Act.

There were 108 persons convicted of drug offences before the Higher Criminal Courts during 1976 compared with 62 in 1975.

### Offender characteristics

Of the 108 persons convicted there were 99 males. This proportion was consistent with previous years, as can be seen in the table below.

TABLE 6.9

**SEX OF OFFENDERS**

| | 1976 | 1975 | 1974 |
|---|---|---|---|
| Male .. .. | 99 | 57 | 44 |
| Female .. .. | 9 | 5 | 1 |
| | 108* | 62 | 45 |

60.4 percent of the persons found guilty were 25 years or over. This was a substantial increase compared to 1975 when there were 35 percent in this category. The increase in older offenders was particularly evident in the 30-39 years age group which increased from 8.8 percent in 1975 to 32.7 percent in 1976.

TABLE 6.10

**AGE OF OFFENDERS**

| | 1976 | 1975 |
|---|---|---|
| 18-20 .. .. .. .. .. .. | 7 | 13 |
| 21-24 .. .. .. .. .. .. | 33 | 24 |
| 25-29 .. .. .. .. .. .. | 28 | 15 |
| 30-39 .. .. .. .. .. .. | 26 | 3 |
| 40+ .. .. .. .. .. .. | 7 | 2 |
| Not known .. .. .. .. .. | 7 | 5 |
| | 108* | 62 |

### Type of substance

There was a substantial increase in the number of offenders "pushing" opiates in 1976 compared with the previous 2 years. This increase was coupled by a corresponding decrease in the proportion of cannabis offences.

* It should be noted that these persons may have appeared more than once during the year. Section 8 shows that only 93 distinct persons had drug cases finalized in higher criminal courts in 1976.

TABLE 6.11

**TYPE OF SUBSTANCE**

| | 1976 N=108 | | 1975 N=62 | 1974 N=45 |
|---|---|---|---|---|
| | No. | Percent | Percent | Percent |
| Cannabis .. .. .. .. .. | 56 | 52.0 | 81.0 | 58.0 |
| Hallucinogens .. .. .. .. | 1 | 1.0 | 5.0 | 22.0 |
| Opiates .. .. .. .. .. .. | 51 | 47.0 | 13.0 | 18.0 |
| Stimulants .. .. .. .. .. | .. | .. | 2.0 | 2.0 |
| | 108 | 100.0 | 101.0 | 100.0 |

The percentages do not total 100 percent in all years because of multiple drug cases.

As it was mentioned in the previous section on offences under parts III and IV of the Poisons Act, it appears that the offences involving the "pushing" of opiates are being regarded very seriously. This has been shown by the increase in the number of offences which are being brought before the higher courts where more severe sentences are able to be passed.

The above trend has been coupled with a gradual increase in the proportion of people being sentenced to periods of imprisonment for all drug offences brought before the higher courts (55.5 percent in 1974 to 77.8 percent in 1976). It was also noted that 94.2 percent of persons convicted of "pushing" opiate drugs were sentenced to periods of imprisonment; 60.8 percent were sentenced for 4 years or more.

TABLE 6.12

**ACTION TAKEN**

| | 1976 N = 108 | | 1975 N = 62 | 1974 N = 45 |
|---|---|---|---|---|
| | No. | Percent | Percent | Percent |
| Recognizance (with or without Probation or fine) .. .. .. .. | 22 | 20.4 | 24.2 | 42.1 |
| Periodic detention .. .. .. .. | 2 | 1.9 | 3.2 | 2.2 |
| IMPRISONMENT | | | | |
| Less than 12 months .. .. .. | 5 | 4.6 | 8.1 | 2.2 |
| 1 year to 2 years .. .. .. .. | 17 | 15.7 | 19.4 | 13.3 |
| 2 years to 4 years .. .. .. .. | 24 | 22.2 | 33.8 | 20.1 |
| 4 years to 9 years .. .. .. .. | 38 | 35.2 | 11.3 | 20.1 |
| | 108 | 100.0 | 100.0 | 100.0 |

TABLE 6.13

**DRUG × ACTION TAKEN**

| | Recognizance with or without fine or probation | Periodic detention | Less than 12 months | 1 year to 2 years | 2 years to 4 years | 4 years to 9 years | Total |
|---|---|---|---|---|---|---|---|
| Cannabis .. .. | 18 | 2 | 2 | 2 | 16 | 7 | 56 |
| Hallucinogens .. | .. | .. | .. | .. | .. | .. | .. |
| Opiates .. .. | 3 | .. | 3 | 6 | 8 | 31 | 51 |
| Stimulants .. | 1 | .. | .. | .. | .. | .. | 1 |

## PART III—DRUG CONVICTIONS IN NEW SOUTH WALES UNDER COMMONWEALTH LEGISLATION

The Bureau of Crime Statistics and Research is indebted to the Australian Narcotic Bureau for its help in tabulating details of convictions in New South Wales under the Commonwealth drug legislation.

The Commonwealth legislation provides for the prosecution of persons for importing or exporting drugs (or being associated with) under section 233B (i) of the Commonwealth Customs Act, 1901 for conspiracy to import drugs under section 86 (i) (a), and for manufacturing prohibited drugs.

In 1976, there were 63 offenders convicted of offences under the above legislation, which was 51 cases less than 1975.

The decrease in the number of convictions was due to the postponement of a large number of prosecutions involving cannabis whilst the High Court of Australia was considering a case which disputed the validity of the definition of cannabis under the Commonwealth Customs Act.

**Offender characteristics**

Compared with convictions under the N.S.W. Poisons Act which were obtained either summarily or upon indictment, a higher proportion of offenders were females under the Commonwealth legislation.

TABLE 6.14

**SEX AND AGE OF OFFENDERS**

| | 18-20 | 21-24 | 25-29 | 30-34 | 35-39 | 40+ | TOTAL |
|---|---|---|---|---|---|---|---|
| Male | 3 | 11 | 22 | 4 | 4 | 3 | 47 |
| Female | 2 | 5 | 7 | 2 | 0 | 0 | 16 |
| | 5 | 16 | 29 | 6 | 4 | 3 | 63 |

TABLE 6.15

**TYPE OF OFFENCE**

| | Frequency |
|---|---|
| Possess on board ship or aircraft | 1 |
| Import/export | 23 |
| Possess prohibited import | 6 |
| Possess prohibited import reasonably suspected of being imported | 28 |
| Aid and abet import/export | 4 |
| Manufacture | 1 |
| | 63 |

There was a decrease in the proportion of convictions for offences relating to cannabis in 1976. This is explained by the reduced number of prosecutions instituted by the Australian Bureau of Narcotics whilst they were awaiting the outcome of a High Court decision relating to the validity of the definition of cannabis under the Commonwealth Customs Act.

TABLE 6.16

**TYPE OF SUBSTANCE**

| | No. | Percent |
|---|---|---|
| Cannabis | 20 | 31.7 |
| Opiates | 43 | 68.3 |
| Hallucinogens | 0 | .. |
| Cocaine | 0 | .. |
| Not stated | 0 | .. |
| | 63 | 100.0 |

NOTE: The total quantity of cannabis was 23 074.5 grams and 337 grams of opiates.

There were more severe penalties imposed for offences involving opiates than cannabis; 37 percent of opiate offences were sent to prison compared to 20 percent of those involving cannabis.

TABLE 6.17

**COURT ACTION**

| | |
|---|---|
| S. 198 of the Commonwealth Crimes Act | 1 |
| Fine | 28 |
| Fine and Recognizance | 4 |
| Recognizance | 10 |
| IMPRISONMENT | |
| Less than 6 months | 0 |
| 6 months less than 12 months | 2 |
| 1 year less than 2 years | 2 |
| 2 years less than 5 years | 7 |
| 5 years less than 9 years | 9 |
| | 63 |

**Quantity of drug by sentence**

Offences involving large quantities of opiates (over 100 grams) received more severe penalties than those involving cannabis. All opiate offenders in this category were sentenced to periods of imprisonment for 2 years or more, whereas those involving cannabis received sentences ranging from fines to 5 years imprisonment.

On the other hand offences involving small quantities of cannabis (less than 50 grams) all received lenient sentences as they were either fined or received a dismissal under section 198 of the Commonwealth Crimes Act, while those involving opiates in this category received sentences ranging from a fine to 5 years imprisonment.

The above sentencing patterns suggest that the courts are treating with severity importing large quantities of opiate drugs which are presumably for distribution, whilst they are more lenient to offenders importing small quantities of cannabis presumably for their own use.

TABLE 6.18

**QUANTITY OF DRUG BY SENTENCE**

| Opiates | Less than 1 gram | 1 gram to 10 grams | 10 grams to 50 grams | 50 grams to 100 grams | 100 grams to 500 grams | 500 grams to 1 000 grams | 1 000 grams + |
|---|---|---|---|---|---|---|---|
| S.198 of the Commonwealth Crimes Act— | | | | | | | |
| Fine .. .. .. | 5 | 9 | 1 | .. | .. | .. | .. |
| Fine + Recognizance .. | .. | 2 | 1 | .. | .. | .. | .. |
| Recognizance .. | .. | 7 | 2 | .. | .. | .. | .. |
| IMPRISONMENT— | | | | | | | |
| Less than 6 months .. .. | .. | 1 | .. | .. | .. | .. | .. |
| 6 months less than 1 year .. | .. | .. | 1 | .. | .. | .. | .. |
| 1 year less than 2 years .. .. | .. | .. | 1 | .. | .. | .. | .. |
| 2 years less than 5 years .. .. | .. | 1 | 2 | .. | .. | 1 | .. |
| 5 years less than 9 years .. .. | .. | .. | .. | .. | 1 | 4 | 4 |

| Cannabis | Less than 1 gram | 1 gram to 10 grams | 10 grams to 50 grams | 50 grams to 100 grams | 100 grams to 500 grams | 500 grams to 1 000 grams | 1 000 grams + |
|---|---|---|---|---|---|---|---|
| S.198 of the Commonwealth Crimes Act— | | | | | | | |
| Fine .. .. .. | 1 | .. | .. | .. | .. | .. | .. |
| Fine + Recognizance .. | 1 | 4 | 5 | .. | .. | 2 | 1 |
| Recognizance .. | .. | .. | .. | .. | .. | 1 | .. |
| IMPRISONMENT— | | | | | | | |
| Less than 6 months .. .. | .. | .. | .. | .. | .. | .. | 1 |
| 6 months less than 1 year .. | .. | .. | .. | .. | .. | .. | .. |
| 1 year less than 2 years .. .. | .. | .. | .. | .. | 1 | .. | .. |
| 2 years less than 5 years .. .. | .. | .. | .. | .. | .. | 1 | 2 |
| 5 years less than 9 years .. .. | .. | .. | .. | .. | .. | .. | .. |

ANNEXURE G

## THE DETECTION AND IDENTIFICATION OF DRUGS IN BODY FLUIDS BY GAS CHROMATOGRAPH-MASS SPECTROMETER

The combination of a gas chromatograph with a mass spectrometer is one of the most powerful instruments available for the analysis of complex mixtures of drugs and their metabolites present in body fluids and tissues. It provides the specificity and sensitivity that is essential for the identification and quantitative analysis of substances which may be present in minute amounts.

Both gas chromatography and mass spectrometry have been developed separately as analytical methods over several decades, but it is only recently that the problems of combining the two together in the one instrument have been overcome.

*Gas chromatography* is a technique for separating volatile substances (or derivatives of those substances that are volatile) by using the difference in their partition ratios between a moving gas phase and a stationary liquid phase, i.e., those substances which have a partition coefficient that favours the gas phase will pass through the instrument more rapidly than those which have partition coefficients which favour the stationary liquid phase. The instrument consists essentially of a long glass tube (column) which is filled with the stationary liquid phase coated on an inert supporting material, e.g., diatomaceous earth, at one end an injection port where the sample for analysis and the flowing gas is introduced to the column, and at the other end a detector to indicate the emergence of the components of the mixture as they are eluted from the column. These parts of the instrument are heated to a temperature which will ensure that the compounds are sufficiently volatile to pass through the column.

The record obtained from the detector is a series of peaks each of which indicates the presence of a component of the mixture. (In some cases a single symmetrical peak may represent more than one compound, each of which has the same partitioning characteristics under the conditions used for that analysis.)

The time that it takes (expressed in minutes) to elute a compound from the column is referred to as its "retention time" ($R_t$) and is a physical characteristic of that compound relative to the conditions of the experiment (e.g., temperature, gas flow rate, nature of the stationary liquid phase). The retention time of a compound can be used to identify it, but as indicated previously, a number of compounds may have the same or very similar retention times under the same conditions of analysis.

The sensitivity of the gas chromatography detectors varies, but the commonly used flame ionization detector has a lower limit of about 10 ng (nanograms), i.e., $10 \times 10^{-9}$ g. The peak height for symmetrical peaks, or the peak area for unsymmetrical peaks, is a measure of the amount of that component present in the mixture.

*Mass Spectrometry* has been known for 50 years, but it is only in the last decade that these instruments have generally become available.

The principle of operation depends upon the production, in the gas phase, of a charged (or ionized) molecule which, in this high energy state, is unstable, causing it to break into fragments which may be charged or uncharged. The charged molecular ion and its fragments are then separated by a mass analyzer which uses the different masses of the ions to focus them sequentially on the detector. Thus if a compound of molecular weight of 300 is introduced into the ionization chamber of the mass spectrometer it will be ionized to produce a molecular ion of that mass. If then the mass analyzer is arranged to scan over the mass range of say 50-300 mass units the detector will receive any charged fragment ion produced from the breakup of the molecular ion, and which has a mass within that range. The number of ionized molecules produced at any one time is a measure of the intensity (or stability) of those ions.

The plot of ions detected at the various mass numbers over the scanned mass range constitutes the mass spectrum of that compound. This spectrum is a particular physical characteristic of that compound and it may be used to identify that compound unequivocally.

**Combined G.C.-M.S.**

The combination of the G.C.-M.S. thus provides a means of separating each component of a complex mixture (G.C.) and each compound can be unequivocally identified by passing it directly into the mass spectrometer to obtain its characteristic mass spectrum.

Such a combination can generate so much data in a very short time that it is essential to have a small computer to accumulate and process the results. The data processing equipment, by time averaging the input signals can enhance the sensitivity of the system by an order of 100 x so that for certain types of compound, e.g., some pesticides, it is possible to detect amounts as low as 100 femtograms, i.e., $100 \times 10^{-15}$ g. However, the more usual lower limit is about 100 picograms, i.e., $100 \times 10^{-12}$ g.

Instruments such as this are essential for the identification and estimation of drugs and their metabolites from body fluids. In fact, no other system currently available provides the means of separating, identifying and quantitatively estimating the components of such a complex mixture when it is present in urine or blood.

Following the ingestion of a normal 5 mg dose of say diazepam (valium), the maximum concentration of the drug in the blood will be of the order of 0.5-2.5$\mu$g/mL ($0.5\text{-}2.5 \times 10^{-6}$ g) and the concentration in the urine (about 1½ hours after dosing) will be about 50 ng/mL ($50 \times 10^{-9}$ g/mL). (These figures may vary considerably from person to person but indicate an order of magnitude.) Along with the unchanged valium will be a number of its metabolites in varying concentrations. The attached diagrams show the analysis of a urine sample from a patient who had taken an overdose of diazepam.

The identification of the components of a mixture can usually be obtained by comparing the mass spectrum of each component with a reference spectrum obtained under the same conditions from a pure sample of the compound. Libraries of reference spectra are available as computer files and currently the instrument in this Department has about 450 drug and drug metabolites, and about 300 pesticide and pesticide metabolites spectra on computer file. This will be extended shortly to take in the *Aldermaston File* which has about 50 000 reference spectra of organic compounds.

The comparison of unknown spectra with the reference spectra is carried out automatically by the computer which provides a list in order of the best fit of the unknown with ten reference spectra.

By using knowledge of the fragmentation processes which occur in ionized molecules it is generally not difficult for an experienced spectroscopist to identify an unknown component from its mass spectrum, especially if it is related to a known drug.

From the attached diagrams (fig. 1) it can be seen that the separation (G.C.) and acquisition of the mass spectra for the components of this mixture took 15 minutes. To this should be added a further 15 minutes for sample preparation and the analysis of the results. However, when a number of samples of blood or urine are available for analysis then the time per sample is somewhat less than 30 minutes.

This method of analysis is widely used in the U.S.A. in hospitals for the monitoring of drug levels in patients and the identification of drugs involved in overdose cases prior to appropriate treatment being provided. It is also extensively used in forensic laboratories for similar purposes.

At present there are two instruments which are specifically designed for this type of biomedical mass spectrometry in New South Wales, i.e., in this department, and in the Faculty of Medicine at the University of N.S.W.

T. R. WATSON,
Professor of Pharmaceutical Chemistry.

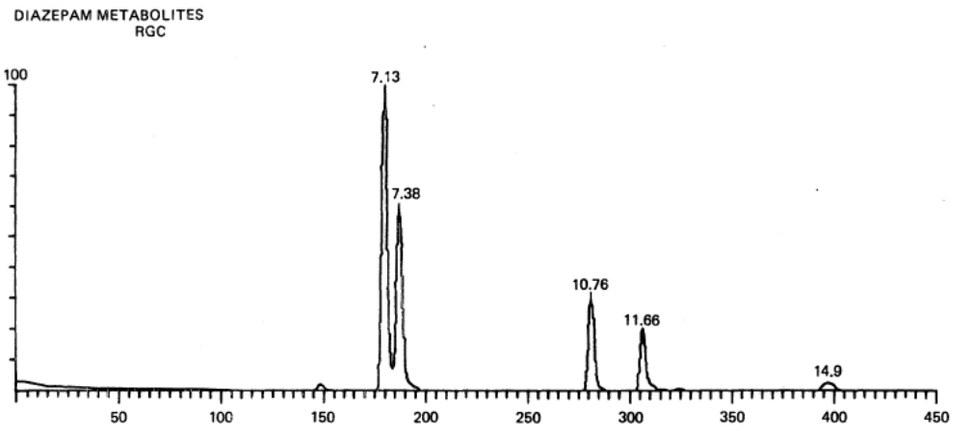


FIGURE 1

This represents the gas chromatographic separation of the metabolites present in the urine following the ingestion of valium (diazepam). The abscissa scale is scan number, i.e., over the period of the analysis the M.S. scanned over the mass range 100-350 mass units 450 times.

The first compound was eluted with a retention time of 7.13 minutes and the mass spectrum of that peak is number 180.

The retention times and mass spectra of the other components are indicated on fig. 1.

*Note:* The small peak at $R_t = 14.9$ is an internal standard added to the sample to calibrate the measurement of retention times.

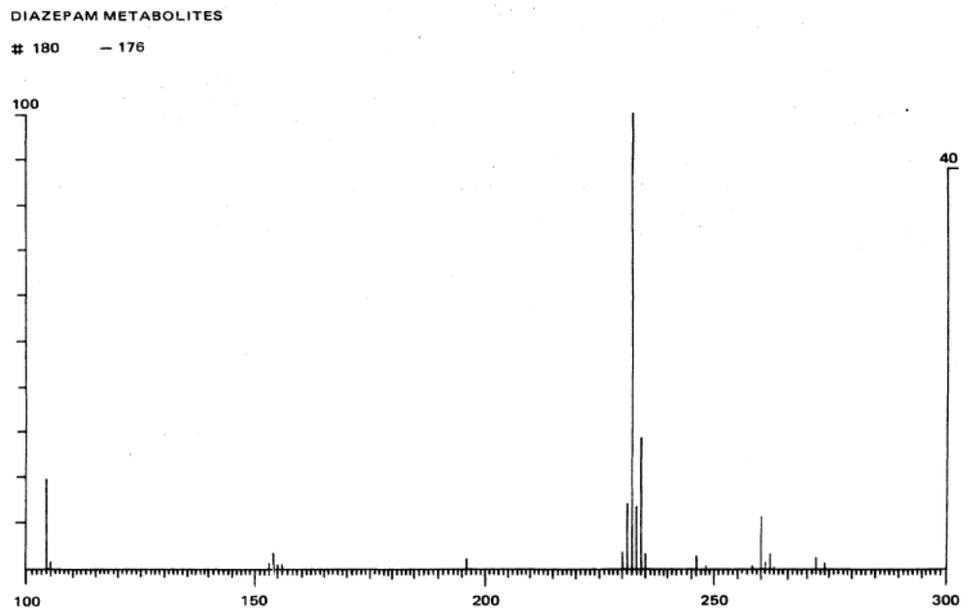


FIGURE 2

The compound eluted at $R_t$ = 7.13 (mass spec. No. 180) has a molecular weight of 231 (233 is an isotope peak due to the presence of an atom of chlorine in the molecule). The peaks at higher mass numbers, viz., 260 and 272, are due to adductions resulting from the use of methane as a reagent gas for the ionization process.

The metabolite is: 2,amino-5,chlorobenzophenone.

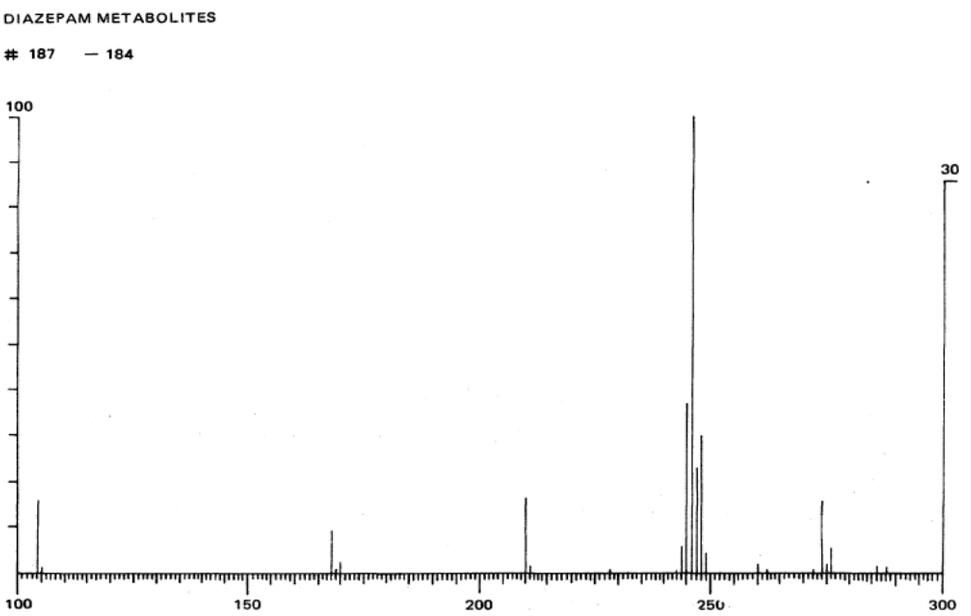


FIGURE 3

The compound eluted at $R_t$ = 7.38 (mass spec. No. 187) has a molecular weight of 245 (247 is the chlorine isotope peak).

The metabolite is: 2,methylamino-5,chlorobenzophenone.

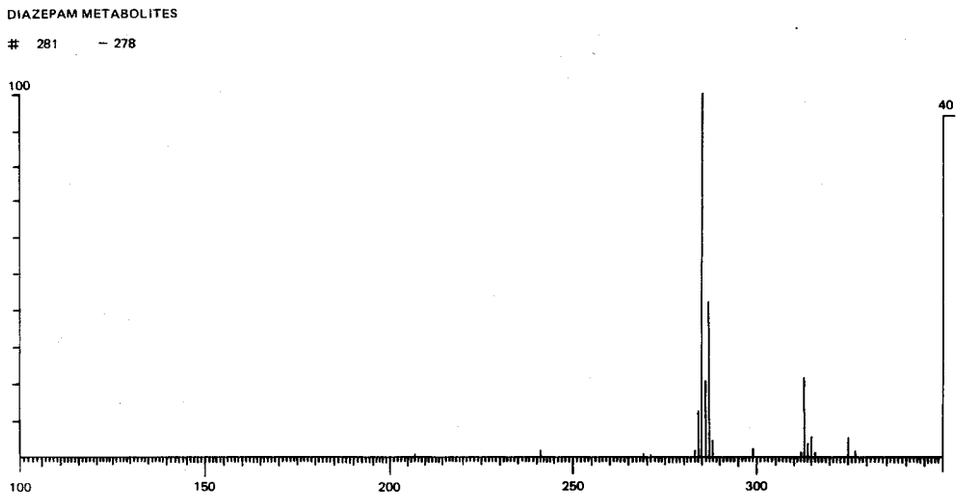


FIGURE 4

The compound eluted at $R_t$ = 10.76 (mass spec. No. 281) has a molecular weight of 285 and is identified as diazepam (valium).

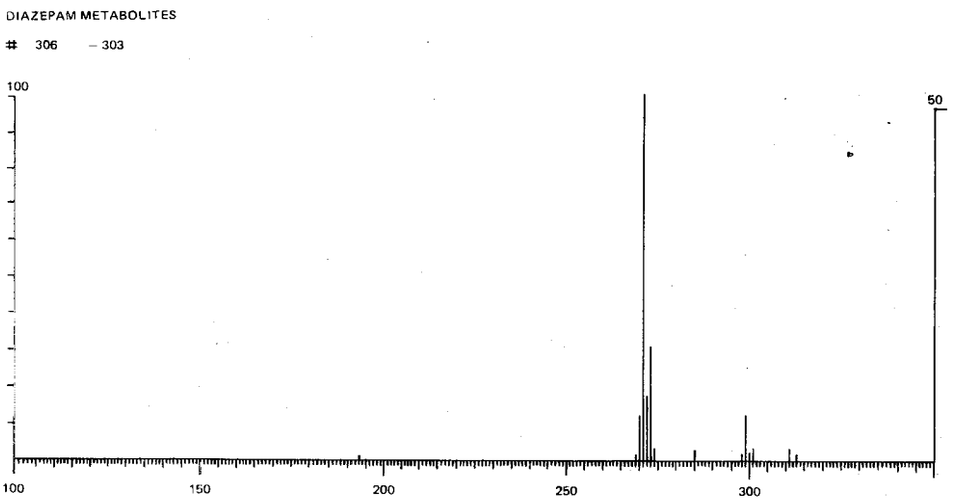


FIGURE 5

The compound eluted at $R_t$ = 11.66 (mass spec. No. 306) has a molecular weight of 271 and is identified as N-desmethyl-diazepam.

ANNEXURE H

## MARIHUANA AND HEALTH—SIXTH ANNUAL REPORT TO U.S. CONGRESS 1976

This report, [1] like its predecessors, summarizes the growing, though still limited, knowledge of the health consequences of marihuana use. It is not as comprehensive and is considerably briefer than earlier reports because it is addressed to a general audience rather than being a summary of the scientific literature for the technically trained. Emphasis is placed on the possibly different effects of marihuana use on those individuals with already impaired physical or psychological functioning from those reported on individuals in optimal health.

The Sixth Report maintains that continued availability of the Fifth Report together with the current summary of more recent developments provides a relatively complete review of current knowledge.

In the foreword, Dr DuPont makes the following statements:

"To the oversimplified question, 'Is marihuana use safe?' we can offer a simplistic but unequivocal 'No'. There is good evidence that being 'high'—intoxicated by marihuana—impairs responses ranging from driving to intellectual and interpersonal functioning. It is hardly surprising that marihuana is not 'safe' in any absolute sense for no drug is or can be under all conditions of use."

"We now know that marihuana intoxication poses a significant threat to highway safety in much the same way that alcohol does. The exact size of that threat remains a matter of conjecture."

"A related source of concern is the increasing number of Americans who use marihuana on a daily or near daily basis. Just over 8 percent of the nation's 1976 high school graduates reported virtually daily marihuana use. The number of 1976 graduates using marihuana on that basis was 40 percent greater than the number making equally frequent use of alcohol."

"To date, most American marihuana users smoke relatively low potency material and only occasionally. The apparently benign picture presented by that type of use . . . may change if more frequent use of stronger material becomes more common."

"This report emphasizes the large and apparently growing number of Americans who have used marihuana. While this finding deserves emphasis, it is equally important to recognize that more than half of the Americans who have used marihuana have quit using it. Even larger is the number of people who say that they have not used and have no intention of using marihuana regardless of the legal status of the drug."

"In recent years, those who have had to deal with legal substances as diverse as alcohol and red dye No. 2 have had to face the fact that these agents are not 'safe' under all circumstances and that whatever social policy is adopted concerning their availability must take this disquieting fact into consideration. Similarly, in the area of illicit drugs, we now recognize that many users suffer no apparent ill-effects. The realization that significant numbers of users of legal substances may suffer ill-effects at the same time that many users of prohibited substances have no problems with their use, has strained our national capacity to deal rationally with the fundamental social policy issues involved. We hope that this report describing the current state of our knowledge of marihuana's health consequences continues to contribute to a better understanding of the complexity of this important social issue."

**New Developments Appearing in the Sixth Report**

1. *Chemistry and Metabolism of Cannabis*

Work is continuing on the development of simple tests, analogous to blood alcohol determinations that might be useful at the site of accidents and in roadside determinations of marihuana intoxication. There are now a variety of techniques suitable for detection by laboratories, although none is reasonably priced or sufficiently simple to be used reliably for this purpose. Emphasis in chemical research has also been on synthesizing the various naturally occurring cannabis constituents, their biological transformation products or metabolites and related chemical substances. Availability of these synthetic materials in research quantities can accelerate research on marihuana detection in body fluids and has implications for assessing the possible therapeutic value of cannabis. Recent research suggests that the effects of cannabis may be partly determined by the route of administration (e.g., smoking v. eating). The blocking by some constituents of important drug metabolizing enzymes in the liver has been reported. Such blocking could cause toxic reactions if marihuana were ingested simultaneously with other drugs normally detoxified in the liver. Tests with animals have shown that the major marihuana metabolites produced by the liver may be different from those produced by the lung. Similar differences have been reported in humans. An interaction between cannabidiol and $\Delta$-9-THC may shed light on the common belief among users that different varieties of cannabis with varying composition have different effects only partly related to THC level.

2. *Animal Research*

Marihuana and related drugs have consistently been found to suppress aggression in animals when they are not under stress. With animals under stress, however, it has been found that marihuana tended to increase aggression. This suggests that the relationship between marihuana and aggression may be more complex than was earlier supposed. Whether similar results would be obtained with humans in stress situations is not known.

3. *Human Effects*

Evidence that marihuana not only increases heart rate, but may also temporarily weaken heart muscle contractions has led the researchers to express concern about marihuana use among individuals with cardiac abnormalities.

Although there is now good evidence that marihuana and $\Delta$-9-THC administered acutely produce an increase in the diameter of the air passages of the lung, chronic use may have quite different implications. Recent work by Tashkin et al. [2] using more sophisticated measures has demonstrated detectable impairment in lung functioning after 6 to 8 weeks of heavy cannabis smoking. The changes found, while still within normal limits, persisted at least 1 week after smoking. This suggests that heavy chronic use could well lead to clinically important changes similar to those found in heavy cigarette smokers.

4. *Special Health Problem Areas*

A report by Dr Nahas [3] 2 years ago indicated that a marked reduction in the *immune response* as measured in white blood cell cultures was found in marihuana smokers. Attempts to replicate this finding and explore its implications have resulted in contradictory reports. This issue of possible impaired immune response remains unresolved.

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[1] "Marihuana and Health, Sixth Annual Report to Congress from the Secretary of Health, Education and Welfare", Washington, D.C.: Government Printing Office, 1976.

[2] Tashkin, D. P., et al, "Subacute Effects of Heavy Marihuana Smoking on Pulmonary Function in Healthy Men", in *New England Journal of Medicine*, Vol. 294, No. 3, January 15, 1976, pp. 125-129.

[3] Nahas, G. G., et al, "Inhibition of Cellular Mediated Immunity in Marihuana Smokers", in *Science*, 183:419, 420, 1974.

Research studies regarding *chromosome abnormalities* have been conflicting and all are subject to criticism. Overall, there is no convincing evidence at this time that marihuana use causes clinically significant chromosome damage. However, it should be emphasized that the limitations of the research conducted thus far preclude definitive conclusions.

The implications of laboratory findings on the inhibition of DNA, RNA and protein synthesis (all of which are basically related to *cellular reproduction and metabolism)* are still unknown.

A recent report by Hembree et al. [4] indicates a decreased sperm count in otherwise normal young cannabis smokers that may be related to use. Some differences in the cellular characteristics of sperm of chronic hashish users compared to non-using controls were reported by Stefanis et al. [5] this year but then functional significance is unclear. It may well be that these findings will ultimately prove more significant for individuals with already impaired fertility or other evidence of marginal *endocrine functioning* than for normal individuals.

In the British study [6] attributing *brain atrophy* to cannabis use, a neurological technique, air encephalography, was used to detect brain changes. In a study of chronic Greek users, a different technique, echoencephalography, was employed and the findings were negative, that is, users were not found to differ from non-users in evidence of gross brain pathology. More recently, two studies [7, 8] have been conducted in Missouri and Massachusetts of two samples of young men with histories of heavy cannabis smoking, using computerized transaxial tomography, a brain scanning technique for visualizing the anatomy of the brain. Computer processing of the data obtained from a large number of measurements makes it possible to construct the anatomy of the brain in a more detailed manner and with greater precision than pneumoencephalography (the technique used in the British study). In neither study was there any evidence of cerebral atrophy. Neither study rules out the possibility that more subtle and lasting changes of brain function may occur as a result of heavy and continued marihuana smoking. Nevertheless, virtually all studies completed up to late 1976 show no evidence of impaired neuropsychologic test performance in humans at dose levels studied so far.

5. *Psychopathology*

Various psychological reactions to marihuana use have been reported in American and Eastern literature. It is difficult to distinguish the role of cannabis from that of pre-existing psychological problems or other environmental precipitants in marihuana-related psychological difficulties. Frequently, heavy marihuana users are also those who have had emotional problems prior to use.

Marihuana flashbacks have been reported recently in a survey of U.S. Army users. The origin of such experiences is uncertain but those who experienced them appear to have required little or no treatment. In the Federally sponsored Drug Abuse Warning Network (DAWN), marihuana ranked 16th among the drugs mentioned in emergency room episodes. In crisis centre contacts, marihuana ranked second only to heroin as the drug involved. This does indicate that marihuana is not an uncommon factor in individuals seeking help.

In the past, the Federal Client Oriented Data Acquisition Process (CODAP), a reporting system designed to monitor Federally supported drug treatment programmes found that more than 10 percent of the effort was being devoted to patients whose primary drug use was marihuana. When it was determined that this was largely due to court and school referrals for administrative convenience, an effort was launched to substantially reduce this inappropriate use of community treatment facilities. As a result, three out of five of the inappropriately used treatment slots were freed for patients with more serious problems of drug abuse.

6. *Complex Psychomotor Performance in Driving and Flying*

Evidence that marihuana use at typical social levels definitely impairs driving ability and related skills continues to accumulate. There is reason to believe that more users drive today while intoxicated than was true a few years ago. In limited surveys, from 60 to 80 percent of marihuana users indicated that they sometimes drive while cannabis intoxicated. Most recently, a study conducted for the National Highway Traffic Safety Administration, of drivers involved in fatal accidents found that marihuana smokers were over-represented in fatal highway accidents when compared to a control group of non-smokers of similar age and sex.

The few studies completed to date have all shown that experienced pilots undergo marked deterioration in performance under flight simulator test conditions while "high".

7. *Tolerance and Dependence*

Carefully conducted studies with known doses of marihuana or THC leave little question that tolerance develops with prolonged use. As was pointed out last year, the meaning assigned to cannabis dependence is often vague. A "withdrawal" syndrome is uncommon and has rarely been reported clinically. Only one research report from Germany has noted it.

8. *Therapeutic Aspects*

For the management of glaucoma, an eye drop preparation has been developed and is currently undergoing testing in animals preliminary to human trials. Marihuana and/or its synthesized constituents have shown promise as potential therapeutic agents in the management of asthmatics and cancer patients following chemotherapy, but much additional work is necessary before such agents become generally approved as standard medications.

9. *Future Research Directions*

While it now appears that infrequent, experimental use at typical U.S. levels is usually without significant hazard, more frequent and especially chronic use may have quite different implications. Our studies of chronic use are decidedly limited. There is an obvious need to study larger samples more carefully to determine the impact of cannabis use on health and the psychosocial functioning of users. Planning for a large-scale longitudinal study is under way.

It is important to know with some precision what levels of marihuana intoxication pose threats in such areas as highway safety and the operation of potentially hazardous machinery.

It is also important to know under what circumstances significant interactions with other drugs occur.

Other findings in relation to immune response, endocrine functioning and basic cell metabolism need to be followed up and the issues they raised, resolved.

Changes in social policy concerning marihuana that have now occurred in eight states provide a kind of natural laboratory for determining some of the impacts of law and

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[4] Hembree, W. C. et al, "Marihuana Effects upon the Human Testis", in *Clinical Research,* 24(3):272A, 1976.

[5] Stefanis, C. N. and Issicorides, M. R., "Cellular Effects of Chronic Cannabis Use in Man", in Nahas, G. G. (ed.), *Marihuana: Chemistry, Biochemistry and Cellular Effects,* New York, N.Y.: Springer-Verlag, 1976.

[6] Campbell, A. G. M., et al, "Cerebral Atrophy in Young Cannabis Smokers", in *Lancet,* (1971) 2, pp. 1219-1224.

[7] Kuehnle, J., et al, "Computed Tomographic Examination of Heavy Marihuana Smokers", in *Journal of the American Medical Association,* Vol. 237, No. 12, March 21, 1977, pp. 1231-1232 .

[8] Co, B. T., et al, "Absence of Cerebral Atrophy in Chronic Cannabis Users: Evaluation by Computerised Transaxial Tomography", in *Journal of the American Medical Association,* Vol. 237, No. 12, March 21, 1977, pp. 1229-1230.

social policy on use patterns. A better understanding of use patterns and their implications for functioning may enable us to develop means of discouraging all forms of drug abuse including that of marihuana without resorting to primarily legal measures. A better understanding of the motivations for heavy use may permit the development of means for early intervention to avert possible life-long patterns of drug dependency. Although marihuana use does not "cause" other drug use in the way once simplistically believed, it is often associated with other drug use. Exploration of preventive approaches which encourage individuals to avoid patterns of drug dependency (both licit and illicit) is needed.

ANNEXURE I

1976-77

PARLIAMENT OF NEW SOUTH WALES

MEMORANDUM

From

THE JOINT COMMITTEE

Of The

LEGISLATIVE COUNCIL AND

LEGISLATIVE ASSEMBLY

Upon

# DRUGS

Ordered to be printed, 30 March, 1977

BY AUTHORITY

D. WEST, GOVERNMENT PRINTER, NEW SOUTH WALES—1977

# MEMORANDUM BY THE JOINT COMMITTEE OF THE LEGISLATIVE COUNCIL AND LEGISLATIVE ASSEMBLY UPON DRUGS

## INTRODUCTION

1. On 12th October, 1976, the Minister for Health, the Hon. K. J. Stewart, M.L.A., moved in the Legislative Assembly that a Joint Committee of Enquiry be appointed to investigate certain aspects of drugs of dependence (other than alcohol and tobacco) in common use in New South Wales.

2. Subsequently the Joint Committee was established with the following membership:

Mr V. P. Durick, B.A., M.L.A. (Chairman).

**Legislative Council**

The Hon. K. H. Anderson, M.L.C.

The Hon. M. A. E. Davis, M.L.C.

The Hon. C. Healey, M.L.C.

The Hon. H. J. A. Sullivan, M.L.C.

**Legislative Assembly**

Mr J. G. T. Jackett, M.L.A.

Mr B. McGowan, B.A., M.L.A.

Mr E. D. Ramsay, M.L.A.

Mr R. C. A. Wotton, M.L.A.

On 17th March, 1977, the Hon. H. J. A. Sullivan, M.L.C., was discharged from the Committee and replaced by the Hon. F. M. MacDiarmid, O.B.E., M.L.C.

3. An investigation of drugs by a Joint Committee of both Houses had commenced in the previous Parliament.

4. The hearings of the earlier Committee were concerned with the pharmacological, psychological and social effects of drugs of dependence in common use in New South Wales that are prohibited drugs, drugs of addiction and restricted substances within the meaning of the Poisons Act, 1966.

5. The Terms of Reference of the present Committee have been extended to cover all drugs of dependence, other than alcohol and tobacco, in common use in New South Wales.

6. In summary, the Committee will enquire into and report on the adequacy of the control of the manufacture, distribution, possession and use of such drugs; the adequacy and appropriateness of penalties for offences related to such drugs; and will investigate the adequacy or otherwise of education, preventative counselling, treatment and rehabilitative service programmes.

7. The New South Wales Government has sought an expression of opinion through the Joint Parliamentary Committee Upon Drugs (hereinafter known as the Committee) in regard to the proposal of the Commonwealth Government for specific increases in penalties for certain drug trafficking offences.

## THE COMMONWEALTH PROPOSAL

8. Arising from a recommendation through the National Standing Control Committee on Drugs of Dependence, the proposal which is under consideration and which has already been approved by Federal Cabinet is to increase the maximum penalties for offences involving the drug heroin and other similar drugs to 25 years imprisonment and/or a fine not exceeding $100,000.

9. On the argument that there now appears to be sufficient authoritative evidence supporting the contention that cannabis (at least in leaf form) is not as dangerous as heroin and accordingly should neither be placed in the same category as this drug nor attract as severe a penalty, the Commonwealth does not intend that the existing maximum penalties (10 years imprisonment and/or $4,000 fine) for offences involving cannabis (in leaf form) be varied.

10. The Commonwealth has previously agreed not to amend or introduce drug legislation without prior advice from the States.

## THE EXAMINATION OF PENALTIES BY THE NEW SOUTH WALES JOINT PARLIAMENTARY COMMITTEE

11. Within its Terms of Reference, the Committee is charged with inquiring into and reporting on the adequacy and appropriateness of penalties for offences related to all drugs of dependence, other than alcohol or tobacco, the application of those penalties and the distinction between penalties for offences relating to their use and penalties for offences relating to their manufacture and distribution.

12. As the voluminous evidence arising world-wide in recent years has demonstrated, finding the proper place for drugs in the lives of people today is a complex problem affecting the whole of Society. In particular, the part to be played by the law hinges on complex pharmacological, psychological and social issues. In this respect further evidence is needed on the situation prevailing in New South Wales, especially with regard to analgesics. Notwithstanding this requirement and a clear indication of an increasing public sympathy for a non-punitive approach to the drug addict, the Committee recognizes that given the evidence of an apparent increase in the availability of hard drugs, especially heroin, both in New South Wales and throughout Australia there is a need for reassessment of the laws relating to drug trafficking.

13. Under New South Wales legislation, cannabis is presently treated as a drug of addiction and the Commonwealth proposes to treat trafficking offences for cannabis (at least in leaf form) separately from the drugs of addiction with which it has hitherto been identified. In view of this and the public controversy within the State surrounding its use, the Committee has dealt with the matter as a separate issue in this memorandum.

## SCOPE OF THIS MEMORANDUM

14. In order to take a comprehensive view of the Commonwealth proposal for increased penalties it is necessary to identify the relationship between existing legislation, practice in the courts and other factors relating to penalties such as programmes for the prevention and treatment of illicit drug use.

Thus this memorandum deals with—

(a) Existing legislation and its defects (paragraphs 15 to 34).

(b) Practice in the courts (paragraphs 35 to 38).

(c) Other factors relating to penalties (paragraphs 39 to 43).

(d) Penalties for trafficking (paragraphs 44 to 54).

(e) Cannabis (paragraphs 55 to 74).

(f) Forfeitures (paragraph 75).

## AUSTRALIAN LEGISLATIVE BACKGROUND

15. Australian legislation dealing with drugs can be either State or Federal. Federal legislation is mainly concerned with the import of drugs into Australia and the control of supply. Since its ratification of the 1961 Single Convention on Narcotic Drugs, the Federal Government has sought to create greater uniformity in the control of drug abuse throughout Australia. The 1971 Report of the Senate Select Committee on Drug Trafficking and Drug Abuse urged that such uniform legislation be directed at controlling the supply rather than the use of harmful drugs. The need for flexibility in the law for possession and use is of particular importance in relation to health education and treatment programmes for drug addiction.

16. Some degree of uniformity in the operation of penalties has been achieved as will be seen from the table at annexure 1 which shows broadly the existing maximum penalties throughout Australia.* In short, the Federal Government has prevailed upon most States to increase maximum penalties to a $4,000 fine and/or 10 years imprisonment for trafficking offences relating to hard drugs. Penalties for possession are less uniform in the writing of the law and probably more so in its actual practice.

## DEFINITIONS OF THE TRAFFICKER, PUSHER AND PEDLAR

17. The Senate Select Committee, 1971, defined the Drug Trafficker thus: "A drug trafficker is one who supplies[1] a drug for reason of profit, disregarding the health and welfare of the purchaser. He is the principal in the distribution chain and is unlikely to indulge in drug taking or to be in direct contact with the user of drugs.

18. Lesser in the distribution chain are the drug pusher who seeks to establish a market for the distribution of illicit drugs and the pedlar who is the final link in the selling of small quantities to individual users. The pedlar is quite frequently involved in the selling of drugs to sustain his own drug-taking habit. The pusher is less likely to be so involved".

19. Figures on sentencing produced later in this memorandum suggest that the courts might experience difficulty in distinguishing between the pusher and the pedlar and, in the spirit of the move towards a more humane approach to the treatment of drug addicts, look leniently on all offenders who traffic to sustain their own addiction.

20. The terms are not defined as such in Federal or State legislation. The public (and lawyers) tend to class all suppliers as "pushers".

21. As the legislation generally prescribes such things as the unlawful possession of a certain drug regardless of the person using it, or purpose to which it is directed, the law does not define users except in regard to supply of drugs for treatment of addicts.

## NEW SOUTH WALES LEGISLATION

22. Legislation on drugs is covered in the N.S.W. Poisons Act, 1966, with amendments. A description of the legislation is set out in annexure 2.

23. Briefly in relation to penalties the N.S.W. Poisons Act, 1966, distinguishes penalties as follows:

(a) *Prescribed Restricted Substance in Schedule 4 (e.g., Valium)*—
Possession: $800 and/or 6 months' imprisonment.
Supply or sell: $2,000 and/or 2 years' imprisonment.

(b) *Prohibited Drugs or Drugs of Addiction in Schedule 8 (Narcotics, Cocaine, Amphetamine, Cannabis)*—
Possession: $2,000 and/or 2 years' imprisonment.
Supply or sell: 10 years' imprisonment ($2,000 and/or 2 years' imprisonment where prosecution elects to proceed summarily).

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[1]The New South Wales Parliamentary Committee notes that this means illegal supply.

*Queensland has recently passed legislation to increase the penalty for trafficking to a $100,000 fine and/or life imprisonment.

It will be noted that the option or addition of a $4,000 fine applies to the supply or sell penalty for hard drugs in most other States.

24. Further, under the Summary Offences Act, 1970, it is an offence to be found in premises frequented by reputed drug offenders or to have habitually consorted with such persons ($200 or three months' imprisonment). Also under this Act the person in charge of premises frequented by reputed drug offenders is guilty of an offence ($400 or 6 months' imprisonment). It would appear that the public is generally ignorant of these provisions.

## INCREASED PENALTIES FOR DRUG OFFENCES SINCE 1970

25. Before the Poisons (Amendment) Act, 1970, took effect, no distinction was made between maximum penalties for offences relating to drug use and maximum penalties for offences relating to their manufacture and distribution. The maximum penalties provided up to that time were—

*Restricted substances:* $800 fine or 6 months' imprisonment.

*Prohibited Drugs or Drugs of Addiction:* $2,000 fine and/or 2 years' imprisonment.

26. The Poisons (Amendment) Act, 1970, introduced the notion of higher penalties for drug trafficking offences. Maximum penalties for offences involving simple possession or use remained unaltered. Supply or sale of a drug of addiction or prohibited drug became a separate offence from possession, and provision was made for such offences to be prosecuted by indictment. Provision was also made for a person having unauthorized possession of more than a prescribed quantity of a drug (based on 10 doses of an hallucinogen or 50 doses of another drug) to be deemed to have possession for the purpose of supply or sale. The 1970 amendment introduced the contentious section 45A reversing the onus of proof (that the drug was not for supply or sale) on the defendant.

27. The maximum penalties provided for drug trafficking offences in the 1970 legislation were—

*Restricted substances:* $2,000 fine and/or 2 years' imprisonment.

*Prohibited Drugs or Drugs of Addiction:* 10 years' imprisonment (where the prosecution elects to proceed by indictment); $2,000 fine and/or 2 years' imprisonment (where the prosecution elects to proceed summarily).

28. These maximum penalties were based on a recommendation made by Federal and State Attorneys-General in 1966, and subsequently endorsed in 1970 by the National Standing Control Committee on Drugs of Dependence.

29. A basic principle underlying these changes was to introduce prescribed quantities for assessing offences of possession to allow for some leniency towards the genuine addict but to crack down heavily on the trafficker.

## DEFECTS IN THE EXISTING LEGISLATION AND THE NEED FOR A FUNDAMENTAL REVIEW

30. The State legislation contained in the Poisons Act, 1966, is the result of an amalgamation of two previously unrelated Act—The Poisons Act, 1952-1961, and the Police Offences (Amendment) Act, 1908-1954. New provisions were enacted in 1966, notably control over the supply (as distinct from sale) of poisons and restricted substances, and provision for the issue of authorities to doctors prescribing drugs of addiction under certain circumstances. The 1970 amendment introduced the notion of leniency towards illicit possession by the addict whilst strengthening the law against illicit supply.

31. In this way the Act stands as the instrument for the differing concepts of legal trading, legal use of drugs for medical treatment and the suppression of illicit use, sale and supply, whilst at the same time providing the only legislation in which moves towards a more humanitarian approach to the treatment of addicts can be framed. The result has been ambiguity, inconsistency and not infrequent weakness in the regard for the law.

32. The Committee believes that fundamental reform will be necessary to reflect changing public attitudes in every area of drug use. The Committee would hope that a review might be set formally in hand in a time-frame which would permit the Committee to take into account the findings before the onset of the next parliamentary session.

33. Whilst in no way wishing to prejudge the outcome of such a review, areas of the legislation appearing to require re-examination are set out in greater detail at annexure 3. The neglected control of analgesics will require particular attention.

34. The Committee also believes that the operation of the Summary Offences Act needs reappraisal as far as it relates to drugs.

## APPLICATION OF PENALTIES IN THE COURTS SINCE 1970

35. The only published statistics that throw any light on drug use are those of the State's Bureau of Crime Statistics and Research. The relevant extract from the Bureau's 1975 Report on Court Statistics is attached at annexure 4. A breakdown of fines is also included in the annexure.

36. In relation to the application of penalties, the significant finding in the Bureau's report is the one contained in table 6.8 which shows that in sentencing patterns there has been a "convergence to the mean" where the sentencing pattern for cannabis, the most frequent drug, now also applies to the other drugs. For opiates this means that the proportion of fines has increased and the proportion of probation and imprisonment decreased. For sedatives the proportion of fines and imprisonment has increased and the proportion of probation has decreased. The figures suggest that the courts are inclined to increasing benevolence towards the hard drug addict and the cannabis user (possibly through tacit acceptance of the inevitable) but are taking a tough line on sedatives which are possibly seen

37. As to trafficking (all illegal suppliers and sellers are described by the Bureau as "pushers") table 6.9 shows not unexpectedly that a higher proportion of "pushers" were sent to prison than "users" and that a greater proportion of the cannabis pushers were sent to prison compared with the proportion of opiate pushers. This suggests that the courts might be judging that the amounts expected to be found in possession of the hard drug addict would be greater than the 1970 Act allowed. Clearly it reflects a less punitive approach to the hard drug as the careless, irresponsible and avoidable middle group.

38. The maximum prison sentence passed under Commonwealth legislation in the State was 8 years (table 6.14) whereas the maximum prison sentence following a State prosecution was 7 years (table 6.17). Thus in no case has the maximum sentence been applied.

## OTHER FACTORS RELATING TO PENALTIES

39. Drug addiction is a major problem in our society. No matter how the issue is seen, whether as a question of proper drug use, appropriate drug use, drug misuse, drug abuse or drug addiction, drugs have become a widespread sociological phenomenon touching on the lives of every one of us. Consumption of legal and illegal drugs rises every year. Some are used for therapeutic purposes under the control of doctors, others for the relief of pain and emotional tension without the control or advice of the medical profession and under the pressure of concentrated advertising techniques. Others are used for pleasure, and controversy exists as to which drugs are so dangerous that they must be banned; under what conditions they should be banned and which should be legalized and allowed to be marketed under marketing conditions. What is clear is that the facilities of the society are simply not sufficient to cater for the increasing problem of drug abuse. Simplistic increases in penalties, and the extension of punitive methods are not sufficient. The community has not been able to come to grips with this complex problem. There are not enough police, not enough medical officers, not enough counsellors, not enough centres where people may seek voluntary treatment, not enough education, not enough knowledge. In many cases we simply do not know the dimensions of the problem. The Committee believes that these problems must be faced squarely and the legislative, administrative and technical support given to come to grips with drug abuse. An effective response to drug use problems can be developed only in a climate of reason and tolerance allowing the community to discern the true costs, and indeed evils, of the inappropriate use of all drugs, whilst rejecting policies based on erroneous concepts, confusion, misunderstanding and panic.

40. One of the major difficulties in confronting the effective handling of the drug problem is the lack of development of existing facilities and the need for a co-ordinated approach between the various agencies involved.

41. The Drug Diversionary Programme introduced in New South Wales in March, 1977, is a welcome step forward in this direction. The New South Wales Government has established an innovative programme of treatment and assistance for addicts of hard drugs. The programme is conducted by the Health Commission in association with the Courts of Petty Sessions. It is a voluntary programme, at this stage limited to the inner metropolitan area, and available to all addicts who plead guilty or are convicted of offences relating to heavy narcotics. Cannabis offences are not included. It is hoped that the facilities available will also be used by judges in the higher jurisdiction. The Committee believes that experiments of this kind should be encouraged and increased in scope. They represent a realistic attempt to deal with the complexity of the drug problem by extending the range of the courts so that they are not merely confined to punitive outcomes. They give an opportunity for educational and medical processes to take effect which may increase the chances of proper treatment for the addict.

42. Although this is the right start the Committee feels compelled to draw attention without delay to the serious lack of residential treatment facilities for addicts throughout the State. Unless immediate steps are taken for improvement in this area, the Drug Diversionary Programme is likely to fail.

43. The Government cannot do it all alone. The Committee has received evidence from a variety of voluntary bodies which give substantial help to persons who abuse drugs. This help is being extended through the generosity of individuals now working to develop new methods of treatment. The police are carrying out important work in seeking out traffickers in dangerous drugs. All of these bodies need to work together. The Committee recommends that early consideration be given to the best way in which this co-ordination may take place so that the resources available and developed by Government are used in the most efficient and effective way. Further there is a pressing requirement to examine legislation and the effects and impact of changes in the legislation. The Poisons Act, 1966, is badly in need of review. As the tragic rise in the number of deaths from drug misuse testifies this is a matter of life and death for many and of preventing much human suffering, not often understood by those not directly touched by it, for a great many more. There is no need for panic but there is no time for delay.

## DECIDING PENALTIES

44. Giving evidence before the Committee, a witness with deep sympathy for the drug addict and a great understanding of the drugs underworld, replied in answer to a question about penalties for the drug traffickers: "It depends what you mean by traffickers. If a person is doing it purely for gain and never uses a drug I would join the firing squad. It is a war. I do not know how you handle a young contact who sells to get more for himself. He is the free agent of the underworld. That is a nasty problem for the law. The thing is to endeavour to catch all young fellows as they reach a certain point in their careers where they want help and will ask for it".

45. This statement reflects the dilemma of deciding what laws should be made for dealing with drugs. The Committee has stressed the need to develop a co-ordinated approach to the problem of drug abuse in New South Wales and to have the sophistication and humanity to extend the approaches in drug abuse from the simple punitive one to that of education and medical treatment where appropriate. Whilst recognizing the need for judges, magistrates and the police to maintain respect for the force of law, the Committee believes that the availability of discretionary powers such as the imposition of a bond as a deterrent to repetition of an offence and the move towards treatment of addicts as an alternative to fines and prison sentences are all steps in the right direction of combating drug abuse through greater community involvement.

46. The Drug Diversionary Programme has received a marked public welcome. It represents a new approach which if it is to be successful will require great care in its implementation. Especially sensitive will be those cases where addicts appear before the courts on pushing charges.

47. Given the non-punitive framework in which these initiatives are set, the Committee emphasizes that in dealing with penalties it will be important to make sure the public does not become confused about the objectives.

48. Notwithstanding these considerations and a growing movement in the community towards changing the law in order to help those who have a craving for drugs, there is at the same time an overwhelming public revulsion against the drugs trafficker who preys on the problems of others to satisfy sheer personal greed. Such people are a menace, they are loathed, and their dealings cannot be tolerated.

49. In considering the penalties for trafficking two things stand out from the court statistics. Firstly the rate of trafficking has not diminished since the introduction of higher penalties in 1970. Secondly the courts have not made use of the existing maximum sentences. For example, in 1975 of a total of 177 trafficking convictions under Commonwealth and State legislation, no sentence exceeded 8 years; and only 18 offenders received gaol sentences between 5 years and 8 years.

50. In any area of the law, finding the appropriate penalty to provide the required deterrent value raises controversial and often intangible issues. The court statistics are some guide but the Committee recognizes the imponderables which can be concealed within them. The organization of the smuggling network, the people employed in smuggling commissions and their attitudes to perceived risk, would have to be clearly identified before positive judgement could be made about the likely deterrent values of particular penalties.

51. The Committee has no absolute information of this kind. However, one thing that is clear is that in many recent cases traffickers brought before the courts had access to huge sums of ready cash. In New South Wales there is no provision for a fine on indictment and in most other States the maximum is $4,000. The Committee believes this situation to be derisory and they recommend support for the availability of a maximum fine of at least $50,000 for indictable offences for trafficking. They further recommend the introduction of a new provision for the attachment of property where the fine is not met.

52. The Committee has found the question of gaol sentences less straightforward to decide upon. Although existing maximum sentences have not been applied, and gaol sentences have fallen as a percentage of total convictions, there is evidence that the courts have been passing increasingly stiffer gaol sentences since higher penalties were introduced in 1970. The Committee believes that it would be consistent with this trend and the public will to crack down heavily on the trafficker to make available to the courts extremely severe penalties for the large scale operator. In recommending this course the Committee advises against maximum penalties widely outside the general scope of the common law. Thus they recommend a maximum gaol sentence for trafficking of 15 years.

53. These recommendations underline the Committee's view that legislative control and administrative reinforcement must be directed primarily at the drug trafficker.

## RECOMMENDATIONS

54. The Committee recommends that—

(1) (i) The penalty for trafficking in the Prohibited Drug (heroin) and Drugs of Addiction listed in schedule 8 of the New South Wales Poisons Act,1966 (with amendments), should be increased to $50,000 fine and/or 15 years' imprisonment.

(ii) There should be provision for the attachment of property where the fine is not met.

(iii) In the case of cannabis in all its forms, the existing penalties for trafficking should remain unchanged pending a full scale review of the Poisons Act.

(2) A review of existing legislation in New South Wales relating to drugs be set in hand as a matter of priority.

(3) Early consideration be given to the best way of co-ordinating the work of both the Government and the voluntary bodies in the drugs field so that the resources available might be used in the most efficient and effective way.

(4) That innovative programmes for treatment and assistance to addicts of hard drugs should be encouraged and increased in scope.

(5) That the resources made available to the law enforcement agencies working for the prevention and control of illicit drug supply should be carefully examined to see what action needs to be taken for more effective suppression of illegal trafficking.

## CANNABIS

55. Much scientific argument has been generated about whether there is more than one species and how to differentiate between them if there is more than one. Since the experts cannot agree, the Committee supports the use of the term *"Genus cannabis"*.

56. The generic term cannabis is often used loosely to apply to derivatives of the cannabis plant in different parts of the world. Marihuana and hashish are the forms of cannabis most frequently used in Australia. Cannabis, although indigenous to Central Asia, may now be found in most parts of the world. It is a hardy plant flourishing under widely varying climatic conditions, although optimum growth requires a hot dry climate. Recent experience in Australia, however, has shown that it may be grown under conditions of great variation of climate. It has long been used as a commercial crop with the fibre being utilized in the production of rope, cord and textiles and the oil extracted from the seed for paint. For longer than medical history has been recorded cannabis has been used for medicinal and religious purposes and as a euphoriant. Nevertheless, modern medical science has failed to establish a therapeutic use for any of its derivatives although there have been reports of limited experimental use in the treatment of dependence of some other drugs and for alcoholism.

57. Marihuana consists of the leaves, flowers and stems of the male and the female plant and hashish is a resinous material obtained from the flowering tops of the female plant. The latter is by far the more potent cannabis preparation. It has been said that cannabis grown in Australia is not as strong usually as the imported variety and is less favoured by regular users. In 1965 tetrahydrocannabinol (THC) was isolated from cannabis and synthesized and it is currently believed that this is the main active ingredient. Synthesized THC has been found to be more potent than preparations produced from the natural plant.

58. Indian hemp is the term used in the N.S.W. Poisons Act, 1966, and section 20 of the Act defines Indian hemp as—

(a) any plant or part of a plant of the Genus cannabis;
(b) the resin whether crude or purified obtained from any plant or part of the plant of the Genus cannabis; or
(c) any preparation containing any such resin,

by whatever name that plant, part, resin or preparation may be called and includes the achene or seed of any such plant but does not include any fibre of any such plant from which the resin has been extracted.

59. In Australia, as in all countries which are signatories of the 1961 Convention on Narcotic Drugs, cannabis is an illegal drug but nevertheless, one being increasingly used mainly in the marihuana form. Although emotions run high between the proponents for and against legalization of cannabis and claims and counter-claims are made by both sides, no irrefutable scientific evidence yet exists to put beyond doubt whether long-term use is dangerous to man. Neither is there irrefutable evidence to show that it is safe.

60. Many conflicting reports have been published about the effects of cannabis on the user. This is probably due to the complex nature of the drug, the variations in its potency and the dosage. Marihuana is not a single simple substance of uniform type. It consists of varying mixtures of different parts of the plant *Cannabis Sativa* with psychoactive properties ranging from virtually nil to decidedly hallucinogenic in its strongest forms and at higher doses.

61. While in general marihuana is a weak psychoactive form of cannabis, hashish is a much stronger form. Although conveniently classified as an hallucinogen cannabis has stimulant, depressant and analgesic, as well as hallucinogenic properties, the predominant effect being essentially related to dosage. Cannabis cannot be accurately classified pharmacologically without specifying dose level.

62. The 1961 Single Convention on Narcotic Drugs lists in four separate schedules those drugs coming within the ambit of the Convention. The fact that both cannabis and heroin are listed in the first schedule has given rise to a great deal of criticism in overseas reports and also here in Australia. The original purpose of classification into schedules was principally an administrative one intended to identify groups of drugs according to the degree of control to be imposed by the Convention. Different controls do apply to each of the four schedules. Nevertheless, the impression has been created by the classification of heroin and cannabis in the same schedule that these two are of equal danger to users. Quite clearly they are not. The wrong impression has probably been strengthened by many of the signatories to the Convention applying the same penalties to offences relating to heroin, cannabis and many other drugs.

63. The 1971 Senate Committee stated that if international controls over cannabis were separated from those applicable to narcotic drugs, particularly heroin, further controversy may be avoided. It would appear that this would best be achieved by transferring cannabis from the Single Convention on Narcotic Drugs to the Convention on Psychotropic Substances where it would be more appropriately classified.

64. The view has been expressed by several people who have given evidence and provided submissions that the penalty imposed for drug offences should bear some relationship to the harmful character of the individual drugs. The Committee finds itself in agreement with this view and believes that the proposed review of the Poisons Act should take this into account.

65. Evidence available to the Committee suggests that cannabis taken in moderate doses may not cause physical damage to the user nor develop a physical dependence. However, continued or long-term use of cannabis may develop psychological dependence.

66. Much evidence has been presented about the difficulty of setting standards to determine the potency of cannabis and the need to frame laws in relation to the quantity in possession.

67. In this context it will be self-evident that if the various types of cannabis preparation were to be separated and different penalties applied to each case, severe technical evidentiary problems could arise.

68. A great deal of publicity has been given to recent moves in various States of the United States of America, to decriminalize cannabis. Recent legislation in the United States and the United Kingdom showing special consideration to the first offender charged with the use of cannabis would be acceptable and is recommended here.

69. The Committee has given great consideration to the consequences of the conviction for a drug offence on the subsequent career of a young man or woman. While realizing that discretionary powers in dealing with offenders still reside with the courts, the Committee believes that these powers should be more widely expressed and exercised.

70. It is the view of the Committee that the first offender should, by bond and probation conditions, be given every encouragement to avoid repetition of the offence. However, where possession of the drug is for monetary gain, more severe penalties are warranted. Of course, this will pose problems in the case of a pedlar who seeks to sell in order to continue his own habit. This apparently does not occur so much with the use of cannabis as with the use of harder drugs such as heroin where it is apparent that many of the pedlars are themselves heroin addicts.

71. Many arguments have been put forward for and against the legalization of cannabis. Some of this evidence has been given directly to the Committee. Other evidence is contained in submissions made available to the committees by professional witnesses and, of course, there has been much public debate in regard to this matter. After considering all the reports and evidence the Committee agrees with the finding of the Senate Committee of 1971 that the present state of knowledge of marihuana shows that it is not as dangerous as has been frequently publicized. The other cannabis derivative used in Australia, hashish, although on a smaller scale, is a far more potent drug than marihuana. The Committee believes that the scientific evidence is not yet sufficiently conclusive to warrant the removal of the existing restrictions on the use of any of the cannabis derivatives.

72. However, a majority of the members of the Committee believes that from all the evidence before the Committee it would appear that moderate users of the drug may suffer effects probably less dangerous than those of alcohol. They may in no sense believe themselves criminal and the existing laws in relation to possession thereby have quite serious implications for society in terms of the future career prospects of many of its young people.

73. These members of the Committee recommend that offences for the personal use of cannabis be no longer considered criminal offences. The Honourable Mrs M. A. E. Davis, Mr J. G. T. Jackett and Mr R. C. A. Wotton strongly dissent from this view. The Honourable H. J. A. Sullivan was absent ill when this decision was made.

74. The Committee therefore recommends that—

(6) the present restrications on the use of cannabis drugs be retained pending the result of further research;

(7) offences for the personal use of cannabis be no longer considered criminal offences—Mrs Davis, Mr Jackett and Mr Wotton dissenting;

(8) the first offender brought before the courts be given by bond and probation every encouragement to avoid repetition of the offence;

(9) a first offender successfully completing conditions of his bond and probation be discharged without an offence and the details of the case be expunged from the record;

(10) possession of cannabis derivatives with intent to make significant profits through sales should incur severe penalties;
(11) every effort should be made through education and improvement in the way of life to discourage recourse to the use of drugs such as cannabis for stimulation or satisfaction.

## FORFEITURES

75. The Committee believes that the principle adopted by Government in environmental legislation should apply to drug abuse. "The polluter should pay to rectify the cost of his pollution". It is recommended therefore:

(12) (i) In those cases where convictions for drug offences incur either fines and/or order for forfeiture of money and goods (not otherwise ordered to be destroyed), such money and proceeds of the sale of such goods should be transferred to a Special Deposit Fund to be used to support programmes for rehabilitation, education and research in the field of drug addiction.
(ii) In setting up such a fund, it would be desirable to introduce a Central Register to record the details of the forfeitures.

76. The Committee wishes to record its thanks to Dr J. Sutton, the Director of the Bureau of Crime Statistics and Research and his staff and to Mr R. Dash of the Health Commission for their great help in preparing material for this report.

V. P. DURICK, B.A., M.L.A., Chairman.

ANNEXURE 1

| JURISDICTION | Narcotic Drugs, Cocaine Amphetamines and similar C.N.S. Stimulants | Hallucinogens | Barbiturates |
|---|---|---|---|
| **FEDERAL** | **All Offences**<br>(Before Judge)<br>Imprisonment for up to 10 years and/or a fine of up to $4,000<br>(Before Magistrate)<br>Imprisonment for up to 2 years and/or a fine of up to $2,000. | | |
| **NEW SOUTH WALES** | **Trafficking**<br>(Before Judge)<br>Imprisonment for up to 10 years | | **Trafficking**<br>(Before Magistrate)<br>Imprisonment for up to 2 years and/or a fine of up to $2,000. |
| | **Other Offences**<br>(Before Magistrate)<br>Imprisonment for up to 2 years and/or a fine of $2,000. | | **Other Offences**<br>(Before Magistrate)<br>Imprisonment for up to 6 months or a fine of up to $800. |
| **VICTORIA** | **Trafficking** (S.32)<br>(Before Judge)<br>Imprisonment for up to 10 years and/or a fine of up to $4,000. | **Trafficking** (S.25A)<br>(Before Judge)<br>Imprisonment for up to 10 years and/or a fine of up to $4,000. | **Trafficking** (S.24(1))<br>(Before Magistrate)<br>A fine of up to $200. |
| | **Forging or uttering a prescription** (S.33(1))<br>(Before Judge)<br>Imprisonment for up to 5 years. | **Forging or uttering a prescription.**<br>Action taken under other legislation. | **Forging or uttering a prescription**<br>Action taken under other legislation. |
| | | **Sale or Supply**<br>(S.18 and S.24(2))<br>(Before Magistrate)<br>A fine of up to $200. | **Sale or Supply**<br>(S.24)<br>(Before Magistrate)<br>A fine of up to $200. |
| | | **Possession** (S.25A)<br>(1) (Before Magistrate)<br>Imprisonment for up to 12 months or a fine of up to $500. | |
| | **Other Offences**<br>(1) (Before Magistrate)<br>Against Part III of Poisons Act (S.34(2))<br>Imprisonment for up to 12 months and/or a fine of up to $500. | | **Other Offences**<br>(Before Magistrate) |
| | **Against Regulations**<br>(S.37(f))<br>A fine of up to $200. | | **Against Regulations**<br>(S.61)<br>A fine of up to $100. |
| **QUEENSLAND** | **Trafficking**<br>(Before Judge)<br>Imprisonment for up to 10 years and/or a fine of up to $10,000*<br>(Before Magistrate)<br>Imprisonment for up to 2 years and/or a fine of up to $2,000.<br>**Other Offences**<br>(Before Magistrate)<br>Imprisonment for up to 2 years and/or a fine of up to $2,000. | | |
| **SOUTH AUSTRALIA** | **Trafficking**<br>(Before Judge)<br>Imprisonment for up to 10 yrs and/or a fine of up to $4,000.<br>**Other Offences**<br>(1) (Before Magistrate)<br>Imprisonment for up to 2 years and/or a fine of $2,000. | | **All Offences**<br>(1) (Before Magistrate)<br>A fine of up to $100. |
| **WESTERN AUSTRALIA** | **Trafficking**<br>(2) (Before Judge)<br>Imprisonment for up to 10 yrs and/or a fine of up to $4,000.<br>**Other Offences**<br>(Before Magistrate)<br>Imprisonment for up to 3 yrs and/or a fine of up to $2,000. | | **All Offences**<br>(Before Magistrate)<br>A fine of up to $200. |
| **TASMANIA** | **Trafficking**<br>(Before Judge)<br>Imprisonment for up to 10 yrs and/or a fine of up to $4,000.<br>**Other Offences**<br>(Before Magistrate)<br>Imprisonment for up to 2 yrs and/or a fine of up to $2,000. | | **All Offences**<br>(Before Magistrate)<br>A fine of up to $20. |

* Queensland has recently passed legislation to increase the penalty for trafficking to a $100,000 fine and/or life imprisonment.

ANNEXURE 1—*continued*

| JURISDICTION | Narcotic Drugs, Cocaine Amphetamines and similar C.N.S. Stimulants | Hallucinogens | Barbiturates |
|---|---|---|---|
| A.C.T. (3) | **Forging or uttering a prescription**<br>(Before Judge)<br>Imprisonment for 5 years<br>**Forging or uttering any document**<br>(Before Judge)<br>Imprisonment for 3 years.<br>**Other Offences**<br>(Before Judge)<br>Imprisonment for up to 3 years and/or a fine of up to $1,000.<br>(Before Magistrate)<br>Imprisonment for up to 12 months and/or a fine of up to $500. | | **Other Offences**<br>(Before Magistrate)<br>A fine of up to $200. |
| N.T. (3) | **All Offences**<br>(including offences involving cannabis)<br>(Before Magistrate)<br>Imprisonment for up to 2 years and/or a fine of up to $1,000. | **All Offences**<br>(Before Magistrate)<br>Imprisonment for up to 12 months and/or fine of up to $400. | **All Offences**<br>(Before Magistrate)<br>Imprisonment for up to 12 months or a fine of $1,000. |

(1) *Before Judge, if lower court or accused so elects; penalty remains as for lower court.*
(2) *Heard summarily, but passed for sentence to District Court presided over by Judge.*
(3) *New Ordinances for A.C.T. and N.T. are being drafted. It should be noted that the maximum penalties are those for the most serious offence.*

## ANNEXURE 2

### THE CURRENT LAW (1976-1977)

1. Persons convicted on "drug charges" are currently prosecuted under the Poisons Act, 1966, as amended. This makes it an offence to possess, use, sell, supply, or manufacture certain restricted substances without authority. The penalties for use, sale, supply or manufacture of a large number of "drugs of addiction", including cannabis, L.S.D. and the opiates, are a maximum of 2 years imprisonment and/or two thousand dollars fine. If an offender is convicted on indictment the maximum penalty applicable is ten years imprisonment. The Act is set out in more detail below.

2. The Poisons Act, 1966, as amended, restricts the types of drugs that can be legally sold possessed or consumed through the classification of drugs, poisons and other "restricted substances" into eight different schedules. The schedules are prepared by the Poisons' Advisory Committee[2] consisting of government appointees. These schedules are as follows, with the substance that is generally well known, given as an example.

Schedule 1: Dangerous Poisons—strychnine.

Schedule 2: Medicinal Poisons—anti-histamine creams.

Schedule 3: Potent Substances—anti-histamine tablets, insulin.

Schedule 4: Restricted Substances—anti-biotics, diazepam (valium).

Schedule 5: Domestic Poisons—kerosene, camphorated oil.

Schedule 6: Industrial and Agricultural Poisons—D.D.T.

Schedule 7: Special Poisons—Thallium.

Schedule 8: Drugs of Addiction—includes Cannabis (Indian hemp) and Cannabis resin (resin of Indian hemp), cocoa leaf, cocaaine, L.S.D., pethidine.

3. The Poisons Act (1966), sets out the conditions of availability that apply to all substances classified in any of the eight schedules. Additionally provision is made in the Act (part I section 4.1 and part IV, division 3) for the total prohibition of heroin.

4. Under part III of the Act, section 16, any person who possesses or attempts to possess a "prescribed restricted substance", unless he is authorized under the Act or seeks to obtain the substance on prescription, is guilty of an offence. Subsections (2) and (3) of section 16 make it an offence to forge or fraudulently alter any prescription or to obtain a prescription by false representation.

Section 18 deals with unlawful supply or sale of substances classified under schedules 1 to 4 for which the penalty shall not exceed $800 or 6 months' imprisonment. Under section 18A where a person who acts in contravention of section 16 supplies or sells any prescribed restricted substances in Schedule 4 the penalty shall not exceed $2,000 or 2 years' imprisonment. Sale or supply is indicated where the amount of the substance is "in excess of the quantity to be prescribed".

5. Part IV of the Poisons Act (1966), deals specifically with "drugs of addiction and prohibited drugs". Under section 21 of the Act it is illegal to—

(a) manufacture, supply, sell or otherwise deal in Indian hemp or prepared opium;
(b) possess prepared opium or Indian hemp;
(c) permit occupied premises to be used for the preparation, sale or smoking of Indian hemp or prepared opium;
(d) knowingly permit leased premises to be used for such purposes;
(e) manage any premises for such purposes; and
(f) possess pipes or utensils for smoking opium, prepared opium or Indian hemp.

6. Likewise it is an offence to supply, sell or possess any other "drug of addiction" unless authorized under the Act to do so (section 21, subsection 2).

7. Further sections of the Act prohibit the forging or fraudulent altering of prescriptions (section 22), the obtaining of any drug of addiction by false representation (section 23), and allow the Government to make regulations concerning the possession and manufacture of addictive drugs by authorized persons (section 24).

8. Penalties provided under section 26 provide for a maximum fine of $2,000 and/or imprisonment "with or without hard labour" for a maximum period of two years and the forfeiture of any article "in respect of which the offence was committed" to Her Majesty at the courts order.

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(2) The Poisons' Advisory Committee consists of the heads of relevant government scientific departments, representatives of the University of N.S.W. and Sydney (Pharmacy and Pharmacology Departments), the police force, the A.M.A., the Australian Dental Association, Sydney Chamber of Commerce, the Retail Traders' Association, N.S.W. Chamber of Manufactures and the Pharmaceutical Society of N.S.W.

9. Sections 18A (2) and 45A (4) reverse the onus of proof in cases involving "quantities" in excess of the quantity prescribed in respect of the drug. It is thus up to the defendant to prove that drugs held were not for sale, rather than for the prosecution to prove that they were "for sale or supply".

10. Proceedings for an offence against this Act or the regulations are heard before a stipendiary magistrate or any two justices in petty sessions.

11. A penalty of up to 10 years' imprisonment stands for persons who are committed on indictment for the offence of selling or supplying heroin, prepared opium, Indian hemp or any drug of addiction (section 45A).

12. The Poisons Act also sets out conditions under which an authorized person may prescribe a restricted drug of addiction.

13. Further under the Summary Offences Act, 1970, it is an offence to be found in premises frequented by reputed drug offenders or to have habitually consorted with such persons ($200 or 3 months' imprisonment). Also under this Act the person in charge of the premises frequented by reputed drug offenders is guilty of an offence ($400 or 6 months' imprisonment).

ANNEXURE 3

## POISONS ACT, 1966

### Some Observations on its Present Construction and Proposed Modifications

1. *General Construction of the Act*

1.1 Legislation leading to the Poisons Act, 1966, followed two quite distinct paths. A line of development from the original Sale and Use of Poisons Act, 1876, can be shown for part III of the present Act, which deals with poisons and restricted substances. In fact, sections 11 to 15, which deal in some detail with the conditions of sale of Schedule 1 poisons, follow almost word for word the corresponding provisions of the 1876 Act.

1.2 Much of part IV of the Act, which deals with drugs of addiction and prohibited drugs, is derived from the Police Offences Amendment (Drugs) Act, 1927. Prior to that time, what little control there was over the sale and use of opium and its preparations was contained in the Poisons Act, and it was not until the late 1930's that synthetic substitutes for opium, such as pethidine and methadone, started to make their appearance.

1.3 The wheel turned full circle by 1966, when the control of opium, its derivatives and its synthetic substitutes was once more a function of the Poisons Act.

1.4 At this time, the use of other classes of drugs was becoming identified as a social problem. Hallucinogens, of which lysergide (LSD) was the most common example, were becoming more readily available and a cult was developing around their use. Cannabis had been known in other countries for centuries, but was beginning to be smuggled into and used in this country. There had been sporadic interest in cocaine, but this was overshadowed by interest in and use of other drugs.

1.5 The Poisons Act, 1966, was a marriage of two previously unrelated Acts, the Poisons Act, 1952-1961, and the Police Offences (Amendment) Act, 1908-1954. Some new provisions were enacted in 1966, notably control over the supply (as distinct from sale) of poisons and restricted substances, control over the possession of certain prescribed restricted substances, and provision for the issue of authorities to doctors prescribing drugs of addiction under certain circumstances.

1.6 This marriage of two different Acts has produced an Act which lacks internal consistency. Drugs of addiction and prohibited drugs are dealt with in quite different terms from poisons and restricted substances. The availability of new drugs with novel properties and changing community attitudes to the use of drugs and the conditions under which they may be used are factors which have led to the application of provisions of the existing Act in ways that were probably not originally envisaged.

1.7 While some re-organization of the Act and the Poisons List is highly desirable, it is difficult to find an arrangement which is clearly better than any other approach. Some countries, such as U.S.A. and Britain, have three separate Acts, a Controlled Substances Act which deals with the distribution, possession and use of drugs of dependence, a Medicines Act which deals with the evaluation of medicines, prescribing of standards for medicines, and restriction of medicines to sale by pharmacists only or sale on prescription only, and a Hazardous Substances Act which deals with the packaging, labelling and sale of non-medical poisons and hazardous substances. New South Wales already have a Therapeutic Goods and Cosmetics Act which deals with many of the matters covered by the British Medicines Act and the U.S. Food, Drug and Cosmetics Act. There is no need to modify the Therapeutic Goods and Cosmetics Act, provided account is taken in the Poisons Act of those matters not covered by it, particularly restriction of the sale of certain medicines to sale by pharmacist only or sale on prescription only.

1.8 It has been suggested to the Committee that the Poisons Act be divided into seven parts (instead of five as at present, disregarding amendments to the Crimes Act and Motor Traffic Act), as follows:

Part 1—Preliminary.

Part 2—Poisons Advisory Committee and Poisons List.

Part 3—Poisons.

Part 4—Restricted Substances.

Part 5—Drugs of Addiction.

Part 6—Specified Drugs.

Part 7—General.

1.9 Part 1 would be similar to Part 1 of the present Act.

1.10 Part 2 would also be similar to part 2 of the present Act, with one significant change to the Poisons List. Additional new schedules would be added and would comprise specified drugs which would be drugs of dependence available on special authority only. Heroin and other opiates not in general medical use might go into one new Schedule, amphetamines and hallucinogens into another and cannabis into a third.

1.11 Part 3 would deal only with poisons, and would comprise relevant clauses from sections 9, 10, 17 and 19. Sections 11 to 15 contain far too much details about the conditions of sale of Schedule 1 poisons, and would be replaced by a subsection requiring regulations to be made on the form of record of sales of Schedule 1 poisons to be maintained.

1.12 Part 4 would deal with restricted substances, and would comprise relevant clauses from sections 9, 16, 17 and 19.

1.13 Part 5 would deal with drugs of addiction. The Act should be more specific regarding licences to manufacture and distribute drugs of addiction, and provisions relating to supply of drugs of addiction should be constructed more along the lines of the provisions relating to supply of restricted substances. Section 21 (1), which deals with prepared opium and Indian hemp, should be omitted from this part altogether.

1.14 Part 6 would deal with the new class of specified drugs referred to at paragraph 1.10. There could be a section specifying the kinds of circumstances in which authority for manufacture, supply and possession could be issued.

1.15 Part 7 would include those provisions in part 5 of the current Act, together with all penalty provisions.

2. *Schedule Three*

2.1 The National Health and Medical Research Council has for some time been considering a proposal for amending Schedule 3 of the Uniform Poisons Schedules, including in that Schedule only the more potent substances at present in Schedule 3 and transferring from Schedule 4 to Schedule 3 a number of substances at present restricted to supply on prescription only. It is envisaged that Schedule 3 would become a list of substances that would not be advertised to the general public, but could be supplied by a pharmacist, without any delegation to assistants acting under his control or supervision) without prescription provided—

2.1.1 the pharmacist is satisfied that the substance is appropriate for treatment of the person for whom it is being obtained; and

2.1.2 a record of details such as the name and quantity of the substance and the name and address of the purchaser is made.

3. *Poisons Licences*

3.1 Section 10 of the present Act provides for the issue of a licence to sell Schedules 1, 2 or 3 poisons to persons who keep open shop for the sale of goods more than 6.5 km from the nearest pharmacy. This provision has remained unchanged over the past 100 years, and was originally intended to provide for the sale of poisons in areas not served by a pharmacy. With improved methods of transport and communication, the distance of 6.5 km (originally 4 miles) is outmoded and should be extended to at least 20 km.

4. *Exemptions for Substances for Pesticide or Photographic Use*

4.1 Section 19 (4) of the present Act exempts substances prepared for pesticide or photographic use from the restrictions on supply of Schedules 1, 2 and 3 poisons. The remaining conditions, mainly packaging and labelling, are those applied to Schedule 6 poisons. However, current practice is to specify pesticides and photographic chemicals that are hazardous or poisonous in Schedules 5 or 6, and the general exemption has become redundant. There are a few Schedule 1 poisons, such as cyanide, which should not be exempted from Schedule 1 requirements even when prepared for pesticide use, and these substances are in fact prescribed as provided for in section 19 (4) of the Act. Nevertheless it would simplify the Act and Regulations if section 19 (4) were to be omitted.

5. *Dispensing Interstate Prescriptions*

5.1 Section 19 (1) (a) authorizes pharmacists to supply restricted substances on prescriptions of medical, dental and veterinary practitioners. Most prescriptions are written by medical practitioners, and all prescriptions for Pharmaceutical Benefits under the National Health Act are written by medical practitioners.

5.2 The term "medical practitioner" is not defined in the Poisons Act, but the Medical Practitioners Act states that any reference to "medical practitioner" in that or any other Act means, unless otherwise specified, a person registered as a medical practitioner under that Act. This means that a prescription for a restricted substance written by a doctor in another State cannot be dispensed by a pharmacist in New South Wales unless the doctor is registered in New South Wales as well as in the State in which he practises. This can be at the very least inconvenient to patients travelling interstate, as they may be required to make otherwise unnecessary visits to a strange doctor to obtain a valid prescription.

5.3 This could be overcome by including in section 19 (1) of the Act a clause to the effect that "medical practitioner" for the purpose of that subsection includes a person registered as a medical practitioner in any other Australian State or Territory.

6. *Forfeiture of Appliances*

6.1 Section 26 (1) provides for forfeiture of articles in respect of which an offence involving a drug of addiction was committed. However, no similar provision is made in respect of articles associated with an offence involving a prescribed restricted substance or prohibited drug. Such articles can include containers, pipes, syringes, raw materials and apparatus used for the illicit manufacture of drugs and so on. It would be highly desirable to extend provisions regarding forfeiture to articles associated with offences involving prescribed restricted substances and prohibited drugs (and specified drugs if such a class of drugs is included in the Act).

7. *Penalties for Trafficking Offences*

7.1 The national Standing Control Committee on Drugs of Dependence (N.S.C.C.) has recommended increased penalties for certain drug trafficking offences. The Committee has dealt with these in the memorandum. At the same time, the N.S.C.C. has reviewed the quantities of drugs prescribed as "traffickable quantities", possession of which is presumed to be possession for the purpose of supply unless the contrary is proved. The new quantities recommended are about four times greater than the present "traffickable quantities".

8. *Cultivation of Drug Plants*

8.1 The only drug plant dealt with specifically in the Poisons Act at present is cannabis. Reliance is placed on the declaration on other drug plants as noxious weeds under the Local Government Act to control their cultivation.

8.2 A new section should be included in the Poisons Act to deal with the cultivation of drug plants. The cultivation, harvesting, possession or processing of opium poppies, coca bushes or cannabis plants should be prohibited without a special authority.

9. *Section 40*

9.1 Once a charge has been laid in a drug case, the question of identity of the substance concerned arises. Evidence to the Committee has indicated that analysis of a "drug" is only undertaken where a not guilty plea was entered.

9.2 Although it is quite possible to convict a person of an offence solely on the evidence of his own admission, if what the accused admits to is the identity of the substance found in his possession, evidentiary problems arise because of the well-established rule that

no one other than an expert can give evidence on matters that call for expert opinion. Thus a drug user cannot properly identify something as a drug, when he is not qualified to make that judgement. In cannabis cases, this problem is obviously of limited difficulty as it is arguable that the user is sufficiently expert to know about the substance he is using (though there are reported experiments in which a cannabis "high" has been experienced under a placebo; this is true of most drugs). But, the law seems clear that, in criminal matters, an accused cannot admit to some incriminating fact that he does not *know*.

9.3 Furthermore, the current law provides an accused with no means whereby he may contest the police analysis of a substance found in his possession. Under section 40 of the Poisons Act, a certificate purporting to be signed by an analyst is *prima facie* evidence of the identity of the substance analyzed. There is no need for the prosecution to prove the signature, employment or appointment of the person signing such certificate, although the defence could contest any of these matters. In fact, the section is a trifle facetious in stating that the certificate is only *prima facie* evidence, since the accused cannot lawfully be given a sample of the substance found for it to be tested by independent analysis and thus, for all practical purposes, the certificate is conclusive. Some other States provide means whereby the analysis can be tested; for example, s. 147 Health Act (Qld.); s. 56 Poisons Act (Vic.); s. 78 Poisons Act (Tas.), and it has been suggested that as minimal reform of the law such reform be made in New South Wales.

10. *Section 45A*

10.1 S. 45A was added to the Act in 1970. It applies to all offences of selling or supplying (a) prepared opium or Indian hemp, (b) any drug covered by s. 21 (2A), and (c) any drug prohibited under s. 32 (1). All these offences may, at the option of the prosecution, be prosecuted on indictment, that is, before a jury, and are subject to a maximum penalty of 10 years gaol. S. 45A (4) provides that a person found in possession of more than the prescribed quantity of such a drug shall be deemed to have that drug in his possession for the purpose of sale unless (a) he proves to the contrary, or (b) he proves he obtained the drug on prescription.

10.2 The legal objection raised against s. 45A is the shifting onto the accused of the burden of proving that possession of more than the prescribed quantity was *not* for the purpose of sale. In the past, it has been settled law, and excellent common sense, that the prosecution in a criminal case must prove all the elements of an offence, including the accused's mental state, if that is relevant, beyond a reasonable doubt. This rule is tempered somewhat, in that the prosecution is not required to negative every possible "defence".

10.3 Further, it has also been argued that s. 45A (4) has had little effect on convictions for trafficking (which have remained at a constant level since 1970) except that it, like all presumptions which are not supported by factual evidence, increases the likelihood of unjust convictions for a very serious offence. In cases that *are* prosecuted under s. 45A, and in which severe sentences *are* given, the amount of drug discovered is usually so far above the prescribed quantity as to render the section unnecessary; the very amount itself denies possession for personal use only.

10.4 On the evidence of the foregoing, there is a need for evaluation of this section of the Act in the light of practices in the courts.

## ANNEXURE 4

## DRUG OFFENCE STATISTICS

(Note by the Joint Committee of the Legislative Council and Legislative Assembly Upon Drugs)

The following statistics have been extracted from the N.S.W. Bureau of Crime Statistics and Research Report on Court Statistics for 1975.

In evaluating them, the Joint Parliamentary Committee on Drugs has noted that the data the Bureau receives are subject to several factors which may substantially affect their content. Some such factors are:

(1) Police priorities as to manpower use will cause them to concentrate upon detection of the use of certain types of drugs; e.g., concern for narcotic use will give it police preference over marihuana and the hallucinogens.

(2) Records of convictions only show those users who come to the attention of the police, and there is no way of knowing whether they are a representative sample of the drug-using population.

(3) Statistics for some offences are artificially high as a result of the practice of multiple charges, e.g., possession and use; separate charges for different types of drugs found in one person's possession.

(4) Simple matters of social class may affect a particular group's percentage representation in the statistics. For example, the middle-class suburban barbiturate user is much less likely to come to police notice than a younger, "hippie-type" user; doctors addicted to opiates may continue in their jobs for many years undetected because of their lack of need to acquire drugs on the open black market.

## SECTION 6. DRUGS

### PART I—OFFENCES UNDER PARTS III AND IV OF THE POISONS ACT N.S.W.

In 1975 courts in New South Wales convicted 3 937 people for violations of Parts III and IV of the Poisons Act—an increase of 81.0 percent of the convictions count for 1974. The numbers convicted in 1974 (2 174) represented an increase of 60.7 percent over the 1973 figure.

**Table 6.1—Offenders under Parts III-IV of the Poisons Act**

| | 1975 | 1974 | 1973 | 1972 | 1971 |
|---|---|---|---|---|---|
| Number .. .. .. .. .. .. | 3 937 | 2 174 | 1 352 | 1 058 | 879 |
| Percentage increase over previous year .. | 81.0 | 60.7 | 27.8 | 20.4 | 36.4 |

An analysis of the significance of these increases should take into account that there was no increase in the size of the New South Wales Drug Squad in 1975. However, the vigorous State wide education programme which the Squad launched in 1974 to improve the drug investigative potential of all members of the police force was continued in 1975.

## SOCIAL CHARACTERISTICS

As in previous years the vast majority of offences in 1975 were recorded against men (87.9 percent in 1974). Pleas of guilt were entered by 96.6 percent of all offenders.

**Table 6.2—Sex of Offenders**

| | 1975 | | 1974 | 1973 | 1972 | 1971 |
|---|---|---|---|---|---|---|
| | No. | percent | percent | percent | percent | percent |
| Male | 3 436 | 87.2 | 87.9 | 87.4 | 87.0 | 80.7 |
| Female | 501 | 12.8 | 12.1 | 12.6 | 13.0 | 19.3 |
| | 3 937 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

More than half (55.8 percent) of the offenders were less than 21 years of age. In fact, only 3.5 percent of cases involved people over the age of 30 years. The age distribution was quite similar to that of other years, although there was a small increase in the proportion of offences committed by those in the 15-17 years' age range.

**Table 6.3—Age of Offenders**

| | 1975 | | 1974 | 1973 | 1972 | 1971 |
|---|---|---|---|---|---|---|
| | No. | percent | percent | percent | percent | percent |
| 12-14 years | 16 | 0.4 | 0.3 | 0.5 | 0.1 | 0.2 |
| 15-17 years | 576 | 14.6 | 11.2 | 11.9 | 8.5 | 12.6 |
| 18-20 years | 1 607 | 40.8 | 39.4 | 40.1 | 38.1 | 44.1 |
| 21-24 years | 1 145 | 29.1 | 33.2 | 31.5 | 37.5 | 29.8 |
| 25-29 years | 402 | 10.2 | 10.3 | 9.8 | 10.4 | 8.5 |
| 30-34 years | 79 | 2.0 | 2.7 | 2.8 | 2.9 | 2.4 |
| 35-39 years | 32 | 0.8 | 0.7 | 1.0 | 0.7 | 0.9 |
| 40+ years | 23 | 0.6 | 0.7 | 0.8 | 1.7 | 1.4 |
| Unknown | 57 | 1.5 | 1.5 | 1.6 | 0.1 | 0.1 |
| | 3 937 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Ninety percent of the offenders were born in Australia and only 6.3 percent were born outside Australia, New Zealand and the U.K.

Some sociological studies have suggested that occupational prestige—the relative social status which the Australian public attribute to different occupations—is an effective indicator of variations in life style and opportunities associated with the concept of "class". The occupation categories used in this report range from A (high) to D (low). Table 6.4 shows estimates of the proportion of the Sydney metropolitan population which fall into each of the four occupational strata.

In 94 cases no occupation was recorded and 704 people stated that they were unemployed—68 housewives were listed and 33 pensioners. In 182 cases (4.6 percent) the convicted person claimed to be a student or a schoolchild.

Therefore of the total cases 2 856 people could be classified according to a prestige rating of their respective occupations. The figure opposite shows that the offender group contained very few A and B status people. However, it should be acknowledged that many defendants may falsify their occupations (by downgrading them) to avoid the possible repercussions of public identification.

As in previous years, D status—unskilled workers—were grossly overrepresented in drug convictions for 1975.

**Table 6.4—Occupational Prestige**

| | 1975 | | 1974 | 1973 | 1972 | 1971 |
|---|---|---|---|---|---|---|
| | No. | percent | percent | percent | percent | percent |
| Professional/managerial (A) | 9 | 0.3 | 0.1 | 0.7 | 0.3 | 0.7 |
| Semiprofessional/middle management (B) | 95 | 3.3 | 4.2 | 4.5 | 4.2 | 4.8 |
| Sales, small business, clerical, skilled trades (C) | 1 441 | 50.4 | 49.6 | 50.3 | 44.3 | 44.3 |
| Unskilled (D) | 1 311 | 46.0 | 46.1 | 44.5 | 51.2 | 50.1 |
| | 2 856 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Slightly more than half (53.0 percent) of the offences were committed in company.

Of the offenders, 83 percent had no prior drug convictions, and 58.5 percent had no previous convictions of any kind.

Two in five (40.4 percent) drug offenders in 1974 were legally represented in court. However, in 1975, more than half (53.2 percent) were represented.

## TYPES OF OFFENCE

Between 1972 and 1975 the proportion of offenders for whom the principal offence was illicit possession of drugs rose from 38.5 percent to 50.1 percent. In each of the years under discussion approximately one in three of the offenders was convicted of using prohibited drugs, and there were only slight variations in the proportion of offences which involved intravenous administering of drugs.

The offence categories which might generally be described as "pushing" (distribute and sell) or illicit procurement of drugs (forge and/or utter prescriptions, manufacture) all decreased proportionately between 1972 and 1974. They accounted for 14.4 percent in 1972 and 7.8 percent in 1974. However, in 1975 there has been a small increase in this group of offence categories, from 7.8 percent to 8.6 percent.

**Table 6.5—Types of Offences 1972-1975**

| | 1975 | | 1974 (N-2174) | 1973 (N-1352) | 1972 (N-1058) |
|---|---|---|---|---|---|
| | No. | percent | percent | percent | percent |
| Possess | 1 975 | 50.1 | 48.5 | 47.8 | 38.5 |
| Use (i.e., take orally) | 1 376 | 35.0 | 36.1 | 33.2 | 37.6 |
| Administer (i.e., intravenously) | 247 | 6.3 | 7.6 | 6.8 | 9.5 |
| Distribute | 28 | 0.7 | 1.0 | 1.8 | 2.4 |
| Sell | 196 | 5.0 | 4.5 | 6.5 | 6.5 |
| Forge and/or utter prescriptions | 80 | 2.0 | 1.3 | 2.5 | 4.5 |
| Manufacture | 35 | 0.9 | 1.0 | 1.3 | 1.0 |
| Not stated | .. | .. | .. | 0.1 | .. |
| | 3 937 | 100.0 | 100.0 | 100.0 | 100.0 |

## COURT ACTION

Between 1971 and 1975, the proportion of offenders for whom the penalty imposed by the courts was a fine, rose from 27.1 percent to 54.2 percent. Fines, as an element in other penalties (for example, recognizance, probation and fine) have been used less frequently by the courts—falling from 5.5 percent in 1971 to 1.9 percent in 1975.

During the same period the courts sentenced proportionately fewer offenders to terms of imprisonment. In 1971, 16.7 percent of drug offenders received gaol terms. The term imposed ranged from less than 14 days to two years. There has been a progressive decline in the use of such penalties, until in 1975, only 5.8 percent of offenders were sentenced to gaol.

Between 1971 and 1972, the proportion of offenders who benefited from the provisions of section 556A of the Crimes Act rose from 0.9 percent to 10.9 percent. However, subsequent years saw no additional use made by the courts of these provisions.

**Table 6.6—Court Action**

| | 1975 | | 1974 | 1973 | 1972 | 1971 |
|---|---|---|---|---|---|---|
| | No. | percent | percent | percent | percent | percent |
| Fine—in default, rising of court | 20 | 0.5 | 0.6 | * | * | * |
| Admonished and discharged | 29 | 0.7 | 1.5 | * | * | * |
| Offence proved, discharged recognizance S556A | 370 | 9.4 | 9.7 | 9.3 | 10.9 | 0.9 |
| Probation with/without fine or recognizance | 1 111 | 28.2 | 30.2 | 34.5 | 39.2 | 53.1 |
| Fine | 2 137 | 54.3 | 50.0 | 44.5 | 37.7 | 27.1 |
| Committed to the care of an institution or specified person | 29 | 0.7 | 1.1 | 0.9 | 0.9 | 2.0 |
| Periodic detention | 15 | 0.4 | 0.2 | 0.1 | .. | .. |
| *Imprisonment—* | | | | | | |
| Less than 1 month | 16 | 0.4 | 1.0 | 0.8 | 0.6 | 0.6 |
| 1 month, less than 6 months | 85 | 2.2 | 2.6 | 3.6 | 3.8 | 4.4 |
| 6 months, less than 1 year | 73 | 1.9 | 1.9 | 4.1 | 4.0 | 6.7 |
| 1 year to 2 years | 52 | 1.3 | 1.2 | 2.0 | 2.8 | 5.0 |
| Not specified | .. | .. | .. | 0.2 | 0.1 | 0.2 |

* These two penalties were not considered as separate statistical categories in years prior to 1974. For this reason no comparisons can be made with earlier years.

## TYPE OF SUBSTANCE USED

Six main types of substance were used. The opiates include heroin and are the so called "hard" drugs as they are highly addictive and damaging. Cannabis (marihuana) is the least offensive as it has yet to be shown that it has any addictive or seriously damaging properties. The hallucinogens such as L.S.D. do seriously affect the mind but they are not physically addictive. The stimulants such as cocaine and amphetamines (speed) cause hyperactivity but are not physically addictive. The sedatives, mainly barbiturates, are the only controlled drugs that can be readily legally obtained as they are frequently prescribed. Some drugs in the other categories have strictly medical use. Heroin and marihuana have no present medical use in Australia.

Since 1971 the prohibited substance specified in the majority of drug cases heard at Courts of Petty Sessions has been cannabis. Between 1971 and 1974 the proportion of cases involving this drug rose from 56.2 percent to 83.9 percent. There was a corresponding decrease in the proportion of cases involving other substances.

In 1975, there was a slight decrease (to 81.9 percent) in the proportion of cannabis cases and a slight increase in the incidence of opiates, hallucinogens and sedatives. However, these figures appear to reflect a stabilizing of rates rather than reversal of the 1971-1974 trend.

**Table 6.7—Category of Substance 1971-1975**

| | 1975 | | 1974 | 1973 | 1972 | 1971 |
|---|---|---|---|---|---|---|
| | No. | percent | percent | percent | percent | percent |
| Cannabis | 3 226 | 81.9 | 83.9 | 79.8 | 69.3 | 56.2 |
| Opiates | 516 | 13.1 | 12.0 | 12.4 | 19.7 | 30.2 |
| Hallucinogens | 138 | 3.5 | 3.3 | 7.8 | 10.8 | 12.5 |
| Stimulants | 20 | 0.5 | 1.2 | 1.5 | 2.3 | 5.9 |
| Sedatives | 108 | 2.7 | 2.5 | 1.8 | 2.7 | 5.8 |
| Cocaine | 22 | 0.6 | 0.6 | 0.4 | 1.2 | 1.6 |
| Other | .. | .. | .. | .. | .. | 0.2 |

Because multiple drugs were used this table adds to more than 100 percent.

Statistics from previous years showed a distinction between types of substance with respect to penalty. In 1975 there was very little difference in sentencing patterns between substances. Table 6.8 illustrates the change in pattern in 1974 and 1975. This change could be described as a "convergence to the mean", where the sentencing pattern for cannabis, the most frequent drug, now also applies to the other drugs. For opiates, this means the proportion of fines has increased, and the proportion of probation and imprisonment decreased. For sedatives, the proportion of fines and imprisonment has increased and the proportion of probation has decreased.

**Table 6.8—Substance by Outcome**

| | Opiates | | Cannabis | | Sedatives | | Hallucinogens | | Other | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1974 N-226 | 1975 N-501 | 1974 N-1754 | 1975 N-3148 | 1974 N-43 | 1975 N-104 | 1974 N-47 | 1975 N-92 | 1974 N-104 | 1975 N-112 |
| 556A/recognizance | 7.5 | 12.9 | 12.5 | 10.4 | 25.6 | 16.3 | 14.9 | 15.2 | 3.8 | 8.9 |
| Probation | 56.7 | 24.7 | 24.3 | 28.2 | 41.9 | 32.6 | 38.3 | 31.5 | 51.0 | 33.9 |
| Fine | 16.3 | 55.3 | 56.6 | 54.9 | 30.2 | 42.4 | 36.1 | 45.7 | 25.0 | 43.8 |
| Institution | 0.9 | 0.8 | 1.2 | 0.6 | 0.0 | 1.1 | 2.1 | 1.1 | 1.0 | 1.7 |
| Prison | 18.5 | 6.2 | 4.7 | 6.0 | 2.3 | 7.6 | 8.5 | 6.5 | 19.2 | 11.6 |
| Note stated | 0.1 | .. | 0.8 | .. | 0.0 | .. | 0.1 | .. | .. | .. |

For each of the substance categories of table 6.9 there was a higher proportion of "pushers" sent to prison than "users". An interesting result is that 30.6 percent (82 of 268) of cannabis "pushers" were sent to prison whereas only 22.9 percent (11 in 48) of opiates "pushers" were so sentenced.

**Table 6.9—Substance, Offence and Outcome**

| | Opiates | | Cannabis only | | Other substance | |
|---|---|---|---|---|---|---|
| | "Push" | "Use" | "Push" | "Use" | "Push" | "Use" |
| 556A/recognizance | 3 | 61 | 19 | 307 | 1 | 128 |
| Probation | 21 | 111 | 99 | 788 | 20 | 72 |
| Fine | 13 | 272 | 67 | 1 660 | 5 | 120 |
| Institution | .. | 4 | 1 | 18 | .. | 6 |
| Prison | 11 | 22 | 82 | 107 | 7 | 12 |
| | 48 | 470 | 268 | 2 880 | 33 | 338 |

## PART II—DRUG CONVICTIONS IN NEW SOUTH WALES UNDER COMMONWEALTH LEGISLATION

The Bureau of Crime Statistics and Research is indebted to the Commonwealth Bureau of Narcotics for its help in tabulating details of Commonwealth drug offences dealt with by courts operating in New South Wales.

In 1975, there were 115 offenders convicted of Commonwealth offences in New South Wales. This was 31 cases more than for the previous year.

### SOCIAL CHARACTERISTICS

Compared with convictions under the New South Wales Poisons Act, a higher proportion of these offenders were 30 years of age or older.

**Table 6.10—Age of Offenders**

| | Number |
|---|---|
| 18-20 years | 13 |
| 21-24 years | 51 |
| 25-29 years | 31 |
| 30-39 years | 11 |
| 40 years + | 4 |
| Not stated | 5 |
| | 115 |

As in part I, there was a high proportion of male offenders.

**Table 6.11—Sex of Offender**

| | Number |
|---|---|
| Male | 93 |
| Female | 22 |
| | 115 |

### OFFENCES

**Table 6.12—Type of Offence**

| | Number |
|---|---|
| Possess on board ship/aircraft | 5 |
| Import | 41 |
| Possess prohibited import | 8 |
| Possess prohibited import—reasonably suspected of being imported | 54 |
| Aid/abet import | 7 |
| | 115 |

### COURT ACTION

Prison terms were imposed on 36 of these offenders in 1975 compared to 24 in 1974. Approximately one in three cases resulted in a fine (with or without recognizance).

There was a decided increase in the use made by the courts of recognizances by themselves (33 in 1975 compared to 13 in 1974). This increase was at the expense of recognizance in combination with probation (1975-4; 1974-10).

### TYPE OF SUBSTANCE

Slightly more than half (sixty cases) of the Commonwealth cases for 1975 involves opiates. This represented an increase of twenty-six cases over the previous year, and followed an increase in 1974 over 1973. Unlike convictions under the New South Wales Poisons Act, cannabis was the prescribed substance in less than half of Commonwealth matters in 1975 compared to almost two-thirds in 1974. In 1973 the level of cannabis was 68.6 percent and in 1972 it was 70.4 percent.

**Table 6.13—Type of Substance**

| | Number of instances* |
|---|---|
| Cannabis | 50 |
| Opiates | 60 |
| Hallucinogens | 6 |
| Cocaine | 2 |
| Not stated | 3 |

* More than one drug involved in some cases.

**Table 6.14—Court Action—Commonwealth Legislation**

| | Number |
|---|---|
| S.19B Crimes Act | 1 |
| Fine | 39 |
| Fine + Recognizance | 2 |
| Recognizance | 33 |
| Recognizance and probation | 4 |
| Imprisonment | |
| Periodic detention | .. |
| Less than 6 months | 1 |
| 6 months less than 12 months | 5 |
| 1 year—less than 2 years | 1 |
| 2 years—less than 5 years | 18 |
| 5 years—less than 9 years | 11 |
| | 115 |

## PART III—DRUG CONVICTIONS IN NEW SOUTH WALES: HIGHER CRIMINAL COURTS

In addition to the sections of the Poisons Act which provide for the prosecution of drug offenders at Courts of Petty Sessions, section 45A of the same Act provides for the prosecution on indictment before higher criminal courts of individuals involved in supplying or selling prohibited substances. Under the terms of section 45A (3), an offender is liable to imprisonment for a period not exceeding ten years.

Of the people brought before the higher criminal court on drug charges during 1975, sixty-two—seventeen more than in 1974—were convicted. There were five females and more than half of the offenders were 24 years of age or older.

**Table 6.15—Age of Offender**

| | Number |
|---|---|
| 18-20 years | 13 |
| 21-24 years | 24 |
| 25-29 years | 15 |
| 30-39 years | 3 |
| 40+ years | 2 |
| Not stated | 5 |
| | 62 |

These cases involved four categories of prohibited substances which are shown below. Cannabis accounted for most cases.

**Table 6.16—Type of Substance**

| | Number |
|---|---|
| Cannabis | 52 |
| Hallucinogens | 3 |
| Opiates | 8 |
| Stimulants | 1 |
| | 62 |

In 1973, all but three of the eighteen cases received prison terms. In 1974, the courts made greater use of fines, recognizance and probation; 19 of the 45 offenders received one or a combination of such penalties. In 1975, fifteen of the sixty-two offenders received non-custodial sentences.

**Table 6.17—Action Taken**

| | Number |
|---|---|
| Recognizance and probation | 7 |
| Fine, recognizance and probation | 8 |
| Periodic detention | 2 |
| Less than 12 months | 5 |
| 1 year—2 years | 12 |
| 2 years—4 years | 21 |
| 4 years—7 years | 7 |
| | 62 |

**PATTERN OF CONVICTIONS FOR DRUG OFFENCES IN N.S.W. HIGHER CRIMINAL COURTS**

| | 1970 | 1971 | 1972 | 1973 | 1974 | 1975 |
|---|---|---|---|---|---|---|
| Penalty— | | | | | | |
| Bond (with, without probation) | 0 | 0 | 6 | 10 | 27 | 25 |
| Fine only | 2 | 2 | 1 | 0 | 0 | 2 |
| Prison: 1 yeer | 0 | 0 | 1 | 1 | 1 | 8 |
| 1-2 years | 4 | 4 | 6 | 6 | 2 | 12 |
| 2-3 years | 3 | 3 | 3 | 6 | 3 | 15 |
| 3-4 years | 4 | 4 | 4 | 4 | 7 | 24 |
| 4-5 years | 0 | 0 | 6 | 2 | 2 | 2 |
| 5-10 years | 1 | 1 | 3 | 5 | 11 | 20 |
| Periodic detention | 0 | 0 | 0 | 2 | 7 | 2 |
| Total | 14 | 14 | 30 | 36 | 60 | 110 |

These figures relate to cases under the—
Commonwealth Customs Act.
Poisons Act.
Government Railways By-Laws.

The proportion of people convicted who are sentenced to 5-10 years' prison has risen from 1 in 14 in 1970 to 20 in 110 in 1975.

**AMOUNT OF FINE—DRUGS 1975**

| Value | Frequency | Percentage | Amount |
|---|---|---|---|
| $ | | | $ |
| 0 | 1 512 | 38.40 | 0 |
| 1 | 1 | 0.02 | 1 |
| 5 | 2 | 0.05 | 10 |
| 6 | 1 | 0.02 | 6 |
| 10 | 2 | 0.05 | 20 |
| 20 | 7 | 0.17 | 140 |
| 25 | 6 | 0.15 | 150 |
| 30 | 5 | 0.12 | 150 |
| 40 | 15 | 0.38 | 600 |
| 45 | 2 | 0.05 | 90 |
| 50 | 276 | 7.01 | 13,800 |
| 60 | 74 | 1.88 | 4,440 |
| 70 | 13 | 0.33 | 910 |
| 75 | 97 | 2.46 | 7,275 |
| 80 | 80 | 2.03 | 6,400 |
| 90 | 2 | 0.05 | 180 |
| 94 | 2 | 0.05 | 188 |
| 100 | 596 | 15.13 | 59,600 |
| 120 | 47 | 1.19 | 5,640 |
| 125 | 13 | 0.33 | 1,625 |
| 130 | 1 | 0.02 | 130 |
| 140 | 5 | 0.12 | 700 |
| 150 | 289 | 7.34 | 43,350 |
| 160 | 8 | 0.20 | 1,280 |
| 175 | 3 | 0.07 | 525 |
| 180 | 4 | 0.10 | 720 |
| 200 | 368 | 9.34 | 73,600 |
| 210 | 1 | 0.02 | 210 |
| 220 | 1 | 0.02 | 220 |
| 225 | 2 | 0.05 | 450 |
| 230 | 1 | 0.02 | 230 |
| 250 | 98 | 2.48 | 24,500 |
| 280 | 1 | 0.02 | 280 |
| 300 | 225 | 5.71 | 67,500 |
| 350 | 7 | 0.17 | 2,450 |
| 400 | 74 | 1.88 | 29,600 |
| 500 | 62 | 1.57 | 31,000 |
| 600 | 15 | 0.38 | 9,000 |
| 650 | 1 | 0.02 | 650 |
| 750 | 3 | 0.07 | 2,250 |
| 800 | 8 | 0.20 | 6,400 |
| 900 | 1 | 0.02 | 900 |
| 1,000 | 6 | 0.15 | 6,000 |
| | | | $403,170 |

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## LIST OF WITNESSES

ADAMS, N., Lecturer in Psychology, Jamberoo.

ANDREWS, Dr G., Commissioner for Personal Health Services, Health Commission of New South Wales.

BADEN, Dr M., Chief Medical Examiner for New York City.

BENTLEY, A. J., Senior District Officer, Department of Youth and Community Services, Wollongong.

BENNETT, E. J., Alderman of the Council of the City of Newcastle.

BENJAMIN, Y. N., Mrs, Psychologist, Wollongong.

BILLINGTON, J. L., Publisher, Rose Bay.

BREEN, J. M. D., University Counsellor, Wollongong.

BRIDGES-WEBB, Professor C., Professor of Community Medicine, University of Sydney.

BRIGHTON, Dr W. H., Acting Director of the Division of Forensic Medicine, Health Commission of New South Wales.

BROWN, B. S., Caravan Park Proprietor, Casino.

BUIVIDS, E., Architect, Nimbin.

CARR, R. D., Grazier, Lismore.

CHEGWIDDEN, Dr M. J., Psychiatrist and Community Physician, Health Commission of New South Wales, Grafton.

CHUNG, Dr K., Medical Practitioner, Coraki.

CLARK, Dr L., Medical Practitioner, Newcastle.

COOK, J. C., Marketing Director, Reckitt Pharmaceuticals.

DADDO, P. M., Vice President and General Manager of Nicholas Pty Limited.

DARCY, Dr L. O., Medical Superintendent, Morisset Mental Hospital.

DASH, R. M., Co-ordinator of Scientific Services, Health Commission of New South Wales.

DAVIDSON, Miss D. S., Community Nurse, Tweed Heads.

DAWKINS, E. J., Minister of Religion, Adamstown Heights.

DENSEN-GERBER, Dr J., Doctor of Medicine and Attorney at Law, New York.

D'EYLAN SPAIN, D., Barrister and Philosopher, Tuntable Falls.

DIEHM, A. P., Director of Central Drug and Alcohol Advisory Services, Health Commission of New South Wales.

DIMENT, Dr E. M., Regional Director of Health, Illawarra Region, Health Commission of New South Wales, Wollongong.
DUGGAN, Dr J. M., Physician.
DUNSTAN, G., Cultural Entrepreneur, Nimbin.
DWYER, Mrs E. A., Postmistress, Rileys Hill.
EBRILL, M. L., Detective Senior Constable, stationed at Wollongong.
EGGER, Dr G. J., Senior Research Officer, Health Commission of New South Wales.
ENGLISH, P. T., Pharmacist, Lismore.
FINDLAY, L. A., Regional Director of Education, North Coast Region, Lismore.
FREEMAN, Dr H., Psychiatrist, Nimbin.
GATELY, G. L., Social Work, Hyman's Beach.
GEAKE, J. G., Innovative Educator, Nimbin.
GERAGHTY, B. M., Regional Director of Health, Hunter Region, Health Commission of New South Wales, Newcastle.
GIDLEY, C. W., Company Executive, Leura.
GILLETT, B. S., Regional Director of Education, Illawarra Region, Mt Keira.
GITTUS, D. J., Farmer, Tuntable Falls.
GLOVER, A., Managing Director, Richardson-Merrell Pty Limited.
GRILLS, G., Student, Northern Rivers College of Advanced Education.
HAYWORTH, R. J., Shop Assistant, Tuntable Falls.
HEAD, Mrs P., Director, Gold Coast Drug Council, Tweeds Heads.
HENDERSON, Mrs M., Housewife, Evans Head.
HORNIBROOK, Miss J. A., Social Worker, Health Commission of New South Wales, North Coast Region.
JOHNSON, V. J., Regional Director of GROW, Wollongong.
JOHNSTONE, D. J., Unemployed, Uki.
JONES, O. L., Psychiatric Nurse, North Coast Region.
KEOGH, C. B., Catholic Priest and Honorary Programme Director of GROW, Marrickville.
KING, Mrs J., Teacher, Bellambie.
KING, W. L., Technician, Bellambie.
KIRK, Dr R. J., General Practitioner, Warilla.
LAKE, G., Health Education Officer, Health Commission of New South Wales.
LEGGETT, D., Farmer, Terrania Creek.
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McEWIN, Dr R. G., Chairman, Health Commission of New South Wales.
McGEE, T. D., Unemployed, Tuntable Falls.
McKAY, B. V., Regional Director, North Coast Region, Health Commission of New South Wales.
McNAMARA, P. A., Solicitor, Kingscliff.
MURTON, Professor K. J., Vice President, Research and Development, Nicholas International.
MUIR, L. V., Ambulance Officer, Bombaderry.
MUIRHEAD, Dr R. T., Medical Practitioner, Mullumbimby.
MUNRO, B. C., Pharmacist, Lismore.
NANRA, Dr R. S., Medical Practitioner, Head of the Division of Nephrology at Royal Newcastle Hospital, New Lambton Heights.
NICHOLS, Dr J., Consultant Psychiatrist, Belmont.
OTTEN, Mrs M., Home Duties, Alstonville.
O'DONNELL, D. J., Medical Superintendent, Lismore Base Hospital.
O'NEILL, P. J. J., Medical Practitioner, employed by the Health Commission of New South Wales as Co-ordinator of Education Services for Hunter Health Region.
PAITSON, Ms M. L., of Ixtlan Farm, Nimbin.
PETROFF, I., Superintendent, Richmond Clinic, and Mental Health Consultant to Health Commission of New South Wales, North Coast Region.
RILEY, W., Welfare Officer, North Coast Region.
RICHARDSON, R. S., Medical Practitioner, Coolangatta.
ROWE, G. P., Psychologist, Health Commission of New South Wales.
RYAN, M., Lecturer, Northern Rivers College of Advanced Education.
SCATTERGOOD, C. R., Farmer, Mullumbimby.
SLATTERY, B. P., Superintendent of Police, Wollongong.
STOREY, Dr D. M., Commissioner for Environmental and Special Health Services, Health Commission of New South Wales.
STEWART, Dr J. H., Renal Physician, Sydney Hospital.
SUTTON, Dr A. J., Director, Bureau of Crime Statistics and Research.
TAYLOR, G., Youth Co-ordinator, Wollongong Council, Engadine.
TATHAM, P., Youth Worker, Wollongong.
WALLACE, Dr D. C., Consultant Cardiologist and Medical Practitioner, New Lambton Heights.
WARDMAN, W. J., Principal, Murwillumbah High School.
WATKINS, Ms K. L., Welfare Worker, Newcastle City Mission, New Lambton Heights.
WEBB, Dr R. A. J., Senior Psychiatrist, Health Commission of New South Wales.
WHITEBROOK, F., Principal, Northern Rivers College of Advanced Education.
WILLETTE, Dr R., NIDA, United States of America.
WILLIS, Dr B., Regional Psychiatrist, Wollongong Hospital.

**The Committee received evidence from twenty-one witnesses in camera.**

D. West, Government Printer, New South Wales — 1978

# PART B

## EXTRACTS FROM THE VOTES AND PROCEEDINGS OF THE LEGISLATIVE ASSEMBLY AND PROCEEDINGS OF THE COMMITTEE

# EXTRACTS FROM THE VOTES AND PROCEEDINGS OF THE LEGISLATIVE ASSEMBLY

*Entry No.* 7, *Votes and Proceedings No.* 19, 12 *October,* 1976

DRUGS.—Mr Stewart moved, pursuant to Notice—

That a joint committee be appointed:

(1) To review and report on available current scientific information concerning the pharmacological, psychological and social effects of drugs of dependence, other than alcohol or tobacco, in common use in New South Wales.

(2) To examine and report on available information on the incidence and trends of the use and misuse of such drugs in New South Wales.

(3) To inquire into and report on—

(a) the adequacy of the control of the manufacture, distribution, possession and use of such drugs; and

(b) the adequacy and appropriateness of penalties for offences related to such drugs, the application of those penalties, and the distinction between penalties for offences relating to their use and penalties for offences relating to their manufacture and distribution.

(4) To inquire into and report whether in relation to the distribution, possession and use of such drugs the following are adequate and appropriate:

(a) general education for persons of all ages;

(b) special education for key groups responsible for education, treatment and counselling, detection and law enforcement; and

(c) preventive, counselling, treatment and rehabilitative services;

(5) To make such recommendations on terms (3) and (4) as the Committee sees fit.

(6) That such Committee consist of five Members of the Legislative Assembly and four Members of the Legislative Council.

(7) That Mr Durick, Mr Ramsay, Mr McGowan, Mr Jackett and Mr Wotton be appointed to serve on such Committee as the Members of the Legislative Assembly.

(8) That the Committee have leave to sit during the sittings or any adjournment of either or both Houses and to make visits of inspection within the State of New South Wales, other States of Australia and the Australian Capital Territory.

Debate ensued.

Question put and passed.

On motion of Mr Stewart, the following Message sent to the Legislative Council—

MR PRESIDENT—

The Legislative Assembly has this day agreed to the following Resolution—

*That a joint committee be appointed—*

(1) *To review and report on available current scientific information concerning the pharmacological, psychological and social effects of drugs of dependence, other than alcohol or tobacco, in common use in New South Wales.*

(2) *To examine and report on available information on the incidence and trends of the use and misuse of such drugs in New South Wales.*

(3) *To inquire into and report on—*

(a) *the adequacy of the control of the manufacture, distribution, possession and use of such drugs; and*

(b) *the adequacy and appropriateness of penalties for offences related to such drugs, the application of those penalties, and the distinction between penalties for offences relating to their use and penalties for offences relating to their manufacture and distribution.*

(4) *To inquire into and report whether in relation to the distribution, possession and use of such drugs the following are adequate and appropriate:*

(a) *general education for persons of all ages;*

(b) *special education for key groups responsible for education, treatment and counselling, detection and law enforcement; and*

(c) *preventive, counselling, treatment and rehabilitative services;*

(5) *To make such recommendations on terms* (3) *and* (4) *as the Committee sees fit.*

(6) *That such Committee consist of five Members of the Legislative Assembly and four Members of the Legislative Council.*

(7) *That Mr Durick, Mr Ramsay, Mr McGowan, Mr Jackett and Mr Wotton be appointed to serve on such Committee as the Members of the Legislative Assembly.*

(8) *That the Committee have leave to sit during the sittings or any adjournment of either or both Houses and to make visits of inspection within the State of New South Wales, other States of Australia and the Australian Capital Territory.*

And the Legislative Assembly requests that the Legislative Council will appoint four of its Members to serve with the Members of the Legislative Assembly upon such joint committee.

*Legislative Assembly Chamber,*
*Sydney,* 12 *October,* 1976.

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*Entry No.* 12, *Minutes of Proceedings No.* 16, 20 *October,* 1976

MESSAGES FROM THE LEGISLATIVE ASSEMBLY.—The President reported and read the following Messages from the Legislative Assembly:

(1) Drugs—Proposed Joint Committee—

Mr PRESIDENT—

The Legislative Assembly has this day agreed to the following Resolution—

*That a joint committee be appointed—*

(1) *To review and report on available current scientific information concerning the pharmacological, psychological and social effects of drugs of dependence, other than alcohol or tobacco, in common use in New South Wales.*

(2) *To examine and report on available information on the incidence and trends of the use and misuse of such drugs in New South Wales.*

(3) *To inquire into and report on—*

(a) *the adequacy of the control of the manufacture, distribution, possession and use of such drugs; and*

(b) *the adequacy and appropriateness of penalties for offences related to such drugs, the application of those penalties, and the distinction between penalties for offences relating to their use and penalties for offences relating to their manufacture and distribution.*

(4) *To inquire into and report whether in relation to the distribution, possession and use of such drugs the following are adequate and appropriate:*

(a) *general education for persons of all ages;*

(b) *special education for key groups responsible for education, treatment and counselling, detection and law enforcement; and*

(c) *preventive, counselling, treatment and rehabilitative services;*

(5) *To make such recommendations on terms* (3) *and* (4) *as the Committee sees fit.*

(6) *That such Committee consist of five Members of the Legislative Assembly and four Members of the Legislative Council.*

(7) *That Mr Durick, Mr Ramsay, Mr McGowan, Mr Jackett and Mr Wotton be appointed to serve on such Committee as the Members of the Legislative Assembly.*

(8) *That the Committee have leave to sit during the sittings or any adjournment of either or both Houses and to make visits of inspection within the State of New South Wales, other States of Australia and the Australian Capital Territory.*

And the Legislative Assembly requests that the Legislative Council will appoint four of its Members to serve with the Members of the Legislative Assembly upon such joint committee.

*Legislative Assembly Chamber,* L. B. KELLY,
*Sydney, 12 October,* 1976. Speaker.

*Ordered,* on motion of Mr Landa, That consideration of the Legislative Assembly's Message stand an Order of the Day for next Sitting Day.

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*Entry No. 7, Minutes of Proceedings No. 17, 2 November,* 1976

DRUGS (*Assembly's Message proposing Joint Committee*).—Upon the Order of the Day being read Mr Landa moved—

(1) That this House agrees to the Resolution embodied in the Legislative Assembly's Message of 12 October, 1976, relating to the appointment of a Joint Committee to review and report on the effects of drugs of dependence, other than alcohol or tobacco, in common use in New South Wales and other related matters.

(2) That the Representatives of the Legislative Council on the Joint Committee be the Honourable K. H. Anderson, the Honourable M. A. E. Davis, the Honourable C. Healey, and the Honourable H. J. A. Sullivan, and that Tuesday, 9 November, 1976, at 3.30 p.m. in Assembly Committee Room No. 2 be the time and place for the first meeting.

(3) That, on this occasion, the Council agrees to waive its claim to equal representation on the Joint Committee and requests that its action in so doing should not be drawn into a precedent.

Debate ensued.

Question put and passed.

Mr Landa then moved, That the following Message be forwarded to the Legislative Assembly:

Mr SPEAKER—

The Legislative Council having had under consideration the Legislative Assembly's Message dated 12 October, 1976, agrees to the Resolution embodied therein relating to the appointment of a Joint Committee to review and report on the effects of drugs of dependence, other than alcohol or tobacco, in common use in New South Wales and other related matters.

(2) That the Representatives of the Legislative Council on the Joint Committee be the Honourable K. H. Anderson, the Honourable M. A. E. Davis, the Honourable C. Healey and the Honourable H. J. A. Sullivan, and fixes Tuesday, 9 November, 1976, at 3.30 p.m. in Assembly Committee Room No. 2 as the time and place for the first meeting.

(3) That, on this occasion, the Council agrees to waive its claim to equal representation on the Joint Committee and requests that its action in so doing should not be drawn into a precedent.

*Legislative Council Chamber,*
*Sydney, 2 November,* 1976.

Question put and passed.

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*Entry No. 10, Votes and Proceedings No. 25, 2 November,* 1976

*And Mr Speaker having consented to the third reading being taken forthwith—*

Bill, on motion of Mr Einfeld, read a third time.

Bill sent to the Legislative Council, together with a Message requesting the Council's concurrence therein.

DRUGS.—Mr Speaker reported the following Message from the Legislative Council:

Mr SPEAKER—

The Legislative Council having had under consideration the Legislative

Assembly's Message dated 12 October, 1976, agrees to the Resolution embodied therein relating the appointment of a Joint Committee to review and report on the effects of drugs of dependence, other than alcohol or tobacco, in common use in New South Wales and other related matters.

(2) That the Representatives of the Legislative Council on the Joint Committee be the Honourable K. H. Anderson, the Honourable M.A.E. Davis, the Honourable C. Healey and the Honourable H. J. A. Sullivan, and fixes Tuesday, 9 November, 1976, at 3.30 p.m. in Assembly Committee Room No. 2 as the time and place for the first meeting.

(3) That, on this occasion, the Council agrees to waive its claim to equal representation on the Joint Committee and requests that its action in so doing should not be drawn into a precedent.

*Legislative Council Chamber,*
*Sydney, 2 November,* 1976.

T. S. McKAY,
Deputy-President.

On motion of Mr K. J. Stewart, the following Message sent to the Legislative Council—

Mr PRESIDENT—

The Legislative Assembly agrees to the time and place appointed by the Legislative Council in its Message, dated 2 November, 1976, for the first meeting of the Joint Committee upon Drugs.

*Legislative Assembly Chamber,*
*Sydney, 2 November,* 1976.

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*Entry No.* 4, *Minutes of Proceedings No.* 18, 3 *November,* 1976

MESSAGES FROM THE LEGISLATIVE ASSEMBLY.—The Deputy-President reported and read the following Messages from the Legislative Assembly:

(1) Joint Committee upon Drugs—

Mr PRESIDENT—

The Legislative Assembly agrees to the time and place appointed by the Legislative Council in its Message, dated 2 November, 1976, for the first meeting of the Joint Committee upon Drugs.

*Legislative Assembly Chamber,*
*Sydney, 2 November,* 1976.

L. B. KELLY,
Speaker.

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*Entry No.* 3 (2), *Votes and Proceedings No.* 19, 4 *November,* 1976

DRUGS.—Mr Deputy-Speaker reported the following Message from the Legislative Council:

Mr SPEAKER—

The Legislative Council having had under consideration the Legislative Assembly's Message of 4 November, 1976, concurs in the Resolution embodied therein relating to the Joint Committee upon Drugs.

*Legislative Council Chamber,*
*Sydney, 4 November,* 1976.

T. S. McKAY,
Deputy President.

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*Entry No.* 12, *Votes and Proceedings No.* 27, 4 *November,* 1976

Joint Committee upon Drugs—

Mr PRESIDENT—

The Legislative Assembly has this day agreed to the following resolution —"*That the Progress Report of the Joint Committee upon Drugs, together with minutes of proceedings and evidence tabled in the Legislative Council and*

*Legislative Assembly on 25 May, 1976, be referred to the Joint Committee upon Drugs appointed this Session"*—and the Legislative Assembly requests the concurrence of the Legislative Council.

*Legislative Assembly Chamber,* L. B. KELLY,
*Sydney, 4 November,* 1976. Speaker.

Whereupon Mr Landa moved, *by consent,* That this House concurs in the Resolution embodied in the Legislative Assembly's Message of 4 November, 1976, relating to the Joint Committee upon Drugs.

Question put and passed.

Mr Landa then moved, That the following Message be forwarded to the Legislative Assembly:

Mr SPEAKER—

The Legislative Council having had under consideration the Legislative Assembly's Message of 4 November, 1976, concurs in the Resolution embodied therein relating to the Joint Committee upon Drugs.

*Legislative Council Chamber,*
*Sydney, 4 November,* 1976.

Question put and passed.

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*Entry No. 5, Votes and Proceedings No. 27, 4 November,* 1976

DRUGS.—Ordered, on motion of Mr F. J. Walker (*by leave*)—

(1) That the Progress Report of the Joint Committee upon Drugs, together with minutes of proceedings and evidence tabled in the Legislative Council and Legislative Assembly on 25 May, 1976, be referred to the Joint Committee upon Drugs appointed this Session.

(2) That the foregoing resolution be forwarded to the Legislative Council with a request that the Council concur in the resolution.

The following Message sent to the Legislative Council:

Mr PRESIDENT—

The Legislative Assembly has this day agreed to the following resolution —*"That the Progress Report of the Joint Committee upon Drugs, together with minutes of proceedings and evidence tabled in the Legislative Council and Legislative Assembly on 25 May, 1976, be referred to the Joint Committee upon Drugs appointed this Session"*—and the Legislative Assembly requests the concurrence of the Legislative Council.

*Legislative Assembly Chamber,*
*Sydney, 4 November,* 1976.

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*Entry No. 4, Votes and Proceedings No. 33, 18 November,* 1976

JOINT COMMITTEE UPON DRUGS.—

(1) Mr F. J. Walker (*by leave*) moved, That at any meeting of the Joint Committee upon Drugs any five members shall constitute a quorum, provided that the Committee shall meet as a Joint Committee at all times.
Question put and passed.

(2) Ordered that the following Message be sent to the Legislative Council:

Mr PRESIDENT—

The Legislative Assembly has this day passed a resolution—*"That at any meeting of the Joint Committee upon Drugs any five members shall constitute a quorum, provided that the Committee shall meet as a Joint Committee at all times"*—with which resolution the Assembly requests the concurrence of the Legislative Council.

*Legislative Assembly Chamber,*
*Sydney, 18 November,* 1976.

*Entry No.* 4, *Votes and Proceedings No.* 25, 18 *November,* 1976

JOINT COMMITTEE UPON DRUGS.—The President reported and read the following Message from the Legislative Assembly:

Mr PRESIDENT—

The Legislative Assembly has this day passed a resolution—*"That at any meeting of the Joint Committee upon Drugs any five members shall constitute a quoroum, provided that the Committee shall meet as a Joint Committee at all times"*—with which resolution the Assembly requests the concurrence of the Legislative Council.

*Legislative Assembly Chamber,* L. B. KELLY,
*Sydney,* 18 *November,* 1976. Speaker.

*Ordered,* on motion of Mr Landa, That consideration of the Legislative Assembly's Message stand an Order of the Day for next Sitting Day.

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*Entry No.* 7, *Votes and Proceedings No.* 26, 23 *November,* 1976

7. JOINT COMMITTEE UPON DRUGS.—Upon the Order of the Day being read Mr Landa moved, That—

(1) So much of the Standing Orders be suspended as would preclude, in this instance, agreement with the resolution contained in the Legislative Assembly's Message of 18 November, 1976, concerning the Joint Committee upon Drugs.

(2) The Council concurs in the Assembly's resolution and requests that its concurrence on this occasion shall not be drawn into a precedent.

Debate ensued.

Question put and passed.

Mr Landa then moved, That the following Message be forwarded to the Legislative Assembly:

Mr SPEAKER—

The Legislative Council, having taken into consideration the Legislative Assembly's Message of 18 November, 1976, concerning the Joint Committee upon Drugs, has, in this instance, suspended so much of its Standing Orders as would preclude agreement with the Assembly's resolution contained therein.

The Council concurs in the resolution and requests that its concurrence on this occasion shall not be drawn into a precedent.

*Legislative Council Chamber,*
*Sydney,* 23 *November,* 1976

Question put and passed.

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*Entry No.* 14, *Votes and Proceedings No.* 34, 23 *November,* 1976

JOINT COMMITTEE UPON DRUGS.—Mr Speaker reported the following Message from the Legislative Council:

Mr SPEAKER—

The Legislative Council, having taken into consideration the Legislative Assembly's Message of 18 November, 1976, concerning the Joint Committee upon Drugs, has, in this instance, suspended so much of its Standing Orders as would preclude agreement with the Assembly's resolution contained therein.

The Council concurs in the resolution and requests that its concurrence on this occasion shall not be drawn into a precedent.

*Legislative Council Chamber,* HARRY BUDD,
*Sydney,* 23 *November,* 1976. President.

# PROCEEDINGS OF THE JOINT COMMITTEE OF THE LEGISLATIVE COUNCIL AND LEGISLATIVE ASSEMBLY UPON DRUGS

*TUESDAY, 9 NOVEMBER,* 1976

At Parliament House, Sydney, at 3.30 p.m.

MEMBERS PRESENT:

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs ANDERSON | Mr DURICK |
| Mrs DAVIS | Mr JACKETT |
| Mr HEALEY | Mr McGOWAN |
| Mr SULLIVAN | Mr RAMSAY |
| | Mr WOTTON |

The following entries in the Votes and Proceedings of the Legislative Assembly and the Minutes of the Proceedings of the Legislative Council were read by the Clerk:

*Legislative Assembly—*

Entry No. 7, Votes and Proceedings No. 19, of Tuesday, 12 October, 1976.

Entry No. 10, Votes and Proceedings No. 25, of Tuesday, 2 November, 1976.

Entries Nos 5 and 12, Votes and Proceedings No. 27, of Thursday, 4 November, 1976.

*Legislative Council—*

Entry No. 12, Minutes of Proceedings No. 16, of Wednesday, 20 October, 1976.

Entry No. 7, Minutes of Proceedings No. 17, of Tuesday, 2 November, 1976.

Entry No. 4, Minutes of Proceedings No. 18, of Wednesday, 3 November, 1976.

Entry No. 3 (2), Minutes of Proceedings No. 19, of Thursday, 4 November, 1976.

On the motion of Mr Jackett, seconded by Mr Wotton, Mr Durick was called to the Chair and thereupon made his acknowledgments to the Committee.

*Resolved,* on the motion of Mr Jackett, seconded by Mr Sullivan: That arrangements for the calling of witnesses and visits of inspection be left in the hands of the Chairman and the Clerk to the Committee.

*Resolved,* on the motion of Mr Ramsay, seconded by Mr Jackett: That, unless otherwise ordered, parties appearing before the Committee shall not be represented by any member of the legal profession.

*Resolved,* on the motion of Mrs Davis, seconded by Mr McGowan: That, unless otherwise ordered, the press and the public (including witnesses after examination) be admitted to the sittings of the Committee.

*Resolved,* on the motion of Mr Healey, seconded by Mr Ramsay: That departmental officers and/or specialists skilled in matters appertaining to drugs as set out in the Terms of Reference may be invited to assist the Committee.

*Resolved,* on the motion of Mr Wotton, seconded by Mr McGowan: That press statements concerning this Committee be made only by the Chairman.

*Resolved,* on the motion of Mr Sullivan, seconded by Mrs Anderson: That, unless otherwise ordered, transcripts of evidence taken by the Committee be not made available to any person, body or organization: provided that witnesses previously examined shall be given a copy of their evidence.

*Resolved,* on the motion of Mrs Anderson, seconded by Mrs Davis: That the Chairman and the Clerk to the Committee be empowered to negotiate with the Treasurer for the provision of funds to meet expenses in connection with travel, accommodation, advertising and other approved incidental expenses of the Committee.

*Resolved,* on the motion of Mrs Anderson, seconded by Mr Jackett: That this Committee request the Treasurer to approve payment of the following:

(1) A daily allowance to each member when he attends a meeting of the Committee on any day on which the House of which he is a member is not sitting, and for each day he is present at an official visit of inspection.

(2) Air travel for visits of inspection when other modes of transport are impracticable.

(3) Travel expenses between electoral districts or place of residence and Sydney for Mr McGowan, Mr Ramsay, Mr Wotton and Mr Sullivan when necessary for the purpose of attending meetings of the Committee.

*Resolved,* on the motion of Mr Sullivan, seconded by Mr Jackett: That the Clerk be empowered to advertise and/or write to interested parties requesting written submissions within the Terms of Reference.

*Resolved,* on the motion of Mr McGowan, seconded by Mr Ramsay: That upon the calling of a division in either House, the proceedings of the Committee shall be suspended until the termination of the division and the return of members affected.

*Resolved,* on the motion of Mr Ramsay, seconded by Mr Wotton: That this Committee requests the Government to have submitted to the Legislative Assembly a motion to ensure that at any meeting of the Joint Committee upon Drugs any five members shall constitute a quorum, provided that the Committee shall meet as a Joint Committee at all times.

*Resolved,* on the motion of Mr Jackett, seconded by Mr Sullivan: That the Clerk arrange for the purchase of an appropriate document case for each of three members of the Committee not previously so equipped, viz., Mrs Anderson, Mr McGowan and the Chairman.

The Committee deliberated.

*Allowances to Members*—Agreed that allowances payable for attendance on non-sitting days and during visits of inspection be paid at the end of each calendar month.

*Arrangements for Visits of Inspection*—Agreed that the Clerk will make arrangements for the Committee as a whole and that any member wishing to depart from such arrangements will be required to make his own.

*Witnesses and Visits of Inspection*—Agreed that consideration of the calling of witnesses, taking of evidence and making visits of inspection be deferred until after consideration of the Progress Report of the Joint Committee upon Drugs, together with minutes of proceedings and evidence tabled in the Legislative Council and Legislative Assembly on 25 May, 1976, and of correspondence and submissions since received.

The Committee adjourned at 4.30 p.m., *sine die.*

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*FRIDAY, 3 DECEMBER,* 1976

At Parliament House, Sydney, at 10.30 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (In the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs ANDERSON | Mr JACKETT |
| Mrs DAVIS | Mr McGOWAN |
| Mr HEALEY | Mr RAMSAY |
| Mr SULLIVAN | Mr WOTTON |

The Chairman introduced Mr G. H. A. James who had been newly appointed as Clerk to the Committee, and also Mr B. Stewart of the Health Commission whose services had been made available to the Committee as required.

The Chairman paid tribute to the valuable contribution which Mr Luton had made in his time as Clerk to the Committee. His remarks were warmly endorsed by the members of the Committee.

The Minutes of the previous meeting, as read, were confirmed.

The following entries in the Votes and Proceedings of the Legislative Assembly and the Minutes of the Proceedings of the Legislative Council were read by the Clerk:

*Legislative Assembly*—

Entry No. 7, Votes and Proceedings No. 19, of Tuesday, 12 October, 1976.

Entry No. 10, Votes and Proceedings No. 25, of Tuesday, 2 November, 1976.

Entry No. 5, Votes and Proceedings No. 27, of Thursday, 4 November, 1976.

Entry No. 12, Votes and Proceedings No. 27, of Thursday, 4 November, 1976.

Entry No. 4, Votes and Proceedings No. 33, of Thursday, 18 November, 1976.

Entry No. 14, Votes and Proceedings No. 34, of Tuesday, 23 November, 1976.

*Legislative Council*—

Entry No. 12, Minutes of Proceedings No. 16, of Wednesday, 20 October, 1976.

Entry No. 7, Minutes of Proceedings No. 17, of Tuesday, 2 November, 1976.

Entry No. 4, Minutes of Proceedings No. 18, of Wednesday, 3 November, 1976.

Entry No. 3 (2), Minutes of Proceedings No. 19, of Thursday, 4 November, 1976.

Entry No. 4, Minutes of Proceedings No. 25, of Thursday, 18 November, 1976.

Entry No. 7, Minutes of Proceedings No. 26, of Tuesday, 23 November, 1976.

A police witness was sworn and gave evidence in camera. The witness acknowledged having received a Summons under the Parliamentary Evidence Act, 1901.

The press and public were admitted.

Cecil William Gidley, Corporate Liaison Manager, the Fletcher Organisation Pty Ltd, and presently also a Director of the Foundation for the Research and Treatment of Alcoholism and Drug Dependence, called as a witness and sworn. The witness acknowledged having received a Summons under the Parliamentary Evidence Act, 1901.

The witness made an oral statement upon which he was examined by the Chairman and members of the Committee. Evidence concluded, witness withdrew.

The Committee deliberated. The press and public withdrew.

The Committee adjourned at 1 p.m. until Wednesday, 8th December, at 10 a.m.

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*WEDNESDAY, 8 DECEMBER, 1976*

At Parliament House at 10.00 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs ANDERSON | Mr JACKETT |
| Mr HEALEY | Mr McGOWAN |
| Mr SULLIVAN | Mr RAMSAY |
| | Mr WOTTON |

An apology was received from Mrs Davis.

The Minutes of the previous meeting, as circulated, were confirmed.

The Chairman introduced Mrs C. O'Regan who had been assigned as a Secretary to assist the Clerk.

Mr B. Stewart of the Health Commission made an informal presentation to the Committee on his work in the drugs field.

Following a statement by the Chairman about the work which the Committee would need to start in motion, the Committee deliberated.

*Resolved* on a motion by Mr Jackett, seconded by Mr McGowan: That the Clerk should be asked to assess the evidence so far collected with a view to advising the Committee on the action needed to provide further evidence on the matters in the Terms of Reference.

*Resolved* by Mr Wotton, seconded by Mr Ramsay: That the Committee should participate in the 7th International Conference on Alcohol, Drugs and Traffic Safety between 23rd and 28th January, 1977, and that the Committee should meet on 19th January to make final the arrangements before the Conference.

The press and public were not admitted.

The Committee adjourned until Tuesday, 21st December, 1976.

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*TUESDAY, 21 DECEMBER, 1976*

At Parliament House, Sydney, at 10.00 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs ANDERSON | Mr JACKETT |
| Mrs DAVIS | Mr McGOWAN |
| Mr HEALEY | Mr RAMSAY |
| | Mr WOTTON |

An apology was received from Mr Sullivan.

Having met, the Committee proceeded immediately to the ABC Studios, Gore Hill, to view the "Four Corners" documentary on the Drug Problem in Sydney.

The Committee deliberated on issues arising in the documentary.

In relation to other business, the Committee *resolved* on a motion of Mr Healey, seconded by Mr Jackett that: the Committee should travel to Melbourne on 23 January, 1977, and returning 28 January, 1977, by air.

On a motion of Mr McGowan, seconded by Mr Ramsay, it was *resolved* that: Mr Wotton be permitted to return to Sydney from Melbourne on Wednesday, 26 January, 1977, to deal with unavoidable personal matters.

In the afternoon, the Committee with apologies from Mrs Anderson and Mr Sullivan, visited the Wayside Chapel and the Drug Referral Centre, Craigend Street, Kings Cross.

Returning to Parliament House at 4.30 p.m., the Committee adjourned.

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*THURSDAY, 6 JANUARY, 1977*

At Bankstown Airport, Sydney

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs ANDERSON | Mr McGOWAN |
| Mr HEALEY | Mr WOTTON |

Apologies were received from Mrs Davis and Mr Sullivan, Mr Jackett and Mr Ramsay.

The Committee conferred at 8.30 a.m. at Bankstown Airport.

Accompanied by Detective Superintendent A. Birnie and Detective Sergeant K. Astill, the Committee then departed to Taree to visit the recently discovered marihuana plantation at Nabiac.

The Committee returned by air to Bankstown Airport at 4.30 p.m.

*WEDNESDAY*, 19 *JANUARY*, 1977

At Parliament House, Sydney, at 10 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs ANDERSON | Mr JACKETT |
| Mr HEALEY | Mr McGOWAN |
| Mr SULLIVAN | Mr RAMSAY |
| | Mr WOTTON |

An apology was received from Mrs Davis.

The Minutes of the previous three meetings, as circulated, were confirmed.

The Committee deliberated on its forthcoming visit to the 7th International Conference on Alcohol, Drugs and Traffic Safety, and the additional programme of visits to Buoyancy Foundation, the Victorian Mental Health Authority and the Victorian Health Education Centre.

On a motion by Mrs Anderson, seconded by Mr Wotton, it was *resolved*: That it would be necessary to advertise that the hearings of the Committee had been resumed and drawing attention to the revised Terms of Reference.

Mr R. M. Dash, Senior Pharmacist, Therapeutic Goods Branch, Health Commission, gave a presentation to the Committee on the operation of the Poisons Act, 1966.

In the afternoon the Committee visited the Headquarters of the Drug Squad and the Brisbane Street Clinic.

The Committee adjourned to 23 January, at 5 p.m.

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*SUNDAY*, 23 *JANUARY*, 1977

At Sydney at 2.30 p.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs ANDERSON | Mr JACKETT |
| Mr HEALEY | Mr McGOWAN |
| | Mr RAMSAY |
| | Mr WOTTON |

The Committee travelled to Melbourne to attend the 7th International Conference on Alcohol, Drugs and Traffic Safety.

The Committee conferred about their respective participation in the Conference programme and proceeded to Newman College for registration.

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*MONDAY*, 24 *JANUARY*, 1977

At Melbourne, at 9 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs ANDERSON | Mr JACKETT |
| Mr HEALEY | Mr McGOWAN |
| | Mr RAMSAY |
| | Mr WOTTON |

Apologies were received from Mrs Davis and Mr Sullivan that they were unable to attend the 7th International Conference on Alcohol, Drugs and Traffic Safety.

The Committee met and attended the official opening of the Seventh International Conference on Alcohol, Drugs and Traffic Safety and the inaugural session entitled "The Dimensions of the Problem".

In the afternoon, the Committee visited the Buoyancy Foundation where they held an informal discussion with the permanent employees on the work of the Foundation.

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*TUESDAY, 25 JANUARY, 1977*

At Melbourne, at 9 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs ANDERSON | Mr JACKETT |
| Mr HEALEY | Mr McGOWAN |
| | Mr RAMSAY |
| | Mr WOTTON |

The Committee met and attended the plenary session of the International Conference entitled "Community Attitudes and Behaviour".

In the afternoon the Committee attended two of the Conference workshops entitled "Effects of Drugs on Driving" and "Assessing the Drug Problem".

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*WEDNESDAY, 26 JANUARY, 1977*

At Melbourne at 9 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs ANDERSON | Mr JACKETT |
| Mr HEALEY | Mr McGOWAN |
| | Mr RAMSAY |
| | Mr WOTTON |

The Committee met and attended the third plenary session of the International Conference entitled "Pharmacology and Analytical Methods".

In the afternoon the Committee attended a presentation for delegates to the Conference by the Victorian Mental Health Authority on drug rehabilitation services. This was followed by a tour of the Authority's treatment centres at Pleasant View and Gresswell.

Mr Wotton left the Conference with permission to return to Sydney.

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*THURSDAY, 27 JANUARY, 1977*

At Melbourne at 9 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs ANDERSON | Mr JACKETT |
| Mr HEALEY | Mr McGOWAN |
| | Mr RAMSAY |

The Committee met and visited the Victorian Health Education Centre. Dr D. W. Rankin, the Chief Health Education Officer, and Mr A. V. Watts, the Administrative Director, gave a presentation on the work of the Centre and its objectives.

During the presentation the Committee viewed several films dealing with the problem of drugs.

In the afternoon, members of the Committee individually attended Conference workshops.

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*FRIDAY, 28 JANUARY, 1977*

At Melbourne at 9 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs ANDERSON | Mr JACKETT |
| Mr HEALEY | Mr McGOWAN |
| | Mr RAMSAY |

The Committee attended the final plenary session of the International Conference entitled "Public Information and Education".

In the afternoon the Committee returned to Sydney and adjourned at 5 p.m., *sine die.*

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*WEDNESDAY, 2 FEBRUARY, 1977*

At Parliament House, Sydney, at 2 p.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs ANDERSON | Mr JACKETT |
| Mrs DAVIS | Mr McGOWAN |
| Mr HEALEY | Mr RAMSAY |
| Mr SULLIVAN | |

An apology was received from Mr Wotton.

The Committe met and took a statement from Mr L. M. Blumenthal, from the Alberta Alcohol and Drug Abuse Commission, Canada.

The Committee deliberated.

The Committee adjourned at 4 p.m. until Friday, 18th February, 1977 at 2.30 p.m.

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*FRIDAY, 18 FEBRUARY, 1977*

At Parliament House, Sydney, at 2.30 p.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs ANDERSON | Mr JACKETT |
| Mrs DAVIS | Mr RAMSAY |
| Mr HEALEY | |

Apologies were received from Messrs Sullivan, McGowan and Wotton.

The press and public were admitted.

Dr Robert Willette, the Head of the Research Division, the United States National Institute on Drug Abuse was sworn and examined.

The press and public withdrew.

The Committee adjourned at 5 p.m. until Monday, 28 February, 1977.

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*MONDAY,* 28 *FEBRUARY,* 1977

At Wisteria Community Health Centre, Westmead

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs ANDERSON | Mr JACKETT |
| Mrs DAVIS | Mr McGOWAN |

Apologies were received from Messrs Healey, Sullivan, Ramsay and Wotton.

Dr Stella Dalton and members of her staff made a presentation to the Committee on the Health Centre's treatment of drug addicts.

The Committee later visited Wisteria House Drug and Alcohol Addiction Unit, Parramatta. Dr J. Roland conducted a tour of Wisteria House and its treatment facilities.

The Committee returned to Parliament House and adjourned at 4 p.m. until Friday, 11 March, at 10 a.m.

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*FRIDAY,* 11 *MARCH,* 1977

At Parliament House, Sydney, at 10 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs ANDERSON | Mr JACKETT |
| Mrs DAVIS | Mr McGOWAN |
| Mr HEALEY | Mr RAMSAY |

An apology was received from Mr Sullivan and Mr Wotton.

The press and public were admitted.

Dr Michael Baden and Dr Judianne Denson-Gerber of the United States were sworn and examined.

The press and public withdrew. The Committee adjourned until 2 p.m.

In the afternoon, on a motion of Mr Healey, seconded by Mr Jackett, the Committee confirmed the Minutes of their meetings.

The Committee deliberated on matters arising from their recent hearings, especially in regard to penalties.

The Committee adjourned at 3.30 p.m. until Friday, 18 March, at 10 a.m.

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*FRIDAY,* 18 *MARCH,* 1977

At Parliament House, Sydney, at 10 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs ANDERSON | Mr JACKETT |
| Mrs DAVIS | Mr McGOWAN |
| Mr HEALEY | Mr RAMSAY |
| | Mr WOTTON |

An apology was received from Mr Sullivan.

Minutes of the meeting held on 11 March, 1977, were read and confirmed.

The Committee deliberated.

A copy of the Draft Memorandum to the Government on Penalties for certain drug trafficking offences and cannabis having been transmitted (by the direction of the Chairman) to each member of the Committee, the Chairman brought up the Draft Memorandum, which was accepted by the Committee as having been read.

The Committee proceeded to consider the Draft Memorandum.

On a motion of Mr Jackett, seconded by Mr McGowan, the Committee *resolved* that: paragraph 74 (7) should be amended to read "an offence for the personal use of cannabis be no longer considered a criminal offence—Mrs Davis, Mr Jackett and Mr Wotton dissenting".

All other paragraphs were read and agreed to.

The Committee adjourned at 1 p.m. until 9 a.m. on 23 March, 1977.

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*WEDNESDAY*, 23 *MARCH*, 1977

At Parliament House, Sydney, at 9 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs ANDERSON | Mr McGOWAN |
| Mrs DAVIS | Mr RAMSAY |
| Mr HEALEY | Mr WOTTON |
| Mr F. M. MACDIARMID | |

An apology was received from Mr Jackett.

The Chairman paid tribute to Mr H. J. A. Sullivan, M.L.C., who had been discharged from the Committee. On a motion of Mrs Anderson, seconded by Mr Wotton, it was *resolved* that: the Chairman write to Mr Sullivan conveying the Committee's thanks for his work on the Committee.

The Chairman welcomed Mr F. M. MacDiarmid, O.B.E., M.L.C., who had replaced Mr Sullivan on the Committee.

A copy of the second draft of the Memorandum on Penalties for certain drug trafficking offences and cannabis containing the amendment to paragraph 74 proposed at the Committee's previous meeting, was accepted by the Committee as having been read. The Committee proceeded to consider the second draft of the Memorandum. All paragraphs were read and agreed to.

On a motion of Mr Healey, seconded by Mr Ramsay, it was *resolved* that: the Memorandum should be tabled in both Houses of Parliament before the end of the current Parliamentary Session.

The Committee adjourned at 10.30 a.m., *sine die*.

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*FRIDAY*, 29 *APRIL*, 1977

At Parliament House, Sydney, at 9.45 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs ANDERSON | Mr JACKETT |
| Mr HEALEY | Mr McGOWAN |
| Mr MACDIARMID | Mr RAMSAY |

An apology was received from Mrs Davis and Mr Wotton.

Confirmation of the Minutes of the previous two meetings were deferred until later at this meeting.

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The press and public were admitted.

By direction of the Chairman, the Clerk read the Committee's Terms of Reference.

By direction of the Chairman, the Clerk read Legislative Assembly Standing Order No. 362 relating to the Examination of Witnesses.

Dr J. H. Stewart, called as a witness and sworn: The witness acknowledged having received a summons under the Parliamentary Evidence Act, 1901.

Evidence concluded, the witness withdrew.

At the request of the Chairman the press and public withdrew.

The Committee deliberated.

Minutes of the previous two meetings, as circulated, were confirmed.

On a motion of Mrs Anderson, seconded by Mr Jackett, it was *resolved* that: with regard to the Committee's forthcoming visit to Newcastle for public hearings during 3 to 6 May, 1977, the Clerk should make all necessary arrangements for accommodation and subsistence and undertake to meet expenses thus arising for all Members of the Committee from Committee funds within Determinations, except in the case of the Chairman who should meet his own expenses and claim separately.

The Committee adjourned at 1 p.m., *sine die*.

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*TUESDAY*, 3 *MAY*, 1977

*WEDNESDAY*, 4 *MAY*, 1977

*THURSDAY*, 5 *MAY*, 1977

At Gosford and Newcastle

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mr HEALEY | Mr JACKETT |
| Mr MACDIARMID | Mr MCGOWAN |
| | Mr RAMSAY |
| | Mr WOTTON |

Apologies were received from Mrs Anderson and Mrs Davis.

The Committee left Sydney by train at 8.20 p.m. on Tuesday, 3 May, 1977, for public hearings in Gosford and Newcastle. The Committee made a tour of inspection of the Drug Referral Centre at Gosford and proceeded to Newcastle.

In the evening the Committee met informally with Superintendent J. Whitfield and Snr Constable Moeller.

On 4 May, 1977, in the morning the Committee made a tour of the Community Addiction Services at Hamilton.

In the afternoon at 1.45 p.m. the Committee were formally welcomed to Newcastle by the Lord Mayor, Alderman G. Anderson.

The press and public were admitted.

At 2 p.m. Mr B. Geraghty, Dr O'Neill and Dr Darcy were sworn and examined.

Following a short adjournment, at 4.30 p.m., Major E. Dawkins of the Salvation Army was sworn and examined.

At 5 p.m. Mr J. K. Barry and Mrs K. L. Watkins of the Newcastle City Mission were sworn and examined.

Evidence concluded, the witnesses withdrew.

At the request of the Chairman the press and public withdrew.

The Committee adjourned until later that evening.

The Committee visited Newcastle Psychiatric Centre in the evening where they met informally with the staff.

On 5 May, 1977, at 8 a.m., the Committee were received at the Royal Newcastle Hospital by Doctors Currow, Toohey and Nanra. Dr Nanra conducted a tour of inspection of the Hospital's Renal Unit.

At 9 a.m. the Committee assembled in the Newcastle City Council Chambers.

The press and public were admitted.

Dr Nanra and Dr Duggan were sworn and examined.

At 11.30 a.m. Dr Nicholls, Dr Wallace and Dr Clark of the Hunter Region Medical Association were sworn and examined.

Evidence concluded, the witnesses withdrew.

The press and public withdrew.

Following the luncheon adjournment, at thirty minutes past Two p.m., the press and public were admitted.

Alderman Bennett, the Chairman of the Newcastle Health and Environment Committee was sworn and examined.

At 3 p.m. Dr Nanra and Dr Duggan resumed their evidence.

The Committee adjourned at 4.30 p.m. and returned to Sydney by train, until Thursday, 26th May, 1977, at 8.30 a.m.

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*THURSDAY, 26 MAY, 1977*

*FRIDAY, 27 MAY, 1977*

At Wollongong

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs ANDERSON | Mr JACKETT |
| Mrs DAVIS | Mr RAMSAY |
| Mr HEALEY | Mr WOTTON |
| Mr MACDIARMID | |

An apology was received from Mr McGowan.

The Committee proceeded from Sydney by train at 8.30 a.m. to Wollongong where they were given an informal presentation on drug and addiction services in the Illawarra Region, including visits to treatment facilities.

Following the luncheon adjournment, the Committee proceeded to the Wollongong Town Hall for formal hearings beginning at 2 p.m.

The press and public were admitted.

The Clerk read Legislative Assembly Standing Order No. 362 relating to the Examination of Witnesses and the Committee's Terms of Reference.

Dr E. M. Diment, Regional Director of Health for the Illawarra Region, Mr B. Willis, Regional Psychiatrist, Mr G. Lake, Health Education Officer, and Mrs Y. N. Benjamin, Psychologist, were called as witnesses and sworn.

Each of the witnesses acknowledged having received a summons under the Parliamentary Evidence Act, 1901.

The witnesses were jointly examined by the Chairman and members of the Committee.

Evidence concluded, the witnesses withdrew.

At the request of the Chairman, the press and public withdrew.

Two witnesses were sworn and examined *in camera.*

The Committee adjourned at 5.30 p.m. until the following day.

On Friday, 27 May, 1977, at 9 a.m., the Committee resumed hearings at the Wollongong Town Hall, Mrs Anderson and Mr Wotton returning to Sydney.

The press and public were admitted.

The Clerk read Legislative Assembly Standing Order No. 362 relating to the Examination of Witnesses and the Committee's Terms of Reference.

Each of the following persons were called as witnesses and sworn:

Mr B. P. Slattery, Superintendent of Police, stationed at Wollongong and Mr M. L. Ebrill, Detective Senior Constable, stationed at Wollongong.

Mr W. L. King, Technician, and Mrs J. King, Teacher.

Mr A. J. Bentley, Senior District Officer, Department of Youth and Community Services.

Mr J. M. D. Breen, University Counsellor.

Mr R. J. Kirk, General Practitioner.

Mr N. Adams, Lecturer in Psychology.

Mr V. J. Johnson, Regional Director of Grow.

Mr B. S. Gillett, Regional Director of Education.

Each of the witnesses was jointly examined by the Chairman and members of the Committee, and all witnesses acknowledged having received a summons under the Parliamentary Evidence Act, 1901.

Evidence concluded, the witnesses withdrew.

At the request of the Chairman, the press and public withdrew.

The Committee adjourned and returned to Sydney at 5.30 p.m. until Thursday, 3 June, 1977.

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*FRIDAY,* 3 *JUNE,* 1977

At Parliament House, Sydney, at 10 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs ANDERSON | Mr JACKETT |
| Mrs DAVIS | Mr McGOWAN |
| Mr HEALEY | Mr RAMSAY |
| Mr MacDIARMID | |

An apology was received from Mr Wotton.

A witness was sworn and examined *in camera.*

Evidence concluded, the witness withdrew.

The press and public were admitted.

The Clerk read Legislative Assembly Standing Order No. 362 relating to the Examination of Witnesses.

Professor Charles Bridges-Webb, Professor of Community Medicine, University of Sydney, sworn and examined. The witness acknowledged having received a summons under the Parliamentary Evidence Act, 1901.

Evidence concluded, the witness withdrew.

At the request of the Chairman, the press and public withdrew.

The press and public were re-admitted following the luncheon adjournment.

The Clerk again read Standing Order No. 362 and the Committee's Terms of Reference.

Mr Max Leslie Ebrill, Detective Senior Constable, stationed at Wollongong, called as a witness and sworn. The witness acknowledged having received a summons under the Parliamentary Evidence Act, 1901.

Evidence concluded, the witness withdrew.

Mr Benjamin John Brown, Caravan Park and Service Station Proprietor, called as a witness and sworn. The witness acknowledged having received a summons under the Parliamentary Evidence Act, 1901.

Evidence concluded, the witness withdrew.

At the request of the Chairman, the press and public withdrew.

The Committee adjourned at 4 p.m. until Tuesday, 21 June, 1977, at 8.30 a.m.

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*TUESDAY, 21 JUNE, 1977*

At Parliament House, Sydney, at 8.30 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs ANDERSON | Mr JACKETT |
| Mrs DAVIS | Mr McGOWAN |
| Mr HEALEY | Mr RAMSAY |
| | Mr WOTTON |

An apology was received from Mr F. M. MacDiarmid.

The Committee departed Parliament House for the Central Drugs and Addiction Services, of the Health Commission at Rozelle, and held informal talks with Mr P. Diehm and his staff.

Returning to Parliament House, and following luncheon, the Committee assembled at 2.30 p.m. for an informal presentation by Mr R. Dash, Senior Pharmacist, Therapeutic Goods Branch, Health Commission of New South Wales, on the Therapeutic Goods Branch.

The press and public were admitted.

Doctor Lesley Osborne Darcy, Medical Superintendent, Morisset Mental Hospital, called as a witness and sworn. The witness acknowledged having received a summons under the Parliamentary Evidence Act, 1901.

Evidence concluded, the witness withdrew.

At the request of the Chairman, the press and public withdrew.

The Committee adjourned at 4.30 p.m. until the following morning, the 22nd June at 8.30 a.m.

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*WEDNESDAY, 22 JUNE, 1977*

At Parliament House, Sydney, at 8.30 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs DAVIS | Mr JACKETT |
| Mr HEALEY | Mr McGOWAN |
| Mrs ANDERSON | Mr RAMSAY |
| Mr MACDIARMID | Mr WOTTON |

An apology was received from Mrs Anderson for her absence during the morning.

The Committee departed Parliament House for the Northern Region Drug and Addiction Service for an informal presentation by Dr R. Spielman and his staff.

Returning to Parliament House, and following luncheon, the Committee assembled at Two p.m. Two witnesses were sworn and examined *in camera.*

The Committee adjourned at 3.30 p.m. until Thursday, 30 June, 1977, at 10 a.m.

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*THURSDAY, 30 JUNE, 1977*

At Parliament House, Sydney, at 10 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs DAVIS | Mr JACKETT |
| Mr HEALEY | Mr McGOWAN |
| | Mr RAMSAY |
| | Mr WOTTON |

Apologies were received from Mrs Anderson and Mr MacDiarmid.

The press and public were admitted.

The Clerk read Legislative Assembly Standing Order No. 362 relating to the Examination of Witnesses.

Mr Gordon Lance Gately, unemployed, and Mr Leonard Victor Muir, Ambulance Officer, called as witnesses and sworn. The witnesses both acknowledged having received a summons under the Parliamentary Evidence Act, 1901.

Evidence concluded, the witnesses withdrew.

Dr W. H. Brighton, Medical Practitioner and Acting Director of Forensic Medicine, called as a witness and sworn. The witness acknowledged having received a summons under the Parliamentary Evidence Act, 1901.

Evidence concluded, the witness withdrew.

At the request of the Chairman, the press and public withdrew.

After the luncheon adjournment, the Committee assembled at 2 p.m. and travelled by car to the Bourke Street Addiction Clinic for informal talks and a tour of the clinic.

At 3.30 p.m., the Committee visited the William Booth Institute for informal talks and tour of inspection.

The Committee returned to Parliament House at 5 p.m. and adjourned until Friday, 1 July, 1977, at 8.30 a.m.

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*FRIDAY, 1 JULY, 1977*

At Parliament House, Sydney, at 8.30 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs DAVIS | Mr JACKETT |
| Mr HEALEY | Mr McGOWAN |
| | Mr RAMSAY |
| | Mr WOTTON |

Apologies were received from Mrs Anderson and Mr MacDiarmid.

Having met, immediately the Committee departed from Parliament House for an informal inspection of the W.H.O.S. Fellowship at Cronulla.

Members of the Committee then proceeded to the Caringbah Community Centre where an informal presentation was given on the drug addiction services in the Southern Metropolitan Region of the Health Commission of New South Wales.

Mr Ramsay and Mr Wotton returned to Parliament House while the remaining members of the Committee visited the Cronulla Drop-in Centre.

The Committee returned to Parliament House at 5 p.m. and adjourned until Monday, 4 July, at 3 p.m.

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*MONDAY* 4 *JULY*, 1977

*TUESDAY* 5 *JULY*, 1977

*WEDNESDAY*, 6 *JULY*, 1977

*THURSDAY*, 7 *JULY*, 1977

*FRIDAY*, 8 *JULY*, 1977

On North Coast of New South Wales

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs ANDERSON | Mr JACKETT |
| Mrs DAVIS | Mr McGOWAN |
| Mr HEALEY | Mr RAMSAY |
| | Mr WOTTON |

An apology was received from Mr MacDiarmid.

Having met at 3 p.m. on Monday, 3 July, the Committee departed to Mascot Airport for the flight to Casino.

The Committee began formal hearings on Tuesday, 5 July, 1977, at the Lismore City Hall where they were welcomed by the Mayor.

The press and public were admitted.

The Clerk read Legislative Assembly Standing Order No. 362 relating to the Examination of Witnesses. The Clerk also read the Committee's Terms of Reference.

The following were called as witnesses and sworn:

Mr B. V. McKay, Regional Director of Health for the North Coast region, Mr G. P. Rowe, Psychologist, Dr M. J. Chegwidden, Psychiatrist and Community Physician, Mr W. Riley, Welfare Officer, and Mr O. L. Jones, Community Psychiatric Nurse.

Mr L. A. Findlay, Director of Education for the North Coast and Mr W. J. Wardman, Principal of Murwillumbah High School.

Mr F. Whitebrook, Principal, Northern Rivers College of Advanced Education, Mr M. Ryan, Lecturer, Mr N. MacKay, Senior Lecturer, and Mr G. Grills, all from the Northern Rivers College of Advanced Education.

Mr R. D. Carr, Grazier.

Mr G. Dunstan, Cultural Entrepreneur, Mr D. Leggett, Farmer, and Mr E. Buivids, Architect.

Mr R. J. Hayworth, Shop Assistant, Mr T. D. McGee, Unemployed, and Mr D. J. Gittus, Farmer.

Mr B. C. Munro, Pharmacist.

Ms M. L. Paitson.

Mr D. D'Eylan Spain, Barrister.

Each of the witnesses acknowledged having received a summons under the Parliamentary Evidence Act, 1901.

Each of the witnesses was examined by the Chairman and members of the Committee. One witness was sworn and examined *in camera*.

Evidence concluded, the witnesses withdrew.

At the request of the Chairman, the press and public withdrew.

The Committee adjourned until the following day at 9 a.m.

On Wednesday, 6 July, 1977, an informal visit was made to some of the new communities in the Nimbin and Main Arm areas.

The Committee adjourned at 4.30 p.m. until the following day.

On Thursday, 7 July, 1977, public hearings were held in the Mullumbimby Council Chambers where they were welcomed by the Mayor. Mrs Anderson and Mr Ramsay returned to Sydney.

The press and public were admitted.

The Clerk read Legislative Assembly Standing Order No. 362 relating to the Examination of Witnesses. The Clerk also read the Committee's Terms of Reference.

The following were called as witnesses and sworn:

Dr R. Muirhead.

Mr J. Geike.

Miss J. Hornibrook.

One witness was sworn and examined *in camera.*

Each of the witnesses acknowledged having received a summons under the Parliamentary Evidence Act, 1901.

Evidence concluded, the witnesses withdrew.

The Committee then proceeded to Lismore, and following a luncheon adjournment, the Committee resumed hearings at Lismore City Hall.

The press and public were admitted.

The Clerk read Legislative Assembly Standing Order No. 362 relating to the Examination of Witnesses. The Clerk also read the Committee's Terms of Reference.

The following were called as witnesses and sworn:

Mr D. O'Donnell, Medical Superintendent.

Mr English, Pharmacist.

Mr J. McKnight, Mr G. Hampton, and Mr A. Deakin.

Dr I. Petroff, Director of Psychiatric Unit, Lismore Base Hospital.

Mrs Bavea.

Each of the witnesses appearing on Thursday, 7 July, 1977, acknowledge having received a summons under the Parliamentary Evidence Act.

The witnesses were jointly examined by the Chairman and members of the Committee. Three police witnesses were sworn and examined *in camera.*

Evidence concluded, the witnesses withdrew.

At the request of the Chairman, the press and public withdrew.

The Committee adjourned until the following day at 9 a.m.

On Friday, 8 July, 1977, at 9 a.m., public hearings were held in the Casino Council Chambers.

The press and public were admitted.

The Clerk read Legislative Assembly Standing Order No. 362 relating to the Examination of Witnesses. The Clerk also read the Committee's Terms of Reference.

The following persons were called as witnesses and sworn:

Mrs M. Otten, Housewife.

Dr K. Chung, Medical Practitioner, Mrs B. Dwyer, Postmistress, and Mrs M. Henderson, Housewife.

Mr H. Freeman, Psychiatrist.

Dr R. Richardson, Medical Practitioner, and Ms P. Head, Director of the Gold Coast Drug Council.

Mr P. A. McNamara, Solicitor.

Mr D. Johnson.

Ms D. S. Davidson, Community Nurse.

Each of the witnesses acknowledged having received a summons under the Parliamentary Evidence Act, 1901.

Each of the witnesses was examined by the Chairman and members of the Committee. Two witnesses were sworn and examined *in camera.*

Evidence concluded, the witnesses withdrew.

At the request of the Chairman, the press and public withdrew.

The Committee adjourned and returned to Sydney at 10.30 p.m., until Tuesday, 12 July, 1977, at 3 p.m.

*TUESDAY*, 12 *JULY*, 1977

*WEDNESDAY*, 13 *JULY*, 1977

*THURSDAY*, 14 *JULY*, 1977

At Canberra

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs DAVIS | Mr JACKETT |
| Mrs ANDERSON | Mr McGOWAN |
| Mr HEALEY | Mr RAMSAY |
| | Mr WOTTON |

Apologies were received from Mr MacDiarmid.

The Committee having met, departed to Mascot Airport for the afternoon flight to Canberra.

On the morning of the 13 July, members of the Committee held informal discussions with Mr H. Bates, Assistant Secretary, Investigations Branch, Department of Business and Consumer Affairs, from 9 a.m. to 1 p.m.

In the afternoon, the Committee visited the Federal Department of Health where they were received by the Acting Director General of Health, Dr Evans.

The Committee held informal discussions with Dr de Souza, First Assistant Director-General, Therapeutics Division, Mrs J. Nolan, Executive Director, Mr Dal Murdoch, Director, Drugs of Dependence and Dr L. Drew, Senior Medical Officer on policies in the drugs area.

The Committee adjourned at 5 p.m. until the following morning.

On 14 July, 1977, the Committee proceeded to the A.C.T. Health Department Drug and Addiction Service where they were received by Dr Malcolm Whyte and Mr George Van de Heide, who gave the Committee a presentation of their approach to drug treatment services in the Australian Capital Territory.

At 11 a.m. the Committee were joined by Dr Robert Irwin, Head of Teacher Education, College of Advanced Education, Canberra, for discussions on drug addiction programmes in teacher training.

At 2 p.m. the Committee returned to the Department of Business and Consumer Affairs for final talks with Mr Harvey Bates.

At 6 p.m. the Committee adjourned and returned from Canberra, *sine die*.

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*TUESDAY*, 26 *JULY*, 1977

At Parliament House, Sydney, at 11.00 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs ANDERSON | Mr McGOWAN |
| Mrs DAVIS | Mr RAMSAY |
| Mr HEALEY | Mr WOTTON |
| Mr MACDIARMID | |

The Committee met at 11 a.m. and deliberated.

The minutes of previous meetings, as circulated, were confirmed.

Mr Jackett was granted Leave of Absence until October, 1977, to undertake a series of visits abroad.

Following the luncheon adjournment, the Committee re-assembled at 2 p.m.

The press and public were admitted.

The Clerk read Legislative Assembly Standing Order No. 362 relating to the Examination of Witnesses.

Dr G. Sutton, Director of the N.S.W. Bureau of Crime Statistics and Research, called as a witness and sworn. The witness acknowledged having received a summons under the Parliamentary Evidence Act, 1901.

Evidence concluded, the witness withdrew.

Mr J. Billington, Sydney Editor of the Australasian Weed and Australasian Seed, called as a witness and sworn. The witness acknowledged having received a summons under the Parliamentary Evidence Act, 1901.

Evidence concluded, the witness withdrew.

At the request of the Chairman, the press and public withdrew.

The Committee adjourned at 4.30 p.m. until Thursday, 28 July, 1977.

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*THURSDAY*, 28 *JULY*, 1977

At Parliament House, Sydney, at 11 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs ANDERSON | Mr McGOWAN |
| Mrs DAVIS | Mr RAMSAY |
| Mr HEALEY | Mr WOTTON |
| Mr MacDIARMID | |

The press and public were admitted.

The Clerk read Legislative Assembly Standing Order No. 362 relating to the Examination of Witnesses.

Mr A. D. Glover, Mr J. C. Cook, Mr P. N. Daddo and Professor K. J. Murton, representing the Proprietary Association of Australia, were called as witnesses and sworn. The witnesses acknowledged having received a summons under the Parliamentary Evidence Act, 1901.

Evidence concluded, the witnesses withdrew.

At the request of the Chairman, the press and public withdrew.

The Committee adjourned at 1 p.m., *sine die*.

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*WEDNESDAY*, 3 *AUGUST*, 1977

At Mascot International Airport, Sydney, at 6.30 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs DAVIS | Mr McGOWAN |
| Mr HEALEY | Mr RAMSAY |
| Mr MacDIARMID | Mr WOTTON |

Apologies were received from Mrs Anderson.

The Committee were met and welcomed by Mr B. C. Bates, Director of the Federal Narcotics Bureau, Mr D. Schramm, Assistant Director, National Enforcement Section, and Mr D. Raynor, Officer-in-Charge of the Dog Detector Unit.

The Committee also met and held discussions with Mr J. Docking, Acting Assistant Collector of Air Services, Mr G. Cotis, Senior Inspector—Passenger Processing (International), Mr J. Greenlands, Senior Preventive Officer—Control Room, Mr B. Wackett, Senior Narcotics Agent, Miss P. Bowman, Narcotics Agent, and Mr J. Stewart, Dog Handler.

The Committee proceeded on a tour of inspection of the Customs facilities at Mascot International Airport, which included a demonstration of the work undertaken by the drug detector dogs.

The Committee returned to Parliament House and adjourned at 10 a.m., *sine die.*

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*MONDAY,* 12 *SEPTEMBER,* 1977

At Parliament House at 10.30 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs DAVIS | Mr McGOWAN |
| Mr HEALEY | Mr WOTTON |
| Mr MACDIARMID | |

Apologies were received from Mrs Anderson and Mr Ramsay.

The press and public were admitted.

The Clerk read Legislative Assembly Standing Order No. 362 relating to the Examination of Witnesses.

The following officers of the Health Commission of New South Wales were called as a panel:

Dr R. G. McEwin, Chairman of the Commission, sworn as a witness; Mr R. M. Dash, Co-ordinator of Scientific Services, sworn as a witness; Mr A. P. Diehm, Director, Central Drug and Alcohol Advisory Services, sworn as a witness; Dr G. Egger, Research Officer, Division of Health Services Research, sworn as a witness; Mr B. T. Mewes, Acting Senior Pharmacists, Therapeutic Goods Branch, sworn as a witness.

Dr A. Field, Acting Director, Bureau of Personal Health Services, was also in attendance.

Each witness acknowledged having received a summons under the Parliamentary Evidence Act.

The witnesses were jointly examined by the Chairman and members of the Committee.

Evidence not completed, witnesses were requested to attend at a subsequent sitting, and withdrew.

At the request of the Chairman, the press and public withdrew.

At 4.30 p.m. the Committee adjourned until Monday, 19 September, 1977.

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*MONDAY,* 19 *SEPTEMBER,* 1977

At Parliament House at 11.30 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mr HEALEY | Mr McGOWAN |
| Mr MACDIARMID | Mr RAMSAY |
| | Mr WOTTON |

Apologies were received from Mrs Anderson and Mrs Davis.

By agreement, confirmation of the minutes of previous meetings were deferred.

The Committee deliberated on matters arising from recent evidence.

The Committee adjourned at 1 p.m. until Thursday, 29 September, 1977.

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*THURSDAY, 29 SEPTEMBER, 1977*

At Parliament House at 10.30 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs DAVIS | Mr McGOWAN |
| Mr HEALEY | Mr WOTTON |
| Mr MacDIARMID | |

Apologies were received from Mrs Anderson and Mr Ramsay.

The press and public were admitted.

The Clerk read Legislative Assembly Standing Order No. 362 relating to the Examination of Witnesses.

The following officers of the Health Commission of New South Wales were called as a panel:

Dr D. M. Storey, Commissioner for Environmental and State Health Services, sworn as a witness; Dr G. Andrews, Commissioner for Personal Health Services, sworn as a witness; Mr R. M. Dash, Co-ordinator of Scientific Services, sworn as a witness; Mr A. P. Diehm, Director of Central Drug and Alcohol Advisory Services, sworn as a witness; Dr G. J. Egger, Senior Research Officer, Division of Health Services Research, sworn as a witness; Dr R. Webb, Senior Psychiatrist in Charge, Drug Education, sworn as a witness.

Each witness acknowledged having received a summons under the Parliamentary Evidence Act.

The witnesses were jointly examined by the Chairman and members of the Committee.

At the request of the Chairman, the press and public withdrew.

The Committee adjourned at 4.15 p.m., *sine die.*

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*THURSDAY, 15 DECEMBER, 1977*

At the University of Sydney at 9.30 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mr HEALEY | Mr RAMSAY |
| Mr MacDIARMID | Mr McGOWAN |
| | Mr JACKETT |

Apologies were received from Mrs Anderson, Mrs Davis and Mr Wotton.

Members of the Committee met at the University of Sydney where they were received by Professor Watson of the Department of Pharmacy and Professor Starmer of the Department of Pharmacology.

The Committee proceeded on a tour of inspection of the work being undertaken in the two departments in relation to drugs and driving. In particular, the Committee heard about the work being undertaken in conjunction with the Prince Alfred Hospital in relation to multiple drug use and of the uses to be made of modern drug analysis technology.

The Committee returned to Parliament House at 3.30 p.m. and adjourned, *sine die.*

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*FRIDAY, 27 JANUARY,* 1978

At Lidcombe Hospital, Sydney, at 10 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mr HEALEY | Mr McGOWAN |
| Mr MacDIARMID | Mr JACKETT |

Apologies were received from Mrs Anderson, Mrs Davis, Mr Ramsay and Mr Wotton.

The Committee met at the Division of Analytical Laboratories of the Health Commission of New South Wales at Lidcombe and were received by the Director, Mr L. G. Clark.

The Committee proceeded on a tour of inspection of the work being undertaken in the Laboratories in relation to drug analysis.

The Committee adjourned at 1 p.m., *sine die.*

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*MONDAY, 6 MARCH,* 1978

At Parliament House, Sydney, at 9 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.P. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs DAVIS | Mr McGOWAN |
| Mr HEALEY | Mr RAMSAY |
| Mr MacDIARMID | Mr JACKETT |
| | Mr WOTTON |

An apology was received from Mrs Anderson.

The Committee met and took evidence, in camera, until 10 a.m.

A copy of a Report of the Committee's findings in regard to its Terms of Reference having been transmitted (by the direction of the Chairman) to each Member of the Committee, the Chairman brought up the draft Report which was accepted by the Committee as having been read.

On a motion of Mr Wotton, seconded by Mr Healey, the Committee resolved that because of the magnitude of the task alloted to them they should continue their investigations and make a further Report to Parliament at a later date; and that their findings to date should be presented to Parliament as a Progress Report.

On a motion of Mr Wotton, seconded by Mr Jackett, the Committee agreed that the Chairman should be paid appropriate allowances with regard to his visits to Adelaide and Perth as set out in a letter from the Deputy Premier on 28th December, 1977.

The Committee proceeded to consider the draft Progress Report

Paragraphs 1 to 288 were read and agreed to, subject to editorial amendment.

The Committee adjourned at 4 p.m. until 10 a.m. the next day.

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*TUESDAY, 7 MARCH,* 1978

At Parliament House, Sydney, at 10 a.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.P. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs ANDERSON | Mr McGOWAN |
| Mrs DAVIS | Mr RAMSAY |
| Mr HEALEY | Mr JACKETT |
| Mr MacDIARMID | Mr WOTTON |

The Committee met to resume consideration of the draft Progress Report. Paragraphs 289 to 321, referring to cannabis were read.

Mr Jackett asked that it be recorded that the views on cannabis which he expressed in relation to the Memorandum which the Committee had presented to Parliament in March, 1977, remain unchanged.

In reply to Mr Jackett, the Chairman drew attention to the statement at paragraph 314 of the draft Progress Report under consideration which stated "The Committee adheres strongly to the views which it expressed to Parliament in March, 1977, that scientific evidence is not yet sufficient to warrant the removal of the existing restriction on the use of any of the cannabis derivatives, particularly the stronger forms like hash oil".

Paragraphs 289 to 321 were read and agreed to, subject to editorial amendment.

On a motion of Mrs Davis, seconded by Mr Ramsay, paragraph 372 was amended to include the addition of the following recommendation "Because of the number of absconders from bail in cases of drug trafficking, early consideration should be given to a review of bail in such cases".

Paragraphs 373 to 481 were read and agreed to, subject to editorial amendment.

On a motion of Mr Healey, seconded by Mr MacDiarmid, paragraph 482 was amended to include the addition of the following recommendation "Personal development courses containing drug education should be compulsory in secondary schools".

Paragraphs 483 to 713 were read and agreed to, subject to editorial amendment.

Question: That the Draft Progress Report, as amended, and agreed to, be the Progress Report of the Committee—put and passed.

The Committee adjourned at 6 p.m., *sine die.*

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*THURSDAY, 9 MARCH,* 1978

At Parliament House, Sydney, at 6 p.m.

MEMBERS PRESENT:

Mr V. P. DURICK, B.A., M.P. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| Mrs DAVIS | Mr McGOWAN |
| Mr HEALEY | Mr RAMSAY |
| Mr MACDIARMID | Mr JACKETT |
| | Mr WOTTON |

The Minutes of the meetings of 15 December, 1977, 27 January, 1978, and 6 and 7 March, 1978, as circulated, were confirmed.

The Chairman, in the presence of the Committee signed the Committee's Progress Report.

Resolved, on a motion of Mr Jackett, seconded by Mr McGowan, that the Progress Report be tabled in the Legislative Assembly by the Chairman, and in the Legislative Council by Mr Healey on behalf of the Chairman.

On a motion of Mr Wotton, seconded by Mr Ramsay, the Committee recorded its warm thanks to the Chairman for the great personal effort he had made in bringing up the Report and the fairness and understanding he had shown throughout the Committee's deliberations.

On a motion of Mrs Davis, seconded by Mr McGowan, the Committee expressed its sincere appreciation of the support that had been given throughout by the Clerk, Mr G. James, and by the Secretary, Mrs C. O'Regan.

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# PART C

# MINUTES OF EVIDENCE

1976

# MINUTES OF EVIDENCE

*TAKEN BEFORE*

THE JOINT COMMITTEE OF THE LEGISLATIVE COUNCIL AND LEGISLATIVE ASSEMBLY

*UPON*

# DRUGS

*AT SYDNEY ON FRIDAY, 3 DECEMBER, 1976*

**The Committee met at 10.30 a.m.**

**Present:**

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| The Hon. KATHLEEN ANDERSON | Mr J. G. T. JACKETT |
| The Hon. MARGARET DAVIS | Mr B. McGOWAN, B.A. |
| The Hon. C. HEALEY | Mr E. D. RAMSAY |
| The Hon. H. J. A. SULLIVAN | Mr R. C. A. WOTTON |

(Evidence of Detective-Sergeant Astill taken *in camera*.)

CECIL WILLIAM GIDLEY, residing at 8 Jersey Avenue, Leura, a company executive by occupation, sworn and examined:

1835. CHAIRMAN: Thank you for offering your services to the Committee. Have you received a copy of the Committee's terms of reference?——W. Yes.

1836. I think that at this stage I should say for the benefit of the members of the Committee that I have known Mr Gidley for some time. He is very much involved in this particular problem which we have been given the task of investigating. I do not think it would be an understatement to say that Mr Gidley has formed firm views in regard to what he thinks should be done. He is more of a practical man than an academic. I suggested to him that he might make a submission to the Committee but he preferred to let us hear what he has to say. On that basis, you might put to the Committee your views in regard to some of these problems, particularly having in mind our terms of reference.——W. Thank you. My involvement in this matter commenced when my son, at age 15, came to my wife and myself and said that he was using drugs and was worried. This was a shock. My mental thought was: what does the stupid little bastard want to play around with drugs for? That was a normal reaction—looking back—but I did not say it at that stage. With our lack of knowledge we thought that the appropriate source was the local doctor. I discovered that he knew little about the problem and he was the first to admit it. He suggested treatment at a modern clinic on the north shore. The boy agreed readily, went there and lived in considerable comfort and during his stay there for something like five weeks, during which period the doctor thought he was o.k., from day to day he enjoyed visits from his mates and got drugs from them. So, that was not a successful venture.

The boy became restless and wanted to leave school. We did not argue. He left but then he got job after job mainly as we now know—and he readily admits it—it was to get money to further his habit. To cut short that stage, he is now in prison for the fourth time, serving a heavy sentence of something like 6½ years with a parole period of three years. I received a letter from him only a few days ago. Our relationship is strong and warm. I have learned a great deal from him concerning life in gaol and also about what goes on in the drug scene on the streets. With this personal problem, my wife and I decided that we should endeavour to learn more about what happens to a young person and, above all, what sort of treatment was available in the hope that you could reclaim a highly intelligent person, such as this lad was, back into what we call normal society.

My business life involved me in trips abroad. On those occasions I took leave and, on my personal bat, visited various treatment centres overseas. I have seen a number of them. The ones that convinced me most of all were called therapeutic residential treatment centres. Those centres avoid the use of substitute drugs or antagonistic drugs. By this time our interest became focused on the narcotic user. I have since broadened my view to concentrate on the compulsive user of any drug. Over the years I have spoken to service clubs such as Rotary, Lions and Apex in an endeavour to stir up sufficient public interest to make available the necessary dollars to establish these drug-free residential communities in Australia. In 1970 I presented a long document to the Foundation for the Research and Treatment of Alcoholism and Drug Dependence, known as FRATADD. That document is still in existence but there is no therapeutic community in existence as yet along those lines.

At one stage I was invited, and attended, the early meetings of the National Drug Advisory Council, where again I received support verbally for the establishment of such institutions, if you like to call them such. I have recently been invited and accepted an invitation to become a director of FRATADD but I think you would understand why I said I will not write anything for the Committee, I have written so much and it has achieved so little. In a sense I have become a little browned-off. But, a tragedy occurred in this city which has given me a new lease of life. You may know of Mr Walter McGrath who saw his son die of an overdose of heroin in his bathroom. Walter McGrath expressed a wish to the police that he would like to meet somebody who would like to get down to the grass roots of the problem. I think it was Superintendent Fred Longbottom who said, "Contact Cec Gidley"—which he did.

Out of that, in the making at the moment is a new foundation to be called the James McGrath Foundation—after the lad. We have a number of people of some status in the community on it. We have decided that in the past a lot of us have tended to say, well, this is a problem for Government agencies to handle. I personally do not think it is. I do not think they can do it alone. I therefore feel that they need help from outside. To that end the new Foundation aims first to raise a considerable sum of money —not less than $500,000. With that achieved it is the intention of the group to set up in Sydney a residential therapeutic community based on the lines of similar facilities such as Phoenix, Daytop, Synanon and Odyssey in America.

I have an extensive personal library of literature on the treatment of drug addicts and amongst them is a particular book called "We Mainline Dreams". I hope some of you have read that. It is a warm document that is written by a woman doctor. She is also a lawyer, psychiatrist and surgeon. Her husband is the Deputy Chief Medical Examiner for New York City. Both people are regarded as outstanding authorities on the drug-free treatment of addicts. I took a punt and suggested to Mr Walter McGrath that he write to this woman, Judianne Densen-Gerber, and invite her to come here and offer her professional advice on how she operates, I think, 40 such residential communities in America at the moment.

To my satisfaction, we have had a positive reaction and she and her husband are coming to Sydney very close to 15th February next year and will be staying until approximately 13th March. We have spoken on the telephone with one of her colleagues. He assures us that her professional services will be gratis. We feel that these two folk can be of great help in a major publicity campaign that we are organizing with a view to stimulating the flow of funds to the Foundation. That is the first step. Prior to all this—as a private individual I was able to talk to the former Minister for Police, John Waddy, and obtained from him without charge for two years, as from 1st January of this year, two abandoned police stations, one at Camperdown and one at Rozelle. They have been rather nicely renovated by means that shall remain unmentioned. The Camperdown one has been presented through FRATADD, because I acted under the name of FRATADD in this matter, to a husband and wife team who formed a little group called DIGS to handle the other drug addict who is suffering from alcoholism. Through my activities in Canberra the former National Drug Advisory Council—which the present Government terminated—$70,000 was obtained with which we have purchased a house at 114 Cavendish Street, Stanmore, where alcoholics will be in residence and will use the Camperdown Police Station as a supported work centre. That is about to happen.

The Rozelle Police Station has been functioning for almost 12 months. In the first nine months it was run by a heroin addict with a long history and his wife who was a heroin addict. They have a little baby. They came to work there and got other current addicts, most on methadone, to work according to their abilities and state of health and who were paid according to what they did. Their tasks include cleaning motor cars, detailing motor cars prior to auction, lawn cutting, house painting, and cleaning up rubbish from yards.

I must say this has been a heart-warming exercise because for the first time in their lives these people have been given tasks on the understanding that they could not be expected to work from 9 to 5. On some mornings they just do not wake up until the late hours. Some mornings they feel as if they have a triple dose of the flu. They suffer from constipation, which is one of the undesirable aspects of methadone and heroin. I have come to have a warm regard for these people who are endeavouring to earn some honest money instead of house breaking and trading in drugs. To me, they have established in a small way that it is possible for some of the addicts who, before, were regarded as almost unemployable, to work—given the concept that they are important, that they work with their peers and are paid reasonable money for their efforts and that in the future they have been promised that we will have a co-operative established in which they become shareholders.

This takes away a lot of the rebellion which many express against the capitalistic system that the boss gets most of the cake and the worker gets little. It takes away that argument a bit because this is their business, and the more they make the more they get. The weakness in this supported work concept is that it is difficult to match the jobs you can get with the people available because they are scattered all over the city. The essential component of the total scheme I have in mind is that the residential community for drug abusers will be linked directly with the supported work centre.

The residential community concept is a little frightening I think to people outside the drug abuse world. This is one of the reasons that I have failed to get enough support for such a drug-free treatment centre to be established. I suppose it is understandable people shrug at the thought of a young addict being asked to come and be interviewed to see if you will accept him into a house. You may tell him to come at 9 o'clock one morning; he arrives at a quarter past 9. You ask him what time is he supposed to be there and he may reply, "You said about 9." We then say that we did not say about 9, to get off, that we do not want him particularly unless he is going to learn some good habits for once. You ask him to come back the next day at 9, or not to come at all. If he does turn up, often he turns up under pressure—an offer you cannot afford to refuse—maybe from a magistrate. When he is interviewed you point out clearly to him that there are a few rules he must obey, or go; that it is a privilege to be there. In a sense, this gives an artificial success rate because you get rid of those who are not really motivated and prepared to have a go at breaking the drug habit.

The rules are simple. While he is there he starts as a beginner. This is what he is told. There is no physical violence or threats permitted, no drugs whatever unless medically prescribed, and no sex until such time as it is considered that he and his wife or girl friend with him have adjusted themselves better than when they came in. Perhaps a little pocket money is permitted and so forth. They live as a very busy community. They have a very tough regime of duties. If they accept these little rules they will be asked, say, to clean the latrines for the first three weeks. Even though he may be a barrister's son or somebody who is used to other things, he does it or goes. If he does not do it well, he is reprimanded.

If they accept this hierarchy and this rigid discipline, at the end of one, two, or three years maybe they graduate. I have seen people graduate from that system who are magnificent; they are tremendous people. Sometimes their heads are shaved by decision of their peers. This shocks some people, but to me it is not as shocking as the life they lead on the streets. I would sooner see them a prisoner with an institutional or community background than a prisoner of the crooks, the thieves and the bashers, and in the gutters—and that is where they finish. It has not been a popular concept to date in this country. They say that the Yanks are different, the British are a bit different and so forth. I do not think they are. There are differences that are minor but to me they are all human beings with similar problems of not being able to beat a drug habit that is destroying them.

Associated with the residential concept you must have the appropriate people to run it. This is the $90 question. I firmly believe—and I think Dr Densen-Gerber will support it—that the medical profession has a relatively minor role to play in the treatment of the drug addict. They have an important limited role, but not in the total rehabilitation or habilitation of these young folk. It is so simple in a matter of days or a few weeks to eliminate completely the drug of their choice from their bodies. That is nothing; the medicos can do that with ease. The psychiatrist has a slightly more important role to structure the programmes of these residences.

The real bridge between the current addict, the medical profession and the associated services such as welfare, employment and the rest, is what I call the recovered addict. He is the man or woman who has been through it. He can interview them in the early counselling stages and tell whether they are playing games or trying to con you. Above all, as he sits on one side of the table talking to them most addicts are convinced, I am sure, that once an addict always an addict. That is their philosophy. But there is a bit of a shock here for them. Here is a guy who has been through what they have been through and is now sitting there as a paid counsellor. He is a person between the professionals and the current pill taker. In his early stages he does not regard himself as sick but we give him the label of being sick. He does not go to the doctor and say that he has taken pills and feels well. And he does feel well. There is a tremendous pleasure and satisfaction from drug-taking. We tend to overlook this. They do not want your help until a certain stage in their drug career by which point I feel we have to be ready with appropriate facilities.

For some it is an inspiration from religion; for others one person suddenly touches them and they change their way of life; for another it has to be methadone; and for others it is the drug-free treatment facility. There are thousands of variations and nobody has the one answer and the one technique to solve this problem. The worst technique we have adopted is to throw them into a standard prison. I am so cranky about this. We have been so wrong. What we could even do, legitimately, is to apply a principle of a quarantine. It is so stupid—words are not strong enough—for us to confine a person addicted seriously to drugs; they are tossed into a futile environment such as a prison which is not designed to cope with them.

I appreciate there is the dilemma in the courts. I appreciate also that a young fellow comes before a court for having stolen $70,000 worth of goods from the community. That is not his real problem; his real problem is that he is a drug addict. My own son was earning successfully anything between $80 and $100 a day, and well able to, from housebreaking and from trading drugs. Most users some time in their career will trade drugs. Often they are not sentenced basically for the drug side but because of the theft, which is inevitable. That is the only way one can get that sort of money. As I said recently to a reporter, I can now almost detect the compulsive drug user in Sydney as he hurries down George Street busy as hell. He is flat out conniving, planning and succeeding in getting that money. So I am very hostile about our lack of speed in finding a better substitute than the standard gaol for a person who is essentially a drug addict.

The other aspect that I think we lack as a community is that there is not enough co-operation and interchange of information between the law enforcement side of the problem—the customs and the police forces—and what I call the demand side of the problem. The demand side calls for the sort of treatment facilities of which I am thinking. It also calls for constant revision of the approach to what they call drug addiction. I used to be a teacher and I think it is an impossible task to expect teachers in each school to become experts in counselling and discussing the drug problem. You should have a corps of special, dedicated people, not necessarily teachers, who can discuss frankly with the youngsters the drug world they will face while at school and when they leave there. A young teacher in the area where I live came to me in great distress. He is a person who is supposed to teach Personal Development. He said that on the question of drugs he did not have a clue, yet he was supposed to do it. Unconsciously he could do more harm than good.

Often it is a little sad to ask a policeman, in uniform particularly, to go to a school and talk *en masse* to the pupils about it. I have a personal belief—and the Committee may disagree with me—that if heroin and other opiates were free to those who wanted them, as long as

they came and asked for them, there would not be many takers. I have a belief that everything we make illegal in terms of human behaviour is something that gives great joy to the criminal class. It is a philosophy in which I believe; many of you may not. The British have gone half way I feel. If you really want heroin in Britain you can still get it, but only from people whose aim in life is to get you off it, and at a price that makes the street price of heroin non-competitive. You will never get rid of the illegal use of these drugs even if you wanted to, I agree; but you can still make it less attractive, less of a wonderful business for the crooks, if there is a much more elastic approach to that small segment of any community that become compulsive users of any drug, whether legal or not.

As I have been doing a considerable amount of the talking, perhaps I should pause, Mr Chairman, and ask through you if members of the Committee would wish to ask me any questions.

1837. CHAIRMAN: You mentioned that your son was 15 at the time when you first became aware of the problem?——W. Yes.

1838. How old is he now?——W. He is coming up 28.

1839. You have lived with this for something like thirteen years?——W. So has he, and he has made very valiant efforts. But there was nothing from that.

1840. On what sort of drugs was he?——W. The whole gamut, finishing of course on heroin, which is the queen of all drugs on the scene.

1841. Did he start on marihuana?——W. He started on the pep pills. He was captain of his football team and the team won their competition. He asked me could he go to the picture show in Manly that night with his team to celebrate. I agreed. After the show a number of the team went to a little coffee shop in Condomine Street, Balgowlah. One of the boys said, "My brother is having his 21st birthday, why don't you come to the party?" As I understand it, my lad and two others said, "We are too tired, we had better go home and have some sleep." An adult sitting in the coffee shop said, "Why do that? Have a couple of these and you will dance all night." They took them, and the lads could dance all night. I handed some of these out during the war to my troops; they are amphetamines and are very effective.

That was the beginning. He was one of those people who—for reasons that nobody can tell me yet—having tried this must go on. We do not know why that is.

Others in the same situation will take it and not go on. It is an unknown factor in the human being. He progressed step by step. He has had everything, including alcohol. This is one of the problems. Most drug users, particularly of the illegal drugs, are poly users. If something is cut off, they go to something else. This is one of the fields of co-operation between customs, police and those trying to treat addicts. If you suddenly clamp down hard and have a real drive against heroin, you can be sure there is going to be an outbreak of use of another drug. It is inevitable that whatever we do, we can only contain but never eliminate the use of drugs, either legal or illegal, to a stage where some proportion of the community will not abuse them.

1842. What is the main feature of the Odyssey programme you mentioned? Is it similar to the residential type accommodation you have mentioned?——W. Yes. To me it has merit. Synanon completely ignores and almost detests the medical profession. Their aim is to get rid of the brain-shrinkers and form a tight community and stay in it for life. It is the other extreme, if you like. There is Daytop, Phoenix and Odyssey. Odyssey has melded together in, I think, the best possible proportions the medical profession, the social worker, the recovered addict, the current addict, with the knowledge that an important component in rehabilitation or habilitation of a youngster is vocational training; to discover some skill that he has so that he can be an honest person and pay his taxes. It is a complete thing. You are always welcomed back. There is a principle of non-rejection. But if you foul up your progress somewhere along the line, you go back to the bottom of the ladder and try again.

It also has an advantage from the drug addict's point of view that it does seem to be authoritarian in the sense that it is not a police department or a welfare department or a taxation department. It is people that they learn to trust because you are there to help them get out of the mess. It is non-governmental. Even though Odyssey could be perhaps half-financed by Government funds, they run it as a private organization. This enables them to employ people who have rather doubtful backgrounds without any of the difficulties that the public service might have.

I had coffee with an ex-bikie two days ago; a tough little fellow, red whiskers, blue eyes and a nice criminal record. He is a recovered addict and he is now counselling addicts under a trained social worker at St George Hospital. He has applied to the Health Commission for a job and it is doubtful that he will get it because it creates problems. I want him, because he is the sort of guy we are looking for.

1843. You say that Dr Densen-Gerber will be here about the middle of February. Do you think that her schedule would be so tight that she would not be able to spare some time to come to see the Committee?——W. I regard that as an official comment from the Chairman of this Committee. May I convey that, or would you prefer to take it up with our chairman? We have to fix the programme. If you want it, it is a guarantee.

1844. CHAIRMAN: Mr McGrath issued the invitation.——W. I triggered it. He is the chairman of our group. I am consultant to the steering group. Its formation is being speeded up by Mr Ryan. We want a tax clearance. We might want your help. We want to be a foundation in existence by the time these people arrive. We are responsible for drawing up a programme for their consideration. It has not been tackled yet.

I am sure I speak for all members of the Committee when I say that we would very much like to interview her.

1845. Mr WOTTON: Having sat on the last Committee, I think I can say that Mr Gidley has made the most outstanding contribution of all witnesses. How related is the Buoyancy situation in Melbourne?——W. They are all fairly similar. They have a farm concept.

1846. Buoyancy, you mean?——W. Yes, this is one essential component. If these people live in the community you have a problem of holidays. A lot of kids have never dug a hole and put a bean seed in and seen something grow. Being close to the earth is a soothing influence on these people. They have anxiety. I have been looking at a couple of properties.

1847. Buoyancy have just acquired their property?——W. Yes. It is a similar concept. I have lived in America from time to time, and I find quite a similarity in the psychology of our people. What happens in America tends to happen two or three years later out here.

1848. Mr HEALEY: Do you believe there should be penalties for traffiickers and pushers?——W. It depends what you mean by trafficker. If a person is doing it purely for gain and never uses the drug, is not an addict, absolutely; I would join the firing squad. It is like what we did to the Japs in the war. It is a war. I do not know how you should handle a young contact who sells to get more for himself. He is the free agent of the underworld. That is a nasty problem for the law. The thing is to endeavour to catch all young fellows as they reach a certain point in their careers where they want help and will ask for it. I get telephone calls. A father calls me and says his son takes drugs. What do I tell him? Do I tell him to ring up the Health Commission? The boy will not go near them. We have long lists of parents. Tell the drug squad? That is very rare. The Salvation Army—yes—but they have limited facilities. Dr Des Ryan, who was deregistered but is re-registered now, is a dedicated doctor looking after junkies with the Salvation Army. There are referral centres. If they go there, where do they refer them? They are put in gaol if they break a few bonds. We lack a range of facilities. You heard Hughes, an ex-junkie. He is dedicated, but he is his own worst enemy when it comes to dealing with people like ourselves. People who are trying to help are convinced that they have the answer, you get conflicts and jealousies between people who are trying to help. There is a co-ordination problem. There is no single answer to getting people off drugs. There is a need for a wide spectrum of treatment. If you passed him around, you might put your finger on the pulse and get him to respond. Sometimes gaol is necessary if he is a natural criminal.

1849. Mr SULLIVAN: I heard somewhere that drugs are available to people in gaol. You said that your son ended up in gaol not because he was naturally a criminal but rather a drug addict. Was he off drugs when he finally went to gaol? Now that he is in gaol, have drugs been offered to him?——W. This is his fourth time in. It is correct to say that some drugs can be obtained in all gaols. I do not say that in condemnation of the gaol system. It is the same with prisoners of war. The ingenuity of people in prison always beats the system. They are not there because warders are crooked though perhaps there is an odd crooked warder. They are there because you cannot beat it. There would be little heroin getting in unless the person inside has people outside with a lot of money, because he cannot steal to support the habit in there. Marihuana and alcohol get in. They find their own things. They mix up ingredients from various sources. They might see the doctor and get some medicine from him. They do not take it, but keep it for later use. They get nutmeg and they get paint. You cannot stop it. I am sure that when my son comes out he will be a very different person because of his association with other deviants. There is the homosexuality problem. Deprivation of sex and female company in prison is inhuman. We have nowhere else to put these people. Perhaps we should think of quarantine. I would put them on an island and make them lead a simple life, feed them, but provide no television, motor cars or anything else.

1850. CHAIRMAN: Do you see any future in the Drug Diversionary Programme?——W. Yes, provided you have somewhere to divert them. At the moment it is in a vacuum.

1851. Mrs DAVIS: Where you have two former police stations set up for rehabilitation of these people, if they go out do you check to make certain that they are not taking drugs?——W. We cannot, but in the therapeutic house daily urine tests are a must.

When I was in England I visited Bethlem Clinic and was impressed with it. What is the difference between WHOS and Odyssey?——W. Not a great deal. I do not know the Bethlem one. I have visited the Hong Kong set-up, and acupuncture and so forth. A lot of things have been done overseas that we have not experimented with.

1852. Is the book you have mentioned available here? ——W. I think it might have been bought out since I have been lecturing.

1853. Could you arrange for the members of this Committee to get that book?——W. I think so.

1854. I think we should read it.——W. I think you should.

1855. Mr RAMSAY: Mr Gidley, I appreciate your sincerity. Do you know whether there are many pedlars who are not users?——W. Normally the trafficker is high up in the scale of things. He never sees or touches the drug. The only way the Americans have been able to cope with this is through taxation. They bring them up on conspiracy charges. I do not know of a really significant arrest in Australia yet—and I think Sergeant Astill will confirm this—of a major trafficker being arrested. They are so well camouflaged. The money is in the wholesale. They buy for 15 cents in Laos and sell for $500 here. They are the real criminals, and they are so skilful and so protected by a pyramid structure that they are difficult to get at. Plenty has been written about this. I do not think we have much hope on the supply side of doing anything except capturing, say, ten per cent of what comes in. It is not realistic.

1856. About a month ago two young men, of 23 or 24 years of age, from Wollongong were arrested for trafficking. Apparently they were not drug users, and they are now in Silverwater. Have you looked at the set up there? ——W. No. They would be small fry in the total scheme. It is a difficult problem. You get a young chap of 23 who has some friends who come down from the East. They give him a packet of snow, he sells it and makes a few hundred dollars. Do you put him into gaol for life? He is small fry.

1857. CHAIRMAN: Mr Gidley, thank you very much for coming. Members of the Committee have appreciated hearing your advice in regard to this most important matter. I sincerely hope that, arising out of our discussions this morning, we may be able ultimately to lend a hand one way or the other, either in our recommendations, or perhaps by putting a shoulder to the other wheel you mentioned. We are under no illusions about the seriousness of the problem. We have been charged with a very important job—to make recommendations to the Government. I thank you very much for your contribution this morning.——W. It is a pleasure and a privilege to be here.

(The witness withdrew.)

**(The Committee adjourned to a date to be fixed.)**

*AT SYDNEY ON FRIDAY, 18 FEBRUARY, 1977*

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The Comittee met at 2.30 p.m.

Present:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| The Hon. KATHLEEN ANDERSON | Mr J. G. T. JACKETT |
| The Hon. MARGARET DAVIS | Mr E. D. RAMSAY |
| The Hon. C. HEALEY | |

Dr ROBERT WILLETTE, sworn and examined:

1858. CHAIRMAN: What is your full name?——Robert Willette.

1859. Did you receive a summons from me to appear before this Select Committee today?——Yes.

1860. Do you understand that that summons protects you in regard to any evidence you may give to the Committee?——I do.

1861. You have had an opportunity to meet and to talk to all of the members of the Committee except Mr Jackett. As I indicated to you in our private conversations, at this stage it would be beneficial for all of us if you could indicate something of your academic background, the type of work you have been doing, your previous experience in Australia, and the more recent work in which you have been engaged. Then, perhaps, you can give us an outline of the basis on which you work. Will you do that?——Yes. My origins in the drug field start in my teenage days when I worked in a neighbourhood drug store. That led me into the field of pharmacy. Academically, I have a Bachelor of Science degree in pharmacy. After obtaining that degree I proceeded to take a super graduate course in medicinal chemistry, which was heavily orientated to the chemistry of drugs, both in terms of how drugs are constituted and how they act. Because in the early days drugs were synthesized from natural products, I was equally interested in synthetic chemistry.

I began my professional career teaching in the College of Pharmacy at Ferris State College, which is in a small town in Michigan. I decided that it would be worth while to get some overseas experience and in 1961 I received a post graduate fellowship from the National Institute of Mental Health, which was part of the National Institute of Health, to work on post doctoral research in the Australian National University, Canberra. Canberra may appear to be a remote place for doing drug research, but the head of the Department of Medical Chemistry at the Australian National University at that time was Adrian Albert, a Sydney born scientist, and one of the foremost thinkers and leaders in drug research. The Australian National University therefore was an ideal place outside of the United States to come and to study. It is interesting to note that since Albert retired he has been teaching in the United States of America, and so there is a complete exchange process. I have seen him a few times in the United States.

At the end of my two year period at the university, and not wanting to leave Australia, I obtained a position with the CSIRO in the Division of Applied Chemistry, where I was working in the field of plant chemistry. We were looking at poisonous drugs, particularly as they affected animals in Australia, but the work had some interesting ramifications in the human drug field because some of the same materials are involved, and some of them have interesting aspects in relation to the treatment of cancer.

I then returned to the United States of America to spend one year at the University of Michigan. My interest is general research in the drug area with particular reference to analgesics of the narcotic opiate class. As a result of my work in analgesics at Canberra, and the effect of opiates, I became involved in research for the National Institute of Mental Health and it was at that stage, starting in about 1970 or 1971 that, in collaboration with the Department of Health for the State of New York and the National Institute of Mental Health, a massive programme in narcotics was initiated. The institute was looking for chemists who had a knowledge of drug pharmacy. The matter came to my attention and it seemed like an opportunity to join what was then a developing federal programme looking at the whole area of drug addiction. That was how I became associated with the institute.

As you may be aware, over the past few years the United States Government has undertaken a massive scale up in the war on drugs and in the past three or four years there has been some adjustment in the organizational structure as to where responsibility lies. I have always been on the health side of the matter. Initially we were a division of the National Institute of Mental Health, and then Congress passed legislation setting up a special institute, the National Institute on Drug Abuse, of which I am a member. Part of it is what is called SAODAP, the Special Action Office of Drug Abuse Prevention. That was established as part of the war on drugs to be a focal point within the central government administration for coordinating and implementing new programmes to deal with drug abuse. That particular structure has its advantages and disadvantages. The United States Congress, in establishing that special action office, gave it a finite lifetime, so that we are predominantly a service institute within a government agency which deals with alcohol abuse, drug

abuse and mental health. It is part of the public health service. We are primarily responsible for developing and implementing treatment programmes around the country. This is done by establishing standards and funding agencies. We probably fund between one half and one-third of all treatment programmes in the United States. The other half of two-thirds are funded by state government or local government or by private foundations or private clinics. The National Institute on Drug Abuse is principally a service research organization and is not regulatory except to the extent that we have programmes that operate on federal funds that come from us. We set the standards for those programmes, which are usually minimal. Drug regulation is in the hands of the Food and Drug Organization. Law enforcement is handled by the drug enforcement organizations. Organizations like the Federal Bureau of Investigation come into the picture only if drugs have crossed state lines or have been brought in from other countries. The Customs people still have a responsibility for checking ports and points of entry. Otherwise it is handled by the State law enforcement agencies. Most agencies have special drug units.

1862. Could you explain how your organization fits into all this?——We have more of a sort of auxiliary role in providing surveys, like statistical data, about general health, and any specific research projects that help to augment the activities of the drug enforcement people. They have rather limited research facilities in some areas in regard to detecting the presence of drugs in individuals. Also, we have a complicated structure in regard to classifying drugs in terms of how they should be controlled. In the area of drug control we have an agency or a working committee. I am chairman of that committee this year; it is a rotating chairmanship. The Food and Drug Administration Organization are members of this organization. We provide statistical and laboratory data on the abuse liability of drugs. The Food and Drug Administration makes a decision as to whether this data is sufficient to change or add a drug to a schedule. Then a recommendation is made to the drug law enforcement agency in regard to implementing those controls. We are not involved in criminal sanctions that might be imposed. Generally we do have some advisory capacity with people who are involved in our treatment programmes and research projects. We may be called upon to testify before any legislative body that might be making criminal decisions about criminal penalties. Recently the penalties surrounding marihuana have been the subject of controversy and discussion. Primarily we do surveys in regard to treatment and information.

The division that I am associated with is responsible for carrying out a wide range of research programmes. I shall leave with you one of these computerized listings. We prepare a report for various congressional committees and for various administrative units within the Government. We do a survey on drug abuse. This year that has extended into alcohol and other abuses. These projects were active during the 1976 fiscal year. which turned out to be a fifteen-month period. A great deal of confusion was created in regard to changing fiscal dates. This list covers almost all the drugs that are known to be drugs of dependence and those that are perhaps under consideration as being drugs of dependence. For example, the anti-anxiety drugs are now controlled under certain schedules of the Drug Control Act. This covers a whole range of different research areas. This is one small segment of the report which should be published about the end of March. I shall be sending copies of this to various groups here in Australia. We have the names and addresses of people and those to contact to give information. We fund projects outside the United States of America. We do not have any grants in Australia at the moment but we deal with a number of other countries. I do not think the Australian investigators have got on to the idea of applying for such a grant. I hand you this report for your general information. (*Exhibit* "1")

There are two or three major areas we are working on that may be of interest in the treatment area. Our division is responsible for developing new treatment methods. Other people take over the responsibility of implementing those treatment programmes. Methadone was one of the first drugs that was used as an adjunct to therapy. There are a lot of problems associated with methadone use. Some of these are controllable; some are not. In about 1970–1971 we started looking at a programme of alternate drugs, maintenance-type drugs, which might be considered under the general category of narcotic maintenance, to use as an adjunct to therapy. We had some experience with methadone. We have developed something called L.A.M., a derivative of methadone, which has a much longer duration of action. This has to be given only three times a week. I do not have a copy of this report here. In fact, I have very few copies of it. The advantage of this is that it minimizes the number of times someone may have to come into the treatment programme to get drugs. Other than that it is no more and no less than methadone. Methadone cannot be equated with treatment; it is an adjunct to treatment.

The other treatment approach which has been developed considerably is a narcotic called naltrexone. This has a blocking effect; it has no pharmacological effects and it is opiate free. This counteracts any of the effects of opiates. If it is given to an addict, you may precipitate withdrawal, which can be dangerous. Sometimes it is used with methadone. It is important to control supplies carefully. This acts against the effects of an opiate. The addict may have had treatment and he may be doing very well; he may have seen the social worker and the psychologist and got a job. Then he may be going to shoot up with heroine. Then that may start him recycling back into his addiction. This prevents that reinforcement of the heroin effect. When he does shoot up with heroin, it has no effect. We have got this under clinical investigation at the moment. In has no side effects other than the usual minimal things that one sees with drugs. Some people complain of an upset stomach, but the effect is no more and no less than with any other kind of drug. We now have that under clinical investigation. This has to be given only about three times a week. In terms of patient compliance and philosophy, an addict or a post-addict has to make a decision three times a week to take this drug.

The other area I have been involved in is research related to the production of drug supplies for research. It was in that capacity that I came to Australia to attend the meeting in Melbourne. We have been collaborating with our Department of Transportation now for about three or four years. Our expertise is in the area of drugs. We have merged forces and collaborated on projects. We have come to certain agreements in this way. One of the areas we are concerned with is in regard to drug involvement and traffic safety. There are two key issues here. One thing is that we do not have random testing. The Department of Transportation started out by looking at fatally injured drivers. In those cases specimens are looked at routinely for drugs.

If it is a non-fatal accident, you have to get a consent from the victim before you can do an assay. In many cases they refuse and you do not know what the

position is. We have been looking at the position in regard to fatally injured drivers. A variety of drugs have been looked at. Our part in that programme has been to develop and establish methods for detecting marihuana or marihuana constituents in the body. It has only been in the past six to twelve months that methods have been developed that are now reliable. We are continually checking the validity of these tests. We are now beginning to examine several thousand samples generated from the Department of Transportation, from fatally injured drivers, looking for the presence of marihuana. One may ask, why marihuana? We have come to what is more or less a conviction, not based on direct evidence but on the basis of circumstantial evidence, but there is probably a cause and effect relationship between marihuana use and traffic accidents. What we are trying to do now is to actually establish the data, the actual relationship that does exist. From our surveys of schoolchildren, we see an increasing daily use of marihuana. In fact the daily use of marihuana exceeds the daily use of alcohol. That is the most accident-prone group as far as traffic safety is concerned.

With that high incidence of marihuana use and the high incidence of susceptibility or high-risk group with traffic accidents there is probably an involvement. We are trying to measure the magnitude of it. Laboratory data has been generated in a number of laboratories around the world. In the United States of America, Canada, Europe and Australia—there is an excellent group working at the University of Sydney—New Zealand, Sweden, Finland—a lot of data has been generated and marihuana alone or in combination with alcohol and other drugs shows a definite impairment in either simulated driving or special psychomotor tasks related to driving. The evidence strongly suggests that it has some impact. We do not have the hard data to show how involved it is or whether there is a direct relationship on the road but laboratory data gives an indication that it possibly could be involved. If one cannot get any laboratory experiments to show impairment there would not be much reason to look for it. All the data is in general agreement that it does impair to some degree. The study we are doing is to try to get a little ahead—one has to think about the appropriate counter measure. We use the term "prevention". One of the general approaches we have taken to prevention is to identify the hazards of use. One of the hazards of marihuana use would be as a safety factor, not only in driving but also in work related jobs. We have been asked by the Department of Defence—we have to do all drug research for the Department of Defence—it has been told by Congress that it cannot do any more because of the LSD escapades of the sixties. They have asked us to do performance-related studies. The Navy is particularly concerned about people watching radar-tracking screens—visual perception and information processing—both of which are affected by marihuana. We are extending our studies into more than just the driving area and are particularly interested in the industrial area. There is a fairly active programme in Australia in the alcohol industrial area and that has been extended into the drug area as well.

As regards marihuana, I had an opportunity to talk to the people at the government laboratory and to your Health Commission people this morning. I was at the government laboratory at Customs House yesterday and I gave them copies of this. (*Exhibit* "2") It is a discussion on most of the marihuana assays that we have been involved in either directly or indirectly. We will, proably some time within the next six months, provide the Health Commission with one or more of the assays to enable them to start looking for the presence of marihuana in some or all of the specimens they receive. There is always a problem of time and effort required: you cannot screen every specimen for every drug; there is not the time or facilities available to do that. In cases where they would be suspicious about marihuana involvement this will provide direct laboratory evidence that marihuana is involved. We do not know yet whether we may have a traffic victim with marihuana present—whether it is directly involved in the accident—but at least you know it is present. I think that has to be done in all countries. The frustration that we all had at the Melbourne conference is that we do not have a background of the drug's involvement in traffic safety as one hazard associated with drug use. By laboratories monitoring or checking specimens coming from all sorts of casualties we should be able at least to have the ability to measure for the drug. Eventually we will be able to get together the data that will say that last year with 10 per cent of samples and this year with 15 per cent of the samples, marihuana is present. A picture will evolve. It will not be easy for us to go out directly and study it. It is not easy to measure. We are looking at other drugs in the same context of the driving area. They are prescription drugs as well as drugs of abuse or drugs that fall into both categories, both illicitly and licitly used. I think eventually we will have some evidence there.

The institute is in a broad range in the drug-control area. For years, through the addiction research centre at Lexington we have evaluated drugs of abuse, particularly narcotics before marketing. We do not have the ability to do that any more as federal prisoners can no longer be used for that purpose. We used to have a group of addict volunteers from the federal prisons and the narcotics could be evaluated before they were marketed. My feeling is now that we will probably have to rely more an animal data to make an estimate of the appropriate drug schedule to put a new drug into and do more post marketing research. The British tend to require much more of that and I think you do that in Australia. You require much better monitoring after marketing. We have not done it. We do not see it until it shows up in emergency rooms or coroners' offices. That is one area in which both the federal—particularly the Department of Health and the Narcotics Department and perhaps the State health agencies may be more interested. This morning the Health Commission people expressed an interest in that they are beginning to collect data on drug-related deaths. That serves as an indicator of health consequences of drug use and misuse. The number one drug cited in our surveys is a widely used prescription drug that has some level of abuse. It is not always the abuse drug that shows up in these cases. That is Diazepan—Valium. There is a system which I explained to the Health Commission people this morning. I shall be sending them copies of the latest reports. It is a reporting system from medical examiners related to drug-related deaths, from emergency rooms for drug overdoses and from crisis centres. They use a standard questionaire and fill in the information that goes into computerised processing. There are something like 1,400 reporting units around the United States and it is collected together by a small number of collectors. That gives some idea of what the health consequences are. It does not totally measure the drug or use or misuse problems. It is one of several indicators we have tried to develop. Another is that of getting information back from the treatment programme. We have some measure of what kind of drug treatment and follow-up is needed. It provides the ability to do follow-up on people in drug treatment. Another indicator is our national school and household surveys of drug use. This gives some idea of how many people are

involved. Most of this is soft data in the sense that it is reported by the individual. We cannot test school children for drug use, that is a sensitive area. Say children up to eighteen or nineteen—we do some in the colleges.

1863. This would be the senior school?——W. Senior and junior. Our drug use reaches down into the junior high and even to top fifth grade and sixth grade primary. Our junior high is seventh, eighth and ninth grade; and senior high, tenth, eleventh and twelfth grades.

1864. You would be making these inquiries in all sections?——W. Yes, they are indicators. They show weaknesses in terms of validity but we use other means, or attempt to use other means of independent checking. None of that is really treatment, rehabilitation or education, it is to try to give us some idea of what is happening, to try to understand the nature of the problem. I think in the past few years we have mobilized what is a pretty sizable and effective approach to getting at the symptoms and the effects of drug use but we are only beginning to get into various aspects of prevention and cause. The causes are so deeply embedded in the nature of our society that it is a difficult area. We have not done a lot in that area. A small amount of our findings at present is directed towards prevention. Initially we were responsible for education programmes in schools and so on. School leavers and civic leaders in the drug-abuse area—I think in their initial naivety and enthusiasm to get out the message out about the hazards and evils of drug use—it actually had a detrimental effect. Follow-up done in relation to the early education programme showed increased drug usage even by increasing awareness or decreasing fear. At one time there was even a moratorium on drug education programmes. The responsibility for that has been shifted—the health part to the Office of Education as an integral part of education programmes, particularly health programmes. In the annual report on activities in that area there was outlined the specific programme of the Office of Education. I am not familiar with the approaches they are using now. I know that the general rule today is for much more careful demonstration projects, more select groups, with good evaluation, before you start nationwide education programmes. You do a small study and try to get some evaluation built into it. You have to plan your evaluation before you start the study. We did not do that in the early days of drug-abuse education—which came out with an adverse effect. I have touched on a whole range of things. I was sent out to the media and asked to make contact with as many government and private individuals here as possible. As an official representative of the Institute I can speak authoritatively about my areas of concern and give my impression or opinion of the attitude within our Institute. We know a little of the attitudes within the new administration of Mr Carter.

I left Washington before Mr Carter became President, but his special advisor on drug affairs was the former deputy director of our special action office, so we are somewhat familiar and have a very close relationship with the new administration, and happily the same feelings about the kind of attitudes that should be adopted and approaches. We are not sure how the new President is going to organize the co-ordination and control of all these drug activities. Fifteen agencies are carrying out research and evaluation on drug abuse.

When you say fifteen agencies, do you mean fifteen government agencies?——Yes. These are just in the federal sector. Agencies is a loosely used term. It might be the National Institute on Drug Abuse, or the National Institute on Alcohol. There are related programmes where alcohol is a problem. When both alcohol and drugs are involved we meet jointly. There are two Congressional committees, at the national level, one being a House select committee for drug enforcement—the law side. The one that we relate to more is a Cabinet level committee meeting made up of representatives at various levels, such as health, education and so on. It is our understanding that the new administration does not favour that particular approach and it may go back to the special office within the President to serve as a co-ordinating group. They are advisory bodies. We may initiate our own terms of reference by recommendation, depending whether administration or legislation; we may recommend that we be given authority to do this, or we prepare our own activities and go to Congress and say that we recommend that such and such law be passed, which would in turn give us a particular term of reference to carry out some activity that is not currently covered by law, or to change the law.

1866. I gather from one of your earlier comments that Dr Denson-Gerber would not be highly regarded in some areas in the United States?——The whole area of treatment is still rather controversial. She is a very competent and learned woman. She is executive director of Odyssey House. That is one of the bigger and better known nationwide organizations that are based on self-help. They have a live-in community approach to drug rehabilitation. They have had a certain level of success. I am not familiar enough with the general treatment area to know whether the Odyssey House approach is any better than any other groups. There is also Day Talk and a whole group of these. We have had some difficulty in communicating with them. They do not generally receive federal funds so we have no direct connection with them in terms of any kind of treatment standards. They have been somewhat reluctant to be involved in any evaluation programmes. At the Institute I do not think that we have any directive that would suggest how successful the treatments are.

One can make a programme look successful if one is selective in the client intake. One has to be careful in saying that one treatment is better than another. In general our methadone treatment programmes are not as successful as others because they take everybody in. If you take everybody in to a treatment programme you will not have as high a degree of success as if you are selective. Maybe Odyssey House in a treatment programme could take somebody in that has been, say, to two methadone programmes and a drug-free programme. There is a big programme now on TM treatment for drug abuse. We are doing research on acupuncture for treating drug abuse. One has to be very careful. You have to do a very conscientious evaluation to get some degree of success. It is like a recycling process, so that when a second or third time addict goes through a treatment programme the success rate gets better. One nas to look at how many treatment programmes he has been in.

1867. Your treatment is purely drug-free all the way?——Yes.

1868. And they are very strict on their staff?——W. Yes. The director of our bureau of research development, which does demonstration projects and new treatment programmes as well as evaluation work, also trains all the drug treatment counsellors. We have a national synod that has a national training centre for drug abuse, and they train treatment counsellors. He spent a week in the Californian hills in the last six months and reported back.

It is almost a religious-spiritual kind of community. I am sure they have great value as a treatment approach for many people. I think our attitude is that you need a variety of treatment approaches. No one treatment is appropriate for everybody.

1869. How do you make these people arrive at Odyssey House?——W. They just walk in, or are referred by social workers or drug counsellors, or other addicts or post-addicts. There is a kind of evangelism involved in many treatment programmes. The example was cited that many programmes used post-addicts as treatment counsellors. There is an evangelism there, which has a lot of advantages. It does not always work.

1870. The Eastland Report has received a lot of publicity here and in other parts of the world. Dr Chesher from Sydney University wrote a very critical article about it. Have you any thoughts in regard to the main findings?—— W. I have not read the Chesher article. We have had some contact with Dr Chesher in the scientific area. I am not sure how he stands on the marihuana issue. Over the years we have provided testimony to the Eastland hearings. I think the last one was about a year ago, or even longer. He has not had a hearing recently. From my point of view, the selection of witnesses to appear before that hearing has been quite biased. Of the data and information provided some was factual and some was opinion.

1871. One of the greatest criticisms has been that it was not conducted on a scientific basis. Would you agree with that?——W. Yes. Most of the evidence was not scientific. We provided a great deal of evidence at the hearings, both verbal and supporting evidence. We are responsible for making each year a report to Congress, which is called the Marihuana and Health Report. It is required by Act of Congress. That served as a basis for our presentations. There has been a great deal of emotionalism. With the Eastland selection of witnesses, generally his administrative staff screens and selects witnesses. It was off on a particular bias. That may or may not slant the volume of the testimony. I think one has to subject it to scrutiny. Our general feeling was it was biased and on the negative side of it, there was not enought in-put from, say, some of the people who have done scientific work. Each scientific report has to be scrutinized.

We try to initiate research with several people along the same lines in terms of validity and confirming. Any one scientific report has to await confirmation and validation. It is not always possible and sometimes takes a long time. Over the past ten years—we started in about 1967—generally all the medical physiological evidence that we have generated does not present a very damaging case from a purely medical—say physiological—viewpoint in terms of the effects of the use of recreational or even moderately heavy use of marihuana.

We have carried out no research within the United States on the more potent forms of hash and hash oils. We have attempted to study other populations in the world where heavy use of other products is common. There is the Jamaican and Puerto Rican studies. We studied the Moroccan population, and one in Greece. Unfortunately from those it is difficult to draw any conclusion. Most of those tended to suggest that they saw very little difference in the heavy cannabis users and the general population. They were small special groups. In general, the population studied had a high level of, say, malnutrition and maybe low education levels, so that the background physiological problems were high. The changes that cannabis may have made were very difficult to pick up.

If one could study a population in a country where nutrition and health were largely favourable, such as in the United States, Australia or European countries, you may pick a different scene. We just do not know. We do not have a large indigenous population of heavy hashish or more potent forms of marihuana users.

1872. In respect of the Jamaicans, the findings were suspect because it was found that they were great drinkers of tea which contained cannabis?——Yes, that is ganja. That is a very potent form.

1873. Have you conducted any experiments to determine the combined effect of alcohol with marihuana?—— Yes, a few, more in the performance related area. In terms of carrying out research on the physiological effects, we have not been permitted by our food and drug administration to give high enough doses. We are constrained by human subject experimentation regulations. We have started some experiments in the Department of Transportation on marihuana and alcohol combinations. They are generally moderate doses and there is an additive factor. They are both central nervous system depressants. As one would suspect, the effects are enhanced by the presence of the other. From the collection of information in this country, New Zealand, America and Scandinavia where the major studies have been, it appears that a person could be as impaired by a lower point, say .05 of alcohol with the drug than with, say .10.

1874. Were you at the workshop while Dr Sally Casswell spoke?——Yes. Our authorities in that area have been generally impressed with her work.

1875. We have been trying to obtain a copy of her papers, but so far we have not been successful. You would have seen the experiments conducted?——Yes.

1876. And the slides that she showed indicating the performances?——Yes.

1877. Would the results that she got conform with your own thinking?——Yes. It occurs with all the studies that have been done along those lines; but you still have to keep in mind that, whether they are in a car driving around a course or in a computerized simulator, they are still in the laboratory procedures and subject to a lot of difficulties. But when you put them all together they all agree in the general tendency to show an additive effect between alcohol and marihuana. Certainly, the combination is going to be more dangerous than either alone.

1878. Just recently there was an announcement made by the Prime Minister that consideration was being given to increasing the penalties for trafficking drugs in Australia. In the correspondence that came to us there was a definition of cannabis in leaf form. Do you see any legal difficulty in differentiating between cannabis in leaf form, and cannabis?——Do you mean in the context of trying to make the penalty for possession in leaf form less than possession in other forms?

1879. Yes.——I do not know if that is totally justified on the basis of the data that we have been collecting or some of the data that the drug laboratory has been collecting here. Some of the leaf forms that you have large quantities of here that we have not seen much of—the Thai sticks and the Buddha sticks—are essentially leaf forms, but they are very potent forms, and some of the leaf forms, the Buddha sticks that have been collected here that have been smuggled in—and there are some locally-produced Buddha stick imitations—are generally not of as good quality. We have seen those in the United

States. They are more potent in some cases than hashish samples. It is a special kind of leaf form and if you look at it under the microscope it almost looks as though it has been dipped in oil. You can see the resin; it is very heavily embedded in resin.

I do not know whether that would be defined as a leaf form. It looks like tiny marihuana leaves; they are carefully selected flower parts and the bracts of leaves from the female plant, and they run as high as twelve per cent active ingredient, whereas the average hashish that we confiscate in the United States that has come to our labs averages probably around five or six per cent hash. Hash oil, the most potent we have seen—and we have only been getting those that come to drug enforcement; we have not obtained samples from the State labs where more variety may be seen, but we are starting to—we have not seen anything over 39 per cent active. Here the best sample the drug lab has is 65 per cent or 69 per cent.

1880. Mrs DAVIS: Sixty-nine per cent to 70 per cent. ——W. Yes, close to 70 per cent. So we get into the monitoring of the per cent activity in hash and hash oil. At the last Eastman hearings the drug enforcement administration in their testimony claimed they were seeing a greatly increased inflow of more potent forms of cannabis. When they were challenged by our scientific people they had no data to support it. So Senator Eastman asked the administration why they did not have the data and they said they did not have the resources or the ability to do it. He asked our director and he said we do have the ability to do it. So Senator Eastman asked us to co-ordinate our efforts, and drug enforcement is giving us all their hash and hash oil samples and any large cannabis seizures, and we have about twelve months' data now and several hundred samples to see whether there is any trend towards any increase in potency.

It is difficult to get that assessment here. We had the same problem. In Australia you have State labs that do carry out a certain amount of analytical work and you have the Government lab which is primarily servicing Customs. All that information does not necessarily get together. Our Customs people, for example, were not carrying out quantitive assays. Rather, the drug enforcement people were not and the Customs were. So we never had a complete data basis. It is important if you are trying to see trends and anticipate legislative changes that may be necessary, to know more precisely what is coming in and what is happening.

Looking at the figures here, it would seem as though you are getting much more potent forms coming in, perhaps because of your proximity to South-East Asia. It appears to be easier at the present time to smuggle goods into Australia. You have immense borders and probably a much greater exchange of people, on tours and otherwise, with South-East Asia than we do. So it seems that you have got to the stage where you are getting much more of these potent forms than we are. We have never seen a seizure of Thai sticks as big as some of the smaller ones you have had here. We do not have as big an exchange.

So I would be very cautious in how that is worded. You know the mix up on cannabis in international law. The single definition in our Act speaks of cannabis sativa as the phycho-active form of cannabis. Scientifically that was a big mistake, because the scientists do not agree on whether there is one or more species of cannabis. We, as a joint venture with the world community working in this area at our marihuana research farm in the Mississippi said that there were ninety-nine varieties of cannabis. We invited the United Nations to hold their international symposium on the botany and chemotaxonomy of cannabis. We were careful to invite all opposing sides of the issue. The group of experts from around the world, Japan, various parts of Europe, the United States, a number of countries that we represent—the Canadian government has done a lot of work in this area—could not agree as to whether there is more than one species or how you can tell the difference if there is more than one. The two things they did agree on, although it has not come out as an official report yet from the United Nations, but it is in progress and may have been presented to the international narcotic control board this month—were that we cannot at the present time definitively say if there is more than one species or how to distinguish between them; and that as far as legal purposes are concerned, all legal groups should consider using terminology to indicate that the material that should be controlled is any form of cannabis containing psycho-active cannabinoids.

1881. CHAIRMAN: Our people got round that by referring to it as Indian hemp or saying the genus cannabis? ——Yes, genus cannabis. Even Indian hemp is one variety. It is not a good universal thing if you start breaking down cannabis. We are in the process of distinguishing penalties on the basis of the quantity of material that is in possession. Our so-called decriminalization move, which has been endorsed by President Carter, is based on a first offender in possession of a small amount of marihuana. A small amount is defined differently by every State. The largest has been two ounces or sixty grammes. Some say thirty grammes. Then the question came up: Well, does it make any difference how potent it is? Thirty grammes of hash is different from thirty grammes of marihuana. We have got into the same sort of debate on how you distinguish. There has been some discussion in the heroin law about making more umbrella penalties for possession of small amounts but when you get into the potency areas you have to consider the ability and the costs involved in trying to carry out the assays. Generally you want to make it as simple as possible.

1882. What did President Carter do?——I do not think any action has been initiated yet, but we do know through his special assistant on drug affairs, who has publicly stated that this administration will endorse the passage of a federal decriminalization law——

1883. It is still a civil offence but not a criminal offence to be in possession of a small amount?——Yes. Some of the States have changed their laws but it must be taken in context. It is somewhat analogous to a traffic fine. It is an offence subject to a fine but it is not a criminal penalty.

1884. They hand out a ticket?——Essentially, yes.

1885. Is that in Oregon?——I think Oregon does that. It is like a traffic ticket—for first offenders, small amounts. If the federal government passes a federal decriminalizing law it is still up to the States to impose whatever law they want. The federal law is needed for a couple of reasons. We have States like Oregon and California where it is an offence, an fineable offence, to possess. To carry it from Oregon to California is a federal felony because the federal law says you cannot do that. The whole reason behind this is that we had something like 600 000 offenders charged with possession of small amounts of marihuana, which are just bogging down the court system, and there have been some undesirable repercussions. The law enforcement people, the police officers, make a judgment: Well, I am not going to assess this proposition because I do not agree with it, and that has corroded some of the

drug enforcement laws. Our judges do not have the ability to make decisions as to penalties as your judges do here. Your magistrate can say: Well, this is a thirteen-year-old kid. Somebody handed him some marihuana. I cannot take any action. Or it may be a twenty-five-year-old peddler. We do not have the ability in our courts to see that kind of discrimination. That is the other part of a sort of decriminalization. It is nothing like legalization; it is not legalization in any shape or form.

1886. In your work do you come in contact with any accident statistics which would give you an indication of the number of, say, mortalities due to the use of drugs? ——The study that we are helping to support with the Department of Transportation now has completed perhaps up to 2 000 injured driver samples. We are now looking at the presence of marihuana in those samples. We were not able to do it previously. In terms of other drugs there has been a significant drug involvent, particularly the central nervous system depressants—barbiturates, valium and those related drugs. But that is only half of the equation. We do not know what to measure that against because the control samples of nine injured drivers are very questionable.

The Department of Transportation pulls drivers out of the traffic and says "We are conducting a drug related traffic accident study. Will you give up a specimen?" If they say "No", they are on their way. They get about an 80 to 85 per cent participation, which I think is remarkably fine.

1887. Would you agree with the statement by Dr Robinson in Melbourne that in this field of fatal accidents where drugs are involved the drugs concerned probably come in the area of barbiturates, valium, amphetamines. ——W. Amphetamines—I don't know. We are not even looking at amphetamines. That is a very complicated issue because in the case of amphetamines there may be an indirect relationship. Truck drivers and people driving long distances are using amphetamines. Their performance may not necessarily be improved but they may be more awake. The methods of detecting amphetamines at low level are not that reliable so we are very dubious about the effects of them.

1888. Otherwise you would agree with that statement? ——W. Yes.

1889. I think she devoted quite a bit of time to the detection of amphetamines and the effect of them, assuming drivers were probably taking them in order to stay awake.——W. Yes. We have had to go through that exercise to assess priorities. Our resources are limited, as any group's resources are. We have had to decide where we are going to concentrate our efforts.

We have survey figures of the age groups involved. We have three groups on drugs that we feel are most important in casualty. We are thinking a bit more broadly than traffic safety, but alcohol is certainly the most over-involved. Then in the younger age groups, because of the widespread use of marihuana and the fact that they are a high-risk group, we feel that is perhaps the second most important group to look at and perhaps close to that or a slightly lower priority are the older age groups with the valium related group of drugs because they are the most widely prescribed and most widely used drugs—for marihuana, 25 or below; for valium, above 25—so we separate those two classes. Our third group is the central nervous system depressants—barbiturates and non-barbiturate depressants.

On volume of use that is the order of priorities. After alcohol the most widely used is marihuana and the valium group of drugs and third depressants.

I showed you earlier a copy of our terms of reference. You will recall that in its broadest terms it includes the minor analgesics. Have you had a great deal of experience in regard to the effects of any of the aspirin compounds? ——W. I have, because prior to joining the drug abuse centre my general area of interest and the area in which I have written was analgesics in general, including the opiates, the anti-inflammatories as well as the antipyretic analgesics—the aspirin group.

In terms of drugs of dependence, we have not done much in this area. The closest we have got in our drugs are the propoxaphenes. They had previously been sold in the United States as a prescribed drug not under narcotics controls. Since a study was done on deaths related to propoxaphenes that drug has been moved into one of the lower schedules, equivalent to your schedule 8, because it has been widely misused. It is not terribly sought after by addicts through legitimate trade channels.

There have been a few Darvon maintenance studies after methadone maintenance carried out for a number of years and this has led to some accidental deaths. Methadone is a very toxic drug if used indiscriminately.

In the aspirin and aspirin combination area we have not done any particular studies but we have some information on them on our surveys of drug users and we see others reported, but we have not focused any attention on those drugs. We know that they present a hazard. The medical and pharmaceutical associations have attempted to restrict their wide scale sale through grocery stores and so forth without any success.

1890. Have you had any experiences similar to what we have had here; in one area north of Sydney apparently there is a much greater consumption of these minor analgesics than in any other part of Australia and by a strange coincidence they also seem to have a lot more people with renal problems. One of the doctors there has done a quite extensive survey of this sort of thing. Have you had that same sort of experience?——I am quite familiar with the literature in terms of some of the difficulties that people have with these drugs. I do not remember any particular area where that has evolved but my impression would be that there would be a very definite relationship because there is no question that both aspirin and the newer substitute paracetamol lead to a number of renal problems and certainly it is very closely related to the amount consumed and frequency of consumption.

1891. The people that put out the pure aspirin claim, rightly or not, that it is not the aspirin that causes the problem but the aspirin in combination with other chemicals. Have you anything to say about that?——From the literature and papers I have seen I do not know if there is any good evidence on either side of that issue. There are a number of problems associated with aspirin use alone. I think that at one time the culprit was thought to be phenacetin which is now available in the United States only on prescription and its use has become fairly rare. It was replaced in most of the combinations with paracetamol, but paracetamol has associated with it a certain degree of toxicity. It is very difficult to do a short term study on that. You have to wait until you get a good clean history of drug use, which is extremely difficult to do because if you are looking at the average population you do not find someone that just uses aspirin. I think eventually a number of cases will be found and studied in

which aspirin was the only drug used and perhaps then you will be able to say whether aspirin is any safer than paracetamol. I think there are certain hazards associated with what one might call the promiscuous or widespread use of any of these products. They have all been shown to cause damage in excessive use, certainly in animals. There is no evidence I am aware of that one is any safer than the other. I think they all ought to be treated with some degree of caution.

1892. I was very interested to hear your comments in regard to education methods and the fact that the office of education seems to have taken over.——Yes. The responsibility for all of our drug education programmes has been shifted from our department of education and welfare to the office of education.

1893. Could you give us in very brief terms the main activities of the drug education programme?——Unfortunately since its transfer to the office of education I am not as familiar with how they operate. I know the general direction has been to try to make accurate and reliable information on drugs available as part of the normal routine health education programme within the school courses rather than having this sort of special attention drawn to drugs.

1894. In other words the instruction would be given by the teachers?——Yes, just in a sort of normal programme, not trying to highlight or dramatize drugs as being one of the hazards of society that people have to be made aware of and not giving drugs any special attention, but making sure that the information supplied is reliable because the credibility gap widens when you give out misleading or false information and it is subsequently discovered. They are not going to believe anything you say after that, so it is important that the information given is accurate. The people that plan and publish the information that goes to the educators have to draw upon a good balanced source because there is so much controversy in the area. You have to have a balanced source of experts that clash over the data and come up with some compromise that seems to be reasonable.

1895. Would you have anything to do with the manufacture and distribution of drugs apart from perhaps testing?——W. Yes. In this area of drug control one aspect of this committee of which I am chairman is the quota system. You have a quota system here in Australia and it is fairly analagous to what we have in that the government sets production quotas for any manufacturing concern and imports—I am not so sure whether we set quotas on exports but at least on imports and manufacture we say "You can only import or make so much of this drug", the idea being to keep the amount available to a minimum. We try to arrive at a reasonable amount on the basis of legitimate medical needs. We have never attempted to deter use of them on prescription by physicians by making less available. We have never attempted to sort of direct the way a physician operates his practice by saying "We are not going to make as much of this drug available so that you cannot prescribe as much". What we have tried to do is assess the minimum needs but we have had quite a lot of difficulty in doing this relying on prescribed use and hospital use.

In Australia you are fortunate that you have a drugs of dependence monitoring system that was started seven or eight years ago and, from what I saw of it, it appears to operate quite successfully so that not only can you adjust quotas on a monthly basis but you know where stocks of drugs are and any shipment between warehouses, manufacturers and overseas is carefully recorded. Our drug enforcement department has for the last six years tried to develop a similar system but it is not yet operational. We have about twenty times the volume of legitimate drug movements that you do but that really is no reason why we should not be able to come up with a comparable system. Twenty times the amount of data should not bother a computer.

1896. I noticed in a United Nations report that there were 32 illegal factories closed in the States in I think the year before last.——What kinds of drugs?

1897. Amphetamines.——W. Yes, amphetamines and hallucinogens. Our biggest drug problem—apparently you have not seen much of it here yet—is phenyclapine—pcp. It is used mostly as an animal tranquilizer but it has become the third or fourth most widely used drug. A number of pcp factories have been closed. It appears to be a hallucinogen.

1898. Mrs DAVIS: Is it like fortral?——Do you know another name for it? It was originally introduced as a general anasthetic for use in humans but there were side effects and it was restricted to animal use. However, it is easy to make from readily available chemicals and therefore it is difficult to have surveillance upon it. The estimates are that 50 per cent of what is sold as LSD is phencyclidine. In fact, there are large phencyclidine areas. It has similar effects to LSD and naive users do not know the difference. It is put into a solution and sprayed on parsley and dried and often it is smoked. Angel dust is the other name for it.

1899. CHAIRMAN: Is there any significance in that? ——It is the term people use. It is also sprayed on marihuana and that is supposed to be a really good experience but it is dangerous. Chronic use of phencyclidine produces paranoids schizophrenic behaviour and people become difficult to treat. Where my girls go to school at the local high school it is fairly common.

1900. Mr HEALEY: What is the annual budget?—— The National Institution of Drug Abuse budget, including all services, is somewhere around $500 million—it is $400 million and something. But, most of the money is earmarked to go to set treatment programmes. Our research budget is $30 million, but that is directly earmarked for research. The evaluation budget is probably another $30 million.

1901. What degree of autonomy do you have in the distribution of the annual budget?——The way we operate is fairly autonomous. We make budget proposals to our agency and they are passed on to the department. We have two budget processes. One is with Congress and one is with the President. There are hearings where our people are represented by the assistant secretary and he has agency directors available to provide any additional information that might be required. There are hearings for the budget itself. They process their own budgets and over a period they may or may not agree and there is always the possibility that the President will veto the Congress budget and so they fight backwards and forwards. It is a rather complex arrangement. Once that is settled and the money is there we generally have to abide by the areas that have been indicated in our priorities. But, you carry out that particular activity and assign the funds on a total level and that is done internally within our own division of research. We used to use a lot of outside experts to advise us in the specifics of this approach as compared with that approach. We still use outside people throughout planning, evaluation and execution. I would say

that $27 million of that $30 million is money that we give out on grants to people to do work for us. Only about $2 million is spent on research work that we do ourselves.

1902. CHAIRMAN: Do you finance university projects?——Yes we do, and about $18 million or two-thirds of our funds are in the form of grants. These are investigator-initiated research projects. About $9 million is used on contract research. We decide that something like, say, driving studies should be undertaken and we call in a group of experts to give us some advice. We advertise for people to bid on it. In fact, it is the same way that we go about building bombers and rockets. However, priorities do change and this gives us some flexibility.

1903. Mr HEALEY: I take it that there is rather a situation of split responsibility between the federal authorities and the State authorities and that the State authorities have primarily responsibility for penalties and treatment? ——Yes, to a point. The only control we have over the States is when we give them federal money. In that case we can set down guidelines for standards that they have to meet. Sometimes our standards are minimum but sometimes they are maximum. Other than that, the States can add to what they do. Criminal penalties under federal laws are minimum but under State laws they can be almost anything at all.

1904. Do you draw any distinction between dependence on and addiction to drugs?——W. There is a lot of debate over the use of terms. I tend to agree with the World Health Organization that drugs of dependence or drug dependence is the better term. Addiction has a more specific meaning and, I believe, a more narrow meaning. There is no evidence that, for example, marihuana is addictive but tolerance to marihuana does develop and we do see some withdrawal symptoms from heavy use of marihuana. There is perhaps a great deal of psychological dependence on it, but, is that really addiction? I think it depends on whose definition one might use. There is no question that drugs of dependence, as a terminology, is something that is understood by everyone. It is said that doctors overprescribe drugs, but is that mis-use?

1905. Mr JACKETT: Is there any sign of a simple drug analysis such as the breathalyster to take up the main problem that I suppose marihuana would be the most concerned—and if not, is there any sign of a computer type machine which might give a very rapid analysis of marihuana in the bloodstream—marihuana and other drugs too? Recently I saw a computer type machine which is able to give 20 different kinds of pathological tests in six and a half minutes. If something of this nature were available obviously it would help in any enforcement programme?——W. At present the first question is one to which I would have to say no, there is not any method available for detecting drugs by the breath, though there has been a considerable amount of research in this area. The Department of Transportation is more interested in driving accidents and the broader area we have been looking at is the detection of the use of marihuana from breath analysis. It is possible and it is described in a publication. We do have some methods which are simple enough, but they involved computers and sophisticated instrumentation is needed. There is a rapid urine test available. The company that has developed it has six drugs which it can screen in six minutes. There are other procedures which take longer. These screenings have advantages and disadvantages and are only for use with urine. We have supported the development of one for marihuana detection and it is undergoing field evaluation now. We have had to develop a computerized method. The simplier it is the less reliable it is, of course, and the less likely it is to show accurate results. We do not know whether there is any need for roadside assay. We are developing portable tests which may show the presence of a drug but we do not know whether any particular level will have any law enforcement value. It will be difficult to say that the presence of marihuana in urine or blood is an offence. It took 50 years to establish that with alcohol and the authorities still do not agree on it. Different world authorities say variously that the vital reading should be .03, .08, .1, .15 and so on, so what is the correct level? No one can agree on that. If you can establish a level which legislators would accept as being something that is not imposing undue penalties on society and will serve as a deterrent for driving, it may be helpful.

1906. CHAIRMAN: You are talking of a machine with a chemical reactor in it, are you?——Yes. One of these can be made portable so if one is conducting random tests on the roadside it may be set up quite easily. However, that is not quite as simple as the breathalyser. But, it would not be too difficult to develop this sort of thing for marihuana and other drugs, with the technology that is available today, and they would be able to come up with an answer.

1907. Would the cost of the tests be high?——W. That is hard to say because we are still researching, but the rapid one-minute urine assay has been used in many laboratories. Cost is a factor; and it would be more expensive than the breathalizer. I think the Victorian people estimated it would cost $5 an assay. Therefore, to do massive roadside testing could be expensive. I think the consensus in Melbourne was that nobody knew whether drugs were involved for sure in road accidents. A big expenditure would be involved in developing a system of finding out, and more res arch is needed.

1908. Mr JACKETT: Some people want to decriminalize the use of marihuana. There seems to be no doubt on the evidence we have had that motor co-ordination is affected by marihuana; would you agree?——W. Yes.

1909. Therefore if marihuana is used by persons who drive, we must regard it as a serious consideration if we are to widen conditions under which it can be used. For this reason it would be essential, would it not, to have some kind of definitive test of the quantity that is likely to affect the person's ability to drive?——W. We are anxious to achieve co-operation between countries, such as with your Health Commission in New South Wales and with the appropriate bodies in the other States, to start using some of these tests. The idea expressed in Melbourne was that every traffic casualty case is measured for alcohol and if the alcohol is above a certain level, the person concerned is required to give a blood sample or to undergo a urine test, or to take both, and then they are checked for drugs. If a check is made for marihuana use and if marihuana is found to be present, that fact will then go to the court along with the other evidence, which will have to make a decision in the matter. I do not think there is any scientific data available that would establish the level at which marihuana use impairs ability. We hope within the next twelve to eighteen months that information will be available, but we have to start collecting the data now, and when we get it the better informed you will be in making your recommendations.

1910. Mr RAMSAY: What is the attitude of the authorities in the United States of America to the methods of treatment used? I know that in one Australian State, namely Western Australia, they do not believe in this

form of treatment. Are you aware of that?——W. There has been some kind of controversy about this matter. Some States do not have any method of treatment, and have developed their own approach to the problem. The frame of reference that one has to use is that methadone is a drug that can be used as an adjunct to the overall treatment programme. It has been misused by some persons in treatment because they misunderstood it. We have some excellent treatment programmes involving methadone and we have some poor ones, and we have a lot of problems associated with those. The original idea was not all that good from the medical viewpoint. However, it is a question of getting the addicts off the streets. That was a few years ago. We have improved since then in most of our treatment approaches and people better understand how methadone should be used. It is not a treatment in itself and it is certainly not a cure, but it leads into other forms of treatment. Counselling is involved, and you cannot take them straight off heroin.

1911. How did the set-up in Victoria in regard to education and treatment compare with the situation in the United States of America?——W. We were not concerned so much with the educational side of it. The treatment programme seemed to be quite well organized and seemed quite reasonable. They had good facilities. Apparently most of it is directed through the alcohol and drug dependence services branch. In that way more uniform standards were available. I do not know how many alternatives there were. We were not told the alternative treatment programmes. What we saw was heavily geared to alcoholism and there is a difference fiscally and physically between the treatment of alcoholism and the treatment of drug abuse. There is a lot of talk about forming a national institute to simplify a lot of paper work concerned with managing the problems of alcoholism and drug treatment. I do not think that will happen. The alcohol lobby is that strong that they do not want to be contaminated by the dirty drug abusers. That is an important element. What we saw was impressive and seemed to be well organized and to compare with some of our better programmes.

1912. Mrs DAVIS: The police chief in Oregon said that when they decriminalized marihuana they felt that their workload would decrease. He then testified that it increased. It has increased because the intake of harder drugs has increased since the decriminalization of marihuana. Would you comment on that?——In Oregon there was no apparent increase in marihuana use. I am not so familiar with the workload situation. It is a different sort of work load. It probably should increase the work load of the police, but not that of the courts. The police were not enforcing the law because they felt that the penalties were too harsh, or something like that. Once the use of marihuana was decriminalized the police were more inclined to enforce the law because they were giving out $100 tickets rather than sending the people concerned into the courts.

1913. You said that you control anti-depressants under your legal system. How do you do that?——Do you mean the anti-anxiety drugs?

1914. I mean both.——Both are included. The secretary, on the advice of the Food and Drug Administration, can move drugs in and out of schedules, and, based on our animal studies, human studies, drug overdose studies, and prescription sales studies we make recommendations, and once the secretary makes a decision, the law enforcement people have to enforce it in that way. The real distinction is the one between section 4 and section 8 of your law. In regard to the valium class of drugs, they go into a lesser schedule. The amphetamines are classified in the same schedule as morphine. We are probably going to move to restrict the use of amphetamines. There was a Senate hearing by Senator Nelson on amphetamines and it is likely that we are going to move to restrict their use. You have significantly contained the use of amphetamines in Australia. Whether that will lead to the use of other drugs, I do not know.

1915. CHAIRMAN: However, that throws the onus on to the doctor because he has to prescribe it, does it not? ——Yes. The biggest problem are the so-called fad doctors who are prescribing millions of doses of these things.

1916. Mrs DAVIS: So you have not restricted them yet?——No, but Senator Nelson has asked us to come back within a couple of months and put forward some submissions on the matter. Our drug control group is inclined to recommend greater restriction in use.

1917. What about the use of amphetamines by lorry drivers, who are abusing ephedrine?——I would not say there is much of that happening there as there is here. There are a lot of roadside sales of amphetamines. They are easy to make. Their precursors are not controlled, but they are on the chemical surveillance list.

1918. We have heard from a lot of witnesses who have spoken of addicts in the 16 to 25 years group or in the 19 to 28 years group, but you are the first one to talk about recycled addicts. Would you comment on that?——The direct treatment programme I am not involved in but it is my impression that we are building up a population of addicts. The records of patients in this area is a delicate matter. We are now beginning to see how many times a person has been treated. The groups that have looked at this have found that the success rate increases proportionately with the number of times a person has been in.

1919. Can you tell me what the maximum dose of methadone is, as you are using it in your treatment?—— We did a very large study of this. Over the years most of the analgesics have been evaluated by our veterans administration. There is a lot of data on this. The results have indicated that the success rate between a high and low dose is not all that different. The tendency is now to try to get people down to the smallest possible dose necessary. A most competent liver expert carries out liver function tests on addicts. This lady doctor is doing many studies in this field. We are going towards a low dose.

1920. CHAIRMAN: Thank you for coming along today and giving us the benefit of your experience. We have had an interesting two hours and the time has gone quickly. If you have any further information available I should like you to forward it on to us.

(The witness withdrew)

The Committee adjourned.

*AT SYDNEY ON FRIDAY, 11 MARCH, 1977*

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The Committee met at 10 a.m.

Present:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| The Hon. KATHLEEN ANDERSON | Mr J. G. T. JACKETT |
| The Hon. MARGARET DAVIS | Mr B. McGOWAN, B.A. |
| The Hon. C. HEALEY | Mr E. D. RAMSAY |

Dr JUDIANNE DENSEN-GERBER, Doctor of Medicine and Attorney at Law, and

Dr MICHAEL BADEN, Deputy Chief Medical Examiner, City of New York, sworn and examined:

1921. CHAIRMAN: Dr Densen-Gerber, will you give to the Committee, your name, private address and occupation?——W. (*Dr Densen-Gerber*) My name is Judianne Densen-Gerber, and I live at 142 East End Avenue, New York, United States of America. My profession is Doctor of Medicine, Board of Eligible Psychiatrists; as well as Attorney at Law, United States; and Professor at Law at several of our universities.

1922. Dr Baden, will you give your full name, occupation, etc.?——W. (*Dr Baden*) My name is Michael Baden. I am Deputy Chief Medical Examiner in the State of New York, which is the equivalent of the Coroners Office here. I am also a Professor of Pathology, and Forensic Medicine at various medical schools in the United States; and Adjunct Professor at Law at the New York Law School.

1923. On behalf of the Committee, I wish to welcome you, and to explain to you that this is a Select Committee of both Houses of the New South Wales Parliament. It is probably not quite the same as the Parliamentary enquiries that take place in your own country, but the purpose of this committee is to investigate the use, abuse, and dependence on drugs. As I said, this is a joint committee of both Houses of Parliament, and the members of the Committee are drawn from all parties in both Houses of Parliament.

1924. We thank you very much for your attendance and we deem it as your doing us a courtesy by coming here to this meeting today. We are engaged in an enquiry which we believe is most important in regard to the health and welfare of the people of our State. Because of our association with Mr Gidley, we have known for some time of your visit to this country. Indeed, we understand that Mr Gidley and Mr Walter McGrath have been responsible for your visit to this country, and we thought that we might have an opportunity of hearing from both of you your thoughts on the matter with which we are dealing. We know that you have both taken a vital interest in this very serious social problem in your own country. First, Dr Densen-Gerber, perhaps you might give us a little of your own story, and the medical aspects of drugs, and your opinions in regard to their social effects?——W. (*Dr Densen-Gerber*) First, I thank you for inviting us and giving us the opportunity to come and speak to you, particularly at the end of our visit, for we are pleased to share with you, the leaders in New South Wales, what we have learned. Perhaps I can in almost one sentence, summarize my feelings. That is that I am experiencing a feeling of *déjà vu*—a feeling that I have been there once before. I was there in 1969, in New York when I began to see young people suddenly turn to drugs like the young man sitting next to me here today.

Prior to 1969 I had been involved in addiction for about three years. The average age of the addicts had been about 25 years. They were mostly male, and they had a typical profile of the criminal type. We saw many of them. I had been sent, in my first year of residency, down to the addiction service of the hospital, where I was training. We had the only addiction service at that time in the entire city of New York. We had fifty beds. You can see that we were unaware in those years. I had been sent there by a rather odd chance. I was pregnant for the sixth time in seven years, and I was a little tired. I went to the Chairman of the Department of Psychiatry and said to him, "This is a little much, and I had better take maternity leave." He said, "No, you don't. Go down to the addiction ward. You can check in. You can punch the time clock. Go home, and no-one will know the difference. Then come back, and we will be covered and you will be getting your credit."

The reason why he felt that way was that in the six years that the addiction ward had been in operation, there had been 17,000 admissions but only eight people had been cured. At a cost of $104 a day, you can imagine what the feeling was at that time. There was a sense of hopelessness, and that there was no way of containing this. You had to go through a kind of procedure, that everyone played that game, but no-one got any better.

I went down there in 1965–66. What I found was a group of young people—and intelligent—and capable of manipulating; but in a negative direction. It was a fascinating challenge. In the beginning—although at the time I did not realize it was—the challenge was complicated by the fact that my primary job was drug maintenance. I began the treatment of addiction by running a methodone and cyclazocine programme. I was giving the doses that were recommended. It was very much working towards chemo therapy. We had a new drug that was non-addictive. Methodone is addictive, exactly like heroin. There is nothing you can say about heroin that you cannot

say about methadone, except it is able to be ingested orally, and absorbed through the gut, and has a longer period of action. It produces the same addiction, the same withdrawal, but a great deal more exaggerated than heroin, but it does block heroin. We were able to give it legally in our country. Cyclazocine, on the other hand, was a drug that did not do these things. We tested it and found out that it injured liver tissues, causing permanent damage in some patients, and was in a high percentage of cases causing an onset of a pseudo-schizophrenic condition. They were paranoid, and did not respond, to phenotiazines, only to cessation of cyclazocine.

While working with these young people from 1966–1969, we began to try to develop a pyscho-therapeutic or psychiatric method of treatment. By 1967 the hospital called me in. This is all written up in my book, *We Mainline Dreams*. They said, "Doctor, we are paid by the Government to test drugs, and the patients must take drugs, even if many of them now want to be drug free". They wanted to be drug free, because they said we were giving them two messages—that their addiction was of choice, and they may make positive choices and be full people; and we were telling them that they were in charge of their own destiny. On the other hand we were giving them a drug because we said they had a permanent disorder, similar to diabetes. They said, "Are we cripples? Or, can we walk forward as other people do?" I said, "You can walk forward as other people do, and we will give it a chance."

The hospital would not permit this. I had been removed from the service at that time, and I had been sent to another service. They felt that the authorities were unwilling to continue with drug treatment without drug replacement. At this time seventeen young people came and rang my doorbell. I was up-tight. They said, "You promised us that we could be changed. That if we wanted to be drug free we could be." At that time they had myself, a second year resident, $3.82, and a commitment to get well. From that we were able to move to the Odyssey Institute system. I shall not describe that now, but Odyssey House is the largest part of it. There are 44 centres serving 12 states in the United States.

We have about 700 in-patients at any time, and about 400 out-patients. I am happy to report to you that many of these people succeed in the programme. We can predict that there will be a minimum of a nine out of ten success rate. So there is no reason to give up on these young people. It is very involved. We go into the kinds of close-knit working relationships between the law enforcement and medical treatment. But they can get well. Nine out of the ten can get well and the other one still needs a great deal of work.

In 1969 something changed. This is something that I fear for your country. In June 1969, with the best of intentions, but with ill-conception and perhaps misinformation, the Attorney-General of the United States, John Mitchell, called for an operation that was named Operation Intercept. It was to remove marihuana from the American scene. We did successfully do that—we showed that it can be done. There was very little marihuana available in New York City, and in the other cities in the United States, in June 1969. In turn, the suppliers of heroin—who I can only characterize as the best marketers and persons understanding business that I have ever seen—took a look at the fact that there was no more marihuana. They said, "If we package heroin in dollar glassine envelopes, we can sell them to the children, and we will get the lunch money that they have been spending on joints of marihuana".

In one month, June, 1969, New York City had 103 overdose deaths of all ages, That is unbelievable. In 1969 we witnessed 232 deaths of just children—teenagers and younger from drugs. We had never had that many deaths before. The year before we had less than 40 deaths of children. It was an absolutely new phenomenon. We saw many things. These children did not have very much mental illness. Many of them came from nurturing environments, which were not the most secure and healthy, but they were children: they were just children. What had happened to them was that their friends began using drugs. One or two children started, and by the time they were done, so many of them were using drugs. In one classroom in the Bronx it was found in 1969 that 39 of the 40 children were using heroin. The non-using child in that class was so withdrawn that he or she—I forget now whether it was a boy or a girl—became so sick as to need the most attention. We have to understand that young people between the ages of 12 and 18 do what everybody else does. If the others are wearing short skirts or long hair, they wear short skirts and long hair. They do whatever it is. That is part of normal adolescence, and the only way you can control the adolescent's development is to put him or her in an environment that is healthy. As I say, the adolescent will do what his or her friends do. The adolescent will do what is offered him by his generation whether it be panty raids, joy rides, drinking, or early sex, and, when the market develops, addictive drugs. That is what I fear so much, for your young children embracing drugs.

In 1969 the Commissioner for Drugs of New York, Larry Pierce appeared on a television programme with me and said there were fewer than 28 children in New York using drugs. I said I thought there were 3 000. When Mayor Lindsay left office in 1972, he admitted to 30 000. That is the point. If I can get across nothing else, I want to get across the fact that drug addiction is contagious: that it spreads like wildfire, and it spreads in children. In addition, with children you have a phenomenon that is even more frightening: the ratio, we found, changed from one in eight being a female to one in three being a female. Along with the great number of women using drugs came promiscuity, venereal disease, and illegitimacy, and the problems that premature parenting causes both the mother and the child. One of our cities, Washington D.C., has just reported more illegitimate births than births to women who are married, and the majority of the mothers are teenagers who have little in the way of coping skills. So we are now approaching our second generation of addicts.

How does this apply to Australia? It applies in two ways. I see here a ripe and fertile soil in your young people. I have brought along today a young man who will tell you a little of his experiences. Later we shall hear from a young woman. There is no difference between these children and the children that we saw in 1969. The second thing is that in 1975 we had a heroin war in the United States of America. The heroin war was between three major cartels, European, Mexican, and the Golden Triangle. The Mexicans and the Europeans have cornered the market. They have driven out to a great extent any of the Golden Triangle business. That leaves that particular group seeking a new market. I know it sounds funny to talk about marketing in the drug business, but you must understand that the forces against the stable society are well organized and highly interested in the almighty dollar, regardless of how they get it. They have good systems of supply. They need a market, Mr Durick, and your police here tell me that the heroin on your streets is Golden Triangle heroin. That tells me that they have analysed the market, and found that Australia is affluent, with restless children here, and they are anxious to develop the market here.

I can give you one other example. The Mexican market analysed the United States of America in 1975, and in May of that year decided to saturate the state of Texas, which for some unknown reason had been left out in the first, early epidemics. Texas has shown since May, 1975, a 3 000 per cent increase in arrests. They have had 38 deaths of children under 6 years of age. That does not mean that children under 6 were taking drugs. It means they chanced upon narcotics and took them by mistake. That is the first jurisdiction that has shown up that kind fact.

I cannot give you all the answers. I come from a country that is being eroded every day by this disease. However, I can tell you something of the mistakes we made, and I can tell you that if we were able to get away from the paranoia that leads us to fight among ourselves, if we were able to sit down and look at this problem critically, as the drug syndicates have done, and if we were as goal-directed as they are, we could design programmes that would be preventive. However, if we squabble among ourselves over territory, which has been the sadness of the United States, we will continue to be destroyed. That is my opening comment.

1925. CHAIRMAN: For the benefit of members of the committee I might say that I did speak to the witnesses before the proceedings began and suggested that each of them make an opening statement, to be followed by a period of questioning by members of the committee, and then the witnesses will have an opportunity to summarize. I would now like Dr Michael Baden to make his opening statement. I understand that Dr Baden is an eminent pathologist, and also has developed a formula, the details of which I should like him to explain to the committee. Would you do that, Dr Baden?——W. (*Dr Baden*) As I indicated earlier, my expertise in the area of drug abuse derives from the Medical Examiner's Office in investigating deaths of people who have used drugs. That is an official position, and I am a public official in that regard. I think it should be made clear, however, that the views I express are my own and not necessarily those of any government body in the United States of America. Unfortunately, we in New York City do see at autopsy and on post-mortem investigation more deaths involving drugs of abuse than occur anywhere else. We have tried to learn something from these data. Perhaps, preliminarily, what I would suggest in that dealing with a disease such as drug abuse, definitions become difficult. Drug abuse is the taking of any substance for non-medicinal purposes, and for purposes of euphoria. The person who introduced that concept to the western world was the English author, Thomas De Quincey. In the 1820's he wrote *The Confessions of an English Opium Eater*. He was the first person to popularize the non-medicinal use of narcotic drugs. He was concerned with chandoo opium.

It behoves you to give some priority to your coroner's system, for it is a useful source of data. You have in Sydney one of the foremost forensic pathologists, Dr Oettle. There are not very many forensic pathologists in the world. It is not a branch of the profession that pathologists go into, because they have to work in government and that is less remunerative and more of a hassle than it is to work as a private pathologist. If I might suggest so, humbly, I should think that a person like Dr Oettle could be used to develop an area that would give you some idea of the number of deaths that occur from drug abuse, and of the changing trends and patterns in drug abuse, because in the autopsy procedure a chemical analysis is made, and it is possible to identify persons who die from taking drugs. We can determine where they came from, and obtain histories that led to the drug taking in each of them, and we can also identify what drugs are taken.

Indeed, in recent years in the United States of America we have seen—and I expect that you are exposed to this here—not merely heroin or narcotics taking, but multiple drug taking. The young people will take anything that is in the medicine cabinet, or anything that they can purchase in the streets. Technically, the narcotic drugs are drugs derived from opium and drugs that cause sleepiness and kill pain, and also are addictive and cause withdrawal symptoms. The first of these was opium. The main ingredient of opium is morphine. It has some codeine in it also. This can be added to chemically with acetic acid, and heroin is produced. These are called semi-synthetic drugs. We got so sophisticated that during World War II, because Germany and the United States of America were cut off from Asia Minor, from whence opium comes, the United States of America created in a test tube artificial opium, such as Demarol or pethidine. The Germans developed methadone, which originally was called Dolophine after Adolph Hitler. These are test tube drugs, but they are called opiates because their actions are the same as those of the drugs derived from opium.

From our experience, concern about the taking of narcotic drugs, such as heroin, stems largely from the association of drugs with crime. Clearly barbiturates and stimulants, such as the amphetamines, tranquillizers such as valium, and so on, can be equally abused and even more destructive than the narcotic drugs because they can cause death during withdrawal. Heroin withdrawal is not life-threatening except in babies, whereas withdrawal from barbiturates is. So we can learn a great deal from how people die. What we did in New York City in 1966 when we first became concerned about drugs was to develop in the coroner's office, as you would call it, a laboratory fer testing urine from drug addicts. I do not know what your facilities are here in that respect, but I do know that you cannot with certainty tell a drug abuser by confronting him and asking him what he is taking, or by looking at his eyes. There is a more objective way of determining what drugs are being used—urine testing. One municipal function that we assumed in New York was to provide a central facility so that any physician, any treatment programme, could collect urine samples from suspected drug abusers and send them to that central facility for impartial analysis. Unfortunately, here again qualified toxicologists are not commonly found, and therefore it is not really feasible for each programme to have its own laboratory set-up. In this regard we found, despite all the disparate drug programmes that were developed in New York City—many of them in conflict with one another—that all drug programmes were very much in need of, appreciated, and co-operated with, one central laboratory that did the urine analysis so that they could determine without hassle and debate, and without arguing with the patient, whether he did use drugs.

Taking this into consideration, what we did in 1969 relative to the formulation to which the Chairman referred was utilize the information we had obtained from an analysis of the drug related deaths that occurred in New York City and compare the results with information relating to known drug abusers. New York City has a population of 18 million. In 1969 heroin was popular among drug users and the multiple drugs had not come

into the addicts area. Information relating to addicts who had died and had been identified by autopsy was known to the health authorities from a compulsory reporting system for physicians and law enforcement people in New York. Prior to 1969, perhaps five years earlier, because of the recognition by the health provisions of increasing numbers of drug abusers, a Central Health Reporting Register was inaugurated. Its records were confidential from the police and it was meant as an epidemicalogical statistical means of identifying the nature of the problem. In 1969 the register had 50 000 different names of known drug addicts in it. In that same year we identified 1 000 persons who had died and were shown to be heroin addicts. When we compared the 1 000 persons identified with the narcotic register it was found that approximately 50 per cent were known previously to the health authorities. We then assumed, realizing a large error potential, that a 100 000 figure of heroin addicts in New York City at that time was a reasonable assumption. This estimate was in agreement with the estimates made from different sources, namely the police department, as to the numbers of addicts, so it seemed to be fairly accurate.

Analysing the data further, of the 1 000 heroin addicts who died in 1969, 500 died from taking the drug heroin, sometimes with barbiturates, and often with alcohol. I leave alcohol out of this discussion as, though it is a drug of abuse, the evaluation of deaths involving alcohol becomes much more complicated. Additionally, alcohol is legal and we are talking about illegal, illicit, improper drugs like heroin. This information became the basis of a formula that was applied nationwide. It postulated that 1 per cent of heroin addicts died each year. That was regarded as an interesting figure because in the population at large usually there is a death rate of 1.2 per cent. However, in the age group we are talking about, teenagers and persons in their twenties, the death rate is closer to one-tenth of 1 per cent, so we had a tenfold increase in deaths among narcotic abusers. Half of the deaths were from drug taking and half were from violence associated with the life style of drug taking—homicide, which has become extremely high among the drug abusing population. In fact, in 1966 there were 600 homicides in New York; last year there were 1 800, the big increase being in the drug abusing population. So, one of the concomitants of drug abuse is or has been an increase in violence, and in homicides in particular.

The formulation that was evolved was used and the number of addicts found at autopsy could be multiplied by 100 to give an approximation of the number of addicts in a community. If one were dealing only with the so-called overdose deaths, it would be used as a bare term. The heroin addict is on a diluted dose. A person taking 5 per cent heroin is taking 95 per cent non-heroin, which may consist of quinine or other substances, in unknown amounts. Many of these deaths we see can be caused by other materials in the drug and not just the heroin itself. In some jurisdictions, since 500 of the deaths were from heroin reaction—half of 1 per cent—they used this formula to find only those addicts who died from drug taking.

I am cautious about the use of this formula outside New York City because it depends very much upon the ability of the coroner or the medical examiner to identify drug abusers. The criteria we use in New York is different to those adopted in Chicago which had had a coroner system in which doctors investigating deaths were not properly trained. The forensic doctor is properly trained but as there are so few such doctors in our country or in England quite often unnatural deaths are evaluated by untrained, non-pathologist physicians and this could lead to the over-looking of deaths involving in drug abuse. The formulation is valid if it is applied to a system similar to that in which New York City investigates deaths and it should be used only as a very general guideline. This is particularly the case when so many deaths involve multiple drug use.

Presently, we see three times as many deaths involving methadone use rather than heroin use. We have more than 35 000 persons under a methadone drug maintenance programme in New York City. Many of these people are on a take-home system where they take methadone home every weekend and on holidays on the honour system and use it by themselves. Each bottle of methadone contains approximately 100 milligrams of methadone in orange juice. That is twenty times the amount of heroin contained in a packet of heroin. The user in the street does not realize that the amount of methadone in orange juice that can be taken by mouth is twenty times stronger than the amount of heroin in a packet. Heroin taken by mouth is broken down by stomach acids. The value of methadone in the maintenance programme is that it is totally absorbed, and that is the main difference. Methadone is totally absorbed through the stomach when taken by mouth and it lasts longer. At the autopsy table we have seen several problems relating to this. For instance children get hold of methadone, thinking it is orange juice in the refrigerator, and they drink it. Security must be maintained. Many female addicts have children and though it is a tragedy this sort of thing can happen.

(*Dr Densen-Gerber*): The other thing about a drug which can be orally administered is that it is more acceptable to the female because the female is not as prone to shoot drugs or to scar her body. It is like tattooing. There is a certain maleness that goes with tattooing that suggests strength, and this does not apply to women. Women are very much more likely to accept an orally administered drug and so again we have the problems of neonatal addiction. Drug addiction in the female has many ramifications different from those in the male, particularly because of child bearing and the damage to the foetus from drugs such as methadone or heroin. Also, the female will have to nurture the child and administer care to the child. When we talk about the effect of drugs upon females we must connect it with her child-bearing role and her child nurturing.

(*Dr Baden*): One of the things that must be mentioned also, especially with methadone use, is that the medical community must be educated to the fact that methadone overdose is quite different from a heroin overdose. Methadone is absorbed through the stomach and it lasts much longer than heroin. A person on a methadone maintenance programme needs only one dose a day because the drug effect lasts between twenty-four and thirty-six hours. Heroin addicts must shoot three or four times a day to maintain the same euphoric state. Heroin breaks down in six hours. There have been a number of deaths, unfortunate ones, where the treating doctor has given an unconscious drug user the antidote for heroin and the person has improved and has been sent home. If the drug user were only using heroin he is cured of the overdose reaction because the heroin and the antidote would wear off at the same time. However, if he has been taking methadone the antidote would wear off in six hours and the methadone would still work on his body and the reaction would come back and death could occur in that way. An educated medical profession, especially in emergency rooms, is necessary to appreciate this problem of methadone overdoses being different to heroin overdoses.

The last point relative to what we learnt from the autopsy table is that we have an opportunity to check back on each of the deaths that occurred, through the police department, families and positions. One of the things that is clear from the users who die is that the age is coming down from an average of about 28 in 1966 to an average of about 22 now. The number of females increased from one out of ten to perhaps three or four out of ten at the present time. In our country 50 to 55 per cent of the deaths are black but this will vary from jurisdiction to jurisdiction. The vast majority of them have had anti-social histories prior to the use of drugs. The concept that heroin, narcotics or other drugs creates anti-social activity is convenient but naive. We have over-reacted to that in our government by considering the bombing of the poppy fields in Turkey to cure juvenile delinquency in the United States of America, that is if we cut off the supply of drugs we are going to make useful citizens out of them. That belief is very naive. About 80 per cent or 90 per cent of people whom we autopsy have arrest records, truancy records, a history of inability to function at home or at school or with friends, before using drugs. A drug is truly a manifestation of a lot of things that are going wrong with a lot of young people.

The autopsy gives us the means of getting one hand on the problem. I would suggest that we should not be totally drug oriented and that we use the drug as a tool to cope with young people who would be problems anyway without drugs. We did have crime before drugs; we had delinquency before drug addiction. When one reads the old chronicles of London and about the Bow Street boys one learns that London was in very bad shape in the 1800's before there was any narcotic abuse. There is a tendency to over-react in respect of drug abuse and to consider that but for drug abuse our children would be doctors, lawyers, politicians and police officers. It does not work out that way. In the great majority of cases a child who uses drugs has been counterproductive, self-destructive, anti-social prior to the use of drugs. I would close with a plea that forensic pathologists and coroners keep this in mind in any kind of programme. However, that requires some recognition of priorities in the fields of developing data, that is, things that should form data. I am talking about hard data, harder than is actually developed from living people, in determining the extent of the problem. The second thing is in regard to urine testing, which thus far is the best single way of objectively determining if somebody has taken a drug.

1926. CHAIRMAN: Dr Densen-Gerber, are you still practising medicine on a regular basis?——W. Full-time.

1927. In New York?——W. (*Dr Densen-Gerber*) Throughout the United States. I am Chief Executive at Odyssey Institute. I am also in full-time employment. My patient load as a supervising psychiatrist is 700 in-patients and about 400 out-patients. I also have a small private practice, mostly to keep my balance because if you did only this kind of work you would get one point of view. I wish to make one comment on what Dr Baden said. The autopsy room provides the one statistic that cannot be manipulated. In other words, often arrests are made in certain classes or certain groups and we do not report the number from a particular class. In death, we have no choice. So that everybody who dies unnaturally regardless of background, has to come to the autopsy room. There is no way of fixing statistics with an autopsy.

Dr Baden spoke about criminal activity. I think that when we are dealing with young people, 12 and 13 years of age, we have to change our attitude a little bit. We have to look rather at children who are distressed or alienated in some way from the parental generation and the values of that generation. That may be different from saying that they are criminals beforehand. They are children who are in trouble in some way or another. We have to look at addiction both as an endemic disease and an epidemic disease. When it is endemic, the host susceptability is extremely important, that is how well and healthy a person is. If he is well and healthy he has a greater resistance to avoid the disease. When a disease becomes epidemic, more people are affected and there is more variation in susceptability. When markets are developed in a country, it becomes epidemic. We have had two epidemics in the United States of America, the first from 1969 to 1972. Many of you will remember the famous statement of our Government in 1972 to the effect that we had a decrease. That meant we had a decrease in the rate of increase; we were still increasing but at a decreasing rate; it was not increasing as much as it was before. By 1975 we began the second wave of the epidemic or a second epidemic.

It is just like the flu. The best way of understanding addiction is very much the way we understand influenza or some similar epidemic in the community. In certain areas there are more drugs or more of the contagious element. We also estimate that about 7 per cent of the children in some areas would take drugs if drugs were available. In epidemic areas it could go as high as a quarter of the population.

1928. You mentioned that you were presently associated with the Odyssey Institute. I notice also that you were founder and executive director of Odyssey House. Can you tell us if there is any subtle distinction between the two positions?——W. Yes. That is very important. There is confusion about that particularly as many of you are reading the book *We Mainline Dreams*. This has been talked about in our Odyssey House work. We started with Odyssey House. The point is that Odyssey House is our drug division. All of the Odyssey House pertains to treatment of drug addiction. I hope we will be coming to Australia. The McGrath Foundation would like to sponsor Odyssey House in Australia. We have a federation and state system. The result is that we have twelve corporations. There is never any mingling of funds. In other words, Odyssey House in Michigan cares for supervision and other work pertaining to Michigan. Therefore it does not go to the federal division of Odyssey. We have that definite division. Odyssey Institute is the parent corporation dealing with issues, not treatment, serving the different States.

In our system we have separate catchment areas and separation of health care. If we did come to Australia, it would be on the same terms, that moneys given or raised in Australia would be for the treatment and use of Australians, certainly not anywhere else. By 1974 we realized that we would not be doing very well in the area of prevention if we treated only the end result, which was addiction. It is important to understand, as Dr Baden said, that addiction is in an individual who has some difficulty. Therefore, the best treatment is to get to the underlying problems, to do a personality reconstruction of the individual who is rehabilitated to help him to be able to cope with the world.

We realized in 1974 that the real problems were the people behind the drugs. I do not mean the dealers; that is a law enforcement problem. I mean the individuals who were susceptible to this. We had to look at the causes and we saw that the causes were child abuse, neglect, learning disabilities and educational problems. We have branched out now in our treatment. It is essential for you to advertise here, to have courses in your curriculum at school and with the parents. The essential one element that we can change is to strengthen the family and the values of the family. We should provide each child, to the best of our ability, with a happy nurturing and a good family so that people will develop inter-personal relationships with their family and have a greater resistance to being addicted to drugs. That is the only way of looking at it.

The real emphasis is to try to understand what is going wrong in all of the western world. Of course, a child aged 13 does not have horns and is not an arch criminal. I feel it is the same here as it is in the United States of America, where some people adopt the attitude of, "Let us line them up and shoot them". I would even, at some level, understand that if there was nothing better one could do to stop it. I would have a lot of trouble putting this child in front of a firing squad because children of that age are just babies. This boy is aged 13. There is a 12-year-old with Mr Gordon. There are also two children, one 15 and the other 16. At some point do we say, "They have horns," when they are this young?

These children have mothers and fathers. We have failed this child. There is no other way of putting it. I think it is extremely important to note that there is no funding for treatment facilities for this work. I have not looked at the position closely, but as I understand it, Mr Gordon is running a house here for about twelve or thirteen children on a day-to-day basis. The real need is the resources with which to help these children, that is the thing. This has to be done by governments.

I came here at the invitation of the McGrath Foundation. Here again, you see someone from a class that you would not have expected. I have spoken to many of Mr McGrath's associates socially and some of them have this problem with their children; it is rampant. James McGrath was the first to die and he will not be the last to die. Somebody has to be first. At this moment I must applaud and publicly thank Mr McGrath who, after having had such a tragedy, wishes to give back to the children of Australia something out of his great personal loss. There is no other way than to look at juvenile justice. You asked about the Odyssey Institute. One of the major schools we are now running is an alternative to the training schools. Training schools in our country are places where children are trained to be adult criminals; they are not schools that really train our young to get out of the criminal behavioural pattern. Half-way houses are very much better for children; if you can get them aged 13 and supervise them your chances of success normally are greater.

1929. I might say for the benefit of all present that Mr Gordon, who has been referred to by Dr Densen-Gerber, is the chief operator of—I think his position is executive director—the WHOS fellowship, a private organization that is doing a good job here in Sydney with rehabilitation work on serious social problems.——W. I should say that I am pleased with the WHOS. Mr Gordon will be leaving next week for six months training in the United States of America. By his admission to me, he is isolated and alone and without anyone to help him and to teach him. He has done it very much off the cuff, as we say, trying to do the best he could, and he had been doing the work himself. There is more to this than having experience; there is training, teaching and help.

1930. In your book, *We Mainline Dreams* you say that Odyssey House works for 80 per cent of those who stay for six months. What percentage do not stay for six months?——W. One out of two. We have the means of solving this problem in the United States of America but we do not seem to want to solve it. It can be solved. The way you keep an addict in treatment is that you give him or her no choice. You can give him no choice in several ways. One is through the courts. They should have special courts. Those ways are by probation or by parole or supervision when they come before the court.

The other way is what we do in New York. We wrote the law there but did not follow through. We have a law in New York State which says that anyone potentially in danger of being an addict or who is one can be incarcerated under civil commitment as a mental patient for up to three to five years. Here was an alternative: people arrested on a misdemeanour faced three years and were civilly committed and those arrested for five years faced a felony. The most important way that the courts decided whether a person was or was not an addict was through the urine laboratory that Dr Baden, my husband, set up. It was permitted to make the judgment concerning addiction based on specific and special tests. It is extremely important that the addict be removed from the community. The British work showed that it is a disease which needs company. The addict has a tremendous drive to share his drug addiction with non-addicts. In two small cities there it was shown that one addict each year may turn on approximately twenty people.

1931. What percentage of those who go to Odyssey would be sent by the courts?——W. Two-thirds in most jurisdictions. In some places such as New Hampshire all of the children are committed. In other words when a child goes for sentence on a juvenile crime the child is given the choice of the State run reformatries or Odyssey. In Utah and Michigan we have something that I think works best. Our patients there, who are adults, are able to serve their time with us. They are sentenced prisoners serving time. Another alternative we will be undertaking shortly in New York and have in Louisiana is that we do the first stages of treatment within the prison itself. There is no reason why it cannot be done in that way. The most important thing is to get on with the first six months treatment so that the individual cannot leave. Leaving is not a failure of medicine, it would be true in anything. If you had a heart attack and went to hospital but decided to walk out after forty-eight hours an awful lot of people would die who would not otherwise die. We cannot treat if we do not have the patient to treat. If the patient is given the option to walk in and out, most patients are not aware of the consequences of their actions and so if the wind blows that day they might go out the door. There must be an educational programme and a vocational programme—employment. Our criterion is that the person is drug free if that person is not committing anti-social acts for which the person can be arrested, and is working. If they are not working they are a drain on the community. We do not consider people who are not self-supporting or in situations in families such as in a marriage, with the woman taking care of the children, as cured. A person has to be in the position where he is not on the public dole. If a person is on the public dole he is still a problem for the community. There cannot be re-entry without vocational and educational programmes In many States there is an

extremely close working relationship with the labour movement. With young people there are apprenticeship programmes such as bricklaying and butchery. That is extremely important. The real problem, initially, however, is keeping the people. That is where law enforcements plays a role. If you do not get them off the streets as fast as you can identify it, you will have spread the disease. Just keep in mind the image of someone with cavitating tuberculosis coughing in your underground and then you will understand how the disease spreads. These people have a need to say to another young person near them, "Share my drugs with me".

1932. At a recent conference in Melbourne a person in a similar position to you, a doctor from London who is associated with the London Medical School and who also assists the coroner there, made a statement that most of the cases that came to his notice were overdoses of barbiturates or cases where one had, say valium mixed with alcohol. On the other hand, I recently heard a doctor say, "Thank God for valium." It has taken a lot of cases away from doctors and a lot of strain from them. What is your reaction to that?——W. (*Dr Baden*) I think it is important to distinguish right at the beginning that there is drug taking and death due to it. Where drugs are taken for purposes of euphoria and disease, if one just takes raw statistics from coroners or medical examiners one finds a large number of barbiturate deaths are present but 90 per cent of those deaths are intentional suicides of older people who in general have not been anti-social. If they did not have barbiturates available they would jump out of the window or take other drugs. There is a problem with the statistics if one just takes overall drug numbers rather than analyse them. There is the drug taking for the purpose of abuse, that is, to get high. There is also the suicide. There is the occasional accidental death but that does not happen too often. In general 90 per cent of deaths due to barbiturates in our country and elsewhere are suicides. It is not young people. Generally it is people in their fifties or sixties who are very depressed. When I last spoke to people from the United Kingdom a few years ago there was more barbiturate abuse among drug abusers there than in the United States. There was also needle addiction. Most barbiturate abusers in the United States take it by the mouth because it is so readily available from the pharmaceutical companies. One should keep in mind that since de Quincey's time drug abuse in a specific area may vary. After de Quincey there was opium smoking, morphine, heroin, pethidine and methedrine in one area. There was a great deal of patent medicine narcotics in the 1900s that people could buy over the counter. Barbiturates were common in London when heroin was common in New York City and methedrine was common in Los Angeles. Cocaine is becoming more common on the eastern coast of the United States. Drug abuse varies in time and location but the underlying reason why people are using drugs is to relieve anxiety, to drop out of society, to have feelings of euphoria and that remains fairly much the same. At the present time valium is the most commonly prescribed drug of a non-antibiotic nature in the world. Recently the second was darven and the third librium. Unfortunately doctors in our country, and I am advised doctors here, are much concerned with applying the technical skills that they know so well to as many patients as possible rather than sitting down and talking to them as used to be more common when doctors did not have these technical skills. It is easier for a physician to give somebody who is overweight amphetamine in one form or another to cut appetite than to sit down and talk to the individual about proper dietary habits. In the United States many people who are overweight have been for years and years on amphetamines and they say how much they are devoted to amphetamines. It is the same with valium. It is an easy way for doctors to relieve anxiety without sitting down and dealing with the person and spending a lot of time talking to him. In a sense valium has been a great help to doctors. It relieves the kind of anxiety that perhaps would be much better relieved by proper discussion with the patient but there is only so much time in a day and also there are financial aspects involved. We do not see deaths from valium alone. Valium taken in large quantities rarely causes death by itself. However, we do see deaths from valium and alcohol, valium and the barbiturates and valium and methadone. There are increasing numbers of deaths from valium in combination with other drugs. From an autopsy point of view any drug can be dangerous. We learnt our biggest lesson in the United States with swine flu immunisation. No matter how good the intention is in giving a medicine there are some side effects. We do not have any drugs without side effects. Certainly, the more valium is used the more potential there is for abuse and a cumulative effect with other drugs such as the barbiturates and the narcotics. In my opinion valium is a greatly overused drug. It is relatively safe. However it is now a major drug of abuse among young people in the United States, partly because it is so readily available and also when a young person takes valium with alcohol or barbiturates they get a better high. It should be carefully monitored. It should never be given to a patient unless it is absolutely necessary. Part of that necessity is not getting the patient out of the office five minutes earlier.

(*Dr Densen-Gerber*): I am not quite as kind as Dr Baden. I have spoken about children being vulnerable. There is another group that is tremendously vulnerable to drug abuse. It is that of the middle-aged woman. In 1914, when we passed our Harrison Act, in the United States, there were 400 000 women on tincture of opium because Lydia Pinkham's monthly magazine advised tincture of opium and alcohol. We laugh in the United States—perhaps with tongue in cheek—that the Act was the beginning of the end of American marriage because Mum, up to then, took the bottle of monthly medication, went and relaxed and had daydreams. What is happening in all countries now is that the woman goes to her doctor with problems of middle age. She is discontented. Her children are leaving and she has no place. She does not feel that she is worthwhile and she sits across the desk from a man who is facing exactly the same problem in his own home. He gives her a drug because he is threatened. When you tell me about a doctor who says, "Thank heavens for valium", I say he is having problems with his own wife. It may be that the woman is no longer a Racquel Welch and sexually attractive which is something which our society regards as of such importance. It may be that she is getting a little dowdy. It may be that her children do not want her. She is going to be put out to pasture like a brood mare, she thinks. She does not need valium; she needs encouragement. She needs to be talked to and understood. We are making alcoholics and valiumics out of millions of women.

1933. We have heard a lot in Australia about Odyssey and other establishments. As you are more acquainted with those than the Committee, could you explain briefly what is the difference between them?——W. Briefly, it is easy to distinguish Odyssey rather than to talk about the other programmes. We are the only psychiatric therapy community for the long term treatment of addiction in the United States. They are almost exclusively self-help programmes based very much on the dynamics of Alcoholics Anonymous. We have social workers, psychiatric nurses and psychologists working with the addict. We realize

that 20 per cent of them suffer from psychotic disorders of a schizophrenic and manic-depressive nature and they are under medication with anti-depressants, etcetera. Some 20 per cent are neurotic and are under more traditional 1 to 1 treatment. Only 60 per cent fall within character disorder. The treatment of a disease belongs with the medical profession; whether they want to admit it is another question. It has all the elements of disease including life threatening. Even though the individual chooses a disease—choice is a funny word—you will hear how children have chosen it. But that is another issue. If I needed a heart transplant I cannot see that I would go to Blaiberg, I would want Christian Barnard. The ex-addicts play an intimate role. They are essentially seeing the patient and working with the patient. They cannot distinguish between the different personality types involved. To turn treatment of the disease over to the ex-addict solely makes it a sub-culture removed from the world at large. If you expect the addict to come out of programmes they have to relate to you and me, and that is important. Further, we have been able to develop a method which is detachable. In other words, I run a programme in New York. I created the Odyssey programme. It works equally well in Utah, 3 000 miles away, and I hope we can have the opportunity to show that is will work 12 000 miles away. It also works with the Yankee from New England, the southern black, the Mormon boy, or the individual carving out the frozen north of Alaska—there is no reason to think that it cannot be employed here. It works with men and women, white or black, 13-years-olds and our oldest graduate in his sixties.

1934. You have said that it is not sufficient in group therapy to "talk the talk" but that they should "walk the walk." What do you mean by that?——W. That is true of all of us. If any group needs to walk the walk as well as talk the talk, it is your group—the politicians. Action is terribly important. Promises not kept destroys peoples' belief in the system. I hope that we will talk today and walk the next time we visit together.

1935. Is it true that at present there is a drug in use that is similar to methadone, and it has to be taken only two or three times a week and it cures drug addiction?——A. (*Dr Baden*): It is LAM—long acting methadone. One of the problems that people who use methadone appreciate is that it has to be given every day, so a person must come to the clinic every day or take home a supply. If the person comes to the clinic every day it interferes with other activities. If a person takes home a supply there is a great potential for selling it, for its mis-use. On the streets of New York city you would easily get $15 or $20, for a days supply. Various drugs are being tested that have the action of methadone but upon injection into the body will last two, three or four days. People are talking about trying to get a six-months' capsule that can be surgically put into the body.

(*Dr Densen-Gerber*): I worked with my nemesis who believed there was a chemical answer to everything. Dr Fink sat me down one day and told me about the magic bullets. You inject into the buttock and sit on it for six months. He wanted every child in the United States to have it so that there would be no more addiction. The problem is that we have 3 000 drugs of abuse. Are we going to develop 3 000 magic bullets? If we do, how are we going to sit on them? It is as simple as that. We have 3 000 drugs of abuse. We cannot bomb the fields of Turkey. Probably some 2 999 are produced by the pharmaceutical industries and we are not going to bomb them. We must get tight licensing and regulations for our pharmaceutical industries and start to convince the doctors that the majority of human illness is in this area, the psychiatric area, and in talking to the patient.

(*Dr Baden*): There are different varieties of the long-acting methadone. The reason that much of this research funding. Doctors will investigate whatever there are funds to support investigating. To understand the actions, methadone is a narcotic, like heroin or morphine. Many years ago it was found that if one is tolerant to one narcotic drug there is a cross-tolerance to all other drugs. The theory behind methadone use ab initio is that if you put somebody on a high dose of methadone and they shoot-up heroin they will not get a euphoric feeling from the heroin because the methadone is already at a high level. That is the reason such large doses of methadone are given. If one is taking 100 milligrams of methadone, in order to get a high euphoric sensation from shooting-up heroin one would have to take more than the amount of methadone already present in the body. To shoot up 200 milligrams of heroin in New York City requires at least 40 bags of heroin over six hours. That becomes very difficult for the heroin addict. If one is on 180 milligrams of methadone one would need to have maybe 300 milligrams of heroin. One could get codeine and such things which have also been used as a treatment for heroin use. If a person had enough morphine or demerol on board and shot up heroin one would not get a feeling of euphoria. The problem with the other drugs is that they have to be taken more frequently. Methadone can be taken in juice and last for 24 hours, so it is more convenient. It is only useful against narcotic drugs. It has nothing to do with alcohol, barbiturates or any of the non-narcotic drugs, so it does not blockade their effect.

One has an option of trying to get the magic bullet for each drug or try and deal with the problem so he does not use any drugs in the future. People can get high on all kinds of chemical substances, both known and unknown, and the problem will come up where we shall need a solution for each one. In the United States when methadone was introduced in 1967 we only had heroin. It could be considered appropriate. Now most of our drug abusers are multiple drug abusers. I gather from the little that we have been able to talk to people in Sydney that that is what you have here—multiple drugs of abuse, not straightout heroin addicts. They take anything they can get their hands on. Methadone is only against the narcotic drugs, and long-acting methadone, hopefully, is a more effective way of dealing with only heroin. That is still in the experimental phase and presumably with technology there should be some way of injecting methadone so that it lasts a week instead of a day. That is the goal to stop people taking heroin or all drugs of abuse—and more than the drugs of abuse. As scientists we are getting diverted by considering heart disease, cancer, the liver and drugs and forgetting about the patient. It may be fascinating to go into all these pharmacological drugs, but it may not have relevance for the addict in the street.

1936. It has been suggested that with your staffing you must be eternally vigilant to make sure that they are also clean. One of the things done is to carry out regular urine tests. How often is that done?——W. (*Dr Densen-Gerber*): A minimum of three times a week. Drugs will pass out of the body. Some will be toxified and metabolized within 72 hours. I had a fascinating programme, which I again suggested with tongue in cheek, but with a lot of reality also. We were in the last difficulty of the first epidemic. I suggested to the then Governor Rockefeller that he pee for the people. There is no question of violation of our

civil rights; when we give a specimen what we are saying is that we are standing up bearing witness that we are not using drugs. It has been suggested in the United States that there would be universal urine screening in the schools. It is the same as with chest X-ray for TB. Nobody fights now about their civil liberties and chest X-rays. I feel the same with this.

I hope that we will have the opportunity to speak to the children here because I think that they have a contribution. All the rhetoric or scientific data from my husband and me is here (indicating head) and we must understand that it is a disease here (indicating gut). This young woman who is aged 16 is a heroin addict. This boy is on valium—pressure cans which cause permanent brain damage and marihuana, hashish oil, and I forget what else he told me. I have not had the opportunity of seeing the young woman and I do not know what she will say, but it will be the same story again and again. It is young people in trouble and we have to provide help. These are our addicts. If you have a thousand in the game today, when I return in six months you will have twice that many, and later four times as many. That is the way it spreads. I think you are at the beginning. It has only been here for perhaps a year or two—not marihuana, that is always here. The heroin market would have started in earnest some time in 1976. The Golden Triangle started coming here when they knew the United States was no longer available for them.

1937. There is a little difficulty with the children so far as the Committee is concerned. The children may not want to be identified. We have not spoken to their parents. If they are to speak of their experiences we would not want them to be embarrassed in any way.——W. It is a sad thing but true that we have to direct them, yet we have to learn from them.

1938. CHAIRMAN: I could not agree more but I have to think of the other aspect of it. I have not consulted with their parents and therefore would be reluctant to hear them. Of course, it would be up to the members of the Committee and I would consult with them to find out whether they want to hear in general terms what is to be said.

1939. Mrs ANDERSON: Within the Odyssey programme what are the major drugs of addiction and what treatment do you have?——It is a straight-out cold turkey job?——First let me say that when I speak of methadone, I am against drug replacement for the treatment of addiction. I am not against the use of drugs for schizophrenia, psychotic behaviour or epilepsy; we use drugs on them. There is one type of schizophrenia—about 5 per cent of our patient population—that would respond better to the opiates. Heroin would be the drug of choice. In 1922 the Germans treated this type of schizophrenia with heroin. The opiates are an excellent anti-phychotic agent. If we were rational we could reach that level of maturity where we could say there are no good and bad drugs; there are only good and bad uses. It is not a bad use in pain post-operative surgery or the treatment of schizophrenia. I have one patient who is 86. I put him on methadone at 82. I would not consider that this particular patient was a subject at 84 for personality reconstruction. It is the same thing with patients who are terminally ill. Give them their methadone.

We do a personality reconstruction. When a patient enters Odyssey he has a mental status, a physical examination and is treated for gonorrhea or other diseases. The women have many more physical problems than the men because of the wear and tear of the street life that they are subject to in prostitution. We do psychological evaluations, I.Q. testing, we test their ability to read and write, and programmes are written up based on our evidence for each individual. A long and short term individual programme is designed for each patient, depending on their problems. The general milieu is to control their behaviour while we develop an ability in the patient to understand their own dynamics, to lead them from self-destruction to self-construction, so that the psychiatrists and the social workers and others can cause personality change. You need a controlling environment, based on your experience of ex-addicts who modify their behaviour. Then the medical profession comes in with its allied professions to change the thinking patterns of the individual so that they no longer want to take drugs.

The major drugs of abuse that we treat are the opiates. Over 90 per cent of our patients are opiate users. That is the major substance of abuse that our country is concerned with. We are federally funded and only permitted to take what we call the codaptable patient, who is on opiates, barbiturates, or major halluciants. Ninety per cent of our patients are on highly addicting drugs. They take those drugs, plus everything else they can get their hands on. They are a pharmacopoea, a medicine cabinet, when they come in.

1940. CHAIRMAN: When you say you are federally funded, does that mean for the total cost of your organization?——No. Of a $5 million budget approximately $1 million will come from private sources, both in kind and in cash. Another $1 million will come from local municipalities other than the cities and the States. The other $3 million comes from our federally funded National Institute for Drug Abuse, particularly the research modules. They fund the research projects. It also comes from Title 20 and Medicaide. So we have assistance by way of third party payments and also third party payments from Blue Cross, Blue Shield and that type of organization. Funding can be extremely varied. We also have some funding from the Mormon Church in Utah. Their funding is most of our foodstuffs. It can come from almost anywhere.

I had the pleasure of speaking with the Prime Minister, Mr Fraser, yesterday. It is essential that Government recognize that it has the responsibility. The private sector can contribute in part but the problem will be so overwhelming and have such large numbers that it is primarily a responsibility of government, for many reasons. This disease is like a national disaster. It will cause crime, great loss of life and great misery to your people in such numbers that it is a function of government. It is beyond the private sector alone.

1941. Mr RAMSAY: You said that resources are federally funded in the United States and that some funding comes from the private sector. To what extent does the State fund these resources?——In two States—Michigan and New York—we are exclusively funded by the State. For the treatment of the adult addict in Michigan we receive—no, that is not correct. In Michigan we get $750,000 for our centre in Detroit and $240,000 divided in half from the federal Government and from the local municipality in the City of Flint. In New York City we get $1 million for the treatment of adults and adolescents, and a little over $1 million from the federal Government for the treatment of the pregnant addict and her child. It is back and forth; it is hard to understand unless I analyse it. In Maine we have a contract where they buy services in New Hampshire.

The funding picture of Odyssey—I am sending to Mr McGrath a total breakdown of the programmes—is a bit of everything. That is the way it grew; it grew like Topsy. The most important thing is the match money. We must have match money. Our Government works on a system that they fund, if they feel the communities want the programme. It is essential that the communities put up moneys because that means you have the grass roots receptivity to treating its own children. Our match is that approximately a quarter of the money comes from the private sector and the rest is matched by Government meeting the needs of its people.

1942. Mr HEALEY: Earlier you mentioned the increase in the number of addicts in the younger age bracket. What are your thoughts on the effectiveness of the education programmes amongst the young people?——Let me warn you first. Be ever vigilant against any education programme which has negative charisma. You can go into a group of children and turn them on by telling them how terrible it is. Adolescence is a period in which the individual is what we call normally psychotic. It is a horrendous period. We all remember how horrendous it was to be 15 or 16. You have to solve all kinds of problems at a time when you feel most insecure. You have to leave your nest or your family and build your own. This is a tremendously difficult time for the human being.

The individual plays what we call emotional Russian roulette. You go joy-riding, speeding, sky diving, because you have to try to feel you are omnipotent to deal with the horrendous problems that you have to deal with as an adolescent. You may say to a child, "You do not have to speed, but you can play Russian roulette by shooting a potentially lethal substance eight times a day in your arm." That turns the child on. It is the same kind of thing with sexual education. You cannot emphasize technique without commitment of values behind it. Many children are being forced to deal with problems way beyond what they can deal with. A six-year-old asks "Where do I come from?" He does not need a lecture on sexuality. He only needs to know that he somehow grew in mummy's belly. We should not take it that the question asked is the way we mean it. The question asked is at the level of six or seven years of age.

The Odyssey Institute believes—and is working for and has the first legislation introduced in California—that there should be courses in human values or human relatedness, along with reading, writing and arithmetic, and that should start with the first grade. The child should begin to talk about what helps the child cope better. Then you bring in sexuality and then drugs and you say, as I say to my own 13-year-old, "What do you think about using drugs or marihuana? Do you think this will help you through your grades and help you to be a better kind of person? What do you think happened to Fred and Jimmy. They had ten years and lost their lives. Jimmy was a living dead for ten years. So, if you want to be a developing happy person, drugs don't get you there." I don't tell them about the molecular structure of drugs, I just say, "Do you think drugs are a good or bad thing?"

We have a book from England that many of us read. It is called 1066 *and All That.* It is a wonderfully funny book. After every event it says, "This was a good thing" or, "This was a bad thing". About drugs we say to our children, "This is a bad thing. That is it. This is not a good thing. It won't get you there".

1943. Mr JACKETT: You said that when marihuana became almost impossible to obtain in the United States in about 1970, the heroin traffic started to really expand and explode. You also said that we can expect heavier marketing of opiates from the Golden Triangle, now that the Mexican and European producers have more or less taken over the market scene. You also said that marihuana is not addictive in the sense that opiates are. Do you think that if marihuana were more readily available here it would be able to meet the strong marketing techniques of heroin? I am assuming that marihuana is much less of a problem than opiates are?——I suppose that is a logical conclusion to what I said. It is a sad one, perhaps. Certainly, I would not dry up the market because then you will have the same thing as we had. So your analysis is probably right.

I cannot on any level understand the decriminalization of marihuana. That is a bad word. Decriminalization means that we look this way and say to a lad "It is all right, you smoke it," and there is nowhere he can legally obtain it. It is also dangerous to decriminalize it because it has to be controlled. If we permit it within our society we have to control it even tighter than we control alcohol, and we all know what alcohol has done to us. During prohibition we did have a smaller number of alcoholics but we did not have a smaller number of people seeking something to take the place of alcohol. If you legalize marihuana you will exchange the present system of ineffective law enforcement and inability and unwillingness to pay the cost of enforcing the policy, but if you have half a million marihuana users, we have 22 million. You will have to pay that price in the sense of dealing with all of the people who begin to use it. So you have the relationship between the availability of the drug and the number of users. If you decriminalize it or legalize it you will have more users and will finish up with more potheads. If you legalize it it will not be for this age group any more than alcohol is supposed to be available to this age group. It would have to be for those above 18 or 21, whatever you have. We have an 18 or 21 age limit in our States.

In addition, the product has to be controlled, just as you know what proof alcohol is. You have to be sure that there is nothing other than marihuana in the marihuana; that it does not contain any other kind of drug that can be taken by smoking. You also have to be sure that it is taxed properly and that it costs enough to make it less desirable. It should certainly cost as much as cigarettes. We cannot just let it run free. Even if it is absent, it certainly suggests to young people seeking the substance that they take the others that are provided, and the others are drugs such as the opiates, the barbiturates, the valiums and others. You also have the problem that it grows so easily here. I do not think marihuana is controllable and I do not like laws that we cannot enforce.

(*Dr Baden*): Sir Isaac Newton observed years ago that every action has a reaction and one of the things we have seen in our drug culture in the States is that whenever a drug gets in low supply, other drugs come up. We found that with methaqualone.

1944. CHAIRMAN: We have already experienced that here. (*Dr Baden*): If a drug is cut off it does not necessarily mean that the person using it is going to be drug-free. It may just mean that he gets other drugs. We all know about DDT. You can use DDT to kill pests but you may wind up doing a lot of other damage later on. There is a quid pro quo for every action you take. This is certainly true with drug use. We should keep in our minds that the person using the drug is in a sense making

a statement that he or she cannot cope in the situation he or she is in. Drugs are often taken as a coping mechanism, one way or the other. We have to go deeper than just eliminate the drug. I daresay you know and the studies that were done in the United States in the 1920's and 1930's by Dr Kolb, who founded Lexington, Kentucky, and Fort Worth treatment centres when he was assistant Surgeon-general in the United States, show that previously anti-social people become drug abusers.

In studying the use of heroin and its abuse in the United States Dr Kolb found that there was a relationship between the taking of heroin and certain criminals in that the criminals would still be criminals if you cut out the heroin. We have to be very careful about what to expect if we turn off an on-going situation, whatever it is. This is especially the case with drug abuse. I think you must consider the ability of our pharmaceutical companies to manufacture. Our pharmaceutical companies in the United States provide all of the drugs of abuse that our kids are on, except marihuana, cocaine and heroin which have to be imported.

1945. Mrs DAVIS: Dr Densen-Gerber, we are all familiar with and grateful for the fact that Mr McGrath arranged your visit to Australia and we are grateful to have had you here this morning. In Mr McGrath's initial publicity about the Foundation he talked in terms of raising I think some $600,000 to start it. You have spoken of the co-operation that you get from the Government of America and the co-operation that we should get from the Government here, Going on from what Mr McGrath has said initially today, what would you now see as the initial minimum outlay for the commencement of the Odyssey Foundation in Sydney, not only in terms of money but also staff?——W. (*Dr Densen-Gerber*) Let me come back to that. I shall be drawing that up in the coming weeks. For the moment we have had a good meeting of the minds. Mr McGrath will be going to the board of his Foundation for the purpose of having Odyssey come to Australia. We are delighted at that. We feel there is a need. I think there are two things. We have to look at the role of government and the role of the private body. My husband spoke about every action having a reaction. One of the most important points to make is that you must have a carefully thought through plan, otherwise you will wast money in the same way as we did, sort of chasing our own tail.

A plan can be drawn up that will take into account all of the permeations that you need to treat an addict. I would estimate that the amount of money that will be needed by taking the number of addicts and multiplying it probably by a factor of 10 000. That does not mean of course $10,000 to treat an addict. In our money at our standard of living it works out between 48 and 61 in American dollars per annum. The reason for the almost double figure is because you will have to provide law enforcement in the courts, so I am trying to say that the treatment modality is probably one-half or probably two-thirds of it and in addition you have the courts, judges, police, gaols, and that kind of thing. So that when you have, by critically examining the situation, some idea of how many addicts you have I would say you would have to multiply it by whatever that factor is. The figure I have heard used for New South Wales is I believe 6 000. What is 6 000 times 10 000?

1946. CHAIRMAN: That is 60 million.——W. (*Dr Densen-Gerber*) Then you will need 60 million. That may sound horrendous to you, but New York City in its first year of trying to cope spent 208 million—that is State-wide. You must understand the magnitude of this problem. If you do not commence this programme, then I predict that you will find yourselves in the same situation as we are. In New York City, unfortunately, the decent people live behind bars to protect themselves and their possessions and the criminal elements roam the streets. Also we are dying under the weight of our welfare system under which one out of every six people is not working and is on welfare and the other five are carrying him on their backs. Many of our able-bodied persons who are on welfare are addicts. So I come to you and say that you have no choice. You will say "You spent 208 million. How can you come here and tell us we should spend 60 million and then you tell us everything went wrong".

My husband has a graph which shows that the more money you spend the worse it gets. The thing is we did not do it right. We hope to provide you with knowledge of the obvious pitfalls. What we did not do is we did not think it through. We did not spend the money in a constructive way. We just let everybody do his own thing. In New York city prior to the fiscal crisis, which would have been the beginning of 1975, we had 1 400 programmes and the addict went to this programme in the morning and that one in the afternoon. Everybody had their own theories and their own ideas. So there was no control of the addicts. Many of them were on six and seven methadone programmes and were given a bottle of methadone from each one. They drank one and sold the other five. By 1976 we had three times as many methadone deaths as heroin deaths. The main thing is to have a carefully thought through and designed programme, and that is something that I say from my own self-interest, Odyssey interest, we can help you out with. We would not want to run the whole thing.

We have a programme design division that does that. We would want to run as little of it as possible. Odyssey treats only those that nobody else will treat. We like to tackle problems, train other people, and then move on. We see ourselves in that role. Some people will need methadone. There will have to be separate centres for juveniles and adults. It is not good to treat a 12-year-old and a 40-year-old heroin addict in the same centre. Juveniles should have their own centres, separate from adults. We have that by law now.

1947. Mr McGOWAN: We have heard suggestions here that it might be a good idea to legalize heroin in order to remove people from the soft culture. Would you also comment on should we make methadone illegal?——W. Let me take the last one first as it is easier. There is a place for methadone. Again I say there are only good and bad uses of drugs. We use methadone trying to treat what is wrong with the addictive person, but it has no relationship. You cannot treat a personality disorder with a drug. It is not amenable to it. You treat a person that has a self-destructive personality by making him self-constructive. If you put such people on methadone, they go on to alcohol with the barbiturates which makes them self-destructive unless you so narcotize them that they do not know what their problem is.

There are those who say that there is a chemical change in the body of an addict, something like diabetes, that makes methadone the drug of choice. I say they lie when they say that and they have proven it to be a lie by their next statement. If it be true that the taking of opiates causes permanent chemical changes in the body, why do they give it to pregnant women? I say they know it is not true. Of course they could not justify what they are doing to foetuses. I am absolutely adamantly opposed to the giving of methadone to pregnant women, I consider

that a crime. I consider what the taxpayer and the Government is doing to be a crime, because the baby does not consent, the foetus does not consent to being addicted, and when you give methadone to a pregnant woman you addict that foetus. We have shown in the United States that that baby is born with a lower birth rate and a smaller head circumference. All our work on animals has shown that.

Animals addicted in utero are re-addicted at a higher rate later on as adult animals. I cannot understand it, the giving of methadone to a pregnant woman unless we can get the consent of the baby in utero. I find that genocide. In the United States we have all kinds of other factors that you do not have here, concerning to whom we give methadone and when and why. People will tell you, and I have argued with them, that the addicted pregnant woman should be given methadone. They say it is better than having her on the streets and on heroin. Anyone knows that the opiate syndrome is a self-destructive syndrome. In my opinion the only way to protect the foetus is for the self-destructive pregnant woman to be placed in a suitable centre for the period of gestation. That is what we do in the State in which I live.

That can be done and must be done. We all know of the world famous work that was done by Dr McBride of your country in connection with thalidomide. If a woman wanted to take it in the third month of pregnancy, because of psychological problems, would you let her, or would you protect the baby. In regard to the legalization of heroin, it depends on your value judgment. Opiates cut all ambition and ability to compete, and place the individual in a corner, curled up, like a foetus. Do we want large numbers of people withdrawing, and sitting in corners like that? They do not present any danger when they are being fed on drugs. You could have opium dens all over Australia, and they would create no problems. They would just be sitting there. It would be like the opium dens in Thailand, where they work all day and all night being slaves of the people for whom they work. The supplier of the opiates is totally in control of the individual, and that is dangerous. There is a reason why China fought the Boxer or Opium Wars—and lost them unfortunately. That was a disgrace to the white race. People on opium are slaves. They do not have any ability to relate to each other. They live in another world.

If you want that, that is a choice that you have to make. If you legalize heroin, the same as marihuana, you will have more victims. However, you will then have to decide the issue of whether you should legalize it for 12 year olds. If you avoid that, you will then get the same problems again. The minute you say that someone cannot take it, you have the seeds of an illicit market. It is the same with the pregnant woman. I do not see how we can legalize it.

I regard as the most dangerous amphetamines; then barbiturates; then hallucinogenes. Then come the opiates; alcohol is fifth, and then marihuana. That is the order of toxicity to the individual that we have to deal with.

(*Dr Baden*) Without all the rhetoric, and when it is taken away, methodone and heroin are identical, as to the manner of operation. The methadone lasts longer, and it can be effected by mouth as well as injection. Otherwise their effects on the body are the same. The argument for legalizing methadone should equally be applied to legalizing heroin, and making it a legal narcotic. That is to say, both would be taken in the same context. However, the insidious problem in legalizing drugs—and this has been proved in our cities—is that the individual who takes drugs takes the view that drug taking is a viable lifestyle. We have increasing numbers of people in our cities who are maintained on drugs—on the dole or welfare. But then there are the children—the second and third generations of drug abusers, who accept this as a viable socially approved lifestyle. That is also part of our considerations about the effects of drugs.

1948. Mr McGOWAN: On the question of rehabilitation, we have a system here in New South Wales whereby, if you are arrested and convicted of using even a minor amount of marihuana, if you are a teacher or a public servant and so forth, you are sacked. I am concerned with that process of double penalty, for it could lead to a situation where that person may well be put on the path towards drugs, through sheer social incompetence and not being able to act professionally. I am talking about minor crimes in respect of which a man might not even be penalized by the court, but he is sacked from his occupation?——W. (*Dr Densen-Gerber*) I believe, particularly with employees who are in a position of trust, and influencing the young, that person must be above reproach. The young learn not only from what you say, but also from what you do, so I am very much concerned at the quality of the people in authority with the young. They are the people that the young want to follow. I would not want to see a person who had been arrested in any way for what I would consider a serious violation—or someone who was prostituting or using drugs or breaking the law—I would not want them influencing my children.

1949. CHAIRMAN: I shall now come back to what I said earlier. There are two young people present, and I said that I would seek the views of the members of this committee in regard to them. I realize that at this stage this is a public hearing and consequently we have here television cameras, photographers, and reporters. Therefore, many of the people in this room have perhaps, unexpectingly, been in the position where they will appear in photographs that will be published. For that reason I am going to ask these young people not to identify themselves. I am also guided a little by Mr Gordon is here, and he is in effect in *loco parentis.*

I intend to ask the children to give to the committee their experiences. But I make an appeal to the media—to as far as possible, not identify the children. They will not identify themselves by name, and I am asking that they not be identified by the media in any other way.

1950. Would you tell us quickly what happened to you?——W. (*Boy*) About how I got into this?——W. I was taking marihuana, hash oil, and trips. With pressure-pack cans. I was going through a fit at school. I did not know today before that day. My mum knew about this place where I am staying at now. I went there and I am staying there now.

1951. How old are you?——W. Fourteen this year.

1952. (*Dr Densen-Gerber*): Not quite? You will be 14 on 18th June?——W. Yes.

1953. CHAIRMAN: For how long had you been using marihuana and hash oil?——W. About a year, a year and a half.

1954. (*Dr Densen-Gerber*): You told me a little about why you started drugs. I asked you, and you said that your father had had trouble with alcohol. What did you tell me?——W. Just what I thought: Since my father had trouble with alcohol, I decided not to use alcohol, because I did not want to be like him. So I used drugs instead.

1955. (*Dr Densen-Gerber*): This is very common. This is one of the things we have found in America. They have seen the violent behaviour brought about by alcohol. It has taken its toll in their families. In his book Jim Murphy—who I hope will be coming to this country to work—clearly states that he could not tolerate the violence from the father with the alcohol. But he could not take the pain of what was happening in the home and heroin kept him quiet.

1956. CHAIRMAN: And now I will ask the girl the same question. What was the position with you?—— W. (*Girl*) I have been using drugs for about two years now. I was smoking hash, hash oil, buddha. I was taking trips—main drugs. I was not shooting heroin; I was snorting it—and cocaine. I was at another place before I came to WHOS. We were allowed to do anything we wanted there. You could do what you wanted to. They did not know where we were half the time. I was not living at home. Mum came down to see me. She rang up this place where I am now. They came over and saw me.

1957. How old are you now?——W. Sixteen.

1958. When you first started, you said that you first started smoking pot?——W. Yes.

1959. Were you alone or were you with groups of boys and girls?——W. I usually smoke with other people, but sometimes I smoke by myself.

1960. You said that you used buddha sticks too?—— W. Yes.

1961. They are fairly costly?——W. Yes.

1962. How much did you pay for them?——W. From $10 to $12.

1963. How would you get that money?——W. We usually go halves in them, and that, with other people.

1964. But even if you paid only half, it would be expensive?——W. I was working for a while. Mum used to give me money but she never knew I spent it on them —and Dad.

1965. (*Dr Densen-Gerber*): Were you unhappy at home?——W. I was sometimes.

1966. Have you any idea how old you were when you started?——W. Fourteen.

1967. What made you start? Have you any idea?—— W. Not yet.

1968. CHAIRMAN: I want to thank you very much for the evidence you have given. We do not want to subject you to much strain, but it is interesting to hear that part of it.

That concludes this part of the committee meeting. I want to thank Dr Baden and Dr Densen-Gerber for coming to give us the benefit of their great knowledge and experience. I want to thank particularly Mr Walter McGrath and Mr Cec. Gidley, who made it possible for you to be here today. I sincerely hope that something will come out of the information that you have given to the committee, and that we may be able to derive some further benefit for the people of New South Wales, particularly the young people in whom you are interested.

(*Dr Baden*): One of the things that went wrong in New York City was that many programmes were privately developed, and they were at odds one with the other. There was no overall central control. This naturally happens where you have a number of voluntary organizations working before the Government comes in. By the time the Government comes in there are thousands of entrenched groups, and they make control more difficult.

This committee might consider identifying this problem, and point out that if the Government steps in in some overall sense, there should be co-ordination of what develops and how it develops, lest developments occur, with many different agencies, before Government intervention. Otherwise, you might have a severe problem to deal with.

(*Dr Densen-Gerber*): I want to thank you for everything. We have been made most welcome here, and it has been very nice.

1969. CHAIRMAN: That concludes this sitting of the committee.

(Committee adjourned at 12.15 p.m.)

*AT SYDNEY ON FRIDAY, 29 APRIL, 1977*

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The Committee met at 9.45 a.m.

Present:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| The Hon. K. H. ANDERSON | Mr E. D. RAMSAY |
| The Hon. C. HEALEY | Mr B. McGOWAN |
| The Hon. F. M. MacDIARMID | Mr J. G. T. JACKETT |

JOHN HUSTON STEWART, Medical Practitioner, sworn and examined:

1970. CHAIRMAN: What is your full name?——W. John Huston Stewart.

1971. What is your address?——W. 177 Eastern Road, Wahroonga.

1972. You have received a summons to attend here today?——W. Yes.

1973. What is your normal occupation?——W. I am a medical practitioner, specializing in diseases of the kidney.

1974. You have given a submission to the Committee, and it has been circulated. I understand that you have some amendment that you wish to make to that submission. Would you like to mention that to the Committee now before we go further?——W. I submitted a preliminary draft to the Committee, and I submitted a final draft only yesterday or the day before. I have no amendments to make to the final draft, which reads:

## ANNEXURE A

SUBMISSION TO THE NEW SOUTH WALES PARLIAMENT JOINT COMMITTEE ON DRUGS, PREPARED BY THE ANALGESICS SUB-COMMITTEE OF THE AUSTRALASIAN SOCIETY OF NEPHROLOGY AND THE AUSTRALIAN KIDNEY FOUNDATION

1. THE AUSTRALASIAN SOCIETY OF NEPHROLOGY AND THE AUSTRALIAN KIDNEY FOUNDATION

1.1 *The Australasian Society of Nephrology.*

1.1.1 This Society has a membership of about 300 university graduates whose work is in, or related to the discipline of nephrology (i.e. the study of the kidney in health and disease). Approximately half practise as specialists in renal medicine or are in training for that purpose; the remainder are divided between medical or scientific research workers and clinicians in related specialties, particularly urology (i.e. surgery of the kidney and urinary tract).

1.1.2 The principal functions of the Society are to provide a forum for presentation of scientific and clinical work, to promote and oversee the training of nephrologists, and to speak for nephrologists on matters of common concern.

1.1.3 The affairs of the Society are managed by an elected Council whose present members are drawn from New Zealand and five Australian States, and a number of sub-committees which are appointed by the Council.

1.2 *The Australian Kidney Foundation.*

1.2.1 The Foundation is a voluntary organization comprising nephrologists, urologists, academics and non-medical persons who are committed to the promotion and support of research and education in nephrology and urology, and to prevention and treatment of diseases of the kidney and urinary tract.

1.2.2 The chief activities of the Foundation are to provide funds for medical and scientific research, to promote preventive medicine through dissemination of information to doctors and the public and by approaches to governmental health agencies, and to support the treatment of end-stage renal failure by encouragement of cadaveric organ donation and through its Dialysis and Transplant Registries. Since 1971 these registries have provided comprehensive, nation-wide data on the number of patients developing end-stage renal failure, the nature of the kidney diseases which have caused this condition, and the type, amount and outcome of treatment given these patients.

1.2.3 The Foundation is controlled by a Board of Directors, and a State Committee supervises its activities in each of the six States. Medical policy is determined by the Medical and Scientific Advisory Committee whose members are appointed by the Board of Directors, the Australasian Society of Nephrology, the Urological Society of Australia and faculties of medicine of Australian universities.

1.3 The Council of the Australasian Society of Nephrology and the Medical and Scientific Advisory Committee of the Australian Kidney Foundation have jointly appointed an Analgesics Sub-committee comprising Drs P. G. Row (Queensland), T. H. Mathew (South Australia) and J. H. Stewart (New South Wales, Chairman) who have been charged with the responsibility of implementing

the policy of the two organizations in respect of the prevention of kidney disease caused by analgesics.

1.3.1 This submission has been prepared by the Analgesics Sub-committee; the views in it reflect a consensus opinion of nephrologists throughout Australasia, and its recommendations represent the official policy of the Society and the Foundation.

## 2. DEFINITION OF TERMS (as used in this submission).

2.1 Analgesics—the simple or non-narcotic pain relieving drugs, including aspirin, salicylates and salicylamide, phenacetin and paracetamol, propoxyphene and the pyrazolone derivatives such as phenazone (anti-pyrine).

2.1.1 Compound analgesics—analgesic preparations comprising two or more pharmacologically active ingredients. A number of compound analgesics have non-analgesic components, e.g., a stimulant such as caffeine, a sedative such as a barbiturate or an opium derivative such as codeine.

2.1.2 A.P.C.—analgesic powders, tablets or mixtures comprising aspirin, phenacetin and caffeine.

2.2 *Medical terms.*

2.2.1 Nephro- or renal—relating to the kidney. Nephropathy—a disease of the kidney.

2.2.2 Medulla of the kidney—the anatomically and functionally distinct inner pyramids of the kidney where the urine is concentrated so as to conserve body water. During water conservation (hydropenia), salt, urea and a number of other chemical substances accumulate at high concentration in the renal medulla. The tip of the medullary pyramid, or renal papilla, projects into the pelvis of the kidney.

Renal pelvis—the uppermost part of the urinary tract, into which urine is discharged from the kidney.

Ureter—the tube connecting the renal pelvis with the bladder.

2.2.3 Renal papillary necrosis—the primary lesion occurring in the kidneys as a result of the toxic effects of analgesics. Tissue death (necrosis) appears first near the tip of the medullary pyramid, and extends to involve the whole of the distal half to two-thirds of the pyramid. This necrotic tissue obstructs the fine tubules of the kidney, resulting in their atrophy and in chronic inflammation in the surrounding (interstitial) tissue. Ultimately there is involvement of the glomeruli and blood vessels, causing chronic renal failure and hypertension. In addition necrotic renal papillae are unduly susceptible to infection, which spreads to the surrounding healthy renal tissue, and to calcification (stone formation). And they may separate to enter the renal pelvis and ureter, causing bleeding, severe pain and/or obstruction to the kidney. The combination of obstruction and infection in the kidney results in a very serious illness, with acute renal failure and septicaemia (blood poisoning).

2.3 Drug abuse—consumption of drugs in excessive quantities or for medically or socially inappropriate reasons.

2.3.1 Drug habituation—compulsive, regular (i.e. at least daily) consumption of drugs for their psychotropic (mood-altering) effect.

2.3.2 Drug dependence—the psychological state giving rise to habituation.

2.3.3 Addiction—that state of drug dependency in which cessation of drug intake causes pronounced withdrawal effects.

## 3. INTRODUCTION

3.1 Analgesic-induced renal disease first became a significant factor in mortality tables for two Australian states, Queensland and New South Wales, about the year 1960 [1, 2] and the earliest Australasian descriptions of the clinical syndrome and pathology appeared during the following two years [3–5].

3.2 Nearly two decades earlier there had been a sharp increase in the prevalence of chronic gastric ulcer in young women living in the same two states [6–9], but the aetiological role of analgesic abuse in this disease was not recognised until the 1960's [10–15].

3.3 Analgesic nephropathy and gastric ulcer are still common in our community, representing the most serious elements of what has been termed in Australia "the analgesic syndrome". Their combined morbidity and mortality place minor analgesics fourth only to alcohol, tobacco and sedatives in the table of our most harmful addictive drugs [16, 17].

3.4 The social origins of analgesic abuse, and its consequences for health run parallel to those of tobacco smoking and, to a lesser extent, excessive alcohol consumption. However, analgesics, unlike the other two drugs, are advertised and sold primarily as therapeutic substances. As such, and in the absence of either a restriction on their availability or professional supervision of their use, the purchasing public are entitled to assume that they would not be injurious to health, or at least that there would be a wide margin of safety between the amounts commonly taken, and those which could cause harm.

3.5 It is the essence of this submission that unrestricted marketing has created in this country, and particularly in New South Wales and Queensland, a situation in which A.P.C. and pharmacologically related analgesics are commonly taken in doses which have proved injurious to health. Moreover, because they are drugs of dependence, this situation cannot be corrected merely by informing the purchasing public of the dangers of compound analgesic preparations.

## 4. THE DEMOGRAPHY OF ANALGESIC ABUSE IN AUSTRALIA

4.1 Analgesic abuse implies regular consumption, without the approval of a doctor, of powders or tablets for the sake of their mood-altering effects or for complaints which either are caused by the analgesics themselves, or else are trivial, so that the amount and type of drug taken are inappropriate [18–24]. When analgesics have been taken in the knowledge that they are potentially harmful [19, 20, 22, 23] and when there has been deception about the amount consumed [19, 23, 25] or difficulty in ceasing the habit [20, 24, 25], it may be said that drug dependency has occurred.

4.2 Most Australian surveys of non-narcotic analgesic consumption have used information obtained by means of questionnaires which also dealt with other forms of drug

intake and various health indices. As a result, their findings have related more often to the current rate of analgesic consumption than to the type of powder or tablet taken or the duration of, or reasons for, taking them. This has made it difficult to distinguish between legitimate heavy usage and drug habituation. However, the pattern of analgestic consumption revealed by these surveys indicates that more often than not, instances of regular, daily ingestion over a period of a year or more have represented abuse.

4.3 *Results of surveys* (*Figure* 1).

4.3.1 Some 16 per cent of the adult female, and rather more than 10 per cent of the adult male population of Queensland take analgesics every day [19, 20, 22, 23, 26–28]. The rate of abuse falls, and the female preponderence disappears as one moves around Australia in a clockwise direction through New South Wales [21, 22, 24, 27, 29–33], the Australian Capital Territory [34], Victoria [22, 35, 36] and Tasmania [37] to Western Australia, where no more than 3 per cent of the adult population of a provincial town were found to take analgesics regularly [38]. No information is available from South Australia or the Northern Territory. Analgesic dependence is clearly less common in Christchurch [2], and probably elsewhere in New Zealand [39] than in the eastern Australian states.

4.3.2 In the three most populous states, where surveys have been conducted both in capital cities and in country towns, no difference was apparent between metropolitan and rural populations.

4.3.3 The highest prevalence of analgesic abuse in any survey was that found in the aboriginal population of an "outback" country town in New South Wales [32]. On the other hand, the habit of taking analgesic powders appears to be uncommon amongst non-British immigrant communities [24, 40, 41].

4.3.4 Regular analgesic consumption may start during the teen-age years [23, 37, 42, 43] but becomes more widespread during young adult life [19, 21, 34, 38].

4.3.4.1 Age-specific rates for regular analgesic consumption have shown a peak prevalence at about 50 years of age in Queensland and New South Wales [18–21, 30, 31, 39]. However, in communities where there is less habituation to analgesics, the prevalence of daily ingestion has been highest in old age [34, 38] when chronic painful complaints are most common. The Queensland and New South Wales data could be explained either by considerable excess mortality amongst analgesic addicts during early middle age, or else by adoption of the analgesic habit in the first place by young adults, especially women, during or shortly after the Second World War [19]. The evidence for this latter possibility now seems conclusive, particularly in respect of aspirin-induced gastric ulcer [6–15].

4.3.5 In Queensland and New South Wales, those principally affected are housewives, unskilled workers and the poorly educated [19, 27, 40]. In both sexes, usage increases with worsening socio-economic status [21, 41, 42], but there is no evidence that woman who work are more liable to analgesic habituation than those who do not [21, 27, 37, 41], or that marital status is a significant factor [27, 41].

## 5. COMPOSITION OF ANALGESICS TAKEN BY HABITUES

5.1 Two brands, Bex and Vincent's, have been taken by more than two-thirds of analgesic habitues in this country [19, 21, 24, 27]. These two Australian proprietary brands differ from most other analgesics sold here in that they contain caffeine, are available as powders, and are retailed chiefly through outlets other than pharmacies [19]. Both comprised aspirin, phenacetin and caffeine (A.P.C.) prior to 1967 when Vincent's replaced phenaceton with salicylamide. Bex substituted paracetamol in 1975. Bex powders each contained twice as much phenacetin (350 mg), but rather less caffeine (68–75 mg) than Vincent's (85–91 mg per powder). Bex has been the more popular in Queensland [2, 19] whereas Vincent's appears now to have the greater share of the Sydney market [21, 24].

5.2 Tablets of aspirin, phenacetin (replaced by paracetamol during the last decade) and codeine are the preparations of choice for about one in ten Australian [21, 27] and nearly all New Zealand habitues [44, 45].

5.3 Single-drug tablets of aspirin or paracetamol alone are preferred to the compound preparations by about one-quarter of Australians who take analgesics every day [2, 27, 28], and by a majority of those who take them less frequently [24, 27] or who live in communities where heavy analgesic consumption is relatively uncommon [36].

## 6. THE SALE AND ADVERTISING OF ANALGESICS

6.1 Fewer than 10 per cent of Australians obtain their analgesics by prescription [27, 35, 46], and less than half of all purchases of these drugs are made from pharmacies [19, 21]. In this latter respect there is a notable difference between tablets of aspirin, 60 per cent of which are sold by pharmacies, and Bex and Vincent's powders, of which only 10 per cent are retailed through professionally supervised outlets.

6.1.1 The six Australian States have yet to place any restriction on the advertisement or sale of non-narcotic analgesics other than a requirement (not universal) to print on the packet of phenacetin-containing preparations a warning against excessive usage. Codeine-containing preparations, however, may be sold only by pharmacists.

6.1.2 In 1967 Federal regulations removed all phenacetin-containing drugs from the list of analgesics which could be obtained by prescription through the Australian National Health Service. In New Zealand the opposite measure was introduced in 1975, viz., to permit the supply of phenacetin only on a doctor's prescription.

6.2 The expenditure on advertising of analgesics by television, radio and the press throughout Australia was about $2 million in 1972 (cf. $5 million on other pharmaceuticals, $7.3 million on liquor and $11.0 million on tobacco in a total advertising budget of $204 million) [47].

6.2.1 Vincent's also advertise widely on hoardings, and Bex by means of placards inside and outside milk bars, general stores and supermarkets.

## 7. CAUSES OF ANALGESIC DEPENDENCE IN AUSTRALIA

7.1 Headache has been the reason most often advanced for regular, daily ingestion of analgesics, its frequency being 65 per cent [27] and 41 per cent [21] in two surveys. In the first, only 6 per cent of habitues admitted to taking drugs for their psychotropic effect, whereas in the latter, 31 per cent did so, a discrepancy due probably to different wording of the relevant questions.

7.1.1 These findings illustrate what is familiar to renal physicians in Australia, namely that the first Bex or Vincent's powder generally is taken on arising to "clear the head" while further doses are taken to relieve the dull headache or "let down" feeling which follows elimination of the drugs.

7.1.2 Caffeine-withdrawal headache is documented [48, 49], and phenacetin may also cause withdrawal symptoms [50], including headache [51].

7.1.3 That recurrent headache is more often a result than a cause of dependence on analgesics is borne out by the observation that habitues may no longer suffer headaches so frequently once they cease taking compound analgesics [44].

7.2 The third, and only legitimate reason commonly given for regular analgesic ingestion is arthritis or other chronic musculoskeletal pain. This accounts for no more than one-fifth of cases in Australia [21, 27].

7.3 Like other forms of drug dependence, habituation to non-narcotic analgesics has been found more commonly amongst those who give a history of domestic disharmony [52, 53], neurosis or other psychiatric disease [20, 22, 32, 53, 54]. There is also a positive association with tobacco smoking [20, 52], and possibly with alcoholism [20, 22, 27, 32, 33, 54], but not with the use of sedatives or tranquillizers [22, 27, 33].

7.3.1 However, it has been observed in New South Wales that groups of women who have taken analgesics even to the point of endangering their health, did not appear to be maladjusted mentally or socially, nor were they less able to be rehabilitated after renal transplantation than patients with non-analgesic end-stage renal failure [23, 40].

7.4 Psychopathic traits therefore can account for but a minority of cases of analgesic dependency, particularly in populations where the habit is very common. Moreover, some other explanation must be found for the demographic pattern of analgesic abuse, particularly the female preponderance and the striking geographic distribution.

7.4.1 Widespread advertising and ready availability appears to have created in many Australian circles a tradition of taking a powder for any minor complaint, a tradition which is handed down from mother to daughter [24, 27, 37], but which may not yet have become established in New Australian families whose mother tongue is not English [24, 40, 41].

7.4.2 On leaving school, young women are encouraged by their workmates to take powders to relieve the tedium of the job or improve performance [24], and the same remedy may be adopted later to overcome the stress of running a household with children and the boredom of suburban life.

## 8. DISEASE CAUSED BY ANALGESICS

### 8.1 *The Analgesic Syndrome.*

8.1.1 Although renal disease is the most dramatic consequence of analgesic abuse, Australian physicians appreciate that the majority of their patients suffer from a constellation of disorders which arise from the toxic effects of aspirin, phenacetin and/or caffeine, and which has been named the analgesic syndrome.

8.1.2 Clearly recognized elements of the analgesic syndrome include peptic ulcer, anaemia, hypertension and recurrent headaches as well as nephropathy [4, 25, 45, 52–55]. To these should be added splenomegaly [56], defective haemostasis [57], complications of labour [24, 58], carcinoma of the renal pelvis [59–61] and possibly occlusive arterial disease [53, 62].

8.1.3 Peptic ulcer, abnormal bleeding and iron-deficiency anaemia, and delayed or prolonged labour can be attributed to aspirin ingestion; met- and sulphaemoglobinaemia, splenomegaly and carcinoma of the renal pelvis to phenacetin; and recurrent headache to caffeine.

8.1.4 Psychiatric disease is generally considered to be one of the causes rather than an outcome of analgesic addiction, and organic dementia due to aspirin or phenacetin intoxication [51, 63–66] has not been described in Australian patients; nor has any association with laxative abuse [67] been noted, presumably because, unlike in Britain, the commonly abused Australian analgesics do not contain codeine.

### 8.2 *Analgesic Nephropathy* [45, 52–55, 65, 68–73, 75–80].

8.2.1 The central features of this disease, pyelonephritis, haematuria and/or colic, obstruction and renal failure which is often acute and reversible, are due to separation of, or infection around necrotic renal papillae.

8.2.2 During life, the diagnosis is generally based upon a substantiated history of analgesic intake exceeding 2 kg, and pyelographic demonstration of calcified or separated (partially or wholly) papillae, or medullary cavitation [55, 81–83] rather than on specific function testing [55, 79, 84] or renal biopsy.

8.2.3 As first recognized in Sweden [69], chronic renal failure is more frequently associated with impaired urinary acidification in analgesic nephropathy [52, 55, 79, 84, 85] than when due to other causes. Possibly as a consequence of the chronic acidosis, azotaemic osteomalacia occurs in non-terminal renal failure due to analgesic abuse, but it is otherwise uncommon in Australia [86].

8.2.4 Calcium deposition resulting in medullary nephrocalcinosis or calculous disease is frequent in South Australia [52] and New South Wales [55, 83]; in the latter State, heavy consumption of analgesics is the second most common identifiable cause, after abnormalities of calcium metabolism, of stone in the kidney [87, 88].

8.2.5 In all Australasian series, with one exception [55], hypertension has been present in 50–60% of patients with analgesic nephropathy [45, 53, 54]; and analgesic nephropathy may well be the second most common (after essential) type of hypertension in New South Wales [74].

8.2.6 Another late complication of analgesic nephropathy is secondary renal artery stenosis due to atheroma (*vide supra*) and causing malignant hypertension or deteriorating renal function.

### 8.3 *Carcinoma of the Renal Pelvis and Ureter.*

8.3.1 In New South Wales, about 40 per cent of transitional-cellcancers of the upper urinary tract occur in patients with analgesic-induced renal papillary necrosis [60, 61]. At Sydney Hospital we see, on average, two new

cases each year of this type of carcinoma, a not insignificant number when compared with 14 cases per year of irreversible end-stage renal failure from analgesic nephropathy.

8.3.2 Neither in histological appearance, nor in their tendency to be multifocal and to infiltrate and metastasise, do these tumours differ from cancers of the renal pelvis and ureter due to other causes. Their prognosis is grave, about 70 per cent of such tumours proving fatal within three years of discovery.

8.3.3 All analgesic-associated cancers reported from Australia have occurred in patients who had taken analgesics containing phenacetin.

8.3.4 A Melbourne research group has demonstrated that one of the metabolites of this drug, N-hydroxyphenacetin, can induce hepatic tumours in rats [91].

8.3.5 While it is widely, and probably correctly believed that phenacetin is chiefly responsible for these cancers, it must be remembered that the majority of our analgesic habitues with pelvic or ureteric carcinoma have been addicted to cigarette smoking, which is also known to be carcinogenic for the epithelium of the urinary tract [92, 93], and many have suffered from long-standing urinary infection or obstruction, which also predispose to cancer of the renal pelvis and ureter [60, 61].

8.4 *End-stage Renal Failure Due to Analgesic Nephropathy* (*Figure* 1).

8.4.1 Despite a high level of awareness in the community of the dangers of excessive analgesic consumption, and in the face of a generally good response of established analgesic nephropathy to active medical and urological therapy [25, 55, 94, 95], papillary necrosis remains the second most common cause of end-stage renal failure in Australia, accounting for some 18 per cent of patients entering maintenance dialysis and transplant programmes [96, 98].

8.4.2 The incidence is highest in Queensland [99] and New South Wales [82, 100, 101], and lowest in Victoria [102], Tasmania, and New Zealand [103, 104], conforming to the pattern of analgesic abuse (Figure 1).

8.4.3 *Post mortem* surveys have shown advanced papillary necrosis in 4–10 per cent of necropsies in Brisbane [1, 2, 39], Sydney [4, 105] and Melbourne [106] hospitals, but in less than 1 per cent in Perth [1] and Auckland [1, 107], thus confirming that analgesic nepropathy is relatively uncommon in Western Australia and New Zealand (these data exclude cases with minor grades of papillary damage). The higher figures quoted above must be interpreted with some care, since all came from hospitals with active renal units. In two hospitals which established renal failure programmes in the late 1960's, Christchurch and the Royal Prince Alfred Hospital in Sydney, the autopsy incidence of advanced analgesic nephropathy rose from less than 1 per cent in 1964 [1] to 3–5 per cent in 1971 [2, 105].

8.4.4 Evidence from death certification, together with prospective autopsy survey has indicated a falling mortality from papillary necrosis in Queensland in the period 1968–1971 [2]. The authors attributed this change to the replacement of phenacetin by salicylamide in Vincent's powders in 1967. However, they failed to take into account the rapid expansion of specialist renal services in Brisbane or the improved standard of conservative treatment for analgesic nephropathy which resulted from a better understanding of the disease. Both these factors would have had their greatest impact in the period under review.

8.4.5 The peak age incidence for patients with analgesic nephropathy starting maintenance dialysis is in the fifth decade [82]; in autopsy series, advanced papillary necrosis has been found chiefly in the 40–80 year old age groups [1, 2, 4, 106].

8.4.6 Women comprise some 60–85 per cent of end-stage or terminal renal failure due to analgesics [1, 2, 4, 39, 105, 106], a distinctly higher proportion than might be expected from the sex ratio of analgesic abuse in Australia (Figure 1). Possible explanations are that women analgesic habitues have on average, a much heavier consumption of powders than do men, that the higher liquid (beer) intake by male habitues is protective, or that their kidneys are more vulnerable due to the greater susceptibility of the femal urinary tract to ascending infection.

8.5 *Non-terminal Analgesic Nephropathy* (*Figure* 2).

8.5.1 No estimate is available of the prevalence in this community of non-terminal renal papillary necrosis, but in the Renal Unit populations (in-patient and out-patient), of the Sydney and the Royal Newcastle Hospitals, analgesic nephropathy is the most common diagnosis, accounting for 25–30 per cent of all cases treated.

8.6 *Costs of Renal Replacement Therapy.*

8.6.1 The only published estimate of the cost of a cadaveric renal transplant operation in Australia was $4,600 in 1973 [108]. This figure excludes the cost of all pre-transplant treatment, in particular, dialysis. Thereafter yearly treatment costs were estimated at $700 per patient [108].

8.6.2 Haemodialysis in a hospital renal unit has been variously estimated to cost, per year for each patient, $4,100 in 1969 (this figure excludes rent, hospital overheads and pathology services), $5,300 in 1971 (exclusive of rent and some overheads) and $7,400 in 1973 [108–110].

8.6.3 Home-based haemodialysis has been costed at $3,500 (in 1971), $3,800 (in 1973) and $6,500 (in 1976) per patient per year [108, 110, 111]. To this must be added the initial cost of providing equipment ($4,400 in 1971 and $2,800 in 1973) and training in the use of the artificial kidney ($2,200 in 1973) [108, 110].

8.6.4 Currently the annual total cost of renal transplantation services in New South Wales would be of the order of $1M (based on 120 transplant operations per year, and 400 patients at present with functioning grafts) and that of haemodialysis $2½ million (based on 150 patients each on hospital- and home-dialysis). Twenty-five per cent of patients entering the dialysis/transplant programme in this state are suffering from analgesic nephropathy [82, 96, 97, 100, 101].

8.6.5 None of the above estimates takes any account of the expense of providing health care for non-terminal renal failure, hypertension, urological disease, peptic ulcer and haematological disorders caused by analgesics; nor do they bear witness to the very real economic hardship and personal suffering endured by patients with papillary necrosis.

## 9. THE RELATIONSHIP OF INDIVIDUAL ANALGESIC DRUGS TO RENAL PAPILLARY NECROSIS

9.1 There is no certain knowledge as to which of the individual components of analgesic powders and tablets causes renal papillary necrosis in human subjects. Australian nephrologists who have relied on epidemiological evidence, with one exception [89, 90] have blamed phenacetin [2, 4, 5, 39, 55, 79], but experiments in rats have implicated aspirin as the major nephrotoxin [112–115].

9.2 The epidemiological arguments are straightforward and well-known; caffeine and phenacetin are the only ingredients common to all those proprietary analgesics which have been incriminated beyond reasonable doubt in the largest series of Swiss [51, 116], Swedish [68–70, 72] and Australian [2, 4, 5, 39, 54, 55] cases of renal papillary necrosis.

9.2.1 Caffeine is exonerated on two accounts. Firstly, it does not cause papillary necrosis in animal experiments [113]; indeed it may partially protect against the nephrotoxic effect of aspirin and phenacetin [112, 117]. And secondly, caffeine is absent from the codeine compound tablets and mixtures which have been associated with the development of analgesic nephropathy in an appreciable number of cases, particularly in Britain [65, 118–120] and New Zealand [44, 45].

9.2.2 Phenacetin is seldom (in Australia, never) taken alone, and all patients allegedly with phenacetin nephropathy have taken salicylate or a pyrazolone derivative in addition. This is true, not only of the patients in the retrospective studies quoted, but also of the analgesic takers amongst the twelve hundred-odd Swiss factory workers followed prospectively for four years [121]. That those workers who gave positive urinary tests for phenacetin derivatives showed some deterioration of renal function while under observation does support the view that consumption of analgesics is harmful to the kidneys, but does not necessarily implicate phenacetin.

9.2.3 However, paracetamol (N-acetyl-p-aminophenol), the chief metabolite of phenacetin, is being used increasingly as a prescription and household analgesic, often without other drugs. One group of 18 patients who had regularly consumed large quantities of paracetamol showed no evidence of renal damage [122], and there have only been isolated cases yet reported of renal papillary necrosis following ingestion of this drug alone [90], with aspirin [90, 120, 123] or with chlormezanone [124]. Not too much weight can be placed on these observations, for paracetamol is not yet as widely sold or heavily abused as was phenacetin, and in individual case reports it has not always been possible to be sure that no other analgesic has been taken [125].

9.2.4 There is a small number of patients who have typical analgesic nephropathy, but who deny taking significant quantities of any analgesic other than aspirin [45, 65, 73, 75, 82, 90, 126–128]. That this is the largest number of cases attributable to any one analgesic alone could be a reflection of the higher and more widespread consumption, rather than the greater nephrotoxicity, of aspirin.

9.3 Experimental work has been done almost exclusively using rats.

9.3.1 Attempts to confirm the nephrotoxicity of phenacetin by giving the drug alone to laboratory animals have failed [129, 130], or yielded minor and atypical lesions [115, 131–133], except in two investigations in which doses of 2–3 g per kg body weight per day were used [113, 134]. Dehydration enhanced the effect of these high-dose regimens [113].

9.3.2 Similarly, the single positive result recorded after paracetamol administration has been with 3 g per kg body weight per day combined with dehydration [113].

9.3.3 Neither the contaminant, acetic-4-chloranilide [129] nor the only other metabolite of phenacetin tested in long term experiments, namely p-phenetidin [130] produced papillary lesions, and short term studies of phenacetin metabolites have shown either no , or atypical, nephrotoxicity [135].

9.3.4 A high proportion of rats fed either aspirin, phenacetin and caffeine together (A.P.C.) [112, 113, 115, 131, 133, 134, 136] or aspirin alone [112, 113, 115] has developed renal papillary necrosis. In the Melbourne experiments, the daily dosage of analgesic was half to one gramme per kilogramme body weight given for two to nine months [112, 113, 115, 133]; in Johannesburg, a smaller dose was used, but for a rather longer period [131, 136]. Aspirin alone has given rise to minor lesions in rabbits [132], but none in pigs [137]. When tested under identical conditions, aspirin and A.P.C. have induced histological lesions of similar frequency and severity, but these observations do not necessarily imply that aspirin is solely responsible for the nephrotoxicity of A.P.C., for as indicated earlier, the caffeine in the mixture is to some extent protective.

9.4 The suggestion that salicylates and phenacetin metabolites enhance the nephrotoxicity of each other [117, 138, 139] could reconcile the epidemiological and experimental data just reviewed; and the parallel observation that aspirin inhibits the activity of the renal hexose monophosphate shunt enzymes, leaving the medulla vulnerable to the oxidant metabolites of phenacetin [138, 139], provides an explanation for their synergism. The potentiating effect of dehydration has been attributed to the concentration of N-acetyl-p-aminophenol, but not phenacetin itself, in the papillae during hydropenia [140–142]. It is not yet resolved whether salicylates also are concentrated preferentially in the hydropenic renal medulla [140, 143].

9.5 *Nephrotoxicity of Other Analgesics.*

9.5.1 Two phenacetin- and caffeine-, but not aspirin-containing preparations, Hjorton's powders and Saridon, have been blamed for large numbers of cases of analgesic nephropathy in Sweden [70, 72] and Switzerland [116] respectively. Both incorporate a pyrazolone derivative, phenazone (antipyrine) in the case of Hjorton's powders, and isopropyl-antipyrine in Saridon. However, there is very little direct evidence that these particular pyrazolones cause analgesic nephropathy. The abuse of phenazone with caffeine, together with smaller amounts of phenacetin and acetanilid, has resulted in but one recorded human case of papillary necrosis [144], and there is just a single example of papillary necrosis in rats given this drug alone [145]. In one experiment, amidopyrine, a chemically related drug, caused typical renal lesions while phenazone induced minor histological changes only [146].

9.5.2 Of the other analgesic and anti-inflammatory drugs tested in laboratory animals, phenylbutazone (a pyrazolone derivative), indomethacin and propoxyphene each induced papillary lesions in isolated instances [113, 145]; however, papillary necrosis was seen in two-thirds of rats

fed mefenamic acid, 100 mg per kg body weight per day for 20 weeks [113, 115, 145]. Of these drugs, phenylbutazone alone has been blamed for human cases, and then, but for one exception [147], only when taken along with large amounts of aspirin [123, 148] or indomethacin [90].

9.6 In this submission, we have deliberately refrained from citing evidence derived from acute toxicity studies, whether in man [149–152] or animals [153–155], for direct histopathological and indirect functional assessment [156] have indicated that the major lesion produced has been proximal tubular necrosis, and no definite relationship has been demonstrated between this and the chronic lesions of human analgesic nephropathy. Exceptions are reports of papillary necrosis in rats given single large doses of salicylate and acetazolamide together [157] or either indomethacin or phenylbutazone alone [158], and a careful study which showed that 5-aminosalicylic acid caused acute papillary necrosis as well as proximal tubular lesions [159]. Because 5-aminosalicylic acid is chemically related to both phenacetin and aspirin, this last observation bears further investigation.

9.7 We have also omitted reference to a large number of negative and inconclusive studies, including those in which infection was introduced into kidneys of animals fed analgesics. These experiments, whose principal message is the difficulty of reproducing the human disease in the laboratory, are fully reviewed by Nanra and Kincaid-Smith [114].

## 10. PREVENTION

### 10.1 *Background to Present Position.*

10.1.1 With an educational programme directed at the public and doctors by the Australian Kidney Foundation and individual urologists and nephrologists during the past 15 years, official pronouncements in 1969 on the dangers of non-narcotic analgesic abuse by the Royal Australasian College of Physicians [160] and the National Health and Medical Research Council [161], improved standards of conservative therapy and replacement of phenacetin by salicylamide in Vincent's powders during 1967, one might have expected that the incidence of analgesic-induced end-stage renal failure would have fallen during the 1970's. There has, however, been no discernible change in the proportion of cases entering renal replacement programmes between 1967 and 1975 [82, 96, 97], although the number coming to autopsy has diminished [2]. A factor to be taken into consideration is that criteria for acceptance on dialysis have been relaxed since the introduction of home dialysis programmes in 1970–71, so that patients in their 50's and early 60's, or those with extra-renal disease, two categories which include a high proportion of analgesic nephropathy, are now more likely to be considered for dialysis therapy.

Whether one is more concerned with the human tragedy of unnecessary suffering and disability or the mounting cost of treating renal failure, much of it due to analgesics, the case for additional action is clear.

10.1.2 One reason given for failure to take positive preventive action hitherto in Australia has been uncertainty about the precise pathogenesis of the analgesic-induced renal lesion. However, there is no dispute that the vast majority of Australasian patients with renal papillary necrosis or other manifestations of the analgesic syndrome have been habituated to powders or tablets containing more than one non-narcotic analgesic together with either caffeine or codeine.

10.1.3 In all publications claiming a substantial reduction in the number of new cases of analgesic nephropathy, the change has followed, and been attributed to the removal of phenacetin (*without substitution by paracetamol*) from analgesics sold directly to the public [2, 119, 162–166]. However, the replacement of phenacetin by salicylamide in one popular brand (Vincent's) of aspirin containing powder taken by Australian patients who have developed papillary necrosis has had no clear-cut effect on the incidence of end-stage analgesic nephropathy here [2, 82, 89, 90, 96, 97]. Moreover, experimental evidence that aspirin is nephrotoxic indicates that exclusion of phenacetin alone would be ineffective unless, at the same time, the rate of abuse of compound analgesic preparations as a whole were reduced [167].

10.1.4 Throughout the debate on the relationship of unrestricted marketing of compound analgesics to the prevalence of analgesic-induced disease in this country, one vital piece of information, namely the quantity of each type of analgesic manufactured or sold within the various States of Australia, has been withheld. Without knowing these data, it is impossible to substantiate or refute statements such as that claiming that one-third of all analgesics sold in this country are taken by analgesic habitues [168], or that phenacetin-containing analgesics are more injurious than those containing paracetamol or an unrelated drug.

10.1.5 The six Australian States failed to take action to restrict the free sale of phenacetin-containing analgesics in the 1960's; now, some ten years later and with more than 500 analgesic patients having entered our dialysis and transplantation programmes in the meantime, can we afford to take less than fully effective measures in 1977?

### 10.2 *Possible Alternative Preventive Measures.*

10.2.1 Ill-health caused by analgesics, whether it be renal disease, gastric ulcer or another manifestation of the analgesic syndrome, results not so much because individual analgesic drugs are particularly damaging to tissue, but because over a long period of time, comparatively huge amounts of analgesic have been taken, nearly always without medical justification. Therefore it is the policy of the Australasian Society of Nephrology and the Australian Kidney Foundation not to seek the banning of any single analgesic drug, but to advocate measures which will curtail analgesic abuse and prevent or break habituation to these drugs. Such measures would stop the use of drugs of dependence for minor complaints and ensure that people who become habituated to analgesics get informed advice and professional supervision.

10.2.2 If preparations containing more than one analgesic component, or an analgesic together with a stimulant were to be restricted to sale by prescription only, these aims would certainly be achieved [5, 35, 45, 94, 169, 170]. Underlying this proposal is the knowledge that dependency rarely occurs with non-narcotic analgesic drugs taken singly, but that nearly every compound preparation contains at least one psychotropic ingredient, commonly caffeine, but in some codeine, phenacetin or a barbiturate, and is therefore potentially habituating.

10.2.3 A less drastic and perhaps no less effective alternative would be to control or prohibit [20, 101] advertising of these compound preparations, and to allow their sale from pharmacies without prescription provided that the purchaser was attended personally by the pharmacist who would be charged with the responsibility of referring for medical advice those customers who appeared to be dependent upon analgesics [25, 43, 160, 169, 171].

10.2.4 It could not be argued seriously that restricting compound analgesic/stimulant preparations in the ways suggested would inconvenience ordinary people, the sick, doctors or pharmacists. Single-drug analgesics and antipyretics would be freely available, as at present, for self-treatment of headaches, musculo-skeletal or menstrual pain, febrile illnesses and the like, and objective study has shown them to be little, if any less potent that the combination preparations [172, 173]. Moreover, being less addictive, single drugs undeniably are more appropriate than caffeine- or codeine-containing analgesics for unsupervised use.

10.2.5 Vigilance would be needed against abuse of the single, non-prescription analgesics remaining on unrestricted sale, for salicylates, phenacetin, paracetamol and propoxyphene all have undoubted acute toxicity to stomach, blood, liver or central nervous system. Serious poisoning might be partially avoided by limiting the number of tablets sold at any one time to less than a potentially lethal dose, and by packaging the tablets individually in foil.

10.3 Although controlling the sale of compound analgesics will go far towards eradicating analgesic addiction and the physical disease which results, it will not correct the underlying conditions which have initiated the drug dependency unless, as some would claim, the analgesic habit is largely the result of commercially successful advertising. The importance of the psychopathology of drug abuse is not lost on those of us who are faced each day with cases of analgesic-induced disease, but a proper analysis of the environmental and emotional pressures suffered by these people is beyond the competence of an ordinary nephrologist or physician. Instead, we must enlist the aid of the social engineer, that mixture of sociologist, behavioural scientist and psychologist whose role in disease prevention is now recognized by the medical profession as well as by governmental health agencies, to devise a preventive programme which combines education with correction of the predisposing factors and a minimum of controls necessary to prevent exploitation of the less intelligent and weaker-willed members of the community [32, 43, 46, 169]. Only by drawing on a diversity of medical and para-medical resources will it be possible to cure, rather than merely to suppress non-narcotic drug addiction.

10.4 So long as identification of individual cases of analgesic abuse depends upon specific questioning, the diagnosis will frequently be missed, because of over-sight by the doctor or evasion by the patient.

10.4.1 Screening programme [23, 24], renal clinics [82] and some gastroenterology clinics [53, 174[ now regularly test their patients' urine for salicylate using Phenistix (Ames) or a solution of ferric ions, procedures which are rapid, easy to perform and sensitive.

10.4.2 Far more hitherto undetected cases would be identified were testing extended to hypertension and haematology clinics, and to general practitioners' surgeries.

10.4.3 Tests for phenacetin derivatives are of less general application since they are laboratory rather than clinical procedures [175].

## 11. RECOMMENDATIONS OF THE AUSTRALASIAN SOCIETY OF NEPHROLOGY AND THE AUSTRALIAN KIDNEY FOUNDATION

11.1 That analgesic preparations containing more than one analgesic component, or including a stimulant or sedative, be placed on Schedule 4 of the Poisons List.

11.1.1 Many nephrologists believe that a prescription should not be necessary for compound, non-narcotic analgesics provided that the restrictions laid down in Schedule 3 of the Poisons List were applied and the pharmacist himself took professional responsibility for dispensing these drugs. However, the present criteria for inclusion in this Schedule, notably the requirement that "excessive unsupervised medication is unlikely", cannot be applied to compound analgesic preparations.

11.2 That all analgesics tablets or powders be packaged individually, and sold in packets each containing less than a potentially lethal dose.

11.3 That information on the quantities of all analgesics imported, manufactured or sold in Australia be published annually.

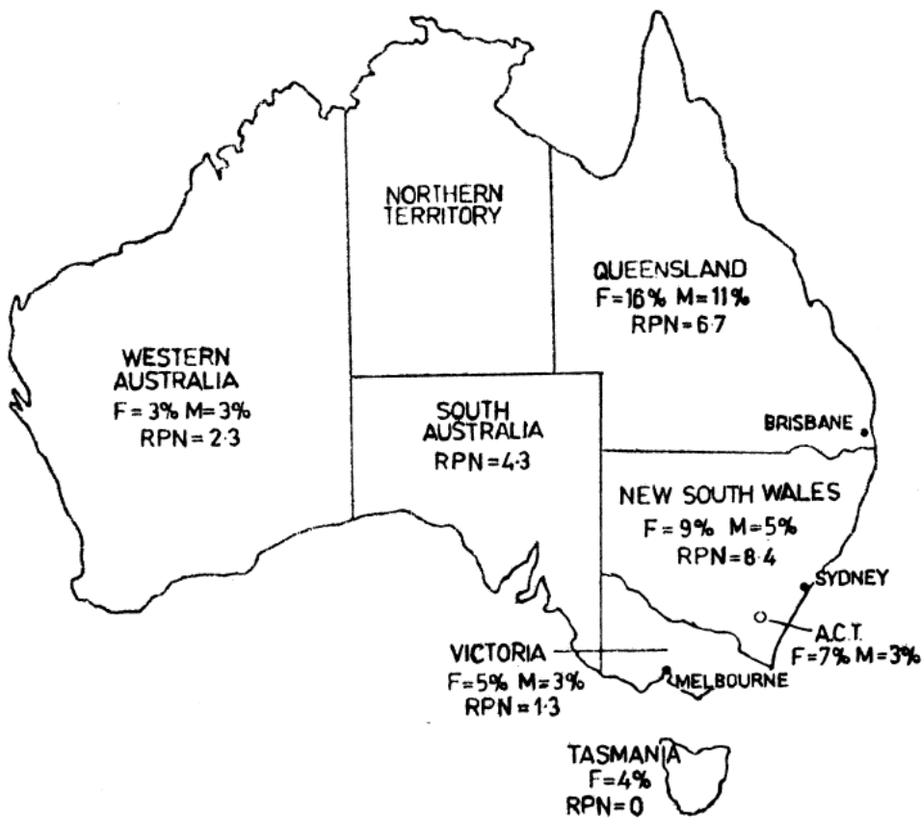
11.4 That a comprehensive investigation into the underlying causes of non-narcotic analgesic dependency in our society be undertaken in New South Wales by nephrologists, sociologists, psychiatrists and community health workers, supported by the Health Commission of New South Wales, the Australian Kidney Foundation, the Australasian Society of Nephrology and other interested bodies.

11.5 That, based on this investigation, an educational programme in the proper use of home medication and psychotropic drugs, and the dangers of their misuse, be devised, taking into account the results of different types of drug education programme employed in the past.

11.6 That detection of analgesic abuse be promoted through more widespread use of drug surveillance by urinary testing.

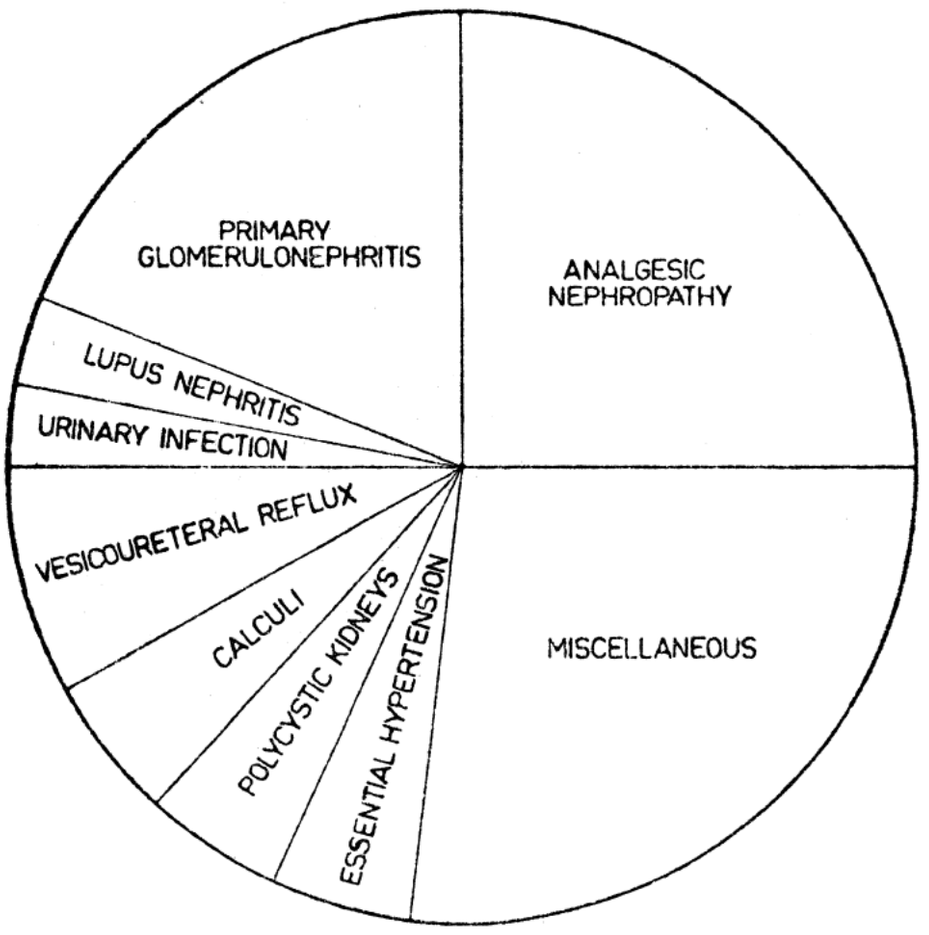
11.7 That encouragement of, and financial support for Australian-based research into the mechanisms of analgesic-induced nephrotoxicity and carcinogenesis be continued and extended.

Figure 1




*The distribution of (a) regular analgesic consumption and (b) end-stage renal failure due to renal papillary necrosis throughout the six Australian states.* Beneath the name of each is shown separately the percentage of adult females (F) and males (M) who take one or more analgesic powders or tablets every day (data obtained from references 19–24, 26–38), and beneath that, the yearly rate (per million of total population) of entrance of patients with renal papillary necrosis (R.P.N.) into the maintenance dialysis/transplantation programme in each state (data abstracted from the twice-yearly reports of the Australian Kidney Foundation Maintenance Dialysis Survey covering the period 1971–6).

Figure 2




*The distribution of renal diseases found in the 637 patients with non-terminal renal failure treated by the Sydney Hospital Renal Unit during the year 1976.*

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1975. CHAIRMAN: I understand that you would like to say a few words in explanation of your views on the matter of analgesic abuse and kidney disease?——W. Yes. I should like to make the point that essentially it is only those people who take large amounts of analgesics over a long time who get the sort of ill health that concerns us greatly, and has drawn us to make the submission. In other words, it is the people who become dependent upon the analgesics—the people who abuse them, and about whom we ask for some action to be taken. So that there is a link between analgesic abuse and kidney disease, not analgesic ingestion and kidney disease.

The second point I want to make is that pharmacological and medical evidence would suggest that analgesic abuse is related to the mixture of components of the analgesic powders and tablets, and probably particularly to caffeine in these powders and tablets. Codeine is also known to be addictive, and the tablets and powders that cause kidney disease which do not contain caffeine almost invariably contain codeine. But it is not the caffeine or the codeine that cause the kidney damage; it is the other ingredients—the aspirin, the phenacetin, the paracetamol, or a combination—and probably more likely a combination of these drugs. So, the second point I should like to make is that it is a combination of a potentially adictive ingredient, together with a potentially nephrotoxic, or kidney damaging, ingredient that is dangerous, and the separation of these two would go far towards avoiding the generation of kidney disease.

Finally, I should like to read two short segments from Goodman & Gilman, which is the authoritative textbook of pharmacology in the western world. This book is published in the United States of America, and is used as standard by doctors of all kinds in all parts of the world. I refer to the 5th edition, which was published in 1975, and under the heading of analgesic combinations and mixtures, says:

> Aspirin, paracetamol and phenacetin are frequently administered with each other and a variety of other drugs, including caffeine, sedatives, and the opioid analgesics. Concurrent administration of an opioid and an analgesic-antipyretic, such as codeine and aspirin, has a valid role in analgesic medication. However, none of the mixtures of analgesic-antipyretics, including the traditional aspirin-phenacetin-caffeine combination, has been shown to provide significant advantage over medication with aspirin alone.

They go on to say that in the United States they believe that these mixtures will no longer be made available to the public once the current investigation conducted by the FDA is completed.

Secondly, under the heading of analgesic nephropathy, they say:

> Despite numerous clinical observations and experimental studies in animals and man, crucial details of the problem remain uncertain. Critical analyses of analgesic nephropathy have been provided by Schreiner (1962), Gilman (1964), Shelley (1967), Gault and coworkers (1968), and Abel (1971).
>
> Although phenacetin has been implicated by some as the nephrotoxic component of analgesic mixtures, it is premature to single out any particular ingredient as the causative factor. It is also impossible to absolve any one component. A more balanced view is that chronic abuse of any of the mixtures may, in the susceptible individual, or in concert with other variables, cause renal injury.

1976. How long have you been specializing in this type of work?——I have been practising in renal medicine since 1959, and I attained specialist status in 1966.

1977. You are recognized as one of the experts in Australia in this particular field?——W. That is correct.

1978. What is your official position with the Australian Society of Nephrology?——W. Currently I am chairman of their analgesics subcommittee.

1979. How many members are there in the society?——W. There are about 300 doctors and university graduates who are members of the society.

1980. What percentage of the members of that organization would be in continuous practice as specialists in renal disorders?——W. About half of them are actively engaged in looking after patients with kidney diseases, and a further segment are surgeons—that is, urologists—who are also in practice looking after patients with kidney disease.

1981. Would you have any idea how many members of the society would be engaged exclusively in renal research?——W. Something like 20 per cent.

1982. You mentioned in your first submission that the recommendations are the official policy of the association. Does this mean that all the recommendations have been submitted to a constituted meeting of the society and accepted as an official policy?——No. The recommendations have been submitted to the members of the society during the past two years, but they have been adopted as the official policy of the society by the council, which has authority in this respect.

1983. Could you explain for the benefit of the members of the committee, who are not as well acquainted as you with these substances, the chemical constitution of aspirin, salicylates, and so on, which are mentioned in your submission? Could you give us a brief description of what they are, so that we shall know exactly what is being spoken of? The first is aspirin?——W. Aspirin is a acetyl salicic acid. Therefore, it is a close chemical derivitive of the salicylates. In fact, it is converted to salicylate in the body, and is effective both in its original form and as salicylate.

1984. The next is salicylamide?——W. That is a somewhat different derivitive of salicylic acid, in that it has an amide group attached. Chemically it is similar; pharmacologically it must be regarded as being somewhat different.

1985. The next is phenacetin?——W. That is an organic chemical derived from phenolic base, with two acetyl groups attached to it. When you remove one of those groups, paracetamol is formed, and that is one of the earliest metabolic changes the drug incurs after entering the body. It is thought, therefore, that the active ingredient of phenacetin, in terms of pain relieving, etc., is paracetamol.

1986. The next is phenazone?——W. Phenazone is also known as anti-pyrine. It is a chemical distantly related to other analgesic substances, which is used very little indeed in English speaking countries, but is used in continental Europe extensively, where it is an alternative for aspirin.

1987. The next is propoxyphene?——W. It is an entirely new and quite separately derived analgesic. It has come into general use only in recent years. It has quite different side effects from aspirin and paracetamol, and has been brought into use largely because it can be used for avoiding these side effects.

1988. Quite often in the submission you use the phrase renal papillary necrosis. Could you explain in more detail what is meant by that?——W. Renal papillary necrosis is

the primary disease of the kidney caused by analgesics. The kidney is divided into two parts—the outer part or cortex, and the inner pyramids or medulla. The apex of these pyramids is referred to as the renal papilla. The function of the kidney which is carried out in these pyramids is to concentrate the urine, to increase the concentration of various substances in the urine.

Not only is the accumulation of these substances increased in the urine but it is also increased in the papilla. In this case, drugs such as aspirin or phenacetin accumulate in the papilla at a higher concentration than in any other part of the body. Because of this, we believe that the primary toxic damage occurs at that site. Necrosis is tissue death or gangrene. The lesion in the kidney is tissue death of the papilla which separates off either partially or wholly from the kidney.

1989. What percentage of the kidney would have to be affected before it would become serious?——W. If the damage is confined to the papillae the kidney disease which results is relatively minor. However, two things happen. First, the dead papilla tend to separate off. If they do, there is bleeding from the kidney and blockage of the ureter, which is the tube leading from the kidney, by the papilla. That means that the function of the kidney is stopped until the blockage is relieved. Second, the dead tissue is particularly susceptible to infection and that infection spreads out from the papilla into the kidney as a whole. So the effects of chronic inflammation and tissue damage extends throughout the kidney. This has three effects. First, there is the acute illness involved with the infection. Second, there is the loss of kidney function as the cortex of the kidney is damaged. Third, there is the generation of hypertension, or high blood pressure, due to interference with the blood flow through the kidney. That is one of the primary causes of high blood pressure.

1990. I understand that analgesic-induced renal disease first became a significant factor in mortality tables in Queensland and New South Wales in about 1960. Were there any particular areas of either Queensland or New South Wales where these things had any great significance? ——W. The data which is quoted there comes from the Commonwealth Statistician and is data for the whole of each State. Therefore it cannot be used to subdivide the States into areas of particular risk. However, our clinical practice shows that there are pockets of New South Wales in which we find a far greater number of patients than in other places. The places particularly concerned are Newcastle, the western suburbs of Sydney and, although I have no personal knowledge of this, I understand also Wollongong.

1991. How did the association between analgesics and the mortality figures first become obvious?——W. In respect of kidney disease, the association is deductive in that there are two major types of lethal kidney disease. One is glomerulonephritis, or Bright's disease, which is categorised separately in the Commonwealth Statistician's figures, and pyelonephritis, or infective diseases of the kidney which are the other major category. It was noted that there was in fact a fall in glomerulonephritis, which has been going on since 1950 and a sharp rise in other diseases of the kidney. Investigations of hospital mortality data at that time showed that sharp rise at least in hospital mortality figures could be accounted for entirely by renal papillary necrosis.

1992. Where was the main clinical and pathological work done during the years immediately succeeding this discovery?——W. Three centres: Sydney Hospital, the Princess Alexandra Hospital, Brisbane, and the Royal Melbourne Hospital, Victoria.

1993. You state that minor analgesics are placed fourth only to alcohol, tobacco and sedatives in the table of our most harmful addictive drugs. What is the basis for this statement?——W. That statement quotes the findings of the predecessor of this Committee and the Senate Select Committee on Social Welfare.

1994. You state that 16 per cent of the adult female and more than 10 per cent of the adult male population of Queensland take analgesics every day but that the rate of abuse falls and the female preponderance disappears when one moves around Australia in a clockwise direction to Western Australia. Have you any explanation for this decline?——W. No. It really is a puzzling feature. I was brought up in New Zealand and there I was never aware of analgesic-taking as a way of relieving tension or a social habit. Compound analgesics were not widely advertised in New Zealand. I believe in the various States in Australia there is a difference in the community acceptance of this habit and the amount of community awareness of the psychotropic effect on analgesics. Perhaps that is the reason.

1995. You state that in the three most populous States where surveys have been conducted both in capital cities and in country towns no difference was apparent between metropolitan and rural populations. In making that statement, would you class Newcastle and Wollongong as metropolitan areas or would you class those with the rural sector because they happen to be away from the main metropolis?——W. I would class them as neither. The reason being that none of the surveys to which I refer have been done in Newcastle or Wollongong; they have been done in Sydney and country towns.

1996. This has a particular interest for us because, as I think you know, the Committee proposes to go to Newcastle next week. You state also that age-specific rates for regular analgesic consumption has shown a peak prevalence at about 50 years of age in Queensland and New South Wales. Have you any explanation for this?——W. Yes. By way of explanation, I think that there is a difference in the sort of person who takes analgesics in Queensland and New South Wales where the habit is common, and the sort of person who takes analgesics in, say, New Zealand or England where the habit is very uncommon. In countries like New Zealand and England analgesic-taking is far more likely to have a medical reason, either a psychiatric abnormality or a chronic painful illness as an underlying factor, whereas in Queensland and New South Wales it is unusual to find a medical explanation for the taking of the analgesics. Second, I believe that the habit became common in Queensland and New South Wales about the time of the Second World War. Maybe it started among the women who were left on their own while their husbands went off to fight. They joined the workforce at that time, and it was perhaps a sort of community activity. Those women who were 20 then are 50 now.

1997. I did not read it that way. I thought you meant that the power-taking or tablet-taking peaked at the 50th year and then dropped away?——W. No. When we look at a static population at any one time, say in the 1970's, there are groups of people of all different ages, but to explain what is happening to them now, one has to consider what has been happening to them all along. Young women who grew up before the war were not introduced to analgesics whereas young women who have grown up since the Second World War have been introduced to analgesics by their families and by their workmates.

1998. Would you say that smart advertising campaigns have probably been responsible for the fact that so many people feel they have to have these analgesics?——W. I think we have got to say that advertising is a factor. In my opinion advertising of these particular compounds has proved very successful indeed.

1999. You say that two brands, Bex and Vincents, have been taken by more than two-thirds of analgesic habitues in this country. Both are produced in powder and tablet form. Is there any evidence to suggest that powders have a different chemical effect from the tablets?——W. Yes, there is some evidence to that effect. In fact virtually all the people who become addicted or habituated to these brands, who have developed kidney disease, have taken the powders and not the tablets. I believe that is because the powders are more quickly absorbed from the stomach and therefore have a more immediate effect. The psychological lift comes within minutes of their taking the powder.

2000. Do you know why Bex replaced phenacetin with paracetamol?——W. I can only guess because phenacetin had been identified by epidemiologists as the cause of the kidney damage. This identification was made in the 1960's. They felt that they had to change. I would point out that it took them a long time to make that decision. Possibly sales were going down because of public concern about phenacetin and that forced them to make the change. That would be speculation.

2001. Vincent's in 1967 replaced phenacetin with salicylamide. Would that have the same explanation?——W. In 1967 a number of medical committees were sitting on the problem of analgesic necropathy and at that time the evidence all pointed to phenacetin rather than other ingredients as the toxic agent. Vincent's were convinced by that evidence and changed their formulation. However, I would point out that there is documentary evidence that the new formulation of Vincents still is nephrotoxic.

2002. Surely it would be true that very few people who take powders or tablets would know what the chemical composition is?——W. I would question that. I think most of them have an idea what the drugs are. Of course the people that I see are those with kidney disease but when I discuss their powder-taking habits with them most of them will admit that their habit was potentially harmful. They know also that aspirin and caffeine are ingredients of these powders.

2003. Single drug tablets of asprin or paracetamol alone are preferred to the combined preparations by about one-quarter of Australians who take analgesics every day and by a majority of those who take them less frequently. Is there any explanation for the high percentage taking the single drug tablets?——W. Many people would take them for genuine medical reasons such as rheumatoid arthritis for which regular asprin taking in fairly high dosage is a primary form of treatment. Others may have some other form of chronic complaint. If one looks at these figures it is seen that generally the older population is taking asprin or paracetamol regularly. They are the sort of people in the age group where they will get more and more ill health and have a genuine reason for taking them regularly.

2004. It is common knowledge that many people take a powder or a tablet soon after they rise in the morning. I think you have referred to that in your submission. Do you think this is merely a matter of habit or do people get relief from taking powders or tablets?——W. There is no doubt that the head is cleared by the powder or the tablet that they take. You would note that on the whole it is more a problem with women than men. With men it is often someone who has been drinking heavily and wakes up with a hang-over type of headache. It is rare for women to be heavy drinkers to that extent but they get up with the heavy feeling that one has first thing in the morning and they use these things because women have to function rapidly and effectively at that time of day. They must get breakfast and get the children off to school, and so they use this as a means of getting themselves going.

2005. You referred to headache and withdrawal symptoms caused by caffeine withdrawal and phenacetin. Has any extensive research been done in regard to this matter? ——W. The research is quite old. The research I quoted was done in Chicago and published in 1943 so it would have been done a bit before then. They took a large group of people and regularly gave them either caffeine or tablets that looked exactly the same but did not contain caffeine. They got these people to record the effects and there was quite a definite effect of withdrawal with caffeine causing headaches and other symptoms.

2006. In one part of your submission you said that regular headaches are more often the result than the cause of dependence on analgesics. Are you aware of any educational programmes which have been carried out in regard to this particular matter?——W. Unfortunately there has been a lack of a well planned educational programme. The Kidney Foundation and other interested parties do publicize their feelings about the relationship of analgesics with kidney disease but it is hardly an educational programme. I understand that the Department of Education is trying to get an awareness in schools of the hazards of drug taking, including analgesics and so on. However, the effect of that has not filtered through to the community as a whole yet.

2007. Mrs ANDERSON: Does the makeup of the genes have any effect on certain diseases? For instance, a male and a female may take a powder to start the day with. Nothing might happen to the male in the family but the female might end up with renal trouble?——W. There is a very close link between the genetic makeup to susceptibility to disease, particularly disease induced by drugs. This is simply because the handling of the drug by the body's metabolism is carried out by enzymes which are direct products of genes. However, except in few cases there won't be a sex difference. It will be genes unrelated to the sex genes, that will be relevant and I do not really think the difference between men and women is due to their genetic, so much as their social differences.

2008. Mr RAMSAY: Do you or your organization have any statistics on the effects of marihuana on kidneys and in relation to kidney disease?——W. As far as I am aware marihuana does not affect the kidneys. I have seen no case of kidney disease attributable to marihuana.

2009. Mr HEALEY: Doctor, you commenced your statement by saying that you were really concerned and that the troubles really started after an individual had taken a large amount of analgesics for a long time. What would you classify as a large amount and a long time?——W. The majority of patients who have advanced kidney disease have taken four or more powders every day for ten years or more.

2010. So any more than four a day is a dangerous margin?——W. Yes.

2011. In your submission you give various percentages. Do you have any specific numbers of people in New South Wales or Australia who are suffering severe renal damage because of analgesics?——W. It is difficult. There is not a register of morbidity. It is not a notifiable disease in the same way as cancer is. One can only guess. We certainly know how many patients in Australia and in New South Wales suffer from end-stage kidney failure because there is a register of those patients. Secondly, we can deduce how many patients are attending the major teaching hospitals with kidney disease due to analgesics. In New South Wales the figure is about 250 patients being treated with artificial kidney machines or with a kidney transplant, following analgesic disease. About 1 000 people with this disease attend renal clinics of the teaching hospitals of this State.

2012. Would those figures be available to the committee? ——W. The figures on end-stage kidney disease are available. I know of nowhere that the patients attending outpatient clinics are written down. Our own figures and those of Royal Newcastle Hospital are available to the committee.

2013. CHAIRMAN: Are these figures supplied to any central authority, such as the Health Commission?—— W. The figures for end-stage kidney disease are supplied to the Australian Kidney Foundation and made available by it to any party who is interested. The outpatient figures would not be made available to the Health Commission, unless requested.

2014. Mr HEALEY: One of your recommendations is that all analgesic tablets and powders be packaged individually and sold in packets each containing less than a potentially lethal dose. What would be a lethal dose?—— W. Each analgesic separately has acute poisoning effects. Salicylate poisoning is not terribly common in this country but it is a common mode of suicide in England. The approximate lethal dose can be derived from the acute poisoning data.

2015. How many powders or tablets, and what would be a lethal dose?——W. In aspirin, fifty, but I point out that I am not a pharmacologist and I am not a specialist in acute poisoning.

2016. Another recommendation was that the detection of analgesic abuse be promoted through more widespread use of drug surveillance by urinary testing. How do you propose that that should be done—on a voluntary basis or that it be mandatory upon doctors, or what?——W. It would have to be voluntarily done at hospitals, clinics and by professional organizations. We planned to promote through these sources the idea that when urine is tested it is tested also for drugs, which is quite a simple process.

2017. Mr MacDIARMID: Drinking alcohol affects the liver and taking analgesics affects the kidneys, as I understand the position. Is more damage likely to be done by someone who takes analgesics and also drinks heavily? ——W. As far as the kidneys go the answer is no, less. Analgesics are concentrated in the papillae of the kidney and they are concentrated more when a person passes less urine, as they are trying to extract water out of the urine. When a person is passing large amounts of urine the practice tends to be that drugs are washed out of the kidneys more quickly and therefore are much less likely to cause harm. Therefore, the combination of analgesics and beer, for instance, is much less harmful to the kidneys than analgesics alone.

2018. You said you were brought up in New Zealand. The climate there is quite cold compared to Queensland, about which some statistics have been given. Would it have anything to do with the climate, from your exerience, that one is more inclined to headaches in a hotter climate? ——W. That may be so. I would not like to speculate but I can say that in hotter climates one tends to pass a smaller volume of urine because of the loss of fluid through the skin in sweating. Therefore, for one to take analgesics in a hot climate one would be more liable to get papillary necrosis. This has been shown in Melbourne where the climate differs from Sydney in that in Melbourne it is a lot hotter and drier in summer and in winter it is a lot colder and therefore the extremes are a lot greater than they are in Sydney. The cases of papillary necrosis coming to post-mortem in Melbourne go up and down with the seasons—up in summer and down in winter.

2019. What is it that starts teenagers off on analgesics? Is it stress in the family home or is it like smoking; they start because their friends smoke? What is the real reason? ——W. I think it is mostly girls that take them rather than boys. I suspect they are started because of menstrual pain. They take something for that and they realize that something they take gives them a bit of a lift and helps them along psychologically and they get into the habit of taking them more and more for other things than their menstrual pain.

2020. You mentioned that men who have a hangover often take tablets in the morning. Are women more susceptible because of the stress and strain of the family home or the marriage, or is it just that once it becomes a habit they continue on with it?——W. I think they are more susceptible because of those features. The woman has pressures on her in the morning and the evening at times when the man is relaxing. She also has fewer safety valves, fewer ways of relaxing and letting off steam, as it were, than a man. The social structure does not give them to her. I think this is probably compounded now that more and more women are going to work. It is still the woman of the home who has to get the breakfast, even if both she and her husband are going to work. It is still the woman of the home who has to do the cleaning up, the washing and the housework in the evening when she comes home.

2021. I suppose it is true to say that many women who work in factories are under constant pressure because the job is boring?——W. I believe that is true.

2022. Mr McGOWAN: Added to that would be the availability of analgesics for self medication. Most homes would have some aspirin—Bex or something like that—permanently in the home and there would be a tendency to medicate for all sorts of things by means of aspirin. That is by the way, I suppose. What percentage of all renal disease in New South Wales, as a guess, is attributable to analgesics and how does that compare with the position in, say, New Zealand or Western Australia?——W. It is not really a guess. In New South Wales the figure is fairly firm at 25 per cent. That applies both to end-stage renal disease—that is serious renal disease—and patients who attend outpatient clinics in the State. In a place like New Zealand the figure would be 5 per cent or less.

2023. So it would be reasonable to say that if we could put controls on analgesics we would be likely to reduce renal disease in New South Wales by some 20 per cent over a period of time?——W. It would be reasonable.

2024. CHAIRMAN: In one section you say that all analgesic-associated cancers reported from Australia have occurred in patients who had taken analgesics containing phenacetin. What is the incidence of cancers caused by analgesics?——W. If I may enlarge a little on that, the fact that analgesic abuse was associated with one particular form of cancer was not recognized until about 1965; it was then recognized in Sweden. In about 1970 it was recognized in New South Wales and there appears to be an increasing incidence of this particular cancer in Australia. It might be that the better medical treatment of the kidney disease itself prolongs the life of people who have renal papillary necrosis and gives the cancer time to develop. I do not know whether you are aware of the relationship of bladder cancer to certain dye industries which was elucidated in the 1940s in England. There it was shown that people who worked in certain dye industries and were exposed to carcinogenic chemicals developed cancer at an average period of seventeen years after exposure to the carcinogen. We believe that the same or a very similar process is going on with phenacetin, which is chemically related to these dyes, and that the development of cancer occurs over a long period of time—maybe seventeen years, maybe longer—and it is only the people who are saved from dying of their kidney disease—papillary necrosis—who then become at risk to cancer and this is why cancer of this particular type appears to be on the increase.

Phenacetin: As I mentioned to you, the first product of phenacetin in the body, when it is absorbed and passes into the liver, is paracetamol and it is believed that paracetamol itself will not induce cancer. But not all phenacetin is converted into paracetamol. Small percentages of it are converted into chemically related substances and it is these chemically related substances which are believed to cause the cancer.

2025. Could I go back to the first part of my question; what is the incidence, say in Sydney at the present time, of the cancer?——W. I am sorry; the answer to that is I do not know, but we are at present conducting an investigation through the Cancer Registry of New South Wales. I can give you approximate figures. These approximate figures are derived from Sydney Hospital data, but they agree with data from Prince Henry Hospital and the Royal Newcastle Hospital that I have examined. They disclose that approximately 15 to 20 per cent of all cancers of the kidney are related to analgesic abuse and there are approximately 150 to 200 cancers of the kidney per year in New South Wales.

2026. Mr Healey referred to your statement or recommendation with regard to packaging. I noticed in some of the newspaper publicity early this week or last week that reference was made to the safety factor and that it is desired to make these products safe where children are concerned. However, from all our experience and reading it is not the children who are at risk: it is the adults. Would you agree with that?——W. Yes. I think we have to divide acute poisoning effects from chronic poisoning effects. As kidney doctors we are worried about the chronic poisoning effects, but we do not want to ignore the acute poisoning effects. Cases of salicylate poisoning are admitted to hospitals fairly regularly and cases of paracetamol poisoning are being admitted to hospital more and more frequently and they are both very serious conditions indeed, but they do not fall within my practice or within my sphere of experience. However, as responsible citizens we should, at the same time as facing the problems of chronic poisoning, also give some thought to avoidance of acute poisoning.

2027. Making allowance for the fact that it is outside your field, could you give us some indication of how many powders somebody would have to take in order to suffer from acute analgesic poisoning?——W. If they took powders the figure would probably be half that which I gave Mr Healey previously and that is about 25. That is because the dose of analgesic in a powder is about twice what it is in a single tablet. But I should say here that most cases of acute poisoning are associated with the single drug preparation rather than powders or tablets.

2028. In that case it would be almost impossible for somebody to suffer accidental poisoning from an analgesic. Surely it would have to be deliberate to take that number of powders?——W. Except in the case of children who might take them thinking that they are sweets.

2029. One aspect of packaging is that if powders or tablets are to be put out in special foils or things of that nature their cost will obviously be increased. Do you think we would be justified in making a recommendation of that nature?——W. Yes, I do. After all, these are items that ordinarily are taken in small amounts and therefore are not a big contribution to the family budget. Although the percentage cost may appear to rise greatly, the total cost to the purchaser would not be great.

2030. How could we find out the numbers of people who are admitted to hospitals with acute analgesic poisoning?——W. I would recommend you to seek that from either the Poisons Advisory Centre at the Royal Alexandra Hospital for Children or from Professor Wade of the Department of Pharmacology at St Vincent's Hospital.

(Short adjournment.)

2031. CHAIRMAN: In most of the recommendations we have received from outstanding nephrologists, they suggest that the danger is in the compounds more than in the single analgesics. I think your recommendations also suggest that compounds should be available only through chemists. Would you like to summarize your views on that?——W. Consistently, it has been compound analgesics that have been associated with more than 90 per cent of all case of kidney disease. That is not to say that single analgesics cannot cause kidney disease, and it is quite clear that at least one—aspirin—does so. It is just that when the aspirin is taken singly it is, apparently at any rate, not taken in sufficient quantities to cause kidney disease. Therefore, we have no real case for draconian restrictions on the single analgesic. I think that the compound analgesics probably cause the damage, for two reasons: first, because they are addictive; and secondly, because there may well be more than an additive effect. There could be a multiplying effect of one from the other. One drug sets the conditions for the other to do the harm to the kidney. Therefore, it is the compound analgesics that we would like to restrict.

Looking at it in a different way, it has been shown on a number of occasions that, for the sort of reasons that analgesics are used legitimately—for the relief of pain—compound analgesics really are no better than the single. Therefore, we feel (a) there is no case for the compound analgesics to remain on the market, and (b) a good case at least to remove them from the free market.

2032. You are saying that the single analgesics should be available freely, as they are at present, but any compound analgesics should either disappear altogether or should be available only by prescription?——W. That is correct. I shall enlarge on that a little. The compound

analgesic of one analgesic anti-pyretic, which is a drug that lowers the temperature, together with codeine, is a reasonable thing to leave on the market, because codeine is a cough suppressant as well as being an analgesic. For bronchitis and that sort of illness, aspirin and codeine together would be a reasonable preparation. That is why codeine was separated out in the NH & MRC recommendations. In regard to the sort of restrictions we propose, the easiest thing would be to make them available on schedule 4 only; that is, by prescription. An alternative point of view has been put both by members of our society and outsiders; that is, that the responsibility for the handing out the analgesics should be taken not by doctors—which would be the case in schedule 4—but by pharmacists. The difficulty about that is to ensure that the pharmacist himself takes professional responsibility for handing them out rather than leaving it to his staff.

2033. Mr JACKETT: I have read the submission that has been made, and I have also spoken with Dr Stewart during the morning tea recess. I have no questions to put to Dr Stewart, although I was interested in the statistics from the various States in the Commonwealth, which seem to indicate that the biggest problem is in Queensland and New South Wales. Do you believe that climatic conditions would have much to do with this?——W. We have already speculated on this and I am not too sure of the answer. I think that, given a hotter climate, the taking of analgesics is more likely to be harmful because the analgesic tends to be concentrated at higher levels in the kidney under those circumstances. But whether the climate is the cause of taking higher or larger amounts of analgesics is mere speculation.

2034. CHAIRMAN: Is there any information available to indicate the quantities of analgesics that are sold in each State in Australia?——W. No, I have been unable to get that information from any source.

2035. These statistics could be of value to you and perhaps to us, in regard to some of the matters about which we have been talking; that is, in regard to the incidence of analgesic abuse in different States?——W. I believe so. I think it would make a huge difference in our assessing the relationship between analgesic consumption and disease if we knew the total consumption.

2036. Mr HEALEY: In your initial draft statement you recommended that a preparation be placed on schedule 3, but in your final recommendation you suggest schedule 4. What is the reason for the change?——W. It was pointed out to me by some of my colleagues in the Kidney Foundation that schedule 3 was basically inappropriate for this because it excludes drugs that are liable to be taken to excess. Of course, analgesics are very much in that category.

2037. CHAIRMAN: I am still a little interested in the aspect of the single drug. Would you say, therefore, that aspirin will do anything, except for serious illnesses, which would require something else—and that would be obvious in the first place?——W. In terms of pain relief, or lowering of temperature, aspirin alone is as potent and strong as a mixture of aspirin plus phenacetin, or aspirin plus paracetamol or aspirin plus salycylamide. This has been proven in experiments of the type I mentioned before, where you get a large group of patients with a chronic painful condition. Most are cancer sufferers. They are given identical tablets, some containing aspirin and some a mixture. Then you record whether they were relieved of pain, and for how long. Aspirin alone was clearly the best analgesic.

2038. What particular recommendations would you like to see a Committee like ours make in regard to the increase of facilities into research for kidney disease?——W. As far as research goes, I think we have to clearly identify two types; one is research into drug abuse or analgesic abuse. That is much more a sociological problem than a medical one, and is an area in which we as doctors feel a little out of place. I have thought—and it is the feeling of my colleagues in the Foundation and the Society of Nephrology that we should get together on that aspect of it with sociologists and psychologists or psychiatrists. Probably the best vehicle would be the Health Commission of New South Wales, which is building up the sort of resources we need to tackle the problem of drug abuse.

The other side of the coin is the direct effect on the kidney of analgesics. That involves laboratory research, which is funded through medical research organizations such as the NH and MRC the Australian Kidney Foundation, etc. On that basis, I think probably all one could expect is that general support is given to providing those bodies with adequate funds to allow that research to take place.

2039. There is cost involved in all sorts of other problems, such as the elimination of pollution. Is any financial support offered by the drug companies, who apparently regarded as the villains in this area, as they produce the analgesics that cause the kidney trouble?——W. Yes, some is. But one has to be very careful about accepting money directly from a manufacturing or a selling firm, because when the money is forthcoming there is either an actual or an implied tag attached to it. It is becoming to be recognized very clearly now that medical researchers should be independent of that sort of pressure when they are doing their research. Otherwise there is a doubt about the validity of the findings when they are produced. We would oppose any question of the firms themselves providing money individually and directly to research laboratories for this purpose. There may be a case for getting them to provide funds which may be channelled to research through an independent research-funding organization.

2040. In other words if they had no control over the actual research that system would be acceptable?——W. That is right.

2041. Do you know of any research that is being done at the present time which is funded by any of the companies?——W. I believe the only place where company funded research is being done is in Melbourne. Some very strict guidelines have been laid down as to how the money is being used.

2042. Mrs ANDERSON: By the people providing funds?——W. By the people accepting the funds who have agreed to do the research.

2043. Mr JACKETT: Throughout your paper I rather think that you make something of a case against the powder as opposed to the tablet form, yet in the recommendations this seems to be left out. I may be incorrect in my interpretation. I felt that the powders, particularly Vincents and Bex which are in powder form, have something against them because they are in powder form. Is there any suggestion that they should be dealt with rather than the tablets? I know that I personally would prefer to take tablets rather than powders possibly because of the effect on my throat or something that happens——

2044. Mr HEALEY: With all due respect to Mr Jackett, we have been through this and the doctor has explained fully.

2045. Mr JACKETT: If it is in the transcript I am happy with that.

2046. CHAIRMAN: The point that Mr Jackett was making was that you explained the difference between tablets and powders but you did not put it in your recommendation. Would you like to comment on that aspect? ——W. What I said before was that essentially the powders are absorbed more quickly from the stomach and therefore they give an immediate effect, or nearly immediate, within minutes effect and therefore are more satisfying to the person taking them because of the lift. However, there is more to it than that. The powders, that is Vincents and Bex, are sold almost entirely through non-professional outlets; they are sold from supermarkets and stores and that sort of thing rather than from a pharmacist, whereas the tablets are very much more sold from pharamacies and have some professional supervision.

Second, the powders are caffeine-containing whereas a good few of the tablets do not contain caffeine but contain codeine. In Australia most of these analgesics contain either caffeine or codeine. In some countries they contain both. In a way caffeine is more habituative than codeine. Two codeine-containing products, namely Veganin and Codral also contain aspirin and paracetamol, which do cause kidney disease and which are associated with a proportion, somewhere between 10 per cent and 20 per cent, of our cases of kidney failure. One would want to ensure that they came under some sort of restriction as well.

2047. Mr MACDIARMID: The commercial world being what it is, is there any possibility that one manufacturer can strengthen his brand with whatever it is he puts in the product to make it more effective than his competitor? Or is that strictly controlled by the Standards Association? ——W. No. For instance, we were talking before about when Vincents took out phenacetin and put in salicyclamide. They increased the amount of aspirin and the amount of caffeine in each powder. So the powder has less phenacetin but in fact has more aspirin and more caffeine. In fact Vincents has more caffeine in it than Bex. When Bex took out phenacetin and put in paracetamol it also increased the aspirin and caffeine content.

2048. Therefore, can a manufacturer virtually put what he wishes in a product?——W. At the moment I believe so.

2049. He can without any control?——W. I believe so.

2050. Mr JACKETT: What was the reason for increasing the aspirin and caffeine content when they made the change?——W. I would be speculating because I do not know. I think the reason for increasing the caffeine content was to increase their effectiveness to the person who is taking them for a lift. The reason for increasing the aspirin content is that many of us believe that salicylamide is a very ineffective analgesic. We believe its pain-relieving properties are very poor indeed and therefore the aspirin content was increased to account for the fact that it was combined with a weaker analgesic.

2051. Mr MACDIARMID: Do the tablets that the medical profession prescribe for whatever the ailment vary much from the commercial preparations such as Bex or Vincents?——W. Yes. When I was a medical student tabs codeine co or tabs APC were standard prescription items and they had rather less analgesic per tablet, that is aspirin, phenacetin and codeine or caffeine, than the Bex or Vincents powder. However, those tablets have virtually disappeared from medical prescribing habits in the 20 years since I was a student.

2052. CHAIRMAN: What training do doctors have in regard to writing prescriptions? Has that varied at all over the years?——W. I believe that in the old days they had good training but in recent years that training tends to be left largely because of the demands on patients in teaching hospitals and because of the expanding volume of knowledge that is required of a medical student. Students more and more spend their under-graduate years at the university studying theoretical material whereas in the old days it was much more of an apprenticeship. Now the apprenticeship time comes after they graduate when they are working as residents in teaching hospitals. Only then do they really learn the practical things like writing prescriptions, as done by example rather than by precept.

2053. Would some of the apparent dangers of the analgesics be included in the present medical courses?——W. Yes. Students are taught about the pharmacology of the analgesics, such as the handling in the body, and toxocology, that is the dangerous side effects, under the heading of pharmacology. Also quite separately in the lectures on medicine they would be taught about the diseases which result from them. For instance, they get a whole lecture on analgesic nephropathy.

2054. Mr MACDIARMID: How many analgesic products by manufacturers come on the market on a world basis at over what period? I have been in a doctor's surgery when he has had samples of some new form of analgesic. He has given me samples and said to take them and see what effect they had. I have taken very few pills over my lifetime, but that has actually happened. What sort of precautions are taken by the medical profession to ensure that they are fairly up to scratch?——W. The number of individual analgesic substances used by the medical profession and also used in proprietary analgesics is relatively small. We have mentioned aspirin, salicylates, salicylamide, phenacetin, paracetamol and propoxyphene. That is just about the whole range of simple analgesics available. Of those, propoxyphene is a relatively new drug introduced within the last ten years or so. Paracetamol has been around for not much longer than that. All the others are old long-standing ones. Most of the new products are in fact different variations on the same theme. Phenazone and its derivatives, which are also mentioned in the submission, are not used in English-speaking countries because they cause agranulocytosis, which is a condition in which the white cells in the blood disappear entirely and of course it is fatal. Because of that phenazone and its derivatives are used hardly at all in English-speaking countries.

2055. Mr JACKETT: Is there any advantage using the dissolving type of powder, such as dispirin, as against the non-dissolving?——W. It is possible, even probable, that the dissolving aspirin is less irritating to the stomach than the tablet that does not dissolve. Also because it is dissolving it gets into the system more quickly. Therefore, if one has a headache it will be relieved in ten minutes or a quarter of an hour rather than half an hour. There are practical advantages but no pharmacological advantages.

2056. Mr MACDIARMID: At what stage of history did any of these analgesics come to the notice of the human race?——W. At the end of the 19th century there was a vast expansion of the chemical industry, particularly in Germany during the 19th century. That is when a lot of these products came on to the market and became part of our formulary.

2057. CHAIRMAN: You might like to summarize what we have been talking about. Are there any particular impressions you would like to convey to the Committee that we have not covered in our questioning?——W. Yes, there is something I would like to say. We, as a group of doctors working in a narrow specialty, are very conscious of the fact that we are trying to impose on the public at large and on medical colleagues a set of rules about commonly used drugs. We have given a great deal of thought to the other side of the case. In other words, we realize that we are denying to doctors and to the public, drugs that they are currently using and which are providing symptomatic relief. However, we think that the sum total of harm being done by these substances so far exceeds the amount of good that can come from them and that the good can be done by other and safer means, that placing some from of control or restriction on analgesics is justified. Philosophically many of us are opposed to controls and restrictions. But when you have substances that are sold as if they are going to do good for the patient when in fact in the long run they will do harm, we believe some sort of restriction is essential.

2058. CHAIRMAN: I want to thank you for giving up your time to come and speak to the members of the Committee and also for the valuable submission you have made. I feel sure that it will be a guiding light in other discussions the Committee will have with other people about this serious social problem.

(The witness withdrew.)

(The Committee adjourned.)

*AT NEWCASTLE ON WEDNESDAY, 4 MAY, 1977*

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(The Committee met at 2.00 p.m.)

Present:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| The Hon. F. M. MacDIARMID | Mr J. G. T. JACKETT |
| | Mr B. McGOWAN, B.A. |
| | Mr E. D. RAMSAY |
| | Mr R. C. A. WOTTON |

BERNARD MICHAEL GERAGHTY, Regional Director, Health Commission, Hunter Region, living at Awaba House, First Street, Booragul, and

LESLIE OSBORN DARCY, Medical Superintendent of Morisset Hospital, residing at Hospital Estate, Morisset, sworn and examined:

2059. CHAIRMAN: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. (*Mr Geraghty*) Yes. (*Dr Darcy*) Yes.

2060. I thank you both for giving the committee the opportunity to hear at first hand from two prominent members of the health services of the State of the difficulties associated with the area. You may feel free to make any recommendation you wish the committee to hear in regard to the importance of the health services or in regard to any of the particular problems covered by the terms of reference. I point out to you that alcohol and tobacco are specifically excluded from the terms of reference of the committee but apart from those two things the terms of reference cover the use and abuse of all other drugs of dependence. Despite the fact that some people might argue about it, the terms of reference also include analgesics. Mr Geraghty, would you please address the committee?——W. (*Mr Geraghty*) Thank you, Mr Chairman. As members of the committee are probably aware, the Hunter Region of the Health Commission was established with effect from October 1974. At that time it was apparent to the administration in the region that there were some problems associated with the abuse of drugs, with particular reference to analgesics, based on the work at the Royal Newcastle Hospital in the renal unit. At the same time, as part of the community health programme we also established a community addiction team which took a much wider view of the drug problem. In order to assess the situation as impartially and in as practical a manner as we possibly could, we established a committee to develop a regional addiction programme. The committee comprised representatives of the medical profession, the commission's staff and a representative from a voluntary organization at that time. The committee has been working over the past two years and has finally produced a draft programme of which a copy has been submitted.

Administration of a programme of intervention and prevention of drug abuse is not an easy one by any means. There are obviously varying ways in which such a programme could be implemented. Up to the present time we have largely used the services of the commission's own staff with educational programmes in various ways through the Regional School of Nursing as far as student nurses are concerned and through the College of Advanced Education as far as teacher trainees are concerned, by contact with leaders in industry in the Hunter region—not restricted to the heavy industries at Newcastle—and in various other ways. The resources available to me as Regional Director at the commission level are relatively small.

The staff in the addiction programme consists of seven people. Also, the services of particular staff at Morisset Hospital and at the Newcastle Psychiatric Centre are available to a limited extent. In respect of those two organizations the staff resources are utilized principally in respect of patients admitted to those hospitals. The future developments of these services, that is whether they be community based and administered by the Health Commission, or whether they should be hospital based and administered by the health services committee either on an area basis or on a specific purpose basis, has yet to be determined. I would suggest that the effectiveness of any programme already existing or to be established would need to have careful regard to the way in which such programme might be administered. I think that this is a fairly broad coverage of the situation as it exists at the present time.

2061. May I ask you a few questions with regard to some of the matters you have raised. Would you elaborate with regard to the voluntary organization which was operating at that time, as you said?——W. The person concerned was attached to the staff of a voluntary organization, to wit, the Newcastle Youth Service, which is still functioning, though it did experience some financial difficulty until recently when it was given a grant to continue its work. The person concerned was the director of that service. He is now in the employ of the Royal Newcastle Hospital and is a psychologist on the staff of the Shortland Clinic which is the psychiatric clinic at the hospital.

2062. What was the grant you referred to that was made to the Youth Service? Was it a grant from the State Government?——W. On this occasion I think it was a grant from the Commonwealth Government but I could be corrected on that. Initially the service was established as a voluntary organization. It was then funded by the community health programme of the former federal Government and the funds were insufficient to allow it to continue. It received a government grant just recently.

2063. The Youth Service caters for a lot more than drug addiction?——W. That is correct. It also provides educational programmes in high schools through addressing meetings of Parents and Citizens' Associations and various other public bodies.

2064. With regard to the nursing staff's training, what would be the approximate emphasis given to that training in regard to drug addiction and dependence?——W. One of the staff of the community addiction service, Mr Walsh, would address each intake of student nurses each year at some time during the study period at the Regional School of Nursing. The intake per annum is in the order of 400 students.

2065. Could they expect to be examined on some aspect of the work?——W. The extent to which they would be examined on it would be small. There could be a question in the total number of questions at the final examination.

2066. How would the service come into the teacher training?——W. As part of the programme which was established in the region, contact was made with the principal of the College of Advanced Education at Newcastle, which was formerly the Newcastle Teachers College and has since become the multi-disciplined College of Advanced Education, with a view to having some time made available for counsellors of the addiction service to address teacher trainees in an effort to make them more aware of the total drug scene with particular emphasis on providing them with better resources to identify any problem that might arise.

2067. Would a Health Commission official address the students?——W. Yes.

2068. You would not depend on the lecturers to pass on the information?——W. No.

2069. Dr Darcy, would you like to say something at this stage?——W. (*Dr Darcy*): Yes. I deal with marihuana first. The use of marihuana seems to be increasing dramatically. Many of the people, and not only the young people, with whom I come in contact, or of whom I have heard, seem to be using marihuana for social intercourse just as the rest of us might use alcohol, to enable them to feel free and to relax together. Most of these young people smoke marihuana as an experiment, give it up after a while and get on the same path of life as the rest of us. The real problem lies in the difficulties experienced by their parents, who are insecure because they do not know what their children are doing. When their child has a glass of beer or drinks some other alcohol, the fact is usually known to the parents, who can smell it on the child's breath or become aware of it as a result of the child's behaviour, which they are used to seeing in other people who take alcohol. They can then bring their expectations to bear on the child by saying such things as, "Drink is all right when you can handle it, but you are young and you will have to find other ways of coping with your anxieties or getting through your periods of anxiety".

When the parents come to me and express their anxieties about their children they say that they do not know whether their children are taking marihuana; they have no way of knowing and their insecurity as a result makes them anxious. Then then tend to blame their children wrongly. I think that marihuana probably will continue to cause problems at the moment mainly between children who use it and their parents rather than for the children themselves because the parents do not have an opportunity of feeding back to the children concerned what sort of behaviour the parents expect in adolescence, and that such behaviour did not include relying heavily on the use of things like marihuana. Personally, I see marihuana use as part of the natural experimenting behaviour of young people, just like driving cars too fast and doing other things they might do because of their youth. Some of these young people might be asked to take or be introduced to harder drugs like heroin or cocaine and because they are in a group, and because they are young, there is a risk that they will be trying something like that simply to keep face even though they do not want to try it. This is damaging to them not only because of the use of dirty needles, hepatitis, but also because of the risk of their becoming dependent on it. However, the taking of those drugs is damaging to their self-esteem, to their concept of themselves as persons. I see a problem in that respect.

At Morisset hospital, and in consultation, I see a lot of people who are referred to me by other doctors who get to know that I am interested in this matter. I talk to young people and I have found that those who are taking heroin have fairly regularly tended to overstate the amount they are taking. When we have to de-toxify them we give them nothing, but observe them, and have noted that very few of them have withdrawal symptoms from heroin. Some of them do, but those who have been relying heavily on heroin for some time have a history of going to other psychiatric hospitals, or of serving prison terms. They are usually the hardest core. Many of the others who come to us come because they have had one or two experiences with heroin and are anxious because they think they might become dependent on it. They want to be reassured, and told how they can handle the pressures applied to them by people who offer them the drug or expect them to take it.

I think that those who need the most help at the moment are the general practitioners. They are asked a lot of questions about this matter to which they do not know the answers. They are asked questions that they cannot answer by parents and by young drug-dependent people because they have not had an opportunity of acquiring sufficient knowledge or experience of the subject. Mr Geraghty's team of community workers and their colleagues provide an extremely valuable service in this respect. I think that general medical practitioners should be encouraged to use that service, and to use the members of the team as a resource, somebody to whom they can talk, not about a particular patient, but about hypothetical questions that have been put to them. In that way they would be able to get a better understanding of the position from the broader experience of the team member, and would know what resources were available to help young people, such as those offered by professional psychiatrists or social workers. It is extremely valuable to a doctor just to know where a social worker can be found. On this aspect I have often felt that even though the Health Commission provides community teams, local government is really the focal point of the community but there is a tremendous lack on the part of local government in the provision of a social worker just to sit in the council chambers where people know they can find her and where she can be more accessible in a safe, non-professional setting; where mothers and others can come and talk to

her and get some reassurance or information without being seen to be going to a doctor or to a professional person like a psychiatrist.

Some years ago we had a closed unit at Morisset where three-monthly admissions were offered to young heroin-dependent people as an alternative to going to gaol. At the time I felt that this was valuable to some of those young persons, but it was even more valuable to their parents who were tremendously relieved to know there was a place where their children would be given some help, where they would be able to build up their health, and gradually learn to relate to their parents and others on a proper basis. Lots of the people who were heroin-dependent were fairly socio-pathic in their behaviour, but gradually they learnt that they could build up relationships with others. This gave them a stepping stone to getting back into the mainstream of life.

I have spoken to our magistrates about whether people should be punished for smoking marihuana. I have said that although I do not think marihuana should be legalized —and it is an offence at the moment, and it is dangerous to them in a way—they should not go to gaol. We have seen people who have been damaged by being regarded as criminals when what they were really were young people experimenting with a new experience. The fact that they were labelled as criminals has been counter-productive for society and bad for them. On the other hand, they should not be told to go away and do nothing about the matter. I believe they should be required to talk to some professional person like a social worker or myself, or to one of the community team members, so that they can discuss with them why they are taking drugs, the situation in which they found themselves placed, and the difficulties they felt in avoiding what their friends were doing. Such a requirement would be far more valuable to us as a community than labelling them as criminals.

It is almost impossible to get people with a heroin problem to stay in hospital. We offer them admission and after they have stayed for a few days they want to leave. I have had very little success in getting people like that to stay in hospital, even though we have an excellent rehabilitation programme with plenty of things for them to do; they still want to be back with their group and do the same things again. Lots of people want to get rid of the Inebriates Act, but it has been extremely valuable to some parents of young people who have taken heroin; it keeps them under control because we have the right to hold them. Usually we apply for a recision after about six to eight weeks and we let them get back to their own lives. We do that no matter what term has been given to them. In that time they learn to relate to people. When they are with us their physical health improves and they put on some weight. If they have had hepatitis we look after them and keep a check on their health. After they have been there for about six or eight weeks they are extremely different people from what they were before and they are much more able to get on with life.

Many people rely on analgesics to make them feel better. We teach our children not to tolerate pain or discomfort. We are teaching the next generation to be dependent on analgesics and similar substances. Society would be better off if the children were encouraged to tolerate a little discomfort and to join groups like scouting organizations where they have to sleep out in the open at night. When children are taught to put up with some discomfort there will be a smaller tendency for them to rely on analgesics, cigarettes and alcohol. There is a group of people who have a different personality from others. Some people do not feel very well and they think that they feel better when they give themselves something that will soothe them. Some people use analgesics, cigarettes and alcohol to make themselves feel better. We see lots of people like this in our hospitals from time to time. We are increasing our problem by encouraging people not to put up with discomfort.

2070. Are you engaged full-time as medical superintendent at Morisset?——W. Yes.

2071. Do you have any cases referred to you as a result of heroin addiction?——W. I suppose that one or two a month would be the maximum. These would be the more serious cases. Perhaps their families have been at their wits end about what they should do. Also, people may come to us as a result of being referred by a magistrate.

2072. Are you acquainted with the drug diversion programme which has been instituted in Sydney; it commenced on 1st March this year. Anybody who comes before a magistrate and pleads guilty or is convicted of an offence relating to heroin or one of the more serious drugs may opt to go on to one of these drug diversion programmes and be given medical assistance. After a minimum of eight weeks they can go for a probation and parole report. Depending on the report that is made, the magistrate decides the sentence. Is there anything like that operating here?——W. I know the system you are talking about but so far nobody has been referred to us as a result of it. When we had the closed unit at Morisset many people who went before magistrates were told that they could either go to Morisset or to gaol. I think they benefitted as a result of their contact with us. I am in favour of such a system. However, admitting a person to a psychiatric hospital is adding a stigma to his life. I think it would be better if they went to a community centre on a fairly discreet basis. If a specialist then decided that they should have in-patient care, they could be referred to a hospital.

2073. Yesterday there was reference made to ward 14 and ward 18 at Morisset. Could you give us some information about those wards?——W. Yes, ward 14 is the acute psychiatric admission ward. People are first assessed and if they are mentally retarded, they might go into the mentally retarded ward. If they are suffering from acute psychiatric problems they may go into ward 14. If they need long rehabilitation, they go into a rehabilitation ward. Ward 18 is our addiction service ward. Ward 18 is an admission ward for people with addiction problems, almost entirely alcoholic problems. Some of them are people with an analgesic, heroin, or other barbituate dependence problems. These people usually stay in ward 18 for a longer period, usually several weeks and sometimes up to three months. Ward 18 is a good unit. People come out of the ward feeling physically better; they are allowed to regain their feeling of well-being. An amount of social work is carried on by two nurses there. This helps people to obtain a better relationship with their families; they are able to clear up their debts and work out their legal problems. When they go back to resume their lives they feel that they are able to cope better.

2074. I was interested to hear the phrase "analgesic dependence". I will read you a paragraph from a submission that was made to the Committee. It reads: "The terms of reference of the Committee are broad and we are aware that the Committee has considered mild analgesics in this regard. We would strongly deny that mild analgesics are drugs of dependence." Would you comment on that?

——W. I am certain that some people we have had contact with are heavily dependent on analgesics. However, analgesics are not drugs of dependence in the two most commonly used senses. The first is the physical dependence where a person may be on, say, alcohol or heroin and when they reduce it the body notices the change because they are going without something that has been incorporated into their metabolism for perhaps several months. The body notices the differences and reacts by displaying several physical symptoms.

In the case of barbiturates and alcohol withdrawal, the body will react dramatically within about thirty-six hours, with feelings of tremors, restlessness and sometimes epileptic fits. Following that there may be an acute brain syndrome where they may become delirious and do not know what day it is. Those things are all very distressing. The second most common type is where after withdrawal they may feel uncomfortable but they do not get those physical symptoms. I think that the analgesics are verging on that second group where the person feels that he is not the same without them and he must get them. A person may be without analgesics while he is in hospital and he may not display any obvious physical symptoms although he may feel terrible. As soon as he gets out of hospital he goes back on them so that he can get this soothing feeling. He may put something in his mouth so that he feels better. The trouble is that many people start off with something like an APC powder to make them feel better. It is not that they feel bad; it is that they anticipate that they will feel better if they take something or if they do not take it they will have troubles.

2075. Does the Cessnock institution come within your region?——W. Yes.

2076. Do you have any relationship with people at the gaol who may have been committed there for drug offences?——W. I act as a psychiatric consultant for Cessnock gaol. I have only seen a couple of such people there, perhaps three or four. I was not asked to see them because of any drug problem but because of associated personality and psychiatric problems that had been noticed.

2077. You would not be in a position to say whether their drug problem is completely overlooked?——W. I think that they are obtaining some benefit from being in gaol. Their drug problem is not being attended to but it is being treated, nevertheless; they are getting by without drugs. They are getting healthier and they are obtaining good relationships with the prison authorities. They have entertainment in gaol and they are mixing with people. In that way their drug problem is treated by their being there. The people who come to Cessnock gaol usually come from other prison institutions and they have probably been looked at in places like Long Bay.

2078. Have you had any practical experience with the methadone programme?——W. Yes, I have been asked to maintain people on it but I am fairly conservative about that programme. I am prepared to conduct a methadone maintenance programme on a person provided that he is holding his job or maintaining his marriage in a satisfactory manner.

2079. Would you say that there is some justification for the methadone programme in the fact that after treatment a person might be able to maintain a normal life?——W. Yes. If a person can do that, I would keep him on methadone indefinitely. Some people do not feel as good as you or I. They do not feel complete people. They say to themselves: "Other people feel all right without taking something. I am entitled to feel all right. Why can I not take something to make me feel all right?" I agree that such people should have methadone plus their own resources. However, many of the people I have been asked to keep on methadone maintenance programmes have just been adding it to their other addictions; they are not working; they may be robbing chemists' shops and doing similar things. They would be just getting an extra supply from me and I am not interested in them. I do not think that methadone was meant to be used in that way.

2080. Mr WOTTON: Would you say that too much use was being made of hospital beds in this area for the use of addicts?——W. (*Geraghty*) There is no direct evidence to suggest that hospital beds are being occupied directly by addicts. There is evidence to suggest that hospital beds are being utilized by people who are suffering acute illnesses as a consequence of addiction to drugs.

2081. Would you say that the incidence of drug abuse is any greater in, say, Maitland or similar small country centres than it is in Newcastle?——W. My general observation within the region is that there is not a major problem in respect of what we might term hard drugs. In specific areas there are problems in the region as a whole, in respect of one or two.

2082. Dr Darcy, do you believe that any legislative provisions to ease the penalties for drug abuse are in the interests of the people concerned and in the interests of society generally?——W. (*Dr Darcy*) Yes, and without wishing to see marihuana legalized, I believe that we are damaging not only the individual young person but his family and doing a disservice to society by heavily penalizing or labelling as criminals young people who have experimented with marihuana.

2083. Do you believe that a comprehensive educational programme relating to drugs should be introduced into our educational system?——W. (*Mr Geraghty*) My answer is unequivocally, yes. (*Dr Darcy*) I have a different approach. I think we are over publicizing drugs. I would rather take a different approach in the schools. I should like to concentrate on teaching schoolchildren, particularly in the adolescent age group, how to get through difficulties, including anxiety-provoking situations, without relying on other things like marihuana, alcohol or cigarettes. We should teach them in adolescence that they are moving from a stage of the dependence of childhood into independence and that it is a rough passage and they feel insecure and unsure that they are worth anything and wondering whether they will make out and whether people will like them or whether they can cope with life. In that situation I think the schools have an ideal opportunity to have group discussions about this—how you get on at a party when you feel awkward, for instance.

We should be teaching young children. Mr Geraghty's community teams should not be worrying so much about drugs but going into the schools, talking to young people and telling them that in fact anxiety at this stage of adolescence is very valuable; that it gives them their cues as to where they are going in life and helps them to modify their behaviour to do socially acceptable things so that we are thought well of by our mates as well as our parents. If we concentrated more on teaching them to tolerate anxiety and used it to learn to do things that would be acceptable, they would go through that rough passage and in adult life would be doing the same things as we are without relying on cigarettes and alcohol, except for social intercourse, but not to get rid of anxiety. That is the approach I would take rather than talking about drugs.

2084. CHAIRMAN: Mr Geraghty, would you elaborate and explain to the committee how you feel such a programme should be implemented?——W. (*Mr Geraghty*) I do not think there is a difference in the basic philosophy as Dr Darcy has put it, and my unequivocal answer. I would suggest that an extension of the resources available either to the Health Commission of New South Wales or the establishment within the Department of Education and the inclusion in the curriculum of Colleges of Advanced Education of a programme to provide schoolchildren at all levels from primary school upwards with the basic approach to social living, as Dr Darcy has indicated, is what is necessary. I think we have two problems. We have an immediate problem to educate children to the dangers of the use and abuse of drugs. If we recognize that there is a problem in society in that regard, we have to attack that problem as an immediate one and provide the best solution we can within the resources, human and financial, available to us. But I think there is a long term approach to the matter also.

Efforts should be made at this stage to plan for the introduction of a programme into the school curriculum which will, without specifically concentrating on the use and abuse of drugs, educate children to learn to live with their anxieties and the problems that they are going to face at various stages through life. Unless we start planning for that sort of programme, we are really going to continue with a management by crisis situation in 1977, 1982 and 1987.

(*Dr Darcy*) I think there is a group of people that we need to educate and that is the parents. They need to be educated to know that there is somebody to talk to about their anxieties, somebody safe and secure, professional people that they can talk to about their uncertainties and feelings of helplessness and hopelessness in the face of doubts that their children may be taking drugs or doing something wrong. Sometimes parents force their children to do something wrong by falsely accusing them. Parents, because of their own anxieties, and because they have no way to deal with anxiety and have to deal with it in some way, lash out and accuse the children of doing something they are sort of half-afraid that the children are doing. In this sort of situation, the parents feel terrible afterwards. They do it because mothers and fathers have no other way of dealing with their anxieties and feelings of helplessness. Fathers react by bashing their kids and mothers falsely accuse them of doing things. Both parents should be made to know that we are there, that they can come and talk with us, that they do not have to deal with it in such a fashion, that there are neutral, safe people to talk to to get things into perspective. They come to us and though we may not have said anything, they go away and say, "You have been terribly helpful, I know what to do now, thank you". This sort of contact with us by parents is probably the most beneficial thing we can do for them.

2085. Mr WOTTON: You mentioned your experience in Cessnock gaol. Do you have any evidence or knowledge of drugs being available in gaols such as Cessnock?——W. Not at all, no.

2086. Mr MACDIARMID: I understand that amongst the young in all walks of life, in all strata of society, at a party it is quite a common thing for people to smoke marihuana whereas it was drinking alcohol perhaps in our generation. You have virtually said that whilst it is wrong, it should be accepted as an experiment amongst the young? ——W. I am saying that it would be nice if the young people did not do it but it is in the nature of youth to experiment and try new things even though they may be dangerous. You and I would not do it perhaps at our age. Young people do it, particularly when they are with a group of other people and if somebody suggests it, it is hard to maintain face in that situation with the pressure of other people saying, "Be in it". Lots of young people will swim in the nude in a group though it is totally against their standards because in the situation they are uncertain of themselves and what other people will think about them if they refuse. It is a situation where we have to teach children to put up with feeling uncomfortable and to get through to the end of it without doing something that they think may be wrong.

2087. You said that marihuana can lead to harder drugs?——W. No, I did not say that. I know that in a circle there will probably be somebody who has tried heroin or something like that. I do not think that necessarily marihuana leads to hard drugs. The group that takes hard drugs comprises different people. We get more of them getting into it. There are people who experiment with marihuana and drugs but the ones we are dealing with who are heroin-dependent are special people with sociopathic problems. Young people are exposed to it, to being asked to take heroin, but I do not think that the ordinary type of young person who, unfortunately, foolishly allows himself to be injected and has done a terribly wrong thing, for certain, but I do not think that one injection of heroin even though it makes him feel warm and lovely is in fact likely to turn him into the type of heroin addict that we get into the hospital. He will regret it afterwards and say, "I was a mug". We have plenty of people who say that.

2088. The people you strike in gaol, you said in a sense they are getting treatment because they are taken off drugs?——W. Yes.

2089. Do you feel that it would be better in another institution rather than gaol, or is gaol the proper place for them?——W. The people in this class whom I have been involved with have been people with sociopathic problems and probably they are in a good controlled situation, particularly Cessnock. Perhaps at Morisset it was ten times better; there was a closed unit and not a gaol. That has its problems too because they are labelled as somebody who has been put into a psychiatric hospital. Professor Yapp in Hong Kong had the same problems at his clinic. It was an institution that everyone knew and labelled.

2090. CHAIRMAN: You do not think they are mental patients?——W. No, not for a moment. They are personality-disordered patients. I have had some who are schizophrenic and also take drugs because they are waffly and drift into situations; they drift into the culture. We have two of them in our maximum security unit at the moment but that is a different group. They would have been schizophrenic without any drugs at all.

2091. Mr MACDIARMID: What effect does marihuana have on driving a motor vehicle compared with alcohol? ——W. I believe it is an intoxicant. It gives an acute brain syndrome. It alters the functioning of the brain cells in a way much similar to the way alcohol does. In small amounts it alters your brain function. I do not know what dose you have to have or anything like that but it is dose related. The more you have the more intoxicated you get. The evidence I have read is that it produces hallucinations and distorted reality like alcohol does in large quantities. I think if you increased the dose of hashish or cannabis or marihuana, in fact you get a dose related effect—more effect as you increase the dose.

2092. Mr JACKETT: You seem to be keen to develop education programmes to overcome problems arising from the use of drugs. How would you hope to increase the work of your region in drug education? Would you hope to do it through the Health Commission, or through the education system by the use of teachers and so on being educated first by the officers of the Health Commission and then going out into the schools, or would you hope to do it by an expansion of the methods you have already outlined which are now used?——W. (*Mr Geraghty*) I do not have a hard and fast view of the most effective way of implementing such a programme. A number of factors have to be taken into account, not the least of which is that the community at large, rightly or wrongly, has some mistrust of the bureaucracy, and any attempt on the part of the Health Commission as an organization to implement such a programme through the use of its own staff, who are employed as public servants, might be misunderstood in that it might be seen as an interference by the bureaucracy in the private lives of individuals, even though the professional person who would be administering the programme would be the same as those in private practice.

The second point to be considered on this aspect is whether such programmes should be administered by the Health Commission or by the individual hospitals within a broad policy framework laid down by the Health Commission or by some such organization having responsibility from government to implement policies determined by government.

A third point, which cannot be ignored, no matter how the programme is to be implemented, is the use of voluntary organizations. In the light of experience it seems to me that no matter how well-intentioned administrators might be, and no matter how well-intentioned hospitals might be in executing a programme such as this, there will always be a substantial number of persons who would prefer to go to a voluntary organization, and I believe that those organizations are capable of carrying out these programmes effectively, and in many cases are much more acceptable in doing so than administrative or professional organizations.

Perhaps I can give some idea of the comparative amounts of money being spent at the present time on the curative aspects of health in this region compared with the preventive aspects, keeping in mind that the health community programme is designed to be preventive and therefore to contain the curative side of our work. In the financial year soon to end we will spend in the order of $100 million on health services—and that is in all the hospitals—on community health and on ambulance services and in administration of those services. Of that sum, $1.8 million will be related to community health programmes.

Long-term implementation seems to me to need consideration not only at government level initially but also at top levels of administration as between the Health Commission, the Department of Education, the Department of Youth and Community Services, and in some way or other involving parents organizations, so that we may get an expression of view at first hand from those who are, as Dr Darcy has indicated, most intimately involved in this scene, apart from the individuals themselves. Whether the Health Commission should provide the professionals to undertake teaching in colleges of advanced education or whether teachers should be trained specially by the Department of Education is a matter to be decided, but I would draw attention to one point that arises in these sorts of deliberations, and that is, that in order to maintain the credibility, those engaged in such a field must have a continuing, personal, professional involvement. Once they are removed from active practice and become full-time teachers, their credibility in their own professional peer group, it can safely be said, would not be as great as it would be if they were engaged in some clinical practice.

2093. Do you feel there is enough factual information about drugs getting through to people? Two aspects seem to arise in this connection. One is factual information about drugs and what they do, and the other is information about the serious consequences that can follow the abuse of drugs. Do you believe that the present situation is satisfactory in regard to what people know about drugs they use that are commonly available to them?——W. Leaving aside comment on the professional aspects of that question, I believe that we do not have sufficient resources available to us, both human and financial, to utilize the services of the mass media in such an education programme. Certainly speaking for this region, I can say there is no lack of co-operation on the part of the media in making available its resources for such programmes. However, we no longer have on the regional office staff a senior health education officer. We do not have a public relations officer or a press officer who is experienced in the preparation and presentation of such information for distribution to the media. We have a limited budget in respect of such matters. The availability of persons capable of occupying a position as senior health education officer is most limited. We have endeavoured to fill the position but the applicants offering are not sufficiently experienced. I think the plain answer to your question is that we are unable in the present situation to provide enough educational material for the community at large.

2094. I take it you would like to have some reasonable sum available for this purpose?——W. Certainly.

2095. CHAIRMAN: In relation to the last series of answers, what area is covered by the Hunter region?——W. From Morisset hospital, which is on the southern boundary of the Lake Macquarie Municipal Council area, to Murrurundi in the north, to a line between Merriwa and Cassilis in the west, and down through Gloucester, Dungog, Bulahdelah to a line between Tuncurry and Forster, and back down the coast to Newcastle. The region has a total health personnel in all organizations of 7 500. There are 2 500 beds available in the fifth schedule hospitals, at Morisset, Newcastle psychiatric hospital, Stockton, Allandale geriatric hospital, and Tomaree Lodge. There are 2 826 beds available in the public hospitals, which are the Royal Newcastle Hospital complex—which has just on 1 000 beds—the Newcastle Mater Hospital, which has more than 300 beds, Newcastle western suburbs maternity hospital, which has 120 beds, Wallsend hospital, which has approximately 200 beds, Maitland, which has about 200 beds, Cessnock, which has about 200 beds, and the hospitals at Kurri Kurri, Singleton, Muswellbrook, Scone, Murrurundi, Denman, Merriwa, Dungog and Bulahdelah.

2096. What is the population of the area?——I will stand to be corrected to within 50 000, but I believe that the population of the region which is in the order of half a million, of whom 400 000 or thereabouts would be in Newcastle City, Lake Macquarie, Port Stephens, the City of Greater Cessnock, and the City of Maitland local government areas.

2097. How many education officers have you?——W. At present we have three. One is located at Port Stephens, one is at Maitland and one is in Newcastle.

2098. Are they engaged in any particular aspect of the education programme?——W. They are attached to the community health teams located at the community health

centres at Nelson Bay and at Maitland, and one is attached to the community addiction service. They are all engaged in specific programmes nominated by the community team leader, and these can vary from time to time.

2099. Take the two at Nelson Bay and Maitland. Would they do any work on drug addiction?——Not on a large scale. That work is left principally to the community addiction team.

2100. Mr JACKETT: Dr Darcy, in your experience at Morisset and Cessnock did you acquire any qualifications in the field of criminology or sociology additional to your medical qualifications?——W. (*Dr Darcy*): I have an honours degree in medicine and a higher degree in psychiatry. I have done a special study of the mentally-ill offender. I have worked at Morisset and have taken care of all of the mentally-ill offenders there since May, 1971. I have been closely associated with the observation section at Long Bay, and also at Callan Park. I have been to New Zealand to study the mentally-ill-offender systems over there.

2101. When you gave evidence about methadone treatment, were you referring to the blockade method or just to a maintenance programme?——W. People do make a distinction. I do not make a distinction. The way I use methadone is, first, to cover the patient for the heroin they have been depending upon so that when it is taken away from them they will not suffer dreadful withdrawal discomfort. However, you do not know how much they have taken. You cannot believe what they tell you. They will tell you anything. Therefore you start off with a figure, and you are always taking a risk here. You choose a figure a little lower than you think is likely. We might start off at 60 or 80 milligrams a day of methadone in orange juice. If the patient has a runny nose and is uncomfortable, obviously the dose was not high enough. You then have to bump it up another 20 milligrams the next day, and gradually alter it until you get a dose on which they can, with their own personality resources, cope with life. You then stick to that.

2102. On the question of marihuana, I take it from what you have said that you regard it as a dangerous substance. Do you know of any cases where anybody convicted of using marihuana as a first offence has been sent to gaol?——W. No, not personally. I know of somebody who was convicted but was given the alternative of going into our hospital.

2103. Is that the only case?——W. That is the only case of which I have personal knowledge.

2104. If an offender is given the benefit of section 556A of the Crimes Act, and comes back a second time, would you say that he had got over the stage of experimentation and must be regarded as having deliberately gone about following a course of using marihuana? Do you consider that the relaxation of the law amounting to decriminalization, would tend to increase the number of people experimenting with the drug?——W. Dealing with the first part of your question, you said that a person who came back and had a second go was obviously bent on doing that. I cannot agree with this. Young people are subject to many social pressures so that they cannot easily avoid taking marihuana again. It does not mean that they have become dependent upon the drug or that they will take it in the future. In some instances young people get into a group and at times they have to be strong to refrain. Many of them will refrain. However, at times pressure is put on them and they will take marihuana.

2105. I am interested to pursue the points that you have put forward.——W. I think you have got to persist with the first approach. You have to put this in the right perspective. Sometimes it takes a while for people to gain confidence or strength. That does not mean that if you are not successful the first time you should not continue. I think that is the best way to get them back into life undamaged.

2106. Have you considered the statement made by Professor Wade that there are no forensic methods to determine the degree to which a person is affected by marihuana or indeed there is no indication at all of the amount that has been used and that it does affect motor co-ordination and the ability to drive a vehicle and the possible genetic effects. Do you not think we should do all in our power to discourage the use of marihuana in the light of the present knowledge that we have about it?——W. I share Professor Wade's views about the long-term effects of drugs and how long it takes to get them out the system. The thing that is certain is that a person's future prospects can be damaged if there is an over-reaction in an attempt to deal with something that is causing public anxiety. It would be better if people did not use marihuana but at the moment this is what the young people seem experimenting with and using. They do this to relieve their feelings of self-consciousness. I think that we could do more harm than good by dealing with our own anxiety by trying to stamp out the use of marihuana as quickly as possible. We may have to overcome our uncertainties for the sake of not doing damage to some of the young people who come to our notice.

2107. Have you any idea of the young people who would be involved in the marihuana scene, in proportion to the young people in the community?——W. After talking to many people, my feeling is that many people are occasionally smoking marihuana in a group situation. I think that the vast majority of these people will be like you and I in ten years' time; they will have no problems.

2108. Mr RAMSAY: How many drug referral centres are available in the Hunter region?——W. (*Mr Geraghty*) The commission has a centre in Stewart Avenue, which is staffed during the normal working week. There is an after-hours telephone number and there is a point of contact at the Newcastle psychiatric centre. There is a point of contact at Morisset hospital. So far as the city area is concerned, the Health Commission provides a service to the community—an addiction service only.

2109. Do you think that there should be available a seven-day-a-week referral centre or centres?——W. Yes, I would agree that there should be more and that they should be available twenty-four hours a day, seven days a week and that provision at least should be made outside normal working hours for intervention in the crisis situation. Again, we have to have regard to the availability of services through such voluntary organizations as Lifeline and the Newcastle youth service. We ought to be co-ordinating those activities and providing better resources for the continuation of their services.

2110. Do you agree that there is a need for trained voluntary counsellors?——W. Yes. It is not easy to maintain the enthusiasm of voluntary workers when a fully paid service is being provided at the same time. In considering this aspect we should pay regard to the point at which these services should be delivered, that is whether we should be maintaining drug referral centres or whether such services should be available at specific hospitals which are staffed twenty-four hours a day, every day of the week, as distinct from setting up a new, costly service.

2111. CHAIRMAN: Does Lifeline receive any financial assistance from the commission?——W. Yes, a small amount of assistance.

2112. Mr RAMSAY: We were informed yesterday at Gosford that it is difficult for a person to be admitted into Gosford hospital unless he is referred there or has collapsed?——W. No case has been drawn to my attention where a person has been refused admission. The admission centre at Newcastle psychiatric hospital, which is at the east end of the city, receives patients at any hour of the day or night.

2113. Would you comment on statements made to the committee to the effect that hard drug taking is not as prevalent in the Hunter region as it is in other areas?—— W. (*Dr Darcy*) I have no way of knowing that. I know from talking to people that the central coast area seems to be a particular problem area. I just do not have enough information about the Newcastle area to say that. Most of our people seem to come from the central coast.

2114. Would you have any information about the incidence of drug taking in high schools in the area?——W. I think that it is a minor problem in the district with which I am familiar, that is Morisset. When young people talk, they tend to speak in anticipation or in imagination rather than in fact. I honestly do not believe that drug taking in schools in the area is at all common.

2115. Have you had a look at the set-up in Victoria in regard to rehabilitation centres? Do you think it would be a good idea to have centres of that type established here?——W. What sort of rehabilitation do you mean?

2116. I mean for people who are withdrawing from their addiction?——W. We have one at Morisset and that is run by the Salvation Army; it is called Miracle Haven. The problem is that many young people do not want to be moved out of their own culture or environment. They want to get back with their friends, and it would be difficult for some people to stay in such a place.

2117. Mr McGOWAN: If the Government were to de-legalize methadone, if it were to make it an entirely prohibited drug so that not even you could prescribe it, in what way would your treatment be affected?——W. The only people who would suffer would be a small group who cannot feel complete without taking something and the only thing that seems to do them any good is a narcotic analgesic. When you get a person like that and you add methadone to him, he plus the methadone can maintain his life and hold his job down, but if it is taken away from him he feels empty; he will want heroin or something to make him feel the same as you and I feel ordinarily. I think they would be the people who would suffer.

2118. If in the process of education it were possible to sort out such a person when he was young, would you put him on methadone?——W. Yes, if you could find them when they were little. We have good institutions like the Girl Guides and interested school teachers and church groups who would get a great deal of satisfaction by making these people into complete persons. However, you would have to get in early. The mothers of these people will tell you that they were different when they were young. It would be a radical thing to start doing that with them and there are other ways of doing it.

2119. That was not a serious question but it leads to this question: I see human beings at any stage in life as being capable of change. You do not. You take the view that once a person has matured, he has a set number of characteristics and dependence upon narcotics may well be one of such characteristics and he is like that for life? ——W. No, they stay different people for life but people tend to mature. We get people into our hospital and they are hopeless. They have never been out of trouble but gradually in the maximum security and other sections until they are released years later, one can see them maturing in their ability to get something from other people, to use people and to feel self esteem and satisfaction. These people mature at about 10, 15 or 20 years later than you or I. You can get the same thing with people relying on drugs or alcohol. Some can gradually heal over a long period and become more mature and better able to cope with themselves and get from life satisfaction but it takes a lot longer than a six months period.

2120. If you give a person methadone how can you ever wean them from it?——W. As the person matures and his self-esteem increases, he says to himself, "I can do it". You and I have optimism. He does not have optimism but he builds it up. They have pessimism. As they mature they see that they can relate to people and people like them. They become slightly different people. They set higher standards for themselves than they had six months before you get them talking to you. They say, "Look, I would like to try such-and-such". With a little bit of success they will try more. They can undergo change and become like you or I.

2121. I realize it is a difficult process. I really do not feel that you have convinced me on the question of treatment programme if the drug were to be taken away from prescription. Is there something else you can use? Another drug?——W. Another narcotic would be the only thing and that would be still bad. In England there are plenty of people who have lived their lives for twenty years on the methadone programme quite successfully and are coping well. The people who look after them are quite satisfied that they have treated them just as properly as another person treats an asthmatic with anti-asthmatic drugs.

2122. CHAIRMAN: Who would determine the allocation of funds of community health programmes?——W. (*Mr Geraghty*) There has been a total allocation from the Commonwealth Government and an allocation from the State Government in each of three financial years, the last one of which will be next financial year, 1977–1978. The distribution of this fund on a State-wide basis is determined at the central office of the Health Commission following the submission of our estimates to Treasury and final incorporation in the Annual Appropriation Bill.

2123. When you first make your submissions, would there be any discussion with your office before the decision is finally made if they want to vary them?——W. Yes, there is discussion. Several discussions take place between the time we submit our new proposals to head office and their final inclusion in the draft estimates that go forward.

2124. In the latest figures we have available, more than 56 per cent of those charged with drug offences were 20 years of age or under. Have you any strong association with the Department of Youth and Community Services with regard to drug addiction services?——W. There is no formal link between the regional office of the commission and the Department of Youth and Community Services in the Hunter Region at which any formal discussions take place. There is considerable liaison between the

members of the staff and the community health teams and district officers of the Department of Youth and Community Services. One of the better examples I can give is the suburb of Windale in Newcastle in which a community health centre is located and accommodation is made available at that building at specific periods of time each week to the district officer of the Department of Youth and Community Services so that he can interview people there and liaise with members of the community health staff on problems.

It is my intention, and I have already initiated action, to try to form a committee comprised of the area director of education, the area manager of the Housing Commission and the two senior district officers of the Department of Youth and Community Services and myself to try to achieve much closer integration and co-ordination of the services of special members of staff of each of our organizations, particularly the social workers, guidance officers of the Department of Education, the members of our community health staff, members of the community mental health staff and psychologists, all of whom at various times are called in, in a consultative capacity by the principals of various schools in the region, particularly the more heavily populated areas and less privileged areas of the community. I feel we have a situation, which is increasing, where there could be duplication of resources between three of those departments, education, youth and community services and ourselves, in particular. My reason for including the Housing Commission is that the organization has two large estates in the Newcastle area, at Windale and Gateshead West, and on information available to us a considerable number of various types of problems arise from those areas. While there is no formal link, as yet, there are informal links at staff level.

2125. At this stage, is the question of the drug problem regarded more than simply a health problem or something that might concern the Youth and Community Services Department?——W. It is a matter for concern not only to the Health Commission staff but also to the Department of Youth and Community Services and to members of the staff of the Department of Education as well.

2126. Do you know of any officers of the Department of Youth and Community Services who could be engaged in regard to drug addiction services?——W. Do you mean specifically engaged in that in the Newcastle area?

2127. Yes.———W. To the best of my knowledge—I feel fairly certain that I am correct—there are no officers of their staff specifically engaged in that service. They have a small staff in the Newcastle region. There are two district officers, one in the city and one at Wallsend.

2128. Would either of you like to add anything further? ——W. I would like to come back to the point I mentioned before and that is the question of the administration of the preventative services that we are talking about. This is important both in the short term and in the long term. I draw attention to the fact that we need, to have an effective programme, all sections of the community, not only the administrative arm of government, involved in the implementation of that programme. We need local medical practitioners, voluntary organizations, parents and citizens' organizations and all sorts of organizations who are in any way involved in it. I draw attention also to the fact that in the past week or so the Minister for Health has made available a green paper as a public consultative document on the question of the future administration of health services in New South Wales. The implications of that as far as the administration of the drug programme, I suggest, might be taken into account by your committee in its deliberations. The whole community health programme has been in existence only something like three years. It is an innovative programme but the rapidity of the change that has taken place in the administration of the health service in the past decade and the fact that it is under review again indicates that that sort of proposal might be considered by this committee. I do not think I can add further to the points I have made already.

(The witnesses withdrew.)

PATRICK JAMES JUSTIN O'NEILL, 14 Helen Street, Merryweather, New South Wales, medical practioner, employed by the New South Wales Health Commission as co-ordinator of education services for the Hunter health region, and adviser on addiction to the Royal Newcastle hospital, sworn and examined:

2129. CHAIRMAN: Dr O'Neill, did you receive from me a summons issued in accordance with the provisions of the Parliamentary Evidence Act?——W. I did.

2130. Would you tell us about the work being done by the community addiction service, and about any other matters to which you believe our attention should be drawn?——W. The brief given to the Hunter Community Addiction Service was examined closely at the outset because we were aware that with the limited resources available, they had to be optimized. We recognize that addiction in our society is three-tiered and that the stereotype, the person at the end of the process, is by no means the total problem, even though most frequently our community services are directed to him. We saw quite clearly that this end-of-the-line person was but the tip of a very large iceberg and that one arrived at the end of the line after a process of continuous use of mind-bending drugs and a series of misfortunes, but that along the line those persons ran into strife when they were still in contact with a job, home, family, extended family, and the usual support system we all have. We saw the ultimate part of the process as being a rejection by society. We believed that the Community Addiction Service should maximize its input at the point of the early symptom bearer. We believed that concentration on this point would enable use to do something also about the first stage of the process, namely the cultural forces at work that pre-disposed a person to strife through the use of mind-bending drugs. We were conscious of the fact that all of us make use of mind-bending drugs to make ourselves more comfortable in certain situations. We are comfortable about our own use of those drugs, and we are sometimes uncomfortable about other persons' use of those and other drugs. The important thing is to obtain a total perspective of drug use by society.

Bearing in mind that other organizations are dedicated to the care of the third stage of the addiction problem, Hunter Community Addiction Service decided to concentrate its efforts on the first and second stages. I agree with everything Mr Geraghty said about the importance of education. I merely emphasize that the word education does not imply just standing up in front of a class and giving information. It implies also changing our culture. Certainly to some extent part of this can be done through the schools, and changing the course adopted by pupils is best initiated by their usual teachers, namely those who have on-going credibility.

The Hunter Community Addiction Service, in conjunction with the Department of Education, has already trained teachers, particularly teachers involved in personal development courses, for this work. I support the idea that we

should train the citizens of the future to be comfortable citizens, but essential to that objective is a clear understanding of what the chemicals are to which the citizen will be exposed so that he may be fully aware of all the dangers he can run into in connection with them. It is naive to teach people just to be comfortable. We must teach them about these chemicals that are constantly around us all. The Hunter Community addiction service emphasizes that in no way is it opposed to the use of chemicals in our complex society at times in order to make our lives more comfortable. We are out merely to abolish the strife associated with the mis-use of those chemicals.

I should like to make some comments about three of the drugs in question. I shall say nothing further about narcotics. I merely ask that the statement I have given the committee on narcotics and the methadone treatment programme be accepted as a formal submission from me.

2131. Do you wish to have that statement incorporated in your evidence?——W. Yes. The statement is as follows:

## NARCOTICS AND THE METHADONE TREATMENT PROGRAMME

*A submission to the Joint Committee of the Legislative Council and Legislative Assembly upon Drugs by the Hunter Addiction Service of the Health Commission of N.S.W.*

### *Introduction*

The Hunter Addiction Service (H.A.S.) is totally opposed to the use of methadone in the treatment of narcotic addiction on a blockade or maintenance basis.

Even within the guidelines established by the Health Commission the H.A.S. firmly believes the use of methadone to be counter-productive in its effect on the problem of illicit narcotic use in this society.

### *Methadone*

Methadone is a synthetic narcotic, longer-acting than the naturally occurring opiates such as morphine and its derivative heroin.

When substituted for heroin or morphine it eliminates the craving for these drugs and in large enough doses prevents the user from getting any "high" if he injects other opiates.

### *Methadone and Withdrawal*

The only area where the H.A.S. sees methadone having any place at all is in the treatment of the acute withdrawal syndrome.

This use however would be quite rare since our experience confirms the U.S. finding that "the seriousness of the withdrawal symptoms has been exaggerated. An exhaustive search of the world literature revealed no instances of death due to uncomplicated withdrawal . . . most (narcotic users) are well aware of the essential mildness of the withdrawal syndrome" (Glaser, 1972).

Other observations in this region suggest the quality of illegal narcotics is extremely low. This confirms the report by Greene and Dupont (1974) who found the average purity of street heroin seizures in Washington was only 1.7 per cent.

Thus it is not surprising that a severe withdrawal syndrome is a rare phenomenon.

### *The Case Against Methadone*

The H.A.S. is opposed to the methadone programme for two very cogent reasons:

(1) We believe the provision of methadone in an area has a "honey pot" effect that attracts and spreads illegal narcotic use like an infectious disease epidemic.

An active methadone dispensing centre provides an ideal trading post for illegal narcotic users.

It is quite possible that the increase in illegal narcotic use occurring in New South Wales in the 1970's is related to the expansion of methadone treatment programmes.

(2) A survey of world literature suggests the early claims made about methadone were exaggerated (Casriel and Bratter, 1974).

There is no convincing evidence that methadone treatment increases the user's chance of ceasing use.

The two year follow up study of the Brisbane Street Drug Dependency Service revealed only 3 per cent in the programme had not used narcotics including methadone for longer than six months (Reynolds and Magro, 1976).

Long term studies of methadone programmes are lacking.

Our feeling is that methadone treatment may reduce the likelihood of a narcotic user ceasing use by providing a stop-gap supply of a legal and highly addictive narcotic when illegal supplies dry up. Thus a period of non use is avoided by the user.

Vaillant's study (1966) and the experience with U.S. veterans of the Vietnam war (Robins, 1973) make it clear that even users heavily addicted to narcotic use can cease use without methadone treatment.

### *Conclusion About Methadone Treatment Programmes*

It is worth stating the view of the American Medical Association on this issue: ". . . continued administration of drugs for the maintenance of dependence is not of itself a bona fide attempt at cure, nor it is ethical treatment" (A.M.A., 1970).

The H.A.S. agrees with this view and is opposed to a "treatment" that prescribes medication which is not curative and which itself is permanently addictive.

The present situation with respect to methadone has an obvious parallel with that occurring in 1898 when heroin (acetylated morphine) was first synthesized and hailed as a cure for opium/morphine addiction (Cohen, 1969).

### *Future Initiatives*

Rather than invest money and resources in dubious methadone treatment programmes the H.A.S. suggests the following moves could be made to reduce the scope of narcotic abuse in New South Wales:

(1) Staff and resources should be moved into the primary intervention level where family, school and whole community drug education programmes are urgently needed.

(2) The co-operation of the mass media should be sought to promote more balanced publicity about drug use and reduce the sensational and counter-productive content that often glorifies and/or scapegoats illegal drug users.

(3) Measures should be stepped up to ensure medical practitioners adhere stringently to Regulation 28 of the Poisons Act, 1966. This will reduce the incidence of iatrogenic addiction and the supply of narcotics available to illicit users.

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The general comments I would make are of a personal nature. The first of them concerns the range of prescribed medications that are available. This subject, I feel has had short measure in today's discussions. However prescribed drugs rank high in the order of drugs abused by our society. I believe they are included in the committee's terms of reference. As the members of the Committee will be aware, the Senate Select Committee that inquired into drugs reported in 1971 on the drugs abused in our society, and listed first alcohol and second nicotine, which are specifically excluded from the terms of reference of this committee. Ranked third and fourth were prescribed drugs, and analgesics.

I am sure that the committee will have to hand details of the incidence of the daily use of prescribed drugs in our society, and will be aware of the fact that probably in the order of one in eight persons over the age of 15 who are believed to be taking prescribed drugs daily are abusing them. In other words, they are not using them according to medical directions, and in many cases are probably seeking additional supplies from alternative medical practitioners. Strife results from the abuse of prescribed drugs. The question is where dosage use end and abusage begins. Each year there is an increasing chemical cop-out and in no range of drugs is it higher than in the range of prescribed drugs. We have been able to establish that in the past ten years there has been an increase in the use *per capita* of prescribed drugs in the order of 85 per cent. That is frightening. It seems as though we might soon have valium put into our water supply.

I believe that strife resulting from the abuse of prescribed drugs is not easily visible. Within the family situation it may be visible to other members of the family, but in society the use of these drugs is not only accepted socially, but indeed is pushed by that society. The fact that the use of such drugs is increasing at the present rate is a matter for concern.

In regard to analgesics, I do not want to pre-empt the evidence that will be given by my colleagues on the Hunter Region Analgesics Working party, who will tell you that the use of analgesics is significantly higher in the Hunter region than in any other part of Australia, and that their use in Australia is significantly higher than their use in any other part of the world. The comment I make is more an emotive one. I am concerned when I meet colleagues from overseas that they laugh themselves silly at our use of compound analgesics. We are unique in the world in our use of them, and that fact is evidently connected with kidney trouble. We are held to ridicule in some places.

I should like to make one remark relating to some evidence given by Dr Darcy. I believe that simple analgesics are virtually non-addictive; that they are completely non-addictive. I cannot think of a single case of addiction to a simple analgesic. On the other hand, I believe that compound analgesics, or mixtures of substances containing one addictive substance, are very addictive. In the most commonly abused compound analgesics, the addictive substance is caffein. I am slightly addicted to it myself. This is much more addictive than is generally realized. It is a substance that will on its own cause certain strife even when not in combination with other things at certain levels. I believe firmly, however, that simple analgesics are not addictive. Certain other compound analgesics that do not contain caffein, but also are addictive because they too contain an addictive substance called codein, which is one of the opiate derivatives and, like morphine, is derived from the head of the poppy. Although present in quite small concentrations in some of these over-the-counter preparations, it is nevertheless addictive when consumed in large quantities. That is why I have emphasized that simple analgesics are not addictive, but when combined with an addictive substance, they are very addictive indeed.

Finally I should like to comment on the use of cannabis. I am a full-time employee of the Health Commission in the Hunter region, and I have probably done as much homework on this subject as any member of the committee, and I know that you too have done a tremendous amount of work on it. I shall not attempt to give you any factual information. I assume that you know everything that I know about cannabis. The only point I make about it is that I am constantly meeting people who are absolutely certain that the use of cannabis should be de-criminalized and I am constantly meeting others who are equally certain that its use should not be de-criminalized. I am the only person I know who is not sure. I honestly do not know whether it should be decriminalized, and I do not envy you your decision.

2132. You mentioned the first stage in the problem of drug addiction, and you spoke about the cultural basis for it. How would you go about trying to change that basis, taking into consideration the limited facilities that are available to a service such as yours, and the limited manpower that you have. You would need a great increase in facilities and manpower, would you not?——W. The point made by Mr Geraghty is that we cannot match the financial resources of the manufacturers and distributors of drugs. On the other hand, he pointed out that we have the co-operation of the media which adopts a responsible attitude. I believe that with further co-operation we can mount a massive education programme that can match what the distributors of drugs are doing. I am convinced that it can be done. I think that people will become more aware of the actual dangers of the drug and of the concept of escaping from uncomfortable reality with the use of the chemicals that are available. At the end of last week I did a show on station 2NX, a local radio station. The show ran for one hour and it was a talk-back programme. I believe that what came across on that show indicates the increasing awareness in Newcastle of the problem of drugs. I should like to present the record of that show in evidence. Following on a brief dissertation on the factual knowledge of analgesics, there was an immediate response on the switchboard and it was dramatic. People telephoned in saying that they have been using some substances for about fifteen years without knowing about them.

2133. We would be quite happy to accept that record. I think that it can be incorporated in your evidence if you wish that to be done?——W. Yes, I would like that (*Exhibit* "4").

2134. You heard a statement that I read to a previous witness, which I will read again to you. The statement reads: "The terms of reference of the Joint Committee are broad and we are aware that the Committee has considered mild analgesics in this regard. We would strongly deny that mild analgesics are drugs of dependence." That is part of a submission from an interested party. You have used the word dependence and you have spoken about addiction?——W. I agree with that statement completely.

2135. A previous witness said, "Thank God for valium." What is your comment on that?——W. It must have been a manufacturer.

2136. No, he was a fully qualified medical practitioner. Does that statement surprise you?——I regret to say, no.

2137. Although alcohol is outside the scope of our inquiry, could you tell us about any cases that have been referred to your centre where you have had a combination

of alcohol with analgesics and serious complications have resulted?——W. Dr Darcy, in his evidence, indicated that it is not uncommon to have multiple use of variable chemicals to escape from reality and this is borne out by my experience. It is almost uncommon to find a person who is escaping from reality with one drug alone. For many people it may be valium and alcohol or alcohol and APC powders. In one case in the Newcastle area a young lady had been using twelve analgesic powders each day and alcohol at the rate of about sixteen middies of beer each night.

2138. For what period?——For a period of approximately ten years. The alcohol was a relatively recent addition. This girl was aged 26.

2139. Mr WOTTON: What would you call a simple analgesic?——W. I believe it is a single substance for use in killing pain and the two most commonly used in our society are pure aspirin and pure paracetamol. The examples are Dispirin in the pure aspirin and Panadol for the pure paracetamol.

2140. Do you believe that any legislative moves to reduce the penalties for drug abuse are in the interests of the people concerned and in the interests of society generally?——W. I am hesitant to answer that. I am aware of the overseas experience in places where it has been decriminalized but I would not like to say that the same sort of things would happen here. I would sooner say that I do not know.

2141. Mr MacDIARMID: I take it from your remarks that you see the greatest need as being education?——W. Yes.

2142. You say that simple analgesics are not addictive but constant use can be health damaging, is that so?——W. Yes.

2143. Mr JACKETT: If the recommendations of the National Health and Medical Research Council are carried into effect so that compounds of particular drugs are placed on schedule 4, why should we expect any improvement in the situation as far as those compound drugs are concerned?——W. If this move were carried through at State level, it would be an educative procedure and it would mark the end of compound analgesics, and I do not think any doctor in his right mind would prescribe them.

2144. Mr RAMSAY: Would you say that education in the field of drugs and drug abuse should take place in the school and, if so, who should carry out that work? Should it be carried out by people in the education department, such as teachers or some properly qualified medical practitioner?——W. I believe that the people best qualified to teach the young are those who have been trained to do so. I believe that those best qualified to teach them specifically in this area of personal growth and development are those who have been trained specifically for that task. Leaving the young aside, I think that we should concentrate on the whole of the population. I think that we must start by educating our medical practitioners. This is one of the many areas that I should like to tackle. Obviously a medical practitioner is more able to get into the ear of other medical practitioners. I should like to educate the doctors of this generation and the doctors of the next generation. As a matter of the highest priority, I should like to educate the schools—in fact everybody, with the co-operation of the media.

2145. CHAIRMAN: Do you know whether anybody is doing this education for the next generation of doctors; is it being done at any university?——W. It has been discussed at an annual addiction seminar for the whole of Australasia. The seminar was held in Canberra last year and a committee was set up to look into this. The members of the committee meet rather sporadically. We are looking into what sort of things should be done such as input training of doctors.

2146. You cannot say whether anything has yet been done in this field?——W. The medical schools here have not yet got any students.

2147. I am speaking about the whole of New South Wales.——W. The University of New South Wales has already got some input into its medical students. They have involved me on several occasions.

2148. Mr McGOWAN: Do you regard APC powers as drugs of physical and psychological dependence?——Yes.

(The witness withdrew.)

EDWARD JOSEPH DAWKINS, Minister of Religion, residing at 68 Princeton Avenue, Adamstown Heights, sworn and examined:

2149. CHAIRMAN: You received a summons issued under my name in accordance with the provisions of Parliamentary Evidence Act?——W. Yes.

2150. I understand that for a number of years you have been involved in various social activities associated with the Salvation Army and in the course of that you have had a lot of contact with drug addicts and their rehabilitation. Would you like to tell the members of the Committee of your general activities in that regard?——W. Yes. The intensity of my involvement in this field commenced about five and a half years ago when one of our young officers came to Brisbane—Lieutenant David Brunt. He had come into the ranks of the Salvation Army officership because of intense interest and previous engagement with drugs, in the Kings Cross area. I was in the Brisbane public relations department and I had to become *au fait* with what he was doing but because of his commitment to this kind of programme and his intense involvement and my belief in supporting a young fellow who was really coming to grips with social problems with such intensity, I thought that I would give this more than official support. I was able to observe at close hand his work for about three years. That proved to be of some value to me when I came here. About two and a half years ago, in January, 1975, I was appointed to Newcastle to take charge of our Man Care operation which included Bridge House. Bridge House, Newcastle, is the same as the Bridge Floor in the William Booth Institute. Do members of the Committee know about that?

2151. No. Would you give some details about it?——W. The Salvation Army's Bridge work is an alcoholic rehabilitation programme. It starts with a person being picked up by a counsellor perhaps at an office in a country centre or even someone who has been through the Bridge programme and referring a person to the William Booth

Institute where we have a hospital. The first part of the hospital is funded under the nursing homes arrangement and a person goes there for two or three weeks. He is treated, whether the problem is alcohol or drugs. Originally it was oriented towards the alcohol problem but in recent years it has developed to cover both problems. The person leaves hospital after two or three weeks and then is assessed and referred to one of our two farms. That happens in every case where the person shows motivation towards rehabilitation. We have two farms, one is called Selah at Chittaway Point for the ladies. The other is called Miracle Haven at Morisset for men. They may be at the farm for from four to twelve months or so and they then go back to a Bridge House either in Newcastle or in Sydney at the William Booth Institute or in Canberra.

They are the only places that we have a Bridge House at the moment. We have a Bridge House in Newcastle although we have not had any persons coming back to Bridge House for drug dependence. We refer people from Newcastle, from our Bridge House to Sydney. That not only provides a bridge back to the community, but as the local counselling centre is the start of the programme for anyone seeking help. I was placed in charge of that aspect of our operation here. Last year, for the twelve months, I had the responsibility of the administration of Miracle Haven at Morisset also, where there was an average population of 68 persons throughout the year. The percentage of those when who were drug addicts, or had been, would have been about 20 per cent. There was some involvement of girls from Selah Farm because they would come up for group work at Miracle Haven. This year my responsibilities have been shortened once again and I am concentrating here at the Newcastle centre, looking after the work we have here. That is pretty well a run down on my involvement so far. Perhaps questions could evolve from that?

2152. Could you elaborate on the type of programme the people would be involved in at Miracle Haven?——W. I suppose we would see the most essential element as that of being development of the personality and assistance given to development so that they can cope with their problem. That is done by group work each week day. There is a group session immediately after lunch and at night time we have groups also. There is a chapel service on Wednesday night and a chapel service on Sunday morning. Two nights a week the bus goes to AA meetings. Though that is not obligatory for the person concerned, he may go to an AA meeting—one or both. We have Bible study also at night time. The groups that meet at midday have the subject of discussion always, the AA step of the week. Our object is based on the twelve AA steps. They work progressively through the steps, one step a week though there are two weeks when we have two steps together. That step, or the two steps, is the subject for most of the group work and chapel service through that week. As well as that, there is personal counselling. They are also involved in the running of the farm. We see that as an essential part of the rehabilitation programme. There is a dampening effect of drugs upon a person's will to work and it is fairly well established that these persons have to find again the pleasure that there is in work, in achieving and becoming part of a team. It gives a tremendous opportunity to them to learn how to relate to each other and how to relate to authority once again. They find themselves working in a community that is largely protected from some of the influences outside the farm. It is a protected community and they find protection there. Then the idea is to take them to the Bridge where they live in and work out. They attend groups. So, they are brought back into the community without sudden exposure to the full force of community pressures.

2153. Would drug addicts be segregated from alcoholics?——W. No, they move through the groups with the others. I said that there are four groups that they move through on the farm. There is the How group for three weeks. Then there is the Red group, the Yellow group and the Blue group. They are Army colours. The expectation is that in the How group they will be largely listening. In that other group, the Red group, they are finding their voices or and participating in the discussion. The Yellow group provides opportunities for them to write screeds. In the Blue group they may be called upon to lead groups. As to segregation, in the groups they are not segregated but there is a segregation that occurs unofficially because of the differences in age between the alcoholics and the drug addicts. Obviously they are going to find different interests because of that, not only that, but in the work situation we find that we have problems with them that we do not have with alcoholics. The alcoholic, despite his problem, has learnt to accept the discipline of authority in a working situation. He is an older man. This kind of thing comes back to him fairly naturally but not so with the drug addict who, in many instances, has not worked much since he left school. He has not learnt how to relate adequately in a work situation to a boss and to his work fellows. There is that problem. During my year there I considered that a ratio of one to five was about acceptable because the alcoholic brings to the young drug addiction understanding of life that he might otherwise not get if we were just to have a colony of drug addicts. So there is a segregation that occurs simply because of age differences and some of the social involvement differences but largely they integrate and things go on quite well.

2154. Do you have any association with people in Newcastle who have just come to your notice?——W. Yes, the other evening when I was in Bridge House a father rang up about his son aged 18. He had just found out that the boy was smoking marihuana. His son had elected to leave home. The father rang me to find out what he could do about the matter. A few weeks ago I took a fellow to Bridge House who had been using heroin. A friend suddenly realized that the fellow was using a drug and confronted him. He admitted it and was prepared to admit that he did need help. I took him down because the one that I had referred to Sydney prior to that, the day after he went there—we sent him by train—and we can always do that with an alcoholic, that is, give him a note and put it in his pocket. If the alcoholic doesn't arrive for two weeks later, he generally arrives with the note. The first heroin addict slipped his mate who was going to meet him there and the next day he was found dead at Kings Cross with an overdose. I see problems in handling the person on stronger drugs that are not present with the person on alcohol or softer drugs.

2155. You would not refer such a person to the addiction centre here in Newcastle or to the hospital, would you?——W. The way we present the matter is this: many alcoholics come to us—and you can understand that we have a greater proportion of them than of drug addicts. We take a lot of them up to Watt Street, and we have referred some to the hospital. When the fact that they have an immediate need for medical attention is so obvious that you cannot miss it, we certainly do that. Dr Fury supports us tremendously well in our work, and at Bridge House every Saturday he has a clinic for the men, to meet whatever their needs are, and is on call to help us at any time.

In referring these people to Sydney it is not a matter of by-passing any local facility, because we always lay it on the line in our counselling that the disease has a physical, mental and spiritual basis. We beg nobody's pardon for coming on strong about God and the need for His help in this matter. We present the problems on that basis and say to them,. "If you want this help, you can have it." If they say, "We do not want the sort of help you are offering," we can talk to them about other services that are available. Although I have a strong personal belief about the way the problem should be approached, it is only right and proper that the person should be able to shop around to find something that suits him, even if I disagree with what he chooses—and I am not suggesting that. This is a vital part of any community service.

2156. Mr WOTTON: When you take a heroin addict to your farm, do you cut him off completely from the drug?——W. Yes.

2157. Without any process of withdrawing him from the programme on which he is operating?——W. That is so.

2158. Does that work?——W. Yes.

2159. When you take a heroin addict out to your farm, would he go straight from being an addict to being a person who was off the drugs?——W. He would not go straight to the farm. He would be in our hospital for the first two or three weeks. If he were on heroin, it is more likely that he would be there from three to four weeks. He would be under Dr Ryan and Dr Nolan, both of whom came through the course themselves. They will tell you the story about drug addiction and alcohol addiction. They understand the position fully. Dr Ryan holds that by helping to get these persons into a healthy condition, to get their digestive systems and so forth functioning properly—and I am getting out of my depth here, but this is basically the way he approaches it—and by ensuring that the person concerned gets good food, and has an adequate supply of vitamins and nutrients, his body will then be able to handle the problems of withdrawal.

2160. Mr MACDIARMID: Do you have any of these people who cannot stand the reform process and leave? ——W. We do.

2161. What proportion of them?——W. I could not give you a figure. When I went to the farm we were losing 20 per cent in the first four weeks, 20 per cent in the second four weeks and 20 per cent in the third four weeks. So there was a loss of about 60 per cent of drug addicts and alcohol addicts in the first 12 weeks. They seem to be the crisis periods—four weeks, eight weeks, twelve weeks. If they get through the twelve weeks they generally stay and do the full course until we suggest that they move on to the next phase of the programme. I can only speak in a broad way about alcohol and drugs together. I have not analysed the figure for drug addicts.

2162. Do you try to trace them when they leave? What happens to them?——W. No, we just tell them that we will still be there when they need our help.

2163. CHAIRMAN: What is their financial situation when they are on the farm? I understand that they would be covered for the three-week period while they were in hospital. Is that so?——W. Yes. They are still on sickness benefits right through their stay on the farm even though they are engaged in work activity. This is done with the full concurrence and knowledge of the federal Government.

2164. Mr MACDIARMID: Do you get subsidies?—— W. Yes, but there has been a big drain on our resources with Miracle Haven and the William Booth Institute too. Part of the hospital treatment has been funded under the nursing homes legislation. When they go to the hospital they are put into a one-bed ward for four or five days, where they are under strict supervision. They then move out into four-bed rooms, and they dress during the day, talk to others, do little chores, and get into groups. The formation of groups in hospital is as much a part of the therapy as it is on the farm. Group work continues throughout the range of activity. It is for the four or five days that they are kept separate that they are funded under the nursing homes legislation. When they move into the other section of the hospital no subsidy is paid for them. We do get a subsidy on the farm for the replacement of equipment, for maintenance of facilities, and so on.

2165. Do you try to run the farm at a profit?——Yes, but this is difficult because, unlike any other organization, we get rid of our best men. When they are fit and well and can handle the work they have been doing, whether it be in the piggery, or the dairy, or elsewhere, we discharge them. So, we are constantly giving away the men who have learnt skills on the farm, and in view of the limited resources we have available, that is a challenging and difficult situation.

2166. CHAIRMAN: It is something like having a new class coming in every few weeks?——W. Yes.

2167. Mr JACKETT: You mentioned age differences. Apparently there is a big difference between the age of the average alcoholic and the age of the average drug addict. What is the average age of the drug addict?—— W. From 18 to 25 mainly. We have had them as young as 15. We had a 15-year-old lad there while we had his father there as an alcoholic on the programme. We have had them up to 29. Because of the mixing of drugs and alcohol now we are finding that the position is somewhat different from what it was 10 or 12 years ago when we developed the programme. The starting age at that time would have been in the early 30's to 35's. We are now getting them down to 23.

2168. How long would the programme last after they leave the farm? What is the follow-up procedure?——W. That varies according to their needs. Some men may need to live in a supporting community for much longer than others. Three months probably would be the ideal, but many of them are there for six months. If a heroin addict were to move out suddenly and find himself running foul of the problem again, we would be ready to receive him back into the protective community where he felt he had the support of other persons until he could move out once again. So the answer is, as long as is required. It depends on the person, his inner resources, and his ability to cope with pressures that are bound to be met with in the community outside. The community outside is not kind.

2169. Have you had much experience of the person who just disappears from the programme and you do not hear of him again, probably because he is back on the heroin? Do you have any sort of medical testing? At the Odyssey Institute in New York it is essential that there be a urine test every day. Is anything of that nature done in your establishment for heroin addicts?——W. No, nothing of that nature at all. Early in my experience down there last year we found that four fellows had imported some marihuana. They had been on much harder drugs. They thought they could just go along having a bit of fun. We were able to pick up this matter, and we discharged them immediately. That is one of the rules of the place: if a person brings alcohol or drugs on to the farm, he is discharged immediately, and in that repsect we are very careful about medication, as are the doctors who service the farm, for we know that this can start the whole process off again. In any event, we discharged these four fellows. One of them immediately turned up at Bridge House. He has been there ever since, and that was 14 months ago. We have been able to give him support and care. One of the other lads, who was very loud-voiced about the whole issue, came back to us quickly. He came from the Wollongong area. He ran foul of the old problem when he left the place. I am not sure about the other two. Major Hicks, who is our administrator there, would probably be able to tell you about them, because it seems that once they enjoy some of the benefits of being clear-headed and able to get on without these things, they quickly return if they find themselves in trouble.

2170. Mr RAMSAY: You said that you sent one young lad to Sydney on the train, and that he died in Sydney of an overdose of heroin. With respect to you, would it not have been better if somebody had gone down to Sydney with him, particularly as he was a young man and was taking a hard drug like heroin? If your organization was not able to do it, could it not have been done by somebody like the Health Commission?——W. I understood at the time that his parents and his mates were going to look after the matter. The parents took him to Broadmeadow, and his mate was to meet the train in Sydney. The timetables of the trains running through Broadmeadow was such that he was able to let the first train go and get on the next one. It arrived at Central station in Sydney five minutes later than the first train, and his mate was waiting at the wrong station. This probably indicates the degree of conflict and turmoil in the minds of such fellows, even though they want rehabilitation.

2171. You said that you discharged four young persons because they had marihuana. Would it not have been better, particularly if we are all intent on helping this sort of person, to notify the Health Commission of what had happened? I understand it is the wish of the Health Commission, and even of the Department of Corrective Services, to give the man who makes one mistake an opportunity to rehabilitate himself. Would you agree with that? ——W. I think that the only way you can do that is by having a list of other places as well as our own that they could refer to, but with a card that can be slipped into their pocket. They may not be in a receptive mood to listen to reason or to react to discipline but they should be aware of this information. At the same time it is terribly obvious once you are in this circumstance that discipline must be absolute in this matter, otherwise you will have tremendous trouble. If you have a rule such as this you have got to stick by it in the interests of the other men who are on the farm. There should be a way of catching that person as soon as possible.

(The witness withdrew.)

JOHN KEITH BARRY, Superintendent of the Newcastle City Mission, residing at 10 Taylor Street, Cardiff, sworn and examined:

KATHLEEN LOVEDAY WATKINS, a Welfare Worker at the Newcastle City Mission, residing at 40 Charlestown Road, New Lambton Heights, sworn and examined:

2172. CHAIRMAN: Would you mind telling the committee about your involvement in the very serious social problem that we are dealing with?——W. (*Mr Barry*) I have been connected with the Newcastle City Mission for approximately six years. For the past four years I have been in full-time employment as superintendent of the mission. We have not been involved very much with the drug problem except in regard to alcohol and smoking. Recently we developed a home for young women and girls. There have just been the odd cases of girls who have been involved in drugs. Mrs Watkins would be better able to speak about that aspect. I am not involved in that home to a great extent. We generally deal with the older type of man who has been affected by alcohol. Some of them have been affected by alcohol for many years.

2173. The mission provides these men with meals, clothing and showering facilities. Also, we give them personal counselling where the drinking problem has become such a state that they are physically affected and unable to move in society with any deal of respectability. Usually we refer them to the addiction centre at Watt Street. Often we take them there ourselves rather than send them there because their condition may be such that they would not be able to make it on their own. We feel that they have to be got there and accommodated. Sometimes we have taken these men to the Morisset hospital ourselves. We provide what we call a half-way house for up to eight men. This has been in existence since 1967. When the men go there, their stay is limited by their conduct. There is no full-time supervision. They are not taken there when they are seriously affected by alcohol. Where they have come to a stage that they have been in the addiction centre and had an opportunity to dry out and have a wish to beat the problem in their own life with some encouragement and help, we put them into this home and endeavour to supervise them.

I visit the home about four times a week at varying times of the day. One night a week I spend about two hours with the men. There are about six men in the home at the one time. I talk to them on a Tuesday. I discuss their problems with them for about two hours. We have a Bible reading and general fellowship together. We show them that we are interested in them and we encourage them to get on to the right track. Occasionally we have one that may break out and go back on to the drink. Sometimes it may be two or three days before we find out and they may be in a bad state by then. We endeavour to encourage them to dry out there, to stay at home and try to beat their problem without going back to the addiction centre.

2174. I must point out that our terms of reference specifically exclude tobacco and alcohol. Though we do not want to minimize the importance of the work that you are doing in the field of alcoholism, we are trying to find out from the experience you have had what your knowledge is about drugs of dependence. We would like to receive anything that you are able to pass on to us in so far as your experience is concerned. We may then be able to make some recommendations that will be of benefit to the community.——W. We are not geared to work with people

who are involved in drugs. On odd occasions men have come there after taking tablets. If we feel that they have not taken alcohol but rather some drug, we take them to the addiction centre and refer them there for treatment rather than try to help them ourselves. In the four years that I have been there, we have been dealing with mostly older men. Not many of these men that I have come in contact with have taken drugs or some kind of tablets but that is about as much as I can contribute.

2175. WITNESS—(*Mrs Watkins*): We conduct a home for homeless girls at Islington. A few girls have been referred to our home by the courts after being concerned in the drug problem. These girls have been mainly itinerants who have come from overseas or interstate and they have landed in Newcastle and found themselves in need of drugs and broken into chemist shops and stolen them. These girls have been apprehended and then charged. So far we have had excellent success with the girls who have come through our house. They have given up the drugs and have mixed with other people who have perhaps been taking drugs but they have stayed away from them. I think that is a good indication that these girls have given the drugs away. We have not seen men who have been under the influence or dependent on any drugs other than alcohol. I would never leave alcohol out of any terms of reference in a drug situation; to me, alcohol is dangerous and prevalent in the community. We do not see many people at the mission who are on drugs of dependence.

2176. We did not draw up the terms of reference and we can only act within the guidelines that have been laid down for us. Would you have many professional medical people available to you to assist girls who have a drug problem?——W. I would refer them straight to the addiction centre, to Dr O'Neill, if they had a drug problem. I am an approved drug educator from the Health Commission, and I have been so for a number of years. I have worked in the drug addiction field under the auspices of the Newcastle Youth Service. This service was given a grant to conduct education work for the Health Commission in the Newcastle area. I have worked a lot with young people. I worked at the youth service specifically in drug education and giving counselling to people, mainly in the education field.

2177. Would you like to tell us about the work you did in drug education?——W. I was most concerned at young people, especially those in the Hunter region, who came to the city for tertiary education and for work. They would hit the city without any resources available to them. We put in for a grant of money so that we could do work in country areas specifically to talk to these kids before they came to the city. We established seminars in country areas as far as Muswellbrook, Scone, Singleton and up towards Taree and Wingham. I suppose we had about twelve centres where we worked in a little over twelve months. We tried to have one seminar each month in a country centre.

We brought about fifty young people together for a day and we talked to them about drug addiction. We showed them films that were supplied by the Health Commission and we talked to them about living in their groups and how they got on with their groups and their parents. Then we tried to get them to do something in the community, to enjoy being kids without turning to such things as drugs. We encouraged them to look for happiness.

2178. Where did that money come from?——W. It came from the New South Wales Health Commission, through a direct grant, I think, from the federal Budget. I think about $750,000 was budgeted a couple of years ago to be used in the field of drug education and we received some of that grant.

2179. Mr MACDIARMID: These girls whom you called itinerants, were they drug addicts when they arrived here or did they drift into drug use because they became unemployed?——W. One girl took lots of LSD trips. I guess she was smoking a fair amount of pot when she was apprehended by the police. Also, she was probably taking proprietary drugs that can be obtained at a chemist shop. I have not come across any heroin or any extremely hard drug. This girl was a young lass who came from Queensland. She was an itinerant. I checked her out for heroin because she was extremely thin. She said that she had never touched heroin but had had other drugs. This poor lass indicated drug addiction. Also, she considered she was an alcoholic because she drank a couple of cans a day. I started to question, how can we get across to kids the need for some sort of education system? I came back, time and time again, to the result that education is the most important thing.

(The witness withdrew.)

(Sitting concluded.)

*AT NEWCASTLE ON THURSDAY, 5 MAY, 1977*

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The Committee met at 9.30 a.m.

Present:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| The Hon. CLIVE HEALEY | Mr J. G. T. JACKETT |
| The Hon. F. M. MACDIARMID | Mr B. McGOWAN |
| | Mr E. D. RAMSAY |
| | Mr R. C. A. WOTTON |

RANJIT SINGH NANRA, Medical Practitioner, 34 Mountain View Parade, New Lampton Heights, head of the Division of Nephrology at Royal Newcastle Hospital, sworn and examined:

2180. CHAIRMAN: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. I did.

2181. I understand that you have some material additional to what you will say here today that you would like to have included in the record as part of your sworn evidence; is that so?——W. Yes.

2182. That material will form exhibit "4" to your evidence. Would you like to begin your evidence now? ——W. Yes.

2183. What I propose to do this morning is to cover a number of aspects of the abuse of headache powders in the Australian community. I shall endeavour first to acquaint you with the medical effects or mal-effects of the abuse of headache powders. Also I shall attempt to define the problem of this abuse and what is meant by the abuse of headache powders. I shall attempt to describe to you the size of the problem in Australia, in New South Wales, and particularly in the Hunter region, compared with the rest of the world. I would then like to share with you the reasons why I think the problem is so great in New South Wales, and particularly in the Newcastle region. Finally, I wish to deal with the financial implications of the abuse of analgesics in the Australian community and the recommendations we would make about the use and abuse of analgesics in this region.

I am speaking today partly as an individual who has had an interest in this field for the past 10 or 12 years, and partly in my capacity as Convenor and Chairman of the Analgesics Working Party of the Hunter region. I propose to show a number of colour slides. I begin by showing you a photograph of two human kidneys. The shrivelled one is taken from a patient who took three or four headache powders a day for 15 or 20 years. I do not have to get involved in medical terms to describe what can be seen there. The kidney is small, shrunken and diseased, and it can no longer sustain proper health or life in that patient.

The next slide shows a kidney with black, dead areas of the inner part, called the medulla. This is known as papillary necrosis, or death of the inner part of the kidney, as the result of the abuse of the common headache powder. The change that you see there is characteristic, and any nephrologist who saw it would know that it could have no other cause.

The next slide shows a case history prepared by a colleague of mine in Canada in 1968, Henry Galt. It is typical. It is a graphic description of the multitudinous problems that occur in such patients.

The next slide shows an outline of a human body with indications of the various effects of the abuse of headache powders. Many of these patients front up for different forms of treatment, such as going to the psychiatric units asking for help, and it is there that the more serious disorders are recognized. An example is premature ageing of the brain. We have recognized that heart disease is very common in people who take headache powders to excess, and in my experience at the Royal Newcastle Hospital 35 to 50 per cent of all patients with analgesic-induced kidney disease have some form of aschemic heart disease. There are a number of other recognized effects, such as those on the ovaries, fertility and pregnancy. Many of these people also appear to have a pigmentation related to a number of different factors. There are many mechanisms that lead to an insufficiency of blood in the body of these patients, and premature ageing is a result. Therefore we prefer to use the term analgesic syndrome because of the many facets of the problem.

The next slide shows that the disease is predominant among women. In an analysis that I made of 279 patients under my care, the ratio of women to men was 6.5 to 1. That ratio is fairly well recognized all over the world. The pattern of intake of headache powders in the community as between females and males is two to one, while the appearance of the disease is in the ratio of six to one, which suggests one of two possibilities. Either women are more prone to damage from headache powders than men, or men are protecting themselves from kidney damage.

This could be related to alcohol intake in the male Australian community. For example, a dockside worker admitted to taking half a dozen headache powders every day in addition to his daily intake of eight or ten middies of beer. He became aware that the abuse of headache powders could lead to kidney disease and he went to his doctor and asked whether he would check his kidneys. A kidney X-ray was done and found to be normal. One Christmas, for some reason or other, he decided to give up his beer drinking habit but stuck with his habit of taking headache powders. He took Bex. Nine months later he had his first attack of loin pain when portion of his kidney was crumbling and going through into the urine. A repeat kidney X-ray done at that time showed the form of damage that is referred to as papillary necrosis caused by the abuse of headache powders. That is an interesting aspect of the prevalence of the problem among females as compared to males. It might not be the total answer. The other important point is that the disease is rare in persons under the age of 30. A lot of women start taking headache powders in their early teens, between 15 and 20, and continue the intake for five, ten, fifteen or twenty years before kidney disease becomes apparent. As a result, the disease is seen after the age of 30, the peak being reached between the ages of 40 and 49.

The next slide shows the medical history of a family, and this has nothing to do with genetics: it is a question of parents passing on a habit through a family. The family lived at Dungog, and there were eleven members of it.

This slide shows another man who died of a heart attack at the age of 39. I show you this to indicate a couple of important medical aspects in relation to kidney disease, for example, kidney failure and high blood pressure. I shall deal now with the development of cancer of the kidney. The suggestion has been made that this cancer is nine thousand times more common in a person who is abusing headache powders. The next picture shows a piece of dead kidney that came from a patient. When this piece of kidney was sieved it was found that it was a dead portion of a kidney. In patients of this type the kidneys rot away and pieces of them pass into the urine. The next slide shows a cancer that has developed in a kidney that was damaged by the use of headache powders.

It is important to indicate the fact that the analgesic syndrome is a chronic long-term disease spanning many years. In the next slide I have taken the hypothetical problem of a girl who starts taking headache powders at the age of 16 because of period pains. Her stomach ulcers and associated problems are seen in the next five, ten or fifteen years of her life. Her kidney disease starts at 30. If she becomes pregnant she will have some complications because of this disease. Over the next ten, twenty or thirty years many complications will occur in this patient. For these reasons it can be said that we are dealing with a chronic disorder with complications that extend over areas of the patient's life. Although the association between headache powder abuse and this form of kidney disease has been recognized since 1953, a number of members of the pharmaceutical industry keep questioning the validity of this association.

On this slide I have marshalled the evidence that associates the use of headache powders and analgesics and kidney disease. The next slide indicates that there are more than 3 500 cases of this condition reported and of this number more than 500 are my patients whom I have seen at the Royal Newcastle Hospital. The pattern of kidney damage is characteristic and specific for this disorder; it cannot be mimicked by any other condition. Patients who take headache powders continually get progressive kidney failure; patients who stop taking powders show continued improvement in their functions. We can produce this disease in animals by feeding them with headache powders. The evidence incriminating headache powders and associating them with this disease is strong.

For the past ten years I have been associated with, and responsible for, a number of experimental studies in which we have fed rats with a variety of pain-killing compounds, the common analgesics. The next slide indicates a normal rat kidney. The next picture shows portion of a rat kidney where the rat has been fed APCs over a twenty-two week period. This condition is identical to what can be seen in human kidneys. If an animal is given a sufficiently large dose of analgesics for a sufficiently long period, this condition can be produced. The analgesics we have studied and have caused this condition include aspirin, phenacetin, paracetamol, and similar substances. In other words, the condition is a common side effect of drugs that are medically described as non-steroid, acedic, anti-inflammatory agents. This class of drugs also has a capacity of irritating the stomach; also, they have a capacity to cause water retention in the body. I wish now to raise an important question. If in the year 1977 I had a drug that produced that kind of damage in 30 per cent to 40 per cent of my rats, should the National Health and Medical Research Council in Australia pass it for human consumption? Would the same drug be passed for human consumption in the United States of America and the United Kingdom? This question needs to be studied carefully. By looking at this slide, I state that this form of disease is caused by the abuse of a compound analgesic mixture and not by the medical use of single analgesics. What I am talking about is not the taking of two aspirin tablets a day or three times a week because a person has influenza. I am talking about the non-medical consumption of compound analgesics at the rate of five, ten or fifteen a day over a period of five, ten or fifteen years. It is a problem of abuse; not a problem of medical usage.

This slide defines what I mean by analgesic abuse. A patient who takes two kilogrammes of aspirin or phenacetin in the form of an analgesic mixture has an 85 per cent chance of developing the kidney damage I have described. Two kilogrammes of aspirin or phenacetin in the form of a mixture is equivalent to an intake of three powders a day over five years. That will result from the intake of five powders a day over three years or fifteen powders a day over one year or one powder a day over fifteen years. The effect on the kidney is a time dose cumulative toxicity. It is well recognized that it is hard to get a truthful history from patients and quantitive abuse is therefore often on the lower side of what the patient has taken. Why do I use the term drug abuse? The World Health Organization expert committee on drug dependence in 1965 described it as the consumption of a drug apart from medical need or in unnecessary quantities. If we take that World Health Organization definition, analgesics conform to drug abuse. Sometimes it is hard to get a history from patients. A patient was admitted to my ward six or eight weeks ago and she had a peptic ulcer, renal failure, hypertension and a premature appearance of ageing. She denied taking any powders. This is what we found in her locker—Vincent's powders, something for the stomach and so on. The compound analgesics that have been associated with kidney disease in Australia are the old APC because the pharmaceutical industry has seen fit to remove the phenacetin and replace it by panadol or salicylamide and call it safe. That was done by Vincent's in about 1967 and by Bex about a year ago. Panadol or paracetamol is the major immediate metabolite of phenacetin and when a person or an animal is fed it it is paracetamol that is the major metabolite that is concentrated

in the kidney. Experimental work done in Melbourne shows that the kidney disease produced by aspirin, panadol and caffeine is identical to that produced by aspirin, phenacetin and caffeine and examples of analgesic disease in patients have been seen by us in patients who have taken that combination.

I wish to emphasize that analgesic nephropathy in Australia is related to abuse of compound analgesics and not to the intake of single analgesics which are probably safe if used medically but there is no evidence that human beings ever abuse compound analgesics except in rare circumstances where there is severe psychological or psychiatric aberration. In 190 patients who came through my clinic where I had personally taken a history I found that 37 per cent were loyal to Bex and did not touch anything else. Twenty-five per cent were loyal to Vincent's powders and 33 per cent took multiple things, that is, they switched from Bex to Vincent's and so on. A small proportion took individual things but that was in relation to joint disease and so forth. Abuse was restricted almost entirely to these two major powders taken in a multiple form or individually. Why do patients take headache powders? Having gone through 500 patients personally, most patients will say that they take them because they have a headache. The headache that they have does not appear to have a medical or organic basis. Some claim to have a medical or organic basis. Some claim to have rheumatism. Some have aches and pains that you cannot define on an organic basis.

If you press the patients they will tell you that they take it because of a habit or as a lift or pick-me-up. It is not uncommon for a housewife, the wife of a shift-worker, to get up at 5 a.m. and say that the first thing she does before she can get going is reach for two headache powders. There is evidence of psychosomatiac, social and psychiatric aberration in these families with associated abuse of smoking and alcohol. The genesis of headaches in these patients is interesting. There does not appear to be any organic base. In the middle of the 1930's it was recognized by pharmacologists that caffeine withdrawal headaches were a reality in human beings. If one took a sufficient dose of caffeine, when the effect of the caffeine went away patients often developed a withdrawal headache. I feel that a lot of the headaches are caffeine withdrawal headaches when the effects of two powders are wearing away. The intake of powders then becomes a vicious cycle. They take more for the headache that results from caffeine withdrawal. That is probably true because when you encourage patients to come off powders completely a month later they say, "I have lost my headaches. They are clear for the first time in the past twenty years". There are six on this slide and perhaps five or six on the other slide that show a number of studies carried out in different cross-sections of the Australian community. A number of patients in these surveys who admit to taking headache powders every day range from 16 per cent, 5.9 per cent, 9 per cent, 11.3 per cent, 11.7 per cent, 10 per cent, 11 per cent, 12 per cent and 15 per cent. The largest, observed by Kamien in an aboriginal population was 46 per cent females and 26 per cent males. A number of studies in different sections of the Australian community indicate that roughly 15 per cent of females take powders every day and roughly 10 per cent of the male adult population. If one accepts 10 per cent as a conservative estimate of the prevalence of the habit in the Hunter Valley, with a population of about half a million people, we have between 40 000 to 50 000 people taking headache powders every day. The hundred patients that I see a year in the renal clinic is really just the tip of the iceberg. With consumption of analgesics it is hard to get accurate figures from the pharmaceutical industry. However, this is a table of consumption of aspirin in 1972 taken from the Proprietary Medicine Manufacturers Council of Australia. The consumption was 1.5 million pounds of aspirin over a 13 million population or an intake of .115 pounds a head. That appears to be lower than in America where consumption is .134 pounds a head. It is hard to equate cause and effect when one sees figures like that in relation to the analgesic syndrome *per se*. We are talking about the abuse of compound analgesics and not the use of a single proprietary agent.

In 1968 Gault, an American, compiled this table which is the *per capita* consumption of phenacetin in the form of compound analgesics. The *per capita* consumption was highest in Australia and lowest in Canada. It is interesting to note that the table seems to mimic the prevalence of incidence of terminal kidney failure in different countries fairly closely. The terminal renal failure in Australia, on a national basis, requiring treatment by kidney machines or transplant is roughly 20 per cent. In Canada and America it is roughly 5 per cent and 7 per cent. How big is the problem in Newcastle? I have indicated the incidence on a national scale. Over a five-year period 50 per cent of all patients requiring this treatment have done so as a result of headache powder abuse. Thirty per cent of the clinical load of the work in my unit is in relation to headache powder abuse. If one looks at all deaths in hospital and looks at the incidence of the disease, 20 per cent of all kidneys I have personally viewed at the Royal Newcastle Hospital have that disease as a result of analgesic abuse.

The next slide shows figures from round the world. In three separate studies in America, the autopsy incidence of renal papillary necrosis was found to range from 0.2 per cent to 0.3 per cent. In eight different studies in Europe it ranged from 0.3 per cent to 4 per cent. In one study in the United Kingdom it was 1.6 per cent. In seven studies in Australia it ranged from 3.6 per cent to 4 per cent. The incidence in the autopsy room in Australia is very much higher than it is elsewhere in the world.

The next slide deals with the reasons why analgesic abuse appears to be prevalent in the Australian community. One is struck by the flagrant advertising of what is a drug on billboards along highways, as the sort shown here.

The next slide shows advertising of the same drug in a supermarket. Such advertising occurs throughout the community.

The next slide shows an advertisement in this country in 1921, reading as follows: "Twenty Aspros a day keeps a man's pain away. Recommended for diverse things, including malaria and sciatica".

The next slide deals with the cost of advertising by the pharmaceutical industry. Two million dollars is spent on advertising analgesics, compared with $5.7 million spent on advertising other pharmaceuticals. $7.3 million is spent on advertising alcohol and $11 million is spent on advertising tobacco. The basic question is why is it necessary to advertise these or any drugs? Why not advertise penicillin or the contraceptive pill in supermarkets, milk bars, and on billboards?

The next slide relates to a study done by the Department of Psychology at the University of New South Wales, which made a survey of 1 000-odd families in Sydney, and about the same number in Brisbane.

The next slide shows the conclusions from that study. For example, 11.4 per cent of those surveyed were daily users of analgesics. It shows that the consumption of analgesics was regarded as a socially acceptable form of urbanized behaviour. That conclusion is important.

The next slide shows that the problem of analgesic abuse was recognized in Australia as early as 1907, when it was reported in a magazine that four or five different powders were being abused in the Australian community, and that the abuse of them led to disease of the heart and of the alimentary canal. The conclusion was what the drink habit is among men in Australia, the headache powder habit is among women. Therefore the habit of taking powders appears to have become culturally part of the Australian way of life, and certainly dates back to 1907.

If we move closer to home, Newcastle, one sees in the next slide the sort of brain-washing that takes place in this respect. The card depicted was purchased from a local stationery shop. It says, "Having a great time at Newcastle. It was a bit of a headache until I worked out my routine—morning Bex and snooze, afternoon and evening sex and booze".

The next slide deals with the predisposition to abuse as a result of cultural acceptance in the Australian community of the taking of headache powders. In Newcastle we have a very high proportion of people of Anglo-Saxon ethnic origin. The abuse of headache powders appears to be restricted almost entirely to the Australian part of the population and not to the new immigrant.

The next slide adds another factor, and that is the abuse of headache powders among various groups in the community. It shows that the abuse is higher in the lower socio-economic group, and in the Hunter region there is a high proportion of under-privileged persons compared with many other parts of Australia.

I wish to turn next, and briefly, to the financial implications to the abuse of analgesics. The next slide shows a patient on a kidney machine. The costs of running dialysis in a hospital begin with an initial capital expenditure of around $8,000, and a maintenance cost for each patient each year of $7,400, though those figures were published in 1973 and need to be up-dated as a result of inflation. For dialysis at home, the capital cost of the equipment is still $8,000, and the training costs and maintenance cost for each patient each year are roughly $8,700. Again those figures need to be brought up to date. On the other hand, the cost of a transplant operation is $4,600 again a figure that needs to be up-dated—but once the patient is taken off the machine obviously the maintenance costs are much less. On a State-wide basis one sees that in New South Wales approximately $3 million is spent on treatment of patients with kidney machines, and roughly $1 million is spent on transplants. At the Royal Newcastle Hospital the figures are $500,000 for dialysis treatment and $100,000 for transplants. It is important to realize that 50 per cent of that amount goes on patients whose disease has been caused by headache powder abuse.

In showing you the next slide it is important for me to raise this question: there is a lot of social and economic disruption, emotional trauma and loss of productivity in the community as the result of sickness caused by abuse of headache powders, but quantifying it is a difficult problem. The point is that the main part of the iceberg in the community is not seen.

I come now to the next slide. Talking in terms of the financial implications of headache powder abuse, I point out that the pharmaceutical industry is opposed to the imposition of any restrictions on analgesics, and that opposition is probably reflected in figures like those that you see in this photograph, which were made available to the Senate Select Committee in 1971, when 2 904 000 doses of headache powders were sold in Australia in that year. Taking the cost of those powders at today's market values, the financial turnover is about $100 million. It is a matter for some wonder that persons like me are attempting to knock a multi-million dollar industry.

In showing you the next slide I wish to highlight another important factor. This is a photograph of a patient who had taken headache powders for 20 years, at the rate of five or ten a day, and developed damage to the kidneys. Parts of the kidney were rotting away and coming through in the urine.

The next slide shows that those pieces of kidney can be identified in the urine. This patient has analgesic kidney disease.

When this patient came to us she had reasonably severe kidney failure. We took her off the headache powders and over a period of four years there was a gradual and progressive improvement in her kidney function. This is an important facet of my submission. If patients are caught early enough and can be encouraged to come off headache powders, they show a tendency to recover and need not go on to terminal renal failure with all the expensive input, financial, hard work, and the like.

In conclusion I wish to submit that analgesic abuse is widespread in Australia, particularly in the Hunter region. It is almost exclusively restricted to compound analgesics. Analgesic abuse is a community health hazard with significant morbidity and mortality. The medical consequences of analgesic abuse, particularly kidney disease and kidney failure, result in a considerable drain on the financial and health resources of this region. The factors that appear to contribute to the abuse of analgesics are flagrant advertising, cultural or social acceptance by the Australian community, and the psychotrophic effects of the drug in a mixture or a component of that mixture.

The recommendations that I make on behalf of the analgesic working party and myself are as follows:

First, that restrictions be brought to bear on the sale of compound analgesic mixtures, preferably by requiring them to be obtained on prescription.

Second, that the marketing of single analgesics be in a form that does not make them readily available for overdose, such as by selling them in a foil.

Third, that there be a curtailment of the advertising of particular drugs in the community.

Fourth, that a community addiction programme be launched.

Fifth, that support for research in the area of analgesic abuse, not only into the medical aspects but also into the social aspects, be supported in New South Wales and in this region.

Finally, I have left out many facts because of the time available to me, but I should be more than happy to deal with them during question time.

2184. CHAIRMAN: Do you hold an official position in the Australasian Society of Nephrology?——W. Not apart from being a member.

2185. How long have you been associated with the society?——W. Ten years.

2186. How long have you been associated with the renal clinic at Newcastle?——W. Five years.

2187. What was your experience in medicine before coming to Newcastle?——W. I was practising renal medicine at the Royal Melbourne Hospital and the University of Melbourne for four and a half years before coming here. Prior to my experience in Melbourne, where I was initially a research fellow, then assistant physician and associate in medicine to the university department, I was a lecturer in medicine at the University of Himalaya in Kuala Lumpur.

2188. I understand that you have gained world reputation for your work?——W. That is correct.

2189. I think you mentioned that Dr Gault was one of your friends. Have you maintained contact with the research bodies interstate and overseas?——W. Yes. I have. Because of my interest in the area of analgesic related diseases I have been invited to participate in international conferences, in Vienna in 1973, on analgesic abuse. In 1972 I was invited to give special evidence to the FBA in America. Last year I was invited to talk to the International Academy of Pathology in Washington on the problem of analgesics and kidney disease.

2190. Do you know of any particular results that might have come about as a result of the addresses that you have given?——W. Apart from highlighting the problem in Australia where the problem appears to be much bigger than elsewhere in the world, there is still not uniform agreement among workers in this area about the relative toxicity of the different components of analgesic mixtures. I wish to submit that that is a scientific argument which is a red herring if it is brought up in relation to a community problem. The problem in the community is the abuse of compound analgesics—it does not matter what the mixture is—whereas the individual components do not appear to be abused. Scientists are arguing continually about the relative toxicity of compound A as against compound B and compound C in a mixture. However, the problem is straightforward, that the community abuses compound analgesics and this leads to considerable strife. Therefore, our attention should be directed towards tackling the problem of abuse of compound analgesics.

2191. You said that about 3 500 cases have been reported and of those you have treated more than 500. The details of these cases have been circulated throughout the world, is that correct?——W. They have been published in scientific journals, yes.

2192. We have received a submission from the Australasian Society of Nephrology. Are you acquainted with that submission?——W. Yes, I had the pleasure of being consulted on that document and it has my full concurrence and support.

2193. Earlier in the day we were discussing certain aspects of the chemicals involved in the various compounds. For the benefit of the committee would you give us your views in regard to the chemical effect of the changes that were made by two of the major producers of these powders?——W. The original compound analgesic in this community was APC, mainly aspirin, phenacetin and caffeine. Experimental work suggests that in animals, both aspirin and phenacetin have significant nephro toxicity or are toxic to the kidneys. Also, that if you add the two together the toxicity is combined. This toxicity, as I have indicated, extends to other single anti-inflammatory drugs as well as paracetamol and so forth. In 1967—it could be 1968—Vincent's removed phenacetin from their compound analgesic and replaced it with salacymide. At that time they indicated that their compound was now safe. Similarly, the Bex powder had a phenacetin component replaced by paracetamol, last year or early this year, again with the implication that the compound was now safe. I have records of patients who are continuing to take Vincent's powders, which does not contain phenacetin, they are still presenting with kidney failure and the analgesic syndrome. My contention therefore is that the mixture without phenacetin is still medically damaging. I indicated earlier that paracetamol or panadol was the immediate major metabalite of phenacetin and that in the body phenacetin is rapidly converted to paracetamol and it is that substance that is concentrated in the kidneys. I wish to submit that the change in formula by the pharmaceutical industry has not in any measurable way reduced the toxicity of this compound analgesic.

2194. The following submission has been made to this committee: "The consensus of medical opinion has now exonerated aspirin and other salicytates, and incriminates phenacetin. That chemical is not now an ingredient of any commonly-used analgesic." I presume that you would not agree with that statement?——W. That is true. I wish to comment on that. It is very hard to find in human or clinical experience an experiment which is going to give us an answer regarding the toxicity of aspirin on its own or phenacetin on its own for the simple reason that aspirin on its own is not abused. Secondly, phenacetin on its own has never been sold in the marketplace, apart from a small company in the United States of America; it is still marketed but nobody buys it.

The result is that there is no human evidence that phenacetin is toxic. There have been more than twenty-eight different studies where people have tried to produce kidney disease with phenacetin and they cannot produce a kidney lesion with it. The reason why phenacetin was first suggested by the original authors in 1963 was because it appeared to be a compound denominator in a number of mixtures in Europe at that time. I propose to quote what was said by an eminent person, Dr Gilman. In a work by Goodman and Gilman entitled "Pharmacological Basis of Therapeutics and Medical Practice" there is a reference to an address given to the American Society of Physicians in 1956. At that time the story was told of a man who went to a party and had his first drink of brandy and soda; his second drink was whisky and soda and his third drink was gin and soda. When this man got drunk he blamed the soda. That, in total, appears to be the evidence against phenacetin.

2195. Do you know Professor Swales, professor of medicine and a lecturer in the United Kingdom?——W. No.

2196. He is reported as saying that analgesics are characterized by renal papillary necrosis and is a cause of renal failure in Australia, Switzerland and Scandinavia but is uncommon in the United Kingdom. He said that the common view is that phenacetin is the analgesic mainly responsible. The evidence that paracetamol causes papillary necrosis in man is based upon a few case reports while the evidence that aspirin caused papillary necrosis is based largely upon animal studies which are of doubtful relevance to man. Would you comment on that opinion?——W. Yes. First, I think the statement that renal failure induced by analgesics is uncommon in the United Kingdom is incorrect. The terminal renal failure programme contributed to by analgesic toxicity throughout the world is as follows: Australia on a national basis, 20 per cent: from two renal units in the United Kingdom, 10 per cent. It is bigger there than has been reported. In Europe it is 63.6 per cent

and Canada 5.5 per cent. There is a problem in the United Kingdom. I think that Professor Swales is misinformed when he makes that statement. As to the last part of his opinion, I have pointed out that it is difficult to obtain human evidence against aspirin or phenacetin or paracetamol because these individual compounds are not abused by human beings and therefore it is difficult to find that evidence. I submit that all the knowledge that is gained in the area of pharmacology is dependent entirely upon animal work and animal experimentation. Therefore, I submit that in 1977, if I had a drug that produced papillary necrosis in 30 per cent to 40 per cent of animals, that food would have great difficulty in being accepted for use by humans, by any health-regulating body. Therefore I suggest that the professor's view is not valid.

2197. Our terms of reference refer to drugs of dependence. A submission that has been made to the committee denies that mild analgesics are drugs of dependence. What is your opinion?——W. What I wish to say is purely my personal opinion but it is based on a wide experience in this area both in research and with patients. If one defined dependence as a situation where a patient continued to take large quantities of a drug for no obvious medical reason and he gets a lift from them and that on stopping that drug he goes through withdrawal symptoms, then the compound analgesic, which may be Bex or Vincent's, is a drug of dependence. The reason is that these patients conform fully to this definition of drug dependence. I think statements such as the one you have read do not really have any scientific basis.

2198. I understand that analgesic-induced renal disease first became a significant factor in mortality tables in Queensland and New South Wales about 1960; did you play any part in the discovery of this association between analgesics and renal mortality?——W. Not in the 1960's. I have made significant contributions to the understanding of this problem after 1960.

2199. Are you aware of how this association became obvious?——W. The association between the abuse of headache powders and analgesics and kidney disease was first brought to the attention of the medical world in 1953 by Spuhler and Zollinger in Europe, and when they became recognized the Australian medical people started looking at their own experience. Pathologists, mainly at Sydney Hospital and Brisbane, then became aware of this characteristic form of kidney change which had been there, I am sure, for years before that but was not recognized. For that reason I think it was the awareness introduced by Spuhler and Zollinger in 1953 that led to our scientists looking at the problem in this country.

2200. We have been informed that 16 per cent of the adult females and more than 10 per cent of the adult male population in Queensland take analgesics every day but that the rate of abuse by the female preponderance disappears as one moves round in Australia in a clockwise direction, towards Western Australia. Have you any theory as to the reason for this decline?——W. That fact appears to be correct and is supported by the fact that terminal kidney failure also follows the same pattern, that more than 70 per cent of all terminal kidney failure is from Queensland and New South Wales. I understand from a medical report by Dr Duggan, my colleague, in a journal recently, that this may be associated with the fact that compound analgesics are sold largely in those two States, Queensland and New South Wales, much more than in other parts of Australia. If that is true and if this sort of evidence can be made available by the pharmaceutical industry, I suspect one would find that the high prevalence of this disease in those two States is in relation to the accepted use of these compounds.

2201. If that is true have you any theory as to why there should be no more sold in those two States?——W. You have asked me for a theory, an hypothesis or opinion. I am prepared to give it, but I have no scientific evidence to support it. I think that it would be related to aggressive marketing and advertising there. One would have to have evidence from the pharmaceutical industry in relation to advertising campaigns and costs in those States compared to the other two States. Climate may be a factor but I think it would be small as a factor. The major factor is the marketing factor in those two States in relation to the other States.

2202. It was said in the submission from the society that in the three most heavily-populated States where surveys were carried out, both in the capital cities and in country towns, no difference was apparent between metropolitan and rural populations: Do you know whether Newcastle was included in the survey? If so, was it included as a metropolitan area or as a rural area?——W. I do not think that Newcastle was included but recently I allowed an organization in Newcastle called Datex to have access to my patient experience. Analysis of the data from my unit suggests that the problem is similar both in metropolitan Newcastle and in the more rural areas, if one can call Cessnock and Kurri Kurri a little more rural than metropolitan Newcastle. In other words, the experience, though small, in relation to patients supports and follows the experience published from other community studies in Australia.

2203. Bex and Vincent's have been taken by more than two-thirds of the people habituated to analgesics. Both are produced in powder and tablet form. We have evidence that powders have a different effect from the tablets. Would you care to explain the difference?——W. The only difference is that the powder contains twice as much of the components as the tablets. In other words it has a double effect. Apart from that there is no significant difference whether one takes the compound analgesic in the form of a mixture or tablet. In Europe the habit is almost entirely for tablets and not powders.

2204. The powder would be absorbed into the lining of the stomach a little quicker?——W. One would think so but I am not aware of scientific evidenec that has looked specifically at that factor but I do not think it would be important.

2205. Bex replaced phenacetin with paracetamol. Do you know why?——W. I know no reason except for the fact that attempts have been made to suggest that the replacement of phenacetin by paracetamol will make the powder safe—I have provided evidence today that scientifically that is not right.

2206. Have you any evidence why Vincent's replaced phenacetin with salicylamide in 1967?——W. I have no evidence why. I do not think that their reasons were published but the replacement of phenacetin was probably related to the misconception in the early days that the whole problem of analgesic disease was related to phenacetin and this may have been an attempt by the industry to make the powder appear a little more safe.

2207. Single drug tablets of aspirin or paracetamol alone are preferred to the combined preparation by about a quarter of the people who take them every day and less frequently. Would you agree that a single agent tablet can be just as effective as one containing two or three compounds?——W. For the treatment of medical ailments, yes.

2208. Reference has been made to headache and withdrawal symptoms caused by caffeine and phenacetin. Have you done any research in relation to this matter?——W. No, no specific research apart from observing this experience in 500, over consecutive patients.

2209. Are you aware of any education programme carried out to prove that recurring headaches are more often a result than a cause of dependence on analgesics?——W. Not personally.

2210. In one of your slides you referred to the association of headache powders with tobacco smoking and alcohol. Would you elaborate on that?——W. The habit of headache powder intake by patients also appears to be associated in those patients with a habit of smoking and alcohol intake and, in some cases, the use of laxitives. All of these I take as a reflection of the psychological disturbance present in these patients.

2211. On 26th April a statement was issued by the acting-chairman of the National Health Medical Research Council regarding the recommendations on the use of analgesics. Are you acquainted with that statement?——W. Yes.

2212. Do you know the main recommendations in it? ——W. Yes.

2213. Do you agree with the recommendations?——W. Wholeheartedly.

2214. One submission that we have received suggests that the answer to the excessive usage of analgesics by a minority group lies in consumer education rather than restrictive legislation. Apparently you favour restrictive legislation rather than consumer education.——W. I would. I have shown evidence today that the medical consequences and the financial implications of analgesic abuse are very heavy in Australia and in this region. There is no evidence to suggest that an educational programme will have any impact on reducing the incidence of the analgesic syndrome and kidney failure related to it. The facts are simple: if patients stop taking analgesics they will improve and the logical way to do it is to remove the analgesic compound from easy access to the public.

2215. Do you think that would be an inconvenience to the general public, in addition to the extra cost?——W. I do not think so because single analgesics which are effective in the relief of pain would still be readily available.

2216. If they are going to be put up in special packs that would increase the cost, will it not?——W. I suspect that it would. I have no expertise in that area but I think the price that one has to pay for them is readily offset by the fact that I have demonstrated that the significant mobility and mortality related to the abuse of analgesics is such that it appears to be unrealistic on the part of the community on the one hand to support heavily financial programmes for the treatment of terminal kidney failure when it should be preventing terminal renal failure.

2217. We have been informed that interested parties are willing to co-operate further with the New South Wales Health Commission in any education programme designed to achieve the enlightened use of analgesics. Are you aware of any such programme in relation to the non-opiate analgesics in this area or in New South Wales?——W. I am not aware of any programme current in this region. The analgesic working party set up by the Regional Director of Health had planned to undertake such a programme but now wholeheartedly welcomes the recommendations of the National Health and Medical Research Council to place restrictions on compounds being abused by the community.

2218. Does your experience suggest that an education campaign linked with more stringent osbervance of safety standards would be sufficient for the marketing of such products?——W. I do not think that there is any published experience from elsewhere in the world that is going to provide us with guidance or evidence in relation to such a proposition. I can only say from my knowledge in this area that restriction of the addictive analgesics or analgesics that are abused will ultimately lead to a reduction of kidney failure coupled with an education programme. This primary intervention by legislation or regulation would probably have a greater beneficial effect.

2219. The safety of all medications is prescribed and controlled by regulatory agencies both federal and State and proprietary medicines and analgesic firms must conform to adequate safety rules for over the counter sale: is there any legal reason why these long-time safeguards should be varied?——W. The so-called long-time safeguards do not appear to prevent a vast cross-section of the community from abusing analgesics leading to considerable medical strife. Therefore the so-called long time safeguards at present are ineffective. That being the case I feel that additional regulations need to be brought in to reduce the consequence of abuse of headache powders and these should be along the lines recommended by the National Health and Medical Research Council.

2220. Do you know of any evidence to suggest that abuse of powders of this type could have any effect genetically?——W. There is some published animal work which suggests that abnormalities of the foetus are seen much more in animals given aspirin containing compounds but human support for that evidence to my knowledge is not present. It may be that some other member of the working party may wish to comment on that later. Another work suggests that salicylates may result in foetal abnormalities.

2221. You have mentioned that it is estimated that 10 per cent of the population here takes at least one powder a day. You mentioned about 50 000 yet you see only 100 new patients a year. In the light of those figures do you think that the cost involved would justify the imposition of these restrictions?——W. I do not see all the disease associated with headache powders in this region. I see only the severe and end stage effects of analgesic abuse.

As I indicated earlier, the analgesic syndrome shows up in many different ways in different parts of the body, and therefore a lot of patients affected by it rightly are going to other medical practitioners in the region. No survey has been done to cost the effect of this on the community, but I am led to believe from the evidence I have given today that there is sufficient ground to place a restriction on the free sale of compound analgesics.

2222. It has been put to us that despite their presumed ready availability in the home, analgesics pose a comparatively minor problem when compared with other medicines, and in particular with common household materials. In the light of that submission we have to consider whether we would be justified in supporting the recommendations that have come from the National Council. Would you comment?——W. I do not agree with the statement that it is a minor problem because the use of analgesics is leading to significant terminal kidney failure in the community.

2223. How many patients are you treating either in hospital or as out-patients?——W. Every year I see approximately 300 new patients, of whom 100 have come to me because of headache powder abuse. Of that 100, approximately 15 go into terminal kidney failure and require treatment on kidney machines or transplants. That is a direct result of analgesics abuse.

2224. The Australian Kidney Foundation's figures indicate that new patients needing dialysis owing to analgesic nephropathy amount to about seven per million of the population each year. Those figures would relate only to what you classify as terminal cases, would they?——W. Yes.

2225. But many others need treatment?——W. That is true. For example, in our own hospital I would see 100 new patients each year who require constant treatment and supervision at hospital clinic level. Of that 100, about 15 would seem to go on into terminal kidney failure and require dialysis or transplants. Therefore, there is a much larger percentage of the population who do not have terminal kidney failure but would currently be being looked after regularly by hospital clinics or by their family general practitioners.

2226. Mr WOTTON: Why is Australia the greatest headache powder-taking nation in the world?——W. I cannot provide scientific evidence in answering that question, but I have attempted to provide some of the answers in the light of my experience and knowledge in this area. The reasons include widespread advertising. The advertising is overt and flagrant in Australia. Such advertising is hardly seen in other parts of the world. Second, I have intimated that headache powder-taking appears to have become a socially accepted form of behaviour in the Australian community, principally among middle-aged women, and that the habit goes back at least as far as 1907. Third, there seems to be some link between the lower socio-economic group and the abuse of analgesics. This may have some influence in the Hunter region, but it does not necessarily explain the national problem. Fourth, I have provided evidence today that the abuse of analgesics seems to be more prevalent in the Anglo-Saxon ethnic group, and that seems to explain the prevalence of the condition in the Hunter region, but may not necessarily explain its prevalence in Australia. So, in answer to your question, I can say only that scientific data is not available, but I have given good reasons which I think are probably operative.

2227. CHAIRMAN: At this stage we propose to vary the procedure somewhat. I wish to interrupt the further questioning of Dr Nanra to give him an opportunity to introduce a patient of his who has volunteered to come here and give some evidence, and then to hear Dr John Duggan. After that we shall hear representatives from the Hunter District Medical Association, who have been kind enough to change their own programmes to come here to help us. Then this afternoon we shall return to the questioning of Dr Nanra and Dr Duggan.

2228. Dr NANRA: Mr Chairman and members of the committee, I should like to introduce Mrs Cronin, who is a patient at the Royal Newcastle Hospital. She developed analgesic nephropathy, had treatment on the kidney machine, and subsequently had a successful kidney transplant. She is willing to answer any question that your committee may want to put to her so that you may learn at first hand the effects of analgesics on the individual.

2229. CHAIRMAN: Thank you, Mrs Cronin, for volunteering to come before the committee. Have you any objection to your name being published?

2230. Mrs CRONIN: No, not at all.

2231. CHAIRMAN: Would you give us a brief history of your association with headache powder abuse or the abuse of analgesics generally, and tell us what has happened to you more recently?

2232. Mrs CRONIN: I started taking powders when I was 13. I used to take two a day. When I was 15 I went into a clothing factory and all the girls there and myself used to take them all the time. When I was 18 I went from about six to about eight a day. By the time I reached 30 years of age I was taking 15 a day for what I thought were headaches. It was really just a bad habit. It was a case of mind over matter. When I got to 30 I had kidney failure, which meant I had to go on dialysis three times a week. Twelve months ago I had a kidney transplant. It is working well now. What I would like to see is powders taken out of the supermarkets. I think that if they had not been displayed and easy to buy, and that if a doctor's prescription had been required, I would not have taken so many powders in the first place. We could go into a shop and say, "I want a box of Bex" or "I want a box of Vincents" and they would hand them over. If you had to have a doctor's prescription, I am sure we would not have been able to take as many powders as we did. I would really like to see them taken out of the supermarkets, if you could do that.

2233. CHAIRMAN: How long is it since you had your kidney transplant?

2234. Mrs CRONIN: Five years ago, and it is going well.

2235. CHAIRMAN: You are now in your mid-30's, are you?

2236. Mrs CRONIN: Yes, I am 36 now.

2237. Dr NANRA: May I ask Mrs Cronin a question?

2238. CHAIRMAN: Yes.

2239. Dr NANRA: Mrs Cronin, what happened to your headaches when you stopped taking powders?

2240. Mrs CRONIN: I still get headaches but I do not take powders.

2241. Dr NANRA: Are the headaches similar to what they were before?

2242. Mrs CRONIN: Yes.

2243. Dr NANRA: Are they as bad as they were before?

2244. Mrs CRONIN: Yes, but now I lie down and put a damp washer over my head and they go away in time. If I had known years ago what Vincent's do to my kidneys, I would not have taken them, and I am sure many of my friends would not have taken them either.

2245. CHAIRMAN: Have any of your friends had similar effects?

2246. Mrs CRONIN: Yes, but they did not get to the stage of having kidney failure, and needing a transplant. They stopped just in time.

2247. CHAIRMAN: Did you ever put a powder on your sandwiches?

2248. Mrs CRONIN: No, nothing like that, but in the end I was taking three Vincent's for breakfast. You get to the stage where you do not want food. You prefer to take a powder in place of your food.

2249. Mr MACDIARMID: When you went into the factory at the age of 15 did you take the powders because of the noise or did you take them to give yourself a lift, and did that apply to the other girls, or what was the reason?

2250. Mrs CRONIN: It was the noise too, but it was just a habit. Nearly every one in the clothing factory takes powders. It is like having a glass of water; when you have a glass of water you take a Vincent's or a Bex. It is just the same as with a person who smokes or has a drink.

2251. Dr NANRA: Did you try taking any other pain killer, like an Aspro or a Panadol?

2252. Mrs CRONIN: No.

2253. Dr NANRA: Why not?

2254. Mrs CRONIN: Because they did not sell them in the factory. They just sold Bex and Vincent's.

2255. Dr NANRA: When you were in the factory did you have to buy them or were they given to you?

2256. Mrs CRONIN: No, we had to buy them. They were threepence then.

2257. Mr MACDIARMID: You thought the powders would fix your headaches because you had read an advertisement somewhere saying that Vincent's or Bex would fix it?

2258. Mrs CRONIN: Yes. It says on the back of the powder to take only one or two and then to see your doctor. That is what we should have done but did not do. We would take one and it would give you a lift. There is something in the powders that gives people a lift. It sounds funny but it is true. If you have not taken them, you would not know. When the effect wears off you take another one. I got up to 15 a day and was having kidney fits and the doctors did not know what was causing them. Then Dr Nanra found out that I had kidney failure.

2259. Mr MACDIARMID: Was there a vending machine into which you put a coin and got out the powder?

2260. Mrs CRONIN: No, they were in a plain box; we just go and buy them. I worked in a factory last year and I told the girls there to take notice of what I went through. Their attitude was that it would not happen to them. Some of them would say, "I take only three a day". That is how I started and then it got up to fifteen a day.

2261. Mr WOTTON: Were you the only girl taking fifteen a day?——W. I could not say that.

2262. Mr JACKETT: Why did you take Vincent's rather than Bex?——W. I have never had a Bex. I think it was because they were there.

2263. Did most of the people working at that factory take those powders?——W. At every factory Vincent's are taken. I do not know if it is stronger than Bex or what the reason is. They all seem to be taking Vincent's.

2264. Mr RAMSAY: I suppose that when you work in that type of industry you would be under a certain amount of pressure and you would become fatigued. Would that cause you to want to take these powders?——W. That was the case with me. I had a responsible job and I was under a lot of pressure.

2265. Mr McGOWAN: Why do you think the foreman kept the box of powders on the desk?——W. She was probably making a profit out of them.

2266. Even if she were not making a profit, do you think she would have kept them?——W. Yes. A lot of girls suffer with migraine and instead of going to a doctor they would rather take a Vincent's powder. I have never had a Bex but they were there to be obtained.

2267. Mr HEALEY: You were still at school when you started taking these powders. Did you take them at the suggestion of your parents? How did you start off taking these powders at that young age?——W. My mother and my grandmother took a lot of Vincent's powders. If anyone had a headache they were given a Vincent's powder. They told me not to take too many of them but they said that one a day would not hurt me. The problem really started at home.

2268. CHAIRMAN: Did you take them for headaches originally?——W. Yes.

2269. Have you suffered from headaches all your life? ——W. I have not had a Vincent's powder for seven years and I get very bad headaches. I know the damage that these things have done to me; they have caused a lot of misery but I woke to myself in time.

2270. Have you had any medical advice as to why you still get headaches?——W. Yes, I get some relief now from wearing glasses but at times I feel as though I would like a Vincent's but I am not game enough to take them.

2271. Mr WOTTON: Can you lead a normal active life now?——W. Yes. There is nothing that we cannot do.

2272. Except have a drink?——W. Yes.

(The witness withdrew.)

*Witness*—J. M. Duggan, 5 May, 1977

JOHN MALCOLM DUGGAN, a Physician, residing at 33 Hebburn Street, Hamilton, sworn:

2273. CHAIRMAN: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. Yes.

2274. I understand that you wish to address the committee largely in relation to your experience with analgesics and their effects in your practice?——W. Yes. My major interest is with diseases in the digestive system, particularly the stomach. I propose to give an historical background about my interest in this field. I shall not deal with kidney diseases which have been well covered by Dr Nanra. I shall be using slides (exhibit "5"). In 1960, following my interest in bleeding from the stomach, I started to study patients who had been admitted to Royal Newcastle Hospital with that condition. In that work I made a study of 1 634 cases. One of the aspects I looked at was the question of patients taking aspirin just before having a haemorrhage.

2275. In 1958 a study in England had suggested that about one-third of patients who had a haemorrhage from the stomach had taken some form of aspirin in the past forty-eight hours. For that reason I looked at this question. When I looked through a patient's record and talked to him, one of the things that became obvious to me was that not only were patients who had stomach bleeding taking aspirin just before the bleeding but also a lot of them seemed to have gastric ulcers. A lot of these patients were women. A lot of them were taking aspirin in the form of APC's pretty regularly.

That study leads to the present situation where Dr Morton Gassman, one of the foremost gastric physiologists in the world, has reported that he can produce ulcers with aspirin in rats. He concludes an article by saying that there is now strong epidemiological evidence of persons who consume large amounts of aspirin having an increased incidence of gastric ulcers. This is different from the apparently spontaneous gastric ulcer. There seemed to be this association in 1960. Now it is recognized internationally that aspirin taken in large amounts causes ulcers. Studies have been carried out in Newcastle, Sydney, Townsville, Adelaide, two American States and Boston, all of which show that people who take aspirin regularly tend to develop gastric ulcers more than people who do not take them.

My studies in this field have been hampered seriously by a lack of data on the consumption of analgesics. I have got letters dating back to 1961 when I tried to get information from the Commonwealth Department of Trade and the Commonwealth Department of Health, and the Board of Trade in Great Britain. I was trying to get some reasonable data on the consumption of analgesics. I did this in order to try to elucidate something about this conundrum and I have received very little help. The most help I have been able to get consists of some references from the Commonwealth Health Authorities, which I shall refer to later.

I propose to examine twelve aspects in a particular outline of this association and I shall touch upon some of the regional differences in analgesic consumption which I think are important. I shall ignore largely the kidney aspect. First, there was an epidemic of gastric ulcers which began in New South Wales and Queensland about 1943. This epidemic was related to the continued use of certain aspirin containing preparations. These aspirin preparations are generally taken in the form of APC's, in fact in about 80 per cent to 90 per cent of cases. At times people who take APC's take vast quantities, in non-therapeutic amounts. An aspect that is often ignored is the fact that patients taking these preparations are often untruthful about their consumption of them when they speak to their doctor. However, we now have methods available to us that enable us to detect analgesic abuse even though the patient swears that he is not taking them. I have pointed out that aspirin taken alone is a safe drug. I should like to produce evidence that caffeine has no pain-relieving qualities. I should like to produce evidence also that caffeine taken in excess causes headaches. Such a headache is relieved by further caffeine.

This leads me to the conclusion that caffeine is probably the reason for the abuse of analgesics. I should like to touch upon the subject that Dr Nanra has mentioned, that the people who abuse analgesic powders get multiple effects. It is not only a question of kidneys; it is a question of stomach symptoms and indeed multiple problems. I have a lot of data here. I should like to refer to the great geographical differences in the consumption of analgesics, unrelated to the need for pain relief. I propose to show you some slides about this. The first slide indicates the sort of condition I am talking about, that is an ulcer in the stomach. I looks something like that on an X-ray. Sometimes it penetrates adjacent organs and sometimes a patient will die as a result of this condition. I emphasize that people may develop this type of ulcer without taking aspirin. My point is that people who take large amounts of analgesics are more likely to get an ulcer and it is in fact slightly different—more than slightly different—from the spontaneously occurring ulcer to which all of us may be prone at some time of our life. Dr Billington, in Sydney, was the first in about 1960 to draw attention to this epidemic of gastric ulcers. He looked at 1 388 inpatients in Sydney hospitals. It has been found that a male is most likely to get an ulcer at about the age of 60; that is the standard throughout the world; it is a disease in an older person. An older person, a male, is most likely to get an ulcer throughout the world, with one exception and that is in a fishing village in Norway where women are more likely to get an ulcer than men. Wherever one went throughout the world, one would expect the shape of the curve to be like that in respect of females. There should be two or three or four men for every woman in those statistics. However, in Sydney hospitals it was found that there were many younger women with gastric ulcers. This was between the years 1946 and 1955.

That is just part of a mass of data he produced. It showed, by looking at the figures, that an epidemic has begun about 1943—in 1943 in New South Wales and about that period in Queensland of gastric ulcer affecting women in middle age. He was unable to say why but was able to say it has something to do with the environment, something women did produced the ulcer. This provoked me to look at the local figures for bleeding gastric ulcers in the Royal Newcastle Hospital. We looked at males 50 to 59 and that is the biggest group affected. With females there was this hump again of women 30 to 40 and 40 to 50. In our community this phenomenon is present. There was an epidemic of gastric ulcers in middle aged women. This was a conundrum I set myself to solve. This is data from a colleague of mine with whom I have worked on the problem. We looked at the evidence for perforation of gastric ulcers, a complication carrying about a 15 per cent mortality rate. In 1944 to 1950 there were nineteen males admitted with a perforated ulcer and five females. That is the figure that one would expect anywhere in the world. It is three or four males to every female. As to the age of the females, there were a few young, a few middle aged and one older. Seven years later the number of women had climbed from five to fourteen. There were

now ten middle aged women but the number of men was the same. Seven years later the number of men remained approximately the same 19,18 and 23 but the women had climbed from five to thirty and included fourteen middle aged. The epidemic is a real phenomenon. These people have a one chance in seven of dying of this complication.

A number of studies ensued. I was given some statistical data about the aspirin intake—I looked at many hundreds. This is a study done with a colleague, of about 295 patients and if we look at people with duodenal ulcers slightly more take aspirin in some form or other regularly than take none. But with gastric ulcers the majority take aspirin regularly. The chances of that being just a random finding are only five chances in a thousand. That is a significant association. We looked at the perforated ulcer, bleeding and the uncomplicated ulcer and having run the gauntlet of disbelief from my colleagues initially we found that people in other parts of Australia started to look at the problem. Doctors at the Royal Prince Alfred Hospital looked at 100 patients admitted there with gastric ulcers. They compared them with patients in the same ward without a gastric ulcer. This slide summarizes some of the figures of the males with gastric ulcers. Fifty per cent took aspirin regularly—daily. Of the females, three-quarters did. When they looked at the patients without ulcers they found that only 22 per cent did. That highlights the prevalence of analgesic taking in the community. For the non-ulcer people, on this line, five took it regularly but threequarters of the women did, as I have said. They found that more of the gastric ulcer patients took aspirin. There was only a chance in a thousand that that would have occurred by chance. They took an average of 6.1 doses a day over a longer time—twelve years. These are significant figures. They are most unlikely to be random finding. I shall not go through the other Australian figures but by now there was a little interest in this overseas. Dr Cameron of the Mayo Clinic had difficulty getting this data published because they did not believe it in America. He took outpatients attending the Mayo Clinic who were well documented. There were forty with gastric ulcers and ten with duodenal gastric ulcers and twenty-five duodenal ulcer patients. Dr Cameron showed that even at the Mayo Clinic 45 per cent of the patients with ulcers were taking aspirin—two doses a day. On his controls, that is the non-ulcer patients, only 8 per cent. Likewise with other ulcers the percentages were lower. There is only one chance in a thousand that that figure could occur in a random fashion.

There is a slide here that will be of interest in our deliberations. He looked at seventy-five controls—patients without ulcers. Only six of them—8 per cent of seventy-five—were taking aspirin regularly. This highlights that Americans do not take much analgesics and that we have more analgesic nephropathy. The average American is less likely than the average Australian to take them. In the Boston collaborative drug study involving nearly 15 000 patients it was shown to a significant degree that people with gastric bleeding or uncomplicated ulcers are more likely to be taking aspirin regularly, in whatever form it is —simple or compound. A small segment of this is of some interest. There is a condition called Hour Glass Stomach where the stomach is constricted with a wasp waist effect from the severe chronic ulcer. That condition has been known for the past 60 years. It affects women more than men. It is known to be rare. We have seen seventeen cases. As has been reported overseas there were more women than men. When we looked at the patients each one was an analgesic abuser. Six had analgesic nephropathy. This highlights that analgesic abuse is likely to cause severe complicated ulcers.

May I touch upon the question of the analgesic syndrome that has been mentioned. This is the collection of symptoms and signs that affect people who take large amounts of analgesic for a long time. In looking at seventy-five people who have ulcer and kidney disease and take analgesics, of the seventy-five that I have observed personally there were five women to one man only. They are predominantly middle aged. We find that the majority of them—fifty-six of the women—take more than two a day. Everyone of the men took more than two a day. In fact, none of them admitted to a small dose. The majority admitted to more than two a day. There were six from whom we could not get the truth as to how much they took. I shall touch upon the subject of the truth of the patient's statements. Forty-eight of the seventy-five took APC. There was one patient who admitted only to taking aspirin on its own. There were another twenty-six who took a mixture. This slide is rather like an earlier one. They generally take Bex or Vincent's or a mixture or sometimes we never get to the real truth of what they have been taking. By testing the blood we have to find out that they were taking them but did not enable us to identify the compound. The seventy-five patients had, in general, been taking the compounds for many years—seventeen for more than twenty-five years. The person with the analgesic syndrome is more likely to be a female, take more than two a day and over a long period of time—not somebody taking aspirin for a week for a backache, but large quantities of drugs over a long time. I emphasize this: of the seventy-five there were thirty-two who at one stage denied doing so. That is an aspect that must involve the committee. Those people looked a doctor in the eye and said "I do not take APCs", but we were able to demonstrate chemically or by talking to a member of the family or in some other way that they were doing so. The fact that the patient is secretive about it highlights the question of abuse of a drug rather than simple use for a legitimate reason. These people are sick. Between them the seventy-five people had 346 admissions to hospital. I believe that that figure is of some relevance to the taxpayer.

May I turn to a more specific examination of some of the figures. We now have in this area data that is unique in the world. A study has been carried out with the collaboration and support of all doctors in the area. We have information on every patient diagnosed as having a gastric ulcer in 1975–76. I emphasize how grateful I am to the medical practitioners in the area in co-operating in this way. We know that there were 144 women diagnosed as having gastric ulcer in that two-year period. We know that in the 30 to 39 year old group three-quarters of them were taking acetyl salicylic acid daily. In looking at the gastric ulcer we have the same sort of curve on the second slide. Middle aged women with gastric ulcers are most likely to be taking a preparation containing asprin. This is a minimal figure because some may not have been telling the truth. We can ignore the bottom line on that as it is not particularly relevant to us. Older women do not take aspirin daily. The people who get into trouble from it are not those with arthritis, rheumatism, fibrositis or spondylitis, they do not take enough—it is the young women with headaches who take it for no legitimate reason. In one study we did of about sixty-five patients there was only one woman taking it for a legitimate reason. The others were taking it for all sorts of pep and stimulant effects of the powders.

The next slide that I show highlights the matter further. Of those 144 women in Newcastle who had gastric ulcer, 18 admitted to taking more than five powders a day. They were predominantly middle-aged housewives. No older women were taking them regularly. The people you would expect to need them were not taking vast amounts.

*Witness*—J. M. Duggan, 5 May, 1977

The next slide deals with men. They did not take vast amounts of asprin. In fact, of the old men with an ulcer, none took large amounts of asprin. So there is a tendency for this problem to occur in men to a much lesser extent than in women. Again we see that 146 men were affected. So Newcastle has the unique distinction of having about the same number of men as women with gastric ulcer. Nowhere else in the world has this been reported authoritatively, with the possible exception of a small fishing village in Norway. We have an epidemic of gastric ulcer in this community. We have had an epidemic of gastric ulcer in New South Wales among women since 1943, and it is associated with the use of APC powders. Asprin taken regularly is associated with chronic gastric ulcer.

I should like now to touch on some of the geographical aspects of the matter. It is difficult to get good figures on the consumption of asprin-related compounds in various countries. The best figures we have been able to find suggest that in Australia the intake is 0.63 doses per head per day. I think that our statement contains a misprint, showing 1.63 doses. In the United Kingdom the intake is 0.33 doses, and in the United States of America it is 0.27 doses. So our figure is twice that of the United Kingdom, and more than twice that of the United States of America. The figures available from the computer in the Commonwealth Department of Health for 1964–65—which relate only to the pensioner medical service, there being no information available on prescriptions for non-pensioners—show that in New South Wales the rate of prescribing asprin-containing preparations was 3.2 times the rate in Victoria. I do not know whether that means New South Welshmen get more pain that Victorians.

At this stage I should like to refer to a statement made in a letter written to the *Australian* newspaper by a Mr P. N. Daddo, vice-president, Nicholas International Limited, Melbourne, and published in the issue of 14th March, 1977. In his letter the writer said:

> The statement that people with kidney failure regularly took powder compounds containing codeine, phenacetin and caffeine is nonsense. There are no such analgesic powders available in Australia either in pharmacies or on open sale and it is doubtful that such a combination has ever been available.

The Commonwealth Department of Health's figures show that in 1964-65 aspirin plus phenacetin plus caffine plus codeine was prescribed to the extent of 192 000 prescriptions under the pensioner medical service in New South Wales, and 25 000 were prescribed in Victoria. Those figures suggest that more than 200 000 such prescriptions were prescribed in New South Wales and Victoria, and that Mr Daddo was not telling the truth.

In 1961–62, under the pensioner medical service, 897 625 prescriptions for either codeine plus aspirin or codeine plus aspirin plus phenacetin, or codeine plus phenacetin plus caffeine plus aspirin, were prescribed. Those figures exclude over-the-counter sales and prescriptions for other than pensioners.

The regional differences in Australia on this matter are quite striking. There were 366 000 such prescriptions written in New South Wales and 3 646 in Tasmania. That is, there were 120 times more prescriptions for these compounds written in New South Wales than there were in Tasmania. I do not have the population figures for New South Wales and Tasmania at that time, but I doubt whether there are 100 times more people in this State than there are in Tasmania. In fact, the figure is very much less.

So, in 1961 and in 1964–65 there were differences in the prescribing habits of doctors. This is part of the story of the regional differences in the usage of these drugs, for in 1961 nobody believed that APC powders could do any harm, and doctors prescribed them freely. I put to you the proposition that the medical opinion became translated into a community opinion.

Professor Bridges-Webb writing in the *Medical Journal of Australia* on the 20th November last, at page 805, pointed out that according to official figures in New South Wales, which had 37 per cent of Australia's population, 52.5 per cent of analgesic sales containing caffeine were made; and that concerning analgesics containing caffeine, the State of Victoria with 27.5 per cent of Australia's population accounted for only 13.7 per cent of those sales.

Having touched on caffeine, and working on the basis that the committee is not interested in my opinion but rather in figures, I should like to quote from a textbook entitled *The Pharmacological Basis of Therapeutics,* by Goodman and Gillman, 5th edition. This is the standard textbook on pharmacology. Turning to the subject of caffeine, one finds the following statement:

> "Caffeine is a powerful central nervous system stimulant. Caffeine stimulates all portions of the cortex."

That is the working part of the brain. The authors then go on to say:

> "Its main action is to produce a more rapid and clearer flow of thought and to allay drowsiness and fatigue. After taking caffeine one is capable of greater sustained intellectual effort and more perfect association of ideas."

When I look in this textbook by Goodman and Gillman for the effects that caffeine has, I find that it deals with the effects on the central nervous system, the cardiac system, the muscular system, gastric secretion, the kidneys, and metabolism, but I find nothing to say it has any effect on pain. Caffeine has no effect in giving relief from pain. The major function of caffeine is to make the person who takes it feel better, and that is why we enjoy our cup of tea or coffee.

However, there is a catch. As long ago as 1943 Dreisbach and Pfeiffer, writing in the *Journal of Laboratory and Clinical Medicine* (1943), No. 28, 1212, reported on some experiments they had done. They gave caffeine in a dose equivalent to about six APC powders, namely 780 milligrams, to normal subjects. They gave them these doses for about a week, and then stopped. During this week the people concerned felt better, but as soon as the doses were stopped, something happened; they developed a headache. If I might quote from the report, the authors say:

> The symtomatology of the headache is remarkably constant and may be summarized as follows:

I think that Mrs Cronin was describing something of this sort.

> On the day of withdrawal lethargy was usually noticeable in the morning, while a feeling of cerebral fullness occurred about noon. Actual headache usually began in the early afternoon and reached a peak three to six hours later. The subjects localized the headache as occipital or central at the onset, which then, in most cases, became generalized and throbbing in character.

The authors say a little later on:

> Headache produced by caffeine withdrawal was found to respond to treatment by caffeine or aspirin.

This is the central issue on which we must touch here. We have a situation in which people are taking six, ten, fifteen or twenty doses of caffeine a day, and as soon as they attempt to stop taking it, they get a severe headache. It has been known for nearly 35 years that such a headache is relieved by a further dose caffeine-containing preparation. So these unfortunate people are totally hooked by the preparation. They need caffeine to relieve the headache produced by caffeine. Meanwhile, other constitutents in the mixture—and I do not think we need concern ourselves with whether they are aspirin, phenacetin, Panadol or whatever—are wrecking their systems. The evidence is overwhelming that aspirin damages the stomach and the kidneys. Aspirin is taken because of the caffeine content. Caffeine has no role in analgesics and abolition of the APC compound would relieve this situation and would abolish the side-effects about which I have been speaking.

2276. CHAIRMAN: We shall now suspend the questioning of Dr Duggan until some time later in the day after taking evidence from the representatives of the Medical Association.

(The witness temporarily withdrew.)

LEON CLARK, an Obstetrician–Gynaecologist in private practice in Newcastle, residing at 24 Carisbrook Avenue, Kotara, sworn and examined:

2277. CHAIRMAN: Did you receive a summons under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. I did.

JAMES NICHOLS, Consultant Psychiatrist, residing at 660 Pacific Highway, Belmont, sworn and examined:

2278. CHAIRMAN: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. Yes.

DAVID CHARLES WALLACE, Consultant Cardiologist, residing at 24 Victoria Crescent, New Lambton Heights, sworn and examined:

2279. CHAIRMAN: I understand that you gentlemen are here representing the Hunter District Medical Association?——W. (*Dr Nichols*) That is correct. I have prepared a submission which, with the leave of the Committee, I shall read. It deals with drug abuse in the Hunter Valley area and it looks at the problem from a consultant psychiatrist's point of view.

Every community in the world has always had problems with abuse of drugs. Drugs can be abused by taking them in excessive quantities when not prescribed, and by not taking them when prescribed. The particular pattern of drug abuse in any community is determined by many factors, one of which is ethnic. The pattern of drug abuse in Newcastle, however, has certain distinct features, the abuse of analgesic powders being of undoubted high incidence in this community. One factor intensifying this is the misleading advertising which has gone on for many years in the news media.

It is considered that the advertisements for APC powders are grossly misleading and have intensified their abuse, that is, the first line of treatment for a headache is not chemotherapeutic; most headaches resolving spontaneously if the patient assumes a relaxed posture. Headaches are also very responsive to almost any form of psychotherapy. The continued presence of headaches usually indicates an underlying personality disturbance which has intensified as a result of intercurrent stress; the headache therefore is a valuable warning sign that the person needs some form of psychotherapeutic intervention, combined with instruction in relaxation techniques. This method of therapy is readily available under Medibank, and is highly effective. Treatment of headaches *en masse* by advertising chemotherapeutic agents must be considered to be obsolete.

The abuse of aspirin is to be seen also in the context of the abuse of other drugs. The commonest drug of addiction in this community, as in nearly all others, is concerned with the excessive consumption of alcohol, and it is considered that the committee's terms of reference should be broadened to include this important drug of addiction. Abuse of drugs has one advantage in that it highlights psychological stress, and it is considered more important to focus attention upon the various stresses to which people are subject, rather than to treat the drug dependence *per se*. This practice has kept, with the aid of the Department of Economics at the University of Newcastle, reasonably accurate statistical records of the stresses which occur in this district. Stress in the area of interpersonal relationships within the family setting is undoubtedly the most significant and most prevalent. This form of stress highlights the importance of personality weaknesses, personality development, and personality clashes, especially within the family setting. A large percentage of the patients seen here have experienced sustained emotional deprivation during the childhood and formative years, which means that the incidence of drug dependence reflects fairly accurately the amount of childhood deprivation occurring in the community.

It is earnestly recommended that in the funding of programmes for treatment and prevention that this point be remembered. Drug dependence, then, indicates an underlying personality disturbance, and it is considered that these are eminently preventable. If all personality disturbances can be prevented by eliminating childhood emotional deprivation, their incidence will decline rapidly over the next 25 to 50 years. It is considered that, on economic grounds, prevention is highly desirable, considering the huge economic loss for such personality disturbances as alcoholism, which on its own costs the community $500 million per annum, rising by $50 million per annum. It has to be borne in mind that this is only one of the personality disturbances, and on my estimation is not the largest, so that the potential saving by the manner as mentioned is huge.

2280. Dr CLARK: The evidence I propose to present is not of a statistical nature; it is rather of a personal nature. I should like to speak specifically of caffeine addiction. I have been associated with a group therapy programme for the past six or seven years. This scheme is designed to help people to give up smoking when they wish to do so. The programme has been called a five-day plan and you may be familiar with it. In this plan we encourage a participant to also stop drinking tea and coffee during the time they are part of the group. We also like to involve a spouse. They have to come along to these group therapy sessions. We encourage them to give away the use of substances that we encourage the participants not to use. An interesting fact arose early in my association with this work. It was found that when the spouses of participants gave away tea and coffee they had very much the same symptoms as those who were

giving up smoking. Two of the most common symptoms they experienced—and I would say that these symptoms are almost universal—were drowsiness and headaches. The headache pattern corresponds with the one that Dr Duggan mentioned in the work he quoted. It generally lasts for about two days. This was of interest to me because obviously those spouses were not giving up smoking; they were simply giving away tea and coffee.

Another comment that is frequently made by people who are giving up smoking is that they have these same symptoms that last for about two days. One interesting comment they often make is that it was harder for them to give away tea and coffee than to give up smoking. The craving for tea and coffee was greater than it was for cigarettes. My experience is that caffeine is a drug of addiction. It is not just a drug of addiction as in APC powders. I do not know whether it is appreciated, but the dose of caffeine in an APC is about 150 mls; in a cup of percolated coffee it is about 150 mls and in a cup of instant coffee it is about 80 or 100 mls. I believe from personal experience that caffeine addiction is probably the most widespread single addiction in this country. We all know about people, particularly housewives, who may have at least ten cups of coffee a day. I come in contact with many housewives in my practice. On many occasions when patients have complained of headache I have asked them to give up drinking tea and coffee to see whether this will help their chronic headache situation. In a proportion of cases this was successful. The other interesting thing was that they found it extremely difficult to give it up even though they were getting headaches, even though they were counselled with the fact that if they stopped their intake of caffeine, it would help. I stress that I am talking about patients who are taking large quantities of caffeine, taking at least ten cups of coffee a day. Many people find it difficult to give it up. My contention or opinion is that caffeine is a drug of addiction; there is a relationship between the intake of tea and coffee and the development of the habit of taking APCs.

That is a logical extension. It involves also an analgesic agent which helps with headache and they get hooked on that type of cycle.

2281. Do you know of any other adverse physical reaction that would be caused by caffeine apart from headaches?——W. Not a lot. I do not think that much work has been done on the effect of caffeine. Even the caffeine intake of people having a number of cups of coffee and tea which needs a lot of study in my view has been neglected. I have been trying to get literature on this. I have got some and I am still trying. It is only recently that I have taken a strong interest in this. There is evidence—I came upon an article that was part of the proceedings of the American Psychiatric Association of 1974 where they talked about a syndrome called caffeineism that is present in patients who take large amounts of caffeine. They stated there that the ingestion of large amounts may cause a whole range of psychiatric disorders but probably the most commonly seen one was a sort of anxiety neurosis syndrome. That is one of the commonest problems in the community and is related to the intake of sedatives and tranquillizers as well. So, we may be treating a drug-induced complaint with another drug. This area needs more study. I do not know of any really good work on it but I think it is something that should be looked into.

2282. Dr WALLACE: I am a consultant cardiologist but I am not speaking here in my function as a consultant cardiologist, I am speaking for the medical profession in the Hunter Valley by virtue of my position on the executive of the Hunter Medical Association. There are two points that I should like to bring up. First, the medical profession would not regard addiction to pharmaceutical agents as different from the two specifically excluded from the terms of reference. We feel that alcohol and tobacco are no different with regard to their addiction potential. Second, the medical profession in the Hunter Valley entirely endorses the views put forward by Dr Nanra and Dr Duggan so eloquently. The medical profession accepts it as the truth. We feel that in ignorance in the past we have helped to contribute to a community attitude because it was felt that APC was harmless and in the same way it was felt that tobacco and alcohol was harmless. That worries us. It came into the same category. However, it has been known to the medical profession and recognized generally by it and accepted by pretty close to 100 per cent of the medical profession now that APCs are addictive and harm the body. They harm particularly in three ways: In the twenties the addicts get problems with ulcers; in the thirties with kidneys and in the forties with coronary artery disease. That is where I come in as a consultant cardiologist.

I wish to put forward a few philosophical points that the committee should consider. First, our discussion has shown that human beings are very liable to abuse chemical substances that give them some sort of psychological effect. We are an addictive race. Anything that has any central nervous effect can be abused in that way. It is true that caffeine is addictive. I have no doubt about that whatever. It has been proved in micro organisms that caffeine is a mutagen so what it is doing to your chromosomes and mine, I am not sure. That is something that has to be looked into. Certainly the use of any of these drugs should not be encouraged. The second point I should like to make is that the damage produced by these substances can be both physical in the way we have heard about in regard to APCs and social. There are vast social problems associated with addiction. Let us talk about marihuana. It is not only the effect which might be mild, for all I know—I have no strong views on the matter—but the social connotations of addiction are all negative. The next thing we have to consider are factors that might be increasing drug abuse: they are peer group pressures and television. I do not think that the community quite realizes the enormous power of television in this nation. It is absolutely stupendous. I hate to think of the malign influence of television in this country. In the early days of television I appeared on a sort of a chat programme with the ABC and for weeks after when I walked out in the street—this was not in Newcastle but in a major capital city—people looked around and said, "I know that face"—after five minutes on television. General advertising is less effective but certainly has its damage. We used to see advertisements for Dr Morse's Indian Root pills on hoardings on the railway. That probably induced people to take them. The other sort of peer group pressure is conformity and hero worship. I went to the Messiah at the Cathedral last night and when it came to the Hallelujah Chorus somebody at the front stood up. Then the audience stood up and sat down again. Human beings conform. They conform in drinking tea and coffee. Others conform in smoking. That is hero worship. There may be somebody you look up to and if he abuses the drug you will. Community attitudes operate.

The other point is the matter that the committee will have to face that it is a grey zone. There are no black and whites. If you drink too much worcestershire sauce you can burn your kidneys out. But you would not feel it was a good idea to ban worcestershire sauce because some people use bottles of it instead of spreading it on

their food. On the other hand, no one would like heroin to be sold over a shop counter. We have to draw the line somewhere in the spectrum. It is not easy. There are inconsistencies that bother the medical profession considerably because here you have conflicting pressures. For instance, I gather that in Alaska you cannot buy saccharine over the counter but you can smoke marihuana legally. That is a rather silly situation. How much should one restrict legal medical preparations? Where does it begin to interfere with personal freedom. I do not have any answers. I do not think that my association has answers. There has been mention of the economics of the situation. The medical profession has a role. It has to take an attitude concerning restrictions for these drugs. We have pointed out that we subscribe to Dr Nanra's and Dr Duggan's statements on the matter about compound analgesics absolutely. We feel that they should be given only by medical prescription and not sold over the counter. It is questionable whether they should be given by medical prescription. On the other hand there is an economic aspect that enters into it. There is need for some pre-doctor self-care in the community. There are times when a person with an obsessive personality just cannot relax. I am sorry to say that I have taken acetyl salicylic acid today. I woke up this morning with a migraine and I knew I had to appear before the committee. I do not think there is any harm in taking aspirin once in a while. I do not think there is any great harm in allowing the general public free access to a certain limited range of medication that is effective. That is a philosophical point to be considered. It is also an economic point because if a patient has to go to a doctor at any time he gets a minor ailment the economic cost of that—what it puts into the pocket of doctors—is enormous. The question of individual versus community good comes up. I think that covers the propositions that the Hunter Medical Association would like to put forward. What is says, in brief, is that we subscribe in every way to the points put forward by Dr Nanra and Dr Duggan. We agree entirely. We feel sorry that our profession has to some extent in the past aided the development of the present situation. We wish to do all we can to prevent the situation developing and to abolish it, if possible.

2283. CHAIRMAN: Is there any educational campaign going on? Has it been going on through our association to alert doctors to the situation?——W. Yes. I doubt whether there would be a practitioner in this valley who had not had some contact with information relating to damage done by compound analgesics.

2283A. Have you had any experience with regard to opium and narcotics?——W. (*Dr Nichols*) Yes.

2284. In this area, with patients?——W. We have had a small amount with opiates. I returned from the United States of America in 1970. We treated 185 heroin addicts and did a statistical study of them. They were not heroin addicts—a pattern sort of emerged which is, I think, familiar. They were unable to secure heroin because of police activities and so went to chemists' shops, bought paregoric and concentrated their attention on it and became paregoric addicts. This was perfectly legal although it was a little expensive, the amount they had to buy. When I came to Newcastle the thing that amazed me was the price of heroin was then quite low, which meant that it was freely available in the streets. There were a few heroin addicts and we did start to treat some with methadone. We treated probably about four or five with methadone and I got into the problems of treating addicts in Australia with methadone and I came to the conclusion that it was not the method of choice in Australia although in the United States of America it definitely has its indications. Since then the number of opiate addicts appears not to be as high. You do not see as many of them now. You can get an idea of the numbers from such things as chemist shop burglaries. It does not appear to be as prevalent as it was. I moved my three addicts to Shortland Clinic when they started a methadone programme there because I felt they were better being treated in such a situation. On talking to the doctors there, I do not think that they are seeing as much as what it would appear to be about five or six years ago.

2285. Where is the Shortland clinic?——W. (*Dr Wallace*) At Royal Newcastle Hospital.

2286. Mr RAMSAY: The doctors in Newcastle appear to be fairly united in this matter, for which I can commend them, but what do you say about the attitude of your State body to analgesics? Are the other doctors in New South Wales of the same view, or they are running a State-wide campaign on the matter?——W. (*Dr Clark*) No, we have tried to have this matter brought to their attention. We hope that in the next six to twelve months what you suggest will happen, but at this stage we do not know.

(*Dr Nichols*) The Australian and New Zealand College of Psychiatrists makes position statements on various matters from time to time. There is a conference coming up at which they will probably make a position statement on alcohol. That is the sort of thing that happens.

2287. Mr JACKETT: Dr Clark, you said that a cup of coffee contains about the same amount of caffeine as a Bex or Vincent's powder, approximately 150 milligrams. Does tea have approximately the same caffeine strength? ——W. (*Dr Clark*) There would be 150 milligrams of caffeine in percolated coffee, but most people drink instant coffee, which contains about 80 milligrams of caffeine. Tea has a very much lower caffeine content, though I do not have the figure available. I know the figure for Coca-Cola: it has 50 milligrams of caffeine to each 12 ounces.

2288. Dr Nichols, you said something about relaxation cassettes being readily available. Would you tell us more about that?——W. (*Dr Nichols*) That is an important point. It provides a therapy so that a person may get relief from the wide variety of symptoms without having recourse to drugs. Many relaxation cassettes have been made. I have made many. I make them for my own benefit because it gets tiring teaching people to relax, and to concentrate. It is repetitive. You have to say the same thing many times. I decided to record these things so that the patient could play the cassette himself. There were unexpected advantages. Other members of the family could use the cassette. If you had a good day and made a good tape, you could mass-produce it. I made a good one and the Department of Economics ran off 30 for me. I think that everyone is now making cassettes. The Department of Psychology has its own machine. The cassettes come in a series. The latest is up to No. 34. If these things can be mass-produced, they can be commercialized, and in quite a few chemists' shop now you can get your relaxation cassette. Learning to relax and to concentrate is the most essential learning any person can have. They are handicapped if they cannot relax and concentrate. There is an important difference in this respect between adults and children. It is very easy to get a child to relax and concentrate. It is felt that this is because the child has not yet been exposed to a lot of stress. It is like teaching a child to swim before it drowns. It fits in with the process of learning, using your brain, concentrating, using your memory, and getting things into and out of your head.

We use the cybernetic approach, in which we liken the brain to a computer and tell the patient that thinking is computation, memory is a memory bank, and talking and writing are outputs. The current cost of a cassette is about $7.

(The witnesses withdrew.)

(*Luncheon adjournment.*)

EDWARD JOSEPH BENNETT, of 57 Grinsell Street, Kotara, New South Wales, a Technical Teacher in the Department of Technical and Further Education, an alderman of the Council of the City of Newcastle, and chairman of the Health, Environment and Welfare Committee of that council, sworn and examined:

2289. CHAIRMAN: Do you have a submission to make to the committee?——W. I do. The Health Environment and Welfare Committee of the City Council, of which I am chairman, was appointed by the Council of the City of Newcastle under the Local Government Act, 1919, as amended, and the ordinances made thereunder. My statement is as follows:

The committee comprises seven aldermen, each of the seven wards of the City of Newcastle being represented by one alderman.

I am also chairman of the Medical Advisory Panel for the Council of the City of Newcastle which considers matters of community health.

The Medical Advisory Panel comprises:

The Health, Environment and Welfare Committee in association with representatives of—

The Health Commission of New South Wales,

The Hunter Medical Association,

The Medical Faculty, University of Newcastle,

The Medical Division, Joint Coal Board of New South Wales,

The Medical Division, Public Transport Commission of New South Wales,

and, by invitation, specialists in areas of research, preventive and curative medicine or human welfare.

Since 15th May, 1973, the council, on the recommendations of the Medical Advisory Panel, has given very active consideration to the problem of the reported high incidence of renal damage in the area.

There has been continuous consultation with specialists and firm efforts to make the public and responsible authorities aware of the community health problem associated with self abuse by the unrestricted consumption of compound analgesics.

Those representations have been made to:

The Federal Minister for Health.

The Premier of New South Wales.

State Ministers for Health.

The Health Commission of New South Wales.

The former Advisory Board of Health, New South Wales.

The Local Government Liaison Committee of the Health Commission of New South Wales.

There have been significant responses to those representations.

On 3rd May, 1977, the Council of the City of Newcastle, on the recommendation of its Medical Advisory Panel, resolved "because of the proven high incidence of kidney disease associated with compound analgesics and the high level of usage in the Hunter Region, the Premier of New South Wales be approached, through local members of Parliament, to promulgate legislation to restrict sale of analgesics as recommended by the National Health and Medical Research Council and that the Health Commission of New South Wales be so informed and requested to support such action."

That was a decision made by council last Tuesday evening. I do not think I can tell you a great deal more.

2290. You said that there have been significant responses to representations made at the federal and State levels. How significant have they been, and what have they been?——W. I think the last correspondence we had came from the federal Minister for Health. His reply was typical of the replies we have had from each of the persons whom we have contacted. He said he was inquiring into the high incidence of drug abuse and that he would keep up posted on his findings. That is the sort of answer we have been receiving. We have been promised information as it comes in.

2291. Does the council have a close association with the hospital?——W. Only with the representatives of the council on the medical advisory panel. Our health department has direct contact with each of the members of the panel and with the staff of the hospital. We have received copies of the recommendations on analgesics made by the National Council, so we appreciate the significance of a motion carried by the Newcastle city council on Tuesday night. No doubt that will be seriously considered by the Premier's Department when representations are made to it.

2292. Mr HEALEY: I notice that all of the bodies you have contacted are outside the Hunter Region. What plans, if any, has the council made to publicise the dangers of analgesics within the city of Newcastle? Has it made any? ——W. At this stage, no. We have had the advantage of the advice of Dr Nanra and others who have been closely associated with this research over the past couple of years, and this prompted discussion on our medical advisory panel. We decided to send correspondence to various persons. We have been waiting for guidance on what we in local government can do about these sorts of things.

2293. CHAIRMAN: Thank you very much. I apologize once again for keeping you waiting.

(The witness withdrew.)

RANJIT SINGH NANRA, Medical Practitioner, 34 Mountain View Parade, New Lambton Heights, head of the Division of Nephrology at the Royal Newcastle Hospital, further examined:

JOHN MALCOLM DUGGAN, Medical Practitioner, 33 Hebburn Street, Hamilton, Director of General Medicine, Royal Newcastle Hospital, further examined:

2294. Mr WOTTON: Dr Nanra, do all members of the medical profession, particularly those engaged in the production and marketing of headache powders, agree with your observations on compound analgesics? I know that this is a difficult question. I am asking you whether the medical profession agrees that you are right. Dr Wallace confirmed that the members of the medical profession in this region agree that you are right, but do they agree with you in Sydney and do the medical people who are making analgesics agree with you, or do they agree with you only tongue in cheek?——W. (*Dr Nanra*) I do not think that any member of the medical profession is involved in making analgesics. I can speak for the Australasian Society of Nephrology, which is the national body representing all persons involved in the treatment of kidney disease, and kidney specialists, and for the Australasian Kidney Foundation, which is a non-profit fund-raising organization, interested and involved in kidney disease and kidney research.

The submission that I have made and the recommendations that I have put forward on behalf of the analgesic working party are in total accord with the views of the two societies, which therefore represent the views of all members.

2295. Have your observations up to date been taken heed of at government level? Have you had any encouragement from the Government in this respect?——W. I think the best encouragement that I can cite is the fact that after ten years of representations at federal level, the National Health and Medical Research Council has chosen to come down with recommendations, as they have done in Hobart recently.

2296. You spoke about problems associated with compound analgesics and you referred particularly to the Hunter region. Do you believe that the problem is greater here than in any other part of the State?——W. The reason for my concentrating partly on the Hunter region is the fact that I feel my duty in this submission concerned two areas of responsibility, the first on a national basis and the second on a regional basis. There is also the fact that in regard to the national problem the society of which I am a member—and I support—have made a written submission and I was therefore highlighting the problems of this region. Having said that, all the data that is available to me leads me to believe that the problem in the Hunter region and Newcastle is much higher than anywhere else in Australia, and much higher than anywhere else in the world.

2297. In your submission you referred to aspirin. Were you referring to aspirin as APC's and Bex powders or were you referring to aspirin generally?——W. (*Dr Duggan*) My interest is in aspirin because since 1938 there have been the suggestion that aspirin damages the stomach. So whenever I ask patients whether they were taking something, I was concentrating on whether they were taking aspirin. In about 1968 I started asking people whether they were taking aspirin. I discovered that those who were taking large amounts of aspirin were those who were taking it in the form of APC's.

All my studies show that of those who take large amounts of aspirin, 80 per cent to 90 per cent of them take it in the form of APC's. So that my evidence would suggest that aspirin is bad. I do not want to damn aspirin. What I wish to do is to damn it where it is used excessively for non-medical reasons taken predominantly as compound analgesics. The situation is that those who need aspirin very often cannot be induced to take enough of it. I am talking of people who are crippled with diseases like rheumatoid arthritis. The major problem is to convince them to take enough to take their pain away. As soon as they think that they are all right, they reduce the dose. These people who have a very definite medical need sometimes get into trouble and this is the price one pays. It is the price that the patients and the doctors expect. The more powerful drugs extract a larger price. So that the problems relating from medical use of aspirin are very small; the problem is with people who take aspirin for non-medical reasons. One of my studies concerned 65 patients who were taking it, of which only one was taking it for what could be considered a legitimate medical reason. He had pain at the side of an old fracture.

2298. Dr NANRA: I have researched this carefully and I have published a number of papers on it. I support what Dr Duggan says about patients with rheumatoid arthritis. The medical profession has tried to give them a fairly large dose of aspirin on its own for many years. We find it difficult to get patients to take the dosage required to arrest the disease although after a period of 20 years or 30 years—and that is the sort of duration of that disease—some of these patients may show some evidence of kidney damage. There is no evidence that these people get terminal kidney failure. The only instances where I have seen patients with rheumatoid arthritis and severe kidney failure is where they are on their own, taking a compound analgesic without the doctor's prescription, his consent or knowledge. I emphasize that the use of a drug such as salicylate or aspirin for the treatment of rheumatoid arthritis is correct. We pay a small price for it. We never see patients with terminal kidney failure in that group of patients unless they are also advisedly abusing compound analgesics.

2299. If a female is taking analgesics or even harder drugs and she becomes pregnant, is there any change of attitude, either psychologically or physically?——W. I can only comment on analgesics. I have no expertise or experience of harder drugs in this area. I have not personally researched the area of pregnancy and analgesic intake. A lot of women who get pregnant tend to go off analgesics but those who are constantly taking analgesics during pregnancy are liable to complications in their pregnancy. The pregnancy may go beyond the date of expected delivery. The effect of analgesics, particularly aspirin, in pregnancy is to prolong the gestation period. I said earlier that animal work leads us to suspect that analgesic that contains aspirin may cause abnormalities and deformities. I am not aware of human evidence to support that but Dr Duggan may know something about it.

The third aspect in relation to pregnancy and analgesics is that once a woman has taken powders and they have caused some degree of physical damage, albeit mild, if she gets pregnant, pregnancy toxaemia becomes a major risk. The pregnancy may go beyond the expected delivery date. Also, there is the theoretical worry of foetal abnormalities and there is this problem of toxaemia of pregnancy which could kill a foetus.

2300. Mr MACDIARMID: In domestic livestock, for instance sheep, one can innoculate a pregnant ewe at a certain stage so that there is an immunity to kidney disease, for about six weeks after the lamb is born until it can be innoculated. In reverse, is it possible for a child to be born with some abnormality, other than the ones you are referring to; in other words, can a child in that situation be born with defective kidneys?——W. Not with defective kidneys. There is no published evidence to show that a child born to a patient who is taking these powders will have defective kidneys. However, the effect of the toxemia, which I have spoken about, of pregnancy is to cut off the blood supply to the placenta, through which the mother feeds nutrition to the child. If that effect is severe, then it is not a viable pregnancy; the patient gets a still birth or it results in an abortion.

2301. Would a patient similar to the ones we saw this morning, who have had a kidney transplant, be able to go through a normal pregnancy?——W. If a patient had absolute normal kidney function after a transplant, there is recorded evidence that she can go through pregnancy normally. If there has been some degree of rejection and damage to the kidney, the chances of such a woman getting a viable child are slim. The limitation is the development of what we call the toxaemia of pregnancy. If the degree of toxaemia is severe enough, it will end up by killing the child by cutting off nutrition at the placenta and theoretically doing considerable harm to the mother.

2302. You said that caffeine is not pain killing but it is addictive; if a person over a long period of time, say ten, twenty or thirty years, continued to take ten cups of coffee a day, what effect would that have on that person's health?——W. (*Dr Duggan*) Some people would say that caffeine is not a drug of addiction in the sense that heroin may kill a user. Nobody is going to die after stopping taking caffeine. However, they develop a need for it. It is difficult to get data on how much caffeine is taken here. Most cultures have some sort of caffeine like drug. The Chinese and Japanese drink tea. The Americans and Europeans drink coffee. Throughout the world most people drink a beverage that gives them a bit of a lift. The amount of caffeine in a cup of tea is not so large; it varies a lot. I do not know of any evidence to show that that has any ill effects; it is like a person having two middies of beer a day; that will not harm anybody.

2303. What about coffee?——W. Coffee raises a vexed subject because coffee is made in different ways throughout the world. The best evidence I know of that comes from a recent Canadian study where the researcher asked people this question: "Will you go out and make me a cup of coffee the way you like to make it?" After it has been brought back to him it is analyzed. There is a tremendous difference in the amount of caffeine in a cup of coffee. Some French people just pour hot water over the grounds and there is not much caffeine. If you percolate a lot you get a lot. A heavily percolated cup has about 75 mgs of caffeine—about the amount of a dose in an APC.

2304. CHAIRMAN: What sized cup—a small coffee cup?——W. These were the standard Canadian cup of coffee—what the people in Canada drink.

2305. Mr MacDIARMID: The Turks and Greeks drink little cups of strong black coffee and use it as a drug to give a lift?——W. I think that we can assume that in any culture where people drink tea or coffee they are basically having it because of the caffeine in it. (*Dr Nanra*) My comments are purely restricted to the kidney area because that is my area of expertise. There has been some hint—although not medically proven yet—that there may be a link between caffeine and bladder cancer. I mention that. There is no proof, but there have been editorials in medical journals raising the probability. In published world literature there is only one recorded instance of a person getting kidney failure when being treated with caffeine citrate in its medical form. It was acute poisoning. On the other hand all the evidence I have from my own animal research and that done by another colleague, David Edwards, who no longer is in Sydney but used to work at Sydney Hospital—caffeine has a mild protective effect on the kidney because it in those kinds of doses promotes extra urine movement but the effective protection is so mild and minimal that it is of no consequence. The dangers and good points in regard to caffeine and the kidney are neglible in its major context. I strongly support what Dr Duggan has said. Its role in the compound analgesic is questionable. It is has no pain killing properties and its role is probably in what takes people back with recurring headaches to the compound APC mixture.

2306. Mr JACKETT: Dr Nanra, in the slides with regard to advertising done by the two main offenders in this regard, am I right in saying you are suggesting that the cumulative effect is not so much to advertise one particular brand as against the other but to advertise and promote analgesic use?——W. I think I have to agree with you on that but if I have a billboard advertising Vincent's and belonged to that company I am basically promoting Vincent's. First, the medical effect of advertising a drug to the nation: to me it is perfectly reasonable that the drug be advertsied to the medical profession. I think that the pharmaceutical industry has a right to survive. If it has a drug it must promote it to the medical profession. It is the question of the ethics of advertising a drug to the nation as a whole. I raise the question: why do not we advertise penicillin on bill boards? When people get sore throats why should not they buy penicillin at supermarkets to extend that same argument.

2307. You heard Mrs Cronin say that she had always taken Vincent's and never taken Bex: have you any idea why she would prefer Vincent's to Bex?——W. I cannot answer that. I have come across the problem, which I have in my writings labelled as brand loyalty. People swear by it. I do not know what it is. Fortunately, that is what has allowed me to conduct the significant community research where I have been able to compare the outcome of kidneys in relation to Bex abuse and Vincent's abuse because I had two pure groups, either taking Bex or Vincent's. One has not contained phenacetin for eight years and the other one has. There was no difference. The degree of kidney damage and renal failure, the percentage who developed renal failure, was identical with the two groups which has led me to take the strong stand that it is a red herring, the issue of talking about which component is the problem. The problem is abuse of compound analgesics which lead to disease and kidney failure. I would be urging my Parliamentary representatives to look at the problem of compound analgesics.

2308. Why is not paracetamol and panadol or panadeine still a worry. If a person has used six Bex a day for the past ten years and switches to six panadol for the next five years, would you feel he was going back or getting better? ——W. That is a good question. I was hoping that you would not ask it but over an experience of more than 500 patients I have, on occasions, seen patients who have kidney disease established by compound analgesics who have come off compound analgesics and have gone on to take aspirin or panadol on its own because they thought it was safe or commercial advertising told them it was safe, or in ignorance the family practitioner told them it was safe. I have seen proof that they get into additional strife but that is in the context of already existing kidney disease. That is why in part of my recommendations I have made a strong plea that if we were to follow the recommendations to a large extent of the National Health and Medical Research Council, it would mean that there would still be easy availability of single analgesics and sufficient research funds should be made available to people like Dr Duggan and myself to measure the success or failure of what intervention is brought into the community because that is the sort of thing we should be doing. Do people, when one withdraws the compound analgesics, turn to the single? There is no evidence to suggest that but it is a question mark. I am not prepared to make wild guesses but if you do bring in legislation, which I would support strongly, I should like to see governments, parliaments and parliamentarians put enough pressure on to support us in terms of finance for evaluating the efficacy of the measurers.

2309. If you put the compound analgesics in schedule 4 by what degree do you feel the consumption of the compound would be reduced?——W. The only published evidence I can quote is from Sweden. In 1961 Sweden introduced legislation to put phenacetin containing compounds in prescription and restriction. Having said that, let us not compare Sweden directly with Australia because the mixture that was abused was phenazone, phenacetin,

caffeine. The mixture abused in Australia is aspirin, phenacetin and caffeine. The medical consequences are not directly identical but there are similarities. The impact of bringing in the legislation was to drop the annual sales of compound analgesics dramatically. I do not have the figures here but I can provide the actual change in so many tonnes from before to after. We can only get that kind of information if the pharmaceutical industry is willing to give us the data which they have. That kind of information is currently available through the pharmaceutical industry but not to medical scientists like us because they will not make it known to us. Another thing I would be urging the committee and the Parliament to do is, in whatever recommendations are made in the future, there would be some pressure brought upon the industry to make available for research purposes so that sufficient guidance can be given to legislating authorities as to what is happening to the pattern of sales. We cannot get access and that, I think, is wrong.

2310. Dr DUGGAN: What do you believe to be the effect of having a compound of aspirin, phenacetin and aspirin or paracetamol, leaving out caffeine in both cases? Would it be something that would seriously worry you? ——W. (*Dr Duggan*) I think the medical feeling would be such that phenacetin is out. There is so much feeling against phenacetin, as Dr Nanra has pointed out, that the question of panadol and kidney disease is something that medical science are still thinking about. My view is that the majority of people are seeking what caffeine gives them and once caffeine is taken out the problem would certainly diminish. It is hard to say by how much but I believe that caffeine or codeine, in some others is the thing that the patient is seeking. May I return to your previous question?

2311. Yes.——W. In 1968 I wrote to the Commonwealth Director of Health trying to get this sort of data and among the data he was able to give me was the rate of prescriptions for pensioners. I emphasize that it was pensioners because that is all the information that was available.

I have here figures relating to prescriptions issued under the pensioner medical service for the old APC powders in the years 1961–62 to 1966–67. Members of the committee will recall that in about 1963–64 there was a lot of talk about analgesic nephropathy, and some work was done on this at Sydney Hospital. The figures are as follows: in 1961–62 the number of prescriptions issued was 390 000 approximately. In 1962–63 it was again 390 000. In 1963–64 it was 250 000. In 1964–65 it dropped to 21 000. In 1965–66 it was 17 000, and in 1966–67 it was 14 000. I believe that this answers your question. If these drugs have to be prescribed but doctors are made aware that the APC powder is dangerous, they respond by reducing their prescriptions from 390 000 to 14 000, in which case it becomes a non-problem.

(*Dr Nanra*) Pharmacologically and scientifically aspirin on its own is an effective pain-killer. Paracetemol or aspirin singly are effective pain-killers. When combined, the pain-killing function is additive, but the toxic effects are additive also. We should bear in mind when we are thinking of leaving a double mixture on the market. I would seriously contend that aspirin on its own is sufficient to deal with all ordinary pain, and if a pain is so severe that aspirin will not deal with it, perhaps the patient should be seeing the doctor. Similarly, Panadol or paracetemol on their own are usually effective, and if the pain again is so severe that they are ineffective, maybe the person concerned should be seeing a doctor.

2312. Mr JACKETT: This question is hypothetical, but it discloses the way I am thinking. If the compounds were put into Schedule 4, the probability is that the manufacturers of the two products with which we are concerned here would switch to producing a single drug, such as aspirin or paracetemol, and begin very strong promotion of the new product. As a specialist concerned with illnesses of the stomach, would you not be seriously concerned with the likely effects of such promotion?——W. (*Dr Duggan*) No. It would not worry me at all because I know that when I have a patient who needs aspirin, I have a problem of getting enough into him. It is an unpleasant drug and it does not make you feel any better.

2313. What about paracetemol?——W. On the few occasions I have tried it I have found it intensely bitter, and I would take it only if I had a bad pain. It does not make me feel better, more alert, more euphoric, or more alive, as caffeine does. So it would not worry me.

(*Dr Nanra*) I support what Dr Duggan has said, but I add that if aspirin or paracetemol are made available on their own as you are suggesting, we must take care that it does not lend itself to overdosing. Let us assume that a child aged eight has access to a bottle of 100 aspirin tablets. An aspirin overdose could be a lethal condition in children. In Britain, paracetemol overdosing is becoming a major problem, with severe liver damage and death ensuing. Therefore, safeguards have to be thought of in terms of having these drugs on sale in a way that does not lend itself to overdosing.

(*Dr Duggan*) In regard to paracetemol, I can only emphasize what Dr Nanra says. It is remarkable that we have not yet imported into Australia the epidemic of Panadol overdosing that is sweeping Britain. It is a major health problem in Britain.

2314. We were told by people from St Vincents Hospital in Sydney that they have had problems of this kind with an overdosage of paracetemol in one of its various forms. Would you like to comment on that?——W. (*Dr Duggan*) We have a few such cases, but we also have a plan prepared expecting this to happen. I am grateful that we have not had to invoke it, except on one occasion in the past 12 months, but there is a real possibility that it will have to be invoked. If the drug companies are impeded in their efforts in one way, I expect that what will occur will be what has occurred in the U.S.A. The financial return from drug development is diminishing. The days are over when you could invent penicillin and make lots of money. The law of diminishing returns has set in, and what is happening in America, and what I would expect to happen in Australia, is that drug companies are moving into the equipment field. They have sold drugs that has given me work, and then they make equipment with which I can salvage my patients. The big drug companies in America are making kidney machines, catheters, tubing of various types, and an incredible array of equipment, to permit us to salvage the patient. I think that is what will happen here if what you suggest is done. They will move into the manufacture of machinery for dialysis and so on.

2315. CHAIRMAN: You are emphasizing that we should try to put both you and Dr Nanra out of business? ——W. If I could play golf every afternoon, it would be magnificent.

(*Dr Nanra*) There is a great need to measure the impact of anything you recommend. We must not be put in the same situation as other countries, where legislation was brought in and five years later we did not know what the legislation had achieved. I am making a strong plea for

whatever recommendation that is made to have built into it some way of enabling us to measure what we are doing. I repeat, we must measure the impact of what we do, or otherwise we can expend a lot of money, time and energy, and still not know at the end of the process whether we have achieved anything. Even if we took every pain-killer off the market today, I would still be in business for the next five, six or seven years, because the base of the iceberg below the water is big enough to keep me going that long.

2316. Mr RAMSAY: Dr Nanra, you showed us a colour slide of a diseased kidney. If the person with that kidney were on a fairly high intake of analgesics, but sought advice from you and stopped taking those analgesics, would the kidney deteriorate any further?——W. It depends on the point at which I catch the patient. If I catch the patient when 30 per cent or 40 per cent of the kidney is destroyed, I could tell the patient that he or she would recover sufficiently to be able to lead a normal life, because we can get by with 50 per cent or 60 per cent of normal kidney function. If I catch the patient when more than 30 per cent or 40 per cent has been destroyed, the chances are that he will remain at that level for the rest of his life. In other words, we can improve the patient or we can arrest the disease. If I catch the patient when he has only 10 per cent of his kidneys functioning, there are set in motion a number of self-generating consequences, so that the patient goes into a state of terminal renal failure. Therefore it depends on the level at which you catch the patient. If there is no abuse of headache powders, there will be no kidney failure for that reason. Abuse of headache powders is responsible for 20 per cent of the national work being done in this field, and that involves a lot of work and a lot of money.

2317. The Australian Consumers Association has said that pharmacists should be qualified to give advice on the use of drugs that are available without a doctor's prescription. Dr Duggan, would you agree with that?——W. (*Dr Duggan*) In an ideal society I would have to give an unequivocal yes. I do not subscribe to the view that doctors are gods and that they are the only people who can give medical advice. However, I would have to put in two provisos. First, there are more customers than there are pharmacists, and the Australian Consumers Association clearly showed that not always does the pharmacist himself sell the drug and give advice on the drug. So in real life it does not always happen. The question becomes a non-issue if a non-painkilling drug, caffeine, is removed as a pain killer, because it has no role in that respect, and it would not worry me what the pharmacist did provided he did not give the patient a drug that would hook the patient without having any capacity to relieve the pain of the patient.

2318. Have you had any negotiations with pharmacists or their organization about the concern being expressed by you and people like you in the Hunter Valley?——W. (*Dr Duggan*) Personally, no. It has been my view for years that only legislative action can fix this problem. That is an aim I have had for ten or more years. I have no faith in education, cajoling, talking to people, motivation, or anything like that. To me it is a simple exercise in legislative and executive function, and that is what my efforts have been directed to.

2319. Mr HEALEY: Have either of you doctors been able to perceive any common proof on an educational, financial or social level among your patients?——W. (*Dr Nanra*) I think the evidence published elsewhere, as well as on patients I have seen, suggests that the problem is much more prevalent in the socially-economically deprived people than in the upper middle class or the upper class people. I do not know the reason for that.

2320. WITNESS: The University of New South Wales did a survey of 1 000 households in Brisbane and Sydney in regard to this. The social classes established numbered from 1 to 5. Class 5 contained people who were non-skilled workers and their wives and children. It was found that they take the most and that social class No. 1 took the least amount. That is not to say that social class No. 1 did not have any other habits. Psychotrophic drugs like APCs are cheaper than psychotrophic drugs like valium and alcohol.

2321. Mr McGOWAN: Do you imply that females are socially and economically deprived?——W. (*Dr Nanra*) No, I think that is another factor. It may be that it is tied in with our cultural acceptance. I did not intend to convey that the women were socially deprived, but it is in that group of people that the women seem to outnumber the men.

2322. WITNESS: It is the women in the socially deprived class who often start taking these things. Such a woman may have a miserable job that gives her no satisfaction; she may work in a noisy environment where she has some compulsion to do an unpleasant job as fast as possible. When she gets married and perhaps has two children her husband may start coming home late at night. If that happens she is in a bind. If the husband feels unhappy in a job, the normal thing for him is to go and have several schooners of beer on the way home. That is not the normal thing in this State for a wife; she has no normal outlet to make her feel better. Her husband may drink beer and he may come along to us later with problems resulting from his consumption of alcohol. However, the wife probably stays at home worrying whether he is out with another woman and she may take APCs. These people have a strong history of social disruption and unhappy marriages. So few of them are women who feel satisfied that life is doing the right thing by them.

2323. WITNESS: The effect of this social acceptance is highlighted by the experience that happened in Sweden at a place called Husqvarna. At that place a Dr Sjorton made a powder and the done thing in that village when a birthday occurred was to give a person a packet of these powders; it became a socially acceptable thing. This happened until some doctors realized that a lot of people from the village were dying from kidney failure; it had become a socially accepted habit.

2324. Would you comment on the proposition implied in this submission that there is sufficient warning placed upon these packages?——W. (*Dr Duggan*) I think the reality of it is that it is not sufficient because it is ineffective. I have shown that about once a week a patient in Newcastle gets a gastric ulcer when he need not have it. In practice, it is indaquate because these people have a psychological need and a headache need. They need these things to make them feel better psychologically or take away the headache that has been produced. The fact that 40 per cent of my patients denied taking these things when they were taking them illustrates the fact that this is not a simple situation; these people have a real problem. Some of these people have looked us in the eye on one or more occasions and said, "No, I have not taken anything." We have had the experience of a patient like that dying and then tablets being found in the bedside table.

2325. WITNESS: No amount of education will stop them. That message has failed miserably and this is indicated by the autopsy records.

2326. CHAIRMAN: When I put that question to the Sydney coroner he said that he could not supply us with reliable figures in regard to kidney failure due to the use of analgesics because those figures were not available to him?——W. I could give you figures in relation to autopsies and renal papillary necrosis. One study was done by me on behalf of the coroner's court in Melbourne in about 1969.

Would there be other cases where people had died from kidney failure where the certificate might have been issued to the effect that death was due to natural causes and no autopsy was conducted?——W. I cannot answer that. The coroner's figures that are available are as a result of the autopsies done by him.

2327. The point is that he cannot give us reliable figures because he concludes that they would not give the full picture. Do you agree with that?——W. (*Dr Duggan*) On my experience throughout the world there is a shortage of skilled medical practitioners to do autopsies. Throughout the world the system generally is that the prime duty of the coroner's medical officer is to determine whether a person has been murdered or died from natural causes. He has a lot of work to do and mostly he is working with inadequate resources. If he can find a coronary or a patch of pneumonia he is not actually concerned about renal failure. Unless Dr Nanra says, "Show me all the kidneys you take out of all dead people, there will be no such statement." If the coroner has told you that he sees very little of this, it is because the community does not provide him with the means to do it.

2328. I understand that at a meeting of representatives of twenty-four hospital auxiliaries at Scone today a resolution was passed dealing with the sale of analgesics at hospital kiosks?——W. (*Dr Nanra*) That is correct. That resolution reads: "Resolution that the sale of analgesics be banned in all hospital kiosks. Resolution was carried unanimously by representatives of twenty-four auxiliaries at a meeting at Scone today."

2329. You said that an epidemic of gastric ulcers occurred in 1943. Have you any idea as to why that occurred at that time? Do you think it was because of the social situation then associated with the war or do you think it may have been due to the chemical composition of the analgesics then?——W. (*Dr Duggan*) I would like to be able to answer that. I have tried unsuccessfully to get the figures in regard to the annual consumption of APCs or constituents but I was unsuccessful. I believe that the answer resides in the data that is available. I do not remember 1943 well enough to know how many women were thrown into noisy factories. If the pharmaceutical industry would release this data, the problem could be dealt with.

2330. You said that about 1 534 cases were studied, mainly in women and that most of them had been taking aspirin or APCc before bleeding commenced. Has anybody else in New South Wales carried out similar studies to yours and have they come up with similar findings?——W. I would not wish to imply that these people were bleeding because of APCs. There was a study of that number, of which 800 were women with gastric ulcers. To my knowledge, such a study has not been carried out anywhere else. The only similar study may have been the one conducted in Boston, which I referred to earlier.

2331. Mr McGOWAN: Given that your recommendations were carried into effect, then we would have a situation where people could buy aspirin, paracetamol and caffeine individually; they could then end up in a worse situation than they are in at the moment because they could be getting a heavier dose than they are at the present time. Would you comment on that?——W. I have never considered that your recommendation would be to allow caffeine to be sold here. I am afraid I have not thought about this. I would certainly hope that caffeine was not sold over the counter.

2332. CHAIRMAN: The recommendation that was referred to reads: "That aspirin, paracetamol and salicylamide and their derivatives should be available by open, over-the-counter sale only when they are supplied as single substances, not combined with any other therapeutically active substance, packed in units containing not more than twenty-four tablets or twelve powders, supplied in strip packs or in containers with suitable child-resistant closures?——W. Thank you.

2333. Mr McGOWAN: Do you think that it is likely that a person would do that, I am speaking about the sort of person that you are dealing with?

2334. WITNESS: I cannot see the indication for marketing caffeine citrate. There is no rationale. It could not be justified because they would be brought before the Trade Practices Tribunal. It has no pain killing properties.

2335. Would they just buy it separately?——W. It should not be allowed to be marketed separately, but having said that, I do not personally believe the spectrum of people that we are dealing with are so psychologically disturbed that they would go to shop A and buy so much of substance A, to shop B and buy substance B and to shop C to buy another substance, substance C. It is a hypothetical situation, but I do not personally believe, without scientific data, that they would be aberrated so bady psychologically that they would do that. Maybe a small number of persons may do it but they are so bad that they need help.

2336. Maybe they would be brought to a recognition of their addiction if they had to do that?——W. Mind you, part of this is happening right now because I know a senior lecturer in biochemistry who could not get codeine because it was well known to the medical profession that he was a codeine addict. He bought vegenin, distilled the codeine out and so on. If a person is that bad he will resort to that sort of thing.

(The witnesses retired.)

(Sitting concluded.)

# NOTES OF INSPECTION

*BY*

THE JOINT COMMITTEE OF THE LEGISLATIVE COUNCIL AND LEGISLATIVE ASSEMBLY

*UPON*

# DRUGS

*AT WOLLONGONG ON THURSDAY, 26 MAY, 1977*

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## AT THE OFFICES OF THE HEALTH COMMISSION OF NEW SOUTH WALES, ILLAWARRA REGION

Mr Mike Hodges, Acting Deputy Regional Director, Dr Cyril Innis, Assistant Regional Director of Health, and Mr Bob Gore, Senior Co-ordinator for Community Health, met the committee and informally gave a general outline of the workings of the Illawarra regional office, particularly relating to drug matters.

## AT THE DRUG REFERRAL CENTRE, KEMBLA HOUSE, 36 KEMBLA STREET, WOLLONGONG

The Committee met Margaret Meek, Counsellor, Roger Gray, Counsellor, and John Sanders, Health Education officer, who, with Dr Innis, described the various types of assistance and service given to people referred to the centre. The centre is staffed by one psychologist, three counsellors, two health education officers and one clerical assistant. Dr Innis, on behalf of the staff at the centre, undertook to provide the Committee with written details of the centre's activities.

## AT WOLLONGONG HOSPITAL, WARD 20

Dr Bryan Willis, regional psychiatrist and unit director of Ward 20, described the ward to the Committee. The ward comprised thirty beds and cared for twenty per cent alcoholic patients and the remainder psychiatric patients, with usually no more than one or two narcotic addicts. Ward 20 was used for detoxification, which usually took one week. Few, if any, addicts who had been treated in Ward 20 had had to return for further treatment after detoxification.

(Inspections concluded.)

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*AT WOLLONGONG ON THURSDAY, 26 MAY, 1977*

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The Committee met at 2.30 p.m.

Present:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| The Hon. KATHLEEN ANDERSON | Mr J. G. T. JACKETT |
| The Hon. MARGARET DAVIS | Mr E. D. RAMSAY |
| The Hon. C. HEALEY | Mr R. C. A. WOTTON |
| The Hon. F. M. MACDIARMID | |

Dr EDWARD MAXWELL DIMENT, Regional Director of Health for the Health Commission of New South Wales, Illawarra Region, 24 Robson Road, Corrimal, sworn and examined.

2337. CHAIRMAN: Dr Diment, did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. Yes, I did.

2338. We have not received a written submission from you.——W. No.

2339. But I understand you wish to make a verbal one before you are cross-examined?——W. Yes.

BRIAN WILLIS, Regional Psychiatrist, 5 Elizabeth Street, Mangerton, Wollongong, sworn and examined.

2340. CHAIRMAN: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. I did.

2341. I understand that you, like Dr Diment, wish to make a verbal submission later?——W. I do.

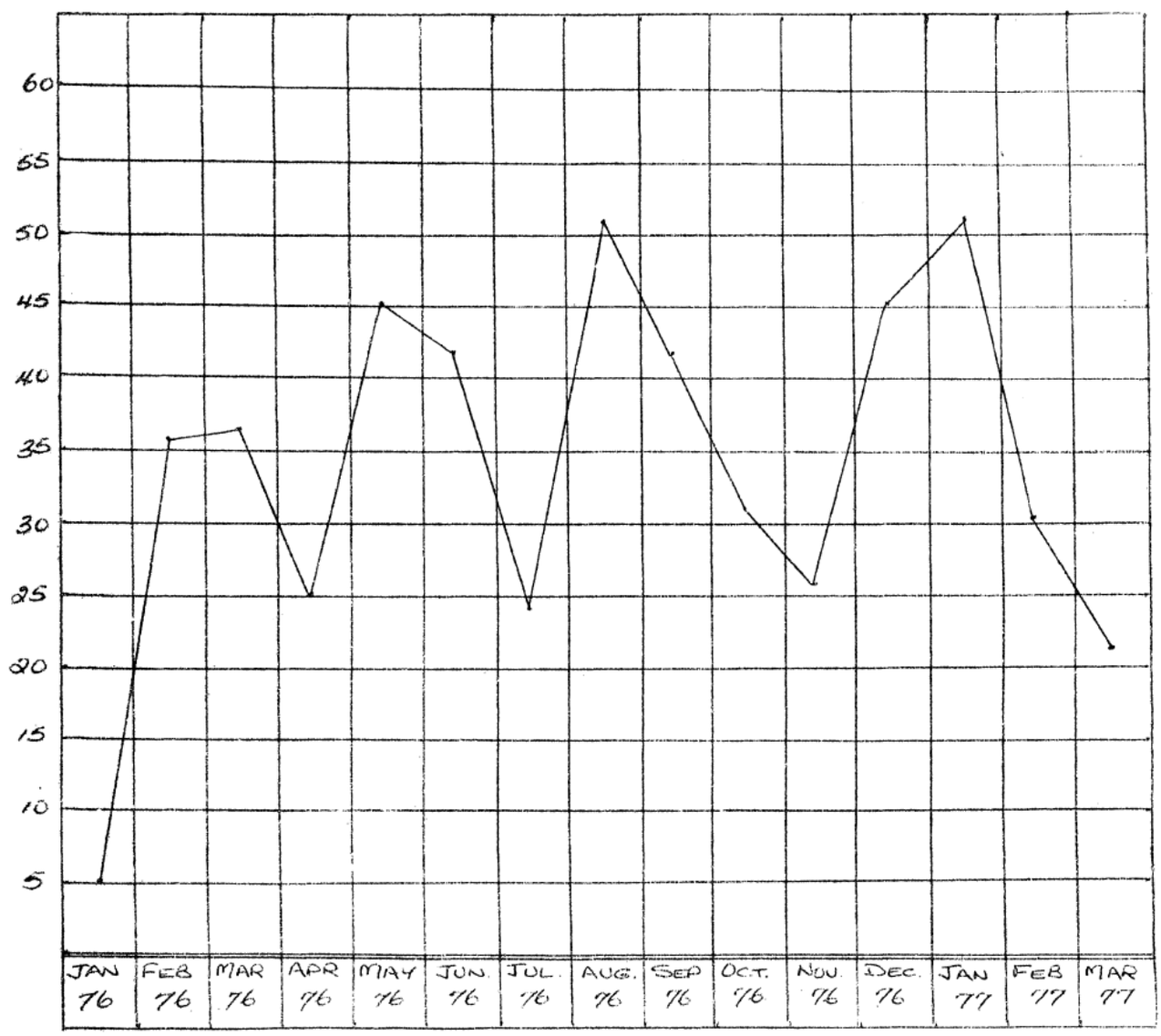
2342. Dr Diment, would you please give us an outline of the area of your activities, the number of people that the area covers and the sort of problems that you feel are associated with the terms of reference of our Committee?——W. Yes. The region is the Illawarra Region, which stretches from just south of Waterfall in the north to eight miles north of Batemans Bay; it does not include Batemans Bay. It also takes in the tablelands area—Wingecarribee shire, Bowral shire, Moss Vale shire and the Shoalhaven shire. From figures I shall present later it would appear that we have major drug problems in this region. I speak mainly of hard drugs—heroin—because our resources are such that we have not had much opportunity to deal with marihuana and other drugs. Our main thrust has been against heroin usage. We have to treat heroin users and of course the users of other drugs, but mainly heroin. The Drug Referral centre in Kembla Street, Wollongong, which you saw this morning, is our main drug referral centre. We also have ward 20 at the hospital which is a general psychiatric ward but is the area in which we detoxify patients if they need detoxification. We also have eighteen health centres, which are generalist centres but in many of them they have a nurse who has a leaning towards the curing of drug problems. These are at Wollongong, Corrimal, Warrawong, Berkeley, Warilla, Dapto, Cringila, Bowral, Milton, Ulladulla, Sussex Inlet, Huskisson, Nowra, Berry, Culburra, Helensburgh, Bundanoon, Moss Vale and Kiama. Problems of addiction picked up by these centres are referred to Kembla House in Kembla Street, Wollongong, which is the main referral centre. I have graphs showing the number of people we treat.

2343. You would like these incorporated as part of your evidence?——W. Yes.

*Witnesses*—E. M. Diment and B. Willis, 26 May, 1977

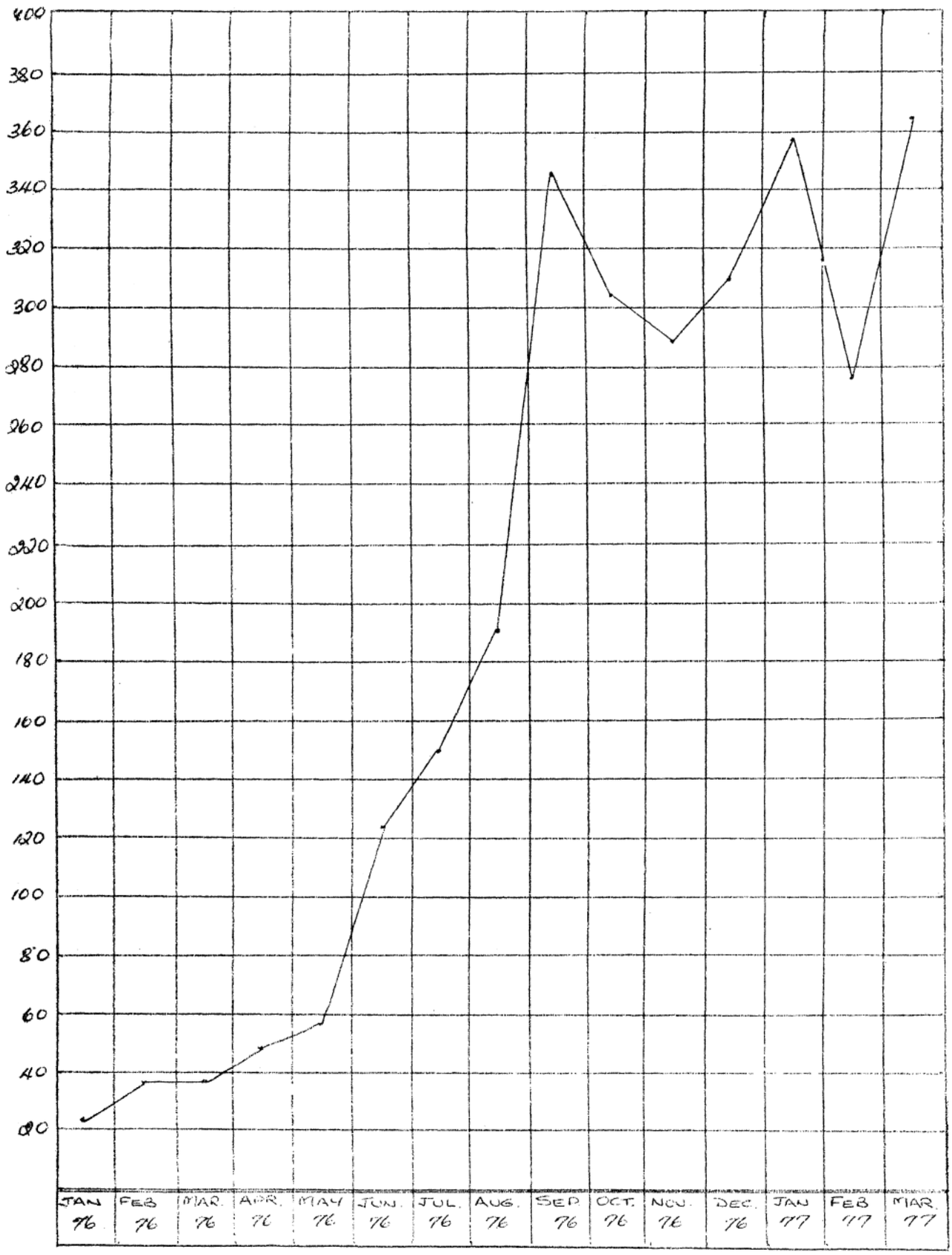
**ALL ADDICTION CASES**

**NEW**



## ALL ADDICTION CASES

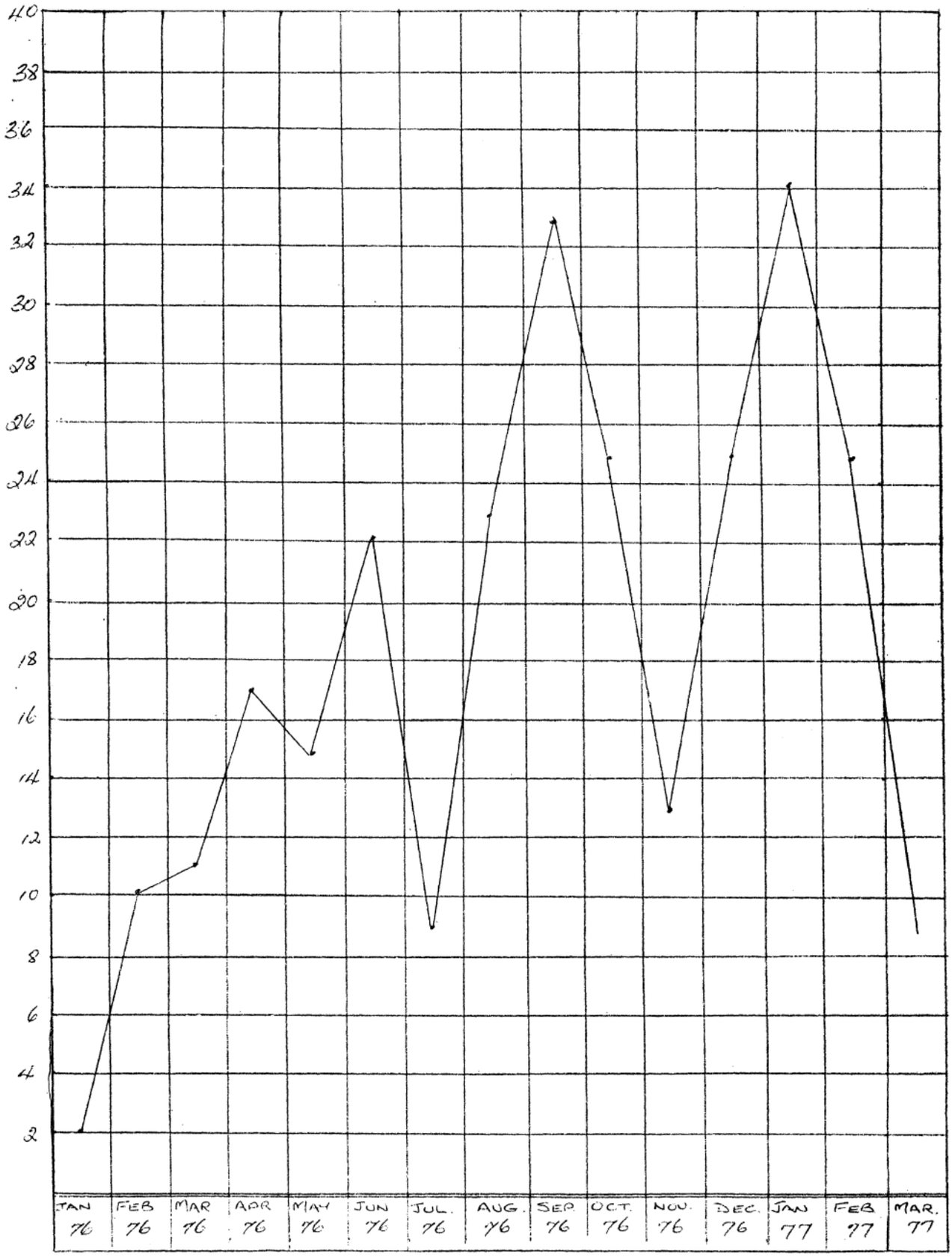
## FOLLOW-UP



*Witnesses*—E. M. Diment and B. Willis, 26 May, 1977

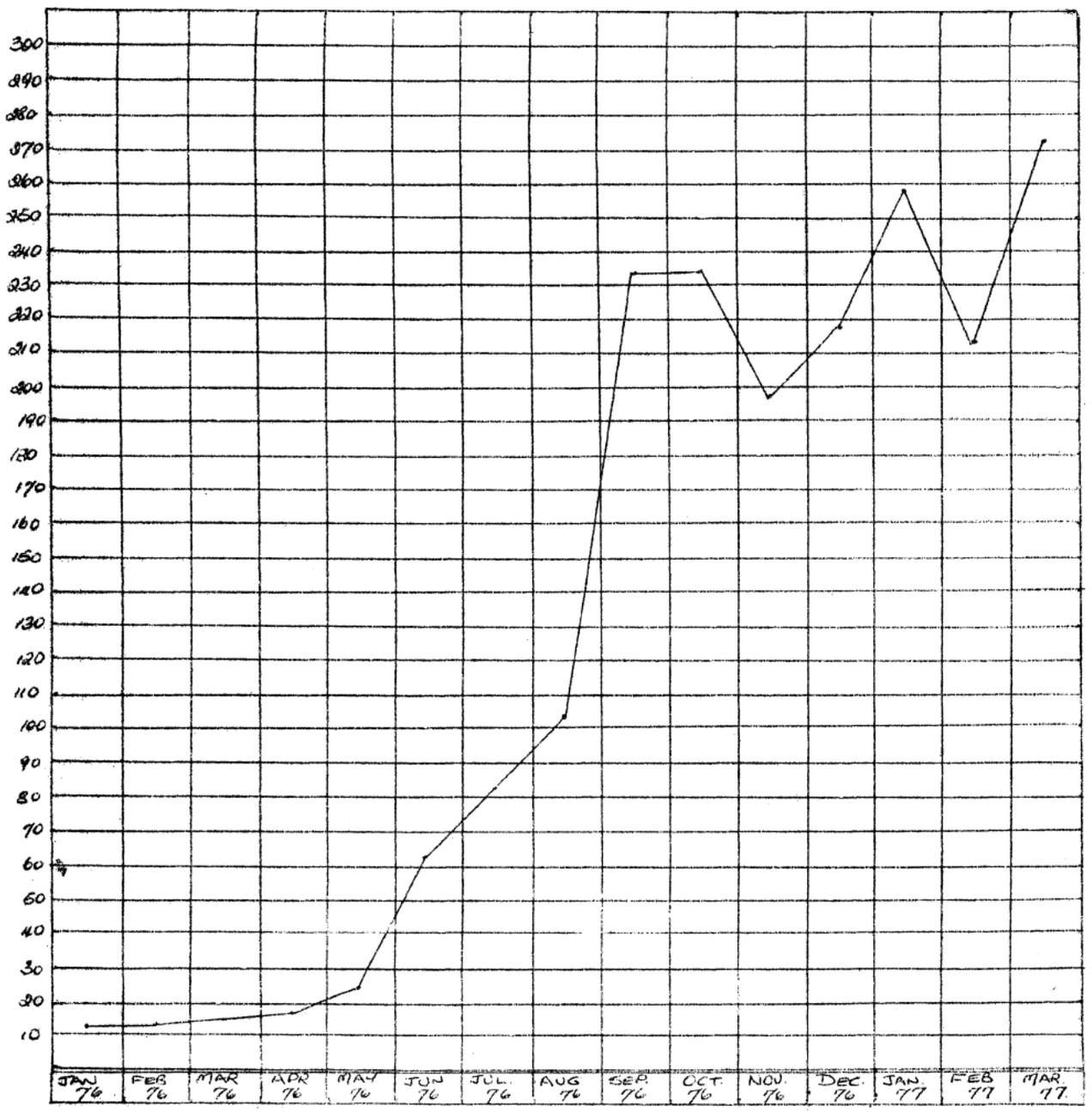
**HEROIN**

**NEW CASES**



**HEROIN**

**FOLLOW-UP CASES**



2344. CHAIRMAN: Would you continue your evidence?——W. Yes. These graphs show the number of patients that we have under treatment at the moment. They cover a period from January, 1976, to March, 1977. We have not the figures for April yet.

The first graph shows all addiction cases and that is new referrals. That shows a mean of about thirty new cases a month. They go up to fifty a month but the average would be about thirty to thirty-five. The next one shows the number of patients under follow-up treatment and that at the moment is 360. From that graph you will see that it rose rapidly in May, June, July and August and is tending to flatten out now. I think my colleagues can probably give better evidence than I on that. They are handling it. The next one shows new heroin addiction cases. You will see that they are running at mean of about seventeen a month. Then the fourth graph shows the number of patients under treatment and being followed up at the moment is 274.

I have always found it difficult to assess beyond that what the problem is—how big it is—where the main trouble spots are. I believe that if we are seeing 25 per cent of them—I use 25 per cent because my counsellors say they believe we are seeing 25 per cent and I think they are being over optimistic—I do not think they are —but if they are, we would be seeing a thousand-odd patients in the central Wollongong area. That is how we worked out the figures. If we try to do it statistically, the evidence we get from addicts and statements made by various people always seem to be more accurate than the statistical figure. I believe we also have a large problem in Warilla, Nowra and Bowral, but again I find it terribly difficult to quantify the problem.

The regional addiction centre is the main referral centre. The graphs show the number of patients treated by that centre. I believe it is over stating to say that we treat 25 per cent of the hard drug users in Wollongong. I do not think Mrs Benjamin agrees with that statement that we do see 25 per cent?

2345. Mrs BENJAMIN: No, I do not.

2346. Dr DIMENT: So that the number would be well over a thousand addicts in central Wollongong.

We also have health education programmes. There is one running in schools at the moment, but I believe that has a minimal effect on prevention. My health education officers could argue about that. A matter of particular interest I think is the personal development programme being run jointly by Australian Iron and Steel and the Health Commission. We started this last year as a pilot study. Mr Lake was involved in the programme at Australian Iron and Steel. He might enlarge on that shortly. The scheme was so successful that Australian Iron and Steel funded the programme this year. We have detached Mr Lake to work at the works, and Australian Iron and Steel supply three staff. The programme was originally directed at apprentices and the results were encouraging. The supervisors told me that as a result of the scheme they could communicate better with the apprentices and apprentices with the supervisors. The accident rate fell. The absentee rate fell and the number of drug problems fell. I believe Mr Lake has the figures on that programme.

2347. Mr LAKE: I have not the figures but I can talk about it generally.

2348. Dr DIMENT: Australian Iron and Steel thought this was so. I would not like to say they have a commercial interest but it was so beneficial that they have assigned three of their staff to run the programme. We now hope that we can get to over 3 000 young people and later on that will extend. That is an interesting preventive measure.

Let me now deal with our shortcomings. The region lacks referral centres. We should like to see them at Warilla, Nowra and Bowral. I believe we have a great problem in the large population in central Wollongong. As I pointed out, the figures can only be estimations. I believe there is also a great need for a half-way house type establishment in Wollongong, Nowra, Warilla and Bowral. I also believe that these establishments would be better run by an independent agent. The commission, being under the control of the Public Service Board, must abide by the Board's rules dealing with after hours work and the marking of motor vehicles and allow no freedom to select the staff we wish. I believe it would be an advantage to have ex-addicts working for us. They speak the same language as the patients. Public service regulations will not allow that. Further, we can get equipment only through the Government Stores Department. That is institutional-type equipment. I notice it is changing slightly. I think you can now have any colour as long as it is black. That is probably over-stating a little. Problems exist in relation to the compounding of motor vehicles. We must compound our cars at night. If our counsellors have to attend a crisis at night they must either use their own vehicles or come back to work and pick up a car to go out, which seems to me to be rather an unrealistic state of affairs. There are other problems. Buying or leasing property becomes difficult if it has to be done within public service regulations. In the circumstances I believe that an independent body could possibly run a drug programme better than could a body under Public Service Board control. If the Health Commission were an independent agency, maybe it could do it but at this stage it is not. That is all I have to say at the moment.

2349. CHAIRMAN: Before we proceed further we shall go through the formal procedure with the other two witnesses and then we shall hear from Dr Willis.

GARRY LAKE, Health Education Officer with the New South Wales Health Commission, Flat 9, 1 Thomas Street, Wollongong, sworn and examined.

2350. CHAIRMAN: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. Yes, I did.

YVONNE NORMA BENJAMIN, psychologist, 11 Morandoo Avenue, Mount Keira, sworn and examined.

2351. CHAIRMAN: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. Yes, I did.

2352. Dr Willis, would you like to address the committee?——W. (*Dr Willis*) Yes. As one of the psychiatrists in the region, I give medical backup support to the addiction team. Those people who came to the Ward this morning will remember I said that the medical problem with addiction is easily manageable and I do not regard it as having any major components. The medical management is, to my way of thinking, very simple. As long as the people are available for treatment and, if necessary, could be made to have treatment for withdrawal from the drug, there would be no difficulty. The difficulty arises in enticing the people to want to withdraw from the

drug in the first place and, having withdrawn, to want to stay off the drug to which they are addicted. I feel that the problem is not a medical one but more of a sociological one, in fact. There are other medical facts like hepatitis and malnutrition and so on and these are not insurmountable problems at all. They are relatively minor complications.

(*Mrs Benjamin*) I agree with Dr Willis in this respect, that the medical withdrawal from a chemical is the smaller part of the problem in reducing addiction or removing the habit. Some of the medical complications that Dr Willis spoke of, while I agree they are a minor part of the problem and they are very easily controlled with proper medical care, the majority of addicts are afraid because it is an illegal activity. When we talk about drugs, it is an illegal activity and they are afraid to seek help from most Government organizations. They are afraid of revealing that they have an addiction and it is difficult to treat them. Apart from the risk of arrest, there is also the risk of people—neighbours, people, families—finding out, because there is a great stigma attached to addiction. I believe that this great stigma is the major component of the sociological problems of the difficulty in treatment and the difficulty in rehabilitation.

2353. CHAIRMAN: Would you give us an outline of what has actually transpired at your centre since you started it early last year?——W. (*Mrs Benjamin*) The house was opened in June 1976. We had some fair contact with addicts earlier in the year and gained a certain amount of trust with them. You will notice on the graphs how the figures greatly rose and rose. There is quite a jump in June when the place opened. The rise after that is mainly due to the good contact we have with GPs who are now referring addicted people to us. The greater source of referrals, however, is from addicts who have already been in contact with us and know that they can trust us as far as confidential information is concerned, and that we do not pull any kind of superior moral stunts on them. They tell one another that it is a safe place to go to have treatment.

What we do is try to make a fairly accurate assessment of the type of drug used, the quantity and for how long. We have a number of treatment schedules that are available. The first thing we offer is live-in treatment at one of the Sydney places. We have no live-in place here in Wollongong at all. We offer that first because the figures from the live-in centres are much higher than outpatients withdrawal so far as success is concerned. If the person is able to leave the area and his work or his family, we can go to Sydney and go from place to place until we find a placement for them because they are not always available. Sydney has its own problem.

2354. Would you organize a placement for them?——W. (*Mrs Benjamin*) Yes. We accompany them there and take them round until we find an appropriate place for them. This is not always possible, so those that we cannot find placements for and those for whom removal from the area would be relatively impossible, we offer a series of withdrawal regimes. If methadone appears to be appropriate, we arrange to take them to see Dr Willis, who is the prescriber of methadone for this area and should be the only person to give methadone for addiction. He arranges the medication schedule. If methadone does not appear to be appropriate for the particular person, we may use largactil or valium or some codeine; or we may use hemineurin. That would take about a week to withdraw them from the chemical. We do this, though, in conjunction with Dr Willis or the person's own general practitioner, sometimes with Port Kembla Hospital.

As Dr Willis said, that is the minor part of it, because the international relapse rate we are told is between $3\frac{1}{2}$ per cent and 6 per cent. That is the recovery rate without relapse. So when you think of the relapse rate, there are a great many other things than taking a chemical from them.

The major problem then is to close up the here and now social and sociological situation that is unbearable to them, that is preventing them from living a normal straight life; things such as employment, housing, personal relationships, inability to cope with the emotions that have been suppressed for so long and have now come out because they are not using the narcotic or whatever the drug is. That is the great problem, especially if they are living in the community. If they have not an initial live-in place, they are out there except between 9 and 5 and having to cope with the things that they have never learned to cope with, especially when their addiction usually starts at about the age of 14 or 15.

After we get things organized so that they can live a reasonable existence, we try to find what they are lacking that made them become addicted in the first place and we work on that. We have a follow-up for two years. We have only been going since June last year but we intend following up each of these people who are willing to be followed up.

2355. Mr Lake, we have heard mention several times today of the work you are doing at Australian Iron and Steel. First, would you give us an outline of your background in this type of work and then specifically we would like to hear a little about your work at Australian Iron and Steel?——W. (*Mr Lake*) There are two things that I would like to talk about. One is what I am attempting to do as far as prevention of drug addiction and alcoholism is concerned, but before I get to that I could talk a little about how we go about preventing drug addiction and alcoholism in the first place.

2356. May I mention, before we get too involved, that our terms of reference specifically exclude tobacco and alcohol, but we are interested in the drug aspect?——W. May I hand around some sheets containing information?

2356A. Certainly. That will be accepted as an exhibit.

EXHIBIT "6".

2357. CHAIRMAN: Would you continue?——W. Yes. It is difficult to cure addicts, therefore it is better to try to stop them becoming addicts in the first place. Now, how can this be done? In my view, drug addiction is part of the price that we pay for the sort of society we prefer to live in. We live in a society that is characterized by two major forces—competition and individualism. What competition does is that it sets up a system of winners and losers, and those who lose tend to develop a negative self-image of themselves, tend to lack self-confidence, lose their self-esteem and develop feelings of powerlessness. Individualism develops feelings of isolation and inability to communicate with others. When you are carrying round these feelings, the temptation to start medicating yourself with drugs becomes strong. If you choose the solution to resolve these feelings by medicating yourself constantly, that is why people develop drug addiction. Whether it is a housewife addict or a narcotics addict, they have very similar underlying causes.

What can drug educators do faced with this problem? The prevention of drug addiction should be aimed at reversing these destructive psychological feelings before they become addicted to drugs. I feel this can only be achieved in a situation where people have the chance to stabilize their ideas and feelings about living—their home, leisure, relationships, drug use. Most of the programmes I have been involved with have been aimed at doing that, to give people a chance to resolve these feelings and do something about them in a constructive way.

I feel also that many drug educators have caused a lot of the drug problems through their methods of education. The two main methods are, first the scare campaign, by showing scare films. What kids—especially young kids—tend to do is pick up underlying messages. The overt message says, "You should not take these drugs," but then the underlying message is, "Isn't it exciting to do it?" Then, giving factual information is another detrimental way of going about prevention of drug addiction. It is saying, "Take these drugs and you will feel different." When some individuals get those sort of messages they could be stimulated to become addicted to drugs.

It was in this context that Australian Iron and Steel last year initiated a drug addiction campaign. They were having some drug problems in one of their areas at the steelworks. What we worked out together—Australian Iron and Steel and the Health Commission—was to hold sort of seminars to put all the people involved in the section through. It was based on the concept of giving them a chance to look at their behaviour and drug use in the context of looking at all aspects of living. In fact, it was extended out to an education for living.

The first day of the course was basically aimed at having a look at the values we hold, our relationship with our parents and the world we live in. On the second day the course was basically aimed at having a look at drug and alcohol use. On the third day they were sent out to various centres to have a look at what was available by way of helping people with problems. They included community health centres, marriage guidance, Lifeline, Kembla House Addiction Centre. It involved also having a look at the Good Neighbour Council. This was to make everyone aware of where they could go for help in the early stages of a problem that may develop during their life, rather than sit on the problem and then try to do something about it by turning to drug use.

On the fourth day we come back to look at how you use these agencies to help with problems and also how you can refer friends to these agencies. Basically, the course is designed to have a look at ourselves and look into the way we live and where help is available in Wollongong in helping people with these problems, especially in relation to safety in that context. One of the problems we did have a look at was the drug and alcohol use and safety aspect. Working around areas which are quite dangerous, if you are using drugs then of course that increases the chances that you might have an accident. It is important for people who work in these areas to understand the effects that both legal and illegal drugs may have upon them in their particular situation. Basically, that is what we are involved in at Australian Iron and Steel. This year we are working with all the first-year apprentices and trainees, involving six hundred, and they go through a four-day seminar. If it proves successful it is planned to expand it to 3 000 or 4 000 of the older employees.

2358. You have suggested that scare campaigns are to be frowned upon. Would you say that one of the points you press is that they should avoid drugs and so on because if they do not there is a greater chance they might have an accident? In effect, are you not using a sort of scare campaign there?——There are different ways of convincing people about drug use. One way, which I think fails, is using scare campaigns. Another way is to get them to develop responsible ways of behaving. I think it is a matter of self responsibility as opposed to just being frightened for a short period.

2359. Dr Diment, you mentioned particularly that there were three areas, Warilla, Nowra and Bowral, that were troublesome?——W. (*Dr Diment*) Yes.

2360. Could you explain a little but further and expand on that? Is it in regard to school children, adolescents or older people, or all of them?——W. Mostly early high school children, so that would be children in the twelve to fifteen year group. There are others at later ages. This was picked up without any quantitative measure. You could not really assess how many people were at risk. The community nurses, at a recent survey which I did when I spoke to all of them about problems, invariably told me that in those areas the major problems were drug problems. A health education officer who goes to schools, not particularly in relation to drugs, asks the children to write on a piece of paper questions that they would like answered. This girl education officer goes to primary schools and at the Pleasant Heights school, located in one of the higher socio-economic areas, found that among the children there questions related mainly to drugs. They were questions such as, what should you do if people put drugs in your drink, what should you do if you were asked to take drugs, how do you know that you are being drugged, and things of that nature. The next most popular sort of questions related to sex problems and I think one kiddie wanted to know whether if he became a fireman he would get to drive the fire engine.

2361. Are you talking about drugs in general or are you talking about marijuana?——W. In that case, drugs in general. I would suggest that the Drug Referral Centre's main thrust is towards heroin. On the figures that does not seem to be so, but in fact I think it is. (*Mrs Benjamin*) It is the most difficult mainly because of the sociological problems attached to heroin. We see a great many pharmaceutical and prescription drug abuses, and alcoholics are included in the all-addiction follow-up figures. The heroin ones are the most difficult because they suffer other side-effects apart from the effect of the drug itself. There are sociological problems such as the amount of money that must be spent, the immense debts that they incur and the physical condition that they get into associated with the use of on-street drugs.

2362. Do you have any people come to you with adverse physical reactions because of too much marihuana? ——W. I have had two or three, both schizophrenic kids who reacted very badly after they smoked marihuana. I have had only two or three in eighteen months. (*Dr Willis*) I have had only one. It is very rare.

2363. Dr Diment, how many people are in your region? Is it somewhere in the vicinity of 275 000?——W. It is 290 000, with about 195 000 in the Wollongong metropolitan area, including Shell Harbour.

2364. How many educators are attached to your region? ——W. Five.

2365. How many of those are engaged in drug addiction work?——W. Two, basically.

2366. Where are they located?——W. One is at Australian Iron and Steel and the other one is at the addiction centre. We are stretched rather thinly.

2367. In other words, nobody is working in the drug addiction field in the Bowral, Moss Vale or Nowra areas? ——W. No, not specifically.

2368. Bowral is one of the areas that you say is a problem?——W. Yes. We lack resources very much indeed.

2369. Do you have the opportunity to make application for additional staff?——W. Yes we do but we are told, and we are given figures to show it, that we spend more money in the Illawarra region—practically double that spent in any other region—on community health programmes, which includes education services. Governments are rather loath to allocate additional funds when that sort of thing occurs.

2370. If more drug educators were appointed to your region who would have to make the decision?——W. There would have to be several decisions made. One would be by the Public Service Board which would have to approve the appointments, because they would be public servants. At the moment there is a freeze, implemented by the public service, on appointment of new recruits. We are static at 327 employees and we cannot put anyone else on. Additionally, the Health Commission would have to decide that the resources were available for the appointment of extra employees and I presume that that would be a matter for Treasury also.

2371. You mentioned a number of employees. Are you confined to a number or is there an establishment for each particular aspect?——W. There is an establishment for each particular aspect, but within reason we are permitted to interchange those. So, although we are static we can interchange staff to a certain degree.

2372. So it would be possible, if you re-assessed priorities, to drop a few people out of one particular aspect of the commission's work in the region and appoint more people to another aspect?——W. Yes, that would be possible. The difficulty then arises, of course, that it would be hard to recruit suitable staff. We have two trained psychologists, Mrs Benjamin and Mr Price. I do not believe we could start an addiction centre without an appropriately trained psychologist. These are very scarce indeed. We would have difficulty trying to recruit the people. On top of that the health education officers are not really trained in drug addiction. There is no training course available for them. Again, we have to give them in-service training which is a long and somewhat difficult business.

2373. Do you think it would be desirable to have a special course to train officers to work in these centres? ——W. Yes, I think that would be most appropriate.

2374. Do you know whether any recommendations have been made at any time for this sort of thing?——W. Not that I am aware of. This is a fairly common sort of tenet, that this should happen, but I do not know of any definite submissions that have been made.

2375. It is often spoken about?——W. Yes, whether anybody has done anything I do not know.

2376. What are the hours of work of the drug centre at Wollongong?——W. The hours of work are nominally nine to five, five days a week. We have extended that by the use of voluntary groups. However, that is being phased out. The voluntary groups have enabled us to keep the centre open for extended hours. (*Mrs Benjamin*) On Tuesday afternoons the centre is kept open until there is nobody left there and also the Narcotics Anonymous group works there for people who have already been chemically withdrawn, in order to assist them not to relapse. Friday evening it usually goes until fairly late, and it depends whether there are volunteers there or whether we are there ourselves. We keep the place open until everybody has gone, though that is not in the public service regulations. However, it is the truth of the matter.

2377. You are bound by public service decisions in regard to hours of work?——W. Yes, we volunteer our own services after hours.

2378. Do you mean what really happens is they do work extra hours but they do not get paid for that extra work? ——W. That is so.

2379. They are to be commended for that.——W. (*Dr Diment*) Yes, indeed.

2380. I think there are seven people associated with the drug centre. Would you give us an outline of the training of those people?——W. (*Mrs Benjamin*) We have two female counsellors. Miss Douglas has a solid, thorough nursing background. In addition, she was a nurse educator. She has worked with addicts in Britain and Europe. She has worked for Booth House in Sydney, an institution run by the Salvation Army for the treatment of alcoholism and drug addiction. She joined the community health service here in January, 1976. She was originally working at Berkeley but found that she was constantly being given all the addicts in that area to deal with, of whom at that time there were a great many. She was dealing almost solely with addicts in that area and when we were offered the opportunity to take on some counsellors in June she joined us. Mrs Meek also has a strong nursing background. She has conducted clinics on her own in Central Australia for Aborigines. She also ran the Papua New Guinea university clinic alone for three months before any other staff were appointed. She is very much aware of minority groups and has no strange feelings towards them. Both of those staff were trained by Garry Lake and myself. Both worked at the centre at weekends for approximately six months before they were appointed as full-time staff.

Roger Gray, the male counsellor, comes from a Christian background. He has been running Christian Involvement Centres, which are houses for youths who are displaced or are in social difficulties and also for alcoholics, for about two and a half years. He has also had training in counselling. We have sent him to Sydney to participate in the Central Metropolitan Region training course for addiction. He is a very satisfactory person to have down here.

John Sanders is a health education officer. He mostly shows films. He is also involved in a voluntary way with a farm that a committee of citizens have organized as a prevention measure for drug addiction. That is being done in conjunction with the Department of Youth and Community Services and the Department of Education. He does this in his own time. Garry has a degree in sociology and another degree in economics. He has also worked as a psychiatric nurse and been a teacher. It was mostly in the psychiatric unit that he acquired a knowledge of drugs.

He was also given some training in Sydney as a health educator with Dr Webb of the Health Commission. I am a psychologist with an Honours Degree. I have taught for two years. I had done a lot of voluntary work with addiction before I joined the Health Commission. I am on the drug committee and the crisis centre committee. Our receptionist, Jackie, is vital. She is a frontline lady. She had done voluntary training with us when we were training our voluntary committee. She is able to recognize a person in physical difficulties. She is far beyond being a normal secretary. You have to have somebody like that at the front door. If the kids are faced with an efficient, conservative looking lady they turn tail and run. She gets up and gives them a cup of coffee, sits and talks with them for a while, shows them around, and generally cases them out to see why they are there.

2381. Are any of your staff ex-addicts?——W. No. We do have some volunteers working for us who are ex-addicts. They are doing a marvellous job for us.

2382. You mentioned earlier that you take people to Sydney and try to get them into one place or another. The type of treatment varies considerably, does it not? ——W. Yes.

2383. For example, at Wistaria House they use methadone but at William Booth they do not.——W. I shall mention a case. We had a fellow who had a 25 caps a day habit. He was very, very ill. Somebody with that kind of habit could not be safely withdrawn without medication. Therefore Booth House was out. We had another one who had something like a 15 or 16 caps a day habit. He had only one kidney and the other one was packing up. These people cannot be withdrawn without medication. At the same time we find—and the Committee for recommendation of methadone use, December, 1976, has now agreed—that methadone is suitable in only a small number of cases. It is no use simply to say methadone is pretty useless. One has to look at addicts individually and assess their needs and match them up with the treatment appropriate to their mental and physical condition.

Further, a great many of the voluntary places are religious in character and they expect a good deal of conformity to the religion in that place. There is no point in taking to such a place somebody who is not going to conform to that type of religious orientation. He will either be asked to leave or will leave himself. At the moment we have an ex-addict helping to look after some kids in Nowra. They are being looked after by medicos including Dr Flynn from Albatross and Bruce Price, the psychologist attached to the Nowra centre, and the general health staff there. That ex-addict is helping to look after the kids we cannot place at the present time.

2384. Do you think that Nowra is a trouble spot because there is a naval station there?——W. I would only be guessing. I have no facts to give you about that.

2385. Have you any idea of the number of people in the under 25 age group in your area?——W. (*Dr Diment*) Not in actual numbers. We have some interesting figures for areas within the region, if that is of any help. In the area south of Lake Illawarra—the Warilla, Shellharbour area—the average age of the population is 12, which means that we have there a very young population. At the other end of the scale, when we come to a place like Sussex Inlet we find that 44 per cent of the population is over 60.

2386. That is a retirement area?——W. Yes. We have several of these retirement areas. These are growth areas. The area has grown very rapidly and this is where the young populations are. This is why I suggest that Warilla would be a good place to establish a centre. However, without suitable people to run it it is difficult to establish. Nowra is beginning to get its own centre. We have recruited a psychologist who will be the basis of a referral centre there, but that is just beginning. It has not yet begun full-time operation but it is on the way.

2387. One of the problems in all of this work is the public service rule that overrides most of the other considerations. One of the main problems here, as I see it, is the same as they have in some other places in the State, and that is that addicts need attention at all hours of the day and night and the centres where they can get attention are not normally available except during public service hours.——W. That is correct.

2388. Would you say that this would be one of the most important reasons why either the hours should be relaxed or independent authorites should operate half-way houses if they are established?——W. Yes, I would. The main problem with drug addiction would, I believe, occur during the night hours, particularly up till 10 o'clock at night or between 10 and 2 in the morning. It is not very useful to have the centre open between 9 o'clock and 5 o'clock during the day, when the main trouble period is between 10 o'clock at night and 2 in the morning. I believe the hours ought to be relaxed. Under the public service rules we are not allowed to employ staff during that period. We cannot even employ them on overtime because overtime has to be approved and can only be approved after a certain time during the day. Those regulations should be altered.

I believe that the rules should also be altered to allow the employment of ex-addicts. The Public Service Board will not employ anybody who has a police record. An ex-addict would surely be a good person to talk to other addicts, but the moment we put up somebody like that the Public Service Board will not approve their employment. Therefore either the Health Commission should become independent, and this applies to other health matters as well, or else these things should be run by an independent body.

2389. Apparently drugs like heroin and marihuana are fairly freely available in the whole of your region?—— W. We believe so.

2390. Have you any idea what is the source of supply of these drugs? Take heroin first.——W. Only by rumours —that is all—nothing definite at all.

2391. Do you have full co-operation from the law enforcement authorities?—W. Yes, particularly lately. I do not think it was always so but of late we have had co-operation. In fact, the local superintendent insisted that we get co-operation and we appreciate that very much.

2392. Dr Willis, could you give us some idea of the numbers that have been admitted to your section in, say, the past twelve months?——W. (*Dr Willis*) About twenty.

2393. What would be the normal length of stay?——W. Four to five days.

2394. I think you did say that it is not always possible to keep them for the length of time they require?——W. That is why I averaged it out at four to five days—that is correct. As you said, they tend very quickly to become dissatisfied with the environment.

2395. You do not endeavour to put them under any compulsion to stay?——W. We cannot. We are in no position to compel anyone at all to stay. Anyone who is sane cannot be compelled to stay in any place at all. These people are not certifiable mentally.

2396. Would you have anybody that would be sent to you from the court on remand with a condition that they go to you for treatment and stay there?——W. They would be under our supervision for only a short time. We may take them for a few days for detoxification. Although they would normally be referred to our charge they would be referred on to the addiction centre anyway. I think that has happened on one or two occasions, but it is not common.

2397. There was only one other question I wanted to ask you, Dr Diment. In conversation that I have had with people in the Education Department, it has been suggested that there is a fairly big problem on the far south coast. Do you get any overflow from there? Would you feel the effects of it in your own area?——W. (*Dr Diment*) Not a great deal. I did have that area to administer for about 12 months in 1974. I then managed to gauge a few things that were going on down there then. There is the town of Cobargo with 600 people, where, we were told on pretty good authority, there were 37 heroin users. That was rather frightening.

2398. Mr WOTTON: The question of the health education officer going to various schools and carrying out his programmes, is that under the direction of the Health Commission or is he rather doing his own programme? ——W. The drug man is rather doing his own programme. The one I was referring to is under the direction of the Commission. She is not exactly a drug health educator, she is a general health education officer. She was the one who found that most of the problems that children asked about were in connection with drugs.

2399. In relation to a voluntary body acting instead of the Health Commission under the control of the Public Service, do you base that mainly on the hours involved? Surely that can be resolved? Or is this another autonomous body that wants the Government to give money and then do its own thing?——W. No. For a start I did not mean a voluntary body. I mean the body must be independent. It may well be a Government body but it must be independent of the Public Service Board, because of the regulations. The regulations I believe would be difficult to repeal or to adjust. They would affect so many other departments where maybe they are a good thing. But in the health field I do not believe it is possible to render an effective health service within the public health framework. I say that because of hours, motor vehicles, staff; we cannot put on appropriate staff. There are many of these difficulties that we experience when we have to do things that may be frowned upon by the Public Service Board; but we have to do them to be effective. They keep saying that we have to be efficient, which means really that we have to do it without wasting money. That is fine, but again, efficiency and effectiveness are not always the same thing.

2400. You mentioned earlier the matter of cars used by counsellors. Have they been reduced latterly?——W. Yes.

2401. To what extent?——W. We now have to reduce the number of cars. The number varies from centre to centre. We have not in fact reduced the number at the addiction centre. Now counsellors, by and large, are not allocated motor cars. None of our staff are allocated cars; they have to use pool cars. They are not allowed to take them home at night. In a drug referral centre this can be very awkward. I have in fact, about two minutes ago, given them instructions that if that happens they are to take a taxi and charge it. So we can get over those things, but again, this unbending regulation does get in the road sometimes.

2402. CHAIRMAN: The staff that are presently working in the region, are they all employed by the Health Commission?——W. No. The health services employ 70 000 employees. It is the largest employer of Government or semi-Government labour. But most are employed by hospital boards. They are mostly employed at the hospital and we have very little control, as the Health Commission, over what the staff at hospitals do. For instance, if a department tends to run down, hospitals almost certainly keep the same number of staff although the workload is less.

Recently the ambulance services have been taken over by the Health Commission; amalgamated, rather than taken over. The ambulance staff are now employees of the Health Commission. The community staff, etc., and the administrative staff are Public Service Board employees. It seems to me to be an illogical situation, and it would be very much better if the Health Commission itself became an independent group, such as the water board or the electricity commission and so on, so that within budgets, and certainly being accountable—I am not suggesting that we should do this just to waste finance, but with safeguards of accountability and so on, it should be autonomous.

2403. Even within the hospitals' system, in different schedules you have different conditions of employment? ——W. Yes. The fifth schedule hospitals employees are public servants, whereas the second schedule hospitals employees are employed by hospital boards. That makes it a very mixed bag.

2404. Mr HEALEY: In the schedule 5 hospitals where employment is by the Public Service Board, they maintain a 24-hour a day service?——W. Yes, they do, but the regulations apply only to nursing staff employed in fifth schedule hospitals. The moment we bring them out to community, those regulations do not apply.

2405. It is just a matter of regulation?——W. Yes.

2406. I mean, a regulation could be introduced to cover referral centres?——W. Hopefully, yes.

2407. Mr MACDIARMID: Could you put your finger on the reason behind these nests or pockets of drug users in places like Cobargo?——W. Yes. Cobargo was just a sort of one-off place. That was just one that came to my notice during the time I had that area to administer. That is a rather unique case. The problem there in relation to marihuana is pretty high also, but this is a resort area and during the summer the young people set up communes in the hills; there is a beach there. The usage apparently rises very markedly during the summer months; obviously because there is a greater population there. But the pockets as we see them are—I think my colleagues would agree—Warilla, Nowra and Bowral. We find it difficult to obtain accurate figures about that, but from reports received from community nurses and citizens' groups, etc., it would appear that the problem is as bad per capita in those areas as it is in central Wollongong.

(*Mrs Benjamin*) I would agree with that, particularly pertaining to the pockets you are talking about. There is a place called Culburra where heroin addicts are present in large numbers. The reason appears to be that it is cheaper to live there. Houses are cheaper to rent, they can grow their own vegetables and they are together. They are out of the usual run of straight citizens. They feel their position rather strongly. And there are no police there.

2408. How much has been done in the summer months in Cobargo to try to track down pushers?——W. (*Dr Diment*) I think a great deal has been done, but again I can only speak from hearsay on that. I believe that since our reports of this two years ago there has been quite a step-up in activity in that area. Again, that is only from what I have heard that other departments have done.

2409. Without denegrating the work that has been done in the field of education, would you agree that perhaps a far greater education programme is needed in the schools? ——W. Yes, we need to teach communication skills. We need personal development programmes and we certainly need education along those lines. I stress patricularly communication skills. After all it is difficult to talk to our children in many cases, with obvious exceptions. I was told that my generation tells children what they should do rather than suggesting to them and asking them what they want to do. I think we do tend to do that and we have lost communication skills. I do not know whether my education colleague would agree with that.

(*Mr Lake*) I think the Education Department has a good personal development course and that is probably the best drug-prevention measure that is currently available in New South Wales. Quite often many teachers feel inadequate about teaching. Last year I was involved with three high schools in the area, working with teachers to implement personal development programmes. I think there needs to be a lot more back-up by the Department of Education to help teachers run an effective personal development programme.

2410. The figures that we were given this morning, suggesting that there are between 1 200 and 1 500 heroin users in this area, are quite alarming?——W. (*Dr Diment*) Yes.

2411. Do you receive many people sent by private practitioners in the area at the drug referral centre?——W. (*Mrs Benjamin*) Yes, that would be our second-largest source of referral, after those referred by previous clients who send along their friends.

2412. Mr HEALEY: Dr Diment, your drug referral centre works on a set budget each year, does it?——W. Yes.

2413. How much is that budget?——W. It is so much for capital and so much for operating and it is about $90,000.

2414. That is for staff wages plus rent of premises and so on?——W. Yes.

2415. Once that has been allocated do the people concerned have a free hand as to what they do with the money?——W. No. The capital cost for rental and furniture and so on is included and to 25th May it is $89,063. In fact, its operating cost for this year will be another $7,000, so the yearly figure will be about $96,000. That is to treat more than 300 people, so it costs about $350 per addict. Therefore, I do not agree with my colleague who says it is expensive. We would pay that much, quite happily, for a major operation, and both groups of people are sick.

2416. What back-up can your drug referral centre expect from the Health Commission in Sydney? If there is a special emergency or a special influx of clients is there any back-up available to them or must they struggle along on what they have?——W. They are expected to struggle along with what they have because the budgets are set but if there were a crisis we could ask for some supplementation.

2417. Is there any back-up service or officers or special expertise to come here from Sydney for, say, a month? ——W. No, but we might get them for perhaps a week, or perhaps on a one-day visit. That is basically an educational programme for our people, but that is all.

2418. Is there any regular consultation between the various area directors with regard to drug problems? Do they get together to find out what the individual problems are and compare notes or anything like that?——W. Yes, there is a regional directors' conference once a month, for one day, but many problems are discussed during that day.

2419. Drug problems are one of the smaller matters discussed?——W. Yes.

2420. Dr Willis, I am interested in your earlier statement that there are no medical problems connected with the withdrawal of addicts. Am I right in that you are saying that as far as an addict is concerned it is purely psychological and all other organs in his body are perfectly healthy?——W. No, I would not agree with that statement at all.

2421. Therefore there must be a medical problem involved?——W. The medical problem—I do not think there is any difficulty in dealing with the medical problem as such, but there is a medical problem there, though it is comparatively easy to deal with.

2422. We have been told by other experts in the field that for the methadone treatment to succeed it could take up to three years before the addict can be completely cured of his addiction yet you tell us it can be done in three days. Why is there such a discrepancy, between the three days and the three years?——W. Yes, I see what you are driving at now. I am talking purely in terms of withdrawal from drug addiction—the detoxification procedure whereby they have no physical withdrawal effects from the drug after treatment. After, say, a week or ten days I can be pretty certain there will be no physical withdrawal effects from the drug. These people who keep methadone up for two or three years are, in effect, providing a crutch for the person who has been addicted in order to rehabiiltate that person. It is more of a psychological crutch than a medical crutch. Methadone, as it stands on its own, is quite useless. Before the addition team started I was giving methadone courses on the road and my results were very poor indeed—probably only one or two successes. Without counselling, methadone on its own is useless.

2423. Mr Lake, this curriculum you gave of the circumstances at Australian Iron and Steel, is that your own work or do you have guidelines from the commission, or do you have a free hand to work to your own programme? ——W. (*Mr Lake*) There are Health Commission policies formulated and I work within those guidelines.

2424. But you are in action, actually doing it?——W. Yes, there are guidelines laid down. At the moment there is no actual policy document which has been accepted by the Health Commission. Within the acceptable guidelines I operate.

2425. Mrs DAVIS: Mrs Benjamin, we have been mainly talking about heroin, but you see total addicts at the centre. Do you see any abuse of drugs like barbiturates or analgesics?——W. Yes, sometimes I see abuses of these drugs by young people who are addicted in a multiple way to a number of other drugs of physiological addiction. The majority of people we have who are addicted to those drugs are ladies over twenty-five and men around about fifty. That seems to be the age group involved. After they find they are addicted they generally report to us and instead of admitting addiction, they just seek help. Usually they have gone from doctor to doctor, so it is not individual doctors who are doing the wrong thing. It is the fact that they are presenting themselves to a number of GPs to stay on the habit. By the time they go around the lot and get back to the original doctor he would think it was quite safe to prescribe again. We see a great many of that type. Dr Willis helps us with the barbiturate withdrawals because they can involve convulsions, coma and death and we would not attempt to withdraw one of those in the home. Chloral hydrate is something we have a great deal of trouble with too.

2426. Have you had many drug-induced deaths in this area, overdoses and so on?——W. Yes, there have been a few of them but sometimes they are people who die from complications of the drug use rather than the actual drug itself. Actually, we have overdoses that we attend to and revive the person and admit them to hospital where appropriate. That happens fairly regularly, usually with heroin, but sometimes with barbiturates. Of our own clients we have only had two die. One was not really death from the drug involved—he suicided by walking into the ocean. The other one was killed in a car accident. We had not had any of our other clients die but there have been a number of deaths in this area, mainly from complications from stuff that the drugs are fixed with —the street drugs are always filthy with other mixtures.

2427. Dr Willis, how many patients do you have on methadone maintenance treatment at the moment?——W. (*Dr Willis*) Only two in this area and soon there will be only one. As a team, and I think I can speak for all of us, we do not agree with long-term maintenance on methadone. As a strict medical principle I feel that though in many cases we might not be able to do much good, it is most important that we should not do any harm. That is my own feeling about it. As a team we decry the wholesale use of methadone. It has a place but it is very limited.

2428. Dr Diment, if you were looking at an in-patient clinic for this area what size would you visualize?——W. For a start I would think an eight to ten-bed unit would be enough. The ideal would have to be worked out from that. I think we could manage with a small clinic and perhaps a live-in facility, with about eight beds. We would need four areas altogether.

2429. CHAIRMAN: How many coroner's courts do you have in the region?——W. Wollongong and Port Kembla, two.

2430. Are the figures from the coroners' courts supplied to you officially?——W. No, not officially.

2431. But you do have ways of obtaining that information?——W. Yes, we do get the information. We employ the government medical officer who does the autopsies.

2432. Were you going to reply to Mrs Davis' question about overdoses?——W. Yes, about the actual number of overdoses and how they have changed since 1973. In 1973, through Wollongong Hospital casualty there were sixty overdoses and it has steadily fallen in 1973, 1974 and 1975, and then went up again in 1976. We believe that that relates to unemployment difficulties.

2433. You have a graph there? Would it be possible to supply the Committee with a copy of that graph?—— W. Yes. We have a graph both for females and males. It has attached to it a document which sets out details of the areas involved.

(*Exhibit* "7".)

2434. Mr JACKETT: Dr Diment, I think we are all aware of the dangers to young people of using scare education methods on the subject of drugs, that if they find something they have been told is not true or is only partly true they tend to play down the truth of a lot of the others things they are told. What do you feel is the state of knowledge in young people on the subject of drugs in schools in the Wollongong area?——W. Very limited indeed. I do not think they are aware but they want to be aware of the problem. They are keen to know about the effects of drugs and how to detect them. Their worry is that they are getting drugs without their knowledge. This seems to come out in the questions that we are asked, "How do I know if people put drugs in my drink?" and so on. I am talking about primary children now. I think they are frightened of becoming addicted or of becoming drug users. I think they are quite scared of this.

2435. On the question of drug education in the schools, it has been put to us on a number of occasions that the best drug educators are their own class teachers, the people from whom they are learning most of the other aspects of their education. What back-up is being given to school teachers in this region by the Health Commission to arm them with the practical information they need to give an adequate drug education?——We run several programmes at the teachers' college. The personal development programme there runs for about three months of each year. This involves four or five of our staff on a short-term basis. They are not there all the time. We are doing that in conjunction with the Education Department. I agree that the teacher is the best person to deal with the question of drugs. It would also be a better idea if the teacher gave the subject as part of a curriculum and not as a special one-off session which causes a bit of excitement to the kids—"Today we are having something totally different". It should come in as part of the curriculum. It should not be made a feature. It should just run through the curriculum, but the teachers may need to be trained in that subject more than they are now.

2436. Earlier you were discussing cars and overtime and other matters. Is it not the situation that if the Government makes provision in the budget for a matter which is approved by the Minister, the Public Service Board has no further interest in it? It is only in cases where something arises after that that the Public Service Board is concerned. We do not want to suggest something that can be done in the ordinary way.——W. (*Dr Diment*) We have recently had a directive that we must compound our cars and that they must have stickers on them and so on. This was given by the Commission, certainly, but it was a Public Service Board direction. We were accused—in a few cases maybe rightly—of allowing our staff to take cars home. We did allow our staff to take cars home on the basis that they were field staff and they could go out in the morning without first going in to a centre. They could do things on the way. This is frowned upon by the Public Service Board who say we are providing transport for our staff from home to work, and on that I presume they are perfectly correct; we are. We allowed this because it was cheaper than compounding them. We had no compound areas. That is the first thing. Secondly, I believe the staff looked after them better when they did this. It was under my direction that they did it. A Public Service Board inspector recently was very critical of that. We have now been ordered to compound the cars at night, in spite of the fact that I think compounding will cost more than the small amount of petrol used by staff taking the cars home.

2437. Mrs Benjamin, what do you find is the main worry of the addicts that come to the centre when they are on a drug like heroin?——W. (*Mrs Benjamin*) Generally they express a fear about whether, when the withdrawal period is over, they will be able to cope without the use of drugs. This is what they express to us as their major fear. There are a number of issues that they are really afraid of. They have employment problems because there is a stigma in the community against illegal drug addicts. If employers know about it they generally will not employ them, even if they have been ex-addicts for some period of time. At the moment we have some highly skilled people who have been drug free for up to eight months who cannot get employment simply because they have been addicts. I know there is an unemployment problem at the moment, but these are highly skilled people who could otherwise be placed. Once it is known that they have been addicts, because they are honest enough to say so, they just cannot get work. Unemployment causes a great number of other social problems. I am probably saying that is the largest of the side issues. On Tuesday evening I asked the young people at Narcotics Anonymous to give me some idea of things that they would like you people to know and, apart from the usual, they need a centre for people to live in for six weeks while they are recovering. One of the things they spoke about was the discrimination in the community, the sense of rejection they feel, that is not extended to alcoholics. Their feelings of inferiority and worthlessness are increased incredibly by medical staff, police, neighbours and the community generally. Whether that is because drug addiction is illegal I could not say, but they feel that the worst problem they have to face is that they are a people apart.

2438. Have they a fear of being prosecuted by the police?——W. Yes. They call that their paranoia. They are so afraid of prosecution. Addicts tell us that many times they are "suspected of using" or they have been "found to be using" they have been what they call "planted", even when they have ceased—that is with drugs that they are not currently using. Many different accusations of this kind are made—not only of planting but also of different treatment of addicts under police supervision from the normal straight criminal. When they go to court they are not believed because they are "just an addict"—"you know what addicts are like"—"these are addicts". If you are an addict, automatically you cannot be believed, no matter what the truth is. This happens to the point where they will not complain any more when they are mistreated in any respect by anybody, because they are afraid. If it happens to be the police they are dealing with they are afraid of repercussions if they complain. So, if anything done to them is improper or not according to law, they feel their stigma which is so clearly demonstrated to them by society. They are even afraid to ask for their court rights as human beings. That is all I can tell you about that.

2439. Dr Willis, what medications are used to help addicts through withdrawal other than methadone or cold turkey?——W. As has been mentioned—largactil, hemineurin, codeine, valium. You could use morphia, if you wanted to. Those are the only four I have used, apart from methadone.

2440. What method is used here with regard to methadone—blockade or maintenance?——W. We do not use blockade at all. We do not order it from this Illawarra Region at all.

2441. So methadone is used only for maintenance?——W. No, it is used for maintenance in only two cases at the present time in this region and it will only be one very shortly. We only use methadone for withdrawal over a relatively short time.

2442. So they have to go somewhere else if they want to be on the methadone programme?——W. Indefinitely, yes. We do use methadone—30 mgs for three weeks or 40 mgs for four weeks. Sixty mgs for six weeks is about the longest time period. The worry is of producing methadone addiction.

2443. CHAIRMAN: Have you had cases of people who have been convicted before the courts of offences connected with marihuana, placed on a bond on condition that they come to you for counselling?——W. (*Mrs Benjamin*) One.

2444. That is in about twelve months?——W. That was marihuana and that was in about May, 1976. That person has now transferred to Nowra and he is seeing Bruce Price at Nowra.

2445. Mrs ANDERSON: People in Warilla, Nowra or Bowral that want counselling or assistance, where would they go to?——W. I should like to see them go to the addiction centre in Wollongong. I realize that that creates transport problems, etc. Fares are expensive and transport between the two areas is difficult. The areas are not very far apart but the journey requires a change of buses. They could go to the Warilla centre where they would be looked after by community nurses, but that would worry me. I should not like to see them there. I think you would agree with that, Mrs Benjamin?

(*Mrs Benjamin*) Yes.

(*Dr Diment*) The counsellors do go down there on occasions.

2446. Mrs ANDERSON: In the statistics you have taken out has any problem of drugs with the migrant population shown up or is it an across the board problem? ——W. (*Dr Diment*) It is across the board. We have not actually done that. Migrants represent about 48 per cent of the population. We have not delineated the problem yet as to whether it is greater in migrants than non-migrants.

2447. You do not even know whether there would be a serious valium problem with migrant women?——W. No. We are finding that somewhat difficult. I do not know whether Mrs Benjamin can answer that better than I can.

(*Mrs Benjamin*) There is not a large problem with women. We have had one new Australian lady who has come to us with a problem at the centre. That does not mean that they are not out there, particularly migrant women. Approximately 10 per cent of the people that we have seen at the centre have been new Australian females. The number is growing. They seem to pass the word to one another.

2448. Among the apprentices at Australian Iron and Steel, what proportion would be young people who have a drug problem as against an alcohol problem?——W. (*Mr Lake*) I would say in terms of using drugs, using marihuana, they are 16 or 17-year-old kids. They have used it at some stage. They do not see it as a problem but after running programmes with them I felt that a number of them were definitely becoming alcoholics. Alcohol seemed to be far more of a problem, a medical problem, than illegal drug use.

2449. Basically, so far as the drug problem is concerned, it is marihuana?——W. They do not see it as a problem, but the drug users do use marihuana. They have seen heroin, and I would say the majority knew where to get it, but none of them had used it.

2450. Mr RAMSAY: Mr Lake, you theorized and generalized in your statement, but have you or the company been able to detect any pushers within the 402 apprentices at Australian Iron and Steel?——W. (*Mr Lake*) No. That side does not concern us at all. We just deal with the kids. So far that has not arisen at all.

2451. If you were working among those young people and you detected that some of them were on drugs, would the company ask them or suggest to them that they seek treatment or would they be dismissed or what would be the position?——W. Australian Iron and Steel has a blanket policy. If you are intoxicated, whether by the use of alcohol or marihuana or any other drug, you are subject to dismissal. That does not always occur in all circumstances. We certainly have nothing to do with reporting on anything the kids say. At the end of the course they are asked to fill in an anonymous questionnaire as to what they thought of the course. We certainly do not report if anyone has been found using a drug. We show them where help is available if they want it, and if they have a drug problem they know where the addiction centre is and they can use that facility. But there is no information spread about what kids are using it.

2452. Mrs Benjamin, in regard to the counsellors at the Drug Addiction Centre at Wollongong, are you happy with the standard required of counsellors to enable them to give advice or would you like to see the Commission or some qualified people train them, as happens in some other areas?——W. (*Mrs Benjamin*) The counsellors that we have working at the centre at the moment, we could not desire any better people. For after hours activities, I deplore the fact that we do not have trained staff available at all times. This is where we lose out, not only in a crisis that might occur during those times, but for people who have to have follow-up after chemical withdrawal. This is totally necessary. Voluntary agencies are very good but we have mucked around with the problem for so long. Voluntary agencies have been helping, but have not achieved very much. If we had properly trained people to cover that period of time for the withdrawing addict and for getting him back on his feet, we could run a proper assessment programme of methods of withdrawal and methods of rehabilitation, test the alternatives, see how successful they are, and we would know something. It has been messed around for too long. These matters are really vital if we are going to do anything but pretend to provide a service.

2453. In other words, you would like to have properly trained people man a centre 24 hours a day, seven days a week?——W. Yes.

2454. Dr Diment, you indicated that you would like to see further drug referral centres at Warilla, Nowra and Bowral. Would you also agree that there is a need for rehabilitation centres such as they have in Victoria?——W. (*Dr Diment*) Yes, there is no doubt in the world about that. We have no place in this whole region to refer people after their initial detoxification. They have to go to Sydney. That is just not good enough. We need what I described as half-way houses. That is not a good description. We need a rehabilitation centre, that is all about it. We need several of them, not just one.

2455. I know that methadone is a highly controversial issue so far as withdrawal is concerned. What is your attitude toward methadone treatment for withdrawal?—— W. For withdrawal, fine. That is one of the methods of withdrawing. I personally do not like methadone as a follow-up treatment at all because I think all you are doing is transferring from one drug to another. As Dr Willis said, by itself it won't work. You need the counselling. That seems to me to give the best method of treatment. So you have any form of withdrawal, including methadone, then the counselling to follow, particularly if you can do that in a rehabilitation centre.

2456. They are the views expressed by the medical people in the Hunter Valley. They will not allow it and they do not make methadone treatment available. They have to go to Sydney?——W. Yes. We do much the same thing, except for the short term.

2457. Do you have any idea of the incidence of kidney disease caused by analgesics in this city? Is it high? Is it one that concerns you?——W. Yes, it concerns me greatly. We have no renal dialysis unit in Wollongong yet. We have one, hopefully, coming. We are also aware that there are 30 people travelling from this area to Sydney three times a week for dialysis. That is a very expensive system in terms of transportation. There is a patient from Shoalhaven Heads. The ambulance has to leave very early in the morning to take that patient to Sydney by 9.30. It leaves from Wollongong. There is some difficulty about using one from Nowra. I think the number of vehicles there is not adequate. An ambulance wagon leaves here about 3.30 a.m. to have that patient in Sydney by 9.30.

That picks up the patient, of course, at 5.30. It is a tremendous added burden to the patient. I cannot give you any idea at the moment of the number of patients who are on home dialysis machines. They are issued from Sydney and we are not told who they are, which is also awkward. So there are many people on home dialysis machines and there are 30 people travelling between Wollongong and Sydney three times a week.

2458. I suppose there are delays sometimes in getting them home after being away all day?——W. Yes, this is another problem. Quite frequently there are delays. Ambulance wagons are not available in Sydney. They have to go up and pick them up. The patient will sit sometimes for some hours in Sydney waiting for transport back again. One wonders about the stress caused to the patients over transportation and delays in transportation.

2459. CHAIRMAN: There is nobody here, I presume, who is doing any research in regard to the use of analgesics?——W. No.

2460. Going back to the graph which you supplied to us earlier showing the number of new heroin cases, as I read it I think there would have been 205 new cases last year?——W. Yes, that could be.

2461. And in one month—I think September—there were 33 new cases?——W. Yes, I think that is right. There were 33 in September, 1976.

2462. For the previous 12 months there were only 19 people who were charged or convicted for the use of opiates in the local courts?——W. Yes.

2463. Could you explain the apparent disparity? Even if the number of 19 doubled last year, could you explain why there would be so many new cases known to you but only about 30 cases of people being convicted?——W. We will not inform the law enforcement authorities if we have a patient for treatment. We consider that privileged. Despite the fact that we could be accused of aiding and abetting, we will not inform authorities of a case. The moment we do, we lose all credibility with any users.

(The Chairman adjourned the public hearing and the Committee heard evidence *in camera.*)

(The Committee adjourned.)

*AT WOLLONGONG ON FRIDAY, 27 MAY, 1977*

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(The Committee met at 9.00 a.m.)

**Present**

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| The Hon. MARGARET DAVIS | Mr J. T. C. JACKETT |
| The Hon. C. HEALEY | Mr E. D. RAMSAY |
| The Hon. F. M. MACDIARMID | |

BERNARD PATRICK SLATTERY, Superintendent of Police stationed at Wollongong, residing at 98 Woodlawn Avenue, Wollongong, and

MAX LESLIE EBRILL, Detective Senior Constable of Police stationed at Wollongong, residing at 28 Blanchard Crescent, Balgownie, were sworn and examined:

2464. CHAIRMAN: Before proceeding further I wish to make a statement in regard to some matters that have been drawn to my attention. Since the adjournment of the committee yesterday, my attention has been drawn to an article which appeared in the *Illawarra Mercury* yesterday morning and which indicated that pressure had been brought to bear on the Select Committee not to use its powers of subpoena to bring customs officers before the hearing. The article went on to say that the *Mercury* understood that the unofficial request came from Canberra. I wish to state publicly, and I hope that this statement will receive the same prominence in the newspaper as the article did, that at no time has any pressure been brought to bear on me as Chairman of the committee not to summons any witness before this committee. Certainly, such a request would not have come from Canberra. The person concerned would be the head of the Narcotics Bureau, Mr Harvey Bates, and as I indicated in a television interview yesterday, Mr Bates has been very co-operative with both me and Mr James, the clerk of this committee. Arrangements have already been made to go to Canberra for a sitting of the committee there. Mr Harvey Bates is going to co-operate to the fullest.

Might I also correct one wrong impression that might have been created by that article. Not only has no-one the power to bring pressure on the committee not to call witnesses, but also the committee has power to summons witnesses under the Parliamentary Evidence Act. This impression could also be created by a statement that appears in this morning's newspaper which indicates that two customs officers had demanded to be heard by the committee. That also is not correct. I was approached to see whether these people could give evidence and I said that we would be quite prepared to hear them.

2465. CHAIRMAN: Mr Slattery, did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. (*Mr Slattery*) Yes.

2466. I understand that you wish to make an oral submission to the committee?——W. Mr Chairman, members of the committee: I would like to make it clear at the outset that I do not set myself up as an authority under the Poisons Act, nor do I claim to have any real experience in the drug problem. The facts that have come to my knowledge have come through personal association with members of the Drug Squad, members of the public and from reading. I have some statistics from police files which may assist.

2467. Mr Ebrill, did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. I did.

2468. I understand that you wish to make an oral submission also?——W. That is correct.

2469. Superintendent, you might continue with your submission to the committee?——W. (*Mr Slattery*) I produce some statistics which refer to the period 1970 to 30th April, 1977. The period from 1970 to 1075 refers only to the Wollongong city area. The figures quoted for 1976 and 1977 to date cover the whole of the South Coast police administration area, which extends from Helensburg to the Victorian border.

2470. Do you wish these figures to be admitted as part of your evidence?——W. Yes, I feel it would assist the committee.

*Witnesses*—B. P. Slattery and M. L. Ebrill, 27 May, 1977

DRUG ARREST STATISTICS—1970 TO 30TH APRIL, 1977. NOTE: ONLY 1976 AND 1977 COVER WHOLE SOUTH COAST

| Ages | 1970 | 1971 | 1972 | 1973 | 1974 | 1975 | 1976 | 1977 to 30–4–77 |
|---|---|---|---|---|---|---|---|---|
| 14 years .. .. | 2 | .. | .. | .. | 5 | 3 | 2 | .. |
| 15 years .. .. | 2 | 6 | .. | 2 | 6 | 3 | 19 | 3 |
| 16 years .. .. | 3 | 13 | 9 | .. | 12 | 9 | 30 | 1 |
| 17 years .. .. | 4 | 12 | 18 | 6 | 18 | 22 | 65 | 11 |
| 18 years .. .. | 4 | 9 | 12 | 12 | 14 | 47 | 49 | 31 |
| 19 years .. .. | 8 | 22 | 16 | 7 | 17 | 35 | 54 | 14 |
| 20 years .. .. | 2 | 12 | 11 | 11 | 18 | 25 | 51 | 17 |
| 21 years .. .. | 4 | 8 | 8 | 11 | 13 | 26 | 48 | 11 |
| 22 years .. .. | 3 | 5 | 5 | 3 | 15 | 19 | 20 | 14 |
| 23 years .. .. | 2 | 4 | .. | 1 | 7 | 18 | 23 | 4 |
| 24 years .. .. | .. | 4 | .. | 2 | 8 | 12 | 18 | 2 |
| 25 years .. .. | .. | .. | 2 | 4 | 4 | 3 | 16 | 6 |
| 26 years .. .. | .. | .. | .. | 2 | 5 | 5 | 15 | 2 |
| 27 years .. .. | .. | .. | .. | .. | 1 | 5 | 6 | 1 |
| 28 years .. .. | .. | .. | .. | 1 | 1 | 2 | 7 | 2 |
| 29 years .. .. | .. | .. | 1 | .. | 1 | 1 | 6 | .. |
| 30 years .. .. | .. | .. | 1 | .. | .. | .. | 4 | .. |
| 31 years .. .. | .. | .. | .. | 1 | .. | .. | 2 | 1 |
| 32 years .. .. | .. | .. | .. | .. | .. | .. | 1 | .. |
| 33 years .. .. | .. | 1 | .. | .. | .. | 3 | 2 | .. |
| 35 years .. .. | .. | .. | 1 | 1 | .. | 1 | .. | 1 |
| 36 years .. .. | .. | .. | .. | .. | 1 | 1 | 1 | .. |
| 37 years .. .. | .. | .. | 1 | .. | .. | .. | 2 | 1 |
| 39 years .. .. | .. | .. | .. | .. | .. | .. | .. | 1 |
| 41 years .. .. | .. | .. | .. | .. | .. | .. | 2 | .. |
| 42 years .. .. | .. | .. | .. | .. | .. | 1 | .. | .. |
| 45 years .. .. | .. | .. | .. | .. | .. | 1 | 1 | .. |
| 46 years .. .. | .. | .. | 1 | .. | .. | .. | .. | .. |
| 49 years .. .. | .. | .. | .. | .. | .. | .. | 1 | .. |
| 50 years .. .. | .. | .. | .. | .. | .. | 2 | 1 | .. |
| Totals .. .. | 34 | 96 | 86 | 64 | 146 | 244 | 446 | 123 |

2471. CHAIRMAN: Would you continue?——W. Yes. I would like to point out that in those statistics it is obvious that in 1973 there was a downturn so far as the figures were concerned. The inquiries I made in that regard indicate that just prior to that a member of the police force, Detective Sergeant Brown, who was engaged in criminal investigation duties, and was vitally interested in the drug field, resigned. The interest that he had engendered fell off and in 1972, for instance, the figures show for Indian hemp, use, the figure was 62, possess 45, sell 1. In 1973 the figures dropped: 35 use, 45 possess and 3 sell. In 1974 the figures went up: 103 use, 89 possess, 5 sell. The figures continued to increase. I would like also to make a point in separating the class of offence. In 1976 of 818 charges which were recorded in the south coast area, 694 referred to Indian hemp—either to the possessing, smoking or selling of it—and 43 referred to heroin. In 1977, to 30th April, of the 205 charges that have been preferred, 185 refer to Indian hemp and 20 to other types of drugs. I do not think that there is anything further that I could add voluntarily at this stage.

2472. Constable, would you proceed with your submission?——W. (*Mr Ebrill*) Yes. As a short resume of my duties, as a member of the police drug squad attached to Wollongong, I have been responsible for the carrying out of law enforcement under the Poisons Act from Helensburg to Eden on the far south coast. We have also carried out enforcement duties in relation to that Act in the Moss Vale and Bowral areas. The majority of the offenders

DRUG ARREST STATISTICS—1970 TO 30TH APRIL, 1977—WOLLONGONG—NOTE: ONLY 1976 AND 1977 COVER WHOLE SOUTH COAST

| | | 1970 | 1971 | 1972 | 1973 | 1974 | 1975 | 1976 | 1977 to 30-4-77 |
|---|---|---|---|---|---|---|---|---|---|
| Total arrests made | | 34 | 96 | 86 | 64 | 146 | 244 | 446 | 123 |
| Total charges made | | 55 | 152 | 152 | 112 | 248 | 411 | 818 | 205 |
| TYPES OF OFFENCES: | | | | | | | | | |
| Miscellaneous | | 1 | 1 | 1 | 1 | .. | 2 | 29 | .. |
| Possessing utensils for smoking Indian hemp | | 6 | 7 | 11 | 12 | 15 | 41 | 85 | 17 |
| Amphetamines | Use | 3 | 1 | 2 | .. | .. | .. | .. | .. |
| | Possess | 5 | .. | .. | .. | .. | 3 | .. | 1 |
| | Sell | .. | .. | .. | .. | .. | .. | .. | .. |
| Barbiturates | Use | .. | 3 | 1 | .. | .. | 1 | 4 | 1 |
| | Possess | 5 | 6 | .. | .. | 3 | 1 | 2 | 1 |
| | Sell | .. | .. | .. | .. | .. | .. | .. | .. |
| Indian hemp | Use | 23 | 55 | 62 | 35 | 103 | 117 | 254 | 63 |
| | Possess | 11 | 38 | 45 | 45 | 89 | 184 | 322 | 99 |
| | Sell | .. | 2 | 1 | 3 | 5 | 13 | 33 | 6 |
| Hallucinogen | Use | .. | 23 | 20 | 4 | .. | 4 | 4 | 1 |
| | Possess | .. | 7 | 4 | 4 | 3 | 3 | 10 | 3 |
| | Sell | .. | 7 | 3 | .. | .. | 3 | 4 | .. |
| Morphine | Use | .. | 1 | .. | 2 | .. | 1 | .. | .. |
| | Possess | 1 | 2 | .. | .. | .. | .. | .. | 1 |
| | Sell | .. | .. | .. | .. | .. | .. | .. | .. |
| Heroin | Use | .. | .. | 1 | .. | 16 | 22 | 43 | 7 |
| | Possess | .. | .. | .. | .. | 6 | 13 | 22 | 5 |
| | Sell | .. | .. | .. | .. | 2 | 1 | 3 | 1 |
| Opium | Use | .. | 1 | 1 | 6 | 5 | .. | .. | .. |
| (No charges for selling) | Possess | .. | .. | .. | .. | 1 | .. | .. | .. |
| Cocaine | Use | .. | .. | .. | .. | .. | .. | 1 | .. |
| (No charges for selling) | Possess | .. | .. | .. | .. | .. | .. | 2 | .. |

we speak to for offences under that Act are in relation to the use and possession of Indian hemp. We have also spoken to offenders in relation to the use and possession of heroin, cocaine and prescribed drugs that are in possession of people without being prescribed under a prescription. That gives a broad idea of the duties that we have been performing.

We have found heroin addiction has increased this year and the use and possession of Indian hemp is widespread. We find that the major inlets into this area for heroin and grass are from the Sydney area, either direct to Wollongong by road or through outlying areas such as Bowral and Moss Vale. We also believe that a number of drugs are coming into this city through Port Kembla, being conveyed from that centre by people working on ships that are patrolling the Australian coastline, and we also believe that drugs are being dropped off at sea along the south coast, picked up by people and transported into this area.

2473. In regard to apprehensions, do members of the highway patrol co-operate with you as a member of the drug squad in policing drug traffic?——W. Yes, they do.

2474. Would you say that a high percentage of the apprehensions come through the activities of ordinary policemen and highway patrol members?——W. A good percentage, yes.

2475. Mr Slattery, would you give an outline of the district that you cover?——W. (*Mr Slattery*) The district is from Helensburg south to the Victorian border. The area does not extend over the Great Dividing Range, and as you know there is very little activity on the mountains. It is just a thin, narrow area.

2476. How far inland would you go from here?——W. Probably at the most about 50 km.

2477. Are Bowral, Moss Vale and Picton in your area? ——W. No, but our drug squad visit there, primarily to assist the superintendent's area at Goulburn where their strength is not as much as ours.

2478. In evidence that has been given to us, the number of people convicted of possession or sale of heroin fell markedly short of the known cases of heroin addiction in this area. Could you give the committee any indication as to why more people are not apprehended when they

are known to the medical people. I appreciate, of course, that you cannot expect the medical people to breach the confidentiality of their records?——W. I think Detective Ebrill will answer that question beter than I. (*Mr Ebrill*) I think first you must realize that the heroin scene, if we can call it that, is a much more involved and intense drug scene than the Indian hemp or grass scene. It is usual to expect that you will get more information regarding the grass scene than you will get regarding the heroin scene. Because of what we believe are top-level people involved in the heroin secene, there is a fright among users regarding reprisals from other people and a secondary fright that their supply might be cut off. In that regard we find it very hard to cultivate useful informants about the heroin scene. The most effective way that we can find out exactly what is happening on this scene is to employ the aid of properly-trained under-cover police drug agents. In my opinion that is the most effective way to find out what is happening in the drug scene.

2479. Have your efforts in that respect been very successful in Wollongong?——W. Yes, they have.

2480. In what way?——W. They have led to four good arrests in relation to the selling of heroin.

2481. These would be people who would be involved at a high level?——W. Not involved at a high level but people who are associated with the high-level involvement. But, you must realize that in most instances this selling operates on a sub-contract basis. You normally find two types of sellers—first, the user/seller who is using the drug and also selling the drug to satisfy his own addiction. In other words, if the user/seller is using four or five capsules of heroin a day, at $30 a capsule on the illegal market, in most cases he has reached a level of addiction that his monetary positon will not allow him to satisfy. So, he has to resort to selling the drug to satisfy his addiction. That is one form of seller. The other form of seller is the person who is in it completely for the monetary gain and is not a user at all.

2482. Those four people you mentioned who have been apprehended, were they straight-out sellers or sellers/users? ——W. Two of each.

2483. Do you have good co-operation with the Customs officers here?——W. We do.

2484. There have been suggestions that Port Kembla is an easy place for drugs to be brought int the country from boats. Would you agree with that?——W. I will agree that at Port Kembla it is a very active port and there are a lot of people coming and going from ships berthed in that port. There are prostitutes visiting ships berthed at that port. I believe there are drugs being brought off those ships by persons of that nature. It is very difficult for a Customs office, with the strength that the Customs office at Port Kembla has, to maintain an effective surveillance on every person who leaves those ships.

2485. Have many of your arrests on drug offences been associated with people visiting the ships or coming ashore from those ships?——W. We made a very good arrest at Port Kembla about nine months ago in relation to a seaman who was selling Indian hemp. On that occasion a young constable who was briefed by us in Wollongong purchased $380 worth of grass from a seaman at his home.

2486. What type of Indian hemp was this?——W. It was Indian hemp in leaf form.

2487. Do you think that most of the Indian hemp that is used around here is imported or would it be produced in Australia?——W. Most of the Indian hemp involved in the drug arrests in this country is grown in Australia. The form of Indian hemp known as hashish, which is the hard block form, is usually imported from Lebanon or Turkey.

2488. Have you any idea what part of Australia is likely to produce Indian hemp?——W. Any part where there is a good, sunny moist climate.

2489. I think you did mention your visits to the Bowral area. Would the offenders there be school children or people who have left school.——W. People who have left school.

2490. Have you had any problems at all in regard to children at school and drug addiction?——W. No, big problems, no.

2491. It has been suggested that one of the bad areas is the far South Coast. That is in your district, is it?—— W. Yes.

2492. Would you have any evidence to substantiate those statements?——W. We have made numerous visits to the South Coast. I think it is on the increase there. We have evidence that drugs are being brought from Melbourne through the far South Coast by road transport. We feel that initially the major problem in that area was that the police were not aware of what drugs were. In other words, they were not able to identify the drugs and they were not up to date with the Poisons Act because of the newness of the problem. That has now been remedied and there are detectives working in the South Coast area. They are trained drug squad men who have been through the drug squad course and that area is now under good surveillance.

2493. Mr Slattery, following on this last point made by Detective Ebrill, are in-service courses conducted to acquaint police with the latest developments in the drug field so that they may identify drugs and know when people are under the influence of drugs?——W. (*Mr Slattery*) Yes, I believe there could be more. I believe the Parliament has acknowledged that, too.

2494. I notice from the figures you have supplied that they seem to follow the same sort of pattern that is evident in apprehensions all over the State over the past three years. Does it worry you to think that this problem is rising at such a rate?——W. Yes, it does. I think it concerns anybody, particularly we in the law enforcement field. I would invite your attention to figures relating to Nowra. I understand, from the sergeant in charge there, that although there is an increase in the figures, the charges in the main refer to visitors rather than to locals. For instance, in 1976 they had thirty-five charges relating to the possession of hemp, thirty-six relating to using, three relating to selling and twenty-eight relating to utensils in possession. The sergeant assured me that not more than 10 per cent of local people were involved.

It might also be of interest to the committee, dealing with Bowral, to know that inquiries I have made indicate that Bowral is the more vital area. There are three adjacent towns—Bowral, Mittagong and Moss Vale. Of a night time Mittagong and Moss Vale virtually close down but in Bowral there is great activity such as pictures, active hotels and so on, and young people are greatly concentrated there. That is why Bowral is ahead of Moss Vale and Mittagong in the figures.

2495. Would you think that the presence of the naval station at Nowra would have something to do with the high incidence of drug abuse in that area?——W. I have no evidence to support that.

2496. One of our terms of reference deals with law enforcement in regard to the use and abuse of drugs of dependence and arising out of that we are expected to make recommendations. Are there any particular recommendations that you would like to see put into effect in regard to this social problem?——W. One thing, and it has already been raised by Detective Senior Constable Ebrill, is that I believe there should be a greater concentration of providing under-cover men. I believe they should not merely come into the area for a week but that they should be here for perhaps even a month at least. As Detective Ebrill has pointed out, particularly when you come to the heavy drugs such as heroin, you must know the people really well before they will even speak to you let alone indicate the source of supply. There must be a real friendship created before you can get that information. That would be one strong recommendation I would like to make.

2497. What do you say, Detective Ebrill?——W. (*Mr Ebrill*) Yes, I would agree with that and I would add that I think drug education could be improved upon, too.

2498. In what way?——W. In the area of school education. I believe there is a drug education programme now in first and second years of high schools. I have spoken to high school students at a higher level who wish it was at their level, at the fifth and sixth-form levels. I think this is something we should look at. Also, parent education is important. It is only a recent problem in this country and many parents do not realize what the drug problem is.

2499. You have always been welcomed when you have gone to speak to these older children at high schools, have you?——W. Very welcome. I have spoken to various high schools in this area and always I have received a good reception. (*Mr Slattery*) Might I say that on one occasion there was a meeting at Lakes Heights with the assistance and co-operation of the Youth and Ethnic people, and we had about 800 people there, children and parents. Detective Sergeant McDonald conducted that meeting and it was highly successful and the people were most interested, particularly the parents.

2500. Mr HEALEY: In view of the marked preponderance of Indian hemp charges and arrests compared with the harder drugs, what is the ratio of associated crimes with drug taking in connection with Indian hemp? Are there just as many crimes flowing from hemp users as from narcotic users?——W. (*Mr Ebrill*) There would be more crime flowing from narcotic offences than from hemp offences.

2501. Mrs DAVIS: Before I ask my question might I ask something of you, Mr Chairman, and that is that both these police officers have been very frank with us this morning so is it within our power to ask the press to restrain what they report about what has been said, particularly with regard to undercover agents?

2502. CHAIRMAN: I spoke to Superintendent Slattery about this before the Committee sat this morning and he had the opportunity to give evidence in camera. However, he feels that the police have nothing to hide and they are proud to talk about the work they are doing and they are quite open about it. I think that is an accurate statement of the situation, is it not, Mr Slattery?——W. (*Mr Slattery*) Indeed it is.

2503. Mrs DAVIS: I was worried about the matter of the undercover agents being reported by the press.

2504. CHAIRMAN: They would not be giving out information that is not already known.

2505. Mrs DAVIS: May I ask Detective Ebrill, in 1974 you charged two people with selling heroin, in 1975 there was one charge and in 1976 there were three charges. What sort of sentences were given to those people?——W. I could not inform you about that.

2506. Mr JACKETT: Mr Slattery, from the figures quoted for the past few years up to 30th April last, what is the usual result of Indian hemp charges, so far as first offenders are concerned? Is there any information that you have as to whether first offenders go to gaol or whether in most cases they have been given the advantage of section 556A of the Crimes Act?——W. (*Mr Slattery*) Yes, that would be a fair statement, that they would be treated in the main leniently. (*Mr Ebrill*) I agree with that and I would add that most people in this area charged with using Indian hemp have also been charged with possessing Indian hemp and that is normally the charge that is proceeded with.

2507. Is there any obvious activity outside schools where drugs might be pushed? From time to time we have learned that this is a fertile area to find pushers; and that activity outside the school gates is an indication that something is going on in connection with drugs. Is that the situation down here or not?——W. I do not think you could say obvious activities but there is activity, mainly within the grass scene, associated with schools.

2508. On a number of occasions we have been told that once people reach about 25 years of age there is a considerable dropping off in charges for the use of drugs. That is very noticeable in these figures you have provided. Once they get to about 25 either they give the game away or you do not find them; perhaps they become more wily. Looking at the figures, a person who was 18 years old in 1970 would be 25 in 1977. Do you find that most of them appear year after year? Is there a pattern of the same people coming back again and again?——W. This pattern is evident at times. I think the main age group for those people who are using grass or some other drug is probably from 16 to 25, as you said. There would be a few either side of those ages—probably from 14 to 30. That would be the major age grouping so far as offenders we have spoken to are concerned.

2509. Taking that age group, do you find there is a tendency for the same people to come up again and again?——W. Yes, there is.

2510. Mr MACDIARMID: Superintendent Slattery, what is the numerical strength of the drug squad in your police district?——W. Currently four men.

2511. Do you think that is sufficient to cope with the problem?——W. No.

2512. In your opinion should the penalties for drug pushers and/or users be increased? Do you think the deterrent aspect should be considered when assessing penalties?——W. No. I think every case has to be taken on its merits and while I should advocate heavy penalties for pushers, I believe that every case of a user must be taken on its own merits. In cases where a bond is granted to a first offender I believe that the bond should embody a requirement that the offender submit to a drug education course. I think that would be helpful. I think it comes back to what Detective Ebrill said a little while ago; in dealing with the age group in question, in the area of drugs education is terribly important.

2513. Detective Ebrill, in your submission you used the term top level people. What exactly did you mean by that?——W. I mean the people that are financing the

deals, people such as businessmen. I think if we were to show slides on the wall here today of all the people that were at the centre of drug distribution in this area we would all get a big shock.

2514. Business people in the community are involved in pushing drugs?——W. Yes, I firmly believe that.

2515. You mentioned the Far South Coast. It seems to me that there are distinct prospects of drugs coming into the port of Eden when the woodchip mill opens there and large ships come into that port to take the woodchips away. Do you do any work in that area dealing with pushers from time to time? You said one of the problems in that area was that the police down there had not been trained well enough in drug problems?——W. Yes.

2516. It seems to be open slather in that area. Would you agree with that?——W. There are problems in Eden. I have spoken to Detective Sergeant Rossini of Bega detectives in relation to this matter. I have received information to the effect that drugs are coming in through the fishing ports and the woodchipping sections at Eden. He is looking into the matter.

2517. Would there be any possibility of fishing boats operating out of Ulladulla picking up drugs off the coast? ——W. Yes, this is a problem right along the coast.

2518. Mr RAMSAY: Detective Ebrill, you indicated that the numerical strength of the police drug squad is now four. How long has that been the number?——W. For the past six weeks.

2519. We have reason to believe that there are not adequate customs officers for detection in Port Kembla. Would that make the work of the police drug squad in the region more difficult and make offences almost impossible to curtail?——W. It is a lot harder without that added strength.

2520. Some drug education officers have close liaison with the schools in this area. Has the education office at any time liaised with police officers or the police drug squad? We have been informed that they know of people that are trafficking outside the schools. Would they have liaised with your squad at any time?——I have had no contact with them.

2521. Superintendent Slattery, do you consider that the decisions by some judges and magistrates are too lenient and show lack of uniformity in imposing penalties and are thus to some extent encouraging trafficking in hard drugs? We have had the opportunity to look at another State. Would you give the Committee your thoughts on this matter?——W. Yes. I believe that particularly in the addictive field and selling, in many cases the penalties are too light but I repeat what I said a little while ago that every case must be taken on its merits, particularly in the field of using drugs. I think the judiciary must always be left with a discretionary power to assess penalty and, as we all know, in dealing with the question of penalty rehabilitation is as important as the deterrent aspect.

2522. Would you say that the incidence of breaking and entering at doctors' surgeries, hospital dispensaries and chemist shops in this region has dropped, indicating the availability of drugs in the area?——W. Yes, it has dropped substantially, but I think that has been brought about also by the restrictions that were placed on medical people. Instead of leaving their drugs out on the shelf they now have to take precautions and those precautions have made it almost impossible for that type of activity to continue.

2523. Detective Ebrill, in the past has there been any liaison between the Health Commission and the police drug squad and, if so, has the police drug squad or its officers referred any addict to a drug referral centre for help?——W. Yes. First, liaison between the Health Commission and the police at this stage is good. Mr Sowerby and Mr Slattery, the superintendents at Wollongong, have a good working liaison with Dr Diment and we feel that we have the same liaison. We refer many heroin addicts to referral centres. However, if after speaking to a heroin addict we feel that talking is no longer going to do him any good, then we feel that charging him and placing him before a magistrate is the only answer.

2524. In Newcastle we took evidence from very reputable people with regard to analgesics. Would you be aware of the seriousness of the analgesics in Bex and Vincent's powders and have your officers come in contact with people who have collapsed from the effects of this type of drug?——W. No, we do not come into contact with those people.

2525. They would be mostly be dealt with by the Health Commission?——W. That is correct.

2526. CHAIRMAN: Have plantations of marihuana been located in your area?——W. Several cases, yes.

2527. Very big plantations?——W. Some big ones have been located in the Moruya and Batemans Bay areas and in the Robertson area. (*Superintendent Slattery*) In the Bowral area in 1975 there was one plantation that I think was over 5 acres in area and in 1976 there was two such plantations in the same area.

2528. CHAIRMAN: Were you successful in eradicating the plants?——W. (*Superintendent Slattery*) Yes, and the offenders were arrested and charged.

(The witnesses withdrew.)

GRAHAM TAYLOR, Youth Co-ordinator, Wollongong Council, of 4 Bettunga Place, Engadine, sworn and examined:

2529. CHAIRMAN: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. I did.

2530. I understand that you wish to make an oral submission to the Committee?——W. Yes, I do.

PETER TATHAM, youth worker, of 15 Kembla Street, Wollongong, on affirmation, examined:

2531. CHAIRMAN: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. I did.

2532. You also wish to make an oral submission?—— W. That is right.

2532A. You have prepared a written submission. Do you wish to have that submission incorporated as part of your evidence?——W. Yes, I do.

WOLLONGONG CITY COUNCIL
SUBMISSION
JOINT PARLIAMENTARY COMMITTEE UPON DRUGS

1. To review and report on available current scientific information concerning the pharmacological, psychological and social effects of drugs of dependence, other than alcohol or tobacco, in common use in New South Wales—

Far more awareness should be publicised and given by the following agencies:

National Medical and Research Council.
Pharmaceutical Companies.
Medical Practitioners.
Drug Referral Centres.
Welfare Workers.

This concerns not only prescribed drugs, but also illegal drugs.

Drugs of addiction will of course create dependence, particularly with illegal drugs. If a person is unable to obtain various drugs, he or she must go through withdrawal.

Psychiatrists, in conjunction with the Health Commission can attempt in a broad spectrum to alleviate the problem, however, this appears to be far too inadequate.

In conclusion, far more advertising is desperately required informing young people and their parents on the use of drugs and long term effects.

2. To examine and report on available information on the incidence and trends of the use and misuse of such drugs in New South Wales—

In Wollongong alone, it is estimated that there are approximately 2 000 young people "hooked" on hard drugs.

Again, it appears to be the responsibility of the Health Commission with the establishment of Drug Committees, social workers, psychiatrists and psychologists.

Consideration should be given to the immediate establishment of Drug Referral Centres, local youth committees being advised and the education of doctors and hospitals, general medical practitioners, welfare workers and members of the Police Department.

It should be remembered that addictive analgesics are prescribed by medical practitioners and, again depending upon the drugs prescribed, could lead to abuse and possible addiction.

3. (a) To inquire into and report on the adequacy of the control of the manufacture, distribution, possession and use of such drugs—

This should be referred back to the National Medical and Research Council regarding the manufacture of drugs to the pharmaceutical companies for the manufacture and distribution, this would also include chemists.

The Police Department should be made fully aware of the distribution, possession and use of both legal and illegal drugs. This would then be referred to youth groups and youth committees who could advise young people on their problems and refer them to necessary agencies plus information on the distribution, possession and use of illegal drugs.

Far more consideration should be given to sentences for pushers and the community should assist in advising authorities of known contacts.

(b) To inquire into and report on the adequacy and appropriateness of penalties for offences related to such drugs, the application of those penalties, and the distinction between penalties for offences relating to their use and also relating to their manufacture and distribution—

This paragraph will be attempted to be answered briefly in two sections:

"Illegal Drugs"—Harsher penalties should be seriously considered for pushers, as mentioned in 3 (a). Fines and short gaol sentences are completely inadequate. However, far more sympathy should be given to the users of drugs, particularly in cases relating to primary school children.

Manufacturers and distributors of both soft and hard drugs would virtually come into the same category for the same sentences as pushers.

Social welfare workers, magistrates, police officers, drug referral centres, hospitals and medical practitioners again should all be made aware of drugs and attempt to work in liaison with each other, with assistance, guidance, advice and education.

"Legal Drugs"—The issuing of prescriptions for various medical complaints, such as narcotics, barbiturates and other drugs should be seriously considered. Again, medical practitioners should be made fully aware of the drugs and the dependence which could be established both psychologically and physically.

Patients suffering from chronic illnesses should have their cases seriously considered by a drug committee for prescriptions.

4. (a) To inquire into and report whether in relation to the distribution, possession and use of such drugs the following are adequate and appropriate: General education for persons of all ages—

At the present moment there appears to be a feeble attempt at the education of the community as a whole in relation to drugs. Serious consideration should be given by combined authorities in a massive education programme, including those referred to in (1).

(b) Special education for key groups responsible for education, treatment and counselling, detection and law enforcement—

An ongoing education programme should be aimed at key groups, such as social workers, youth workers, youth groups and any other interested individuals or bodies relating to law enforcement, detection, treatment, counselling and referral.

(c) Preventive, counselling, treatment and rehabilitative services—

Ongoing treatment of patients should be considered and treatment from psychiatrists, hospitals and wards should be transferred to "cottages".

Sympathetic and understanding personnel would be required for the treatment and rehabilitative programme.

Funding for all programmes should be made available by either the State or Federal Government.

5. To make such recommendations on Terms (3) and (4) as the Committee sees fit—

With reference to terms (3) and (4), recommendations are included.

Conclusion—

A more concerted effort should be made covering the whole ambit of preventive education, counselling, treatment and rehabilitation, particularly in relation to some way of counteracting the general apathy to the community as a whole in this field.

I have been employed by the Wollongong City Council for a period of just over four years as youth co-ordinator. In my position with the council I am trying to give opprtunity to young people to engage in various activity classes, recreation classes and so on, and I have been approached by a number of young people who have told me of their problems with drugs, where these drugs are coming from and in a sense from there I try to direct them for help to various agencies.

2533. How long have you been associated with the council?——W. Four years.

2534. What type of activity are you normally engaged in?——W. The promotion of various recreational activities aimed at young people in the area administered by the Wollongong City Council.

2535. You mentioned something about people telling you where drugs come from. What did you mean by that?——W. That is in relation to marihuana. There are quite a number of plantations in the area from Helensburgh down to Kangaroo Valley, which I am led to believe are in existence, along with other plantations in the hills to the west of the city.

2536. Do you know of any move to set up a commune in the Kangaroo Valley?——W. Only rumours, but they are fairly strong rumours.

2537. Do you know of any people who have come to settle there?——W. I believe there were attempts made some time ago and now they are trying to set up another commune in that area.

2538. Mr Tatham, would you give the committee a brief outline of your activties as a youth worker with the council?——W. (*Mr Tatham*) I started with the Shellharbour Council on 21st February this year as a youth worker. I see youth work as being an educational process for the young people. The sort of activities that we have tried so far are, we run a community centre out there, a disco, and also do some counselling referral work. Most of this work has been tied up with Legal Aid and the Drug Referral Centre in Kembla Street. A few people who regularly attend the centre were busted over the weekend. Since I have started, quite a number of people have come to see me about their problems and about the law regarding the use of illicit drugs.

The people attending the Drug Referral Centre were smoking marihuana in a public place. They were picked up on Saturday, they saw me on Monday and I took them to the Drug Referral Centre for counselling, then to Legal Aid so that they would understand their rights. The sort of comments that these people made were that they saw marihuana as no longer a problem; not so much of a problem but a way of life with the people with whom they mixed. They used it fairly regularly. They were 17 or 18 years old. The reasons they gave were: "All my friends use it. It is better than beer. If I didn't use it, I would drink beer." I see my role as being an educative one. I say to them, "This is what will happen if you use it, and this is where you can get information regarding the use of drugs."

The commune to which you refer might be the one that is called the Mount Bluehaven Planetary Arts and Crafts Association. That was set up as a co-operative. It is a farm of about 50 or 60 acres. They intend to sell shares at $250 each, which gives each shareholder an interest in the farm. The aim was to grow vegetables and foodstuffs and to make the place self-sufficient, as I understand it. It seemed quite a good idea, but they have a long way to go, I think.

2539. Mr HEALEY: Mr Tatham, what are your qualifications for the job that you have?——W. Willing and able. I am part-way through a degree course for the Diploma of Commerce, although I have stopped doing it at the moment because my work takes too much time.

2540. Have you had any training in counselling?——W. My works is mainly as a listener. If I feel that a person needs extra help—some people just want somebody to listen to them. If they need more than that, I refer them to someone else.

2541. CHAIRMAN: What were you doing before you came to Shellharbour?——W. I worked in various personnel departments in the steelworks.

2542. Mr MacDIARMID: What area is the farm in Kangaroo Valley?——W. It is off Broken Back Road.

2543. But the area?——W. I think it is about 50 acres. The reason for selling the shares was that they wished to purchase a further 150 acres.

2544. Mr RAMSAY: Mr Taylor, from your experience and contact with the young people in the district, do you feel that the extent of drug use is becoming more prevalent?——W. (*Mr Taylor*) Yes, I do, particularly in relation to hard drugs. We got to the stage recently when we ran a monthly dance which normally attracts between 400 and 600 young people. Several months ago we had to ask to check young ladies' handbags and also to check fellows coming in for drugs and alcohol. It was getting too bad at the time.

2545. Do you have any liaison between the police officers and the Health Commission officers?——W. Yes, I do. Also, if I am told by any young person that he knows a particular place where drugs are being pushed, I hand the matter over to the police authorities.

2546. Mr Tatham, do you have any contact with the young people in the schools?——(*Mr Tatham*) Yes. I am working with youth. Most of them are still going to school.

2547. Do you find that the situation in the schools is bad so far as drugs are concerned?——W. Yes. I think that quite a large number under the age of 18 are using, mainly marihuana, and also stronger derivatives of marihuana, like hashish and something called buddha sticks. Mainly that type of drug.

2538. Mr Taylor, what would be the worst area that you have come across in regard to drug misuse?——W. (*Mr Taylor*) Again, let me say that this is only hearsay. Starting right from the top, in the north, an area not administered by council; that is Heathcote. Then, in the Austinmer–Thirroul area; Wollongong itself; and then round the Port Kembla area.

2549. Do you find that the young people who have a problem in regard to drugs are reluctant to go to seek treatment because of fear of police action against them? Do you find that this would be a deterrent to their seeking treatment?——W. Most certainly. (*Mr Tatham*). I agree with that. I was talking to an ex-heroin addict on Tuesday who said he would rather die before he went to the police, and he was sincere in that statement. I do not know why, but that was his statement.

2550. CHAIRMAN: How long had he been off it?——W. Three years.

2551. Mr HEALEY: How had he got off it?——W. Through the Health Commission.

2552. The local Health Commission down here?——W. I think the local Commission but I would not be certain.

(*The witnesses withdrew.*)

WARREN LESTER KING, Technician, and JULIE KING, Teacher, both of 14 Owen Park Road, Bellambie, sworn:

2553. CHAIRMAN: Mr King, did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. (*Mr King*) Yes.

2554. I understand you wish to put forward a submission. Do you have a submission in writing?——W. Yes, there is a written submission which is a proposal to establish a rehabilitation centre.

2555. Do you desire to have that incorporated as part of your evidence?——W. Yes. The proposal reads:

PROPOSAL

To establish, maintain and further develop a rehabilitation and education programme for drug dependent persons which can be duplicated and set up at minimum cost and which utilizes the existing resources and knowledge of the national community.

It is proposed to establish this programme initially in one Health Region of New South Wales—Illawarra or a Sydney region.

Funding is required for a centre which will provide a residential programme necessary for persons who need, for a successful recovery from drug abuse, to break a dependency on an unhealthy environment.

This establishment will be used to further develop and refine the use of the Grow Programme and Grow Communities for drug rehabilitation and mental health and drug education, and will act as a national resource centre progressively initiating the setting up of similar centres in other states.

The growth of the national Grow community (320 groups) makes possible the continuation of the rehabilitation programme which provides the necessary long-term re-education and support carried out in the community. (W.H.O. bases recovery statistics on a two year period).

This project provides a unique opportunity to establish a successful Australian nationwide rehabilitation and education programme in that it is:

(a) Based on the proven success of the Grow Programme of mental health. (Although the project is designed specifically for problems of drug dependence, rehabilitation will emphasize mental health and education for living using the Grow Programme of personal growth.)

(b) Designed to utilize the existing National Grow Organization. Present programmes are either isolated or incomplete.

(c) Designed to be duplicated and maintained at low cost.

*Background Information*

1. Grow is a uniquely structured mental health programme and is essentially three things:

(i) a programme of rehabilitation and personal growth;

(ii) a group method;

(iii) a caring and sharing community.

2. Grow's Twelve Step Programme of Growth is based on the successful experience of hundreds of recovered members over the last twenty years and is presented in the language and at the level of the ordinary person.

3. Grow's Group Method supplies the much needed social instrument for the integration of the solution throughout society. Its group meetings are structured so as to be at once positively educational yet easily mastered and run by non-professional people.

4. Grow's Caring Community provides the necessary context of involvement and concern and seeks to co-ordinate the best in lay leadership at problem level.

5. While Grow to date has not primarily dealt with drug dependency, our credentials for knowing something about it are very solid. Grow, originally called 'Recovery', was in fact born out of the womb of A.A. in 1957. Its first meeting was chaired by Renee, a former mainline morphine addict who recovered through A.A. and Grow after ten years of addiction and is now a Grow group organizer in Cairns. The means of liberation for her and for hundreds of others like her in Grow have always been the leadership of recovered abusers, the Grow Programme of adult living and the transforming impact of real friendship.

Grow's increasing contribution to the understanding and solution of drug problems of all sorts is attested to by the inclusion of Grow leaders as speakers at four drug conferences in the past year.

*Project Design*

1. Staff Requirements:

| | Salary |
|---|---|
| | $ |
| Administrator (1) ..... | 10,580 |
| Programme Co-ordinator (1) ..... | 9,700 |
| Field Worker/Education Officer (1) ..... | 9,700 |
| House Co-ordinator (1) ..... | 9,700 |

Staff would be available outside normal working hours, during weekends and public holidays; no overtime is involved.

House Co-ordinator will have nursing experience.

The persons indicated will be responsible for the positions designated, however, all staff members will re required to share in all duties to best take advantage of each one's personal resources.

2. Accommodation Requirements:

A large home with large grounds, reasonably close to city, which would accommodate twelve to fifteen residents plus accommodation for at least one staff member; other staff should be domiciled on same property or in close proximity.

*Project Design and Function*

1. The centre will have initially the necessary facilities to accommodate 12 to 15 persons plus a live-in staff of two other persons. Voluntary help to assist in implementation of daily activities would be available.

The period of residency will be between three and twelve months depending on the severity of dependence and rate of progress through the programme.

Residents accepted will have a presenting problem of either illicit drug abuse and dependency on the accompanying subculture, or pharmaceutical and/or prescribed drugs with accompanying environmental stress.

*Structure of House Programme*

2. The house will provide a caring educative programme and community, which will provide motivation and support for the residents' growth to whole persons able to think and choose in terms of consequences, with an understanding of what is normal and healthy.

With the emphasis on mental health and education for living through the Grow Programme of personal growth, the programme will be geared to avoid institutionalization and encourage at all times positive progress towards reintegration, firstly into the general Grow community and thence into society.

The house programme will be structured in terms of levels of growth. Progress from level to level will be determined by group assessment of progress.

*Proposed Levels*:

Level 1: Entry into Programme—

(a) Persons referred to Centre required to show minimal motivation to change before admission.

(b) Withdrawal (if necessary) under medical supervision.

(c) Complete medical check (local M.D. or Health Commission).

(d) Psychological appraisal (Health Commission).

(e) Initial introduction to Grow Programme and Group Method.

(f) Expressed willingness to co-operate with Grow helping methods and to conform to house rules.

Level 2:

Re education using Grow Programme. Based on daily schedule of education, work, therapy and related activities—a sixteen hour daily involvement using the Grow philosophy of the developing adult. Implementation to include:

(a) Daily internal Grow group.

(b) Housework and maintenance.

(c) Self-actualising groups, e.g. relaxation, creative, physical and educative activities. These activities designed to re-establish physical awareness, creative abilities and intellectual capacities. (Voluntary resource persons).

(d) Outside activities.

Level 3:

Entry into general Grow Community—

(a) Residents encouraged to move into active participation in outside Grow Community by taking part in general groups, leadership meetings, community weekends, leadership training and other wholesome activities.

(b) More responsible leadership in house—chairing internal groups, inducting new residents, clerical house activities and record keeping.

(c) Activities and duties designed to gradually establish a routine commensurate with outside employment.

(d) Residents to plan and gradually put into effect a personal reintegration programme, including accommodation and employment or further education, for themselves.

Level 4:

Re-entry to general community—

(a) Ex-residents will continue to receive support from and be encouraged to participate in the larger Grow community. In turn, they, as maturing Grow leaders, may be used in the house as an important resource for the in-residents at other levels; their voluntary leadership would be a vital part of the in-residents Grow group.

(b) Contact with discharged residents will be maintained by the staff Field worker/Education Officer. This will provide additional support to discharged residents and necessary material for the evaluation of project.

*Project Design and Function*

3. Additional General Guidelines—

(a) All encounters will be in groups. No one-to-one help or counselling in the programme. If it is necessary, outside professional help will be sought for this purpose.

(b) As the general physical health of new residents is expected to be low, one staff member will have nursing experience to aid in the supervision and care of residents' health under the direction of medical officers providing services to the centre. All staff to be instructed in basic first aid and emergency procedures.

(c) Regular urinalysis of staff and residents will be carried out by a person or agency independent of the residence.

(d) Liaison will be maintained with the Drug Addiction Team of the Health Commission concerning medical and other associated problem areas and with other social or spiritual community agencies.

(e) Live-in staff and residents would be required to contribute part of their income towards food and recreational activities etc. with a maximum limit.

(f) All work, such as cooking, cleaning, gardening, clerical work etc. will be shared by residents.

(g) Evaluation will be built into the programme from the outset. Advice and help of the Health Commission will be sought in designing evaluation procedures.

(h) Records will be kept of all activities and groups.

*Goals, Values and Specific Objectives*

1. General Goals—

(a) To make available on a national basis a rehabilitation programme which is whole in outlook and relatively unconditional. Present programmes are either limited to motivation only or have the acceptance of a religious creed as a condition of entry.

(b) To provide resources for the general community by developing an education programme in liaison with such departments as Education, Probation and Parole, Youth Community and Ethnic Affairs, Community Health Services.

(c) To increase the national recovery rate of persons with drug dependency.

(d) To establish a national resource centre for both rehabilitation and education to promote better understanding of the problems of drug dependency in the context of Mental Health.

(e) To research and evaluate the extent and nature of the problems of drug addiction and to evaluate methods employed in programme.

2. Values—

Key Perspectives for Understanding the Problem and its Solution:

(1) The difference between *normal and abnormal*:

Normal, in its true sense (= healthy) means mature, strong. Whereas it entails being both free and whole, its common counterfeits are a pseudo-wholeness at the expense of freedom, and a pseudo-freedom at the expense of wholeness.

(2) Full appreciation of all the *causes*:

There are four causes that can influence human behaviour—

nature (or constitution)
Culture (nature, environment)
Personal Action
The Overall Cause
(thought to be Personal—God)
(thought to be Impersonal)

The programme must involve and co-ordinate the representatives of all four causal agencies—voluntary self-help, doctors, social welfare workers, ministers of religion.

The key or central cause is the human person himself—and mental health is primarily self-understanding and self-regulation, and subordinately understanding and regulation by professionals.

(3) What is Drug Abuse Mainly?

Two common approaches are to view the addiction as primarily a criminal thing and a problem of law-enforcement or a medical problem of helplessly sick persons. Both these approaches are wrong.

The addict is neither mainly bad or mainly sick to begin with, but immature.

Any addict, once addicted, is sick and needs to be helped as such. Yet he is not merely sick but also responsible, and no one can cure him without building on his unique responsibility.

The problem is primarily one of personal and social inadequacy or immaturity—of people who have not learned how to live, and have dropped out of the painful growth process.

If the drug dependent person is sick, the sickness is primarily mental sickness (while having its undeniable physical aspects and consequences).

In drug dependence the most crucially difficult and resistant part is not the brief withdrawal crisis, in which medical intervention is most helpful, but the psychological dependence, which may take months or years to break.

The drug problem is therefore above all a problem of wholesale motivation and education for mental health; in other words, both personal and community education for full human maturity or adult living.

What is lacking above all, and what we intend to provide, is an educational and rehabilitative programme of growth begun in a residential setting and carried into a real-life context (extra-institutional) of a community that is growing together meaningfully and successfully.

3. Specific Objectives—

(a) To acquire a large home in an appropriate Health Region and Grow Region for the residential program for addicts referred from any source.

(b) To operate the proposed rehabilitation and education program with resultant successful intial recovery of residents.

(c) To continue the rehabilitation and education program in the existing Grow Community and thence into the community in general.

(d) To evaluate over a bi-annual period the success of the program.

(e) To carry an educational program into the general community through the services of the staff field worker/education officer and recovered Grow leaders.

DETAILED COSTING FOR ILLAWARRA REGION

*Operating Costs*

| | $ |
|---|---|
| Salaries | 39,680 |
| Superannuation | 2,000 |
| Workers Compensation | 530 |
| Long Service | 800 |
| Leave—holiday loading | 600 |
| Rental | 8,000 |
| Maintenance and repairs | 2,000 |
| Motor vehicle repairs, running costs, etc | 4,500 |
| Insurance | 300 |
| Telephone | 1,500 |
| Gas and Electricity | 800 |
| Stationery | 600 |
| Postal | 300 |
| Fees—services rendered | 1,000 |
| Furnishings, utensils, tools, etc. | 2,000 |
| Travel and accommodation | 800 |
| Advertising | 300 |
| Freight | 150 |
| Miscellaneous | 1,500 |
| | $67,360 |

Total Premises—

| | 1977–78 | 1978–79 | 1979–80 |
|---|---|---|---|
| | $ | $ | $ |
| Rented | 101,360 | 69,500 | 69,500 |
| Purchased | 163,360 | 66,500 | 66,500 |

Triennium Cost—

| | |
|---|---|
| Rented | 240,360 |
| Purchased | 296,360 |

*Capital Costs*

| | $ |
|---|---|
| Building acquisition | 70,000 |
| Building alterations | 7,000 |
| Furniture and equipment | 10,000 |
| Motor Vehicles— (2 sedans, 1 mini bus) | 17,000 |

2556. CHAIRMAN: Mrs King, did you receive a summons issued under my hand in accordance with the provisions of the Parliamentarly Evidence Act?——W. (*Mrs King*) I did.

2557. You are associated with that submission, are you?——W. Yes.

2583. Mr King, would you like to address the Committee in regard to your work and any of the ideas you have which might be of interest?——W. (*Mrs King*) I am not working in the drug field but have been involved in Grow, a mental health organization, for three years. I have had some training as a crisis centre volunteer. I have a history of drug dependence and a successful recovery from that drug dependence. I have been involved in Grow youth groups so though I do not have any qualifications, or special qualifications, I have my own experience and my experience in mutual help groups, helping young people and adults, a large number of whom have had drug abuse and dependency problems. Perhaps Julie might give you an outline of our proposal.

2559. Yes, certainly, but before that, you mentioned recovery from drug dependence. How long is it since that occurred?——W. I abused minor analgesics for about sixteen years and also after some emotional problems about six years ago I was prescribed drugs by a doctor. I was told by the doctor that I would probably have to take them all my life. They were sedatives, tranquilzers, anti-depressants, barbiturates and sleeping pills of a few different types. I was dependent upon them for approximately three years. I had myself in a situation where I thought I would always have to take them and I was convinced that I could not do without them. But, by going to Grow I learned that I should not need to take all those pills—I was taking thirteen or fourteen a day, different types, and at times abusing sleeping pills and sedatives. I learned that I should not have to take all those drugs to live my life, which is a fairly ordinary life.

Over a period of about six months I got to the point where I decided to stop taking them. That was on the advice of a doctor as well as encouragement from the group I was attending. I stopped, and though I found it difficult for a while to cope without them, once I stopped I realized the effect that they had upon me. I had had very few feelings and after stopping I felt much more alive. I think that was one of the most important things that helped me in my recovery from my emotional problems.

2560. You mentioned that you were abusing minor analgesics. What were they—APC powders and tablets? ——W. Mainly APC powders.

2561. How many were you taking?——W. Probably six or eight a day and sometimes less.

2562. For how long?——W. About sixteen years.

2563. Do you think they have had any adverse effect on you physically?——W. Some slight, hardly noticeable kidney damage but nothing to worry about, I have been told. Also, I used them as a coping device.

2564. How old are you now?——W. Thirty-four.

2565. When did you actually start on these?——W. When I was sixteen or seventeen.

2566. Any particular variety?——W. Bex and Vincents.

2567. Both?——W. Yes.

2568. Any one in preference to another?——W. Initially Bex but for the most part Vincents powders.

2569. Would you explain the main activties of Grow? You might tell us how does it get its name?——W. Grow is a community organization engaged in the field of mental health. Its aim is personal growth through mutual friendly help. We have weekly meetings and there are a number of groups in this region. In fact, Grow is going into oversea countries such as Hawaii, New Zealand, England and Ireland and we are getting requests all the time to start groups in other parts of Australia and in other countries.

2570. Yes, Julie, would you outline the proposal?—— W. (*Mrs King*) Our reason for coming today is to present our proposal for a rehabilitation programme. I have much the same background as Warren. I am the immediate past-secretary of Wollongong Drug Committee and we are both organizers of Grow groups. We are both involved in leadership training within Grow. This proposal is a development by the Grow movement from its groups to hopefully set up a live-in rehabilitation house in a health region of New South Wales, initially.

2571. Would you like to summarize any particular aspects of your proposal?——W. Yes, the proposal is to set up a rehabilitation house which will be a growth of the work that Grow is already doing in mental health. We see the success of this type of programme arising from the fact that there is already established a Grow community in all health regions of New South Wales and in every State of Australia so that the residents in the house will move from a protected environment where they are learning the Grow programme of growth into the already established Grow community so they will receive the support, friendship and help of people who are meeting in groups in the region in which they live. This proposal is distinct from a short term detoxification unit. This is seen as a long term rehabilitation programme for persons who have a history of dependence which is major abuse and which is supported by unhealthy dependence upon their environment, that is, the drug sub-culture. It is not a place to dry out people and put them back into the community. It is a place where people can come and build up habits that they need in order to cope without using drugs.

The programme envisaged is from three to twelve months, depending upon their progress in the programme, and the strength of the dependency that they have to break. From the house they will move into the Grow community which is already established and attend the groups in the community. From there the tenth step of the programme is to take a place in society. The final result will be people moving out into society independent of the groups. It is a scheme that we have drawn up so that it could be duplicated and set up with the help of the core group that goes through in the first twelve months. The Grow programme stresses adult education for living rather than treating the drug problem as such. We see drug usage as a symptom of an inadequacy or immaturity in the person's ability to cope with life on an ordinary level. The programme is designed to re-learn habits of thinking, behaving and acting.

2572. This would be the first time a centre of this type has been established in New South Wales—one that came to fruition?——W. Yes.

2573. Is there any other similar establishment anywhere else in Australia?——W. No. The establishments that are already working are either limited to withdrawal and motivation or are conditional upon people taking on a religious belief.

2574. There would be no exclusion that way under this proposal?——W. No.

2575. You see yourself then as a sort of adjunct to the established government agencies in the rehabilitation of people and getting them back into normal community life?——W. That is right.

2576. Have you made any approaches to any government instrumentality in regard to these proposals?——W. The proposal has been accepted in principle by this regional health directorate. It is at the moment in the hands of Peter Diehm, who is the head of the Drug and Alcohol Advisory Council.

2577. Has Mr Diehm given you any encouragement to believe that it might be accepted?——W. Not at this point. We are still waiting.

2578. Have you spoken to him personally about the matter?——W. No.

2579. It has only gone through the normal channels? ——W. It was handed to him by Grow in Sydney—National Grow.

2580. Is there anything further you wanted to put to the committee in regard to your submission? I think we have the idea of it fairly well; it has been well prepared? ——W. The only thing that is holding up the establishment of this is finance. It has been thoroughly worked out and it is a matter of getting finance now.

2581. Of course when you talk about finance, there are two aspects to that: first the capital outlay and then the recurrent expenditure to maintain it?——W. That is true.

2582. Mr HEALEY: Is there any reason why such an organization as you envisage should not be part and parcel of the Health Commission and under its jurisdiction? Why could not the Health Commission run an adjunct similar to this?——W. There is no reason why it could not, but it does not. I believe it is against the policy of the Health Commission to get involved in half-way houses or rehabilitation centres. I think they say that these should be undertaken by independent community organizations.

2583. On page 8 of your submission in the second paragraph you say that present programmes are either limited to motivation only. The evidence so far indicates that if the motivation is not there, there is practically no chance of rehabilitation and kicking of the habit. Why do you say that programmes are either limited to motivation only? Motivation seems to me to be the prime factor in rehabilitation?——W. The rehabilitation must follow the motivation, and so often this does not happen.

2584. Your submission continues: or have the acceptance of a religious creed as a condition of entry. We have not come across that as a condition of entry into a rehabilitation centre, that a person has to be of a particular religion in order to be treated?——W. It is in some cases.

2585. Mrs DAVIS: This project that you envisage setting up, do I understand that you would initially treat the addict and then he is to stay with you once he is helped and then go out into the world when he is able to stand on his own feet?——W. (*Mr King*) If you turn to page 5, we have four proposed levels of progress through the programme. Level 1 (a) is that persons are required to show minimal motivation for change before admission. The aim is to get the people back out into the community, and all our efforts would go in that direction. They may not be completely able to stand on their own two feet. We would expect them to be able to work. The long-term rehabilitation would be carried out in the community, with them living in the community with the support of the already established Grow groups. So we do not aim to have people completely rehabilitated when they leave the house. Level 3 (d) says that while they are in the house we would expect them to plan and gradually put into effect a personal re-integration programme, including accommodation and employment or further education, for themselves.

We are very much aware of the problem of institutionalization and dependence on the house as a protective setting. We see that initially, some dependence on a healthy atmosphere as a stage of growth from dependence on drugs. Our aim would be to have them grow through that dependence and build up personal habits, healthy habits of living, and healthy ways to cope with the stress of living, then go out into the community and continue their rehabilitation and growth in the general Grow community.

2586. On page 4 you say that the period of residence will be between three and twelve months. Do you not feel after the initial three or four weeks that possibly these people could be starting to feel that they are able to cope with things and that some of them might look for jobs, although they could stay with you if they wanted to?——W. (*Mrs King*) I think the fact that they may feel that they can cope is a different matter from them having built up the resources to be able to cope. The successful programmes in America are much longer than this. They are the ones that do not have a high relapse rate. They are much longer than twelve months. One of our aims is to reduce the relapse rate, and we do not feel this can be done under the three to twelve months period, because of the fact that the person will have broken the dependency on the drug but still has to establish relationships with friends who are drug free and be able to fit into the community away from the sub-culture that they were dependent on before, which is going to take more than the initial motivation to change, which is a feeling that they want to change. They still have to work on building up the resources, which is why the programme is the length that it is.

2587. Mr JACKETT: What you are concerned with is, of course, much wider than drug addiction. Would you envisage that drug addicts who have successfully withdrawn would need to have a different residential locale, as it were, from those who were not drug dependent cases but purely of mental strain and stress? Would you envisage that segregation or not?——W. Yes, we do. We would not separate people who were dependent on pharmaceutical and prescribed drugs from people who are on illegal drugs. The rehabilitation house is for people with a drug dependency. It is not rehabilitation for people from psychiatric units that do not have drug dependency, although the same growth programme is being used for both. Once they are going to the general groups in the community, which starts at level 3 in the programme, they will then be working on the programme with people who do not have a dependency but are still working on building up the same resources in order to cope.

2588. But basically they would need to be segregated with their own type of problem?——W. Yes. Breaking the ties with the environment that they have been living in is one of the problems.

2589. So a person must be activated to be rid of his or her addiction, I suppose that would be the case?——Yes, definitely.

2590. Is the action of operations so far as drug addiction envisaged by Grow something akin to the Odyssey House concept?——W. We have studied that over a period of about eighteen months. Our Grow leaders in Sydney have been in touch with Judianne Densen-Gerber. We did not find anything in her programmes that did not agree with what we are using in our Grow programmes now, apart from some of the disciplinary measures taken in their houses. As shown in their book, so much of the project is moulded by the residents within the house, and we are quite aware that a lot of our programme will be moulded by the core group that passes through in the first twelve months.

2591. Mr JACKETT: But you do not go as far as that, do you?——W. No.

2592. In other words, you would not envisage people being thrown out, as they sometimes are, because they breach the rules?——W. This would depend a lot on the residents' opinion of those because they are part of the group. A lot of the responsibility must be taken by the residents in the house. We are not going to do it for them. I would envisage that some people would have to leave the programme for breaches in use of drugs, but as for head shaving and some of the other disciplinary actions, no, they do not come into our programme at all.

2593. Mr McDIARMID: On page 12 of your submission you set out the detailed costing for the Illawarra region. Is it your proposal that the Health Commission should finance this scheme?——W. Yes.

2594. Totally, for the purchase of the house you mention and the running costs too?——W. Yes.

2595. How is Grow financed now?——W. Through the regional health scheme.

2596. You refer to accommodation requirements. Do you have any places in mind or is this what you have to achieve?——W. We do not have any place in mind.

2597. Are you being realistic to think that that sort of accommodation could be purchased for $70,000?——W. (*Mr King*) I think it is unlikely that we would purchase. We would most likely rent premises.

2598. Mr RAMSAY: Mr and Mrs King, have you or either of you had a look at the rehabilitation centres in Victoria and Newcastle, particularly in Victoria where they are run by the Health Commission?——W. (*Mrs King*) We have not been able to look in depth at any of them because we are both working out of this field and until such time as we can work in the field we cannot do that.

2599. To pursue further the question Mr Healey asked, in regard to the structure of your organization that it should not be run by professional people, do I assume in saying that that professional people would not have suitable capability to help people with drug problems?——W. (*Mr King*) We think that professional people play a big part in helping people with drug problems and Grow can only operate at the lay level. The experience of Grow over the past 20 years makes us experts in living. There is definitely a lot of medical aspects to drug problems that must be treated by professional people. Our programme is designed to use the Health Commission services available in the community in conjunction with our own services. It is estimated that 85 per cent of mental patients need friendly help and they need to develop relationships in the community and the main part of their help needs to come from equals, such as people who have been through the same problems and have recovered and people who can understand. Nevertheless, professionals do play a part and would play a part in this proposal.

2600. Mrs King, you said many organizations or programmes are either limited to motivation only after acceptance of a religious creed as a condition of entry. Can you tell me of any place where that is the situation?——W. Yes, the Christian Involvement Centre, which is about the only live-in place in this region. Also, the Salvation Army, which runs a farm, and requires attendance at services.

2601. That is not the case in Newcastle with the Salvation Army, from the evidence that we were given there? ——W. That is for the long term rehabilitation, is it?

2601A. Yes, and also that is not the situation in Victoria, where they are run by the Health Commission.

2602. CHAIRMAN: Thank you, Mr and Mrs King, for giving up your time to come here, making your submission and your proposal and answering questions of the members of the Committee.

(The witnesses withdrew.)

ARNOLD JOHN BENTLEY, Senior District Officer, Department of Youth and Community Services, residing at No. 20 Gooyong Road, Keiraville, sworn:

2603. CHAIRMAN: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. Yes, I did.

2604. I understand you wish to make an oral submission to the Committee?——W. Yes. A number of matters have concerned me in regard to what I have read in relation to these proceedings. One I would like to draw to the attention of the Committee, so far as my department is concerned, is in relation to the number of young people using hard drugs. My department is involved in the supervision of juveniles released on probation from the courts. Apparently, in the district which I control, from Helensburgh to Gerroa, we do not have one single probationer on probation for the use of hard drugs. We do have something like perhaps one-tenth of our probationers involved with the use, selling or smoking of marihuana; but none in relation to heroin. I came here in August of last year and I cannot recall any juvenile being released on probation for smoking or using heroin. I do not detract from the fact there is a growing problem, but I thought that that was signficant enough to mention to the Committee.

2605. How many officers do you have under your control?——W. Fifteen field officers and a total staff of twenty-six.

2606. Those fifteen field officers would be involved in all aspects of youth and community welfare work?—— W. Yes. We do not have any direct dealing with the identification of drug use and it usually only comes to us as a corollary of something else that has happened, such as a release on probation or a parent approaching us for advice and assistance with an uncontrollability issue and that might or might not involve drugs.

2607. One of our terms of reference deals with the incidence and trend in the use and abuse of drugs in New South Wales. Have you any particular ideas in regard to that term of reference as it applies to the Wollongong area?——W. I was told when I came here that 90% of high school students, if you said to them, would you know where to go to get marihuana, would say yes. I have done a little bit of investigation into that, including speaking to my own boys, one of whom is a high school student and one of whom has left school, and though they are not angels they do not know where to go to get marihuana. Other young people to whom I have spoken loosely know that you can get it at such and such a point or at such and such a location, because someone told them that, but as for them being able themselves to go there and direetly approach a person who can allegedly give them some, my inquiries indicate that that is not so and that they cannot do that.

2608. Have you any idea about illegal growths of marihuana plants?——W. Not here but I did have some incidence of that at Blacktown where I was previously stationed and some of my officers detected growths of marihuana and appropriate action was taken. By talking amongst juveniles and one giving information about the other, and

things of that nature, this was ascertained. I have not detected any of that type of activity since I have been in this area, from last August.

2609. Perhaps the children here are more tight-lipped than elsewhere?——W. It could be.

2610. You said you have not one probationer for hard drugs. Have you any knowledge of the ages of those who have been before the courts and then sentenced, other than placed on probation?——From memory there would be few under 15. The vast majority would be over 15 and in most cases or in a fair percentage of cases over 16. We deal with juveniles up to the age of 18 but we do not have very many under the age of 14.

2611. Supposing somebody in his early 20's was before the court and the case was adjourned for a report by a probation officer or a parole officer, would your department then have to take an active interest?——W. No, that is the problation service which was formerly known as the adult probation service. It is a different function, for people over the age of 18 years. We deal only with juveniles up to the age of 18 years. There is a major probation service in this area with quite a number of officers and they would be dealing with those adults.

2612. What department controls those officers?——W. The Justice Department.

2613. So it would not come within the scope of community services?——W. That is a very interesting question in relation to the Youth and Community Services Act of recent years. My department's officers now have an increased involvement in the community. If we had a particular family under our notice for neglect and an adult member of that family became involved in a drug issue, then we would have an involvement in that family, but not particularly because of the drug issue.

2614. Would you see it as an advantage if this barrier were removed and you continued to take an interest in these people after the age of 18?——W. It would need quite a deal of legislation.

2615. I am not talking about legislation. Assume that aspect can be dealt with.——W. And provided we could presume a staff increase as well.

2616. I am only talking about the change of administration from one department to another. Do you think that is a disadvantage or should it stay as it is?——I think it should stay because our officers are trained basically in relation to the under eighteens.

2617. Mr HEALEY: You say you are not deeply involved in the drug scene but you did say that sometimes a parent or even a child might come to you with worries about a drug problem. When this occurs do you or your officers counsel them or give them advice or do you send them off to the Health Commission? What do you do with them?——W. It is largely on an individual basis. The officer deals with the case as he sees fit. If a person is motivated to seek help, probably counselling is better than something punitive. If a parent seeks our help in relation to a general uncontrollability issue and the juvenile is totally unco-operative and drugs are one of the major involvements, then we would take him before a court and lodge a complaint of his being uncontrollable. That is where there is no motivation; but if there is motivation, obviously counselling is of benefit.

2618. Are your officers qualified to counsel in the drug area?——W. Not specifically—only general counselling. Some of them have made it their business to get knowledge and education about drugs and how to approach the issue and some of them work on a voluntary basis with drug referral centres in their own spare time.

2619. Officially there is no liaison between your department and the Health Commission in this field?——W. No.

2620. Mr JACKETT: Is there any obvious activity discernible outside schools, particularly high schools, in this area that would indicate that drug pushing is going on? Is it obvious that drug pushers arrive outside schools in the morning and afternoon?——I know that does go on, but not at first hand. I have been told that it happens. I have not personally encountered it but I have no reason to believe there is anything major or anything really organized.

2621. Would it be part of the task of officers of your department to keep an eye on that aspect?——W. There is a provision in the Child Welfare Act under section 72 by which we can take action in relation to the use of drugs, but we do not usually do that. We leave it to the police. In addition to showing that they are in fact using or selling or whatever other involvement there is, we also have to show that by reason of so doing they are in need of care, protection or control, and we cannot always show that to the satisfaction of the court, so it usually reverts to a police proceeding.

2622. Do you feel that there is an increase in pushing activity among children still at school? Is this on the increase in this area or not?——W. I have spoken to something like six or eight headmasters of major schools and none of them has been prepared to admit to me that he has a problem in his school or that he has a problem that is surfacing. Maybe they give recognition to the fact that there is a problem but as far as they are concerned it does not appear to be surfacing at school.

2623. Mr RAMSAY: Am I to assume from your opening remarks, where you indicate that you deal with those who are released on probation, that you deny the high incidence of drug taking by juveniles?——W. No, I do not think so. I did not mean to convey that, but I probably did wish to remove some of the hysteria that may surround it. If there is a big problem it has not surfaced at our level of involvement.

2624. Would you base your knowledge of the magnitude of drug misuse in this area entirely on those who are released on probation?——W. No. We only get a minute percentage. Obviously if we want to believe what we are told there is a much bigger problem than we come in contact with.

2625. Are you aware of the overwhelming evidence given to this Committee, including police statistics for the past few years, indicating a huge increase in drug taking?——W. Yes, I am. I am more aware of it in relation to the use of marihuana than I am of heroin. Our statistics show that locally we would have something like a 100 per cent increase in juveniles released on probation for the use of marihuana or one of the associated things—use, smoking or selling—over the past twelve months, so it is increasing.

2626. Would you have any other way of coming in contact with drug takers, or traffickers for that matter, than those released on probation?——W. Not unless a person sought our assistance or parents sought our assistance.

2627. It could well be in those circumstances that there is need for extreme concern in regard to the increase in drug taking?——W. Yes, I firmly believe there is need for extreme concern.

2628. Mr MacDIARMID: You have stated that as you see it there is no apparent drug use in the schools, on the admission of the headmasters you have spoken to. If it is detected, what steps are being taken in the schools?——W. The Health Commission has drug education programmes. We did have a drug education programme in some of our institutions but we abandoned it. I was told that was done largely on the basis that the people attending it were not motivated to listen and to attend. The juveniles were in the institution because they had to be there and they had to go along and listen to the lectures because they were told to. However, when it was left on a voluntary basis they stayed away in droves. It was found that it was much better to engage in individual counselling of those who were motivated to seek it, so I think our department has abandoned exhaustive drug programmes within the institutions.

2629. If a child is discovered using drugs in a school, is he suspended or sent to a referral centre or what happens?——W. In a school in the area? It is so rare to my knowledge that I really do not know what would happen.

2630. What happened in Blacktown?——W. Some headmasters do suspend the children, but to be effective the suspension has to be confirmed by the area directorate in the form of an expulsion and very few reach that stage. It is usually solved on a counselling basis or, if it is an extensive matter, a police charge. But just what procedure you would follow if a boy went into the headmaster's office who was known to be using or smoking or trafficking in any drug; in my view it is so rare that I do not know what would happen.

2631. CHAIRMAN: Last year twenty-one people aged fourteen or fifteen were arrested on drug offences in the South Coast police district. Have you any idea what would have happened to those people? They are obviously of school age?——W. Could I ask was that in relation to hard drugs? Most of them would have been processed before the court and in the case of some juveniles who are employed they could have been fined or if the magistrate saw fit he would have released them on probation.

2632. They would not come to your notice unless they were released on probation?——W. Not unless a report was sought from us.

(The witness withdrew.)

JOHN MICHAEL DIEHL BREEN, University Counsellor, 2/12 Hercules Street, Wollongong, sworn and examined:

2633. CHAIRMAN: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. I did.

2634. Do you desire to make a written or oral submission to the Committee?——W.A written submission, but what I have done is, in view of the fact that I have experience and evidence in various areas, I have prepared a list of about twenty things which your Committee may or may not wish to look at. I have not been engaged in one of these inquiries before. I thought that was the most useful way that I could help.

2635. If you have a written submission it can be incorporated in your evidence and then you can elaborate on the points that are there.——W. Could I table it before you?

It reads:

MICHAEL D. BREEN, COUNSELLOR WITH THE COUNSELLING CENTRE

Experience:

Counselling in various fields from 1956.
Drug Programmes in U.S.A.
Youth Leader training in Ireland.
Regional Additions Council, Bathurst—Region 7.
Training Counsellors for Health Commission in the area of drug and alcohol dependence.

Planner of programme for professions in Drug Awareness.

1. Voyeurism—

Much drug talk seems to provide space for some of the community to "watch".

Definition of a drug conference.

2. Persecutable groups—Ideal groups in the community—neither is based on facts.

3. The Problem—Layer upon layer.

4. Do gooders—the dangers of police, service club and other agencies working in the preventative area and that is the only area where they are tolerated.

5. Priorities in Planning—Prevention or cure—leaving the 1 and going after the 99.

6. If alcohol is a downer—a depressant, why does it liberate so many Australians to behave in a more liberated fashion? "The real problem" maybe freeing our people from inhibitions.

7. G.P's being trained in awareness overprescribing and patients not being taught to destroy old prescriptions.

8. Teaching parents to detect the signs is almost useless, if not destructive. Parents are then the extension of an arm of the law which is doubtful and conflicts with the role of parent.

9. How often are there convictions or arrests for people other than growers or users or pushers of drugs?

10. What is an addiction—who agrees?

11. Statements to the press by this enquiry should be vetted—counter productive statements on radio.

12. What is the philosophical basis for legalization for this inquiry?

13. Pharmaceutical Companies—who looks at the way they invest or advertise?

14. Why does so much of the drug policy and scene in general come from the U.S.A. and not the U.K. or Scandinavia?

15. Is there any parallel for drugs in our society? Does anything like this exist which can be legislated about in the same way?

16. Legalization *v.* Prohibition.

Prohibition increases use and illegal activity as well. The pharmacological effects of drugs do not include anti-social acts; these come from illegality.

17. Where does someone in our community get a balanced point of view? Where do I?

18. From what are people being protected?

19. Certainly not from the Medical Profession or the Government which gets revenue from alcohol.

20. Viable preventative programmes will be opposed most by those who want more stringent methods to deal with the drug scene.

2636. CHAIRMAN: Would you like to elaborate on your submission?——W. I could elaborate on any part of it, but I feel that it is a matter of the approach to the whole problem as it is seen by the community, particularly in the area of attitude change. From my studies and my experience I think that attitudes are the things that seem to increase the problem rather than solving it, that many people who are supposed to be involved in solving the problem are making it worse. One thing that has been drawn to my attention and has not been dealt with by the

Committee is the absence of simply destroying old prescriptions. A large percentage of people who take overdoses use drugs that were prescribed for something else. Simply because the prescription is lying there it is used for a stress situation to take an overdose. I once heard of a service club doing something useful with regard to drugs by asking people to contribute old prescriptions on a door-to-door collection basis. They then destroyed them. I feel that a lot of the other things that are done by service clubs and do gooders are in fact quite counterproductive. I fear the danger of saying that in front of the press because I fear the press also contributes to the counterproductive approach. I think that even the way this inquiry was reported from Sydney helped in that very way. Things like shock tactics, horror films and so on only encourage the person who wants to do something shocking or horrible. It does not stop them taking the drug.

2637. Could you explain briefly what your activities would be as counsellor at the university?——W. My activities are seeing students as individuals or in groups, or any member of the university community who comes to me. It is working in conjunction with another counsellor, hopefully to provide preventative programmes to stop the problems arising or to pacify those who are at risk. Also to deal with people who are in crisis situations, to help them bring about what change they want by counselling interviews or some other intervention, such as some group process or psychodrama or relaxing techniques or something like that.

2638. So your activities go far beyond advising students in regard to courses that they will take?——W. That is the least and the most uninteresting of my work.

2639. In your counselling activities do you have much contact with students who have drug problems?——W. A common misconception is that the counsellor knows the drug scene best on the campus. I do not, and I do not know who does. I think this is part of the problem, that in fact we are there but are often seen as people who are connected with the administration, people who are connected with the establishment or the police, and therefore students tend, I think—I am not certain about this—to use other agencies. It is a large component, I think, of other problems. We distinguish between a presenting problem and a real problem. A presenting problem might be, "I am finding it difficult to study." The real problem might be that they are having some difficulty at home or having difficulty in adjusting themselves to life, and the symptom might be some use of a drug.

2640. I see that as part of your experience you have trained counsellors for the Health Commission in the area of drug and alcohol dependence?——W. Yes.

2641. What would be your own particular training which would qualify you to give that training to others? ——W. My own training in educational psychology particularly, which is a Master's degree which I have from the United States, and experience that I gained there also; training undergone here in Australia at places like the Cairn Millar Institute, or the Counselling Institute in Sydney, or workshops that we counsellors go to to improve our skills; like workshops at Armidale and workshops in psychodrama.

2642. What sort of experience did you have as a youth leader in Ireland?——W. My experience was more in dealing with youth leaders; in helping a particular organization with its training of youth leaders.

2643. How long were you there?——W. Fourteen months.

2644. That was in southern Ireland, I presume?——W. Yes. No bullet holes to speak of.

2645. You mention in your submission priorities in planning; you say prevention or cure—leaving the one and going after the ninety-nine. Would you elaborate on that a little?——W. Yes. It seems to me that the community at the moment is very concerned, for some reason or other, to deal with people who are using drugs of one form or another, but the resources used there are not helping other people who may become users or may become at risk. I keep falling into the difficulty of talking about using drugs, but we all know that alcohol is the main problem. We do not want to deal with that really because it is our problem as well. There is no reason why a person should not be able to kill himself or involve himself in dangerous activities, and I see that perhaps our resources would be better used if we helped people who wanted help rather than chasing after people who are using prohibited substances.

2646. How long have you been at the university?——W. Since the beginning of January.

2647. So you would not have any knowledge as to whether the drug problem has increased there in recent years?——W. Not really. Except by talking to people or something like that.

2648. Mr HEALEY: In paragraph 8 of your submission you say that teaching parents to detect the signs is almost useless. How do you justify that statement?—— W. I think by the time that parents suspect that a child is using a prohibited substance a whole lot of other things have gone too far. The problem at that point is that the parent will be punitive or hurt, that he will become involved in seeing it as some sort of rebellion against him or something like that; whereas, if we must teach skills to parents, our efforts would be better employed in teaching them to talk to a child so that the substance was not used.

2649. But do you not think there is also a big possibility that if the parent is taught to detect the first signs, he will seek help for the child at an early stage. You seem to be advocating that there is to be no help for the child at all until it is more or less beyond recall?——W. No, I am not saying that. I am saying that in situations where there is no problem, a parent sniffing for symptoms will cause a problem.

2650. That is not the way that I read it. You say: Teaching parents to detect the signs is almost useless, if not destructive?——W. Could I ask you whether you know lots of people who have an alcohol problem? Can they detect the problem for themselves?

2651. No. I know many persons who have an alcohol problem who would be most offended and upset if you told them they had.——W. And I know lots of people who use all sorts of substances who would be equally offended.

2652. But I am talking about the parent-child relationship. I can see only good coming from the parent being in a position where he may be able to detect, early in the child's life, that it is taking a substance that it should not be taking. He can get help for the child.——W. Yes. If you use the analogy of helping with school work it might clarify what actually happens. If parents can detect, as they can through reports and so on, that a child is not doing well at school, they can get help because there is no social stigma, there is no legal question involved, and therefore the child is much more at liberty to respond to the help. One of the things that is very difficulty about being a counsellor is trying to deal with somebody who has been sent to you. The person must freely respond to

any sort of treatment. It seems to me that any "heavy" treatment on the part of police is in fact counter-productive.

2653. Mrs DAVIS: Would you elaborate on paragraph 14 of your statement?——W. It is a hunch that I have, and it is not based on terribly much firm evidence, that substances like methadone are used here—and hemineurin —in much the same way as they were used in the United States, which we are lagging behind, but we are taking our lead from there. A parallel to the point raised by Mr Healey about parents is with regard to police. In Scandinavia whenever a person is arrested for a drug offence, at the same time a social worker must be contacted. It seems to me that police are excellently trained for lots of things, but I have every sympathy with the policeman who has no human relations training to deal with tragedies like death, drug users and so on. I feel they are being pushed beyond their limits in having to deal with these people.

That is the sort of thing that I am referring to. It seems to me that in England there is a much more liberal approach to prescribing for people who call themselves addicts. But also, like America, we are far more concerned to focus on drugs rather than substances, and here again alcohol is the thing which keeps most people away from work, wrecks most families, causes most physical pain and accounts for something like 10 to 15 per cent of all hospital admissions.

I fear that what is happening is that, as in lots of other areas, we are importing a problem. There is quite a parallel with blacks and Aborigines; we in fact import a problem from the United States.

2654. Mr JACKETT: What expert qualifications have you in the field of criminology and sociology?——W. I am almost totally a lay person. I suppose I could point to studying philosophy for three years, studying ethics, sociology. But I am not a criminologist.

2655. I take it that you have tertiary degrees?——W. I have four—four and a half.

2656. I have been reading paragraph 4 of your submission. In the United Kingdom does not the whole tenor of their approach to hard drugs consist in allowing people to continue the habit almost indefinitely? In other words, it accepts the fact that they have no incentive to get away from the habit?——W. Yes.

2657. Do you find that satisfactory?——W. Yes, certainly. I feel that that is in fact the case with far more dangerous substances. People who want to injure themselves in some other way—alcohol and tobacco are perhaps far more addictive substances than heroin, and people are allowed to continue their addictions until they die.

2658. You would therefore see no virtue in, for example, the Odyssey House approach to addiction in New York? ——W. I am not exactly sure what you are saying.

2659. Odyssey House is a set-up whereby people who have been addicted to heroin—and it has been stated to this Committee by Dr Densen-Gerber that there are some 50 000 heroin addicts in New York alone—help themselves in a very significant way and they are successfully kicking the addiction. From what you have just said you would see no great virtue in an operation like that?——W. I said no such thing. I said that if people wish to continue in addiction that is their business. If they wish to cease the addiction then also it is their business, as it is with regard to tobacco and alcohol. I point out that Dr Densen-Gerber is one authority only and argument from one authority is poor argument indeed.

2660. I was not suggesting that she was making an incorrect assessment. What I was saying particularly was that if people could continue their addiction and there is no incentive to get them off it I should imagine you can see no virtue in an operation such as that suggested by Dr Densen-Gerber and others in that field?——W. In that situation those are people who have voluntarily sought to change their habits, just as people can go to Weight Watchers and take on programmes to stop themselves smoking or to become better drivers or something like that. It is a voluntary thing and that is why it works.

2661. If heroin is freely available, as it is in England to anybody addicted to it, apparently, there is no reason why, especially when there is no great cost involved, they would ever want to get off it?——W. I do not know. I cannot speak for a heroin addict. I have never been addicted to the substance. But, heroin was not a prohibited substance in the United States until 1914, and at that time it became a problem. It was not a prohibited substance in Turkey until fairly recently. In the Iran Parliament they had an opium smoking room.

2662. Surely you are not suggesting that these things only become a problem once they become prohibited substances?——W. I am suggesting exactly that, as with alcohol in the United States in the time of prohibition.

2663. It does not obviously follow. There must be other considerations that bring it to that point?——W. Historically that has been the situation, with more people making money from it. Every social evil has its vested interests. There are more vested interests in dealing with a prohibited substance than there are in dealing with a legal one.

2664. Mr MACDIARMID: Agreeing that alcohol and tobacco are accepted in the community, do you suggest that drugs should also be put on the same basis?——W. Yes. If I am pushed right to the ultimate on that I would be prepared to say yes.

2665. You say that marihuana is quite prevalent in the universities. If that is so, what is the attitude of the university authorities to drugs in universities?——W. I do not know.

2666. Alcohol and tobacco, particularly alcohol, are allowed in universities?——W. Yes.

2667. And the previous answer you gave suggests that universities adopt a tolerant view to the use of drugs. Is that right?——W. That is terribly hard to say without sounding snobbish, but I think universities are usually a step or two ahead of the community in terms of enlightenment and I hope that they remain that way. They are more tolerant in things like women's issues, alternative points of view and so on. I am not being facetious when I say that I do not know the university's point of view. The Vice-Chancellor has never told me to adopt a particular policy on drugs or on alcohol and I think he leaves that to my responsibility.

2668. CHAIRMAN: The council of the university would never have made any formal decision in regard to it?——W. Not that I know of.

2669. Mr MACDIARMID: Is the issue ever discussed at staff level?——W. Yes, often, in smoke-filled rooms while people are socked stupid with martinis.

2670. In your experience are any of the staff also involved in drugs?——W. I claim privilege not to answer that question. The only answer I can give as a professional person would be no.

2671. Mr RAMSAY: The question was raised with regard to paragraph 8, teaching parents to detect signs being almost useless. Do you agree that it is in everybody's interests to find out as much as they can about drug misuse, whether they have children or not? Surely you would agree that it is in the interests of the whole of the community to know as much as they can about it?——W. Yes. I think there is almost nothing you cannot say that about. It is a matter of priority. It is a matter of what you spend your time learning about. It seems to me that a lot of the community is quite frightened of drugs but loves peering through a keyhole at people shooting up dope or playing with dirty syringes or people who are supposed to do anti-social things. The more I study this kind of problem the more I become aware of the fact that it seems that alcohol is the focus but we avoid the focus. I would be interested to know how much of the time of this Commitee has been spent discussing alcohol.

2672. CHAIRMAN: Might I remind you that alcohol and tobacco are outside the terms of reference of this Committee.

2673. Mr RAMSAY: And that is not from our own choosing.

2674. CHAIRMAN: We did not choose the terms of reference?——W. I see. Well, federal Ministers for Health have said that this is the problem. What I feel it is necessary for us as people to do is find and research ways in which we can drop inhibitions and behave the way we would really like to behave without having to use substances to do it.

2675. Mr RAMSAY: You have had considerable experience, no doubt, and with respect to paragraph 11, you said that statements to the press by this inquiry have been made. Do you mean by this Parliamentary Select Committee?——W. I did not exactly know how to put that and I have not put it particularly well. I would hate to be quoted on notes which I tried to get ready quickly. What I heard was, and I must be careful because it was probably one of the people present now, someone being interviewed on AM, saying things that sounded like Lady MacBeth, about the smell created by crushing a marihuana plant in one's hand and rubbing them together, and then falling for the four card trick when the particularly unscrupulous press interviewer who asked the question whether the gentleman had ever smoked it, which was quite irrelevant. If he had been a gynaecologist the person would never have asked him whether he had had a baby.*

2676. Do you say that that statement should be vetted and do you suggest that there should be a vetting or veto of any statements that might be made?——W. I suppose the long range thing is that the press must be educated to take a responsible stand, seeing that it is in a responsible position. From what I have seen of the Wollongong press it is certainly not in that responsible position. However, I think that someone like Bob Webb in the central office or Peter Dhiem, or perhaps these kinds of committees, should appoint someone in the central policy-making area to be spokesman. I presume you know to whom I am referring.

2677. Yes, we do. Most of your evidence has been in the form of questions to us?——W. They are matters I like to inquire about.

2678. Quite. You mention in paragraph 17, where does someone in our community get a balanced point of view—where do I?——W. Yes, that means me.

2679. Of course. I suppose the terms of this inquiry would be to try and get that sort of thing. The terms of reference, as the Chairman mentioned, were not set up by us but by other people and we can only carry those terms of reference in relation to our inquiry?——Yes.

2680. With regard to paragraph 13, those are the matters which I am sure my colleagues on the Committee are looking at. I might say that in evidence in Newcastle the medical fraternity was most unified in its efforts to stamp out the use of analgesics in the Hunter Valley, which is a tremendous problem there. They are vitally concerned about it. Evidence was given in regard to, Don't share your day with a headache, take Bex or Vincents, and that sort of thing. Is that the type of thing you are concerned about?——W. Yes, even the advertisements to doctors in medical magazines, things pointing out the counter productive effect of mixing alcohol with certain drugs as prescribed.

2681. CHAIRMAN: Have you ever seen a marihuana plantation at close quarters?——W. On what scale do you want me to answer that question?

2682. Just yes or no?——W. Yes.

2683. Do you know the difference between a male and a female plant?——W. Yes, I think I could tell the difference.

2684. Have you ever had a lush female marihuana plant in your hand, squashed?——W. No.

2685. I was the person about whom you were referring in regard to the interview and if you had not had a squashed female marihuana plant in your hand I suggest that at your first opportunity you should do so and no doubt it will considerably broaden your education?——W. Perhaps you might take me to a plantation so that I may do so.

2686. Mr MACDIARMID: You see a problem with analgesics in society do you?——W. Yes.

2687. Yet earlier you said, if someone wanted to kill themselves with drugs it is their own business and their own problem?——Yes.

2688. Is there not an inconsistency?——W. No, because you can kill yourself with a motor car or a chair or an axe or anything. The problem is, why you want to kill yourself?

2689. On one hand you think they should be protected from the over-use of Bex and Vincents and on the other hand you think they should have free use of other things? ——W. I think they should be the protector otherwise the responsibility is taken from people who never learn to grow any responsibility. Educate, by all means, but if we take responsibility away from people and if you cannot read your Bible when you go into Russia because it is taken from you at the border, or your copy of Playboy, while in Russia you will never develop a morality as to how to use the Bible or Playboy.

(The witness withdrew.)

ROBERT JAMES KIRK, General Practitioner, 109 Little Lake Crescent, Warilla, sworn and examined:

2690. CHAIRMAN: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. Yes.

2691. Did you wish to make a written or an oral submission to the Committee?——W. Oral.

2692. You might tell us a little about your activity in this area, how long you have been here and anything that you feel will be of interest to the Committee in its investigations into this matter and the use and abuse of drugs of

dependence?——W. I have been in the Wollongong area since 1965. I commenced practice in the Shellharbour district in 1967. My specific interest commenced late in 1975 when my partner, Dr Talib, and I started to see a sudden increase in heroin addiction, almost to the point of an epidemic—larger than the type of infectious epidemic you see with chicken pox or mumps. We were seeing up to twenty a week each, which is a large number. Why they suddenly came to us we were not sure, but we spoke with Dr Diment and I spoke with one of the social workers here—I have forgotten her name—as to why we might be seeing them. The answer was that we were listening to what they had to say and we were issuing them with physeptone. Between that period and the middle of last year when the story got into the press about the incidence we continued to see them. About two months after that, following a statement in the press that we were working with the police, we stopped seeing them and we have seen practically none since.

My specific interest was the number in the area and the fact that, despite all the literature, there did not seem to be anything at all available that you could do for these people. The stories they told were always the same. They wanted their last dose of physeptone to get them off heroin. We soon found that they were either selling the physeptone or using it to spread out their heroin usage. Very few of them were genuine in their intentions. I think in that period I saw one person who appears to have controlled her usage of the drug. As for the others, I think they have just moved on to other doctors or other areas to obtain a listening ear.

2693. Warilla has been mentioned as one of the problem areas.——W. Yes.

2694. You mentioned that you were each seeing up to twenty patients a week, but now they seem to have moved on. Do you think they have actually moved out of the area or that they have just gone to other doctors?——W. There is a lot of surfing around Warilla and a lot of them were associated with the surfing crowd. I think a lot of them are still in the area. I see some of them along the beaches. I do not know what they are doing to obtain their heroin. It must be expensive now and many of these people were on the dole. If they are paying $30 a cap I worked out the only way that they could survive is to keep pushing it harder, so my thought was if that were the case and if their usage increased, which it would anyhow with time, they had to involve more of their friends to afford that $30.

2695. Yes, but that is only presumption on your part. You have no definite evidence from people involved on the scene?——W. When we were involved with them we did ask a lot of questions and they were very willing to tell us a lot. What they told was quite startling on just how broad the problem was, but they all said it was easier to spread your business because the whole scene was new and there was not hot competition. So if you wanted to obtain more business, then at another party you only had to pick up one extra user and distribution through that one would lead to others. It grows like a very quick pyramid.

2696. When you mentioned twenty patients a week, a lot of those would be the same people coming back?——W. No, that was what startled us.

2697. Twenty new ones?——W. They were twenty new ones, yes. That is when it got to its peak. We became so worried and concerned about the whole thing that I went to Sydney to see—was it Mr Coleman who was then the——

2698. The Minister for the Police?——W. Yes, the Minister for the police then. I went to see Mr Coleman because I felt the problem was so bad that something had to be done. Dr Talib flew to Canberra and he spoke to Dr Jim Cairns on the issue. I believe it was that action that promoted more speedy movement on the issue by the police. I remember we made a statement in the area and we were howled down by a couple of local aldermen who made statements in the press that we were exaggerating our story. Well, later on our story was confirmed. We felt the area was understaffed—there were too few people who understood these problems. I, for one, had never seen the problem and I did not know how to handle it and I found that no one else did.

2699. What actual period are you referring to now?——W. September/October, 1975, to June/July, 1976.

2700. Would all of these cases that you were dealing with have come to the notice of the Health Commission?——W. Yes, the majority, I think.

2701. Yet, for the whole area in July, 1976, there were only nine new cases reported. Does that surprise you?——W. Yes, because of the conflicting issues that occurred during this period—they were just staggering to me. That is why I thought the whole thing was crazy. Nothing that anyone was saying was making very much sense and no one would answer our questions.

2702. In January, 1976, only two new cases were reported.——W. Well we must have been seeing them all in Warilla.

2703. But if you were reporting them to the Health Commission surely they would have incorporated them in their figures?——W. I am sorry—I did not ring up every single new case. Some of them had been through centres in New South Wales but they were coming to us for the first time.

2704. What do you see as one of the most important recommendations that this Committee could make in regard to this very important social problem?——W. Learn a lot more about it. I think very few people know anything about heroin. I do not think that it should be attacked any differently as a problem from any other drug issue but it is just that with heroin we know so little about its management. I presume, since so much work has been done on the subject in New York, that that would be one area that surely should be able to give us some enlightenment as to the problems in management.

2705. So far you have confined most of your discussion to heroin. Our terms of reference cover all drugs of dependence apart from alcohol and tobacco. Have you had any experience recently of people who have been dependent on analgesics?——W. Yes.

2706. I am referring to minor analgesics.——W. You mean the aspirin range of drugs?

2707. Yes.——W. Yes, I think that is a very serious problem and it is a problem that has been neglected far too long. I think in our area the number of people who are dying slowly of kidney disease through analgesic problems is higher than the number of people dying from cancer of the lung. I am sure it is.

2708. But it is a slower process?——W. Yes, it is slower, and it is so very costly, and it is so very costly because some of these people require dialysis and renal transplants.

2709. Have you any personal theories about how this analgesics problem should be dealt with?——W. I think the analgesic problem is a very simple one. They are sold by advertisement and so you stop the sale of them by stopping advertising. I think it is as simple as that. I think the advertising programme for analgesics is brilliant because the advertisements persuade you that you must take an analgesics even if you do not want to.

2710. Do you feel that you know anything about the clinical aspects of analgesics and their effect on the kidneys?——W. I have read umpteen dozen articles about that.

2711. In other words you have been dependent on the research done by other doctors?——W. Yes, but I think that in most cases you have only got to take the history and you know what the blood tests are going to be like before you get them back and you know what the X-ray of the kidney will look like.

2712. Have you experienced any of these cases where people seem to carry on a family tradition?——W. Yes.

2713. "I take Vincents because my mother and grandmother took it."——W. Yes, definitely.

2714. Mr MacDIARMID: Do you try to talk people out of taking these minor analgesics when you see that they have a problem?——W. Yes.

2715. Mr RAMSAY: Are you aware of the uniform opposition by doctors and the medical profession in the Hunter Valley to analgesics?——W. Yes.

2716. What would be the attitude of the medical profession here? Would you know of that? Would it be similar? Have you got an organization like they have up there opposing it?——W. No, there is not one here but I think I can get out my final year lecture notes for 1964 and the views of the unit at Prince Alfred in those days were the same. They have not altered. It is just that they have organized and increased the tempo.

2717. There has been some change in the mixtures in Bex and APC powders, has there not?——W. Phenacetin was removed because it was claimed it was the number one problem. But if you take enough aspirin by itself you will do just as much damage. What has happened is that instead of taking one packet of the old mixture they now take one and a half packets of the new mixture.

2718. What is your attitude in regard to the treatment of withdrawal by methadone?——W. Therein lies the question I was trying to find when we started to see these problems. That is what has got to be found out by a committee like this. I do not really know. As far as I can see, the whole thing is a bit of a joke because the majority of people involved only use it to spread out their programme for the utilization of the stuff, especially if they are on heroin. Very few will get off it.

2719. Would you like to see a drug withdrawal centre developed in the Warilla–Shellharbour area?——W. If there is no bureaucracy, and if there are people who know what they are doing. I do not want about 16 secretaries and one personnel; I want 16 personnel and one secretary.

(The witness withdrew.)

NEIL ADAMS, Lecturer in Psychology, Consultant and Counsellor, residing at Mistfall Glen, Fountain Dale Road, Jamberoo, sworn and examined:

2720. CHAIRMAN: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. Yes, I did.

2721. We have received a submission from you. Is it your wish that it be included as part of your evidence? ——W. Yes.

*Preamble*:

This submission is not based upon any specific research, for reasons detailed in section 1. It does reflect the opinions and experience of the Wollongong Drug Committee, which has been active in the areas of drug education and counselling for some years. More particularly, the author's own twenty-five years experience of teaching and counselling in schools, universities, youth groups and other community groups contributes to the submission.

The general theme of this submission is that in general, the use of drugs is extremely likely to detract from an individual's efficiency in coping with life problems and to reduce his/her attempts to achieve maximum fulfillment; and in influencing the individual this way, drugs must also adversely affect society as a whole, and are hence a social problem and not simply a matter for individual choice. Consequently, the attitude taken in the submission is that, although drug use *per se* should not be regarded as a criminal behaviour, it is an indication of the individual's need for social intervention in his/her life. Further, it is urged that every reasonable effort be made to reduce the availability and use of drugs, and to educate the public as fully as possible about the personal and social disadvantages of drugs and about socially and psychologically preferred alternatives.

*Recommendations*:

To those ends, specific recommendations are made that:

1. The availability and promotion of drugs be minimized, through:

(a) Increasing the efforts to control and eliminate trafficking in illegal drugs. This may entail increasing penalties associated with criminal activities in this area;

(b) Discouraging the legalizing of any drugs of addiction or possible addiction;

(c) By encouraging, perhaps even coercing, medical practitioners to review their own prescribing habits and to consciously reduce the number and size of prescriptions for drugs upon which people may become dependent;

(d) Severely curtailing and closely supervising the advertising and availability of drugs of dependency through pharmacies and other outlets.

2. The potential disadvantages and dangers of continued drug use be made more widely known, and concurrently access to and information about alternatives which are more beneficial should be improved, so that people can not only make more discriminating choices but have the opportunity to implement their decisions.

This recommendation points to:

(a) Public education, preferably through subsidized self help and community-based groups; the education to be directed towards information about physical, psychological and social effects of drugs and towards helping people develop more fully the personal resources they might use instead of reliance on drugs.

(b) Provision of counselling expertise in virtually every medical practice. This could well entail the need for financial assistance to each medical practice to establish facilities and obtain personnel for this service.

*Supporting Evidence and Arguments*:

In this section of the submission, the comments made are tied to the corresponding sections in the terms of reference.

*Terms of Reference*:

1. I have four comments to make here—

1.1. Regrettably, much of the research has been conducted by researchers who were not entirely disinterested, and consequently many of the research findings are unavoidably suspect. This is not to impugn the integrity of the researchers concerned, but social psychological research in a number of areas has clearly demonstrated that, quite unwittingly, researchers will often obtain the experimental results they expect.

1.2. It has become fashionable in some social science circles to evaluate all scientific generalisations in terms of their implications for "personal freedom" on "the integrity of the individual", and to justify this value judgement on the unspoken but equally untenable value judgement that

the individual has higher importance and more rights than the community (society) of which he is a member. Consequently, the use of terms like "for the social good", in arguments about personal behaviour is rejected by such social scientists. Instead, they tend to argue strongly in support of the individual's right to choose any pattern of behaviour, however, personally or socially deliterious. I would strongly advocate the opposite stand; that we are members of interdependant communities and societies, and to allow a weakening or unnecessary damaging of any member detracts from the efficiency of, and adds to the psychological and economic costs of, the community.

1.3. The above comments, notwithstanding, it does seem that more of the recently accumulating evidence has highlighted deliterious effects rather than beneficial consequences of drug use, particularly those drugs which have no or very little medical use for relief of symptoms. My own observations over the past decade, possibly biased but certainly sympathetic, of numerous young people who have used one or more drugs for personal reasons or social reasons (I should elaborate briefly on these below) have convinced me of certain relationships.

Consistent, long term drug users—especially those who begin their consistent use before the completion of adolescence—appear to be less socially competent and less capable of achieving other kinds of personal fulfilment than non drug users. While it is perhaps not scientifically defensible to attribute cause, I have no doubt that the drug use has at the very least exacerbated natural or early acquired inadequacies, and has prevented the learning or developing of more effective coping patterns. Even in older adolescents and young adults, I have observed that moderately heavy drug use is likely to precipitate or aggravate a falling away in competence and social relations.

Further to this point, I would make the comment (to be elaborated on verbally) that the young adolescent who incorporates consistent drug use into his/her pattern of behaviour is also very likely to build this into his identity —to classify himself as a drug user and to turn automatically to drug use for relief of any frustration or as a source of pleasure and self fulfilment more readily available and appropriate than any other.

I mentioned above personal and social reasons for taking drugs, and while research has revealed many ostensive reasons, these seems to be categorizable into a very few basic ones, upon which I shall comment briefly:

*Personal Reasons*:

(a) For pleasure; directly, in the experience of the drug itself; or to in some way enhance other sensory experiences.

(b) To help meet personal needs which are not otherwise being resolved—to reduce anxiety, to achieve intellectual or emotional comprehension or awareness, to alleviate depression, to attain feelings of worth or satisfaction.

In both cases, the effects are unlikely to last any longer than the physical effects of the drug, and the individual has gained from the experience no new information about how to cope with the internal or external environments. As long as the individual is failing to develop more effective and efficient coping behaviours, he is becoming an increasing undercontributor in his society. Nevertheless, I recognize that the mature adult may be entitled to seek pleasure in any way he/she chooses, so long as it does not infringe on the freedom, comfort or safety of his/her fellow members of society. Neither do I see anything reprehensible in seeking pleasure, unless that seeking required the exposure of others to risks which they should not be expected to take and may not be aware of nor prepared to meet.

This is just the situation which applies with drugs: If they are to be made legally and readily available to those mature people who, consciously aware of the risks and coping successfully with life still choose to use them, they must be equally freely available to those less competent, less prepared, less able to make a rational choice. Our society would be irresponsible if it allowed this situation to develop any further than it already has with the legally available drugs of prescription and social use. Just as, in a family, the responsible members must be prepared to forego some pleasures in the interests of the protection and security of the young; so, in society, the more mature must be prepared to relinquish some rights if the pursuit of those rights increases threat to the less mature and less competent members.

*Social Reasons*:

(a) In response to pressures (sometimes very subtle) or needs to retain group acceptance or recognition. If significant peers use drugs, it is difficult for many adolescents if not impossible—to resist these pressures to conform to group patterns of behaviour.

(b) To "facilitate" interpersonal interaction; to "improve" one's ability to empathise, to communicate, etc.

The first of these social reasons is very largely a function of the *availability* of drugs, as much as any other factor. The second might, for the majority of users, be well described as a "snare and a delusion". It has the same general value and consequences as has the use of drugs for "reducing" personal inadequacies. In the long term, it achieves nothing more than aggravation of whatever problems already existed.

1.4. It is clear from the foregoing facts and arguments, as well as being implied by a considerable body of otherwise "neutral" research, that the availability of drugs is a major factor in their use. Since it is also clear that any benefits available in the use of drugs are, in sum, very much out weighed by the social costs or dangers, the conclusion which must be drawn is that any action which can be taken to reduce the availability of drugs must be taken, despite the effects of this action on that minority which might be competent to use drugs for its own purposes.

*Terms of Reference* 2

No specific comments other than (1) an iteration of the point that evidence can be distorted not only in the interpretation but also in the collection; and (b) many apologists and advocates of drug use point to recent survey results which indicate large proportions of young people having experience with drugs, and use this as the basis for an argument that "if so many do it, it can no longer be considered wrong". In counter to this rather persuasive argument, two points must be made: a distinction (in this numbers game) should be clearly made between consistent, relatively frequently users and "dabblers" who use drugs largely because they are available and it is becoming an accepted thing to do; and again, this increased use is largely a direct consequence of availability.

*Terms of Reference* 3

(a) Bluntly, control in all three respects, manufacturing, possession and use; is very much less adequate than it needs to be for both licit and illicit drugs. Optimally, use should be controlled primarily through the informed personal decision of prospective users, but in our present society, there are many who are incapable of making informed choices. The young and immature will probably never be capable of making choices when one of the major determinants of the choice involves awareness of long term consequences.

(b) For illicit drugs, penalties for manufacture and supply seem too inconsistent, and perhaps still too slight. For licit drugs, the rewards for manufacture and supply are obviously excessive, encouraging the legitimate "pushing of these drugs through extravagant advertising campaigns, often aimed specifically at medical practitioners and pharmacists. *Both* penalty and reward systems should be revised. The use of drugs, if it in any way exposes other members of society to risk either through the behaviour of the individual while under the influence of drugs (e.g., while driving) or by increasing the availability of drugs generally should be curtailed, as gently but as firmly as possible. People identified as consistent users of any drug should be assisted to enter into some personal development programme (through counselling, workshops, or whatever) and if their drug use is infringing damagingly on the rest of society, should be required or coerced into such programmes, or forego their rights to interact freely with society. Unfortunately society at present categorizes much irresponsible people, drug abusers, as either "sick" (perhaps "disturbed") or "criminal", and I don't believe that either category is really appropriate. However, they can certainly *not* be regarded as fully responsible either, and so society's intervention in their lives is legitimate and desirable.

*Terms of Reference* 4

(a) General education is a necessary but not a sufficient condition for the diminution of drug use in society. Categories of people particularly in need of education are those in medical, counselling and teaching professions—too many members of each of these have favourable or neutral attitudes to drug use.

(b) Highly desirable. Any education programmes should include substantial segments on the psychology of drug dependence and on alternatives to drug use.

(c) Should all be expanded; especially the preventive and counselling (which I interpret as preventive or ameliorative).

*Terms of Reference 5*

I commend for the Committee's considerations the recommendation outlined in the early part of this submission.

I thank the Commission for the opportunity it has given me to express these views.

NEIL ADAMS.

2722. CHAIRMAN: Would you like to elaborate on that submission?——W. I think I should say a little about my own background as a justification for my making so bold as to take up your time. I have been teaching now for about 25 years, and counselling, after training in my own undergraduate degree and with the Education Department as a counsellor in 1960; counselling for some sixteen or seventeen years. Although I work as a lecturer primarily, for many years I was the only counsellor that the university had, and I did that in conjunction with my lecturing. I still do some counselling work.

I have been very much involved in youth work for a number of years. For several years the surfboard riders in the Shellharbour area met almost weekly at our place. On one weekend we had about 50 of them spend the whole weekend. I have kept in close touch with young people, and particularly the sort of young people who are likely to be involved with drugs. Although I do not have any hard research evidence to offer you, I do have the evidence of my own fairly extensive experience with people who have been involved.

I am sympathetic to young people, I want to make that clear, and to any people who have difficulties in their own handling of life's problems, whether they include drugs or not. It is as a result of this experience that I have come to the view that I have now, that drugs in general are a very poor alternative when you look at the alternatives available for coping with life's problems and for achieving pleasure and satisfaction. I elaborate on those points in the course of this paper.

Anything that we as a society can do, first to minimize the need for drugs in people—and I am sorry to see that alcohol and tobacco are not included in your terms of reference because when I talk about drugs I include them, particularly alcohol. What I have to say applies to the majority of other drugs, both drugs of prescription and illegal drugs. Anything that we can do to minimize the need for these drugs, to teach people appropriate alternatives and to provide those appropriate alternatives for society, is one avenue of activity, and also anything that we can do to minimize the availability of drugs, both drugs of prescription and illegal drugs, we should do.

I would like to emphasize some of the points I make in relation to each of the terms of reference. One of my reasons for not getting a list of possible studies to quote to you is bound up in the first point that I make, that even though researchers may have the best of intentions, it is extremely likely in a lot of cases that their own expectations or prejudices will colour the outcome. A lot of social experiments have been done to demonstrate this, using experimenters who were given expectations and who then produced results that conformed with those expectations. This has been done so many times that it is now accepted that experimenter affects intrude into almost any kind of study. That is so particularly in this area of drugs where so many of us strongly oppose, and so many of us strongly favour. When we carry out interviews or empirical studies, quite without deliberation on our part we colour the course of events and then interpret the results we get in such a way that the results support our hopes or expectations about them. I make this point strongly because you will hear a lot of conflicting evidence, and a lot of it has to be regarded as being suspect on these grounds.

The second point I want to make in relation to this general comment on evidence is that I personally feel that it is very unfortunate that a lot of social scientists—many from my own area, many like Michael Breen—have opted for emphasizing the dignity of the individual or personal freedom or the rights of the individual to make his own personal choice. I feel that in a society as complex as ours is, where we are interdependent upon each other, we cannot take unto ourselves the right to make entirely individual decisions, particularly when the consequences of those decisions are likely to affect other people. The consequences of decisions about drugs influence other people in at least two ways: first, if we do, while under the influence of a drug, perform something like driving a car in public, that makes us a danger to others, and since almost all drugs do reduce our ability to make rational decisions, you cannot say in advance, "But when I take a drug I will not involve myself in that sort of activity". Although you may decide that in advance of taking a drug, once under the influence of it your decision is likely to change.

The second reason for not being able as a society to leave freedom of choice to the individual in this area is that if we do decide for the option of leaving drug taking open to freedom of individual choice, it means automatically that we have to make drugs freely available so that those who choose to use them can do so. In doing so, we make them freely available not only to those who are mature enough and competent enough to make reasonable choices, but they are also freely available to the young and immature as well as those who have not yet learned better ways of coping with problems.

There is a lot of evidence—not simply research evidence, but social observation type evidence—to reinforce the proposition that one of the major factors in increasing drug use is the factor of availability. If you make drugs available you can be certain that more people will use them.

I do not want to labour the points that I have already made in the submission. I say a little about the reasons for taking drugs, as I see them and categorize them. I hope you will have the time to read the rest of the things that I have said there. I think now it might be better if I just left it to the Committee to ask any questions that they desire.

2723. I notice that you are making your submission on behalf of the Wollongong Drug Committee. Would you tell us a little more about the committee, its composition and activities?——W. Yes. I have been involved with it almost since its inception. It was formed in the early 1970's by a number of people who were concerned at the then growing drug problem in the Wollongong area as they saw it. The original intention of the committee was, after it had been formed and had discussed the aspects of the problem, to discover more about the extent of the problem in Wollongong and at the same time do what they could to counter what seemed to be the growing influence of drugs. The main avenue of action that they took in those early days was the educational avenue of organizing workshops and five-day seminars.

I think I have been involved in the organization of leading groups of discussion and participating in almost every

workshop that the directorate has held since then, apart from the year I was away overseas. We organized workshops and provided speakers for any group in the community that might want someone to talk about drug effects. We had quite a lot of people who were much more expert than I in the pharmacological and medical effects of drugs, medical practitioners and pharmacists. I am reasonably knowledgeable about psychological effects, particularly long term.

2724. Do you ever get the feeling that in organizing these workshops the people you really want to get to, because of their lack of co-operation, are not the ones that actually come?——W. We certainly do not reach a lot of the people we would like to reach. We do get that feeling on occasions, particularly when we organize a workshop specifically for certain people. We arranged a workshop specifically for teachers in an area and through the local education authority we arranged to get at least one teacher from each high school. We did reach the people we wanted for that period. We had a teacher from each high school who had been through the workshop and had been in discussions about drugs and so was better able to help youngsters in the school.

2725. Mrs DAVIS: Do you have much of a drug problem in the university?——W. I believe so. As Michael Breen was saying, universities like to regard themselves as being in the forefront of social experimentation and it is one of the things that students in high schools are much acquainted with because of a greater freedom in university and the fact that many of the responsible people there either condone or actually advocate the use of drugs. Yes, I think there are a good number of people who use drugs more heavily than they ought to. The majority of these, that I have personally known of, are people who generally do not last very long at the university. Some get right through but whether they get through with as high a level of pass as otherwise they would, I very much doubt.

2726. Mr MacDIARMID: You said that some areas of the university, and schools I gather, condone and actually encourage the use of drugs. Do you mean to say that? ——W. Yes, I wanted to say that. Encouraged, perhaps not so much through example, although some make no secret of the fact that they have used or do use drugs, but encouraged through their advocacy of personal freedom and support, which I too would advocate, if it does not impinge upon the more important social values. But, from advocating personal freedom they mention specifically things like drugs.

2727. What you are really saying is that university authorities have a very lenient view towards the use of drugs in universities?——W. No. Universities are rather special sorts of places in that the relationship between the authorities and people who operate there are rigid in some respects but in others very very open. I think that anybody in the academic area would feel justly that his rights as an academic were being infringed if the administration or even perhaps the university counsellor were to say, you should not talk about that set of ideas or that set of behaviours in that way. That is one of the things about the university that people can explore different approaches to living as well as say engineering and science.

2728. If a student were found to be using a hard drug in a university would that be accepted and nothing happen to him?——W. I think what I have been saying must be taken only to apply to soft drugs and marihuana in particular. Specifically to answer your question, if anybody were known to be a heroin user then it would be unlikely that nobody at all would accept the responsibility of seeking help or trying to counsel that particular individual in order to seek help.

2729. Have you ever had that experience as a counsellor?——W. With heroin only indirectly. I have had people whom I have known to be using other drugs who have come to me saying they are worried about so-and-so who has got on to heroin and what would I advise them to do and I have made the offer for them to come and see me for counselling but I think once a person is on heroin it is partly a medical problem as well as a psychological and counselling problem, so I have also recommended that I think it would be better for them to see someone with medical expertise so that whatever else might be wrong it might be diagnosed and prescribed for properly. Whether or not that advice has been followed I do not always know.

2730. Mr RAMSAY: On page 1 of your statement you refer to drugs of addiction or possible addiction. What do you mean by possible addiction?——W. It is argued by a lot of people who favour drugs like marihuana that it has not been demonstrated that these are addictive. I would say that there are very high probabilities that some people might become dependent at least on those drugs. I have said that just to cover the fact that it has not yet been demonstrated. Marihuana may be a drug of dependency if not addiction.

2731. What would be your attitude, in regard to say a first offender with marihuana, so far as penalties are concerned?——W. Because of what I say later on in my submission, that there is an indication for continued involvement and an indication of a need for some sort of life adjustment or psychological counselling, the first offenders would really need—we do not have the resources, of course—some sort of case study done so that before any decision is made about what should be done for them people would know whether the offence for which they had been picked up for the first time was a casual experimentation or whether it was the culmination of three or four years of extensive use.

2732. For a study to be made on that basis it would be of some magnitude?——W. It is unrealistic, yes, to expect that, so I guess to err on the side of leniency you should, as a first offender, regard him as somebody who has not done anything but experimenting, but at the same time he should be someone upon whom tabs should be kept. I do not like the concept of big brother but I like even less the concept of drugs spreading through our community.

CHAIRMAN: Thank you, doctor, for your assistance.

(The witness withdrew.)

(Luncheon adjournment.)

VINCENT JAMES JOHNSON, Regional Director of Grow, 284 Northcliffe Drive, Lake Heights, sworn and examined.

2733. CHAIRMAN: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. Yes.

2734. I understand that you wish to make a submission to the Committee. Is it a written submission or oral?—— W. It is a written submission. It reads as follows.

Mr Chairman, Gentlemen,

Firstly, I would like to thank the Joint Committee of Inquiry and Dr Max Diment, Regional Director of Health, for the opportunity of giving evidence before this Parliamentary Committee.

My name is Vince Johnson, I am presently Regional Director of Grow, based in the Illawarra Health Region, and Honorary Secretary of the Wollongong Drug Committee.

The Joint Committee has already been addressed by representatives from Grow who have presented a programme which includes a radical new community approach in education for living through mutual help groups and a prevention and rehabilitation programmes for drug dependents. Dr Neil Adams, past Chairman of the Wollongong Drug Committee, has also appeared and given evidence. However, the evidence I propose to give is based on several factors:

1. My own personal experience as a drug dependent person.

2. My experience as a member of the Wollongong Drug Committee including two periods of Honourary Secretary; in this context I shall endeavour to give a history of the Wollongong Drug Committee.

3. The sponsoring of Grow by the Wollongong Drug Committee to the Illawarra Health Region, my secondment as an officer of the N.S.W. Public Service to work with Grow for 15 months from 1st July, 1974 and my resignation from the Public Service to work fulltime with Grow.

I was first appointed to the Department of Technical and Further Education in 1940 and remained with that Department until January, 1976 including three years service with the R.A.A.F. For many reasons completely unknown to me at that time I became a drug dependent person and lost control over the stable management of my life. I did not have any real insight into myself and my capacities and personal resources to make discriminating choices were minimal.

In 1964, through talking with a person who had recovered from drug dependency, I was introduced to a self-help, mutual-help group which gradually helped me change my life.

My career as a member of the Administrative and Clerical Division of the Department included a period of being passed over for promotion because of unsatisfactory behaviour. After two to three years free of drugs this position changed, relatively swift promotion followed, culminating in my appointment as Registrar of the Wollongong Technical College in 1971.

I joined the Wollongong Drug Committee at the beginning of 1972 and became Honorary Secretary in September, 1972. In this role I was influential to some degree in having the concept of the Seminars and Workshops broadened to include representatives from self-help, mutual help groups, e.g., Grow, A.A., Al-Anon, Teen Challenge, The Richmond Fellowship, etc. It should be noted that the Public Service Board approved special leave on full pay for me to attend a Drug Seminar in 1973. The insights I gained in this participation were tremendous. The multi-disciplinary approach, the break-up into small groups, group discussions, etc., were all very helpful in broadening my educational background regarding my own and others dependency on drugs.

## BACKGROUND AND HISTORY OF THE WOLLONGONG DRUG COMMITTEE

In 1971 public awareness of drug problems was beginning to stir in Wollongong and the Health Department had numerous requests, both for information and help. As a result Dr Edgar Wallace, Medical Officer for Health in Wollongong, called a public meeting to bring together those who were interested, tap available resources and try to decide what the problems were and what could be done about them.

The Wollongong Drug Committee was formed out of that meeting. It contained an interested and valuable cross section of the community and the original executive included Mr Maurice Sherley, S.M., Chairman, Kevin Lawler, Pharmacist, Treasurer and Dr Beryl Ford, Secretary.

In those days the committee formulated its role in three areas:

1. Activism against the promotion of drugs.
2. Drug education.
3. Drug counselling.

The membership of the Committee has varied over the years and has included at various times officers of the Department of Education, Technical Education, Health, Child Welfare, Sport & Recreation, University of Wollongong and the Institute of Education; Students, Teachers, School Counsellors, High School Principals, members of mutual help organizations, representatives from the Pharmaceutical Guild, Trades & Labour Council, a Stipendiary Magistrate, a Lawyer, Doctors, Psychologists, the Home Mission Society, Ministers of various religions, housewives; employees of Wollongong Council, A. I. & S., John Lysaghts, Metal Manufacturers, E. R. & S. etc., the Police Department was represented some years ago, before the advent of the Drug Squad.

Membership has varied over the years and resignations and drop-outs have occurred because of personal commitments, job transfers and similar reasons; in other cases this has occurred because dramatic results were not observed in the sort of work being undertaken and some persons appeared more interested in trying to find "quick" solutions to the problems associated with drugs.

Meetings were held monthly and gradually a Workshop Design was established and several seminars were conducted, including a special one for teachers. Following the resignation of the executive in 1972 Dr Neil Adams was appointed Chairman, Mr Tom Bowman (Wollongong Council), Treasurer and myself as Secretary. As Secretary I continued the liaison, established by Dr Ford, with the Mental Health and Drug Education Division of the Department of Health in Sydney. The existing Executive of the Committee is Mr Vince Schubert, Hypno-Therapist and University student, Chairman, and Mrs Pam Haane, teacher, Treasurer. Between my two periods as Honorary Secretary of the Committee Mrs Julie King who presented the GROW Submission this morning occupied this position.

In early 1972 the Committee gained access to some funds available within the Department of Education to employ a part-time clinical Psychologist for approximately 3 hours per week for a limited period. This Psychologist was involved in counselling a group of young people who had sought help from the committee.

Another activity of the committee was to try to meet the needs of specific groups who requested information on drugs. This was met by approved educators addressing meetings, perhaps showing suitable films and involving participants in group discussion and answering questions where appropriate etc. Groups addressed included Mothers Clubs, School groups, Church groups, many varied Service Clubs, Scouts, Rangers, Parents & Citizens organizations, Country Women's Association etc. Approved Educators were members of the Drug Committee who had attended at least one workshop/seminar, participated in group discussions, and were considered suitable and acceptable to the executive of the Drug Committee and the Mental Health & Drug Education Division, in Sydney; approved Educator fees were paid by the Department, after certification of claims by the Secretary of the Committee.

It gradually became clear that the most effective method of disseminating information, however, was going to be through holding 5 day Drug Seminar/Workshops regularly. In addition, if we were to attract funds from the Mental Health & Drug Education Division, the committee's role must be restricted to that of prevention and education, as funds from this source could not be used in rehabilitation or counselling. At the same time local resources were very limited in rehabilitation and counselling and those people professionally qualified in this area were already over committed.

In 1973 the Drug committee prepared a constitution which was formally approved by the Chief Secretary's Department and became registered as a charity. In this way we were able to issue tax exempt receipts when funds were raised locally.

The objectives of the Wollongong Drug Committee as formulated in this Constitution are as follows:

*Objectives*

1. To establish and maintain up to date information about the use and misuse or abuse of drugs in Australian society in general and in the Wollongong and nearby areas in particular.

2. To co-operate with the Department of Health in the provision of an educational service with respect to the physical, psychological and social effects of drug usage.

3. To provide and/or support a counselling and other case-work services as necessary to meet the needs of drug users requesting such services.

4. To liaise with all other community agencies involved directly or indirectly in the areas of activity suggested in the preceding objectives.

5. To involve responsible and appropriate members of the community in the activities of the committee.

N.B.: The use of the term "Drug" is meant to refer to any chemical substance which may be inhaled, ingested or injected and which can adversely affect the physical and/or psychological status of the individual if used inappropriately or excessively.

Because fund raising is both time consuming and disheartening and membership was essentially of a voluntary nature and, noticeably members were also heavily committed in other community activities, the committee has never been particularly active in trying to raise funds; nevertheless it became

appropriate to mention our need for funds when advertising Seminars throughout the media and we did get some local support.

The activities of the Drug Committee were particularly time consuming for the executive and in 1973 approval was given for a position of part-time typist (2 days per week) to be established under the control of the Health Commission. This lady has been particularly helpful to the committee.

Activism against the promotion of drugs has been an ongoing function of the committee, using the media and maintaining contact with other involved bodies. Our main role however has been in increasing community awareness of personal needs in education for living, that drug dependency cannot be viewed in isolation but in the context of mental health, and inviting public participation in Seminars/Workshops. We endeavour to reach key people in the community who may be in a position to influence others. It was often disappointing to find that members of the Public Service, e.g., teachers, could be officially granted leave by the local Head of Department to attend, but that local staffing problems in the school or whatever often prevented them attending the full five days of the seminars.

Some important developments emanating from Committee activities are as follows:

1. Drop-in Crisis Centre. People who had participated in the seminars decided to meet to see what they could do to help. Following liaison with the Health Commission in 1976 a group of people staffed Kembla House from 8.00 p.m. Friday nights to 6.00 a.m. Saturday mornings. This was extended gradually to also include the period 8.00 p.m. Saturdays to 6.00 a.m. Sundays. To achieve this, a public meeting was held and 40 members of the community became involved. The Drug Committee organized training sessions for these people who made themselves available, for 4 hour sessions to staff the Crisis Centre in pairs and provide a willing ear and empathy to any person, whatever the crisis, who may have wished to drop in. Funds available to the Crisis Centre Committee were negligible and consequently, in spite of some media publicity, the nature of the help available and the existence of the Centre were not generally known to the persons in crisis who may have benefited. The service continued for nearly 12 months but as enquiries were minimal the service was disbanded.

2. At one time in the Wollongong area at least one teacher from every High School had completed one of our five day seminars and was therefore available to provide some help. This would no longer apply.

3. Some members of the Drug Committee were able to support the W.H.O.'s organisation (We Help Ourselves) in running weekly Drugs Anonymous meetings in Wollongong over a period of several months. This occurred in late 1973.

4. The Wollongong Drug Committee sponsored a public meeting in the Wollongong Town Hall on the 30th April, 1974, to introduce Grow to the Illawarra Health region. Subsequently six Grow groups were formed in Wollongong during May, 1974, and up to 18 groups have operated at one time or other throughout the Illawarra Health region.

5. Because of the activities of the Wollongong Drug Committee over the last six years, it is felt that the Committee has had some part to play in influencing attitudes, both community and official to the extent that better facilities are now available for drug dependent persons. However, we are not suggesting that current available resources are by any means appropriate or can in any way meet the ever increasing local needs.

The needs the Wollongong Drug Committee was formed to meet are now being filled to a large extent by other resources. Some of our committee members are Health Commission personnel and the development of Health Commission services is meeting more community needs.

Serious consideration was given at one time in 1976 to disbanding the Committee. However, it was felt that being a community based organization, the Committee still had an important role to play in sharing the experience and knowledge gained and of perhaps influencing official decisions. This year the Drug Committee has accepted an invitation from the Regional Director of Health, Dr Max Diment, to act in an advisory capacity to the Health Commission on areas considered within its competence. Dr Cyril Innes is Co-ordinator and maintains liaison with the Committee.

Following the decision to continue operating it was decided to provide further seminars and the most recent one in Wollongong was conducted in November/December, 1976. This was a departure from our regular routine and the seminar was organized on five consecutive Friday evenings. This was to make provision for people who could not obtain leave from work, find baby sitters etc. The committee felt that the seminar could not be considered as successful as the fulltime 5 day seminars we had conducted previously. By the fifth Friday numbers had dwindled significantly. Our experience reveals that it is much more effective to conduct more concentrated sessions over a 5 day period where much information and meaningful discussion may be provided and so develop relationships and involvement with participants and speakers in a spirit of learning and education.

In April, 1977, a 2 day seminar—Friday and Saturday—was staged in Bowral following repeated requests from the Bowral Municipal Council. The seminar was well received locally and a steering committee of interested citizens has been formed to enquire further into providing a similar sort of service in the area of learning and drug education. The next meeting of this Steering Committee is scheduled for 31st May and I have been invited to attend.

The most suitable seminar venue used to date in Wollongong has been the Barclay Reception Centre. On other occasions we have used the Nurses Training Centre, Port Kembla Hospital and facilities at the University of Wollongong, when available.

Fees were not charged for participation in the Seminars/Workshops and morning and afternoon tea/coffee (drug break) and lunch were provided free of charge—these concepts the Committee would like to continue so that finance should never be a bar to attendance. At the same time donations to the Committee would be tax deductible and this is announced so that voluntary donations from those able to afford it could be accepted and receipts issued.

I would like to conclude this background to the Wollongong Drug Committee by tendering a personal testimony of one of our members, a lady teacher at one of the High Schools in Wollongong—

> In 1973, when I attended my first Wollongong Drug Committee seminar, I was interested on two counts—firstly, my daughter was then a teenager and secondly, I was, and still am, a teacher at a largish girls' secondary school. I felt that in both these capacities I needed to know what pressures were being placed on the young, how they reacted and why they reacted.
>
> I went off on the first day filled with zeal, imagining that I would come away with a trained eagle eye able to spot a drug user at twenty paces and a trained nose that would be able to tell the difference between mere loitering and more nefarious activities in the toilets. I had a vision of myself striding along school corridors like an avenging angel about to return the fallen to the fold. How I was to achieve this, I was not quite sure—school counsellors, parents, police I supposed.
>
> How wrong I was on all counts. To begin with the word "drug", was hardly used at all on the first day of the seminar so that I began to feel that it was like those other four-letter words that we don't use in polite society. Then, of course, my delusion about starting at the wrong end—with the obvious symptoms—had to be straightened out.
>
> The next shock to me was the discovery that my perspection of drug-taking seemed to be based purely on the use of illegal drugs, and so, I had to put teenage drug abuse into an established hierarchy of drug use, and abuse, in our society. Man's very long history of drug use, in a socially acceptable sense, and the price he has paid for drug abuse, *should* have made me aware of the need for education to prevent the abuse.
>
> I had very skilled lecturers—some of their techniques I still use in my own classroom—and by the end of the first session I had begun to question my own attitudes. I began to see drug use and therefore drug users in a much more realistic perspective. The step to realising that drug education means developing people's attitudes so that drugs, all drugs, are socially acceptable only when used in a controlled manner, came relatively painlessly. Drug education was the same as education for living for the people I was involved with—based on the development of the ability to make discriminating choice.
>
> I was changed as an individual by that seminar and I think that in both my capacities, as a mother, and as a teacher, I became a little more useful.

I would now like to refer to and quote from the Australian Senate Select Committee's Report of 1971 which is still particularly relevant and extremely significant. I quote:

1. Its opposition to a harshly penal approach, while opposing any further legalization of drugs liable to abuse.

2. Its insistence that the drug-dependent person be accorded the dignity and provided with the treatment that is due to a sick person.

3. Its further insistence that "this is essentially a mental health problem."

4. Its warning as to the unsatisfactory and isolated nature of present programmes.

5. Its call for "total programmes of health education in which drug abuse would be seen in the correct perspective."

6. Its belief that "little short of a revolutionary approach to education will be successful".

Dependence on any drug must be seen not in isolation but in the context of the *person taking it* and the *social or cultural environment* in which it is taken.

The key or central cause is the human person himself—and mental health is primarily self-understanding and self-regulation and subordinately understanding and regulation by professionals.

The young to some extent learn drug taking from the alcohol-and-tobacco-dependent and pill-popping older generation. The Wollongong problem of child alcoholism as revealed by John Sanders, Health Commission in the Illawarra Mercury on Wednesday, 25th May, 1977, is very real and not confined to Illawarra; Barry Benjamin's "sensational" story in the same paper "Hard drugs are turning our society insane" will startle many people and achieve??? what???

The problem certainly appears to be primarily one of *personal and social inadequacy or immaturity*—of people who *have not learned how to live* and have dropped out of the painful growth process. It becomes therefore above all a problem of wholesale motivation and education for mental health; in other words both *personal and community education for full human maturity or adult living,* of taking *personal responsibility* for living one's own life and learning how to make *discriminate choices.*

It would appear that a lot of drug education programmes tend to be fragmented, splintered, sectional, focussing on one aspect of the problem and neglecting others or focussing on one segment of the population, such as the young, and neglecting another section, such as the adults. Brief hit and run sessions can perhaps do as much harm as good. Sensational articles in the press, T.V. or films, designed, hopefully, to discourage by fear tend to have opposite effects to what was, no doubt, intended—and yet these sorts of coverage sell papers, TV programmes, etc., and competition and profit are the name of the game.

Advertising drugs which can be harmful to a person if used inappropriately or excessively is another means of "education" designed by psychology-trained marketing experts on the basis of creating a "need" where genuine need does not really exist—this of course applies to most T.V. advertising.

To return to a concept of the Senate Select Committee's Report of a "revolutionary approach to education in Health in which Drug abuse would be seen in its correct perspective", I would suggest that a main aspect of the problem is how to incorporate professional help as needed, without its becoming the primary or dominant feature of the programme; for no single profession, nor any combination of professions, has the answer to this fundamental human need for mental health and shared growthful living. It is being increasingly, if slowly, recognized now that mental sickness (including drug dependency, etc.) is not simply or primarily a medical problem. There are many social and other aspects to it which are equally important. There is no such thing as an expert, professional or lay person, in the art of living; of the lay self-help/mutual-help phenomenon 0. Hobart Mowrer, Professor of Psychiatry at the University of Illinois, U.S.A., has written the following:

> "Quietly but surely, a revolution is taking place in a vital aspect of American life . . . I refer to the spontaneous appearance of a wide variety of special groups and associations, inspired and operated largely by laymen, whose main objective is to provide restorative experiences which scores of people have sought, but failed to find, at the hands of would-be professional healers, religious and secular alike. Alcoholics Anonymous is one of the oldest and best known of these organizations but there are many others . . . Significantly, some of these groups specify that no clergyman, psychiatrist, psychologist or sociologist shall hold office therein, and professional leadership is dimly viewed by all of them." (from pp. iii–vi of The New Group Therapy)

Inspirational self-help (emphasizing personal responsibility and personal resources) and mutual self-help (emphasizing people need people, co-operation and pooled resources) has broadened, on the one hand, from an article of faith for fortune seekers, to, on the other hand, an instrument used in the hope of achieving all kinds of life's blessings. Dr Len Borman, Director of the Centre for Urban Affairs at Northwestern University, U.S.A., writes:

> ". . . perhaps there are few segments of our population that have not or could not benefit in some way from participation in self-help, mutual aid groups."

Borman estimates that in U.S.A. there are half a million such groups:

> ". . . covering self fulfilment or personal growth, social advocacy, alternative patterns for living, total living-in arrangements and mixed types."

Although the mutual help organizations in community mental health have much in common there are important differences between them. For example, some, such as Grow, stress the achievement of traditionally approved personal growth goals. Others are critical of such goals and while endeavouring to bring peace of mind to members, they present their members as natural products of their inheritance and environment arguing that *traditional attitudes* must be changed. Grow has seen its contribution in broader terms than the characteristic of this latter type and tends to emphasize traditional philosophic/religious concepts and stress the need for *personal change.*

In the areas of prevention/rehabilitation in mental health the intelligent self-activation of the individual, caring and sharing friendships and peer leadership are fundamental. In this regard Grow saw the need to create a social means or group method which ordinary people can use and which was attractive to problem-people as learners and solution-people as leaders. Secondly, Grow recognized that, blended with such a group method there should be an educational programme intelligible to members. Such an educational programme had to be rooted in experience and demonstrative in a very practical way, of the path up and out from human inadequacy or maladjustment *to mental health and personal maturity.* Thirdly, Grow discovered the benefit of establishing, between and around the groups a caring and sharing community of people appreciating each other's personal value as unique and dignified beings and mutually contributing leadership in a spirit of truth and friendship. Consequently Grow has fashioned since its beginnings in Hurstville, Sydney, in April, 1957 (20 years) three (3) essential ingredients of its large scale peer-based community mental health programme—

(i) an effective group technique;

(ii) a practical educational programme;

(iii) a sharing and caring community of people co-operating with competent authorities and seeking and obtaining the co-ordination of its self-help/mutual-help work with that of the various professional and other agencies operating in the same field.

There are quite a number of professionals who are members of Grow groups, but they are not there because of their professional competence but participating as ordinary members willing to share their personal experiences, strengths, weaknesses and hopes.

In N.S.W. alone Grow Groups have increased, through sheer need, from about 34 to approximately 128 in the last two years. Groups have also spread to four other countries.

In concluding my submission on Grow I would like to mention an experience with a special experimental Grow group. Fifth form students at a High School in Wollongong, the first of its kind. The personal testimonies of two of these students are attached. The latter by Vicki H. mentions, in part, peer group pressures—the subject was drugs—although she does not specifically mention this. I am grateful to the teacher, Mr David Troup, who acted as sponsor to this group and to the co-operation extended by the Principal, Deputy Principal and also Mr Brian Gillett, Area Director of Education.

*Recommendations*:

1. The Wollongong Drug Committee wholeheartedly supports the proposal for establishment of a Grow Rehabilitation Centre for Drug Dependents based on its Programme of Personal Growth to Maturity and recommends to this Joint Committee that the proposal be adopted as a means of education and rehabilitation in N.S.W.

2. To pursue the educational aims suggested in this submission—

(a) That a position of full-time Secretary to the Drug Committee be established in the Illawarra Health Region to organize and arrange 5 day seminars for the community of the Region and carry out other duties as determined by the members of this community based committee.

(b) That a second position of Receptionist/Typist be established to provide the necessary administrative back-up and support to the Secretary.

(c) To consider the provision of similar assistance for like groups in other areas of urban concentration.

3. That arrangements be made to encourage the attendance of all public servants, State and Commonwealth as participants and/or speakers at Drug Seminars by granting special leave on full pay. Hopefully this would be an example to industry, commerce, councils, authorities etc.

4. That special funds be made available for the operations of the Drug Committee so that access to seminars may be open to all persons interested throughout Illawarra.

5. That if funding is provided it should not be tied to any particular department but operations be controlled by the Honorary Executive, which would be responsible to:

(a) the grass roots members of the Committee; and

(b) the usual audit by the Department of Services.

6. Voluntary donations from the Community should be encouraged so that the community may share in the work and have a responsibility for its continuance.

7. That the above be considered as a pilot scheme, and, depending on community impact and development, considered for spread to other regions in N.S.W.

8. That the know-how developed by Grow over the last 20 years be tested in the implementation of the Worker Participation Scheme in the N.S.W. Public Service recently announced by the Hon. Neville Wran, Q.C., Premier of N.S.W.

ANNEXURES

1. Grow Personal Testimonies—School Students.

2. Grow Friendship Brochure.

3. Statements by the Hon. Neville Wran, Q.C., Premier of N.S.W. on—

(a) Grow.

(b) Friends of Grow.

4. Statement on Friends of Grow.

5. Conditions of Employment of Grow Staff.

6. Grow Magazines—latest issue and the special issue of the Magazine on Drugs.

7. Grow Media Kit.

8. Wollongong Drug Committee Seminar Programmes.

PERSONAL TESTIMONY OF 5TH FORM STUDENTS AT A HIGH SCHOOL AT WHICH A MODIFIED FORM OF GROW GROUP OPERATED FOR APPROXIMATELY SIX MONTHS. THE GROUP COMPRISED 8–10 STUDENTS. THE GROUP AS A WHOLE WERE WILLING TO CONTINUE IN 6TH FORM BUT PRESSURE OF 6TH FORM WORK AND MISCELLANEOUS SCHOOL ACTIVITIES RESULTED IN THE GROUP HAVING TO BE CLOSED.

That first meeting that Vince held with the whole form had very little impact on me at all. It seemed a good way at getting out of a period and I really didn't take any great notice of what he was saying at the beginning. But as he talked about how Grow helped people cope with their problems and how they were able to join society again, I began to take a great deal of notice. At first I thought, how can it help me? I didn't have any problems, since I'm the kind of person who doesn't like to talk about my problems and solve them myself. But at this time I was having a very serious problem understanding my parents. One which I didn't even acknowledge to myself.

That very first meeting I attended was just out of idle curiousity and when I walked in and a small blue book was thrust at me, I thought not one of these religious things. When the opening routine was begun with a short prayer I thought oh no, what have I let myself in for. But when the Grow commitment was read I felt reassured, that it wasn't a recruiting office for the church. That first time I was self-conscious of the people around me and was convinced that I couldn't talk about my problems in front of them. But as soon as we began to talk I felt I could relax, assured that what we discussed wouldn't leave that room.

The 12 steps, the overall key to Mental Health and the Stabilizing Four Questions are particularly important to me. Through these and Grow I was able to put my problems in proper prospective and order. I learned to understand and to see my problems from my point of view and others as well. After a few weeks I began to look at what my parents had to contend with and in their attitudes to me. I realized that they loved me and I had to understand them as much as they had to understand me.

This is what Grow did for me and I'm proud to be associated with it. That doesn't mean that I wont be going because my problems are all solved. Far from it. But at least at Grow I can get other people's ideas and outlooks and not be influenced by only my own. So to all those who think they have no problems, have a good hard look at yourself, then consider going to Grow.

VICKI N.

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Grow assisted me in many ways, it changed my outlook on many things, it helped me handle the problems that seems to be in the majority and that is my parents.

Grow every Friday was a place I could go to and rid myself of all the little things that were worrying me, if I had no gripes at that time, then possibly I was able to help another with his or her problems, this group really proved that two heads are better than one.

Priorities, this is a word which means a whole lot more to you in senior years at school and at home. You're all of a sudden laden with a much larger workload than you've ever been faced with before and I found I didn't know how to handle it, what with pressures at home and at school I found myself sort of lost in between it all.

Naturally you have got to rate schoolwork fairly high on the priority scale, this I found out very quickly, so I gave up a little more of my leisure time, then I had it, but it's something you have got to be prepared to do yourself, no-one is going to make you, Grow helped me realize and adapt myself to this situation.

Not only did I face pressure out of school, but also there was a considerable amount of pressure at school, not from actual schoolwork but with some of my peers. There was a crisis point at which stage I had to work out who were friends and who were not, Grow helped me. And as we all know a friend is something we all need, but more importantly we need a friend who we can trust and respect.

Grow is a most appropriate word for the group, it helps you in many, many ways, one more way being the satisfaction, that you could really help a friend, through the group. As you grow both physically and mentally you will find as I did, life isn't as bad or as complicated as it looks if you approach it in the right way.

VICKI H.

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WHAT IS GROW?

The "GROW" Community Mental Health Programme helps people in times of emotional stress through a process of mutual help and friendly leadership. "GROW" is free, non-denominational and open to all.

"GROW" Groups were funded in N.S.W. in 1957 and have weekly meetings in many different places across the nation. There is a tremendous demand for "GROW" to establish new groups, and "GROW" urgently needs additional resources to maintain and expand its service to our fellow citizens in need. "GROW NEEDS HELP—BECOME A FRIEND OF GROW"

Telephone:

Sydney 274 736, 271 917.

Wollongong 28 9706, 29 6435.

ANNEXURE 3A

GROW, the voluntary self-help organization which enables people who face hardship in coping with the ever-changing complexity of our modern society, is an organization which deserves the support of the entire community.

Government does assist those in need but a Government cannot assist all those who need assistance—we just do not have the financial resources necessary.

Consequently, any organization which can help those in the community who suffer, who feel unwanted, who feel unneeded, is an organization which should be supported.

GROW is such an organization and therefore, I have pleasure in recommending its aims and aspirations to the people of New South Wales.

NEVILLE WRAN, Q.C., M.L.A.,
Premier of New South Wales.

ANNEXURE 3B

Message from Hon. Neville Wran, Q.C., Premier of N.S.W. to Friends of Grow—

"In every community there are people whose capacity to cope with the variety of problems confronting society in the 70's is not adequately developed.

But organizations like GROW are carrying out important work by helping people to cope with their problems and motivating them to realize their full potential.

GROW meetings involve a group of people getting together and openly discussing their troubles. This method has been shown to be one of the most productive and fruitful means of encouraging people not only to face up to, but to help them resolve their individual problems.

GROW has played a significant role in helping many of these people in the community both in Australia and overseas to overcome times of worry and trauma and set them on the road to being able to tackle their problems with a confident and positive approach.

This work must continue to reach out and provide help where it is needed in the community and Friends of Grow is to be congratulated on the tremendous job it is doing in assisting and promoting GROW. Without the support of such a body of concerned people GROW would not be able to effectively operate in the community.

I extend to Friends of Grow my best wishes for a pleasant evening and success in the future."

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ANNEXURE 4

Friends of Grow, designed as a Service Club for men and women, was sponsored by the Wollongong Apex Club to promote and support Grow throughout Illawarra and, hopefully, raise funds to meet Grow's commitment in raising voluntary donations of funds under the Community Health Programme. This became appropriate and most desirable because of the minimal staff establishment of Grow in N.S.W. viz. 4 Field Workers, Leadership Training Co-ordinator, State Administrator, Regional Director, Information Secretary, 2 Stenographers (1 full-time and 1 part-time)—10 positions; other needs are met to some degree, by voluntary assistance of Growers.

It is significant that in Victoria the State Government provides the funds to meet Grow's commitment under the Community Health Programme.

Friends of Grow is an antonomous body, at present seeking registration as a charity to qualify to receive tax exempt donations for direct transmission to Grow, with social, recreational and educational overtures—regular dinners with guest speakers —the ongoing details and plans being considered at monthly meetings of the executive or general meetings of members.

It is intended to spread and develop Friends of Grow throughout major towns in N.S.W. by seeking sponsorship by other local Service Clubs.

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ANNEXURE 5

Some relevant employment factors concerning full-time staff in GROW—

1. Staff may work up to 60–70 hours per week with no opportunity, because of work pressure, of taking time off in lieu.

2. Staff are on call each day and night including weekends.

3. Staff do not claim, seek or can be paid overtime.

4. Staff do not and cannot charge for services rendered.

5. In all cases salaries for full time GROW staff are pitched considerably lower than that which would be paid in the Public Service, commerce and industry.

6. A superannuation scheme has not yet been implemented.

7. Staff are allowed four (4) weeks recreation leave per annum, being considerably lower than that allowed in the Public Service for officers working comparable hours per week.

8. Staff work at community and training weekends as required, generally speaking, without compensatory time off in lieu.

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2735. CHAIRMAN: I do not wish to go into this in much detail, but when you say you are a drug dependent person yourself—again, I hope that the press will respect your request earlier in regard to this matter—that covers a wide field——W. Alcoholic. I am addicted to tobacco. I eat too much and I gamble.

2736. When you talk about workshops that were held and you had a teacher from the schools, I presume from what you have mentioned, as was mentioned in earlier evidence, that the general impression is that these were worthwhile and successful workshops.——W. Yes. At the end of each workshop there might have been 30 to 40 people who attended them—we find a large majority of them want to come back. When I mentioned the crisis centre, and taking three workshops to finally get them going, everywhere we went there seemed to be no way of co-operating. One of the reasons that membership of the committee has changed so much is that people were saying we did not appear to be getting anywhere, there was no quick solution.

2737. In some of these high schools there would be 40 or 50 teachers on the staff. That seems to suggest that in effect you are only getting a small percentage of the possible numbers present.——W. Yes. This is why I recommend that leave be granted to public servants. Mr Gillett has said that teachers can attend. That was great, at the top level. But one finds there are staffing problems in the schools and teachers cannot be released.

2738. You refer to the recommendations of the Senate committee report at page 9 of your submission. You say you would like to refer to it and quote from it. You say it is relevant and significant. However, you do not say whether you agree with the recommendations that are made there?——W. I agree with the whole six of them.

2739. Particularly in regard to items 1 and 2?——W. I certainly oppose the harshly penal approach. I personally would oppose any further legalization of drugs on which people could become dependent, for very much the reasons that Dr Adams put forward earlier. As a society, even if the more mature members can handle drugs, we are exposing the immature and the young to grave dangers of not being able to develop their personalities.

2740. Have you had any experience of young people here who have been adversely affected personality-wise by this harsh penal approach?——W. Not personally. I am aware of it. I have seen individual cases reported in the newspaper.

2741. Do you know of any who may be affected in their vocations by a harsh penal approach?——W. I know of people who have been refused employment in the State Public Service because of having a criminal record in connection with drugs, and for no other reason.

2742. You referred to the Seminar at Bowral. Who would have attended that seminar, and how many would have attended?——W. About 35 people attended. I did not go myself. One of the aldermen is chairman of the steering committee which has been set up. I have a list of the minutes of the first meeting and there seemed to be about 20 people who attended that meeting. They are interested in what we have learned, and they want to equip themselves further. At the moment they are talking, I gather, about where they should start. They are interested, and everything that can be done should be done to stimulate

this interest so that they are going somewhere. It is frustrating to try to find answers to problems. We were hung up in our early days because of officialdom and apathy in the community. People do not read newspapers or look at news programmes.

2743. In effect, they were interested citizens.——W. Yes.

2744. Would this seminar have arisen, and the interest of citizens been aroused, because of a particular drug problem in Bowral?——W. From the conversations that I have had with the people there, they were just concerned about drugs, mostly about illegal drugs. What our seminar would have done would have been much along the lines as revealed in the personal testimony I got from that teacher. Apparently a large majority of the people attending suddenly woke up to the fact that "The answer to this problem rests with me and my attitude. I can't change anybody else; but I can do something about me."

2745. Your recommendation in regard to rehabilitation apparently arises out of the recognition that at the present time there is virtually no half way house or anything of that nature to enable these addicted persons to come back into the community after treatment?——W. Yes, but I am also aware that in some traditional half way houses they can become institutionalized. Grow is very much opposed to this concept of institutionalization. There does not appear to be anything local to cater for the increasingly large numbers of people who are drug dependent, yet essentially the proposals put forward by Julie and Warren King this morning can only cater for about 12 people.

2746. If you are catering for 12 people, that is something.——W. It has to start somewhere.

2747. Mr HEALEY: How many known drug abusers in the Illawarra region would be attending at this moment Grow rehabilitation seminars or programmes, and how many would have attended in the past 12 months?——W. I would find that very difficult to answer. So many people that come to Grow who have been addicted to one drug or another—and I am talking mainly of prescription drugs —have been told by doctors they have some metabolic imbalance in their make-up and that they might be on drugs for life, yet they have been able successfully to get off them. As to numbers, I could not say because I did not attend all the groups. But it is quite common.

2748. Mrs DAVIS: Would you like to enlarge on the testimony of the first girl that you mentioned? I have read the testimony of both girls. One of them talked about new pressure. Do you tell us that that was the drug scene?——W. Yes.

2749. Did she describe it to you?——W. No, she did not. In the second last paragraph she talks about considerable pressure at school, not from school work but from some of her peers. The crisis point was where she was being offered drugs—marihuana, I guess. We did not try to delve into it. In Grow we talk about people being required to tell the truth, but not the whole truth. Only as much as they wish to reveal. We make a point of not putting pressure on people in groups.

2750. Mr JACKETT: We have been told that there are about 1 200 to 1 500 heroin users in Wollongong. Does that figure appear to you as being a correct one?——W. I would not have any means of commenting. At various times I have seen figures from the Addiction Services Centre at Kembla House and I have noted that it has been increasing, but I am not aware of any heroin user that may have attended a Grow group. We have had experience of people who have been on LSD and who have successfully got out of that situation.

2751. You are not aware of much activity in the heroin scene?——W. No. The only experience I had was several years ago. I was contacted by telephone by one of the local priests. There was a young married couple who were withdrawing from heroin and I did not know what to do. We got two groups of people to go down and spend time with them, sitting with them and listening to them and helping share the experience with them. But that is the only direct contact that I have had.

2752. Mr MACDIARMID: The Bowral–Mittagong–Moss Vale area, we have been told, is one where drugs are quite prevalent. There does not appear to be any real activity in that area both at the level of drug referral centres and at other levels. Would you like to comment on that?——W. I know that recently a community support centre was up there and there was a psychiatrist up there and some community nurses. But how effective that could be I do not know. There are just no rehabilitation centres as far as I know in any part of the Illawarra health region. I certainly see a need for one but I am also concerned about long-term education. I guess that We Help Ourselves—WHOS organization—when they were meeting down here I attended their meeting for about 3 months. During that time there was not one local person attending, although there was quite a lot of publicity. Eventually, WHOS ran out of money and could not keep coming down.

I have had approaches from one or two people addicted and in the drug scene, about Grow. They have never come along to find out what we had to offer. The person who chaired the first meeting of Grow, which was known as Recovery in 1957, was a hard line cocaine addict and mixed up in the criminal scene, and her story appears in an issue of the Grow magazine. She talks about the many years she had of getting over the psychological addiction and how both AA and Grow helped her.

2753. How do you see the problem being attacked, on the basis that prevention is better than cure, in those areas that I have mentioned?——W. I have recommended that there should be some fulltime people solely responsible for running five-day seminars or something like that, that the drug committee has been able to do on a voluntary basis. We might get people from Sydney or anywhere. It is in the group discussions that people get their attitudes influenced. People in positions of influence, such as teachers, can carry the message. But I see now that is such a personal thing. What we need is more and more people. On the other hand, I see our Grow groups as being an education media. People come along and find that they have a responsiblity for living their own lives and learning how to make a choice. It takes a long time. Some people come along to groups and then drop out after one meeting. I guess as a population we have been used to this. We have been looking on the doctor as God. We go to him and get a pill and we get relief from symptoms and think that we are fixed.

2754. You place great emphasis on education at all levels. If it were possible to finance it, do you think a programme of education to the whole community from television would be a way of getting the story over?—— W. I think it is rather depersonalizing. I think there is a need to have human contact established. There needs to be a discussion. Someone has to be sitting at this table, a group of us, talking about how I was, how I felt, what happened to me, and the circumstances I got myself into. A person who is coming in for the first time and is experienced in these feelings suddenly says, gee, that is the way I have been feeling, what happened to him, why did he get well?——W. I guess the first thing engendered in

the drug group or the AA group is that hope is transmitted. Hope is that perhaps there is a way out and if only I could tell them who I am. Most people, particularly those who cannot communicate, have this problem and they get this hope for a start but perhaps something like this could happen to them.

2755. Mr MACDIARMID: You are talking about people who are addicted? I am talking about people in society who are may be led into that field. I am saying it could be prevented rather than cured?——W. Our programme of addiction that the Drug Committee puts out would be helpful. At the same ttime the Grow group would also help these people. You get to the point of taking drugs, as was mentioned earlier. That is the end result. This is a process of feeling one out, a loner, difficulty to talk to people and not having a true friend. We say friendship is the key to mental health. To have someone that I can tell the untellable to. This does not happen quickly. In Grow we say you want a friend, you have to be a friend. You have to be a friend before you can qualify for friendship. We demonstrate that caring for people and sharing experience is the way up and out.

2756. CHAIRMAN: You said that the WHOS people operated here, apparently from Sydney, and you could not get any local participation?——W. Yes.

2757. Are you talking about people who run the organization more than the people who attended the meetings as customers?——W. WHOS was composed entirely of people addicted to drugs in one form or another. They would get a bus down from Sydney and conduct a meeting at the Smith Family. They put advertisements in the paper and they were holding meetings. I missed one or two meetings but as far as I am aware there was nobody local who turned up to have a look, except for one or two people from AA and from the Drug Committee.

2758. No addicts came along?——W. No.

2759. Only the people from Sydney?——W. Yes.

2760. Thank you for giving us your time and the benefit of your experience in this field.

(The witness withdrew.)

BRIAN SOMERVILLE GILLETT, Regional Director of Education, Illawarra, residing at 5 Yates Avenue, Mt Keira, sworn:

2761. CHAIRMAN: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamnetary Evidence Act?——W. I did.

2762. I understand that you wish to make an oral submission to the Committee?——W. Yes, but I wish to make it quite clear that I do not have any particular expertise in the field of drug addiction. Any knowledge that I have is knowledge that I have gained from working in schools and in more recent times working with schools, and from evidence given to me at varying stages by principals of schools, discussions with teachers in personal development programmes, specifically or partly designed to do something about drug education. As far as I am concerned, if you look at the incidence of drug-taking in schools, it is virtually impossible to get any reliable evidence. It is one of those things that is hidden. The students cover up and parents cover up and if it is reported to the medical practitioner obviously it is not going to be disclosed from that source. So, over the past two years I have been asking principals to feed as much information as they can and to seek it out in all manner of ways so we might get at some of the problems and remedy some of the situations, but invariably they point to the almost impossible task of getting evidence.

I do not think that teachers in the main, are really trained to identify the results of drug taking in any case. They are more wise to it now than they were before, but in the main they would not even be aware that a student was in the habit of taking drugs, whatever form it takes. From just discussing this with principals they almost invariably maintain that alcohol is the most common drug that children take and they maintain that this is pretty widespread and that in quite a number of cases it is taken to excess. In fact, in quite a number of schools these days they are very worried at having school socials for that very reason, as it is difficult to keep alcohol and other drugs away from the scene.

Also, it is even difficult to keep people not associated with the school away from the scene and they are not always the best of types. So, in Wollongong at times we have the unfortunate situation where so-called enforcers are hired by the school to keep undesirables away. As a result of that we have quite a number of schools that are turning quite away from having such gatherings. Also, a lot of schools are very worried about excursions particularly at times for more mature students. There have been some rather unpleasant incidents—not in this region I am glad to say, but in New South Wales—over the past twelve months resulting from abuse of alcohol.

So far as marihuana is concerned, I have not had any reported smoking of marihuana on premises but I have no doubt that there must be some of it going on. It appears that marihuana is readily available around schools. Who is doing the supplying and who does the pushing is one of those things that cannot be identified, although it appears that in most instances the principals believe that it is the students themselves who are actually involved in the drug-pushing situation. We have had one instance of a teacher being reported by students for pushing drugs but it turned out to be a false accusation and in fact it was actually a malicious accusation against the teacher concerned. The matter was followed up by the police and the teacher was not a pusher, certainly.

We do not have any direct evidence of teachers being involved in drugs and I certainly hope they are not. However, I think it would be ludicrous to say that quite a number of teachers are not sympathetic to the use of marihuana. No doubt quite a few of them do use it themselves if not at the school premises then away from the school premises. This region goes from the coast up to the Tablelands and along, and this year two teachers have been dismissed for possession of or smoking of marihuana —two young teachers, both in their first year.

One of the things that concerns me is that from time to time it appears from my observation and from information that has been fed to me that in our universities and our teacher training establishments the use of drugs is apparently quite widespread. Once again, one of the people concerned is also a noted footballer and last year he was convicted and gaoled.

As far as heroin is concerned, I have had only one reported instance and that was not associated directly with the school, but it was a school student and it was out of school hours at a social gathering where a girl was injected with heroin with quite a bad result. That was at the weekend and it was not done by a school child. We do not have any evidence that that is available around schools.

With regard to educational programmes, there is plenty of opportunity in the personal development programmes for dealing with drugs and drug education. Similarly in health education programmes and in social science teaching, where there are themes which can bring in drug

education. In science itself, and even in English programmes with the thematic approach these days, it is quite possible to develop a drug education programme.

We are fortunate to have the Health Commission cooperating with us and it provides people for drug education courses in schools. If I were trying to evaluate this programme and its work I would have to say I do not think there is a tremendous amount of value in it at this time. It is difficult and it is only a subjective estimation at this stage, but for a number of reasons I think there is a great deal more to be done in this area before it is worthwhile.

If I were looking for reasons for drug abuse, as you know there are literally dozens of potential reasons, but it appears to me that with young people it almost invariably starts with a poor self-concept, almost invariably some psychological problem. I think that is where we in education could perhaps move a lot further in trying to identify those people who are at risk and trying to ensure that they get that little bit extra, and perhaps the more personal approach that Mr Johnson was speaking about. The peer influence is important. I have two young daughters and I am aware of the tremendous influence that their peers have on them. How can we turn that peer influence to more positive things? I certainly do not have an easy answer to that. I think it is something we have to look at. Of course, the risk and thrill business seems to be part of the scene. It also appears that in a lot of cases the students who are at risk have poor relations with adults and particularly with their parents. This has the effect that they tend to become alienated as far as the school is concerned. This gives rise to a further problem that the people we want to get to with educational problems, people that need help, are often alienated from the school and therefore are not able to be reached with the help that the school could provide.

As far as a programme is concerned, I think one of the limitations we have at the present time in developing a worthwhile educational programme is a lack of reliable research data. It is terribly hard to teach children if you have not got a good number of the answers. If you start talking about values you are on dangerous ground with a lot of them because they will twist it around. It is difficult at times to talk about the dangers of marihuana if we have not sufficient evidence that will convince them that it is harmful or it is more harmful to them than something else. There is also the problem of the double standard. If we start talking to them about alcohol they are going to see a good many of their parents and teachers imbibing at various stages and sometimes to excess. I think it is terribly difficult at times to get the message across. I think also it is most important that we have an understood government policy. That is why I welcome this inquiry. I hope that its deliberations will lead to just that. Once again, it is very difficult to try and take a stand on something that the government of the day has no definite policy about one way or the other.

At the present time the Education Department is being strongly questioned with regard to double jeopardy when we dismiss teachers for drug offences. This of course opens the way. If we start to go one stage further where action is not taken against them when they are convicted of drug offences it is going to be very difficult then to convince children that they should not take drugs. I think too that it would be quite ludicrous to think that schools can provide the answer. As I said before, some of the children are alienated from the school, for a start. A child spends a very small percentage of its time at school and more and more demands are being made on schools to make up for a lot of things that are not being done by parents and other institutions in society that used to carry quite a deal of the weight. I think that in many instances schools are becoming somewhat confused by this. Certainly they are being criticized because they are not paying sufficient attention—many people believe—to the three Rs and paying too much attention to social education—such things as drug education—and if we try to load more into schooling I do not think we will necessarily be doing the right thing. I feel we should be doing more but we cannot do it alone. I should like to see a co-ordinated, many-pronged approach. I think we are now reaching towards regionalization in many ways and it is much more possible to establish a programme involving the Health Commission, the police, customs, the media, youth and community services—all of these—and of course the service clubs have now become interested in this area. All these people have an interest in the matter and we should get together and combine rather than move off in different directions. There is a tremendous amount of expertise around. Mr Johnson is one example. From listening to him I discovered that he has a tremendous body of knowledge there which would be of infinite value in developing any worthwhile educational programme.

I think we have also got to get to the adults, but how do we get to them? I do not have an easy answer. Somehow or other we have to get to more parents than we do at the present time and not only with regard to drug education. Recent evidence implies that most children start failing in life and failing at school before they reach school. The first five or six years of their lives, which they spend in a home situation, largely determine their success in all sorts of ways from there on. So it would appear that we need to do a lot more with regard to the education of adults and not only in the field of drug education and drugs.

One of the particular problems we face whenever we get into the area of personal development is to find appropriate personnel. As I have said, quite a number of teachers would not agree with a lot of the things that you and I would believe in. They are more concerned with the freedom of the individual and with the permissive approach to things and with the use of drugs. A lot of teachers are not prepared to be involved in this matter, maintaining that they have not the expertise or knowledge and, probably rightly, they should not be involved. The personnel that we are looking for will certainly have to be people with commitment and with sensitivity. They are in the community but they are not necessarily in the schools. Once again I think here we come up against the age old problem, almost a demarcation, that the people who are probably best fitted to give these programmes are not teachers and yet we would have to employ them in schools to work with children and I think that it must be as part of the curriculum—not an addendum—not something separate—not so-called guidance for one period a week, but part of the integrated curriculum so that it is developed over many years, starting in the primary school; so that the understanding is gradually developed in the children; so that they have an opportunity to mature their attitudes and develop their values. I should also like to see youth involved in this sort of programme. Last week I was approached by a group of young people from a particular church who said that they would like to work more with young people and they put up the idea that a lot of their members were people who had been rehabilitated. I met these young people. I think they would be the ideal type of people at times to be involved in a programme with youth. They could do the sort of things that Mr Johnson talked about. They could talk from experience. It would be an experience that I think most others would not want to repeat.

2763. How long have you been in Wollongong?——W. I came here in 1971.

2764. How extensive is the area that your directorate covers?——W. From Helensburgh to the border along the coast, inland to Mittagong and Bowral, along the tablelands, across to Crookwell, then down around Canberra to the border, across through Cooma. In terms of State regions it is the Illawarra and the South East region.

2765. You mentioned that recently two teachers were found guilty of drug offences and dismissed. Were these offences at school?——W. No. One was a case of a chap picked up by the police for bald tyres. It was during his holiday time. The policeman smelt the aroma coming from the car, searched the car and the chap was charged with possession. The other was the case of a girl who was growing marihuana in her flat. The police knew of it and eventually moved in and charged her.

2766. Are there any particular areas in your directorate which cause you a lot of concern and worry in regard to this problem?——W. I suppose you always have to say that the city area provides a potential market and a market that must be very attractive to the drug pusher, although in a city you tend to find things hidden. Things do not surface in the same way as they do in a country town. The ones that have caused us more concern have been some of the smaller country towns. Bega was one. Nowra is another. In Nowra I think it is the beach areas where the problem is. We had one instance of a chap who was a teachers' scholarship holder. He was reported as being on drugs. We reported it to the police and they found that he was living in shanty-type accommodation around Nowra. In Bega, once again there seemed to be some hippy-type developments along the far South Coast and some of these hippies are ex-teachers. Some of them have approached us for employment at various stages. You can guess what our reaction has been to re-employing them. The cases in Crookwell were quite sad. There were four young people involved who went through teachers' college together. Only one has been charged so far. They developed the habit in teachers' college and they have continued it. I think that the ones that really concern us would be the isolated ones because there we feel that it is away from influences. Here in the city we feel there is a lot of effort going on and I hope there will be a lot more. But we should not ignore the small country towns.

2767. A submission was made to the previous Committee with regard to university preparation of teachers and a section was devoted to training on drugs—an optional part. From all of this it would appear that there is not a great emphasis given to this aspect in teacher education these days?——W. No. I think you would probably find that is it minimal.

2768. You mentioned earlier that the teachers probably would not be qualified to determine the symptoms of a person who was on drugs. Do you think this could be rectified by a more intensive section in their training dealing with that matter?——W. Yes, I think it could be done through their training. In fact, probably because there are so many of them at that stage experimenting with drugs, a very intensive drug education programme in universities and teachers' colleges would not go astray. But I think there is also a need for a programme for teachers. The Health Commission does this sort of thing at various stages. They have films that assist, although I think it is often difficult to get information of that type through films. You really need to see the person physically before you can identify the problem. Even so, I think in many instances you may find it difficult, not being a medical practitioner. But I do not think there should be any difficulty at all in teachers identifying the obvious.

2769. It is obviously very difficult to try and train teachers to give an adequate drug education programme? ——W. Yes.

2770. Do you think that carefully prepared TV programmes would be an answer to this, because they would get to a lot more people more effectively?——W. I am not an addict of TV education. Frank Meaney, an inspector of schools, one of our people, who is much more an authority on TV than I am, considers that it is a tremendous avenue. He thinks that probably my generation, not being used to it, do not look for it; we look for other ways. But the younger generation do and so perhaps the generation coming through now, who have grown up with television, you would certainly get to. Once again, Mr Johnson talked about the personal aspect. I think it is a personal matter. To me any film would appear to be just a little bit impersonal. But I would suggest that any avenue that is likely to have an effect should be explored. You can then evaluate it. If you try it you can evaluate some of the effects of it. I think the situation is becoming so serious that we have to explore every possible way. I would not like to see us descend to the level that they are at in parts of the United States and Europe. We will have to take very positive steps, otherwise we will find we will go in a similar direction.

2771. Mr RAMSAY: We had a submission this morning which said that teaching parents to detect signs of drugs in children is useless, if not destructive. I am sure you would not agree with that, would you?——W. I think parents must be aware. I have nothing against the law myself and I think it is about time that everybody else had a similar attitude to the law. It is to help and protect society. I could not agree with that, but I think the sort of drug education programme that I would have would not be on the protection side, but to understand the reason why young people turn to drugs, and when they get into that situation of conflict, to understand how it develops. It is difficult to understand the adolescent. They are awkward people at that stage, for a number of reasons, but it is essential that parents come to understand them. That does not mean that they have to become permissive with them, either. At the same time, I think they have to understand that they are going through a difficult stage and to adopt various strategies to try to live with them amicably and not to alienate them.

The schools, too, have a tremendous task here. Unfortunately, in too many instances they have alienated young people. Often the programmes of work that children have been subject to have not been relevant to their particular needs. We have been somewhat academically orientated. If a child does not do well at school, it is not a happy place.

2772. Mr HEALEY: Is there any area of conflict between the education department and the Health Commission as to who should deliver health education in the schools?——W. Initially in discussions with the Health Commission at the head office level, there was some conflict as to the approaches to be adopted. Early in the piece some of the people who were giving the programmes, in their enthusiasm adopted teaching measures that were not, let us say, the sort of measures that teachers would like to see, and they tended to reflect on the teaching staff of the schools. But I think most of them have been ironed out. We have no conflict in this region. Once again, this takes funding. I have nobody in particular in drug education to whom I can turn. There is no person on my staff to whom I can turn. It has to be advice from a variety of sources. I look to my regional guidance officer, but he is not an expert on drugs, and he is busy in other directions.

There would have to be a concerted effort to provide personnel who could spend time developing programmes, working with the Health Commission and all the various other people available on society, so that we get a series of programmes with the intention of providing something that is of great value. I believe that most of our drug education programmes have been of pretty limited value because we have approached them traditionally. You cannot teach young people about drugs. It is not a teaching problem. You do not stand up and talk and chalk them into not being drug addicts. What you are seeking is a behaviour change in many instances, and that is difficult and involved. Often it is very personalized.

2773. Mr MACDIARMID: I take it from your remarks that if a teacher in any particular school has an attitude of freedom of the individual, even to the point of permissiveness, he is allowed to project this idea to the children?——W. No. Well, there is nobody that is going to supervise everything that every teacher does. If a teacher was preaching permissiveness as far as drugs or sex or anything else is concerned, and that was questioned by parents or children, that teacher would obviously have to be disciplined and would be disciplined. In every school there should be supervision of the teaching programme. The principal, I suppose, is the one ultimately responsible for seeing what the school is about, what each teaching programme is about. If there were a section relating to drug education he would ensure that it would not be approached from the permissive point of view.

2774. Would the principal of a school attend staff meetings?——W. Yes.

2775. And give instruction as to the way in which he wanted the school taught, or is each teacher given a great deal of freedom?——W. There is a lot more freedom these days than there used to be, but there is still a considerable structure. I do not think we have moved as far as, let us say, Victoria has. There virtually the curriculum is the task of each individual teacher, and as a result I think you could probably get far more of that sort of attitude. I think ours is still fairly well structured. There are still syallabuses which give a fair amount of freedom, but not too much. Any teacher who was preaching that type of thing or teaching that sort of thing, or even raising it, would become known very rapidly. Word gets around and it would be up to the principal to take action. I will put it this way: we have had instances of it and the teachers have decided to resign.

2776. It appears from the evidence that in Wollongong the drug scene starts at about the age of 14 or 15, then progresses to 18 or 19, and at 25 it starts to drop off. So it seems that the period at school is vital?——W. Yes. We need to start at the last year of primary school, before they reach high school, because in high school they come under quite severe pressures. High school is not as friendly a place as primary school; you do not have your classroom teacher to relate to. You have a variety of teachers who do not know much about you. It is not possible for a high school teacher to get to know as much about each individual student. It should start in the last year of primary school and concentrate on the early years. If they start at 14, obviously the problems are being laid in those early years of adolescence.

Once again, I think that there is a lot more that we can do but I think it would be wrong to say, "Let us set up an education programme in schools," and think that that will solve the problem. It will only be one small part of a complex and intensive approach that will have to be adopted.

2777. I see that statistics demonstrate the fact that the average child spends six years of his life watching television?——W. Yes.

2778. Obviously, it is a medium that gets through to the people?——W. Yes. A child in his lifetime spends far more time watching television than he spends at school or at any other form of education, so it must be getting through. It is a matter of how you get the message through. The television people are experts at it. Television can turn people to things, so I suppose it can turn people away from things.

(The witness withdrew.)

(The committee adjourned.)

*AT SYDNEY ON FRIDAY, 3 JUNE, 1977*

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The Committee met at 11.15 a.m.

**Present:**

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| The Hon. KATHLEEN ANDERSON | Mr J. G. T. JACKETT |
| The Hon. MARGARET DAVIS | Mr B. McGOWAN, B.A. |
| The Hon. C. HEALEY | Mr E. D. RAMSAY |
| The Hon. F. M. MacDIARMID | |

CHARLES BRIDGES-WEBB, 9 Appian Way, Burwood, Professor of Community Medicine, University of Sydney, sworn and examined:

2779. CHAIRMAN: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act, 1901?——W. Yes.

2780. Before this meeting of the committee continues I place on record the fact that the earlier proceedings this morning were in camera and that we are now in open session. Professor would you care to make your statement to us at this stage?——W. Yes. My particular interest in the matters being considered by this committee relates to caffeine-containing analgesics. I have interests in other aspects of the committee's inquiry, but I have entered into some correspondence in the *Australian* newspaper, as you are probably well aware, and I have given Mr James, the secretary of this committee, a copy of a letter that I wrote with Dr Grounds to the *Medical Journal of Australia*. That letter was published at the end of last year.

Caffeine-containing analgesics have been of interest to me for some time because of the known evidence that there is a degree of abuse of analgesics in Australia. I do not think that that is questioned, though there may be some question about the extent of the abuse. I have always been interested in why analgesics should be abused, because apparently the common analgesics, aspirin, salicylates, paracetemol and phenacetin do not seem to be the sorts of drugs that produce dependence, euphoria or any pleasant symptons that would tend to lead to habituation, dependence or even addiction.

There seemed to be some evidence that it was not the plain analgesics that were being abused, but the mixtures of analgesics, particularly compounds containing caffeine, which were widely advertised. Caffeine is a known stimulant. It is known to have some mildly addictive properties. It appeared to me and to Dr Grounds, with whom I was working then, that it was the caffeine that made people become, as it were, hooked, to use a colloquial term. Therefore I think I have gone on looking for evidence to support this view. I am willing to admit that the evidence is not by any means overwhelming, but this raises another question and that is why caffeine was used in these compounds in the first place.

This matter goes back a long way. I do not pretend to be informed on the subject, but I have yet to be convinced that the caffeine that is compounded with analgesics serves any useful purpose. Caffeine is said to enhance the activity of the analgesics, but such enhancement could be achieved by administering a slightly larger dose of those analgesics if it were just the pain-killing property that was required. Caffeine is not compounded with the analgesics widely used in medical practice because those analgesics can be given in effective pain-killing doses without the need to compound them with caffeine.

The essence of my submission is that caffeine does not have to be compounded with analgesics. There is some evidence that it leads to habituation and therefore causes continued, increasing, and permanent ingestion of regular quantities of these analgesics over a long period of time. To my mind there is quite a lot of evidence that this may lead not only to kidney damage but also to gastric ulceration and other undesirable effects on health. One could well make the same point about some other drugs that are compounded with analgesics. I could comment on the matter more widely, but perhaps I should rest my submission there and see whether members of the committee want me to enlarge on any aspects.

2781. In giving evidence at Newcastle one of your colleagues said that these unfortunate people are totally hooked by such preparations and that they need caffeine to relieve the headache produced by caffeine. Would you agree?——W. That is so. There is pharmacological evidence that caffeine itself can cause headache and you get to a vicious circle situation where withdrawal of the caffeine causes headache and so you have to take more caffeine-containing analgesics to relieve it. We are in a situation where the caffeine is provoking that vicious circle.

2782. A further statement made by the same witness was that the evidence is overwhelming that aspirin damages the stomach and kidneys and that aspirin is taken because of the caffeine content, and that caffeine has no role in analgesics. He submitted therefore that abolition of APC compounds would relieve that situation and do away with the side effects of which we are speaking. Would you agree?——W. There is some confusion there because he refers to aspirin when I think he should be referring to APCs. I think it is undoubted that aspirin is a gastric irritant and may cause gastric ulcers. It certainly aggravates them. Caffeine keeps people going and ingestion of these drugs provokes headache as well as having stimulating effects. I do not think there is any evidence that caffeine itself does any damage to the kidneys or stomach or to any other organ of the body although its role as an adjunct in the cause of kidney damage has not been proven. The committee has had evidence that caffeine may act in a protective way on the kidneys when compounded with analgesics, but there is equally strong evidence that caffeine plus analgesics may be more damaging to the kidneys than analgesics alone. Caffeine on its own has some known effects on kidneys, and theoretically there seems to be a reason to think that caffeine plus analgesics may be more damaging to the kidneys than analgesics alone. We do not know. The evidence that I know of in this field is quite unsatisfactory.

2783. It is often said that university people get into their ivory towers and forget what is going on outside. Do you practice in addition to your work at the university? ——W. Yes. I was a general practitioner for fifteen years before I came to my present position at the university eighteen months ago. Although my department is called the Department of Community Medicine, general practice accounts for a large part of the department's teaching responsibility. I am still involved with a general practice in Burwood on a part-time basis for a couple of sessions a week and I still do some after-hours work in general practice. So I am still very much, part time in active practice.

2784. Do you know Professor Gassman, vice-president of Nicholas Research International?——W. No. I had not heard of him until I read his letter in the *Australian*.

2785. Apparently he has the same relationship with you?——W. Yes. I am sure that is so.

2786. Do you know Professor Swales, who claims that renal failure owing to analgesic abuse is uncommon in the United Kingdom?——W. I do not know him. I know it is said that renal failure owing to analgesic abuse is uncommon in the United Kingdom, and, I believe in the United States of America.

2787. This matter was raised at Newcastle because Professor Swales is one of the authorities who has been quoted by some proponents of the use of analgesics in support of their case. I was wondering whether he was a person of world-wide repute. He is not known to you? ——W. No. But the fact he is not known to me does not mean anything. In my field I would not be expected to know particularly experts in the field of pharmacology and therapeutics.

2788. When you are talking about your work as a professor of community medicine, you would suggest, would you, that that covers the use of all types of drugs? ——W. Yes.

2789. I take it you are aware that this committee's terms of reference deals only with drugs of dependence, their use and abuse, and excludes alcohol and tobacco? ——W. Yes.

2790. In addition to your work in regard to analgesics you have a great interest in the community aspect of drugs such as heroin?——W. Yes, I have. I have an interest in all drugs, including the hard drugs heroin, morphine and so forth; even in drugs which are not normally thought of addictive—the problem of drug use in the community and symptoms based on such things as antibiotics. I know this is not within the terms of reference, but I think I made the point in my letter that there tends to be in Australia, although it is now being combated, a climate of social opinion that is very permissive towards the use of drugs at the drop of a hat, as one might say, and without due consideration of the fact that with any drug used for any purpose one must always take into account and weigh up the possible effects versus the possible disadvantages both to the indivdual and to the community as a whole.

2791. What association do you have with people of equal status as yourself working in the same field?—— W. Do you mean in community medicine?

2792. In medicine, first in Sydney, and then wider?—— W. I have quite a wide association and contacts within the faculty of medicine at the University of Sydney, but not universal. I have been here only 18 months. I came from Victoria and I have not had the advantage of widespread knowledge that one gains when one has grown up in a place. I know Professor Webster at the University of New South Wales. He is Professor of Community Medicine there. I know him quite well, and the members of his department. I know a lot of general practitoners in Sydney. I am closely associated with the Royal College of General Practitoners. That involves my knowing a lot of general practitoners even throughout Australia.

2793. Does your work entail any type of research in regard to, say, the use of analgesics or do you depend on the research work of others?——W. I have done no work personally nor been involved in any work personally relating to analgesics. My interest has been in assessing the work of others. I have been involved in research, of course, but not regarding the question of analgesics.

2794. This was one of the things that Professor Murton alleged against you: "Unlike Professor Bridges-Webb, I have allowed such studies to embrace the recorded observations and data accumulated throughout the world." I think you did reply to that?——W. Yes. My feeling about that was he may well have more information about analgesics and their relationship to the kidneys and other organs but, nevertheless, I am not convinced that that greater knowledge of his, which I am sure he does have —to me he has not given any evidence that this has placed him in a position to refute with confidence my arguments. I have an open enough mind. I have said that there are a lot of things uncertain, yet I feel that there is enough evidence for me to make up my mind. I have an open enough mind to be willing to be convinced by evidence that Professor Murton or anyone else can bring forward. I feel, for instance, that other than boosting

himself by stating what a wide knowledge he has that he has not in fact referred to any evidence which I find convincing.

2795. He followed on to say that your views seem parochial because where he had discussed the subject in depth with world figures in their specialized medical and scientific fields, he inferred that you had not?—W. He did infer that. That is perhaps a little unfair. I have pointed out that later in his letter he referred to micro-sociological factors. I am not sure what micro means. I think he means in a particular situation. In my reply I said that was one reason I felt perhaps someone looking at a world-wide situation was not familiar enough with the local scene here to know the particular needs. I even went so far as to say that I did not think that the decisions of the American Food and Drug Administration were necessarily entirely applicable to the situation that exists in Australia. I still believe this is so.

The other aspect of Professor Murton's widespread knowledge is that he is a pharmacologist and may have great knowledge in depth about drugs, analgesics and their effects on the body but by inference one might consider that his knowledge of the sociological factors to which he referred might be less than mine. I do not presume to say that it is, but that is a possibility.

2796. You referred to the fact that the Food and Drug Administration in the United States of America is of the view that analgesics are not the cause of renal failure. Do you think that might be because in the United States the people are not heavy analgesic users by comparison with others?——W. That would be one conclusion that might be drawn, yes. Obviously one views a situation somewhat differently according to the degree of priority, whether this is a problem. It seems to me by the very fact of your committee's interest that this is seen as a problem in Australia which is at least worthy of time to look at critically and to gather evidence about it. Perhaps in America this would not be seen as a problem worthy of such attention.

2797. In evidence given previously to the Committee it was suggested that caffeine was both addictive and physically damaging. Would you like to comment on that statement?——W. I am aware of enough evidence that it is addictive to have convinced me at least that it causes effects which result in two things. It causes people who take it to feel better and, therefore, to want to take more and to get to the stage where if they stop taking it they get side effects such as headache and withdrawal symptoms which makes them want to keep on taking it. I am aware of enough evidence on that to convince me. What was the other part of the question?

2798. Whether it was physically damaging?——W. I am not aware of any definite evidence of it being physically damaging other than one or two papers that are rather old now, I think dating back to the 1950's, referring to its possible damaging effect on the kidneys in association with analgesics. I am not aware of any evidence of caffeine itself being damaging other than I believe that the problem is that it is the addictive vehicle which causes continued ingestion of analgesics and the analgesics do physical damage.

2799. Community medicine is a relatively newcomer in this particular section of your profession. Have you any particular observation you would like to make to the Committee in regard to community medicine as such and which concern the affairs of this Committee. I do not mean in the broader field?——W. Yes, I think this follows on from my comments when we were talking about Professor Murton. In the field of community medicine, while we do not aim to have a detailed objective knowledge in depth of such topics as pharmacology, what we aim to do is to look at subjects in breadth and consider, for instance, drugs in relation to their therapeutic use, their abuse, the sociological factors, which are important, the appropriate place of advertising, the importance of home remedies, the question of community education in relation to what is the appropriate use of a home remedy and at what stage should a person seek medical attention.

These sorts of things must be related to the practice of medicine and primary care, which is the particular aspect related to community medicine, particularly general practice but also includes other aspects of primary care, such as casualty department work in hospitals. To me community medicine attempts to take the broad view and to relate a number of disciplines to medicine and to the community. Because we have accepted this discipline it has given us a different sort of perspective to that which might well be held by a pharmacologist, for instance, or even a specialist renal physician, where their overall knowledge of the interactions of medicine and the community may be less. I do not say that it is, because it is personal and individual and depends on the particular interests of the person. But the academic discipline is of a different nature.

2800. More than once the committee has been told by witnesses that many doctors in private practice would not recognize some of the symptoms of a drug addict, or if they did they would not really know how to treat them. Have you any scheme at this stage to give the equivalent of in-service courses to doctors who graduated some years ago in order to bring them up-to-date with modern trends? ——W. Yes. In fact this is already occurring. There might be argument whether it needs to occur more or less, or to be differently directed. I mentioned the College of General Practitioners, which has a role in post-graduate education for general practice and in continuing education of general practitioners. It runs courses. Drug use and abuse is certainly a topic which is fitted within the overall sphere of activities of the medical education committee of the college. I think the other Royal colleges, such as the College of Physicians and the post graduate committees of the universities would includes topics such as this in their refresher courses and post-graduate activities. For instance, next month I am to speak at a meeting at the Prince of Wales hospital on the use of drugs by doctors and the risks of causing dependence by inadvisable use of drugs of addiction. That is part of a post-graduate course run by the College of General Practitioners in educating doctors.

More attention is being given to the question of drug use and abuse, and necessarily so. Certainly it is something of which medical educators in my field are aware and anxious to cover. If I could go back to your original comment that it has been said that doctors in private practice—and I am glad it was private rather than general practice because I think it would apply across the board—are inadequately prepared to recognize and/or treat problems of drug use and abuse. I am unaware of any evidence that shows how widespread is this inability to recognize. These sort of things are stated and there is plenty of anecdotal evidence. For instance, one can get evidence from doctors working in the drug addiction services of the Health Commission. But often the patients who end up there are in fact those who have been inadequately treated elsewhere. What one really needs to know is to what extent drug abuse and addiction is in fact satisfactorily treated in private practice because it does not come to the attention of other people who are usually the sort of people to give evidence from their experience.

We have to be a little wary of the evidence on which this is based. Anecdotal evidence, yes, obviously, I would like to see every doctor able to recognize and treat these conditions; every doctor practising in fields where they are likely to meet this. Equally, obviously this does not apply. How great the deficiency is is another matter.

2801. You make that quite clear. I did not say that it was the feeling of the committee.——W. I realize that.

2802. The opinion had been expressed to the committee on more than one occasion?——W. That is my comment.

2803. What is the situation in regard to your own undergraduate courses in preparing doctors to deal with addictive drugs?——W. This is a co-operative venture in which we are interested. This is included in the curriculum, and in this regard we are co-operating particularly with the department of psychiatry, because that is the other particular discipline which bears upon this. We have run one short course for fourth year students this year on drug addiction and related problems. I do not know to what extent this topic tends to come up amongst others in the teaching hospitals, in the course of teaching medicine and surgery, but it certainly is a topic that will be further elaborated in the community medicine course, which the students in the new curriculum at Sydney University do not start until October. As you are aware, the new curriculum was started in 1974 and students this year are the first to take it. I have not been associated with the old curriculum because my appointment was 18 months ago and was to fit into the new curriculum.

I do not think this sort of topic was emphasized enough in the old curriculum but I believe that we are beginning to use emphasis. It will take time to ascertain what is the proper amount of emphasis to give to it. It is certainly a topic that we are aware of and will be attempting to cover in association with other disciplines.

2804. The abuse of analgesics in New South Wales and Queensland appears to be far greater than, say, in Victoria.——W. Yes.

2805. Have you any explanation for that?——W. No, I have not. I am convinced that there is enough evidence to show that. I am disappointed that we cannot get definite evidence. It distresses me that we cannot get evidence from manufacturing companies about the amount of drugs or even the relative amounts of these drugs distributed and sold in the various States. I have tried before, without success.

The evidence is all indirect rather than direct evidence of total sales or volume or production. I am convinced that this is the case, but as to why, I do not know—nor have I seen any papers or evidence of anyone trying to collect the answers. Why should Queenslanders or people in New South Wales be more prone? I do not know whether there are historical reasons, whether advertising has been differently promoted in these States. I cannot answer your question. I can see that it is an important question to attempt to answer, and I would be most interested in any evidence that helps to answer it.

2806. The analgesic problem seems to be greater here. Have you had enough experience of it to know whether addictive drugs like heroin are a greater problem in Sydney than in Melbourne?——W. No. I was not practising in Melbourne, I was practising in Traralgon in Gippsland. While there was some problem there—as I believe there is right throughout the country—it was something that I came across very rarely. I was not at all *au fait* with the situation that existed in Melbourne or Sydney, nor do I think that I am very well informed about the situation in Sydney. My information is of a fairly general nature.

2807. In relation to the survey that you carried out at Traralgon, you said that only 13 per cent of the people interviewed nominated a caffeine-containing analgesic as being one that they would use for pain, and I think by comparison 67 per cent in the Sydney survey. Was that it?——W. No, that was that 13 per cent nominated analgesic as what they would use for pain, but the evidence is that 50 per cent or 60 per cent in surveys of the people who are regular analgesic users—or abusers—appear to take compound analgesics. My point was that compound analgesics are not those which are named by people if you ask them what they would use for pain, whereas they appeared to be a large proportion of patients who regularly take analgesics for other than medical reasons. They take compound analgesics. I went on to make the inference that perhaps the greatest use of compound analgesics is by the people who are habituated and addicted.

2808. In other words, they are taking it because they are habituated or addicted, to get relief from pain?——W. Exactly.

2809. Have you any evidence, either verbal or written, that any patient is habituated to analgesics that does not contain caffeine?——W. No. This was something that Dr Grounds and I were interested in but were never able to obtain it. In our reading and in conversation with the doctor, we were never able to get any unequivocal evidence of addiction to plain analgesics—that is, aspirin or paracetemol—whereas there is plenty of evidence, both anecdotal and survey, of addiction to the compound analgesics. As I say, I would be most interested to have even one or two case reports of patients who regularly take a plain aspirin and appear to be addicted to it. I am sure it happens, because if you look hard enough you can nearly always find it. It seems to me that it is unusual for this to happen, because we have not been able to obtain evidence of it. I stand ready to be corrected if this evidence is produced.

2810. Mr JACKETT: Professor, you said that there seems to be evidence that caffeine can itself cause headaches. From a technical point of view how does this work? It has a stimulatory effect, but why does it cause headache?——W. Caffeine has a vasodilating effect. It dilates some blood vessels. It would appear that it can cause vasodilation, and this may cause headaches. Migraine is a type of headache. The mechanism if migraine is known to be caused by dilation of blood vessels in the scalp and within the scalp. Possibly caffeine can cause headaches in an analagous way by its effect on blood vessels.

Here again I would state that I am not an expert in the pharmacological effects of caffeine. This is my present state of knowledge, and I believe this is inadequate. Therefore, I am not competent to give you evidence on this point. I can only state my own opinion based on my present knowledge, and state that I might well have, and should have, refreshed my memory on caffeine. If I were going to go into any work on this topic—and I believe that this is an area in which perhaps my interest is being aroused. and this is part of my being here—I would have to brush up on a lot of these things. So I make that great qualification.

2811. Have you any knowledge of the proportion that the compounds bear to the plain, single-factor analgesics such as aspirin and paracetamol in countries like the United States of America? I know that analgesics are used a great deal less in other countries than in Australia, apparently, but I am referring to the proportion of the compounds to the single components. Have you any knowledge of this in America, England and other countries?——W. I believe, although I cannot quote the evidence on

which I base my belief, that caffeine-containing analgesics are either not used or are very little used in the United Kingdom and the United States of America. On the continent of Europe the varies quite a lot from country to country. In some countries they are widely used, and I believe that Czechoslovakia is one of these. Again, I am sorry that I cannot give you the detail of the evidence, which was a personal letter that Dr Grounds had from a scientist over there. There are some European countries where caffeine-containing analgesics are widely used on a level perhaps comparable to Australia where there is an analgesic kidney damage problem. There are other countries similar to Britain where they are little used. Again, this is my belief, but I cannot quote the evidence on which I base it. Therefore, I could be proved wrong.

I am sorry to qualify my answers so much, but I think this is important. I want to give evidence, but I want to make it clear that I believe it is soundly based. But if, for instance, Professor Murton and I were having a dialogue, he may possibly produce some evidence which I would have to evaluate, and this is the sort of thing you want to know. Therefore, when I am stating something which is perhaps based on flimsy evidence which I cannot substantiate, I will say so.

2812. There is apparently a great need for more evidence of the proportions of multiple or compound analgesics in other parts of the world as compared with single component analgesics in various countries of the world so as to give us the kind of information that we need to know, or to explain the apparent phenomenon in Australia, and particularly Queensland.——W. Such evidence would be valuable on a worldwide basis and even different parts of Australia. As I say, I would be delighted if such evidence could be produced. It would help us all very much.

2813. What did you mean when you used the words mild addictive qualities of caffeine?——W. This morning in talking with you I have rather loosely used the words addiction, habituation and so forth. Perhaps to say mild addictive qualities might be a contradiction in terms. I am using addiction in the sense that a drug of addiction is one that can cause physical dependence, so that withdrawal of the drug causes physical side-effects which are distressing to the patient and are measureable in some way. I regard caffeine as a drug which is addictive, in the sense that headaches can be a withdrawal symptom if caffeine has been taken for a long time and is stopped. Headaches will occur as a withdrawal symptom. They are mild in the sense that, to my knowledge, the headaches may be very distressing to the patient but are not in any way life threatening and are not so distressing that they lead to the patient, for example, needing to be hospitalized; whereas the withdrawal symptoms of heroin, say, can be life threatening.

2814. What I had in mind was that the addictive part of it was mild. I was wondering whether you mean that the addictive part was mild as compared with say heroin or the narcotics and so on?——W. That is what I mean.

2815. Mr HEALEY: Was it you or Professor Webster that was in the process of establishing or had established a training unit for students in conjunction with the Western Suburbs Hospital?——W. It is I.

2816. In that establishment, in view of the increasing number of drug problems caused by narcotics, barbiturates and right down through the others, is it your intention to establish a clinical record of the cases that come to you from the general public so that perhaps you will be able to build up the sort of records and evidence that you say are lacking at present?——W. First of all, the unit at Western Suburbs Hospital is simply an education centre and will not be in any way a treatment unit so there is no question of medical records. It is an educational headquarters. My department already has one practice in which I am involved and it will be using other general practices in city and country areas, some of which already have suitable records from which information could be extracted. In the general practice at Burwood we are at the moment in the process of developing a record that will allow us to obtain information about every contact the patient has with the practice—the illnesses and problems from which patients suffer and the drugs which are prescribed. This refers to drugs that are prescribed. However, I believe this is a pilot system and once we get it going, if it works, we will run it and de-bug it and get the kinks out of it and then we will be able to use it more widely and institute it in a number of practices that are associated with us for research and teaching. I believe that we could then use this mechanism to gain information about the drugs the patient is using or the extent of such problems as analgesic abuse. What I am trying to institute is a mechanism for obtaining information in general practice, about general practice particularly, but with a method that would allow it to be used for a variety of other purposes and specific surveys and the use and abuse of analgesics would lend itself to being monitored. Yes, I have in train a programme which we are instituting which could well allow us to look at this question or any other question that crops up in the future where information from this source is required.

2817. Mr MACDIARMID: I take it the basis of your argument is the simple fact that only five per cent of analgesics prescribed by doctors contain caffeine; therefore, why should it be in any other analgesics?——W. That is a simplification, but that is what I have stated. I used it because it was the only evidence I had. I am not convinced that the caffeine serves any necessary purpose in combination with analgesics. The situation is quite different with another drug that has been mentioned from time to time; that is codeine. Codeine is in fact an analgesic in its own right and to compound codeine with these other analgesics makes therapeutic sense to me; whether it should be available over the counter is another matter entirely. But I see no purpose in putting caffeine in analgesics, seeing that I had evidence that only five per cent of analgesics prescribed in general practice contained caffeine—and that was from the morbidity survey with over 1 000 doctors participating—there seemed very good reason to infer from that that the doctors did not see any great need for using caffeine-containing analgesics.

2818. A substantial witness gave evidence before the committee in which he stated:

> There is some hint, although not medically proven yet, that there may be a link between caffeine and bladder cancer. I mention that. There is no proof, but there have been editorials in medical journals raising the probability.

Would you like to comment on that?——W. I know nothing about that so I cannot help you on that.

2819. Mr McGOWAN: Could I put an argument to you and ask you to comment on it? The argument runs like this: Food is freely available in the community and some people abuse it—that is, they eat too much and put on weight and this at a cost to the community in terms of heart disease. There are other specific things. Children may eat too many lollies and thereby become sick and we have to have people to clean it up—not to the extent of requiring treatment at community cost. The argument will undoubtedly come to us that since there is no necessarily proven distinct connection between analgesics and analgesic nephropathy, that therefore the analgesics should be freely

available in the community for people to use, despite the fact that a minority of people will abuse them. Would you comment on that, please?——W. Yes. First, could I just dispose of the point about nephropathy. That is only one of the problems. It receives a great deal of emphasis, but let us not forget the gastric ulcer problem with analgesics; the rare but sometimes serious allergic problems related to aspirin; haematological changes—the blood clotting or lack of it changes. You will have had evidence, I think, of a range of other pharmacological connections, so I should not want to be entirely bogged down on the kidney problem although that looms most large.

But getting back to your argument about whether analgesics should be freely available; I readily admit that all that a medical scientist or professor or a person such as myself can do is give to evidence which I feel is cogent; you may not. I think the proper thing to do is to raise something that we can talk about together as a community. You are representatives of the community in your responsibility. I should say that the argument that you quote, in no way do I see it as being an invalid argument. I think it is one of the factors that we must take into account. The reason why I believe that something should be done in this circumstance, whereas at the moment we are not considering doing anything about the food situation or other particular situations, is the size of the problem, both in terms of community costs and resources and in terms of personal disadvantage to people. I am convinced that the problem is large enough and the solution is reasonable enough in terms of cost and in terms of all sorts of other factors for something to be done. As we are all aware, there are some other people who on the same evidence will not reach that conclusion so I shall state my case strongly, I shall listen to what others say and say, "Right, I do not regard myself as having any special expertise or reason why I should make decisions for the community. I believe I should put the evidence that I have strongly, as I am doing, and go along." I would not refute that argument that you present. I would say that I realize it is one of the factors you will have to take into account in your deliberations.

I find very interesting this question of to what extent should we restrict things or legislate or make regulations to govern matters such we are discussing. There are some very nice and difficult points to be raised in the question of where does the overall public interest lie? I am convinced that in the case of caffeine a solution exists that is reasonable and that is within the overall framework of the community situation, and that action should be taken. Does that answer your question?

2820. What is the solution that you say exists?——W. I think the recommendation of the National Health and Medical Research Council, that plain analgesics remain freely available but that compound analgesics be restricted, is a good solution. I am not completely convinced that it is the best solution. Again, as in answering the other question, I would say I have not thought about this but I heard raised the question of if you restrict it to sale in pharmacies and not in supermarkets or milk bars, does this do any good? There is evidence that in pharmacies analgesics are still sold by untrained lay assistants and there is no more control that way than if they are sold in a milk bar, but they may be more expensive. That is a reasonable argument, but that seems to be a solution. I certainly do not want to see analgesics not freely available but I do want to see compound analgesics not freely available and I believe that the restriction of their sale to pharmacies on prescription is another matter. There I begin to be not certain because again I have not weighed the evidence. I hope that that is the sort of thing that will come within the ambit of your committee. Obviously you have many other things to consider. I have not got a ready answer to the solution, except to say that I believe compound analgesics should not be freely available anywhere other than in pharmacies but whether you take it further and restrict them to prescription only is another matter. It has been said that if you restrict them to individually wrapped things in small packet size people will still shop around and get their quantity. Maybe they will, but a financial burden is being imposed. If people want to beat any system, they will. Let us face it. There is no perfect system. Always we have to make our judgment in terms of what is a reasonable compromise .

2821. Mr MACDIARMID: Surely if there is a problem, merely to take it out of milk bars and put it into pharmacies would not solve the problem?——W. No.

2822. Very often pharmacies are open longer than any other type of shop. We have all night chemists.——W. I think that really I come down to saying that we have to restrict it even further to prescription. As I say, that still leaves the pain killers available for people who need relief from pain when they have a cold, as I have at the moment, and other simple things. I believe they should be available.

2823. Mr MCDONALD: Are you aware of any other disease, if we can call it a disease, similar to this particular problem—in other words, something which is generally available throughout the world but which in a particular localized area, such as New South Wales and Queensland, causes community concern?——W. Just off the cuff, I cannot think of one. I am aware of other drugs being used in other countries that are of concern in some countries. Some drugs are used in some countries and not in others, for legal or manufacturing reasons. There have been instances—I cannot pinpoint one at the moment—of drugs being used where they are a problem in Europe and not in America. The American Food and Drug Administration has very strict guidelines—some say too strict because they say that many drugs being used in Australia are not yet freely available in America, to their detriment—I mean used in medical practice, not by the community.

There is some evidence that their restrictions are too harsh and deny people reasonable access to their medical practitioners. I know of that sort of situation—but something entirely comparable off the cuff—no.

2824. CHAIRMAN: In an important submission given to the committee some weeks ago it was pointed out that analgesic toxicity is responsible for 20 per cent of renal failure in Australia: can you tell the committee what causes the other 80 per cent?——W. A variety of conditions. Just to list some—I am not sure what the order of priority would be in terms of frequency. Congenital— people born with malformed kidneys of one sort or another. Acute nephritis or chronic nephritis which is an immune disease. Pyelonephritis which is infection of the kidney. I would say that congenital, chronic and pyelonephritis would be the major causes. They are quite different diseases. There would be a lot of other things that can be associated with other disease—poisoning by a variety of things other than analgesics—chemicals used commercially and so forth. There would be a variety of other causes which would lead to chronic renal disease—kidney stones causing bank up problems which is usually associated with pyelonephritis. We get the infection along with this so it is hard to sort out how much is due to the stones or due to infection. Those sorts of conditions would be responsible for the 80 per cent.

2825. They would cause the actual renal failure?——W. Yes, hypertension is another thing that can cause renal failure. Probably it would loom high in the cause of renal failure.

(The witness withdrew.)

*Upon resumption*:

2826. CHAIRMAN: I declare this meeting open and ask the secretary to read the Joint Committee's terms of reference.

2827. I now ask the secretary to read Legislative Assembly Standing Order No. 362 in order that witnesses and other interested persons may be aware of the procedure for the examination of witnesses by the committee. In this regard, although there is mention of the Legislative Assembly's standing order, the Parliamentary Evidence Act, in its application to the provisions of this Act, states that reference in that Act to a committee shall extend to include a joint committee of the Council and Assembly appointed either before or after the commencement of the Parliamentary Evidence Act, 1939.

MAX LESLIE EBRILL, a Detective Senior Constable of police stationed at Wollongong, residing at 28 Blanchard Crescent, Balgownie, sworn and examined:

2828. CHAIRMAN: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act, 1901?——W. I did.

2829. You have been recalled to this committee to clarify your answers to questions put to you during the committee sittings in Wollongong last Friday. Subsequent newspaper reports may have given your answers a meaning not intended by you or understood by the committee. Is it correct that in answer to a question as to what you meant by "top people involved" you said: "I mean the people that are financing the deal, people such as businessmen. I think if we were to show slides on the wall here today of all the people that were at the centre of drug distribution in this area, we would all get a big shock."?——W. Yes, that is correct.

2830. And in answer to a subsequent question by Mr MacDiarmid that businessmen in the community were involved in pushing drugs, did you say, "Yes, I firmly believe that"?——W. Yes.

2831. I think you are aware of the way in which your first answer has been misinterpreted, and I now give you a chance to clarify that?——W. Thank you, Mr Chairman. I appreciate the opportunity of re-appearing before this committee because I feel that some statements made by me before the committee in Wollongong on Friday, 27th May, have been wrongly emphasized or misrepresented by the press. In discussion with you regarding drug pushers, I categorized them into three areas, the user-pusher, the pusher dealing purely for monetary gain, and the top-level people behind the scenes, those people at the centre of the drug distribution—in other words, the people financing the deal. When asked by you to explain top-level pushers, I used the term "slides", although we were not in possession of the same but only hypothetically illustrating to you that if we could show up some of these people in the South Coast area who were involved in drug distribution at this level, people would be surprised.

A number of businessmen in the Wollongong area have been arrested and charged with selling and possession of drugs. Information was supplied by informants to effect those arrests and additional information was supplied by those informants and other informants that other business people in the Wollongong and surrounding areas are actively involved at the centre of drug distribution. In my opinion, that information is correct.

2832. Have you received co-operation from your superiors in Wollongong in your work?——W. I have.

2833. And as a member of the drug squad, you would also have superior officers in Sydney?——W. Yes.

2834. Have you received co-operation in your work from your superiors in Sydney?——W. I have.

2835. Mrs ANDERSON: Do you feel that the publicity that has been given to your evidence at the hearing in Wollongong will inhibit, in any way, your work in the drug squad in future?——W. I think it could have two effects but in the long term I think it will be beneficial.

2836. Mr RAMSAY: Would you be able to inform the committee of the names of the business people involved? ——W. What is the chairman's decision on that matter?

2837. CHAIRMAN: Quite frankly, I do not understand the question. Mr Ramsay, are you talking about people who have already been charged?

2838. Mr RAMSAY: Yes, as indicated by Detective Senior Constable Ebrill in his evidence.

2839. CHAIRMAN: The witness said that some business people had been charged. Also he said—virtually, it was his opinion—that there were top people, such as business people, involved in the drug scene in Wollongong. If Detective Senior Constable Ebrill considers that he could give names at this stage but is not in a position to say definitely whether these people are associated with this matter, I do not think he should state the names publicly.

2840. Mr RAMSAY: Could the names be given *in camera?*

2841. CHAIRMAN: Would you be prepared to write the names of the persons concerned and give them to me?——W. Yes, I am prepared to do that.

2842. Will you give them to me at your convenience? ——W. I will.

2843. Mr MACDIARMID: I raised this question in Wollongong with Detective Senior Constable Ebrill, just for clarification. There is no doubt in my mind that in answering the question Detective Senior Constable Ebrill conveyed that the police did not have in their possession slides depicting any businessmen. He made that perfectly clear, and I am sure that the members of the Committee accepted that when we were in Wollongong.

2844. CHAIRMAN: Might I also add to what Mr MacDiarmid has said. I offer my congratulations to Detective Constable Ebrill for the manner in which he gave his evidence before the committee last Friday. I have consulted the members of the committee and we all agree that he was one of the most impressive witnesses who has given evidence before us. It is most unfortunate that the misinterpretation of his evidence received such publicity. I have read a transcript of his evidence and the evidence given by Superintendent Slattery. After a full consideration of all that evidence I agree with Mr MacDiarmid that at no stage did any of us feel that such a construction could be put upon it. Indeed, if it had been, we would have pursued the matter further. The transcript of evidence shows that at that stage the committee went on to another topic. Detective Senior Constable Ebrill, I now discharge you from further attendance, and I thank you. You will make that information available to the committee at your convenience?——W. Yes.

(The witness withdrew.)

BENJAMIN JOHN BROWN, Caravan Park and Service Station Proprietor, residing at 60 Hair Street, Casino, sworn and examined:

2845. CHAIRMAN: Mr Brown, did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. Yes.

2846. I understand you wish to make an oral submission. Is that correct?——W. Yes.

2847. Would you go ahead?——W. Well, to understand the drug abuse problem in Wollongong would take a long time, to my knowledge. This is relevant to when I was at Wollongong some 4 or 5 years ago. To understand the problems that existed there one has to go back to the somewhat cosy arrangements that existed before the ongoing administration of the police force in that area at the time and various businessmen in the area at the time. I can elaborate on it later on if required. I am here to help if I can in some small way and I am open to you and your committee's questions. I will truthfully answer such questions as I can.

2848. How long were you in the police force?——W. Twenty-five years.

2849. When did you resign?——W. June, 1973, I think it was.

2850. Where were you stationed?——W. At Wollongong.

2851. Why did you resign?——W. Shortly, in frustration. I had 25 years service on the job. At last I was doing a job that I thought was constructive and worth while. It was a job that I—I won't say enjoyed doing, but I got some satisfaction out of doing it. I had teenage children of my own at the time and I could see what was happening to kids that they went to school with, at their own school, and kids that they played football with. They were physically deteriorating under my own eyes. The department selected me to go to Sydney for some drug squad training, in 1969 I think it was. I went back to Wollongong and became interested and involved in it and applied myself diligently to it, I hope, and tried my best to do what I could to try and make thinks a bit better for the people who were there, not with a great deal of success at times, I suppose, but at least I tried.

2852. The Sydney *Sun* on 1st June reports you as saying you resigned because you could not do anything about the drug scene. Was that the only reason?——W. No. To run back through it quickly, I had been on leave and I returned to work. I had been there for about ten minutes and was told that the superintendent wanted me. I thought, "Christ, here we go, what have I done wrong? It could not be much, I have only been here ten minutes". I went to see the super. He said, "You have been transferred to Sydney, Ben". I said, "Is it on paper, boss?" He said, "No, not yet; it is only a phone call." I said, "Any idea where to?" and he said, "No, just to the metropolitan area to a station to be advised", which is normal routine I suppose. I said, "Would you say this would be a punitive transfer boss?" and he said, "No, just a transfer. We are one over strength". That was in the police department pyramid system. At that stage there was a first class sergeant, two second class detective sergeants at Wollongong, including myself, and one at Port Kembla. I said that that was fair enough but I knew that both those senior fellows were in ill health. So I went to Sydney to see about this transfer, which is not unusual. One has to make some inquiries. I saw the then chief of the drug squad, Detective-Sergeant Cec Abbott—I do not know what rank he is now and he might even be out of the job, but Cec was the boss there then. I thought quite highly of him and I hoped he thought the same of me. I saw Sgt Abbott and told him I was on transfer to Sydney. I said, as the officer in charge of the drug squad in Sydney would I be acceptable to him on his staff in Sydney. I said I was being transferred to Sydney and would I be acceptable to him, as officer in charge of the drug squad, as a member of his staff. He said yes, he would be most pleased to have me as I was the senior experienced drug squad chap out of the actual drug squad who was not actually on it, but he was in the process of being promoted and that the second in charge, Detective-Sgt Ken Astill had been promoted to first class sergeant, so their status quo was upset and they were not too sure whether Mr Abbott was going to stay and Ken Astill was going to move up or whether Ken Astill was going to take over as boss and Cec Abbott was going to move on. So, to cover both ends I went to see Ken Astill and asked him the question, if I was acceptable to him to come on to the drug squad if I could do it and he was quite happy about that. Then I saw Detective Inspector Ken Worland who was then the country detectives inspector and asked him about the transfer and got the same reason there, that it was one over strength, which is the normal routine. I asked him could I see Supterintendent Vic Moore, Superintendent of Detectives or the CIB, one or the other.

Eventually I got to see Supt Moore and was told the same thing there about being one over strength. I said, "Fair go boss, you have Brucie Boyd who is a Detective-Sgt at Wollongong". Bruce had the misfortune to fall off a chair and his back was in a brace, his neck in a sling and he was anything but fit and well but he was still on deck. I said, "He cannot last that much longer. He will be medically unfit sooner or later. There is Ron Pyne at Port Kembla, he has hardening of the arteries or something or other and he is not too well. Why the sudden rush to get rid of me?" He said, "We are desperately short of detective-sergeants second class in Sydney and we need them up here as quick as we can". I said, "I have seen Cec Abbott and I have seen Ken Astill and I have asked them if I am acceptable to them on the drug squad and they are both happy to have me. If I come to Sydney can I get on the drug squad?" He said "All I can tell you, Ben, is that if you come to Sydney you will go to a station to be selected and you will not be going to the drug squad". I said, "That is definite, sir?" He said, "That is definite" and I said, "Thanks very much". It took a bit of wind out of my sails. I said, "Christ, this is good, you put your work into it and this is what you get". I went home to talk it over with my wife. If you can't lick 'em join 'em and if you can't join 'em leave 'em, so I left them and resigned.

2853. Were you instructed that you were wasting your time crusading against drugs in Wollongong?——W. That was an observation by Mr Superintendent Vic Moore. His exact words, as far as I can remember, were that as a trained detective-sergeant I was wasting my time on drugs and that it was a passing phase and it would not last and I should be out chasing thieves and burglars. With due respect to the ladies present, I said, "Christ boss, you are not with it. If some thief or burglar breaks into your place or my place and steals the bloody place blind——" I apologize for the language but this is in the first person, "——they can take the wallpaper off the walls and you can sit down with your wife and a pencil and paper and work out what has been damaged and get most of it back from the insurance company but when that mob come in—not in your case because they would be grandchildren, but in my case they are teenagers—and they insidiously work themselves into the house and they take those kids from you and destroy them and turn them into vegetables, how the bloody hell can you get them back? It is not a passing

phase, chief, and I don't agree with you." Which was not unusual. I said, "I don't agree with it one bit but I hope you are right and I am wrong because if I am wrong we will all be in front." At that stage I didn't have much to lose because I had half decided that I was going to toss it in so I could afford to be a bit rude at that stage. You don't often get a chance. That was their attitude, that it was a passing phase and it would not last and I would be better off chasing thieves and burglars. This was the underlying feeling of the department for some years. I can go back further if you wish. Generally I can give you no times and dates because I have just come down from Casino on a plane and I have not seen a file or a piece of paper and I have had to ad lib as far as I can, truthfully, but ad lib.

2854. Do you think prominent businessmen in Wollongong were involved in drug trafficking while you were there?——W. Yes.

2855. Were any such people arrested by you for drug trafficking while you were stationed at Wollongong?——W. Yes. Again, I am trying to think of names. It is a bit difficult. I am a shocker on names. I was in a party with other police that arrested a couple—two or three—a couple of fruiterers or fruit stall fellows at Woonona.

2856. Those records would be available?——W. Yes. There was about $500,000 of Indian hemp recovered in that lot.

2857. Would there have been other businessmen arrested by police while you were there?——W. Yes, we locked up another young bloke who had a discotheque and he had obtained a quantity of LSD in Sydney—I keep forgetting the relativity—and took it back to Wollongong and I got information from the drug squad up here about it so I borrowed a most improbable looking young policeman from Port Kembla and got him to go to the shop posing as the courier from Sydney and he was fortunate enough to get this stuff handed over to him and we charged that fellow. That is two that come to mind. As I say, I am not trying to be evasive but there is a lot of time gone by since then and I am trying.

2858. My question was, were there any other businessmen arrested by other police?——W. I am sorry, my apologies. I do not think so. Not that I know of. I do not say there were not, but I do not recall any.

2859. Apart from LSD, what types of drugs were being used and sold?——W. At that stage, Indian hemp in its leaf form and a little hashish, morphine, and opium derivatives. Amphetamines had been and gone at that stage but there was quite a variety of LSD both in tablet form, tickets, and micro-dots. They were quite readily and freely available in the Wollongong area at that stage.

2860. In that article in the Sydney *Sun* of 1st June that I referred to just now you are also reported as saying that the problem was worse in Wollongong now than when you resigned. First of all, is that report correct and, if so, on what evidence do you base your statement?——W. I have not seen that report. I accept what you read to me as being in the paper, but without any apologies to the gentlemen of the press I would say it has probably been misquoted. I said I could not see any reason why it would not be any worse than when I was there.

2861. Prior to your transfer to Sydney you alleged you made continued allegations about drug trafficking in the district. How were those allegations made, and to whom? In other words, were they in writing, or oral, or both? ——W. Both.

2862. And to whom?——W. If you will bear with me, I made numerous requests orally to my immediate senior officer, the detective-sergeant in charge, and through him to the detectives and the superintendent, to try to get an offsider. The usual procedure in the police force is that plain clothes men work in pairs, and the senior chap trains the younger fellow. That is normal. This drug work grew as things progressed and as I got more experience and got more knowledge about it, and most of the time I was working on my own. This can be substantiated from my daily duties pad sheets. There were times when I was with an offsider. There was Detective Jones, Detective Woods, and Detective Coghlan. I think that for a short time there might have been my old vice squad mate, Detective Kovaks, but for most of the time I was the odd man out except when we worked normal routine night work and I would have an offsider then. Within the police force you are restricted in what you can do. You are only a little fellow and you cannot ruffle the bosses too far. At least I tried. I went to what we would call press and put it on paper at one stage, asking for assistance. To the best of my recollection the file came back from Sydney. I am not sure whether it was over the superintendent's hand or not, but it was certainly from Sydney. To the best of my recollection, to quote the comment, which has burnt into my head, to concede a drug abuse problem existing on the South Coast would be a reflection on the administration of this department. That was their attitude.

I used to use my own private car to go and see informants or parents. There is not much point in trying to take observations of a place or going to see an inquiring parent in a police car with an aerial or a sign on the roof. They were the only ones available. It was either that or use your own car, which again departmentally was wrong, but still it had to be done. I could not get a non-departmental type of vehicle, so I used my own.

2863. In the *Illawarra Mercury* of 28th May last you were quoted as saying that some businessmen were behind the drug scene and getting a big dollar out of it in 1971 and that the involvement of businessmen in Wollongong was well known. You were quoted as saying that some of them have big names and big money is involved. First of all, is that report a correct report? Second, if it is, and if these people were so well known, why was no action taken?——W. With respect, the *Illawarra Mercury*—have I a copy of that? I would have to check the calendar and make sure I have the right date on it. They are strangers to the truth at times, if I can put it that way. I do not remember saying anything like that to the *Illawarra Mercury*.

2864. You would not have used the phrase that some of those involved are big names and big money is involved? ——W. No, I may have used the phrase that big money is involved—which would be normal—but I am 500 or 600 miles away from Wollongong and I would not know what is going on down there. I do not get a copy of the *Mercury*. I do not even see much of the Sydney papers. I only get the local paper. I am not greatly interested in Sydney any more.

2865. You alleged that after giving a drug lecture at a local primary school, when you named businessmen as drug dealers, the lecture was reported in the *Illawarra Mercury*, and you were taken to the local station for questioning by fellow policemen. Is that so?——W. There again, there is a little bit of journalistic licence. That was about five years ago. It was a combined church group meeting in conjunction with the drug abuse committee and rehabilitation committee in Wollongong, of which I was a member. It was open to the public. There were other guest speakers on the rostrum that night. I was one of

them. After we had completed our addresses we were open for questions. Again this is going back from memory. I was asked a question something along the lines, "Who is behind the drug scene?" To the best of my knowledge the answer was that it would be normally respectable businessmen with reputable businesses who would have the money to finance this type of deal because young people on the street just do not have that type of money. They would not be handing it out themselves. They would be handing it out through distributors for sale on the streets. On the same night I was asked another question as to how secure our high schools were—our high schools in the Wollongong area. I recalled that I knew of no high school in the area that was immune from the threat of drug abuse, which I thought was a fair and reasonable answer. Being involved in the work—I do not know what the number of high schools down there is now, but there were about fourteen high schools there then and from conversations with young people, interviews with persons who were interested, and just general information around the place, it would be a conservative estimate to say there would be at least an average of 100 young persons per high school using some form of drug, which works out at about 1 400 kids, which is enough to make someone worry, just talking about the kids at school without worrying about kids that had left school. That is what I said. No more, no less.

It would be about 7 o'clock the next morning that the PD truck from Wollongong arrived at my place out at Dapto. I am just trying to think who the uniformed officers were, but I can't. It was a little passing phase. The upshot of it was that a politician in the Wollongong area apparently had been got out of bed early by some irate businessmen. He in turn got the Commissioner of Police out of bed and complained about the startling headline in the paper. The commissioner was upset. He got the superintendent out of bed. He in turn sent a truck out to get me out of bed in a transfer of irateness, I guess. I ended up in the superintendent's office. He wanted to know what was going on and I said, "That is the truth, sir. They asked me. I told them". What transpired there was that I got a bit of a carpeting for being so outspoken at a public meeting. I said, "That is what it is all about. These people want to know what is going on and it is our job to tell them. It is their kids". If you take this one high school, you can take it word for word. What is wrong with that? It is true. If we tried to do any better we would have to put a ring of security around the place and body search everybody going in and out. That was just one of them, but I survived that one too.

2866. Your evidence agrees with that story. It follows on and says that a parliamentarian had telephoned the police commissioner and all hell broke loose. You said it was a Liberal Party politician from that area?——W. The gentleman concerned is deceased. He is not here to defend himself or answer it and I did not want to use his name unless I had to.

2867. How do you know he rang the police commissioner?——W. That is what I was told by the superintendent. Mr so-and-so rang the commissioner and got him upset, and that is why I was there. I am prepared to say who it was if necessary, but seeing the gentleman is deceased, I do not wish to name a fellow who cannot defend himself.

2868. What makes you think the Commissioner of Police issued any instructions in regard to your subsequent treatment?——W. Would you repeat the question?

2869. What makes you think the Commissioner of Police issued instructions in regard to your subsequent treatment that morning?——W. Oh, I am sorry. Well, the superintendent told me the commissioner had been on to him because this parliamentarian had been on to him, so it would necessarily follow that as I was at the end of a line, I got it. I was the fellow who made the statement.

2870. Do you know if the person who rang the commissioner was active in the drug scene at all?——W. No, no way at all. It was a member of Parliament. I am not implying he was involved.

2871. I did not want a speech, I only want yes or no in regard to that. Did you feel you were gagged because of political intervention at that time?——W. No, sir.

2872. You are alleged to have said you were hauled before the boss more times than you could remember. Were all those disciplinary measures taken in regard to your activities in the drug scene, or for other matters?——W. No. This goes back a long time, to about 1960 when I was sent to Wollongong as a relatively young fellow, straight out of uniform and straight into the vice-squad with a sergeant named Sergeant Worrell. We were sent there. There was the superintendent. He was a detective from Albury. He died in the job. I am trying to think of his name. It is getting back too far. But he was a very honest, straight-shooting fellow, and we were under no misapprehension as far as he was concerned. We had to get in there and clean up Wollongong. And we did: we tried. After this gentleman died a series of other superintendents followed on, and quite often either Sergeant Worrell or myself was required to attend the superintendent's office in respect to our activities for locking up SP bookmakers. The common complaint generally was that we locked up too many.

2873. But not in regard to your work generally: your work was never unsatisfactory from any other point of view?——W. Perhaps a bit too zealous.

2874. If I can put some words into your mouth, you claim you were being paraded because you were doing your job?——W. I was doing what I was paid to do, yes.

2875. Would it be correct to say that you might have a few old scores to pay back for events five or six years ago?——W. No, sir. These things are dead, buried and gone, but it is part and parcel of the background of what was going on at Wollongong. There is no satisfaction—in fact it leaves a taste of acid in my mouth—sitting here thinking about things that happened not only to me but the four policemen who were on that vice squad. They have all come undone. I think there is one left.

2876. They are all out of the force?——W. There is one left and he has been returned back to uniform.

2877. Who was the detective-inspector in charge of the district at this time that we are talking about now, just before you finished there?——W. Just before I finished—just one moment; Sid—a Mr Workman.

2878. Was he acquainted with your views in regard to the drug traffic?——W. Yes, I would say he would have to be.

2879. Did he agree with you?——W. He didn't quite disagree nor did he agree. He was not there very long before I left, but I can be more specific if you want me to on other matters, but as far as Mr Workman was concerned he was not there very long.

2880. Who was there before him?——W. He was the first detective-inspector who was there.

2881. A great deal has been written in general terms about businessmen. Surely in an area like Wollongong it should not be hard to identify people who were the centre of the problem?——W. With respect again to you, I am not trying to evade what I said, but what I said was said five years ago. I did not specify or be specific as to which businessmen were concerned. Unlike now, I did not have——

2882. The resources?——W. No. I am trying to think of the right word—the Parliamentary privilege. I was still in the police force and I had to be very careful then what I did say. It was bad enough what I did say was translated into the papers without adding fuel to the fire because everytime an article appears in a newspaper, whether a local newspaper or a metropolitan newspaper, in Sydney they have several staff sitting there cutting out with big scissors and marking with big crosses and it is sent to the fellow for full report on what he said and why, and you say as little as possible because you know this is going to happen. This is what I am trying to get across: that what I said was said five years ago about a situation that existed at Wollongong at that time.

2883. In other words you are telling us that you knew businessmen, or you suspected businessmen, were involved? ——W. Yes.

2884. You could not prove they were involved, and you think today the position is just the same?——W. Yes, sir.

2885. Geographically where were the greatest trouble spots in the Wollongong area when you worked there?—— W. In respect of drug abuse?

2886. Yes.——W. The main street is Crown Street. There was a considerable amount of trafficking going on there. And at the discotheques. I think we had two of those. They were virtually impossible to do anything about there because just about everybody in Wollongong knew me for I had been there for some time. To get into these places we had to go up a very narrow staircase to get into the place so there was any amount of time to signal we were coming. With the other premises, one had to go through a small door into the foyer and through another little door to get into where the action was. Then again th. places were that dark you virtually needed a 6-cell torch to see across the room, apart from the noise. This is where one was at a bit of a disadvantage because you did not have young fellows as your offsider to send in first. Someone has to be the goodie and someone the baddie. Sending a baldy looking bloke like me into a juvenile disco just wasn't on.

2887. At least they seemed to be centralized, they were not dispersed through the area?——W. That is in Wollongong. Then there is a couple of hotels at Fairy Meadow. It was quite widespread there. And Port Kembla. But most of where the action was was in the Wollongong city area where the main entertainment facilities were. The growing of marihuana took place in the foothills behind the town. We got a few of those. As I reiterate, the main business transactions were in Crown Street or the hotels in Sydney, the discos and two hotels at Fairy Meadow.

2888. Did you feel that drugs were being brought ashore from boats in the harbour at that time?——W. Yes.

2889. Were you ever successful in catching any of the people bringing the stuff in?——W. No, sir. From memory again I was lucky in this respect. Some of the chaps I had worked with on the drug squad in Sydney had resigned from the police force and had joined the narcotics bureau. I had a working liaison with them and information like that I could not handle I would pass on to them and they would take their own steps.

2890. Mr RAMSAY: Did you on a number of occasions ask your superior officers for more trained men to be added to the drug squad in Wollongong?——W. Yes, sir, even untrained men; I just asked for help, an offsider.

2891. It was completely understaffed—would you say that?——W. Yes. Do you believe that your insistence to have a proper drug squad in Wollongong and your advice to senior officers—and I know that you are fully qualified and that this is some five or six years ago—were the reasons for your transfer out of the drug squad?——W. I would say it would have some bearing on the matter because at that stage there was not a legitimate drug squad in the Wollongong area. I suppose you could say that I was a pretender. I was not classified as drug squad, I was just performing the drug squad type duties—that might be a bit clearer.

2892. Is it a fact that a police superintendent at Wollongong at that time had threatened to destroy you utterly for being outspoken in regard to drug matters?——W. That was in respect of another matter. He was a very tall fellow, taller than I was, and he looked down and he said, "I will destroy you, I will destroy you utterly." I said, "With due respect to you, sir, first you have got to catch me and then you have got to fit me, and I will appeal against it and I'll subpoena Detective-Sergeant Fleming to repeat this conversation; now see how you go." And I left, I was not staying around after that. But he did not destroy me, he destroyed himself eventually.

2893. At the time you left the force was there a file in existence—and I think the Chairman had something to say about that regarding the whole drug scene, and, if so, did you have access to that?——W. I am not trying to be finicky on this one to you. There were several files circulating over a period of time on the escalating numbers of persons who were coming under police notice. There was one where a report in the *Illawarra Mercury* caused a fervour. I am just trying to think what the figures were, Mr Chairman, and I am not trying to be evasive. I think it was Peter Cullen who was the reporter who put an article in the paper that the figures were whatever they were, three or four hundred over the six months. Again I was called into the superintendent's office, and this was a Mr Hamer at this time. In no uncertain terms he accused me of supplying Peter Cullen with information that was restricted and departmental. I assured him that I would not touch Peter Cullen with a 10-foot pole because we were at the opposite ends of the spectrum. But he said it could not possibly be right so I had to report on it. I used the figures from the statistic sheets that were supplied to me by the drug squad which lists the name and address of the offender, and unless they have changed, going across the sheet the various types of drugs that were used. They were on-going figures.

When I took the file back to the superintendent he said it could not be right because the figures were up about 100 per cent on what they had been some three months previously. So I assured the superintendent that they were correct, they had been compiled from the statistic sheets that I maintained. I said if you like I will go and get them, and I brought them back and he saw what they were. I said, "They have been there since about 1969 and you are the first person who has looked at them." He wanted to know why they were not brought under his notice. They had been where I was sitting and under cover and not available for public viewing. They were fairly big sheets and I had made a cover to put over them. Again he just could not or perhaps would not accept the fact that the figures had just about doubled in six months. But they were figures, not my imagination.

2894. Other than the huge increase in drug trafficking, were there any other matters that you are able to give to the committee that were alarming to you at that time?——W. No, I do not think so. I am not trying to be clever or evasive, but it was just a file that passed through and I am just trying to remember what was in it. It was mainly to try to refute the figures quoted by this Peter Cullen. To give him credit, he is an investigative reporter of quite considerable talent, I would say. He had sources of information up and down the coast, and he would obtain his figures from the various police stations or court houses, perhaps, where other drug arrests had been made, and it would not be hard to be pretty close to the mark. Except for the children's court matters, the other matters were dealt with in open court.

2895. At the time five or six years ago, did any of the businessmen that you knew or suspected were involved in the drug trade or the drug scene have any connection with the Tiki coffee lounge activities? I am sure that a murder took place there at the time?——W. A one-word answer—yes.

2896. They did have connections. Would you say that if your advice, given to senior officers at the time, and your recommendations, had it been acted upon, to your knowledge many young lives would have been saved, and certainly a lot of the drug-taking would have been curtailed? Would you say that?——W. I hesitate to answer because it makes me feel or look a bit egotistical. But I am afraid it is the truth. There is no satisfaction in saying yes, I was right, but if they had tried to little bit harder and a little bit sooner, perhaps things would not have been as bad down there as I assume they are now.

2897. Mr HEALEY: Could you recall for how long the Wollongong station had been one over strength before you were transferred?——W. It would be from the date that I was promoted to the rank of detective sergeant second-class, and honestly I cannot remember what that date was. But I had been a detective sergeant for some time. I cannot give the figures.

2898. Would it be 12 months, or three months?——W. It would have been 12 months or more, yes.

2899. Mr JACKETT: Can you recall precisely when you addressed that seminar or whatever it was at the high school?——W. No. It was not in a high school. It was in a school hall at Fairy Meadow and it would be perhaps 1970 or 1971. To be more specific than that—I could not do it now. I have just walked in cold with no records.

2900. Were you then a detective-sergeant second-class?——W. I may have been third-class, I do not know about second-class. There is not a great distinction, just an effluxion of time.

2901. Why did you mention the Liberal Party member to the *Mercury* in your interview last week, when today you are very reticent and anxious not to mention him by name. Everybody in Wollongong would, of course, know to whom you were referring?——W. I can tell you his name if you wish me to mention it.

2902. It seemed to me that it was very obvious in the *Mercury* to whom you were referring, to anybody in the Wollongong area?——W. With respect, I do not think I used the words Liberal Party member to them.

2903. That is how it was reported?——W. With respect, you have seen other publications in the *Mercury* too, and as I said a little while ago I do not wish to say or do anything to cause embarrassment, of a deceased person.

2904. Could I come back to the time of that meeting at which you made the statement and as a result of which you claim that the Police Commissioner was onto your superintendent? Can you be a little bit more specific as to when that meeting was held?——W. No.

2905. Can you be clear as to what year it was?——W. No. As near as I can be, it would be 1971 or 1972.

2906. Would it surprise you to find that the member for Wollongong was not a Liberal Party member after February, 1971?——W. No.

2907. In other words, you are saying that the meeting was held in 1970 or before February, 1971?——W. At no stage did I say that the person concerned was a Liberal Party member.

2908. I know you did not; I did not say you did. I said, would it surprise you to find that the Liberal Party member to whom you are obviously referring was not the member for Wollongong from February, 1971, so therefore if it was in 1971 or 1972 the member of Parliament who would have made representations to the commissioner on behalf of people that you have not named would not have been a Liberal Party member?——W. No, it would not surprise me if it was 1970, but I know who I was told made representations.

2909. You have gone on record again apparently last night in this context, that it was a Liberal Party member who did in fact bring about the action——?——W. That is correct. Whether it was 1970, 1971 or 1972 I do not know. I honestly do not care.

2910. You do not know that in fact he made representations at all; you were only told?——W. Yes.

2911. Mr MACDIARMID: In your 25 years service in the police force, did you consider yourself an efficient member of the force?——W. Yes.

2912. Can we assume that over your period of service you may have clashed with your superiors over policy?——W. Yes; over interpretation of policy, yes.

2913. As a member of the drug squad during your career in the New South Wales Police Force, are you suggesting in your submission that you were not encouraged by your superiors to pursue drug pushers and/or users?——W. Yes.

2914. In your experience, is the drug squad generally efficient?——W. Yes, very. And dedicated. The fellows up here in Sydney are terrific.

2915. Is it numerically strong enough to cope with the problem?——W. Then or now?

2916. In your time?——W. I would say they were understaffed then. I do not know how they are now. I think it was about 14 men there then to cover the city.

2917. In answer to a question of the chairman you agreed that Port Kembla was a point of entry for drugs into Australia?——W. Yes.

2918. From overseas ships. What steps were taken in your time to try to stop that?——W. From memory again, I spoke to either Detective-Sergeant Astill or Detective-Sergeant Abbott, and the importation of drugs or prohibited imports or matter is not our jurisdiction. It is the Customs Department's job. So I passed it on to the fellows in narcotics and let them carry on. It was out of my jurisdiction. I would have no power to deal with it, nor the facilities.

2919. Was it part of your duties to police the South Coast area or just the near Wollongong area?——W. I was stationed at Wollongong, but one worked where the job took one.

2920. Would there have been other points of entry on the South Coast, such as boats at Ulladulla?——W. Yes.

2921. Or even the port of Eden?——W. Yes.

2922. CHAIRMAN: How far afield did you range in those days from Wollongong?——W. Down to the border.

2923. Mr McGOWAN: Do you think that you came under fire from the department for doing your job because it was embarrassing to other officers who were corrupt in the sense that they were taking money or favours from drug dealers?——W. Yes, but not restricted to drugs —I am sorry, not restricted to dealers.

2924. Could you detail the sort of corruption you are talking about? There are many styles of it?——W. Yes,

2925. Is it friendship, position in society? How do you define it?——W. Well, with your consent I will give you—I mentioned earlier when we first started at Wollongong, in the vice squad there was a Sergeant Worrell, Frank Worrell, who was a very strict Methodist in the true sense of the word. He was a very hard-sell Methodist, Frank. I worked with Sergeant Worrell with another pair of chaps named Mick Martin and George Kovaks. We had been selected out of uniform, popped into plain clothes, which is unusual, to try to put the cleaner through Wollongong, which we tried.

An SP bookmaker who was arrested quite a few times, by the name of John Darcy Comerford, came into the little vice squad office one day when I was there with Sergeant Worrell. This is the first person. He said to Sergeant Worrell, "You are in for a shock. I have been to Sydney, and you will be told to lay off." Sergeant Worrell said to this fellow Comerford, "I don't take orders from you. Piss off out of the office."

The following Saturday, if my memory is correct, we raided Mr Comerford's establishment at Bellambi and arrested him and a number of others. Sergeant Worrell gave the evidence of the arrest at the court on the Monday morning and his words were, as far as I can recall: "At about such-and-such a time on such-and-such a Saturday, in company with other police I visited premises off Bellambi Lane at Bellambi where I saw the defendant, Mr Comerford, who said to me, 'I did not expect to see you here, sergeant,'" and Sergeant Worrell said. "No, I do not suppose you did, after telling me you had been to Sydney, to stay away from the place." Ten days later Sergeant Worrell was back in uniform. That is one incident.

For a little while I was in charge of the vice squad and a Sergeant Lehman was the officer in charge. We proceeded to carry on as best we could. Then Sergeant Lehman became promoted and again it dropped back to me as the vice squad chap. We eventually wore them down. I think there were thirty-three betting shops at Wollongong when we started and we ended up with nil—open betting shops; we could not do much about the telephone fellows.

Then a Superintendent Newman came down relieving one day and asked me how many betting shops were in Wollongong. I said, "None, sir." I did not know him; he was a superintendent. He said, "Do not tell me lies. How many betting shops are there?" I said, "With respect, sir, you have asked me a straight question. I have given you a straight answer. I do not appreciate being called a liar. I do not see much point in pursuing this conversation. You can check with Ken Manning, the superintendent's clerk. He is a lay preacher with the Methodist church and perhaps his word would be better than mine." I left him at that.

Then some time later the vice squad at Wollongong was disbanded and replaced with what they call the 21 division. Sergeant Prosser was brought in to head that up and they carried on for a while, but they came to grief, too. As a matter of fact, that is the incident Mr Ramsay referred to at the Tiki massage parlour. This is the superintendent that was going to destroy me who was subsequently destroyed through that.

2926. CHAIRMAN: When you say he was destroyed do you mean departmentally?——W. Yes.

2927. He was not forced out of the force over any revelations there though, was he?——W. No. I think he went out medically unfit. Prosser was charged.

2928. Mr McGOWAN: Is medically unfit a euphemism for being got rid of?——W. You could interpret it that way.

2929. Did you yourself ever come across or hear of the process of planting of drugs on people in order to gain convictions to keep up the level of arrests while letting the true criminals go?——W. I have heard it and I have read about it, but I have not experienced it.

2930. Mr RAMSAY: In view of the question asked by Mr Jackett, a member of the committee, in regard to the member of Parliament, would you now name the member of parliament who, you were told, had made a report to the Police Commissioner?——W. Mr Jack Hough.

2931. Mrs ANDERSON: How long were you stationed in Wollongong altogether?——W. Thirteen years.

2932. Where were you before that?——W. A little place called Yanco, out in the Riverina—a one-man police station.

2933. You did not have any experience in the drug traffic in Yanco, did you?——W. They don't have much experience at Yanco at all. It is only a little place.

2934. Mr JACKETT: What was the date on which you left the police force?——W. Somewhere about the middle of June—I think it was 1973.

2935. How long was that after that meeting at Fairy Meadow?——W. Years later. This meeting at Fairy Meadow, with respect, was a little flash in the pan. It was nothing.

2936. But you claim that as a result of it you were carpeted by your superintendent at the request of the Police Commissioner?——W. Yes.

2937. As a police officer who would obviously have been trained to use his memory, can you not recall when you were carpeted on that occasion at the request of the Police Commissioner?——W. No. If I may—through you, Mr Chairman—I carried out my duties which included a lot of guest speakers from round the Wollongong area, to service clubs, parents and citizens meetings, right down the coast as far as Bega and to try—I am not trying to evade or avoid your question but to try and pinpoint one little meeting—I just can't do it, I am sorry.

2938. In this particular case I am not asking you to recall the meeting. What I am asking you to recall is the date or the time when you were carpeted by your superintendent because the Police Commissioner had been in touch with him?——W. I can't.

2939. Mr MACDIARMID: Getting back to the discotheques in Wollongong that you mentioned, you claim you found it very difficult to be able to do anything about the drug problem, if in fact it was there?——W. Yes.

2940. Do you really feel that enough energy was directed to track it down in those cases?——W. I was having considerable trouble down there with a young Greek fellow whose name is about that long (*indicating*) and I can't remember it, who was selling LSD, quite a considerable quantity, in Wollongong. I saw Inspector Lehman, the Officer-in-Charge, about it. Luckily, I used to be his offsider. I got permission to contact the drug squad in Sydney to send down what we call their dog squad. I do not know if you have seen them or met them or know about them but they are unorthodox-looking fellows, with long hair and beads—they fit into the usual street scene. The dog squad—that is normal language. I am not trying to be facetious to you.

2941. I was not aware of the name.——W. That is the terminology that we use—the dog squad—which was forthcoming. They came down. I borrowed legitimately a beat-up old panel van and we stuck that in the main street with a young fellow whom I had arrested at his home with his parents. They were good, clean living, church going people. The day I arrested him his mother and father were about to go to church. The father was a deacon and the mother was the organist. This kid had been supplying LSD that he had obtained from this Greek. I buckled this kid in front of his parents and he produced the stuff out of the pocket of his dressing gown in front of mum and dad and sort of knocked things around a bit on Sunday morning. I just want to get to your question about the observation people, the dog squad. They came alongside and they offered their boy to help catch this chap that had been bringing the stuff down. We sat him up in the back of the panel van. I had got a loan from the department of a big pack sack radio, a portable radio. The observation people—I will call them that, it sounds nicer —were equipped with little portable transistor two-way radios and they were dispersed around the street, shop doorways, etc. We sat there until this young fellow arrived on the scene, the Greek, and we observed and we reported to the units that this chap had arrived on the scene, to keep an eye out for him. The only thing that we could describe that would mark him out from the others was that he had these Adidas striped boots—football boots with the stripes down the side. Otherwise he was just a young chap with a "T" shirt, jeans and long black hair. That is the only description we had of him. So we kept this fellow under observation, saw him make what appeared to be sales of something—there was something changed hands and money changed hands—so each time that a transaction was observed, one of the observation team was detailed off to follow that fellow to arrest him away from the apparent seller, until we got sufficient to support a charge of supply, and still——

2942. CHAIRMAN: This would be normal police work?——W. Right.

2943. It would be done every week of the year?——W. Except at Wollongong.

2944. This was the only time they came there while you were there?——W. Yes. On the Monday morning I was again in the superintendent's office being carpeted for bringing the dog squad into Wollongong. Nothing was said about getting the pedlar; nothing was said about cleaning up the street. All I got was standing to attention in front of the superintendent and being roasted about lack of courtesy, lack of spirit, lack of honour; lack of every blooming thing except intestinal fortitude for doing this, bringing the dogs in. The main crime was, and I had to admit it, that I had not conferred with the superintendent. Then I woke up—the inspector had not told him. So I was ordered to stay within the precincts of the station; he was going to contact Sydney and have me departmentally charged for bringing these fellows into his area. I had to get on to Detective-Sergeant Abbott. He in turn got on to the superintendent of the CIB, Detective something or other—with goldie coloured hair. With your permission, might I ask another police officer behind if he can help in this matter. It was Mr Lendrum. He had to get in touch with Mr Lendrum and pass it back to the superintendent that I had done all I could to lay off. All I was doing was trying to do my job—nothing wrong with that.

2945. Mr MACDIARMID: You are suggesting you were carpeted for doing what you considered to be your job? ——W. Yes. I was being carpeted in front of the superintendent not for plucking this fellow, not for arresting this fellow, but for not trying to find the superintendent and tell him I was going to bring these fellows in to do it. It gets back to what Mr Ramsay said; the last thing he wanted in was the under cover blokes because he had this connection going with the Tiki massage parlour where the bloke was murdered. It is just not good working conditions. I appreciate that, as you said, Mr Chairman, I may have an axe to grind. I do not have an axe to grind. I am telling you and your committee the truth. I wouldn't care if these blokes weren't here. They are of no consequence to me. You asked me what was going on down there and I am trying to tell you without getting upset or swearing.

2946. CHAIRMAN: You have suggested at least twice that approaches were made by apparently fairly powerful fellows in Wollongong to Sydney to have certain action taken in regard to SP betting?——W. Yes.

2947. Do you know whether similar approaches were made in regard to people in the drug scene?——W. I do not know. That is honest. I would be the last bloke to find out, except when it happened.

2948. Yes, but you knew about what had happened in regard to SP betting?——W. Yes.

2949. You never had a similar experience in regard to drugs?——W. The only reason I found out was Cummings was stupid enough to tell us what was going to happen and it happened.

2950. Before we conclude this sitting, is there anything else that you feel that we may have missed and that you would like to put before the committee?——W. No, just that I hope that in perhaps some small way I may have helped you and your fellow committee members to try and understand just what was going on down there and perhaps what Ebrill and Kenny Watts and them may have encountered if this committee had not been formed, because you just can't beat the system, sir—no way—and if you can't lick them, join them.

(The witness withdrew.)

(The Committee adjourned.)

*AT SYDNEY ON TUESDAY, 21 JUNE, 1977*

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The Committee met at 4 p.m.

Present:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| The Hon. Kathleen Anderson | Mr J. G. T. Jackett |
| The Hon. Margaret Davis | Mr B. McGowan, B.A. |
| The Hon. C. Healey | Mr E. D. Ramsay |
| | Mr R. C. A. Wotton |

Doctor LESLIE OSBORN DARCY, Medical Superintendent, Morisset Mental Hospital, sworn and examined:

2951. CHAIRMAN: Dr Darcy, you have received a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. Yes.

2952. I understand that you wish to give some evidence in addition to the evidence that you gave at Newcastle on 4th May?——W. Yes.

2953. Since that time you have addressed two letters to the secretary of this Committee, one dated 9th June, 1977, and the other dated 14th June, 1977. Would you like to have those letters included as part of your evidence before the Committee?——W. Yes. The letter of 9th June, 1977, reads as follows:

PROPOSAL WHICH MAY ELIMINATE ANALGESIC NEPHROPATHY

1. There seems to be to be overwhelming evidence to suggest that analgesic nephropathy is linked with the taking of compounds containing aspirin, phenacetin, paracetamol or salacylamide and caffeine, rather than single analgesics.

2. These compounds are almost always obtained by the taker on his own initiative rather than at the direction of his medical adviser.

3. The taker is convinced that the compound will make him feel better in one way or another and the habit is so strong that he really must be receiving positive reinforcement for it to persist.

4. It is my opinion and I believe there is evidence to support it, that there is a high correlation between compound analgesic taking, smoking and alcohol over-usage. It seems to me that this might be based on a genetic predisposition acting through a psychological makeup including a dependency on soothing.

5. Because of this, I suspect that the major factor in the continued taking of compound analgesics is the caffeine component which would satisfy the psychological need for soothing or lifting the mood.

6. In other words, the person is taking the caffeine by habit and the two analgesics which go along with it are of little importance to him.

7. My proposal is that the use of caffeine in compound analgesics or substitution of it by any other stimulant be immediately prohibited, but that no regulations at all be introduced to ban the use of compound analgesics.

8. It is my belief that the absence of caffeine in the compound analgesic would result in the loss of positive reinforcement and the habit of taking the compounds would very quickly be extinguished in the taker, with the result that the sale of compound analgesics would plummet to negligible amounts.

9. In my opinion, even if the money spent on advertising were doubled, it would not prevent the decline in use.

10. Doctors would not be restricted in any way from prescribing either single or compound analgesics and the pharmaceutical firms could not argue that unsubstantiated damaging claims were being made against their analgesic products.

11. Because of the drop in usage of the compound analgesics, analgesic nephropathy could well drop progressively in incidence and perhaps eventually disappear.

L. DARCY,
Medical Superintendent.
9th June, 1977.

The second letter, which is dated 14th June, 1977, states:

COMMENTS ON QUESTIONS RAISED BY RECENT DRUGS COMMITTEE SITTING AT NEWCASTLE

1. Compound versus Single Analgesics

I don't think the fact that the powders are compound analgesics matters at all. In my opinion, if the caffeine was left in the same dose as it is now in APC powders and either one of the analgesics alone was combined with it in double the normal dose, the takers would end up with exactly the same incidence of renal damage. The vital combination is:

(1) the presence of caffeine,

(2) the presence of an analgesic damaging to the kidney and

(3) a genetically susceptible person.

2. Brand Loyalty

This, in my opinion, comes about in the following way. The person has some discomfort and has a personality (probably genetically influenced) which makes him seek soothing. He takes one type of powder and because of the caffeine in it, feels better soon after taking it. This favourable effect of the response facilitates the taking of another of the same powder when he next feels discomfort and seeks soothing. Once this stimulus-response pattern is set up with that brand of powder, the needs of the person are met, that is, there is an effective way of feeling better readily available when he wishes to use it. There is no incentive to change to another brand and in fact, a disincentive to change as there is no experience with the new brand so there is always the doubt that it could be even as effective as the first brand. To change, he would have to give up an effective established habit for a mere possibility of gain and people usually don't do this.

3. Danger of Addictive Substances

The fact that a substance such as caffeine is addictive does not ensure that a person who uses it will become addicted to it. The people who become addicted to addictive substances are different or special people. Almost all of us have had narcotic analgesics as premedication for an operation and some people have had quite large doses of and prolonged treatment with narcotics due to war injuries, post operatively or in painful illnesses, with no addiction at all developing.

Those who become addicted are using the drug because it soothes them and makes them feel better and their particular psychological makeup places a high value on this. A stimulus-response pattern of behaviour quickly becomes established in these people and it is very difficult for them to break the cycle on their own resources.

4. Restriction to Prescription Only

I have no doubt that if compound analgesics were to be restricted to prescription only the use of them would fall. At the same time, there would probably be great pressure from some people on doctors to prescribe them, just as there is at present for valium. It would seem much simpler and more direct to merely prohibit the use of caffeine or any similar stimulant in conjunction with any analgesic, simple or compound.

5. The Complaint of Headache

An interesting point is that "pain" or "ache" is a subjective complaint and may be describing different sensations in different people. It is not at all certain that an analgesic is the rational treatment of the sensation the person feels. Sometimes the sensation is really a tension in muscles which would not be described as pain by other people. Perhaps merely lying down for a half an hour to relax or even sitting down to a cup of tea and a few biscuits would be very effective in alleviating the condition.

Most psychiatrists and many general practitioners know that people who are depressed feel many sensations as pain but these complaints vanish when the patient is given antidepressant tablets for a period.

L. DARCY,
Medical Superintendent.

2954. CHAIRMAN: Have you any further comment to make?——W. Yes. I was given the transcript of the session of this Committee that was held in Newcastle, and I read on past the evidence that I had given. I became quite interested in what some of the others had to say about analgesics, and I felt that I could not agree with some of the approaches that they made. Therefore, I felt that I should like to comment, and to give some of my own ideas. That is why I expressed my thoughts in the two letters that have already been referred to. I understand that you have had an opportunity to look at those letters. I was interested particularly in how it might be approached, so that the least number of people could be disturbed, and yet we could perhaps cut down on the damage occurring to people, particularly in regard to analgesic nephropathy.

It seems to me that the reason why people take APC powders, and keep on taking them, is because of the caffeine in them. The caffeine is a stimulant, and it makes people feel better. I felt that I could not agree that there was very much difference between taking single analgesics or compound analgesics. People suffer damage to their kidneys with compound analgesics, which are easy to get; however, if a combination of aspirin and caffeine or a combination of phenacetin and caffeine were available, and packaged attractively and advertised, people would probably start taking those, and they would have exactly the same problems. They would become dependent upon the caffeine in them, and they would continue taking them indefinitely whenever they felt they needed a lift, or wanted something to relieve a headache or some other discomfort. If we want to try to cut down on the damage that the analgesics are doing to the kidneys, and to a lesser extent to the stomach and other organs, the most direct approach, which could hardly be argued against by any chemical company, would be to remove the caffeine. Then, like all learning, the habit the people develop by taking something and keep on taking it, would be extinguished by not getting the effect or the lift that they get from the APC powders. To ban caffeine, or to make it impossible for people to combine it or other substances in damaging analgesics, could hardly be argued against by the chemical companies, because they claim they are marketing an analgesic.

We know that many people are given multiple analgesics by doctors, but they do not become dependent upon them. As Dr Duggan pointed out in his evidence, it is hard to get people with rheumatoid arthritis or some other disease to continue taking analgesics in a sufficient dose to get the anti-inflammatory effect that is required. I believe that doctors would resist being restricted in their ability to prescribe what they wanted to, and some would want to prescribe combined analgesics or would be asked by their patients to prescribe combined analgesics. If there is no caffeine in these combined analgesics, or if the doctor is able to prescribe them, feeling confident that the person concerned will not become dependent and it will not go on to damage kidneys or stomach, I do not believe that, even though evidence has always been presented that the combined analgesics do the harm, there is any difference between combined analgesics and single analgesics, except that the combined ones are commonly combined with caffeine.

If you put some caffeine with aspirin alone, and put double the dose of aspirin so that it equated with the aspirin plus phenacetin, or aspirin plus paracetamol, and combined them with the same dose of caffeine—about 100 milligrams or something like that—you would find they would get much the same kind of necrosis as they were getting with aspirin and phenacetin combined.

Have you any evidence, apart from the feeling that that would happen? Have you carried out any experiments to fortify the opinion that you have expressed?——W. No, but in the psychological theory of learning, when you combine a good result with something you do, you tend to do that thing again. You quickly learn to do the action over and over again, to get the given effect. When you take away the reward, the behaviour is extinguished. When you take away the reward, what you learn is extinguished. It does not mean that you are the same person you were before you started to learn, because if you put another dose of caffeine in with the powders you would immediately re-learn all you had learned before, and you would re-commence the behaviour once again. But I think that, if you were to take the caffeine out of the powders, you would find that the drive to take the powders would be extinguished.

2955. In other words, if there is any dependence in the APC powders, it comes from the caffeine?——W. Yes.

2956. You are talking of physical dependence?——W. It is psychological dependence. You hardly ever see physical dependence with the people who are taking heroin, for

instance. You see it almost invariably with alcoholics and people depending on barbiturates, but you do not see it commonly with people taking heroin, because they usually do not take enough and regularly enough to develop physiological dependence. We do not see them having withdrawal symptoms, except on rare occasions. Some do, but not many.

2957. Mr RAMSAY: Some time ago we had a man who gave evidence in regard to drug-taking in gaols. Would you know if this is prevalent? He said that somewhere about 75 per cent of people in institutions like gaols were taking drugs. Would you know about this? ——W. I am not familiar with the gaols in general. I am a little familiar with Cessnock corrective centre. It is my opinion that it does not go on at Cessnock. But I have heard Professor Yap of Hong Kong speaking here to a meeting of the Australian and New Zealand College of Psychiatrists. He said that he had a closed situation in Hong Kong, and that they have a terrible job keeping the drugs out of that situation; he said that they managed that to a great degree. We ran a closed unit at Morisset hospital behind a high brick wall, but still some people got some drugs occasionally to the patients in the closed unit there. That is another thing in which you might be interested. We did run this closed unit at Morrisset hospital. Patients came as voluntary patients; others were inebriates with heroin dependence, and there were others who had been given the alternative of going to gaol because of their heroin use or possession or coming to us for a period of some months. The unit went quite well for some time, until they became very mischievous to the staff. That happens with most units with young people on the staff, for they start to identify with the patients, and feel that the patients have as many controls as the staff, and they take them to do many tasks around the hospital. It became too haphazard, and we had to close it.

2958. Ward 22 at Morisset hospital is unused. That is where we ran it before, behind the wall. The other ward is used for maximum security patients. I do not know the Government's view, but if ever the problem became big, and the gaols did not want to cope with these people, an alternative way of managing heroin-dependent people would be to have them volunteer to come into our closed situation. It would have to be kept closed. They would have to come in as voluntary patients for three months. That is similar to situations in other parts of the world, such as at Hong Kong, where Dr Singer was involved. If they wanted to leave, they would have to give seven days' notice, the same as an ordinary voluntary patient, and we could let them go. But there would be the proviso that they could not come back in for another month. They could re-admit themselves if they wanted to. There is a 24-bed unit, which could be valuable for looking after any drug-dependent people on a voluntary basis, but still a completely closed unit where they were kept away from their associates completely, and where they could build up their health.

2959. How long do you keep them, in these circumstances, for success?——W. Dr Singer says six months but I think three months would be of tremendous help to them. It would build up their health, get rid of any hepatatis that they might have, help their livers and build up their nutrition. It would put the minds of their parents at rest, knowing that they were well cared for. They would have an opportunity to build up a relationship with a stable staff. They would be able to get into a work habit. But, they would not be able to have leave to visit relatives or friends for three months. At a later stage, or if they got into trouble with the police, they could re-admit themselves if necessary.

2960. Mrs ANDERSON: Would you allow them visitors?——W. We allowed visitors on Saturdays, Sundays and public holidays on the same basis as for the maximum security patients but they are devils and visitors will bring in things such as postage stamps with LSD on the back of them. They try to conceal drugs and bring them in. I think it is too risky to have visitors and I do not think it is any great sacrifice for them to be without visitors for three months. Many of these people do not see their parents for periods of three months when they are in gaol or even out of gaol.

2961. CHAIRMAN: What about parents? Would you allow them to visit?——W. Yes, we recognize that parents would be likely to have an interest, but their friends are too unreliable.

2962. Mr RAMSAY: Are they really friends?——W. They have said so.

2963. Mr HEALEY: In the first paragraph of your first submission you say that there seems to be overwhelming evidence to suggest that analgesic nephropathy is linked with the taking of compounds containing aspirin, phenacetin, paracetamol or salacylamide and caffeine, rather than single analgesics, but in the first paragraph of your second statement you say that you do not think the fact that the powders are compound analgesics matters at all. Have you any comment on that?——W. The only way you can get caffeine is with compound analgesics without a doctor prescribing them, so they are really taking caffeine all the time and the compound analgesics are going along with it and damaging their kidneys. If they could get caffeine plus aspirin they would be doing exactly the same and taking caffeine all the time and the aspirin would be going along with it, damaging the kidneys. If you take the caffeine away, I think they would stop taking them altogether. The people who take an aspro occasionally would not have a box of APC powders because there would be no caffeine in them. Am I putting it clearly enough? Does it make sense to you?

2964. No. In your submission you say, "I don't think the fact that the powders are compound analgesics matters at all."——W. Yes. If powders were called APC powders but you took out the paracetamol and had aspirin with the caffeine and you were really taking a single analgesic, you would still get the same amount of kidney damage at the end of 20 years. The reason you get the damage now is that people keep on taking powders because of the caffeine and the only way they can get it is with compound analgesics. The compound analgesic is doing the damage but not because it is a compound analgesic but because it happens to be the thing that goes with caffeine. If there was only aspirin and caffeine and they took it there would still be the same amount of damage to the stomach and kidneys.

2965. CHAIRMAN: Anybody who is a prolific tea or coffee drinker should not be urged to take APCs because they get caffeine from those beverages?——W. Yes. People take these things because they have a beneficial effect. Some people think they will get a headache if they do not take an APC powder. Most of us get pleasure, relief or relaxation by just drinking a cup of coffee or cup of tea. We all seem to do it. Most of us do not have to go further and take APC powders. But, it is a special type of person who is genetically susceptible and that person seeks soothing much more than you or I do.

2966. It has been suggested to us by eminent medical people that it is not the aspirin alone that does the damage but it is the aspirin in combination with another chemical and the interaction of the chemical causes the damage to the kidney?——W. I do not believe that. I think aspirin

is an irritant to the kidney tissue, as it is an irritant to the stomach tissue, and it will do damage on its own. It is doing damage now because it is combined with caffeine. That is what makes people have more and more of it. It would be sufficient on its own if people took it in large amounts.

2967. Mr JACKETT: Are there any kinds of headaches or pains which you know of which can be helped by caffeine in a compound?——W. As I mentioned before, the thing that people call pain and a headache is different in different people. You and I might say we do not feel too good today, but we would not describe it as a pain. Another person might say, I have a pain, though they feel the same as we do. To them, they notice things much more and they would want to get rid of it and they would not tolerate it for any longer than they had to. They would have to have an aspirin to help them out. So, they take an aspirin. Some people get to the stage where they get up in the morning without a headache but they take something to ward off a headache that they might get in a few hours.

2968. Does caffeine itself assist in the elimination of any pain?——W. Yes, it lifts the mood. When our mood lifts and we feel better we can afford to disregard discomfort. Take depressed people. As a psychiatrist, the depressed persons come along and see the doctor and say they are not eating and they are not sleeping and that they have no interest and have pains here and there and cannot get comfortable. The doctor starts treating them for depression and their mood lifts and as their depression goes away they do not mention the pains any more. They do not notice them. They might feel sensations but they do not complain. They might feel pain but they do not have to do anything about it.

2969. If the use of caffeine were banned would there be any kind of pain which people could legitimately claim they could not get caffeine to relieve?——W. One of the ladies who gave evidence to Dr Duggan was asked did she still have headaches and she said she did. He asked what she did about them and she said she just put up with them. She tolerates them with the support of a group of people who see her regularly. She knows that they are on her side and they help to give her the dialysis and that sort of thing. She probably does not have what you and I call a headache. She has an uneasy discomfort which she says is a headache and she tolerates it. She goes without caffeine and she puts up with it because she has the support of the people about her.

2970. What about the large number of people who get some kind of help from caffeine, if it is completely withdrawn?——W. They are probably getting help from an analgesic and they would ask the doctor for something for the pain and he would give them an aspirin or an analgesic and he and the patient will soon realize that what they are complaining of might not be a pain that can be cured by an analgesic but might be a need that has to be met in some other way, perhaps by comfort or understanding or by relieving stresses at home. That sort of thing might help them to get to the real problem and the doctor or the psychiatrist or the social worker can help.

2971. Mr JACKETT: With regard to aspirin or phenacetin or paracetamol, do they have any addictive contents?——W. Not that I know of. It is hard to get people to take them in sufficient dosage at times because they are irritants. I do not think they are addictive in any way at all.

2972. You say you propose the use of caffeine in compound analgesics or substitution of it by any other stimulant be immediately prohibited. What other stimulants would you combine in that as being other stimulants?——W. I would not let them have codeine and I would not let them have ritalin or any other mood lifting substance. I would not let them use anything that tends to be addictive.

2973. Would that be easily determined?——Yes, I think so.

2974. How many other pharmaceutical substances would be involved?——W. I cannot think of any, readily. You can use ritalin only for special purposes so the only one I know of is codeine. Doctors use codeine with combined analgesics but I think that should be stopped, too. Even though it has a pain-killing effect it does have a tendency to make people depend upon it. It would not matter much. Compared with caffeine and some of the other stimulants it is only minor.

2975. But there would be a lot of stimulants? They are not limited to two or three?——W. Amphetamines have been banned. That was a wonderful boon. We never see amphetamine-addicted people, now. We see a few people who get into trouble with weight-reducing tablets, but that is all.

2976. So you do not see a great deal of difficulty in carrying out that suggestion of yours in paragraph 7?——W. No, and I do not think it would cost the manufacturers anything in their manufacturing process. They can still call their tablets APCs and they can put chalk or calcium carbonate in as an excipient to keep the same weight, instead of using caffeine. If they take caffeine out probably it might alter the manufacturing techniques and they might have to put some powder in as compensation. Also, there might have to be compensation paid to them by the Government for the material they have in stock.

2977. Mrs DAVIS: We know that there are certain people who are addicted to powders because of the caffeine in them. Do you honestly believe that they would just give them up and not want to go on to something else and do you not think that this will turn a lot of them to drink or sleeping pills or something like that?——W. I do not really think so. I think they will complain and I think they will see their doctor and ask him what to do about it but I do not think they will turn to drink. There is not very much else they can turn to, except valium, which is the universal soother at the moment. I think it will direct people to their doctor and the doctor is in the position to offer supportive help. Also, there are community supportive help teams of social workers. It would be a good thing in directing people's attention towards their real problems.

2978. Mr WOTTON: I was interested in what you said about this unit at Morisset. This morning we heard of people going through withdrawal symptoms being put into a cab and taken from hospital to hospital, looking for a bed. There seems to be no place for treating these people. Would it be possible for you to do a costing exercise to give to this Committee to let it have a close look at the cost of what you have given us? What you have said appeals to me as being the sort of place we might be looking for that can be put into operation to fulfil a very definite need at perhaps not a great deal of cost. We would want to know the staff required to run it and so on. I think there is a lot of merit in it?——W. It would be useful but I could not undertake to do it. You can get the answer by asking the Health Commission how much it cost to run it when it was doing so. We still offer voluntary admission at Morisset hospital to addicts. Any of the heroin-dependent people in the whole of the north eastern part of the State can come there. In fact, we have accepted many people from Sydney at our hospital but they do

not stay for any length of time, unfortunately. That is the point. Anyone coming there must undertake to be in hospital for three months. After a week they might say that they are not interested further and they have to give one week's notice during which time they might change their mind. If they do go out they are out for at least a month. It is only a twenty-four bed unit and we do not want people jumping in and out of it, such as at Wisteria House.

2979. We have a mammoth problem in society. Is not it time that these people involved in it were told what they had to do rather than them have the opportunity to volunteer to have this sort of treatment? I think we are still pussy-footing around. If we have this problem we must accept it and clean it up.——W. If it is compulsory admission we could not discharge them if they broke out and did something wrong. There are maximum security patients there, too. We closed it up before because they were so mischievous and we had them in with these other people. We had to have the right to put them out if they tried to break through a wall or something of that nature. We never did have it so that we had the right to keep them there. They had the right to elect to go there instead of to gaol but if they did some damage to anybody else we could say to them, "Sorry but you must go and we will tell the court and the magistrate can do as he wishes." We had a way out and we could get rid of them. If that sort of fellow did not do the right thing the court would have the right to put him in gaol. I think gaols do have controls which are quite valuable for some of these people.

2980. CHAIRMAN: Previous evidence suggested to us that only 20 per cent of people in Australia who suffer renal failure can attribute it to analgesic toxicity. Have you any idea of what would be the cause of the other 80 per cent?——W. Yes, infection would be the greatest cause by far. It is an extremely common disorder. Most women have had it at some stage or other and it is not uncommon in men. It is a tremendous cause of hypertension, high blood pressure and renal failure. High blood pressure does cause damage to kidneys, secondarily, and high blood pressure can cause kidneys to be damaged through renal failure. The sort of damage we call papillary necrosis is only caused by analgesic nephropathy.

2981. I am only talking about general effects?——W. Kidney infection and hypertension would be the commonest. A few rare ones are due to renal abnormalities such as double kidneys, and so on.

2982. Thank you for the further evidence you have given us today, Dr Darcy.

(The witness withdrew)

(The Committee adjourned)

*AT SYDNEY ON THURSDAY, 30 JUNE, 1977*

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(The Committee met at 10 a.m.)

Present:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| The Hon. MARGARET DAVIS | Mr J. G. T. JACKETT |
| The Hon. C. HEALEY | Mr B. McGOWAN, B.A. |
| | Mr E. D. RAMSAY |
| | Mr R. C. A. WOTTON |

GORDON LANCE GATELY, residing at 51 Sirus Street, Hyam's Beach, unemployed, and

LEONARD VICTOR MUIR, residing at 58 Burrill Street, Bomaderry, ambulance officer, with the Illawarra Regional Health Commission, sworn and examined:

2983. CHAIRMAN: Have you gentlemen received a summons under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. (*Mr Gately*) Yes. (*Mr Muir*) Yes.

2984. Mr Gately, I understand that you have volunteered to come before this Committee in order to give your experiences and also to point out some of the lessons that you feel are to be learned from your own experiences and the experiences you have had with other young people. I think at this stage it would be appropriate if you were to go ahead and tell us in your own words what you want to tell us?——W. (*Mr Gately*) I can give you a basic rundown on my past. At 14 years of age at Bankstown boys high I was involved in a situation where there was a peer group in that particular school that was involved in drugs. One of the drugs being consumed was a drug by the name of Romola, which is a morphine-based cough suppressant. These are readily available in the school because they can be purchased easily over the counter of a chemist. This is going back to 1964. I took that drug because I liked the narcotic effect. There were many other drugs available at the school at the time—the hallucinogenics, the amphetamines, the barbiturates. These were all being dispensed in and around the school. Most of them were being legally obtained on medical prescriptions. They were not an illicit drug at all.

I proceeded to take these cough-depressant tablets for 12 months not realizing that they were an addictive substance. I got to the stage where, if I did not take the tablets prior to going to school, I became physically ill; so I continued to do so. Things progressed, and I am a firm believer that drug addiction is an illness and that the progress of the disease is just something that is drug addiction itself. I believe it is a disease and one suffers personally from it.

At that time Romola was taken off the free list through therapeutic goods and whatever. You could not purchase it over the counter. It became a restrictive substance. At that time I was physically addicted. I needed it just to get to school. At the same time things had developed to a stage where kids were starting to do break and enters on chemists, and morphine sulphate itself was starting to be distributed through the school.

It was four days after my fifteenth birthday that I started to use morphine sulphate by intravenous injection and from there on, until two years ago, I was heavily involved in narcotic use and the sale of it. I used to sell it myself. I assume that you have already been informed about the actual disease of drug addiction and what a drug addict will do to obtain the drug. There are the stories of hospitalization, psychiatric institutions, the help that I tried to get from Health Commission resources, but none really proved successful until I came across a man by the name of David Gordon. That was approximately four years ago. That man provided me with an avenue to recover. I have not carried a physical addiction now for two years.

I am not one to be able to relate very much on what I have got up to as a drug addict. Most people in this room would have an idea. If someone wants to know something, I would prefer him to just ask. I could spend hours going through what I went through as a drug addict, but that is something most people would know anyway.

2984A. Tell us more about the last four years?——W. I ended up in Gladesville Psychiatric hospital approximately four years ago. I was put on a methadone block aid programme, and that is the worst physical addiction I have ever carried. It is 180 mg of methadone a day. This is when I came in contact with a doctor by the name of David Smith, a psychiatrist at Gladesville hospital at the time. He in turn was connected with David Gordon. When the time came to reduce the methadone dosage I physically could not handle it. No hospital in Sydney would accept me trying to carry out a physical withdrawal from such a large dosage.

David Gordon at that time had a home in Warren Road, Marrickville. He accepted me into that home and he, as a layman, with other recovered drug addicts, succeeded in withdrawing me from that dosage of methadone, without any great physical problems and without any great stress on my own behalf. It has been the easiest physical withdrawal I have ever undertaken from a narcotic, and it was in a private home with laymen, not in a hospital.

There was no clinical type of environment, just moderate use of sedatives and a lot of support from other recovered addicts. That has just been a progression in itself for four years. It took me nine years to get to that point where I ended up seeking the help of David Gordon, and it took me two years to stop all drug-taking. I went through the normal relapse situation for over two years but I have not carried a physical addiction since.

At no time did any government organization ever offer me that type of help, and I could never get it in any psychiatric hospital or from any Health Commission referral service. I found that help from just a man and other recovered addicts.

2985. Very strong physical symptoms are normally associated with withdrawal?——W. Yes.

2986. You say that this was the easiest withdrawal you have had?——W. Yes.

2987. To what would you attribute the fact that it was so easy?——W. The strongest drug present for the physical withdrawal was other people—constant 24-hour support for five days—and mild sedatives. I have here a list of the sedatives used, how they are prescribed and what the dosages are over a period of five days. Today I am doing the same thing myself.

2988. Would you tell us what you would do if somebody who came along to you was in the same condition as you were in?——W. We have a medical officer whose name is Dr Mike Flynn; he is a lieutenant commander with the Royal Australian Navy Air Arm at Albatross Air Base. He has a look at the person to see if he is suffering from any renal, liver or bowel problems—a twisted bowel or anything like that—before any medical treatment is started. If any such problem is detected we ask the Shoalhaven Hospital to supervize the initial withdrawal. If that hospital will not accept the person we bring him up to the Booth Clinic or the Langton Clinic in Sydney, but we try to remove him from that environment within four or five days and bring him back to our own live-in accommodation on the shores of Jervis Bay. If the person has no true physical problems that can be detected, the doctor prescribes the necessary medication and I accept the responsibility for distributing it at the prescribed times. We have undertaken twenty-one of these withdrawals on the premises and I have not yet had one problem. Twelve of those twenty-one people are today maintaining a totally drug-free life. Seven are in residence with me at the moment.

2989. Over what period?——W. Five days for heroin.

2990. No; over what period have the twenty-one people you mention been withdrawn? How long have you been operating?——W. Since 22nd April, 1977.

2991. Could you give us a little more detail about the past two years?——W. The past two years have been a period in which I found myself having to use a philosophy to maintain the sobriety to which I have referred. That philosophy is based on Alcoholics Anonymous and in turn I think Narcotics Anonymous. That is a philosophy of honesty and openness—things like that. If I apply for a job today and I am quite honest with the person who wants to employ me and tell them I am a drug addict but I do not use the drug today. I firmly believe I will be a drug addict for the rest of my life but I do not have to use the drug. I cannot obtain employment. It is practically impossible although I have good skills in the fields of electrical engineering and electric motor control gear. While I was a practising narcotic addict I always worked but today I cannot get a job, simply because people do not want to accept the fact that I can say I am a heroin addict but I do not use heroin any more. I tell them this and they check everything and are full of reservations; they do not want to know me. Len Muir has done a lot of work in the Shoalhaven Shire and we have created a situation today that has never existed anywhere else in Australia. We have taken the problem of addiction to the people, talked to them about it, tried to explain all the repercussions of it, the physical effects of the drug, what sort of person is likely to become a drug addict. We have tried to get the members of the community to accept their own problem and attack the problem themselves, rather than rely on the Health Commission or the Salvation Army and similar groups.

2992. How are you doing this—through public lectures or attending public meetings held by other people?——W. Len Muir would be the man to answer that.

2993. Mr Muir, it might be appropriate at this stage for you to tell us of your involvement in this scene?——W. Basically I became involved because I am an alcoholic. I am a member of Alcoholics Anonymous. I first got drunk at fourteen years of age but I never really started drinking until sixteen. I progressed. By the time I was eighteen I was in trouble. I was dependent. I got into bits of scrapes along the line—motor cars rolled over and things like that—it was not very pleasant. That continued until I got married. Why anyone would want to marry me at that stage, I would not know. I first heard about Alcoholics Anonymous when I was twenty-four. That was through a member of AA. At that stage I did not think I was an alcoholic. I felt sure that I had a drink problem and that a lot of the problems associated with my life were related to drinking, but I could not accept the word alcoholic, which was unfortunate, because I had to go through another four years of physical problems and liver problems and severe mental strain. All that time I was worried that things were wrong and that the home life was wrong. In retrospect I see now that my wife was on the verge of a nervous breakdown when I got off it. I was having mental blackouts. These were periods in which I was fully mobile for six to eight hours at a time and next morning had absence of recollection of the period. I do not know what, but something happened and I thought back to my original contact with a member of AA and I saw this as perhaps the answer to my problem. I went to AA on my twenty-eighth birthday. I was troubled for quite some time about this alcoholic bit. By continual counselling, other members of AA put me on the right track. They suggested that it did not matter what I called myself—a problem drinker or whatever—the mere fact that I was sober and my life was coming back into proper perspective was surely the most important thing to me. I accepted that and went on to maintain my sobriety and grow up in maturity, I felt. I came to feel that I owed society something for what I had inflicted on it during my drinking days. I looked around to find something I could do. I became associated with the honorary service of the New South Wales Ambulance Board and worked at that for three years. My original application was lost. Two applications were lost, because I mentioned in them the problem relating to my alcoholism. I was told to fill in another application and leave some things out of it.

I did that, and I was accepted as an honorary bearer with the Ambulance Service. I went down to Nowra 11 or 12 years ago and joined the permanent service there. I did not tell my first boss that I was in Alcoholics Anonymous because of the type of man he was, but the first thing I did when my second boss came was to tell him that I was in Alcoholics Anonymous. All the fellows on the staff there know that I am in Alcoholics Anonymous, and all the doctors and sisters at the Shoalhaven Hospital are aware of this. The doctors send people to me.

This brings up a point in connection with Alcoholics Anonymous. Because of its traditions, it prevents the members of Alcoholics Anonymous from stimulating interest in the problem of alcoholism at a public level. That being so, I wanted to do something, for I felt that the time was ripe for something to be done. I approached the Health Commission, and Dr Diment agreed to set up the first seminar we had in Nowra in March of this year. We believed that the many helping organizations in the community did not know that the others existed, and did not know each other's role in the community. We got together representatives from the Navy—commanders from the naval bases at H.M.A.S. Albatross and Creswell—people from industry, Lifeline, the Salvation Army, the clergy, doctors, hospital staff, social workers and so on. We got as many as we could find, and 85 attended the first seminar. There was Dr Brian Willis from Wollongong, a psychiatrist, and Dr Benjamin from Kembla House, a psychiatrist. We had doctors. A member of Alcoholics Anonymous who was in the Navy. He set up people from the Department of Social Security and the Department of Youth and Community Services. There were people from all walks of life. After each two speakers, we broke them into groups, and had them talk about the speaker. They then came back with their questions.

The fantastic thing that day was that we had commanders from the Navy talking to ex-addicts and ex-alcoholics. The whole thing started to fit together from that point. We have had three other seminars, and we have worked towards setting up a crisis and rehabilitation centre in Nowra. We had absolutely no intention of going to the public. At the first seminar I met Gordon Gateley, although I think I met him years ago in Wollongong. We talked, and apparently Gordon liked what was happening, and he started to set up a house in Nowra. We had absolutely no intention of going to the public. We wanted to build up our resources, and we wanted to get a good team of recovered addicts in the area, so that they could help with the counselling required when we went to the public about it. We virtually worked by invitation with all these seminars, and we deliberately avoided going to the press. We did not feel that we could get the message across, and we wanted to be stable in our own organization before creating any flak.

We were forced into the situation when the lad Anthony Walsh almost died, and his father said that he was going to name people, and so on. That hit the headlines, and we were right in the middle of it then. I thought at the time that the exposure was going to wreck all our work, or at least put it back twelve months. However, it reinforced the people of Nowra, and it brought them together to such a degree that we now have three of the recovered addicts from Hyam's Beach working in a voluntary capacity in the town area. They have been accepted. The exposure reinforced the business people, solicitors, chemists, doctors and people from all walks of life in their desire to see something done. It reinforced school counsellors, hospital social workers, and everyone is more and more involved in the community.

Tonight in the school of arts a public meeting has been convened. Dr Diment will be there. The meeting was convened by Mr John Hatton, M.L.A., who has been a tower of strength to us in what we have been trying to do. Steering committees have been formed to draft a constitution. We have a list of office bearers, which comes as a suggestion from the steering committees to the public meeting tonight. Of course, none of us might be on the new committee, but we hope that it is formed. We are aiming to have the house at Hyam's Beach and another half-way house. We have a farm of 30-acres and a house, and we hope to set up a 24-hour crisis centre in Nowra, so that people from all walks of life, whether addicts, alcoholics or people affected by domestic issues, can go there when they are in trouble 24 hours a day.

My experience has been that one-third of the problems develop in the day and the other two-thirds develop between 9 p.m. and 9 a.m. I know this is so because most of the calls that I receive relating to alcoholism come after 8 p.m. and before 3 a.m. That is a time when the other agencies are closed. We envisage a centre with a living-in recovered addict. By the time they get to the town centre the other recovered addicts would be straight in two or three months. By the time people get to that centre they are straight in this time. They are rehabilitated, and they are then in a position to counsel others who might come there for help. We hope that from that point they will spend one month to six weeks there, and then go back to the community or back home. By that time we believe they have got to the point of having changed their lifestyle, are chemically free, have an idea that they have a responsibility in the community, and can make a useful contribution towards society again.

We see this happen, and there is acceptance by organizations and people there. We have talked to all the service organizations. We say that we do not want our recovered people sitting on their tails all the time, and if the local organizations have a clean up campaign, we ask them to give us a call and we will make sure that our people will get up and do something. The co-operation in Nowra has been fantastic. A motor dealer, Chas Tierney, provides us with transport. He gives us a traded-in motor car which is not in any way detailed. He gives it to the system to use for a month, and in that time we clean it up, detail it, and put it back on his lot. This has a two-fold purpose. We are not asking for something for nothing, he is providing us with transport, and the recovered people are doing the cleaning up of the motor car. In other words, they are doing something, and they are getting back towards feeling that they have to do something for what they get out of life. These people are on sickness benefits. We have offered them to the community, to mow lawns or do any job around the town, so that they can get back to talking to people again and feeling that they have a place in the community. They have to go out and mix as a person and not as an ex-addict. We have taken them to meetings in the town, and they have come away from them delighted because they have mixed freely with people and have been accepted back into the community.

This is a community problem, and it has opened up new avenues. Every day we meet a new challenge. For instance, we have one lass with a kiddie. The Department of Youth and Community Services said that this was not a good set up for the child, so we had to find somewhere for the child to stay. We see now that we can get involved with more people with this problem. We have found another need. If this happens again in future, we shall have people ready and willing to look after this type of situation. We are involving the total community, and that is where we are at the moment. The Health Commission people in Nowra have given us fantastic support.

Of course, they are goverened by the public service regulations. For instance, they cannot work after 5 p.m. This is where we see the role of the crisis centre coming in. We can look after the people after 5 p.m. Hopefully we shall have rooms to bed them down for the night until 9 a.m. the following morning until the other agencies are open.

2994. CHAIRMAN: Mr Muir, you were talking about seminars that had been organized. I understand that you have a document relating to them. I suggest that you might incorporate that in your evidence. Would you care to do so?——W. Yes. We invited the people who attended to let us know something about themselves. The document that I am about to incorporate in my evidence was sent out in connection with the second seminar, giving the addresses of persons who were involved in the first seminar, and a little information about them. I have a good deal of other literature of a similar nature that I would be happy to forward to you. The document to which I refer reads as follows:

Supt A. R. Heslin, P.O. Box 1499, Wollongong 2500.

Mrs Yvonne Benjamin, P.O. Box 1499, Wollongong 2500.

Dr Max Diment, P.O. Box 1499, Wollongong 2500.

Michael J. Walsh, P.O. Box 1499, Wollongong 2500.

Mr F. Ring, Bomaderry High School, Cambewarra Road, Bomaderry.

Mr Lyn Fowler, Nowra High School, P.O. Box 183, Nowra.

Captain Malcolm Baird, H.M.A.S. *Creswell.*

Commander Moore, H.M.A.S. *Albatross.*

C.P.O. T. McDonald, 19 Douglas Street, Nowra.

Mr Terry Bourke, Inspector of Schools, 48 Berry Street, Nowra.

Sister L. Laukaitis, H.M.A.S. *Creswell.*

Mr Norm Tillbrook, Personal Officer, Wiggens Teape, Bolong Road, Bomaderry.

Mr Bill Daley, Solicitor, 43 Berry Street, Nowra.

Ambulance Staff, Ambulance Station, Bomaderry.

Fr G. F. Mayne, Catholic Chaplain, R.A.N.A.S., Nowra (2 0381, ext. 276 day; ext. 252 night).

Senior Chaplain R.A.N. Walter Wheeldon, H.M.A.S. *Creswell,* Jervis Bay, 42 1001.

Rev. Claydon, Padre H.M.A.S. *Albatross.*

Dr Michael Flynn, Medical Officer, H.M.A.S. *Albatross* (2 0381 or home 2 3582).

Matron J. Staples, Shoalhaven District Hospital, Nowra.

Sister S. Booth, Deputy Matron, Shoalhaven District Hospital, Nowra.

Sister Durant, Shoalhaven District Hospital, Nowra.

Mr Harry Steele, social worker, Shoalhaven Hospital, Nowra. Rehabilitation counsellor, member of home help service, Royal Blind Societ yof Sydney.

Mr Greg McManus, social worker, H.M.A.S. *Albatross* (2 0381, ext. 277).

Mr Tom Cusack, Department of Youth and Community Services, 64 North Street, Nowra (bus. 2 0001, after hours 2 4123 and 2 2551).

Mr Peter Miller, Department of Youth and Community Services, 2 0001.

Mr Ray Spratt, Department of Youth and Community Services, 2 0001.

Mr John Knight, Department of Social Security, Holt Building, Kinghorne Street, Nowra (2 0105. Social Worker each Monday, M. McGee).

Mr Harold Hunt, Alcoholism Liaison Officer, Aboriginal Health, 9–13 Young Street, Sydney (Sydney 2 0563, ext. 758).

Mrs Nola Roberts, Aboriginal Health, 47 Berry Street, Nowra, 2 5062.

Mrs Jean Carter, Aboriginal Health, 47 Berry Street, Nowra, 2 5062.

Sister Pat Daley, Aboriginal Health, 47 Berry Street, Nowra, 2 5062.

Mr Gordon Gately, W.H.O.S. (We Help Our Selves) drug education and rehabilitation. Works on a house system where those that are well help the still suffering addict, giving moral support and counselling. People go out to work from the house until they are prepared to enter society on their own.

Mrs Crystelle Marum, Occupational Therapist in Charge, Rehabilitation Unit, Shoalhaven District Hospital, Nowra (2 0301). Patients are treated from hospital wards and from their homes. The unit teaches people to cope with problems, how to dress, swim, play bowls, relax, and to do everyday chores.

Parents Without Partners meet every third Monday at 46 Albatross Road, Nowra (2 4854, 2 4543, 47 8212), P.O. Box 1010 East Nowra.

Mr Malcolm Bowmaker, 46 Albatross Road; Mrs Whitby, 20 Allowrie Crescent, East Nowra. Parents Without Partners membership open only to lone parents, and provides personal support to lone parents and children, trips, outings. Counsellors available.

Mr Arthur W. A. Pascoe, Dip. App. Psych., and Sister L. J. Pascoe, D.C. Clinic, 78 McKay Street, Nowra (2 4856). Available for counselling and analysis and therapy for all psychological problems including habitual abuses.

Mr Howard Cranston, School Counsellor, High School, Bomaderry (2 2692, 24 2555). Is concerned with pupils who have physical, social, educational and emotional problems where this has some affect on school learning. Contact with parents in these circumstances are welcomed, particularly if this can increase the school's understanding so that the child may be more effectively integrated into the learning situation.

Mrs Margaret Ann Crossley, Mistress in Charge of Girls, Bomaderry High School (2 2692, 2 4255). Has a deal of experience in helping teenage girls and understanding their problems. Has a great need of knowledge of groups and people who can help by working with the child and in the child's home.

Mrs Pamela Cotterell, Mistress in Charge of Girls, Nowra High School (2 2957). Experienced in counselling students with social, psychological and physical problems. Has attended seminars on drug abuse in Wollongong and Sydney and is interested in the establishment of a drug education programme in Nowra.

Shoalhaven Aid & Information Centre (2 5077). A voluntary community information service for referral for all types of problems. Has rooms for the use of community groups. Provides rooms and takes bookings for marriage and family counsellor each Thursday. Information centre is at 7 Collins Way, Nowra 2 5077.

Lifeline, Shoalhaven Branch (2 5042). Lifeline provides a telephone counselling service with a direct line to its Wollongong office. Any urgent calls are answered by trained counsellors living in Nowra. Marriage guidance counsellor each Thursday at Shoalhaven Aid & Information Centre (2 5077).

Mrs Leslie Currie, 6 Hewlett Ave, Nowra (2 2712). Representative for Naval Wives Association.

Mrs Toni Shields, Naval Wives Association: (2 0381, ext. 550).

Emergency Housekeeping Service. Miss Kay Harrisson, 7 Collins Way, Nowra (2 5077). Provides housekeeping service for sick or aged people. Paid for by the Government but a small fee may be charged if means test applies.

GROW. Mrs Jan Small, 12 Tallyang Street, Bomaderry (2 0150), or phone Mr Vince Johnson, at 30 Kenny Street, Wollongong (28 9706, 29 6435). GROW is a voluntary organization of persons who admit that they are unable to cope with, or are maladjusted to life, and earnestly desire to improve and are willing to embark on a programme of personal growth. self activation and mutual help, in order to attain maturity, which GROW defines as mental health. Meetings are held every Thursday at 7.30 p.m. in the Shoalhaven Aid and Information Centre, 7 Collins Way, Nowra 25077.

Mr Steve Roberts, Health Surveyor, P.O. Box 42, Nowra.

St Vincent De Paul Society. Mr Theo Spurr, 40 Bunberra St., Bomaderry, Mr Pat McGuire, Junction St., Nowra.

Rev Pennman, 3 Kinghorne Street, Nowra. Presbyterian.

Rev Cloutt, C. E. Rectory, Worrigee Street, Nowra.

Mons. Purcell, Catholic Presbytery, North Street, Nowra.

Lt Ray Soloman, Salvation Army Citadel, Worrigee Street, Nowra.

Dr W. and P. Ryan, 19 Worrigee Street, Nowra.

Dr J. Spivey, 37 Berry Street, Nowra.

Dr L. Simes, 88 Bridge Road, Nowra.

Dr C. Shepherd, 45 Junction Street, Nowra.

Dr R. Kingston, 45 Junction Street, Nowra.

Dr G. Erwin, 67 Worrigee Street, Nowra.

Dr I. Hannan, 45 Berry Street, Nowra.

Dr Turnbull and Dr McGrath, 52 Berry Street, Nowra.

Dr C. Plaude, 19 Kinghorne Street, Nowra.

Dr R. Sinnamon, Owen Street, Huskisson.

Dr W. Bennett, Berry.

Rev. N. Gray, 18 Junction Street, Nowra.

Alcoholics Anonymous. The Secretary, P. O. Box 625, Nowra. (2 3968, 2 3568, 2 2709.) Meets every Sunday night at the Nowra Technical College. Counsellors available at any time day or night.

Alanon. The Secretary, P.O. Box 625, Nowra (2 3568). Meets every Sunday night at Wesley House, Berry Street, Nowra. Counsellors available by phoning 2 3568.

Health Commission:

Dr Ruth Redom, Bowral Support Centre, Bowral.

Dr Rolla Henderson, 47 Berry Street, Nowra.

Mr Bruce Price, Psychologist, 47 Berry Street, Nowra.

Mr Maurie Plaxton, 47 Berry Street, Nowra.

Kay Arneil, 47 Berry Street, Nowra.

Home Help Service, Colins Way, Nowra.

Berry Community Support Centre, c.o. Berry Baby Health Centre, Prince Alfred Street, Berry. Tel. (042) 641 272. Nurses: Margaret Gillen, Ruth Oxlade. Cl. Asst: Kathy Black. Area Covered: Berry, Gerroa, North to Werri Beach, Gerringong, Shoalhaven Heads, South to Bomaderry, Broughton Vale, Jaspers Brush, Meroo.

Nowra Community Support Centre, 47 Berry Street, Nowra. Tel. (042) 2 5062. Nurses: Gae Goodger, Rhonda Pinninger, Greg Flemming. Cl. Asst: Bernice Morgan. Area Covered: South as far as Falls Creek, Bomaderry, East Nowra, Cambewarra, West to Albatross, Klimpton.

Culburra Community Support Centre, 167 Prince Edward Avenue, Culberra. Tel. 47 1655. Nurse: Audry Collins. Area Covered: Culburra, Orient Point, Currarong, Callala Point, Callala Bay, Greenwell Point, Crookhaven Heads.

Huskisson Community Support Centre, c.o. Baby Health Centre, Watt Street, Huskisson. Tel. 41 5582. Nurse: Lee Rolfs. Area Covered: Huskisson, Vincentia, Tomerong, Bream Beach, Erowal Bay, Woollamia, Hyams Beach, Jervis Bay.

Sussex Inlet Community Support Centre, cnr. Jacobs Drive and Nelson Street, Sussex Inlet. Tel. 41 2373. Nurses: Lyn Grundy, Cheryl Thompson. Cl. Asst: Janis Taylor. Area Covered: Sussex Inlet, Sanctuary Point, St Georges Basin, Wandandian, Bendalong, Basin View.

Milton/Ulladulla Community Support Centre, cnr. Princess Highway and South Street, Milton/Ulladulla. Tel. 55 2668. Nurses: Wendy McAuley, Maureen Priestley. Cl. Asst: Wendy Nicholas. Area Covered: Milton, Ulladulla, Mollymook, Fishermens Paradise, Conjola, Lake Conjola.

2995. Mr Gately, you said that you still have seven addicts with you, is that so?——W. (*Mr Gately*) Yes.

2996. What are their backgrounds and what are their present activities?——W. Initially I moved down to Hyams Beach to live there. I liked the area. I had spent fifteen years on and off residing in the Shoalhaven area. I knew the people from the Health Commission there. They knew that I was a recovered addict. A young man found himself in trouble. He collapsed in the main street of Nowra under the influence of largactil and a multitude of other tablets. The Health Commission people rang me and asked whether I would take him into my home to settle him down and look after him because no organization in Sydney would accept him; ward 20 at the hospital refused to accept him too. So they gave him to me. That is how it started. Young Tim is 19. He stayed with me for five weeks, and from what I know about him today he is drug free. He has now returned to Sydney and is residing with, I think, his godfather. That was the first contact. From that point it gradually grew and grew.

2997. That was only in April of this year.——W. March. I did not start to do anything official. I was not motivated at that time to do anything like what I am doing today. As things progressed, there was a change. I began by taking Tim into my home, and then the Health Commission got in touch with me about another one, then another one, then another one. Twenty-one people have been through the place up until last night. It has even reached the stage where Henry Roland Higgs came to me for help on reference by the Health Commission. I looked after him and got him off the chemical to which he was addicted. He had to appear before a court in Queanbeyan. I do not operate under any name, but I do have literature that is produced by the We Help Ourselves organization. Henry Roland Higgs came back to me from court under a bond, which I produce, putting him under my care and supervision. That is something I do not want. If the courts start referring people to me, I will not be able to cope with them.

2998. What were the conditions of the bond?——W. That he place himself under the supervision of We Help Ourselves, that is, Mr Gordon Gately, and attend for treatment at Hyams Beach via Nowra. That was a misinterpretation by the magistrate who apparently read the literature produced by David Gordon and assumed that I represented the organization We Help Ourselves. I do not. If this young man's probation officer decides that Henry needs supervision, he comes down and talks to Henry on the property at Hyams Beach. This is something that comes from the Australian Capital Territory.

I have had inquiries from other people. I have had two inquiries from Melbourne, asking me to take people, and I have had two inquiries from Tweed Heads asking me to take people. In the past four days I have had 29 inquiries about making residential accommodation available for people from both Brisbane Street and from Health Commission resources in Wollongong. Physically and financially I cannot handle it. Because of the co-operation that we got on Nowra after educating the people to what we were doing, what happens today is that I can bring an addict into my home and Dr Flynn will assess him or her physically. We can detoxify that person and within three weeks he or she is out helping another helping-organization in the community. A prime example was seen last Sunday. We changed the minds of an entire community in one street in Nowra. A woman named Lally Beverly had suffered a heart attack, and physically was unable to attend to the upkeep of her property. Recovered drug addicts did her lawns and gardens. They went right over the property and cleaned it up, doing such things as getting the cobwebs out from under the eaves, and doing things that she generally was physically incapable of doing.

People in the street asked who was doing this, and she was honest enough to tell them. Since then I have had inquiries from six people in that street wanting to know whether we will do the same for them.

2999. You did this voluntarily and without payment? ——W. There was no payment except for a cup of tea and some biscuits at the end of the job. That was payment enough because the kids find that they can relate to a person who does not use drugs.

3000. You have seven people with you at the present time?——W. Yes.

3001. Where do they come from?——W. Four come from the Wollongong area, two from Sydney, and one from Nowra. It has got to the stage now where I am getting more and more inquiries from Sydney. My priority is to the people of the Shoalhaven shire because they are the ones who have helped to provide the on going support. The physical detoxification is very easy, but the re-assimilation of the addict into the community is difficult, and that is the problem we have to overcome.

3002. How did you arrange things financially?——W. After a time I saw a need and decided to carry on. I approached the head of the Drug Squad, Ken Astill, and told him what I was going to do in the Shoalhaven shire. I asked him whether he had any objections. He said, "Go for your life and good luck. Do not let it become a crash pad". I then approached Dr Max Diment and told him what I wanted to do and how I intended to go about it. He agreed and wished me good luck. Away I went. I then approached the Department of Social Security, the Commonwealth Employment Service, the Department of Youth and Community Services, and the Health Commission in Nowra and told them what I was going to do in a physical way at Hyams Beach. By going to the Department of Social Security and explaining what I was doing and telling them I would like these people to be on sickness benefits for two months and that a certificate would be issued by Dr Flynn for two months, I got the co-operation of the department to the extent that their cheques come through in fourteen days as against the normal six weeks. This is the result of seeking the co-operation of existing organizations. The cheques are sent to Mr Bruce Price, who is a psychologist with the Health Commission. He keeps the cheques. The kids sign them. Twenty dollars is taken out of the cheque and balance is held in trust for them until they are ready to leave Hyams Beach. In two months of operation it cost me $649 in rent, electricity food and other necessities. I have come out $29 in front from those deductions of $20, maintaining a steady population of seven in the house. I can accommodate 14, but I could not cope with fourteen financially because of the food and power they would consume. There is the other property I can use at Hyams Beach if I want to, but until I can manage financially I cannot take more than seven.

3003. CHAIRMAN: In effect, the only source from which you are getting real financial assistance is the Department of Social Security?——W. You can put it that way—but no, the only financial assistance I am getting is from the addicts themselves. They are entitled to that sickness benefit.

3004. If they were not getting money from social security you would not have any financial resources at all? ——W. I would not be there, it is as simple as that. It is ironic the way people begin to assist me. There is a girl by the name of Lisa. I was driving to Nowra and I saw this girl on the side of the road being extremely ill. I stopped and talked to her and I knew she was on drugs, and I told her so. I said, "What have you taken that has made you so ill?" She denied it, but then she turned up at the Nowra community support centre looking for help. She wanted methadone, and Bruce Price knew that prescribing methadone was the wrong thing to do, so he contacted me. Lisa is now chemically free and has been for six weeks. She now works in a pre-school kindergarten in Nowra. That came about by an approach being made to the pre-school kindergarten. We explained the situation, that she had been on drugs but that she had reached a point where the chemical had been removed and she wanted to do something. The kindergarten was asked if it would provide an avenue, and it did. It allowed her to work in that pre-school. I have never seen a girl happier. She now has no desire to take drugs because she has been accepted by the staff of the kindergarten, by the mothers and by the children themselves, so she is happy.

3005. You have mentioned Lisa and you have mentioned Tim. What is the situation in regard to the two sections in the one place? Do you have any problems?—— W. No. The house is structured in such a way that they can be segregated. There are three cardinal rules if anyone wants to undertake withdrawal in that house. Rule 1 is, no drugs of any description—and that includes aspros, vegenins, alcohol; no drugs of any description. The second golden rule is that there is no physical violence of any type; and there is no physical or sexual contact between male and male, female and female or male and female. Break any of those rules and you are immediately thrown out.

3006. You told me earlier you had a list of people supplied to you known to three of these seven people. Would you like to elaborate on that? I think there were thirty-four names on the list?——W. Yes. The several people residing with me at the moment, I asked them would they be prepared to disclose the names of people that they knew as personal friends who had died in the past 12 months. Of the seven, three said yes, and I came up with twenty-four names. I know of ten myself that I have not put on the list. Five of those deaths have occurred in the Shoalhaven–Illawarra region, and the rest in either Bankstown or the inner city region of Sydney.

3007. That is, of those thirty-four?——W. That is inclusive. That includes a death last Thursday.

3008. Would you like to have that list incorporated? I do not think anybody could be identified from it?——W. It gives the Christian name, the initial of the surname and the age. That is all. If you want it, you are welcome: It reads:

ROB, G., 16.
KIM, B., 18.
MICK, C., 23.
JENNY, H., 20.
SAM, K., 25.
PAULINE, Z., 20.
SUE, G., 17.
CHARLIE, T., 18.
LAURIE, G., 21.
COLIN, B., 26.
TONY, S., 21.
LYN, C., 23.
ROBERT, N., 24.
CAROL, M., 24.
CAROL, R., 20.
GRAHAM, C., 22.
RUSSEL, R., 28.
LES., 34.
PETER, E., 17.
PAT., 33.
TREVOR, D., 24.
TOMMY, G., 22.
MICHEAL, T., 27.
ARCHIE, M., 26.
JOHNY, Y., 16.
NIEL, B., 18.
LUCIEN, 24.
DEBBIE, W., 18.
JACOB, L., 18.
ROGER, B., 22.
JOESEPH, M., 18.
ROWENA, T., 18.
GLEN, O., 17.
LYN, T., 26.

3009. Mr MUIR: There was another death in Wollongong last Thursday.

3010. Mr GATELY: That was Robert G., who was 16 years old. The situation in Wollongong at the moment as a result of Operation Tip and the rest of it is that there is now a drought of the narcotic. Kids are still physically addicted. They have no alternative place to go for treatment. This is why inquiries coming in my direction have sky-rocketed. They are substituting. They are getting prescribed drugs—the barbiturates and sedatives—but the worst drug available now is a drug called Mandrax. If a kid came to me with Mandrax in one hand and heroin in the other and said, "Which one is the best to use?" I would tell him the heroin, because more people die from Mandrax than from heroin. This kid, because heroin is in such short supply in Wollongong, got himself a load of adulterated heroin. He had a kidney and liver problem to start with and, because of the toxic cutting compound in the heroin itself, he died from renal failure. This is the sort of thing that is happening in Wollongong at the moment.

There is a letter here that I will tender if you want to accept it. It is from a Mrs Yvonne Benjamin and it states that they have attended ten over-dose cases in the past 12 months, only three of which have been during 9 to 5 working hours. They attended this particular death. It was estimated that he had been dead 15 minutes before they got to him. They could not do anything. The situation now is that, because of Public Service Board regulations and so forth, Yvonne cannot attend these particular overdose cases. That woman has saved ten lives, but because of public service restrictions, if she attempts now to go out to an over-dose case and treat it—they ring her rather than the ambulance or the police because they know she is trusted and respected and will help, but if her son is using her car she cannot attend because the Health Commission have taken her car from her. That is not the fault of Max Diment or of Mr Stewart, it is just because of the general bureaucracy of the Health Commission. They try to do everything they can within the limitations that they have. If it were not for the Health Commission I would not be able to operate. It is just through their personal resources—the people resources. I cannot use their typewriters or telephones—all that sort of thing—but their people help me tremendously.

3011. CHAIRMAN: Has Mrs Benjamin indicated that they would like assistance from you?——W. Yvonne Benjamin and Max Diment are prepared to employ me but, again, Public Service regulations state that because I have a criminal record I cannot be employed.

3012. Is there any objection to having that letter from Mrs Benjamin incorporated in your evidence?——W. No. You are quite welcome. The letter is as follows:

46 Kembla Street,
Wollongong.

28th June, 1977.

Dear Gordon,

In answer to your query about overdoses: In the last twelve months we have had ten (10) O.D's. Only three (3) of them have been during working hours. We have revived all but one who had been dead for 15 minutes before we got there (that 15 minutes is an estimate based on condition of the body and information received.)

The treatment figures have been tendered to the Parliamentary Committee already, by Dr Diment. The new figures will be available in early July.

Thank you for taking our kids and looking after them. If we get a live-in centre here for withdrawal and motivation the O.D's will be reduced as will the relapse rate. At the moment, however, you've the only satisfactory resource for this purpose, unless the kid happens to be financial enough to pay into Medibank Private or Table 1 in a private fund.

Yours faithfully,
YVONNE BENJAMIN.
(Psychologist.)

3013. Mr MUIR: This bears out what we are trying to do at Nowra with our 24-hour crisis centre. At Wollongong they had to form a crisis committee to run Kembla House so that there was someone there after 5 o'clock. In all sincerity I ask the committee to give consideration to the setting up by the Health Commission of a twenty-four hour crisis centre on a trial basis. This morning I spoke to a man who said he would be happy to work in such a centre but he is not prepared to step outside the regulations and work after hours. I think it is clear from the evidence presented so far and my own personal experience that crises do not occur between nine and five.

(*Mr Gately*) I suppose all this has been explained to the committee before, but the point I am making is that we seek the co-operation of the community and ask the community to accept its own problem rather than call upon the Health Commission or the Chief Secretary to do the job. We ask the community to accept its own problem and to get together and do something about it. This is what has happened in Nowra. We can offer the addict an opportunity to get back into the community but I am now turning away an average of four people a day who are seeking physical health.

3014. CHAIRMAN: Can you give us any figures covering the period since this campaign started?——W. (*Mr Gately*) In the week prior to Operation Tip the new working case load was 148. During the first week of that operation the working case load dropped to fourteen with only two new contacts. They had been averaging something like three to four contacts a day. In the second week their case load contact was eighteen, and they are cases that were already on the books and that had no contact whatever with anybody.

3015. No new cases?——W. No new cases. Everybody was scared to seek help because of the media coverage. Lord knows what they were up to, but they would have had to have been doing some drastic things to obtain their supplies. The third week, when Operation Tip tapered off, their initial contact case load jumped to 62. People came back looking for help and they found fourteen new cases straight off when the Tip campaign eased off. Up until last night their case load stood at 54 with nine initial new contacts. In 1976 the weekly average was nine. In the third week of Operation Tip it had jumped to fourteen. I think that discloses something. The resources were not there to cope with that initial jump in case load and a lot of it came in my direction. I have taken into the house at Hyams Beach more than I should. The way things are at the moment I shall have to ask three or four of those people to start making alternative arrangements.

3016. Can you suggest to the committee any recommendations that we ought to make to the Government which might assist you in the efforts you are making on behalf of addicts?——W. Yes. I shall quote another instance. The FRATADD organization has been given or has raised $50,000 to set up what we have been operating in Nowra, but there are two factions in the organization

that are fighting against each other and the $50,000 is sitting in the bank. FRATADD ring me up and say, "Will you take three of our kids, three of our suffering addicts", because they cannot do anything with them. These are the people who have $50,000 sitting in the bank. If the Health Commission offices refer a person to me I will accept that person. All I ask is that the Health Commission subsidize us to the tune of $20 a week for each person referred. I am not asking for great heaps of money. If a drug addict is put into the Langton Clinic it costs the community something like $84 a day. We are operating on $20 a week. If I had an additional $20 a week I could expand and grow. The community is helping all the time.

3017. You mentioned your association with David Gordon and Dr Smith. I suppose you realize that David Gordon has recently been to America?——W. Yes.

3018. There is a suggestion that he will become associated with the Odyssey Institute. Have you studied the Odyssey method at all?——W. I have. I have studied the Odyssey, the Synanon, Daytop. I have looked at all these programmes. I have been involved in practically every programme that is operated in Australia. I have done aversion therapy and shock therapy. You name it; it has been tried on me. David Gordon is a man I respect very much. He has a lot of good ideas. Unfortunately, he has changed horses in mid-stream. I sincerely believe that a community can accept its own problems and do something about them if it is educated in the right way. We are launching an education programme tonight, and this is the sort of literature we distribute. You will see that there is no word Drug on there at all. That is the literature the people see. If they care to open that pamphlet they will see the word drug but if we put 500 copies of this pamphlet, *Drugs and Their Effects*, and 500 copies of this one, *The Way We Live Now*, 250 copies of *The Way We Live Now* will be left at the end of the night and no copies of *Drugs and Their Effects*. That is simply because of the word drugs, so we cover up that word. The actual drugs themselves are not mentioned. The pamphlet deals more with the person that has the need to use the drug. If somebody wants to pick up literature he will pick up the lot at one time, rather than looking for the sensational aspect of it. I do not know whether any member of the committee has ever seen these two pamphlets that we have put out, one called *A Child Talks to His Parents* and the other called *He Has Not Been the Same Lately—I Wonder If It Is Drugs*. These pamphlets are asking parents to communicate with a child that they think may be on drugs, without getting into all the pitfalls that parents tend to get into when drugs are discussed.

3019. Have you had any training in dealing with this problem or are you relying on your own experience?——W. It is just that I know how I have been treated in the past and how I would like to have been treated and what has actually happened through the process of the WHOS fellowship, the process of things at the Langton Clinic and at Gladesville. They have all educated me one way or the other, but the most important thing that has educated me is the simple fact that I am a drug addict myself.

3020. Mr Muir, who would this proposed 24-hour crisis centre in Nowra deal with? Would it be confined to addicts?——W. Any form of crisis a person might have. Even a recovered addict, if he felt uneasy in the middle of the night, would have somewhere where he could go and sit down and talk to somebody. I think that is the important thing. I find this terribly important myself. I have had alcoholics ring me at 3 o'clock in the morning because they have been under tension and almost at breaking point. The centre would be for anybody in a crisis at all—somebody that needs help in the middle of the night.

3021. Mr JACKETT: Mr Gately, you have suggested that prospective employers seem to clam up as soon as you disclose that you have had problems. I think Mr Muir also indicated that. How deep do you feel this revulsion is and how universal is it, in your experience? ——W. (*Mr Muir*) I think it runs right through the whole community because people do not understand what the problem is about and they are frightened. Because they are frightened they do not want to have anything to do with the people involved. Education can change that. That has been proved. After the first blow up in the papers in our area, after about three days I went around people that I thought would not want to continue with us and found that the reverse was the case. These people knew that had happened; they had been working on it beforehand and, like us, they were disappointed at what had happened and were all the more determined to help. In the ambulance station where I work there are twenty people who were aware of my problem. Gordon comes in to see me at times and seminars have been held at the ambulance station and I have found that members of our staff who were formerly afraid of the situation will now approach Gordon and engage him in conversation. I think we have to get our message across to the people, not in a sensational way but showing that people can be helped and that addicts are not freaks; they are your children and mine.

3022. Do you feel that the government is worse in its attitude than other prospective employers? I am speaking about the government in its administrative sense.——W. Yes. My misdemeanours were very minor but I could not possibly get into the Health Commission now because of them. I am in the Commission and I have been in it for eleven years. I was on a section 556A bond for a minor offence while under the influence of drink and because of that I could not get into the Health Commission today.

3023. Is the public service more rigid today than it has ever been?——W. Yes. That is because we are now under the Public Service Board. I have been alcohol free for sixteen and a half years but because that offence is there it is there. I do not know how I would stand with the Health Commission today if it came out. I did not declare it in my original application and have not declared it since.

3024. Have you any ideas about what should be done for government departments to be more sympathetic?——W. I do not know whether sympathy comes into it.

3025. I mean, sympathetic towards an applicant for employment.——W. I think it is a matter of understanding. This type of process is the only way. We have seen it in Nowra. There was a chemist there who was alarmed about the drug problem, but it was not until we sat down and talked for one and a half hours in my own home that he changed his attitude, and decided that something could be done. Before that, he was wanting to throw everyone out of the town. I think it is basically a matter of understanding.

3026. Do you believe that government employment regulations should be altered to enable those who have got over their problem to obtain employment with government departments.——W. (*Mr Gately*) I can give a precedent of what happened in the United States. What amazes me is that Australia follows American trends, but has not done so in this area. A precedent was set in 1971 in the State of New York as a result of the work of Dr Densen-Gerber. James Murphy was a notorious dealer in narcotics, and used to carry firearms. He went through the Odyssey programme, and remained chemically free for twelve months. At that time Mayor Lindsay of New York employed him as the co-ordinator of drug services. He has been a great success, and he has created a phenomenal number of avenues for drug addicts to seek help in New York. However, Australia still procrastinates. The day that the Health Commission is removed from the bureaucratic processes of the public service will be the day that Australia starts to go ahead with welfare work not only in this field but also in fields like Aboriginal welfare, child welfare and alcoholism. All these problems need the help of dedicated people on a constant, 24-hour basis. These people are there already, and they want to do it, but they are scared of losing the security of their jobs. (*Mr Muir*) We heard this expressed this morning, when we spoke to a man who said that he would be happy to work on a 24-hour programme, but there was no way that he would step outside the public service regulations to do it because he would leave himself open to charges of negligence. For instance, if he were in his own car and something happened, he would lose his job.

3027. In other words, you suggest that there should be a place in Health Commission programmes for the use of people who are off the drugs, to take part in the rehabilitation programme?——W. Yes. They are doing this as far as possible at Moree with Aboriginal alcoholics. They employ there recovered Aboriginal alcoholics to work among the Aboriginal people. It is a special programme to meet the needs of special people. That is exactly what we are saying. You can walk into a room and you can identify an alcoholic. I can do that, and Gordon Gately can identify drug addicts. There is a bond between the two. A man might knock on my door and say, "I am here from Shepparton". Immediately there is a bond between us, and we know and trust each other.

3028. How did they overcome this problem in Moree? ——W. I have heard this second hand, but I know there are one or two of these people employed there. You would be able to get the details from Harold Hunt, an Aboriginal who is with the Department of Aboriginal Welfare. I understand that this system is operating and working well.

3029. You have both said that you became involved during your school days. What sort of approach do you think should be made in relation to drug addiction in the schools.——W. (*Mr Gately*) It is necessary to have drug addicts to educate the children. We proved this with the Navy personnel at HMAS *Albatross*. In the education programme there they had a man who came from the naval police. He spoke to the ratings about drug abuse, and the first thing he did was to show them exactly what the drugs were; he showed them marihuana, heroin, and so on. When that happened, everybody's eyes lit up, and they were in the position of saying, "Now I know what the genuine stuff looks like". Bob Hindmarsh and myself did the final part of the education programme. Those sailors were given a questionnaire. They were asked, "What did you learn from the sergeant?", and their answer was, "Nothing". Then they were asked about the questions that myself, Bob Hindmarsh and Tommy, another recovered alcoholic, were asked; they were asked about the way we answered them. We did not get one negative answer from the ratings on that air station. At the same time, they did not learn a thing from the so-called professional educator in drugs.

3030. What about in the schools? You said that you were both involved in the schools. What sort of education do you think should be undertaken there in this field?—— W. I do not know whether anyone has taken into account the person. If you find a desire to use the chemical, you know that something must be wrong. I might speak to a group of school children, and if the education department found out about it a couple of teachers would probably get the sack. The point is that I can go into a classroom and, because I am what I am, I can feel and know which of the children are likely to become drug addicts. I know this from the sort of questions they ask and how they behave. They have certain traits, and you can see a potential pattern developing long before they take the drug. It is more important to talk to the children about their problems rather than to educate them in what drugs are. The only person who can do that to a great extent is someone who has experienced those feelings that made them use the chemical to survive. That is the education programme we are looking for.

3031. Mrs DAVIS: Mr Gately, you said that Dr Diment would be happy to employ you?——W. Yes.

3032. But he cannot do so because of public service regulations?——W. Yes.

3033. What would he have in mind if he were to employ you?——W. They are aiming at establishing a live-in unit of their own, under Health Commission supervision. They made a tentative offer to me to run it, and I said that I would be interested. However, because of public service regulations and a lot of other harassing around, they were unable to go ahead with it. That is another reason why I went ahead and did what I have done.

3034. In regard to people who are in the drug trade and are not addicts but are in it purely for the money, what sort of punishments would you expect us to recommend?——W. A 25 years minimum. The person involved in the sale of a narcotic drug simply for profit should be given no option but a 25-year minimum gaol sentence. A medical practitioner who sells methadone prescriptions for $50 each should be put against the wall and shot. He has taken the oath of Hippocrates, and I believe that any person who takes an oath, such as a lawyer or a councillor—and has sworn to God that he will undertake certain things, but then he gets involved in such things as narcotics, the death penalty is not good enough for him.

3035. CHAIRMAN: Could I come back to a statement you just made. Do you know of any doctors who are reputed to take $50 for a methadone prescription?—— W. I did. I could get involved in allegations, but I have not been involved in narcotic use for some time.

3036. But that has happened?——W. Yes. I have bought the prescriptions myself. But that was two years ago.

3037. Mr WOTTON: You mentioned guidelines of your methods, based on your experience. You said that you had tremendous admiration for David Gordon, but you said that he has changed his horses in midstream?——W. Yes. David Gordon has been on the right track all the time. He has approached the problem of addiction not by treating the drug but by treating the person—forgetting about drugs entirely. But this Odyssey programme involves an extremely hostile confrontation. I firmly believe it is unnecesary. You lose more people than you keep in that sort of situation. Whereas, if the drug addict knows that he is accepted for what he is, and he can walk down the main street of a town and not be pointed and leered at, but is accepted as someone suffering from an illness and trying to overcome it, that is the biggest step forward. I do not believe that undergoing a programme of complete withdrawal from society is the right approach. You still have to confront society sooner or later. That is what we are trying to do. That sort of thing breaks down the attitude of an entire street. The Department of Youth and Community Services has a certain bureaucratic hierarchy, but they ring me and ask me to supply a recovered drug addict as a baby sitter for one of their people. I think that certain officers in that department would be in trouble, but we do that sort of thing quite well. One girl went into a home as a baby sitter, and in the medicine cabinet there was a pretty potent narcotic. When we went to pick her up she was extremely agitated and nervous because she knew the narcotic was on the property. She did not take it because she realized that she had the responsibility of looking after two children. That is the sort of thing that breaks it down.

3038. You mentioned a girl named Lisa, who is undertaking some work?——W. Yes, she lives with us.

3039. Does she earn any money?——W. She earns no money at all. One of my rules is that anyone who goes out to work does not receive monetary payment.

3040. Does the same apply to you when you give the final lecture in the programme for the naval ratings?——W. You tell them about the emotions and feelings you go through, with using drugs and then getting off them.

3041. Yes, but you do that in a voluntary capacity? ——W. Yes.

3042. Are you for or against the campaign by Tip? ——W. I am totally against it.

3043. Mr McGOWAN: Have you much contact with school children who come to you?——W. Yes.

3044. Can you tell me of your impression of their reaction to the school system, and whether the school system contributes to their problem which leads to addiction?——W. It contributes 100-fold. This is an experience in itself. A school with 1 200 children is such that one must ask, "Where is the personal interaction between the teacher and the student?" How can a student turn to the teacher for help when a teacher is involved with 34 students in one classroom? The schools with the lesser problems are those that have about 500 to 700 pupils. Once a school gets over 1 000 pupils, it has seething problems, for there are too many children to control, and the teachers cannot get personally involved and discuss problems with the children. They have to be authoritative figures, and that is the end of it. Otherwise they would not be able to accomplish their lesson programmes.

3045. Mr HEALEY: Mr Gately, you said that you have a successful programme of treatment. Would you care to have a copy of it incorporated in your evidence?——W. Yes. I have a book showing the medication to be dispensed to persons who are undergoing physical withdrawal. I can furnish the committee with a copy of the regime that is used. The figures given are maximum doses, and you will find that we give only one-third of what is medically recommended. The documents are as follows:

HEROIN WITHDRAWAL REGIME

DAY 1—Two heminuerin every two hours.
Codeine phosphate: 30 mg every 6 hours.
Valium: 10 mg every 4 hours.
Norflex: 100 mg every 8 hours.

DAY 2—Three heminuerin every four hours.
Codeine phosphate: 30 mg every 8 hours.
Valium: 10 mg every 6 hours.
Norflex: 100 mg every 12 hours.

DAY 3—Two heminuerin every four hours.
Codeine phosphate: 30 mg every 8 hours.
Valium: 10 mg every 8 hours.
Norgesic: 1 tablet every 6 hours.

DAY 4—Two heminuerin every four hours.
Codiene phosphate: 30 mg every 12 hours.
Valium: 10 mg every 12 hours.
Norgesic: 1 tablet every 8 hours.

DAY 5—Two heminuerin every six hours.
Lomotil: 5 mg every 6 hours.
Valium: 5 mg every 8 hours.
Norgesic: 1 tablet every 8 hours.

DAY 6—Valium for day sedation only when required.
Lomotil: 5 mg every 8 hours.
Norgesic: 1 tablet every 12 hours.
Heminuerin (at night only): 2 caps at 11.30 p.m.

From this point on medication should only be given when the apparent symptoms are obvious, three or four nights of lost sleep is expected, medication should not be given between 12 a.m. and 12 p.m.

BARBITURATE WITHDRAWAL REGIME

DAY 1—
Seconal: 100 mg caps, 200 mg every 4 hours.
Dilantin: 100 mg tabs, 100 mg every 12 hours.
Norflex: 100 mg tabs, 100 mg every 8 hours.

DAY 2—
Seconal: 200 mg every 6 hours.
Dilantin: 100 mg every 12 hours.
Norflex: 100 mg every 8 hours.

DAY 3—
Seconal: 200 mg every 8 hours.
Dilantin: 100 mg every 12 hours.
Norflex: 100 mg every 8 hours.

DAY 4—
Seconal: 200 mg every 12 hours.
Dilantin: 100 mg every 12 hours.
Norflex: 100 mg every 8 hours.

DAY 5—
Seconal: 50 mg caps, 150 mg every 8 hours.
Dilantin: 100 mg every 12 hours.
Norflex: 100 mg every 8 hours.

DAY 6—
Seconal: 50 mg caps, 150 mg every 12 hours.
Dilantin: 100 mg every 12 hours.
Norflex: 100 mg every 8 hours.

DAY 7—

Seconal: 50 mg caps, 100 mg every 12 hours.

Dilantin: 100 mg every 12 hours.

Norflex: 100 mg every 12 hours.

DAY 8—

Nembudeine*: 2 every 6 hours.

Dilantin: 100 mg every 12 hours.

Norgesic**: 2 every 6 hours.

DAY 9—

Nembudeine: 2 every 8 hours.

Dilantin: 100 mg every 12 hours.

Norgesic: 2 every 8 hours.

DAY 10—From this point in the withdrawal all medication should be stopped for 8–12 hours, then a general heminuerin regime should be commenced. This should be backed up with valium and the appropriate anti-cramp controls.

Lomotil: 5 mg every 6 to 8 hours.

Heminuerin: 2 every 6 to 8 hours.

Valium: 2 every 6 to 8 hours.

Norgesic: 2 every 8 hours.

Taper over 72 hours.

* Nembudeine—Pentobarb 30 mg, paracetamol 300 mg, codeine 15 m.

** Norgesic—Orphenadrine cit. 35 mg, paracetamol 450 mg.

1—AKINETON: 2 mg. Spasticity and cramps.

2—AVIL: 50 mg. L.S.D. termination.

3—AVIL AMP'S: 50 mg. L.S.D. overdose.

4—CODEINE: 30 mg. Gastric control, early heroin withdrawal.

4A—COGENTIN: 2 mg. Counter against largactil side effects.

5—DILANTIN: 100 mg. Counter against fit during barbiturate withdrawal.

6—HEMINUERIN: 192 mg. Sedation in heroin and barbiturate withdrawal.

7—LARGACTIL: 100 mg. Anxiety and nausea during heroin and barbiturate withdrawal.

8—LOMOTIL: 2.5 mg. Gastric control.

9—LUMINAL: 30 mg. Early barbiturate withdrawal.

10—MAXOLON: 10 mg. Actual vomiting control.

11—NEMBUDEINE: Tablets. Later barbiturate withdrawal.

12—NORFLEX: 100 mg. Early heroin cramp control.

13—NORGESIC: Tablets. Later heroin cramp control.

14—SECONAL: 50 mg. Mid barbiturate withdrawal. (100 mg also.)

15—STEMETIL: 5 mg. Nausea and migraine.

16—VALIUM: 5 mg. General sedation.

17—VALIUM: 10 mg amp's. Muscle spasm and violent behaviour.

18—VANDID: 5 per cent sol, amp's. Barbiturate overdose only.

3046. You started from nothing and you are not employed. How did you come to have the house at Hyams Beach?——W. The premises belong to my mother and father. It was just a holiday home for them. I pay them $70 a month rent for it, which I think is reasonable enough. It is not a great deal for a property of that size. I have the use of another two properties at Hyams Beach. If I decide to take advantage of them, they will cost me $20 a week. The farm, of 35 acres, is paid for at a nominal rent of $5 a week because we had a talk to the man who owns it about what we were up to. The House in Nowra is owned by a Christian-involved man and he allows us the use of it for $30 a week. It is a substantial house. However, I cannot use it until I am guaranteed that the rent can be paid in one way or another. Either the community itself will pay the rent or there will have to be a subsidy. If something could be done whereby for every dollar we contributed the Government contributed 50c, we could plod on for all time without problems, simply using the resources that are already available, such as those of the Department of Youth and Community Services, the Commonwealth Employment Service and the Department of Social Security. It is just a matter of co-ordinating existing resources and of educating people in regard to what we are on about. There is no backlash about socialism and the like. We can get on with the job of treating people who are suffering from drug addiction, and we can do so without hoo-ha.

3047. Mr RAMSAY: You said that you were opposed to the campaign being conducted by the *Illawarra Mercury*. Have you spoken to that newspaper's reporters? ——W. Six month ago I approached the *Illawarra Mercury* and asked whether they would run a series of articles to educate the public on the disease of addiction: on the fact that one drug addict would involve another four people with the disease: that sort of thing. They did not want to know about it. They refused. There was no political mileage in it, there was no immense sales potential for them to print that sort of thing.

3048. They would not be looking for political mileage would they?——W. There was no mileage of any description.

3049. You mean there was no sensationalism?——W. Right.

3050. Have you spoken to any of the reporters from that newspaper over the past four weeks?——W. Only to a roundsman who turned up at John Hatton's office. A basic outline of what we were up to was given to him, and you see the result in this morning's edition of that paper.

3051. Would that roundsman have been Mr Peter Cullen?——W. I did not take any notes. He stood at the door and hemmed and haed. John Hatton said a few things and I sad a few things, and that is the result.

3052. Did you intimate to him that two young addicts had died since the *Illawarra Mercury* campaign began? ——W. Yes.

3053. Were they local youngsters?——W. Yes.

3054. What evidence did you have to support the allegation that they had died from Mandrax and barbiturates? ——W. The coroner's report on one of them is still being processed. The other one I knew personally. I saw the body and I know what a drug overdose does to a person.

3055. Had this person been to you?——W. We had contact with him once.

3056. Do you consider that addicts who need help would prefer to go to another area for that help and for treatment? Are you aware that that does happen on a fairly large scale?——W. Yes, and I totally discourage it because it is just another syndrome of the disease of addiction, where there is a running away from the problem. If you want to get physically and emotionally well, get well in the community you know if that community can be educated to accept you for what you are. If you do, you stand a 100 per cent better chance of recovering than you do by running away and trying to come back.

3057. I have evidence of young persons who would prefer to go to other districts for treatment so that it is not known that they are addicts.——W. They like to go away, get physically well, put on a couple of stone, and come back and get stuck into it again. (*Mr Muir*) Or pretend it did not happen. (*Mr Gately*) Or pretend it did not happen. One has to accept the fact that one is suffering from the disease of addiction and is susceptible to addiction to chemicals, to understand it, and to learn from it. If that is done, the addict stands a chance of recovering.

3058. CHAIRMAN: For those reasons you would prefer to deal with people from the Nowra area rather than with people from elsewhere?——W. Yes.

3059. Mr RAMSAY: Are you aware that a number of people from Wollongong and the South Coast are treated in Sydney?——W. Yes.

3060. And also from the North Coast, and that although they have available to them on the North Coast counselling and treatment, they prefer to come to Sydney? ——W. Yes, and when they get back to where they came from, has anyone bothered to follow up on the relapse rate?

3061. You said that a 16-year old lad died in Wollongong last week?——W. Yes.

3062. What narcotics were involved?——W. A mixture of methadone, mandrax and heroin.

3063. How did you become aware of that?——W. A member of the Health Commission informed me that this kid had died. It was explained to me what had happened. There were so many suspicious circumstances: no syringe was found, there were puncture marks on the arm, and there was a belt bruise around the arm. These are the things you look for.

3064. CHAIRMAN: Mr Gately, you said that more young people die from Mandrax than die from heroin. What is the basis for that statement?——W. Perhaps they do not die from direct ingestion of the drug itself, but Mandrax is such a mind-changing drug that I can understand the kid on the trainline at Cronulla, for example. He was under the influence of Mandrax. I have known so many kids to die behind the wheel of a car while they were under the influence of Mandrax, perhaps not as a result of a direct overdose but the results are the same. They wrap themselves around trees in cars, fall under trains, or down stairs, and suffer brain haemorrhage or concussion. When such a case goes through the coroners court usually the death is just said to have been due to misadventure. The symptoms of brain haemorrhage are not referred to. They do a test for alcohol but quite often they do not go further than that. They do not do bile count to see whether there is any foreign substance in the bile.

3065. The figures supplied to us from the Sydney coroner's court show that Mandrax is one of the drugs that could cause death.——W. Mandrax can be a direct cause of death where there is an overdose, where quite a few a taken, but it is not so much that sort of death I am concerned about. I am concerned about the situation where a person loses total control of his mobility and rational thinking. He thinks he is walking on a flat surface, and when he comes to a flight of stairs, he lacks the necessary co-ordination to deal with them because of the Mandrax, and falls down the stairs. That involves a large cost to the community in ambulances, hospitalization, and so on.

3066. All of your evidence seems to suggest that the drug problem in the Wollongong and Nowra areas is just as bad as published reports say it is. It seems to be quite important that if the problem is to be overcome the first people who have to be repressed are the pushers. Why is it that pushers seem to be able to operate without any problems at all?——W. This is a very touchy subject because the majority of pushers of narcotics are drug addicts themselves.

3067. We realize that that is the problem, but in turn they must get the drug from somebody who is not an addict but is in it for profit only?——W. Seven years ago I got together $2,000. I got a girl to purchase an air ticket to Penang. It cost $720 return. I gave her the balance in cash and she came back with enough heroin, which she bought in Asia, to supply half of Bankstown for six months. But I needed the drug myself physically, she needed the drug herself physically, and the people who were purchasing it needed it physically. That is the main basis for the smuggling of drugs and drug distribution in Australia: drug addicts toddle off to Penang, Jakarta or Vientiane and bring the drug back.

3068. You would not put her on a plane without giving her the name of somebody to contact, would you?—— W. All you have to do in Penang is get into a tricycle and ask the driver where you can buy heroin, and you score heroin: You have it. It is as simple as that. People say they want to deal with the problem by getting rid of the pushers by shooting the pushers. I say that if you want to go to that extent, go over and shoot the opium growers in Thailand, because that is where it is coming from. If you look at the history of heroin in western civilization, you will see that over the past seven years there has been an escalating heroin war, with the Mexican suppliers competing for the American market against the French-Chinese connections, the triangle connections. The south-east Asians lost and Australia is the best market for them after America.

3069. Mr RAMSAY: If you believe that the campaign in which the *Illawarra Mercury* is involved is not a good one, why do you give the paper such intimate information?——W. It is intimate to the extent that I am trying —and though I am making the fatal mistake time and time again, I persevere in the hope that one day I will succeed—to get the press to do what it is supposed to do, and that is to help the community.

3070. Not the *Illawarra Mercury*.——W. I agree. I give up after this morning's edition. The one thing that I will follow up is that quite often I get into a situation where I am talking to kids in the Wollongong area about marihuana smoking and about getting involved in taking other drugs. They are involved in an illegal activity and the worst thing that can happen to me when I am trying to get the kids to understand and accept what their superiors are trying to tell them is when they say to me,

"Why in hell is that casino operating in Kembla Street? Why do I have to appear before a magistrate for having a marihuana joint in my possession when everyone knows that you can go and spend $2,000 in Kembla Street in that casino and know damn well that the money is taken from the casino to certain boutiques in the Wollongong area?" Trafficking is starting to get bigger and bigger.

3071. Mr RAMSAY: You mentioned the casino in Wollongong. Do you know of any involvement of addicts at the casino?——W. I was involved myself two years ago. I could tender evidence on that score but it would be futile because all the people have gone on holidays. I have come across certain clothing articles that have come out of the boutiques that have totally irrelevant tailoring features in them. They have come in from Thailand. They have been cut and opened and there is quite enough room in some of them to bring in a kilo at a time. The same thing applies with certain types of sandals that can be purchased from the boutiques. They have false soles in them. I have come across all that. I had all that, and I have thrown the lot out.

3072. CHAIRMAN: Would you elaborate in regard to the money that is transferred from the casinos to the boutiques?——W. I was involved in a relationship with a girl who worked in the casino in Kembla Street. It was an intimate relationship and she told me everything that used to go on. There was a tally at the end of the night and $X would be taken. She and the guy who was manager of the boutique would take the money to another boutique. It would be taken from Kembla Street to the proprietor of a boutique at his home. She used to go along with the guy. What hope does anyone stand when that sort of corruption is going on and kids throw that back into my face when I try to get them to accept the standards that they are expected to live under?

3073. Mr RAMSAY: Would you have any of the names of these boutiques?——W. You know them already: "The Shady Lady", the lot.

3074. Would "Tramps" be one?——W. Yes.

3075. Nancy Michael?——W. Yes, they are all in it. This is a question I ask: Why did Peter Wilson go for a charge of administration and possession when the man is not a narcotic user?

3076. I cannot answer that, either.

3077. CHAIRMAN: Who is Peter Wilson?——W. He is the proprietor of "The Shady Lady". He was running red hot. He was known as a supplier. He appeared before a court on a charge of administration and possession, only he is not a user, nor is his wife. That is the charge he got. I am pretty disgusted about it.

3078. Have you any knowledge of people being charged in regard to the possession or use of marihuana when it is common knowledge that they were in possession of other heavier drugs?——W. Not to that extent. I have known people to be arrested with a pretty hefty amount of narcotics and appear before the courts and be charged with only a minute amount. Where the balance has gone, I do not know.

3079. These are people that you know personally?——W. People who eight months ago would have been prepared to say that and correlate that, but today they cannot, simply because of the repercussions of Operation Tip and this inquiry, simply because the inquiry has been public.

3080. Not all of it has been public?——W. No, but enough to scare most people who do know, away from testifying.

3081. Mr RAMSAY: What is your attitude to this drug inquiry? It will go far beyond just the question of looking at the problem of drug addicts. We believe in helping, and this is what we are aiming to do finally, but what is your attitude to the committee of inquiry? Their views will have to be made public finally?——W. Yes, well, if you remove the demand, there will be no supply. That is being idealistic, I suppose, but it is an approach that I think should be seriously looked at. If it does not become a saleable item any more, you lose your traffickers, anyway. It is a little phrase, but educate and there will be no necessity to rehabilitate.

3082. Communities have had drugs down through the ages for thousands of years?——W. The worst drug in this world is alcohol.

3083. Apart from that, you even have people who use rhubarb?——W. There is a certain residue that you can get out of rhubarb if you are crazy enough to spend the thousands of dollars on the equipment you would need to extract it. It is not a drug that I would appreciate or use.

3084. You are concerned, I take it, that people in high places are allowed to get away with things——?——W. I am pretty well cheesed off at the double standards that exist all round.

3085. If I may say so, I am personally, also, but I shall do all in my power—and I hope that people like yourself will continue to do so—to help the addicts?——W. I can do very little. I could help 14 at a time, but I can't; I can only help seven at a time.

3086. The Chairman might indicate to you that we might be making some recommendations——

3087. CHAIRMAN: This was the point of my question earlier as to the recommendations you feel could be made to the committee that would assist you?——W. It is simply summing it up by saying that laymen——

3088. It is a matter of dollars and cents?——W. Yes, but laymen are proven to have more success in the field of addiction than anyone else. In short, I could work for the Health Commission but I would be under their bureaucratic control and probably would not be able to do what I am doing today. The Health Commission can send people on to me as a referral and subsidize them to the tune of $20 a week. It is simply done. There is no great problem in that and there is no great capital expenditure involved. Who wants $500,000 to set up a drug addiction unit? I started with $11.

3089. Mr RAMSAY: Would you not agree that people who are adequately and properly trained could help addicts?——W. Yes, they help immensely, but again the actual recovery side of it is best accomplished by recovered addicts and alcoholics. All that on-going support is paramount, by trained personnel such as psychologists and doctors, but these people have to understand what the disease is.

3090. Mr WOTTON: You spoke about the way that David Gordon changed his attitude. We have seen that a dozen different people might have a dozen different cures? ——W. I believe there are a hundred and one cures.

3091. It is hard to find out which is the best?——W. But there is no cure, that is another thing. There are a hundred and one ways to assist an addict to recover and get off the chemical that he is addicted to, but there is only one avenue for the addict to regain any stability in life, and that is that the addict himself accepts that he is an addict, and that the community accept the problem and accept the person back into the community.

3092. CHAIRMAN: Thank you both very much for your attendance. Dr Brighton is here and we shall now hear his evidence.

3093. Mr MUIR: Is there any message you would like us to take back to the meeting tonight?

3094. CHAIRMAN: I think the only message that you can take is that you have been here and that you have been listened to most attentively by the members of the committee. It would not be within my province to make any public statement in regard to the matter.

3095. Mr MUIR: I have been personally impressed by the way we have been received here. It is great that this is going on. I think it is only through things like this that people will become educated.

3096. Mr WOTTON: Then you do not agree with this article that this committee is a waste of time?——W. No. What I think is wrong is the way that it has been reported. It only drives people underground.

(The witnesses withdrew.)

WILLIAM HAROLD BRIGHTON, residing at 12 Arundel Street, West Pymble, medical practitioner and Acting Director of the Division of Forensic Medicine, Health Commission of New South Wales, sworn and examined:

3097. CHAIRMAN: Have you received a summons under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. Yes, I have.

3098. On a previous occasion I and some members of the committee had a conversation with the City Coroner, Mr Goldrick. Arising out of that conversation, Mr Goldrick provided us with some interesting statistics. I understand that since then Mr James has had some conversations with you and, as a result, you would now like to present some evidence to the committee?——W. When Mr James spoke to me last week he told me that you had had information from the coroner and he asked me if we thought that we in the Division of Forensic Medicine, in the situation in which we were placed at the time, could make any contribution to an ongoing study of the problems associated with drugs. I thought about it while we were talking. We are very much aware that our statistical records are not of much help at the present time. The statistical records of the division have been slow to develop and there are reasons for this. The material supplied to the committee by the coroner is probably the best that is available from the combined efforts of his section and ours. We are largely integrated with the coroner and all the material that comes through our division is really the coroner's business. From the administrative point of view we are part of the Health Commission but from the point of view of the materials we handle and the information we have we are virtually working for the coroner and the Department of Justice.

I think I should indicate briefly what the division does in association with the coroner and then carry on with some of the things that I mentioned to Mr James which may have some bearing in the future upon what we may be able to provide. We carry out autopsies in terms of the Coroners' Act under the direction of the coroner, the object being to find causes of death and any other information that may relate to that happening. As a result we frequently resort to analysis of organs and body fluids. This process is automatic under some circumstances in our daily work. Sometimes we know that there is a history of drugs having been taken. At other times we may suspect it from looking at the organs as we do autopsies. At other times it is from sheer necessity when we cannot find a basis for diagnosis of the cause of death. In certain situations we are required by statute—such as in motor vehicle accidents—to take a sample of blood for estimation of alcohol content. I do not think at the present time we are required to ascertain the level of any other drug in the blood, and there is probably a reason for that at the moment. That is probably something that needs to be looked into and developed, in the light of what has been said here this morning. We receive information back from the analyst via the coroner's office. We send the organs out on behalf of the coroner and then receive the information back through him. We then reconsider the entire problem in the light of the information from the autopsy and the analyst's report and any other investigations, and decide what we think is the best opinion as to a cause of death. We supply this to the coroner in the form of a report, together with any materials that have come to us, such as the analyst's report and so on. That virtually is a run-down of our procedures. Basically, we are there to establish certain facts for the coroner.

It has been obvious to us for some time that many things arising out of these examinations are probably of use from the public health point of view and perhaps even in areas wider than that, as I have become aware from listening to what has been said here this morning. Over the years I have been working at the division the amount of time which could be spent on various functions has been limited and one of the things that has rather fallen by the wayside has been a systematic indexing of results. Last year the systematic indexing of certain aspects of the results was commenced. I believe the city coroner has been carrying out this type of survey on his own behalf for a few years. The document which you have would be the most recent one. It is an interesting document and contains a lot of information derived from the police and the Division of Forensic Medicine and, I presume, ultimately his own findings in the court. There are some areas in which we may consider that problems exist at present and the coroner may not, but it is obvious that from time to time he picks up matters such as people dying from drugs that are not on prescription and things of this kind. I am aware that coroners over a period of time have been concerned about such matters and made remarks about them in court and sought to have them publicized, but this has not happened to any great extent. I do not believe any attempt has been made to look systematically at the information. I think perhaps what Mr James elicited from me and Dr Oettle, the acting Deputy Director, is that a systematic examination and monitoring of the statistical results and other available information could reveal some problem and that problem could then be referred to a team of people who could look more closely at it. To illustrate what I mean, early in my association with the division I became aware that many people who were apparently suffering from acute psychiatric disturbances were being referred to private psychiatrists. I am speaking from memory. I do not think they were necessarily referred

to the psychiatry units of the then Health Department Such people would while waiting to see the psychiatrist be given barbituate drugs as a sedative, which they would then take in overdose proportions and die as a result. As that sort of pattern was becoming obvious from information supplied by the police and others, at about the same time a couple of young psychiatrists were making a study of this matter. They published their results, indicating that in their view cases of this kind were not being dealt with as rapidly as they should have been after the primary aid was given, and also as a result of having been given relatively large quantities of barbiturates people were dying perhaps unnecessarily. A systematic examination of the records of those deaths, conducted not by our division and not through the Health Department at that stage but by an independent inquiry, confirmed the problem and probably resulted—although I am not sure of this—in a reduction in the amount of barbiturates that could be prescribed at any given time and also in the taking of a different view of the management of certain psychiatric disorders. I feel that a good statistics indexing system would pick up this sort of thing more effectively than we can, relying on a day-to-day reading of the information in cases and carrying it in our heads. I have not since come across a similar obvious pattern and before a large sum of money is spent on the introduction of such a statistics indexing system consideration should be given to how often it is likely to bring such a problem to light. I think there has been a tendency in recent years for deaths to occur from overdoses of drugs used to treat psychiatric disorders, which may indicate a problem in the management of certain mental disorders, but that is only a thought in my mind and I have no positive figures to put forward in support of it. One of the drugs used against depression is amitriptyline and I have a subjective feeling at the moment that probably that drug is involved quite often in overdose deaths. However, quite apart from the therapeutically prescribed drugs, which may cause problems if over-utilized, the management pattern of which may need to be altered, there are the drugs that are not medically supplied, those that are not obtained on prescription. Chloral hydrate is a well known one. I think the synthetic bromides have now been made unavailable without prescription. Previously they were drugs which could be readily bought and which people often used in overdose proportions.

Another area that might be more definite, upon which I can speak, is one that the former witness spoke about, Mandrax and drugs other than alcohol being involved in motor vehicle accidents. By and large, we are not in a position at this stage to give any confirmation or otherwise of that suggestion, but it is felt among those of us who work in the field that other drugs should be screened for as well as alcohol. However, the process itself would add to the cost of the procedure. One of the objections that has been raised in the past has been that if we obtain this information and then we might not be in a position to say very much about its relationship as a contributing factor to, say, a vehicle accident. Whereas we understand quite a lot about what alcohol does, when the matter of other drugs is raised in terms of the courts and the law, the interpretation of results would probably be a quandary for people at this stage.

It is a rather circular type of argument, because until you carry out this kind of investigation, you will not be in a position to know the answers anyway. It has been suggested, even if you find a therapeutic level how would you interpret this as an argument against doing screening. This is largely based on the view that, when subjected to legal argument and interpretation, it would create more problems than it would solve. I do not hold to that, but I see the problem, and I feel that perhaps it would be worth, even for a limited period, proceeding with that kind of programme. That is, to analyse, say, specimens of blood or organs for the presence of drugs other than alcohol in vehicle accidents. The same could apply to other situations.

As when young people are involved in sudden death and the cause of death is known—for instance, drowning—probably more could be said about it other than just leaving it at the fact that they were drowned. I hasten to add that in many cases of this kind, with non-vehicular fatalities among young people, we do not infrequently now screen for other drugs, but not as an absolute routine. As far as narcotics are concerned, I do not know how much information we would be able to lay before any inquiry that is not already known at present. Sometimes the drug can be established by analysis, but a lot of narcotics deaths are such that a drug is never recovered. It is an extremely difficult procedure to analyse and get a result when there is only a tiny amount left in the body. The narcotic drugs disappear quickly from the blood, and they are mostly found in the reservoirs, such as the gall bladder and the urinary bladder. We are unable to establish the amounts used from the information we have got. More often than not this is because the analysis comes not from the blood sample but from a pool of fluid which has accumulated over an indeterminate time i.e. urine and bile. We could supply up-to-date statistical figures for the specific area we cover and we have probably got ourselves to that degree of involvement in the rural areas in New South Wales so that within a year or so of keeping tab on the deaths we can perhaps supply specific State-wide information, which may be valuable. At the moment we could deal only with that particular area that the City Coroner covers.

3099. If you had to carry out an autopsy on someone involved in a fatal car accident, you could determine quite clearly the amount of alcohol present?——W. Yes.

3100. Would it be possible to determine whether the person also had say, marihuana as well as alcohol?——W. I think at the moment that is not capable of being analysed in a quantitative sense. The Government Analyst has told me that traces of it can be established, say, from the skin, fingers and so on, but not analysed in a quantitative sense, in the same as alcohol and quite a lot of other drugs.

3101. So it would not be possible to know how much was present?——W. No.

3102. Or for how long it was since the person had been in contact with, say, marihuana?——W. Unfortunately, no.

3103. In regard to the monitoring process to which you referred, as the Health Commisison is virtually your employer, I assume that at the present stage, if you felt there was a need for tightening procedures, you would automatically make a recommendation to the Health Commission?——W. You mean, in relation to indexing.

3104. Yes.——W. We have done this. In recent times we have had a visit from the management services section of the Health Commission. It is virtually the systems and methods organization. With the commission, and also with the old Health Department, all procedures are devised, instituted and maintained by the management services section. Rightly so, they are very strict about people not setting up their own ideas if they are not in accordance with an appropriate system and method. They also inquire very strictly into cost benefits and so on.

My predecessor, until he stepped down in August last year, had during the previous twelve months set up an indexing system which, in the main, I believe was quite a good system. At that stage it had not been cleared by the management services people, and when they looked at it recently at my request, in conjunction with all other aspects of organization, they decided that there were certain aspects of it that were too cumbersome in terms of administration. I find myself at the point now where we are back to square one, and have been asked how often this information will be used, and who will have access to it. We are asked whether it will be worth while spending this money, and so on. In other words, we are virtually back to the planning stage, to satisfy people that what we are asking for is going to be worth while, and also at the same time they want to know what it is we are asking for.

3105. You mentioned your association with a sort of back-up with the coroner. But you have a wider field of responsibility, as a section of the Health Commission, particularly in regard to pathology.

3106. Do you feel that sometimes you are regarded as the poor relations?——W. There is no doubt that we cannot complain, for instance, about our present building facilities and so on. We have an absolutely magnificent set up. The change was like from rags to riches; it was unbelievable. I cannot say that we are regarded as poor relations within the commission. In the field of pathology perhaps over the years, clinical pathology with respect to hospitals and so on has been the most popular side of pathology without doubt. But there is a greater awareness of the need for good forensic pathology, and also the integration of the two types of pathology. But what is happening in terms of statistics and the records, there has been a feeling that the division they are going to run up a lot of figures, and who will look at them. There will continue to be the question, what is it all about? There is little real sympathy with the Division having its own system behind the rejection of it. They say, "Perhaps next year. Staff is not available." That has been the pattern, I think.

3107. One of our terms of reference relates to drugs of dependence. That would include analgesics. In your conversations with the coroner he said that it was virtually impossible for them to list, as they have done in regard to certain other drugs, renal failure due to overdose or continued abuse of analgesics?——W. Yes.

3108. Have you any comment to make on that statement?——W. Probably the true position is that when we give a cause of death, if we find the type of kidney tissues —lesions in the kidney—to be consistent with that of, say, a chronic overtaking or overdosing of analgesics, at this particular stage it is unlikely it would appear stated that the cause of death is positively due to analgesics, being a legal document. There are probably other reasons why this type of lesion might occur. It is a bit like saying that cirrhosis of the liver is due to chronic alcoholism. But that does not follow in every case, because there are less frequent reasons for cirrhosis of the liver. There has to be a very good history, and this is what we sometimes lack, not because of anyones failure, but simply because the person concerned might be isolated, perhaps living as a recluse, or in some way not having the contacts that we could readily refer to. Therefore, we do not know the true medical history.

3109. Would you see many cases of death due to renal failure?——W. I do not think so; not specifically in those terms. But there are a lot of people whose kidneys are in bad shape. However, as far as relating kidney damage due to, say, analgesics, the answer is no. They are more likely to find their way to hospitals, to be diagnosed in a hospital, and to be given, perhaps ultimately, a death certificate by a doctor outside our system. The kind of poisoning which has destroyed the kidney would not be the final cause of death appearing on the certificate. It would be a pathological problem in regard to the kidney.

3110. I suppose that you, like us, would find it interesting to know the background story to some of the cases represented by the figures that have been supplied to us?——W. Yes.

3111. I am intrigued by the possible social histories of some of these cases. I notice that last year there were twenty-two cases of death due to hard drug overdose? ——W. Yes.

3112. You would automatically carry out an autopsy in those cases and would it be on your recommendation that the case would go into that category?——W. Yes, as a result of our findings.

3113. Would you have access to the details of the social backgrounds of those people, or are you interested only in their bodies?——W. Information is supplied to us by the police department, which could probably give you a more detailed background study than I could. The police department prepares an official history for the coronor on a particular form known as P79A. It lists certain statistical and other matters such as age and marital status, and gives a short account of the circumstances.

3114. It has been suggested that in many cases the females involved have been engaged in prostitution. Has that come to your notice?——W. One case in particular has. I cannot say that it is an isolated case; it just happens to be one of which I am aware. She was a massage parlour worker. I think there have been others, but I would have to refer back to the police notes to say definitely. The case of which I speak very definitely was in that category. I have only a vague idea about the others, but I believe that there have been quite a number of them.

3115. It has been alleged also that many of the criminal elements are involved in the drug scene. Have you any evidence on that line?——W. In terms of members of gangs, gunmen and the like, I am not really aware of the position.

3116. Would you suggest that if we wanted to follow up this aspect, we would have to get the police reports to which you have referred?——W. Yes. I suggest that the police would give you the social backgrounds of these people better than we could.

3117. Do you suspect there are many cases in which the cause of death is given as something other than drugs when the person concerned is a drug addict?——W. No, I do not think so. What might not be known is that the death could be attributable to drugs other than alcohol. I think this was brought out somewhat by a previous witness. If we do not screen them for drugs other than alcohol, we would not know. It could be that we know death was caused by a fall or by a vehicle crash, and

probably some alcohol would be involved, but we would not know what else was likely to be involved. I would say that situation would exist, particularly in motor-vehicle accident cases. In other cases I would say that death is attributable to what are called natural causes or to some positive drug findings, as a rule. In other words, there is nothing misleading about the final diagnosis.

3118. Mr JACKETT: Pharmacologists have said that marihuana has a long life in the body. I understand that that is because there is a residue in the fatty tissues, is that so?——W. Yes.

3119. In view of what you have said about the difficulty of detecting marihuana, is there any way in which you can determine the presence of marihuana in a body on autopsy?——W. I am afraid not. I should like to go into that. As far as I am aware, about the only way evidence can be obtained is by swabbing the skin of the fingers with some chloroform, from which swab the analyst is able to determine whether some residue or trace of marihuana is present. Beyond that I am not aware of any method, but I would certainly like to look into that. I cannot answer you at the moment.

3120. Mr RAMSAY: You said that you would like to see introduced some systematic indexing of drug deaths. Who should do such indexing?——W. The three departments principally concerned at the moment probably overlap in their efforts. They are the coroner's office, our own department, and the Government Analyst. I do not know how it could be achieved, but perhaps the three departments could work together and, instead of overlapping, have a common data processing unit with the appropriate staff. The members of those three organizations could establish a classification in which information should be recorded. As with all such indexing systems one would have to know beforehand what was wanted. If it were to be an important monitoring system for the State so that certain trends could be determined in deaths due to accidental drug overdose, or anything else, such as deaths due to drugs that had been prescribed or deaths caused by non-prescription drugs, we would want to know precisely what was being looked for. If social backgrounds of persons who died from hard drugs were wanted, that would have to be stated as well.

3121. CHAIRMAN: Do you think that this information could be handled more appropriately by Dr Sutton's bureau?——W. I went to a particular meeting and became aware that criminal statistics were being kept. Is that the organisation to which you refer?

3122. I am talking about statistics generally.——W. It might not be necessary to spend a lot of money on something new. The machinery might already exist.

3123. That bureau has the administrative machinery available and as you have said, if a process were evolved, the data could be collected, and all the bureau would have to do would be to process it.——W. Yes.

3124. And then make it available to the three departments you have mentioned and to anybody else who wanted it?——W. I think that probably that would be the best way to do it initially, and possibly in the long run too because, particularly if you intend to continue with your monitoring, you will certainly need something that can be sustained and will not be subject to sudden stops and starts.

3125. Mr RAMSAY: Would you agree that many more deaths could be attributable to drug overdose than we know about?——W. I doubt that very much. The Coroner's Act is such that unless somebody is deliberately outside the coronial system, doing something that is contrary to what is laid down in the law—and I do not think anybody would be—I could not see too many of these cases getting past. If a doctor does not have a specific understanding of a person's condition, not having seen that person for three months, he is obliged to refer the death to the coroner.

3126. Do you consider that the three departments to which you have referred could within seven days of the event furnish to some authorative body a record of any death due to drug overdose?——W. I think it should be furnished as rapidly as possible, remembering that the time interval from when we start is equal to the time taken to make the analysis. We might suspect that something has happened, but we would not know positively until two or three weeks afterwards.

3127. I know that forensic medicine is an interesting and challenging profession, if not always the cleanest job in the world. Thank you for your evidence. We shall be in touch with Dr Sutton, and perhaps will follow up the suggestions you have made about a means of identifying by a more elaborate process, and of indexing, some of these cases. We shall leave that to the experts to work out.

(The witness withdrew.)

(The Committee adjourned at 1 p.m.)

*AT LISMORE ON TUESDAY, 5 JULY, 1977*

(The Committee met at 9.30 a.m.)

Present

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| The Hon. KATHLEEN ANDERSON | Mr J. G. T. JACKETT |
| The Hon. MARGARET DAVIS | Mr B. McGOWAN, B.A. |
| The Hon. C. HEALEY | Mr E. D. RAMSAY |
| | Mr R. C. A. WOTTON |

BERNARD VINCENT McKAY, Regional Director of Health for the North Coast Region, of 46 Ballina Cutting, Lismore, sworn;

GEOFFREY PAUL ROWE, Psychologist, of Ferris Lane, Ruthven, via Lismore, sworn;

MICHAEL JOHN CHEGWIDDEN, Psychiatrist and Community Physician with the southern area of the North Coast region of the Health Commission of New South Wales, of 11 Gill Street, Kempsey, sworn;

WILLIAM RILEY, Welfare Officer attached to the Richmond Clinic, of 90 Byron Street, Bangalow, sworn; and

OWEN LLOYD JONES, Community Psychiatric Nurse, of Georgica via Lismore, affirmed and examined:

3128. CHAIRMAN: You have each received from me a summons issued under my hand according to the provisions of the Parliamentary Evidence Act, 1901?——(*All witnesses*) Yes.

3129. I have received a submission from the Regional Director of the commission. Mr McKay, do you wish to have that incorporated as part of your evidence?——W. (*Mr McKay*) Yes. The submission has been prepared by a working party of people working closely with drug addiction in the Richmond–Tweed part of our region. The submission reads:

HEALTH COMMISSION SUBMISSION TO THE JOINT COMMITTEE OF THE LEGISLATIVE COUNCIL AND THE LEGISLATIVE ASSEMBLY UPON DRUGS—RICHMOND/TWEED AREA

This submission is presented not as a thorough presentation of Health Commission policy on drug education, but to highlight local characteristics of the drug problem and to present information on current and projected programmes for drug education being undertaken by the Health Commission in the Richmond/Tweed area.

*Extent of Drug Misuse*

There are at present no comprehensive statistics of over-all epidemiology of drug abuse within the Tweed/Richmond area. However, admissions to the psychiatric acute admission centre (Richmond Clinic) may supply a very approximate indication of the extent of drug abuse.

*Admission Figures for Richmond Clinic in Relation to Drug Usage*

| | 1.7.75 to 30.6.76 | 1.7.76 to 24.6.77 |
|---|---|---|
| Analgesics and Prescribed Medication .. | 41 | 47 |
| Alcohol ..... | 87 | 87 |
| Opiates ..... | 18 | 30 |
| Marihuana ..... | — | 1 |
| Hallucionogenics ..... | 3 | 3 |
| Opiate Addicts Treated on Methadone Programme at Richmond Clinic .... | 37 | 38 |
| Total Drug Admissions ..... | 186 | |
| Opiate Addicts Currently on Methadone Programme in Richmond/Tweed area | | 13 |
| Total Drug Admissions ..... | | 219 |
| Total of All Admissions ..... | 674 | 665 |

These figures of course do not include admissions to Lismore Base Hospital and other hospitals in the area. There are also a number of patients who would attend the only specialized drug service in the immediate area which is on the Queensland Gold Coast.

Most hospitals refer on to Richmond Clinic for acute withdrawals, as do the police. However Tweed Heads is performing withdrawal on a limited basis and at present wishes to extend this facility.

It would appear from these statistics that Marihuana does not constitute a medical/psychiatric problem on the North Coast.

This is not to say that Marihuana is not in common usage. Analgesics, prescribed medication and alcohol obviously form the majority of drug induced admissions. The high figures for opiate abuse are cause for immediate concern. It is our impression that by far, the majority of these abusers are not local residents but addicts who have come from the metropolitan areas (this is evident from our files). Many of these

seem to have come to the area with a genuine desire to remove themselves from ready access to drug suppliers. Opiates do not seem to be readily available in this area.

The overall supervision of the methadone drug on the North Coast is supervised from Richmond Clinic. Authority to dispense is delegated to hospitals and pharmacies in outlying areas.

*Current Programmes*

We will consider current programmes under primary, secondary and tertiary.

*In primary prevention* there is realistically at present almost nothing being done. We do have limited staff; 1 addict counsellor and 3 other staff members who are peripherally involved. These staff supply basic drug information *on request* from interested bodies, e.g. schools, service clubs, etc.

We are aware of the existence of intensively structured drug education programmes available from the drug education service. However, we do not employ a drug education team and there are at present no specialized programmes available in this area. It would also appear to us a logical assumption that to combat the barrage of pro-drug mass media advertising would require resources far exceeding our possible capabilities.

We would also recommend, given our available resources, that our major effort would be in educating the educators, e.g. trainee teachers, teachers, lecturers, etc., rather than direct education of the school children, parents, etc.

*Secondary Prevention.* In our opinion the existence of community mental health teams has partially improved the area of early detection (secondary prevention). It is difficult to supply hard data to substantiate this claim, however, assessment and referral networks are now available, visible and more tightly structured. It is universally recognized that clinical treatment of drug abuse is a very difficult area with a very low success rate. Again realistically speaking, we are performing a holding and supporting operation rather than achieving major cures. We believe that in this holding and supporting operation the services of voluntary organizations are invaluable and our major effort is in facilitating such organizations.

One obvious projected programme that would involve Health Commission in direct service would be apprehended drunken driver education programmes. This is a field into which we intend to move, but again at present feel hampered by lack of specialized staff. We are appreciative of the quite extensive consultation available to use of the Sydney based Drug Education Service.

*Tertiary Programmes.* Tertiary facilities in this area are mainly in the field of alcoholism. One such facility exists in the vicinity of Wauchope. A similar facility attempted locally failed through lack of referrals. At present we see no necessity for a local long-term care facility for abusers of drugs other than alcohol. Regarding Aboriginal abusers, it is considered these are best served by Benelong's Haven, Sydney and Kinsella House, Kempsey. We are actively supporting attempts by local Aborigines to start a similar service in Lismore and while basically aimed at the alcoholic, such a service could cover the general field of addiction.

Whilst appreciating that drug abuse is a major factor in ill health in our society we are concerned at the apparent double standards and inconsistencies in drug legislation and its application. We would particularly question whether present legislation concerning marihuana is a constructive deterrent against its use and abuse.

3130. CHAIRMAN: Would you like to elaborate on the submission?——W. Yes. The witnesses who appear for the Health Commission appear because we feel that it may give the committee the opportunity to assess the particular problems and to give the committee some idea of what is happening in the North Coast region. Mr Rowe is a psychologist attached to the northern area of our region and as such is a member of the community health team in Lismore. He also works in the surrounding areas. Dr Chegwidden is in the southern part of our region. Mr Riley is welfare officer attached to the Richmond Clinic in Lismore. Mr Jones is a psychiatric nurse who works also in the northern part of the area.

The region runs from the Queensland border to a point south of Nabiac, which is south of Taree. It runs for almost 600 kilometres. It is fairly narrow as it only goes as far as the top of the mountain region, about 100 kilometres from the coast. It has a population of approximately 251 000 people. For health services we serve also the southern part of the Gold Coast, as you will see when we go to Tweed Heads. Tweed Heads hospital looks after a portion of the Queensland population. We have a leakage from the Hunter region into the southern part of our area. For administrative purposes we are divided into three areas. The first region runs from the Queensland border to a point between Maclean and Coroki on the coast. The central area runs from Maclean to just south of Macksville. The southern area runs from Kempsey to Nabiac. Our services have been provided on an area basis. In the drug addiction field we have a drug addiction council. There is one in each of the areas. We have also a psychiatric services group in each of the areas. Since the introduction of the community health programme, in the past three years we have put into the field about 120 operatives under the community health programme. Of those 120 about 60 are community nurses. We see this as our first line of attack.

Our philosophy has been not to develop specialist service that you would have seen in the city and bigger areas such as the Hunter region and Wollongong—and I refer especially to addiction services—but we have tended to see all our community health workers as front line troops. We see each operative as a general community health worker supported by specialists of varying types. We see the role of specialists as educating those front line troops.

That is the entry to our system. As regards psychiatric services, the only in-patient service is the Richmond Clinic attached to the Lismore Base Hospital. Again this fits into our philsophy of trying to integrate our services. To run separate services is terribly confusing and not very successful. Country people tend to look towards a hospital as the sponsor and centre of health care. With our community health services a lot of our staff are employed by the hospitals in rural areas.

For problems like drug addiction and psychiatric services we have tended to view the general hospitals as a resource which should be used in our philosophy of total health care at the community level. As regards psychiatric services, we have three psychiatrists supported by welfare officers, a social worker and a psychologist, in the three areas. They have tended to be our front line troops with drug addiction as they are probably closest to it. That sums up generally the regional approaches.

(*Mr Rowe*) I am the community psychologist. Most of the work is in Lismore. I also do some work in Casino. My points about drug abuse are made in the submission. It is pretty much the same as the rest of Australia; analgesics, prescribed medication and alcohol seem to be the cause for the majority of patients that we see. We see a fair number of people addicted to opiates. These are mainly people coming from the city. One of the problems with setting up treatment facilities in country areas is that they actually attract people from the city. For instance, when one sets up a methadone programme, addicts in the city become aware of the areas where these programmes are set up and they migrate to those areas. Fairly often addicts in the city are advised by counsellors in the city to move to country areas so they are away from immediate contagion. One of our problems is whether to set up specialist facilities or not. As I have also pointed out, marihuana is not in this area a clinical psychiatric problem, although undoubtedly it is a very widely used drug, particularly among the young. It is a fairly unfortunate smokescreen in the area of drug abuse. A lot of energy is focused on the marihuana question. It begs the issue of drug abuse. It is very much a legal problem and most of

the people who get into trouble with the authorities are the young hairies. I would say very often these people are using rather than abusing.

(*Mr McKay*) There is one point that I missed. The voluntary agency is another important group up here. We have tended to try and sponsor voluntary groups. On Wednesday you have a visit to the Buttery, which is one of the groups that we are supporting through the community health programme of the Health Commission. It has been supported to the tune of about $12,000. We have tried to link in the problems of health and welfare by forming health and welfare councils of voluntary agencies. There are 16 of these councils on the North Coast. We see that as an important weapon in the education of the public, which is the key to most of our problems. Dr Chegwidden was a psychiatrist in charge of an addiction unit at Broughton Hall before coming to this region.

(*Dr Chegwidden*) One of the important things that has already been mentioned and is worth emphasizing is the fact that if one sets up specific programmes, such as a methadone programme, this will attract addictive people. We see no opiate addicts in the southern part of the region at all, or in the central part, because there are no actual programmes. I recall going to Melbourne four years ago and when the Melbourne people were setting up their programme I saw the same people that I had seen at Gladesville Hospital, at Parramatta and at other places. It is worth emphasizing that when one sets up a specific programme one attracts the people to come to those programmes. They tour the country from treatment place to treatment place.

In the southern part we do not see the problem of opiate addiction. My experience of seven or eight years in the psychiatric system is that marihuana is not a psychiatric problem. One could count on the fingers of one hand the people whose admission to psychiatric units could even be remotely associated with the use of marihuana. In Broughton Hall we treated over 2 000 alcoholic and soft drug addicts. Of the alcoholic female admissions 25 per cent were dependent upon prescribed drugs as well. So one in four of the women were dependent on drugs and about one in ten of the men were also on prescribed drugs. We tend to talk more about marihuana and opiates, which are small compared with prescribed drugs, which cause the same sort of withdrawal symptoms that we get from alcohol.

The services that we require are first and foremost preventive. How does one do that? I have yet to see anybody come up with any solutions for preventive measures. I think the problem will get worse, mainly because of our problems with unemployment. You cannot divorce these problems from unemployment. As people are finding more and more time and less and less to do certainly the places that they are congregating in our part of the region are in pubs. How do you move into that area? That is something we have been searching for but do not seem to have the solution. As I said before, the setting up of a special unit is dangerous. The facilities that we have for withdrawal from drugs and from alcohol are very poor. It should be done in every general hospital. My own fellow professionals are poorly trained in this field. Probably the worst training doctors get is in the field of addiction. They do not know how to treat withdrawal except by giving other drugs to compound the problem. This is why we set up a special unit in Sydney which dealt with 2 000 people in less than two years.

Rehabilitation has been mentioned. Voluntary agencies seem to do this far better. So I see the role of the professional in this area is in primary prevention, whatever that may be. People are trained to expect drugs to deal with all their pains. By using another drug routinely to deal with withdrawals we take away any of the pain that people feel. Our professionals are trained to reduce all pain, to do away with pain, so that people are not motivated to change. I feel that our role is very much in the area of motivators. Once a person is motivated to get well he can go to Alcoholics Anonymous or Drugs Anonymous. Finally, rehabilitation is a very moot point at present. When unemployment is running here at 5 per cent and higher, what are we going to train people to do?

What are we to teach people to become? How can we take somebody whose life has been almost destroyed through drugs or alcohol and say to him that we will rehabilitate him towards work. That is what we have done in the past. Gladesville hospital was full of 55-year-olds who had been trained to be Qantas pilots. We have to think in new terms. Perhaps it is not without interest that the film which won the academy award was entitled "Leisure". Perhaps we should be teaching people how to deal with increased leisure hours. (*Mr Riley*) My job at Richmond clinic falls mainly into the field of crisis intervention which would be, when talking about drugs, counselling of relatives, clients or patients who are involved with drugs. Few of the drugs are the opiates. I am talking about analgesics—valium and so on. These patients may be involved in withdrawal. It is a matter of counselling the relatives about how it happened, what they should be looking for in the future and contact with general practitioners or others. I have nothing to do with the methadone programme inside the clinic except for having an occasional relative referred—that is handled by the clinic staff. The field of health education is handled at present mainly—what little is being done—by Mr Rowe and Mr Jones. That also applies to people involved in addiction. There is a wealth of information that comes from other services that has to be assessed, as to whether we can use it. As co-ordinator, part of that is my job. We are asked to talk to various groups of people. We prefer education to take a certain line. The Health Commission has a policy on that. I am involved in that. My job involves mainly crisis work—the person in trouble at the time. Somebody rings up and asks for help. I may not do it, but I will find the person who can help them in the situation. (*Mr Jones*) My work as a community psychiatric nurse is involved in educating the other community nurses on how to approach drug problems that they might have in areas of the work. Part of my work is allaying the fears of anxious parents who come to the centre and are concerned about drugs and what they should do, whether there are problems or whether there are not. Also lately an increasing part of my work has been drug education towards school teachers and parents and citizens associations. More recently again, I have been involved in schools with school pupils talking about peer group pressures. It is mainly education and helping parents and citizens get the drug issue in a proper perspective.

3131. From what you have outlined the region is the Queensland border to south Nabiac. I presume that in that area there would be something like a quarter of a million people?——W. (*Mr McKay*) Two hundred and fifty-one thousand in the 1976 census.

3132. How many drug education officers are there in the whole region?——W. We have no such person as a drug education officer. There are three counsellors who take that role—treatment, prevention and rehabilitation. We have one health education officer. They are difficult to find, as you have probably found in your travels. She has been with us for about four months and is working up programmes in all sorts of areas, not just drugs, but that is an important area. There is also the peripheral staff

attached to psychiatric units such as psychiatrists, social workers and sociologists who are required to give support and education in this field. Our philosophy is to try to make every community worker equipped with some skills in the area of education. We see the real problem, especially for prescribed drugs, as an important one, which we hope to overcome with education.

3133. Would your main target be the high schools, in that field?——W. Yes, we see the educators and people to be educated. We have a college of advanced education. It is important that we do more to educate the people who are doing the educating.

3134. Are there any other tertiary institutions in the region?——W. No. The University of New England at Armidale has extension offices located in the region—two extension officers—so they have an interest.

3135. Approximately how many high schools are there in the whole region?——W. About thirty. There are twenty-six hospitals and you can usually add a few more for high schools.

3136. You are acquainted with the marihuana plantation that was discovered in Nabiac in January of this year? ——W. Yes.

3137. Have you any knowledge of any such plantations in your region, that have been discovered in recent times? ——W. I think there were one or two outside of Mullimbimby of quite large proportions as well.

3138. You mention in the submission that at present there is no comprehensive set of statistics of the overall epidemiology of drug abuse within the Tweed–Richmond area. What is the reason for that statement?——W. The only ones we come in contact with are really the acute situations, which are admitted to the Richmond clinic. We have those particular statistics showing the ones that have been diagnosed as drug caused. The problem is that in the hospital situation and in the community it is difficult to detect until the situation becomes chronic. There is the magic fillip syndrome. A lot of people believe a drug will take away pain and ensure life continuing. It is a phenomenon of the public to take a good deal of drugs. It is not seen as a drug by the majority of the people. This is why our education has to be more directed to the young. The medical profession also do not particularly see this as a real problem.

3139. Would Richmond clinic be the only official place for admission of drug addicts in this region?——W. Yes. There are two doctors at Tweed Heads who do detoxify some patients but that has given problems in terms of availability to appropriate accommodation in the hospitals and care for those people. I do not doubt that there are peripheral problems in most of our general hospitals in terms of people admitted to overcome some particular problem from abuse of a prescribed drug. I am sure that the diagnosis would not show that on the medical record. It would be some other reason.

3140. They are not admitted as drug addicts as far as you are concerned?——W. No. (*Mr Riley*) Sometimes we have the patients at a later date in Richmond clinic and the file does not show drug addiction. It may not show anything at all except the actual cause may be physical. We know that the person is just the same—from our own inquiries. That is quite common.

3141. Officially, Richmond clinic is the only State institution which is available between Newcastle and the Queensland border for the treatment of such patients.—W. Yes. (*Mr McKay*) As to methadone, there are two people who are authorized to prescribe, in the region. One will be appearing before the committee. There is Dr Rogers who is our psychiatrist at Coffs Harbour. He has four people on the programme at the present time. If he does not have the in-patients facilities he might use the actual hospital. Some of the hospitals have secure rooms. If he has a particular problem he transfers to Richmond clinic or Newcastle, depending on the nature of the problem.

3142. Have you had to deal with any doctors who have been illegally prescribing methadone?——W. No, I have not. It has not been brought to our attention at this stage but we believe that it is probably happening. We have no proof.

3143. Have you knowledge of any cases of people who have paid exorbitant amounts for prescriptions of methadone?——W. I have no personal knowledge—only hearsay. There are certainly stories of traffic in prescriptions for methadone.

3144. One of the members referred to analgesics. On our visit to Newcastle we were acquainted with the problem of the abuse of analgesics in the Newcastle districts and in some of the areas immediately to the north. Are you acquainted with the problem that exists in that area? ——W. Yes, I am.

3145. Does the same sort of problem exist in this area? ——W. I think it probably does. We do not have the sort of renal unit that Newcastle has, therefore we have not got the facts that they have been able to gather, but we have an ageing population on the North Coast because people come here to retire. Perhaps some of the others could talk about those in detail but there is no doubt that we are looking at the moment at setting up a dialysis unit and the demand for it is higher. I would think that the figures produced at Royal Newcastle Hospital, knowing our population and its similarity, relate to that, and that we have the same sort of problems.

3146. Is there anybody here who has made a study of the cases of renal failure similar to the studies made in Sydney and in Newcastle?——W. Not directly.

3147. If I were to ask you if you knew of the cause of renal failure apart from ordinary disease it would only be an opinion and not based on the experience of a study? ——W. That is true.

3148. In regard to the methadone programme, I notice you have a few people still on the programme at the Richmond clinic. Is there any particular reason why those people are kept on the methadone programme?——W. I might ask some of the other witnesses to answer that. Perhaps Dr Chegwidden has had experience. (*Dr Chegwidden*) I think it is dangerous. The first person who decided to swap one drug for another was Sigmund Freud who, in about 1890, decided to cure morphinism by giving patients cocaine, which killed them off a lot more quickly. On the methadone programme a lot of people use it because it is not addictive, but that is not so. We can guarantee a person to become not just dependent upon the drug but completely addicted if he uses methadone. There are tremendous loopholes and dangers in the methadone programme. A lot of people who abuse opiates do so sporadically, when the drugs are available. When they are not available they do not use them at all. These people go on to methadone programmes and that guarantees their addiction. It is difficult to get someone off methadone. One way is when they get married and make a fresh start. It has been recommended by the drug committee of the Health Commission quite recently firstly that we should not be using methadone for everybody until every other form of treatment has been known to fail. Also, that we should be aiming at three months withdrawal in

using methadone, and at most one year. It is accepted that there will be some people who will be on methadone for life.

One of the most distressing things that has come out of the methadone programme is the change. In St Vincent's hospital, Melbourne, about two years ago I was with an American who was among the first to use methadone, and now he tells people to please stop using it. He said that about 70 per cent of the people on the methadone programme are addicted to alcohol. They have to get their high somehow. I do not know whether you have met with the people from WHOS, but their cards before they were destroyed showed that of 1 000 addicts 65 per cent were also abusing alcohol. When they were blocked from getting their high through drugs they used alcohol. It was another form of addiction. This crazy medical idea that has gone on since Sigmund Freud's day to stop one form of addiction by creating another form of addiction on the assumption that it will get something out of the way is quite wrong but it is still blindly followed. Fortunately, some people are re-thinking about methadone being the universal panacea that it was thought to be five or six years ago.

3149. I notice in the submission that it is said that authority to dispense methadone is delegated to hospitals and pharmacies in outlying areas. Is there strict supervision?——W. Yes, that is to dispense but not to prescribe.

3150. I realize that. Is there strict supervision of that dispensing?——W. (*Mr Jones*) At the Richmond clinic people on the methadone programme have strict supervision as to either daily pick-up from the clinic or if they live a long way away and out of town they might be given two or three days supply at a time. Most of the people who are on it have been referred by a Sydney agency. Full documentation has to come with each person and they have a photograph that they must produce before they are given methadone.

3151. In the submission it says that authority to dispense is delegated to hospitals and pharmacies in outlying areas. What do you say about that?——W. (*Mr Riley*) I think that can be answered best by saying that we are careful in Richmond clinic as to who get that authority to dispense. For instance, it would not be just given to four or five chemists in each town. It would be given to one chemist and he would be required, and usually does, to say that so-and-so did or did not call in or is giving him a fair sort of hassle about his methadone. I think every possible chance has been covered, but I suppose, like all human beings, that one will go astray sometimes. I would not be able to say who has authority at the moment. It does vary. Those figures of thirteen still on methadone would include perhaps three in Byron Bay this week but next week none in Byron Bay. I could not say at this moment that there would be a chemist in Byron Bay who would be a contact for an addict in that town without transport. We try even up to a 20-mile radius to get the addict to come to Richmond clinic daily. That is part of the hassle. (*Mr Jones*) At Mullumbimby the hospital had an authority and patients had to go to that hospital if they lived in that area.

3152. You are quite satisfied that there is fairly strict supervision of the dispensing?——W. (*Mr Riley*) Yes, as good as possible. (*Mr Rowe*): We do not take spot checks but we have confidence in the people who are authorized to dispense. That is our main control. We have pretty close consultation with them and we put a fair amount of trust in their ability to distribute it properly. We do not have things like spot checks to see that that is being followed through.

3153. It is quite normal to prescribe methadone for someone who is not an addict?——W. (*Dr Chegwidden*) For intractable pain, yes. It is said that people feign pain to get it but so far as I am concerned it is all hearsay. It is merely folklore to say that addicts will go around town and see a doctor and say they are up from Sydney travelling to a new treatment area in Brisbane and are stuck in the town without methadone and will go crazy for a hit if they do not get some so please subscribe some. That is the sort of story that is well known. I might point out that doctors are trained to believe their patients. They are trained to believe everything that one says. They are clearly not trained to handle these situations. Look at the turnover of staff at Brisbane Street clinic and you will see what a distressing sort of task this is. General practitioners cannot handle it.

3154. Whose responsibility would it be to police pharmacies to find out whether there had been undue dispensing of methadone? Would it be someone in this region or someone from the inspectorate in Sydney?——W. (*Mr McKay*) In Sydney, from the Commonwealth. The Commonwealth has jurisdiction and a computer which is loaded to throw out all sorts of dispensing patterns in relation to the over-dispensing of items. Usually the Commonwealth informs our inspectors and they take it from there. If there is a doctor over-prescribing a particular drug we would become involved in it.

3155. Someone made a statement that there is no opium addiction in the southern part of the region. This would suggest that the only real problems are, say, Lismore and along the coast. Would that be correct?——W. I think what Dr Chegwidden was saying was that the fact that there is no methadone programme in the southern part of the area tends to mean that the addicts don't gather in those areas. Of course, if there is someone there with a supply of heroin no doubt there would not be a demand for methadone.

3156. Have you had psychiatric problems that have arisen from an overdose of Mandrax?——W. (*Dr Chegwidden*) Yes.

3157. Very often?——W. Not often. I think it has gone out of fashion. I left Sydney in February and we did not see many. We had 2 000 people in the unit which dealt only with alcoholic and soft drug withdrawals and mandrax did not seem to be a problem. The biggest problems we found were such things as tranquilizers, including serepax, which has replaced valium as the universal panacea for curing all ills. Valium causes a withdrawal as severe as alcohol, including the full DT's. Chlorale hydrate, which can be bought over the counter, and that sort of drug, causes problems. Mandrax does not seem to be a problem any longer. People have a bad trip and their friends know how to get them out of their bad trip. They sleep it off and that is it and they do not need psychiatric treatment. As admissions, we see two or three people only with mandrax problems. It is a hallucinogenic if you use enough of it, but you stay awake.

3158. We know from figures from the Sydney coroner's court that chloral hydrate can be quite lethal. Do you feel that that builds up a physical dependence?——W. Yes, similar to alcohol. It is difficult when talking about drug addiction but we think about people who become dependent upon any form of oral medication as addicts. Alcohol is the commonest one. We find that people will swap one for another at any time if there is something else available. That is what you find with the methadone programme. When good heroin is freely available people will use that and the methadone programme takes a dive but as soon as the heroin is not available the methadone is used again.

Chloral hydrate is one that alcoholics who stop drinking alcohol become addicted to. Valium is another one. I have seen people use up to 1 500 tablets of valium per week. One man I saw take a handful at a time, and he was still walking around, though he was staggering a bit. People build up a tremendous tolerance to some of these drugs, whether they be chloral hydrates or any other drug that can cause dependency, or anything that affects the central nervous system and gives you a buzz and makes you feel good. People will use and abuse these things and they will swap one for another. I am distressed that my own profession should join in this game and do it for people.

3159. Mr McGOWAN: Would you like to give the methadone programme away.——W. (*Mr Rowe*) It is difficult to do that. If you do, what do you do with the people involved? From our point of view, the trouble it causes may make us think that we would like to get rid of it but I do not really know what we would do with the number of addicts here.

(*Dr Chegwidden*): As you know, Wistaria House was the first place to use this treatment. When a person was sent overseas to study this treatment, he came back with a methadone programme. That is the only research that went into it. We are now beginning to see that it does not work. Some people, for instance the Wistaria team, say it is marvellous. We seem to rush into things without making full investigations first. Then we find that it is going wrong. I would like to see it a banned drug.

3160. Not even prescribed?——W. Yes, especially not prescribed by my fellow practitioners. They will not listen to anybody's advice on this matter; they seem to think that they know best.

3161. Mr JACKETT: Do you use the blockade method of methadone treatment?——W. I am not involved in a methadone programme at Lismore.

3162. Is the methadone that is used in the programme used in a maintenance or blockade way?——W. I think it is generally accepted now that if you are going to use it at all, you should use high dosages, about 100 to 120 milligrams. The old way of using it, with about 35 milligrams was pretty useless.

(*Mr Rowe*) Almost all our people are on maintenance. As far as I know, nobody is on blockade.

(*Mr Riley*): I do not think we have anybody on blockade. Why they may be on a dosage of forty milligrams is that as we pointed out in our submission, they come from outside our area. These people are registered addicts. When they come through, we have to check with Sydney. They might tell us that a person is on 40 milligram maintenance and that is usually carried through after the doctor has seen them. So that we do not use blockade as such. (*Mr Rowe*): The addicts are from the metropolitan area; none of them are local addicts.

3163. How long does it take to withdraw them when they are on methadone?——W. Between a week and three weeks. The local centre is not set up as a long term in-patient centre.

3164. You like to keep them for about a week if they have acute withdrawal problems?——W. (*Dr Chegwidden*) Yes. Nobody dies from a withdrawal from opiates in the withdrawal stage. The symptoms we treat are acute anxieties. There is no need to use opiates to withdraw people from that. It is the same with valium, alcohol and other drugs. Perhaps a lot of the confusion about blockade and maintenance is that the turnover among the Brisbane Street staff seems to be about 100 per cent every three months. You are not sure what the policy will be from month to month. One of the most constructive things I have noticed is that the clinic there is using treatment such as the relaxing techniques as an alternative to the methadone.

3165. Do you have many problems with mandrax being combined with alcohol?——W. Any combination of drugs seems to have a cumulative effect. It seems to be common among psychiatric nurses, not the ones working in the community but the ones in some of the larger centres in Sydney like Callan Park and Gladesville. In those hospitals some nurses seem to use those drugs. I have been asked to write a prescription when I have been told, "I have not been sleeping very well". When I have looked, I have been able to see immediately what has been going on. I can see what is happening straight away.

3166. With regard to barbiturates, has there been any loss of life in the past four years in this area because of the problems of withdrawal from drugs, particularly barbiturates?——W. That has been known, but I think more people die from maltreatment. At McKinnon, in the past two years without any fatalities, they have used intravenous treatment on one person out of 2 000; they have used drugs in withdrawals in only 9 per cent of cases. These were the most severe alcohol and drug dependent people. If those people had walked into a general hospital, they would have been given intravenous therapy. I was in St Vincent's Hospital last year as a patient and a man died in the room next to me with a drip going. Everything seemed fine. The nurses said that he was just an old alky who had been in many times before. I think that people are often given intravenous therapy like the drip and then a nurse is left to carry on with it. Often she may be a second year, untrained nurse. There is a tremendous danger in overtreatment. I think that some people who die in general hospitals do so as a result of overenthusiastic treatment and lack of knowledge of how they should be treated. I was lecturing to some fifth year medical students at Sydney University and they were in their fifth year. I was the first person to be talking to them on alcohol addiction. So that to my way of thinking the position is not much better than it was twenty-five years ago.

We can make excuses for ourselves and say that we are pressed by everybody coming to us asking for those magic bullets about which much has been said. Also, the drug companies are piling our desks with literature. Unfortunately, a drug called Hemineurin was the subject of a lot of this type of advertising. They had the words "Hemineurin" and "Alcoholism" in large letters on the literature. These things are being given out like lollies. I think that if you are sitting here in five years' time, you will hear talk about people with problems of withdrawal from Hemineurin. As soon as you get a drug of addiction that works well when it is used properly, some people will abuse it. My profession says that it is capable of policing drugs, but I point out that we should look at the evidence of what has happened in the past to see how well they have been policed. We are jealous of our profession. We do not like anybody talking about it because we think we are the experts. The fact is that we are not the experts; that is a myth that has been built up over the years. When you talk about people dying of drugs, I think many people die of drugs like APC powders. People should think about the cost of a dialysis unit. We are starting to do something about APC's but pharmacists do not like you not to allow them to give out drugs. My profession would not like you to put restrictions on their prescribing habits.

3167. CHAIRMAN: I suppose you are acquainted with the Commonwealth proposal that compound analgesics should be available only on prescription?——W. Yes, that the only things that should be sold are aspirins, phenacetin, paracetamol or caffeine separately.

3168. Mrs DAVIS: Do you have any problems getting beds for the treatment of drug dependants?——W. (*Mr McKay*): Yes. General hospitals are not terribly keen on this particular problem. I think the real trouble is that it is often left to the nursing staff to deal with the problem. The general practitioner or the local doctor may not know a great deal about it and they tend to put these people into hospital, to tranquilize them and hope that they will go away. Another problem is that they have not got the sort of facilities. They have now asked us to set aside a couple of beds for this particular purpose. Some of their colleagues are upset about this because there is a shortage of beds in Tweed Heads. That is the only place. I think the facilities are there if we can develop them so that we can provide the appropriate sort of care.

3169. Do you feel in this area you are getting a legal over-prescription of drugs?——W. (*Dr Chegwidden*) By looking at the figures for prescriptions over a four-year period, the prescriptions for valium were in the first five tablets for every man, woman and child in Australia. The next year it was seven. The next year it was fourteen and then seventeen. It is now going down. It is going out of fashion. We had a good press about two years ago pointing out the dangers. We got Doug Everingham on side and there was a lot of adverse publicity for the abuse of valium. What happened then was that they used serepax. Over prescribing—yes. Doctors did not have drugs, except for pain killers, before 1900. There were no drugs at all. We have suddenly decided that we can cure all ills with drugs. Drug companies have a tremendous investment in selling them and people are looking for the magic fillip because we live in difficult times. It was said that 3 000 years ago there were difficult times—there always have been. People are always looking for something to make them feel good.

3170. In this area do you have over prescription?——W. No—the only way you would know would be from the Commonwealth figures, which they pull out of the computer. That is a federal matter.

3171. You are not seeing many people as a result of over prescribing?——W. No, we are an over-doctored town in the area and doctors do not refer people to the community service. They deal with them themselves. As has been pointed out, you would have to look at the hospital statistics. People are not admitted for this. The man who died in the St Vincent's hospital in the room next to me died due to congestive cardiac failure. There was no mention of the fact that he was an alcoholic. The figures are difficult. We see the majority of people—women suffering from emotional problems have been given all the pills, one after the other, and it is only when they get back to the little yellow one that they realize that the doctor has run through the list and they are not getting better. Then there might be relaxation response or more constructive ways of dealing with stress and tension.

3172. Mr WOTTON: You stated that you did not consider that marihuana is a medical or psychiatric problem on the North Coast. This is in line with a fairly comprehensive agreement that rather is inclined to say that marihuana is o.k., it is not as bad as alcohol. Do you believe that it will be a problem in the future or that we are trying to play it down and say that it is all right? Do you think that it is a problem in itself and that people should be discouraged from using it?——W. (*Mr Rowe*) I think most psychotropic substances have a potential abuse and I think marihuana probably does in the long term. I think it is probably less dangerous than alcohol. Yes, discourage it, yes.

3173. Dr Chegwidden, you mentioned, and I think it has been said fairly strongly, that users of opiates are all imports to the area and the programme for curing them is making a problem in itself. What came first, the programme or the users?——W. (*Dr Chegwidden*) I have been here only since February. Perhaps those who have been here longer could say. It has been pointed out that every single person on the treatment programme has come from Sydney.

3174. It was not the programme that brought them here? What came first, the chicken or the egg?——W. (*Mr McKay*) It might have been a dead-heat. (*Mr Riley*) Richmond clinic opened in 1973. We did not start with a methadone programme. Obviously there were addicts in the area because we were getting asked for methadone early. We did not start the present programme probably until 1974—you could have two shillings each way. The addicts were here but we did not have a programme. We started a programme because of the number of addicts who were asking for it.

3175. In your education programme to teachers, parents and pupils do you have specific guidelines or do you educate as you see the problem yourself?——W. (*Mr Jones*) Our programme of education is one of getting drugs in their proper perspective. We find that a lot of questions are being asked of us. They ask what heroin is, what marihuana is and what different substances are. Basically we give a general over-view of the different drugs, what their effects are and what we feel are the major problems in order of appearance on psychiatric admissions.

3176. In other words, an educator such as yourself, one in the southern part of the State, the western area or the metropolitan area may all be telling the people something different?——W. It is possible but more and more with drug co-ordinators in each area we are getting more concerted and more specific guidelines. (*Mr Riley*) Part of the job of a person like me is to know what the educators are saying so that they stick to Health Commission's policy. (*Dr Chegwidden*) That does not mean that what the educators are saying is correct—we might all be saying the wrong thing together.

3177. There has been divergence of opinion expressed by a lot of people. The committee could get 101 different ideas on treatment. That does not make our task easier? ——W. I appreciate that.

3178. Mr HEALEY: In reply to a question from the Chairman about statistics you said that an addict must be admitted to the Richmond clinic before he becomes a statistic on the Health Commission's records. What happens at the early stage of use or abuse with a person who would like to kick the habit and comes to you? Do you keep no records of that?——W. (*Mr McKay*) They would go to the psychiatric clinic. The psychiatric nurse would be the person at the first point of contact and hopefully they would come into our system somewhere. That is why we are trying to establish a machinery whereby if they touch any part of our system they will be referred to the appropriate person, the Richmond clinic or the psychiatric service. It may not be the Richmond clinic, it may be the psychiatric service and the other two areas and there would be a record taken. They would enter our system whether they are actually admitted as an in-patient or treated as an out-patient. That would be determined by the psychiatrist or person seeing them.

3179. You said they had to be admitted to Richmond clinic before the figures were available.——W. No, they would be taken as out-patients, not necessarily in-patients. I was trying to emphasize that they could go to another hospital, under a private doctor, and we would never know.

3180. Dr Chegwidden, you made the statement that general hospitals and general practitioners were ill-trained in the treatment of drug abuse yet it has been said by Mr McKay and you that the policy of the Health Commission in the area is against the setting up of specialized units to deal with these problems. If, in your opinion, hospitals and doctors are ill-equipped to deal with the problems, surely the aim of the Health Commission would be to have a specialized unit.——W. (*Dr Chegwidden*) I know that was the policy. I remember Barclay going into that at length five years ago. It was why we set up McKinnon in Sydney. In terms of the number of people we have we would perhaps agree that we would like to have areas of the general hospitals set aside for this purpose because obviously throughout the withdrawal stage there should be twenty-four hour monitoring with nurses exceptionally well trained—it is not just the doctors. Doctors normally write a prescription and tell the nurse what to do. The nurse is there with the patient twenty-four hours a day. They are the people we should be educating perhaps more than the doctors. While there is a dual system, a system which means that the sicker people get the more money the health people get, there will be conflict with people talking about preventive measures and seeing people do not get into trouble with health. There will always be that conflict. We know that doctors are jealous of their positions. Certainly they do not listen to professional Health Commission people. I think that to set up a separate unit would be a retrograde step in the country. If we could train people who could handle these things in every general hospital, in other words if every general hospital had one or two beds set aside and perhaps two or three nurses trained in a unit such as McKinnon, we do not use the doctors. I was the unit director but the nurses were trained to do the whole lot and they do it better than doctors. I think that the nurses are the people who should be trained to handle this. Then, how does one get a doctor to listen to a nurse when a nurse says to a doctor, "What about such and such", from her own experience? The doctors looks down and says, "You are only a nurse". Nurses are not yet looked upon as professional. (*Mr McKay*) There is a conflict. I do not think we see all hospitals as drug addiction and withdrawal centres but we can nominate within our district a hospital run on that line with staff trained to undertake that role.

3181. Would you elaborate on the last paragraph of your submission?——W. (*Mr Rowe*) We are referring there particularly to the fact that marihuana and narcotics are lumped together under the same classification. That does not seem very sensible. We see narcotics as extremely dangerous and marihuana does not have anywhere near the danger of a narcotic. Also, it seems that marihuana usage is a fact in the community at the moment. The application of laws against its usage is making a large legal problem but I do not really see that the laws are constructively preventing people from using it.

3182. What would you consider to be a constructive deterrent?——W. I would feel that if it were decriminalized but kept as a civil offence it would be a more reasonable and fair approach to it.

3183. Mr RAMSAY: Do you have a record of the number of deaths of people through drug mis-use in this region?——W. (*Mr McKay*) No, but I could get some idea. In country areas autopsies are not always carried out. (*Mr Riley*) We do not have records at Richmond clinic. We do not have people die there from drug overdosage. I do not know how you would get those figures.

3184. Do you not think it would be in the best interests of the community to have a complete check of these matters?——W. (*Mr McKay*) Yes, we have been operating for only three years as a region and we have just got our programme finalized. One of the problems with drug addiction or epidemiology of disease or other things in this region is that we have only just reached a stage of joining up the programme and there is now some feedback of diagnoses on admissions.

3185. There might be a number of deaths in car smashes caused by drugs, but if there are no autopsies they would go unnoticed?——W. (*Dr Chegwidden*) There would be autopsies on accidents but I suppose the police would have those records.

3186. At Richmond clinic what is the average number of addicts to pass through there in say a day or a week? ——W. (*Mr McKay*) There is an area of hallucinogenics which we have not dealt with yet but Mr Jones could answer your question. (*Mr Jones*) Until June, 1977, there were 38 for the 12-months period and it is increasing. (*Mr McKay*) In total there were 209 people with addictions who went through there last year, for all types of addiction. Taking alcohol out of it there would be something like 140, which is an average of about three a week. (*Mr Riley*) There would be three people at any time at Richmond clinic who would have some form of addiction.

3187. How many can be treated there?——W. Earlier this week Richmond clinic had five extra beds in use and its usage is 75 per cent to 100 per cent and there is no more room.

3188. How many beds are the——?——W. (*Mr Jones*) It is a 23-bed acute admission centre with an average stay of twelve days. (*Mr McKay*) It is the only psychiatric in-patient unit on the North Coast.

3189. Are there other volunteer establishments?——W. Perhaps at the Buttery, where they take referrals from the courts and from city agencies. There might be two or three people there at a time but that is the only other group active in this field of addiction.

3190. Mrs ANDERSON: Mr Riley referred to crisis counselling. Is this available outside public service hours or is it just a 9 to 5, five days a week function?——W. I would answer that by saying that I had a telephone call at 10.30 last night when I was called to a patient who was in a psychotic episode. (*Mr Jones*) Richmond clinic operates twenty-four hours a day and the staff is available for consultation but not necessarily visits. It operates as a lifeline centre in this area. (*Dr Chegwidden*) Do not let us paint a nice picture about it. Public Service regulations say we cannot have overtime and we must work from 9 till 5. We do not have flexi-hours here. Where we set up a programme working into the evening we are officially not allowed to do so but there must be work in the evening. The staff is told that they may unofficially have time off to make it up but if they are caught doing so they could be in trouble. The Public Service regulations preclude that. The vast majority of health workers in the community service, apart from nurses attached to the hospital, work more than 9 to 5, Monday to Friday, and crises occur in the evenings and at weekends far more than they do between the hours of 9 to 5. (*Mr McKay*) It is one of the real criticisms made by private practice doctors. It is one of the reasons we tend to run a community service from the hospitals, twenty-four hours a day, seven days a week. It is difficult to run a health system under Public Service rules.

3191. Is there any conflict or resistance by GP's to the existing position?——W. It depends upon the GP's personality. We have been fairly lucky. We have seen develop here a good relationship between the authorities and local doctors. However, it is still a battle to get them to use community health services. We have tried an experiment which works well. We have attached a community nurse to a big practice which gets us referrals from there.

3192. Is there any lack of rapport between them and the community physicians?——W. (*Dr Chegwidden*) Yes, I think there is. I do not think this area works very much as a community. The one in the central area has worked for a long time quite well. In Kempsey during the war there was a population of 9 000 people with three doctors. Now the same population has thirteen doctors. We are rapidly becoming over-doctored and at the end of this year there will be a double graduation and they will all be looking for the mighty $80,000 a year that they seem to be able to get from Medibank. I do not think they will be using our services any more than they do now. That is why I think the Government was wise in setting up community health services. The Government wanted us to spend more money and time in the area of mental retardation, mental health, alcoholics, drug dependency and geriatrics, which are all areas the GP's do not make a fortune out of and do not know much about and therefore do not like to handle. I believe that New South Wales has missed the boat. The minute doctors in private practice feel that someone is encroaching on their territory they become suspicious. As a psychiatrist I would almost diagnose some of them as being paranoid. We are not threatening private doctors at all.

3193. CHAIRMAN: Gentlemen, thank you for bringing to us details of your knowledge and experience. We are most grateful and what you have said will assist the Committee greatly.

(The witnesses withdrew.)

LESLIE ALLAN FINDLAY, of 21 Robrown Drive, Lismore, Director of Education for the North Coast Region of the Department of Education; and

WALLACE JAMES WARDMAN, of 6 Emerald Place, Murwillumbah, Principal of Murwillumbah High School, sworn and examined:

3194. CHAIRMAN: Mr Findlay, I understand that you have volunteered to give evidence to the committee in your capacity as Regional Director of Education?——W. Yes.

3195. I should be pleased to have your submission. ——W. I believe that in the North Coast region we are very fortunate in that there is very little problem indeed in the schools so far as drugs are concerned. We do have some problem with alcohol and tobacco, but we have very few problems as far as other drugs are concerned. I am in regular contact with the principals of the twenty-two high schools and of the seven central schools that have secondary pupils. I know that they are ever vigilant. During last week I rang every one of those principals so that I could be brought up to date with the position. The principals informed me that in the past four years as a group they are aware of only seven instances in which youngsters have been involved with the smoking of marihuana. None of those instances took place in the school.

All the principals stated to me that they have no doubt that there is something of a drug problem in the North Coast regions with post-school people. They have no doubt that marihuana can be obtained. They have regular discussions with their school pupils and the school pupils are not backward in stating that if they wanted marihuana they could get it. There may be cases other than the seven of which I am aware. Perhaps they are cases known to the police and to the Department of Youth and Community Services that have not been reported to the principals. I doubt whether there would be many.

At one of our southern high schools there is a boy attending at the moment who was convicted of a drug offence last year involving marihuana. He was placed on a bond. After discussion with me the principal took the boy into the school again; he was re-admitted. He is continuing in year 12 this year. That is the policy that we would adopt; we would not ban a boy from school. This lad has been allowed to return. He is the only one in that category.

Personal development courses are being offered in all but three of our secondary schools. In the three schools where these courses are not offered there are courses in health education. So drug education is being given in all the schools in the North Coast. At this moment I am certain that we have no serious problem. I only hope that it remains that way.

(*Mr Wardman*) As I live at Murwillumbah I am conscious that the drug scene, as the students call it, is about. There are regular instances of the apprehension of people growing marihuana. Obviously it is available to young people, especially in the Gold Coast area, if they wish to have access to it. In the three years that I have been at Murwillumbah High School there has been only one instance where we thought we apprenhended a student who had smoked a marihuana cigarette at lunch time, away from the school. The case was investigated by Detective Sgt Jones of Murwillumbah police. He is not sure at all that she smoked a marihuana cigarette. He thinks she was persuaded that she did and her hysterical reaction had something to do with that. The only other instances that I know of where my students have been exposed to drugs were two cases of overdoses of sleeping tablets. In one instance the student was found at school. It was a new student from the Sydney area who was reacting against almost forcible transportation into my area. The second instance was a teenage girl reacting against a broken love affair. She took the dose at home and not at school. Both students returned to school, one the day after and the other two days after.

No member of my staff has had experience with a student who smoked a marihuana cigarette or a student who has taken any other form of drug. In the school we run a personal development programme which at particular intervals introduces drug education. The main problem in the high school as I see it is not with those types of drugs but with tobacco and alcohol. Under-age drinking seems to be an increasing problem and certainly there is no decrease that we can measure in the instance of student smoking, in spite of our pretty active drug education programme in that area.

3196. Could you tell the committee, please, the area that is covered by your administration?——W. (*Mr Findlay*) The North Coast region extends from the Queensland border to Tuncurry on the south. It is bounded by the escarpment on the west.

3197. Broadly, you would cover about the same area as the Health Commission?——W. Yes, I would think so.

3198. Is there co-operation between the Department of Education and the Health Commission with regard to these personal development programmes and drug education generally?——W. Yes. My officers are in communication with the officers of the Health Commission, with the

police and with the Department of Youth and Community Services. I believe that there is good contact between all the departments.

3199. Would these seven cases to which you refer all be cases of police apprehensions or cases that have come to the notice of the principal?——W. Three of them were police apprehensions. Three were cases where the principal suspected that there were drugs. In another case a minister of religion reported to the principal that he knew that the boy had marihuana. In all cases the police are brought in; the principal endeavours to persuade the parent and the child to report it to the police rather than have us report it. In every case where the principal has discovered it the parents and the child have themselves reported it to the police.

3200. Could you enlighten the committee about the personal development courses given in the school, particularly how they are planned and what would their association be with, say, drug education programmes?——W. (*Mr Wardman*) In relation to the question you asked a few minutes ago, we rely very much on guidance from the Health Commission for the manner in which we go about drug education. The advice is not to treat it as a separate thing in itself but to integrate it with health education and personal development. This course tends to involve all sorts of sociological aspects including sex education. The emphasis is very much on community accepted attitudes to good health. The course begins with a physiological programme. The element of drug education comes into it in Year 7 in my school; it is concerned largely with tobacco and the harmful effects of drugs like that on people. By the time the student gets to Year 9 at high school he has been educated in regard to tobacco and alcohol and he has been introduced to the dangers of hallucigens and narcotics. I have left out analgesics which are dealt with as extensively as we can. All those areas are dealt with. Students see films that are designed to educate them and they discuss the situation in a mutual support group situation. They participate in a carefully planned programme to make them aware of the dangers of experimentation in drug areas.

3201. Have you any evidence of abuse of analgesics amongst the school population?——W. I am probably not technical enough to deal with analgesics. I have had two cases of an overdose of sleeping tablets but I would not be prepared to say what they were.

3202. I was thinking more of evidence of people taking Bex powders or Vincent's APC's.——W. They are not dispensed in the schools. I have no evidence of over-usage of those things although I am told that it is the case.

3203. Having regard to your proximity to the Gold Coast, which apparently is a notorious area for people on drugs and the fact that you have apparently had no great problem in this area, to what do you attribute the fact that you seem to be free of a serious drug problem? Is it because of the attitude of the children or the close supervision that is given by the teachers, or is there some other reason?——W. I would like to say that the personal development programme is effective but I have no evidence of that. I think that much of what is written about the drug scene in newspapers does not refer so much to the high school student who is fully occupied and has all his time taken up. I think it refers more to the adolescent who has left school and is looking for what drugs offer him. My group of 1 100 students seem to be calm and ordinary people. They seem to live in school fairly happily. We take care to see that there is no area in the school in which the use or sale of drugs occurs. We supervise our playground through playground duty rosters. We have close contact with the students. The students tell me that marihuana is available on the Gold Coast. Only one student has ever confessed to me that he has smoked marihuana. Another student confessed to someone else that marihuana has been smoked. People in the community tell me that I have a drug problem in my school. It is much like a recent instance that got a lot of publicity and involved the mayor of the Gold Coast. He was given some evidence by two students, but there was not much publicity when they withdrew those statements and made a public apology for the inconvenience they had caused. We can never get back to the actual person who uses drugs. We can get within three of him. It disappears into a rumour situation all the time. I do not think it is the high school student who has the need; I think it may be the adolescent who has left school who probably has the need. Probably that is the reason why I have not got that problem, but I am conscious that it is about.

3204. Have you had any cases in your school of students being addicted to either heroin or cocaine or similar things?——W. No, nor, do I have a teacher in my school who has an experience with that type of situation.

3205. Following a statement that the greatest problem may be with the adolescent who has left school, do you think that the Department of Education has a great responsibility in regard to those adolescents and, if so, are there any programmes to occupy them?——W. (*Mr Finlay*) Yes, I believe that we have a responsibility. I think that on the North Coast about 12 per cent of our Year 11 students are there because they have been unable to find employment. There are probably others who might benefit from returning to school but have not done so. I have suggested to the principals of the North Coast region that they should consider—and they are considering it at the moment—offering alternative courses rather than highly academic courses to those youngsters who are back at school simply because they cannot get jobs.

3206. Is there any programme for those children who have no intention of returning to school or is that the responsibility of some other government department?——W. We have no programme for them. The technical colleges have been offering trade courses for them and there has been some worthwhile response to that. I do not feel competent to speak on that because the technical colleges do not come in my jurisdiction.

3207. Mr HEALEY: As to the students who have been returned to the schoolroom, what has been the reaction to them by other students?——W. At the school where that student was returned to the classroom, I understand that he was quite readily accepted; there was no problem. The behaviour of the students has been watched carefully. The principal is keeping an eye on the situation and at this stage there is no reason for concern.

3208. Mr McGOWAN: Was there any reason given by the principals of the three high schools that do not have personal development courses, as to why they do not have them?——W. Before a personal development course is introduced, it is discussed with the Parents and Citizens' Association; it is introduced with the consent of the association. The principal in each of those cases has discussed the situation with the Parents and Citizens' Association which has been of the opinion that they would prefer not to have personal development courses. I believe that they will probably change their minds. Personal development courses are fairly new. In the case of the three schools that have not introduced the courses, I would think that the Parents and Citizens' Associations have been a little wary, waiting to see what happened in the other schools. They have worked so well in the other schools that I suspect that the three schools that have not introduced them will probably do so before very long.

3209. Would it be possible that they did not have teachers sufficiently trained for personal development courses? What is the training, if any, for such teachers? ——W. In answer to the first question, it may be that the principal himself decided, but he would have discussed it first with the Parents and Citizens' Association. It may be that he decided that he did not have people who were competent to cope with the problems of a personal development course. There are in-service education courses in personal development. We, in the North Coast region, have organized and run several of these. We do not have any operating at the moment because I feel that we have satisfied the demand. If these three schools that are not in the programme decided that they wanted to come in, we would mount a course of in-service training in personal development.

3210. We have heard evidence in other areas that the Health Commission has had difficulty of access to high schools, in particular to the teachers. Are you aware of any problems like that here?——W. No, I am not aware of any problem. I have a close association with the Health Commission and I am sure that association goes right through the whole of the region.

3211. Would you describe the situation in the high schools as to any individual counselling that is available to students who might possibly be at risk, in other words, to students who are disturbed in one way or another?—— W. (*Mr Wardman*) Every high school has a school counsellor. My school has the services of a school counsellor two days a week. Of course that is inadequate, probably through the economics of the situation. The form master exercises a full responsibility but in my school that gives him about 220 or 230 students and that is too many. He works through a group of class teachers. They are responsible for groups of about thirty or a little more than that number. Both the deputy principal and myself in my school have a philosophy of education which recognizes the need for support groups—mutual support groups—to give students who have these sorts of problems somewhere to go and somewhere to talk, and, perhaps somewhere to find themselves without referring to some other advice. I think it is probably in the atmosphere in the schools. Probably some of the best work done here is not seen; it is done by teachers who have a rapport with their students and speak to them all the time. There is a great deal of inter-action by students and staff in my school, at lunchtime and in the playground—in fact in all sorts of ways. I think we do fairly well with that sort of counselling. Students know the lines of communication; they know they have access to the form master and the principal and they know the school counsellor is there. They are invited regularly to seek help in all sorts of ways. There is a fairly active programme from the school counsellor and class teacher to attempt to provide for the needs of these children. We are conscious that much of this is not done in the family any more. One of the reasons why some of the parents object to the personal development programme is that they feel that this is the role of the family and the family ought to be made responsible for it; that it should not be the role of the school.

We know now that is not so. The personal development programme is framed to offer the mutual support that extended families used to offer.

3212. Mr JACKETT: In the personal development programme operating in the region is there a good deal of consultation between the programmes in each of the schools to develop the programme as regards drug education along fairly clearly defined lines? Do they tend to be given a great deal of factual information about drugs and, what aids such as films from "Film Australia" and so on are available for use?——W. (*Mr Findlay*) The programme is quite highly organized. We have in the region two teachers whom we regard as our personal development advisers or consultants. They have gone away to courses that have been arranged by the State development committee of the Department of Education, the central body of in-service training, and returned to the region and mounted courses here. We have gathered together in various centres teachers involved in personal development programmes and they have been advised by the two advisers. So, a common course really is used throughout the region. It is one that contains a good deal of factual information. Films and cassettes are available. We have quite a number of them in the professional resources centre at Lismore. These may be—and are—regularly borrowed by teachers engaged in the personal development course.

3213. Do you feel the current lack of any serious problems in the schools in the region is due in any measure, particularly in the past two or three years when there have been serious problems in most areas as far as the harder drugs are concerned, to the quality of personal development programmes you have instituted?——W. Yes, I do. I believe to some extent it is due to that yet I have another matter that worries me. Mr Wardman touched on this. We deal with tobacco and alcohol in the personal development courses and we have not been very successful in educating youngsters against tobacco. That is a problem that worries them, principally on the North Coast. I sometimes think that we need closed circuit television in the toilets so that we can find out who is smoking in the toilets. Incidentally, it is interesting to note that the girls are worse offenders than the boys. There is a good deal of smoking in some schools in the toilets but despite that there has been no evidence to date of any smoking of marihuana. It is tobacco. If our personal courses were as successful as I should like them to be perhaps we would have had a greater impact on the tobacco smokers.

3214. Have you had any problems with the over-use of mandrax by any of your students?——W. (*Mr Wardman*) None within my experience within the department at any time.

3215. Or other drugs such as valium and so on, which could have been taken from the parents?——W. Only the two incidents I mentioned where two girls, in the past three years at Murwillumbah High School have taken over-doses of tablets that were available in the home.

3216. Mrs DAVIS: This is a purely hypothetical question; because you do not allow smoking in schools do you feel it is the forbidden fruit attraction whereas if it were allowed that might not be so?—— (*Mr Findlay*) It could be. Yes, that could be so. We had one school in the North Coast region, prior to my arrival in the region—I did not change it—before I came there was one school in which the principal allowed cigarette smoking. He allowed the seniors to smoke in certain areas of the school. I have spoken to the new principal who has banned cigarettes. I asked him does he or his staff believe that the problem is worse now then when he predecessor was there. His answer was that he does not think it is any worse.

3217. Mrs ANDERSON: Is it any better?——W. No, it is about the same—no better—no worse. The forbidden fruit element does not appear to have been significant in that case. (*Mr Wardman*) Is not the problem social acceptance? We set the example with alcohol and tobacco. It is our generation. Until recently the suggestion was made to students that when you get to the stage when you can smoke and drink you have grown up. That is from our generation. I have discussed this with a member of Parlia-

ment at a hospital fete. He was telling me about the drug problem at my school. He had a smoke in one hand and a drink in the other.

3218. Mr WOOTON: Both witnesses have emphasized that they really do not believe that there is a problem in the region or in Mr Wardman's schools. In the other areas in which you have both been in the past do you think there is such a problem?——W. (*Mr Findlay*) I was director of education in the Riverina area from 1970 to 1974. The situation there at that time was about the same as it is here at this time. There was no real problem there. (*Mr Wardman*) I came from Telopea Park High School in Canberra and the situation was different there from here. In the safe at that school there was marihuana that had been taken from students. I knew that students in the school smoked marihuana nearly in the same situation as possibly is occuring among our students—it was the Saturday night dance and that sort of situation—the social situation outside the school scene. After a $250,000 investigation of drugs in Canberra high schools three years ago the answer was still what I believe it is here; the problems are tobacco and alcohol and there is little evidence of any major use of either harihuana or the harder drugs.

3219. Mrs ANDERSON: The Health Commission people touched on the question of hallucenogenic mushrooms; have you seen any evidence of that?——W. Not in my experience.

(The witnesses withdrew.)

FRANK WHITEBROOK, Principal, the Northern Rivers College of Advanced Education, residing at 11 Bruxner Crescent, Lismore Heights, sworn;

MAURICE RYAN, Lecturer at the Northern Rivers College of Advanced Education, residing at 54 Spring Street, Lismore, sworn;

NORMAN MACKAY, Senior Lecturer at the Northern Rivers College of Advanced Education, residing at Forestry Road, Dorroughby via Lismore, sworn; and

GREIG GRILLS, Student at the Northern Rivers College of Advanced Education, residing at 8 Cottee Street, Lismore, sworn:

3220. CHAIRMAN: The Committee has received a submission from certain members of staff and a student of the Northern Rivers College of Advanced Education. Is it your wish that that document be incorporated as part of your evidence?——W. (*Mr Whitebrook*) Yes. The submission reads:

SUBMISSION TO THE JOINT COMMITTEE OF THE LEGISLATIVE COUNCIL AND LEGISLATIVE ASSEMBLY UPON DRUGS

by

CERTAIN MEMBERS OF STAFF AND A STUDENT OF THE NORTHERN RIVERS COLLEGE OF ADVANCED EDUCATION

1. *Introduction*

This submission is relevant to Item 3 (b) and Item 4 of the terms of reference of the Joint Committee.

The following report contains the results of a survey of student opinion conducted in the last week of June, 1977. The details of the questionnaire are included with the responses. One hundred and forty students completed the questionnaire. Information concerning eight types of drugs (opiates, analgesics, transquillizers, hallucinogens, hypnotics, alcohol, marihuana and tobacco) was sought.

While alcohol and tobacco are not within the Committee's terms of reference, they were included for comparative purposes.

The questionnaire was available to students present at the College during the period 27th–30th June, 1977. Note that the sample is not random nor representative. The total enrolment of full time students is about 700. Many were not attending the College during this time as they were involved in practical teaching activities. The percentage of students responding in each category is reported.

QUESTIONNAIRE

This questionnaire is being circulated to gather information for a submission to the Joint Committee of the Legislative Council and Legislative Assembly upon Drugs.

It is designed to yield information on drug usage and attitudes towards drugs among students of the College.

All information will be treated as confidential.

If you have any additional opinions or information you would like to put before the Inquiry, please contact one of the following members of staff:

Norman Mackay
Beth Freeman
Klaas Woldring

1. Indicate how dangerous you consider the following drugs to be by numbering the following items 1 to 8 (1 = most dangerous):

——— heroin/morphia
——— pain killers (e.g. Bex)
——— tranquillizers (e.g. Valium)
——— hallucinogens (e.g. L.S.D.)
——— sleeping tablets
——— alcohol
——— marihuana
——— tobacco

Coding problems preclude a simple summary of this data.

Seventy per cent of respondents considered opiates the most dangerous: hallucinogens (of the L.S.D. type) were considered the next most dangerous group. Forty-one per cent of the respondents considered marihuana the least dangerous drug of those listed.

2. In my opinion, the following drugs are not at all harmful, a bit harmful, very harmful, extremely harmful:

| | Not at All | A Bit | Very | Extremely |
|---|---|---|---|---|
| | | | | % |
| heroin/morphia | <1 | <1 | 14 | 85* |
| pain killers (e.g. Bex) | <1 | 50.7 | 36 | 12.5 |
| tranquillizers (e.g. Valium) | <1 | 24.7 | 54.8 | 19.2 |
| hallucinogens (e.g. L.S.D.) | <1 | 12.7 | 36.7* | 50* |
| sleeping tablets | 4.8 | 46.9 | 41.3 | 6.9 |
| alcohol | 7.6 | 54.9 | 28.5 | 9 |
| marihuana | 17.8* | 56.9* | 18.5 | 6.9 |
| tobacco | 6.5 | 67.6 | 19.4 | 6.5 |

Eighty-six per cent were of the opinion that hallucinogens (e.g. L.S.D.) were "very" or "extremely" harmful.

Eighty-five per cent of respondents considered opiates as "extremely" harmful.

Eighty-four per cent considered marihuana to be "not at all" or "a bit" harmful.

3. Which of these drugs do you think are addictive?

| | Yes | No |
|---|---|---|
| heroin/morphia | 98.6 | 1.4 |
| pain killers | 85.5 | 14.5 |
| tranquillizers | 92 | 8 |
| hallucinogens | 88.4 | 11.6 |
| sleeping tablets | 82.2 | 17.8 |
| alcohol | 88.6 | 11.4 |
| marihuana | 50* | 50* |
| tobacco | 88.5 | 11.5 |

A large majority (between 82 and 98 per cent) considered all the drugs listed, except marihuana, as addictive. With regard to the latter substance, the sample was equally divided, 50 per cent considering the drug addictive, and 50 per cent non-addictive.

4. Should there be criminal penalties for the use of the following drugs?

| | *Yes* | *No* |
|---|---|---|
| heroin/morphia | 56.4* | 43.6* |
| pain killers | 9.9 | 90.1 |
| tranquillizers | 21.8 | 78.2 |
| hallucinogens | 52.5* | 47.5* |
| sleeping tablets | 8.6 | 91.4 |
| alcohol | 9.4 | 90.6 |
| marihuana | 20.9 | 79.1 |
| tobacco | 4.3 | 95.7 |

Slightly more than half the sample regarded criminal penalties appropriate for the use of opiates and hallucinogens (L.S.D.). A large majority felt that criminal penalties were inappropriate for marihuana (79 per cent) and all others listed.

5. Is your knowledge of the nature and effects of these drugs adequate (i.e., has your education about drugs been sufficient)?

| | *Yes* | *No* |
|---|---|---|
| heroin/morphia | 40 | 60 |
| pain killers | 43.4 | 56.6 |
| tranquillizers | 39.3 | 60.7 |
| hallucinogens | 39.9 | 60.1 |
| sleeping tablets | 46.8 | 53.2 |
| alcohol | 80.3* | 19.7 |
| marihuana | 70* | 30 |
| tobacco | 83.8* | 16.2 |

Alcohol and tobacco appear to be drugs for which responding students felt they have adequate knowledge. Seventy per cent felt their knowledge of the nature and effects of marihuana to be adequate: for all other categories trends suggest that just over half the students feel their knowledge is inadequate.

6. Should the College provide courses in drug education?

| *Yes* | *No* |
|---|---|
| 85.3 | 14.7 |

7. Should drug education be part of the primary school curriculum?

| *Yes* | *No* |
|---|---|
| 67.8 | 32.2 |

8. Should drug education be part of the high school curriculum?

| *Yes* | *No* |
|---|---|
| 95.9 | 4.1 |

*Questions* 6, 7 *and* 8

It is clearly the opinion of the majority of respondents that drug education should be included at the tertiary and secondary levels. Two thirds feel that drug education is appropriate at the primary school level.

9. Do you consider your parents' knowledge about the following drugs to be accurate?

| | *Yes* | *No* |
|---|---|---|
| heroin/morphia | 21.7 | 78.3* |
| pain killers | 41.7 | 58.8 |
| tranquillizers | 37.4 | 62.8 |
| hallucinogens | 15.4 | 84.6* |
| sleeping tablets | 44.4 | 56.6 |
| alcohol | 71.7 | 28.3 |
| marihuana | 23.2 | 76.8* |
| tobacco | 77.5 | 22.5 |

For all drugs except alcohol and tobacco, the respondents considered that their parents' knowledge was inadequate—particularly so for opiates, hallucinogens (L.S.D) and marihuana.

10. Do you consider that people with problems associated with drug dependence should be:

| | Given counselling and treatment? | Dealt with by the processes or of law? or | Other? |
|---|---|---|---|
| heroin/morphia | 84.7 | 11.5 | 3.8 |
| pain killers | 88.8 | 1.5 | 9.7 |
| tranquilizers | 92.2 | 1.6 | 6.2 |
| hallucinogens | 82.9 | 11.6 | 5.5 |
| sleeping tablets | 93.8 | 0.7 | 5.5 |
| alcohol | 90.2 | 3 | 6.8 |
| marihuana | 82.2 | 5.4 | 12.4 |
| tobacco | 84.7 | 0.7 | 14.6 |

A clear majority of respondents favoured counselling and treatment for persons with problems of drug dependence. Even in the case of opiates and hallucinogens (L.S.D.) 90 per cent still favoured some kind of treatment as opposed to the processes of the law for these people.

*Conclusions*

1. In relation to Item 3 (b) of the Committee's terms of reference, the results of this survey (question 4) reveal that this sample of this section of the community considers criminal penalties for the use of alcohol, tobacco, analgesics, tranquilizers, hypnotics, marihuana and tobacco are inappropriate: opinion is almost equally divided on the appropriateness of criminal penalties for opiates and hallucinogens (of the L.S.D. type). Responses to Question 10 show that counselling and treatment are regarded as much more appropriate than the processes of the law for drug dependent people.

2. Regarding Item 4 of the terms of reference, the respondents are of the opinion that their own education is adequate regarding alcohol, tobacco and marihuana, but that half of them feel they do not know enough about the other types of drugs listed. The respondents clearly feel their parents do not know enough about opiates, hallucinogens and marihuana, and half of them feel their parents' knowledge of other types of drugs is also inadequate. The response to Items 6, 7 and 8 shows that drug education is seen as appropriate at the secondary and tertiary levels.

3. Answers to Items 1, 2 and 3 show that this sample of this section of the community makes a distinction between opiates and hallucinogens of the L.S.D. type on the one hand, and marihuana on the other in terms of their opinions of the extent to which they are dangerous and harmful. The latter are seen as less dangerous and harmful than the former. It is encouraging to note that all the drugs listed (except marihuana) are regarded as addictive: it appears that current drug education programmes have been effective in their emphasis on the inherent danger of dependence.

3221. CHAIRMAN: Are there any other matters which you would like to put to the Committee?——W. (*Mr Whitebrook*) In broad terms only. I would indicate that although I am the principal of the college and I have been there for four years, I have had experience in other places in the State, including Wollongong. I felt I would like to make that known to the Committee so that its members might know something of my background. The answers to the questionnaire were obtained in an endeavour to bring before the Committee in a degree of usefulness which will indicate itself to the Committee some indication of the knowledge of students about drugs and their attitude towards them in a variety of ways. I have mentioned one matter about how careful one has to be in taking notice of questionnaires, especially when they are at the first level. I express my thanks for the co-operation of the staff and students who helped in this way.

3222. Is there anything further you wish to say, Mr Ryan?——W. (*Mr Ryan*) No, except that I am willing to answer any questions. (*Mr McKay*) Likewise. (*Mr Grills*) Yes, likewise again.

3223. You say enrolment is approximately 700 and the number sampled was 140. That is a fairly comprehensive result compared with most Gallup polls and samples of that nature, is it not?——W. (*Mr Whitebrook*) Not quite, in that the 140 students were not sampled on a random basis. They were the students who happened to be at the college at the time. When one takes a sample normally, such as the polls mentioned, one does it in a particular way. Because of the absence of a large number of students I have no way of knowing whether this is representative or not. These were the students on hand. They were students in teacher education and students in business. The age ranged quite a bit. By and large the average age of students who come to us from schools would be 18 years 4 months. Most of the students coming to us are already adults. We have a much more mature group who are already working in part-time occupations as well as people who have decided to undertake tertiary education long after their school days. Some of those people were involved in this questionnaire.

3224. We might look at the tables. Let us look at paragraph 2. Do any of the results there surprise you a great deal?——W. (*Mr McKay*) The 84 per cent who considered marihuana to be not at all or a bit harmful and the 85 per cent who considered opiates as extremely harmful and the 86 per cent who were of the opinion that hallucinogenics such as LSD were extremely harmful —I think that tells the story.

3225. Would it surprise you that more than 50 per cent did not think sleeping tablets were harmful?——W. I think, as a personal opinion, there would not be a very wide exposure to sleeping tablets among student communities.

3226. What about table 3? Was there anything in that one that surprised you a great deal?——W. Once again the results indicate that students believe all of these drugs listed to be addictive except for marihuana, about which student opinion was equally divided. Once again, it would appear that marihuana is selected out by the students.

3227. Would you look at the fourth table. Do you think it is surprising that about 10 per cent would impose a criminal penalty for the use of pain-killers?——W. Yes. Of course, another way of saying that is that 90 per cent were opposed to it.

3228. Do you think they really realized what a criminal penalty was, when answering the questionnaire?——W. It is hard to see any ambiguity in the question.

3229. As the question is posed, I do not think it is ambiguous but do you think the people who were asked the question really knew what the impact of the words criminal penalties was?——W. (*Mr Ryan*) I do not think we could answer that question. (*Mr Grills*) From the point of view of students in this college, being mature and of adult age, and some who have come back to education at a mature age, and also having regard to the kind of courses that they are undertaking in teacher education, which comprises the majority, I would like to venture to say that the majority of students are aware of what was implied by the use of the words criminal penalties. The college makes a strong effort to broaden the thinking of students about the environment and life generally and I doubt that words such as criminal penalties would be so ambiguous or so far removed from their experience that they would not understand them.

3230. More than 85 per cent were of the opinion that that college should provide a course in drug education. Is it the intention to take advantage of this indication from the students and put some form of drug education into the course?——(*Mr Whitebrook*) It is a guide to the administration and the academic staff of the college that this ought to be done. One of the situations that faces a tertiary institution is that these people are by and large almost 100 per cent adult when they come to us. I have had the experience in another place of attempting to formalize this and I cannot remember the scheme having been particularly successful, even though we had good and adept people involved. It was revealing to me just how much students did know about drugs in that situation. This is possibly because of the personal development courses mentioned earlier. It is a matter of how one includes these in the curriculum or outside the curriculum and I would say that probably we should get further indications from students to find out how this might be done as effectively from their point of view. It might well be that what I or someone else thinks would be the best way to go about it is inappropriate in their terms.

3231. Have you any drug problems with your students? ——W. I do not know. It is easy to say no but I cannot say yes. I simply do not know. In a situation like this the principal would probably be the last person to find out about that sort of happening. So far as I am concerned, I am not aware of any problem in the college or in any other college other than what I pick up by reading newspaper articles.

3232. Mrs ANDERSON: Is there any counselling available at the college for anybody who might have a problem?——W. Yes, we have a highly competent medical officer on the staff of the college.

3233. Are any of the others on the panel aware of a drug problem in the college?——W. (*Mr Grills*) There is a problem when you use that word problem because of a misusage. One might have a perception of what problem means in their mind and when you used that word to convey a question you convey something entirely different. There have been cases of students having been apprehended for drug offences but the numbers involved in my mind do not constitute a problem. A number of students have been involved in drug offences but it is so minimal compared to the social and almost epidemic problem of alcoholism among people that it does not matter. No member of this Committee could say there is a problem until the word problem is defined.

3234. I thought you would know what I meant. Is there any evidence of students using or abusing drugs, and I do not just mean marihuana?——W. (*Mr McKay*). There have been two or three incidents this year where students or ex-students have been convicted for possession or other crimes associated with marihuana.

3235. What about heroin?——W. Not to my knowledge. (*Mr Grills*) Being a student maybe I can offer an opinion from among the students. We have to offer evidence in terms of impressions. We have not had the opportunity or the need to provide researched evidence. My impression is that in two and a half years as a student there has never been any occurrence of use or abuse of hard drugs. I do know that there are some students who use marihuana. I do know that they have sources in town, which I imagine the police and judiciary people would be able to give you evidence about. I am older than many of the students on the campus and therefore I do not mix socially with as many of them as younger people might. In my experience of the college I have never seen marihuana used and I have never heard of it being used and I have never been subject to anyone bragging that they have been using marihuana. I suggest that marihuana as a drug is no longer glamorous as it was some years ago and therefore people do not want to be associated with it for the various reasons that they had previously and therefore they do not worry about it now.

3236. Mr JACKETT: Does it not seem strange that, in view of the fact that the students felt that their knowledge of alcohol, tobacco and marihuana was adequate, they felt tobacco was less harmful than marihuana, particularly when one considers that the effect of marihuana on the ability to drive a car or engage in other activities that call for motor co-ordination is more closely akin to alcohol than tobacco? In other words, one's ability to drive is not affected by tobacco as much as it is by marihuana. Have you any views on this?——W. (*Dr Whitebrook*) We have just given the bare percentages. There are tests known as tests of significance which may show that those figures are not really significantly different. So it would be hard to say without the brand of sampling that we were not able to do, that in fact those figures ranging between 70 and 80 were really significant. I can offer no explanation why the difference you see could be there. Because of the narrow margin I would prefer to interpret it as not really being significant.

3237. Mr WOTTON: According to question No. 5, some 70 per cent of students felt that they had adequate knowledge about the effects of marihuana and some 80 per cent felt that their knowledge of alcohol and tobacco was adequate. Their parents are basically the same except in respect of marihuana when there is a complete switch from 70 per cent to some 23 per cent?——W. (*Mr McKay*) Marihuana is a drug used by the younger age groups so they would not expect their parents to be aware of it.

3238. CHAIRMAN: Have most or all of the students at your college been trained as teachers?——W. (*Dr Whitebrook*) No. About 530 are being trained as teachers and the balance, about 160, are being trained as business people, at the moment.

3239. Is there any differentiation in drug education or the preparation for drug education between the courses that are given to prospective teachers and the courses given to the remaining students?——W. Yes, the curriculum for prospective teachers contains components of health education, sociology and social science which would be relevant in terms of an elongation if you like of the personal development course that is carried on in the secondary schools, as it is related to their preparation as teachers in the one instance and as it is related to their preparation as citizens in the second. The amount of time that one can spend on these sorts of things is limited by the amount of time that is asked for in other subjects. With almost every other subject of interest in the teachers curriculum the proponents ask for more time. In answer to your question, there is a big difference between the curriculum for a primary school teacher and that for a business person. To the best of my knowledge there is no inbuilt component of drug education in the course *per se* for the preparation of the business education people. If we did that I would be needing to ask the question, "Are there courses on drugs, however, one might describe it, in universities, for the preparation of the commerce and business people?" I think the answer would be no, other than what student counselling can give.

3240. In the introduction you mention that many students were away on other duties. They would be mainly teachers doing practical teaching?——W. In every instance.

3241. Nearly all the people surveyed would be doing the business courses?——W. There were first year students in attendance. The first year students do not go to block practice, as we call it, like second and third year students. Those figures merely indicated we were not able to get answers from all the students present at the college at that time.

(The witnesses withdrew.)

ROBERT DOUGLAS CARR, Grazier of Yian, Boat Harbour Road, via Lismore, sworn and examined:

3242. CHAIRMAN: Have you received a summons issued under my hand as Chairman of this committee?——W. I have.

3243. Would you give the committee an outline of your activities as a Commonwealth public servant?——W. It goes back a long way. I was a telegraph messenger and postal assistant prior to the first war. When I came back from the war I resigned and I was called back into the public service. In the second war I was seconded to a food production job in the army. As such I was designated a State public servant. At the conclusion of the second war I was called back into the public service as a Commonwealth public servant. My particular duties were as supervisor at the mail branch in Sydney. For five years I put in most of the time as a Commonwealth public servant in charge of the overseas shipping and mail section, which dealt largely with overseas shipping and customs.

3244. When did you leave the Commonwealth Public Service?——W. In 1962, I retired due to old age.

3245. You have been living in this area since then? ——W. I have lived on the Richmond River for the whole of this century and a year or so in the last, other than times when I have been away.

3246. You are now an active grazier?——W. Yes.

3247. In a letter that you forwarded to the secretary of the Committee you mentioned something about the growing of marihuana in this area. Have you anything about which you could advise the committee in that regard?——W. I know this area and the State forest very well. What I am concerned about is that in February this year I noticed something said by the chairman of what is called the Far North Coast County Council. It has rather a strange and unusual set-up within this area. If you look at the map at the back of this room you will see the relevant area. Within that particular area part 22 of the Local Government Act, which deals with the control of noxious weeds, is vested in this particular council. It is not an elected council in the same way that the Lismore city council is elected. Outside the Richmond Range, by and large the administration of part 22 of the Act is in the hands of the elected councils. I will put it this way, within the Richmond Range—that is what the map refers to—local councils such as the Lismore city council and Ballina shire council, Casino municipality and the Tweed shire council have no jurisdiction in regard to noxious weed control. The Copmanhurst shire, Grafton city council, Nymboida shire, Maclean shire and Tenterfield shire all more or less bound the outside of the Richmond Range and they control noxious weeds. As far as I know they have nothing to do with the growing of cannabis which would be entirely outside their scope.

In February this year I was alarmed to notice that the chairman of the Far North Coast County Council, Councillor H. J. Shearman, and the county clerk, Mr M. F. Bailey, who has his office in Casino, both claimed in the *Northern Star,* one on 17th February and the other on 18th February this year, that the control of cannabis was their particular duty or responsibility. I must make this little correction. In all the press and county council references they speak of marihuana. I know it only as cannabis. In my opinion they are two different things in that one is the product of the other. One is a drug and the actual cannabis, the growing thing, is another thing. I am most alarmed and disturbed if the detection, searching for and destruction of cannabis within the Richmond Range becomes the responsibility of the Far North Coast County Council. Why I am concerned is that the Far North Coast County Council has under its jurisdiction three noxious weeds which I will mention. The three that are most important here are called groundsill, crofton weed and mistflower. Councillor Shearman and his county clerk, Mr Bailey, say that cannabis is a weed within the meaning of the Act, exactly the same as these other three that I have mentioned. If they are acknowledged on the list of their responsibilities, and I can go back say for 25 years, during that time these three particular weeds for which they are responsible have increased out of hand. In fact they have run wild not only over the State forests but also on the roads and private properties.

3248. I propose to read you section 20 and section 21 of the Poisons Act. After my reading of that Act you will realize that it covers every body in the State. Both the Department of Health and the Police Department have the duty to implement the provisions of the Poisons Act. That duty does not devolve on any county council.——W. If there were cannabis growing in the garden outside this building, do you say that would be a contravention of the law?

3249. Yes, it is an offence to grow cannabis.——W. The far North Coast County Council is constituted under the Local Government Act and I would like to know whether that department has any responsibility in that matter.

3250. If the council owns land on which marihuana is being grown, it has a responsibility. The Health Commission administers the Poisons Act so that the Minister for Health would have the ultimate responsibility. The Police Department also has a responsibility to take any action.

I think we are getting away from our real purpose. You made a statement that some people were aspiring—as you put it—to corner the business on the river.——W. Yes.

3251. What business are you talking about?——W. I am talking about the far North Coast. In my opinion, some of the officials of the far North Coast County Council are attempting to control the power, to say to one person that he can grow it but to tell another person that he cannot grow it.

3252. You are quite emphatic that some people are growing cannabis themselves or they are allowing other people to grow it, and that other people are put in a different position?——W. Yes. I am saying that these officials are aspiring to put themselves in a position of being able to do that.

3253. Mrs ANDERSON: A county council has delegated powers.——W. I would not enter into a discussion about that but I would differ from you on it.

3254. If there are people on the council indulging in the sort of things you allege, they could be put in the position of disqualifying themselves.——W. I concede for the moment that the Far North Coast County Council is legitimately in charge of the control of the three noxious weeds I mentioned. I am saying that their control of those three weeds is farcical. They are allowing certain people to grow these three weeds unmolested and they are prosecuting people for doing the same thing; in other words, they are discriminating between different members of the community. Also, I have evidence, which I am willing to give at any time, that one of the worst offenders against the law relating to the control of noxious weeds, or the three noxious weeds I referred to, are county councillors themselves. There is no way in which the electors can remove those people from office; they do not nominate themselves for office nor are they nominated for those positions.

(The witness withdrew.)

GRAEME DUNSTAN, Cultural Entrepreneur, of High Street, Nimbin, sworn;

DUDLEY LEGGETT, farmer, of Terrania Creek, sworn; and

EDWIN BUIVIDS, Architect, of Lillian Rock, Nimbin, affirmed, and examined:

3255. CHAIRMAN: Have you received from me a summons issued under my hand in accordance with the Parliamentary Evidence Act?——W. (*All witnesses*) Yes.

3256. I have received a submission from the Home Builders Association of the Rainbow region. That is from yourselves?——W. (*Mr Dunstan*) Yes.

3257. Do you wish to have that incorporated as part of your evidence?——W. Yes. The report reads:

SUBMISSION TO THE JOINT COMMITTEE OF THE LEGISLATIVE COUNCIL AND LEGISLATIVE ASSEMBLY UPON DRUGS BY THE HOME-BUILDERS' ASSOCIATION OF THE RAINBOW REGION

0.0 *Summary*

0.1 The Homebuilders' Association, which is a group acting for the interests of the new settler movement of the Far North Coast, submits that the penalties and legislation pertaining to the controls of marihuana in particular and drugs in general, is inappropriate because—

(i) The application of the controls leads to their abuse by authorities who consciously or unconsciously use the legislation to repress minority groups such as the new settler movement.

(ii) Their existence implies that drug use and abuse is a major problem. The Homebuilders' Association believes it is another symptom of a deeper social malaise with which controls and penalties for which drug education programmes and progressive legislation are "band-aid" solutions.

(iii) The penalties and controls make no attempt to deal with a deeper social malaise, of which drug use and abuse are but a symptom.

1.0 *Homebuilders' Association, Rainbow Region*

1.1 The Homebuilders' Association was formed this year "to promote, publicise and further the interests of owner builders of the Rainbow Region" which is the district of the Richmond–Tweed catchment.

1.2 The association expresses itself in the following activities:

(a) Organizing social events, dances, plays, dinners, speakers and film nights that stimulate cultural interaction within and without the membership.

(b) Making representations to local, state and federal government in the interests of its members.

(c) Arranging conferences, radio discussions and dissemination of information in regard to building your own shelter.

(d) Operating a Building Resources Centre for the collection and redistribution of second-hand and other building supplies.

(e) Working towards the establishment of a co-operative workshop for "soft" technology, repair and maintenance (cars, in particular) and manufacture (solar panels, tools, etc.).

1.3 The Association prospers, having at present 102 financial members (individuals and households) concentrated in the Larnook, Nimbin, The Channon and Rosebank districts north of Lismore.

1.4 The Association sees itself as part of a larger immigration movement happening in the North Coast hinterland areas —the new settler movement.

2.0 *The New Settler Movement*

2.1 In the last five years a remarkable repopulation has been taking place in the hinterland of the far north coast of N.S.W. An estimated 6 000 people have moved there to take up landholdings or rent farm houses. This new settlement has more than balanced the ongoing urban drift of the established families and their children in some places. Although the net increase in population may be only small in these places (e.g., 500 in the old Terania Shire) the positive effect is to stabilize the smaller country centres like Mullumbimby, Nimbin, The Channon and to revitalize and enrich the district culturally.

2.2 This population shift is remarkable because the area has known endemic rural recession with the collapse of its dairy and cattle industries and the whittling away of its timber resources. Apart from the tourist and retirement potential of the coastal strip, the economic future of the hinterland had come to be regarded by the experts as grim. "Get big or get out" had become the sloganized advice to its farmers.

2.3 The new settlers are exploring lifestyles that affirm unity over separatism, personal spiritual growth over material acquisition, co-operation over competitiveness, harmony with nature over exploitation of nature and self sufficiency over consumer dependence on professional services. In agriculture small scale, diversified and labour intensive is valued as more ecologically sound than chemical weed control and fertilization and high energy consuming machinery. The lifestyles, described by some of the new settlers as New Age, has many points in common with that of the selectors who created this rural area in the first place.

2.4 As an immigration movement the new settlers movement is a new and hopeful phenomenon for the proponents of decentralization. It is a migration motivated by cultural factors, proving that, given a basic level of social security and a post scarcity attitude, it is possible to relocate according to lifestyle aspirations. This means that it is not a necessary condition to industrialize and ensure jobs as a first step to population movement—instead people will be drawn to a region for the lifestyle and will generate the industry appropriate to support that lifestyle.

2.5 The new settler movement is significant for the economic recovery of the hinterland areas. New settlers have rented deserted farm houses and taken up land considered as unproductive. They have cushioned the effect of population decline and stimulated the local economy with a money movement through appropriate multipliers estimated by Dr R. G. Munro, Head Research Unit at the Northern Rivers College of Advanced Education to be of the order of $360,000.00 a week.

2.6 Like all migration movements the new settlers of the Rainbow Region find that there is a conflict between the expression of their values and the social attitudes, regulations, by-laws and so on that reflect the institutional values. Time and caring energy will resolve these conflicts because the similarities between old and new settlers outweigh the differences and the desire to live in peace is common to all.

2.7 A major conflict of values between the new settlers and the existing social mores of the region is in their attitudes to use of drugs, marihuana in particular.

3.0 *Marihuana and New Settlers*

3.1 The new settlers movement of today is the hash pipe dream of yesterday. Or so it seems, for the interest in consciousness altering drugs and homesteading have their common source in the cultural and political dissent, examination and ferment that took place in years of the Vietnam War protest. This is not to suggest any necessary or casual link between the two but rather to suggest that they co-exist as part of a whole constellation of values and ideas called counter cultural.

3.2 Marihuana is the drug of conviviality of the new settlers just like alcohol is for the mainstream culture. One is more likely to be offered a friendly joint than a beer in a new settler household. Even so opinions about it vary. Some say using marihuana is a pathway to a different consciousness of the world, others say it has lost its power and still others say it's a hindrance; some are full on into it, some smoke to share special times with friends and others see it as a phase passed through.

3.3 There is a certain appropriateness of marihuana to the lifestyle of the new settlers. The urban to rural shift has required a slowing down and tuning in to the new environment and the effects of marihuana facilitates a laid back approach to living. What's more marihuana is easy to grow and become self sufficient in.

3.4 Though not all use marihuana and even fewer cultivate it, within the new settler movement marihuana usage is regarded as neither bad nor mad nor unhealthy. It is regarded as a non issue and quite irrelevant to the issues of surviving as households, as a movement and as a species. Irrelevant, that is, except for the fact of the harassment of new settlers by police using marihuana as a pretext.

3.5 The harassment is real and ongoing. On 12th August, 1976, the residents of the Co-ordination Co-operative at Tuntable Falls were woken up by police pointing shotguns. Sixty police had been mustered for a carefully planned military style campaign against the Co-operative where firearms are forbidden. The raid received national publicity and subsequently the search warrant was found to be illegal. The point to make about the police action is that it was implemented for essentially discriminatory reasons, and the excuse for harassment was the enforcement of drug laws.

3.6 Despite the outrage expressed at the Tuntable Falls raid, the police have continued to raid and harass new settlers in the district though the targets are usually smaller. The raids occur approximately fortnightly. In some cases, the house searches are just a business of procedure of bored detectives, in other cases they are accompanied by assault and abuse of the householders. The raid on the community known as Crystal was followed up by the detectives involved who next day drove the building inspector to Crystal and so initiated local government action against the community.

3.7 It is appreciated that the role of policemen in a society undergoing rapid social change is not an easy one. And it is not made any easier in this region by ill informed and bigoted attitudes of the Member for Byron, who referred to the new settler movement as "the non-productive exercise in filth and confusion at Nimbin". (*Northern Star* 4/2/77.)

3.8 The effects of the police raids are the following:

(a) Conflict and antagonism is stirred up within the community against new settlers. For example, while most regarded the police at Tuntable as a threat to the civil liberties of minority groups, the Parents and Citizens Association of Mullumbimby High School (with the endorsement from the P & C at the Nimbin School) wrote to the Premier to commend the action and urge more like it.

(b) The new settlers, who are essentially highly moral people, are being systematically turned into criminals. The fines become a form of tax for trying to live honestly or rationally and differently to the mainstream society.

(c) For the new settler movement, fear of police informers leads to paranoia and a restriction to openness and information flow. This in turn leads to a ghetto mentality which both prevents integration into the surrounding community and encourages further discriminatory reactions.

4.0 *Marihuana and the Law*

4.1 The Homebuilders' Association believes it is neither the responsibility nor the right of responsible government to make laws to protect people from themselves. We believe that the use of marihuana is a victimless crime. As such its enforcement inevitably leads to abuse by the enforcement agencies. In this process individuals are denied the liberty to choose their lifestyle and police integrity is corrupted.

4.2 The Homebuilders' Association opposes decriminalization of marihuana as a halfway measure in itself contradictory. It is contradictory because it shifts blame to the dealer and yet the dealer exists as a logical consequence of there being users. Decriminalization at once recognizes the right to use marihuana and then denies the right to acquire it.

4.3 The motivation for decriminalization is the realization of the inappropriateness of the laws. The Homebuilders' association believes that any laws in regard to marihuana would be inappropriate and so call for a delegislation of it, a complete removal of any reference to it in any statute.

4.4 Our experience with the suffering and oppression caused by laws and penalties that attempt to control marihuana leads us to the conclusion that there is no such thing as an appropriate drug control law. We believe that all laws relating to the control of the use and distribution of drugs ought to be repealed.

5.0 *Government and the Future*

5.1 We live in extraordinary times. Our society is suffering a famine of spirit. The great myths of God, King, Country and Progress no longer inspire nobie and selfless effort and in their place the myth of bliss through material consumption has arisen. This escalated greed now threatens environmental breakdown and war over supply and control of necessary raw materials. We cannot expect to survive as a society (and perhaps a species) if we do not undergo massive changes in our personal lifestyles and our social structures.

5.2 But hope springs eternal and even as this industrial era moves into decline, the seeds of the next era are being sown. An amazing fragmentation of social values is being experienced at present and people everywhere, individually and in small groups, are exploring better and more fulfilling ways to live. The new settler movement is part of this, as is the feminist movement, the spiritual groups both Eastern and Christian, and the personal growth movement generally. It is as if the species is instinctively exploring the variety of options before taking the next direction in evolution.

5.3 The Homebuilders' Association believes that the survival of humanity on Earth depends on humanity solving the problems of war and the eco-instability of our wasteful and destructive exploitation of energy resources and raw materials. Whilst many talk about solutions, the new settlers view their lifestyles as their own personal attempt at and commitment to the resolution of these problems. We live in faith that, out of our experience and in synthesis with the experience of all others of good will on planet Earth, we will find a way to survive and live in peace. In this regard the new settlers believe their movement to have national and international significance.

5.4 In these times the role of responsible government is to look beyond the mirrors and mirages of opinion poll politics and provide leadership in the generation of enthusiasm amongst the people for the challenge of the future. It can do this by putting faith in the people, a faith that, given freedom of organization and of information and relief from miseducation and useless restriction, the people will make meaningful decisions for the conduct of their lives.

6.0 *Appendices*

Homebuilders' Association objects of association.
Homebuilders' Association policy statement on building regulations and land zoning.
Personal statement by E. Buivids.

## HOME BUILDER'S ASSOCIATION—RAINBOW REGION

The *general object* of this Association is to work towards such social, environmental and legal conditions as best foster the growth of an harmonious and unitive lifestyle. Activity is presently concentrated in the "Rainbow Region", that is, the Richmond–Tweed catchment area, not out of provincial parochialism, but rather due to knowledge that if we can kindle a fire of example and awareness across this natural unit of terrain, then the value and truth thereof will flow on elsewhere . . .

The *specific objects* of the Association are:

(1) To promote, publicize and further the interests of Owner-Builders in the Rainbow Region.

(2) To produce publications communicating to the Government (on all levels) and to the public, concerning the positive atributes (economically, socially, etc.) of the life- and building-styles of Owner-Builders in that region.

(3) To achieve rezoning under the *Local Government Act* of certain areas wherein are being practised such special community experiments as decentralization, group-centredness, co-operation, unity, and harmony with environment.

(4) To seek official endorsement of the SROB (Semi-Residential Occupancy Building) experiment into hamlet-centred building regulations, it having lately been indicated that no further areas were to benefit from this arrangement.

(5) To inform concerning building methods and requirements, and to communicate the beauties and satisfaction of constructing one's own home.

(6) To form a fund for and to assist in the legal defence of Owner-Builders.

(7) To work towards conservation of raw resources and the harmony of activity with environment.

(8) To affirm those traditional qualities of self-sufficiency and of resourcefullness such as made possible the original pioneering of this Region.

*Membership* is open to anyone interested in the attainment of such objects. There is a joining fee of $5.00 per family or household. Such money will be applied exclusively for achieving those objects.

MEMBERSHIP APPLICATIONS FORM

I, (names ..... wish to become a member of the Home Builder's Association in the Rainbow Region.

Address (postal):

Fast contact address:

Enclosed is $5 Annual subscription fee and $ Donation.

May the longtime sun shine upon us.

STATEMENT CONCERNING DRUGS

In the society of Man, freedom of the individual is at once the most treasured, and the most threatened aspiration. Without this freedom, freedom to grow, to experiment, to think, to nonconform, to create, man sets limits on his development and his potential.

With respect to marijuana, and drugs in general, it is my belief that legislation outlawing the production and use of drugs is unemocratic in that it opposes individual freedom by taking away the right to self-determination. For a stable society to exist, individuals must take full responsibility for themselves, and regulate their behaviour so as to uphold the freedom of others.

Historically, prohibition has invariably failed. There is ample evidence to support the view that the effect of prohibition is the opposite to that intended by its self-righteous proponents. Like Adam most of us find the forbidden fruit irresistible, so that a host of potential users are attracted to drugs by the sensationalized publicity their illegality generates. In addition, production and marketing become infiltrated by the criminal elements of society and ultimately come under the control of organized crime. Equally important, it makes criminals of citizens who, apart from using drugs, are law-abiding.

To raise our consciousness above the need for drugs is the prerogative of each one of us. Clearly, our society has not evolved sufficiently to be rid of this need, as the enormous consumption of all kinds of drugs testifies. On the contrary, modern, industrialized society uses more, and a greater variety, than any other society in history, reflecting the alienation and frustration of the individuals in it. The drug problem is but one manifestation of the disharmony in our society, and cannot be solved by attacking the symptoms and ignoring the causes.

The negative energy expended in persecution can be immediately turned into positive energy by using it to eliminate the environmental deficiences which cause our neuroses, which in turn, cause us to take drugs for help and relief. What justice in persecuting the users of one drug, say marijuana, while use of drugs such as tobacco, alcohol, analgesics, barbiturates, amphetamines, etc., is not only permitted, but openly encouraged, more accurately, "pushed" by big business. Society is protected by laws related to anti-social behaviour, so that an individual, regardless of whether is using legal or illegal drugs, is held responsible for his actions.

Opposition to drug law reform comes, in the main, from the conservative and establishment strata of society. Marijuana use, in particular, and increased political awareness and social conscience appear to go hand in hand, and the majority of marijuana users are ideologically at odds with the materialistic consumerist system in which we live. In the Rainbow Region, i.e., the Tweed–Richmond catchment, centred north of Lismore, the persecution of marijuana users can be seen as politically motivated in that, the victims are associated not only with marajuana use, but more importantly, with alternate lifestyles whose values are often radically opposed to the established order. Thus the drug laws are being used politically to harass and suppress a highly critical minority group who are openly attempting to reduce the power and impact of materialism and are stressing instead the spiritual well-being of man.

During the 3 years that I have lived in this area there have been infrequent police raids on new settler households, gradually increasing in frequency and culminating in the paramilitary operation against the Co-ordinate Co-operative at Tuntable and the low-level spy planes of more recent times.

Among the new settlers drug use is accepted as a matter of personal choice. Marihuana is widely and openly used and takes much the same place in social interaction as alcohol does in society at large. The heightened awareness accompanying a marihuana "high" is often used positively, for instance to improve personal relationships, so that it becomes an aid in raising consciousness. Also, heightened sensory perception acts as a stimulus to creativity, in art, music, play, and in living. These positive attributes of marijuana are used in the new settler community, together with many other experiments in 1 lifestyle, in order to find individual and social harmony.

In addition to marihuana, the new settlers use the Gold Top mushroom (*psilocybe cubensis*), which grows prolifically in the Far North Coast area. The use of this drug is not as widespread, nor as frequent, and the experience is more intense. At its most positive it has been likened to revelation, or the receiving of grace, or the being at one with everything. Alcohol and tobacco are used in moderation, if at all. "Hard" drugs, such as heroin, are not used.

Even as the persecution continues, the place of drugs in the culture of the new settlers is being determined by individual self-regulation and co-operation, determined with apparent success as there is no drug problem in the community.

ED BUIVIDS,
1st July, 1977.

POLICY STATEMENT

0.0 PREAMBLE

0.1 In the last five years a remarkable repopulation has been taking place in the hinterland of the far north coast of N.S.W. An estimated 6 000 people have moved there to take up landholdings or rent farm houses. This new settlement has more than balanced the ongoing urban drift of the established families and their children in some places. Although the net increase in population may be only small in these places (e.g., 500 in the old Terania Shire) the positive effect is to stabilize the smaller country centres like Mullumbimby, Nimbin, The Channon and to revitalize and enrich the district culturally.

0.2 This population shift is remarkable because the area has known endemic rural recession with the collapse of its dairy and cattle industries and the whittling away of its timber resources. Apart from the tourist and retirement potential of the coastal strip, the economic future of the hinterland had come to be regarded by the experts as grim. "Get big or get out" had become the sloganized advice to its farmers.

0.3 The new settlers are exploring lifestyles that affirm unity over separatism, personal and spiritual growth over material acquisition, co-operation over competitiveness, harmony with Nature over exploitation of Nature and self sufficiency over consumer dependence on professional services. In agriculture small scale, diversified and labour intensive is valued as more ecologically sound than chemical weed control and fertilization and high energy consuming machinery. The lifestyles, described by some of the new settlers as New Age, has many points in common with that of the selectors who created this rural area in the first place.

0.4 The survival of humanity on earth depends on humanity solving the problems of war and the eco-instability of our wasteful and destructive exploitation of energy resources and raw materials. While many talk about solutions, the new settlers view their lifestyles as their own personal attempt at the commitment to the resolution of these problems. We live in faith that, out of our experience and in synthesis with the

experience of all others of good will on planet earth, we will find a way to survive and live in peace. In this regard the new settlers believe their movement to have national and international significance.

0.5 Like all migration movements the new settlers of the Rainbow Region (as they refer to the Richmond–Tweed catchment) find that there is a conflict between the expression of their values and the social attitudes, regulations, by-laws and so on that reflect the institutional values. Time and caring energy will resolve these conflicts because the similarities between old and new settlers outweigh the differences and the desire to live in peace is common to all.

0.6 Since housing is so fundamental a concern and since land use is directly related to lifestyle, it is not unexpected that the first uniting issue of conflict for the new settlers should be around housing and demolition orders. On 23rd January, 1977, a Homebuilders Association was formed "to promote, publicise and further the interests of owner-builders of the Rainbow Region. What follows is the first attempt to construct a policy on the changes the new settlers seek in regard to building regulations and land zoning.

0.7 At the same time we are aware that the issue of providing housing has much wider implications. Housing is a national crisis issue and the professional solution has priced itself beyond the reach of the majority of the citizenry. To own a house implies committing oneself to a mortgage and guaranteed income level for the majority of ones working life. Encouraging owner-building is a means of creating more and cheaper houses. It will also lead to the development of creative solutions to the problem of shelter that the professional system, bound by finance and market considerations, cannot explore.

0.8 If readers find our policy for owner-building incomplete or impractical in some way we can only reply that this is a beginning. In this country there is no large or ongoing owner-builder reform movement. This statement is the combined thinking of the interested people who gathered in the name of the Homebuilders Association (together with a dash of inspiration from Ken Kern et al *The Owner Builder and the Code*) to conceive a policy. We hope that as a first step, distributing this policy statement will lead to feedback and contact with new and other ideas. All reader feedback will be evaluated and responded to and, with permission, published in Homebuilders Association publications. Please write Box 22, Nimbin 2484.

1.0 LIFESTYLE GENERAL

1.1 We believe that everyone should be free to build a home as long as in the process, the rights of others are protected. It may be necessary and desirable to regulate commercial building but regulation should not automatically include or inhibit the owner-builders of homes.

1.2 We believe that, if owner builders when they start do not know how best to create their structures, they will profit in the learning derived from the experience and the community will gain wiser, more resourceful and self reliant citizens. Allowed freedom of choice in a climate relieved of miseducation and useless restriction the human community has made and can and will make building decisions meaningful for itself.

1.3 We seek the recognition of the validity and value of our lifestyles within the existing social order and a sympathetic interpretation of land zoning and building regulations or where necessary the creation of special provisions to accommodate the land use and building types evolving from the lifestyles.

2.0 BUILDING REGULATIONS

2.1 We oppose Statewide uniform building regulations and seek a code flexible enough to reflect local needs and resources. In particular we seek recognition of the distinction between houses built for personal shelter and houses built for profit and the distinction between rural and urban houses.

2.2 We believe the legitimate domain of building regulations is solely in the protection of the interests of third parties with regard to health, safety, environmental impact and structural quality.

We believe matters of private design (including choice of building life span) and construction (including choice of material and means of construction) to be outside the domain of building regulations in regard to the owner built house.

2.3 In this regard we seek inclusion in building regulations a clause to make special provision for buildings constructed by the property owner or his agent for the owners use or for people related by blood or law (as for example by membership of a land owning entity like a co-operative or company) or for any other persons the owner may nominate from time to time to be residents.

2.4 In respect to owner-builders we seek a change in the role of building inspector. We believe he/she should be a public servant advising owner builders on techniques of home building and helping with solutions to building problems.

3.0 LAND ZONING

3.1 We support the preservation of the rural nature of the region, in particular preservation of bushland and rainforest, ecologically sound reafforestation, weed eradication and encouragement of native flora and fauna.

3.2 We seek special land zoning which will permit sharing of land with others either communally, in hamlets sharing common facilities or in clusters of self contained dwellings or in any other manner of group sharing.

3.3 In particular we seek wider application of Special Residential Occupancy Building (SROB) category. This was a State Planning Authority endorsed category that has already permitted the construction in the region of some hamlets in which adjacent dwellings share communal kitchens, bathrooms, toilets, laundries and so on.

4.0 PRAYERS

4.1 Let the music keep our spirits high
Let our buildings keep our children dry
Let creation reveal her secrets by and by
By and by,
When the light that's lost within us reaches the sky.
(from Jackson Brown's *Before the Deluge*)

4.2 But you, children of space, you restless in rest, you shall not be trapped or tamed.

Your house shall be not an anchor but a mast.

It shall not be a glistening film that covers a wound, but an eyelid that guards the eye.

You shall not fold your wings that you may pass through doors, nor bend your heads that they strike not against a ceiling, nor fear to breathe lest walls should crack and fall down.

You shall not dwell in tombs made by the dead for the living.

And though of magnificence and splendour, your house shall not hold your secret nor shelter your longing.

For that which is boundless in you abides in the mansion of the sky, whose door is the morning mist, and whose windows are the songs and the silences of night.

(from Gibran *The Prophet* speaking on houses)

3258. CHAIRMAN: I notice in your submission you referred to one of your aims being the organization of social events and so on within and without the membership. What sort of membership do you have? Is it a club membership, or are you only speaking about that as a loose term?——W. The membership has 102 financial members. Anyone can join. Usually we invite people to join as households. We sit down and talk about common problems. The main area of our activities concerns owner building, which is not only getting more acceptance for owner building and changes in the regulations here. The only way one can come here to live is to build a house. People cannot come to live in the country and expect to have a suburban dwelling. People have to build their own if they are to have shelter at all. That is happening. We are working towards making that more legally viable and acceptable in the community. At the same time we help members to get together the information and resources necessary to build their own homes.

3259. From what has already been said I presume that you have a fairly good cross-section of the community represented in your membership? I am talking more in terms of occupations?——W. Yes. A lot of people are interested in owner building and we are applying this sort of information and encouragement to lots of other people in the area. I would say our membership largely reflects the new settlements we have made in Nimbin, and mostly people in the arc north of Lismore such as Rock Valley, The Channon, Nimbin and over Rosebank way. We have 102 financial members but we feel that we express the sentiment of many more people in the area.

3260. You mention your major conflict with the existing social malaise is in regard to the drug marihuana. I presume by that you mean you would like to see marihuana legalized?——W. Indeed we do. We go further than that and say it ought to be de-legislated. We do not think that there is any requirement for any mention of it in any statute at all. The laws that relate to it now are totally inappropriate, they lead to lots of suffering and misery for people. I will go further than that. Police raids have been going on since the Tuntable raids last August. They have continued. That raid received a lot of publicity because it was so big. However, police raids continue on households in the area approximately once a fortnight. They come at 7 o'clock of a morning with search warrants, presumably legal. In some cases it is just a business of procedure of bored detectives. In other cases they are accompanied by assault and abuse of the householders. In a small way it is like a cuff across the head. It goes further than that. Often the police follow up these raids by involving other authorities in harassing the community. In the case of a raid on a community known as Crystal it was followed up by the building inspector who was shown the buildings by the police who said that they were illegal and for him to do something about it. The result was that Terania shire drew up demolition orders on the buildings. They have been put up in the most beautiful situation with the most incredible aesthetic care, like a park in that place. The result of the police action was to throw a shadow on it, making these people criminals running for their lives. I do not think that helps the immigration movement and it is essentially racist in its action.

The effects of the police raids have been that conflict and antagonism is stirred up within the community against new settlers. For example, while most regarded the police at Tuntable as a threat to the civil liberties of minority groups, the Parents and Citizens Association of Mullumbimby High School, with the endorsement of the parents and citizens at the Nimbin school, wrote to the Premier to commend the action and urge more like it. That is extreme. The police made these people stand up in conflict. The new settlers, who are essentially highly moral people, are being systematically turned into criminals. The fines become a form of tax for trying to live honestly and rationally and differently from the mainstream society. The new settler movement is experiencing a fear of police informers from within. This raises the level of paranoia between people and restricts their openness and the flow of information between them. This leads to further discriminatory action from people who regard them as a closed group. My point is that the reason the police are doing this is because of the drug laws. In our experience of marihuana there is nothing to suggest there are any victims involved. The police are using these laws to harass a minority group in the area.

3261. Some of the reports which came out about the original police raids suggested that there were people who escaped the police net who might have had drugs which were more powerful than marihuana. What is your reaction to that statement?——W. (*Mr Leggett*) I am not speaking from personal experience because I do not belong to that community, but I do not know anybody in this area who uses anything but marihuana. That is all I can say. To me it is just speculation that people will always make. I do not think that there is any ground for that sort of thing.

3262. You are talking about the present; what was the position at that time?——W. I have been in this area for five years with the exception of eighteen months when I was overseas. In all that time I have never experienced anybody in this area using anything other than marihuana. (*Mr Dunstan*): You cannot separate a person's lifestyle from his drug style. People are essentially poor in this area. There are no jobs here; there is a 16 per cent rate of unemployment. People come here and they accept a level of poverty. They cannot afford to buy hard drugs. You could not afford a heroin habit up here. These people grow marihuana for themselves.

3263. Mr JACKETT: Why do you say that the use of marihuana is an integral or essential part of your way of life?——W. (*Leggett*) It certainly is not an integral part of it. A number of people who are living this way of life do not find marihuana necessary in any way. I belong to a group that is in that category. We never have it at our place and we do not use it and all of us have used it in the past. We have experienced it. We just find that we do not need it any more; it is something that people use like anything else at a given time if they find that it suits their purpose. The thing about marihuana is that as far as I am concerned it is purely a psychological thing; people believe in it and they use it as a way of relating to one another. People have done that in the past with alcohol and tobacco. The thing is that a lot of these people are concerned about their physical health, and this is one of the reasons why they find marihuana, but not tobacco and alcohol, acceptable. It is well-known that both those things do physical damage where marihuana does not. For that reason I am much happier to see people using it if they have to use something. I think that most people in this lifestyle would not like to depend on anything as a crutch. You cannot draw the line; everybody will have some sort of crutch at some time, but it is certainly not something one needs to hang on to any longer than one might want to. People believe in it; it is not that it has some magical power which puts one aside from other people.

3264. Mr Dunstan, what is your answer to that question?——W. (*Mr Dunstan*) I should like to refer you to the relevant report that we have submitted. We say that the new settler movement of today is the hash pipe dream of yesterday, or so it seems. Drugs had their source in the cultural and political dissent and ferment that took place in the years of the Vietnam war protests. This is not to suggest any necessary or casual link between the two but rather that they co-exist as part of a whole constellation of values and ideas called counter-cultural. Marihuana is the drug of conviviality of the new settlers just as alcohol is for the mainstream culture. One is more likely to be offered a friendly joint than a beer in a new settler household. Others say that it has lost its power and still others say tha it is a hindrance. Some smoke to share special times with friends and others see it as a phase passed through. There is a certain appropriateness of marihuana to the lifestyle of the new settlers. The urban to rural shift has required a slowing down and tuning into the environment, and the effects of marihuana facilitate a different approach to living. What is more, marihuana is easy to grow and to become self-sufficient in.

3265. In your submission you said that marihuana was the drug of conviviality. It is an illegal drug. Why do you pursue your argument in regard to legalization?——W. The new settler movement sees this as being a cultural edge. They see this as expressing a movement that is going to flower in later years; it is a reflection of the ecological crisis and that sort of thing. People are thinking about the future, and they think about the process of change. They do not think so much about what is the case now but what things are changing into. Laws have always been changing. It is a point of which side of history we are on. If you see a law changing, you see it changing because people do not recognize it as a prohibition anymore. When parliament repeals a law, people do not begin there; there is a build-up to it. You would not

be sitting here today, if there were not people like us, living this life style and trying new things and experimenting outside the law. We have to go there to find the new future.

3266. What is your attitude to the fact that inherent in marihuana and cannabis there are certain dangers to health? After all, they are both drugs, and some experts have said that the motor co-ordination of an individual is undoubtedly affected by them. Why do you say it is an essential part of your culture?——W. (*Mr Buivids*) Apart from the negative aspect of marihuana, there are also a lot of positive aspects and it is those positive aspects that the new settler movement is interested in. As to this aspect, I refer you to the part of the report that says that among the new settlers, drug use is accepted as a matter of personal choice. Marihuana is widely and openly used and takes much the same place in social interaction as alcohol does in society at large. The heightened awareness accompanying a marihuana high is often used positively, for instance to improve personal relationships so that they become an aid in raising consciousness. Also, heightened sensory perception acts as a stimulus to creativity in art, music, the play and living. These positive aspects of marihuana are used in the new settler community, together with many other experiments in life style, in order to find individual and social harmony.

3267. (*Mr Leggett*) After concluding my tertiary education in engineering, I studied psychology at the university. I have always been interested in that study. I am interested in how and why peoples' minds work in what they do. Therefore, I have always looked at the whole drug phenomenae from the psychologist's point of view, as to why people do things and what they do. I have formed my opinion on that background. I have seen a wide range of the whole drug phenomena. I lived for about three years in a country where marihuana is legal. That was in Laos. A number of other drugs were legal at that time so I think I have got some experience in seeing what does happen when there is no illegality about these things. You do not see the sort of abuses there that you see in a country where it is illegal. The illegality of a drug creates the abuse; it is not the other way round. I think that is something that we have got to understand. That is why I am most concerned about changing the law. It does not affect me personally. I could not care less if I never saw any drug. My view is based on my observation of what people do with what is called a drug. A drug is some name that is being given to something that simply results in change of people's consciousness and psychic attitudes. To call something a drug is something that we have to be very careful about; it is something that is misunderstood a lot.

It causes a physiological change in the body which is a chemical thing. Every type of food we ingest does the same thing; it causes a change in the body's chemistry. If you call that a drug, you can call anything we take into our body a drug. What we are concerned about is the change on the mind. A lot of people believe that good health food changes your mind. Do we call all those foods drugs? Whether a change of mind is good or bad is another thing which is questionable and subjective. People have grown up with a cultural image about this thing; it has been used in the past by previous cultures, therefore it has an historical background and that is why some people choose something like it. It changes the body's chemistry, but the change in mind is something that is culturally induced and it is a change that has come about by the use of this particualr drug at this particular time in history. What you are seeing is a cultural propogation of ideas and attitudes. People are opening their minds to a new cultural awareness.

3268. Mr JACKETT: Mr Leggett, you spoke about the legalization of drugs. If you had your way, would you legalize heroin?——W. Certainly not tomorrow. I would say that it would need an extensive education programme, especially now that our culture has become so confused about what it all means. I think that one would have to move at a progressive rate towards that. I cannot believe that we should have any laws that protect people from themselves. I do not think that is on. Society should create laws to protect people from other people. Once you go beyond that barrier, there is no way of drawing the line and it leads to all sorts of problems in society. People must have that free choice to use what they wish for themselves. I think we should be progressively working to get away from the idea that you can prevent people doing what they wish to do for themselves. We need very much more education on the whole thing. The people who know about these things should be listened to, the people who have experience of these things and have a real understanding of what goes on.

3269. Mrs DAVIS: Mr Dunstan, what is the general health of the community you were talking to the committee about—where these homes have been built?——W. (*Mr Dunstan*) I find that a difficult question to answer. I have just come from talking to my healer. Nimbin has a healing centre run by a couple of acupuncturists. It is probably the most healing atmosphere I have ever been in. It is there as a community service. People care much more about their bodies. Tonight I am going to a counselling group, a group of people who are interested in personal growth. It is that sort of concern about changing yourself and becoming a different person. The whole myth of the new age is that we will evolve. We believe that unless you have a healthy body you do not have a clear mind. People smoke marihuana and look after themselves as well.

3270. Mr RAMSAY: What is the number in your community at the moment?——W. (*Mr Buivids*) Six thousand perhaps—it has been estimated at that by Dr Roger Munroe.

3271. Mention was made of financial membership. What are they committed to pay?——W. (*Mr Dunstan*) Five dollars a head for a household to join. We use the money for publications. We are getting together a resource centre where people will handle building supplies—second-hand building materials and so on.

3272. Are there any standards you live by? If somebody created a lot of problems would they be asked to leave? ——W. The most rigorous standards apply to our community.

3273. But could you explain what the standards are? ——W. Truth—being honest with each other and developing ourselves personally and spirtually—attuning to each other and the environment in which we live.

(The witnesses withdrew.)

ROBERT JOHN HAYWORTH, Shop Assistant of the bush stores, Tuntable Falls Co-operative

TERENCE DESMOND McGEE, Unemployed, of Tuntable Falls and

DAVID JOHN GITTUS, Full-time Farmer of Tuntable Falls, affirmed:

3274. CHAIRMAN: Each of you received a summons issued under my hand in accordance with the Parliamentary Evidence Act?——W. (*Mr Hayworth*) Yes. (*Mr McGee*) Yes. (*Mr Gittus*) Yes.

3275. I understand you have made a written submission. Do you wish to have it incorporated as part of your evidence?——W. (*Mr Haworth*) Yes—that is for me personally.

STATEMENT OF R. J. HAYWORTH

I appreciate that the terms of reference of this enquiry do not include alcohol. In the following I wish to bring to the attention of the committee what I believe to be some of the social effects of marihuana, particularly in relation to isolated rural and often itinerant groups, both "hippy" and "straight", and it is necessary to mention the social effects of alcohol in passing by way of contrast.

Marihuana is challenging and in some cases replacing alcohol as the main social drug in some of these groups, such as itinerant pickers, and young aborigines.

Most people would agree, unless they are puritans, that a mild euphoriant, moderately used, can have a beneficial effect on the health of both the individual and the group to which he belongs.

In towns, there is more restraint on overuse of alcohol, simply because there are more people about. In isolated bush areas this does not apply, and drink often brings out the bully and tyrant in those that happen to be physically stronger, with the police force a long way away. Much of this drunken bullying comes down heaviest on women and children. This leads to a deterioration of relations between the sexes, and the brutalization of any kind of family life. One of the worst, but not the only example of this process is among some aborigines.

Against this background, the increasing use of marihuana, particularly by younger blacks, could be the biggest single factor in saving them from alcoholic genocide.

This may sound exaggerated, but apart from general observation, I have lived for a year close to an aboriginal settlement and watched this development. No one beats their wife under the influence of marihuana. Brawls and physical violence are completely unknown while pot is being used, often among the same people who, when on an alcoholic binge, are very prone to it.

The position and respect shown to women improves in pot smoking groups. Rape, for instance, is *totally* unknown under the influence of marihuana, possibly attributable to an increased sensitivity to others feelings, but more likely simply the removal of the brutalizing effect of excessive alcohol.

The relative cheapness of marihuana also means that not a large proportion of wages or social services are spent on it when it is the preferred drug, as is the case with alcohol.

For the past 3 years work groups from Tuntable Falls have gone to both the wheat and the grape harvests in the western areas of the state. The farmers (the wheat growers of the Narrabri area and the grape growers of Mildura) claim to prefer them (and people of a similar life style) to other itinerant work groups prone to alcohol use, where violence and the unreliability that follows are likely.

In this context it may be noted that in the nearly 4 years of the existence of Tuntable Falls as a community several hundred diverse people have settled their affairs peacefully.

All investigators have agreed that pot is not physically addictive. What has less often been emphasized is its apparent ability to break addiction to more dangerous drugs, alcohol, tobacco and heroin.

In the case of alcohol, the two simply do not mix. If you smoke on top of a lot of alcohol you are likely to be physically sick. The contrast between the terrible hangover from booze and lack of deleterous after effects with pot brings home to many the physical damage caused by excessive alcohol.

But more interesting, and verifiable in many cases, is the number of people who have broken from truly addictive substances such as tobacco and opiates.

In the long run also, excessive use of pot sems to decline. Many of the settlers at Tuntable Falls came from a background of large cannabis usage. Many have now given it up, along with *all* drugs, and with most of the others usage is only a very small fraction of what it was five years ago.

Of course, it may be argued that having a more purposeful life and working for something you believe in could have been the main reason for decreasing drug use. It is unlikely that drug use can ever be separated from the social background—witness increased hard drug use among the young unemployed. And yet the most vocal political opponents of decriminalizing abuse often ignore this social background—the lack of real opportunity for many to change and control their lives.

One of the gravest charges laid against pot is that it leads to experiments with harder drugs. This is certainly not true of the present wave of heroin users, who seem to have graduated straight from hard liquor to hard drugs. It is significant that most heroin peddlers operate in pubs.

To these mostly unemployed young working class users marihuana is often seen as a "sissy" effeminate drug, lacking in mackismo and virility.

They have probably taken to both drink and hitting drugs to reassert their "toughness" possibly to compensate for the disintegration of personality that comes from long unemployment, low status and continuous contempt against them of the "dole bludger" type.

Of course, making any drug illegal forces much of its distribution into criminal hands, who will indiscriminately push anything that gives profit. Even then marihuana is far less associated with professional criminals than any other drug.

The very fact that pot can be grown so easily militates against complete control by *any* big organization, criminal or otherwise.

We can only put forward as our sincere belief that if the growing and consumption of small amounts of marihuana were permitted there would be far fewer people using the two destroyers, alcohol and heroin.

If any of the claims made here seem exaggerated or biased they are mostly of a nature that could be verified or not by research, which I think is important as it is the sociology of drug use which is the key to its understanding and control.

BOB HAYWORTH.

3276. CHAIRMAN: Your name appears on the submission, Mr Hayworth. Would you like to address the committee?——W. Our main interest in the whole thing is to keep narcotics out of rural areas such as we are in and to de-emphasize alcohol. The general gist of the submission is along those lines. We feel that there is some kind of social drug associated with every kind of community and that in the conditions we live in, marihuana is the safest social drug and it causes less trouble, fighting and strife. That is what we are saying, virtually. (*Mr McGee*) Dave Gittus and I have been secretaries of the co-operative and Bob has been a co-ordinator at times. Dave will give an idea of the social problems we have had there. The only real violence we have had has been induced by alcohol. Most likely we would feel that the really important thing to us is what the committee is going to be thinking of doing about narcotics because our personal situation is not a problem. We are not going to gain anything particularly by being here. The problems we see are the young people coming from the city who are messed up by amphetamines or other pills like that, mixed in with alcohol, and also some have narcotics as well. We have a good record of helping people who have been on narcotics.

3277. You are talking about opiate narcotics?——W. Yes. The reason why we have not got a narcotics problem is that the people can, in small bits, grow their own grass and because of that they do not come in contact with professional pushers. The few who drop down to Sydney now and again and meet old friends find that all the pushers in Sydney are selling anything they can sell. It happens that narcotics and things like it have a much higher percentage of sale—a lot more money can be made from them. As well, the grass market into Sydney is a lot easier to control and/or gets controlled by criminal elements supplying narcotics and it means that every now and again Sydney and all large cities goes through marihuana droughts and the young kids—who go to 12—at least 16 to 20 is the substantial part, keep going back to the same person asking for some grass and all a person has are narcotics.

This sort of situation does cause problems. We know people with friends who have been involved in this sort of thing. These people, simply because there was nothing else available and they were bored silly and had the problems of young people, tried out the harder narcotics. The reason why they do this sort of thing is because the

same person who sells grass sells narcotics. If all milk bars sold beer and spirits openly to kids, kids would be drinking beer and spirits a lot younger than they do now and they would be involved in it at an earlier age when they have less discernment as to the difference. We suggest that the Parliament of New South Wales by its allowing narcotics and grass to be totally criminal in the action of selling is more than anyone else responsible for all the new narcotic addicts that occur in this State. If at any time or at any stage this situation where the seller of one is also the seller of the other, were changed, the day after the change there would be a change in the statistics of new young people trying out narcotics.

3278. You cannot blame members of Parliament for making up the minds of those people who decide to try out narcotics?——W. No, but I do not blame the member of Parliament for all the persons who have car accidents and all the persons who contract cancer and so on. Despite the responsibilities of Parliament, if they know there is a bad highway stretch which causes accidents simply because it is not up to standard, and maybe because it is a one-way road and it is used as a two-way road—that falls within the responsibility of the Parliament. When Parliament can see a clear problem and it is a clear problem in the trafficking of two different kinds of drugs at the same place, it should separate them.

3279. You told us you made up your own mind to live a particular type of life?——W. Yes, we had to move 600 and even 1 000 miles to do that.

3280. But you made the decision?——W. Yes.

3281. And Parliament did not stop you from making that decision. You made your own decision. The point is that someone who goes on to narcotics makes his own decisions and the Parliament does not make the person buy it and use it. You blame members of Parliament for making up the minds of other persons, apparently?——W. I suggest that such discussion could also be had about the brands of cigarettes. Theoretically Parliament does not have any influence on whether people smoke cigarettes but because smoking is legal and cigarettes can be smoked in a milk bar children have easy access to them and can buy them.

3282. Could one of you explain the method of operation of your co-operative?——W. (*Mr Gittus*) Up to last Easter I had been secretary for the previous two years, which included the period we were under police harassment. It is a registered co-operative run by a secretary and seven directors who put in an annual report and financial statement with an audited account, and general meetings are held. The day to day business is run by tribal meetings held on a fortnightly basis. Other than that it is largely a matter of people taking on the responsibility themselves to be socially aware to find their real role in society. The smooth running of the co-operative we have found comes back to being totally honest and respecting the other person's position and respecting other members of the community. The rules we run by are very loose and open and lead to a lot of discussion at tribal meetings. To make a rule on the co-operative requires a lot of discussion. We are very averse to making rules as to how people should behave themselves and conduct themselves. We try to incorporate the widest possible range of lifestyles within the community and it cannot be summed up as a hippie community or any sort of community really. What we have been aiming for and to a large extent achieved is to provide the most rich variety of community life which allows for the most fertile ground of awareness and discovery of all facets of life. I have travelled around Australia quite a bit and I think we have achieved that. Living at Tuntable does not revolve around dope. Dope revolves around life. A lot of people on the property who do not have anything to do with this particular aspect of the life are automatically branded as dope smokers and are rounded up automatically in police raids. People who might not have any feelings at all on the subject become involved but that is not why I am here. The reason I thought I had something to offer was as a parent. I moved to this area because of my children. I wanted to bring them up in an atmosphere which I thought would foster their truth and intelligence to enable them to make it in the world. That is what Tuntable is doing. It is perfectly satisfactory for me. I am very happy with the way the children are less afflicted with behavioural problems that exist in the outside world.

3283. How many children do you have?——W. Personally I have three, two of my own and an adopted child, but I feel responsible for all the children there, which is somewhere between forty and fifty children. The only problem I have had with the upbringing of children is that I want them to live in truth and honesty and in fact they live in contradiction in a world with their parents in a loving relationship and in harmony and peace and living a good life if they see the contradiction that their world is astray every time someone is arrested and taken away for smoking grass. I was smoking grass before my children were born. I have one child aged four, one aged three and one aged two. They were born into that world and into that contradiction of a good world and a good life and a good home and this is the only aspect I have ever come into contact with the law over. I was arrested last August and the charges were dropped yesterday in Lismore court. The children do not understand what is going on. They do not understand how it is that they can go to school but not be allowed to mention the way in which their parents live, even though they know there is nothing wrong with it.

3284. Would it be your experience that as people get older they tend to drop the smoking of pot?——W. The average age of people out there is terribly imbalanced. We do not have many old people living on the property. I cannot really give an answer to that question.

3285. I was referring to as people get older. You would be older than some of those people. Have you found that they tend to drop it as they get older?——W. No, it becomes such a social habit and a way of life, to walk into a stranger's house and have the ice broken by them bringing out the best pot in the house and rolling a joint, and sitting down and feeling at peace with those people, maybe not even saying a word, and to walk away from them when you have met them only for the first time, thinking of them as brothers and sister.

3286. Just like having tea and scones, you suggest?——W. Yes, or perhaps a good brand of spirits.

3287. Mr WOTTON: How many are in the community at Tuntable?——W. It is not a constant figure but there would be a core group of 120 at least and it would go up to almost 200 at times and it might drop to even less than 120 at other times, depending upon the seasonal work. During the season people go to places like Mildura for work. We have more than 700 shareholders and many of them visit when they get away from the university or their work. (*Mr McGee*) They are planning housing in the future, those people.

3288. Their main income is seasonal work, is it? What are their means of income used to maintain the community?——It is widespread. There would be 200 different ways of earning income. Some people take work at Darwin and places like that. We have regular work in the wheat harvest out west and also at Mildura. You will notice in

the submission that farmers find it useful to have us around because there is not the same alcohol fights that come from drinking. On our place the only fights we have had have been alcoholically induced and one of the main offenders, the local property drunk, has made a huge change over the past couple of years. He will still get drunk a bit, but he is not as bad as he used to be.

3289. Do you own this property?——W. Yes.

3290. How big is it?——W. 1 200 acres.

(The witnesses withdrew.)

BARRY CHARLES MUNRO, residing at 26 Music Street, Lismore, pharmacist, sworn and examined:

3291. CHAIRMAN: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. I did.

3292. Do you wish to make a submission to the committee?——W. I do. I was virtually elected by my colleagues around town to come to this inquiry to give you the pharmacist's view in the market place and some of the peculiar things that happen and some of the things asked for that are not controlled at the moment. There are one or two things I would not like published, especially certain preparation names. If that is OK by you, I am quite prepared to carry on now.

3293. Perhaps you might write them down and hand them to me?——I do not mind mentioning them so long as they do not get into the press.

3294. This is a public hearing and if the press chooses to publish these things there is nothing I can do about it? ——W. It is corporation names that I am concerned about. I do not want everyone to find out what they are and what they are used for.

3295. Perhaps it might be best if I appeal to the press not to publish them and to use their discretion in these matters. Thank you, gentlemen.——W. I have here comments from my colleagues and I shall read those comments. One particular preparation, phensydil, a cough mixture, is something that pharmacists in Lismore have made almost a prescription line. You can buy it anywhere in New South Wales as an open sale. In the past couple of years we have found that there has been an upsurge in demand for it. We were curious to know why so we made inquiries and found out that some people would buy a bottle of the mixture and a middy of beer, drink half the middy of beer and pour the mixture into the beer and drink it down and go for a trip. Phensydil has a good bit of codeine in it and it probably makes them feel good for a time. In our wisdom we decided we would stop the sale of phensydil in Lismore and I think we have succeeded.

Another one is Dormail, which is a sleeping preparation. The demand for that suddenly shot up. We have a compact block around town in the shopping area and often we send a note around for various comments. We did so on this occasion and found that the sale of this had gone up considerably. Amongst ourselves we stopped the sale of dormal without prescription. We probably had no legal right to do this but the pharmacists in this town think they have some professional right to stop the sale of anything that seems suddenly to become a seller higher than the norm. One other thing that my colleagues and I have been worried about is the prescription by some medical practitioners of this area of drugs of addiction.

Last year I was on roster and I received a prescription for palfium tablets for a lady from one doctor not in Lismore. Someone brought the prescription in for this young lady. Next day the same prescription for the same lady from another doctor also outside Lismore was brought in by a different person. That same night when I was on duty again I received a third prescription for the same young lady for the same tablets. I thought that this was rather funny so I spoke to the president of our association. He suggested that we send a note around the block for starters to find out if the name had popped up regularly. The name did pop up regularly and in fact so regularly that she had got 700 tablets in the area within three months. That was a lot of palfium. Subsequently we inquired of other pharmacists at Ballina and at Byron Bay and Alstonville and found that she had obtained 1 800 palfium tablets in three months. There was no problem about us giving them to her because the prescriptions were there and everything was quite legal. We think the medical practitioners should look at these schedule 8 prescriptions closely. There is not enough control, sometimes. I would not like this sort of thing to be published. We do not think the medical practitioners in this area, and I am not speaking only about Lismore but all medical practitioners, should prescribe schedule 8 drugs so freely. Some of them prescribe those drugs freely. My colleagues and I would like also to talk about things such as Bex, Vincents, barbiturates and valium but we do not know whether they are included in the terms of this inquiry.

3296. They are——W. The analgesics story is quite a different matter. There will be some self-regulatory ideas coming up about this in the near future, no doubt. The pharmacists of Lismore, should they find something strange happening, try to control it in their own way. We stick to the law and we do not think there is any handling of illicit drugs among us—in fact, I am sure of it. That is all I have to say.

3297. Let us look a bit further at Bex and Vincents. What caused you to mention those things?——W. One of my colleagues mentioned them.

3298. Does he offer any suggestions in relation to them? ——W. No, but I think our guild is coming out with a suggestion and there will be smaller packs in future, not so much with Bex and Vincents but with Codral and Panedeine and that type of thing.

3299. Are you aware of the recommendation that was recently made by a national committee that all compound prescriptions containing aspirin and these other things should be on prescription when there are two or more of them?——W. Yes. I think it may be using a sledge hammer to kill a flea. Of course, where you get abuse you must have more control.

3300. What would you consider to be an abuse of Bex or Vincents powders? In other words, how many would a person have to take before you would consider him to be abusing them?——W. If they took 12 a week they would be looking for trouble.

3301. Would you be surprised to know that some people take 12 a day?——W. No I would not. I know some who take two before they get out of bed in the morning.

3302. And some have been doing it for years?——W. Yes, and they end up with renal transplants.

3303. You mentioned this girl with the large number of palfium tablets prescribed. Are there any cross-checks between the pharmacists in the area in regard to any drugs that are on prescription?——W. No. It should really be policed by the Police Department. We do see the chap coming around checking the D.D. books. I am sure if one of the detectives said to me that somebody is on pethedine that we could find out in an hour how many they have had from the pharmacist by the registered medical practitioners prescriptions.

3304. That is closing the gate after the horse has escaped. You mention that it only came to your notice because you saw the prescription for the same person on different doctors?——W. Yes.

3305. Is it possible to evolve some sort of cross-check so that that situation could not arise?——W. I do not think so. There are so many medical practitioners and pharmacists in the area. One would need a central computer in Sydney or in Lismore where they could put it through virtually instantly.

3306. Have you had any experience or have you heard rumours of chemists dispensing methadone contrary to regulations?——W. None.

3307. Have you heard of any cases where doctors are supposed to have been selling methadone prescriptions for inflated prices?——No.

3308. There is another similar product, Elix-nocte. Is that sold at all?——W. I use Dormel. I could have used chloralhydrate, or chloralhydrate derivatives. They are the same thing. There may have been other towns, I am only talking about Lismore.

3309. In recent figures supplied to us from the Coroners Court it was surprising to see the number of people who had died from accidental overdoses of chloralhydrate. Have you had any experience of the same sort of thing happening in the same area?——W. No. We are asked quite frequently and we just say that we have not got any. That is as far as it goes. Noctec capsules is another one.

3310. Mr HEALEY: When was the last time that an inspector of the therapeutic goods paid a visit to Lismore? ——W. I think the local sergeant was the last time.

3311. I am speaking about an inspector from the therapeutic goods?——W. Not for some time. I could not tell you exactly. It would be some little time.

3312. Mr WOTTON: You may have heard earlier someone say that in no way should legislation be introduced to protect people from themselves. Is not this exactly what you are talking about? If you had a carte blanche to every body for drugs of addiction the thing would become intolerable, and they should be protected?——W. We are going into a moral angle here. I think that some people have to be protected from themselves. Most of us have not got to worry, we are very lucky.

3313. Mrs DAVIS: When you were having the waves of interest in these particular drugs did you find it fell into a certain age group, those who wished to buy them?—— W. No. They would be from, say, 16 to married women with children.

(The witness withdrew.)

MARTHA LOUISE PAITSON, of Ixtlan Farm, Nimbin, on affirmation:

3314. CHAIRMAN: What are you employed as?—— W. A gardener more or less. I share the workload.

3315. Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. I did.

3316. You have previously had communications with the Premier?——W. Yes.

3317. Do you wish to make a submission to the committee?——W. Yes, I will read it if I may. In the past I have sampled, for the purpose of self-education, just about every type of drug available that in any way produces changes in the mind. I also meditate. I find this very useful for that purpose. The only drug I feel I have used to excess or that is actually harmful to me is tobacco. The substances that I personally prefer are pure LSD once every year or two for the purpose of spiritual inspiration, and the herb *cannabis sativa,* or marihuana, which I have used regularly for about ten years.

The effects and uses of this herb are many. It can be used as a relaxant, helping one to be calm and more tolerant; it can help one to sleep or to stay awake; it inspires creative thinking and doing; it excels in easing the discomforts of influenza; and the plants, grown as a companion crop with brassicas, will repel the cabbage butterfly.

The actual physical effects from cannabis are few. The eyes redden somewhat, the mouth becomes slightly dry and the heart beats a litle faster for a while. It is usually quite difficult to ascertain whether a person is stoned. A person who is skilled in the use of the herb will show no impairment of his motor faculties, unless he has been trying very hard to get too stoned to move. In fact, he will probably find that the stronger mental concentration which is encouraged by the intelligent use of cannabis improves his co-ordination. Also, cannabis has a very fortunate inbuilt feature lacking in alcohol and most other drugs, that is, one usually becomes acutely aware of dangers inherent in such activities as driving and exercises greater caution than when not stoned—even to the extent that it may be preferable to wait until the effects have worn off before attempting anything involving good co-ordination and reflexes. In the ten years that I have used cannabis I have had periods of heavy usage, light usage, and periods during which I did not use it at all. The only ill-effects of heavy use is boredom. There are no traumas of withdrawal when, due to lack of supply or interest, I stopped using it for a spell. Being stoned is a nice feeling so it is not surprising that many users smoke daily. But it certainly is not addictive.

I think the most important reason why cannabis is used is for its social value. For those who are tired of the violence and lechery of social drinking, cannabis is a pleasant alternative. The passing round of joints or pipe or cookies and subsequent laughter and jollity, or quiet conversation—or both—is a happy and powerful bonding ritual. The illegality of the herbs only serves, if anything, to spread the bond. It certainly does not deter any of us.

In my estimation, there are possibly as many as half a million cannabis users in Australia. I have met them in all walks of life. Even some parliamentarians smoke dope. It is incredible that such a harmless and widespread activity should be the target of so much heavy legislation. The only danger of cannabis is inherent in its illegality, which promotes an ignorance which can estrange parents and children, husbands and wives, neighbours and friends. Not unnaturally, most people think that if a thing is illegal it must be horrible. Yet more serious is that, since users cannot grow their own with impugnity, its supply can become an underworld activity, linking this mild herb with all the other evils that implies. This applies to all drugs: making them illegal causes a great deal more criminal activity than just their use. If drug-taking is a problem, chasing the users into hiding certainly is not going to help us deal with it.

Cannabis itself is not a problem. It is time that Australia grew up and stopped trying to make it one. Perhaps it is also time to try a more humane and workable approach to the control of the use of heavy drugs such as opiates, tranquilizers and barbiturates. It is no secret to any of us that these have become a serious problem in Australia, particularly the opiates as they can usually be obtained only illegally. Such drug abuse is symptomatic of aliena-

tion, boredom and lack of hope. These are a by-product of modern city living. People do not become alcoholics, junkies or Valium addicts because they are evil themselves but because they are in an evil situation and do not know how to get out. Making criminals or even social outcasts of them does not solve anything; it just compounds the problem. Cannabis could even be part of a solution to these problems. It is cheap and easy to grow; it needs no processing; it is much less physically harmful; and it is neither as disorienting nor depressing as the alternatives of alcohol, tranquilizers, barbiturates and opiates. It can change the mental state, which is why people take any drug, without harm.

There is one last thing I would like to say that relates specifically to the North Coast. We have a situation here that is developing similarly all over the country in rural areas, except that it is further developed and on a bigger scale in this region. This is the resettlement of the area, which was previously dying with the local industries, by people who have been fortunate enough to recognize the hopelessness of the big city situation in relation to themselves at least. The majority of these new settlers are young and rather idealistic and probably pretty ignorant of country ways. As in any situation where there is a large influx of new people to a settled area, there is resentment, suspicion and prejudice on the part of the old settlers. There is an attempt to discourage the newcomers and to send them away. If a legal means can be found it will be used. In this case, the legal tools available have been unapproved owner-built dwellings and the use of cannabis. The latter tool has been used extensively in the last year or so, more or less since Eric Strong was transferred to Lismore as chief detective. The local media and the State member for Byron, Jack Boyd, have been most energetic in their efforts to create a problem where none exists, to stir public feelings against the new settlers and to encourage police action against us.

We are gradually becoming accepted—even respected—members of our local community, in spite of such slanderous harassment, as ignorance dies and awareness of our contributions grows. But if the State Government can do anything to help take the heat off us then we will be able that much more freely to get on with the business of working with our neighbours to make this community a fine and happy one for us all.

3318. I understand that subsequent to the big raid by police in August last year that at least fifteen people have been arrested since then. Did you say that?——W. More than that, at least that number up to now.

3319. You also allege that together with the arrests there were beatings and police urinating in water tanks. Have you any personal knowledge of that?——W. No, 1 have only heard from friends of mine.

3320. Have you grown marihuana?——W. Not exactly. I have never been able to get it beyond the seedling stage.

3321. You are dependant on your friends when you say that you have been a regular smoker?——W. That is right.

3322. You have been fortunate enough to get it from them at a cheap price?——W. Usually.

3323. You would like to see marihuana legalized?——W. Yes.

3324. What would be the advantages of that?——W. There would be numerous advantages. The people who otherwise are useful citizens would no longer be criminals if they used it; it would sever the link between grass and hard drugs. So many people use it who are not doing anything wrong. It seems ridiculous and incredible that it is illegal.

3325. You have a property of your own in this area?——W. I am a shareholder at Tuntable Falls.

3326. You said marihuana could do no harm; is that your own personal opinion or do you have some good reason for saying that?——W. It is my personal opinion as a result of a certain amount of education. I read most of the things which I come across which concern marihuana. Most of the responsible research that has been done into it has shown that it is not particularly harmful. Naturally, anything that is used to excess can be harmful. If you have six teaspoonsfull of sugar in your cup of tea it wll be harmful. Smoking is not a good thing either. I am trying to remain an ex-tobacco smoker.

3327. You say that anything taken to excess can be harmful?——W. If someone smoked heavily, say ten or twenty joints a day for some years they would probably start having lung trouble.

3328. You said you smoked heavily when you were bored. How many would you have to smoke when you got bored?——W. It does not work that way. I am speaking specifically of a couple of times, one when I was stranded in Asia for some months waiting for a ship to get me to Australia. I did not have enough money to travel or to do anything much so I had to stay put. The boredom caused the smoking; there was nothing else to do. I stayed around smoking with my friends. Over a period of time smoking, with nothing else to do, becomes very boring. Maybe I was smoking ten joints one day and three the next day. I find that I got bored; other people do not find that.

3329. Do you smoke cigarettes?——W. No, not now.

3330. Did you at that time?——W. I cannot remember. I am an intermittent smoker. I have been trying to stop for years. I am not sure whether I was smoking then or not.

3331. Mr HEALEY: You said you have experimented with practically all drugs. How old were you when you first started?——W. I was probably about three weeks old when they gave me my first drug.

3332. No, when you took your first drugs?——W. I drank at high school; it was part of the social thing. I did not really like it much. I guess that the first thing I ever tried was marihuana when I was about 20, and that is when I gave up alcohol. I realized that if I wanted to relax with friends I did not have to drink. After that I went through another period. That was in 1967, the beginning of the hippy movement. That is part of what was happening. There was experimentation with a lot of drugs. LSD was available freely in America as were other hallucogens. I sampled various types of these. When I was in Asia I visited an opium den and that was pretty horrible. I spent another time of a week and a half on heroin, very much for the purpose of self-education. It was horrible. I am not the sort of person who is inclined to that sort of thing. I did not enjoy it. I felt it was necessary to give it a go because there were so many people who use it, and I feel that it is important if one comes in contact with people who use it to have some personal understanding of why they use it.

3333. Mr JACKETT: You said that marihuana did not affect the motor co-ordination?——W. Yes.

3334. That is contrary to the opinions expressed by a professor of Pharmacology at the University of New South Wales and Dr Chesher, lecturer in Pharmacology at the University of Sydney. Both those people said that they support the decriminalization of marihuana but are very much against the legalization of it. They both claimed that it does seriously affect the motor co-ordination.——

W. I wonder how much they smoked. I am glad you asked that because I would like to say something about it. One of the common effects of cannabis is a sort of paranoia or extreme shyness. I know that when I first smoked it I found that I did not want to move; I sat still all the time; I was afraid that I would fall on my face. In my submission, I referred to the skilled and intelligent use of cannabis, not its indiscriminate use. It is possible to learn the use of the herb so that it, if anything, improves your co-ordination. You can get enough in you that you would not be able to move; you do not want to move or you cannot move with co-ordination. It is almost like relearning a skill. I am a dancer by nature. I know that when I began smoking it was difficult to dance; I was afraid that I would make a fool of myself and it upset me because I love dancing. Somewhere along the way I got rid of that inhibition and realized that it was not stopping me from dancing at all. I find that I am inspired in dancing if I have a smoke. It is the same with driving. People who have been smoking generally drive slowly and much more cautiously because they are more aware of the dangers and the fact that there might be a raving maniac on the road at that time. You get this sort of awareness and sensitivity to danger. There is a greater concentration. I am assuming that this is not overdone. Usually, someone who has smoked a great deal does not want to drive. My experience, and that of all my friends who I have talked to about this, is that once you have learned to use the drug properly there is no effect.

3335. CHAIRMAN: What type of dancing are you referring to?——W. I did classical dancing as a child, but I just like free dancing.

3336. Mr McGOWAN: You spoke of the skilled and intelligent use of marihuana. How do you achieve that in people who are perhaps not intelligent?——W. That is difficult. I can only tell you from my own personal experience. I think the way I did it was through smoking with friends. Smoking cannabis with friends produces a sort of sensitivity; a personal thing happens between people.

3337. CHAIRMAN: You are obviously an intelligent person. Would you become intolerant of people who are not as intelligent as yourself?——W. Not usually.

3338. Mr McGOWAN: What of the situation of an unintelligent and emotionally disturbed person?——It could be useful for such a person; it makes people slow down enough to start seeing things. With a person like that, it would be best if they first began with loving friends who perhaps knew a little more about it than they did.

3339. What would be the position if they were with people who were inclined to use others?——W. It is not as dangerous as alcohol. People do not get violent on it. If you had a smoke you could not care less about fighting or doing anything violent to people.

3340. Do you believe that there are any chemical substances which should not be freely available?——W. That is a hard question to answer. I am horrified by heroin use and the use of amphetamines and barbiturates and all the things that so many people take legally. Ideally, they should be freely available to people so that there is no criminal element involved in it, but that would need a powerful education programme.

3341. Could you give me a practical answer; would you allow cyanide or any substance at all to be freely available in a community?——W. I have not thought it through well enough yet but as far as I can say now, certainly not.

3342. Given that you will classify chemical substances into two groups, those that are freely available and those that are not, why should marihuana go from the one which is not freely available into the one that is freely available?——W. Because it does not belong in the group it is in. It is a herb. I use herbs for teas and for medicinal purposes. It is used in Asian countries as a medicinal herb and is now used in America as such. I understand that it is legal in California and you can grow your own in the backyard. It is like trying to put milk in with other chemical substances and saying it should be illegal—people can get sick from drinking too much milk. It does not relate. It is not the same thing at all.

(The witness withdrew)

DAVID D'EYLAN SPAIN, Barrister and Philosopher, residing at Numenadi Hamlet, Tuntable Falls, affirmed:

3343. CHAIRMAN: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. I did.

3344. We have received a submission from you. Do you wish to have it incorporated as part of your evidence?——W. I do.

STATEMENT FOR THE PARLIAMENTARY COMMITTEE ON DRUGS CONCERNING MARIHUANA

The solid physical body of the human being is surrounded and interpenetrated by an etheric body, invisible to the eye but visible through Kirlian photography, and it is this which vivifies what would otherwise be a corpse. Also attached to this entire physical apparatus, through the medulla oblongata at the back of the head, and through the ajna chakra in the forehead, respectively, are two other bodies, composed of increasingly fine material (atomic) substances, namely the astral (emotional) and the mental bodies. According to the vibration of certain seed atoms, whole masses of other atoms, bearing those tendencies of thought and feeling which come to operate through the physical brain and heart, are held in orbit.

Now when certain drugs are ingested, especially those known as hallucinogenics, then an alien element is introduced into the physical set-up which causes it to become preoccupied on its own level of intelligence, thereby freeing the individual's awareness for experience of astral and mental phenomena which can now flow through openings in the etheric sheath which would normally, due to ingrained habit and conditioning, be hardened against their entry.

In these times of mass-education, stereotype conditioning, benumbing technology, individual impersonality and alienation, and environmental ugliness, there is often a need for individuals, finding themselves crushed by experience or at a deadend of creativity, to experience what can be a very encouraging or calming insight or state which is induced by the hallucinogen. In this regard, which applies especially in the cities, the comparatively mild and harmless herb marihuana is most useful, as has been known to pharmocopeia since thousands of years. That this herb is comparatively harmless, whatever certain extremist academic experts may have said, is obvious in the light of its continued widespread usage, without particular ill personal or genetic effect, amongst that western generation now coming into maturity. Certainly marihuana is less dangerous than alcohol, the carcinogenic nicotine, or many drugs now prescribed by doctors, especially the barbiturates and amphetamines.

It must be borne in mind, however, that all the world's highest philosophies and religions proscribe intoxication, and since human freedom and fulfillment is to be realized in consciousness, the antithesis of matter, so use of drugs or herbs can only be of limited usefulness. They can become enervating crutches and negators of inspired motivation unless the insights won are integrated into a basically drugless life, so as increasingly to heighten and harmonize the vibrations of all the atoms in all the bodies which compose each human being. It is upon the tension between the material vibrations of such atoms and the indwelling "divine" spark of Infinite Consciousness (and hence Energy) that is forged and formed the immortal soul of each individual.

The true answer lies in transforming the environment, both socially and physically, such that every human never deviates from happiness (whatever the emotions engendered by the buffeting of life) from a sense of progression and fulfilment from unity with Nature and from comradeship with his fellows. Of paramount importance in human being attunement to such conditions (wherein we would dwell intuitively but for what

the theologians term the "fall from grace") is the predication of our civilization upon that which is mentally and intellectually supremely intelligent. This planet, with its military, economic, environmental and economic + social strife, is manifestly far from that state. The way thither, with co-ordinated understanding and activity, could (in this peaceful and wealthy continent of Australia) be surprisingly quick, however, and I indicate in attached essays how such a way might be explored.

All elements of society should work together in achieving this synthesis and this attunement to a spontaneously-harmonious + fulfilling lifestyle. In these circumstances, it is totally unproductive and reprehensible for the established government, with their own destructive drugs and their own manifest inability to simplify the destructive problems facing our human civilization, to hound and beleaguer thousands, and often the most creative ones, amongst that generation now coming into maturity. There is a deal too much inexperienced prejudice in this attitude, not to mention uncreative bigotry. Far better to realize that the threats to human civilization are too dire for more time and energy to be spent upon this fearful patriarchic policing of a comparatively mild, and even quite creative, indulgence.

Waste of legislative and judicial time, and conditioned bigotry in the mass public mind, is one thing, the often-brutal and unsympathetic nature of the police attitude is another. Persons performing this function, at present unfortunately a necessary one for preserving some semblance of order amongst our divided society, are often drawn from the less-educated and aware sections of society, and are, accordingly, although not a few are admirable men dedicated to justice and propriety, easily given to unthinking conditioning, they become the brutal, dehumanized functionaries of a job, and in this officiousness can, by search, arrest or bashing, cause much harm to persons who have occasioned ill to no-one.

One of the most upsetting aspects of this abuse is the "planting" of marihuana upon persons whose social caste or lifestyle is, whilst not sympathetically considered or comprehended, the object of such one's prejudice. Then, too, there is the use of force and the fabrication of evidence and of admissions. It must be stressed here that these practices are not performed by all police, or even by a majority of them, but just how large the minority is should at any time be investigatable by a citizen's ombudsman. At least the removal of that unachieving legislative proscription against marihuana, entirely from off the statute books, would save not only legislative and judicial effort, but would minimize opportunity for certain police to exercise these malfunctions.

Would legalization lead to major abuses? I think not. Already users are becoming increasingly aware that the answer lies in consciousness alone, and that drugs are an unsatisfactory and temporary way of permanently maintaining this. As the environment becomes harmonized, and capable of providing fulfilment, so usage will increasingly dwindle. Paternalistic interference in the freedom of individuals to smoke marihuana is, in these troubled times, quite unproductive.

DAVID D'EYLAN SPAIN,
Barrister-at-Law.

3345. CHAIRMAN: In your submission you say:

> It must be borne in mind, however, that all the world's highest philosophies and religions proscribe intoxication.

Would you not say that a person could become intoxicated with marihuana?——W. Yes.

3346. Are you then saying that anybody who is addicted psychologically to the use of marihuana therefore could not expect to be a philosopher?——W. I would expect the quality of that one's philosophy or religion to fall somewhat short of perfection. However, in these times with human kind involved in so many strifes and conflicts and so much ugliness within their minds and in the environment—of the fall from grace, as the theologians would say, it may be that usage of certain substances, among them marihuana, peyote and psilocybin, may open up the centres of consciousness within the individual using them. I suggest that that one perceives a glimpse of worlds and realities beyond his normal condition and so by incorporating this fresh awareness to his drugless life is able to live closer to that transcendant reality which is occasioning all existence on the planet into the infinite consciousness to which we will eventually evolve. So, while in an absolute sense one should avoid intoxication even by the comparatively mild herb marihuana or the quite rewarding substance psilocybin, until we human beings are no longer in the state of fall from grace as the theologians call it, with separatism among our communities and partisan strife, lack of accord between human kind and nature, economic, marital and industrial strife, ill health and alienation between people—while those problems exist it may be that smoking marihuana, for instance, will be found to bring a fresh knowledge and outlook on life within the individual and groups of individuals and so augment this process of humans resolving the problems of separatism.

3347. The terms of reference of our inquiry deal with drugs of dependence. As such, we have to try to confine ourselves to that, more than the effect the drugs would have in regard to your approach to a particular philosophy or way of life. For the present we will try to stick to drugs of dependence, more so than the philosophical outlook. You mention in your submission the often brutal and unsympathetic nature of police attitudes. Would you like to expand on that?——W. Yes. I have known cases where police, usually the rather younger and inexperienced ones, have tended to treat members of what might be termed the alternative society—people wearing long hair or beards and somewhat unkempt—perhaps with a certain suspicion and disdain—to take them in, question them, search them and even arrest them upon not finding any evidence of marihuana, or very little. Sometimes this substance has been planted or stashed upon suspects.

3348. Have you had experience of that personally?——W. Not on my own person, but I know people who have had this item stashed upon them and have subsequently been charged. It is difficult to disprove.

3349. In effect, you are taking the word of the persons concerned. You have no personal knowledge of this yourself?——W. I have never been arrested for this substance and have not had it stashed upon my person. However, I do hold statutory declarations from ones so affected.

3350. When you use the words, "the brutal and unsympathetic nature of the police attitude", you are speaking of secondhand experiences—experiences that have been related to you by other people.——W. Yes, but experiences have often been related to me in a legal capacity, as somebody with legal knowledge.

3351. Mr RAMSAY: When the police came on that raid last year was there any damage done to community property there?——W. Not that I know of—if so, certainly very little. The police were, by and large, well behaved. I think the presence of powerful firearms and also some cases of stashing the marihuana did occur.

3352. How often would you get police going in there now?——W. Not at all.

3353. They do not go in there now?——W. Not at all.

3354. They do not go in there now?——W. Perhaps the local policeman might come every two or three months to look for someone or check up but there is certainly no uniformed or usual presence of police on the property.

3355. Mr JACKETT: Do you believe that a person smoking marihuana does not suffer any loss of motor co-ordination as we have been told today?——W. I should say that is probably so. There are losses in some regards because smoke does irritate the lungs and intends to inflame the nasal passages and redden the eyes. Breathing is man's link with the infinite mind beyond and that function should be as pure in the individual as possible. But as regards motor functioning, from my observations I have seen indi-

viduals smoking but doing the most delicate tasks photographic or electronic, for instance of brain and hand co-ordination or using machines; and I could certainly not say there is any marked destruction of motor ability.

3356. Have you driven a motor vehicle having just a short time before, smoked marihuana?——W. No, I follow the ways of Buddha and Christ and I am speaking to you from a purely objective mental standpoint. I cannot give personal evidence about driving a motor vehicle under the influence of anything.

3357. You are satisfied that there is no loss of motor co-ordination?——W. Yes, certainly—not enough to worry about compared to other drugs such as alcohol or even the ill effects of eating highly chemically impregnated food or soporific meat or nicotine.

3358. Suppose you were working in a steel works and the crane driver who had the big ladle of molten steel working above you was high on marihuana, how would you feel about working below?——W. I would not be happy about it but I do not see marihuana being used in such ways but rather as a sacrament in more or less sacred, organized circumstances like perhaps at every new moon. Then, there might be a smoking of marihuana among the local community in a particular area. But, my whole outlook is seeing it as a key, something that can be used to unlock doors so that you can see in, but you cannot go into the new rooms the doors of which it opens unless you tend to live without such drugs or such material items which alter the way in which awareness is flowing into one's organism. So, it becomes a responsible sacrament to use this sort of item and it should not tend to be used in the instances you have cited.

(The committee adjourned.)

(The witness withdrew.)

*AT MULLUMBIMBY ON THURSDAY, 7 JULY, 1977*

(The Committee met at 9 a.m.)

Present:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| The Hon. MARGARET DAVIS | Mr J. G. T. JACKETT |
| The Hon. C. HEALEY | Mr B. McGOWAN, B.A. |
| | Mr R. C. A. WOTTON |

3359. CHAIRMAN: I declare this session open. I ask the Secretary to read the Committee's terms of reference.

COLIN ROBERT SCATTERGOOD, a farmer of Upper Main Arm, Mullumbimby, sworn and examined:

3360. CHAIRMAN: Do you wish to tender a written submission or make a verbal statement?——W. I will give a verbal statement. After fifteen years of marihuana being reasonably available, the Government's action of attempting to clean up the area by the use of aircraft and weed inspectors has caused, for one thing, the price of marihuana to rise. Marihuana is still available but at a much higher price locally. The Government's action of using aircraft in looking for crops of marihuana has affected the local alternative population. If they wish to have drugs of any sort, they have to turn to the harder drugs. However, marihuana is still available although it usually comes from the cities. The action I have referred to has also allowed city syndicates to raise their price of marihuana. I am speaking mainly of marihuana because I feel that this district is not a hard drug area. From what I have seen, marihuana is practically the only drug used here, that is, if it is to be called a drug at all. In the six years I have lived here I have not seen any obvious indications of a generally increasing degenerate society after people have smoked marihuana. I believe also that marihuana should be dropped from the provisions of the law. There are numerous drugs that can be grown readily. One is Rhu, from which a tea can be made; it can be used for various reasons; that herb is not on the list that is issued by the Government yet it is possible to get high or stoned on Rhu which grows practically everywhere. It seems that city syndicates are organized in the collection and distribution of marihuana. One of these syndicates came to this area not so long ago and offered seeds. They said that they could arrange for the collection of marihuana if anyone wished to grow it. From what I understand, a few farmers have turned to growing marihuana because they did not have much success with their other income ventures. Some of these people have been apprehended.

Until last year many people in this area grew small quantities of marihuana. This enabled young people, maybe the alternative people in this district, to sell it and this enabled them to meet their budgets. Work is hard to get in this area. Many young people are on the dole, so that by growing, say, thirty or forty plants people can smoke it themselves and maybe sell some to raise a little money. One interesting point I have noticed is that of the larger crops grown locally, that is crops of one acre or more, the subsequent apprehension by the police of the offenders has usually proved to involve not alternative types but temporary residents, possibly from the cities. This was certainly so in the case of drugs found in the Uki and the Mt Warning district. There is a fairly good relationship with the local police and the council in this area. The majority of the alternative people living in this area are not squatters. They have purchased their own land. In the first year I came here I estimated that $100,000 had been paid for land in the Main Arm area alone. I find it hard to understand why people arrested for the possession of drugs are treated as criminals. Some of these people may be sick and require hospitalization rather than being placed in a prison where they are likely to meet harder criminals. I know of two cases of people being arrested in this area where the police have taken large sums of money from them. When the case comes to court the sums of money mentioned have been small. Mainly these have been people who have been arrested in the city rather than in Mullumbimby, even though they may have been local people. They may have gone to the city to sell the drug that they have grown here. From my personal experience it seems remarkable that the police spend so much of the taxpayers' money endeavouring to apprehend marihuana users when that money could be better spent in catching people engaged in crimes of a more serious nature. From my personal observations, which extend over more than fifteen years, I have not seen one case where people smoking marihuana for a number of years have acquired a craving for harder drugs.

3361. You say that you know of cases where money has been taken from persons concerned in the sale of marihuana, which has been in excess of the sum stated to have been taken from them. Is that statement based on second-hand or third-hand statements?——W. It was said by the people who were apprehended by the police.

3362. You never had any personal experience of that sort of thing?——W. No.

3363. Have you ever been apprehended by the police? ——W. I have not been apprehended. However, about five years ago the police had a warrant that enabled them to search the area but they did not find any marihuana on our land. We have about 430 acres.

3364. You spoke of weed inspectors using aircraft in this area. Are you certain that those aircraft were used by weed inspectors?——W. I can go only on what I read in the newspapers about that but it was quite obvious that the planes were searching the area. That type of action could be regarded as harassment. They spent a week flying over here. In some cases the plane flew no higher than a hundred feet. They flew across the valley and they flew back again at about one hundred feet. They did this continuously for a number of days. It was obvious that they were looking for marihuana.

3365. The people in the aircraft did not tell you that they were looking for marihuana?——W. It is only what I read in the newspaper. It is only assumption on my part.

3366. Is it correct that there have been some quite large seizures of marihuana crops in this area and some of them had a street value of millions of dollars?——W. There have been seizures of marihuana in the area, yes.

3367. But none in your particular area?——W. Yes, there have been one or two seizures in the Upper Main Arm area, but they were not worth millions of dollars. I would say that it would be approximately some thousands of dollars, certainly not millions of dollars.

3368. You say the marihuana available here usually comes from the cities. What is your reason for making that statement?——W. Possibly the seeds used here originally came from the cities or from overseas. When there is a so-called clean up of the area by weed inspectors and police, the marihuana becomes less readily available here and it can be obtained in the cities where there seems to be ample supplies. It comes to this district and is offered for sale. This would indicate that some of the syndicates have large quantities of the drug. On one occasion I was in a hotel in Bondi. I was talking about Mullumbimby. Someone came up to me and asked me if I was able to supply marihuana in large quantities. They said they would be interested in purchasing 50 lb or over of marihuana per week and that they would supply seed and irrigation equipment. They said also that they could arrange the collection of the crop. I was not able to help in any way.

3369. You said a shortage of marihuana would make people turn to other drugs. You made a subsequent statement that people who are marihuana users have no craving for harder drugs. There seems to be a contradiction there.——W. That is correct. It could indicate that if the police wished to continue to, as they say, try to clean up the area of marihuana, the people interested in smoking other than ordinary cigaretes, who wish to get high, could turn toward other drugs.

3370. Most of the proponents of the legalization of marihuana contend that marihuana has no effects that are similar to the effects that you get from harder drugs. Will you agree with that?——W. I am not a medical practitioner so that it would be hard for me to answer that question.

3371. You say that you have smoked marihuana?——W. Yes, I have smoked marihuana on many occasions. My personal experience is that I have been able to carry out a perfectly normal day's work; I have been able to carry on normal living. By that, I mean that I have not become degenerate as a result of smoking marihuana. I find that there is only a pleasant sensation of getting high.

3372. It was suggested to us yesterday that you could get high just by being in a room where other people were smoking marihuana?——W. Yes.

3373. Surely the sensations would not be anywhere near the same as if you were smoking it yourself?——W. It depends how close you were to the person smoking marihuana. If it were in a confined space people who were not smoking it would get the effects by inhaling it as if they were smoking it themselves, though perhaps not to the same extent.

3374. Have you ever mixed alcohol with marihuana? ——W. Possibly.

3375. Have you ever taken alcohol at the same time as you have been smoking marihuana?——W. Yes.

3376. Have you found that to have an adverse reaction? ——W. I find a similar effect really except with alcohol, with too much consumption of it you suffer from headaches and things like that, whereas with marihuana I cannot say I have ever suffered with headaches or the morning-after feelings. The effects of marihuana wear off reasonably quickly, maybe within a couple of hours or so. I do not consume alcohol very much at all.

3377. Do you know many people who do mix the two of them?——W. It is not usual to mix the two other than maybe alcohol being available at a party as a general social status thing. Most people would prefer to try marihuana, I think.

3378. Apart from your statement about being approached in a hotel at Bondi you said that city syndicates were well organized in the provision of seeds, irrigation equipment, arrangements for collection. Can you elaborate on that?——W. This was indicated to me by the particular person who spoke to me in the city.

3379. So it was only the one instance?——W. The only other instance I have had was not to me direct but it was fairly common knowledge that not so long ago there was another gentleman up here from the city and he came to the area asking people if they were interested in growing marihuana. He did not come to me personally but I understand he was also advising people that he could provide seeds and would help them generally in the growing of marihuana.

3380. I am probably paraphrasing what you said but I think you suggested that the people who had been arrested for large scale growing of marihuana were virtually strangers to the area?——W. It would seem that some of the people who have been arrested in the area for growing large quantities of marihuana were comparatively new arrivals. They were not the people who had arrived here six years ago with the idea of settling here. This would be in the majority of cases, I would assume.

3381. You would not link them in any way with your own community?——W. In no way.

3382. Mr HEALEY: You mentioned that there is a partial drought at the moment and there is an escalation of prices. What is the going price?——W. I. understand it would be about $30 or $35 an ounce.

3383. We have been told throughout this inquiry that it has been that price for the past ten years?——W. If you buy it locally from your local friends it would be in the region of $20 to $25.

3384. CHAIRMAN: There are fairly heavy handling charges involved?——W. Yes.

3385. Mr JACKETT: What is your educational background? Do you have any degrees?——W. I received the school certificate in England and I left school when I was sixteen.

3386. You have not any specialized qualification?——W. No.

3387. Precisely what do you mean by the use of the word stoned?——W. For example, in the early stages of taking a little alcohol it would be slightly similar but as far as the general feeling of nausea, it is not there, and with marihuana it is a pleasant feeling. For example, you are driving and you have had too much alcohol, you have little control over the car. You might feel that you have complete control but it is the opposite, and often there are bad accidents through this. If you drive under the influence of marihuana instead of wanting to go faster you want to do the opposite and you go extremely slow and in fact you probably have a great deal of control over the car. Other than that it is just a general feeling. You might enjoy music or pleasant conversation. I have never seen a case, as a result of marihuana, of people who want to become aggressive, which I have seen with alcohol.

3388. Leaving aggressiveness out of it, what you claim is that your ability to control the motor co-ordination is not affected by the use of marihuana?——W. It is certainly not affected to as great an extent as it would be by alcohol or harder drugs.

3389. In your opinion did you have any worse control over a vehicle than if you were completely sober and had not ingested marihuana?——W. You would not have worse control. You would probably have more concern for the effects of your driving, knowing that you have been smoking marihuana and in fact your driving would be very similar to if you had not had something except you would be far more aware of the situation.

3390. Are you aware that the expert evidence of a professor of pharmacology at the University of New South Wales and Dr Cheshire who has done a great deal of work in this field as lecturer in pharmacology at Sydney University, both state definitely that the motor co-ordination is seriously affected by persons ingesting marihuana?——W. I suppose they would be speaking from observations. I am speaking from personal experience.

3391. They were using scientific methods of determining the effects of marihuana upon the individual in various tests. Do you claim that your experience by ingesting marihuana is more reliable than the work that they have done scientifically in this field?——W. I am only stating my own personal experience. I cannot argue the point with someone who has done extensive research into the situation.

3392. I take it that the lifestyle which you and others who have come up here from city backgrounds to farm and so on is contrary to the use of marihuana to obtain something which is a euphoria. Is it not contrary to all the rest of the lifestyles that you are adopting to smoke marihuana?——W. It seems to be part of the lifestyle. When I came from the city, with many young people, it was common practice to indulge in smoking marihuana. However, over the past couple of years I have seen that people are less interested in smoking marihuana and in fact they are less interested in indulging in drugs or alcohol generally. So it may be a phase that many people have gone through. When I came here I noticed that marihuana was used quite extensively but in the past couple of years I have seen evidence of far less use of marihuana generally among the young people and among the alternative people in this area.

3393. Then why does it seem to be such a big issue in your community?——W. I do not think it is such a big issue at this stage except that we are surprised that marihuana is treated so heavily by the government and by the law.

3394. It has always been this way. It has always been illegal?——W. It has not. As far as I know marihuana was not illegal before between 1940 and 1950. From what I have read in papers and in other places marihuana was not illegal and it only became illegal after certain people requested that it be made illegal, probably people from churches and so on. It was not illegal prior to some twenty-odd years ago.

3395. You said that a number of locals have been sentenced to prison as a result of marihuana offences. How many local people have in fact been sent to prison in this way?——W. Let us say that they were sent to prison for a short period pending their case coming up in court. I know of two people and possibly more.

3396. CHAIRMAN: But not prison sentences?——W. No, but they have been in prison.

3397. Mr JACKETT: You do not know of any who have been sent to prison for the use of marihuana?——W. No.

3398. You said that the effects of marihuana wear off in a couple of hours or so. Do you know that that is completely contrary to the statement made by Professor Wade, Professor of Pharmacology at the University of New South Wales, who said that the one thing that really worried him was the long half-life of marihuana in the body and that it remains with a person and it takes very few cigarettes to keep that person at a perpetual high? Why did you make that statement about the effects of the drug wearing off like that?——W. From my own experience of smoking marihuana. I am not very interested in marihuana myself now. I was interested when I first came to the district. Of my friends and associates, I think I can say the same thing. I am talking of my own personal experience. If it has a permanent effect on my body health I will know in due course.

3399. Mr WOTTON: You mentioned city syndicates putting up the price. Are you or any of the people in your vicinity able to tell us who those syndicates are?——W. I should not think so.

3400. You were most critical of the weeds inspectors and the police for their action in what they were doing with aeroplanes in trying to detect these things. Would it be a surprise to you or would you be able to say that perhaps the majority of people in the overall district would commend them for their action in trying to do their job?

——W. Most reports in the paper indicate that marihuana is a pretty lethal substance to be in possession of. Most of the reports indicate that marihuana is extremely harmful. From my experiences I would disagree with that. People going on what they read in the papers or hear in the news could possibly get the impression that it was a good idea to so-call clean the area up of growing marihuana.

3401. You contradict yourself because a moment ago in answer to a question by Mr Jackett you said that if it does affect your body in time to come you will find that out as you go on?——W. As I say, it has not affected me.

3402. It has not affected you up to date?——W. That is right.

3403. You answered a question, I think by the Chairman, about your ability to drive a motor car. What about your working ability? Does it impair you in doing anything so far as work is concerned, whether it be technical or physical?——W. Yes.

3404. It does impair you?——W. Yes, it does impair you.

3405. You said that you got your higher school certificate before you left England. Did you smoke marihuana before you left England?——W. No, not in any way.

3406. Mrs DAVIS: We have heard reports in Sydney that marihuana is available in combination with other drugs. Have you had experience with the imported marihuana that has come in?——W. No.

3407. It is just straight marihuana?——W. Just straight marihuana.

3408. Mr McGOWAN: You said that a shortage of marihuana could lead to people turning to harder drugs. Are you referring to your society?——W. No, it is just an assumption. It is a possibility, from observations possibly.

3409. I put to you the proposition that the weed inspectors and police are doing their job, as expected of them by society, in carrying out the law?——W. Yes, they are carrying out the law as expected of them by society because from the reports in the papers the general public could have quite likely the wrong impression about marihuana, in my estimation.

3410. You are not saying really that weed inspectors and the police are wrong in what they are doing?——W. Certainly not.

3411. You used the word harassment?——W. Would not you consider aircraft flying over your lands continuously as somewhat annoying? Also police came out with a warrant that most likely was not legal. It did not have a name on it. The inspector who actually visited there asked me what my name was and he then wrote it on the warrant in front of me. He did not have a warrant to search our land that had any name on it as the time.

3412. You are complaining about the technicalities? ——W. That was just a technical point, yes.

3413. If honey were illegal I would follow the bees.—— W. That is quite likely.

3414. I still put the proposition that they are doing a job?——W. Sure, they are doing a job. As I said before, our relationship with the local police and local council is very good. We have not had a great deal of problems or any trouble really with the local police or council. In fact we have had a lot of help. There was only that one case of which I spoke. This was some 5½ years ago and I believe that the inspector came from Murwillumbah.

3415. CHAIRMAN: Where was the warrant taken out? ——W. I would say in Murwillumbah.

3416. You did not check to see where it was taken out? ——W. I cannot quite remember. I just know that the inspector's name was Crapp.

3417. You heard the terms of reference of the committee read previously. All your evidence so far has revolved around marihuana. That is the only part of our terms of reference that really upsets you, the present legal situation in regard to marihuana?——W. Yes.

(The witness withdrew.)

RODERICK THOMAS MUIRHEAD, registered medical practitioner of Upper Arm, Mullumbimby, sworn and examined:

3418. CHAIRMAN: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. I did.

3419. Do you wish to make a written or oral submission to the committee?——W. I will make an oral submission. I have been in this particular area since April, up around Mullumbimby. To put some of my remarks into perspective, I am a medical practitioner of 22 years standing. I practised orthodox medicine for the past 17 years and in the last four I have been quite discontent with what I was doing medically to people. I went to Sydney and studied alternative healing techniques. I spent the last three and a half years doing acupunture, and looking at drugless therapies generally. I am no longer interested in prescribing a lot of medical drugs and medication because they have disastrous side effects. The committee would probably be aware that at least 50 per cent of our occupied hospital bed state is of people who take the doctors' drugs, not because they do not take the doctors' drugs. In other words we appear to be doing almost as much damage healingwise as we are by trying to cure or to prevent disease. It is relevant to this inquiry for it to know that I have worked for six months doing a trial course on acupuncture in the Brisbane Street Clinic of the New South Wales Health Commission where I was employed from about November to April 1975–76.

I do not think that I have anything relevant to say about the first part of the terms of reference. I want to concentrate particularly on area 4, (a), (b) and (c). We were able to locate and identify some of the problems that arose in the treatment of drug addicts down there. I have here a statement by the Minister for Health who talks about a drug diversionary programme. I think the whole programme itself is rather pie in the sky. The whole idea of taking drug addicts out of court and putting them into some form of a treatment situation is excellent, but when you look very closely at what the medical profession and the allied professions have to offer, there is nothing to work on really apart from this dreadful drug

of addiction, methadone, which is supposed to replace some of the hard drugs. From my point of view methadone is a completely immoral drug. It has worse side effects, it is more toxic and has a greater degree of dependence on it than even the drugs that it is supposed to be combating, such as heroin. The withdrawals are far more disastrous than some of these other drugs. What else is left? There are counselling techniques which are based largely on a psychology that arose in the early part of the twentieth century. It is based on Freudian–Rank–Adlerian psychology which is all negtaively based.

If one looks at the question of counselling, one finds that counsellors are intent on bringing up the negative aspects of the personality. For instance in Brisbane Street we found that the counsellors were very concerned with identifying what is going wrong with the patient, not hopefully finding out what is positive in their own personality so they could build that up. Most mental approaches to drug addiction are the drug induced ones. They substitute one drug for another. The approaches include an intensive seeking out of effects with very little attempts to pursue the causes of these drugs.

If one looks at the terms of the drugs of dependence, one finds that if one wishes to obtain the conceptual framework then any drug that takes over a person and says that this will cure him is a drug of dependence. One has to look at the whole problem. As you are well aware, Valium, Mogadon and Tricyclic drugs are drugs of addiction. I do not mean to be offensive, but if you are talking about pushers and pedlers of drugs, the medical profession—my profession—have become the pushers. Up to the present moment we have had very little opportunities to offer any viable alternatives. One talks about preventive medicine but in point of fact it does not exist today until you start to look at alternative approaches like acupunture, yoga, Ti-chee and herbology. You look at diagnostic means to find these out, like iridology and so forth. The point I try to make here is that we are still rooted very much in the past and we have not yet developed viable forms of treatment that would not cause as many harmful side effects as we hope to cure. The attitude of the counsellors themselves—and I include my own former attitude about this also, I cannot say that my hands are clean—we work with what we have. The fact is that what we have had to work with up to the present moment is grossly inadequate. But we keep on acting as though what we knew was all that there was to know about things so we keep on pushing these old methods of treatment.

How successful was this experiment in Brisbane Street? I would say that of the 100 per cent of the people who approached us for treatment some 50 per cent dropped out, not because acupuncture did not work but because it did work. They were faced with the existential moment of truth when they found there was something that could help them. Looking back on it, of those 50 per cent that walked out I think as a doctor and as a person enthusiastic about what he was doing, those patients were driven to treatment long before they were ready to accept it. Now we have to look at the whole problem of motivation. It seems to me in this area courts will make persons accept treatment long before they are ready and therefore all our efforts at healing them are in a way doomed to failure. That is an appalling negative thought but the fact is—and I think you could probably gather this from comments from various people in the profession and allied professions and from drug addicts themselves—they will come only when they feel the need to, not when we think they should. Of the 50 per cent who did remain for treatment there was a 100 per cent cure of them. The point here is that the motivation to cure a disease must come from the person concerned, not from people outside of them.

I think there is going to be a lot of expensive waste of public moneys in driving people to a cure. I feel sorry that we are left in a position therapeutically where a person has to come along of his own volition and say that he wants out. I deplore that in a way but I have to respect that a person has a right to run his own life. I have to respect that public moneys are not to be wasted in this area. Some of the cases were interesting. I recall a patient who came in for treatment who was on a 100 milligram methadone dose plus a $120 a day habit—this was at the Brisbane Street clinic. We took him off cold turkey and he has been free of any addictive qualities since then. That was more than eighteen months ago. I do not think that the Health Department is sufficiently aware of the fact that there are very beautiful healing techniques available and really they do not want to know about them because they are not in charge of it. We are drifting into an area of healing where the average medical practitioner does not have a clue about acupuncture and cannot really recommend it. Furthermore, a lot of healing in the area is drifting heavily away from the medical profession into the hands of what I should like to call healers. The people with whom I have been associated in healing areas in the past four years are not medically qualified but they pay an intellectual respect to learning their new techniques and they have a feeling for people. We know that that has disappeared from the medical profession. The committee should look at the fact that a lot of valid healing is done outside the medical profession. These people have intellectual integrity, sensitivity and compassion for the people they treat. May I invite questions now?

3420. CHAIRMAN: In your experience at Brisbane Street who was the officer-in-charge of the establishment? ——W. I was the doctor there at the time and nominally in charge of it. I would be working under the regional director of health for the inner metropolitan area. I categorically refused to prescribe methadone on the ground that it was an immoral drug and subsequently, arrangements were made for a roster of psychiatrists to come in and administer methadone treatment.

3421. You refused outright to prescribe methadone? ——W. Yes.

3422. Have you any idea whether there has been any combination of methadone and acupuncture treatment for an addict?——W. To give acupuncture a really fair go we would treat only those who were off all kinds of drugs. Our main experience was with people who came off all kinds of hard drugs cold turkey.

3423. In the alternate healing techniques you were developing had you been using acupuncture to a great extent at Brisbane Street?——W. Yes, very much—exclusively.

3424. It was the only form of treatment that you used at the clinic?——W. Yes.

3425. You referred to the drug diversionary programme and said it was pie in the sky. I presume that because you referred to the statement that was issued by the Minister for Health you know all the details of the programme?—— W. Not all the details, not necessarily, but I know the habitual methods of thinking and thought patterns of the Health Department and the people concerned.

3426. This was not a Health Department programme, it originated in the Attorney-General's office and has been organized through the Department of Justice in co-operation with the Health Commission. The idea is to try to rehabilitate drug addicts.——W. Yes.

3427. And, at the present stage it is confined to those on hard drugs. Do you realize that?——W. Yes, I do.

3428. In many cases these people are first offenders but they do not have to get the consideration from the court. The case is adjourned for eight weeks for medical treatment, counselling and probation or parole and then they have to come back to the court. That is the meaning of the word diversion. I wanted to make sure you knew that because it seemed a strange phrase to use when subsequently you sort of applauded the idea. I presume from your statement that it is the medical profession you are really attacking when you make that statement because you say they have nothing to offer in regard to treatment? ——W. I think that "attacking" is too harsh a word. I am still a doctor and proud of it. I think that we have not identified sufficiently well the therapeutic methods that work.

3429. When one of your medical colleagues was giving evidence some time ago before the committee he said that there was no medical problem in detoxification of a person on heroin; would you agree with that?——W. I do not understand in what context he was talking.

3430. That was the statement he made.——W. No detoxification problem?

3431. No medical problem in detoxification of a heroin addict. He did not see it as a medical problem.——W. I do not know. The whole basic metabolism of a person is upset when he is on hard drugs particularly and that has to be coped with. The people for instance, are suffering from a kind of malnourishment because in a way there is an almost latent—hidden—kind of starvation condition because the whole body process has been diverted by the drug intake, to gear itself to some form of abnormal metabolism. I could not agree with that for a moment.

3432. Do you regard marihuana as a drug of dependence within the terms of reference?——W. No, definitely not. There is no question of drug dependence. I have worked exclusively in this area. I have, in the past, used it and enjoyed it and been able to keep up with a full professional life. I would have been smoking on and off for about fifteen years. When I was in orthodox medicine I was seeing seventy or eighty people a day. I have since learnt that you cannot carry on healing at that rate. I have deliberately set out to treat only fifteen a day because that is all the time I have in one day to treat people. I do not believe that one should cram one's surgery with a whole lot of people who are growing dependent on me, and remember, a doctor is a drug of addiction.

3433. You do not think a person could become psychologically dependent on marihuana?——W. No, definitely not.

3434. You have not seen any patients that you feel are psychologically dependent on it?——W. Not at all. If it is available you do not worry about it. You are not trying to establish contacts. You just carry on and do whatever you have to do. That is a widespread experience among most marihuana users.

3435. Would you explain in more detail the case you referred to about eighteen months ago where a chap was on 100 milligrams of methadone and had a $120 a day habit. You then mentioned something about cold turkey. Would you give the full import of that?——W. I was illustrating the powerful healing tool in acupuncture and other drugless therapy. If you look at western medicine, it is entirely symptomatic. It will try to treat a symptom. If you are nervous you will be given valium or be given an appropriate tablet but there is no attempt to go for an underlying cause. This is where a healing such as acupuncture comes in. I do not want to give a great rave about acupuncture.

3436. What were the details of the case to which you referred? What actually happened? You said that the patient came in on 100 milligrams of methadone and a $120 a day habit. I did not quite get the import of the next part of your evidence, as to how you took him off? ——W. We took him straight off all drugs and simply gave him acupuncture treatment whenever he showed withdrawal symptoms. They come in sweating, cramping, their mind is shrieking in pain and so on. You put in the acupuncture point and within three-quarters of an hour instead of lolling back hopelessly and unable to engage in social interaction they are symptom free, relaxed and talking relevantly.

3437. Acupuncture is an ancient technique.——W. Very much so.

3438. It went out of favour for a long time—it would not be because it is a modern fad that you have taken an interest in it?——W. No—I may have started that way. I was dissatisfied with what I did medically and about five years ago I invited an acupuncturist to my clinic to see what she could do, to let me know if we could take any patients off drugs. It evolved from there. I could see change happening that I could not believe in. Modern medicine had no concept, to explain what was happening. I decided that I had to find out for myself. I left orthodox medicine, went to Sydney and have been studying it for the past five and a half years. I do not agree with my colleagues going to Hong Kong, in a cynical fashion, buying a diploma after a ten-day course and setting up in acupuncture. I think that is totally dishonest and does not show any kind of integrity at all. I think there is as much to learn in acupuncture as in western medicine. You cannot do it in ten days.

3439. Mr McGOWAN: You mentioned herbology. Would you explain to me the difference between the use of herbs and the use of drugs?——W. Yes, it is the allopathic and homeopathic approach. With orthodox medicine there is some kind of medication that will remove the symptoms but with no attempt to get to the underlying cause. With homeopathy you administer small amounts of drug that will encourage the display of symptoms and in this way the body will build up its own defences. One is a symptomatic approach and the other is a deeper underlying approach to the disease process. I believe that medical educators are concerned with what we are doing with modern medicine and herbs have been here a long time and are gaining increasingly. We have to look at what works. My approach is pragmatic—I will use what works, provided that it does not cause marked side effects.

3440. The difference is not in the thing but in the person using it?——W. I would not make the distinction really. I think the two modes of approach are polarized: they are directly opposite one and the other. In one way you

treat symptoms and the other you do not. You call upon the body to form its own defence reaction to remove the symptoms. The other is where you make the body build up its own defence. That is the homeopathic approach.

3441. Would you use tetracyclin?——W. I think we are in a position now to choose the best of both worlds. Modern medicine has done some extraordinary things; it has developed some extraordinary techniques. I do not think that we can say that everything we have done is good so you have to pick and choose the best of both worlds.

3442. We have had evidence that methadone may be useful to treat long term addicts and that blockade treatment is the only way in which they can survive in the community.——W. I would have agreed with that statement about four years ago but I do not agree now, knowing what I know now and seeing other things work. I could not agree today that such a drug should be tolerated when we have more effective means; it is more poisonous, more toxic and it has more side effects as well as a greater degree of dependence. How can you justify it in that situation?

3443. Some people have told us that marihuana could well be useful in the treatment of methadone or heroin addiction. What is your view on that?——W. One or two of the people I have treated have asked me whether it would interfere with the treatment if they had an odd smoke to relieve some of the tension. I do not believe in giving people advice; I can only point out that advantages and the disadvantages and allow them to make up their own minds. As a result, one or two did have a smoke and as far as I could see it did not interfere with their self-planned programme of withdrawal from a harder drug. It may be that it has some use there. I have not done any survey about this so I am not fully informed about it. From where I sat, it did not seem to interfere with anything at all.

3444. Would you recommend it as a technique?——W. It has none of the disadvantages of the heavier drugs. Again, from where I sit and looking at a lot of literature, if some people need a little extra help and confidence in themselves, which no one can give them, I do not think it would set back their treatment.

3445. Do you think its use would give them some confidence?——W. I think it could give them some confidence. If you look at the way we interact with each other, we seem to be negative and hypocritical. I think that human nature is basically positive but somewhere along the line something went wrong. We have learned attitudes that are subversive and negative to each other. If anything, they are looking for something they believe in themselves but which society does not provide them with. I think that this is a partial explanation why some age groups take marihuana and the older age groups go along to the doctors and demand their kind of sedatives. I do not make any distinction between a drug addict that the medical profession has induced and one that pedlars have induced in society. I think that in this context one could well say that doctors now are becoming some of the heaviest pushers of drugs in the community. That is a serious statement to make.

3446. You said that people become psychologically dependent on drugs prescribed by doctors. However, you make a distinction by saying that people do not become dependent on marihuana.——W. I think that these people come to the country to recreate in this environment some of the things that they have missed in their own upbringing. I do not think they have come to the country to be long-haired layabouts. These people have definite high ideals of what they want. Unfortunately, they have not looked at the other side of the question, of what they should make available to other people. They must not cheat or lie because that is the kind of society they have come away from. They have learned the things they wanted to get away from; now they have to learn not to do the same things themselves.

3447. A thirteen-year-old school child does not have those ideals. Is he likely to become psychologically dependent in the same way that a person can become psychologically dependent upon a drug?——W. I think the answer is that everyone is getting more and more psychologically dependent on drugs.

3448. Mrs DAVIS: Would you say that Dr Dalton's use of the blockade treatment is ineffective?——W. SHE and a great many of other concerned doctors are acting in the best circumstances of what they have.

3449. Would you agree that methadone is not negating the craving for heroin?——W. Obviously. Some English speaking countries have put their addicts back on to pure heroin rather than get them on to this dreadful drug methadone. Obviously, they are not accomplishing what they set out to accomplish. Further, I think that it would depend on the individual rather than any general statement you make about methadone.

3450. Are you familiar with the work of Dr Popov? ——W. I know Dr Popov very well. Dr Popov and I were approached by the Health Commission.

3451. You were the other doctor?——W. Yes. Unfortunately, money went dry. I was supposed to go out and talk to several organizations. At that stage I was going to set up a clinic of my own. I told them that they were welcome to use it if they wished but that was the understanding on which I left the Health Commission. Then we went to Glebe Point Road and set up an acupuncture clinic there but, regrettably, the Health Commission did not wish to pursue the question at all.

3452. Do you think that if that original programme of yourself and Dr Popov were allowed to be developed and more people were trained, we might start to get more value for our money in regard to health treatment?——W. I do not doubt that for a moment. However, you are talking about taking the healing task out of the hands of the medical profession and I do not think that is likely.

3453. You were getting a great deal of successes?—— W. We were getting astounding successes. I just could not believe what was happening. Unfortunately, there was no official recognition of any kind but I think we tended to worry them a little. They never knew anything about acupuncture then. You just could not turn over the control of this kind of thing to an administrator who did not understand what was happening. Some important work has been done in Hong Kong by two doctors. This work has been duplicated all over the world. I still have a lot of learning to do in acupuncture. I have been studying it for three-and-a-half years and I still have a long way to go. The time will come when we will get more expert in things like this. As I am not there at the present time, I shall turn to routine medicine to treat certain things.

3454. Since you have been here, have people come from outside the district to be treated by you for drug addiction?——W. There has been a case where a girl was on, I think, 100 milligrams of methadone. I think she started the treatment last Monday, seven or eight days ago. Unfortunately, I have been down to Sydney for the past two days. As far as I am aware, the word about her was that she was doing very well. She even exposed herself quite deliberately to the possibility of going back on to the drug. She went through without any problem at all.

3455. Mr WOTTON: You spoke about the drug diversionary programme. What is your attitude to the efforts of these people in centres where there are no drugs available, places like The Buttery and the WHOS organization at Cronulla. What is your attitude to the treatment that they are giving there?——W. I do not know how to answer that because I do not know enough about it. I think the fact that they are surrounded by positive, warm, loving people is a powerful healing factor in itself and one that seems to have slipped away from the hands of the medical profession because they are too busy. Doctors do not want anything to do with drugs; they find it too time consuming. They prefer to write out a prescription on a piece of paper.

3456. Do you agree that the drug problem in this country has become serious only in the past twenty years? ——W. Yes.

3457. Do you think there is justification for being slow to accept new methods?——W. I think anything that comes on the scene is suspect until it is well and truly proven. It is human nature to advance slowly. While I regret the non-acceptance at present, I know in time that it probably will come about and the only way to allow it to be seen to come about is by putting your muscles where your mouth is and doing something about it yourself.

3458. What is your attitude towards drug education in schools and tertiary institutions? Do you believe a greater emphasis should be placed in the curriculums to try to educate young people about some of the problems associated with drug abuse?——W. That is a really important question. We must look at our models of learning. How does a person learn? Does he learn by reading a piece of paper, watching something on a screen or by experiencing something? I think most modern educators would agree that you can only talk relevantly and meaningfully about something that you yourself have been through. An extension of what I say is that perhaps kids have to find out the hard way about drugs. It is an appalling statement to make but the fact is, has all this increased education done any real good? Are there inroads being made into these problems? Has any good really been done? Have smokers been stopped from smoking by being shown cancer of the lung films? You can talk about it at the hypothetical level but many educators these days, particularly in the alternative movement, say the only way to find out about something is to do it. They say that to find out about a motor car you should strip it. They say let us stop looking at pictures of carburettors and shoot the kids out into the yard with an old heap and let them get cracking on it and learn something about it. That is the problem of education. How do you learn, not what you learn. I do not have any kind of answer to your question, I am sorry.

3459. Mr JACKETT: You were saying that you felt counselling techniques were negatively based?——W. Yes.

3460. What would you regard as a specific positive approach?——W. Often at the clinic I listen incidentally and extently to many counsellors in their discussions with patients. They say something like, "Gee, you are not looking too good today, are you" and that is the kind of negative comment that grabs anyone who has a problem. It is like bringing them down to earth when they are looking for something positive to talk about. Possibly that is one of the reasons why they have become addicted in the first place. They are tired of being pulled down by other people. If you talk to the average person in the street and listen to the tone in the voices and what they talk about and how they talk about it and ask yourself are they talking positively or negatively you will get some understanding of the whole approach of negativity. They do not know how to be positive. It is a common problem. When you do find someone positive you know jolly well that there is something different to the kind of down-in-the-mouth negative approach usually used. I am talking about the whole way people interact with other people.

3461. In other words you believe that in the counselling of drug addicts that they should be sort of lifted by the very approach of the counsellor away from the addiction and problems that they have associated with it and what has brought them to the point where they have resorted to drugs rather than accept the drug situation as something that they must overcome?——W. I do not think I can give you an adequate answer to that. But, if the committee interviews a lot of addicts would it ask them one question—are their counsellors helpful and hopeful or not? Find out the answers from the drug addicts themselves. It is an important question. They will talk quite freely if you allow them to but how can you go to a doctor and criticize him if you might have to depend on him? You won't say anything about him when you feel you might have to go back and see him next day when you want help. If you would ask the drug addicts themselves what is the attitude of their helpers towards them, positive or negative, I am sure you will get answers to that question.

3462. You have said you do not believe a heroin addict can be helped until he reaches the point where he wants to be helped and he wants to break the addiction?——W. Yes.

3463. You do not believe that anything can be done prior to that point?——W. No, not in the way of curing him, but he can be given support. We must tolerate a level of inactivity in our therapeutic approach to give him an environment where he can learn to feel confidence in the people he might have to call upon for help later.

3464. Do you believe that heroin or narcotic addiction can ever really be cured?——W. Yes. I would not be in the healing game if I did not believe that.

3465. We have had evidence from many people that ultimately there is no real cure. How can you account for that?——W. Thank you so much for illustrating the point. That is the negative approach about which I spoke. That is what comes from that kind of counselling, the non-verbal messages to the person involved. The approach is something like, "You poor old thing, you are stuck with it, aren't you?" I blissfully cannot go along with that. This is an attitude we must identify. People with this attitude should not be allowed to counsel anyone, let alone a drug addict.

3466. Some educators say that the use of the word ex-addict is counter-productive as far as our drug addiction is concerned because it encourages young people to wish to experiment with drugs of addiction that they can, if it does not work out, beat the habit, although the average person generally has the feeling that heroin addiction is permanent. I think the use of the word ex-addict is regarded seriously as a bad feature of drug addiction?——W. I am sure it is. It is a label of aggression in the same way that you can say you catholic, you negro and things like that. Addict is the same sort of term. It can be broadened beyond drug addiction. The use of any adjective to describe a person is an act of aggression against that person. When you label people like that with an individual label they are stuck with it. A label like that is laying down an expectation of a certain kind of behaviour from that person. Labels are not helpful or productive in any way.

3467. Do you regard marihuana as a herb or a drug?——W. Queen Victoria used infusions of marihuana in her teapot for her periods. This is well known. It can be used in two ways. As a tea it would become apparently some kind of therapeutic. It has a use for stomach conditions such as ulcers and general tensions and nervous states. If you smoke it then simply by the fact of changing the form of administration you pass from a medicine to a drug of addiction. It is confusing to me.

3468. CHAIRMAN: In your medical practice have you experienced any cases of addiction to analgesics or barbiturates?——W. I am pleased you asked that question. Last year at the Glebe Point Road clinic Channel 9 came in and that morning we were having a clinic among medically-induced drug addicts. The people had been on tricyclates, valium and the rest of it. These people were interviewed and a film was made. The material obtained was intensely informative and it had a lot of revealing content in it, but for whatever reason, it never came to air. If you would like to know what happened you could subpoena Channel 9 for that film and I think it would increase your understanding of this whole problem.

3469. What was the main theme of the film?——W. These people who had been treated for five, ten or even twenty years had been warned by doctors that if they ever came off those drugs they would be hopelessly invalided. The fact was that they had been off them and they were blooming in health and doing extraordinarily well. I do not knock the doctors for this. They were working within the framework of the references they knew. They cannot extend that framework without knowing about alternatives.

3470. Thank you, doctor, for the assistance you have given the Committee.

(The witness withdrew.)

JOHN GREGORY GEAKE, of Crofton Road, Nimbin, innovative educator, on affirmation:

3471. CHAIRMAN: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. Yes.

3472. You wish to make a verbal submission to the committee?——W. Yes. I would like to make a submission touching on two points. The first is to deal with marihuana and the second is to do with a drug education programme in schools. Seven years ago I was a witness at the Commonwealth Select Committee on Drugs on behalf of what became the Australian Union of Students. At the time that union believed that marihuana should be either legalized or decriminalized. It was one of the first organizations in Australia to state publicly that case. I thought that it may be of some interest to review quickly the evidence that we gave them, to look at it in some sort of historical perspective and to use my friends and myself as case histories of the use of marihuana over that period. What we said at the time centred really around two points. One was on the balance of evidence, looking at the research and so on, marihuana was a fairly harmless substance as drug substances went. The second point was that it had very wide use and for it not to be recognized with some legitimacy was causing problems. A lot of the problems lay in the fact that it was prescribed rather than legalized.

Since that time I have maintained my circle of friends. Marihuana has been part of our social life. If there were any major problems with its use over that period we would be able to tell. I am speaking about a 10-year period. I will leave it to your questions for me to be examined on the case history in detail but I would say in general there have been no great problems. We all seem to be very satisfied with our lives. We have all started families and have young children growing up. Those who choose to are holding down jobs, some of them quite highly paid, prestigious jobs. The group has widened to encompass other people finding similar sorts of backgrounds and attitudes.

In general, I think with the group marihuana has played an interesting role as a social lubricant but it has not presented any major problem that has needed a great stop-and-look-at-it-all approach. As a group we are continuing to use it. The only problem has come about by some of the people moving to a particular area. In the city with such a background of criminal activities, the fact that it has been illegal has been irrelevant. None of us has had any difficulties with the police. I do not think any of us have had to buy marihuana, due to some judicious home gardening. When one moves to an area where there is less of a background of activity, such as the North Coast, such an illegal activity obviously becomes more evident. I think some people are feeling that now. As has been said, the police are doing their job. Nevertheless, from the point of view of the marihuana user, it seems a sudden harassment and that a sudden problem has come about through the use of that substance.

My second point concerns drug education programmes in schools. We need to think carefully about what sort of programme needs to be introduced into schools. First, there should be a programme. It should be a programme that is rather different from the programmes and subjects that are presently taught in schools. I have some misgivings as to the efficiency of present educative methods and the school as an institution of learning. I fancy that it is a rather inefficient means of learning. Nevertheless schools exist. All our children pass through them. Clearly the school should be a place but not the only place where a drug education programme should take place. To do it one has to look carefully at the question why people take drugs. When one asks that sort of question one comes up with a number of hypotheses. They all make it rather difficult to determine behaviour. Most answers seem to be

either a need because a person is feeling that he is not coping in some way, or he is taking drugs because he is getting a high or peak experience from it that he is not getting in other aspects of his life. Either way it seems that those motivations will get around almost any legislation to do with drugs. That is fairly evident in the amount of drug taking occurring within the schools. Be they school rules or community laws, if the motivation is strong enough the kids will do it. We need to look at why that is going on and if we can do that and evolve a programme that encompasses those sorts of feelings at the level of the kids at school we might be in some position to regulate the taking of, say, opiate drugs. I have been in the position when teaching high school of having a student die of an overdose. He was given some heroin at a party. Obviously the kid who gave it to him had given him too much. He was a bright lad and a student leader. I do not think he was a regular drug taker, but that he was experimenting in the party mood.

I feel rather strongly that we need to do something in the schools. But it has to be done with the consciousness of the students in mind. A general studies course that is given now where drugs are this week and racism next week is not adequate. Like a lot of courses in schools, it will just turn the kids off. A course which is based on the medical facts of how dangerous narcotic drugs can be is not adequate either. In a sense this creates a danger about drug taking which a lot of people find appealing. I suspect that is why a number of people continue smoking cigarettes, they know that they increase their chance of lung cancer and heart disease. A great number of people continue smoking cigarettes and I suspect that one of the reasons is that they are doing something that is a bit risky; they do not get to do many risky things in their lives and so this is one thing to which they are attracted.

The sort of course we need is one that will spend a lot of time and energy in the schools. It will recognize that there is a function of schools other than teaching subject curriculum for exams. It should be a course conducted not necessarily by people in the present teaching profession. There may be others in the community who would be better equipped to operate such a course. It would be a course that requires a lot of feedback with the kids involved and which perhaps involves them in experiencing other sorts of highs and experiences through other techniques, for example Yoga, transcendental meditation, rock climbing, canoeing and so on, so that they may gain an appreciation that there are other ways of feeling good, and the importance of feeling good through drugs may be diminished. Obviously there is a place in the course for education on the medical-chemical side. Fundamentally it has to operate at that sort of consciousness. If it does not, if it is just a course that comes from the top as another list of do's and don'ts it will not be terribly successful.

3473. How old are you?——W. Twenty-nine.

3474. Would you give the committee a broad outline of your educational background?——W. I did a degree at the University of New South Wales and got an honours degree in physics. I was involved in student politics. After that I was full-time president of the Students Union and I was on the executive of the Australian Union of Students. I have taught at various innovative schools around Sydney, both high school and primary school. I have been involved in forming groups such as the Innovative Education Association of New South Wales, which is involved in co-ordinating activities of a number of progressive schools. Three years ago I moved to this area where I have started a family. I am now involved in setting up progressive schools in this area.

3475. You say that some of the people with whom you are associated are in highly paid and prestigious jobs. Do you mean in the area or away from it?——W. In the area and in Canberra, in the universities in the city, in the public service.

3476. These are friends of yours but not necessarily people living with you?——W. That is right.

3477. One of the problems with a drug education course is that it can be counter-productive. Would you agree with that?——W. Yes.

3478. Would you agree that it is possible that if a course is not implemented properly it would arouse interest in drugs rather than point out the dangers that are involved in the use of so-called hard drugs?——W. It could do. I wish to make a comment about adolescent or high school kids doing almost anything. There is always a group that is fairly aggressive, loud and demonstrative about what they are doing, whether it is driving a car, riding bikes or taking drugs. That would be a minority group. Most adolescent high school kids are very quiet and apprehensive about taking on new experiences. One gets a different response with different groups. Unless such a course is drawn up with great sensitivity and care it could be counter-productive. At least it could be nil productive.

3479. You mentioned the death of a student who took an overdose of heroin at a party. Although it may be a little brutal, do you not think that it would be a very effective means of pointing out to his fellow students the effects of something like that when it could cause his death?——W. I think that his death had a marked effect on his friends, yes.

3480. You mentioned drug education courses in high schools and you said that they would possibly be left better in the hands of people who are not teachers. Teachers have a responsibility as public servants and they must always be alert to that. These people about whom you are speaking would have no responsibility to the Department of Education, is that not so?——W. Not necessarily. If they were being employed, be it part-time or whatever, to teach such a course presumably once they are on the payroll they would take on the same responsibilities.

3481. You do not see them as volunteers but as people who are paid?——W. I would say so, yes. I am envisaging a course that involves not just the casual hour a week but a good percentage of the time, involving lifestyles and a number of other things. It is only in that broad context you will get anywhere.

3482. In effect they would really be teachers?——W. They would be. The situation with a lot of teachers in the department—I do not want to put them all down—some are used to the idea of teaching subject curriculum where what you are going to teach is laid out for you and you can go through it at a certain rate. This sort of course is not one you can prescribe a curriculum for. You need people with great sensitivity to educate and talk on issues as they come up and can tune in with the feedback of the children involved.

3483. Have you introduced any programme of drug education as part of your innovative work?——W. Yes.

I was a science teacher in the schools, obviously by background training. In the science programme with chemistry and biology, there were good opportunities to look at the scientific aspects of drugs. With chemistry there are good lessons, using drugs as chemicals. You can look at the biological side and how drugs interact with other drugs in the body. I ran a general studies at the high school which was a prototype of the sort of course of which I am speaking which looked at the different philosophies of life and basic psychology, comparing western attitudes with eastern attitudes through western philosophers like Alan Watts. We looked at the idea of drugs as a means of changing consciousness and people experiencing different mental states. From that point of view we put the whole thing in a context of psychology and philosophy. That is the sort of approach we have to take with drugs. It is hard to legislate, or as a teacher, to dictate the mental state of people. One of the drug problems is that we are limited severely in determining what is going on inside the heads of other people. I think that we should be, but we have to recognize that there are lots of different mental states that people experience every day and drug states are another lot, in addition. But, it is naive to think that there is a normal state and then there are drug states.

3484. You have made the statement that marihuana is harmless.——W. I said, in balance. I do not believe that it is utterly harmless or does not have any side effects, but given the balance, if it was going to be very harmful it would have shown up within the group of friends who have been using marihuana for over ten years.

3485. You have suggested that none of them have shown harmful effects from its use?——W. No, they always seem to have achieved what they have set out to do. They are happy, balanced people with families, yes.

3486. Mr JACKETT: When you said you were doing innovative education, how are you doing it in the area? Are you in the department?——W. No, outside the department. There has been a school recently formed as what loosely is called the community school—formed outside the department—in Lismore. It was formed by a number of teachers and parents who have recently moved—some not so recently to this area. Looking at a small school where the teaching methods would be more of what is commonly called the open classroom technique, I have been involved in getting that off the ground, forming a co-operative and sorting out an education programme. I am doing mathematics programme with the children. It involves primary age children. There are several other groups in the area that are talking about setting up similar sorts of small schools run on the open classroom line.

3487. It is purely at the primary level so far.——W. Yes.

3488. Does drug education some into it?——W. I could not say for the community school—I will say it will, yes. As a matter of principle, yes, it will. We have only been going this year but certainly at primary level is the place to start.

3489. What age would the children be there?——W. On the average they range from about 4 to 8.

3490. You said that the school is a rather inefficient place of learning and that courses on drugs giving factual information tend to turn people on.——W. Turn on or off, I think I might have said.

3491. What is your view of a good education course in drugs? Should it be done by teachers in the school environment, that is people the children are in contact with every day, or do you feel that it should be done by people trained through, say, the Health Commission?——W. Perhaps a bit of both. Perhaps it needs a co-operative effort. The sort of course I imagine needs a lot of participation from the students. I do not think that the sort of course where someone sits out the front giving the traditional talk and chalk is efficient or helpful. It needs to be a course where the students are involved in the discussion as much, perhaps, as the leader of the group —which might be a more appropriate terminology. For some teachers I think it will be easy and for others difficult. For some Health Commission people who are more trained in this sort of work it may be fairly easy but they may not have had as much experience with children, they may have had more experience with adults. I think it will need a co-operative effort.

3492. What is your view of the personal development course in high schools?——W. I have not had a lot to do with them because they were introducing them as I changed from a high school to primary. I suspect that they would be running into that sort of problem. It needs essentially a change in style and method of teaching as much as introducing the new content. It needs to be at a level that is seen to be top priority—not an additional thing tacked on after curriculum subjects are done. This should be the course, and then come to the other.

3493. Do you feel drugs should be played down rather than up in the context of personal development courses? ——W. No, it should not be. It should try to be there in proportion to how drugs are in the lives of the students involved. Obviously that varies with the students, but it is fairly important even if a lot of students are not participating in drug taking, the fact that some of their peers are makes it an issue. It has to be there but in a proper context of how they are looking at life.

3494. With regard to marihuana you said that you felt on balance it was probably not very harmful?——W. Yes.

3495. Do you believe that it does, or does not, have a serious effect on motor co-ordination when people have ingested it or have become stoned?——W. I think it certainly has an effect on motor co-ordination. I could not do a test to say whether it is proportional in a strict mathematical sense but, yes, I do not think I would be driving in fence posts if I was stoned as well as I would normally, or drive a car, for that matter, but if I am driving a car and someone is sitting beside me and I am feeling rather sexually turned on towards her I am probably not driving the car as well as I might or, if I am feeling depressed. There are lots of mental states that we experience. Some are good for driving cars and motor jobs, others are not. I do not know how you can effectively legislate against people forming mental states that are not appropriate to driving cars.

3496. If marihuana is legalized, as has been suggested by a number of people in this district, or even decriminalized, do you believe it would increase the dangers that would flow from people who were stoned driving motor cars in a more dangerous way?——W. No, I do not because I think the marihuana use in this area among the circle of friends I have mentioned will not change by its legal status. It is a well established pattern of use. People have got used to the effects and know how to compensate if they have to do something while they are stoned. I do not think that will change.

3497. This is hypothetical: suppose you were working in a steel works on ground level and the crane driver operating the big ladle with the molten steel above you was stoned on marihuana, how would you feel?——W. That would depend what he was like as a crane driver before. If I had confidence that he was a competent crane driver that would really mean that I have confidence in him operating the crane in all sorts of conditions. I know that sometimes he will have had an argument and sometimes he will feel angry and at other times he will have his mind on what he is going to do that night, and so on. If he is someone I feel no total confidence in, I would be worried, yes, but otherwise, no.

3498. You would not be concerned if he were high on marihuana?——W. No, that would not be as important as my overall judgment.

3499. Mrs DAVIS: Early in its hearings a witness before the committee testified that he used marihuana as a relaxant, having been introduced to it in Vietnam. He used to come home and have a small amount as a person would have one drink or a few cigarettes. He did not smoke. He felt relaxed. In this area the one word that seems to be uttered more and more is that one has to get stoned. Nobody has yet used the word relaxed. Why is so much put on the attitude that one gets stoned?——W. It may just be the use of terminology which identifies the group of marihuana users from non-users. I think that I would use it in that context sometimes in some situations. I know that I come home, feel a bit frazzled about something and it is good to have a drink or a joint, to relax. I think that I would see it in that sense. It is more a matter of terminology. It may show that a group of marihuana users are feeling something in common, against those who are not, and there tends to be the group terminology, a bit like CB radio.

3500. Can you differentiate between relaxation and intoxication?——W. I think the only way you can really appreciate the marihuana state is to try some yourself. I do not agree that it is absolutely similar to having alcohol or tobacco. I think that it is a different kind of relaxed euphoric state. I do not know how I could describe it better.

3501. What some of your people mean is that they use it for relaxation, not to get intoxicated?——W. I would say so. Some use it to get intoxicated. In my circle of friends, it is used like alcohol. There is a sort of drink before dinner to relax and then you go to a party and, to use common terminology, you get fairly wiped out.

3502. Mr WOTTON: As to the term innovative educator, is that your own terminology?——W. It is a self-styled terminology but it describes better what I am doing than saying I am a teacher.

3503. Does this school have the blessing of the Department of Education?——W. Yes, it has been granted registration this year and it now gets (per capita) grants and so on.

3504. CHAIRMAN: We have been told that the excessive use of marihuana causes boredom. Do you agree with that?——W. I cannot find enough time to do all the things I want to do. It has not made me bored. I do not think it has affected me either way. That is why I think I moved to this district. I wanted to try to live on a farm, build my own house and raise a family. It is a bit more adventurous than the way one might be expected to act in the city. I rather like a bit of adventure.

3505. Are you a heavy smoker of marihuana?——W. No.

3506. You would not be in the position where you would get bored smoking marihuana?——W. I do not know anyone in my group of friends who says they are bored. The only thing they ever complain about is that they do not have enough time to do all the things they want to do.

3507. Do any of your particular friends not smoke marihuana?——W. Yes.

3508. Could you estimate the percentage?——W. No. I thought you might have asked me that question and I was trying to think about it on the way over.

(The witness withdrew.)

JULIE ANNE HORNIBROOK, a social worker residing at Jiggi, sworn and examined:

3509. CHAIRMAN: Did you receive a summons issued under my hand in accordance with the Parliamentary Evidence Act?——W. Yes.

3510. I understand you wish to make a verbal statement to the committee?——W. Yes. I decided to make this submission in answer to a couple of questions that the committee prepared for the radio programme the other night. I shall make a couple of comments and tell you a couple of experiences of my own. One question asked whether there were any assumptions that anyone wanted to challenge in the terms of reference. I would like to comment on the preoccupation with controls and penalties referred to in the terms of reference. I ask myself, why is there this emphasis? Cannabis is included as a drug of dependence. A man named Neil Blewett has presented a paper entitled "Marihuana, the most victimless crime of all". No doubt you have heard this kind of evidence. The paper reads, in part: "Cannabis is not really an addictive drug, that is, no physiological or pharmacological dependence arises from taking it and no withdrawal sickness is occasioned by its cessation. That especially distinguishes it from narcotics which are clearly physically addictive. So, why the preoccupation with control?" If punishment is going to be applied, it seems to me that it is linked with morality; a sin must have been committed and you punish because of the sin. It seems to me that the issue is a challenge to Protestant ethics of self-control and hard work. So to me it is an issue of enforcing traditional values which seem to be undergoing social erosion. Some people want to change the accepted norms and values and there is a power group that tries to stop this change. It seems to me that controls are not going to provide answers. All they will do is unite a movement and send it underground; they will not stop it. It is important to look at the underlying thing. What is it that makes people use drugs? Let us find that out before we start enforcing penalties. So that with respect to the terms of reference I would say there is no point in looking at prevention and treatment in isolation. Let us take a look at the structure of Australian society and western influences. We live in a mature culture which is consumer oriented and very institutionalized. It seems to me that this climate is inducive to the use and abuse of drug taking in society. People are alienated from the source of production. They have a general feeling of loss of power over their lives; there is a loss of control. They have an overwhelming feeling of helplessness. The general public is hooked by the media, through television,

radio and newspapers. The media is controlled by profit—motivated bodies. Where profit is concerned, it seems to me that there are very few moral scruples. All of that has got to be kept in mind so that people grow up with a kind of consumer approach. There seems to be a lot of self-destructive drive because people have such a feeling of loss of control and power so there is widespread use of drugs.

Before we change those feelings of helplessness, treatment is not going to have much effect. I see no point in singling out particular drugs of dependence because while these feelings persist, people are going to abuse themselves in many ways. Some groups will choose one form; another group will choose another form. We need to look at our food habits and our own general life style to see where this abuse lies. In the list of headings "Social response to drug use", the question is asked, what is the conventional response to boredom? That suggests that not everybody turns to drugs. It seems to me that any entertainment, any distraction, and the general use of drugs is an approved response to boredom. It is not unusual; it is so well proved in our society that a lot of times we do not notice it. People will continue to use these things because they are looking for a form of fulfilment which they do not find in their daily life. The question goes on to ask: Is the use of drugs the price to be paid for achievement in our society? In one sense it is. I ask you to look at what you mean by achievement. Can we use the word achievement when the cost is so great? You ask about the extent of the use of drugs. I think the way to find out is to look around. Look at yourselves. Generally in our culture there is a lot of obesity that is caused by over consumption of food and alcohol. Our bodies are clogged up through lack of exercise. How often are we able to eat fresh food and drink fresh water? We do not even have control over what sorts of food go into our body. That seems to be the extreme in a feeling of loss of control and power. Our bodily needs are very few so excess is abuse. As well, with the toxins in our body it is difficult for our minds to be clear. I think there is evidence around of this also. There is a lot of noise, violence and panic in our society. I think that there is little rationality in the world. That shows that what is happening can easily be related to the abuse of our resources. Also, while this is happening we are becoming removed from our environment and we attempt to use substitutes. Up here you have got an example of a whole alternative movement looking for a more satisfying life style.

Cannabis is certainly in use. You have had a lot of evidence of this. I think that as people are starting to gain more control over their bodies and their life style, building their own homes, growing their own food and learning crafts and trades and developing spiritual communities, that drugs will be used less. I certainly notice that tea, coffee and alcohol and the use of refined foods are very much less noticeable around here. I think already there is a change in attitudes to drugs. As well, people have moved up here in the past few years to get away from that consumer society. Also, it takes a while to change old habits. I do not think that we can expect too much too soon. So that we need to change our attitudes from having a negative approach to a positive one. Education seems to be the process of doing this but I think we need to be aware that any real attempt to change attitudes would be considered to be subversive, particularly by the Government. The Government is not interested in bringing about its own downfall; it wants to preserve the existing culture and institutions as they are. So that unless there is a programme of education on a massive scale, it will be ineffective. I have got a couple of examples to illustrate the ineffective programmes at the moment. For instance, look at the application of penalties. In 1972, 90 per cent of convictions for drug offences were in respect of people under thirty years. No doubt you have a lot of evidence about this. From my experience, it is not only this group of people who use and abuse illegal drugs. I see people using Cannabis among the professions and in government departments and business. The use of it is so widespread that if you associate it with any one particular group, you are merely indulging in a tactic of discrimination. I know from my experience of working in a government department that I feel that I have a certain immunity against penalties for using Cannabis. I use it; I carry it with me in my handbag. I do not worry very much about having it with me. If I go to do some shopping, I might leave my handbag in the car. Sometimes I wonder vaguely if I should do that but I know that I look respectable. I have a certain status; I know that I have a government position and that I am not in real danger of being busted. If I resigned from my job and started wearing different clothes, I would then be a single female, young and unemployed. Then I certainly would not carry my dope around with me in my handbag; I would be protective and careful about it. I am certainly aware of the difference in approach to the use of penalties. So while penalties might have some positive value, they always seem to be selectively applied. See other evidence of Hornibrook.

Let us take a look into resources into drug education on the North Coast. I know that the submission from the Health Commission indicated that there are few resources being generated into drug education nor do we see them being greatly increased. The community health programme was introduced with a lot of high ideals and approaches to changing attitudes but as well the community health programme, the way it is presented, does seem to doctors as a threat to them. The Government tried to counter that by saying that the community health programme is set up to support what the doctors are doing. The Government says, we want to support what you are already doing. In saying that those of us who work in the community health programme immediately have our hands tied. We are always trying to get the doctors on side and to impress them that what they are doing is in line with what we are doing. In Lismore, as part of the family medicine programme, we have a monthly discussion group and people from different professions meet together to talk over particular issues. In theory in that group we should be able to put our own points of view and discuss them openly. But, I always find we can never do that because if we speak too honestly the doctors think they are being threatened and they withdraw or are angry so that is not an effective approach. The doctors themselves find it difficult to talk about problems that they have in treatment. They become locked in to this kind of status that is attributed to them. They find it difficult to say, "I really don't know the answers, either." So they fall into the pattern of prescribing drugs and so on. I think the only way to break this pattern is for each of us who decide to take responsibility for ourselves, for the direction of our own lives and for our own health. When there is a problem or you want some need of change take a look at yourself. Use outside influences when needed to be used but use them selectively and do not just be a consumer.

I have thought about this sort of thing a lot myself and I try to apply it in my own life. Recently I had an accident where I broke both my ankle and my wrist. I had the experience of being in hospital for several days. When I first went into hospital the doctor came to see me and gave instructions to the sister. She came over to

me and was about to give me two injections, one of pethedine for the pain and one of valium. I knew this only because I said to the sister, "What are you doing to me? I do not know that I want it", and she told me what she was going to do. I told her I would have the pethedine because I was in pain but I did not want the valium. I had been doing a lot of deep breathing exercises and I thought I was relaxed in myself so I did not need to be put out to it. I bargained with the sister and we did a deal and she said, "If you are quiet in an hour and asleep I won't give you the valium." So we made that arrangement and I did not have it. As a side effect to the pethedine I vomited. This happened a few times and I told the sister. She said it was just a side effect but she said further, "Why don't you tell the doctor?" I told the doctor and the first thing he said was "Oh well, that is no problem, we will give you largactil." I started to protest that I did not want it and he did not want to hear about it so I had one injection of largactil. I did not vomit but I had the side effects from largactil. It was O.K. to have pethedine for a little while for the pain, if I am prepared to accept the consequences of having the side effect of vomiting. I would have looked at myself during that situation. I do not need to be continually separated from my pain in my body.

When my ankle came out of plaster the doctor said, "You may have some pain with this but I can easily prescribe indocid for you to help the pain." I decided that I did not want to take indocid but what I did do was try to take responsibility for myself. I used acupuncture, particular herbs, I concentrated on diet, I used polutices for my ankle, massage, hot and cold baths, meditation, rest and exercise. So I am really doing a whole lot of things to try and make my ankle better. It has become a positive learning experience and process for me to keep in touch with these sorts of things. The doctor's response was to prescribe drugs. I knew he meant well but he really does not have much contact with me. The doctor I was going to is a member of the family medical programme discussion group that meets once a month. He is one of the two doctors of the sixty in Lismore who go to that discussion group so by local standards he is an aware GP, though he has no understanding of the sorts of ways he should treat me as a patient. As well, many patients are not aware of this process, either. They think they are in the system that will help them but in fact it won't. I think this is the way we must begin the process of education, by looking at ourselves.

3510A. CHAIRMAN: You mentioned one case in regard to the terms of reference and said that cannabis was not physically addictive and therefore it should not be considered?——W. Yes.

3510B. I do not think it has ever been contested seriously that cannabis is physically addictive but there is quite a body of argument to suggest that it is psychologically addictive. Would not you agree, therefore, that it becomes a drug of dependence and therefore comes within the scope of the inquiry?——W. I am saying, what is the point of having that kind of argument? Let us take a look at why you should want to have penalties and controls for that particular form of behaviour.

3510C. Do you take APC tablets at all?——W. No.

3510D. Have you ever taken them?——W. I suppose a few times as I have grown up and people have said, "Take this dear, it will help you", but certainly I would not take them now.

3510E. Why?——W. Because I believe they are quite detrimental to my health.

3510F. In your social work do you come in contact with any people who seem to be abusing analgesics?——W. I do not directly, no.

3510G. You mentioned that things like tea, coffee, sweets and refined foods should be used a lot less and we would be a lot better off. It is not necessarily true that you have to go into an alternative society to live that way?——W. No.

3510H. Many religious organizations and other social groups have done that sort of thing while living a life close to what is considered normal by our society?——W. I think people who do that are people who have decided to take a stand against the general consumer's approach. They have decided to take responsibility for their own health.

3510I. Have you had any complaints at all at first hand of doctors charging excessive fees for prescribing drugs?——W. No.

3510J. Mr WOTTON: If everyone looked after themselves you would be out of a job and we would not have need for doctors or advisers or educators even?——W. The Health Commission would take on a very different role, yes.

3510K. Mr JACKETT: While I think it is clear that few research workers seriously claim that marihuana has no addictive qualities, there is a large body of scientists and workers in this field who claim that there are in fact serious long term and short term effects from marihuana. If there were no controls and penalties do you think that the use of marihuana would increase and if it increased and the state of knowledge on the subject got away from the arguments that have been put forward by scientists on both sides, would it be found that they became arguments against marihuana and serious long term effects were indicated, would it not be too late to get the drug under control and therefore do not controls need to be maintained until the state of research is a great deal better than it is now?——W. I think it would be very nice if people did really have this concern for each other, that they were harming their health and that was the reason for it. That would be fine. But, it is not. The rest of our society behaves in such a destructive way so why do we single out one drug which has fairly seemingly harmless effects? This country will probably go ahead and mine uranium. Look at the enormous consequences that that might have. We kill each other on the roads in motorcars. Why do not we look at that more closely? We consume alcohol daily so let us look at that, too.

3510L. But there are certain sanctions upon the use of drugs of certain types?——W. Yes.

3510M. In view of the fact that there is a great deal of argument between medical authorities on all of these drugs, including marihuana, is it opportune in the present state of the lack of complete knowledge to lift the sanctions on that particular drug?——W. I think we need to take all of the issues into account and not just look at the pharmacological side of it. We must look at peoples' rights to choose what they do to themselves and you must look at morality of legislating about that.

3510N. The legislation is there now and it has always been there. Is it wise or opportune to leave it at a time when the state of knowledge on the subject is so limited and there is considerable research being done on the matter throughout the world?——W. In view of the person's right to choose what he wants to do it is important to lift that legislation.

3510O. Would you suggest that the same principle would apply to heroin?——W. If people make a positive decision to take responsibility for their lives and to find out what will be the effects of different things they do, then a person would be, if he used heroin, doing it in a responsible manner, so yes.

3510P. CHAIRMAN: Thank you very much for your evidence. I understand that there are present some prospective witnesses but as we are already more than half an hour late in finishing this part of the committee's hearings I regret that we will not be able to take any more witnesses at this location.

(The witness withdrew.)

(The committee adjourned to Lismore.)

AT LISMORE ON THURSDAY, 7 JULY, 1977, P.M.

DAVID JOHN O'DONNELL, Medical Superintendent at Lismore Base Hospital, a qualified medical practitioner residing at 58 Bright Street, Lismore, sworn and examined:

3511. CHAIRMAN: Do you wish to submit a written submission or do you wish to make an oral statement to the committee?——W. I shall provide an oral statement. From the newspaper report of proceedings in this inquiry, it would seem that the evidence presented has been of fact in small degree and opinion to a far greater degree. I do not think I am in a position to add very much to the amount of factual evidence. My evidence will be mostly of opinion based on experience. I should like to present my evidence in two parts: First, with respect to legally prescribed drugs; and second, with respect to illicitly procured drugs. In my position it is hard not to be impressed with the many admissions to hospital that involve those who have been the subject of what I would call open-ended prescribing. If I were to say that a certain number of admissions involving diarrhoea as a presenting complaint are evidence of a physician-community dependence on antibiotic drugs, I might be open to rebuke for exceeding your terms of reference but I have no illusions that this minor example of general dependance on drugs is indicative of the extent that hospitalizations have a major content of drug-induced cause. The components of this dependence are the search for the magic bullet, the overt need for relief from the anxiety of the age we live in, the increasing level of educated ignorance of public and practitioner. Therapeutic nihilism is a courageous philosophy in the face of pressure from patients, pharmaceutical representatives and crowded waiting rooms. I believe that there is a definite cost care-less influence in prescribing, particularly in the instances of entitlement in the Department of Veterans Affairs, I know that I am not alone in this and in the belief that the cost care less influence extends to the pharmaceutical benefits scheme even though the $2 fee might be expected to act as a deterrent.

I maintain a random drug dossier and have an example of an elderly lady admitted in a confused state, believed by her doctor to be of psychiatric origin, but upon investigation it was the result of drug intoxication. A very large paper bag—one that would hold six large beer bottles—contained a total of 53 medicine bottles comprising 32 drugs, singly and of differing constitutions. This lady was an old age pensioner. Another example is that of a repatriation patient whose hospitalization involved him receiving thirty-six different drugs, thirty-three of which he was taking prior to his admission. It is my opinion that there is a reality of reliance on drugs, presenting as an epidemic of dependence. To some degree I believe a solution is available through the medical profession not only in establishing inducements to maintain the currency of knowledge in therapeutics but also to become involved in group dynamics to counteract the public dependance on drugs for every ailment and stress of life. I am far from convinced that education is what is needed. I believe that there is a simpler aspect which is involved as an essential principle of administrative management. This principle seems always to be at the bottom of the list, yet when it is applied with tenacity and publication to those persons being monitored it is extraordinarily effective in obtaining results. I refer to a process of monitoring. At the base hospital, the monitoring systems are somewhat unique and staff limitations preclude extending it into all the activities that it would be preferable to encompass. However, we did make a start in the prescribing activity of the hospital when we had Mr John David as our chief pharmacist.

Mr David's monitoring programme was comparable with that carried out at a major Sydney teaching hospital. Two periods of four weeks were randomly chosen but an educational programme for nursing staff only was instituted in the intervening period and it did not involve the medical staff in any way. The results were interesting and to my mind suggested that if the medical staff had been aware, the effect would have been different. Effectively, there was a change in the pattern of drugs used, towards safer and less expensive ones but there was not the dramatic reduction in drug use that was effected at the Sydney hospital. There, in the intervening period between the two programmes of monitoring, they involved an education programme including the resident medical staff. Mr David is now chief pharmacist at Port Kembla. He has assured me that he would give evidence if called upon at another time and place. I am convinced that the publication to the profession of the results of a drug monitoring system for each and every practitioner would result in peer pressures to make practice more current, more effective and more appropriate. This would be done without invoking punitive actions by authorities. Finally, I should like to express some opinions on the subject of illicitly procured drugs. I believe that many who have given, or may give evidence to this inquiry have a vested interest in libertarian attitudes. Some, with the best of intentions, seek public avoidance of alienation of those they hope they can help. It is an enigma of influence in the drug scene that some professionals see a need to be participants. They are sure that they cannot afford to offend their prospective clients. Others, be they counsellors or therapists, need their clients simply to justify their existence. It is noticeable that there is a forgotten flotsam of the drug scene. The underlying mind-expanding philosophy of illicit drug use has its casualties in those whose minds are exploded. There are those who can, through basic ego stabilities, and those who just cannot handle illicit drugs. I act as the medical assessor for an organization, which I am not able to name because I have not got their permission, that provides accommodation for those in need. For practical purposes, I am called upon only

when there is doubt as to the nature of the need. Already, I have had several experiences of those with exploded minds who are rejected as beyond help by the professional services.

One such involved a young man close to withdrawal, his personality characterized as psychopathic, judged hopeless. He had presented to a general practitioner. The general practitioner, perhaps in all innocence, had given him a starter pack of an anti-psychotic drug containing thirty tablets, indicating to the lad that he should take no more than three each day. When I interviewed this lad twenty-four hours later, he had consumed all thirty tablets and was spaced out, to use that parlance. I believe that, by right, he should have been in an irreversible coma but his tolerance was phenomenal as a result of all the other drugs he was accustomed to using. Recently, my wife drew my attention to a small advertisement in our local paper which read: "Oscar—have run out of cornflakes—Felix". Can we afford libertarian attitudes? I believe that on the advice of those who have this sort of vested interest that I have referred to, the Chronic Inebriates Act is in danger of repeal. Alcohol is not your problem, but there are chronic alcoholics with progressive organic disease of the liver and nervous system who create a nuisance till they die, which may take some time, but for whom incarceration and prevention of access to alcohol is the only solution. I am convinced that the same principle applies to the forgotten flotsam of the illicit drug scene. It worked with tuberculosis with extraordinary results. That is the end of the evidence I wish to provide.

3512. CHAIRMAN: In the case of the woman who had fifty-three bottles containing thirty-two different drugs, had they all been prescribed by the one doctor?——W. They had been prescribed by doctors. I do not know how many were involved. Essentially, it probably should have been only one but we are not able to ascertain that.

3513. Would you have any idea over what period that was?——W. It was a relatively short period, perhaps two or three years. They were all fairly recently-made bottles.

3514. In the case of the repatriation pensioner, he would have probably gone to only one doctor?——W. Yes, except that he could have gone to a number of doctors in the one group.

3515. Those doctors would have common records about their patients?——W. Yes.

3516. If one of those doctors in a group prescribed drugs, the next one to see the patient would know what had been prescribed them previously?——W. Yes.

3517. You say you are not convinced that education is needed in regard to this matter. From what you have just said, perhaps education should start right at the top at the medical level?——W. Yes. As I see the problem, essentially you can provide education, but it depends on the person who is being provided with it and whether they are particularly receptive to it. You really only begin to realize what knowledge you need when you apply it in practice. Unless you personally monitor what you are doing in terms of assessing the results of your effort, there is little inducement to improve upon the currency of your knowledge. I think the first step, that is something which induces people—particularly practitioners—to improve the therapeutical and the practical basis of what they are doing is by a monitoring programme which reveals discrepancies between practices.

3518. I suppose that you would have a lot of contact with doctors in a fairly wide area around this district? ——W. Yes.

3519. It has been alleged in some cases, not necessarily here, that doctors have prescribed drugs of dependence but they have insisted on being paid sums like $40 or $50 for the prescription. Has that sort of thing happened here?——W. I have no knowledge or experience of any practitioner practising that.

3520. Mr HEALEY: Would you go along with the proposition of compulsory refreshers on a regular basis? ——W. No, that is one of the things I was trying to get across. Any compulsion closes the mind to what is being compelled. I feel, also, that there should not be any punitive action taken against anybody who does not upgrade himself and keep up with current practice. With compulsory education, you are just trying to talk to a lot of closed minds. If you could induce someone to feel that he needs to acquire education he will seek it and get it without being compelled to do so.

3521. How would we be able to ascertain that they were in fact doing that without a periodical examination? ——W. I worked for the Commonwealth Department of Health several years ago and they had a huge monitoring system of all prescriptions under the pharmaceutical benefits scheme. They sent out inspectors to discuss with individual doctors the results of that monitoring system but that is a one-to-one example and it is not a monitoring system which is published to the profession so that Dr X and Dr Y might compare the way they are doing things. The example I gave is from a recent editorial in *Lancet,* February, 1976, where there was a system of monitoring whereby a certain number of doctors agreed to allow themselves to compare and discuss results of comparisons. There were considerable results in terms that the doctors having compared themselves did improve their practice and it showed up in the background of their practice. For instance, doctors from India and Pakistan tended to use the more expensive drugs than the local graduates used and as soon as they saw that the local graduates tended to use the less expensive type of drugs they were prepared to change their form of prescriptions. They discussed it among themselves. That is where the results of a monitoring programme published to the individual practitioners and the profession as a whole would be an inducement or a sufficient push for the profession to upgrade its knowledge.

3522. CHAIRMAN: In your position as a medical superintendent of a base hospital would the results of that monitoring programme be made available to you?——W. No.

3523. Not even in regard to drugs of dependence, as a summary?——W. No it is not made available to anybody outside the Commonwealth Department of Health, and the section concerning pharmaceutical benefits.

3524. Although the Commonwealth might know that something was happening you would not know unless they told you?——W. They would not tell me because under the Act it is not a system which is allowed to be available to anybody. They will send an inspector to the doctor whose level of prescription is so obvious that someone needs to talk to him but nobody else would ever know.

3525. Mr McGOWAN: Why are you opposed to punitive action being taken against people who bring about an epidemic in the proportion you talked of?——W. Probably plain practical politics. Punishment meted out on a sufficient scale causes revolution. I would rater try to indicate to people that they can improve and there is a natural tendency to do that. For example, there is a

system of monitoring the utilization of a particular resource at the base hospital. When we started doing this there was great objection to it being done but the utilization was something less than 40 per cent of the available time. Having instituted it, it is quite obvious that everyone is trying to get to a level of use and make the best of the situation that they possibly can. There is no punitive action taken but they are simply told that it is obvious from the result that the use is less than average and therefore they try to improve. With prescribing you would say why do you use the most expensive drugs when in effect the condition can be treated far better with less expensive, more appropriate and more effective drugs.

3526. We have had evidence from addicts who have said that the easiest people in the world to con are doctors and they have a whole number of different ways of presenting so they will achieve their particular end to get pethidine or whatever it might be. The doctor believes that what they say is right because doctors are used to believing people rather than disbelieving people.——W. I would agree entirely with that. Even from the point of view of being a hypercritic such as I am in terms of being an administrator I can be taken in because I like to believe in people. Medicine is a practice of humanitarianism and you do not look to be hoodwinked by your customer. I think probably an example of that is the pseudo patient technique which has been used particularly in psychiatry to try to trick doctors into doing what would appear to be the wrong thing but obviously just as actors can put across a good enough story to convince the audience of the genuineness of their emotion and so on, I do not think doctors are any less dramatically responsive to a good act.

3527. Thank you, doctor, for assisting the committee.

(The witness withdrew.)

PETER THOMAS ENGLISH, retail pharmacist, residing at 96 Ballina Road, Lismore, sworn and examined:

3528. CHAIRMAN: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. I did.

3529. Do you wish to make an oral statement to the Committee?——W. Yes. The reason for my wishing to make a submission is that it is a simple one but I think it would be of use to you. I have been a practising pharmacist in the retail business for approximately twenty years. Prior to that I was in drug manufacturing for five years and I worked as a hospital pharmacist. I conduct two pharmacies in the Lismore area, one at Goonellabah and one at Alstonville. My wife is a registered pharmacist also and she does dispensing at St Vincent's Hospital and I do it there sometimes. I feel there have been three events or changes in the prescribing habits and drug regulations which have been retrograde to the distribution and handling of Schedule 8 type drugs. At the pharmacy at Alstonville we had a breakage and enter on 9th March, 1974, for the purpose of stealing Schedule 8 drugs. I was equipped with a regulation type steel safe which was jemmied open. I had that repaired and I replaced it with stock. On 25th June, 1975, it was again jemmied open. By this time I had reduced my Schedule 8 stock as far as possible except for the few drugs which the local doctors requested me to keep on hand. The safe was again repaired. On 18th October, 1975, it was again broken and entered and jemmied open. This time I decided not to bother about having the safe repaired. I secreted the drugs in other parts of the pharmacy. On 15th December, 1976, and 17th June, 1977, the pharmacy was again broken into. So, five times the place has been broken into. Allowing that there have been two attempts to break in which were abortive and also there has been one attempt to break into the pharmacy at Goonellabah, that is a fair amount of activity. It was wrong to have steel safes in the first place. The control of drugs would be better served by having safes removed from pharmacies and allowing the individual pharmacist to use his own initiative and such as to how he secretes these drugs throughout his stock. A person breaks in and sees a safe and it is not a hindrance but a help. They are easy to jemmy open. When the materials were dispersed through the normal Schedule 4 items in the dispensary they were quite safe and away from the public and it was difficult for a person, unless well informed, to break in and remove those drugs. It could not be done with ease.

The second point I wish to make is the requirement of the N.P. on prescriptions. Since this has been introduced it has increased the pressure on chemists to provide drugs. This is constant pressure. I believe that the average pharmacist resists this as far as possible but because the customer has been informed of drug names the pressure is on all the time to supply drugs without prescription and no doubt it is on the doctor too. When drugs were anonymous we did not have this problem at all.

The other thing that has happened is the strip packing that is good for chemists and saves them a lot of work in terms of counting but it is not good otherwise. The labelling of drug names is a retrograde step also. It puts the name of the substance before the eye of the layman. A lot of problems have stemmed from those three factors. That is the evidence I wish to give and I think it is of a practical nature.

3530. Mrs DAVIS: I agree with the last three items mentioned by Mr English. Some five or six years ago we did not have people coming into a pharmacy and asking for valium; they would just ask what are the little yellow pills and one could say that they have to go back to their doctor. There was never an argument. Now one tends to get into tense arguments and terse situations all because of this, do you not?——W. Yes.

3531. CHAIRMAN: Are you suggesting that the tablets made up in that form should not be identified in any way? ——W. Yes. I think that they should be identified with the label and the number on the label, or a suitable universal code.

3532. Would not that be about the same as the present situation?——W. No. Previously it was simply identified by a prescription book number. If anybody wanted to know what they were taking, or the doctor wanted to know, he simply rang the pharmacist who looked it up in that book from the number on the label. But now the name is on the label itself, by regulation—unless the doctor specifies non-n.b., and if he does that you have to remove them from these things and put them in a bottle. The system before worked perfectly well, there were no problems.

3533. Mr McGOWAN: We have had evidence basically to this effect: a person who is allergic to penicillin has penicillin prescribed for him and the only way in which he can protect himself is by actually knowing the name of the commodity they have been given. Does not a person

have a right to know what he is ingesting?——W. Yes. There are multiple brand names of penicillin of course and it depends how the doctor writes the prescription. If the doctor writes it as a trade name then the trade name is typed on the label. If he writes it an penicillin, then we must have it that way. If the doctor writes Diazepam but Valium is left, the person may bring it back with Valium all over it and say that this was the Valium he has been taking before. Because you have not removed the Valium and put Diazepam it causes complications.

I agree about the allergies. I think this could be best handing at the prescribing level by the doctor saying to the person, "This is penicillin I am writing." Surely at that stage the doctor would assess whether the person is allergic to penicillin compound or not. We make a practice of mentioning that a person is getting an antibiotic, penicillin or something of that nature, and quite often you pick up the situation where the customer is allergic to the compound. But that is only through mentioning it. I doubt whether the trade name would be sufficient unless they had a full list of these penicillin compounds in their mind.

3534. You are saying that you pick it up when the doctor has not picked it up?——W. Yes. We make the practice of saying that this is penicillin. Every now and again they say, "My kiddie is allergic to penicillin", or "It is not penicillin, is it?" and you say, "Yes, it is." Usually they ask too.

3535. Surely the customer has the right to every piece of possible information that he can get, including a pamphlet on side effects, about every drug which he ingests? ——W. I will not dispute that but what I am saying is that since this requirement to label these things, in my opinion it has created a greater demand for the S4 drugs than we were ever used to before. Also I believe it increases self-medication and the swapping of pills with the nextdoor neighbour, particularly with anti-depressants and analgesics and this type of thing.

3536. Mr JACKETT: One of the things that impressed me about the present system was that for the first time we are getting information on the bottles about the dangers specifically. This would not be possible if there was no information put on the packet, as you have suggested, would it?——W. If there were specific dangers about the medication it should be an extra labelling requirement. I think that is necessary. What I am saying is that generally bandying around a trade name on a drug particularly, like a brand of soap, as it were, has a detrimental effect. If there were some other requirements, certainly that should be included on the label.

3537. In some cases they would identify the drug label? ——W. Yes, but that would probably not constitute any more than 5 per cent of the drugs about which we are talking.

3538. The former committee was told by a representative of the pharmaceutical guild that there were quite a number of cases where it was important for individuals to know that certain drugs had inter-reactions with other drugs. If there were no labels by which one could identify, one may not be aware of the dangers of what one was taking?——W. It gets back to the prescriber. A doctor has a person's history card, unless the person is going to another doctor and confusing the issue, which does happen. He is in a position to see if there would be a drug interaction, before he prescribes the compound.

3539. Mr WOTTON: Do you believe that the sale of analgesics should be restricted to pharmacies or do you consider that their sale should be restricted to a degree, say, to pharmacies or doctors' prescriptions, or should it be an open slather in milk bars and everywhere, as now?—— W. I do not believe that it should be open slather in either milk bars or pharmacies because of the kidney problems and so on that we know about these days. I think that they should be in smaller packs but I do not think they should be generally bandied around. The pharmacist has a responsibility here. He has to be educated to be aware of this responsibility. We are in a fairly close knit community in our part of the world but if we observe that someone is regularly buying an analgesic we make it our business to inform the doctor very quietly that so-and-so seems to be taking a lot of Vincents, Bex powders or Disprin or something of that nature. I think that is really the best way of handling them rather than scaring them out of taking them, because they will just go somewhere else to buy it.

3540. Mr McGOWAN: In the five times that the cabinet was broken into were you carrying much methadone? ——W. No, I had some physeptone tablets there then.

3541. You were not dispensing it regularly?——W. No. I recently had a situation where I was requested to dispense methadone to a drug addict. I suspected the last break and enter was because this information filtered out among his friends and that was the reason for the last entry. This was hidden away, I did not have it in the drug cabinet. As a result of this the person decided not to come back again because he felt he had been incriminated. I would think seriously again about accepting the responsibility of issuing methadone to a drug addict.

3542. CHAIRMAN: Have you any idea what the other drugs might have been that they were after?——W. No, because they took the whole lot—methadone, morphine—whatever was there they took the lot. Strangely there were some asthmatic drugs, which meant in three cases asthmatic drugs have been taken.

(The witness withdrew.)

IGOR PETROFF, Superintendent of Richmond Clinic, Mental Health Consultant to the Health Commission, North Coast region, and private psychiatrist, on affirmation:

3543. CHAIRMAN: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act?——W. Yes.

3544. Do you wish to make an oral submission to the committee?——W. Yes. I am more prepared to answer questions, but there are a few points I should like to bring out. My feeling on the topic is that I do not know of any simple solutions. I certainly await with considerable expectation your recommendation after you have surveyed the whole scene in New South Wales. I think that any simple solution is naive and does not really take into account all facts.

The second point I make is to make a plea for the methadone programme. Some people in our society have not the resources—the ego resources—to do anything but to get on to drugs. The lower end of that spectrum turn to, say, heroin, the opiates and the narcotics. I see them in a most humane way. My responsibility as a psychiatrist and a doctor is to alleviate their pain. I am the only person in the Richmond–Tweed region who can prescribe

methadone and from our experience here the methadone programme is very successful. We are certainly very tight in our selection of who receives methadone and who does not. At the present time there are about 13 people on the methadone programme. Despite the high unemployment in the region practically all of them are working and making something out of their lives. The fact that these people are liars, cheats, are thieves I really view as a symptom of their illness. I cannot get away from the medical model. I cannot but see their problem as a medical one. One does not kick the guts out of an epileptic who is throwing a fit in the middle of the street and say to him, "You rotten so-and-so". These people because of their background and upbringing really have no choice. By the time that they are on to heroin I think that that is it. Their difficult and annoying behaviour and imposition on the hospital is a symptom every bit as real as those of somebody presenting with a bellyache or some other problem. Again you may find different evidence in other parts of New South Wales, but certainly here on the North Coast our methadone programme I consider to be fairly successful.

I keep an ear close to the ground. I do not think there is too much heroin available in this area at all. Of the thirteen we have on the programme only three are locals. They are a fairly motivated group. Of the ten others of the thirty-eight we have treated only three are locals. They picked up the habit, one in Canberra and two in Sydney. The rest are importations who have tried to get away from the habit. We are fortunate in that this group is fairly highly motivated to get off drugs. That may not be your experience in other areas—in Wollongong, Newcastle or Sydney. Of the 600-odd admissions in the past twelve months only one was because of marihuana. I really do not see that as any sort of problem. The one case was not so much for medical reasons but for legal reasons. He was referred to us by a solicitor so that he could be assessed, to go to court. We served a legal rather than a medical or a psychiatric purpose. So, medically speaking, I do not see marihuana as a great problem in this community. I am not advocating anything. I do not think anything is simple. I know that in India where the drug is marihuana rather than alcohol their mental hospitals are just as full of demons as a result of marihuana as ours are full of alcoholics. I do not think that there is any naive or simple solution to the problem. As to analgesics, a lot of my patients, psychiatric patients, because I refuse to give them any more tablets than I do, swallow huge amounts of analgesics such as Vincents and Bex. There is nothing I can do about that. No amount of education will convince them. They know that they are doing wrong but it is almost a compulsive habit. They are slowly dying. In the four years I have been in the area they are falling to pieces with renal complications. I feel that the committee has some responsibility for the sort of editorial—I am not laying it on the committee—with a razamataz—but the editorial in today's paper portrays great doom, vigilance and that something is going to descend on us because of one marihuana smoker who was admitted to Richmond clinic. That has incensed me a bit because I do not feel that any great doom will befall the community and I am close to the source. My overall philosophy is that there are so many ways of destroying oneself we can destroy ourselves equally well with marihuana or alcohol or playing chicken with cars or any sort of thing. I feel that drug taking is symptomatic of a fairly demoralized, disintegrated community. We are chasing our tails and closing the gate after the horse has bolted in bringing in any measures in connection with drugs. It is an escape from reality. That is how I see it. What I am saying is that a percentage of the community is going to destroy themselves in one way or another. Also, I am recognizing that some people could go through a crisis. The ridiculous naive suggestions that methadone should be freely available from every general practitioner to anyone who wants it is outrageous. First, it is naive to think that there are not rogues within the medical profession who will not run a lucrative practice by giving methadone to everybody. Also, that a 14-year old girl who has just run away from home will not react to methadone as a way of getting over the crisis when, if they were denied methadone or opiates or anything they would probably resolve the crisis and go on to a successful resolution of the problem and possible adult and mature growth.

3545. CHAIRMAN: You said we can destroy ourselves with marihuana; do you know of any death that has occurred through overuse of marihuana?——No.

3546. You were referring to a number of patients taking analgesics in huge amounts; could you give an indication of how many such patients you might have seen?——W. I would say that I have six in the practice currently who freely admit it and say they cannot stop taking them that they have to keep taking Bex after Bex—three packets a day.

3547. Younger or older?——W. Middle age—suffering from other conditions.

3548. Do you point out the dangers of renal failure? ——W. It means nothing. Something like 2 per cent of Queensland women die from analgesic nephropathy.

3549. You are making a plea for the methadone programme: are you talking about all methadone programmes irrespective of dosage?——W. I think if that is not considered the methadone programme is not running well. It is a sham to give someone 10, 20 or 30 milligrams of methadone. You either give it to them or you do not, in such doses that it is going to blockade them and stop them using heroin as well to get a flash. That means they have to be checked daily.

3550. How long would you keep it on?——W. Until they are ready. Until they have resources or capacity to make some sort of adult life—whether it is having a wife and responsibility and a job—until it is no longer attractive for them to be in the scene. It may be for the rest of their lives.

3551. You feel that would totally devolve on the medical practitioner?——W. Yes, on selected medical practitioners.

3552. Mr HEALEY: Why are there thirteen on methadone? What was so special about them that they could not respond to other treatment, with detoxification?——W. The problem is not detoxification. That is fine, we can detoxify them and that will put them in withdrawal symptoms. They will not have tears, nose running, an ache in the guts, muscle cramps, shivering and goose flesh; we can get them off the withdrawal programme quite successfully using valium and hemineurin. I always tell them that it is a gaol sentence. I tell them that they may remain on methadone for the rest of their lives, that it is a choice they are making. I warn them that I am replacing it with a synthetic and legal narcotic which will be just as difficult to get off as the heroin. So, they are warned, but some people will be withdrawn and they say that they cannot think of anything, they cannot do anything without

constantly thinking of scoring. They say they find themselves unconsciously fraternizing with people with whom they should not fraternize. They say they take frequent trips to see their mother but the whole aim is to score. An analogy would be a fat man going on a diet—he cannot stop thinking about food. That interferes with every aspect of life—except you multiply it about one thousand times.

3553. There has been a lot of evidence given to the committee that by counselling and other methods it can be done. Methadone is not permitted and would not be administered under any circumstances?——W. Yes.

3554. They have their success rates?——W. Sure. The thirty-eight we have had on methadone would be a small percentage of the people who present to us. I would talk in terms of hundreds. I still do not know whether they are taking heroin or not, the other seventy. I am not saying I am giving methadone to everybody. I make sure that they have a genuine habit, are over eighteen, with no multiple drug abuse and I warn them that they may be addicts for life.

3555. You are certain that they are not still on heroin? ——W. We make urine checks. It has to be properly policed.

3556. Mr JACKETT: You used the word blockade: do I take it that you believe in methadone only for blockade purposes?——W. No, I believe in maintenance. I think maintenance is acceptable.

3557. Do you use blockade?——W. Blockade and some maintenance.

3558. How long do you take to wean them off it when you use blockade?——W. The idea is that we blockade initially and then we get them on to maintenance.

3559. How long does it take for the blockade?——W. Six or twelve months.

3560. Mr WOTTON: We laymen, listening to experts, get just as many medical practitioners saying that the methadone programme is a disaster and not to have a bar of it and just as many people saying what you have said? ——W. No, there is no simple solution. It needs assessment. I hope that I am giving the total picture. I am not advocating across the board methadone. I am advocating stringent controls. There are cases that deserve methadone.

3561. CHAIRMAN: You claim that the greatest thing in its favour is that people can resume a reasonably normal life?——W. Right. It stops them getting into other behaviour and pretending that they have renal problems or breaking into chemists shops and staying out of crime. I think I know the Sydney programme: something like 50 per cent are still using heroin. That was because the methadone programme was oversold. The danger was great. From what Ingrid Reynolds has published, something like two-thirds are scoring heroin even though they are on methadone.

3562. Mrs DAVIS: Did I understand you to say that in India the problem is that people are in hospital because of marihuana and they do not have an alcohol problem? ——W. That is right.

3563. How do you feel about the decriminalization of marihuana?——W. I do not think it should be decriminalized. How do you then stop people if you do that? It just poses so many problems. If you decriminalize it, who is going to grow it and supply it? What I am saying is that it is not a danger at the moment. I hardly know of anybody in a young age group who is not using it. It is a problem; it is not a medical problem but it may be a legal problem.

3564. CHAIRMAN: Is it a psychological problem? ——W. I do not say that. As I said, there was only one admission and that was because of legal reasons. That person was there because his solicitor thought he should be assessed before he went before the court. He was admitted for something like twelve hours.

3565. I asked you whether it was a psychological problem, not a psychiatric problem.——W. There is evidence of a motivational syndrome. That means you do not give a damn about anything.

3566. Mrs DAVIS: You have knowledge about the problem in India. What is it about the drug that puts people in hospital in India?——W. It is just the extreme abuse, just the same as we have with alcohol. The interesting part is that some people who smoke it are so really personality disorientated that they invariably turn to alcohol. They give up pot smoking; it does not give them the same kick. It is not as dangerous as alcohol, but they then turn to alcohol for a complete bombing out.

3567. What do you think of the theory that they may turn to heroin?——W. It is not true. I do not know of anyone among the twenty year olds who has not tried pot.

3568. Mr McGOWAN: You said your patients on methadone were fairly highly motivated to getting off drugs. Will you explain that philosophy?——W. It eases their pain; it is the swapping of a lesser evil.

3569. Would you say that if it were used properly it should not be banned, despite the fact that there has been a lot of evidence, particularly from addicts, that it is abused?——W. I know of one general practitioner who prescribes methadone when he should not. It is against the law. Obviously that law should be given more teeth. The medical branch in Sydney should telephone him and tell him that there is a suspicion that he is giving heroin to addicts, that it is illegal and that he has to stop it or else.

3570. Would you be in favour of legalizing heroin for the medical use you are talking about?——W. No.

3571. So that addicts would be given heroin rather than something like methadone?——W. No, I think that methadone is superior in that it has got a long action.

3572. We have heard medical evidence to the contrary. There is evidence that it is worse because it has a long action.——W. Yes, you cannot withdraw them as well. However, the fact is that I am not worried about whether they come to the clinic for the rest of their lives, picking up methadone. I am worried that they are making something out of their lives. You cannot work on heroin but you can work on methadone. It is a thirty-six-hour action;

so that you are more or less stable and you can still be a reasonable mother or father and collect the dole or go to work. That cannot be done on heroin. What you are saying is right, that it is harder to withdraw eventually with methadone because of the long action.

3573. Given that we have an increasing heroin problem, so will we have an increasing methadone problem?——W. Yes. Things are bad, society is pretty crook.

3574. We had evidence this morning from a doctor that people in your position have negative attitudes; they say that this problem cannot be cured, therefore, the patient will be maintained in this way for the rest of his life.——W. I never say that. It is their choice when they want to withdraw. When they want to withdraw they have got to come into the clinic and be withdrawn within three weeks. It has to be within three weeks; there is none of this two bob each way business. I say: "I have got nothing against you personally but I know that you are a liar because it is a disease. The disease causes you to lie, cheat and play tricks. You are trying to deceive me. I see that as a symptom of your illness".

3575. CHAIRMAN: Are there many who do not accept your rule and go away?——W. Yes.

3576. What percentage?——W. Of thirty-eight, we have got only thirteen now. When I first started I was hard on people. I did not see it as a medical problem; I saw them as liars rather than that they were lying as a symptom of their illness.

(The witness withdrew.)

*AT CASINO ON FRIDAY, 8 JULY, 1977*

(The Committee met at 9.15 a.m.)

Present

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| The Hon. MARGARET DAVIS | Mr J. G. T. JACKETT |
| The Hon. C. HEALEY | Mr B. McGOWAN, B.A. |
| | Mr R. C. A. WOTTON |

MAUD OTTON, Home Duties, residing at 7 Green Street, Alstonville, sworn:

3577. WITNESS: I am in a fairly unique position: I have a son in the police force, one who committed suicide from the result of drugs and another who is a schizophrenic from the result of drugs.

3578. CHAIRMAN: Did you receive a summons issued in accordance with the provisions of the Parliamentary Evidence Act?——W. I did.

3579. Would you proceed?——W. It started after Vietnam. The boys were returning home. The first indication I had of any trouble in my family was in 1972. A son of mine asked me to come to the North Coast because he was in deep depression after drug usage. I do not think that any child starts on drugs from, say, cigarettes or beer. I think they first start with marihuana. I think they graduate from there. I have met a lot of other people since and helped a lot of other people through religious organizations and through the police. In each case I have asked where they started. It has always been on marihuana. Whether it is harmful—it may be to one and not to another—I do not know. My eldest son who is a policeman, if you were to give him a tetanus injection in about five minutes time he would be in an oxygen tent fighting for his life and yet he is a black belt karate exponent. A tetanus injection may not affect someone else. This son was 27 years of age when he died.

3580. What was his Christian name?——W. Alan Keith. I have the psychiatric reports. I have noticed that a lot of people have given evidence that they have taken drugs or that they have not. There is really no proof of that—you do not know who they represent. I am open to any questions. I just make those points. He did take his life. He dug his own grave. He did not intend to be found. He talked it over at great length because from 1973 to 1975 we had been trying to persuade him to stay alive. I have been in and out to psychiatric centres, to private doctors and to the police. The police helped me a great deal in the situation. I have heard a lot of stories about the police from other people for whom I have great respect. I do not think anyone is getting together enough on the matter. I do not think they are in the position, some of them, of having to live with it, like me. In the home people might not want to go to sleep to 4 a.m. and it is essential to stay awake because you do not know what they are going to do—I do not mean just suicide.

3581. You said that Alan Keith went to Vietnam?——W. Yes.

3582. How old was he then?——W. Twenty—in the 20-year old group.

3583. It was while in Vietnam that he started taking drugs?——W. I should think so—he might have had a touch of marihuana before then, I do not know for sure.

3584. It was heroin he was taking when he was in Vietnam?——W. Not necessarily. I think there are a lot of different drugs they take. They go from marihuana. You have heard the various drugs they have had. I think they try the lot.

3585. It is your own son that I was trying to find out about. You knew what he was on when he came back. Was it heroin that was his main problem?——W. I do not think it was just heroin, I think a mixture of drugs.

3586. He was on heroin plus something else.——W. I do not know for sure. He has been on different drugs. I can follow that up. The doctors at the psychiatric centre——

3587. What have they said about it?——W. I would have to get in touch with them personally. I would not be sure.

3588. I thought you were referring to a statement from a doctor.——W. No. That all can be obtained.

3589. Have you any idea what it was that eventually caused him to take his life?——W. Deep depression.

3590. What type of drug?——W. He was on no drugs at that stage. He had been given, from the psychiatric centre, a six-weeks supply of tranquillizers and sent home to me. At this stage I think, everyone was doing their level best that way to find the drugs to help the addict, but perhaps some were the wrong drugs.

3591. How long after he was sent home did he take his life?——W. He would come home and go back again. At one stage I had to get the police to stop him taking his life.

He won the army boxing, he was a signaller and had been in heavy action.

3592. You said he came home from the psychiatric centre.——W. This was the first time in the psychiatric centre, in 1973. After he had been home a while there was no improvement. I went to the private doctor and told him about the six weeks supply and he was not too happy about that, neither was I. At this stage I informed the police. I knew that I could not handle him if he decided to do anything untoward.

3593. Did you try to take control of the dosage?——W. I had no opportunities. He would throw them around the yard every time. If he had a cup of coffee he would smash the cup on the ground. He did not attempt to hurt any person but the depression was getting worse. A lot of things were thrown about. If he left the house, sometimes he would go to Mullumbimby at 2 a.m. If he decided to take off I would follow. It got to the stage where I sent for his younger brother because I could not handle it and thought perhaps, being of the same generation, he could help. I think that was a mistake. It caused the other one to get into the same scene.

3594. When you say into the same scene, what do you mean?——W. He is now schizophrenic, due to drugs.

3595. What drugs?——W. Various—started with marihuana once again. That is the one they think is harmless. I do not know whether it is harmless or not. I could not at this stage believe that it is.

3596. Do you know any other drugs he has been on? ——W. He says he has been on various drugs but I could not be specific.

3597. Do you know any other people your sons have mixed with who are involved in the drug scene?——W. I know one who was hanged at Manly dam. Whether he hanged himself or was hanged, there will always be a doubt. He was the only son of a friend of mine. I have a picture here in which half the boys in the picture are now dead.

3598. How many boys in the picture?——W. There is a class from Balgowlah high school. This is an old photograph taken in my backyard. In those years—there would be about half the number that used to hover around there then.

3599. How many are there in the photograph?——W. Three boys and one girl. There are twelve of them in this photograph. There are more than that. My sons have a number——

3600. To be clear, there are twelve in the photograph? ——W. Yes.

3601. Three boys and one girl out of the twelve are dead?——W. Yes.

3602. How long is it since the photograph was taken? ——W. This was when they were teenagers. That would be fifteen years—in latter years a lot of the boys are dead because from what I can see they start at about 16 taking drugs and by the time they are 28 or so either their livers, kidneys, lungs or brains are damaged. I took a boy to a minister of religion—I will leave him unnamed—to get help through a private doctor. What I do with my young sons is one thing, with somebody else's it was an entirely different matter. He would come to me for help. He was desperate and depressed. The private doctor tried to do something for him. They had to restrict him and put him in hospital. Eventually they had to let him go because there was absolutely nothing they could do for him medically. The only thing he has to look forward to at 28 years of age is death.

3603. How long have you been living in the area?—— W. Since 1973 when I was sent for. I have moved twice. I have lived in Byron Bay and Mullumbimby. When I first landed here I knew there was something wrong with my son. They are very independent people and if they ask me to come, I come. I had $200 and a caravan. I wandered up here not knowing what to expect. Now I know, but a lot of parents could not handle this.

3604. You are talking about parents in this area or where you resided before?——W. I have met people in caravan parks who have either leased or sold their homes, they have a caravan and are moving around Australia so that they will not come in contact with their children.

3605. Mr WOTTON: What psychiatric centre was your son in?——W. Rydalmere.

3606. Would you personally like to see any easing of penalties for drug taking or drug abuse?——W. I have thought a long time about this. I should think that there are a great number of young people in these communes who feel they are right and they say that marihuana is harmless. I feel that it puts the police in a very difficult position if they have either to raid places or try to find out things the way they do because they are making enemies of two societies that should not be enemies. I know both sides of the question because I have been emotionally and practically involved and the police have to do a job.

Some people think that marihuana is right. Others have a religious belief and they feel that their belief is right. These people are fighting each other. There must be an easier way. It would not help anybody if marihuana were made legal and the children of the family brought it into the home. If that happened, I think there would be more missing persons than there are at the present time. Up to now my generation and the next generation have not been able to get together on this thing; it is too soon.

3607. Why did you refer to missing persons in that context?——W. Because there are so many missing people. Every police station has a long list of missing persons.

3608. Mr JACKETT: Do you know what sort of tranquilizers your son was sent home with from the psychiatric hospital?——W. I cannot remember. My memory is not very good. Perhaps it was a drug that is not being used at the present time. After that, I followed various seminars to see what was going on. My family never had things like aspros in the house. One of my boys never lost a day's schooling. They were pretty healthy. We never had any problems so far as sickness is concerned. These things are quite foreign to me. About a year ago I saw a list of things that should not be taken. Perhaps there has been a change since then in the drugs that are now being used.

3609. You do not know whether it was one of the barbiturates?——W. No. There was a great bottle of these things and they were thrown away.

3610. Do you think that it would be wrong at the present time to relax the laws in regard to marihuana?—— W. Yes, at the moment.

3611. Mr HEALEY: What is the relationship at the present time between your two sons who are, as it were, on opposite side of the fence?——W. They have always been close and they always will be close.

3612. There is no conflict about this thing?——W. No conflict. When it came to the point of that son having to be put into the psychiatric centre, it was his elder brother who did it. My daughter was involved in this.

My eldest son's wife and my daughter's husband was involved; they all got together and they sat on this boy and tried to save him. He knew that what they were doing was for his good.

3613. Mrs DAVIS: Would you say that the older residents of the district are against these new people coming to the area?——W. They were for a time but they got used to the idea. It was pretty heavy for a while. I do not think that these young people deserve that. I think that they are desperate. At one stage I had to take seven envelopes from different young people who came to me. I took them all at once but I did not read them; I sent them to a member of parliament because no one would give these people social service benefits. They were wandering around and they were in a real mess. That sort of thing is no good for the police and it is no good for them. Another thing is that my son's skeleton remains were found on 16th April, 1975. I could not pick up his remains. I wrote to the Commissioner of Police and I got the R.S.L. involved. I have a letter from the Commissioner of Police.

3614. Where were his remains found?——W. In the forest beyond Nambour. His remains were brought down and they were buried a short time ago. Any parent who is put in that situation would go through a pretty traumatic time. I kept my own family out of this because my daughter and her husband have their own lives to live and they have children. My eldest son has his life to live, and, apart from that, he does not have the time.

3615. CHAIRMAN: Is there anything else you would like to put to the committee?——W. I cannot think of anything now. My mind has been full of this for the past few years. So many things have happened. Many parents could not handle it and I do not think that they should have to handle it.

3616. Mr JACKETT: We have had evidence from another person in much the same position as yourself. She said that there was no communication between the various authorities and the people about this kind of problem. She said that some of these people suddenly find that their family has been caught up in the drug situation. They are then put in the situation where they have no idea about what they should do.——W. I can understand that. This is why I am against legalizing it at this point. I do not think they can handle it now.

3617. CHAIRMAN: Your son's treatment was taken out of your hands and the experts took over but they were unable to do anything with him?——W. At that stage the experts knew more about it than I did. I was flying blind. My mother and her sister were nursing sisters in the First World War. We have people in professional positions. If you have people who have never had any background or experience of these things, they would not be able to cope.

(The witness withdrew)

ELIZABETH AMY DWYER, Postmistress, residing at Riley's Hill; and

MARJORIE HENDERSON, a Housewife, residing at Davis Lane, Evans Head, sworn and examined:

KENNETH CHUNG, a Medical Practitioner, residing at Corokai Hospital, on affirmation.

3618. CHAIRMAN: You have each received a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act. Do you wish to make a written submission or give oral evidence to the committee?——W. (*Dr Chung*) I am appearing today to make a verbal statement of my evidence. I shall make my statement on what I understand to be the problems of drug addicts. As a medical practitioner I can say that in any society there is an abuse of chemicals which a person will voluntarily utilize either for reasons of achieving a sort of pleasure or to alleviate body or psychological discomfort, irrespective of the harm to the individual. I see this in my practice. There are three categories: recreational drugs, prescription drugs and drugs of addiction. Recreational drugs include substances like tobacco, alcohol and cannabis. Prescription drugs include aspirin and barbiturates, and the major drug in question now, which is heroin. That is a drug of addiction. It is perhaps the most pertinent question in our community now.

As to what extent there is a problem in this area, I shall give the sort of experience that I have had. I have been in Australia now 10 months. The first two months I spent at Casino in private surgery and had no occasion to meet with drug addicts. Since I started at Woodburn, where I have my own practice, for the period from 28th April until 7th July I have seen a total of 15 patients who have come in and said to me they have a problem with drug addiction. To my mind this is fairly alarming. From these 15 people I get information that there is also a larger problem not seen by the medical practitioner but which exists in our communities. My patients come from as far as Byron Bay to my area in Woodburn and Evans Head. What other sort of data would you gentlemen like?

3619. Our terms of reference cover the use and abuse of all drugs of dependence. You mentioned 15 patients. ——W. With heroin addiction.

3620. You say that they have come to see you. Obviously they are people who are dependent on a drug of addiction. Did they come to you for treatment or to try to get methadone or something of that nature? Would you elaborate on that?——W. Yes. In the early part of my association with the drug sub-culture it was my belief that they were earnestly seeking a remedy to the problem. Now that I have seen them for these few months, of the 15 patients I have had only one put into hospital and had him withdrawn from methadone. I believe that he is now re-integrated into society. The other patients I have had my doubts about. One is still under supervision at the moment. Two I consider potential patients. In retrospect I feel that the other 11 have been perhaps druggies who are out to score. Perhaps they thought I was easy game and came to see me. I feel that my practice has attracted this group of people.

3621. I suppose the word got round quickly that there was a new doctor?——W. Yes, I think so.

3622. How old were these people?——W. The ages range from 18 to 30.

3623. Do you find it a little bit unusual to have heroin addicts at the age of 30?——W. No, I do not. I imagine there is a fairly large percentage who could also be within that age group, although the predominant age in the group is from 18 to 25. I have only two patients in the 30 age group. One gathers from hearsay that the older group also exists, although the younger age group is from where the larger number of my patients come.

3624. Have you any idea where these patients originally resided?——W. A number of them are from Sydney. In fact I think something like 80 per cent of the patients I have seen have lived in Sydney at some time or another in their lives. A few are in transition and only about two of them are from my local area of Woodburn–Evans Head.

3625. Are they occupied at present or unemployed? ——W. Essentially they belong to the labouring class. They will be either bricklayers or unemployed. I have not met one who has a continuous occupation.

3626. Have you had any problems at all with people living a communal sort of life that exists in some areas? ——W. No, not much exposure to that group of people.

3627. Did you have much experience with heroin addicts before you came to Australia?——W. I suppose I would have very definite opinions about heroin addiction. In 1972 I graduated from the University of Malaysia in Kuala Lumpur. After two years of compulsory service with the government I was in private practice in my home place and I was first exposed to the problem of drug addiction there. We had our own local kids being on drugs but we never really assessed the problem then. I was merely participating as a general practitioner trying to help a drug addict through a difficult period. Since my arrival in Australia I have been more or less amazed with the fact that heroin addiction is in such epidemic proportions. I find it a cause for alarm.

The British imported opium into China in the 1840's at the time of the first opium wars. Since that time until today the problem of opium addiction has remained in some Asian countries. In Malaysia, after the use of opium after so many generations I still see the group of people who are still opium addicts. After more than a century the problem still remains. They have just become older addicts, that is all. When I see the number of young people on heroin, with the enormous repercussions to their later life, it is alarming. I am concerned because it is a big problem. I have the feeling that the services we can provide and that I can provide are perhaps not adequate to handle the problem of heroin addiction.

3628. Following on your last statement, if a young person of, say, 18 years of age presented at your surgery and it was obvious to you that that person was heavily addicted to heroin, how would you treat that?——W. At present my main aim in the management of a case of drug addiction is to start by building a rapport. If there is a drug addict around the area I like to keep lines of communication with him so at least he will be under some sort of surveillance. In other words, I am interested in building a rapport with them. While I go through the process of building a rapport, I do prescribe methadone so that they can perhaps alleviate their condition, but it is on the understanding that they are to be motivated to want to withdraw from this drug of addiction, as time goes on. They would usually get the first prescription of methadone and subsequently I put pressure on them to go into hospital to withdraw. If they fail after a couple of prescriptions I usually tend to end the contract with them, saying that perhaps I am not in a position to help them and that they should perhaps try different centres.

3629. When you ask them to enter hospital, to where would they go?——W. I would put them into Coraki Hospital.

3630. You are authorized by the Health Commission to prescribe methadone to addicts?——W. No, I am not. I have not sought authorization. I realize I have prescribed methadone before and I am not quite sure of my legal position in this respect.

3631. Have you had any great problems with patients for whom you have prescribed methadone?——W. Not so much problems. I cannot have sufficient surveillance over them. This is something that I find I lack in handling patients with drug addiction. They are perhaps widely distributed and I do not know what is going on with their lives and so forth.

3632. Where would they pick up the methadone that you prescribe?——W. From the pharmacists in and around the area—from Woodburn, Evans Head, Ballina and Byron Bay.

3633. Mrs Henderson, would you like to address the committee?——W. (*Mrs Henderson*) I am involved with the young people in Evans Head. At Christmas time in 1975 there was a great deal of pot smoking going on round the town, and I guess also the harder drugs, the barbiturates. At the court at Woodburn in 1976 some 40 young people from the town appeared. It was almost all the male population under about 19. They appeared at the court for minor misdemeanours. This was a shock to me. If it had been one or two children I would have thought probably their family background had something to do with it, but when there were so many it caused me to ask what was the community doing for these young people. I offered by putting up a sign to provide lunch if these young people wanted to give a day to the community for nothing. We have been going ever since then.

Most of the young boys and girls in that group have taken drugs at one time or another. As far as I know this has stopped. I feel that what led most of them into it was the sheer boredom and frustration of being just a nobody. They did not have jobs. We have a high unemployment rate, something like 15 per cent unemployed in this area, which is three times the national average. The status that these kids had in the community could be equalled only by the status of the Aboriginal people in the community, which is right at the bottom. Since then they have built up by getting together. By getting together and finding other children have problems the same as theirs and talking about it, something like 40 children have come through this group. At the moment we have 16. Most of the others have gone on and got apprenticeships or jobs. The group has changed as there is a turnover.

3634. What is the general age of the group?——W. We do not have anyone over 21. The general age is from those who leave school about 15 up until they have been two years out of high school and have still not got jobs. Some have quite good qualifications such as higher school certificates and school certificates. I know that young people start taking drugs, starting on marihuana and going on to something a bit more exciting, ending up as a patient of Dr Chung on heroin, or down in Sydney, because they are bored. It starts with boredom. Then they get together in a group. The area is well served as far as adult recreation goes, but as far as young people are concerned, there is no provision at all, nobody seems to care much. People think that they have many beaches, why do they not go fishing or swimming. The young people about whom I am speaking are locals. We have never had one itinerant join our group, they have all been locals. There is no recreation field worth speaking of. The one at Coraki has a toilet block. The one at Woodburn is brick. Evans Head has a toilet block that is wood and there is no provision for sport. They kick footballs around but the opportunities for kids to get together and begin taking drugs is there.

This group of kids I have now come out openly and talk about hard drugs in the area and pot, too. Recently I sent a young chap to a job on a station. I thought he was quite reasonable. After two days they rang and said there was nothing they could do with him, that he was completely spaced out. He did not know where he was and what he was doing. Parents find it hard to accept that he is taking drugs. They have taken him once to Richmond clinic, I guess for the last time. I find that parents' attitude is that their children would not do it. You have to be careful that you do not find yourself in a position where they say that you are slandering their children. The other

thing that concerns me is older people. I have been involved with senior citizens and I have been their secretary for six years. A lot of older people want drugs and they put pressure on their doctor. It seems to be a status thing, and if they go to the doctor and do not get two or three prescriptions they think they are not being treated properly. One person at one time had four doctors, one at Evans Head, one at Woodburn, one at Casino and one at Lismore, and she got prescriptions from all of them. She was quite unreal most of the time. She is not alive now. It was boredom. Once her children grew up and left her, she was a woman of 40 or 50, she began taking barbiturates. People do this, they take barbiturates and Bex and Vincents and it is widespread among men and women. They are easily obtainable.

3635. Social conditions would not have changed very much in the area yet the young people today use drugs as an outlet whereas their mothers and fathers did not do so?——W. Social conditions have changed. In our era the young people would have gone away to get a job but in the past four or five years things have got worse and there is no employment in Evans Head or Woodburn.

3636. Go back to just before the last war when there was a high rate of unemployment, probably worse than at any time since the depression. At that time there was not a problem with drugs in this area and these people would have been bored but they did not get involved in the drug scene?——W. There was a very high alcohol intake in those days.

3637. That still exists?——W. Yes but probably money was not as available. Today kids have got money. The pressures on these people push the drugs along.

3638. Do you have any idea where they come from? ——W. No.

3639. Do these children ever tell you where they get them from or give you any idea of how they come into the area?——W. I have talked a great deal and had a lot to do with the local policeman. We have talked about this and there is no doubt that they know when a shipment is coming. Our local policeman searched a place for six hours for a shipment of heroin but could not find it.

3640. He had good reason for thinking it was there? ——W. Yes, very good reason. The Lismore police also know where it comes from. The shipments do come in. The constable said to me that when you are looking for marihuana there is always plenty of it lying around and it is easy to find but when you are looking for heroin you are looking for a small quantity and it is extremely hard to find.

3641. That is so, but the question I was raising was whether these young people in their discussions with you ever give you an indication of where the stuff actually comes from. You used the word shipment. Have you any suspicions that it is landed from the sea locally?——W. I used the word shipment because that was the word the constable used to me. I would swear that none of the group I have in now are on drugs of any sort.

3642. You mentioned one young fellow who was taken by his parents to Richmond clinic and you said you guessed that would be the last time. What was the reason for that statement?——W. It was not because of the clinic. I have a great deal of respect for what goes on at that clinic. I think it is because the parents do not accept that he is taking drugs.

3643. I did not want a reflection upon the clinic if it was not intended?——W. No, not at all.

3644. Mrs Dwyer, would you like to address the committee?——W. (*Mrs Dwyer*) I am speaking in connection with my work with the community aid council which was formed in 1974. I have been secretary of the council since then. One of the first things we were asked to do was to make a needs survey through the community. We discovered cases of drug dependency in every walk of life. This was not hard drugs but drugs obtained over the counter and by prescription. An analysis of these cases found the causes to be inability to cope with modern life, loneliness, malnutrition where people lived alone and a general ignorance of sound nutritional standards, boredom, inability of the elderly to cope with day to day household tasks, broken families, isolation through lack of transport, family problems and a lack of understanding of roles, financial problems and stresses. We were aware of some problems of alcohol but most drugs were pharamaceutical. Of these many were readily available over the counter and many were obtained with a doctor's prescription. We found that abuse of the over-the-counter drugs was the result of brain-washing advertising on television, radio, bill-board and the press. People read advertisements and it seemed an easy cure to any ill that they had. Drugs obtained from doctors were prescribed initially because the patient was either unwilling or unable to identify the area of trouble and found it easier to persuade himself that he was physically ill. An overworked doctor, ignorant of the patient's homelife and personal problems, gave the assistance he had been trained for, he wrote a prescription. The patient felt a sense of respectability in getting medical attention but the cause of the problem remained unidentified. The number of prescriptions one could bring out of the surgery became a status thing. Sleeping pills, nerve tablets, pain tablets, were collected with enthusiasm. I have known people to hoard, swap and to go concurrently to two doctors to get more drugs.

The council went beyond the business of just assessing the needs. It tried to identify them as well as alleviate the problems. The first thing it set up was an information and referral service for people with problems so we could direct them to people with expertise and where possible to bring people with expertise to this area for the convenience of clients, particularly legal aid and social workers. We take company to the lonely and endeavour to bring them into the community. We enable the elderly to get meals on wheels and thus combat malnutrition in this way. A person living on their own often makes do with any sort of meal. We provide training for the meaningful use of leisure to combat boredom. We provide home help for the elderly, the infirm, post-operative and new mothers. We help broken families to re-establish a pattern of living. We try to provide transport for shut-ins. This is a big difficulty in the area. We provide information and referral to those who might have family problems. We provide self-help therapy and relaxation sessions for people with stress. Some of the other services provided by the council are massage, ray lamp treatment, diet and nutrition discussions, personal development classes, small group dynamics, film making, art, lapidary, horticulture, local history research, help with job application, community development and communication development between local groups, government personnel at each level and with public servants.

In summing up, caring is the key word. These people felt that nobody cared for them. Their families had gone and they had a lack of communication with their families and with society. It was found that all age groups and levels of society suffered from ignorance of names and roles of areas of bureaucracy and that bureaucrats and public servants had been frustrated by their inability to help the people they were meant to help. However, once

communication had been established they were most helpful. They attend our meetings and get to know the people whom they were meant to serve. I can speak from my own personal experience. I used to be terrified to go into a government department and ask for assistance. I did not know how to frame a question and I did not know whether I would be a nuisance. But, having met these people and provided the means of communication between them and the ordinary person on the street, it is very rewarding for both sides to see how people are helped and how the people with expertise want to help others. It is something that has not been experienced in our area before. I would like to point out to this committee that the wealth of the nation lies in the health and happiness of its people and their environment more than in its gross national product.

3645. CHAIRMAN: Did parliamentarians affect you in the same way as public servants?——W. Parliamentarians have been most helpful at three levels. After the initial battle of suspicion and credibility and lack of faith in anything we could do, we have succeeded. Now I would say that anybody who has been approached by the community aid council has been extremely understanding and helpful. It has surprised me and possibly them too.

3646. Would you indicate to us the area covered by your organization?——W. The four villages of Coraki, Evans Head, Woodburn and Broadwater and the intermediate rural areas. It is very difficult to help people in rural areas because of lack of transport. Transport is a problem we have not yet solved. We are in the process of trying to set up a wheels unlimited organization.

3647. Dr Chung, can you indicate whether you have any patients who are apparently having problems with regard to analgesics and barbiturates?——W. (*Dr Chung*) Not to the point where I find it serious. There might be an occasion where I will caution a patient to restrain and find an alternative, but I do not say that that is a drug abuse problem.

3648. You have heard mention here of one lady who was currently getting pills from four different doctors. We have heard similar evidence in other places. Do you have any consultations with your fellow doctors in the area in regard to this sort of thing to try to prevent it? ——W. (*Dr Chung*) With some particularly difficult patients, yes. If we are aware that the patient is seeking treatment from different doctors, yes.

3649. If somebody came to you from a different town that would make you suspicious?——W. Yes, I would inquire why the patient is coming the distance to see me, to ascertain if there is a drug related problem or he considers he had unsatisfactory treatment before.

3650. Mr WOTTON: These fifteen people you are treating, are they involved in the so-called alternative lifestyle?——W. No, they are drop-outs from schools who have gone into labouring jobs. I do not identify them as the hippy type.

3651. Have you had any association with alternate lifestyle people?——W. Some exposure, yes.

3652. Do you believe that their lifestyle is helpful?—— W. I respect the opinion that they want an alternative from the present system.

3653. Mrs Henderson, is it your experience in dealing with people that the majority of them started with marihuana before going to the hard drugs?——W. (*Mrs Henderson*) Yes.

3654. Mrs Dwyer, there are places like the Buttery which you would probably know, do you?——W. (*Mrs Dwyer*) Yes, I have been there.

3655. Do you have faith in that sort of therapy?—— W. Yes, I do. We work closely together.

3656. You think we should have more of such places? ——W. Yes, very definitely.

3657. Mr JACKETT: Dr Chung, I noted that you place drugs into three categories, recreational, prescription and addiction. You place marihuana in the recreational category rather than addiction but it is placed in the narcotic group: what is your view about marihuana as regards legalization, decriminalization and so on?——W. (*Dr Chung*) I have strong views about marihuana. I do not classify it as a narcotic drug. I do not see the relationship of a person using marihuana graduating to strong drugs. I regard it as a recreation drug much the same way as alcohol is. I do not imagine that it is a problem or that it could be a big problem.

Regarding the legalization or decriminalization, I do not think I have clear answers in my mind about whether it is desirable because there is always the thought that any dependence on drugs, whether alcohol or heroin, is still bad, especially in western society where alcohol is taken for granted easily. I could imagine that marihuana could also be taken for granted. I discourage the use of recreational drugs but because they exist and I accept that marihuana is like alcohol, a recreational drug, I am only concerned with heroin really.

3658. Mrs Henderson, you placed stress on boredom, you felt that as far as young people were concerned it was probably one of the reasons why you took up the whole question. We have heard in evidence that when people find themselves up against the problem of their children taking drugs they are completely at sea about what to do. They are completely bewildered that it has come into their families. Do you feel what is being done from the point of view of public education by health authorities is leaving the parents out of the area, quite apart from the children?——W. Yes. Apart from boredom there was an aimless sort of no future feeling about these young people. My first aim was to do a public relations job and sell them as worthy young citizens to the town. It was amazing how you could change community attitudes towards the children. It was quite an unenviable task to go to the parents of the boy and tell them he was coming from Narrabri and was he on medication. All the indications that he was taking drugs were there but the parents did not see them. They thought he had sinus trouble. They said sometimes he lay in bed until 12 noon and then he got up and he can switch off and does not hear. All the indications were there but neither of the parents saw it. It was the father who felt there was something wrong. They wanted me to tell him. I said that I was afraid the father would have to tell him. They were not going to lay it on me. I think education is throughout the whole drug scene. I have said to elderly ladies, who say that they must have a sleeping tablet every night, that older people do not need as much sleep as they used to, they think they should sleep like a log until 7 a.m. but they sit around and doze and then they wonder why they cannot sleep, after sleeping all day, and then they take another pill. I have told them that they would be better off having a warm glass of milk. I guess if one looked at the old garbage dumps and saw the patent medicines that we have consumed over the years for all sorts of things—Australians have always been a little hypochondriac. There are newer drugs and they try them out. It is difficult, but what we have been trying

to do—I am on the Community Aid Council—we have been trying to find other alternatives. Last night I was at a public meeting at the school at Evans Head. There were forty people there. They ranged from teenagers through to an elderly lady. It was to form a community learning unit, a branch of the College of Advanced Education. I am on the council of the college. It will bring to Evans Head lecturers—we may find some in our own area. Last night we sent around a piece of paper and asked the people what they would like to do. We got back twenty-four different courses from cake decorating, navigation, learning how to fish properly, parenting, early childhood and going right through the whole spectrum to leatherwork, pottery and ceramics which were at the top of the list. We formed a committee of ten Evans Head people, with a representative of the college council as well as myself. I think that is what it is about. Schools are closed from 3.30 p.m. to 9 a.m. and we hope to see lights in them every night of the week.

3659. Have you any ideas about what the government, I mean government authorities, should be doing to help parents to understand the problems associated with drug taking when they find their own children are involved? They are suddenly confronted with the fact that their own children may be taking drugs and getting into the drug scene? Have you any thoughts on that?——W. Yes. I believe it is no use treating the child and ignoring the parents. The whole family has to be looked at. This is where social workers from the Health Commission and from Social Security come in. We have good contacts with Social Security. The whole family should be looked at. It should involve the community nurse who also works for us. The parents are at sea. They do not want policemen on their doorstep. They may not mind a nice young lass who sits and talks. There is a different attitude. One cannot throw a nice young girl down the front steps. The parents get more than protective: in a small country area it is different from the city; if a police car arrives in front of your house every one knows within half an hour but, if a nice young lass comes and sits down it is a different matter. It could be anybody. The community has to do something. The government can make all the laws but if the community is apathetic it will not achieve anything. The community has to support whatever is going on and support their neighbours. That is who it is happening to.

3660. There has to be found some way that government can get through to the people what to do when they are suddenly confronted with the situation?——W. Yes. The avenues are there with the Health Commission and Social Security. It just comes down the chain.

3661. Mrs Dwyer, do you believe that your committee's work is showing any real improvement in the approach of the children in the district to the work that you have been doing among them in terms of awareness of drug taking problems? Have you seen any specific improvement?——W. (*Mrs Dwyer*) My work takes me, not so much among young people, as younger married women and the older generation. It involves both sexes. I go further than saying that the difficulty springs from the home, it springs from the Australian way of life. There is a double standard throughout society. People find it confusing—adolescents and adults—I do not know how it will be done, but until it is cleaned up right at the top you cannot put the blame on the child who is a victim of our way of life. We have to get back to more quality of life although that was ridiculed in the paper the other day. It was said that there should be less emphasis on that and more on the gross national product. I do not agree. I think it stems from our standards of behaviour falling. There has been a revolution in Australia since the 1940s in the way of life. That has taken a large section of the population from the country to cities and has made many of our problems. People feel that they have no one to care for them—their families have gone. The same thing has happened in the cities. Though I do not live in the city my family has had to go there. I raised five children and they could not get work locally. When I first heard that the two sexes were sharing homes, I was appalled. It was their way of building up the family that they were bereft of by our change in life from a rural to an industrial community. This is sad.

3662. Mr HEALEY: Dr Chung, what would be the approximate population from which you draw your patients?——W. Woodburn is my town and it has a population of probably between 300 and 500. Some patients come from Evans Head. Evans Head has a population of 1 005; it is a tourist town that gets an influx of people in the tourist season.

3663. Mr McGOWAN: Do you think that the use of the present penalties in respect of convictions for smoking marihuana discourages people?——W. I do not think that punitive measures against people who smoke marihuana discourages them from that practice. I am undecided about whether those laws are necessary to prevent the younger group being affected by the use of marihuana. I think that other measures could be taken instead of sending people to gaol and fining them. I think that alternative methods could be used to discourage people from smoking marihuana. (*Mrs Henderson*) It does not do any good at all; in fact it does a great deal of harm. Some people might have smoked marihuana only once and been caught. They might not have repeated that experience. It is the same with people who try alcoholic drinks once and do not have them any more. It is wrong to penalize people for smoking marihuana on one occasion only. I do not know what I think about marihuana. It is not necessary to put people in gaol and to fine them heavily; it might put them on to something else. It seeks to make them anti-social. The police are against it. We were lucky in our town because we got over it. We had an understanding policeman. We do not have the sort of resistance against the police that there has been in some places. (*Mrs Dwyer*) I do not think that the criminal law should be invoked to deal with marihuana users. I have read everything I can about marihuana. I think that it is non-addictive. Another thing is that there are double standards. You will do more harm than good by making criminals of marihuana smokers when people who use other drugs go unpunished.

3664. Mr JACKETT: Do you know of any cases where a person was sentenced to gaol after using marihuana for the first time?——W. (*Mrs Henderson*) No. The boy I spoke of was in gaol over things. He was on a bond over other charges. He had been in a home. He was caught with marihuana.

3665. You do not know of any case where people have gone to gaol for smoking marihuana for the first time?——W. No. I think some people were fined about $200.

(The witnesses withdrew.)

HARRY FREEMAN, Psychiatrist, residing at Crofton Road, Nimbin, affirmed and examined:

3666. CHAIRMAN: Have you received a summons under my hand in accordance with the Parliamentary Evidence Act?——W. Yes, I have.

3667. I understand you wish to give part of your evidence publicly and some of it in camera?——W. Yes.

communication had been established they were most helpful. They attend our meetings and get to know the people whom they were meant to serve. I can speak from my own personal experience. I used to be terrified to go into a government department and ask for assistance. I did not know how to frame a question and I did not know whether I would be a nuisance. But, having met these people and provided the means of communication between them and the ordinary person on the street, it is very rewarding for both sides to see how people are helped and how the people with expertise want to help others. It is something that has not been experienced in our area before. I would like to point out to this committee that the wealth of the nation lies in the health and happiness of its people and their environment more than in its gross national product.

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3658. Mrs Henderson, you placed stress on boredom, you felt that as far as young people were concerned it was probably one of the reasons why you took up the whole question. We have heard in evidence that when people find themselves up against the problem of their children taking drugs they are completely at sea about what to do. They are completely bewildered that it has come into their families. Do you feel what is being done from the point of view of public education by health authorities is leaving the parents out of the area, quite apart from the children?——W. Yes. Apart from boredom there was an aimless sort of no future feeling about these young people. My first aim was to do a public relations job and sell them as worthy young citizens to the town. It was amazing how you could change community attitudes towards the children. It was quite an unenviable task to go to the parents of the boy and tell them he was coming from Narrabri and was he on medication. All the indications that he was taking drugs were there but the parents did not see them. They thought he had sinus trouble. They said sometimes he lay in bed until 12 noon and then he got up and he can switch off and does not hear. All the indications were there but neither of the parents saw it. It was the father who felt there was something wrong. They wanted me to tell him. I said that I was afraid the father would have to tell him. They were not going to lay it on me. I think education is throughout the whole drug scene. I have said to elderly ladies, who say that they must have a sleeping tablet every night, that older people do not need as much sleep as they used to, they think they should sleep like a log until 7 a.m. but they sit around and doze and then they wonder why they cannot sleep, after sleeping all day, and then they take another pill. I have told them that they would be better off having a warm glass of milk. I guess if one looked at the old garbage dumps and saw the patent medicines that we have consumed over the years for all sorts of things—Australians have always been a little hypochondriac. There are newer drugs and they try them out. It is difficult, but what we have been trying

to do—I am on the Community Aid Council—we have been trying to find other alternatives. Last night I was at a public meeting at the school at Evans Head. There were forty people there. They ranged from teenagers through to an elderly lady. It was to form a community learning unit, a branch of the College of Advanced Education. I am on the council of the college. It will bring to Evans Head lecturers—we may find some in our own area. Last night we sent around a piece of paper and asked the people what they would like to do. We got back twenty-four different courses from cake decorating, navigation, learning how to fish properly, parenting, early childhood and going right through the whole spectrum to leatherwork, pottery and ceramics which were at the top of the list. We formed a committee of ten Evans Head people, with a representative of the college council as well as myself. I think that is what it is about. Schools are closed from 3.30 p.m. to 9 a.m. and we hope to see lights in them every night of the week.

3659. Have you any ideas about what the government, I mean government authorities, should be doing to help parents to understand the problems associated with drug taking when they find their own children are involved? They are suddenly confronted with the fact that their own children may be taking drugs and getting into the drug scene? Have you any thoughts on that?——W. Yes. I believe it is no use treating the child and ignoring the parents. The whole family has to be looked at. This is where social workers from the Health Commission and from Social Security come in. We have good contacts with Social Security. The whole family should be looked at. It should involve the community nurse who also works for us. The parents are at sea. They do not want policemen on their doorstep. They may not mind a nice young lass who sits and talks. There is a different attitude. One cannot throw a nice young girl down the front steps. The parents get more than protective: in a small country area it is different from the city; if a police car arrives in front of your house every one knows within half an hour but, if a nice young lass comes and sits down it is a different matter. It could be anybody. The community has to do something. The government can make all the laws but if the community is apathetic it will not achieve anything. The community has to support whatever is going on and support their neighbours. That is who it is happening to.

3660. There has to be found some way that government can get through to the people what to do when they are suddenly confronted with the situation?——W. Yes. The avenues are there with the Health Commission and Social Security. It just comes down the chain.

3661. Mrs Dwyer, do you believe that your committee's work is showing any real improvement in the approach of the children in the district to the work that you have been doing among them in terms of awareness of drug taking problems? Have you seen any specific improvement?——W. (*Mrs Dwyer*) My work takes me, not so much among young people, as younger married women and the older generation. It involves both sexes. I go further than saying that the difficulty springs from the home, it springs from the Australian way of life. There is a double standard throughout society. People find it confusing—adolescents and adults—I do not know how it will be done, but until it is cleaned up right at the top you cannot put the blame on the child who is a victim of our way of life. We have to get back to more quality of life although that was ridiculed in the paper the other day. It was said that there should be less emphasis on that and more on the gross national product. I do not agree. I think it stems from our standards of behaviour falling. There has been a revolution in Australia since the 1940s in the way of life. That has taken a large section of the population from the country to cities and has made many of our problems. People feel that they have no one to care for them—their families have gone. The same thing has happened in the cities. Though I do not live in the city my family has had to go there. I raised five children and they could not get work locally. When I first heard that the two sexes were sharing homes, I was appalled. It was their way of building up the family that they were bereft of by our change in life from a rural to an industrial community. This is sad.

3662. Mr HEALEY: Dr Chung, what would be the approximate population from which you draw your patients?——W. Woodburn is my town and it has a population of probably between 300 and 500. Some patients come from Evans Head. Evans Head has a population of 1 005; it is a tourist town that gets an influx of people in the tourist season.

3663. Mr McGOWAN: Do you think that the use of the present penalties in respect of convictions for smoking marihuana discourages people?——W. I do not think that punitive measures against people who smoke marihuana discourages them from that practice. I am undecided about whether those laws are necessary to prevent the younger group being affected by the use of marihuana. I think that other measures could be taken instead of sending people to gaol and fining them. I think that alternative methods could be used to discourage people from smoking marihuana. (*Mrs Henderson*) It does not do any good at all; in fact it does a great deal of harm. Some people might have smoked marihuana only once and been caught. They might not have repeated that experience. It is the same with people who try alcoholic drinks once and do not have them any more. It is wrong to penalize people for smoking marihuana on one occasion only. I do not know what I think about marihuana. It is not necessary to put people in gaol and to fine them heavily; it might put them on to something else. It seeks to make them anti-social. The police are against it. We were lucky in our town because we got over it. We had an understanding policeman. We do not have the sort of resistance against the police that there has been in some places. (*Mrs Dwyer*) I do not think that the criminal law should be invoked to deal with marihuana users. I have read everything I can about marihuana. I think that it is non-addictive. Another thing is that there are double standards. You will do more harm than good by making criminals of marihuana smokers when people who use other drugs go unpunished.

3664. Mr JACKETT: Do you know of any cases where a person was sentenced to gaol after using marihuana for the first time?——W. (*Mrs Henderson*) No. The boy I spoke of was in gaol over things. He was on a bond over other charges. He had been in a home. He was caught with marihuana.

3665. You do not know of any case where people have gone to gaol for smoking marihuana for the first time?——W. No. I think some people were fined about $200.

(The witnesses withdrew.)

HARRY FREEMAN, Psychiatrist, residing at Crofton Road, Nimbin, affirmed and examined:

3666. CHAIRMAN: Have you received a summons under my hand in accordance with the Parliamentary Evidence Act?——W. Yes, I have.

3667. I understand you wish to give part of your evidence publicly and some of it in camera?——W. Yes.

3668. We will hear the public part of your evidence at this stage?——W. Thank you. Might I say that I am a private psychiatrist but that I do some consulting work for the Health Commission and I work also for the Health Commission at Richmond clinic on a part-time basis. I live on a farm in Nimbin. I have not got a lot to say but there are a couple of issues that I think are of particular interest. I am most concerned about prescribed drugs and about opiates and the way they are used. In my capacity as a psychiatrist I guess I see quite a few of the people who get into difficulties both with prescribed drugs and with opiates. My opinions about opiates are those that I gave to you before but I want to reaffirm that. I believe that opiates should be prescribable by any doctor. I do not think there is any way of dealing with the problem of addiction to opium or the opiates other than to make them readily available but only when prescribed by a doctor. I think in this way you can effectively bore most people out of using the opiates, provided you can reliably educate the doctors who prescribe them not to do so without ensuring that a lot of talking goes on between the doctor and the patient getting them. I believe that the use of opiates should be decriminalized as has been done in some countries. I cannot see that criminalizing the use of them is doing anything but increasing the likelihood that they will have people pushing to use more.

As far as prescribed drugs are concerned you will hear more about those from Rod Richardson later on. I agree with him that we now have in the community a climate, and I am referring to doctors, nurses and all sorts of people who are responsible, that is saying that good health is something that you can only get at the hands of experts and probably only experts who have access to drugs and technology. That is disastrous. Good health should be something we should all have access to by virtue of our own labours, beliefs and actions. The more we believe that good health can only be gained by regular access to professional people, drugs and high technology, the more we will have an uncontrollable juggernaut with regard to health through our delivery services. I believe that is a serious problem. I believe doctors overuse virtually all drugs. They are merely reflecting and reinforcing the attitude that health is a thing that you do not get merely by leading the right sort of life. So long as they do that we have a quarter that says the introduction of foreign substances into the body is OK. That is a problem. It is not really OK and we should not believe that. Those are the attitudes I want to present to you. So far as marihuana is concerned, later on I would like to talk about that.

3669. You say you live in Crofton Road, Nimbin. Is that on a farming property?——W. Yes.

3669A. Do you farm as well as pursue your medical activities?——W. Not really. It is a situation where a few families live. It is something of a commune, a non-nuclear living situation, and we share things.

3670. Do you not regard cannabis as an opiate, or do you?——W. No, it is not an opiate.

3671. I rather thought from a comment you made that you might have classified it with heroin?——W. No, not at all. I believe there is no question about whether marihuana should be decriminalized. I think the use of opiates should be decriminalized. I am not happy about the idea of legalizing it but it is a better alternative than decriminalization.

3672. What do you mean by decriminalization?——W. Not to make it an offence against the law.

3673. But that is not the meaning of decriminalization? ——W. Decriminalization has a number of meanings.

3674. You are talking about legalizing it?——W. Do you think so?

3675. To me that is what it sounds like, to say it is not an offence?——W. In that sense you would have to say that making love is legal in our community and in that sense I am talking about legalizing marihuana, yes, as I would feel that making love should be legalized.

3676. I do not see the comparison. If it is not an offence to prescribe a drug like heroin to my way of thinking it does not compare with decriminalization. The point I make is that something could be done which is an offence but it is not a criminal offence. Do you see any differentiation between the two meanings in regard to, say, heroin?—— W. Not really. I do not think that legislation about behaviour like the use of drugs is a way to alter the way of a community or govern its use of drugs.

3677. Do you classify all drugs as the same?——W. Yes. I do not think the use of the law is a way to deal with or change the way the community uses drugs. Indeed, I do not think legislation ever actually does do that. It is always a matter of interpretation and a certain group of people have a law used against them and another group of people largely do not. I do not think you can legislate about something as important as the community's attitude towards the use of drugs. The law is not that simple. The law usually follows the community's attitude rather than setting an attitude.

3678. So you say it is not only decriminalization of use of drugs but you want their use legalized?——W. How do you make something legal?

3679. Perhaps you take it out of the statutes?——W. You say really that you decriminalize something to make it legal.

3680. That is not my interpretation. However, the committee wants to get your ideas of what you mean and we want to ask you questions about your views?——W. My view is that so long as you try to have legislation about the use of drugs that will not really have any useful effect on the use of drugs and in certain circumstances it may lead to some drugs being used more than they are now. The use of opiates, if it were legal as it is in the United States compared to Great Britain where they did not make the use illegal but a person simply had to have a prescription from a doctor, there was an increased use of drugs in the United States compared with Great Britain.

3681. Have you studied the drug scene in the United Kingdom?——W. I have read a fair bit about it.

3682. Do they have a heroin problem?——W. Yes, but it is nothing like the problem where the drug is illegal.

3683. Do you think they have a problem with illegal heroin in England?——W. Of course they have a problem but it is nothing like the problem that there is in the United States where the drug is quite illegal.

3684. You would expect that if the use of heroin is legalized there would be no problem at all?——W. No. I think there would be less of a problem. I do not think there is no problem with alcohol because it is a legal drug. I think there is probably less of a problem than if we prohibited it. Prohibition with alcohol did not work and prohibition cannot work with drugs.

3685. Mr JACKETT: Do you believe that the community generally favours the legal use of drugs of all kinds including opiates? I ask the question because of a remark you made in the course of your testimony that the use of statutes and law should follow the community attitude?

——W. I did not say it should but I said it usually does. I think it usually does. In this regard I think you will find that most people in our community would not feel that opiates should be legalized. I do not think they would have a real understanding of the situation and in their ignorance I think they could possibly believe that the opiates should be legalized.

3686. Do you believe that the community generally would favour legalized use of the drug cannabis and the derivatives from it?——W. The community up here in the north would not. Fewer people would believe that it should be legalized than would believe otherwise.

3687. You said it is less of a problem in Great Britain where opiates are freely prescribable by a medical practitioner. Do you believe that there is less of a problem there than there is, say, in the United States or in Australia and is that the reason why the community should follow the course that has been adopted in England?——W. I cannot think of a better reason. I believe that strongly. If a particular approach to a problem has proven to be much more successful than another approach then certainly that is the approach one should tend towards.

3688. In spite of the fact that figures for opiate abuse are increasingly rapidly in Great Britain and it may well be that they can reach the proportions ultimately that have been reached in America?——W. But they have not reached those proportions.

3689. The process is not complete?——W. No, but they have not reached those proportions and the drug laws in Britain were framed early in the 1950's and more than a generation has gone by with those particular drug laws.

3690. I invite your attention to the fact that it is still too early to come to such a conclusion and make that the reason why we should adopt that kind of law?——W. I guess you then have to get on to the corollary of keeping the use of opiates as an illegal phenomenon. The corollary is something like the methadone programme and I am sure you have had the methadone programme done to death before you. To me, even the death rate of the methadone programme is not something that compares favourably with the death rate of people who continue to use opiates that they obtain on the street.

3691. Mrs DAVIS: Would you explain your attitude to the methadone programme?——W. I am not allowed to prescribe it. Only one person in any particular region is, so I do not use it. My attitude is simply that it is a fairly moral one more than anything else. I do not really believe that we should live our lives intoxicated. I do not think that is much good to them or to the community. It simply swaps one chronic intoxication for another and there is not enough to suggest that living on methadone for three or four years—which is what usually happens—that people who decide to do that really are any better than the people who may be continuing even to use the drug. In terms of the death rate, which is a terrible method to use, even in terms of morbidity, it seems that the methadone programme and its success is more related to the sort of people who use it and their keenness. I think that in any sort of institutionalized solution to a problem you get variations in its effectiveness that are more dependent on the sort of people using it.

3692. Mr WOTTON: If the use of opiates were no longer an offence, if its use were legalized, do you not, in the way you are putting it, remove the control of the use from the law to the medical profession?——W. Yes, you do. I said I did not think that a medical solution to a problem like opium addiction was a wonderful solution but I think it is better than a legal solution. Restricted availability of drug is just asking for it to become very illegal with pushing and all those sorts of things entering into it.

3693. In all practicality, that would be not realistic would it?——W. What?

3694. To place the control of the use of heroin in the hands of the medical profession?——W. Why not? Why could not you just suddenly——

3695. You only have to look at the way doctors are going on in Medibank.——W. You are saying that to hand it over to doctors would be fairly dangerous. There is a lot in that. In a recent survey of the medical profession it was found of the 100 surveyed there were 15 addicted to alcohol, 3 to other sorts of preparations and 1 to opiates. So, our record is not good with our own use of drugs. On the other hand I suspect that there is a small enough number of us for you to exert some sort of control over us whereas when it comes to making the police force or whatever it is, responsible, there are much greater numbers involved and there would be even less hope. Sure, there would be problems, but I think it would probably be the lesser of the two evils.

3696. Mr McGOWAN: You said that you are opposed to the methadone programme but would allow its free prescription by doctors.——W. Yes, the methadone as such varies with whoever prescribes it. What I am really saying is that the methadone programme, if it were a regular programme, could not possibly work. The people would not be using it properly—the addicts—and the people would not be dispensing it properly. You have to take a chance on the medical profession when it comes to opiates. I agree that it is a big chance but the methadone programme, I think, would be less of a solution than taking that chance with doctors.

3697. Earlier you said that doctors are over prescribing drugs—virtually all drugs.——W. Yes.

3698. In other words, you would expect methadone to be over prescribed?——W. Yes.

3699. And heroin to be over prescribed?——W. Yes, I sure would.

3700. Do you maintain that heroin should be freely available in the supermarkets?——W. No.

3701. You only want it available from doctors?——W. Yes. I am talking about a solution of desperation. I do not like medicalizing the problem but I do not see a better solution.

3702. You are using the term medicalizing rather than freely available?——W. Yes.

3703. CHAIRMAN: It has been put to the committee by more than one person that one of the features of methadone is, with all its drawbacks, it at least sends people back into the community, whereas a person on heroin rarely is in a physical or mental condition to work but many people on methadone treatment can perform normal functions. What is your reaction to that statement? ——W. I know that some people who administer the methadone programme say that but as you will know also, many people who administer the methadone programme would say they have not found that terribly often. I want to look at it in a more overall sort of view. I do not think that the methadone programme is going to solve the problem of a community taking too many drugs. I really feel that a Parliamentary inquiry should be—and I am sure you are—looking at how to get people not to take drugs, not how to simply cure the problem because all the cures are going to be second rate and,

in many ways, desperate sorts of things. I think that the methadone programme is a desperate solution to drug addiction in an area like this with massive unemployment and a large group of poor people bearing the brunt of the tightening-our-belts policy. I think that methadone could not possibly alter the quality of life of any of the people using drugs. In other words they would be unemployed before and unemployed once they got on to methadone.

3704. Let us take it away from the local scene and discuss it in general terms. Supposing it was an area where there was full employment and you did not have the question of unemployment to consider: Do you think methadone in those circumstances would be able to play the part that has been suggested to us?——W. It would get those people who use drugs—maybe—into the community for a few years. I do not think it would alter the increase in the use of drugs in any way.

3705. Drugs is a general term.——W. Yes, but it would not alter the gradual increase of use of opiates either. It has never been shown to do that. I guess I am more interested in trying to alter the over use of drugs. On medicalizing it initially you will get an upward curve, just as the national health scheme was overused initially. I feel that after it settles in, that is, the medicalizing process, that should eventually result in a diminution in the use of the drug.

3706. You have already indicated that you feel a big percentage of doctors are not properly educated to deal with the problems at the present time?——W. Yes.

3707. Have you any positive statement to make in regard to methods that could be recommended to overcome those deficiencies?——W. I feel that it is in the nature of the training that we receive at university, that our attitudes are so disastrously moulded. I think that a sort of on-going education, an in-service training, is not good enough. We are trained at university towards high technology medicine and the use of drugs and towards really accepting the idea that only we know how to keep people healthy and they do not. As long as we are trained in that sort of way I think we will have fairly disastrous results. The medical education of doctors has to change in universities, I think.

3708. Abuse of the harder type drugs has only been a more recent phenomenon—in large quantities—so that there are many doctors in the community who would not have had the opportunity to receive that education at university that perhaps we would expect from a doctor coming out at the present time. How do we overcome that deficiency?——W. Again, I suppose some sort of adequate peer review by the doctors and on-going in-service training would just about be the only way. Dotcors are pretty elitist and do not like being told what to do by anybody except other doctors. We would have to try to institute in some way a much more effective peer review system with respect to prescribing habits.

3709. How would you do that?——W. I suppose that I would be hoping that the A.M.A. would be starting to look towards setting up that sort of thing in the profession rather than wait for it to be imposed from the outside—I think they are—I think they will—they will have to.

3710. With the patients you have to deal with, roughly what percentage come to you because of some abuse of drugs?——W. I have had a look at the situation in this community and, if we do not count alcohol, it is responsible for——

3711. Leave out alcohol and tobacco?——W. Yes—probably—it looks as if it is about 10 per cent of the people I see are over-using some drugs.

3712. Of that 10 per cent, what percentage would attribute their illness to some form of analgesics?——W. The vast majority, to that or an hypnotic or sedative or something like that. The vast majority of 10 per cent are women who are either using hypnotics, sedatives or analgesics.

3713. Many of those cases are due to over-prescription by doctors?——W. The vast majority of cases.

3714. Have you had many cases in this area where people have gone from one doctor to another to build up their stock?——W. All those patients I have just talked about have to use more than one doctor to get their supply.

3715. Have you recommended to the doctors concerned that there should be some sort of consultation to overcome this problem?——W. I usually do.

3716. Has that been effective?——W. In individual cases, yes. It could be effective.

3717. CHAIRMAN: As I indicated earlier, Dr Freeman wishes to give some of his evidence in camera.

(*The public gallery was cleared while Dr Freeman gave evidence in camera.*)

ROBERT STEWART RICHARDSON, Medical Practitioner, of 147 Musgrave Street, Coolangatta; and

PATRICIA HEAD, of 6 Lemana Lane, Burleigh Heads, Director of the Gold Coast Drug Council, on affirmation:

3718. CHAIRMAN: Have you each received from me a summons issued under my hand in accordance with the Parliamentary Evidence Act?——(*Both witnesses*) Yes.

3719. Doctor, do you wish to give a written submission to the committee or a verbal one?——W. (*Dr Richardson*) There is a bit of both. I have a written submission which I shall give to you.

3720. Do you wish to have it incorporated in your evidence?——W. Yes. It reads:

## SUBMISSION OF GOLD COAST DRUG COUNCIL

### INTRODUCTION

Our Gold Coast Drug Council has been operating for five years, and we began with three calls per week; we now have grown to receiving 2 000 calls per year; this does not include our follow up calls and personal contact with clients. We are involved with all age groups, the youngest being a girl of eight years and the eldest was aged seventy-five. With most of our drug problems there are underlying social problems which have led to the drug situation. We cannot help anyone who does not want to help themselves, i.e. the initial call or contact has to firstly come from the client. Our Centre is mainly a referral one, and the services we offer include:

A 24 hour service, volunteers are on duty from 9 a.m. to 10 p.m., seven days per week. After 10 p.m. we have a telephone answering service operating.

Counselling by phone or person to person.

Information on any drugs, legal or illegal.

Referral. We are able is necessary, to refer a client to a professional in whatever field is required.

Legal—we can help to arrange legal representation.

We are a crisis centre in the case of *overdose* and *emergency transport to hospital,* etc.

We can arrange *accommodation in time of crisis* (not as the centre).

We have an *extensive education programme* in which we give lectures and have discussion groups to schools, service clubs and community groups. We can show relevant slides and photographs.

Our organization includes the facilities of the Centre as a central contact with medical facilities available through several doctors on the coast, mainly with Dr Richardson's surgery at Coolangatta. *The Tweed Heads Hospital have facilities for a detoxification unit.* We have a house at Mt Tamborine in the Gold Coast Hinterland, which will be operating in the very near future. We will have young people stay there for a short period of time where they can be psychologically withdrawn from their drug, or to re-organize their minds and bodies, to learn of an alternative style of life to which they have been accustomed.

We hope to make our house self-sufficient with vegetables and herb growing, certain farm animals, a craft shop, etc. We also have a second hand goods shop at Coolangatta, proceeds of which help in the running of the Centre. Combined with donations and fund raising, these are our sole means of support.

We are currently working on a scheme of short term education on various suitable occupations for young people such as sewing, gardening, hotel work and furniture making. Our main aim is to give these young people some training in relative work, enabling them to obtain employment or to make themselves self sufficient. There is practically no work available here on the Gold Coast for young people so the unemployment is very high, and for the school leaver this situation is intolerable. Within a year this person becomes depressed, bored and disillusioned, and subsequently develops a negative attitude.

We receive referrals from most organizations on the Coast, Life-Line, hospitals, doctors and police department. We find there is a very real need for advice and referral of young people in the areas of V.D. and many other social problems.

All discussions and information is strictly confidential, and we are not in any way connected with the Police Department. Anyone who comes to the Centre may feel assured that their confidence will be respected.

We try to keep the Centre as informal and on an individual basis as we can, as many of our clients (especially young people) tend to shy away from any institutional body. Each person is an individual and deserves to be treated this way.

## GENERAL INFORMATION RELATING TO THE GOLD COAST

70 per cent of children under three years take some form of drug, e.g. teething syrup.

40–60 per cent of the 16–25 years age group have used illegal drugs.

98 per cent of all adults use some form of drug through choice or as prescribed by their doctor, e.g. coffee, alcohol, cigarettes and valium.

Five out of six children will be offered some sort of illegal drug by the time they are 15 years old.

It should be noted that drug abusers are not necessarily immature, irresponsible, rebellious or alienated. Nor are they necessarily young people.

Drug use is part of the present human existence whether we like it or not, and a greater understanding of this problem is needed.

Once a person has been convicted of an offence involving drugs in Queensland, he/she has a criminal record and there is a number of serious consequences, i.e., cannot join the public service, cannot obtain a visa to certain overseas countries and can be excluded from certain professions.

In the state of Queensland, the penalty of a convicted dealer or pusher is $100,000 or life imprisonment (25 years jail).

There are drugs in all high schools on the Coast.

There would be 600 heroin users here, mostly social users, and 100–200 addicts. The youngest girl we have treated for addiction was 13 years.

20 per cent of 16–26 age group have used mushrooms.

There have been 4–6 deaths over the past twelve months due to narcotic overdose. This would be a conservative estimate.

The most commonly used legal drugs are alcohol, cigarettes and coffee.

Marihuana is the most commonly used illegal drug.

We believe that there should be no distinction between legal and illegal drugs, that is, the Commission's terms of reference, the exclusion of cigarettes and alcohol is a mistake. The reasons why a young person starts to use alcohol, cigarettes and illegal drugs are the same. The major reasons being: curiosity, boredom, peer group pressure, and pleasure—governed by the fact of availability. The everyday use of alcohol is more widespread and a more serious problem than the occasional use of the illegal drugs such as marihuana. Young people will not accept the hypocrisy of double standards.

## (A)—THE DRUGS

The drugs that have been considered by the commission are all used by young people for the reasons outlined above. One year ago a particular type of person would use narcotics because they were used only by injection. Now the most common form of use is by inhaling heroin powder (snorting and sniffing), and ordinary everyday teenagers who are psychologically healthy are using narcotics in this way. Various psychological reasons for the use of narcotics have been put forward. These include depression, inadequacy, personality problems, nihilism, etc. and although these factors may still apply to the intravenous use of narcotics, it is important to realize that they do not necessary apply to nasal use or to the use of their illegal or often medical drug use. There are some exceptions to this now. Barbiturates, volitile substances and analgesics tend to have more associated psychological pathology. The sedatives are used by young people for the reasons in (A) above. However, they are more associated with patterns of abuse rather than ordinary drug use.

We will distinguish between drug use and abuse later. The use of volatile substances is almost always associated with the age group under 14 years, and we have found that there is a great deal of personality disturbances in these people and their prognosis is not good. In the middle-aged groups there is gross abuse of the sedatives and analgesics, the basic psychological pathology behind this is reactive depression, probably in the category of substances of dependence. The Commission should also include such drugs as tea and coffee and a whole range of others that are not usually considered. We have patients who are dependant on nose drops, asthma drugs and even anti-arthritic drugs such as Indocid.

The chemical properties of all the drugs should be examined by the Commission for some common properties, they must:

(a) alleviate boredom;

(b) provide pleasure and euphoria.

If you exclude the factors of curiosity and peer group pressure as being the initial introducing factors, then the reason why people continue to use drugs in non-medical senses are "because they make you feel good" and that is the reason why people start their day with a cup of coffee and a Bex, Valium tablet, a cigarette, a marihuana joint or a snort of heroin. We have to then consider the drugs that have the most euphoric effect, namely the narcotics. A person who is more depressed or bored and inadequate is particularly at risk to a continued dependence on those drugs. It is only because of peer group acceptance that middle-aged housewives are using Valium instead of heroin, coupled with the factor of availability.

## (B) MEDICAL AND NON-MEDICAL USE

It would have been better to discuss the use and abuse of drugs rather than medical and non-medical use. We think that it is very important to distinguish between the use of alcohol, marihuana, narcotics, tranquilizers, the amphetamines, the volatile substances and hallucinogens, which normal healthy people use. Again we list the reasons: Boredom, peer group pressure, curiosity, for pleasure, and the abuse of these substances wherein the psychological pathology lies.

We must define drug abuse as being where a person cannot function in society without a level of the particular drug in his or her system, or where a person uses a particular drug to the point of complete intoxification. He who cannot function without a cup of coffee is a drug abuser, and he who has the marihuana cigarette after dinner for pleasure is not a drug user. It may well be that the use of alcohol has some beneficial effects, but in the same way, the use of marihuana or even coffee may have some beneficial effects in terms of acceptable relaxation and enjoyment.

It seems that those people who introduce others to drugs more than any other group—namely doctors and chemists, have the least knowledge about what they are doing in terms of creating drug dependence.

## (C) DEPENDENCE

We have discussed our definitions of drug abuse which is also a concept of dependency. Dependence is a characteristic of the user and the situation in which the drugs are used. There is a deal of dependence in the addictive drugs, basically addiction as a characteristic of the drug.

(D) EFFECTS OF THE USE OF DRUGS

In discussing the Hallucinogens which include marihuana, the drugs distort time and space, heighten all the senses (sight, touch, taste, feel and smell), and deepen the mood that the person is in at the particular time. That is, if someone is happy they become happier and if depressed they become more depressed. They increase sexual pleasure but decrease sexual desire. These are the short term effects of intoxication. The long term effects of heavy use involve a flat effect, a motivation, impaired ability to form relationships and inability to concentrate. These effects may be termed "being spaced out". In acute intoxication of hallucinogens, the user is strongly affected by the environment and the moods of the people he/she is with. The user of marihuana affects the performance of the individual in a very minor way. Some people work harder and more conscientiously and others become inefficient and unproductive. In intoxication of L.S.D. or Magic Mushrooms the person's work performance is impaired. The Hallucinogens do not affect the person's estimate of his/her ability to perform tasks, however, narcotic intoxication strongly raises the user's estimate of his tasks. We think the user of Hallucinogenic drugs does assist the user to expand his consciousness or understanding. There is no doubt that an L.S.D. trip is an extraordinary experience and it may be said that these experiences do help the individual to understand themselves better. An average group of four people would smoke 3–4 marihuana cigarettes between them to maintain a pleasant high over an evening. Generalizations are very hard to make, as individuals react differently to all "mind altering" drugs and this factor is compounded by the environment, the attitudes of the other people and to a certain extent, the length and nature of the previous users experience. Most people claim that the first 3–4 times they have used marihuana it has no effect at all. It can be said that the use of drugs in general is harmful both to the community as well as the individual, as they do impair the performance and heavy use of any intoxicating substance must act as a poison. There are degrees of harm for example—moderate use of marihuana may be compared to the moderate use of alcohol in terms of harm to the individual. However, the moderate use of alcohol creates greater harm to society than the moderate use of marihuana. On the other hand (and in the same context), use of marihuana is about as harmful to the community as the use of cigarettes —that is, not much. However, the moderate use of cigarettes appears to be more harmful to the individual.

It is possible to measure the harm caused by the use of the legal drugs such as alcohol, cigarettes or aspirin, but not the use of the illegal ones. We feel sure there are some beneficial effects to society in the moderate use of marihuana. In terms of relaxation and decreased aggression marihuana is basically a non-aggressive drug and appears to be related to less crime and family destruction than alcohol. We always compare these two drugs, as they are used socially in the same way for relaxation, pleasure and "letting your hair down". Most of the harmful effects of the Hallucinogenic drugs are associated with the legal consequences and it may be said that the worst thing about the use of marihuana and, to a certain extent, Magic Mushrooms and L.S.D. is getting "busted". We have never seen any permanent damage to the individual or to society from the occasional use of L.S.D. or Magic Mushrooms or the moderate use of marihuana. We class the mild use of marihuana as 3–4 joints a week, moderate use 2–3 joints a day and heavy use greater than 5–10 joints a day.

(E) EXTENT AND CAUSES OF USE OF DRUGS

It is our experience on the Gold Coast that up to 40 per cent of people aged between 16 and 25 use marihuana, and up to 15–20 per cent use other Hallucinogens. The use of marihuana has increased steadily over the past ten years to the point where it now must be regarded psychiatrically as a normal part of adolescent behaviour in the same sense as experimentation with alcohol, cigarettes and sexuality. The abuse or heavy use of marihuana may still be associated with psychological problems such as inadequacy, depression or anxiety.

The factors that have lead to the increase in the use of marihuana are:

(1) Increasing leisure.
(2) Increase in availability.
(3) Increase in curiosity.
(4) The increasing pleasure-seeking society.
(5) The other factor of peer group pressure is still the same (all-age groups).

However, once you reach a certain percentage of people using a drug such as marihuana, peer group pressure becomes an expending rather than a limiting force to marihuana use. It is now of grave concern that the increasing use of heroin by sniffing is leading to a peer group six that has become highly encouraging to other young people to use the drug. The biggest problem in terms of the treatment of drug abuse is the multi-drug user. A person who has the personality to abuse drugs is capable of switching fairly rapidly from alcohol to barbiturates to marihuana, etc. The most important factors influencing the person to commence the use of the drug are: Curiosity, boredom, pleasure and peer group pressure.

It is so important to remember that these are the factors that start people using drugs, the other factor is the availability of the drug. Availability of drugs is unimportant as most illegal drugs are freely available. The cost is not very important nor is the legality or risk of prosecution. Advertising or social pressure may be regarded as peer group pressure and therefore it is important. The need to obtain relief from tension or personal problems is more likely to lead to drug abuse—these are unimportant factors, and obviously the desire to experience pleasurable effects of drugs is the most important single fact of drug use. Once again, that must be distinguished from drug abuse. It appears to us that there is no evidence that the use of marihuana contributes to the use of the other drugs. The role of the mass media is very important for two reasons: (1) Publicity encourages curiosity; and (2) when young people's heroes are arrested on drug charges there is a type of peer group pressure applied for them to use a drug.

Although we are not familiar with the patterns of drug use in your State, it is our opinion that the use of marihuana on the gold coast will continue to escalate. The use of the other hallucinogens such as LSD or magic mushrooms will continue to escalate but to a lesser degree and the use of narcotics is going to increase out of proportion to the other drugs. The use of alcohol and tranquillizers will stabilize and the use of cigarettes will decrease.

(F) THE USERS

Drug users cannot be distinguished from the general population by age (there are different age groups for definate drugs), sex, occupation, employment status, level of education, marital status, family background, contact with the law, relationships with other persons, previous drug use or knowledge of the effects of drugs. The only other factor of some importance is contact with other drug users. It is inaccurate to say that users of drugs suffer from personality disorders or social maladjustment no more than to say that people who engage in sex suffer from personality disorders or social madadjustment. The use of drugs is immaterial to these things, however it is accurate to say that abusers of drugs suffer from the above conditions. Most of the young people that we see regard the law to be wrong, police to be enemies, treatment institutions to be too authoritarian or "wowserish" (rightly or wrongly) and the rest of the community to be hypocritical. There is little evidence that the illegal use of drugs is associated with other forms of illegal behaviour (excluding of course the selling of the illegal drugs). Heroin is an exception to this because of its expenses and therefore it is associated with burglaries, prostitution, etc.

(G) SOURCES AND DISTRIBUTION OF DRUGS

We are unable to comment on the distribution of drugs in your State. However, it is extremely easy and profitable to import drugs into Australia. An 18 year old need only spend $1,000 ($500 air fare, $500 for Buddha sticks from Bangkok) bring back 10 000 Buddha sticks worth $100,000 on the market. He has approximately a one in ten chance of being caught. It is so easy to illegally smuggle, that there is little if any need for organized criminal networks.

(H) ENFORCEMENT OF THE LAW

The rate of success of the authorities in detecting and prosecuting drug users is so small as to be irrelevant. The only area of some success would be in the import of such drugs. The main difficulties being that the peer group regards the laws as being wrong and the local drug pusher is likely to be regarded by the young people as a friend. There is no field of law where the techniques of law enforcement agencies invade civil liberties or practises discriminatory enforcement more than the drug laws. Respectable people use illegal drugs but they are never caught. The average picture of a marihuana smoker or an LSD user or a heroin user is a "dropout", a "hippie" or a "drifter", and this is totally false. There is a strong need for restricting the powers available to the authorities in drug law enforcement. There should be no discretion available to the police as to whom they should prosecute. It can be argued that convictions are too easily obtained and that lawyers should be available to young people and interviews should be tape recorded, as rumours of planting of evidence are too strong to be ignored. The courts are too harsh with their penalties.

(I) SOCIAL RESPONSES TO DRUG USE

The appropriate response of the community should be that all drugs are bad. However, people should be aware of the facts about drugs and if they are going to use them, they should use the safest, take reasonable precautions of health, use them in moderation. The use of drugs both legal and illegal should be considered as a medic and social matter and the importation and sale a legal matter. The only factor by which we can contain illegal drug use is availability.

(J) GOVERNMENT POLICY

The Government should not seek to regulate the individual's behaviour when that behaviour, although perhaps harmful to him, is not harmful to others. If the regulation of the use of drugs is desirable, the emphasis should be on education to sensible drug use, the treatment of those with problems, and the imposition of criminal sanctions on the producers and distributors. The use of cannabis should be legalized but not the production and sale, and the use of narcotics should be decriminalized but not the production and sale.

It is not possible or useful to formulate a Government policy on drug use specifically excluding alcohol and tobacco.

(K) PUBLIC EDUCATION AND INFORMATION

Information should be made readily available to all people relating to the use of drugs, through schools and all media outlets. There are dangers in making this information available as they increase curiosity, however, while we have people who are curious, bored, pleasure seeking and susceptible to peer group pressure, they are going to use drugs and all we can do is to minimize the destructive effects.

Our summary will include what we think can be done to help the situation.

(L) TREATMENT

A person who abuses drugs, is 'sick' (inappropriate word) when they are unable to function without the drug or if it is affecting their everyday relationships and performance. The person himself should be responsible for identifying that problem, or his immediate family or friends, and a drug user (generally speaking) should be the one to desire help and/or treatment. An existing treatment practice that should be discouraged is the one of compulsory treatment. The voluntary way is the only form of treatment likely to be effective. Compulsory treatment can only be justified as a means of keeping people out of gaol.

When a person uses heroin he mostly supports his use by obtaining more than his own immediate use, sells the rest to support his habit, i.e., each person who uses, increases or introduces others at the same time. Heroin is contagious social behaviour.

SUMMARY

To summarize, we think it is essential that tea, coffee, cigarettes and alcohol should be included in this Commission. That by recognizing that alcohol is one of society's greatest problems today. That we are a dependent society and that in first recognizing this, to seriously try to put it in its right perspective and make genuine efforts to help.

Undermentioned are some of the things that can be done to help:

(a) Ban the advertising of all drugs from slimming pills to aspirin and alcohol. *There should be no "legal taking of drugs".*

(b) Accept that all young people are going to be exposed to illegal drugs, and most will experiment. Young people should be taught that all drugs are dangerous, but that some are worse than others, and that some are beneficial.

(c) Institute a drug education programme in schools based on honesty, understanding of the situation, and knowing all the facts.

(d) Introduction of programmes on human relationships and intercommunication should be essential in all schools.

(e) Get doctors to stop over-prescribing drugs. About 50 per cent of those prescribed are unnecessary and doctors must take a big part in the responsibility of the drug problem.

(f) Make adults take a close look at their own drug habits:

Alcohol.
Tea and coffee.
Aspirin.
Cigarettes.
Sleeping tablets.

Nobody has the right to moralize any one else's habit if they have one themselves, i.e., double standards.

(g) *Encourage people who have a drug problem to seek help.* There are many people with this problem who are frightened to go for help for fear of being discriminated against or frightened of police involvement. Treatment of an alcoholic is accepted, but the treatment of a drug addict is rejected by most people. This is tragic.

(h) Young children are idealists, and given a cause, they will fight for it—there are so many things that need fighting for. There should be so many important things to do that drug taking will appear a waste of time. Remember, one of the causes of drug abuse is boredom. Our society crushes the idealist spirit of the young, which could have so much to offer.

(i) News about drugs, arrests, etc., should be reported as little as possible in the media.

In conclusion, everyone is an individual, and each has the same right to be a person, and to make their own decisions as the next person. Do we have the right to discriminate?

WITNESS: There are some comments to be made on it and on what Dr Harry Freeman said when he said that I would follow on with some of the things that he said. First, to go through the terms of reference, I cannot answer any question on the first part, to review and to report on the available information. As regards the second part, to examine trends, we might go through the drugs individually. The first would be marihuana. It is fairly obvious that in the last few years there has been an increase in the use of marihuana. I would estimate in the 16 to 26 year age group in this area up to 40 per cent of people would have tried it. The only school that is really involved in New South Wales which is part of the Gold Coast would be the Tweed River High. As in all other Gold Coast schools, marihuana, LSD and magic mushrooms—the gold top mushrooms—are freely available in that school. Murwillumbah does not quite fit into this sort of geographical area but there are also drugs available in those schools. The main thing is that the use of marihuana has become so prevalent that I think the old reasons for its use such as inadequacy, broken homes and those sorts of things no longer apply. With young people the use of such drugs as magic mushrooms or marihuana must be looked at as being almost normal adolescent behaviour, in the same way as experimentation with alcohol, cigarettes and sexuality. I do not think if a kid or a young person under 26 or 30 is smoking marihuana that it is an indication of anything psychologically abnormal about that person.

The use of LSD has declined over the last few years. There are a number of reasons for that. One is that there has been quite a lot of publicity about the possible damaging effects of LSD. But in this area in particular the main factor is the increasing use of magic mushrooms which produce the same sort of effect but which are free and are regarded as being less dangerous perhaps because they are supposedly more natural than LSD, which is synthetic. The only thing which is of concern is heroin. There has been a fairly massive increase in the use of heroin in the Gold Coast area in the last few years. The most disturbing feature is the trend towards sniffing or snorting heroin, which is inhaling it. Years ago there was a certain psychology in the people injecting themselves because it requires a certain psychology to inject yourself with any substance. But now that people are inhaling heroin, once again it is a group of young people who are psychologically normal, who are experimenting with heroin. It is just as addictive by snorting it. After a while when you damage the inside of the nose you tend to have to turn to injections because you no longer absorb it through the nose or lungs. With the increase in snorting, with the younger kids, those 15 or 16 years of age, it seems to me that there will be an increase in the next year or so of injecting heroin as well.

As I said, the reason it worries me is that normal healthy teenagers who are not disturbed are using it.

There is an increase in the use of cocaine as well. It is not very great at this stage. I am quite sure it will become one of the fashionable drugs in the next few years. It is regarded as being highly desirable among drug users. One has to look at why this is happening; why the use of marihuana, magic mushrooms, heroin and cocaine has increased. You look at the reasons why people start to use these drugs anyway. There are about four reasons: curiosity, boredom, it is a pleasure and it is peer group pressures. The most strongest factor would be pleasure. Most people use these drugs because they make you feel good. Curiosity is a factor because there has been much more publicity over the past few years. Possibly boredom is the result of increased unemployment. People are still pleasure-seeking. When you have a small number of drug users the peer group pressure tends to be against drug use, but if you get a reservoir of drug users at a certain level then the peer group pressures tend to encourage further drug use among the group. Peer group pressure is certainly towards using marihuana. At this stage that pressure is probably against using heroin, but because we are building up such a reservoir of heroin users it concerns me a little that the reservoir of peer group pressure may actually exert an influence to use heroin among the general school population or young population. The only other factor is availability, and that is the only area where the law can hope to be involved.

There is no way you can legislate against curiosity, boredom, pleasure or peer group. All these drugs are pretty freely available, including heroin. Admittedly heroin is not available at certain times when there has been a big attack on heroin and morphine or its supply. But basically it is freely available to those people who want it. Certainly all the other drugs are quite freely available—there is no question of their availability. The only one with limited availability is cocaine.

The second part is section 3 of the terms of reference, the adequacy of the control of manufacture and distribution of drugs. I think there is just no control really for the distribution of illegal drugs. It does not exist. As regards the adequacy and appropriateness of penalties, there is no field of law where it is used in a less-wise fashion than with the enforcement of the drug laws. There is selective enforcement. I believe the penalties for the crime are outrageously high and cannot be justified under any circumstances at their present level. To a certain extent, as Dr Freeman said, the law as it stands tends to worsen a drug problem, and in some cases it actually increases drug use.

As regards general education, I would just go off illegal drugs for a minute. I agree with Harry Freeman that the legal prescription drugs are a far more serious problem. I think the doctors are to blame for the over-prescription of legal drugs. I would go further than Harry Freeman when he said that something like 10 per cent of his patients, he thought, were over-using legal drugs. From what I have seen in my practice—I hope that it does not continue after I have seen them as patients—up to 70 per cent of people are unnecessarily using prescription drugs. I regard that as a major factor in medical and social illness in our community. It is extremely dangerous the way the doctors over-prescribe most drugs. Almost every drug you care to name is over-prescribed. Certainly in the local area there is gross over-prescription of the opiates such as pethedine and morphine. We certainly have a reservoir of legally created heroin or narcotic addicts.

I would also support as a positive measure, not because I think the use of marihuana or any other drug is good for you—I think it is bad for you—the legalization of marihuana and certainly the decriminalization of other drugs such as the non-narcotics or heroin. The use of magic mushrooms or gold tops is an interesting point in question. A few years ago magic mushrooms were not illegal. They were used hardly at all. Then we had a few cases of people who were taken to hospital because of the bad effects from hallucinations. There was a great deal of publicity. It was made an offence the same as all the other drug laws. Since that time there has been a massive increase in the use of magic mushrooms. The situation would be much better handled if nothing were done at all. I would agree also with Dr Freeman that you cannot legislate against this sort of social behaviour.

The next point is the methadone programme. That programme as it stands is a fairly complete disaster. It is far more difficult to get on to a methadone programme and to stay on one than it is to remain a heroin addict in the street. I think this is absolutely crazy. One has to look at what is the aim of the methadone programme. If you aim to stop the selling of heroin it does not work because it is so hard to get on the programme and stay on it. It is easier to remain an addict and therefore to be dealing with heroin. You may say that it is to stop crime associated with heroin use. It does not do that. Rehabilitation is of limited effectiveness. In some cases it may allow people to work. I think the main thing wrong with the methadone programme is the way it is administered. It is not a very effective method for handling any of the four problems that I have mentioned and that it is supposed to be designed to do. Some things can be done. It is also a mistake for the inquiry not to include drugs such as alcohol and cigarettes.

3721. CHAIRMAN: If I may interrupt you, the committee did not draw up the terms of reference.——W. I bring that in in the summary of what might be able to be done. Some of the things you can do, as lawmakers if you like, is to ban the advertising of all drugs from slimming pills to aspirin to any other kind of drug, and to accept that all young people are going to be exposed to illegal drugs, or at least 90 per cent of them, and probably most of them will experiment with the illegal drugs. They should be taught that all drugs are dangerous, that some are worse than others, and if you are going to use even the illegal drugs you should use the least harmful and take all necessary precautions to minimize the damage you could do to yourself. That can be an education programme sort of thing.

Also, there should be drug education programmes in schools based on the philosophy of all drugs are bad, but the facts must be given accurately. If you accept that they will experiment they must use them in a sensible way. Somehow doctors must be stopped from over-prescribing. I do not know how to do that. Perhaps it should be part of the education in medical schools. There is such an enormous problem in legal drugs that it dwarfs the problem with illegal drugs. The over-prescribing of legal drugs is a medical problem and the other problem is a social problem. Part of the reason why I think marihuana should be legalized and drugs such as opiates decriminalized is that when people require treatment and help they are more willing to seek it than if they know they are likely to have a criminal record if they are caught for what they are doing. The treatment of alcoholics is accepted. I think the treatment of a heroin addict should not be regarded as any different to that. Another effect is something that the parliamentary committee can do nothing about, and that is the curiosity and the role of the media in encouraging curiosity. That is very strong indeed. If we had not had all the publicity about illegal drugs the incidence of their use would be much less. That is one of the biggest factors in inducing drug use.

3722. Thank you, Dr Richardson. Mrs Head, have you anything to say?——W. I think Rob has said it all. I think what should be introduced in all schools to help is a programme in human relationship and inter-communication. I think that is the side of life that has been sadly neglected. The rest of it has been covered. I agree with everything that Rob has said.

3723. I notice that you, doctor, are from Coolangatta and Mrs Head is from Tweed Heads. Do you both belong to the Gold Coast drug council?——W. Yes.

3724. What area is covered by that council and what is the main centre of population in the area?——W. The Gold Coast drug council does not even get underneath the shell of the drug problem on the Gold Coast. It gets only a few of the people, the ones who come to it, and the problem is much more widespread than that. The council operates from Murwillumbah, Nimbin through to Brisbane, and it has had calls from Gladstone and Darwin.

3725. How is the council composed?——W. It is entirely voluntary workers, about thirty, doing shifts of five hours each. It offers a 24-hour service. Someone mans the centre from 9 in the morning until 10 at night and there is a phone-answering service after that. We give information on drugs legal or illegal and we give counselling either by telephone or person to person. We give referrals where necessary to any professional in whatever field is required. We can arrange for legal advice. We have hospital services at Tweed Head hospital. We are a crisis centre in case of overdose and we have emergency transport to hospitals. We can arrange accommodation in emergencies but not at the centre. We have an extensive education programme in which we can give lectures and arrange discussion groups to schools, service clubs and community groups. We can also do group therapy among young people. Those are the main things we do.

3726. Doctor, can you tell us whether there are any differences between the regulations for the use of methadone in Queensland as compared with New South Wales? ——W. I do not use the methadone programme in New South Wales at all. We have some at the Tweed Heads hospital but I am not completely familiar with the way it is administered from Sydney. There is only one doctor in this area who can use methadone. From what I have heard from drug addicts and Dr Freeman, who does not use methadone, it is probably as difficult to get methadone in New South Wales as in Queensland. In Queensland the situation is that if you have a patient whom you think needs methadone I must refer him to Dr Bentley, a psychiatrist at Southport. He assesses him and does an eight-page questionnaire with him and he must fill it in with him, and an identity card is produced showing all his scars and nicknames and a photograph. He telephones Brisbane for approval for the use of methadone. They give him verbal approval and he rings me to give me verbal approval to dispense it and he rings the pharmacist to give him approval to give it to me. Finally all the paper work is done and we all have it in writing as to who prescribed it and who dispensed it and I pick up the methadone twice a week for each patient I have on the methadone programme. It is an incredibly complicated long drawn-out procedure and it is easier for a drug addict to stay on heroin.

3727. How often do you provide methadone to a patient?——W. Every day in a therapy form. There is a problem with those from New South Wales who come to us in Queensland. We see a lot of people from New South Wales. In those cases we send them to Richmond clinic for in-patient work or to Dr Petroff for the methadone maintenance and he can refer them back here and have their methadone picked up from Queensland hospital. It is a totally inadequate situation because there is no follow-up counselling. Those living in New South Wales we are going to register in Queensland mainly because that is where my practice is and there is no-one else in this area to do it.

3728. What precautions do you take to see that someone is not obtaining methadone in New South Wales and in Queensland at the same time?——W. All of the people on the methadone programme go through the central office in Brisbane with identity cards and so on. The drug dependency unit is in liaison with the drug dependency unit in Sydney and they would have the same type of files. It does not particularly concern me that they are doing this. I do not see it as a major problem if they get it from two different places daily. I think that is irrelevant to the problem. But it does not happen because of the liaison procedure.

3729. If they were supplied with doses on Friday to keep them going until Monday would that make a difference?——W. In a solution form?

3730. Yes, and they gave it to their friends and did not use it themselves?——W. I do not see that as a problem. I am sure it does happen but I do not see it as a real problem.

3731. What would be the situation if someone presented themselves at the drug centre obviously in need of medical attention? What is the procedure in regard to heroin overdoses?——W. Not an addict but an overdose?

3732. Perhaps an addict who has had too much heroin and is about to go through withdrawal?——W. (*Mrs Head*) First we would transport him to the surgery to have him assessed by Dr Richardson. Then we would follow on his advise as to what was necessary to be done from there. If he has taken an overdose he would need emergency help. Depending on how he was it would be straight to the hospital and he would be dealt with from there.

3733. By the medical staff at the hospital?——W. Yes, we do not attempt to treat anybody with an overdose at the centre. They are always taken to the surgery or to the hospital at Tweed Heads.

3734. You are quite confident that once people come to you there are resources you have available and from those resources the patient would get all the attention that was required?——W. Yes. (*Dr Richardson*) That does not mean that it would do them any good but they do get the attention.

3735. You mentioned that you would ban all advertising and so on. Has your practice brought you in contact with people who have suffered obviously from overdoses of analgesics?——W. I could not even number them, it is so many. It is an occurrence that is so relatively common that I do not even take note of it.

3736. What are the main symptoms you notice in these people?——W. Usually I see people who have been analgesic abusers who are hypertensive with high blood pressure. That seems to be the usual way. Someone comes in for routine blood pressure checks and you see that it is elevated and despite the way they try to cover up it usually comes out that they have been heavy analgesic abusers. I could not number them. There have been three deaths among the people I know of, let alone damage, and I have seen a number of people whom I have sent to the renal unit at Brisbane.

3737. Is there any way of determining the number of people who have died from abuse of analgesics?——W. I am sure the figures are available but I do not have them.

3738. They do not seem to be available in New South Wales and that is what prompts my question?——W. There is only one renal unit in Queensland and it is at the Princess Alexandra hospital.

3739. We know the number of people who have had attention in renal units but unfortunately many people have died from side-effects from perhaps abuse of analgesics over the years and the death certificates have probably been signed for them that their death is not attributed to abuse of analgesics. I was wondering if there was any way in Queensland in which that could be determined?——W. I do not think so. When I think of the ones who have died in Tweed Heads from whatever, ulcers and haemorrhages, you just don't write them down as analgesics.

3740. You also suggest that a drug education programme in schools should be based on necessity and understanding of the situation and knowing all the facts. Are you acquainted with the personal development course run in some of the high schools in this area?——W. No. I think personal development courses are the way it should be done and not drug education courses in isolation.

3741. So people should be encouraged to seek help if they have a drug problem?——W. Yes.

3742. How would you do that?——W. It is part of the problem with the way we approach drugs. This whole business of legality and illegality of these substances make it very difficult for a young person to seek help or to seek answers to questions. If they are even the littlest bit afraid that they will get into trouble, though it may be totally unjustified, if they talk to the teacher about smoking marihuana or if they admit to the doctor that they are, or to a hospital or a policeman, they just keep quiet. If there is any risk that they will be convicted of a drug offence most young people realize the consequences in these days of such a conviction and most people of that age are just too scared to seek help or advice. There is a social stigma attached to the whole thing. It is O.K. to seek advice about alcohol but you would be put down if you started to ask questions about how much marihuana you could smoke in a week without getting into trouble physically with it. If a teenager went to his teacher and asked how much dope he could smoke in a week without getting into physical trouble—that is quite different to asking, how many drinks could he have without getting into physical trouble. We must change that social attitude.

3743. You said that in the Tweed River High School drugs are freely available and at Murwillumbah not so easy to get but still freely available. When you were talking about drugs what did you have in mind?——W. (*Dr Richardson*) I was talking mainly about marihuana, LSD and magic mushrooms. With heroin, you could make the contacts there, I am sure, but you would not be able to probably buy the drugs there. They are more likely to be sold around town. You can certainly buy marihuana and LSD.

3744. At the school?——W. At the school.

3745. Not among the schoolchildren, but at the school? ——W. Among the school pupils.

3746. There is a difference. You can buy them from people going to the school but not at the school?——W. I do not understand what you mean?

3747. If a student wanted to buy it where would he buy it? Would he be able to buy it at the school from somebody who went to the school—away from the school?—— W. Probably both—certainly both. He could buy it from people at school. There are plenty of stories—not just stories—cases of people tripping on LSD and magic mushrooms in school, in class, in this area.

3748. In recent times?——W. In recent times. Youngsters with magic mushroom sandwiches to take to sports day and things like that.

3749. Does it surprise you that all the top people from the Education Department in the area state that there is no drug problem?——W. I does not surprise me at all that they say that. I do not think they have any idea. I do not see how they could get an idea.

3750. Surely if you are a principal of a school you would have an idea?——W. I think you would have no idea. You could be tripping in class. I shall not name this school now but there is a school in this area where eight of the thirty kids in a class were tripping on magic mushrooms during the day in class and I am sure that the teacher did not know because I saw these kids the same day and I did not know until they told me that they were as high as kites on magic mushrooms.

3751. How did you know?——W. I know the kids pretty well and they said later on—they had been talking to me for a while—they said, "Do you know that we are tripping?" I had another look at them. After looking back in retrospect, if you like, it was obvious but until they mentioned it, it had not occurred to me to look for those sorts of signs. They talked to me for half an hour before they said this and you could notice changes in their moods that goes with the sort of drug.

3752. You do not think they might have been blowing bags or pulling your leg?——W. I have seen several hundreds of people under the influence of LSD or magic mushrooms.

3753. It seems strange that you would not detect the symptoms then?——W. You would not, unless you were looking for it. I would not be able to detect a few people who had a half a dozen beers for lunch but if I am talking, in close conversation, I might be able to identify that they had.

3754. Is there any other case you can add apart from that particular one?——W. That was in one class at one time—quarter of the kids were tripping. There is the business of magic mushrooms in sandwiches to take to school lunches or sports programmes. (*Mrs Mead*) We have had several cases, in the centre, of young people taking mandrax through classes. When parents found out they came to us worried about it and we have talked to the children. They have admitted taking them in class. (*Dr Richardson*) It is impossible for the Director of Education to have any idea—and the school principals. I know a few teachers in the schools who say they can tell the kids that walk into the class stoned from marihuana or whatever and they do not do anything about it. They say that for a number of reasons, first, what will they do in the first place—suppose you do know the kid is smoking marihuana—you have to be able to prove it. Second, what right have you to do anything about it, anyway?

3755. The teacher is in loco parentis, with a responsibility to the parents.——W. Quite, but certain teachers, ones who smoke marihuana themselves, for instance, and eat magic mushrooms, have said to me, "I know the kids in my class who are stoned during class". He has said, "I do not mind a smoke myself now and again so I am not going to do anything about it. I have told them on the quiet that they really should not do it at school." That is the sort of attitude you have to deal with. I do not think that a headmaster would know—or parents—if their kids were high at a particular time.

3756. Mr JACKETT: You said that you felt 16-to-26-year-old children going to school in this area—about 40 per cent of them would be smoking or would have experimented with marihuana?——W. Yes.

3757. Do you think that if it were proved conclusively that marihuana was dangerous that figure would drop quickly?——W. I do not think it would really change. I think it has been proved that marihuana is harmful to the health. I do not dispute that. I think it has been proved, but at the same time the kids can always point out to you that it is probably as harmful as cigarettes and it would take a lot of proving to prove that it was more harmful than cigarettes. As long as that situation applies young kids will use it: they can say to me, "You smoke cigarettes, why cannot I smoke marihuana". I do not think if you said, yes, there is an eightfold increase in the chance of getting lung cancer or having a heart attack at 60 or getting emphysema, bronchitis or ulcers from smoking marihuana—I do not think it would make much difference to its use in the same way as it has not to cigarette use.

3758. The fact that it is unlawful should not make an impression upon the children?——W. I think it makes little impression because people in that age group are more influenced by their peer group than a different generation or different little society to them. They tend to do two things. First, they take notice of their friends rather than their parents or the legislators, if you like. Second, everybody has this attitude that it will not happen to them. It is the same as driving a car without a seat belt or drink driving. They think to themselves, "You can get a $10,000 fine or two years in gaol but I am not going to get caught".

3759. Do you think that the community generally would favour the legal use of marihuana or of any other drugs and favour the decriminalization of the harder drugs? Do you feel that the community would favour legalization to effect that?——W. I doubt it. I doubt if they would favour that sort of legalization. I do not really have much more to say.

3760. What do you think should be done to rectify the position as far as young people in this age group pursuing a course which seems to be fairly clearly unsatisfactory is concerned?——W. In using the drugs?

3761. Yes.——W. I think that eventually this drug will be legalized. I think it is only a matter of time. Whether that will be good or bad I do not know. I think it will resolve it. When the community is prepared as a majority to say, yes, it should be decriminalized, it probably will be, as in other countries. I think that will happen. Unfortunately it means that the drug problem we have is going to continue till then, with legal enforcement, gaol sentences, perhaps police corruption and those things will continue until we change the laws. I should like to encourage all these young people not to use marihuana, L.S.D. or heroin but, if they are going to use it I will tell them how many joints they can probably smoke a week without it hurting them, how to use clean needles and not to get hepatitis and so on. That is the way I would do it.

3762. Do you appreciate that legalization has not seriously been put forward by the authorities, or seriously put forward in any western country, it is only decriminalization that has been put forward and, in some cases, adopted?——W. Decriminalization is almost a fashionable catch cry that does not have that many beneficial factors. The only good in it that I can see is that you do not get a criminal record, you do not lose your visa or your public service job and so on. I cannot see how it will stop in any way the use of illegal drugs, in fact it will continue how it is. It will be illegal, with people selling it illegally and so on. The same people selling marihuana will still be selling heroin. They would much rather have people on heroin and encourage that. I do not think it will make any difference to the drug problem. It is a sort of half-hearted sop to the public—we are not going to legalize it because we are anti permissive, so we will decriminalize it and hope to appease everybody. I do not think that is a constructive move.

3763. Accepting that it is a serious problem that young people are tending to use these drugs which are illegal and, so far, have not been decriminalized, what do you think should be done?——W. I only accept that it is a serious social problem because we have made it that way. Accepting the fact that it is illegal and therefore because so many are doing it it is a serious problem—that is what you are asking?

3764. Accepting that there is detriment to the health of those who use it.——W. In a minor sort of way, I suppose there is. I do no think that there is any answer to that. I think that while the situation remains as it is all the problems associated with illegal drugs are going to continue. I do not think there is any way that any government is going to decrease the use of illegal drugs. The only exception perhaps would be importation of such things as heroin which is a Commonwealth customs kind of matter. That is the only thing you can do. You are asking what can we do. I guess all we can do is have drug education in schools, a thing with interpersonal relations and so on. If you have all the factors of curiosity, boredom and peer group pressure and pleasure you cannot change those things. The only one you can possibly change is boredom. That enters into interpersonal relationships and unemployment but you will not change the other factors. While there are curious, pleasure-seeking kids with friends who smoke pot or use heroin you will have them doing it, no matter what you do.

3765. As to the use of marihuana or cannabis derivatives in one form or another, there has been evidence that the motor co-ordination is seriously affected by their use. Positive measures can be taken to gauge the amount of alcohol that has been taken but there are no forensic methods available at present to determine whether a person is under the influence of cannabis when driving a motor vehicle. Do you regard that as a serious problem?——W. Yes.

3766. A much more serious problem than the use of alcohol and tobacco?——W. I do not see why you should say it is a much more serious problem. I would regard driving under the influence of cannabis as serious. I am sure that many accidents are likely to be caused by that and that they go unnoticed because as you say, there is no way of telling. I would regard that as an extremely serious problem. I think the fact of whether marihuana is legal or not has nothing to do with it. In this area marihuana can be got as easily as alcohol. Whether it is illegal or not, you are going to have that problem. I think it should be a major, serious crime to drive a vehicle under the influence of cannabis; in the same way that it should be a far more serious crime than it is at the present time to drive a vehicle under the influence of alcohol.

3767. CHAIRMAN: People are charged sometimes with driving under the influence of a drug?——W. Yes, but it is hard to prove.

3768. Mrs DAVIS: Do you know whether people using gold top mushrooms get the same sort of flashback as they get with the use of LSD?——W. Yes, if these sort of

things exist at all. I am not quite sure what flashbacks are. I think it is an acute panic reaction that occurs at a later stage.

3769. Have you had to hospitalize any people who have had an overdose of this drug?——W. I have not done so. I know that some people have been hospitalized but I do not know whether it is the best treatment for them. There is usually an acute panic reaction and they have to be talked down, given coffee and reassured before it wears off. I have not had to hospitalize anyone but I know that people have been hospitalized.

3770. During the past 3 years have you seen any deaths occur as a result of an overdose of mandrax, barbiturates or some of the freely prescribed anti-depressants?——W. There have been probably four deaths that I can think of from an overdose of narcotics. Two of those deaths occurred at a place just north of the border. There have been a few that I am not too sure about. They could have been deaths from narcotics; there were strange circumstances like drowning. I do not think I have had any deaths from mandrax and things like that. I am sure that the hospital would know about that. I have not had any deaths in my practice from an overdose except the two from heroin. They were kids of about 18 or 19.

3771. You have not heard of any?——W. It is not something that I would take much notice of. Though it could be a fairly common sort of thing, I personally do not know.

3772. Mr WOTTON: Where did you graduate?——W. The University of Queensland.

3773. How old are you?——W. Twenty-nine.

3774. Where did you practice prior to going to Coolangatta?——W. I did a residency at Southport. I worked in the United States of America, in California for 8 months and in New York and Europe.

3775. Are the gold top mushrooms you speak about the common toadstool?——W. Yes, probably they are.

3776. You said you knew of a class where eight kids were stoned and that the teachers would not do anything about them. As a member of your profession, did you do anything about it?——W. I have no intention of doing anything about it.

3777. Are you serious when you say that it is as easy to get marihuana as it is to get alcohol?——W. It is in this area.

3778. Mr McGOWAN: It has been suggested by various people that perhaps our drug education programme is pointing in the wrong direction, that it seems to be directed entirely to the younger members of the community and that more attention should be given to the education of parents so that if they came across the problem in their own family they would be better able to know what to do about it?——W. I think that this is pretty difficult. I could not recognize somebody high on marihuana, for instance, even if I do know what to look for.

3779. I am talking about heroin addiction at a fairly advanced stage?——W. In the case I spoke about, the parents did not know until their kids were dead that they had used drugs. In a case like that how can you educate people to pick up the symptoms? These kids were perfectly healthy; they seemed to have no problems but one morning they were dead. What can you do about that? A more valuable type of programme would be to start with parents of young families and develop an anti-drug attitude in their young children. The parents could be educated not to give the young children sleeping mixtures at night, a drop of whisky or half a valium. You could start with the parents of young children and develop in them an anti-drug attitude.

3780. You said that as the law is at the moment, in some cases it leads to the use of drugs. You spoke about gold top mushrooms; do you think that is true also of marihuana?——W. I think the use of marihuana became fashionable. I think that in regard to the use of marihuana, the law has been irrelevant; it has made no difference. At the present time it may be that the law encourages the spread of heroin by the fact that it is a criminal offence to use heroin; it is an illegal activity. It is most difficult for these people to get treatment because the drug is illegal, therefore it is easier for them to remain heroin addicts, and the only real way to remain an heroin addict is to sell to somebody else.

3781. As to marihuana, you said that in some cases the law brings about the use of that drug or increases its use? ——W. About marihuana specifically?

3782. Yes?——W. No, I do not think so in the case of marihuana. If I said that before I meant in some drugs, in different ways.

3783. You have said that driving under the influence of cannabis should be a crime?——W. Yes.

3784. Presumably you say that because you think it would discourage people from driving under the influence of cannabis. However, you also seemed to hold the view that the ingestion of cannabis cannot be discouraged by continuing to treat it as a criminal act?——W. Yes.

3785. Could you explain that?——W. If you are going to smoke cannabis, that is up to you; if you are going to drive a car after smoking cannabis, you may run the risk of losing your licence.

3786. Many people do not lose their licence for driving under the influence of alcohol?——W. Of course they should, but that is a different question.

(The witnesses withdrew)

PHILLIP ANTHONY McNAMARA, Solicitor, carrying on practice at Murwillumbah and Tweed Teads, residing at 105 Kingscliff Street, Kingscliff, on affirmation:

3787. CHAIRMAN: Did you receive a summons issued under my hand in accordance with the Parliamentary Evidence Act?——W. Yes.

3788. I understand that you wish to make a verbal submission to the committee?——W. Yes. My leading submission is given in my capacity as solicitor and as private citizen, that certainly marihuana and also psylocybin, lysergic acid, mescaline and hashish should be segregated from other drugs treated by the Poisons Act, and penalties, remedies, police powers and so on modified accordingly. My view is that the smoking of marihuana, the possession of quantities of perhaps less than 4 ounces and the growing of not more than six plants should not be an offence under the law. My view is also that the sale of marihuana should be regulated by law only to prohibit the addition of imports and harder drugs such as narcotics into cannabis leaf.

My view as a lawyer is that the Poisons Act needs to be changed in a number of respects. The main respect is that the scope of the regulations should be altered to take the prohibition of drugs like psylocybin, LSD and mescaline out of the regulations, if they are to be dealt with by legislation at all, and they should be dealt with by the

Act so they are controlled by the Parliament and not by the government from time to time. My view generally is that delegated legislation is obnoxious in essence and it should be confined to as small a compass as possible. Further, in relation to the Poisons Act, the search warrant provisions, which are section 43, should be altered. At present it provides that a search warrant issued by a Justice under that provision will be in force for one month. I submit that the time period should be restricted to the day on which the warrant is issued and the following day. I submit also that the power to issue the warrant should be confined to a magistrate or a senior judge. If the committee does not recommend to the Parliament that the smoking of marihuana be made lawful, the Poisons Act should be modified to put marihuana, its use and possession into a separate category from the other drugs, and penalties reduced accordingly.

I wish to address the committee on the discrepancy between the legal treatment of drinkers of alcohol and the users of marihuana. It is an offence for a person to drive a motor vehicle under the influence of alcohol. It is not an offence to take alcohol. It is an offence to drive a motor vehicle under the influence of marihuana. But penalties for the use of marihuana, even in the privacy of one's own home where there is no possibility that the crime will have a victim other than the taker, are out of all proportion to the penalties inflicted, at least in this region, on people who drive a motor vehicle under the influence of alcohol. In this region magistrates tend to be rather lenient on drinking drivers and rather heavy on pot smokers. The same is true of the police. For example, a person convicted of smoking even one joint in cannabis leaf may expect to receive a fine between $150 and $250. The possession of quantities of less than one ounce will result in a fine of about $200, and the fine will be $400 in the case of about 4 ounces. A fine for the possession of utensils, such as a pipe or bomb, would be about $100. On the other hand if a driver is convicted of drinking with the prescribed content of alcohol in his blood he may expect a fine of about one week's wages, between $120 and $170, and a suspension of about one month. It is no longer a case of a practitioner congratulating himself if he achieves a result in those terms, even for a level between .175 and .225. Even though the law provides for a penalty of $400 by way of fine or up to six months' gaol for someone driving with the prescribed content of alcohol in his blood, those penalties are never applied in practice in this region.

Recently there was a case reported in Lismore where a driver was convicted of driving a motor vehicle with .175. He lost control of the motor vehicle in the main street of Lismore, inflicted about $1,500 damage on shop premises; he was fined $150 and disqualified from driving for only twelve months. I have acted for defendants with readings up to .225 resulting only in fines of not more than $100. It is my view also that restrictions on drugs other than marihuana and apart from the opiates, about which I cannot speak as I am not an expert on those drugs at all, should be increased to make it more difficult for people to obtain drugs like valium and mandrax. I know from my own professional experience people get two or three prescriptions for drugs of that kind. I have a rather substantial divorce practice and I know many of the women whom I see, whose marriages have broken down, are taking valium. I would say that more than half the women whose marriages have broken down, who are not living in a de facto relationship which gives the emotional stability everybody needs, would be on valium or some form of anti-depressant.

My view is the present regulation of drugs in New South Wales is motivated by political reasons rather than strictly medical and that the police control of marihuana in this region is to prevent this region from being freed up. Also it is in an attempt to control the social order and preserve the status quo. Marihuana has been used in other cultures for thousands of years. For example, in China it has been used for over 4 000 years to treat neuroses. From my personal observation of people who have taken marihuana quite heavily as opposed to people, say, on valium, it would be better for people to be prescribed marihuana by doctors than to be prescribed valium.

It seems to me that the main drug problem in the northern area of New South Wales is the police harassment of the offenders and not the actual consumption and use of drugs like marihuana and hash. As doctors have said before the committee today, a person who is having difficulty with drug consumption is in fact deterred from going to seek help by the present enforcement of the law in this area. That situation will be remedied if marihuana is made lawful. The emphasis under the Poisons Act in relation to other drugs is supportive rather than prohibitive. They are my submissions.

3789. You said that you are not an expert in the field of opiates. Apparently you consider yourself to be an expert in the field of marihuana. What makes you an expert in regard to marihuana?——W. Wide personal observation of its consumption and of people who have smoked it, and the consumption of it.

3790. Are you aware that one of the reasons that regulations are often used is to make the legislation more flexible?——W. I am, yes.

3791. And that any regulation that is gazetted may be set aside by a vote by either House of the Parliament, within fourteen sitting days?——W. I am aware of that too.

3792. Mr JACKETT: You said that you thought it would be better in many cases for people with problems to be prescribed marihuana rather than valium.——W. Yes.

3793. Have you any technical qualifications in this field which would enable you to support that statement?——W. No, only my view as a citizen, a fairly well-educated citizen.

3794. Mrs DAVIS: Have you personally defended any people who have been brought up on alcohol charges? ——W. Not defended in the stricter sense of the word. I have appeared on a plea of guilty to a charge like that.

3795. Have you heard from any people that when they were apprehended they possibly had on them a larger amount of marihuana than what they were originally charged with in court?——W. No, I would say not.

3796. You have heard of no cases like that?——W. No.

(The witness withdrew.)

(*The Committee heard evidence in camera.*)

DIANE SHIRLEY DAVIDSON, a Community Nurse, at the Community Health Care Centre, Tweed Heads District Hospital, sworn and examined:

3797. CHAIRMAN: Did you receive a summons issued under my hand in accordance with the Parliamentary Evidence Act?——W. Yes.

3798. We have received a submission from yourself and Miss M. Quirk, another community nurse. Do you wish that submission incorporated in your evidence?——W.

Yes. That submission reads:

SUBMISSION OF D. S. DAVIDSON

On behalf of the Community Nurse Service which has operated for the past two and a half years from Tweed Heads, I wish to submit some of the practical problems found in relation to the taking of prescribed drugs in the home.

Drugs are a substance designed for the treatment, relief or prophylaxis of disease. However when abused or as we consider in this submission misused they are potentially dangerous.

(1) Drugs are prescribed for patients with little explanation of what the medication is or why it is required. There are two factors involved:
   (a) The doctor does not offer sufficient explanation.
   (b) The patient does not seek explanation for what he does not understand.

   Possible solutions—
   (a) To reinforce the advice given, the doctor be requested to ask the patient to repeat directions for the medication.
   (b) Where this will not be effective, then a typed (not written) instruction be given to the patient to take home.
   (c) Duration for which the medication is required should be specified.
   (d) Utilization of pharmacists who have trained as specialists for consultation with patients, however close co-operation would be required with the patient's doctor.

(2) Age would not appear to be taken into consideration especially in relation to sedatives, tranquillizers. Children require different strength of dosage according to their age and the older and aged person often requires similar considerations. One of the complex factors with this problem is that medical officers are not present when the patient takes the medication and cannot observe the reaction and therefore are unaware that the patient is at risk because of the adverse reaction, e.g., injury as a result of falling.

   It is unfortunate that patients often fail to advise the doctor of an adverse effect.

(3) Medications would appear to be prescribed without a thorough check as to what the patient is already taking. This type of problem arises commonly where patients are accepting treatment for the same complaint from more than one source:
   (a) Obtaining treatment from hospital outpatient, G.P. and specialist.
   (b) Doctor shopping.

   Other causes of the problem are:
   (a) Different trade names given to the same drug, e.g., Digoxin and Lanoxin.
   (b) Several similar acting agents taken at the one time, e.g., Chlotride and Lasix.

(4) There are problems in relation to the labelling of bottles. Some are listed herewith:
   (a) Containers should bear name and strength of contents.
   (b) Use of different trade names are confusing.
   (c) Full directions for use should appear on *all* containers.
   (d) Containers should never be labelled—"take as directed".
   (e) Original manufacturers or packers labels with drug names and expiry dates should not be obscured by pharmacists label.

(5) Old medications should be disposed of, not stored for extended periods. It is suggested that all containers include expiry date. Also, if a change in treatment is made by the doctor, this should be accompanied with advice for disposal of previous medications. Many medications become poisonous if stored for too long a period, e.g., Tetracycline.

(6) Disposal of Drugs—Public education is necessary to ensure that drugs are not disposed of by potentially dangerous means, e.g., rubbish bins, rubbish tips (accessible to young children).

(7) Frail aged people with poor eyesight are very frequently incapable of reading labels. This is not sufficiently taken into account when prescribing. Consequently medications are taken incorrectly. For example:
   (a) One bottle may be found to contain several different tablets.
   (b) Poor memory span often results in overdose or underdose situations. With the use of education and reinforcement aids, e.g., the Dosett, it is possible to eliminate this problem to a great extent.

3799. CHAIRMAN: Would you like to enlarge on that submission and perhaps give us some examples?——W. Sometimes drugs are prescribed to patients with little explanation of what the medication is or what is required to be taken. Recently a patient was found to have been given a prescription that is usually given to diabetics. When he was asked whether he was a diabetic he answered that he was not. For the past 4 years he had been treated as a diabetic and given this prescription. Some patients are given medication which they seem to take blindly; they seek no explanation of what they are taking. That man was a diabetic and he had never been told.

3800. Have you had many cases of patients needing hospital treatment because they have taken an overdose of say, a tranquilizer in the belief that what they were taking was the right dose when in fact it was stronger than they should have been taking?——W. No, not directly. A lot of my work is involved with the frail aged. Sometimes they do not understand the effects of what has been prescribed for them. For example, they may be prescribed mogodon and they will take two tablets which will have the effect that if they get up during the night they will fall because they have not got their balance. They may have to seek hospital treatment as a result of injuries they have incurred while under the influence of that drug.

3801. Would it be correct to say that most of your activities would be in regard to the abuse or the overprescribing of legal drugs?——W. Yes.

3802. Your work is almost entirely with the frail aged?——W. Not entirely but a great deal of it is because of the population in this area and the fact that it is a retirement district.

3803. Do you have any examples of people having gone to more than one doctor because they have felt that he was not giving them enough of their tablets to keep them going?——W. That goes on in every community. Some people do go from doctor to doctor to collect a supply. In most cases it is not so much a case of abuse; it is more misuse through their complete ignorance. In some cases a person may be treated by a medical practitioner and then referred to a specialist who also gives him a prescription. Instead of stopping the first lot that he was prescribed, he will take both and not be aware that he should not be taking one lot.

3804. That is covered in your submission; you say that patients are not given sufficient directions in regard to the use of a drug?——W. Yes.

3805. Mrs DAVIS: You say that one cause of the problem is that different trade names are given to the same drug?——W. That is correct. Sometimes it is not so much the name that is so important but the reason why the doctor has prescribed the drug and why he wants them to use it.

3806. Mr HEALEY: What was the rationale behind your statement in the submission that containers should never be labelled "Take as directed"?——W. I think it is feasible that every container that is given to a person by a chemist should have written on it exactly how it is to be taken.

3807. You said in your submission that containers should never be labelled "Take as directed"?——W. Instead of the bottle being labelled "Take two tablets once a day", it is labelled "Take as directed". The patient is supposed to know how to take them.

3808. Mr McGOWAN: In paragraph 7 (b) of your submission you refer to the Dosett. Will you explain that?——W. The Dosett is a container that has been put out by one of the drug companies. It is marked off into the seven days of the week with a slot for each day, for the tablets to be taken at morning, lunch time, dinner time and tea time. The frail aged may take medication and forget that they have taken it. With the Dosett, it is possible to eliminate this problem to a great extent.

3809. CHAIRMAN: I commend you for the submission you have made and for appearing before the committee.

(The witness withdrew.)

(The committee adjourned.)

*TWEED HEADS, FRIDAY,* 8 *JULY,* 1977

3810. CHAIRMAN: I would ask members of the public to retire so that the evidence of the next witness may be taken in camera.

3811. WITNESS: I have nothing to say to the inquiry that I would not be more than happy to say in public, and publicly, and I would welcome the return of my friends and neighbours to this room so that I may speak before them and you at the same time.

3812. CHAIRMAN: I have very good reasons for asking the people to leave. I feel that members of the Committee may put to you certain questions which you might subsequently want to have treated as confidential. However, at the end of your evidence if you would like it to be made public I will see that that is done. At this stage the hearing will proceed in camera. If you do not wish to appear before the Committee under those conditions you are free to leave now.

3813. WITNESS: No, I wish to give evidence.

*DAVID HUGHAN JOHNSTONE,* unemployed, residing at Chowan Creek, Uki, affirmed and examined:

3814. CHAIRMAN: Did you receive a summons issued under my signature in accordance with the Parliamentary Evidence Act?——W. Yes.

3815. I understand you wish to make a verbal submission to the Committee?——W. I do.

3816. Would you proceed?——W. I was delighted to meet you informally on Wednesday afternoon but I was concerned with the fact that at this late stage of the hearing of the Drug Committee, and during its visit to the Northern Rivers; where you had expressed interest in cannabis in leaf form, that in a question asked, it seemed that the inquiry had had very little experience with the substance cannabis. So, I have managed to obtain some which I have brought with me today, and with your permission I would like to tell you what I can about it.

3817. Please proceed.——W. This is a little tin of North Coast heads. Basically I guess you know all about the plant by now and how it grows and which parts of the plant are particularly effective in terms of being desired for smoking. That is a head picked at its absolute best for smoking. I had the choice and I considered the possibility of putting together a nice blend of local tops but I thought it would be more realistic if I showed you this. You have probably seen a deal and you have heard of people being in possession of seeds. That is because they buy a deal with seeds in it. When I have smoked the dope, what I have left is the seeds and that is how people usually get caught with seeds.

This is a funny situation. I have never smoked in front of people like you before. I have been smoking marihuana for fifteen years.

3818. If you are thinking of rolling that here and smoking it here there is no need to go that far. All you need to do is tell us what you want to say about it. For your benefit might I say that most of the members of this committee have seen marihuana plants which were probably far more lush than any you have ever seen.——W. I guess you have.

3819. And further, we have had the opportunity to see it in various forms.——W. Fine, but have you actually seen anybody smoking it? Would you welcome that opportunity? I would be delighted to do so now.

3820. I would rather you did not do that.——W. Then may I continue rolling it because on leaving here I intend to in fact smoke it publicly.

3821. What you do outside this committee room does not concern members of the Committee but whilst you are here you must abide by the rules of the Committee. I suggest that rather than roll the cigarette now you put it away and back into the tin. If you propose to smoke it somewhere else roll it afterwards, outside, where you will not be bound by the rules of the Committee.——W. O.K. If we cannot do a practical demonstration I have some recommendations I would like to put to you. May I preface these by saying that most of my friends are vitally concerned in this issue but are not available this afternoon because they are at work cutting cane, in banks and at the Tweed shire council.

3822. The submissions are already prepared, are they? ——W. Yes they are, and I have copies. It is a recommendation for action requiring the immediate legislation of cannabis leaf and its use. It recommends the release of all cannabis prisoners and the expungement of records of conviction of people who have cannabis convictions and also an apology for all those who have been affected by what you are continuing to do. I suggest that the manufactured products, which are largely imported, such as hashish and hashish oil, be subject to an excise duty and treated like alcohol and sold under government quality guarantee. It could be bought from the governments of Afghanistan or Nepal which put government seals on blocks of hashish. In terms of treatment for people with drug problems I have been active in community work for the past two years in this area and my own personal opinion now is that absolutely nothing can be done medically for someone who is determined to end his own life, whether it be by driving a motorcar in an insane fashion or self-destruction by administration of materials which the person knows to be dangerous. However, I think as a community we must take steps immediately to provide assistance to people who ask us for help. We must provide the help that they ask for and not the help suggested

by our existing hospitals and welfare agencies. We must go back to the grass roots and ask the people concerned what they want. That is what I have done. I have asked what is it that they want. What we ask for is a cool place in the country where we won't get hassled and where we can get our heads together. A lot of us are going to need assistance from cannabis to do this. Some of us do not have a tolerance to alcohol. Certainly we do not like chemical methods of pulling our heads about. In terms of self-medication, I intend to smoke cannabis for my own health and well-being on my own. It is my judgment as to what is best for me at the time.

3823. You realize that the recommendations made to us by you have been given to us before and there is nothing new in what you say. I suppose the section in regard to supportive havens for those experiencing drug problems and desiring help in the way it is expressed there might be different, but all the other recommendations have been given to us not once but many times before?——W. I see.

3824. Mr WOTTON: Has any help been given to you or any of the havens of which the chairman spoke by governments or the community?——W. We are having trouble communicating. I live in the Northern Rivers area and in the three and a half years I have been there I have never come across any hard drug problem at all.

3825. I do not mean that. I mean aid from governments to help you in the sort of things you are asking for?——W. No. In fact government agencies have tended to be most repressive and in desperate need of drug education themselves. I am appalled at the amount of ignorance that has been shown on public platforms in this area.

3826. The reason I asked that question was that at one of the havens we saw I noticed a sign asking the people to gather together and discuss how a $3,000 grant could be spent?——W. Yes.

3827. So you did get a grant?——W. Yes, I went to the Department of Youth and Community Affairs. I knew I would go broke up here and I would not be able to continue the project I had. I figured to pick up some cash or work when the time arose. When it arose we were in the middle of a beef bust and a depression. I was considerably hairier at that time than I am now. I came into violent confrontation with the Commonwealth Employment Service and I discovered that the least likely you were to get employment then the least likely you were to get government assistance of any sort. I followed it through and I appealed to the Social Securities Appeal Tribunal and wrote to the secretary of the department. I got involved with the Murwillumbah community aid organization which was funded through the Department of Health. I saw problems of unemployment, growing unemployment, widespread boredom and feelings of dissociation and so on. I found the same prejudices and ignorances in that organization that we struck outside in terms of "dole bludgers".

3828. In fact you did get a grant?——W. I called a public meeting and we made a submission to the Department of Youth and Community Affairs for a grant to do three jobs. We wanted to try to provide for needy people and to provide for the small community of which we were the centre, and also provide a central meeting place for the people who had recently come into the area and to service them in terms of accommodation directories and so on. Only this week we had a call from Doug Anthony's office about someone who had approached them and she said she believed we were the only ones who could help. We have had referrals from the Murwillumbah community aid people who have said we are the only ones who could help. We have also had people from the Youth and Community Affairs Department. It appears the government does not have any interest. We will do it ourselves. We do not need them. We are working towards setting up a haven. In fact, we already have one. We have a nice place there where we have some nice men, some nice ladies and some very nice kiddies. They have offered to take people in there. Where we do have a problem is in the withdrawal stage and the anxiety stage and we are looking for something to relieve tension and anxiety effectively. I believe that cannabis is as good as anything I have ever come across to achieve those ends. I am really asking that those people who want it should be allowed to have it.

3829. Mr JACKETT: Are you seriously suggesting that cannabis should be used by medical authorities as a means of assisting opiate addicts?——W. Yes, most definitely, and also alcoholics and people trying to get off nicotine. I came off nicotine with dope.

3830. I have not seen that as a serious suggestion from any medical authorities. Can you support that with any indication of a medical authority who has suggested that it is one of the means that could be adopted?——W. You gentlemen would have more expert evidence than I, but I understand cannabis, officially or unofficially, was being used at Broughton Hall for psychiatric treatment and with quite good results when treating alcoholics until such time as the "terrible genetic damage" rumour was learnt of by the Government which decided that people of childbearing age should not be administered it while under the protection of the Government, and it was withdrawn.

3831. Do you know of any expert medical knowledge that suggested that should be done?——W. I am uncertain about my ability to handle alcohol and I have to be careful with it. If I am careful with alcohol and take nothing to relieve anxiety and tension after I have been working hard, long hours and not eating properly. I find myself in the situation, which probably you have done, and say "I really would like a drink". I would rather prefer to have a smoke in that situation. It achieves for me more than a drink. I feel it is less risky to myself.

3832. CHAIRMAN: You would not look for both together?——W. Not normally. They tend to be counter-productive.

3833. You are putting them as alternatives?——W. Yes.

3834. But it is a fact that most people who smoke and drink smoke a lot more when drinking?——W. Tobacco?

3835. Yes?——W. With tobacco yes, cannabis, no. They in fact drink less with cannabis. I am speaking as a layman but I understand that alcohol, being a depressant, puts you in more need of nicotine and there is a vicious cycle. Cannabis is not a depressant in that sense. I was a heavy smoker from age 15 to 35. I gave up for twelve months and at one stage I was given a block of hashish and had no grass to roll it with. I rolled it with tobacco and within two days I was addicted again. I used cannabis to come off nicotine simply by having a joint every time I felt like a cigarette and within two or three days I was off it.

3836. Mr JACKETT: Are you qualified in any way? Do you have any degrees?——W. No. I have an advertising certificate from technical college which involved four years night work. My main interest has been in the media, you might say. I have been involved in record companies, television promotion, newspapers and retail store promotion. I have been involved in television and film production and direction. I was assistant director for a number of features and have done some television stuff.

3837. What was you last position?——W. Before I dropped out—I was working for Crawford Productions. I found that traumatic for me. It was a difficult position for me. I was hired to achieve a particular job and I found when I got there that the management was in fact a problem, in terms of allowing me to get on and do the job. I was in a difficult situation there. I had basically made up my mind when the Crawford offer came through for a twelve months contract to go to Melbourne, to drop out of commercial television. I knew myself that I was in danger with my state of health. I knew I could not continue to punish myself in that way, working those hours and smoking so many cigarettes and getting little sleep. I made a decision that I must break that link and in fact I did. I came to the country and I really did not know quite what to do. I took some months in a self-healing process. I sat by the creek and read books about meditation and yoga. I am a vegetarian and have been for five years. I am into natural healing and am learning more about it. I do not know that they ever give degrees in natural healing but that is where my interest lies.

3838. Did you do that up here or in Victoria?——W. Here—I think it starts when you are born—the development of your character and body and learning to make the most use of your resources.

3839. Had you had associations up here before that? Were you in the habit of coming to the Gold Coast?——W. No, I am a mountain person. I am in disguise today. I am in fact what may be called a hippy. I do not look like one today. I came here to the hills. My plan was to come to northern New South Wales, have a look at the Nimbin area and if I found something in the area I would settle, otherwise it would be Maryborough, Queensland, New Zealand or buy a boat and sail until I found an island. I found a piece of land. That provided the haven for me that I needed. I feel I have made good use of it and am now productive and creative and whatever as a member of the society we are in. My own interest is to see if I can improve that.

3840. Why did you describe yourself as unemployed rather than a farmer?——W. I would not presume to put myself down as a public servant. I am receiving an unemployment allowance. I am available and willing to accept any work. I am living on that $47 a week. My official classification according to the Commonwealth Employment Service is unemployed.

3841. CHAIRMAN: We are getting away from the drug question and time is getting away.

3842. Mr JACKETT: I am getting back to it. What is your view about heroin and what should be done about it?——W. Education and support, primarily. Having started smoking marihuana fifteen years ago, the very same things I hear people saying about heroin, I remember them saying about marihuana. They are not saying that anymore—addictions and psychological dependence. It seems to me, from my experience, that the dangers of heroin have been grossly exaggerated. I think with education and support the problem would be self-regulatory provided we can remove the profit motive. We can do that simply by making it more easily available. They tell me that heroin is as cheap as aspirin. Who will bother pushing it then? Those who are into that trip will be into it, no matter what you do.

3843. You favour legalization?——W. Yes—the mechanics of it I do not know. I have not put my head into heroin because it is not a problem that is relevant to me except that if somebody has a 'smack' problem and wants help we can provide it, but in terms of the law situation I do not know—with cannabis I know what the law should be, for certain.

3844. While heroin is illegal what do you think should be done about pushers—people in the scene to make a profit?

3845. CHAIRMAN: Mr Jackett, this witness did not make any submission in regard to heroin. It is a little unfair to question him about these things.

3846. WITNESS: Thank you.

3847. CHAIRMAN: He made a statement that he read out and it does not deal with heroin. He has made a submission with regard to cannabis. I think that his opinion in regard to what should be done relating to heroin is really a little irrelevant.

3848. WITNESS: Thank you. I would rather confine myself to cannabis leaf on the North Coast. Could I request that the evidence given be published or made available?

3849. CHAIRMAN: Certainly. The reporter will note that.

(The witness withdrew.)

*AT SYDNEY ON TUESDAY, 26 JULY, 1977*

The Committee met at 2 p.m.

**Present:**

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

*Legislative Council*

The Hon. KATHLEEN ANDERSON
The Hon. MARGARET DAVIS
The Hon. C. HEALEY
The Hon. F. M. MACDIARMID

*Legislative Assembly*

Mr B. H. McGOWAN, B.A.
Mr R. C. A. WOTTON

Dr ALAN JEFFREY SUTTON, of 50 Kenneth Street, Longueville, Social Researcher, Public Servant, sworn and examined:

3850. CHAIRMAN: Have you received a summons under my hand issued in accordance with the Parliamentary Evidence Act?——W. I have.

3851. I have received a printed submission from you setting out the evidence that you wish to give today. Do you wish to have that incorporated as part of your evidence?——W. Yes.

BUREAU OF CRIME STATISTICS AND RESEARCH

*Collection of adequate Drug Statistics prepared for Joint Parliamentary Committee upon Drugs, 26th July, 1977*

My evidence this afternoon is for two purposes. Firstly to provide to the Committee statistics of drug convictions in New South Wales in 1976 and secondly to make some comments on statistics research required to monitor the drug problem in New South Wales.

*A. Drug Offences, 1976*

Each year the Bureau of Crime Statistics and Research provides statistics of convictions in the Courts of Petty Sessions in New South Wales for violations of Parts III and IV of the Poisons Act. The statistics for 1976 together with the detailed analysis of their significance will be presented with other court statistics in a single publication towards the end of 1977. At the request of the Select Committee of the New South Wales Houses of Parliament upon Drugs a summary of these figures has been prepared and is provided to the Committee with the permission of the Minister of Justice.

In 1976, 4 707 people were convicted for violation of Parts III and IV of the Poisons Act, an increase of 19.6 per cent over 1975. The numbers for the past six years are shown in the following table.

*Table I—Offenders under Parts III and IV of the Poisons Act*

| | 1976 | 1975 | 1974 | 1973 | 1972 | 1971 |
|---|---|---|---|---|---|---|
| Number ..... | 4 707 | 3 937 | 2 174 | 1 352 | 1 058 | 879 |
| Percentage increase over previous year .. | 19.6 | 81.0 | 60.7 | 27.8 | 20.4 | 36.4 |

It is impossible to come to a firm explanation of the slowing down of the increase in drug convictions from 1975 to 1976, based solely on the information in the table. Throughout 1975 and 1976 the size of the drug squad in New South Wales has not changed but the active education programme carried out by the drug squad in previous years was continued in the various sectors of the State. Some authorities have suggested a pattern in drug usage in which after a period of rapid increase, the growth of usage levels off to a plateau as the saturation of the likely community of users is completed. The rate of increase for different drugs does not appear to be greatly different from the average 19.6 per cent increase and the proportion of convictions for cannabis is similar to that in 1975. No detailed figures are available yet and a complete analysis can only be provided when the report is published.

An analysis of drug convictions by local government area has been carried out specifically at the Committee's request and is attached. It should be noted that the frequencies given show the number of persons convicted for offences in that area in 1975 and 1976. The statistics given in the Bureau report on Court Statistics, 1975, showed the area of residence of offender. It was thought to be more valuable for the Committees purposes to give location of offence, but residence of offender will also be given in the complete report.

*B. Monitoring the drug problem*

1. Purposes of statistics

Although talking about statistics I want to emphasize that both quantitative and qualitative information is necessary. The characteristic of the information required is that it is systematically and objectively collected. Of course, the information collection cannot be free of assumptions. It would normally be directed towards some policy or series of policy options. Information collected in this manner can assist in rational planning whereby a series of objectives are outlined, a set of alternative plans for meeting the objectives set down and the advantages and disadvantages of each option is compared. In the ideal situation an administrative programme is developed for the most feasible alternative and its progress monitored and evaluated. The process is cyclical because objectives and procedures may be altered through experience.

If we are to operate in this way we must have reliable information. Such information provides data for policy formation, helps us to estimate the size of problems, exposes unintended consequences of our actions, helps us to evaluate the implementation of policy.

This is the framework within which the Bureau of Crime Statistics and Research seek to operate. It conducts applied research to assist in the development, monitoring and evaluation of policies and programmes within the criminal justice system and areas of related social problems.

2. Application to the abuse of drugs

The Committee is of course aware that the literature on the abuse of drugs is now of vast proportions. And yet, even the definition of the term drug is subject to argument as Roman Tomasic points out in his summary of the literature in Drugs, Alcohol and Community Control published by the Law Foundation. For practical purposes, we can take a more pragmatic view. The substances which have been defined as illegal or are likely to be subject to control are the subject of this paper.

We can trace the stages of consumption from manufacture or growth through supply, distribution, consumption, consequences, both personal and social, and in the case of illegal drugs treatment and/or arrest and punishment. If we are to undertake rational planning for drug control we require statistical monitoring of the movement of the drugs through each of these stages. This is true even if policy were changed, say in the case of cannabis to decriminalization or legalization

In the latter case commercial production would need to be carefully monitored similar to that in the commercial distribution of tobacco or alcohol. Alternatively, if it is to be totally suppressed then we need to know the dimensions of illegal growth or impact. In the case of decriminalization where there would be substantial differences between the penalties for supply and usage there would be an even stronger case for monitoring, although the problems would be formidable given the suitable climate for growth of the drug in New South Wales.

Similar issues would also apply to the control of other prohibited or restricted substances, the status of which is changed with changed conditions.

The statistics which are currently available are not directed to the understanding of drug abuse as a social or psychological problem. They are mostly collected for other purposes such as the calculation of pharmaceutical benefits, the estimation of imported material, the arrest rate in order to plan the distribution of policy activity, the admission to medical facilities particularly when physically based treatment is administered and the recording of mortality. The existing statistics are well summarized in a Health Commission report by Roy McCulloch, then of the Drug and Alcohol advisory service. In McCulloch's report estimates of production have to be made from statistics of pharmaceutical benefits. No statistics are available of the production of pharmaceutical drugs by the drug companies.

This is a matter which should be kept under close consideration when social and medical problems arise from drug abuse. It is difficult to undertake effective planning when statistics of production have to be estimated in this roundabout manner. McCulloch also gives production figures for alcohol which are easier to estimate because precise import and production figures are required for duty and tax purposes. He also gives crime statistics from the New South Wales Police Department and court statistics from the Bureau of Crime Statistics and Research. It is interesting to note that the type of statistics published by the Bureau is frequently not available in other States. Prison statistics are also given by McCulloch.

The Crime Intelligence Centre of the Commonwealth Police publish an annual collection of drug statistics supplied by State Police Forces and Federal agencies. It gives a summary of type of offender, nature of offence and details of stolen, smuggled and seized drugs. The lack of information on amount seized shows the difficulty of estimating production in an illegal situation. It seems essential that some formal registration procedures for seized drugs should be instituted, particularly when they are locally produced in quantity.

Another source of data involves surveys of drug usage. These are summarized in Bell and Champion's reports for the Health Commission. Community surveys of drug usage are difficult to conduct. They require the careful preparation of sampling, questionnaires and introduction to the respondent. The respondent must be completely confident that the confidentiality of his answers will be respected and that there is no advantage from overstating or understating his or her usage. I would be inclined to doubt the feasibility of a large scale, regular community survey to monitor drug usage. If it was thought that results would be used for drug control policy it is unlikely that the validity of results or co-operation would continue. Further, drug policy is likely to be oriented to particular localities through community or health education and justice programmes. It would be far too expensive and difficult to provide data from a state wide sample survey which would be accurate for local areas. Such programmes will need to be based on single studies for a particular purpose or area, from official statistics or perhaps from surveys of client populations presenting to health and welfare services. A summary of these surveys can be found in the Australian Law Reform Commission publication "Alcohol, Drugs and Driving".

Perhaps the main value from such surveys is to assist in the development of health, education and justice programmes by the provision of information on location of usage and type of user. However, conclusions would be very general. It seems unnecessary to attempt to establish the precise number of users when we do not have a clear cut solution to the drug problem. It would be a different matter if, say, we were designing spectacles for persons of poor eyesight. Then we would know what technological aid to provide for persons of a particular category and it would be desirable that our error or estimate be very small. In the case of drug services, there is no one service which solves all the problems in every case. A feasible range of services is necessary. Policy regarding health and justice programmes should be based on an analysis of clientele, provided of course the service is available comprehensively or, at least, to a known population. Under such conditions encouragement of new ideas will be essential and new services developed and evaluated.

## 3. Issues for study

There are a number of more specific issues to which research should be directed.

### (a) *Monitoring supply*

This is a complex issue. Part of the supply operates in a through marketing procedure. For illegal drugs the market is covert. The issue would not be so serious if it were not for the addictive nature of some drugs. It is therefore essential that supply be carefully monitored. As new drugs are produced and more discovered about existing ones there will be a need to change the law and regulations. Even if currently illegal drugs were wholly or partly legalized it would be essential to monitor supply as regulation of production would be required. Hence whatever the changes in policy, if material planning is to be achieved, growth, manufacture and importing must be under close control.

### (b) *Distribution*

There would be continuing research on the nature of the appeal of drugs to the community. This will be essential as different approaches to the problem are tried. A diversionary programme which it not matched to the characteristics of the clients will be less likely to be successful.

### (c) *Effects of drugs*

There will clearly need to be continued research on the effect of drugs on driving. The efforts paid to the effects of alcohol need to be extended to other drugs of addiction, which is being done in a number of research centres.

The association of drugs and crime is a matter for close study. Firstly there is the problem of crime committed to finance a drug habit. The police record where drugs are stolen but it is more difficult to establish where money or goods are stolen to buy drugs. This should be studied more closely if we are to develop any preventative procedures. Another problem is the degree to which persons under the influence of drugs commit crimes as a result of that influence. Drunk-driving offences may be put in that category but it is also asserted that more serious crimes are committed in this way. Of course, there are offences involving violence where it is possible to trace the will to alcoholism but it is much less certain that crimes like a planned bank robbery could be committed under the influence of drugs and as a result of that influence. The Bureau made a preliminary attempt to investigate this matter in its study of armed robbery but it is not always easy to obtain such information in the context of crime investigation and available records do not provide a reliable source of information. Further study would clearly be desirable.

## 4. Outcomes of the arrest process

The Bureau of Crime Statistics and Research has provided annual reports of the outcome of the judicial process in New South Wales for some years.

The Court diversionary programmes introduce a new element in this area. The programmes were developed by Committees chaired by the Chief Stipendiary Magistrate, Mr M. Farquhar. Research Staff have been attached to the Bureau to undertake an evaluation of the drug diversion programme. It will be necessary to monitor the progress of each individual who passes through the diversionary streams. From the point of view of the justice system it is an obligation of such programmes to provide to magistrates a clear picture of the progress of each individual during their period in the treatment programme.

## 5. *Co-ordination*

Diversionary programmes illustrate the results that can be achieved through co-ordination of different agencies. Courts, police, probation service, health and justice research are all involved together with voluntary agencies. This co-ordination is necessary throughout the whole range of the production and consumption of drugs. Social problems as complex as that of the abuse of drugs require co-ordination of agencies and basic research. The research should be directed to evaluate clear policy alternatives and to monitor production and consumption of drugs. It should provide feedback of information so that agencies can more effectively match their actions to their objectives.

| | Local Government Area of Offence | | Drug Frequency | | |
|---|---|---|---|---|---|
| | | | 1974 | 1975 | 1976 |
| 001 | Ashfield | M | 14 | 21 | 28 |
| 002 | Auburn | M | 9 | 24 | 48 |
| 003 | Bankstown | M | 50 | 110 | 169 |
| 004 | Baulkham Hills | S | 24 | 27 | 21 |
| 005 | Blacktown | M | 86 | 189 | 198 |
| 006 | Blue Mountains | M (City) | 2 | 4 | 8 |
| 007 | Botany | M | 32 | 34 | 38 |
| 008 | Burwood | M | 21 | 50 | 35 |
| 009 | Camden | M | 25 | 8 | 10 |
| 010 | Campbelltown | M (City) | 9 | 20 | 27 |
| 011 | Canterbury | M | 21 | 46 | 57 |
| 012 | Concord | M | 5 | 22 | 20 |
| 013 | Drummoyne | M | 12 | 22 | 14 |
| 014 | Fairfield | M | 15 | 45 | 95 |
| 015 | Holroyd | M | 9 | 30 | 40 |
| 016 | Hornsby | S | 22 | 63 | 58 |
| 017 | Hunter's Hill | M | 3 | 9 | 4 |
| 018 | Hurstville | M | 22 | 44 | 49 |
| 019 | Kogarah | M | 19 | 20 | 26 |
| 020 | Ku-ring-gai | M | 18 | 33 | 57 |
| 021 | Lane Cove | M | 4 | 26 | 30 |
| 022 | Leichhardt | M | 41 | 81 | 82 |
| 023 | Liverpool | M (City) | 46 | 97 | 155 |
| 024 | Manly | M | 33 | 79 | 59 |
| 025 | Marrickville | M | 30 | 119 | 73 |
| 026 | Mosman | M | 7 | 32 | 35 |
| 027 | North Sydney | M | 27 | 53 | 56 |
| 028 | Parramatta | M (City) | 50 | 84 | 102 |
| 029 | Penrith | M (City) | 29 | 39 | 81 |
| 030 | Randwick | M | 98 | 148 | 126 |
| 031 | Rockdale | M | 35 | 28 | 40 |
| 032 | Ryde | M | 17 | 55 | 52 |
| 033 | South Sydney | M | 11 | 17 | 29 |
| 034 | Strathfield | M | 6 | 12 | 14 |
| 035 | Sutherland | S | 76 | 134 | 150 |
| 036 | Sydney | M (City) | 199 | 380 | 370 |
| 039 | Warringah | S | 105 | 163 | 137 |
| 040 | Waverley | M | 96 | 206 | 267 |
| 041 | Willoughby | M | 21 | 49 | 56 |
| 042 | Windsor | M | 14 | 32 | 31 |
| 043 | Woollahra | M | 35 | 39 | 45 |
| 051 | Blue Mountains | M (City Part) | 9 | 15 | 9 |
| 052 | Colo | S | 7 | 9 | 9 |
| 053 | Gosford | S | 37 | 91 | 102 |
| 054 | Wollondilly | S | 3 | .. | 8 |
| 055 | Wyong | S | 19 | 46 | 58 |
| 061 | Cessnock | M (Greater City Part) | 3 | 15 | 24 |
| 062 | Lake Macquarie | S | 37 | 54 | 79 |
| 063 | Maitland | M (City) | 6 | 14 | 19 |
| 064 | Newcastle | M (City) | 101 | 116 | 204 |
| 067 | Port Stephens | S | 6 | 7 | 26 |
| 071 | Cessnock, Greater | M (City Part) | .. | .. | .. |
| 072 | Denman | S | .. | .. | .. |
| 073 | Dungog | S | 3 | 3 | 1 |
| 074 | Gloucester | S | .. | 5 | 1 |
| 075 | Merriwa | S | .. | .. | 4 |
| 076 | Murrurundi | S | 1 | 1 | .. |
| 077 | Muswellbrook | M | 1 | 8 | 2 |
| 078 | Patrick Plains | S | 6 | .. | 1 |
| 079 | Scone | S | 1 | 2 | 8 |
| 080 | Singleton | M | 1 | 1 | 7 |
| 081 | Great Lakes | S | 14 | 9 | 22 |
| 091 | Kiama | M | 3 | 1 | 6 |
| 092 | Shellharbour | M | 10 | 17 | 15 |
| 093 | Wollongong, Greater | M (City) | 111 | 155 | 251 |

| | *Local Government Area of Offence* | | *Drug Frequency* | | |
|---|---|---|---|---|---|
| | | | 1974 | 1975 | 1976 |
| 101 | Bowral | M | 1 | 11 | 2 |
| 102 | Mittagong | S | .. | 2 | 3 |
| 103 | Shoalhaven | S | 10 | 25 | 47 |
| 104 | Wingecarribee | S | .. | 3 | 5 |
| 111 | Ballina | M | 4 | 1 | 8 |
| 112 | Byron | S | 16 | 33 | 16 |
| 113 | Casino | M | .. | 8 | 13 |
| 114 | Gundurimba | S | .. | .. | 2 |
| 115 | Kyogle | S | .. | 6 | .. |
| 116 | Lismore | M (City) | 8 | 20 | 45 |
| 117 | Mullumbimby | M | 3 | 3 | 3 |
| 118 | Terania | S | 4 | 7 | 12 |
| 119 | Tintenbar | S | 1 | 5 | 7 |
| 120 | Tomki | S | .. | .. | 1 |
| 121 | Tweed | S | 15 | 33 | 10 |
| 122 | Woodburn | S | 1 | 4 | 19 |
| 131 | Bellingen | S | .. | 3 | 17 |
| 132 | Coffs Harbour | S | 93 | 58 | 55 |
| 133 | Copmanhurst | S | .. | .. | .. |
| 134 | Grafton | M (City) | 10 | 11 | 18 |
| 135 | Maclean | S | 1 | 14 | 11 |
| 136 | Nambucca | S | 8 | 9 | 1 |
| 137 | Nymboida | S | .. | .. | 2 |
| 138 | Ulmarra | S | .. | 3 | .. |
| 141 | Hastings | S | 9 | 11 | 7 |
| 142 | Kempsey | M | 3 | 10 | 9 |
| 143 | Macleay | S | 3 | 6 | 19 |
| 144 | Manning | S | 12 | 8 | 17 |
| 145 | Port Macquarie | M | 17 | 15 | 15 |
| 146 | Taree | M | 8 | 27 | 41 |
| 147 | Wingham | M | .. | .. | 3 |
| 151 | Armidale | M (City) | 6 | 7 | 9 |
| 152 | Dumaresq | S | .. | 1 | .. |
| 153 | Glen Innes | M | 5 | 2 | 13 |
| 154 | Guyra | S | .. | 2 | .. |
| 155 | Inverell | M | .. | .. | 4 |
| 156 | Macintyre | S (Part) | .. | .. | .. |
| 157 | Severn | S | .. | .. | .. |
| 158 | Tenterfield | M | 2 | .. | 2 |
| 159 | Tenterfield | S | .. | 1 | 30 |
| 160 | Uralla | S | .. | 1 | .. |
| 161 | Walcha | S | .. | 8 | 5 |
| 171 | Ashford | S | .. | 2 | 3 |
| 172 | Barraba | S | .. | .. | 3 |
| 173 | Bingara | S | 1 | 1 | .. |
| 174 | Cockburn | S | 1 | 1 | 4 |
| 175 | Gunnedah | M | 4 | 3 | 5 |
| 176 | Liverpool Plains | S | .. | .. | .. |
| 177 | Macintyre | S (Part) | .. | .. | .. |
| 178 | Manilla | S | .. | .. | .. |
| 179 | Nundle | S | .. | .. | .. |
| 180 | Peel | S | 1 | .. | 1 |
| 181 | Quirindi | M | .. | 3 | .. |
| 182 | Tamarang | S | .. | .. | .. |
| 183 | Tamworth | M (City) | 10 | 18 | 6 |
| 184 | Yallaroi | S | .. | 1 | .. |
| 191 | Boolooroo | S | .. | .. | .. |
| 192 | Boomi | S | .. | .. | 1 |
| 193 | Moree | M | 3 | 1 | 3 |
| 194 | Namoi | S | .. | 2 | 2 |
| 195 | Narrabri | M | .. | .. | 3 |
| 201 | Coolah | S | 1 | .. | 4 |
| 202 | Coonabarabran | S | .. | 4 | .. |
| 203 | Cudgegong | S | 1 | 3 | 2 |

| | | *Local Government Area of Offence* | | *Drug Frequency* | | |
|---|---|---|---|---|---|---|
| | | | | 1974 | 1975 | 1976 |
| 204 | Dubbo | M (City) | | .. | 3 | 5 |
| 205 | Gilgandra | S | | 3 | .. | .. |
| 206 | Mudgee | M | | 3 | 4 | 4 |
| 207 | Narromine | M | | .. | .. | 1 |
| 209 | Talbragar | S | | .. | 1 | .. |
| 210 | Timbrebongie | S | | .. | .. | .. |
| 211 | Wellington | S | | .. | 4 | 8 |
| 221 | Bogan | S | | .. | 1 | 2 |
| 222 | Coonamble | S | | .. | .. | .. |
| 224 | Walgett | S | | .. | .. | 8 |
| 225 | Warren | S | | .. | 1 | .. |
| 231 | Brewarrina | S | | .. | 5 | .. |
| 232 | Cobar | S | | 1 | 3 | 8 |
| 233 | Darling | S | | .. | .. | .. |
| 241 | Abercrombie | S | | .. | 1 | 1 |
| 242 | Bathurst | M (City) | | 11 | 29 | 21 |
| 243 | Blaxland | S | | 6 | 1 | 7 |
| 244 | Canobolas | S | | 1 | 1 | .. |
| 245 | Lithgow | M (City) | | 3 | 5 | 4 |
| 246 | Lyndhurst | S | | .. | 7 | 3 |
| 247 | Oberon | S | | .. | 2 | 1 |
| 248 | Orange | M (City) | | 11 | 17 | 12 |
| 249 | Rylstone | S | | .. | .. | 2 |
| 250 | Taren | S | | 1 | .. | 8 |
| 261 | Bland | S | | .. | .. | 1 |
| 262 | Boree | S | | 1 | 2 | .. |
| 263 | Condobolin | M | | 3 | 1 | 6 |
| 264 | Cowra | M | | .. | 9 | 6 |
| 265 | Forbes | M | | 1 | 6 | 2 |
| 266 | Goobang | S | | .. | 1 | .. |
| 267 | Grenfell | M | | .. | .. | 1 |
| 268 | Jemalong | S | | .. | .. | .. |
| 269 | Lachlan | S | | .. | .. | 1 |
| 270 | Molong | S | | 1 | .. | .. |
| 271 | Parkes | M | | .. | 1 | 1 |
| 272 | Waugeola | S | | 2 | 2 | 5 |
| 273 | Weddin | S | | .. | .. | 1 |
| 281 | Bega | M | | 3 | 1 | 6 |
| 282 | Eurobodalla | S | | 3 | 20 | 39 |
| 283 | Imlay | S | | 9 | 11 | 13 |
| 284 | Mumbulla | S | | .. | .. | 12 |
| 291 | Bibbenluke | S | | .. | .. | .. |
| 292 | Bombala | M | | .. | .. | 1 |
| 293 | Cooma | M | | 3 | 4 | 7 |
| 294 | Monaro | S | | 1 | .. | 3 |
| 295 | Snowy River | S | | 2 | 8 | 11 |
| 301 | Boorowa | S | | 1 | .. | 2 |
| 302 | Burrangong | S | | .. | .. | .. |
| 303 | Crookwell | S | | .. | .. | 1 |
| 304 | Demondrille | S | | .. | .. | 2 |
| 305 | Goodradigbee | S | | .. | 1 | .. |
| 306 | Goulburn | M (City) | | 4 | 9 | 8 |
| 307 | Gunning | S | | .. | 3 | 1 |
| 308 | Mulwaree | S | | .. | .. | 1 |
| 309 | Murrumburrah | M | | .. | .. | .. |
| 310 | Queanbeyan | M | | 13 | 8 | 18 |
| 311 | Tallaganda | S | | 1 | 3 | .. |
| 312 | Yarrowlumla | S | | 2 | .. | 5 |
| 313 | Yass | M | | .. | 4 | 1 |
| 314 | Young | M | | 1 | .. | .. |
| 321 | Coolamon | S | | .. | .. | .. |
| 322 | Cootamundra | M | | 1 | 5 | 3 |
| 323 | Gundagai | S | | .. | 1 | 2 |
| 324 | Illabo | S | | .. | .. | .. |

*Witness*—A. J. Sutton, 26 July, 1977

| | *Local Government Area of Offence* | | *Drug Frequency* | | |
|---|---|---|---|---|---|
| | | | 1974 | 1975 | 1976 |
| 325 | Jindalee | S | 1 | .. | .. |
| 326 | Junee | M | .. | .. | .. |
| 327 | Kyeamba | S | 11 | 1 | 1 |
| 328 | Lockhart | S | .. | .. | 3 |
| 329 | Mitchell | S | 8 | 12 | 3 |
| 330 | Narraburra | S | .. | 1 | .. |
| 331 | Narrandera | S | .. | .. | 4 |
| 332 | Temora | M | .. | 1 | .. |
| 333 | Tumut | S | .. | .. | 4 |
| 334 | Wagga Wagga | M (City) | 10 | 25 | 11 |
| 341 | Carrathool | S | .. | .. | 1 |
| 342 | Hay | S | .. | 1 | 5 |
| 343 | Leeton | S | .. | 4 | 10 |
| 344 | Murrumbidgee | S | .. | .. | .. |
| 345 | Wade | S | 5 | .. | 14 |
| 351 | Albury | M (City) | 11 | 19 | 16 |
| 352 | Corowa | S | .. | .. | 5 |
| 353 | Culcairn | S | .. | 1 | 2 |
| 354 | Holbrook | S | .. | .. | 1 |
| 355 | Hume | S | .. | .. | .. |
| 356 | Tumbarumba | S | 2 | .. | .. |
| 357 | Urana | S | .. | .. | 1 |
| 361 | Berrigan | S | .. | .. | .. |
| 362 | Conargo | S | .. | .. | .. |
| 363 | Deniliquin | M | 2 | .. | .. |
| 364 | Jerilderie | S | .. | 2 | .. |
| 365 | Murray | S | .. | .. | .. |
| 366 | Wakool | S | .. | 3 | .. |
| 367 | Windouran | S | .. | .. | .. |
| 371 | Balranald | S | .. | .. | .. |
| 372 | Wentworth | S | .. | 1 | 3 |
| 381 | Broken Hill | M (City) | 1 | 1 | 6 |
| 382 | Central Darling | S | .. | .. | 1 |
| 383 | Unincorporated | | .. | 2 | .. |
| 401 | Lord Howe Island | | .. | .. | .. |

3852. CHAIRMAN: Do you desire to address the committee on the matters that you have set out in that document?——W. The purpose of my submission is to provide two pieces of information. The first is the drug offences for 1976, convictions before courts of petty sessions. I understand this information may be of value to the committee in its future deliberations. Normally we would publish these figures somewhat later and they would be incorporated in a larger publication of all the court statistics for 1976. We analysed these in the past few days so that we could make them available to the committee today. Two items are covered. The first is the overall number of convictions in New South Wales, the number of persons convicted of offences under Parts III and IV of the Poisons Act. That figure is 4 707, which is an increase of a little under 20 per cent on the previous year. The notable thing about that is that the increase has now dropped to a figure between 1971 and 1972, after the substantial increases in the years 1974 and 1975. It is hard to explain this type of bald statistic as there are so many reasons why people appear before the courts. One possible explanation—perhaps the most optimistic and encouraging one—is that, as some authorities have suggested, drug usage follows a kind of growth pattern and after a period of rapid increase there would be a tailing-off of that increase to a plateau. It may be that we are on the beginning of that but I should not like to assert that. It is merely a proposition. Another possibility is that since these figures relate to convictions and therefore to offenders brought by the police to the courts, it could be that the rapid development of the drug squad and its work throughout the various sectors of the State resulted in a kind of education programme to inform people in the regional police stations about the presence of drugs and how to detect them. It may be that we have now reached the point where the available resources have reached their limit and this is the level of offences that they can now detect. It may be that both of those explanations are true. It is hard to tell.

The other statistics, which we have provided at the back of the submission, are contained in a large table which lists each local government area and the number of persons convicted of offences in that area. I should make it clear that these are offences which were committed in that area. In our previous reports we have given the area of residence of the offender. For the committee's purposes it seemed to us that it might be of more value to have the location where the offence was committed. We have quoted them for three years in order to show the trend and to point out that when the figures are low the fluctuations in them can be substantial, so it is unsatisfactory to look at a figure which shifts from three to three to one and then talk about a two-thirds decrease or something of that sort. In some municipalities it will be seen that the figure has gone up and then down. For example, the

City of the Blue Mountains went from nine to fifteen and back to nine. I do not know that anything can be said about that except that it is a fairly low figure. In other places the number of offences has increased. The metropolitan area has generaly higher figures than the country. That is one point that can be made. Some country areas have shown substantial increases; for example, Newcastle and Wollongong, though I suppose they are country metropolitan areas. They have both increased steadily. Certain parts of the metropolitan area have increased, but some of the inner metropolitan areas appear not to have done so. It is hard to draw a pattern across such a wide range.

One has the feeling, as with many offences, that some sort of wave goes through an area, and people know about it and become aware of an activity that has been indulged in. Then it goes up for a while and then tails off. Perhaps that is what we are getting in certain parts of the metropolitan area where there was a rapid increase and there is now a slight tailing-off reflected in the overall result. In other country areas we are now getting an increase which may later tail off. The figures relate to convictions for 1976 and do not cover this year.

The second part of my submission relates to general questions. I wish to speak to those, but perhaps questions relative to the statistics might be asked at this stage?

3853. So that there is no misconception about this, perhaps at this stage we should emphasize what you have stated on the first page; that is, it is a slowing down of the increase of the drug convictions from 1975 to 1976; it is not a decrease?——W. That is so.

3854. The percentage increase has dropped away considerably compared with the previous year?——W. That is correct.

3855. I assume the final figures will follow the outlines in previous years, so that ultimately we shall have a break-up of offences in regard to opiates, narcotics, cannabis and so on?——W. Yes.

3856. It is a little too early to have those available for us?——W. Yes.

3857. I suppose you would be aware of the apprehension figures for the period from 1973 to 1976? Are you supplied with any apprehension figures from the Police Department?——W. No, only as they appear in the police annual reports. So far, they are up to 1975, and we do not have figures for 1976.

3858. The figures made available to us from the police and the coroner's court seem to suggest that there has been an increase in the use of opiate narcotics, in the order of something like three and a half to four times, over the period 1973 to 1976. If you compare the 1973 and 1976 figures in your table, you would be getting up to between three and a half and four times:——W. Yes. But statistics of crimes known to the police will always be higher than the court statistics. They cover all individuals apprehended on suspicion of an offence. Charges are not necessarily brought against all those people. Furthermore, there is no clear relationship. In some cases more than one charge might be laid against one person, and in other cases charges might be withdrawn. It is a complex matter to try to link the two. Generally the crimes known to the police are always higher than our figures.

3859. But the numbers would be for each year?——W. Yes, the trend should be similar.

3860. The trend in your figures seems to be similar to the trend in the figures from the police and the coroner's court?——W. Yes.

3861. Is it possible that your bureau at some stage could be supplied with any figures from drug companies in regard to dependent drugs, list drugs as opposed to illicit drugs? That is, to be supplied with the figures showing the supplies of illcit drugs that are available?——W. As I understand it, that is not available to anybody at the moment. The normal channel would be through the Health Commission; in the Research Division a number of people looked at that question, but I understand that the production figures are not available.

3862. I was wondering whether you would have any idea of how they might ultimately become available to you, as a statistics bureau, so that in turn they would be available to people like us? Perhaps that is an unfair question at this stage; it has nothing to do with your submission?——W. It relates to the second part. I should expect that the companies would strongly resist the provision of that information, and it would have to be required by legislation. I would not be sure about that, but that is a speculation.

3863. There is an overflow into the coroner's court, where they deal with people who die from causes that are not perhaps exactly the same as those stated on the death certificate supplied by the medical officer?——W. Yes. That is the purpose of the estimation in my submission; that is, to indicate the kind of pattern of statistics we would require if we handled the drug problem on a comprehensive basis. Shall I continue with that?

3864. It might be better if you dealt with the second part first. Then the members of the Committee might like to ask you questions.——W. Yes, Although we are talking about statistics, I wish to emphasize that we are referring to both quantitative and qualitative information. We endeavour to quantify everything we handle, in the sense that this supplies repeated measurements. But often this is not possible. I emphasize that the information I am now talking about would not be only statistical but also of a more descriptive kind. Also, we would be looking to collect information systematically and objectively. But I might be criticized by my former academic colleagues, who would argue that everything we collect would be biased in some way. I aim to see that the bias is towards the policy problems that confront the Government of the day. So that information could be collected not only for the Government but also for all bodies concerned with dealing with a problem that spreads across all of our society. Most of our contentious problems are like this, and they require co-ordination, and spread over more than one administrator. Looking at the drug problem itself, we find there is a vast literature of it, but there is even some doubt in some of the literature on the definition of drugs. We can take a more pragmatic view. I shall deal with the substances that are illegal or are likely to be subject of control.

Logically we can trace the stages of drug use from manufacture or growth, through supply, distribution, consumption, consequences, both personal and social, and in the case of illegal drugs, treatment and, or arrest and punishment.

If we are to undertake rational planning for drug control, we require statistical monitoring of the movement of the drugs through each of these stages. This is true even if policy were changed, say, in the case of cannabis, to decriminalization or legalization. Then the question of monitoring for control of growth and supply would disappear, but there would be a need to monitor for growth and production, just the same as with tobacco and alcohol. That would be another process of complete legalization. With decriminalization, you would be met with the same problem. We would need to know the dimensions of illegal growth. There would be a great disparity between penalties for supply and actual use. This would have a profound impact on the supply. Therefore, we would again need to know the details, and we would need to know the growth, the supply, and how to cope with it.

3865. These things arise from my concern with monitoring the problem. But the point about measuring and monitoring is that you inevitably get into policy and management, and the decisions made. The implication I draw, therefore, is that there would still need to be substantial growth and supply monitoring no matter what the policy. Even if we were to decide tomorrow that there would now be substantial penalties for, say, using marihuana, we would have to push out a philosophy and attempt to suppress it totally. That applies to the other kinds of drugs as well. This relates also to the supply of pharmaceutical products, even though they are carried out under normal industrial conditions. The quantity of material supplied has to be made public. We have no idea except by estimation through pharmaceutical benefits and the like how much is produced at any time.

Most of the statistics which are supplied are for different kinds of purposes, either pharmaceutical benefits, the estimation of imported material, the arrest rate in order to plan the distribution of police activity, the admission to medical facilities particularly where it is physically based treatment and also the recording of mortality. These things are fairly well represented in a report to the Health Commission by Roy McCulloch who was then of the drug and alcohol advisory service. This report brings together the kinds of statistics which are available. It is interesting to note that where McCulloch's report gives the production figures for alcohol these are easy because precise figures are required for duty and tax purposes. He gives crime statistics from the N.S.W. Police department and court statistics from the bureau of crime statistics and research. Prison statistics are also available. He does not record the statistics of the Commonwealth Police which are published through the crime intelligence centre. Commonwealth Police collect drug statistics from the State police forces annually and federal agencies. The report gives a summary of the type of offender, nature of offence and details of stolen, smuggled and seized drugs. It is interesting to note a lack of information on the amounts seized as recorded in the Commonwealth statistics. Obviously there are difficulties in an illegal situation but it seems to me to be essential that there should be some form of formal registration procedure for seized drugs. These procedures, if they do exist, do not appear to be applied broadly enough especially where locally some drugs are produced locally in quantity.

There is another source of data about surveys of drug usage summarized in Bell and Champion's report to the Health Commission. Community surveys of drug usage are difficult to conduct. This is a sensitive area and the surveys require the careful preparation of sampling questionnaires and an introduction to the respondent. The respondent must be completely confident that the confidentiality of his answers will be respected and that there is no advantage from overstating or understating his or her usage. This is a major problem in social surveys of this kind. I think they can certainly be of value from time to time but I admit that their feasibility on a large scale is doubtful. If it were thought that a regular survey of usage were being conducted and that this would have the effect of drug control that would more than likely invalidate the results over a time and certainly would reduce co-operation. In any case, they are very expensive to conduct. As I suspect we would want data statewide from local areas to provide enough information to give reliable statistics on a statewide basis, the cost of the survey would be enormous. Certainly, it would get close to the cost of the present operations of the bureau of crime statistics and I am not sure that it would be of great advantage.

What I think is more important is the lack of studies and statistics of client populations in relation to particular services. There have been a number of studies and a report of the Australian Law Reform Commission entitled *Alcohol, Drugs and Driving*. They are sometimes criticized because of course they are a biased sample of those people who present at clinics. On the other hand, a great many of the programmes likely to be developed in future are likely to be on a local basis or to be referring to particular conditions at a particular time. It would seem more appropriate to give facilities and ensure that the individual and the local areas can assess the problem for themselves when new things are developed rather than try to conduct a State-wide operation in this sort of survey. I should emphasize that I am distinguishing surveys of the community on a sampling basis from official statistics collected as part of the bureaucratic process. One of the essential problems is that we did not know precisely what surveys to believe. If we knew exactly how many people were using what at a particular time it would still not tell us the answer as to what would help them recover. We would still not be able to say which services exactly should be provided at a particular time and place. We do not know what is going to be the most successful. Indeed, some will be successful over a period and then fade out. This would be suitable for some persons but not others. Therefore we are not in a situation of trying to estimate something in relation to, say, spectacle provision under the national health service for people with poor eyesight, where we know exactly what to supply for a particular kind of deficiency and therefore there is no real necessity to spend a fortune in measuring precisely the usage rate across the country.

I have picked out a number of issues which I think would repay study and collecting data in monitoring the drug problem. Firstly, I have mentioned monitoring supply and the need, whatever the changes in the law, to monitor supply and control it. Next is distribution. If we are going to use education as one of our tools there seems to be some dispute about the efficacy of it but we must know what the appeal of drugs is to a particular sector of the community at a particular time and it may be that in a context of a programme developed in that area we would want to undertake a survey to ascertain the attitude of people towards drugs in order to design diversionary and educational programmes of a suitable nature. I am sure the Committee has considered in detail the effect of drugs upon driving, and this matter has been studied by others. Obviously we need to know something about it. We are now in a situation where the effect of drugs on driving is distinguished from the effect of alcohol and it needs to be studied carefully. One question which comes up often in bureau studies is the relationship of drugs and crime. Firstly, there is the problem of crime committed to finance a drug habit. The police record where drugs are stolen but it is more difficult to establish where money is stolen specifically to buy drugs. This needs to be more closely

developed as to procedure. There are serious problems in evaluating this sort of thing. One anecdote which was given to me about a study of the problem in the United States involved a serious ratio of stealing from buses and drivers of buses and it was not detected that the crimes were for addiction purposes. The authorities organized things so that the buses did not carry money and immediately there was an increase in taxis robberies. The money was put back into the buses but in steel safes. In the event drivers were attached in order that the attackers could get at the safe. So it seemed a most unsatisfactory solution to the government at the time but the only suggestion that was put forward was by the Speaker who said that the buses should be free and then there would be nothing to steal and at least the buses and their drivers would be safe.

Clearly, if you are dealing with a drug related crime it is not dealing with something related to preventative procedures. We need to know to what extent crime is motivated by drugs. There are a great many unsubstantiated assertions made about these matters. Also assertions are made about the effect of drugs directly on crime as to whether a person under the influence of drugs will actually undertake a crime which he would not commit otherwise. I guess you can trace alcoholism to crimes, such as driving offences where people are injured, and also crimes of violence. Sometimes it is asserted that even bank robberies may be done as a consequence of drugs but when we made a study of armed robberies we tended to look at this. I would not say they were. We did not know. It is not really possible to tell. In the rush of a police investigation of a robbery of that kind it is not always easy for the police even with the best will in the world to obtain information which clearly points to the presence of drugs on a person. Certainly it is not within the records subsequently on any reliable basis. Even though it might be asserted that there is a drug link, we do not know what the nature of the link might be.

Another issue which has been raised recently is the diversionary programme set up by committees chaired by the chief stipendiary magistrate, Mr Farquhar. Research staff have been attached to the bureau to undertake any valuation of the drug diversion programme. It will be necessary to monitor its progress closely relating to each individual who passes through the diversionary stream. From the point of view of the justice system there is an obligation upon such programmes to provide to magistrates a clear picture of the progress of each individual during their period in the treatment programme. In this way there is at least some clear perception on the part of magistrates of what people are going to when they are sent to prison. The diversionary programmes open up another area of attitude to court procedures. Sometimes there is a different type of approach to justice. On one hand it is helping people to treat themselves and improve themselves and on the other hand it is looking at the fairness of justice applied to people who have some sense of responsibility and assume responsibility for themselves. If the magistrate is carrying out justice he must know what is happening to the people whom he permits to divert. That needs to be looked at carefully. The programmes have only barely commenced so there has not been time to deal with them properly. Diversionary programmes illustrate the result that can be achieved through co-ordination of different agencies. It is often a remarkable achievement that brings together people from justice, health, magistrates, police, probationary services and voluntary agencies, all working to provide a programme on a co-ordinated basis. Almost any realistic solution or method dealing with the drug problem will involve that kind of co-ordination. My particular interest in speaking today is to make the point that in this stage of developing such co-ordinated procedures it is important that adequate action be undertaken and that a system be set up through which information can be transferred easily from one part of the system to another. There are no automatic transfers of information between government departments, even within the justice system. Of course, there is not any co-ordination of this sort of information that I was asked about before, as to what is the relationship between police and court statistics. My point is that if we are to deal with the complex questions of this kind we must deal with that kind of problem also.

3866. CHAIRMAN: I gather from your comment that at this stage you would not be in a position to make any evaluation of the efficacy of the drug diversion programme?——W. No. It commenced only in March and we are just beginning to put the two people on. One person has started and one person has been advertised for and is about to start. We shall then move on to it and I should think it will be a little time before an evaluation can be made. I understand that the Health Department research division is beginning to set up the monitoring system for people progressing through all of its treatment centres. That seems to me an essential part of the drug treatment centres of the Health Commission that has to be tightened up. I think it is important that that be done. It will be some time before we can come to a conclusion.

3867. Evidence has been given here by people with relatives and others that they know who are in gaol for offences not directly but indirectly associated with drugs. You mentioned that type of person a little while ago. Can you see any way in which you could obtain statistics about people who are in gaol for offences not directly associated with drugs but who have previously committed some offence associated with drugs? I think you said it is not on record at this stage but can you see any way in which such statistics could be obtained?——W. It would certainly be possible to move back through the records to determine whether prior convictions were drug-related or not. Do you mean convictions for the usage or supply of drugs or drug-related convictions?

3868. The people who are involved in pushing drugs, if they are not users, will not become involved in the normal crime scene. We are not particularly interested in them at present. We are interested in those that are in gaol because of their involvement in the drug scene but are there at present for an offence which, on the surface, is not associated with drugs. Is there any way in which we could find out how many of them there are?——W. I think it would be fairly straightforward to find the number of people who are in prison at any time for any offence who have had a previous drug conviction, but whether or not one was the cause of the other would be much more difficult to discover. Something might be gained from interviews with these people. That would be a long shot and any conclusion come to as a consequence of such an interview would be rather speculative, but I think it could be a worthwhile exercise. I am inclined to the view that the relationship of drugs to other crime might best be studied at the point of apprehension, if it were possible to work with the police to that end. That is the time when, from our experience, police officers talk about the drug problem as it is associated with a crime. That is the time when relevant information could be obtained from the police and the person apprehended. Once a person is in prison it would seem to me very difficult to get an accurate picture.

3869. A person charged with housebreaking probably would have been committing the offence to get money to buy drugs to help his addiction. When he was charged

with housebreaking there would be no mention of his drug addiction in the charge sheet. Similarly, if somebody under the influence of drugs held up a bank or committed any sort of armed hold-up, the fact that drugs were responsible for the crime, even though indirectly, would not be recorded. Would there be any way in which we could possibly get some figures of that nature?——W. It could not be done on a statistical basis. The relationship between a previous conviction and a current conviction could only be discovered by talking to somebody in relation to those events. I think that once a person is in prison it would be only the prisoner that you could talk to. I think that would be worth doing, but I am being cautious because I am not exactly sure that it would be possible to develop a technique by which one could ensure that the information obtained was reliable. I should like to clarify the point about the apprehension end of the spectrum. I do not mean that we should go to the court papers as such. We should go back beyond that. For example, the records that we used in our study on robbery were those of the squad dealing with that offence. These relate to the events at the time and are not necessarily information that is available even to the court. Further, the closer one can get to the event, the better the recollection of the officers concerned, who are then more willing to talk about it.

3870. Mr HEALEY: Could you tell the committee the types of information that are not now readily available to you and that you have to go and seek, which you feel would be of assistance in the compilation of statistics if they were automatically supplied to you by the various government departments concerned?——W. If it were our task to co-ordinate them, which it is not because it would have to be done jointly by several departments with a wide range of responsibility, we would need figures on production of drugs and other products that were likely to become illegal or be placed under control or regulation. We would need to know the quantities of drugs seized. For example, the Commonwealth statistics of imported drugs seized by the Australian Narcotics Bureau are shown as heroin 5 kg, 938 kg and when it comes to marihuana seizures by State police forces the figures given are 673 kg, 21 joints, 163 cigarettes and 3 859 seizures with no quantity stated. That lack of detail would need to be rectified. That deals with the production side of the question.

Dealing with the question of usage, I have spoken out against the survey approach. I think it is up to the Health Commission research division rather than us to provide statistics covering the flow-through of people in treatment programmes. We would want that information for our evaluation purposes, on the basis of co-operation with the Commission. Another set of statistics or type of information we need is what is done with people who go through the treatment programmes, what activities they undertake, how often they attend and what type of evaluation of the programme is made by the persons undertaking it. We have found a tendency among health welfare personnel undertaking programmes of this kind to retreat behind a doctor-patient relationship and suggest that they could not possibly provide the material because it is confidential. I contend that since we are dealing with an interaction primarily with the justice system, the position is not like that at all. The justice system has to account for each person and what happens to him and I contend there is an obligation on the health system and the justice system to mesh in that way. It is a fundamental problem and the Health Commission will describe that to you in its own submission and its programmes. It is a difficult problem but we would want that information.

We would also want to be able to work closely with the police in relation to drugs and crime. We would want the information on the understanding that if it were being used for crime intelligence purposes it would not be made public. On that understanding we would wish to be able to summarize the sort of information used in the crime intelligence system and collected by police officers, in order to be able to draw conclusions about the overall relationship between drugs and crime. That is not available at the moment except on an inadequate basis. Those are the types of information that come to mind immediately.

3871. Mr WOTTON: Once you have obtained the information that you are trying to get from the various departments to use in your monitoring system, what do you do with it then? Do you hope that a format can be developed that will be acceptable for use in the treatment of drug addicts?——W. Yes. The ways that we deal with this information at present are that it is first analyzed and other information that is relevant to its usage is collected. There is not much point in simply providing a large computer print-out if one cannot interpret it for the people who want to make decisions on the basis of it. We do that. When required, we provide reports on these matters to the individual departments or officers concerned so that they can deal with internal matters in their own departments without necessarily publishing that material, particularly where it contains sensitive information. On the other hand, as a principle, we publish in every area that we investigate and we generally write a report that will be informative to the general public and to those people who are working in the area concerned. We attempt to put it out in two forms. We generally print the statistics as does the Australian Bureau on a national level. Where the information is relevant to a particular policy problem we publish it as a research report in which we interpret the results and make comments about possible use of the figures. That is the sort of thing I would have in mind. At a certain point we have to stop and it is then the responsibility of somebody else to make decisions and assess the information. It is the management tool I am speaking about.

3872. You said you believed there should be a better method of recording drug seizures. Do you believe there is a present abuse of seized drugs?——W. It would seem to me to be in the interests of everybody handling this issue that the amount of material seized in offences be clearly made public. That is as far as I would go.

3873. Mr MACDIARMID: In your submission you dealt with the association of other crimes with drugs. Yesterday I heard an interview conducted with a reformed drug addict who claimed that some people on drugs would require as much as $150 a day to enable them to purchase drugs and continue on with them. That indicates to me that many major crimes, such as bank robberies, may be associated with drugs when, generally speaking, those people that are on drugs are unemployed and would need to commit crime to get that sort of money. Do you think enough is being done at all levels to discover the association of crime with drug use?——W. No. I think much more could be done. I think it would be a reasonable guess that a fair proportion of the crimes committed would be drug-related but I should suggest not perhaps to the level of bank robberies.

3874. Is it not possible that bank robberies could be committed by persons associated with the peddling of drugs?——W. I think that is true but it has to be remembered, for instance, that in New South Wales last year

there were 492 armed robberies—that is robberies committed by persons with a weapon—of which only a proportion and not by any means the largest proportion were committed against banks. I think a large number of offences occur in the street and outside premises, often committed by a single offender, offences in which somebody is injured or attacked for money or other valuables and these offences could be done in a spontaneous way as a consequence of the need to get drugs. The offenders are difficult to apprehend. The offence is often committed in an isolated place, in the dark, and it is hard for the police to pick up the offender. Bank robberies have a high rate of apprehension of the offender because of the speed with which the police can act.

That disposes of the basic issue, that we ought to make a closer study of this problem but I want to make the point that I suspect the problem will be most severe in relation to breaking and entering offences and armed robberies carried out at a lower level than the kind of complex planning that is often done in a successful bank or payroll robbery. I am not disputing it would not occur in some instances, but if we are to examine it seriously we would be looking more at the other kind of offence. We are hoping now to study robbery, and we are getting ready for such a piece of work. This is probably a good opportunity to start introducing into such a study a specific look at drugs. To do it properly you would need a single project to be developed.

3875. Mr McGOWAN: You work in association with the Drug Squad?——W. Yes, we have had good relations with the police in this sort of work, but we are not part of the Police Department. Obviously we have to ask specific permission in every instance. Sometimes when you are looking at problems associated with managements questions, you are as welcome as perhaps the Public Service Board might be in our own department when they are looking at things. You have to remember there is always going to be difficulty in co-operation between departments when the information being looked at is such that they are naturally concerned what it is to be used for. We are trying to develop confidence with them, so that they will see it is only for mutual benefit.

3876. There has been an upsurge of bank robberies in Australia in modern times. Obviously banks are places where money is kept. But there must be a reason for it? ——W. At the risk of simply making a guess, I do not think it can be traced directly to drugs, although drugs might be a small factor.

3877. You do concede that there needs to be more work done?——W. Yes, absolutely. It would be part of my argument that we need to look at the relationship—a spill-over effect of drugs to other crimes.

3878. CHAIRMAN: Probably you are aware that recently the National Standing Committee on Drug Dependence recommended to the health Ministers in the various States that combined analgesics should at some time be available only on prescription. If such restrictions were brought in, it would probably be necessary to keep a close watch on the statistical side of the supply of these drugs? ——W. Yes.

3879. Would you see that as a function for your office, or would it be more for the Health Commission?——W. I think it is a matter for the Health Commission, where it is a health question. Where is interacts with the justice system, I hope we would be able to look at such a problem together. It is not possible to say specifically that it should be our responsibility or the responsibility of someone else. It is a matter for the people to whom it is applied.

3880. You would be involved when someone is trying to get around the system?——W. I would say that would be a definition of the bureau's work. It is crime, and related social problems. You cannot describe it in a statutory way. It is a matter of co-operation.

3881. You might have read the publicity given to the statement by the Premier in regard to the establishment of a drug authority. I think he made his first statement at a drug diversion programme at Bourke Street. Have you any thoughts on the constitution of such a drug authority? ——W. The first thing that strikes me about it is that a drug authority would need to be strongly staffed. It needs to be a full-time operation, with a chairman who can devote all his time to linking together all the various complex issues. It needs some sort of back-up staff. The various contributing departments should have representation or it will weaken the basis for co-operation. On the authority there should be representatives from the contributing departments, so that they can work together without feeling that their autonomy and responsibilities are being eroded by an overwhelming superdepartment. Most people react against that. On the other hand, it would need statutory powers to collect the material. There could be occasion when that would be desirable. I have argued that the bureau should not have statutory powers for data collection, because that can rebound if you try to force people to provide information. But a drug authority would have such a wide responsibility that it would need some form of statutory power—at least consultative. It would need an executive officer and a staff who are highly qualified, enough to understand the full ramifications of the area. It would need strong representation from community groups that are undertaking treatment programmes. The Government would not be able to do all the treatment activities that would be desirable and would be of value in particular local areas. There should be a fairly solid representation from people outside. By solid I do not necessarily mean large numbers, but sufficiently well established to give a good channel-through from the authority and agencies working in this area. There should be contributions from the victims and the people who know about the drug problem first hand. There should be some representative or representatives from the public in that sense.

That would be my view, but I emphasize that, whoever is operating it at the executive and chairing level, would need a powerful capacity to co-ordinate and to induce co-operation. It could not be something that could be set up as simply another authority with a well defined charter. It would have much more overlap than other kinds of statutory bodies. There are enough problems in the planning field, which also has statutory authority, but at least in that field one is talking about matters that can be separated. However, here we are talking about social problems that cannot be handled in a clear cut and simple way. This requires careful thought.

3882. CHAIRMAN: Dr Sutton, I want to thank you for your attendance here today, and I repeat what I said in the memorandum of 30th March. The Committee is indebted to you for your assistance, and I thank you again for the obvious time and effort that you have given to the presentation of this material to the Committee. Also, I express our thanks to Miss Ros Wood, who has been your understudy here today, and has been very helpful to myself and Mr James.

(Short adjournment.)

*Witness*—J. L. Billington, 26 July, 1977

JAMES LEON BILLINGTON, Publisher, residing at 668 Old South Head Road, Rose Bay, sworn and examined:

3883. CHAIRMAN: Have you received a summons under my hand issued in accordance with the Parliamentary Evidence Act?——W. Yes.

3884. I understand that you have a submission in regard to a cannabis control board and you would like it incorporated as part of your evidence?——W. Yes. The submission reads:

CANNABIS CONTROL BOARD

By establishing the Cannabis Control Board, cultivators can be issued with a licence on entering the contractural agreement with the C.C.B. that cultivator sells to the Board predetermined quantity at guaranteed prices. This enables quantity and quality control by the C.C.B. and the collection of taxes. The government, while being free of the responsibility has a source of legitimate revenue and information available from the C.C.B. The C.C.B. issues distributors with licences and provides Cannabis graded under close scrutiny. The whole of the C.C.B. covers cultivation, classing, distribution. This would provide detailed information of actual consumption figures that would assist research.

"The Policy advocated is one of Control and Restriction . . .

In the Resolution which the Government of India adopted as its official reaction to the report, the full outlines of this policy are presented. Here we will consider only a few examples of how this policy was carried out on the practical local level.

Control over consumption implies control over source, and many of the provinces of British India had effective controls long before the Commission was called into being to study these matters. In most provinces the course of preference was to have a system of licensing and taxation, with comparatively severe restrictions on operating outside the system coupled with substantial rewards for operating within. There was, really, very little economic incentive for illicit traffic in hemp drugs with the possible exception of Charas.

The licencing of cultivators was the first point of control. Cultivators who applied for and received permission to grow Cannabis entered into a first contractural agreement with the government, an agreement which, while it gave the cultivator every latitude needed to pursue his profitable occupation, was primarily designed to facilitate government control and supervision. In addition, many farmers were also licenced as exclusive vendors, which greatly simplified matters for the government."

The connoisseur's Handbook of Marijuana by William DAnial Drake Jr, pages 98–99.

An alternative form of control or supervision of Cannabis exists within the concept of the C.C.B. The farmer applies to the C.C.B. for permit to cultivate a predetermined quota of Cannabis to be sold to the C.C.B. at a mutual agreed price contracturally bound. The C.C.B. issued a licence under condition laid down by the C.C.B. Conditions between farmer and C.C.B.—land, size, soil, rainfall, etc.

As purchaser of harvested crop C.C.B. maintains supervision over quantity of crops from quota on licence. C.C.B. maintains quality control ensuring only finest preparation used for medicinal therapeutic and recreational use. Production and research enables multiple use of all of the plant Cannabis providing raw material fibre for paper and textiles of a thousand varieties.

The C.C.B. would allow free enterprise employment in farming, marketing, consuming providing massive revenue for the Government and employment for thousands.

The Indian Hemp Commission of 1896 sponsored by the British Government saw advantages with supervision of cultivation but suggested Government should remain out of distribution. C.C.B. issues licences to distributors enabling supervision of quantity and quality control.

Considering conservative estimate 100 000 regular Cannabis users the major health concern would be quality supervision. The C.C.B. offers the only avenue for quality supervision to those 100 000 and it provides the Government with millions in revenue (sales tax, income tax, etc.) instead of expenditure involved in attempting to enforce the law, police, solicitors, courts, magistrates, prisons, and detention centres, armed forces, politicians, parents, etc. The cost is high.

The creditability of law makers and law enforcers has been shattered by maintaining current hard line attitudes towards Cannabis. It can only be restored when Cannabis becomes a non-issue.

In accordance with the U.S. National Commission on Marihuana and Drug Use the Foundation recommends the following changes in Federal and State Laws:

Possession of Marihuana for Personal use would no longer be an offence, but Marihuana possessed in public would remain contraband subject to summary seizure and forfeiture.

Casual distribution of small amounts of Marihuana for no remuneration, or insignificant remuneration not involving profit would no longer be an offence.

A plea of Marihuana intoxication shall not be a defence to any criminal act committed under its influence, nor shall proof of such intoxication constitute a negation of specific intent.

3885. CHAIRMAN: Would you like to elaborate on that or give any other evidence to the Committee?——W. I would like to give an outline. From all the evidence we have available it would indicate that whatever efforts we make to try and deter people from using cannabis, in the past ten years we have grown to 250 000 people using cannabis. The same situation happened in America where they once adopted an attitude of heavier penalties but found it did not work. On the West Coast eight States de-criminalized cannabis. New York under Rockefeller felt that the answer to the problem was heavier penalties and longer sentences in gaol but this finished up with New York getting the worst drug problem in the United States. The suggestion is not that the law itself was the only contributing factor. One would acknowledge that density of population is involved. In the United States it does not appear that the problem is now any bigger on the West Coast. The real problem that they have in New York is with heroin. When we relate that situation to Australia we could find that the same situation applies. Where penalties are heavy and the profit in cannabis is not to be compared with heroin you do find a connection and the only connection is that with the profit motive. Therefore, instead of someone being quite content to have a bag full of grass some of them move a match box full of heroin for twenty times the profit at a similar sort of risk or even less of a risk because heroin does not have the same aroma that marihuana or grass or hashish has. When it comes down to it, individuals have a right to use what they so desire. We have heard evidence which indicates that an individual has died from too much water at the age of 17. They attributed cancer as the cause of death for this particular lady. Her mother had died of cancer before her. She had been drinking four gallons of water daily for four years in an attempt to purify her body. Nobody is going to suggest that we ban water because it has essentially caused harm. I suggest that a similar situation exist with cannabis. All the results indicate that cannabis in normal use is not harmful. We do not have an epidemic problem on our hands with cannabis. We have been to doctors and institutions and rehabilitation centres and no people there are suffering from the effects of marihuana.

The greatest problem that comes from marihuana is confrontation with the police when they might just suspect that you have possession of cannabis. This gives the police a free go to come into your home and invade your privacy on something that really should not concern them at all. If anything it is a medical problem and certainly not a legal problem. I fail to see how the police department can cope with something that is supposed to be a medical problem. I do not see how they are equipped to do it. The police have become bunnies in the situation.

They cop all the abuse. The situation has changed from when I was a child when we had some respect for the police. Now they are often called pigs. One of the reasons they are called pigs is because of the unpleasant job they have to do in relation to this matter. It was with this in mind that we looked at the problem of trying to find some solution. What happens if we do what New York did and make them heavier penalties and longer gaol sentences? I am on record on Channel 9 in Victoria in 1975 in saying if the law did not change eventually there would be blood in the streets. I said then that the situation would get to such a point that retaliation would come from those people who are suffering. I suggest that in Maroochydore in southern Queensland there was an attempt to blow up a police officer. That is quite so. The attempt failed and subsequently some children were killed. The gentleman responsible is now in Queensland gaol as the result of that.

There have been instances of missing people who have been found in the ocean with no clue as to why they are there. Lately we have heard of the gentleman in Griffith who is missing, presumably over cannabis. So long as the law exists in its present form the situation is being set up for the criminal element to come in and take over. Unless some form of government-regulated control is brought in the situation will continue to get worse. It is uncomfortably true that while most of us are engaged in a free society with the profit motive, trying to work to earn some money and make ends meet, there are always a lot of people interested in making a quick dollar from smuggling birds out of the country or smuggling guns or moving guns legally under the auspices of defence. Uranium has no potential for harm, we are told. Have we forgotten Hiroshima? I would argue that marihuana could not compete with the potential for harm of uranium. Taking these things into consideration it appeared to me imperative that to avoid a future civil war and avoid getting our undermanned police force, instead of protecting people and property, into areas of moral judgment, which is what the cannabis issue is—it is all right for somebody to sit there and have a cup of tea or a cup of coffee, which some medical people call drugs; it is all right for others to smoke tobacco, and alcohol is tolerated though we know it is the most devastating drug available in the community, not only because of deaths from road accidents and drownings and people who have had too much of it hitting others on the head, as well as broken marriages—I could go on but I am not here to talk about alcohol. That evidence is available at any government clinic throughout the country. The same evidence is not available about cannabis.

As water has a potential for harm, cannabis also has a potential for harm, but that is in the abuse of cannabis rather than the normal use. In this area I offer volume 1 of Australasian Weed and volume 1 of Australasian Seed and I should like to quote from a paper that will be handed to the committee as evidence; it was prepared by Dr John Helmer to be presented at the Autumn School of Studies of Alcohol and Drugs, St Vincent's Hospital, Fitzroy, Victoria, in May, 1976. Dr Helmer has a B.A. with honours from Melbourne and an A.M. and Ph.D. from Harvard. At the moment he is working in the White House on a committee for President Carter. That is the esteem in which this gentleman is held. I should like to quote part of his article on the connection between narcotics and crime. Being a new American researcher, the doctor goes into quite a few things about the apology on narcotics and tries to defuse quite a few myths about addiction. He also mentions something in this article called criminogenesis and he suggests that the law creates the crime rather than the act that the individual is doing, which by a lot of standards is totally in accord with democratic and Christian beliefs, and that is that cannabis in its natural state is a herb; it is not a drug like aspirin or Bex or analgesics that you have to go to a pharmacy to get. Those things are chemicals that have to be prepared by a fully qualified person. One of the reasons why cannabis will never be able to be stamped out is that if one drops a seed into some soil it grows without a great deal of attention. That is another reason why it is difficult to apprehend cultivators of cannabis. They do not have to spend all their time looking after the plant. One of the obvious advantages of government control or government regulation would be the elimination of the criminal element, which would reduce the chance of people being introduced to heroin. There is nothing in cannabis itself that can lead to the use of another drug. It has been suggested in quite a few studies that most people who smoke marihuana are the type that would try it anyway and that those who do not because of the law probably would not try it even if it were legal. A study in Oregon, where it has been decriminalized for four years, confirms this. After 1973, when cannabis was decriminalized, the use rate went up by 2 per cent the first year and the next year it increased by one per cent, which sort of went along with the suggestion that those people who want to experience life as it comes will do so and those that have a pleasant experience will repeat it and if it is an unpleasant experience they will not.

Taking all those things into consideration, I should like to avoid civil war at all costs. Times have changed. It is not like the dole bludgers; we can bash them because they have not got a job. We have been bashing smokers for some ten years. It is not just the unemployed drop-out hippie that uses cannabis. It has been shown that the users of cannabis are people from all walks of life—doctors, lawyers, politicians, nurses, school teachers. We have had evidence of school teachers who have suffered twice under the present law, first when they got a penalty for being in possession of it and second when they lost their jobs because of an outcry that they are unfit to teach children. It is all right to have the socially accepted drugs like alcohol, but if a teacher uses cannabis he is a bad example to his students in that he is breaking the law and showing a disregard for it. These contradictions make it very hard for people in 1977 when they and their friends have been subjected to police harassment for the past ten years. For this reason we brought up this concept of a control board. Unless the cultivation and distribution is controlled, there is no control whatever over the situation. With this in mind we suggest that the individual should be able to grow whatever he wants to in his own backyard, so long as he does not infringe upon the rights of his neighbour or neighbours. It is all right for something like fluoride to be introduced into the water supply but that can cause problems to your plants and it could be argued that the Government should not have the right to do that. If an individual wants fluoride, let him have it. If cannabis can be grown successfully in the backyard, we could follow the Californian law which allows six plants per head per household. That would solve the problem that occurs when someone wants cannabis and goes down the street to get some and is told there is no cannabis but he can have some lovely Penang rocks that will blow him right out. That is the type of expression that is used in such circumstances. Here we have someone who normally would not want anything to do with it, and before you know what is happening the supplier has rolled up a $20 note or a $50 note—it could be at a party, which is where the problems often start—one finds some people that are very much their own person; they are going to do what they are going to do, regardless of the influence of other people, and they will hop into whatever is going.

Before they know what is happening, somebody has handed them a little thing like this, told them to put it in their nose, block off the other nostril, sniff and see what happens. In it goes, and it goes back through the nasal passage and hits them and this effect takes place. That is the way that cocaine is generally used. For those of you who may read Cosmopolitan, there is an article in that on cocaine use in Los Angeles and some of the problems associated with it. That is how individuals come in contact with that sort of thing. On the other hand, cannabis is never snorted. I do not know anyone who uses it that way. It is very rarely used as a drink and not often used in food preparation. It is mainly used in smoke form, similar to what the Indians did the other day in Canada with Prince Charles when they sat around in a circle and had a peace pipe. The problem comes in because people are introduced to other drugs by the distribution people. It is not the drug itself. It is the method of distribution that causes the problem and we see the answer to that problem in the control board and the individual being allowed to grow his own cannabis in the backyard, thereby eliminating the need to secure his supply from the source where he could get other drugs.

It will be found also that some people do not wish to have their own cannabis all the time. All round Australia people will tell you that home-grown is the best smoke available, but there is another body of thought that prefers what is called hashish. I am sure members of the committee are by now aware of the difference between the two. It has taken these people thousands of years to learn the art of cultivation and preparation of hashish. There is a definite art to it.

The Indians have been doing this from time immemorial. Their farms are about twice the width of ours, and it is almost hereditary. There is an involvement of grinding up the grass in the first place, and the thumb takes a different spread. After many years they have a thumb that is used for that. We cannot expect people here to be making hashish as good as the hashish from overseas. There will be a body of individuals who will want the right to have hashish, just the same as some people who drink beer would not deny Scotch to their friends. Some people do not like beer; they might consider the smell repulsive. However, they enjoy a Scotch, a vermouth, or whatever it is.

If you solve the whole problem, it is no answer to say that anyone can grow it in his backyard. That will not solve the problem, because people will be in the black market, importing the finest hashish. Where there is a demand there will be a supply. If the Government does not want to have any part of it, and does not want to collect the revenue that is available, if they say there is inflation at present, that is OK, and millions of dollars will go through the community every week regardless of what the Government does, without any tax collected. Unemployment will still roll on. Whereas, we could have people engaged in an industry. We do not have to freak out and think that we are simply talking about marihuana. I am talking about cannabis. This bank note I show you is made essentially of cannabis. The ordinary paper that we use comes from trees, but it is too weak for bank notes, so they use this. The ordinary paper would not last long enough, and therefore currency is not printed on wood pulp paper. With the resources available in this country, as far as scientific technology is concerned, we would probably find hundreds of other uses for this plant. The army would probably be a good client for cannabis, for instead of making the uniform, shirts and trousers from cotton they could be made from cannabis. Therefore, we are depriving our farmers of an opportunity to grow a product, and instead things are being bought from overseas. It is quite remarkable. We say that we want to help our farmers, and that we want to stop them from coming from the country to the cities. We say that we want to give them a marketable crop. But that is all nonsense when the Government does not do this, and it leads to more harmful effects.

The Eastern report showed some scientific evidence that cannabis could be an addicted drug, but to find this they got people to smoke huge concentrations of thc. They took them into a controlled situation in a laboratory. They put them on massive doses of thc for a short period, then whipped them off 24 hours later, and analysed the physical effects in their make-up. If you stuffed someone full of milkshakes for two days, and put them off milkshakes, you would find the same reaction. In other reports it is shown that cannabis taken under normal circumstances is not a drug of addiction and dependence. That does not say that everyone could not become dependent on it. There are nymphomaniacs who enjoy sex. Some people enjoy smoking, and they will repeat it because it is pleasurable, but not because it is addictive.

I have a book here by Joseph Berke and Calvin C. Hernton. It is entitled, "An Interpretive Study of the Effects of Marihuana and Hashish—The Cannabis Experience". It goes into it in detail and tells you, from thinking, why people smoke; from the artist's point of view, where he feels he is being aided and where he is hindered. It talks in terms of when you have your first smoke, and on reaching the high point, of where you have too much, and you are stoned and out of it. In regard to marihuana and driving hazards, I recommend no one to drive a motor car under the influence of any drug, whether it be marihuana or alcohol. Just as they have indicated, for the inexperienced user, driving a car would be diabolical, not only for him but anyone on the road as well. The evidence also indicates that for the experienced user it is not the same problem. The reasons are again given in this particular book, and other evidence in respect of the individual becoming more aware of what is happening around him. He becomes aware of sight, sound, colour and everything happening. The point I have mentioned—which is referred to as the high, the top point referred to as being stoned—or as some people call it, being wasted. Suppose after a hard day's work a man comes home; the children are fed and out of the way; he then relaxes with television or good sounds. They sit down and have what you would call a good session.

The Government is collecting taxation at the moment on some of the implements used in the marihuana business. It is collecting taxation from cigarette papers. The sale of Tally Ho cigarette papers has gone up extraordinarily over the last two years. This is not because the sales of roll-your-own tobacco has gone up. Also, it is collecting taxation on all sorts of papers, pipes and all sorts of apparatus. People sell them and pay taxation.

That is the sort of general introduction to where I stand on the particular situation. The individual should have the right to grow his own in his backyard for his own use. Beyond that, there could be a cannabis control board or marihuana marketing board, just as you have for products like wheat and sugar. Then you would have regulated control. If the individual wants to grow some for his own use, that is o.k., but if he wants to grow more than that he would apply for a licence, setting out that he had 20 acres of land and wanted to grow 5 acres. If a man wanted to grow marihuana, he would apply for a licence, and the board would exercise production control. It would estimate the quality of the cannabis and decide whether it was for therapeutic, medicinal or recreational use. Further, it would assess the rest as being suitable for fibre, which could be used for various purposes.

We are responsible for looking after the future of our children. I have two children, and I am very concerned for their future. I was born in the city, and when I was six years of age I could swim at the Redleaf pool. That does not happen now, and children have to swim outside the harbour. My son is only 18 months old. What will it be like when he is 21 years old? We must reach agreement on this question. If a man wants to grow a crop, he should be able to apply to the board and get a licence. That would solve that problem, and the board would have quality and quantity control. That would overcome 90 per cent of the existing problems. I think at this stage I am now available for questions.

3886. CHAIRMAN: On what have you estimated your figure that 250 000 people are using marihuana now?——W. That was from Mr Wran. We have estimated some 750 000 throughout society. It was recently estimated that 10 per cent of schoolchildren between 13 and 17 years of age are smoking marihuana today. Some would rather smoke marihuana than drink alcohol, because of the less harmful effects. If you work out how many schoolchildren there are in New South Wales, that gives an indication. Then you go to the universities, and you get another big figure there. We are finding people in all walks of life. We have done quite a few surveys.

3887. That is a little outside the scope of the question. You have made a statement that cannabis is not harmful?——W. I tried to say that water is harmful if you get in it and cannot get out. I am sorry, I said harmless.

3888. You said not harmful.——W. In normal circumstances, not harmful—correct.

3889. You are making quite a plea for the legalization of cannabis, mainly because of the problems associated with it if it is illegal. What is your attitude in regard to heroin?——W. If you are in a car accident and break a leg, heroin will stop pain. Used for recreation, it is a total disaster. There are many reasons for this. One effect of the drug itself is that, unlike cannabis, it is addictive. There is a physical and mental thing that arises, and in the end you finish on a methadone programme. I could recommend to anyone to leave it well alone. But I do not think the answer is making it illegal and send out the police department to solve the problem. That is crazy. It must be solved medically, and not by a law. In regard to the qualifications of the police department, a policeman has to be under 6 feet and over 5 feet, and must go to high school. I do not see how he would be qualified to treat such a tender and emotional question. It must be done through government and medical areas, and not through police intervention. That has worked nowhere on earth, and I am sure it would be no different here. Compassion does not exist for the police. They are doing their particular job.

3890. If you are putting a plea for the legalization of cannabis, surely on those grounds you are putting a plea for the legalization of heroin, because it is illegal at the present time, and the sort of social problems that arise from heroin also arise from cannabis.——W. I would have to agree to that. It would be much better off if the heroin available came through a doctor or the Health Department rather than through the black market. I would offer as evidence this report from Dr Helman. If you trace it back, what the individual gets on the street is rarely pure heroin. Most people die from adulterated heroin. It starts off as pure heroin and it finishes as carbonate of soda.

3891. That is the theory behind the treatment in the United Kingdom at present, but it is not successful.——W. But is the other treatment successful?

3892. Forget about that for a moment. The theory behind the treatment for heroin addicts in the United Kingdom at present is to give them pure heroin, and they will not need to look for the other. However, in practice it has not turned out that way, and many people are dying from adulterated heroin in the United Kingdom. Does that upset your argument?——W. No. The same thing could be argued with cannabis. With cannabis some individuals are fed up and concerned with what is going on, and say that the cannabis cannot keep them cool.

3893. If you legalize the drugs you still have these problems?——W. No. If you legalize it, you eliminate most but not all of the problems. Then these other things compound that problem.

3894. While the law is as it is in regard to cannabis or any other thing, do you think teachers should be penalized if they break that law?——W. We have a situation that is the same as Vietnam. There was a time when we felt we should be out to help the people there. We went about it, but now we believe that what we did was wrong. The same thing happens with cannabis. We are trying to treat what we think is a problem one way. Now we think it is wrong. *Seed* talks about the war between the CIA, and no doubt there is some involvement here. We do not see anywhere a medical problem like heroin or aspirin should be treated in any way by such penal measures as introducing the police and prison.

3895. Why do you say that coffee is more harmful than marihuana?——W. There is the evidence from overseas. At last year's conference of pathologists Dr Andrew Ostler gave figures showing what happened with heroin on the kidneys and livers. It was the caffein in the coffee, and he showed what happened to the livers and kidneys. After I saw that I asked whether he could show us photographs of the effects after cannabis. But we could not see them. They had the effects of aspirin, heroin, analgesics and everything else, but they did not have the evidence with cannabis. I can relate to one but not to the other. I can see that cannabis is the law. I can see that there were 3 000 convictions, with people going to court and to gaol. I can see that. But then somebody says, "You get hair on the backs of your hands or you will grow breasts if you smoke marihuana". That just does not happen, and there is no evidence to support it. It was mainly through Dr Ostler's report, which has subsequently been offered as evidence in other places, but I found that caffein was more harmful.

3896. In the Technical Information Bulletin the National Drug Information Service in October last year had an article on a study that was conducted at the University of California. It related an experiment dealing with the effects of marihuana on pilots who undertook a simulated flying task. The summary was that the pilots who were intoxicated with marihuana experienced a decrease in performance in all the parameters tested over the various times. Do you think those pilots could have been affected in the same way by caffein?——W. No. Cannabis acts on the central nervous system; caffein does not act on the central nervous system.

3897. Would you be happy to know that you were flying with pilots who had been smoking marihuana?——W. If there were a choice between a pilot smoking marihuana and a pilot drinking alcohol—

3897A. I did not ask you that.——W. Of course not. I think a pilot should be someone responsible enough to know that when he is in the air he should not be taking anything. At the weekend it would not matter.

3898. It could affect his performance?——W. I would say definitely it could.

3899. Mr HEALEY: In your statement you said that a person who smoked marihuana and drove a vehicle was a menace to himself and other users of the road?——W. The inexperienced user, yes.

3900. He is still a smoker. Yet you say there should be no police intervention and no penalties for smokers of marihuana? Yet on your own admission he is a menance to himself and others on the road. You say there should be no action taken by the police against him. How can you say that?——W. Ninety per cent of the people getting apprehended and busted are in the privacy of their own homes.

3901. But that was not my question.——W. Yes it is.

3902. I am talking about the road user. You mentioned the person who smoked marihuana and drove a motor car, and you said that he was a menace to himself and the other users of the road. Then you said there should be no police intervention in regard to the smoking of marihuana, and there should be no penalties. Surely anyone who is a menace to the rest of the people on the road should be subject to some penalty, and there should be some control over his actions on the road?——W. Definitely, I agree with you 100 per cent. If someone drove a car under the influence and did something wrong they should suffer. A plea of self defence because of marihuana intoxication cannot be entered. That is the whole point. What people are being apprehended for is possession and use. If they possess and use, then as a result of that there is some form of offensive behaviour that breaks the rules, that is when they get penalized, but not just for having it. It is the same with drinking. You are allowed to drink but you cannot run out onto the street and urinate. It is the same with cannabis. There are members of society who can have an occasional smoke of marihuana and create havoc. They are in the minority. If that were not true we would have multiple deaths on the road that you could not account for.

3903. We already have multiple deaths on the road that have not been accounted for?——W. Alcohol. That is not related to cannabis. That is what happens when you cannot find a solution. Just blame cannabis. That is what happens.

3904. What statistics can you produce to show that a road death has been attributed to cannabis?——W. Dr Milner said——

3905. Never mind about Dr Milner. What can you produce by way of statistics that road deaths have been attributed to marihuana in the same way they have been attributed to alcohol?——W. I cannot.

3906. A further thing you said was police harassment. Can you give the Committee any specific instances of police harassment not hearsay?——W. Okay, sure. In 1973 when I was in Victoria——

3907. Confine it to New South Wales; this is a New South Wales Committee.——W. I appreciate that but I work on a national basis.

3908. We are working in New South Wales.——W. That creates a problem because I have only been here for two months this time.

3909. Then you would not have any knowledge of any police harassment in New South Wales?——Not first hand.

3910. Have you ever seen marihuana growing?——W. I have grown it myself in my back yard.

3911. You have never seen a plantation of it?——W. Not a plantation.

3912. You made a statement that you put marihuana seeds in the ground and that they do not need attention and away they go?——W. That is right.

3913. You know that plantations need a tremendous amount of cultivation and attention and fertilization?——W. A plantation does need full time care as opposed to what is in your back yard.

3914. You can put any seed in the ground and it will grow?——W. Yes. In 1968 it went around that seeds should be thrown all over Australia and so grow it all around the country and in ten years everything would be okay. I think a lot of people did that.

3915. What is the normal use for you?——W. At the conclusion of my activities of the day have a smoke rather than as with happens with unemployed-pillaging, robbing and raping to make ends meet. There is a percentage of those who smoke a lot of cannabis, of course. In that way it has probably saved a revolution. It has been suggested that the Maoists believe that if marihuana had not reached Australia this country would have been entirely communist by now.

3916. What do you regard as normal use of marihuana? Could you answer that question?——W. A couple of smokes a day at the end of the day's work, like a normal drink.

3917. Mr WOTTON: How many people do you know who have been gaoled for smoking of marihuana?——W. For the smoking of it very few. It has mostly been because they have been involved in a situation where smoking is one thing but they want to know how you get it and the key is the drug pusher and that scene——

3918. You have answered my question.——W. Yes.

3919. Mr McGOWAN: You said that individuals have the right to use what they want. Would you include heroin?——W. I personally would not.

3920. Cocaine?——W. From the results I have got back cocaine is not the problem that heroin is and it would be okay.

3921. Strychnine?——W. Not personally.

3922. You said individuals have a right to use what they want. Would you extend that principle to strychnine?——W. I would not.

3923. Plutonium?——W. The individual has the right to use what he wants in so far as his own body, mind and soul are concerned. That is what I try to illustrate. It is one thing for me to do it to myself but it is another thing for me to drop hashish in your cup of tea. That would be unforgiveable. I would not do it. I see this body of mine as something between my creator and me. If I tread on your toe you say that that is not fair or if I mess around with your water supply you say that is not fair. What I do with my own body in my own time is my own business. Until I drive my motor car or whatever and do something wrong, that is when it becomes an affair of the State. If a democratic society is worth living in what you do with your own body in your own home must be your own business and not that of the State.

3924. You would not have any laws against self mutilation?——W. At the moment you can jump off the Gap. I believe in education. With the cannabis research——

3925. What is your answer?——W. Education is the answer. I do not believe in banning. That creates a black market. Education is necessary.

3926. You have said that legalizing marihuana would do away with all the problems. I put it to you that if we do legalize marihuana we would then have a situation where perhaps two million people might smoke it and after some thirty years or perhaps a hundred years we might find that it does have adverse affects, so why take the risk?——W. Cannabis has been used in India for thousands of years and in South America for hundreds of years and it was only in 1976 in Jamaica——

3927. CHAIRMAN: Is marihuana still legal to be used in India?——W. In parts, but owing to the United States Government intervention it has changed. They have gone up into the mountains where it was originally grown——

3928. You have answered the question. I wanted to correct an impression you had given.——W. The United States Government has made its presence felt here as well as in India.

3929. Mr McGOWAN: What about if we find in the future that it is harmful, as has been found with tobacco? Should not we be careful?——W. That is why we should set up a control board. At the moment 250 000 New South Welshmen use marihuana and they would not know whether it was good, bad or indifferent. If you people are concerned with those people you must be concerned with what they are having. To get control over that you must have control over the cultivation of the product.

3930. The situation still arises that if we introduce another drug into society—you speak of hashish and tobacco and alcohol, and I agree with you—that is further opportunity for people to become intoxicated and there is the possibility that further social ills will arise from it?——W. It is not a question of introducing another drug. If it was I would agree with you but how can you introduce something if 250 000 people have already got it?

3931. I am talking about a question of perhaps 2 million people in the future. That would be a lot more people to become intoxicated because they would have the opportunity if it were more readily available. Would not that be more harmful to society?——W. There is no evidence anywhere to indicate that that would happen. The Oregon report says that it has gone up only 2 per cent so I cannot see it happening here. But, those using it would do it in the safest manner.

3932. You point to various aspects such as advertising and you told us of the sort of advertising you would not want to see. Do you not think that this would have an extended social effect? Would not commercialism bring about the forces of the commercial world?——W. If we cannot establish a marihuana marketing board then in five years the multi-nationals will have set it up. There is no doubt about that. They are only waiting for the right time. Philip Morris and W. D. and H. O. Wills would not touch it now because it is illegal but as soon as things change they will be in there straight away and they already have the tobacco farms and the distributing outlets. They will advertise like crazy. I do not want to see that. As soon as the situation changes they will be in there for what they can get.

3933. Would you say that the majority of people in New South Wales are opposed to legalizing of marihuana? ——W. No, not the majority.

3934. Mrs ANDERSON: Would you introduce your children to the use of cannabis?——W. My daughter understands what cannabis is, yes. I believe education is the answer.

3935. Would you introduce her to the use of it?—— W. No. That is her decision entirely. She will make that later. She is only eleven now. She understands it full well. My mother enjoys a drink as does my father, who is a hard-working man, an engineer.

3936. How do you explain the distribution of these papers to school children?——W. Because you are not doing anything about it. School children are not getting information that is legitimate. They are told that marihuana leads to heroin.

3937. How do you know that?——W. We get a lot of feedback. I have been engaged in this for four years.

3938. How long have you been in New South Wales? ——W. I was born here. I had a residence in Melbourne but last year I spoke with Mr Walker on this same matter and I have made frequent visits to New South Wales and spoken at universities.

3939. You believe that distribution of this to school children would do something about giving them a better knowledge of the subject?——W. If school children take it home to mother and father it would be one of the greatest steps forward we could have.

3940. I know what step I would take if one of my children brought it home to me.——W. That is the problem. You don't want to know.

3941. I do, but this would not tell me.——W. It is the most credible argument around on this subject.

3942. I am afraid we could not agree on the interpretation of the world credible?——W. This could be so, but I know a lot of people take more notice of people who use the substance than those who do not. I am not saying that is right or wrong. I am saying that someone who has never used cannabis can get up and say that it is harmful and most people will take no notice.

3943. That is like saying that somebody who does not drink but has lived with an alcoholic does not know anything about alcohol?——W. No, I would not go so far as to say he does not know. I am talking about credibility.

3944. You are saying that unless somebody has used cannabis he would not know what it is about?——W. No, I am saying that individuals who are out there would take more notice of someone who has used it than they would of someone who has not. At this stage I go back to John Helmer, who appears to be one of the leading experts that was in this country. After he went through the whole of 26 pages he recognized that the directions of change can be determined only after a much more intensive period of research, debate and experimentation than has ever been conducted in Australia and in this context the voices of the drug users themselves must be clearly heard and their right to speak more firmly protected under the law and respected in society at large. I finish off by quoting from Voltaire who said that "I cannot agree with what you are saying but I will defend your right to say it."

3945. Surely we have a right to defend children from the circulation of this sort of material on your assumption that they are not being told any story at all?——W. Could you tell me what it is in that that you object to?

3946. There is one section that relates to dipheads that I should not appreciate being given to any children I was associated with?——W. I can understand that you would want to censor it. I understand how you feel.

3947. Have any of your children been brought before a court for a cannabis offence?——W. No.

3948. Mr MACDIARMID: The whole thrust of your argument has been that under normal circumstances marihuana is not harmful. Would you like to see a society in Australia where the workman goes to Louis at the Loo at lunchtime and has a beer with his steak and he could then smoke a marihuana cigarette?——W. I should like to think that in such a multi-racial society as we have we could tolerate such things and I should like to think before I die that that is what has happened. I should like to see a situation where we tolerate you having a cup of tea or coffee or a smoke, whether we agree with you or not, but I should like to think that we should be able to tolerate it and not have the situation in which you strike at somebody smoking marihuana for having committed an offence.

3949. Is the publication of this paper your means of livelihood?——W. That is the major source of my income, the publication of this paper. Before that I was with the Cannabis Research Foundation but since May I have been connected with the Australasian Weed and then the Australasian Seed. It is hoped that this will continue as part of the debate as we are getting it all from one side and not too much from the other side. That is my source of income.

3950. CHAIRMAN: Who finances the Australasian Seed?——W. The Australasian Seed was financed by a couple of people who were most concerned that there was no vehicle discussing the question and that all we got was in the paper.

3951. You have not answered my question. Who finances the Australasian Seed?——W. First, subcribers. There are a couple of people involved in the public company who have put in the money to finance it. From then on it is 60 cents a copy.

3952. Did you get 60 cents from each of the children to whom it was distributed?——W. No. They were free copies. We are not allowed to sell it to children. They were given to children to take home to their parents. If there had been anything sinister in that I should not have been here today and those other people would not have been before the media. We believe it is through opinion and discussion that the problem will be eradicated.

3953. How many issues of the paper have been put out under the various names?——W. The Seed, 25 000 were printed on the first run. The Weed, there were 15 000 on the first run and 5 000 on the second run. The distribution is——

3954. Over what period?——W. The first one was May and the next one was June and July. It has taken us that long to do it.

3955. You depend on that for your existence?——W. I depend on this paper for my existence. At this stage I provide for my family with this paper, yes.

3956. How is it distributed?——W. As I mentioned before, there are some shops that are also contributing to the Government's coffers that distribute this paper, as well as at universities, at colleges and at markets—places like that where people who have what is called a hawkers' licence do that sort of selling—and at bookshops and record shops—those sorts of outlets. We have not gone through the newsagents yet because we had problems with classification on the first one.

3957. Is anybody in New South Wales financing it?——W. Not the company itself. It is a private company, a proprietary company registered in Victoria. The people in New South Wales who finance it are those who buy the paper. That is how we can print the next edition. As the distribution is going up we should not have too many financial problems.

3958. If it becomes a restricted publication——?——W. I will be on unemployment benefits. The Government will have put me out of a job.

3959. In speaking of the control board you mentioned the situation in India?——W. Yes.

3960. You spoke about control and restrictions. Is it not true that the situation you are talking about there is one that existed at the end of last century and early this century when the growing of cannabis for the production of jute was a very profitable industry and the object of the cannabis control board was to protect the quality of the jute that was produced?——W. In 1896 when the British commission into Indian hemp took place they made certain recommendations including one that there should be licensed cultivation and that the Government should control it but should have nothing to do with the distribution. At that time from the research that was done the evidence was inconclusive about whether cannabis would be a problem to the English working in India and the Indians working on the plantations. In spite of that evidence, the La Gardia report——

3961. We are not going through the whole series of cannabis reports. I am just going back to the submission you made. You are trying to create the impression that what was done in India was in order to produce a better quality marihuana. I am saying that the whole idea of the creation of that cannabis control board was to protect the quality of the jute that was being prepared because in those days jute was a very valuable farm crop?——W. Yes.

3962. It has now been largely superseded by the production of nylon and plastic bags?——W. Yes, and the Government still uses the jute today for the armed forces. I would agree that what I have done here is apply the principle of control and regulation at the beginning.

3963. But the jute was not smoked?——W. No. The flax is also used in the same way.

(The witness withdrew.)

The Committee adjourned.

*AT SYDNEY, ON THURSDAY, 28 JULY, 1977*

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(The Committee met at 10 a.m.)

Present:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| The Hon. MARGARET DAVIS | Mr R. C. A. WOTTON |
| The Hon. KATHLEEN ANDERSON | Mr B. McGOWAN, B.A. |
| The Hon. C. HEALEY | Mr E. D. RAMSAY |
| The Hon. F. M. MacDIARMID | |

3964. CHAIRMAN: I declare the session open. Before the proceedings commence this morning I propose to make a short statement to remove some misunderstandings that seem to exist in some sections of the news media.

On more than one occasion recently it has been mentioned that this Committee would probably be winding up at the behest of the Government. I wish to repeat what I have said on more than one occasion previously, that this select committee is a joint committee of both Houses of Parliament; it was elected by Parliament and its terms of reference were determined by Parliament. In due course, after the Committee has finished all its investigations, it will report back to Parliament; it will make certain recommendations, as it did in the memorandum that was presented to Parliament on 30th March, and subsequently the Government may or may not accept those recommendations. It is no function of this Committee to have any legislative power whatsoever; all it will do is to submit its report to Parliament, and subsequently the Government may or may not act on its recommendation. I now ask the secretary of the Committee to read the terms of reference. (*Read*)

JOHN COSSINGTON COOK, 6 Dunoon Avenue, West Pymble, marketing director, Reckitt Pharmaceuticals;

ARCHIBALD DONALD GLOVER, 17 Alma Street, Pymble, managing director of Richardson-Merrell Pty Limited;

KENNETH JOHN MURTON, 34 Kensington Road, South Yarra, Melbourne, Vice-president, Research and Development, Nicholas International; and

PETER NORMAN DADDO, 9 Clendon Close, Mount Eliza, Victoria, Vice-president and general manager of Nicholas Pty Limited, sworn and examined:

3965. Each of you have received a summons issued under my hand in accordance with the Parliamentary Evidence Act. The committee has received a submission on behalf of the Proprietary Association of Australia. The first part of that submission contains a section dealing with the situation of the association as a representative of various sections of that organization. Do you wish to have that submission incorporated as part of your evidence? ——W. (*Mr Glover*) We do. In addition, I wish to make some more observations to the committee.

3966. One part of this document is your submission, and then there are a number of appendices?——W. Yes.

3967. I presume you wish to have the submission incorporated as part of your evidence at this stage.——W. We would like the entire document accepted. That submission is as follows:

## INTRODUCTION

In submitting these comments the Proprietary Association of Australia (PAA) has accepted an invitation to do so from the Joint Committee on Drugs of Dependence.

The Association has paid particular attention to the Committee's "Terms of Reference", and it is possible that in confining our comments within the parameters as we understand them, we have omitted to cover all the relevant areas of investigation. If this is the case we would appreciate an opportunity to augment, or elaborate upon, the material submitted for consideration.

PAA represents some fifty manufacturers of over-the-counter medicines, and can be described as "the voice of self-medication". The range of medications marketed by the member companies is extremely comprehensive as will be seen from the list of these products, broken down by type and function, attached to this submission.

Although PAA does not have access to individual company sales figures, and hence is unable to quote the combined turnover of its members, either in units or dollar value, it is nevertheless acknowledged that analgesics undoubtedly represent a significant proportion of the total. PAA therefore shares the concern of the medical profession, and indeed the community at large, at the apparent excessive use of analgesics by a minority group.

In this submission to the Committee, we have reasoned that the answer to this problem lies in consumer education rather than in restrictive legislation, which would not deter the determined abuser but would inconvenience the general public, in addition to placing additional cost pressures upon the public and the health care system.

## SUMMARY OF SUBMISSION

1. Mild analgesics are widely available and their desirability as home medicine reflects many decades of beneficial use by a large proportion of the world's population. Their safety, when taken in recommended dosages and according to directions, has been established.

2. This Association questions the value of restricting their availability. To support this statement, we quote from the report of the Senate Select Committee on Drug Trafficking and Drug Abuse, 1971.

> It accepts the evidence so far available that consistent and excessive use, without medical direction can be harmful but because of their widespread value for intermittent relief of minor complaints, it would be unreasonable to limit their availability to medical prescription. Nor does the Committee see any value in their sale being restricted to pharmacies only.

3. We believe the present system of distribution is satisfactory and best serves the needs of the community. It is accepted that among a small minority of people there is a tendency to abuse mild analgesics. We submit that a remedy for this small but worrying abuse is not through restriction, but through public education. This industry is already emphasizing the need for the public to use its products strictly in accordance with directions. We are willing to co-operate further with the N.S.W. Health Commission in any educational programme designed to achieve enlightened use of proprietary medicines.

4. We would welcome the study recommended in 1971 by the Senate Select Committee on Drug Trafficking and Drug Abuse and have offered every assistance in the collection and in the analysis of data.

## PAA'S PURPOSE AND COMMUNITY SERVICE ROLE

The Association was formed in 1974 as a national organization to represent virtually all segments of the proprietary medicines industry and is in fact the voice of self-medication.

PAA speaks for some fifty manufacturers of over-the-counter medicines which are packaged and labelled in accordance with the appropriate Federal and State legislation, and which are intended for use in self-care. As an integral part of Australia's health care system, members of PAA are dedicated to making available to the public quality products which are both effective and safe for use as directed.

*Objectives of the PAA*

At the inaugural meeting, the members adopted a Constitution (see Appendix 7) in which the Association's objectives were defined as:

(a) To promote, foster and advance, in a manner consistent with the public interest, the progress and development of the industries which manufacture, produce, process and/or distribute proprietary products of all kinds as defined as Industry Products.

(b) To do those things which are in the interests of the proprietary products industry such as encouragement of scientific research, the promotion of safe and efficient handling and usage of Industry Products, the conduct of industry conventions, the extension of consumer education in the use of Industry Products and the publication and distribution of matters of interest to members of the Association or the public.

(c) To co-operate with and offer advice to Federal, State and other authorities in matters pertaining to the proprietary products industry and to provide a single organization to which such authorities or organizations may turn for discussion of matters of common or mutual interest.

(d) To keep members of the Association informed in regard to legislation and of commercial or technical developments of Australian or overseas origin which are pertinent to the industry.

(e) To establish and maintain liaison with similar organizations in Australia and overseas.

(f) To establish and maintain a Code of Ethics.

(g) To foster and encourage a spirit of friendly co-operation among Members and to promote in every possible way friendly relations between Members and the general public.

(h) To participate in co-operative enterprises with the various branches of the proprietary medicines and related industries.

(i) To do such lawful things and take any necessary or desirable action to accomplish these objectives and to promote the interests of the Association.

*Structure and Office Bearers*

Policies of the Association are formulated by the Board of Directors which is composed of the President, Vice-President, and not more than ten directors. The President and Vice-President are elected by the Board at its first meeting after the Annual General Meeting, and are nominated from the elected members of the Board. In order to preserve a national perspective the Board includes not less than three Directors, preferably resident in Victoria, from members with head offices situated in Victoria.

The active management of the Association is under the direction of an Executive Director, supported by a secretariat.

*Committees and General Activities*

The Association relies heavily on various committees each of which functions under a Chairman appointed by the President. The Association staff works in close co-operation with the committees.

These committees deal with matters involving Federal and State Government legislation, public affairs, manufacturing and industrial practice, marketing, legal aspects, and co-operation in the activities of the World Federation of Proprietary Medicine Manufacturers.

In addition to the Annual General Meeting, the Association aims to hold at least one Seminar or Congress each year. Members in attendance hear distinguished speakers from government, science and industry, present informative views on matters of current interest.

Informal sessions are held from time to time to brief members on current developments of interest, and the Association's Newsletter is an informative update reporting relevant events in government, industry and the Association. The latest information bulletins on pertinent legislation or industrial activities are provided to members.

Presentations at Seminars are printed and distributed to members and attendees, providing a contribution to source material on the industry.

At the request of members, the headquarters staff answers individual inquiries for information or assistance.

*PAA's "Code of Ethics"*

The Code owes its origin to the determination of the Association to secure the universal acceptance and adoption of high standards in the marketing of products designed for self medication.

The Code therefore represents an act of self-discipline. Acceptance and observance of its provisions are a condition of membership of the Association, and the Code is administered by the Executive Committee. A copy of the "Code of Ethics" is attached to this submission (Appendix 6).

## SELF-MEDICATION AND THE PUBLIC WELFARE

Self-medication is a vital element of the nation's health system. The institution of proprietary medicine has performed extremely well in many ways that contrast most favourably with other parts of the system. Over-the-counter products, which have for so long benefited so many in terms of personal health and sense of well-being, have also been of significant benefit to the health care economy.

*Domestic Remedies for Minor Ailments*

The majority of Australians seem to suffer very frequently from a variety of usually trivial, minor illnesses. An interesting survey recently conducted in the United Kingdom estimated that 20 per cent of people with minor illnesses immediately consult their family doctor and approximately 15 per cent endure their symptoms stoically without seeking relief by self-medication. The majority, 65 per cent attempt some sort of self-cure. Thus most people tend to treat themselves for minor ailments such as a cold or transient headache, simple indigestion, a sort throat, or temporary constipation and the like. Providing their symptoms are not alarming, the majority of people prefer to purchase their domestic remedies rather than to waste their doctors' time.

*The Cost of Health Care*

The total cost of health care in Australia in 1975 was approximately $3,800 million of which $288 million was spent on prescription medicines and approximately $80 million on proprietary type products or home medication. So that in very general terms, and assuming Australian attitudes to health care are similar to those of the United Kingdom, 60 per cent of health care problems are treated with approximately $80 million worth of product, and the remaining 40 per cent cost the nation 3.7 billion dollars.

*Relieves Burden on Medical Profession*

There are already too few doctors for our increasing population, most of them are overworked, and in consequence often have insufficient time to elicit proper medical history or carry out thorough physical examinations for all complaints they treat. If a patient had to visit his doctor each time he required an aspirin, an antacid, a laxative or a cough mixture the entire health care system would undoubtedly collapse.

A major function of self-medication is to maintain the patient in a comfortable state as perceived by him without having to burden a doctor. Another is to relieve the latter of treating conditions where the patient can be trusted to make judgments with little or no health risk.

*Safety of Proprietary Medicines*

The safety of all medications is prescribed and controlled by regulatory agencies, both Federal and State. By definition, proprietary medicines, while efficacious, are required to be adequately safe for over-the-counter use. Although marketed to be easily accessible, legal safeguards have long been enacted to protect the public.

*Benefits to the Public*

The proprietary manufacturing industry has therefore a real obligation to the public.

Public confidence in home medication requires of the manufacturer that he accept and discharge certain important responsibilities—among these, that he produce his products in accordance with the latest advances in technology, and he employ the finest quality control procedures in order to assure product uniformity, purity, potency and stability and that he markets these products truthfully and responsibly. The public benefits from the conscientious striving of the industry to attain even higher standards, and in turn, the industry benefits from the public confidence such performance inspires.

## NEED FOR STATISTICAL INFORMATION RELATING TO SELF-MEDICATION HABITS AND PROPRIETARY MEDICINE CONSUMPTION

It is regrettable that PAA does not have definitive, detailed industry-wide data on overall consumption of proprietary medicines, or any comprehensive, current measure of consumer usage and attitudes to these products. Equally, State and Commonwealth Health authorities lack this type of information. In the absence of this type of information, all too often we are prone, industry and Government, to present generalized and incomplete reasoning for and against the free sale of proprietary medicines.

Although PAA is in the process of rectifying this situation to some degree, it cannot undertake, alone and unaided, an in-depth national consumer survey of the type required to provide the non-existent data.

For this reason we have already proposed, in a submission to the Senate Standing Committee on Social Welfare, that the Australian Department of Health should initiate and finance a national survey to measure consumer usage and attitudes towards proprietary medicines. Our proposal follows the recommendation included in the 1971 Report of the Senate Select Committee on Drug Trafficking and Drug Abuse, which was as follows:

> It is urgent that the Commonwealth Government finance and actively encourage research into all those aspects which would make Australia's knowledge of the causes, effects and methods of treatment available to combat the abuse of drugs.

*Proposals for Sociological Study*

The survey would seek to define:

1. The degree to which the Australian public apply self-medication:
   - by socio-economic groups; and
   - by age groups;
   - all broken down to show the position in metropolitan and rural areas.
2. Usage in an average week by product type, broken down as above.
3. Types of ailments treated and degree to which such treatments are perceived to be efficacious, by product type.
4. Perceived benefits and ill-effects (if any) by product type.
5. Awareness of need to follow label instructions for use, dosage, cautionary statements, etc.
6. When medicines are stored in the home, and why.
7. Any special precautions taken to keep medicines out of the reach of children.
8. Where proprietary medicines are usually purchased or procured by consumers.
9. Consumer opinions on the role of media advertising as a primary communications system on proper use of proprietary medicines.
10. Cost/benefit analysis, developed from consumer opinions, on—
    - Cost of self treatment for simple ailments, compared with treatment by doctors/hospitals for same types of ailments.

Our industry believes this type of national survey would be of major benefit in ascertaining the true role of proprietary medicines in the Australian health care system.

To our knowledge, no similar consumer survey of the broad scope proposed has ever been conducted in Australia, though individual manufacturers have made this type of survey for their individual products on occasions.

*Benefits to be Derived from Survey*

The benefits of such a survey are likely to prove substantial. It could clarify several important and unanswered questions as:

- the degree to which simple ailments are capable of accurate self-diagnosis and effective self-treatment within all sectors of our community;
- the degree to which this self-treatment enables the public to obtain relief from ailments which otherwise may keep them at home/in bed/away from their regular occupations;
- the degree of awareness among the public on the need for proper use and storage of home medications;
- where and why consumers procure these products;
- attitudes to relative costs and convenience of self-medication compared with other available forms of treatment;
- areas where more effective consumer education may be needed on use of medicines.

We feel this type of measurement has never been done, but could prove to be significantly important to Australian and State Health Authorities, the medical professions and the pharmaceutical industry.

Ultimately, and of primary importance, its findings could result in substantial benefit to the Australian public.

*PAA's Practical Assistance*

Our Association is prepared to form an expert working group to assist the Australian Department of Health in designing a detailed questionnaire and plan for such a survey. This group would work closely and effectively with the Department's officers to ensure any survey conducted is objective and impartial, accurate and comprehensive.

We will also co-operate as fully as possible in all other possible ways in any such project, in the belief that this would go a long way towards replacing subjective, often-biased opinions with enlightened and factual measurement of the true significance of proprietary medicines and self-medication habits in the community, and the real efficiency and comparative cost to the public generally.

## CONSUMER EDUCATION—A MAJOR NEED

As already stated, the proposed survey would be of major benefit in measuring consumer usage and attitudes towards proprietary medicines in general and analgesics in particular.

The safety of aspirin and aspirin/salicylamide/caffeine mixtures is adequately established, and certainly there is no published evidence that they are harmful. This view is shared by the Australian Kidney Foundation, who have stated 'analgesic nephropathy is entirely preventable if the headache and pain relieving remedies are used in accordance with the manufacturers' instructions and with due regard to the warnings on the label.'

For various reasons (which a national survey would hopefully clarify) it would appear that a relatively few consumers of analgesics are either unaware of the risks involved in excessive usage, or do not attach sufficient importance to the dosage instructions.

PAA has repeatedly stressed the importance of mounting educational campaigns aimed at persuading the consumer to use self-medication as directed, but until such times as we are able to pinpoint the geographical problem areas and the socio-economic groups most affected we are unfortunately compelled to direct our efforts towards the total community. The wastage factor is considerable and the costs unnecessarily high.

In the coming year the PAA, in connection with the Pharmacy Guild of Australia, will distribute two million leaflets which explain, in simply terms, the safe and proper use of self-medication. Additionally, we will employ the media, trade press, club and group meetings, schools, and the combined field sales forces of member companies to convey a similar message.

## ANALGESICS—THEIR USE AND ABUSE

This section of the submission deals specifically with *mild or non-narcotic* analgesics.

The term *mild analgesic* is applied to preparations containing aspirin or other salicylates, or paracetamol, or preparations containing one or more of these analgesics with caffeine.

Mild or non-narcotic analgesics are formulated to relieve minor pain or mild feverish symptoms. Like all proprietary medicines they should be used strictly according to directions. The desirability of mild analgesics as home medicine reflects many decades of beneficial use by a large proportion of the

world's population. Their safety, when taken in recommended dosages and according to directions, has been established. They are used responsibly and safely by the vast majority of consumers who should not be penalized by restricting the sources of supply.

*Terms of Reference*

The Terms of Reference of the Committee are broad and could be considered by some to include investigations into the use of mild analgesics.

While the Proprietary Association of Australia would strongly deny that mild analgesics are "drugs of dependence", it is possible that the subject of mild analgesics will be considered by the Committee.

The subject of mild analgesics is complex and is at present being examined in depth by a working party appointed by the National Health and Medical Research Council expressly for this purpose. The working party was appointed by that Council at its 82nd Session in October 1976 with the following Terms of Reference:

(1) To advise Council on the ready availability of such analgesics to the public;

(2) whether specific analgesics should be restricted in their availability and if so by which means. (Hansard, Senate 2nd December 1976, page 2484).

Therefore, the PAA submits that the Joint Parliamentary Committee should await the findings of the National Health & Medical Research Council before making any decision or recommendation on mild analgesics.

*Current Controls and Proposed Restrictions*

The manufacture and distribution of all medicines, including all analgesics, is strictly controlled by Federal and State Legislation such as the Therapeutic Goods & Cosmetics Act of New South Wales, The Therapeutic Goods Act of the Coommonwealth and the Trade Practices Act, as well as by the Code of Good Manufacturing Practice administered by the Commonwealth Department of Health, and of course by the manufacturer's independent controls.

There have been proposals from some sections of the community to restrict outlets as a means of controlling the use, or the excessive use, of mild analgesics. This Association submits that misuse or excessive use will not be controlled by merely restricting outlets of distribution.

The determined user will shop around restricted outlets to meet his requirements. The temptation to hoard mild analgesics if supply outlets are restricted and the consequent possibility of accidental poisoning as well as excess use would create more problems than those sought to be removed.

Furthermore, limitation of pack size is not an effective control device for similar reasons.

The report of the Senate Select Committee on Drug Trafficking and Drug Abuse (1971) is worth noting:

> "It accepts the evidence so far available that consistent and excessive use, without medical direction can be harmful but because of their widespread value for intermittent relief of minor complaints, it would be unreasonable to limit their availability to medical prescription. Nor does the Committee see any value in their sale being restricted to pharmacies only.

In our view, to restrict the existing channels of distribution would substantially inconvenience the general public, increase the cost of mild analgesics, and in general, impair and impede the community health care system.

In our view the Committee should not be unduly influenced by opinions expressed by some clinicians, who look at analgesic mis-use from a purely clinical view point. Clinicians do not necessarily consider the wider public health issues outside their specialities, nor understand the broad ramifications of the recommendations they put forward.

*Use of Analgesics*

This Association has seen no evidence to support the view that the incidence of excessive use of analgesics in the community is more than minimal.

The terms "use", "misuse", "overuse" and "abuse" are frequently employed, and since there are significant distinctions in their meanings, it is important that they are understood.

"Use" is defined as the taking of a product or substance for its intended purpose in the appropriate amount, frequency, strength and manner.

"Misuse" is the taking of a product or substance in other than the recommended appropriate amount, frequency, strength and manner, which may result in damage to the person's health or general well-being.

"Overuse" is a form of misuse in which a product or substance is taken in too great a quantity, or too frequently for too long a period of time, i.e., in excess of recommended dosage instructions.

"Abuse"—another form of misuse—occurs when a person deliberately takes a product or substance for the purpose of achieving a desired effect which is not intended or recommended.

Figures on the consumption of aspirin in Australia, the U.S.A., the U.K., and Europe in the attached table (Appendix 1) show that the annual consumption per head in Australia is similar to North America.

To restrict the availability of mild analgesics to pharmacies only, or to limit pack size, would we believe have virtually no effect on consumption habits of the determined abuser.

A claim by pharmacists that they could effectively control the sale of analgesics and thereby their use has been shown to be invalid as will be seen in Appendix 3 (*Choice*, February, 1976). The survey of 97 pharmacists reported here showed no real involvement between pharmacists and consumers who purchase analgesics and there was no suggestion of restriction being offered by the pharmacists to purchasers of large quantities.

*Renal Damage*

One of the main reasons for restricting the distribution of mild analgesics has been a claim to reduce the incidence of renal damage. This is not a result of the medical use of mild analgesics. All mild analgesics contain the warnings on the label, such as "Caution: This preparation is for the relief of minor and temporary ailments and should be used strictly as directed. Prolonged use without medical supervision could be harmful".

> "Warning: This medication may be dangerous when used in large quantities or for a long period."
>
> "Warning: Use strictly in accordance with directions."

*Analgesic Nephrotoxicity*

Analgesic nephropathy was first reported by Spuhler and Zollinger (1953) and since then has become a recognized entity and has been reviewed extensively. This subject is dealt with at some length in Appendix 3.

*Safety Packaging*

Regarding safety packaging of analgesics, this Association unequivocally endorses the use of child safety packages in either closeable or non-recloseable types.

This Association is anxious to co-operate with Commonwealth and State Departments of Health regarding the development of adequate and appropriate standards for child safety packages. The industry is prepared to introduce safety packaging as soon as approved packaging and new equipment and other facilities can be installed.

*Advertising*

The advertising of all medical and therapeutic products is, we submit, most adequately controlled. All radio or TV advertising of medical or therapeutic products must be approved by the Commonwealth Department of Health under regulations laid down under the Broadcasting and TV Act.

All advertisements in newspapers and magazines must be submitted to the Media Council of Australia for approval. Such approval is based on the Media Council Advertising Code of Ethics which requires the advertisement to conform to the Guide to Advertising of Proprietary Medicines and Therapeutic Appliances and this guide is virtually the same as the rules laid down by the Broadcasting and TV Act.

Additionally, product claims in advertising are strictly controlled by:

(a) The Public Health Act.
(b) Poison Acts.
(c) Weights and Measures Acts.
(d) Therapeutic Goods Acts.
(e) Broadcasting Control Board standards for air media.
(f) Consumer Protection provisions of Trade Practices Act.
(g) Voluntary Code governing proprietary medicines.
(h) Proprietary Associations own "Code of Ethics" (see Appendix 6) and other relevant Acts and regulatory systems.

The Association submits that all advertising of medicines is therefore thoroughly examined to ensure that it is informative, responsible, and not in any way likely to mislead members of the public.

Contrary to opinion in some quarters, advertising does not in fact increase usage of mild analgesics. The sales of these products over the last few years have been static—what has altered has been market share between brands.

## CONCLUSIONS

This Association believes the present system of distribution is satisfactory and best serves the needs of the community. It is accepted that in a small minority of people there is a tendency to excessive use of mild analgesics. We submit that a remedy for this small but worrying abuse is not through restriction, but through public education and sociological aid.

This industry is already emphasizing the need for the public to use its products strictly in accordance with directions. We are willing to co-operate with the N.S.W. Health Commission in any educational programme designed to achieve fully enlightened use of proprietary medicines.

Some would have us believe that Australia is unique as a country and our sociological needs and habits differ from all other countries in the world. To establish a clear profile we would like to see implemented the recommendations of the Senate Select Committee on Drug Traffic and Abuse for a far reaching sociological study.

We would welcome the study recommended by the Senate Select Committee and have offered every assistance in the collection and in the analysis of data as per attached (Appendix 4) copy of letter to Mr R. P. Joske, Secretary, Senate Standing Committee on Social Welfare.

Appendix 1

## PRODUCTION AND USE OF ASPIRIN

| Country | Population 1974 (millions) | Estimated production (million kg per year) | Consumption per head per year (gm) |
|---|---|---|---|
| Australia .. .. | 13.34 | 0.681[1]<br>0.785[2] | 51<br>59 |
| Canada .. .. | 22.48 | 1.0[1] | 44 |
| United Kingdom .. | 55 | 2.042[4] | 37 |
| United States of America. | 211.9 | 14.837[1]<br><br>13.725[3]<br>15.245[5] | 70<br>50[2]<br>65<br>72 |
| Western Europe incl. U.K. | 334.5 | 6.9419[1] | 21[6] |

[1] Monsanto Australia Limited, Private Information.

[2] Rainsford K. D., (1975) Aust. J. Pharm, **56** (666) 373.

[3] The United States Dispensatory 26th Ed. 1967 p. 170.

[4] Anon. (1972) Lancet **1**: 477.

[5] Weis, H. J., (1974) J.A.M.A. **229** (9): 1221.

[6] In Western Europe mild analgesics such as the pyrazolones are used extensively, hence the lower aspirin usage.

Appendix 2

## ANALGESIC NEPHROPATHY (1974–1976)

Since the December 1974 Review of the Clinical Pharmacology of Acetaminophen (paracetamol), there has been no significant change in the availability of definitive evidence as to the cause of analgesic nephropathy.

Tthe studies involving phenacetin have been studies of analgesic mixtures and, although nephropathy has been recorded following long term excessive consumption of these combination products, it has not been established that phenacetin is the component responsible.

In a longitudinal study of 623 women with a control group of 621, Dubach et al[1] investigated 5 conditions believed to indicate possible urorenal disease. They concluded that "high users of . . . analgesic mixtures do have a higher incidence of abnormal kidney function than casual users and non-users, but that the absolute incidence over 4 years is quite small even among high users". However, this study had several limitations as pointed out in the report: because analgesic intake was detected only by the presence of the main phenacetin metabolite, paracetamol, in the urine, the investigation could yield little information on the effect ingestion of other components of analgesic mixtures might have on the kidney, and on whether these effects would be independent or synergistic.

In reply to this study, Bengtsson[2] commented that the incidence of renal lesions was seriously underestimated because the methods used found only the most advanced lesions of the papillae when the aim should be to find the incidence of early or moderate lesions.

Parker and Shaw's study[3] was also carried out on analgesic mixtures, and involved 33 patients, 24 being ongoing and 9 retrospective. Although the authors suggested that phenacetin was responsible for the renal damage produced, they recommended that until it is certain which drugs are responsible for analgestic nephropathy "clinicians would be wise to regard both phenacetin and aspirin as culpable." In their discussion, Parker and Shaw mentioned one case, not included in this series, in which ingestion of paracetamol alone was followed by pyramidal necrosis, but no details were provided.

Nanra and Kincaid-Smith[4] argue that "aspirin and not phenacetin appears to be the major nephrotoxic agent". They found that patients with rheumatoid arthritis appeared to have a milder form of analgesic-induced nephropathy compared with that of analgesic abusers and concluded that this was because rheumatoid arthritics generally consume aspirin alone, whereas analgesic abusers take analgesic mixtures which the authors consider to be more nephrotoxic. Further, the analgesic treatment of arthritic patients is often intermittent whereas analgesic abusers' consumption is constant.

The idea that analgesic mixtures are more nephrotoxic than individual analgesics has also been expressed by other writers. Mathew[5] states that "there is an apparently synergistic effect" in the capacity of analgesic mixtures to damage the kidney. There are conflicting views as to which is the major nephrotoxic agent: Nanra[6] says it is aspirin while phenacetin plays a secondary and synergistic role, whereas Kramer suggests that "aspirin may have only an addictive effect with phenacetin in causing renal damage".

Many investigators believe that cessation of treatment with phenacetin may be followed by improved renal function. Kramer[7] related the change in renal function with serum creatinine level stating that "cessation of phenacetin consumption is usually associated with stabilization of renal function in patients with serum creatinine levels below 1.5 per cent; with elevated serum creatinine there is a slow progression of the disease".

Mathew[5] commented that "in general the renal function will stabilize and occasionally slowly improve if analgesic abuse stops". He believes that when renal function continues to deteriorate after withdrawal of analgesics, it is caused by self-perpetuating mechanisms taking over and causing further deterioration.

There is still much controversy over whether or not paracetamol, the major metabolite of phenacetin, is implicated in analgesic nephropathy.

Nanra[6] found that aspirin appeared to be more nephrotoxic than paracetamol when renal papillary necrosis and papillary damage were produced in rats by gavage-feeding with a variety of analgesic compounds. However, this was at large doses of 500 mg/kg/day of aspirin and 3 000 mg/kg/day of paracetamol.

Silberbusch et al[8] suggested that the basic mechanism of renal toxicity in long-term abuse of phenacetin may be a more or less continuous high tissue concentration of paracetamol in the medulla. They formulated this idea because their investigation of paracetamol loading on its kidney excretion suggested the development, during loading, of a specific factor which enhanced its excretion and diminished its back-diffusion, thereby causing accumulation of paracetamol in the medulla.

Char et al,[9] in a case report on a neonate with renal failure after polyhydramnios, suggested a possible relationship between this and maternal paracetamol ingestion but concluded that the relationship was "impossible to prove retrospectively".

It can be seen from the literature since the December 1974 Review that no significant conclusions have been reached on the role played by paracetamol in analgesic nephropathy. It

is evident that long-term abuse of analgesic mixtures may lead to nephropathy, but there is no conclusive evidence that phenacetin is the causative agent. Furthermore, although paracetamol is the major metabolite of phenacetin, it has not been proved that paracetamol is implicated in the development of analgesic nephropathy.

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[2] Bengtsson, U. Phenacetin-containing analgesics and chronic renal disease. Lancet: 1195, May 24, 1975.

[3] Parker, R. W. and Shaw, R. E. Analgesic abuse in urological practice. Br. J. Surg. 62 (4): 298–302, Apr. 1975.

[4] Nanra, R. S. and Kincaid-Smith, P. Renal papillary necrosis in rheumatoid arthritis. The Med. J. of Aust. 1: 194–197, Feb. 15, 1975.

[5] Mathew, T. H. Analgesic nephropathy. Aust. Family Physician. 5: 314–323, April, 1976.

[6] Nanra, R. S. Pathology, aetiology and pathogenesis of analgesic nephropathy. Aust. and N.Z. J. of Med. 4: 6, 602–3, 1974.

[7] Kramer, P. Analgesic nephropathy. Med. Klin., 70 (20), 889–895, 1975.

[8] Silberbusch, J. et al. The influence of paracetamol loading on its excretion by the kidney. Neth. J. Med., 17: 108–114, 1974.

[9] Char, V. C. et al. Polyhydramnios and neonatal renal failure—a possible association with maternal acetaminophen ingestion. J. Pediat., 86 (4), 638–639, Apr., 1975.

Appendix 3

## A VIEW OF THE PROPOSED SCHEDULING OF COMPOUND ANALGESICS 1975

### SUMMARY

There has been a demand for so called mild analgesics either singly or in combinations, to be restricted in their sales outlets by having them scheduled.

This submission opposes the scheduling or limiting of sales outlets of mild analgesics. It is based on the following points:

1. The safety of mild analgesics and selected mixtures has been demonstrated in published medical and scientific papers.
2. There is a need for home medication and manufacturers have initiated campaigns to educate the public on correct dosage and correct use of these preparations. Legislation to restrict the sales of mild analgesics would place an additional strain on an overtaxed medical profession, place further restrictions on the Australian citizen with an accompanying loss of personal freedom.
3. Restriction of sales to pharmacies only would inconvenience the public and would significantly increase the cost of these preparations, thus penalizing in particular, the older, less mobile and less wealthy members of the community.
4. The influence that pharmacists would have on possible unwise use by counselling customers would be minimal. Surveys have shown that the large majority of purchases of Schedule 2 and 3 products are neither conducted by qualified pharmacists nor is advice given about the preparation to the customer.
5. The public health risk from either deliberate abuse of accidental over-dosage with mild analgesics containing salicylates is quite low compared to household products and other drugs. Deliberate abuse is unlikely to be reduced unless preparations are placed on a prescription only basis—this is entirely unwarranted for this type of medication.

### INTRODUCTION

The term mild analgesic is generally applied to aspirin and other salicylic acid derivatives and paracetamol. This submission is specifically concerned with the compound analgesics containing aspirin, salicylamide and caffeine.

The case to schedule mild analgesics of this type is usually based on the following premises:

1. Aspirin or aspirin, phenacetin and caffeine mixtures are nephrotoxic.
2. Aspirin-containing compounds cause gastric intestinal effects.
3. Some individuals are hypersensitive to aspirin.
4. Aspirin may interact with and negate the effect of other drugs if taken concurrently.
5. Aspirin-containing compounds are a cause of accidental poisoning.
6. The use of caffeine in these analgesic preparations is unwarranted.

Evidence is now presented to refute these arguments.

### ANALGESIC NEPHROTOXICITY

Analgesic nephropathy was first reported by Spühler & Zollinger (1953) and since then has become a recognized medical entity and has been reviewed extensively (Shelley 1967; Abel 1971; Linton 1972). Except for two cases, in these reviews all patients had ingested preparations containing phenacetin so this was considered to be the agent responsible for the kidney damage.

This view is still held by many (de Wardener and Koutsaimanis 1971).

Phenacetin is not used alone in treatment so that its effects have not been defined in man, and the conclusion that phenacetin is the common factor is not a sufficient explanation for the cause of analgesic nephropathy. Many of the drugs with which it is commonly combined, or their metabolites, are nephrotoxic to some animals under certain circumstances (Saker & Kincaid-Smith 1969; Nanra & Kincaid-Smith 1970; Calder et al., 1971, 1972; Nanra et al., 1971), and this has led these workers to incriminate aspirin or impurities in phenacetin rather than phenacetin itself.

Further evidence indicating that phenacetin in mixture with other analgesics is the causative agent of analgesic nephropathy comes from the paper of Murray (1972) where he reported "Since phenacetin was withdrawn from Askit Powders and Beechams Powders in 1966* these preparations have declined in importance as a cause of analgesic nephropathy in Western Scotland". This is similar to findings in Scandinavia, where phenacetin was restricted to prescription only in 1961 and its consumption fell tenfold. In Sweden, Bengtsson (1967) noted a steady fall in the percentage of cases of "chronic pyelonephritis" related to analgesic ingestion from 58 per cent in 1961 to 25 per cent in 1965, and stated later (Bengtsson 1969) that the "pattern of chronic non-obstructive pyelonephritis is changing in a favourable direction." Similarly, Nordonfeldt (1972) found a decrease in the number of deaths from analgesic nephropathy from 1967 onwards, while in Denmark Kjaerulf & Harvald (1968) found that the incidence of renal papillary necrosis declined from 4 per cent of all necropsies in 1969 to 2 per cent in 1967.

Beechams Powders now contain aspirin 79.3 per cent, salicylamide 7.34 per cent, caffeine 2.79 per cent, calcium phosphate 9.54 per cent and flavouring.

Gault et al (1968), reported "Although the association of renal disease with the excessive consumption of analgesics may be coincidental in some of the reported cases of analgesic nephropathy, the similarity of figures in six series from five countries for total phenacetin consumption and the duration of abuse before renal disease was diagnosed makes a direct relationship much more probable than mere coincidence. The correlation between annual per capita consumption of analgesics (as indicated by figures for phenacetin) and the numbers of cases of renal disease associated with heavy analgesic consumption in different countries may be used as further evidence of nephrotoxicity." Similar findings have been reported in Finland and Sweden by Kasanen (1973).

Kincaid-Smith (1967) indicated that the evidence against phenacetin is epidemiological and warned that there have been no reported cases of fatal renal papillary necrosis where phenacetin alone had been ingested, although cases had been recorded involving salicylates alone and no phenacetin (Harvald 1963; Lawson & McLean 1966; Olafsson 1966; Prescott 1966). Wigley (1971) reviewed these cases and others (Prescott 1969; Wigley 1971), and remarked that only one case was described in detail (Prescott 1969), and that generally it was not stated how carefully phenacetin intake was excluded.

A review of these quoted "salicylate nephropathy" cases follows.

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* Askit Powders now contain aspirin 750 mg, aloxiprin 200 mg, caffeine citrate 110 mg, aluminium glycerate 30 mg.

One of Lawson & McLean's (1966) cases of rheumatoid arthritis was subsequently reported to have methaemoglobinaemia and so presumed to have taken phenacetin (Koutsaimanis & de Wardener, 1970). The conclusion drawn by Lawson & McLean was "neither rheumatoid arthritis itself nor the administration of salicylates could be held responsible for the high incidence of renal disease, but mixtures of phenacetin and salicylates had a damaging effect." Harvald (1963) diagnosed 66 cases of renal papillary necrosis between 1957 and 1960. Five patients were diabetics, eight had urinary tract obstructions. Of the remaining 53 patients, one had consumed salicylates alone, a second had been receiving intensive treatment with para-aminosalicylic acid, the remainder had consumed excessive quantities of mixed analgesics containing both phenacetin and salicylates. Olaffson's (1966) two reported cases of salicylate nephropathy had consumed a salicylate/caffeine combination, although they were not absolutely certain of this because of the length of time over which the product was taken. In their words—"as far as could be ascertained by careful investigation, only acetylsalicylic acid and caffeine (were consumed) in two cases." Murray et al (1971) studied 86 patients presenting to a renal unit over five years, with a history of prolonged analgesic abuse and no other cause of renal damage.

In only two cases a preparation not containing both phenacetin and aspirin was used. "56 took analgesics for headaches of a psychogenic type, four for other psychogenic pain, and 20 for what they believed were their psychopharmacological features." Only six took analgesics for pain of an obviously organic nature". (Murray et al, 1971).

Prescott (1966) reports one patient out of 36 with renal disease and analgesic abuse, who did not take a phenacetin/aspirin combination; in this case it was aspirin/paracetamol. There was no case of salicylate-only ingestion. In this study 21 of the 36 patients favoured codeine-containing preparations, and 12 gave inappropriate reasons, e.g. insomnia or stimulation, for taking them.

The annual consumption of aspirin alone in the community is considerable. For example in Australia 52 gm per head of population and in the U.S.A. 61 gm per head, but there have been remarkably few reports of renal papillary necrosis in patients taking aspirin alone. Investigations have been done recently by a team of New Zealand physicians (New Zealand Rheumatism Association 1974) and Macklon et al (1974), at Newcastle upon Tyne, U.K., on the renal function of patients treated with large doses of aspirin for long periods for rheumatoid and osteo arthritis. These investigations support earlier work (Sorensen 1966) that patients given up to 5 gm of aspirin per day show no evidence of any convincing association between progressive renal impairment and aspirin dosage. The two studies concluded that evidence against aspirin alone is extremely weak.

Bell et al (1966) report "The rarity of pure aspirin nephropathy will surely have much greater significance than the rarity of phenacetin nephropathy"—because phenacetin, unlike aspirin, is rarely, if ever, prescribed alone.

From all this evidence it is concluded aspirin is not nephrotoxic. The editorial in the British Medical Journal reviewing Macklon's and the New Zealand Rheumatism Association studies concluded—"The evidence against aspirin is extremely weak and that no convincing evidence exists to restrict sales on the basis of nephrotoxicity."

*The Situation in Australia*

In Australia Burry et al (1974), in a survey involving almost 1 600 autopsies in Brisbane reported—"There has been a sharp fall in total death rates for diseases of the urinary tract since 1968. Autopsy studies indicate that this is due to a decline in deaths from analgesic nephropathy and it is suggested that this decline is due to a change in the composition of analgesics rather than to any diminution of analgesic abuse rates". This refers to the removal of phenacetin from one major brand of mild analgesic.

A similar statement was made by Ferguson (1975) who claimed that the high incidence of analgesic nephropathy in Queensland is due to the high consumption of aspirin, phenacetin and caffeine preparations. The incidence of renal nephropathy in Queensland has declined since 1969 and he considered this is due to a change of formulation rather than to the frequency of abuse.

Both these statements indicating a decline in the incidence of analgesic nephropathy have been made at a time when the awareness of the problem is at its greatest—doctors now have better case detection and diagnostic methods for this disease.

*Why is Phenacetin in Mixture the Cause of Nephrotoxicity?*

Calder et al, (1971) studied the comparative nephrotoxicity of aspirin and phenacetin derivatives when administered as single intravenous doses to rats. They reported—"Phenacetin derivatives tended to produce more severe renal damage and to be nephrotoxic in smaller doses than aspirin derivatives."

A review of recent literature on analgesics and the kidney (British Medical Journal, 1973) states—"Numerous studies in rats have established that, in this animal, salicylates and salicylate-phenacetin mixtures both have a greater propensity to produce papillary necrosis than phenacetin alone and have pointed to salicylates as the principal offenders. But the fact that papillary necrosis is exceedingly rare in people who have abused salicylates alone must make this unlikely."

The findings of any animal work are only of relevance when they are duplicated in man. To this end the selected experimental animal should metabolize the drug and react to its presence in a similar manner to man.

McIver & Hobbs (1975) used pigs as experimental animals because their kidneys closely resemble the human kidney and their pharmacological response to salicylate is similar to that of man. They found that when pigs were dosed with 1 g/kg of aspirin per day for 10 months, representing a cumulative dose greater than 2 kg, no evidence of analgesic nephropathy was found. This contrasts with the work of Nanra & Kincaid-Smith (1970), who used rats as their experimental animal, an animal whose kidney structure is different from the pig and man.

The effect of aspirin, caffeine and other drugs on the excretion of phenacetin metabolites has been studied. Excretion of the sulphate conjugate of N-acetyl-p-amino phenol was impeded or significantly reduced, and there was an increase in the urinary excretion of the glucuronic acid conjugate, the cysteine conjugate and the unconjugated compound (Gault, Shahidi & Gabe 1972; Smith & Timbrell, 1974). It has been suggested that modification of the metabolism of phenacetin may have some bearing upon this drug's nephrotoxicity.

*Other Factors*

The incidence of papillary necrosis has been found higher in summer than in winter, and this may be explained on the basis of dehydration. Thus, Nanra et al, (1970) writes—"The seasonal variation in the incidence of papillary necrosis in Melbourne supports the view that a high environmental temperature renders the kidney more vulnerable to the effect of certain drugs. This could explain the higher frequency of papillary necrosis in the north of Australia (Burry 1966; Kincaid-Smith 1968). It is suspected that in America the distribution of analgesic nephropathy is also related to high environmental temperatures (Levin 1969). The association between environmental temperatures and renal papillary necrosis may be explained on the basis of dehydration. Papillary necrosis associated with the administration of various substances in animals is more frequent in the presence of dehydration. (Kincaid-Smith 1968; Fuwa & Waugh 1968; Saker & Kincaid-Smith 1969.)"

## GASTRO-INTESTINAL EFFECTS

The subjective effects include nausea and epigastric discomfort.

There are several reviews of the voluminous literature on occult blood loss. There are many conflicting conclusions, but the generally accepted view is that there is a correlation between aspirin ingestion and occult blood loss. (Winkleman 1960; Smith 1966a; Salter 1968; Langman 1970.)

In approximately 70 per cent of people taking salicylates, there is an occult blood loss of 2–6 ml/day, a loss small enough generally not to be of any clinical significance. In a few subjects the loss may be greater, and there is the possibility of iron-deficiency anaemia developing.

Salicylates may be a precipitating factor in overt gastric haemorrhage (Smith, 1966)b in some patients where no other cause has been identified; this may be due to aspirin, although the causative role of aspirin has not been proved. It has been suggested that stress (Jennings, 1965) and excessive alcohol (Goulston and Cooke, 1968; Astley, 1967) may also be predisposing factors.

The value of aspirin is far too great to restrict its indicated uses, although the potential to cause gastro-intestinal upset should be borne in mind. (Winkleman, 1960.)

## HYPERSENSITIVITY

An estimate has been made that approximately 1 in 500 people are hypersensitive to aspirin and react to it with skin eruptions, oedema and asthma. (Gardner and Blanton, 1940.)

Only a small proportion of these show a severe reaction. There appears to be an increased sensitivity in middle age (Samter and Beers, 1967, 1968), when people who have previously taken aspirin without side effects may start to show hypersensitivity. This effect seems not to be a true allergy as no specific antigen has been found.

## DRUG INTERACTION

There is a growing awareness of the problems of in vivo drug interaction, and drug manufacturers these days are careful to advise doctors of drugs that interact with their product. This information is then relayed to patients. Also, manufacturers are indicating the contraindications and interacting drugs on the product labels and enclosures together with statements on all mild analgesic preparations that they are intended for the relief of minor or temporary ailments, should be used strictly as directed and that prolonged dosage without medical supervision could be harmful. The problem of drug interaction with minor analgesics is therefore minimal when they are used in accordance with directions.

## ACCIDENTAL POISONING

Aspirin and aspirin-containing analgesics have been criticized as a public health risk because of the incidence of accidental poisoning. Recent statistics show that this criticism is not justified when related to the incidence of poisoning caused by other products. Published figures show that aspirin is a minor cause of poisoning compared with common household substances. Figures for Victoria (1974) published in the Fifty-Second Report of the Commission of Public Health, include the following reported poisonings:

| | |
|---|---|
| Cough Medicines | 104 |
| Barbiturates and other "sleeping" medications | 76 |
| Perfumes | 66 |
| Other cosmetics | 87 |
| Other disinfectants | 638 |
| Turpentine | 78 |
| Plants | 211 |
| Adhesives | 52 |
| Salicylates, "baby" and "child" | 21 |
| Salicylates, "adult" | 58 |
| | 4 232 |

The National Poisons Service, Department of Health, A.C.T., in its September, 1971, Bulletin give the figures for all deaths in Australia by poisoning in 1970 as follows:

Analgesics, antipyretics, salicylates and congeners account for *one death* compared with—

| | |
|---|---|
| Pesticides, fertilizers and plant feeds | 10 deaths |
| Barbiturates | 20 deaths |
| Petroleum products | 3 deaths |
| Tranquillizers | 5 deaths |

Of the 185 accidental poisonings from salicylates and congeners in 1970, 164 (or 89 per cent) occurred in children under five years of age. Scheduling would not in any way stop or diminish these unfortunate happenings.

## CAFFEINE

Analgesic combinations such as aspirin and/or salicylamide and/or caffeine were introduced to synergistically enhance the pain relief from individual analgesics. The caffeine also corrects any sedative effect by mild direct mental stimulation. It produces peripheral vasodilation and reduced cerebral blood flow, that is believed to be responsible for the striking relief of hypertensive headache by the xanthines. (Goodman & Gilman 1970.)

The therapeutic value of caffeine in compound mild analgesic tablets is evidenced by monographs for these preparations in the 1973 British Pharmaceutical Codex and the 13th Edition of the National Formulary. Whilst these tablets contain aspirin, phenacetin and caffeine and phenacetin is, as we have attempted to demonstrate earlier, the causative agent of analgetic nephropathy, no such accusations can be proven about caffeine. It is significant that the Council of the Pharmaceutical Society of Great Britain and the American Pharmaceutical Association, publishers of the latest editions of the British Pharmaceutical Codex and the national Formulary have continued to maintain monographs of caffeine-containing compound mild analgesic tablets. Other authoritative text-books have this to say about the use of caffeine in analgesic preparations—

Model (1974)—"Most headaches that cause patients to consult a physician are caused by tension. Tension headaches are a response to intra-psychic stresses (faulty patterns based on faulty learning), as well as extra-psychic stresses (realistic external problems). Often an element of depression is involved. Furthermore, the sufferer often finds that tension headaches interfere with his ability to perform his regular duties, which leads to exasperation and often to intensification of the pain . . . The drug of choice in the symptomatic treatment of headaches of these types is caffeine."

Laurence (1973)—"Headache originating outside the skull may be due to muscle spasm (as in tension headache or frontal headache from eye strain) or to arterial distension. It may also be a referred pain from, for example, the teeth, neck or nasal sinuses. Treatment by drugs is directed to relieving the muscle spasm, producing vasoconstriction or simply administering analgesics, beginning of course, with non-narcotics. Combinations of analgesics, with each other and with caffeine, are more effective than the ingredients given alone."

Bowman, Rand & West (1972)—"The medicinal uses of caffeine are few. It is occasionally used as a respiratory stimulant and has been combined with mild analgesics where it is believed to potentiate their action." The absence of any statement indicating undesirable side effects must be inferred to say that there are none.

Caffeine has been claimed to be nephrotoxic (Prescott 1965a, 1965b; Vinci 1914), but this has been disputed by Douthewaite (1965) Inglis (1966) and others. (Anon 1965).

Furthermore, a recent study by Nanra & Kincaid-Smith (1970) has led to the suggestion that caffeine might reduce the nephrotoxicity of aspirin in rats, possibly because of its diuretic effect.

Acquired tolerance to the diuretic and parotid gland secretion activity of caffeine has been demonstrated unequivocally by Eddy & Down (1928) and Winsor & Strongin (1933), but acquired tolerance to the central nervous effects of caffeine has not been demonstrated convincingly in man. (Goldstein et al 1965, 1969.) This was reinforced by Colten et al (1968) who stated—". . . tolerence to caffeine in man appears to be of a low magnitude." On the question of dependence Crossland (1970) states—"Throughout the world man has, for centuries past, made drinks from plants (tea, coffee, cocoa, cola, etc.) which contain one or more of the xanthine derivatives and a large part of the human race has developed a psychological dependence on these drugs. The dependence is of a benign form which causes neither physical nor psychological harm."

## HOME MEDICATION

The proper use of home medicines considerably lightens the burdens of community health care services and allows them to function more effectively. Mild analgesics such as aspirin which are freely available to the public come into this category and are used for the relief of minor pain and ailments. It is generally quite safe to use symptomatic treatment and to consult a doctor only if relief is deferred or if the pattern of illness is unusual. This is in accordance with the instructions on the pack of aspirin and aspirin-containing analgesics. This instruction reads as follows—"This preparation is for the relief of minor and temporary ailments and should be used strictly as directed. Prolonged use without medical supervision could be harmful." This label direction, proposed by the pharmaceutical industry and endorsed by the N.H. & M.R.C. is now mandatory. It appears in this or similar form on packets of analgesics and also in advertisements for these products, reflecting the industry's concern for responsibility in advertising of their products.

Responsible advertising helps to promote widespread understanding of how to use home medicines and is a useful step towards improving the safety and efficacy of self-treatment and the quality of decisions made about when to seek professional advice, and eventually the understanding and use of health care services. This is supported by work of Jefferys et al (1960) and Butterfield et al (1971), who found that people who take home medicines also attend their doctors but those who rarely visit doctors, rarely take home medicines. Thus, with little guidance, the public has decided to use—

(a) home medicines mainly for the temporary care of minor symptoms; and

(b) doctors for more unusual problems.

The labels on open-selling home medicines in Australia now emphasize that if recommended doses do not relieve symptoms, people should seek professional advice, *not* take larger doses.

The claim that Australian people are "pill poppers" has had some publicity. This is a glib emotive statement that attracts attention but is not substantiated by facts. The number of prescriptions written on NHS in Australia in 1974–75 was approximately 100 million for a population of 13.5 million. This number of prescriptions include all physical dosage forms but it would be fair comment to say at least 50 million prescriptions were for tablets, each prescription being for up to 100 tablets.

On the other hand, the number of tablets and powders sold outside of pharmacy was equivalent to 21.2 million scripts of 50 tablets. These figures conclusively demonstrate that the Australian public exercises responsibility and caution in self medication, depending on the medical profession to recommend the mort potent medicines in greater quantities. The Australian people are a sophisicated population, have an enlightened approach to home medication and would not accept imposed stoicism.

The majority of medications purchased other than by prescription would be aspirin-containing mild analgesics. Using the consumption of aspirin, the major constituent of such preparations, as the yardstick, we find Australia's per capita consumption is of the same order as Canada, United Kingdom and the United States of America.

*Consumption of Aspirin*

| Country | Population 1974 (millions) | Consumption (million lb p.a.) | Consumption per capita gm p.a. |
|---|---|---|---|
| Australia .. .. | 13.34 | 1.5[1]<br>1.73[2] | 51<br>59 |
| Canada .. .. | 22.48 | 2.2[1] | 44 |
| United Kingdom .. | 55 | 4.5[4] | 37 |
| United States of America. | 211.9 | 32.7[1]<br>30.25[3]<br>33.6[5] | 70<br>50[2]<br>65<br>72 |
| Western Europe incl. U.K. | 334.5 | 15.3[1] | 21 |

[1] Monsanto Australia Limited, Private Information.
[2] Rainsford, K., (1975) Aust. J. Pharm. **56** (666) 373.
[3] The United States Dispensatory 26th Ed. 1967 p. 170.
[4] Anon. (1972) Lancet **1**: 477.
[5] Wesi, H. J., (1974) J.A.M.A. **229** (9): 1221.

*Restriction of Sales*

There is no evidence to show that restricting sales outlets for aspirin, or products containing aspirin, will reduce the consumption of analgesics by the determined purchaser.

The result of restricting outlets would be inconvenience to the normal user and almost certainly extra expense. If mild analgesics were scheduled and if pharmacists applied their normal 50 per cent mark-up, prices to the consumer of these preparations purchased through the 5 700 pharmacies in Australia would increase by between 12 and 23 per cent.

It has been stated that the advantage of scheduling mild analgesics would be that customers would receive advice from pharmacists. Presumably this will involve the pharmacist giving some sort of lecture to the intending purchaser—but what will he talk about? Indeed why should he talk about aspirin or other mild analgesics in particular? He would probably provide a greater community service if he warned customers about the toxicity of other household materials, such as cosmetics, which are responsible for more accidental poisonings than salicylates.

Further, how will the pharmacist find time to provide this service? If mild analgesic mixtures are scheduled each pharmacy in Australia would have to make an average of twenty additional sales a day—each one presumably by a qualified pharmacist and accompanied by "advice". In a survey of Melbourne and Sydney pharmacies in 1972 only 24 per cent of Schedule 3 sales were handled by qualified staff. A similar private survey conducted in 1975 in Sydney pharmacies in which a customer requested large quantities of non-prescription analgesics showed that only 21 per cent of Schedule 2 products were handled by qualified staff. Furthermore, only 4 per cent of the sales provoked a comment of genuine concern to the purchaser about the product and 6 per cent of the sales of Schedule 2 items were offered with a discount.

What reason is there to believe the situation would change if aspirin and aspirin-containing mild analgesics were scheduled?

The Restrictive Trade Practices legislation is clearly against creating any monopoly situation, especially where extra cost to the public is involved.

In this regard it should be noted that a section of retail pharmacy is actively recommending that "the Guild should work towards a monopoly of medicine sales". (McBride, 1975.)

Scheduling of aspirin would not alter the situation with advertising of aspirin or products containing aspirin.

Advertising of these types of preparations is governed by the Commonwealth censor (air media) and by the advertising code for press. Copy is required to be factual and medically justifiable.

It is sometimes claimed that advertising of medicines encourages unnecessary use. Commercial experience is strongly to the contrary. In a multi-entry market, such as the analgesics, the result of advertising is to change a customer from one brand to another. The total market varies only slightly.

Further, in a free-enterprise society it is reasonable for a manufacturer to make direct contact with potential consumers, advising them of the name of the product and its uses.

## THE SOLUTION

We believe that the safety of aspirin and aspirin salicylamide caffeine mixtures is adequately established—indeed there is no published evidence that they are harmful, which is in distinct contrast to aspirin-phenacetin mixtures in particular.

After reviewing the question of drug abuse the Senate Select Committee (1971) placed amongst its recommendations:

1. It should be compulsory for minor analgesic tablets to be individually wrapped.
2. Every encouragement should be given to the pursuit and extension of research into kidney disease in Australia and to the relationship between kidney disease and the misuse of analgesics.

Some manufacturers are now using strip packaging for aspirin and other mild analgesic tablets. They have already given substantial financial support to medical studies on aspirin and aspirin-containing preparations and their medical uses.

The Royal Australasian College of Physicians in 1969 in a statement on analgesic nephropathy included amongst its recommendations—

1. Improved control of advertising of proprietary analgesics, particularly advertisements which state that these are safe or exhort people to take them.
2. Labelling of analgesics that they should not be taken for prolonged periods without seeking medical advice, that they should never be taken in doses larger than those recommended, and that they may cause serious kidney damage.
3. Research into all aspects of analgesic nephropathy, including the factors leading to abuse of analgesics.

In general manufacturers of minor analgesics endorse these recommendations and have implemented them. In doing so, they have assisted in the decline in incidence of nephropathy, which we believe, is due to a change in composition of analgesics (removal of phenacetin) and a greater awareness by those people who need to take analgesics for care in the use of these products. The latter probably arises from a better level of public information from the cautionary statements now on most packs and labels and a genuine concern on behalf of most manufacturers for responsibility in advertising. This belief is reinforced by the Australian Kidney Foundation, 1974, who state—"This disease (analgesic nephropathy) is entirely preventable if the headache and pain relieving remedies are used in accordance with the manufacturer's instructions and with due regard to the warnings on the labels".

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*Appendix 4*

*"The chemist asked me why I wanted so many. He said he was concerned that they would be taken all at once by somebody. I asked for 12 packs of 20 . . . he suggested that I buy packs of 50 because they were a better buy."*

## MINOR ANALGESICS

*Is the pharmacist really concerned?*

Moves by the Federated Pharmacy Guild of Australia to gain a monopoly on sales of home medicines were reported in CHOICE in August last year. Over recent years the Guild has been pressing forward with its campaign, calling, in the first place, for restrictions on the sale of everyday pain killing drugs, or minor analgesics (which include compounds like aspirin, paracetamol and salicylamide), and warning of the growing rate of drug abuse associated with them. Taken occasionally, these medicines will relieve a headache or perhaps a nagging toothache, but if you are taking something like APC at every opportunity you may well end up with a serious kidney problem.

Certain mild analgesics, such as the two brand-leading powders, BEX and VINCENTS, can be bought at any supermarket; others, the Schedule 2 (S2) drugs (for example, CODRAL tablets) are classified by the State governments as restricted medicinal substances, and are available only at pharmacies. The Guild claims, quite rightly, that pharmacists have the specialist knowledge required to advise on the proper application of these drugs, cut down their abuse and, where necessary, limit their sale. Thus, it argues, it is in the public interest to make all mild analgesics available only through pharmacies where, in most cases, they cost more.

ACA decided to put these claims to the test. We asked members of our buying panel throughout Australia, including all capital cities, to buy from randomly chosen pharmacies unusually large quantities (12 packs of large sizes) of five common pain relievers—BEX and VINCENT'S powders, and CODIS, CODRAL and VEGANIN tablets. As the tablets contain between six and eight milligrams of codeine phosphate each, they are considered more potent and are S2 items, "pharmacy only" lines. Only one bulk purchase was attempted at each pharmacy visited.

Although we wanted to know whether or not the drugs could be bought over the counter in such large quantities, we were also very interested in whether the pharmacist himself or only an assistant made the sale, what reaction the purchase evoked, and what, if any, advice was offered. Summarized details of the sales of both powders and tablets are given in the Table.

*"Next time you want a dozen ask for a discount for a bulk purchase"—remark by pharmacist.*

In all, 97 pharmacies were visited in the survey. At 27 we tried to buy powders, and at 70 we asked for tablets. On 73 occasions sales were made by an assistant, and at only three were our buyers refused the dozen packs asked for, the pharmacist limiting the sale to one pack. The general impression from the survey was that in many cases the pharmacies were not interested in knowing the reasons for such a large purchase of potentially harmful medicines. In the 29 instances when the pharmacy could not meet the full order an alternative was suggested to make it up, or an offer was made to obtain the outstanding packs as soon as possible. In eight cases a discount price was given for buying in bulk!

*"I requested 12 packets of Vincent's, although I could not see them displayed. The pharmacist picked them up from behind the counter and talked about the weather."*

The major reaction to the request for such a large quantity of drugs was none at all. One in five purchases was greeted with some surprise, although this did not usually affect the outcome of the sale. In general, requests for tablets produced more reaction, both serious and lighthearted, than for powders.

*"I'm sorry, the chemist said you can only purchase one pack of any analgesic"—remark by assistant.*

In only eight cases was there anything approaching what our buyers considered to be genuine concern shown at the purchase of so many packs at one time. And in spite of this, all but three sales went through. It should perhaps be pointed out, however, that being "out of stock" could be a tactful way of refusing to make a large sale. On two occasions sales were limited to two packs, and these could conceivably have been veiled refusals.

*"Doctors get a bit upset if they are taken in large doses"—remark by pharmacist.*

Pharmacists should be qualified to give advice on the use of drugs available without a doctor's prescription, and anyone wanting that advice has only to ask. Whether or not pharmacists alone are responsible enough to administer the sale of analgesics need not concern us here—our survey shows that in practice they don't appear to take this responsibility seriously. And after all, anyone wanting a large quantity of minor analgesics badly enough can easily get them by buying small amounts from different pharmacists.

The profit margins of pharmacies are usually higher than those of supermarkets, and ACA considers that with the way pharmacy is structured at present in this country there is no valid reason why minor analgesics should not be available from the shelves of supermarkets at competitive prices. This opinion has been reinforced by the results of our survey.

People who misuse these drugs are not going to be deterred by their sale being restricted to pharmacies, and those of us with limited and occasional requirements should be allowed to benefit from the price savings that would result if minor analgesics were more widely available.

It is a fundamental belief of ACA that the consumer should get value for money. If the cost of the same product varies from one seller to another we urge you to buy the cheaper unless, and this is the point, some additional service or benefit goes along with the sale. We found little reason to suggest that pharmacies are at present offering any such additional service or benefit to the public when they sell minor analgesics.

TABLE—DETAILS OF SALES

| | Total | Powders* | S2† |
|---|---|---|---|
| Purchases attempted .. | 97 | 27 | 70 |
| Served by pharmacist .. | 18 | 6 | 12 |
| Served by assistant .. | 73 | 19 | 54 |
| Served by both .. .. | 6 | 2 | 4 |
| Sale made .. .. .. | 94 | 26 | 68 |
| Sale refused .. .. .. | 3 | 1 | 2 |
| Discount offered .. .. | 8 | 1 | 7 |
| Different size or brand suggested .. .. .. | 20 | 2 | 18 |
| Offer made to obtain (insufficient stock) .. | 9 | 2 | 7 |
| Reactions to order: | | | |
| None .. .. .. | 51 | 19 | 32 |
| Lighthearted .. .. | 13 | 3 | 10 |
| Surprise .. .. .. | 20 | 4 | 16 |
| Genuine concern .. | 8 | 1 | 7 |
| Other .. .. .. | 5 | .. | 5 |

* Bex and Vincent's.

† Codis, Codral and Veganin.

*Phenacetin in Bex powders*

One unexpected finding from the survey was the variation in the composition of BEX powders. Some of the powders purchased contained aspirin, caffeine and phenacetin and some of these had a warning that that particular pack "must not be sold outside of Victoria and Tasmania."

Recent publicity about possible adverse effects of phenacetin on the kidneys has prompted most manufacturers to withdraw it from their products. BEX now substitutes paracetamol, and we were surprised to find BEX powders still so freely available with the phenacetin component.

*Appendix* 5

THE PROPRIETARY ASSOCIATION OF AUSTRALIA

Comprising the Home Medication Industry

Chamber of Manufactures of New South Wales,
60 York Street, Sydney, N.S.W. 2000,
G.P.O. Box 3968, Sydney, N.S.W. 2001.
Telephone 290 0700
4th August, 1976.

Mr R. P. Joske,
Secretary, Senate Standing Committee on Social Welfare,
The Senate,
Parliament House,
Canberra, A.C.T. 2600.

Dear Sir,

This submission follows our earlier contact with you and responds to your advertised request for interested parties to contribute to your inquiry.

In previous years this Association's predecessors have made submissions to The Senate Select Committee on Drug Trafficking and Drug Abuse, as well as making several submissions to The National Health and Medical Research Council over a period of years in relation to the sale and distribution of analgesics. Also, member companies have made submissions to the National Health and Medical Research Council and to the Public Health Advisory Committee from time to time in relation to the sale and distribution of analgesics and on home and self medication.

We do not propose any similar submission in this instance.

Instead, we would like to propose that the Australian Department of Health should initiate and finance a national survey to measure consumer usage and attitudes towards proprietary medicines and we refer you here to page 88 of the 1971 Report of the Senate Select Committee on Drug Trafficking and Drug Abuse wherein it recommends as follows:

> It is urgent that the Commonwealth Government finance and actively encourage research into all those aspects which would make Australia's knowledge of the causes, effects and methods of treatment available to combat the abuse of drugs.

And this proposal would help define:

1. The degree to which the Australian public apply self-medication:
   - by socio-economic groups; and
   - by age groups;
   - all broken down to show the position in metropolitan and rural areas.
2. Usage in an average week by product type, broken down as above.
3. Types of ailments treated and degree to which such treatments are perceived to be efficacious, by product type.
4. Perceived benefits and ill-effects (if any) by product type.
5. Awareness of need to follow label instructions for use, dosage, cautionary statements, etc.
6. When medicines are stored in the home, and why.
7. Any special precautions taken to keep medicines out of the reach of children.
8. Where proprietary medicines are usually purchased or procured by consumers.
9. Consumer opinions on the role of media advertising as a primary communications system on proper use of proprietary medicines.
10. Cost/benefit analysis, developed from consumer opinions; on
    - cost of self treatment for simple ailments, compared with
    - treatment by doctors/hospitals for the same types of ailments.

Our industry believes this type of national survey would be of major benefit in ascertaining the true role of proprietary medicines in the Australian health care system.

To our knowledge, no similar consumer survey of the broad scope proposed has ever been conducted in Australia, though individual manufacturers have made this type of survey for their individual products on occasions.

The benefits of such a survey are likely to prove substantial. It could clarify several important and unanswered questions as:

- the degree to which simple ailments are capable of accurate self-diagnosis and effective self-treatment within all sectors of our community;
- the degree to which this self-treatment enables the public to obtain relief from ailments which otherwise may keep them at home/in bed/away from their regular occupations;
- the degree of awareness among the public on the need for proper use and storage of home medications;
- where and why consumers procure these products;
- attitudes to relative costs and convenience of self-medication compared with other available forms of treatment;
- areas where more effective consumer education may be needed on use of medicines.

We feel this type of measurement has never been done, but could prove to be significantly important to Australian and State Health Authorities, the medical professions and the pharmaceutical industry.

Ultimately, and of primary importance, its findings could result in substantial benefit to the Australian public.

Our Association is prepared to form an expert working group to assist the Australian Department of Health in designing a detailed questionnaire and plan for such a survey. This group would work closely and effectively with the Department's officers to ensure any survey conducted is objective and impartial, accurate and comprehensive.

We will also co-operate as fully as possible in all other possible ways in any such project, in the belief that this would go a long way towards replacing subjective, often-biased opinions with enlightened and factual measurement of the true significance of proprietary medicines and self-medication habits in the community, and the real efficiency and comparative cost to the public generally.

All of which is respectfully submitted.

Sincerely,
The Proprietary Association of Australia,
A. D. GLOVER, President.

***Appendix* 6**

THE PROPRIETARY ASSOCIATION OF AUSTRALIA
CODE OF ETHICS

Introduction

(a) The Proprietary Association is the voice of Self-Medication. It speaks for manufacturers of proprietary (over the counter) medicines and related health care products which are prepackaged and labelled in accordance with the appropriate State and Federal legislation, and which are intended for use in self-care.

As an integral part of Australia's health care system, members of the Association are committed to making available to the public quality products which are both effective and safe for use as directed.

(b) Medical products owe their existence to research carried out by their manufacturers or to the development by them of results of academic research. For any medication product on the market a manufacturer will have adequate pharmacological and clinical evidence supporting therapeutic claims made for the product, and will have met all the statutory requirements for the testing, manufacture and marketing of that product.

(c) While it is possible to legislate satisfactorily for the testing, manufacture and control of self-medication products, appropriate standards of marketing conduct cannot be defined by the same means. For this reason, members of The Proprietary Association of Australia have concurred in the promulgation of a "Code of Practice" and are agreed to submit to its restraints.

(d) Observation of the Code by Members therefore represents an act of self-discipline. Members and their employees

should be constantly aware of the responsibilities to which they are committed. Similarly, those persons and organizations having dealings with the Association will recognize the standard of conduct which its members endeavour to maintain.

(e) The Code is administered by the Executive Committee, comprising the President, Vice-President, and immediate past-President of the Association.

(f) The Committee meets as required to deal with complaints and to secure compliance with the Code.

(g) The Committee also makes such recommendations as it deems fit for the amendment of the provisions of the Code.

## THE CODE

1. *General*

This Code will be complied with in respect of all methods of communication and irrespective of the type of audience.

2. *Claims and Comparisons*

2.1 Claims for the usefulness of a self-medication product must be based on an evaluation of available evidence and must reflect this evidence accurately and clearly.

2.2 Exaggerated claims will not be made and all-embracing claims and superlatives avoided. Claims must not imply that a product, or an active ingredient, has some special merit, quality or property unless this can be substantiated.

2.3 No advertisement will denigrate or attack unfairly any other product, goods or services.

3. *Methods of Promotion*

3.1 Methods of Promotion must never be such as to bring discredit upon, or reduce confidence in, the proprietary medicine industry.

3.2 All methods of communicating promotional information must be carried out in accordance with the requirements of the Code.

4. *Standards of Advertising Practice*

4.1 Every member will be held responsible for the contents and form of any advertisement which may appear over his name in connection with his goods, and Members of the Association should provide their Advertising Agents with copies of the Code.

4.2 The word "Advertisement" when used in this Code includes every form of communication, whether in a publication, or by display of any notice, or by means of any catalogue, price list, leaflets, booklets, letter (whether circular or addressed to a particular person) or other document, or by words inscribed on any article, or by exhibition of a photograph or film, or by way of sound recording, radio or television, or in the spoken word, or in any other way.

4.3 These standards will also apply to packaging material including all labels, cartons, direction folders, and other packaging components bearing printed matter.

4.4 All advertising must be accurate and truthful. No advertisement will:

(i) Offer any medicine or treatment for serious diseases or conditions which should properly require medical treatment.

(ii) Contain any offer to make diagnosis or prescribe treatment.

(iii) In any way tend to induce fear that the reader, viewer or listener is suffering, or without treatment may suffer more severely, from any illness, ailment or disease.

4.5 Advertisements as defined will conform, both in text and illustration to canons of good taste.

4.6 Promotional Material should not imitate the devices, copy slogans or general layout, adopted by other manufacturers in a way that is likely to mislead or confuse.

4.7 Telegrams must not be used for promotional purposes, except when these are directed to wholesalers and distributors or retailers.

4.8 Advertisements must not contain any implication that the product is recommended or used generally by medical or paramedical persons such as doctors, dentists, pharmacists, nurses, dietiticians or physiotherapists or by any person using a title implying that such a person is so registered.

4.9 No address, title or description which may imply that a product emanates from any hospital or official source or is other than a proprietary medicine, will be used without substantiation.

4.10 Testimonials used in advertising must be unsolicited and must be limited to the genuine views of the user, and must not be used for more than three years after the date on which it is written. Testimonials will not contain misleading or extravagant statements which are contrary to the provisions of the Code.

4.11 No member will promote to the general public, any prize competition which is intended to encourage the purchase of a proprietary medicine.

4.12 No member shall advertise an offer to return money to dissatisfied users of proprietary medicines.

4.13 No member of the Association will use 'Subliminal Advertising", i.e. the deliberate use of visual or aural messages designed to influence people in ways of which they are not consciously aware.

4.14 Slogans, which because of brevity or for any other reason, are capable of misinterpretation must be used only in association with copy which clearly indicates their correct meaning.

5. *Relations with General Public and Media*

5.1 Requests from individual members of the public for information or advice of a diagnostic nature must always be refused and the enquirer recommended to consult his or her own doctor.

5.2 Requests for information on proprietary medicines must be presented in a balanced way to avoid the risks of raising unfounded hopes in the public mind from the results of treatment.

6. *Responsibilities to Governments and Health Authorities*

6.1 All statutory requirements, including registration, manufacturing, packaging, labelling, advertising, health and transport regulations shall be complied with as a minimum standard.

6.2 All voluntary schemes and arrangements agreed between the Association and Commonwealth and/or State authorities must be adhered to, both in principle and in spirit.

7. *Responsibilities to the Association*

Members will:

7.1 Co-operate in the investigation of problems concerning the safe use of industry products which may, from time to time, be initiated by the Association.

7.2 Co-operate to whatever extent they are reasonably able in programmes conducted by the Association, either on its own or in collaboration with Government authorities, which are aimed to educate the user or the consumer in the safe and proper use of industry products.

7.3 Assist the Association and/or Government authorities to the full extent that they are able in consideration of any existing regulations or voluntary schemes, or any which may be proposed, having in mind both their responsibilities under this Code and the needs and legitimate interests of the Industry.

7.4 Draw to the attention of the Association any information which may lead to improvement in standards of correct and safe use of industry products.

7.5 Ensure that all responsible persons in their employ are aware of the contents of this Code and that it applies to their organization and products by virtue of membership of the Association.

7.6 While recognizing that they may be in direct competition with other members and their products, promote the use of their own products in such a way that will not reflect adversely on the good name of another member or his products,

7.7 Be responsible to ensure that his products and activities conform to the provisions of this Code. In particular he will be responsible for compliance with Good Manufacturing Practice, Warehousing, Quality Control and other standards to achieve uniformity.

8. *Conclusion*

The "Code", as set down, represents an act of self-discipline. Acceptance and observance of its provisions are a condition of membership of The Proprietary Association of Australia.

Member companies also acknowledge that the "Code" itself is to be applied in spirit, as well as in the letter, so that high ethical standards are followed throughout the industry.

## THE PROPRIETARY ASSOCIATION OF AUSTRALIA—CONSTITUTION

1. *Name*

The name of the Association is The Proprietary Association of Australia.

2. *Association with the Chambers of Manufactures*

The Association shall seek to be a Division of the Chamber of Manufactures of New South Wales and shall at all times work in close liaison and harmony with State Chambers of Manufactures and shall encourage and foster membership of such State Chambers of Manufactures by its membership.

3. *Office*

The office of the Association shall be established in such location in the Commonwealth of Australia as the Board may determine.

4. *Interpretation Clause and Definitions*

In this Constitution unless there is something in the context inconsistent therewith:

The Association means The Proprietary Association of Australia.

The Board means the Board of Directors of the Association.

Industry Products means products used for the purpose of or in connection with

(a) preventing, diagnosing or alleviating a disease, ailment, defect or injury in man;

(b) influencing, inhibiting or modifying a physiological process in man;

(c) testing the susceptibility of man to a disease or ailment; or

(d) destroying or inhibiting micro-organisms that may be harmful to man

and which are available to the public without medical prescription.

Finished Products are Industry Products in which are labelled and packaged for consumer sale.

The term Company shall include natural persons, sole proprietorships, partnerships, joint-ventures, co-operatives, corporations, trusts, or other forms of business entity ivolved in the research into and/or manufacture and/or formulation and/or registration, including importation, of industry chemicals and/or products.

The term Subsidiary Company shall mean any company or business entity, as defined above, which shall be in excess of fifty per cent (50%) owned by a member Company, which shall be the Parent Company. A subsidiary Company, which shall not be eligible for membership if its Parent Company is a member. The Turnover of Industry Products by such Subsidiary Company shall be included in the declaration of Turnover by the member and Parent Company. Subsidiary Companies of non-member Parent Companies are eligible for membership and the Turnover, if any, of Industry Products of the Parent Company shall be included in the declaration of Turnover by the Subsidiary Company.

Distributor means a company purchasing Industry Products from a Company primarily for re-sale to Wholesalers and/or Resellers.

Wholesaler means a company purchasing industry products from a Company or Distributor primarily for resale to resellers.

Ancillary Company means a company giving ancillary or subsidiary service to the Proprietary Medicines industry.

Turnover is a Member's total annual net sales proceeds of all Industry Products in the Commonwealth of Australia, (excluding export sales to other areas) as used for the Member's accounting purposes during the last financial year of the Member and includes the Turnover of Industry Products of any majority owned Subsidiary Company.

Alternatively, if a Subsidiary Company is a Member the Turnover, if any, of Industry Products of the Parent Company is included.

Financial Year of the Association means the twelve (12) month period from the first day of July to the thirtieth day of June, inclusive.

Month means calendar month.

Member unless stated to the contrary, shall be understood to include Associate or Honorary Life Member.

5. *Objects*

The objects of thc Association shall be:

(a) To promote, foster and advance, in a manner consistent with the public interest, the progress and development of the industries which manufacture, produce, process and/or distribute proprietary products of all kinds as defined as Industry Products.

(b) To do those things which are in the interests of the proprietary products industry such as encouragement of scientific research, the promotion of safe and efficient handling and usage of Industry Products, the conduct of industry conventions, the extension of consumer education in the use of Industry Products and the publication and distribution of matters of interest to members of the Association or the public.

(c) To co-operate with and offer advice to Federal, State and other authorities in matters pertaining to the proprietary products industry and to provide a single organization to which such authorities or organizations may turn for discussion adn matters of common or mutual interest.

(d) To keep members of the Association informed in regard to legislation and of commercial or technical developments of Australian or overseas origin which are pertinent to the industry.

(e) To establish and maintain liaison with similar organizations in Australia and overseas.

(f) To foster and maintain a Code of Ethics.

(g) To foster and encourage a spirit of friendly co-operation among Members and to promote in every possible way friendly relations between Members and the general public.

(h) To participate in co-operative enterprises with the various branches of the proprietary medicines and related industries.

(i) To do such lawful things and take any necessary or desirable action to accomplish these objectives and to promote the interests of the Association.

6. *Membership*

There shall be two (2) classes of members:

(a) Member: Any Company, carrying on in Australia the basic manufacture of and/or basic and applied research into, and/or formulation, and/or importation, and/or the registration of Industry Products.

(b) Associate Member: Any Company, including Distributors, Wholesalers or Ancillary Companies, which carries on in Australia the packaging or promotion of Industry Products or the manufacture or fabrication of packaging for Industry, Products or the manufacture or operation or equipment or devices for the application of Industry Products. Associate Members shall have all the rights and privileges of Members.

7. *Honorary Life Membership*

Any individual who, in the opinion of the Board, has rendered distinguished service to the Association or to the Industries concerned, may, by unanimous vote of the Board, be elected to Honorary Life Membership. Honorary Life Members shall not be entitled to vote on any matter or hold elective office or the office of Director.

8. *Election to Membership*

All applications for membership shall be submitted to the Association Office in writing and in a form as determined by the Board. All applicants for membership shall agree to conform with the Code of Ethics. The Board shall decide by majority vote on the admission of the applicant to membership and as to the applicable class of membership.

9. *Termination of Membership*

(a) Any Member may resign from the Association by mailing written notice of such resignation to the Association, accompanied by the payment of all dues and amounts then owing to the Association.

(b) A Member may be suspended or expelled for any action which is inconsistent with, or detrimental to, the Objects of the Association or where a Company spokesman has knowingly made or published or cause to be made or published false, fraudulent, derogatory or harmful statements concerning the Association, its Officers or employees, or for the failure to pay dues within three months of the opening of the financial year, provided that:

The Member concerned shall be given at least thirty (30) days written notice by mail of the alleged offence or default, and that the suspension or expulsion shall be upon the affirmative vote of at least two thirds ($\frac{2}{3}$) of the members of the Board.

(c) If the Board shall determine by majority vote that any Member has discontinued the activities which qualified him for membership, the membership of that Member shall automatically terminate at that time.

10. *Officers and Board of Directors.*

(a) The management of the Association shall be vested in a Board of not more than twelve (12) Directors which shall consist of the Officers being the President, Vice-President and not more than ten (10) Directors. The President and Vice-President shall be elected by the Board at its first meeting after the Annual General Meeting and shall be nominated from the elected members of the Board. The President shall not continue in office for more than three (3) consecutive years.

(b) Officers and Directors shall take office immediately following the Annual General Meeting each year.

(c) There shall be not more than one Director from any Member Company.

(d) (i) Election of Directors shall be by postal ballot of Members prior to the Annual General Meeting and shall be conducted by a Returning Officer appointed for that purpose by the governing body of the day.

(ii) In order to preserve a national perspective the Board shall include not less than three (3) Directors, preferably resident in Victoria, from Members with head offices situated in Victoria. The Returning Officer is authorized to ensure election of three (3) Directors aforesaid by giving priority to them over all other candidates.

(e) Nomination for the office of Director shall be in the form as determined by the Board.

(f) The Board may fill any casual vacancies that may occur.

(g) The Board may appoint, within the limits of approved finance, such paid officers and staff as may be required to achieve the Objects and to administer the day-to-day affairs of the Association. The termination of such appointments shall also be by decision of the Board.

(h) The Board may arrange for any organization or person to provide secretarial and other services, including accommodation of the Secretariat.

11. *Duties*

(a) The President: The President shall be the Chairman and Chief Executive of the Association and shall, if present, preside at all business meetings of the Association or of the Board. He may nominate a Chairman for non-business meetings or sessions of conventions. He shall ensure that all orders and resolutions of General Meetings of the Association or of the Board are carried into effect and he, or the Vice-President, together with one or more other Officers designated for the purpose by the Board, shall, unless otherwise determined by the Board, sign all documents requiring the signature of the Officers of the Association. He shall have such other powers and duties as are elsewhere provided for in this Constitution or as may be assigned to him from time to time by the Board.

(b) Vice-President: The Vice-President shall assist the President and in the absence or the disability of the President, unless otherwise determined by the President or the Board, perform the duties and exercise the powers of the President. He shall also perform such other duties as may from time to time be assigned to him by the Board.

12. *Committees*

(a) The Board shall be the supreme governing body of the Association, subject only to direction by General Meetings of the Association.

(b) The Board may appoint such Committees as are required for the management of the Association.

(c) The Board shall determine the areas of operation and Terms of Reference of such Committees, which shall report to the Board and shall remain in office until replaced in whole or in part or disbanded.

13. *Subscriptions*

(a) Annual subscriptions shall be determined by the Board.

(b) Annual subscriptions shall become due on the first day of July in each year and be payable without default on or before the thirty-first day of August in that year.

(c) Members shall advise a firm of chartered accountants or such other independent agency as appointed by the Board their turnover in Industry Products in the defined Categories. The independent agency shall calculate, advise members of, and collect subscriptions due for and on behalf of the Association.

(d) The turnover in Industry Products submitted by an individual Member and the subscriptions calculated therefrom shall be strictly confidential information between the independent agency and the individual Member and shall not be disclosed to the Association or any of its officers or to any other Member.

(e) Notwithstanding anything contained in this Constitution, the Board may if it sees fit and upon adequately documented application from the Member concerned, vary the requirements of the Constitution in order that the applicant's membership may be obtained or retained, subject to the subscription paid being no less than that required in the terms of this Constitution.

14. *Accounts*

The Board shall cause proper books of account to be maintained and shall present a full statement of accounts at each Annual General Meeting. All payments shall be made by cheques signed by such persons as are authorized by the Board.

15. *Auditors*

Auditors shall be elected annually at the Annual General Meeting.

16. *Meetings*

(a) Annual General Meeting: The Annual General Meeting of the Association shall be held between July and November each year at a time and place as determined by the Board.

The business to be transacted shall be:

To receive the Minutes of the preceding Annual General Meeting.

To receive the Report of the Board and, if thought fit, to approve recommendations of the Board.

To receive the audited statement of accounts for the preceding financial year.

To declare the ballot for the election of Directors for the ensuing year.

To appoint Auditors and fix their remuneration.

To transact any other business of which notice shall have been given to the Association at least fourteen (14) days before the Meeting is held.

(b) General Meetings: General Meetings may be convened on the direction of the Board or by the requisition of at least twenty per cent (20%) of the Members. At least thirty days notice of a Meeting called for the purpose of amending this Constitution shall be given to all members specifying place, day

and hour of the meeting and the business that shall be brought before such a meeting. No business other than that stated in the notice, except of a formal nature, shall be brought forward at any Meeting.

(c) Board Meetings: The Board shall meet at least four times annually.

17. *Voting*

Except as otherwise directed in this Constitution any question for decision at any Meeting shall be determined by a show of hands unless a poll is demanded by at least one third (⅓rd) of the Members personally present and entitled to vote. The Chairman of any Meeting shall have a deliberative and casting vote, and his declaration of the result shall be final and conclusive. Each member shall have only one vote.

18. *Quorum*

The quorum for a General Meeting shall be twenty per cent (20%) of Members entitled to vote. The quorum for a Board Meeting shall be six.

19. *Adjournment*

The Chairman with the consent of the Meeting may adjourn the Meeting from time to time and place to place, but no business shall be transacted at an adjourned Meeting other than that left unfinished from the original Meeting.

20. *Proxies*

Any Member entitled to vote at any General Meeting may appoint a proxy in writing in the common or usual form addressed to the Chairman of the Meeting and lodged with the Association office not less than forty-eight (48) hours before the time for the holding of the Meeting at which the person named in the instrument proposes to vote.

21. *State Activities*

The Board shall keep under review the needs of Association activities in all States and may establish appropriate State Branches and/or Committees to attend to State activities. Any Branch or Committee so appointed shall act within the policy framework, guidelines, terms of reference or by-laws determined by the Board from time to time.

22. *Amendment to Constitution*

This Constitution may be repealed, in whole or in part, or amended in any way by the authority of a special resolution of Members in General Meeting. A special resolution shall be passed by a majority of not less than two-thirds (⅔) of such Members being present and being entitled so to do vote in person or by proxy at a General Meeting.

23. *Winding Up*

(a) In the event of the Association being unable to function in the carrying out of its Objects as defined under clause 5 it shall be wound up.

(b) In such case the Board is authorized to pay all accounts due by the Association and to collect all moneys payable to it. The credit balance—if any—remaining to the Association and any other assets shall not, nor any part of them, be the subject of any distribution to Members or a Member but shall be handed over to an organization having the same or similar Objects to those of the Association and having in its Rules provisions that no distribution shall at any time be made to its Members.

Members of the Association shall decide in General Meeting the organization to which such assets and/or funds shall be handed. In the event of no such alternative organization being available, the credit balance shall be payable to a charitable organization as determined by Members of the Association in General Meeting.

24. *Indemnification*

Every office-bearer and Member of the Association and/or Board, the Secretary or other officer or servant, of the Association shall be indemnified out of the funds of the Association against, and it shall be the duty of the Board out of the funds of the Association to pay, all costs, losses, and expenses which any such office-bearer, member of the Board, the Secretary, officer or servant may incur or become liable to by reason of any contract entered into or act or thing done by him as such office-bearer, member of the Board, the Secretary, officer or servant, in any way in discharging his duty while acting under and in accordance with the instructions of the Board, except such shall happen by or through their own wilful default.

*Appendix* 8

## THE PROPRIETARY ASSOCIATION OF AUSTRALIA

*List of Members*

Abbott Laboratories Pty Limited.
Australian Pharmaceutical Industries Limited.
Bayer Pharmaceutical Company.
Beckers Pty Ltd.
Biochem Pharmaceuticals Pty Ltd.
The Boots Company (Aust.) Pty Ltd.
British Medical Laboratories.
Burroughs Wellcome & Co. (Australia) Ltd.
Calva Chemicals Pty Ltd.
Cambridge Laboratories Pty Ltd.
Cooper Laboratories Pty Ltd.
Cyanamid Australia Pty Limited.
F. H. Faulding & Co. Ltd.
Fawns & McAllan Pty Ltd.
Fisher & Company.
Fisons Pty Limited.
Glaxo Australia Pty Ltd.
Hoechst Australia Liimted.
I.C.I. Australia Limited.
Kingsgrove Laboratories Pty Limited.
Laxettes Pty Ltd.
J. McGloin Pty Limited.
Menley & James Laboratories.
Merck Sharp & Dohme (Australia) Pty Ltd.
Miles Laboratories Australia Pty Ltd.
Monsanto Australia Limited.
Muir & Neil Pty Ltd.
Nicholas Proprietary Limited.
Parke Davis & Company.
Pfizer Pty Ltd.
Pharmacode Pty Ltd.
Prosana Laboratories Pty Ltd.
Reckitt & Colman.
Rexona Pty Ltd.
Richardson-Merrell Pty Ltd.
Riker Laboratories Australia Pty Ltd.
R. P. Scherer Pty Ltd.
The Sheldon Drug Company Pty Ltd.
Sigma (Pharmaceuticals) Pty Ltd.
Soul Pattinson (Laboratories) Pty Ltd.
Sterling Pharmaceuticals Pty Limited.
Upjohn Pty Limited.
Vitamin Supplies Pty Ltd.
Ward & Ward (Aust.) Pty Ltd.
Watts Winter & Co.
H. W. Woods Pty Ltd.
World Agencies Pty Ltd.

*Appendix* 9

## THE PROPRIETARY ASSOCIATION OF AUSTRALIA

*List of Member Companies and the Products they Market*

ANALGESICS

Bayer Aspirin—Bayer Pharmaceutical Co.
Bex Powders and Tablets—Beckers Pty Ltd.
Bufferin, Bufferin Forte, Tempra Drops, Tempra Syrup, Tempra Tablets, Panaceta—Bristol-Myers Pty Ltd.
Codral Tabs (Blue Label), Codral Tabs (Red Label)—Burroughs Wellcome.
D & M Tablets—Cambridge Laboratories.

A.P.C. Tablets, Ascotin Tablets, Aspirin Tablets—300 mg, Aspirin Soluble Tabs, Hycodin Tabs, Palfium Tabs, Palfium Ampoules—F. H. Faulding.

Codacton Tablets—Fisher & Company.

Panquil, Paraspen—Fisons Pty Ltd.

Angesil, Aspirin, Provoprin, Provoprin 500, Solgesil—D.H.A. (A.P.I.).

Alka-Seltzer Tablets—Miles Laboratories.

Sedosal—Muir & Neil.

Aspro Clear, Aspro Regular, Aspro Soluble, Vincent's Powders, Vincent's Tablets, Decrin Powders—Nicholas Pty Ltd.

Disprin, Codis—Reckitts.

Codaspren—Sigma.

Kodeen (Codeine Compound Tabs), Tynees (Baby Aspirin)—World Agencies.

## ANALGESICS—TOPICAL

Thermorub—Fisons Pty Ltd.

Mentholatum Deep Heat Rub—Laxettes Pty Ltd.

Caligesic Cream—Merck Sharp & Dohme.

Bonjela, Transvasin, Blue-Gel, Sedaural—Muir & Neil Pty Ltd.

## SEDATIVES AND TRANQUILLIZERS

Dormel—D.H.A. (A.P.I.).

Pentone Capsules—F. H. Faulding.

Fishaphos Plus Tablets—Fisher & Co.

Seducaps—Lederle (Cyanamid).

Manialith—Muir & Neil.

Karmavar Tabs—World Agencies.

## STIMULANTS

Alert Tablets—Hoechst Aust. Ltd.

No-Doz—Muir & Neil.

Caffeine Plus—Riker Laboratories.

## COUGH AND COLD PREPARATIONS

Cold Sore Balm—Abbott Laboratories.

Codral Cold Tablets, Actifed C.C., Codral Linctus, Sudelix Elixir, Sudelix Junior Elixir, Codral Lozenges, Vasylox Junior, Vasylox Plus Nasal Drops, Vasylox Nasal Spray—Burroughs Wellcome.

Breezeazy Tablets—Cambridge Laboratories.

Clearaphed, Heenzo Concentrate, Heenzo Ready Mix, Panelix Plus, Panelix Junior, Syrup Ephedramin No. 1 and No. 2, Triolix—D.H.A. (A.P.I.).

Honeybrom, Pectolin, Senega & Ammonia, Friars Balsam, Eucalyptus Oil—F. H. Faulding.

Pharmacol Linctus & Lozenges, Pharmacol Junior—Fisons Pty Ltd.

Savacol Throat Lozenges—I.C.I. Aust. Ltd.

Mentholatum Balm—Laxettes Pty Ltd.

Contac 500, Contac Throat Lozenges—Menley & James.

Tusselix Forte, Durazol Nasal Drops & Spray—Fisons Pty Ltd.

Medic, Hudsons Jubes, Hudsons Eumenthol Cough Mixture—Reckitts.

Vicks Cough Drops, Vicks Cough Syrup, Vicks Formula 44 Cough Mixture, Vicks Formula 44 Cough Discs, Vicks Formula 44C Cough Mixture, Vicks Inhalers, Vicks Sinex Nasal Spray, Vicks Theryx Cold Tablets, Vicks Vaporub—Richardson-Merrell Pty Ltd.

Hearnes Mixture—Riker Laboratories.

Double "D" Eucalyptus, Double "D" Eucalyptus Cough Drops Sheldon Drug Company.

Chest Rub, Elixacaps, Elixamine, Elixamine Expectorant, Elixamine Junior, Elixamine Linctus, Dramide Cold Sore Cream, Endamide—Sigma (Pharmaceuticals).

Orthoxicol Cold & Flu Caps, Orthoxicol Cough Suppressant—Upjohn Pty Ltd.

Asmolets—World Agencies.

## ANTACIDS

Pepsillide Tablets, Pep-uls-ade Tablets, Ulsade Tablets—Cambridge Laboratories.

Alucone, Alusorb, Trisil—D.H.A. (A.P.I.).

Magnos, Milk of Magnesia, Efferdex—F. H. Faulding.

Gastreze—Fisons Pty Ltd.

Almacarb Suspension, Almacarb Tablets—Glaxo.

B.F.I. Powder—Merck Sharp & Dohme.

Alka-Seltzer Antacid Saline—Miles Laboratories.

Caved-S—Muir & Neil.

Rennie—Nicholas.

Dexsal—Reckitts.

R. M. Hardys—Ingestion Powder and Tabs—World Agencies.

## LAXATIVES

Ford Pills, Ford Lax Junior—British Medical Laboratories.

Green Label Pills—Cambridge Laboratories.

Lubarol—D.H.A. (A.P.I.).

Epsom Salts, Castor Oil, Evactil, Magnesium Sulphate Dried, Liquid Paraffin—F. H. Faulding.

I-So-Gel—Glaxo.

Laxettes, Chemlax—Laxettes Pty Ltd.

Senokot—Reckitts.

Phospho-Soda—Sigma (Pharmaceuticals).

Schumanns Salts—World Agencies.

## ANTI-DIARRHOEALS

ADM Wellcome—Burroughs Wellcome.

Glucomagma—D.H.A. (A.P.I.).

Kaogel—F. H. Faulding.

Diareze Suspension, Diareze Tablets—Fisons Pty Ltd.

Kaoquin—Sigma.

Kaocon—Upjohn Pty Ltd.

## HAEMORRHOIDAL AND VARICOSE VEIN PREPARATIONS

Glycerine Suppositories, Palfium Suppositories, Paxyl Suppositories—F. H. Faulding.

Variaid Ointment, Variaid Tablets—Fisher & Co.

Hemocaine Ointment and Suppositories—Fisons Pty Ltd.

## SLIMMING PREPARATIONS

Ford Slimming Tabs—British Medical Laboratories.

Trim Tabs—Lederle (Cyamamid).

Redupon, Toppexin 6, Vitacel—Riker Laboratories.

Spinndell Tablets, Statavar Tablets, A.S.T. Tablets, Swedish Milk Diet—World Agencies.

## TONICS

Phospherine Liquid, Fishaphos Tablets—Fisher & Co.

Sanatogen—Fisons Pty Ltd.

Incremin with Iron Syrup, Incremin Vitamin C Tonic, Accomin Adult Tonic—Lederle (Cyanamid).

B.G. Phos Elixir—Merck Sharp & Dohme.

Scott's Emulsion—Scott & Bowne.

## MEDICATED SKIN PREPARATIONS

Butesin Picrate Ointment—Abbott Laboratories.

Silicoderm-f—Bayer Pharmaceutical Co.

Moisturelle Lotion, Moisturelle Cream, Free and Clear, Scrub Out—Bristol-Myers.

Ringworm Ointment Wellcome, Tineafax Ointment, Tineafax Powder, Toilet Lanoline—Burroughs Wellcome.

Nixoderm Ointment, Acnaveen, Aveenobar, Aveenobar Oilated, Aveeno C.O. Bath, Aveeno Oilated Bath—Cooper Laboratories.

Dab-on Antiseptic, Dermecyl Ointment, Dermecyl Powder, Lipcain, Phytex, pH Antiseptic Cream—D.H.A. (A.P.I.).

Calamine Lotion, Camphorated Oil, Gard Medicated Soap, Glycerin and Borax, Magnoplasm, Paxyl Cream, Paxyl Burn Relief (Aerosol Spray)—F. H. Faulding.

Medi Creme, Medi Pulv, Zambuk—Fisons Pty Ltd.

Siccolam Paste, Seba-Med Medicated Soap, Mycil Antibacterial Powder, Mycil Aerosol Spray, Mycil Antibacterial Ointment, EDP Antiseptic Powder—Glaxo.

Mediclear Anti Acne Treatment—Hoechst.

Savlon Antiseptic Cream, Savlon Antiseptic Liquid, Savlon Dry Antiseptic Powder Spray, Savlon Medicated Powder—ICI Aust. Ltd.

Paige Fingertip Cream—Laxettes Pty Ltd.

Deep Care Hand Cream, Deep Care Nappy Rash Cream—Lederle (Cyanamid).

B.F.I. Powder—Merck Sharp & Dohme.

Pharmaton Skin Activator, Royal Bath Pharmaton—Muir & Neil.

Ungvita—Nicholas.

Dettol Liquid, Dettol Antiseptic Cream, Sapoderm Soap, Sapoderm Skin Cleanser, Sapoderm Skin Cream—Reckitts.

Lanolin, Zinc Cream, Zinc and Castor Oil Cream, Tri-Physol, Z.S.C. Dusting Powder—Sigma.

Action Lotion, Action Antibacterial Pretreatment—Upjohn Pty Ltd.

Eichorns Remedy—Ointment—World Agencies.

## MEDICATED HAIR PREPARATIONS

Anti-Dan Foam—Bristol-Myers.

Sebaveen Shampoo—Cooper Laboratories.

Vitapointe, Genisol—Fisons Pty Ltd.

Dangard Medicated Foam—Hoechst.

Savlon "D" anti-dandruff foam—ICI Aust. Ltd.

Pharmaton Hair Tonic—Muir & Neil.

Sapoderm ZP Shampoo—Reckitts.

Action Foam—Upjohn Pty Ltd.

Selsun—Abbott Laboratories.

## SUNSCREEN PREPARATIONS

Sunlaze Cream, Solray Leg Tan—F. H. Faulding.

Lip-sed—Fisons Pty Ltd.

UV Cream, UV Lotion—ICI Aust. Ltd.

Sea and Ski Suncare Range, Aftersun Skincare Range—Menley & James.

Skol Suntan Preparations—Scott & Bowne.

Sunbalm, Sunbronzer, Superscreen, Tan'n'Ban—Sigma.

## ANTIRHEUMATICS, ETC.

MacKenzies Menthoids, Menthoids Plus—British Medical Laboratories.

Potaba Tablets and Capsules—Cambridge Laboratories.

Mentholatum Deep Heat Rub, Mentholatum Deep Heat Lotion—Laxettes Pty Ltd.

Heat Rub—Scott & Bowne.

Malgic-Adrenalin Cream, Arthrex Tablets, Coppano Tablets, Sal Urem—World Agencies.

## DENTAL HYGIENE, ETC.

Ora-sed—Fisons Pty Ltd.

Oraltone—Hoechst.

Branalcane, Griptight Regular, Griptight Orthodontic—Muir & Neil.

Steradent Tabs, Steradent Powder, Steradent Denture Cream—Reckitts.

Fasteeth, Fixodent—Richardson-Merrell Pty Ltd.

Mulkets—Riker Laboratories.

Oralex, Nuralgon, Apthosa—World Agencies.

## EYE/EAR PREPARATIONS

Murine, Clear Eyes—Abbott Laboratories.

Opsis, Visamide—D.H.A. (A.P.I.).

Optik Eye Drops, Optik Golden Eye Ointment—F. H. Faulding.

Oticane—Fisons Pty Ltd.

Optazine Eye Drops—Lederle (Cyanamid).

Golden Eye Ointment, Visopt Eye Drops—Sigma.

## VITAMIN PREPARATIONS

Critisun, Polyvisol Drops and Tablets, Sustaforte Capsules—Bristol-Myers.

Calcium Gluconate, Calcium Lactate, Multi Vitamin Capsules, Vitamin B1, Vitamin C Plain, Vitamin C Orange—D.H.A. (A.P.I.).

Ascorbic Acid Tablets, Cod Liver Oil, Ferocal Tablets, Gerovit Capsules, Glauber's Salts, Milk Emulsion, Nutril Capsules, Nutrilmin Capsules, Salt Tablets, Saltose Tablets, Vitaphen Tablets, Vitin Ointment—F. H. Faulding.

Citradex Multivitamin Tabs, Multivite-Six Tablets, Haliborange Tablets, Cytacon Liquid and Tablets—Glaxo.

Leder-C, Leder-E, Accomin Multivitamin Capsules—Lederele (Cyanamid).

Vitamiles One-a-day, Vitamiles Vitamin "C" (Orange), Vitamiles Vitamin "C" (Lemon)—Miles Laboratories.

Geriatric Pharmaton—Muir & Neil Pty Ltd.

Altorvite, Tab-Vita B Fort, Penta-Vite—Nicholas.

Toppin 22—Riker Laboratories.

S & B Vitamins & "Vykmin"—Scott & Browne.

Vitamin E, Scorbies, VAM—Sigma.

Unicap Chewable, Unicap T—Upjohn Pty Ltd.

## BABY PRODUCTS

Nursil Syrups—The Boots Company.

Drapolex Cream, Drapolex Creamy Change Lotion—Burroughs Wellcome.

Cradolene, Ellico Baby Herbal Shampoo, Ellico Baby Oil, Ellico Baby Soap, Ellico Covitol Cream, Ellico Rose Hip and Orange, Ellico Zinc and Castor Oil—D.H.A. (A.P.I.).

Fisher's Teething Powders—Fisher & Co.

Infacol Emulsion and Syrup—Wisons Pty Ltd.

Deep Care Nappy Rash Cream—Lederle (Cyanamid).

Am-o-lin Baby Cream, Am-o-lin Nappy Change Lotion, Am-o-lin Nightgard Cream, Am-o-lin Petroleum Jelly—Miles Laboratories.

Truflo Feeding Bottles and Teats—Reckitts.

Milgard Nappy Change Lotion, Milton Antiseptic, NapiSan, Infa-Care—Richardson-Merrell Pty Ltd.

Tynees Teething Jelly, Tynees Thummie, Neversuck—World Agencies.

## TOILETRIES

Barrier Cream, Hand Care (Aerosol), Honey and Almond Lotion, Silcon, Skin Reviver, Neutrogena, Gard Antiperspirant, Gard Deodorant Talc, Toilet Lanoline, Bay Rum, Shave, Lavender and Musk, Solyptol Baby Powder, Solyptol Soap, Solyptol Liquid Soap—F. H. Faulding.

Skin Repair—Fisons Pty Ltd.

Clearasil, Oil of Ulan, Ulan Night Cream, Herco Olivol Hand and Body Lotion, Lemon Delph Cleansing Milk, Lemon Delph Skin Refresher—Richardson-Merrell Pty Ltd.

Clocream Skin Care—Upjohn Pty Ltd.

## ANTISEPTICS/DISINFECTANTS AND HOUSEHOLD PRODUCTS

Metaphen (tinted and untinted)—Abbott Laboratories.

Hexsotate—D.H.A. (A.P.I.).

Betadine Antiseptic, Betadine Surgical Scrub, Boracic Acid, Ethereal Soap, Flavine Solution, Glycol Spray Diluent, Hydrogen Peroxide, Iodine Tincture, Mercurochrome

Solution, Mouthwash Tablets, Novosol, Solyptol Antiseptic, Solyptol Antiseptic Cream, Sterex, Ultrafresh, Poisoned Wheat, Faulded Aerosol, Moth Marblcs, Naphthalene Flakes—F. H. Faulding.

Cornkil, Wartkil, Bansuk—Fisons Pty Ltd.

Pergalen Ointment—Hoechst.

Carnation Corn Plasters, etc., Salicylin-P—Muir & Neil.

Pea-Beu Insecticide, Outdoor Insect Repellant—Richardson-Merrell Pty Ltd.

Repellem Aerosol, Repellem Gel, Repellem Liquid—Sigma.

Wartex—World Agencies.

MISCELLANEOUS

Sucaryl Tablets & Liquid—Abbott Laboratories.

Dimins, Fenox, Sweetex, Tussils, Sugarine, Sweetene, Glucomed—The Boots Company.

Antepar Elixir & Tablets—Burroughs Wellcome.

Cenovis Yeast Tablets, Pressor Salt, Orgamin Tablets—British Medical Laboratories.

Desista Tablets, Dale Dehydrated Goat Milk—Cambridge Laboratories.

Amosan, Flurets Drops & Tablets—Cooper Laboratories.

Repalyte—D.H.A. (A.P.I.).

Bengers Food—Fisons Pty Ltd.

Orion Urine Culture, Kabikinase, Quinine Bisulphate Tablets, Quinidine Sulphate Tablets, Glycerin, Glucose Syrup, Lactose, Lemon Saline, Lemon Barley Water, Olive Oil, Saccharin Tablets, Liquid Saccharin, Solvent Ether, K2r Spot Lifter—F. H. Faulding.

Beta-Sol, Citrets, Folette Tablets, K. Thrombin Tablets, K. Thrombin Ampoules—Fawns & McAllan.

Formulax Tablets, Hold and Care—Hoechst.

Refrane—Lederle (Cyanamid).

Simpkins Glucose Sweets, Simpkins Mini Tabs, Nisin—Muir & Neil.

Saltadex, Pripsen—Reckitts.

Expernic Paint, Vi-Pernic Tablets, Settlers—Sigma.

Pax Products—World Agencies.

3968. CHAIRMAN: I understand that you wish to make a further submission?——W. That is correct. The following observations support and, where necessary, amplify this association's submission to the joint committee, made in January, 1977.

THE PROPRIETARY ASSOCIATION OF AUSTRALIA

PAA, as a National organization representing some fifty manufacturers of over-the-counter proprietary medicines, wishes to make the following observations for the Committee's consideration:

(1) Self-medication is more readily available, more convenient and less costly than professional help in relieving certain minor symptoms and transient ailments.

(2) Self-medication keeps the individual functioning at times when he may otherwise be unnecessarily indisposed by minor ailments, such as simple headache, indigestion, coughs and colds, or constipation.

(3) Self-medication relieves what would otherwise be an unnecessarily heavy load on the medical services.

(4) The need for self-medication is so great that if simple, effective Home Medications are not available, the layman is likely to seek other ways of treating himself which may be unreliable and less simple to control and direct.

(5) The cost today to the consumer for proprietary medicines is the lowest element in the total health care system.

(6) We must all be able to obtain relief from temporary ailments, such as headaches, sore throats, indigestion, coughs and colds without consulting a physician.

(7) Analgesic products, as a group, are probably the most frequently used form of proprietary medicine.

We believe proprietary analgesics provide a safe, effective means of obtaining relief from a wide range of simple ailments.

(8) This Association has seen no scientific evidence to support the view that the incidence of excessive use of analgesics in the Australian community is more than minimal.

(9) PAA is committed to an active education programme to help persuade the consumer to use medicines strictly as directed and, with the co-operation of other interested bodies, we believe this will contribute importantly to enlightened self-care.

We are also prepared to work actively with Health Commissions in any public educational programmes to this end.

(10) All PAA members ensure that their proprietary medicine advertising strictly observes all relevant laws and regulations. As well, we are committed to honest advertising, and we actively support the recently-introduced Voluntary Proprietary Medicines Advertising Code, together with a strict Code of Ethics established by PAA.

We also believe advertising plays an important part in helping to ensure that the public understands when and how to use our products for safe and effective relief from minor ailments.

(11) PAA members, as a group, constitute a large industry using significant quantities of Australian-produced materials and providing direct or indirect employment for many Australians.

(12) As the national body for our industry, PAA is a member of the World Federation of Proprietary Medicine Manufacturers. This world-wide Council, representing membership from 24 countries, was recently officially recognized by the World Health Organization as an approved Non-Government Organization.

In announcing this in March, 1977, Dr V. Fattorusso of WHO stressed WHO's concern to assist in extending better primary care to the world public and acknowledged the importance of proprietary medicines in meeting this need.

(13) Overall, PAA and its members are committed to a programme that will progressively encourage a better understanding of the true role and significance of proprietary medicines in Australia's broad health care system.

This will entail a sustained and meaningful consumer education programme to encourage sensible, enlightened use of our products. PAA or its individual members are also prepared to initiate research programmes to provide factual measurements of the true significance of analgesics and proprietary medicines and self-medication habits in the community.

3969. CHAIRMAN: Does any other member of your group wish to add to those observations?——W. Not at this stage.

3970. One part of your submission states that the association has seen no scientific evidence to support the view that the incidence of excessive use of analgesics in the Australian community is more than minimal. The committee has heard evidence that would suggest that excessive use of analgesics is more than minimal in some sections of the community.——W. In making that statement I was referring to the Australian community as a whole. We have no data that shows any excessive usage in local communities or in any particular city in Australia, so this reference is on a national basis.

3971. Has your Association figures available to it to indicate where analgesics are used most in Australia?——W. I will ask one of my colleagues to reply to that. (*Mr Daddo*) Does the question relate to geographical location?

3972. Yes.——W. We have per capita figures that relate to State by State consumption of analgesics. I could particularly relate that to our own company. To identify anything on a smaller locale outside a total State in terms of sales volume is extremely difficult. The main reason is that most member companies of the Proprietary Association distribute their goods through a network of wholesalers and the nature of that distribution makes it impossible for us to identify, for example, that sales in Geelong might be of any particular volume. We know that Melbourne wholesalers will buy from us direct in Melbourne and service the Geelong area. It is similar in places such as Wollongong and Newcastle in New South Wales and in places like Toowoombah in Queensland; it is impossible for us to identify individual regions within a total State.

3973. To come back to my original question, the Association as such has no figures available to it to indicate the areas where analgesics are sold?——W. (*Mr Glover*) That is correct. Our individual members have figures relating to their own——

3974. But they do not supply them to your Association? ——W. No.

3975. If this Committee were to try to obtain those figures it would have to go to each individual member of your Association that prepares analgesics?——W. Yes.

3976. The Committee has had evidence that renal papillary necrosis, the primary lesion that occurs in the kidneys, is the result of toxic effects of analgesics. Apparently you contest that statement, whch was made to us by one of Australia's leading renal experts?——W. I will ask Professor Murton to reply to that. (*Prof.* Murton) I do not think that we do contest this. There is ample evidence to suggest that analgesic nephropathy is linked with the intake of phenacetin. I do not think that there is any doubt about that at all; all nephrologists would agree to that. I think equally they would agree that the long-term effect of phenacetin is considerable. In other words lesions that occur by high intake of phenacetin will be present several years after phenacetin ceases to be taken. Our view is that there is no evidence at this moment—indeed, there is evidence to the contrary to suggest that high intake of analgesics as are commonly used, namely aspirin, caffeine and paracetamol, show no evidence of papillary necrosis. The evidence against this is the studies carried out worldwide but I will refer only to those which have been carried out in this area, namely, in New Zealand and more recently in Brisbane, which show that when aspirin is taken in high dosages, for example for rheumatoid arthritis where one is taking something like twelve or sixteen tablets a day for many years, on autopsy the incidence of necrosis in the kidney is no greater than normal.

3977. What would you define as analgesic abuse?—— W. That is a very difficult question. I would have to take refuge in the figure I have just quoted on aspirin, where in rheumatoid arthritis patients take up to sixteen tablets a day for several years, with no untoward effect. So it must be in excess of that.

3978. You do not agree with the contention that it is the compounding of the chemicals that causes the trouble? ——W. Unless one includes phenacetin I see no evidence to suggest that compounding brings this about.

3979. What is the difference between phenacetin and paracetamol once the body has absorbed the chemical? ——W. Quite marked in terms of the metabolite. If one studies the effect of phenacetin and paracetamol on the kidney one will find paracetamol has no effect at all on the kidney.

3980. So if you had a powder containing aspirin, paracetamol and caffeine it would not have the same effect as aspirin, phenacetin and caffeine?——W. That is so.

3981. One of the professional witnesses who previously gave evidence before this Committee spoke about the effect on the kidneys of a time dose cumulative toxicity. In other words he was suggesting that if one took these analgesics they had a cumulative effect just the same as if one were to take the whole lot at once. He said that 2 kilograms of phenacetin or aspirin in the form of a mixture is the equivalent of intaking three powders a day for five years, five powders a day for three years or fifteen powders a day for one year. Would you agree with that statement?——W. Yes, I think I would.

3982. Therefore, if somebody were to take as many as fifteen powders a day for a year you would expect to find at the end of that year—and I am talking now about a compound powder—that there would be some effect on the kidneys?——W. Yes, if, as you indicated, phenacetin was one of those ingredients.

3983. But if phenacetin was not in it, paracetamol was substituted?——W. I think it is extremely doubtful. I have seen no evidence to suggest that there would be any kidney damage.

3984. Have you any evidence of experiments carried out on rats or other animals to try to prove what you are saying is wrong?——W. Yes. In fact we have supported a study which has been completed recently at the Radcliffe Infirmary in Oxford and also at St Vincent's hospital in Melbourne. There, very large doses of aspirin, well in excess of the sixteen tablets a day that I was referring to in the treatment of rheumatoid arthritis, were given to rats with no damage to the kidneys whatever. I think I should add that I believe all that really indicates is that the rat perhaps is an unsatisfactory animal model.

3985. Mr Glover, when you appear as a member of the Association you speak with authority for all the members before the Committee, say some fifty members?——W. (*Mr Glover*) That is correct.

3986. I come back to what I asked earlier about company figures. Is there any way you could suggest that we might be able to follow up this matter in order to find out exactly how many of these analgesic powders and tablets are used in any particular part of Australia?——W. We have no mechanism in our Association to provide that information at this time. We have a wide range of members many of whom are not prepared to divulge their sales figures on a public basis. We have never seen the need as an Association to assemble that type of information. Any request that we made to members of our Association would be met with a partial response, I think.

3987. You feel, do you not, that you have a responsibility to the public in regard to this matter, the idea of analgesic toxicity?——W. We feel a very definite sense of responsibility to the public.

3988. I suppose that it is well known to you that Newcastle is regarded as a centre that is famous for the number of people who have suffered renal damage?——W. Yes, we have heard that.

3989. And that is normally attributed to abuse of analgesics?——W. Yes, we have certainly read statements to that effect. As Mr Daddo mentioned earlier, we have

no way of providing any information on the sales of analgesics in Newcastle as a locality for the reason that all our products, not just analgesics but all forms of pharmaceutical products, are distributed through a variety of wholesalers who sell their products not just to Newcastle but in fact throughout New South Wales.

3990. If there is one particular area that is notable for the number of people who have suffered renal damage surely the members of your Association have a responsibility if they suspect the analgesics are responsible?——W. Yes, but our members do not have any factual information on which to form any opinion as to the consumption of analgesics in Newcastle or any other area of Australia.

3991. We cannot get the figures either.——W. (*Mr Glover*), We, as an association, made a submission to the Senate Select Committee in which we pointed out the inadequate statistics available within our industry or to the community generally. We proposed that some form of meaningful trade and consumer research be conducted to define this type of issue. We also said that we, as an association, were willing to work closely with government authorities in developing that form of research. Subsequently the committee notified us that it would be unable to carry out this type of work. However, I agree that there is a need for factual data to answer the sort of question you are asking.——(*Mr Cook*) The details of that proposal are contained in appendix 5 of this document. In a letter to Mr Joske, the secretary of the Senate Standing Committee, the association held clearly the PAA view on the type of research that is needed in this country to establish exactly where the problem lies.

3992. But at this stage nothing has been done——W. (*Mr Glover*) No.

3993. Individually or collectively?——W. No.

3994. You stress the necessity for education in regard to the use of analgesics. What has your association done in this matter?——W. Right now we are finalizing plans to distribute some 2 million leaflets which, as you can see from the one I have here, say, "Use medicines properly. Take medicines only when you need to—they can't help you unless used properly. Follow directions carefully. Read the directions given on the package carefully before using a medicine. Take the recommended dose only—neither more nor less. Keep to the recommended time intervals between doses. Consult your doctor. Doctors and pharmacists will help you if you need advice about your medicines. You should always: Consult your doctor if an illness persists; consult your doctor, if already under medical treatment, before taking home medicines. Do not take several different medicines at the same time unless your doctor tells you to. Don't give adult medicines to children. Do not give an adult dose of medicine to children unless it is indicated on the package label. Give the recommended children's dose. Do not give any medicine to babies under six months of age without first consulting your doctor. Home medicines are designed to provide treatment of simple ailments. Properly used they make a valuable contribution to the health and well-being of the community." We are right now in the final stages of planning to distribute 2 million of these leaflets through retail stores and any other medium that we can find that will ensure that they reach the Australian home. This is just the beginning of a programme that we, as an association, have named as our highest priority. In addition to that, I think you are well aware that strict codes are already established for both labelling and advertising and our members uniformly ensure that they follow these legal and voluntary code requirements.

3995. Is there any suggestion of your having a TV campaign?——W. We have talked about it, but so far we have not developed any specific plans. I think we all agree that there is a need to carry this message through every possible medium that we can afford. We have plans under way to address groups within the community, emphasizing this sort of story.

3996. I think in your submission you suggested that you were prepared to approach the Health Commission of New South Wales and to co-operate with them?——W. That is correct.

3997. Has any approach been made to them?——We have already talked with members of the Health Commission and they have agreed that there is a need and they are willing from their standpoint to co-operate with us in any joint ventures that we come forward with. This leaflet is our first effort and we shall do this probably independently of the Health Commission. We shall distribute this through pharmacists and the like. As our programme develops there will no doubt be areas where we can collaborate with the Health Commission here and in other States and we shall do that.

3998. That pamphlet deals with medicines in general, does it not?——W. That is correct.

3999. At this stage, as you heard in the terms of reference, we are dealing only with drugs of dependence.——W. That is so.

4000. At this stage analgesics are included. Some people might consider that they are not drugs of dependence but they are certainly being considered by this Committee because that proposition has been put to us. We are interested now to see what efforts can be made to educate people concerning the excessive use of analgesics and if we accept evidence that has been given by some of the professional witnesses before this Committee we shall probably have to make some sort of recommendations about them. Would you tell us your feelings on what educational measures should be taken, apart from say a pamphlet, only in regard to analgesics?——W. I think our advertising of analgesics always emphasizes the need to adhere strictly to the recommended dose. We also say in all of our advertising of analgesics that if pain persists, the person affected should consult his or her doctor. That is a standard statement that appears on our labelling and in all of our advertising and I think every member of our association who sells analgesics is striving mightily to ensure that that message gets across.——(*Mr Cook*) This is true. I have very little to add to what Mr Glover has said. The advertising is controlled by a number of legislative and self-imposed regulations. It is designed to inform and to control the consumption, as are the warning labels which all of us have on our analgesics. However, I think we are talking about social aspects of the abuse or alleged abuse of analgesics. I think here we are in an important area, wondering whether there is anything more that we as marketers of analgesics can do beyond the warnings we put on our labels and the responsibility we show in our advertising. I believe this is nothing more than a social problem in isolated areas that we cannot yet identify in the community.

4001. You mentioned that if the pain persists they should consult a doctor, but a submission has been made to us that often powders are taken in order to cure a headache and subsequently the person concerned suffers withdrawal pains from the non-use of the powders so he or she goes and takes another powder to overcome the headache. What is the answer to that problem?——(*Prof. Murtin*) I think there is a great deal of hearsay in this

withdrawal headache syndrome. At the moment the amount of caffeine that is used in powders is slightly less than one takes in coffee. If one takes that to its logical conclusion one would assume that if one took half a dozen cups of coffee one would get withdrawal headaches. There is no scientific evidence to suggest that that is so. I accept Mr Glover's point that it is a social problem, but I think there must be a medical problem here that has to be unravelled. If we accept that there is a high degree of intake of analgesics in certain pockets of Australia, we have to relate these to other parts of the world and see if there is a correlation there. Recently I did a world tour, looking into this problem and discussing it in the United States and in the United Kingdom, and undoubtedly there are such pockets. In Europe there are pockets in Switzerland. This has been diagnozed because of the specific work that is carried out in Switzerland. The fascinating thing to me about this problem in Australia is that in those areas which have been identified by some authorities as being pockets of high usage one would except to get physiological dehydration. If that is so I think we have an entirely different situation and I should be perfectly prepared to accept that in a physiologically dehydrated state one might get what are commonly regarded as withdrawal headaches. We are dealing with micro areas of incidence.

4002. In your submission you refer to the inconvenience to the general public that would occur from attempting to deal with the determined abuser. It is obvious that you take the attitude that it would have to be a very good educational campaign to deter the determined abuser? ——W. Yes.

4003. So probably the people that we are trying to help most would be those that, in spite of all the educational efforts, would still abuse analgesics. How are we going to get to those people?——W. (*Prof. Murton*) Frankly, I think that no one has yet solved that. If one looks at the determined abuser, the greatest number of deaths—forgetting about heroin for the moment—is from barbiturates and the determined user of barbiturates will not be deterred by education or by scheduling for prescription only. I think that is a problem that the world simply has not solved.

4004. Have you had any evidence submitted to you on people abusing simple aspirin with drastic results?——W. (*Mr Glover*) No.

4005. Yet we have evidence that with the compounds renal damage is caused. So you would agree that it is the compound analgesics that cause the renal damage?——W. (*Professor Murton*) Yes, if they contain phenacetin.

4006. But only if they contain phenacetin?——W. Yes. (*Mr Glover*) As an industry we ceased using phenacetin in proprietary medicines some years ago.

4007. I realize that. You are well acquainted with the decision of the National Health and Medical Research Council?——W. Yes. It came to us in the form of a recommendation.

4008. Their decision of 26th April, conveyed to all State departments of health, was that aspirin, paracetamol and salicylate should be available for over-the-counter sale only when supplied as single substances, and not combined with any other pharmaceutical active substance; that the units contain no more than 25 tablets, and supplied in strip packets or containers with suitable child resistant closures? ——W. Yes. We are certainly aware of that. As an association, we disagree with that recommendation, for the reason that we believe there is no scientific evidence or scientific basis for that recommendation. That was the gist of our submission to the N.H.M.R.C. prior to their making that decision.

4009. Why do you think they made that decision if it were contrary to scientific evidence?——W. I think it was based more on circumstantial evidence or factors than on science.

4010. It would no doubt have a big effect commercially on all the members of your association who produce these compound analgesics?——W. Yes, it certainly would. Also, I think it would result in some inconvenience to the public. I should like to repeat that, in our view, the vast bulk of Australian consumers of analgesics use these products carefully and sensibly. We are talking, therefore, of a very small sector of the community who are inclined to overuse these products. As a result, our view is that, if the N.H.M.R.C. recommendations are carried through into the interstate legislation, this will result in inconvenience to the general public. In other words, it would be regulating for abuse, and this to us seems to be wrong.

4011. You feel that the great majority of people are going to be penalized because of the actions of a few who are abusing analgesics?——W. Yes, I think so. (*Mr Daddo*) Could I support that with some evidence that has been taken from a series of articles in the Medical Journal of Australia from 1969 onwards. It was clearly evident that 90 per cent of the community used analgesics in a quantity less than one or more tablet every day. These articles have appeared with a dosage regimen related to one tablet or powder per day as the criteria, and 91 per cent of the population in New South Wales, 97 per cent of the population in Western Australia, and 96 per cent of the population in Victoria do not take analgesics at a level that was above the base criteria.

4012. You would have no objection to the other section, dealing with strip packets or containers with suitable child resistant closures?——W. (*Mr Glover*) We support that fully.

4013. But you are completely against all these things in compound being included in the poisons schedule, so that they would be available only on prescription?——W. That is correct. Could I add, that there seems to be a misapprehension in our community that there is an ever-increasing excessive use of analgesics. The factual situation is that the market volume of mild analgesic tablets or equivalent powders has remained static over the past four recorded years, 1973 to 1976. Within this time the volume of tablets has increased 26 per cent, while powders have declined 9.4 per cent. So that the total share for powders has declined, from 29 per cent in 1973 to 23 per cent in 1976. Note that as the population has increased the market volume has remained static, so that the use per head of population has declined. The source of that information is from Nielson, an established research agency, and another body called I.M.S., International Medical Statistics, who carry out chemist audits.

4014. The figures from which they get that conclusion are the sort of figures that would be very valuable to this committee, if we could get them?——W. I again have to say that these bodies cannot provide that sort of information on a regional or provincial basis. That is our problem. The data I have quoted from here is available on a State or national basis, but they break it down no further than that.

4015. Professor Murton, are you quite satisfied that any complications from the overuse of analgesics are due only to failure to observe dosage and directions for use?——W. Yes, I think I am. I think the complications which arise are entirely due to overdose and stepping aside from the recommended dosages.

4016. It has been put to us that excessive use of analgesics will also produce heart complications as well. Would you agree with that?——W. No, I cannot say that I go along with that. I have not seen any animal evidence or any clinical evidence that is irrefutable.

4017. You are definite that the intermittent use of combined analgesics for the relief of pain or minor complaints causes no real physical harm?——W. Yes, I think I would say that, with the proviso that the compound excluded phenacetin. I will refer to the N.H.M.R.C. proposals. I am totally persuaded, by having discussed it with the members involved, that they paid very little attention to the long-term effects that high use of phenacetin would have. This was in marked contrast to the stance taken by the F.D.A. panel in the United States of America. It is interesting that only this week the Canadian Medical Journal has published an exhaustive study in Toronto, where incidentally the incidence of analgesic nephropathy was 50 cases per million. The Kidney Foundation in this country found that it was between 6½ and 7. That is the information we had. I mention the 50 because it may be a sort of level that we are considering in Newcastle. Phenacetin was withdrawn in Canada 7 years ago, and it took between 4 or 5 years before a decline in the incidence of analgesic nephropathy was noted; then it became very marked. Phenacetin was removed only two years ago in Australia, and it is far too early to note that sort of decline. But the decline noted in Canada has been paralleled by Sweden and Switzerland, and I am sure it will be paralleled here. However, the time is yet too short. That was played down and overlooked, or at least paid scant attention, by the N.H.M.R.C.

4018. In other words, you contend that the phenacetin causes the damage, and it is liable to come to the surface later?——W. Yes. As you mentioned, it has those chronic effects. (*Mr Glover*): We made this point in a submission to the Senate Select Committee early this year. I shall quote from this submission, which deals with recent findings on caffeine. We said:

> We believe there is no factual foundation for the assertion that use of caffeine in mild analgesics tends to encourage overuse. Certainly no such scientific evidence was made available to the U.S. Food & Drug Administration when it recently declared aspirin and caffeine combinations safe for self-use in home medication. The evidence supplied to the FDA OTC Review Committee was vast and extensive, yet no data questioning the safety of aspirin-caffeine compounds was presented. This, we feel, is most significant—especially as the FDA has an impeccable reputation for the screening of drug safety and, indeed, has been criticized in some medical circles as being too cautious in its judgment.
>
> Caffeine has been incorporated in mild analgesic products for many years, but its true therapeutic role and mode of action, except in some types of headache, have not been fully understood. Moreover there has been no reliable technique for assessing mild analgesia and a lack of knowledge of the mechanism of pain and analgesia.

My reason for reading that is to draw to the attention of this Committee the fact that compound products on sale today are generally a combination of aspirin or some other analgesic, plus caffeine. Phenacetin has been removed.

4019. Mr Daddo, in a submission put in by your company, you quoted Professor Swales in the United Kingdom. Can you tell us something more about him. Do you know him personally, or who he is?——W. (*Mr Daddo*) Perhaps Professor Murton could deal with that. You are referring to the *Practitioner* article in October 1976?

4020. Yes?——W. (*Professor Murton*) Professor John Swales is Professor of Medicine at the University of Leicester in the U.K. and is an eminent nephrologist. I think the work he was concerned with was renal failure with phenacetin. He was pursuing the point that you raised earlier on phenacetin and paracetamol. He was doing work with rats, and found evidence of some necrosis with very high dosages of paracetamol. But this work has since been reviewed by Professor Swales himself. I think this is why he goes on to say that animal studies are of doubtful relevance to man. I think that is right, and that in rats you can produce papillary necrosis with some experimentation, and with others none at all. That shows it is a totally unreliable animal species. It is for that reason we are now concentrating on primates and pigs. The results we are getting seem to be much more relevant. It is terribly important to get an animal study. There is no other way to determine excess dosages. We have just completed a study at the Radcliffe Infirmary in Great Britain. We have isolated kidney tubules. We are using human materials, and confronting these tubules with excessive doses of analgesics. This will be the first time one has done this with human tissue.

4021. One professional expert gave evidence that these substances had produced papillary necrosis in 30 or 40 per cent of the rats that he was using in his work. He said also that any food that had the same result would have great difficulty in being passed for human consumption. Do you agree with that?——W. No. I know this work and I am familiar with the condition of the animals that were used for that study. For that reason I decided that we had to get some first-rate pathology carried out. It has been shown quite conclusively that if one takes aspirin in extraordinarily high dosages there may be no papillary necrosis; it is a question of getting the toxic element down.

4022. Apparently Australia has analgesics with a high degree of toxicity. I understand that the figure is higher in some parts of Europe.——W. I think this is right. We have got to solve that problem. Indeed, the research that our company is undertaking is being aimed as trying to resolve that. We all have our own hunches on this question. My own hunch, I must confess, is that it is related to this dehydration factor, but then caffeine would be an advantage because it flushes the kidneys; it is a very reasonable diuretic.

4023. It is a fairly well established fact that as one goes south from Queensland, the incidence of this habit becomes less?——W. That is right.

4024. That would fit in with your idea about dehydration?——W. Yes. Another interesting point is that if you take a band around the world, you would find that New South Wales and Queensland would be among the few areas where the white population does hot, manual work in high temperatures and heavy humidity. I think we have got to pursue this point. We are mounting a massive research programme and I hope that we can get the co-operation of pathologists in Brisbane and Newcastle to help us.

4025. It appears that women suffer from this disease more than men yet they would not be out in the sun as much as men. Would that upset your theory?——W. I do not know whether it has anything to do with being out in the sun. I think that basically it is to do with the general temperature and humidity. If one works in an office in Brisbane, one's body could become dehydrated.

4026. Goodman and Gilman is a recognized text book? ——W. Yes.

4027. Apparently it has a good reputation?——W. Yes.

4028. One part of that textbook states that none of the mixtures of analgesic-antipyretics, including the traditional aspirin-phenacetin-caffeine combination, has been shown to provide significant advantage over medication with aspirin alone. Do you agree with that?——W. I think that is looking at the question through the eyes of a pharmacologist; that text book deals basically with clinical pharmacology. I think the author is saying that the methodology that is used to measure pain has not shown significant increases in pain relief when these combination analgesics are put together. In the past three or four years there have been some reports, particularly from the United States of America, which have shown what is termed a synergy between aspirin and, say, caffeine. However, I think we are in danger of looking only at animal studies, and basically Goodman and Gilman are concerned with that approach. With analgesics, we have got to establish the treatment of cause and effect. Also, we have to recognize the idiosyncratic response of some patients to certain analgesics; in other words, the type of analgesic that relieves your pain may not relieve mine.

I am not really ducking the question because basically how a drug works is still much in the mists of oblivion. We do not know how many drugs work. We know what they do but we still do not know really how they function. Caffeine particularly falls into this category. Fortunately, in recent years Professor Vane has started to link the action of aspirin and the action of caffeine with a new understanding of how they work. This will have a tremendous impact on all our thinking. We now believe that aspirin works by preventing the formation in the body of a product known as prostaglandin. That is a triggering mechanism for the stimulus of pain. When one talks in terms of caffeine being not analgesic what one is saying is that when one gives caffeine to a rat it will not give an analgesic profile in the same way that morphine and aspirin does. But that is purely because we are looking at the effect, we are trying to damp down the pain stimuli. If I may remind you, if one takes for example migraine, many who suffer from it know they are faced with a very high pain threshold. The most highly prescribed combination drug for migraine is ergotamine and caffeine. Neither of those drugs has any analgesic profile in animals. The reason is that they hit the cause rather than the symptom. Although the newest addition of Goodman and Gilman may bring it up to date, that is what they are missing, by interpreting animal observation and saying it does not respond to our normal analgesic profile. It is entirely a question of cause and effect. I am sure this is the role that we shall find and Vane has shown in a very persuasive series of papers that caffeine does not stop the synthesis of prostaglandin but antagonizes it once it forms. Hence it could be argued that if you want a combination to combat pain you want something that will stop the synthesis of prostaglandin and also antagonize the pros taglandin once it is formed.

4029. In the same textbook it is said that despite numerous clinical observations and experimental studies in animals and man crucial details of the problem remain uncertain. It then goes on to quote a few people who have been involved in this field of analgesic nephropathy and it says that although phenacetin has been implicated by some as the nephrotoxic component of analgesic mixtures, it is premature to single out any particular ingredient as the causative factor. It is also impossible to absolve any one component. A more balanced view is that chronic abuse of any of the mixtures may, in the susceptible individual, or in concert with other variables, cause renal injury?——W. Yes, I go along with that. I think that is a very balanced comment. With chronic abuse, one can only say that on the evidence that we have at the moment phenacetin undoubtedly causes it. It would be premature to say that it is the only analgesic that does this. All I am saying at the moment is we do not have the evidence that we have with phenacetin. The work has to be on-going to establish this.

4030. One of the things that worries me as a member of the Committee is that it might, say, absolve the other chemicals on advice of people like yourself and subsequently it may be determined that they are guilty; the signs have been there all the time but somehow or other they have been overlooked. So there is a possibility that the Committee could come under fire for accepting the advice that these chemicals in compound do not cause analgesic toxicity?——W. I quite understand your dilemma. My own posture on this is to say at the moment I am totally persuaded on phenacetin—so much so that I persuaded my own company to take it out in 1967, which was well ahead of most legislation. The writing was very much on the wall. I was much involved in the American work at that time, which was in connection with phenacetin.

4031. You are still quite emphatic with phenacetin and paracetamol?——W. They are chemically linked but in the metabolic breakdown they are quite finite. I have no fears on that at all. I have certain fears on paracetamol overdosage, about which everyone knows of course, but that is not related to kidney damage. My own posture on this is to say that at the moment I am convinced on phenacetin. We must have on-going research into aspirin and aspirin/caffeine. Luckily because aspirin is given medically in such high doses it is a perfect drug to study in this way. One can look at all types of studies and do a complete epidemiology survey. I am very hopeful that Dr Edwards of Adelaide, where they have this wonderful retrieval system of clinical data, will be able to collaborate with us on this. My own feeling at the moment is that I am totally unpersuaded that aspirin will cause analgesic nephropathy, but I have a completely open mind and I hope that the research we are doing will reveal more information on this.

4032. Mr MacDIARMID: In paragraph 7 of your submission you state, "We believe proprietary analgesics provide a safe, effective means of obtaining relief from a wide range of simple ailments." Yet the Royal Australian College of Physicians in 1969 when dealing with analgesics recommended: "1. Improved control of advertising of proprietary analgesics, particularly advertisements which state that these are safe or exhort people to take them." What you are really saying is that they are safe?——W. (*Mr Glover*) If taken in accordance with the directions.

4033. One or two a day and not abusage?——W. That is correct. As I mentioned earlier, all our advertising, our package labelling and directions for use emphasize the need to use these products in accordance with direction, and the copy goes on to say that if the pain persists to consult a doctor.

4034. Would you agree that advertising has been directed at selling analgesics without any regard for public health generally?——W. No, I do not subscribe to that point of view at all. Nowhere have we urged people to do more than use it when there is a temporary pain. We have limited our claims to those straightforward ailments that the average man or woman can identify. We emphasize the need if there is any sort of chronic pain to seek medical advice.

4035. In the pamphlet that was read out the association advises people to consult a doctor if pain persists, but powders are still being advertised on the radio and the advertisements are designed to indicate that people should do nothing but take them, even when they get up in the morning. I heard such an advertisement recently on the radio.——W. I am not familiar with the advertisement you are talking about but if that were the case I should be very surprised because there is a strict code for analgesic advertising and all our members follow that code.——(*Mr Daddo*) I think we could submit to this Committee a transcript of our current commercials in the industry so that that can be verified.

4036. CHAIRMAN: That would have to be at some later stage.——W. (*Mr Glover*) I do not have them here with me but I think if the Committee saw a range of advertisements for analgesics the members would see that each of them has a pretty clear-cut exhortation to use the product properly and to use it in accordance with the directions on the pack or on the label.

4037. Mr MacDIARMID: Certainly the advertisement I heard on the radio within the last fortnight did not indicate that. If phenacetin is the problem that is readily admitted and Canada and a number of other countries removed it from analgesics several years ago, why was Australia so slow in removing it from analgesics only two years ago?——W. I have never asked that question of the companies involved but I surmise that they made that decision when as individual companies they were convinced that phenacetin needed to be taken from their product on the basis of medical or scientific evidence.

4038. Most large companies, no matter what their field of operation, have a back-up research organization. Was no research done at the industry level on this question?——W. None at the industry level, no. I should mention that our association is in its third year. Prior to that there was no national body for our industry but there were three sectional groups. Since we have been together as a national body phenacetin has never been a factor because it had been taken from the products that we sold.

4039. CHAIRMAN: If at this stage a company wanted to put out a powder containing phenacetin, as it used to, there would be nothing to stop it?——(*Prof Murton*) Yes. I was going to make the comment that the legislation from Canberra became law only two years ago. In fact, Australia was very much later than almost the rest of the world in bringing in a ban on phenacetin.

4040. Mr MacDIARMID: That was by legislation. If there was evidence around the world that phenacetin was damaging the people who took it, do you not believe the industry had an obligation to do something about it?——W. I think one analyses the matter accordingly. I suppose because I was intimately involved in the study that I was persuaded from the word go, but in those days I was alone; quite a number of companies were not persuaded at that time and decided to do their own work.

4041. Will you not agree that the industry's advertising is directed at selling the product at all costs rather than the interests of the health of the community?——W. (*Mr Glover*) Not at all costs. Our advertising never encourages overuse or abuse or improper use.——(*Mr Daddo*) I think we take the view that we have a responsibility to advertise, in an informative and educational way, the products that are part of the home medication picture. We have a real responsibility to make sure that the information is known and understood and is supportive of the information we provide to the medical profession about proprietary medicines. For example, recently a variation of Aspro was released and considerable work has been done with the medical profession to ensure that its members are completely aware of the product and understand it. The members of the medical profession are able to answer whatever questions consumers may have after seeing that product advertised through any form of media, without the necessity for the consumer to go to the doctor's surgery for the product.

4042. I must say that I query the second part of paragraph 10.——W. (*Mr Glover*) The point that the public understands how to use our products for safe and effective relief?

4043. We have had witnesses before us who have suffered dramatically from taking more analgesics than they should have—it may have been that they were working in a factory or they were brought up in a family whose members were used to taking certain things, but they have been damaged for life as a result.——W. But is that the result of advertising or is it the result of some sociological problem?

4044. It may be a sociological problem, but I do not believe the people concerned were aware of what was likely to happen to them if they took more than they should.——W. That is the point I am making.

4045. CHAIRMAN: We could take Mr Daddo's company, which puts out Vincents. We have been told we can take Vincents with confidence. What can one be confident of if one takes 15 a day for 5 years? One can be confident of finishing up with renal damage.——W. That phrase was used for many years. It is no longer used and has not been used for some time. Further, we do not know the extent of the people who take 15 a day but we know that they are in the minority, from all the information available to us. We certainly do not subscribe to that situation under any circumstances.

4046. If there are many people taking 15 a day we probably do not have the medical resources to cater for them.——W. (*Professor Murton*) But we do know that one can take 16 a day and have no ill effects.

4047. Sixteen powders?——W. Absolutely. This is the pattern. Whether they are powders or tablets makes no difference at all. A patient will take that amount for rheumatoid arthritis.

4048. Are you talking about aspirin or compound tablets?——W. I am talking about aspirin, but aspirin and caffeine would make no difference.

4049. Mr HEALEY: What if you add the third component; still no effect from 16 a day?——W. I think the only third component that would make any difference at all would be phenacetin, from the evidence we have at the moment.

4050. Mr MACDIARMID: I have seen no evidence of the public being made aware that by taking too many of that product they could suffer renal damage. How can you possibly claim that the taking of these things is safe when some people might only need two for a headache and other people might take six or ten a day, which could be damaging to them?——W. (*Mr Cook*) I think there is a limited amount of time available for advertising. We are in the business of selling products and informing the public of those products. If, when we have convinced them to buy brand A as opposed to brand B, they go to the pharmacy or to the grocer's shop, pick up a packet of whatever they have been convinced they should buy, they can read the pack and the warnings thereon telling them of the limitations of dosage. If we have to put everything including the kitchen sink into our advertisements the price of medicines will rise because we would have to use a lot more time on the radio and television to put all those things in our advertisements. But the industry is not at fault in not doing it. It is where it is doing it that is important: It is doing it on its packs.

4051. Mr WOTTON: I think it was Mr Glover who mentioned a recommendation that the association made to the Senate Select Committee about obtaining factual data for various areas.——W. (*Mr Glover*) That is correct.

4052. And that they were not able to go on with it? ——W. That is correct.

4053. Also that the companies would be very loath to supply the information. Do you believe it would be in the interests of everybody that companies be required by legislation to supply that information?——W. No. I do not think that would really achieve the purpose. We, as an industry group, are now studying our own resources to see what we can generate in the way of meaningful consumer research. What we proposed to the Senate Select Committee was that as there is little or no valid statistical information on the use of home medications in Australia, this information be obtained through some form of definitive factual research programme aimed at establishing what consumer habits exist, whether or not there is any tendency to overuse or abuse or misuse of any product, and that this be used as a basis for identifying causative factors. Whether our types of product are being ill-used can really be determined only by talking directly with the consumer. That information will not be obtained by looking at trade sales information because that is only a reflection of consumer habits. To do this sort of work properly in depth would take a good deal of money and effort. Originally our proposal to the Senate Select Committee was that the industry and the federal government should collaborate in this matter and the recommendation was based on a finding of an earlier senate committee in 1971 which recommended that this sort of work be done. Recently we learned from the Senate Committee that they could not work with us in any way on this matter so we are now at a point where we are looking at ways of doing something on this ourselves. I think there is a broad community need. If I could make a recommendation to you, Mr Chairman, and your Committee, I think this is the sort of work that should preferably be done on a national basis and if for any reason that is not possible it should be done on a State basis. None of us—whether the industry, the Health Commission of New South Wales or any other interested party in our field—has any overall understanding of the degree to which ill use, abuse or overuse is occurring. We hear a lot of secondary commentary, some of which is probably true and some of which is probably distorted or inaccurate, but personally I think proprietary medicines have a meaningful role in our health care system and we as an industry want to do all we can to ensure that they are used properly. We want information directly from the consumer on the degree to which there is overuse or incorrect use in any form and what is causing it. It may be physiological factors like dehydration which Professor Murton mentioned. It may be the end result of hard manual labour. It may be simply one of those traditional things that grows up in a home where Mum or Dad overuse some product and the habit is passed on to other people in the house. All these things are possibilities, but we do not have any hard facts.

4054. It is mentioned in your submission, I realize; but what is the attitude of the industry to the suggestions from some quarters that the analgesic should be available only from pharmacies? We have had evidence about people working in factories and in industry, who can simply go to the foreman, who has a tray full of analgesics, and they can take them whenever they like. What is the industry's reaction to analgesics being restricted for sale by pharmacies, rather than being available at all sorts of places, including trains and so on?——W. (*Mr Cook*) Obviously some large manufacturing businesses provide mild analgesic compounds or tablets for their staff but, coming from an industry that makes a lot of them, I suggest that they are not available on the floor of our factory; if they were, there would certainly be problems with stock control. However, on the broader point, in regard to whether they should be available through pharmacies, apart from the normal sociological effects of denying the natural, free right of the consumers to purchase where they will, we became aware, when looking at this problem, of two surveys done into the types of control that could be exercised by pharmacies on the sale of analgesics. You might be aware of those; they have been documented, and formed part of our evidence. There is no control of people who require an analgesic merely because it is purchased from a pharmacy. The studies undertaken indicate that in a great percentage of instances the qualified pharmacist was not even responsible for the sales. In some cases he even recommended larger quantities, because there was a better price on it or bonus offer to the pharmacies. Are we asking that this control be exercised because we believe it will benefit the consumer? I doubt it. It will inconvenience the consumer, and many of them are not able to get to pharmacies. There are many fewer pharmacies than grocer shops. We must ensure that we comply with the provisions of the packaging regulations. Also our advertising, which we control, says that the product is safe; if used as directed, and to see a doctor if the pain persists. All the things we have done in our attempt to make the product safe, and I see no need to confine it to pharmacies.

4055. Mrs DAVIS: Professor Murton, earlier in this hearing a doctor mentioned that people take powders as stimulants. He said that, if you wanted to help them, take the caffeine out. He felt that the kidney problem would drop in corresponding ratio?——W. Undoubtedly caffeine is a stimulant. But I fail to see the difference between taking aspirin and caffeine in a fixed combination and taking aspirin indiscriminately, and then drinking tea or coffee. If there were an incidence of analgesic nephropathy, one would expect to see it with rheumatoid arthritis patients, who have high-dose aspirin. You must assume that these patients take coffee and tea during their treatment. There is simply no evidence that I have seen that would suggest that that is so. Undoubtedly one takes tea and coffee for stimulation. That might be one of the side-effects of caffeine, but I find it difficult to dissociate the combination of the tablet and the indiscriminate use of tea and coffee. (*Mr Cook*) In the orange and blue submissions we have discussed caffeine. It is interesting, in regard to the whole analgesic abuse subject in Australia,

that in a paper in 1970 it was said, "Furthermore, the recent study by Nanra and Kincaid-Smith (1970) has led to the suggestion that caffeine might reduce the nephrotoxicity of aspirin in rats, possibly because of its diuretic effect." They are two experts who have more or less condemned analgesics in the Kidney Foundation, and they themselves now have favourably commented on caffeine.

4056. CHAIRMAN: That was seven years ago?——W. Indeed.

4057. Mrs DAVIS: Earlier the Chairman drew your attention to the fact that we have heard that people have withdrawal symptoms from powders?——W. Yes.

4058. I know of cases of people who take 20 or 24 powders a day, and would take five or six immediately on getting up in the morning. If you took five or six Vincent's powders, would you suffer withdrawal from that?——W. (*Professor Murton*) So much depends on the individual. I think you have raised a point that I had not considered earlier; that is, the high dosage taken at one time. That would undoubtedly give you a different effect than if you were to give it as, say, a drip feed throughout the day. I do not know, but if taken in high concentration, I would not be surprised if you did not get withdrawal symptoms.

4059. It is not possible with one, two or three a day? ——W. I would think it very unlikely.

4060. CHAIRMAN: Would you consider that a person who took powders in those quantities would be dependent on those powders?——W. We are talking about 15 a day?

4061. Start off with four or five in the morning?——W. Yes, I would think they would be.

4062. They would be drugs of dependence?——W. It depends on the cumulative effects. If I am going to take five a day, they certainly would not be, if you look at the problems of aspirin taken over the years. But I find it difficult to believe that, if you start with five in the morning, you would not finish up taking 20 or 25 during the day.

4063. That is what I am getting at?——W. Yes, absolutely.

4064. You would define them or classify them as drugs of dependence?——W. Only in those cases, but I would be inclined to think that they would be very much in the minority.

4065. But people would be dependent on them?——W. Yes, you will always find those things.

4066. It would not be psychological dependence so much as physical dependence?——W. I would not like to comment on that.

4067. Mr McGOWAN: You mentioned about taking caffeine in a powder, and then having a cup of tea or coffee. If people were to take a combination powder with caffeine, and then have the tea or coffee, they would be getting a double boost of the caffeine?——W. Yes.

4068. They would get up in the morning and have two or three powders, and then have their cup of tea or coffee. If you had a person taking a large number of powders, say, 15 during the day, and drinking tea or coffee, would you agree that he would have a high level of dependence on caffeine?——W. Yes.

4069. Either psychologically or otherwise?——W. Yes.

4070. Given that there are such people, would it not be a good idea to remove caffeine from the powder, and to allow the sale of the single analgesic, and then let them have their cup of tea or coffee?——W. It depends on whether you want drugs taken indiscriminately or in a carefully controlled combination. Once again, I think you are suggesting that you legislate for the few to the inconvenience of the majority. I am personally totally against legislation by abuse. If that is taken to its logical conclusion, it must be the death of home medication.

4071. Maybe it would be a case of *reductio ad absurdum,* but it would not necessarily be a logical conclusion. In regard to the restricted sale, I have seen analgesics—mainly Vincents and Bex—sold in school canteens. Do you think that is a good idea?——W. (*Mr Glover*) Speaking personally, no, I would not do that. But I think probably there are occasions when a child might need an analgesic. I would not like to have the child purchase that product without supervision of some sort.

4072. Would the same apply to hospital canteens?—— W. That is a different situation, I should think. At the hospital canteens they could be bought by people in the hospital, or people visiting the hospital who need that sort of product.

4073. You put forward quite a convincing case when you said that, if we are going to restrict sale, we should not restrict it to pharmacies. The logical conclusion is to put it on prescription?——W. I am not sure that is logical. But if you put them on prescription, you would really inconvenience the public in many dimensions. First, if they were on prescription anyone requiring a simple analgesic would then have to obtain a prescription. That would have two effects; first, there would be the cost of the prescription; and second, there would be a massive overload on the already overburdened medical services.

4074. I was referring to compound analgesics, which seem to be a major problem. If you say that we should not legislate for abuse, perhaps it might be possible to legislate for prescriptions for just those things that are abused? That is, the combined analgesics, generally speaking in powdered form—namely, Vincents and Bex? I am not talking about single combined analgesics such as Aspro and all those things. I am talking specifically about Vincents and Bex?——W. Our position is that compound powders or tablets are not a problem, except in that very small portion of the community who are inclined to overuse or abuse these products. But I believe Professor Murtin has made a case this morning to support the efficacy and safety of aspirin and caffeine, or any other such combination, when used in accordance with the directions.

4075. Would it be possible to provide people with the same opportunity for self-medication if there were single analgesics available and no compounds? In other words, when they found the need for an analgesic with two efficacies, they would take a tablet containing aspirin and a tablet containing caffeine, or a tablet containing paracetamol?——W. (*Professor Murton*): I would have thought that you would not have favoured caffeine tablets.

4076. But this is a product that is sold by one of your companies? It is listed in the information here?——W. I suppose it is possible. I personally do not like *ad hoc* treatment by the consumer. I would have thought the balanced combinations, which have been proved and tried over the years, would be best.

4077. But the balanced combinations containing phenacetin have been proved over the years?——W. That is true.

4078. In regard to advertising, I make the same point again. I have seen television advertisements which say, "It is your day. Do not share it with a headache". I fail to see that that follows your code of being informative and educational. Poster advertising is the same. It is more expensive, but it certainly gets the message across. If you added the precautionary comments, such as those with tobacco, you would be attempting to get to the minority of people who use these preparations? Have you any comment?——W. (*Mr Daddo*) I think that any advertising on television and radio, which may carry the phrase "It is your day—don't share it with a headache" would always have the warning that Mr Glover had referred to on more than one occasion this morning. It would equally have, as an integral part of the commercial content, a phrase like "If the pain persists, refer it to a doctor" and a warning to study the directions on the packet. In regard to poster advertising of the product you are referring to, this has been a long term strategy of sight and sound. When Vincents started many years ago there was simply radio for sound and posters for sight and it was a reminder to people who were out and about and suffering from headache or pain. That sight method was used on rather large hoardings. I do not think they have a warning that if pain persists they should see a doctor, simply because there is only so much that you can take in on a poster as you drive past it. Also, the poster strategy for Vincents in the future is not to be an ongoing thing.

4079. Do you have any figures in your own company as to the relationship between advertising and the use of analgesics? Have you had high advertising expenditure on, say, Bex and Vincents over the years and is this related to the high level of use, compared with another country which may have a low level of use; in other words, in such a country would there be less advertising?——W. I am not aware of such information being available. (*Mr Cook*) I do not think there is any international evidence on the correlation between the weight of advertising and consumption in this respect.

4080. You would not know, for instance, whether there was a proportionately higher level of advertising here compared to the United Kingdom?——W. In the case of my own company, the *per capita* sum spent on advertising is slightly lower in this country. That is the position with my own company but I realize it is an inadequate statistic. (*Mr Glover*) One of the popular mis-statements that I read in commentaries about our industry, particularly in regard to analgesics, is that over $2 million is spent on advertising on analgesics in New South Wales alone. I cannot say where I read that but I recall having read it. The fact is that $2,800,000 was spent nationally on television, radio and all forms of press advertising last year. The average national expenditure in the five years from 1972 to 1976 was $2,300,000 and because of huge increases in advertising rates, the actual advertising dropped by about 30 per cent in that period. The source of that information is the well known research firm of Bruce Tart Research Services Pty Limited. Also, it was embodied in a statement published in the *Australian Financial Review*. So that there is a decline in advertising weight for analgesics nationally.

4081. That is analgesic advertising?——W. Yes.

4082. Do your manufacturing companies make contributions towards the social cost of analgesic abuse? Do they contribute, for instance, to the Kidney Foundation or assist to purchase renal dialysis machines?——W. The Proprietary Association of Australia does not make any such contributions. I cannot say what individual members of our association may do. We have never explored that. (*Professor Murton*) We support the Kidney Foundation. (*Mr Cook*) In addition to that, a number of analgesic-manufacturing companies, as Professor Murtin has indicated, put a lot into research. We are not entirely happy with the situation, either one way or the other. We make funds available to the Kidney Foundation for research and we endow a number of research units at some universities to continue investigations into the whole question of analgesics.

4083. One of the major problems of research is the lack of information about the production of analgesics, specifically Bex and Vincents. Would you be willing to make those figures available to the committee or to the researchers?——W. Are you talking about production?

4084. Yes, how much is produced each year?——W. (*Mr Glover*) The association does not collect that sort of information; it would be a matter for individual companies to decide whether they were willing to divulge that information. The association cannot commit itself to provide that information to the committee because it does not come within its constitution or its way of working.

4085. CHAIRMAN: Also, you would have the same sort of situation that happened recently in regard to powdered milk; your products may be produced in one State and distributed all over Australia?——W. Yes, most companies produce in one or two locations and distribute nationally from those locations.

4086. Some of your products would be sent abroad? ——W. Yes. I am not sure how much of our business is exported but I know generally of several companies that export from Australia to areas like South East Asia.

4087. Mr McGOWAN: Given that there is a lack of statistics so that researchers cannot find the relationship between production and the degree of disease, would it not be a good idea to place compound analgesics on prescription so that we could have exact production figures.—— W. That would be one way of doing it but it seems an extreme way of finding out this information.

4088. We have been told that the companies will not provide that information. The committee has been given evidence that people have approached companies and were not able to get the information they required.—— W. I am willing to give a commitment to explore this with our members, to ascertain whether they are willing to provide that sort of information on some kind of privileged basis, but I cannot make any other commitment about it. (*Mr Daddo*) It would be far more relevant if the whole nature of the research you suggested in this proposal were undertaken concurrent with the information from manufacturers so that we had in perspective just where the pockets of abuse, which we know to be a minority, were taking place. It is not satisfactory to adopt a piecemeal approach to research. We need to know far more about this, with legislative authority as well as the help of people in the industry.

4089. CHAIRMAN: Would most of your firms spend 3 per cent of their income in advertising?——W. (*Mr Glover*) I do not know that. I have only the actual expenditure figures. (*Mr Daddo*) To some extent that depends upon the time a product has been in the marketplace. For instance, with the product I referred to earlier, there would be a whole instructional campaign involving the medical profession and consumers and perhaps as high as 25 per cent or 30 per cent would be spent in the introductory period. On the other hand, with maintenance advertising programmes for products such as Vincents, it could be as low as the 3 or 4 per cent you spoke of.

4090. Mrs ANDERSON: One of you gentlemen said that you did not like ad hoc treatment by consumers. Item 6 of your submission refers to people taking treatment without consulting a physician. Is that not a sort of ad hoc self-diagnosis by the consumer?——W. (*Mr Glover*) In the strict sense you are right. What I was really referring to there was the fact that the average adult can identify that he has a headache or a stiff muscle or some similar mild, transient ailment. He can identify that to a point where he knows what he needs to do to remedy the problem. If he has a simple headache and he takes aspirin or an analgesic, he will obtain relief. That is what I was referring to. I suppose that it is an ad hoc form of treatment.

4091. Are we not expecting a lot from the average citizen? We have been told that the highest prevalence of analgesic use was in the Aboriginal population, in outback country towns, in Queensland and New South Wales, among housewives, unskilled workers and poorly-educated people. You are asking those people to diagnose their complaints. Do you think that if it were made more difficult for them to get these things, there might be less abuse of them?——W. (*Mr Glover*) I do not think we have any definitive research to be able to answer your question adequately, but we know the level of comprehension on the part of the average Australian consumer, most of whom can read and write.

4092. That would not be true of the Aboriginal population?——W. I agree with that. Advertising and printing on our packaging is in plain, simple terms. We do not use involved words or scientific phrases. As a result, I believe the average consumer would be able to understand our directions for use and our cautions. This is because the average consumer uses these products sensibly and in accordance with directions.

4093. If it is necessary for to put in large print the proportions that you say should be taken, would it not be reasonable to suppose that you should make more prominent the precautions that should be taken instead of that being shown in smaller print? In regard to taking these preparations for influenza, you have used bold print, but the warning that is inadvisable to take more than a certain number of powders is in small print. Would it not be better to use larger print for that?——W. (*Mr Glover*) Speaking personally, I would tend to agree with that. (*Mr Daddo*) One aspect that we should keep in mind is that this is not something that came into the community in the 1970's. These drugs have been freely available worldwide as an integral part of home medication which is perhaps older htan the medical profession itself, but in the form that they are now in, for at least 50 or 60 years. As Mr Glover said, I think the acceptance of the Proprietary Medicine Association by the world health authorities as late as 1977 recognizes that this body acknowledges the role played by home medication, and that in principle the consumer is an adequate interpreter of his or her problem and is capable of making a decision whether to treat it in the first instance. The consumer is the one person who can test the efficacy of home medication quicker than anybody else.

4094. It may still cause the same great personal damage; it does not mean that back in history it was not being abused; we do not know that.——W. No, I accept that point.

4095. Mr Glover, with over-the-counter sales in pharmacies what degree of responsibility does your Association members have for other home remedies or products that could be easily purchased? For instance, there is a lot of abuse of cough mixtures by young people. The committee has had evidence that they have been abused. It is well known in drug programmes generally that things are easily obtainable over the counter from pharmacies by young people, as alternatives.——W. (*Mr Glover*) Exactly the same rules for packaging and labelling wording and advertising apply to all forms of products, not just the analgesics. In other words we universally spell out the dosage. We include any cautionary statements that as individual companies we feel are appropriate. Most of the cough liquids with any combination of ingredients considered to be a combination that is effective and yet dangerous if abused are sold through a pharmacy only.

4096. That brings us back to the average consumer who buys it as a cough mixture, but there are also those who do not buy it as a cough mixture or for use as a cough mixture?——W. I am aware that there are some sectors of the community that over-use or abuse cough liquids. I do not know the degree to which that is going on; I can only surmise from what I have read that it is very small. Inferentially you are proposing regulation for abuse. That means to say you are putting forward a proposition that we should control the majority in order to curb a very small minority.

4097. I do not agree with that because recently when we were in Lismore we were told by a pharmacist representing all the pharmacies in the town that when they find young people in particular are buying around the pharmacies certain products to excess they voluntarily withdraw them from sale. If the pharmacies in a small area identify and take some action purely as a service matter surely if the proprietary Association has some evidence like that it could initiate some programme to control it themselves, or to have it available only on prescription? ——W. Indeed we would if we knew about those things. In my two years as president of the Association I have not seen any such statement from any pharmacist.

4098. Would it be an idea for the manufacturers and your Association members to make some inquiry from the Pharmacy Guild?——W. That is a very sound suggestion. We are in touch with the guild at regular intervals. They have never raised that with us.

4099. Professor Murton spoke of two research programmes, one in the United Kingdom and one at St Vincent's in Melbourne. Were you responsible for the funding of those programmes?——W. Yes.

4100. When you funded them did you lay down the guidelines for the research?——W. (*Prof. Murton*) No. We were approached by St Vincent's to see if we would support this. In fact we have had an on-going research programme with them. In this instance they found that the input of the Radcliffe Infirmary would provide them with just the expertise that they wanted to complete this. This was how it was done. We were fully aware of the work that they were doing. Basically the rationale behind it was that they were not persuaded by the evidence of the rat toxology work and they wanted to bring in better expertise to see if they could expand the knowledge we had.

4101. (*Mr Glover*) May I clarify something that Mrs Anderson said? I believe you said at the beginning that you had some evidence presented to you that back country Aborigines were the highest abusers of analgesics?

4102. Mrs ANDERSON: No, the highest prevalence of analgesic use was that found in the Aboriginal population of an outback country town in New South Wales.——W. That is an interesting piece of research. If as has been suggested by many, not only in this session but at other times, advertising is an important part in analgesic abuse, I would suggest that outback Aborigines in small country towns have very little opportunity to either see or hear advertising.

4103. Mrs ANDERSON: There are lots of signs nailed to posts and walls in country towns.

4104. Mr McGOWAN: And they have television.

4105. Mr MACDIARMID: I can remember when I was going to school seeing advertisements for Vincents in trains.

4106. Mr RAMSAY: Mr Cook, you indicated that you were not aware that analgesics were readily available in factories. I put to you that powders are available on the factory floor, particularly in the clothing industry in the Hunter Valley. In fact witnesses have indicated to that effect. They were taking fifteen powders a day. Do you think that is a good situation so far as the health of those workers is concerned?——W. (*Mr Cook*) You have the advantage in that I have not been to a clothing factory in the Hunter Valley. I was speaking of my own knowledge of the few factories in which I have been where the products are confined to the dispensaries and are not on the factory floor. If they are, I agree it is entirely undesirable.

4107. In your opening comments you said that your Association has no scientific evidence to support the view that the incidence of excessive use of analgesics in the Australian community is more than minimal. Mr Glover, do you have any direct consultation on behalf of your organization with the Health Commission in the various States?——W. (*Mr Glover*) Yes, we do. (*Mr Daddo*) I think it is interesting that the Acting Minister for Health in Victoria at the completion of the National Health and Medical Research Council hearings and subsequently at the Ministers' meeting in Hobart, on advice from his department indicated that no evidence was put before them that his department and/or he as the Minister could go along with the regulations that had been recommended, that lack of scientific data in his department's view existed.

4108. You said that no data was available in regard to the consumption of analgesics in individual areas. Members of the medical profession in the Hunter Valley, where there are some very eminent doctors, have facts and figures available to them from the Health Commission. You do not think that your organization should consult with the Health Commission in this regard?——W. (*Mr Glover*) Yes, I do, and indeed we have done that, but the Health Commission is unable to give us the sort of information that we need, that is scientifically valid. I think that is the point. We certainly hear a good deal of statements about the Newcastle area but we cannot confirm that this problem is due to analgesics and analgesics alone. In other words I think that there are plenty of other problems that exist in that area and they have not been identified.

4109. CHAIRMAN: Dr Nanra, who has been mentioned earlier before this Committee, said that every year he sees approximately 300 new patients of whom 100 have come to him because of headache powder abuse. Of that 100 approximately 15 go into terminal kidney failure and require treatment on kidney machines or by way of transplants. That is a direct result of analgesic abuse. That would seem a fairly strong statement when you say you have no evidence linking analgesics?——W. I am saying scientific evidence. (*Mr Cook*) That is not scientific evidence; it may come from scientists but it is not scientific evidence. (*Mr Daddo*) The latest information from the Australian Kidney Foundation is evidence which you may or may not have tabled here. The incidence of analgesic nephropathy recorded in the latest report for the year to 30th April, 1976, is summarized as follows: Some 20 per cent of 727 patients were on dialysis at 30th April, which approximates eleven per million of population; 20 per cent of 450 new patients accepted, which is 90 patients, represents 6.7 patients per million of population per year; or 20 per cent of 427 new patients established on dialysis, which is 86 patients, which is 6.4 per million population per year. That is the incidence of analgesic nephropathy recorded by the Kidney Foundation, which has statistics from its dialysis evaluation.

4110. Mr HEALEY: I return to the matter of lack of information regarding production and consumption. In your submission you say that it is regretted that the PAA does not have definitive, detailed industry-wide data on overall consumption of proprietary medicine. In your compendious submission you say that the number of tablets and powders sold outside of pharmacy was equivalent to 21.2 million scripts of 50 tablets. If you say you do not have any definitive, positive information on the overall consumption how can you come up with those figures? ——W. (*Mr Glover*) We have certainly some trade information. I was referring in the lack of definitive information to the lack of information on consumer habits.

4111. I am sorry, but it says overall consumption. After that you go on to consumer habits. You say that you have no definitive, detailed industry-wide data on overall consumption but you then mention a definitive figure of 21.2 million scripts of 50 tablets?——W. That is true. That is a national figure. As I mentioned earlier, individual company members of our Association have State figures but we do not have detailed information by region or by city.

4112. It says "overall". It does not indicate region by region or city by city. I would say that the word "overall" means what it indicates, overall. You do not have definitive data on that, yet you can come up with this figure of 21.2 million scripts of 50 tablets?——W. Yes, we have that information on analgesics; we do not have the same sort of information for every other category in which our member companies sell products.

4113. You have that information on analgesics, definite overall consumption?——W. That is correct.

4114. I would ask you to elaborate on the previous paragraph. You say the claim that the Australian people are pill poppers has had some publicity, that this is a glib emotive statement that attracts attention but is not substantiated by facts. Then some figures are given: 50 million prescriptions for tablets, each prescription being for up to 100 tablets. Let us be generous and say that those 50 million prescriptions were only for 50 tablets. That would be two billion five hundred thousand million tablets prescribed there. If one takes your next figure of 21.2 million scripts for 50 tablets that represents one billion and sixty million, making a total of three billion five hundred and sixty million tablets taken by the Australian people each year, which works out roughly at 263 tablets a person, which again would be the equivalent of one tablet every day for every man, woman and child in

Australia for five day a week. Do you say that would not be an excessive amount of pill taking and that it is a glib statement not substantiated by facts?——W. The facts are that sales of mild analgesics at retail level total $50.3 million a year, or 1 831 million tablets or equivalent powders, which I think is close to the figures that you have quoted. We were referring in that submission to statements that have been made that have estimated the size of the analgesic market at various times between 100 million and 150 million. In fact the market is $50.3 million per year in sales.

4115. There is nothing in the submission that mentions sales. You say the fact that we have been called pill poppers is a glib statement and unsubstantiated. On your own figures, which are very conservative, some three billion five hundred and sixty million tablets a year are taken by the Australian population. That is not a glib statement. I would say that it substantiates the fact that we take an excessive amount of tablets?——W. In Australia the consumption of aspirin is somewhere between 51 and 59 grammes per head per year whereas in the United States it is somewhere between 50 and 72 grammes per year. In the United Kingdom it is 37 grammes and in Canada it is 44 grammes, so Australia is at the high end of the per capita consumption trend in those countries. Earlier I mentioned that the overall market is static, it is not growing, and as the population is growing the per capita consumption is actually declining.

4116. Under self-medication and the public welfare you say that over-the counter products, which have for so long benefited so many in terms of personal health and sense of well-being, have also been of significant benefit to the health care economy. Which particular medications are you referring to when you say they provide a sense of well-being as distinct from personal health?——I think any product that relieves an ailment—be it headache or indigestion or any other simple ailment—it automatically promoting well-being in that individual. That is really what we meant by that statement.

4117. In your submission you mention overworked doctors and I think you said here that analgesics are of great assistance in relieving the burden on doctors. You say there are already too few doctors for our increasing population. Why is it that the AMA is now waging a campaign to restrict the entry of foreign-trained doctors into Australia because that association claims there are too many doctors in Australia?——W. I do not know. I cannot answer that definitively. It has always been our understanding that the medical profession is overloaded.

4118. Mrs ANDERSON: I was interested to hear Mr Cook say that he wanted some scientific evidence and that some of the evidence given by scientists was not scientific. That was in connection with some information that the Committe was given by Dr Nanra. Dr Stewart presented a document to this Committee and gave evidence before it and in that submission he said: "No estimate is available of the prevalence in this community of non-terminal renal papilary necrosis, but in the Renal Unit populations (in-patient and out-patient), of the Sydney and the Royal Newcastle hospitals, analgesic nephropathy is the most common diagnosis, accounting for 25–30 per cent of all cases treated."—W. (*Mr Cook*) When I say that it is not necessarily scientific, what I am saying is that to date nothing has been published which indicates, when people talk glibly and scientifically if you like, that the renal papillary necrosis is caused entirely by the use of analgesics, with no other concomitant drugs of one kind or another, whether it be alcohol or drugs for hypertension. Until there is evidence that the person who came in presenting with nephrotoxicity lived on a diet of analgesics and analgesics alone and it caused this renal papillary necrosis, I do not believe it is scientific evidence. I believe there are many other factors and that if these people are abusers they are not abusing only one thing; in all probability they are abusing other things like alcohol. Is there some synergistic relationship between the analgesic and the condition of nephropathy? We do not know and nobody has yet produced any scientific evidence to show whether there is or not.

4119. This submission was prepared by a subcommittee comprising Drs Row, Mathew and Stewart, who were charged with the responsibility of implementing the policy of two organizations in respect of the prevention of kidney disease caused by analgesics, so they had a specific task to do and out of that came this report?——W. Yes, that is right.

4120. This was a submission from the Australian Society of Nephrology and the Medical and Scientific Advistory Committee of the Australian Kidney Foundation.——W. The point I am trying to make, and I think Professor Murton would cover this more scientifically and adequately than I, is that the mere title presupposes that analgesics alone are causing the trouble. It prejudges the issue by the sheer title of the investigation before it has even started.

4121. Mr MACDIARMID: Mr Cook is inclined to disregard the work of Dr Nanra in this field, but he is considered a world authority. This Committee saw with its own eyes a housewife from the North Coast—which is a semi-tropical area—who was not exposed to hard labour in the sun, who started the day by taking an analgesic, whether a Vincents or a Bex I cannot recall——

4122. CHAIRMAN: She took Vincents because both her mother and grandmother had taken them.

4123. Mr MACDIARMID: I did not want to place emphasis on one brand. The woman was not addicted to alcohol or any other thing. Dr Nanra categorically said the breakdown in her condition was due to analgesics. Surely that is scientific enough?——W. Yes, it may be and it may be a sample of one, but the point is that you have the evidence. We are talking about published evidence. None of this work that we have seen to date has examined the lifestyle of the person affected. You must remember it is usually a case of post death examination and that examination has to be conducted by asking other people how much the deceased took, what did he or she take, and there has been very little examination of the lifestyle and product usage and other things of these patients with this nephropathy to discover what they have been taking. I think it is a mistake to condemn analgesics alone. We feel that a person who abuses analgesics probably abuses other things as well. If Dr Nanra in bringing that patient in here had given her full life history over the past ten years and all the concomitant therapy that that woman had had, perhaps there may have been some scientific basis to be examined. Without that knowledge it could be that some of the other things she was taking could have had an effect on her kidneys. (*Mr Daddo*) At a seminar on "The role of proprietary products in health care" in Sydney in June, 1976, Mr Peter Baume asked:

> Dr Storey, recognizing that home medications are very extensively used and generally produce very good and beneficial effects, and looking through the programme and realising that I can't find anyone else

more appropriate to present this question to, are we able to measure in this country, the contribution of home medication to the production of illness, and could you identify the kinds of problems which I, as a legislator, have to be aware of, when I worry about the place of home medication?

*Answer*: I don't think, Senator Baume, that we have enough Australia-wide morbidity statistics to define with any certainty the extent to which the misuse of home remedies might be contributing to community morbidity. My colleagues who practice in nephrology, do make statements, which I think are based on their own experience rather more than any wide statistical collection. Nephrologists who work in large metropolitan hospitals suggest that a third of the patients coming under their care for renal lesions, have had those lesions at least contributed to, by the misuse of analgesics. One hears that sort of figure quoted. I have no authentic figures that I could stand by on an Australia-wide basis.

I think that is really what we are talking about.

4124. Our investigations reveal that in a particular area of New South Wales, notably Newcastle, and the Chairman has quoted the figures to you, Dr Nanra is getting something like 300 new patients a year and the use of analgesics in Newcastle is as high as anywhere in Australia.——W. We seek that research. That is what has to be done.

4125. Mr McGOWAN: I am concerned with the question of what is scientific and what is not. I can see what you gentlemen are getting at; you cannot find a direct relationship between analgesics and kidney lesions, nor do you know if it does occur why it occurs. However, if you go back earlier to the doctor's evidence, it is not known how analgesics work upon the brain either, so no work has been done on that subject. Am I right in stating it that way? You said you know what it does but you do not know how it does it?——(*Prof. Murton*) That is so.

4126. Could it be that we know what it does to the kidneys but we do not know how it does it?——W. No, I do not think that is true. I think this whole question of analgesic abuse is very much in its infancy. Dr Nanra may well find he is getting 300 new patients every year. Certainly I have read everything that he has published so far and if I have a criticism of him it is that there is no case history supporting the patients that he is concerned with. You will get an observation that this patient admits to taking 15 powders a day but there is a total absence of background of a case history, and if someone is taking that number of powders a day no one will convince me that he or she is not emotionally disturbed and if I am told that that patient is not having concomitant synergistic therapy I simply will not believe it. I think this is the sort of work that Dr Nanra and his colleagues have to do. I think they are doing a splendid job in highlighting this problem but I think there is a lot of work that the kidney foundation and the renal clinics have to do. Certainly the work that has been produced so far is still unproven, except as I said earlier in certain instances.

4127. CHAIRMAN: Dr Nanra produced case histories when we were in Newcastle.——W. He has not published anything.

4128. But surely he is using those case histories as a basis for the statement he is making——

4129. Mr MACDIARMID: We could give you the example of a girl with kidney damage at 27, who left school at 13, who had a family history of analgesics taking. She was taking 15 a day while working in a clothing factory. By the age of 24 her kidneys had packed up. So far as I am concerned Dr Nanra had done a case history on that patient.——W. But what else was she taking?

4130. She was a normal married woman. She was not taking alcohol.——W. And she had no other therapy at all?

4131. Mr WOTTON: She had three children. She had lost her husband by the time she was 23. That is the emotional factor you are talking about?——W. The thing I find surprising is that a patient who is as emotionally disturbed as that is taking nothing other than analgesics. I find it astounding.

4132. Mr McGOWAN: On the question of analgesics on the factory floor, are you aware of dispensing machines for analgesics? Can you tell us who manufactures and sells such machines?——W. (*Mr Glover*) I have seen them from time to time. I do not know who manufactures them or sells them. As an individual I do not know and certainly the association does not have any information on that that I am aware of.

4133. Would it be a method of retailing of which your association approved?——W. Personally I should not think so.

4134. In regard to market volume and statistics remaining static, and the consumption *per capita,* could it be that analgesics, partly because of the investigations of this Committee, are less popular in the community? Has this brought about a reduction in their use, or has it brought about a more careful use of analgesics? And that this has been balanced by an increased number of abusers? That is another way of interpreting the same statistics? ——W. That could be so. We lack any figures to confirm or deny it. I should like to think it is the result of more careful use of the products. We have no information on consumer habits five years ago or ten years ago—or even today—to give any meaningful comparison of consumer habits. (*Mr Daddo*) Perhaps the taking more care aspect is more important. In 1973 a certain number of analgesics were sold through non-pharmacy outlets, but in 1976 it was down to 50 per cent. That may suggest that people are taking more care, and there is an element wanting to know more about it. Hence, they move to the pharmacy.

4135. Mr WOTTON: Have you any evidence or information that young people generally take a lot less analgesics than they did years ago, by virtue of education? From my own experience in my own family, I find that they rather shy away a lot more than their elders?——W. (*Mr Glover*) Yes. I think I share that view. That is only my opinion. But we do not have any information that is valid or wide. I know from some consumer research studies my company has done in other fields that there is a smaller predilection to use any form of proprietary medicine among young people than among their parents. I think that is the product of probably a better education or a better general understanding of the dangers of using these sort of products, or their use incorrectly.

4136. Mr MACDIARMID: Or would it be because there are other things that are attracting their attention?——W. It could be, but I do not know.

4137. CHAIRMAN: In the case of Dr Nanra, I asked him a question in Newcastle. I asked, "You said about 3 500 cases have been reported, and of those you have treated more than 500. The details of these cases have been circulated throughout the world?" His answer was "They have been published in scientific journals." I though I should make that known.

4138. On pages 7 and 8 of appendix 3 of your statement there is a discussion on gastro-intestinal side effects of phenacetin. The latest is 1970. I understand that recently Professor Grosman of the University of California, an acknowledged world expert, published a work implicating aspirin as a cause of gastric haemorrhage. It looks to me as though this is a little overlooked there. Dr Duggan, when we were in Newcastle, also spoke about the effect of analgesics in relation to causing ulcers. Have you anything to explain in regard to gastrointestinal effects? ——W. The present position, I do not think there is any doubt that in some patients aspirin will cause occult blood loss. Indeed, in the case of rheumatoid arthritis it is one aspect that they have to look into very carefully and report back to their doctor. Yes, it is an established side-effect. that occurs with a very small number of users. But we must accept that it is a side-effect.

4139. We can take it that there is a fairly high correlation between gastric ulcer and aspirin abuse?——W. No, I won't accept that. Certainly there is a link between occult blood loss and aspirin. (*Mr Cook*): It is well documented. A relatively small number of people have this idiosyncrasy.

4140. On page 15 of your submission it says, "This association has seen no evidence to support the view that the incidence of excessive use of analgesics in the community is more than minimal."

4141. In the same summary on page 14 of Appendix 3 there are figures of the consumption per capita in Australia. That would average out I think at two doses of analgesics over three days for every man, woman and child in Australia. This excludes any consideration of the big variation in use?——W. (*Mr Glover*) Yes.

4142. It has been calculated that about five times as much analgesic is used in Queensland as in Western Australia, per head. Would you say that is only minimal?——W. You could certainly do mathematics on these figures, but what is excessive use? Is it one tablet a day, or one every two days, or three every two days? I do not know. After all, we have a fair proportion of our population who are on long-term therapy on proprietary analgesics, for conditions such as arthritis. They take many times that dosage, and from what Professor Murton has said, they take it without any side-effects. How do you define excessive use?

4143. We are asking the experts to tell us that?——W. (*Prof. Murton*) That is the problem. If you take 16 tablets a day without any untoward effect, anything above that I suppose one must regard as abuse. But one or two tablets a day, to me, is certainly not abuse.

4144. What about eight or ten a day? Take powders, for instance. Apparently they act more quickly than tablets? ——W. I do not accept that proposition. I do not think they act any quicker. But that is a side issue.

4145. Mr McGOWAN: Why are they presented in powder form?——W. Why do we have any range of product forms, anyway? Why do we have more than one analgesic?

4146. I know that they come in tablets and powders. Why do the people want to take the powders when they can simply throw a tablet down? I thought the reason was that the powders acted more quickly, and the person got a quicker lift?——W. If you take tablets in water, that is the quickest way of getting a reaction, without any shadow of doubt. (*Mr Glover*) The powder form is probably tradition, more than anything else.

4147. CHAIRMAN: We have had professional evidence that suggested that the powders were absorbed into the bloodstream or the body much more quickly than the tablets?——W. (*Professor Murton*) If you take a tablet in water it is by far the quickest way of getting it into the bloodstream. That is supported by evidence.

4148. Have you anything further to put to the Committee?——W. (*Mr Glover*) No.

4149. We want to thank you very much for giving up your time and coming before the Committee to give this evidence. I hope arising out of the information you have given us, the Committee will be in a far better position to answer some of the questions that were posed to us in our terms of reference.

(The witnesses withdrew.)

(The Committee adjourned.)

*AT SYDNEY ON MONDAY, 12 SEPTEMBER, 1977*

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(The Committee met at 10.30 a.m.)

Present:

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| The Hon. MARGARET DAVIS | Mr B. McGOWAN, B.A. |
| The Hon. C. HEALEY | Mr R. C. A. WOTTON |
| The Hon. F. M. MacDIARMID | |

*Witnesses*:

Dr RODERICK GARDNER McEWIN, Chairman, Health Commission of New South Wales, of 146 Tunstall Avenue, Kingsford,

ROBERT MACDONALD DASH, co-ordinator of scientific services, Health Commission of New South Wales, of 4 Blair Place, St Ives,

ANDREW PETER DIEHM, director of the Central Drug and Alcohol Advisory Service, Health Commission of New South Wales, of 17 Virginia Street, Blacktown, and

Dr GARRY EGGER, senior research officer, Health Services Research, Health Commission of New South Wales, of 29 Bay Street, Mosman, were sworn and examined:

4150. CHAIRMAN: Have you received a summons under my hand, issued in accordance with the Parliamentary Evidence Act?——W. (*Dr McEwin*) I have. (*Mr Dash*) Yes. (*Mr Diehm*) Yes. (*Dr Egger*) Yes.

4151. You appreciate that at meetings of the former committee submissions were tendered and evidence was given by yourself, Dr McEwin, and other members of the Health Commission; all that evidence, by resolution of the Parliament, has been transferred on to this committee so that we have the advantage of all that was said formerly. In addition, you will recall that Mr James and I had an interview with you and Mr Dash at the Health Commission at which we pointed out that because of the variation in the terms of reference we felt that there were certain things that you, as the chief health advisers to the Government, might want to put before the committee and there were also a few other matters that might need expansion or clarification. I thank you for the submission that you have made to the committee. Do you wish that to be incorporated as part of your evidence today?——W. (*Dr McEwin*) Yes.

REPORT BY THE HEALTH COMMISSION OF NEW SOUTH WALES TO THE JOINT COMMITTEE OF THE LEGISLATIVE COUNCIL AND LEGISLATIVE ASSEMBLY UPON DRUGS

TABLE OF CONTENTS



1. *Introduction*

1.1 The Health Commission of New South Wales welcomes the opportunity to submit further evidence to the reconstituted Joint Parliamentary Committee on Drugs.

1.2 The areas in which the Health Commission has been requested to provide further information include:

1.2.1 matters not covered by the previous terms of reference, particularly the use and abuse of non-prescription drugs such as analgesics;

1.2.2 relationships between the Health Commission and law enforcement authorities, particularly the Police Drug Squad;

1.2.3 data on mortality and morbidity over the past ten years arising from drug abuse;

1.2.4 information on the manufacture, distribution and possession of drugs;

1.2.5 information on pharmacy inspection procedures and the frequency of such inspections;

1.2.6 information on the Health Commission organization and staff available for and engaged in drug education, counselling and treatment programmes;

1.2.7 information on recent trends in drug abuse.

1.3 These are all areas in which the Health Commission is involved. This submission examines the extent and nature of that involvement.

1.4 The previous terms of reference stated that the Joint Committee was interested in the drugs of dependence in common use in New South Wales that are prohibited drugs, drugs of addiction and restricted substances within the meaning of the Poisons Act, 1966.

1.4.1 The Health Commission supports the reconstituted Joint Committee's revised terms of reference, believing that the drug abuse phenomenon in New South Wales does not correlate exactly with substances classified under the Poisons Act.

1.4.2 The Health Commission is concerned with the administration and enforcement of the Poisons Act.

1.4.3 Additionally, the Health Commission's activities, particularly those relating to the educational, counselling, treatment and rehabilitative services, are directed towards all drugs, including alcohol and tobacco. It is obvious, therefore, that in this submission reference will be made to all psychotropic substances which are liable to abuse.

1.5 Finally, since the last submission was made to the Joint Parliamentary Committee on Drugs, representatives of the Health Commission of New South Wales prepared a report and were witnesses for the Senate Standing Committee on Social Welfare concerning continued oversight of the drug problem.

2. *Further Review of Information on Drugs*

2.1 A number of additional publications and reports prepared by officers of the Health Commission are included with this submission. The focus of this information is on prevention of drug abuse.

2.1.1 A research paper Early Adolescent Antecedents of Narcotic Abuse (Exhibit "A") and an application paper Prediction and Prevention of Drug Abuse (Exhibit "B"), prepared by Dr R. A. J. Webb, M/s I. Reynolds and Dr G. Egger, identifies at-risk groups at an early age and highlights the ways and means of prevention and lists the counter productive ones.

2.1.2 An article Psychotropic Drug Use in the Elderly—Public Ignorance or Indifference? written by Mr S. Chapman for the *Medical Journal of Australia*, 1976, 2:62–64 (Exhibit "C") identifies the elderly as an at-risk group in respect of drug dependence.

2.1.3 A report on a possible alternative to drug taking which examines a method of prevention and self management of anxiety entitled An Evaluation of Relaxation Courses written by Mr J. d'Agapeyeff is attached (Exhibit "D").

2.1.4 Preventive strategies are included in an article Alcoholism and Drug Dependence—A Survey of General Practitioners' Opinions written by M/s I. Reynolds for the *Medical Journal of Australia*, 1975, 1:167–169 (Exhibit "E").

2.1.5 A teacher guide on the health education aspects of the Use of Drugs prepared by M/s H. Creighton and produced in conjunction with the New South Wales Department of Education by the Health Commission is attached (Exhibit "F").

2.1.6 A paper which examines the principles of and guidance for Alcohol Education was produced by a working party convened by M/s C. Hicks and consisting of Health Education Officers of the Commission (Exhibit "G").

2.1.7 A pamphlet *The Drug Issue—A Guide for Parents* written by Dr R. A. J. Webb, M/s P. Murray and Mr L. Field and produced by the Division of Health Education of tht Health Commission is attached (Exhibit "H").

2.1.8 An article "Drinking and Drug Taking Patterns of 8 516 Adults in Sydney", written by M/s I. Reynolds and M/s J. Harnas, officers of the Health Commission in conjunction with Dr H. Gallagher and Mr D. Bryden, of the Medicheck Referral Centre was published in the *Medical Journal of Australia*, 1976, 2:782–785 (Exhibit "I").

2.2 The use and abuse of non-prescription drugs is receiving increasing attention within the Health Commission.

2.2.1 Non-prescription medicaments include—pain relievers, cough mixtures, travel sickness tablets, nasal sprays/drops, cold tablets and some weight reduction tablets/preparations.

2.2.2 The non-prescription drugs which are causing the greatest problem in terms of number of people involved in their use and abuse are the pain relievers (minor analgesics).

2.2.3 Minor analgesics are drugs widely used in Australia in the home treatment of common maladies such as headaches, toothache and influenza. However, it is becoming increasingly evident that minor analgesics are also being used regularly for non-medical purposes by a significant number of people.

2.2.4 The most common ingredients of minor analgesics and their effects include:

*Aspirin*: has three main properties of therapeutic importance—analgesic (the relief of minor pain); antipyretic (the reduction of fever); and anti-inflammatory (a reduction in the inflammatory response). Side effects include nausea, gastric irritation and internal haemorrhage.

*Phenacetin*: analgesic and antipyretic.

N.B. paracetamol has replaced phenacetin in most preparations because of its reputed toxic effects on the kidney; however, the nephrotoxicity of paracetamol appears to be identical to that of phenacetin.

*Paracetamol*: a metabolite of phenacetin used as an analgesic and antipyretic. Side effects are not commonly experienced, although gastric irritation with vomiting and haemorrhage are possible.

*Codeine*: is used for the relief of cough and for the relief of mild to moderate pain. Side effects may be nausea, dizziness, drowsiness and constipation.

*Caffeine*: acts as a mild stimulant of the central nervous system and produces condition of wakefulness and increased mental activity. Side effects include nausea, headache and insomnia.

*Salicylamide*: has properties similar to but milder than those of aspirin.

*Calcium Carbonate*: is an effective antacid since it acts as a buffering agent to lesson aspirin's irritant effects on the stomach. Side effect is constipation.

2.2.5 The preference of most regular consumers appears to be the compound preparations. Formerly, the two most widely used compound preparations (Vincent's and Bex) contained aspirin, phenacetin and caffeine (A.P.C.). Phenacetin has now been replaced by salicylamide in Vincent's and paracetamol in Bex. The great majority of people who take powders regularly do so for headache and/or "nerves". These headaches arise from a combination of mental and physical stress. There is also the rebound headache that occurs when the effect of the caffeine begins to wear off in an habitual user.

2.2.6 The evidence from surveys conducted in Australia of the high consumption of minor analgesics gives rise to concern about its adverse effects on health. For the year ended 30 June, 1974, New South Wales (with 35.7 per cent of the national population) consumed 41.5 per cent of minor analgesics.

2.2.7 The following table, taken from the Health Commission's *Informed Opinion*: Number 14—"Use of Psychotropic Drugs in Australia" prepared by Ms P. Healy, examines the rates of analgesic usage reported in various surveys from 1968–1974. The wide variation in results could in part be due to small population samples in some studies and different rates of use among the populations studied. The evidence suggests that approximately ten per cent of the Australian population consume analgesics daily.

| Date of Survey | Authors of Survey | Sample Population | Per cent who currently use analgesics* | Per cent using analgesics daily* |
|---|---|---|---|---|
| 1968 | Unisearch .. .. | Sydney & Brisbane—15+ years population. | 83 per cent .. .. | 11.4 per cent. |
| 1968/70 | Gillies, Skyring, Livingstone. | Sydney—industrial and clerical workers and housewives. | ..... | 7.9 per cent males<br>14.7 per cent all females<br>13.9 per cent "housewives". |
| 1971 | Kamien .. .. .. | Bourke, N.S.W.—15+ years Aboriginal population. | ..... | 45.1 per cent females.<br>25.6 per cent males. |
| 1971 | Hennessy, Bruen, Cullen | Canberra—adult population | 76 per cent .. .. | 2.9 per cent males**<br>6.7 per cent females<br>4.9 per cent total |
| | | Canberra—13-18 years population. | 68.4 per cent .. | 0.7 per cent** |
| 1971 | George .. .. .. | Sydney northern suburb—14+ years population. | 66.7 per cent males<br>78.1 per cent females<br>72.4 per cent total .. | 9.4 per cent males**<br>13.7 per cent females<br>11.6 per cent total. |
| 1971/72 | Finnigan, Burry, Smith .. | Brisbane—women attending ante-natal clinic at Women's Hospital. | ..... | 72.2 per cent—16 per cent |
| 1972 | Krupinski, Stoller, et al. .. | Melbourne—13 to 23 years population. | 73.4 per cent .. | 5.9 per cent secondary students**<br>1.9 per cent tertiary students<br>9.5 per cent working youth<br>4.6 per cent total |
| 1973 | George .. .. .. | Sydney western suburb—14+ years population. | 69 per cent males ..<br>80 per cent females<br>75 per cent total .. | 8.2 per cent males**<br>13.9 per cent females<br>11.3 per cent total. |
| 1973 | Murrell, Moss .. .. | Adelaide—2 suburban areas. Infants 5-14 months. | 19.2 per cent | ..... |
| 1973/74 | Irwin .. .. .. | Canberra—high school students. Years 1-6. | 35.2 per cent (1973)<br>30.8 per cent (1974) | ..... |
| 1974 | Carrington-Smith .. | Hobart—Women aged 18-60 years. | 85 per cent .. .. | 11.7 per cent** |

* Per cent of total population.

** Daily or most days of the week.

2.2.8 Australia has one of the highest rates of analgesic-related kidney disease (analgesic nephropathy) in the world. Analgesic nephropathy is a form of kidney disease that is characterized by renal papillary necrosis and subsequent renal failure. In recent years, people suffering from analgesic nephropathy have accounted for at least one-third of renal deaths in Australia.

2.2.9 Twenty per cent of those people admitted to hospital for dialysis treatment or kidney transplant are there as a result of analgesic abuse. The cost of in-patient renal maintenance dialysis in 1976 was estimated to be $11,000 per patient per year. It is impossible to measure the other physical and emotional costs associated with kidney failure.

2.2.10 Analgesic abuse is also associated with anaemia, heart disease, premature ageing, gastric ulceration, platelet dysfunction and other blood disorders and there is also the possibility that heavy use of analgesics during pregnancy is associated with birth defects.

2.2.11 A recent study on licit drug use in an inner-western municipality of Sydney has been completed and the report is at present being finalized. The report contains data on the prevalence of use of popular pain relievers and psychotherapeutic drugs; specific information about the user, including reasons for use; and it studies the relationship between current drug taking and the nature of contact, if any, with medical and community health services.

2.2.12 Dr R. Nanra, Royal Newcastle Hospital, will be making an independent submission to the Joint Parliamentary Committee on behalf of the Analgesic Working Party in Newcastle.

2.2.13 Dr J. H. Stewart, Sydney Hospital, will also make a submission on analgesic abuse and renal papillary necrosis in Australia on behalf of the Australasian Society of Nephrology.

2.2.14 A pamphlet on analgesic use and abuse written by M/s P. Murray and Mr L. Field is currently being produced by the Division of Health Education of the Health Commission.

2.3 In the interests of prevention of human suffering, efficiency in disease management and reduction in costs of treatment programmes, the Health Commission would favour the allocation of greater effort towards prevention of analgesic abuse.

3. *The Relationship between the Health Commission and Law Enforcement Authorities, Particulary the Police Drug Squad*

3.1 The Inter-Departmental Drug and Alcohol Advisory and Liaison Committee, established at the direction of the Premier, provides a formal relationship for representatives of the Health Commission and law enforcement authorities including the Police Drug Squad, the Department of Corrective Services and the Justice Department. Other Departments represented on this committee are: Education, Youth and Community Services, Treasury and the Chief Secretary.

3.2 The Drug Education Advisory Committee has met on a monthly basis for the past six years. Representatives from the Health Commission's Drug Education Unit, Division of Health Education and Therapeutic Goods Branch attend this meeting along with members of the Police Drug Squad and the Narcotics Bureau. Other members of the D.E.A.C. include representatives from the Department of Education, John Fairfax and Sons, Association for Mental Health, Youth Education Seminars, Australian Seventh Day Adventist Church, Pharmaceutical Society of N.S.W. and FRATADD.

3.3 The Health Commission, the Police Drug Squad and the Justice Department are each represented on the Diversionary Programme for Convicted Drug Offenders Committee.

3.4 There is frequent informal contact between the Officer in Charge of the Drug Squad, the Director of the Central Drug and Alcohol Advisory Service of the Health Commission and the Chairman of the Board of Magistrates. It is considered that this communication could be more productive if set up as a formal working party.

3.5 From the time the Therapeutic Goods Branch of the Health Commission was formed in 1967, every effort has been made to establish a close working relationship with members of the Police Department and, in particular, with the Police Drug Squad. This liaison has resulted in the following activities:

3.5.1 Officers of the Therapeutic Goods Branch and the Drug Squad frequently work together on investigations involving the diversion of drugs from licit channels.

3.5.2 Members of the Drug Squad, and the Police Department in general, regularly contact the Therapeutic Goods Branch for advice and assistance on matters of a technical nature relating to drug handling by pharmacists, medical practitioners and private hospitals.

3.5.3 Where matters of a regulatory nature, which are more properly within the area of responsibility of the Therapeutic Goods Branch, are reported to the Drug Squad they are usually referred to the Health Commission for attention. Similarly, matters concerning illicit drugs which come under notice of Therapeutic Goods Branch Inspectors are referred to the Drug Squad.

3.5.4 The relationship between the two bodies has been further developed in recent years when the Police Department established a training programme for detectives specializing in vice and drug matters. Therapeutic Goods Branch officers are regularly invited to address participants in these programmes on relevant aspects of poisons legislation, thereby forming valuable personal contacts.

3.5.5. The only area in which the Therapeutic Goods Branch has declined to give information to the Police Drug Squad, and this is rarely sought, is in respect of particulars contained in the confidential files of clients on the methadone programme. Where such a request is received it is referred to the client's counsellor for attention.

3.6 The role of the Police Department in providing drug education has altered dramatically over the years partially as a result of liaison with the Drug Education Unit attached to the Central Drug and Alcohol Advisory Service. The factors which highlight the change include:

3.6.1 The Police Drug Squad has cut down on its lecturing commitments and refer many requests to the Drug Education Unit for attention.

3.6.2 The Police School Lecturing Section has been trained by the Drug Education Unit, at the request of the Education Department, on productive techniques of drug education. As a result of three training workshops, drug education programmes for schools are currently being designed by members of the Police School Lecturing Section with the co-operation of the Department of Education and the Health Commission of New South Wales.

3.6.3 Consultation between members of the Drug Squad and of the Drug Education Unit resulted in the division of responsibility for drug education at the Police Academy. The Drug Squad provides lectures on illicit drugs to the initial trainees and the cadets whereas the Drug Education Unit facilitates discussion of licit drugs, including the psycho-social aspects of drug use and abuse, with the Police apprentices.

3.7 There has existed for many years a high degree of co-operation and communication between the Health Commission's Drug Education Unit and the Customs Narcotics Bureau.

3.8 Interaction between the law enforcement authorities and the Drug Education Unit has been further enhanced by: Involving members of the Drug Squad and the Narcotics Bureau as session leaders for special training courses, buying films for use by the Drug Squad and conducting training sessions for the Commonwealth Police at North Head.

4. *Data on Mortality and Morbidity Arising from Drug Abuse*

4.1 The Health Commission's Division of Analytical Laboratories collects and collates mortality data on cases where drugs or poisons found in the body were of such concentration that it is likely they were the cause of death. The tables including the classification of toxicological results for 1974 and 1975 are attached (Appendix A and B).

4.2 A more detailed report of deaths related to drug abuse from 1974 through 1976 is at present being compiled by the Health Commission for limited distribution. The report, when available, will be forwarded to the Joint Parliamentary Committee on Drugs.

4.2.1 In the report, a sharp increase is shown in the number of deaths from narcotic abuse for 1976. The data must be interpreted cautiously because the 1976 figures are laboratory data and not completed coronial inquiries.

4.2.2 The mortality data indicate that deaths due to narcotic overdosage during 1976 approached a rate of one per week, representing an increase of about 200 per cent over each of the previous two years. A disturbing conclusion from this is the probable escalation of narcotic abuse in the community.

4.3 The Health Commission has published a report entitled "Some Recent Statistics on the Use and Abuse of Alcohol and Drugs in New South Wales". The report, prepared by Dr R. McCulloch, provides morbidity and mortality statistics from 1972–1976 concerning the abuse of alcohol and drugs. (Exhibit "J", see pages 33–53).

4.4 A pilot study was undertaken from 1968–1976 in the Riverina, Hunter and parts of the Metropolitan Health Regions in order to obtain morbidity data on general hospital admissions. There is no formal report on the data collected at this time; however, the Health Commission implemented a State wide data collection system for general hospital admissions from 1st July, 1976.

4.5 It has been suggested that a standardized indicator of morbidity is needed for the community health services. Although many of the health regions have implemented their own system of data collection there is no agreement on one standardized method of data collection and more specifically on how to measure drug related morbidity.

5. *Information on the Manufacture, Distribution and Possession of Drugs*

5.1 Manufacturers of drugs of addiction, whether for human or animal use, are required to be licensed under the Poisons Act, 1966. Such licenses specify the drugs which may be manufactured and the conditions of supply (see Appendix C). Manufacturers of any substance for human therapeutic use in this State must be licensed under the Therapeutic Goods and Cosmetics Act, 1972. This means that, with one exception—a firm which manufactures veterinary products only—all firms which manufacture drugs of addiction are licensed under both Acts. Licences under the latter Act rarely apply to substances or products, but rather to classes of products, for example biological products and sterile products.

5.1.1 All manufacturers of therapeutic substances are subject to regular inspection by Health Commission officers alone or, more usually, by Commission officers together with officers of the National Biological Standards Laboratory in Canberra.

5.1.2 Firms are inspected for conformity with the Australian Code of Good Manufacturing Practice, the principal purpose of which is to ensure that products manufactured meet standards of quality.

5.2 Like manufacturers, wholesale distributors are required to be licensed under both Acts if they handle both therapeutic substances for human use and drugs of addiction. Licences for the former group may limit the holder to certain classes of goods depending on how such goods are scheduled under the Poisons Act. (Appendix D and E). Licences to supply drugs of addiction by wholesale rarely limit the drugs which may be handled but do impose limitations on sale. (Appendix F). Included amongst those licensed in this group are three firms engaged in fitting out and servicing liferafts. These licences are limited to specified drugs and for the purpose of servicing sealed first-aid kits.

5.3 Licences are also issued under the Poisons Act to those private hospitals and nursing homes who wish to be empowered to obtain drugs of addiction by wholesale, as distinct from those who merely act as custodians of such drugs prescribed for patients in the hospital. These licences always nominate the person (usually the matron) who is to be responsible for the storage and handling of drugs of addiction.

5.4 Licences currently in force comprise:

5.4.1 Licences to manufacture drugs of addiction = 34.

5.4.2 Licences to sell drugs of addiction by wholesale = 53.

5.4.3 Licences to supply drugs of addiction in a private hospital = 96.

5.5 All firms licensed under 5.4.1 and 5.4.2 above, apart from being subject to random checking of their records and stocks of drugs of addiction, are required to submit weekly reports to the Health Commission of *all* transactions (incoming and outgoing) involving drugs of addiction.

5.5.1 These reports are forwarded to the Commonwealth Department of Health for processing under that Department's National Computerized Drug Transaction Monitoring Scheme. This scheme enables the Department to cross match entries in order to ensure that goods supplied by one reporting authority are matched with a corresponding incoming entry from the receiving reporting authority, and enables the Health Commission to readily obtain information about purchases by any distributor of drugs of addiction.

5.5.2 Distributors other than wholesalers, such as pharmacists, doctors and veterinarians, are not required to submit reports.

5.5.3 At the end of each calendar year all reporting authorities are subject to complete stock check of drugs of addiction, including raw materials, in-process goods and finished stock, which serves to validate reports made during the year. Discrepancies detected, if any, are investigated.

5.6 The possession of drugs of addiction is controlled under section 21 of the Poisons Act (Appendix G) and under Regulations 53 and 54 of the Poisons Regulations (Appendix H).

5.7 The possession of prescribed restricted substances is controlled under section 16 of the Act (Appendix I), section 19 (2) (Appendix J), Regulation 32 (Appendix K) and the Schedule under section 19 (1) (b) (Appendix L).

6. *Information on Pharmacy Inspection Procedures and the Frequency of Such Inspections*

6.1 Routine inspections of pharmacies are designed to cover all relevant requirements of the Poisons Act and Regulations. Reports on such inspections may consist simply of a completed summary of the inspector's findings where the pharmacy is basically well conducted, with provision for a revisit to correct matters of a minor nature, if necessary, or may comprise a full narrative report and statement of interview if gross deficiencies have been detected and prosecution is likely to follow. The summary report serves both to minimize report writing and to ensure that important matters are not overlooked during the inspection.

6.2 Inspections usually commence with an examination of the way in which drugs of addiction are stored (adequacy of storage facilities and security in general) recorded (whether the drug register is maintained and up to date) and accounted for (whether prescribed stock checks have been performed and whether stock corresponds with drug register balance). Drug register entries are cross-checked against retained prescriptions and the latter are examined for possible forgeries and to ensure that they have been correctly processed. An examination is made of the drug register entries to ascertain whether drugs have been prescribed for a particular patient continuously for more than two months. If so, a check is later made of authorities issued by the Commission under section 28 of the Poisons Act and, where necessary, the prescriber reminded of his obligations under that section. It is usual to obtain, prior to the inspection, computer print-outs of drugs of addiction purchased by the pharmacist, to validate drug register entries.

6.3 The following matters are also examined during the inspection:

6.3.1 prescription recording and handling in general,

6.3.2 uncollected dispensed medicines for correct labelling,

6.3.3 prescription book or prescription recording system (Appendix M),

6.3.4 dispensary stock, in general for correct labelling,

6.3.5 shop stock to ensure storage requirements are met.

6.4 A desirable inspection rate is considered to be each pharmacy in the State every two years and this level was achieved when the Poisons Branch, as it was then called, was formed in 1968 and five inspectors were able to devote the bulk of their time to routine inspections. Since then the rate of such inspection has progressively dropped as a result of new legislation (Therapeutic Goods and Cosmetics Act, 1972) coming within the Therapeutic Goods Branch's administration and the erosion of time available to inspectors because of the need to attend to matters of a more urgent day to day nature. The net result is that only two inspectors are available to carry out investigations under the Poisons Act and most of their time is devoted to investigations, leaving little time for routine inspections. When such investigations involve visits to pharmacies, the opportunity is taken to carry out a general inspection.

6.5 Routine inspections of pharmacies serve not only to ensure that the requirements of the law are being met but, perhaps more importantly, provide valuable intelligence on drug use and abuse in general and facilitate the detection of problems at an early stage.

6.6 The Health Commission would favour the regionalization of much of the work of the Therapeutic Goods Branch but staff limitations have prevented this from occurring so far.

7. *Information on the Health Commission Organization and Staff Available for and Engaged in Drug Education, Counselling and Treatment Programmes*

7.1 *Central Administration*: Under the Health Commission Act, a Commission of five members is appointed, members holding the following offices:

Chairman.

Commissioner for Personal Health Services.

Commissioner for Environmental and Special Health Services.

Commissioner for Manpower and Management Services.

Commissioner for Finance and Physical Resources.

7.1.1 A recent reorganization of the central administration of the Health Commission provides for two bureaux responsible for planning, policy and co-ordination of services: The Bureau of Personal Health Services and the Bureau of Environmental and Special Health Services. The Division of Health Services Research and the Division of Nursing are separately responsible to the Commission, while the Secretariat provides the resources needed by the bureaux.

7.1.2 Within the central administration of the Health Commission the Adviser on the addictions is responsible to the Commission through the Principal Medical Officer, Bureau of Personal Health Services.

7.1.3 The Bureau of Environmental and Special Health Services is responsible for the fulfilment of certain obligations imposed by the Poisons Act, and has a major administrative responsibility for controlling the prescribing of Methadone for addicts, and for the authorization of prescribers.

7.1.4 The Medical Committee referred to in sections 29 and 30 of the Poisons Act advises the Health Commission in respect of applications for authority to prescribe drugs of addiction.

7.1.5 Organization charts are attached as follows:

Appendix N—Central Office.

Appendix O—Secretariat.

Appendix P—Bureau of Personal Health Services.

Appendix Q—Bureau of Environmental and Special Health Services.

7.2 *Regional Administration*: The Health Commission's organizational emphasis is upon its regional structure. Seven regions have been established in country areas together with regions based on Newcastle and Wollongong and four to cover the Sydney metropolitan area.

7.2.1 A Regional Director of Health has been appointed to each region, the important feature of his place in the organization being shown by the fact that he is directly responsible to the Commission as a corporation and not through any division or branch of the central administration. As far as his region is concerned, the Regional Director is the Health Commission. His authority and responsibility (under the direction and control of the Commission) spreads over the whole of the services, and the whole of the regional resources needed by those services, in giving effect to the Commission's policies. A sample organization chart for one of the larger regional offices is attached. (Appendix R.)

7.2.2 Under the regionalization of health services, each health region has substantial autonomy in determining the nature and extent of treatment and prevention services in the region, and the proportions of the regional resources which are allocated to alcohol and drug problems in the region. A proposed organizational model for addiction services in a metropolitan health region is attached. (Appendix S.)

7.3 *Central Services*: The Central Drug and Alcohol Advisory Service, now administered through the Inner Metropolitan Health Region, has responsibility to the Commission and to all Health Regions in the following areas:

policy formulation in relation to both treatment and prevention services;

staff training programmes;

forward planning for development of services;

monitoring of regional services.

7.3.1 There are two central services within the Health Commission which contribute to health education programmes in the field of addictions. These are, the Division of Health Education and the Drug Education Unit attached to the Central Drug and Alcohol Advisory Service.

7.3.1.1 The Division of Health Education is responsible for:

theoretical input to programme planning;

the ultimate production of literature;

evaluation of the drug education programmes.

7.3.1.2 The Drug Education Unit is responsible for:

formulation of policy on drug education;

provision of resource material for professionals;

consultative services to Health Commission staff;

training of Health Commission personnel and of other government departments;

special projects, such as drink-driver rehabilitation and alcohol in industry.

7.3.2 The number of centralist staff provided by the Health Commission for addiction prevention and treatment programmes and services is included in an attached table (Appendix T).

7.4 *Regional Services*: Drug and alcohol co-ordinators have been appointed in every health region to assist in the organization and administration of regional addiction services and programmes.

7.4.1 The attached tables (Appendix U) indicate the numbers and locations of addiction staff in the regional community health services throughout the State.

7.4.2 The tables differentiate between those Health Education Officers who are accorded specialist status and work exclusively in drug education, and the generalist Health Education Officers whose responsibilities cover all aspects of health education, including drugs and alcohol.

7.5 Policy documents regarding the Health Commission's intentions for the future development of addiction services and programmes are under review. These policy statements will be made available to the Joint Parliamentary Committee when finalized.

7.6 A Review of New South Wales Health Commission Treatment Services for Narcotic Dependent Persons prepared by M/s I. Reynolds, M/s J. di Giusto and Dr R. McCulloch is currently being used as a base document for a review of other existing Health Commission treatment services. (Exhibit "K").

8. *Information on Recent Trends in Drug Abuse*

8.1 The Health Commission's Central Drug and Alcohol Advisory Service and Division of Health Services Research have been primarily responsible for providing statistical data concerning the use and abuse of drugs in New South Wales.

8.2 The article on Drinking and Drug Taking Patterns of 8 516 Adults in Sydney, by M/s I. Reynolds, et. al. (Exhibit "I") contains data that was obtained from a questionnaire administered by Medicheck. The patterns of drug taking are similar to previous surveys; however, the prevalence of alcohol use appears somewhat higher than earlier reports.

8.3 The report referred to earlier in this submission by Dr R. McCulloch (Exhibit "J") contains data on the apparent consumption of drugs and alcohol in New South Wales and in some cases Australia (see pages 2–9) as well as crime statistics related to drugs and alcohol which were divided into two main groups: Court based and prison based statistics (see pages 10–32). The findings of this report will be used by the Health Commission for planning and educational purposes.

8.4 A follow-up report: "Drinking and Drug Taking Patterns of 23 000 Sydney Adults: A Comparison Between Two Samples", written by M/s I. Reynolds, M/s J. Harnas, Dr H. Gallagher, and Mr D. Bryden compares the earlier sample of 8 516 (1975) with a further sample of 14 516 (1976). The total of 23 000 adults who had been through a Medicheck screening is by far the largest ever studied in Australia and is considered to have provided a reliable body of data. (Exhibit "L".)

8.5 A report: "Monitoring Drug Use in New South Wales —1971 to 1973" (Part I), prepared by Dr D. S. Bell, Mr R. A. Champion and Dr A. J. E. Rowe was based on data collected from annual surveys of more than 7 000 respondents, of whom 5 000 were high school students. The monitoring of trends in drug use provides a perspective for the understanding and management of people who have problems with drugs (Exhibit "M").

8.6 A second report: "Trends in Marihuana Use in New South Wales—1971 to 1973", prepared by Mr R. A. Champion outlines the history of marihuana in New South Wales and reviews previous epidemiological studies. A model of the systems of supply, use and control of marihuana is presented to take account of the major factors influencing the prevalence and incidence of marihuana consumption (Exhibit "N").

8.7 The third report: "Monitoring Drug Use in New South Wales—1971 to 1973 (Part 3)—Correlation of Trends, Deviance and Attitudes", prepared by Dr D. S. Bell and Mr R. A. Champion contains three sections: The first deals with trends in drug use; the second considers the relationship between drug use and various kinds of deviance; the third section shows the attitudes which are associated with the use and abuse of drugs (Exhibit "O").

8.8 A report to the Child Health Committee of the New South Wales Health Education Advisory Council on Adolescents and Alcohol in New South Wales prepared by Dr G. Egger, Mr R. Parker and Mr P. Trebilco represents a joint effort of the Department of Education and the Health Commission of New South Wales. (Exhibit "P".)

9. *Recommendations for Modification in Drug Legislation, Services and Programmes*

9.1 In general the Health Commission would like to see drug dependent people treated as sick persons, albeit the sickness is of an anti-social nature. The Health Commission would not like to see the medical model abandoned for a criminal/legal one as often happens when drug abuse threatens to get out of hand. (For definition of drug abuse models see Appendix V.)

9.2 The Health Commission would like to see preventive services strengthened, as it recognizes that treatment of narcotic addicts is usually unsuccessful. Follow-up studies have shown an almost universal relapse to use of narcotics or other drugs. This pattern is world-wide.

9.3 The Health Commission would like to co-operate with the Education Department in setting up a comprehensive preventive programme in schools.

9.4 A previous proposal for modifications to the Poisons Act has been submitted to the Joint Parliamentary Committee by an officer of the Health Commission. A copy of that proposal is attached. (Appendix W). In addition to the modifications in that proposal, it is recommended that the following section on analgesics be added:

9.4.1 Non-opiate analgesics (mild analgesics) in common use can be divided into three broad categories when considering them for scheduling purposes. These categories are:

9.4.1.1 single substances, usually aspirin, its derivatives and related compounds (such as sodium salicylate and salicylamide) and paracetamol (for example, Aspro, Disprin, Panadol);

9.4.1.2 combinations of one or more of the foregoing substances with caffeine (for example, Bex, Vincent's);

9.4.1.3 combinations of one or more of the foregoing substances with codeine (for example, Veganin, Codis, Codral, Codiphen).

9.4.2 Single substances mentioned in 9.4.1.1 above and combinations with caffeine mentioned in 9.4.1.2 above are currently unscheduled and therefore unaffected by the provisions of the Poisons Act and Regulations. Combinations with codeine generally contain 1 per cent or less of codeine, and are therefore controlled as Schedule Two poisons, which can be sold without prescription by pharmacists.

9.4.3 The preparations most commonly involved in cases of kidney damage requiring dialysis or transplant surgery are combinations with caffeine referred to in 9.4.1.2 above. It is presumed that the caffeine plays a significant role in dependence leading to analgesic abuse. Combinations with codeine have been used as raw materials for the illicit manufacture of heroin.

9.4.4 Analgesic substances should be included in Schedule Three of the Poisons List, with exemptions for preparations of single substances packed in child-resistant packages containing a limited number of doses. This would have the following effects:

9.4.4.1 preparations of single substances (aspirin, paracetamol, or salicylamide) packed in child-resistant packages containing a limited number of doses would remain on open sale in pharmacies, supermarkets and general stores;

9.4.4.2 other analgesic preparations would (subject to acceptance of the proposal outlined in paragraph 2 of Appendix W) be available for sale without prescription by pharmacists, but could not be advertised or promoted by display to the general public.

9.5 The Health Commission recognizes the need for studies in the areas of causation of drug abuse and its prevention.

10. *Summary*

10.1 The Health Commission is involved in most aspects of this further inquiry, as described in the revised terms of reference. In particular, the Commission:

10.1.1 places emphasis on prevention of drug abuse in New South Wales, with the focus of this submission on the prevention of minor analgesic abuse;

10.1.2 values both the formal and informal relationships it has with law enforcement authorities;

10.1.3 collects data on mortality and morbidity arising from drug abuse yet recognizes the need for a standardized and more comprehensive data collection procedure within community health services;

10.1.4 administers legislation on the manufacture, distribution and possession of drugs;

10.1.5 has a programme of pharmacy inspections, but recognizes the need for more frequent inspections;

10.1.6 provides staff for drug education, counselling and treatment programmes within existing community health services;

10.1.7 conducts surveys on the incidence of and trends in drug abuse.

10.2 The Health Commission is concerned about recent evidence which indicates a dramatic increase in mortality arising from narcotic abuse.

10.3 Recommendations arising from this submission are summarized as follows:

10.3.1 drug dependent people need health* care;

10.3.2 additional staff should be recruited to strengthen preventive services;

10.3.3 a comprehensive preventive programme in schools should be implemented;

10.3.4 availability of minor analgesics and advertising of all psychotropic substances should be controlled;

10.3.5 studies that examine causation of drug abuse and its prevention should be undertaken.

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* The Health Commission uses the World Health Organization's definition of health which is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

11. *References*

Exhibit A—"Early Adolescent Antecedents of Narcotic Abuse", by Dr R. A. J. Webb, M/s I. Reynolds, Dr G. Egger.

Exhibit B—"Prediction and Prevention of Drug Abuse", by Dr R. A. J. Webb, M/s I. Reynolds, Dr G. Egger.

Exhibit C—"Psychotropic Drug Use in the Elderly—Public Ignorance or Indifference?", by Mr S. Chapman.

Exhibit D—"An Evaluation of Relaxation Courses", by Mr J. d'Agapeyeff.

Exhibit E—"Alcoholism and Drug Dependence—A Survey of General Practitioners' Opinions", by M/s I. Reynolds.

Exhibit F—"Use of Drugs", by M/s H. Creighton.

Exhibit G—"Alcohol Education", by M/s C. Hicks, et al.

Exhibit H—"The Drug Issue—A Guide for Parents", by Dr R. A. J. Webb, M/s P. Murray, Mr L. Field.

Exhibit I—"Drinking and Drug Taking Patterns of 8 516 Adults in Sydney", by M/s I. Reynolds, M/s J. Harnas, Dr H. Gallagher, Mr D. Bryden.

Exhibit J—"Some Recent Statistics on the Use and Abuse of Alcohol and Drugs in New South Wales", by Dr R. McCulloch.

Exhibit K—"A Review of New South Wales Health Commission Treatment Services for Narcotic Dependent Persons", by M/s I. Reynolds, M/s J. di Giusto, Dr R. McCulloch.

Exhibit L—"Drinking and Drug Taking Patterns of 23 000 Sydney Adults: A Comparison between two Samples", by M/s I. Reynolds, M/s J. Harnas, Dr H. Gallagher, Mr D. Bryden.

Exhibit M—"Monitoring Drug Use in New South Wales 1971 to 1973", by Dr D. S. Bell, Mr R. A. Champion, Dr A. J. E. Rowe.

Exhibit N—"Trends in Marihuana Use in New South Wales—1971 to 1973", by Mr R. A. Champion.

Exhibit O—"Monitoring Drug Use in New South Wales (1971 to 1973)" Part 3—Correlation of Trends, Deviance and Attitudes, by Dr D. S. Bell and Mr R. A. Champion.

Exhibit P—"A Report to the Child Health Committee of the New South Wales Health Education Advisory Council on Adolescents and Alcohol in New South Wales", by Dr G. Egger, Mr R. Parker, Mr P. Trebilco.



Appendix A—Classification of Toxicological Results, 1974.

Appendix B—Classification of Toxicological Results, 1975.

Appendix C—Form 5 (Poisons Act) re: Licence to Manufacture, Supply or Sell Drugs of Addiction on Premises Licensed for the Purpose.

Appendix D and E—Form 4 Reg. 16 (Therapeutic Goods and Cosmetics Act—Sections 17–20) re: Licence.

Appendix F—Form 7 (Poisons Act) re: Licence to Supply or Sell Drugs of Addiction.

Appendix G—Section 21 (Poisons Act) re: Control of Possession of Drugs of Addiction.

Appendix H—Regulations 53 and 54 (Poisons Act) re: Control of Possession of Drugs of Addiction.

Appendix I and J—Sections 16 and 19 (Poisons Act) re: Control of Possession of Prescribed Restricted Substances.

Appendix K—Regulation 32 (Poisons Act) re: Control of Possession of Prescribed Restricted Substances.

Appendix L—Schedule under section 19 (1) (b) (Poisons Act) re: Authorizations of Certain Persons to Supply Restricted Substances on Medical Authority to Patients in Hospitals or Inmates of Institutions.

Appendix M—Approved Systems for Recording Prescriptions.

Appendix N—Organizational Chart for Central Office.

Appendix O—Organizational Chart for Secretariat.

Appendix P—Organizational Chart for Bureau of Personal Health Services.

Appendix Q—Organizational Chart for Bureau of Environmental and Special Health Services.

Appendix R—Sample Organizational Chart for one Regional Office.

Appendix S—Proposed Organizational Model for Addiction Services in a Metropolitan Health Region.

Appendix T—Table of Central Staff Available for and Engaged in Prevention and Treatment Programmes and Services.

Appendix U—Tables of Regional Staff Available for and Engaged in Drug Education, Counselling and Treatment Programmes.

Appendix V—*Four Drug Abuse Models from Drugs Demystified,* by Dr Helen Nowlis, The Unesco Press, Paris, 1975, pp. 13–16.

Appendix W—Poisons Act, 1966: Some Observations on its Present Construction and Proposed Modifications.

Appendix A

## CLASSIFICATION OF TOXICOLOGICAL RESULTS, 1974

The following table lists some of the results of visceral examinations for the calendar year 1974. Only those cases have been listed where the drugs or poisons found were of such concentration that it is likely they were the cause of death. The column headings have the following meanings:

*Coronial Findings.* Cases are listed in these columns when the finding of the Coronial Inquiry has been received.

*No Coronial Findings.* In those cases where no record of a Coronial finding has been received, a tentative classification of results has been made based on the information available.

"A"—The concentration of the compound found was such that it was considered to be the cause of death.

"B"—The concentrations of the several compounds found were such that together they were considered to be the cause of death.

"C"—The concentration(s) of the compound(s) present, together with a significant concentration of alcohol, were considered, in total, to be the cause of death.

Total—The sum of the results in the other columns.

| Compound | Coronial finding | | | No coronial finding | | | Total |
|---|---|---|---|---|---|---|---|
| | A | B | C | A | B | C | |
| Alcohol | 3 | .. | .. | 2 | .. | .. | 5 |
| Alprenolol | 1 | .. | .. | .. | .. | .. | 1 |
| Amitriptyline | 2 | .. | 1 | 1 | 2 | .. | 6 |
| Amylobarbitone | 11 | 15 | 6 | 14 | 5 | .. | 51 |
| Arsenic | 3 | 2 | .. | .. | .. | .. | 5 |
| Barbitone | .. | .. | 1 | .. | .. | .. | 1 |
| Bromides | .. | 6 | 1 | .. | 6 | .. | 13 |
| Butobarbitone | 1 | .. | .. | 1 | 1 | 1 | 4 |
| Caffeine | .. | 3 | .. | .. | 1 | .. | 4 |
| Carbamazepine | .. | .. | .. | 1 | .. | .. | 1 |
| Carbon Monoxide | 20 | 4 | 1 | 5 | 1 | .. | 31 |
| Chloral Hydrate | 31 | 4 | 4 | 8 | 3 | 1 | 51 |
| Chlorbutol | .. | .. | .. | .. | 1 | .. | 1 |
| Chloroquine | .. | 1 | .. | 1 | .. | .. | 2 |
| Codeine | .. | .. | .. | .. | 3 | .. | 3 |
| Cyanide | .. | .. | .. | 1 | .. | .. | 1 |
| Cyclobarbitone | 1 | 1 | .. | .. | .. | .. | 2 |
| Desipramine | .. | 1 | .. | .. | .. | .. | 1 |
| Dextromoramide | 1 | .. | .. | .. | .. | .. | 1 |
| Dextropropoxyphene | .. | 2 | .. | .. | 3 | .. | 5 |
| Diazepam | .. | 9 | 1 | .. | 7 | .. | 17 |
| Dibenzepin | 1 | .. | .. | .. | 1 | .. | 2 |
| Digoxin | .. | 1 | .. | 1 | .. | .. | 2 |
| Dimethoate | .. | .. | .. | 1 | .. | .. | 1 |
| Diphenhydramine | .. | 1 | .. | .. | .. | .. | 1 |
| Diquat | .. | 1 | .. | .. | .. | .. | 1 |
| Doxepin | 1 | .. | .. | .. | 1 | .. | 2 |
| Drowning | 13 | 3 | 1 | 7 | .. | .. | 24 |
| Ethyl Fenthion | .. | .. | .. | 1 | .. | .. | 1 |
| Glutethimide | 1 | 2 | .. | 1 | 1 | .. | 5 |
| Glycols | .. | .. | .. | 1 | .. | .. | 1 |
| Imipramine | .. | 1 | .. | .. | 1 | .. | 2 |
| Lead | .. | 2 | .. | .. | .. | .. | 2 |
| Mephenesin | .. | 1 | .. | .. | .. | .. | 1 |
| Meprobamate | .. | 1 | .. | .. | .. | .. | 1 |
| Methadone | 4 | .. | .. | 2 | 1 | .. | 7 |
| Methapyrilene | .. | .. | .. | .. | 1 | .. | 1 |
| Methaqualone | 4 | 8 | .. | 1 | 2 | .. | 15 |
| Morphine | 3 | .. | .. | 2 | .. | .. | 5 |
| Nitrazepam | .. | 1 | .. | .. | .. | .. | 1 |
| Nitrite | .. | .. | .. | 2 | .. | .. | 2 |
| Nortriptyline | 1 | 1 | .. | .. | 1 | .. | 3 |
| Orphenadrine | .. | .. | .. | 2 | .. | .. | 2 |
| Paracetamol | 1 | .. | .. | .. | 6 | .. | 7 |
| Paraquat | .. | 1 | .. | 3 | .. | .. | 4 |
| Pentobarbitone | 39 | 16 | 15 | 12 | 20 | 2 | 104 |
| Phenindione | .. | .. | .. | 1 | .. | .. | 1 |
| Pheniramine | 1 | .. | .. | 1 | .. | .. | 2 |
| Phenobarbitone | 2 | 2 | 1 | 1 | .. | .. | 6 |
| Phenytoin | .. | 2 | .. | 1 | .. | .. | 3 |
| Primidone | .. | 1 | .. | .. | .. | .. | 1 |
| Propoxur | .. | 1 | .. | .. | .. | .. | 1 |
| Quinalbarbitone | .. | 13 | 4 | 2 | 2 | .. | 21 |
| Quinidine | 2 | .. | .. | .. | .. | .. | 2 |
| Quinine | 1 | .. | .. | 1 | 1 | .. | 3 |
| Salicylamide | .. | .. | .. | .. | 2 | .. | 2 |
| Solvents | .. | .. | .. | 1 | .. | .. | 1 |
| Strychnine | 2 | .. | .. | 1 | 1 | .. | 4 |
| Theophylline | .. | 1 | .. | .. | .. | .. | 1 |
| Thioridazine | 2 | 1 | .. | 1 | 1 | .. | 5 |
| Trichloroethylene | 1 | .. | .. | .. | .. | .. | 1 |
| Trifluoperazine | .. | 1 | .. | .. | .. | .. | 1 |
| Trimipramine | 1 | 1 | 1 | .. | 1 | .. | 4 |
| Zinc | 1 | .. | .. | .. | .. | .. | 1 |

Appendix B

## CLASSIFICATION OF TOXICOLOGICAL RESULTS, 1975

The following table lists some of the results of visceral examinations for the calendar year 1975. Only those cases have been listed where the drugs or poisons found were of such concentration that it is likely they were the cause of death. The column headings have the following meanings:

*Coronial Findings*: Cases are listed in these columns when the finding of the Coronial Inquiry has been received.

*No Coronial Findings*: In those cases where no record of a Coronial finding has been received, a tentative classification of results has been made based on the information available.

"A"—The concentration of the compound found was such that it was considered to be the cause of death.

"B"—The concentrations of the several compounds found were such that together they were considered to be the cause of death.

"C"—The concentration(s) of the compound(s) present, together with a significant concentration of alcohol, were considered, in total, to be the cause of death.

Total—The sum of the results in the other columns.

| Compound | Coronial finding | | | No coronial finding | | | Total |
|---|---|---|---|---|---|---|---|
| | A | B | C | A | B | C | |
| Alcohol | 5 | .. | .. | 8 | .. | .. | 13 |
| Amitriptyline | 3 | .. | 2 | .. | .. | .. | 5 |
| Amylobarbitone | 18 | 9 | 6 | 5 | 11 | 7 | 56 |
| Arsenic | 2 | .. | .. | 1 | .. | .. | 3 |
| Butabarbitone | .. | 1 | .. | 1 | .. | .. | 2 |
| Butobarbitone | 2 | 1 | .. | .. | .. | 1 | 4 |
| Carbamazepine | .. | .. | 1 | .. | .. | .. | 1 |
| Carbon Monoxide | 22 | .. | .. | 6 | .. | 1 | 29 |
| Chloral Hydrate | 19 | 4 | 4 | 4 | .. | .. | 31 |
| Chlordane | .. | .. | .. | 1 | .. | .. | 1 |
| Chlorbutol | 2 | .. | .. | .. | .. | .. | 2 |
| Chlorpromazine | .. | .. | 1 | .. | .. | .. | 1 |
| Chloroquine | 1 | .. | .. | 2 | .. | .. | 3 |
| Coumaphos | .. | .. | .. | 1 | .. | .. | 1 |
| Cresols | .. | .. | .. | 1 | .. | .. | 1 |
| Cyanide | 3 | .. | .. | 1 | .. | .. | 4 |
| Cyclobarbitone | 1 | .. | .. | .. | .. | .. | 1 |
| Dextropropoxyphene | .. | 1 | .. | .. | .. | 1 | 2 |
| Diazepam | 6 | 3 | 3 | .. | .. | .. | 12 |
| Diazinon | .. | .. | .. | 1 | .. | .. | 1 |
| Dibenzepin | .. | .. | .. | 1 | .. | .. | 1 |
| Dieldrin | 1 | .. | .. | .. | .. | .. | 1 |
| Digoxin | 1 | .. | .. | .. | .. | .. | 1 |
| Dimethoate | 1 | .. | .. | .. | .. | .. | 1 |
| Doxepin | .. | .. | .. | 1 | .. | .. | 1 |
| Ethyl Fenthion | 1 | .. | .. | 3 | .. | .. | 4 |
| Fluorochloromethanes | 1 | .. | .. | .. | 1 | .. | 2 |
| Glutethimide | .. | .. | .. | 2 | .. | .. | 2 |
| Hydrochloric Acid | 1 | .. | .. | .. | .. | .. | 1 |
| Imipramine | .. | .. | 1 | .. | .. | .. | 1 |
| Malathion | 2 | .. | .. | .. | .. | .. | 2 |
| Metasystox | .. | .. | .. | 1 | .. | .. | 1 |
| Methadone | 2 | .. | 1 | 1 | .. | .. | 4 |
| Methapyrilene | 1 | .. | .. | .. | 1 | .. | 2 |
| Methaqualone | 3 | 2 | 1 | 2 | 4 | .. | 12 |
| Mevinphos | .. | .. | .. | 1 | .. | .. | 1 |
| Morphine | 3 | 2 | 2 | 3 | .. | .. | 10 |
| Nitrazepam | .. | 1 | .. | .. | .. | .. | 1 |
| Nortriptyline | 1 | .. | 1 | .. | 1 | .. | 3 |
| Orphenadrine | 1 | .. | .. | .. | .. | .. | 1 |
| Petrol Vapour | 1 | .. | .. | 1 | .. | .. | 2 |
| Pentobarbitone | 32 | 12 | 17 | 24 | 6 | 3 | 94 |
| Phenols | 1 | .. | .. | .. | .. | .. | 1 |
| Phosdrin | .. | .. | .. | 1 | .. | .. | 1 |
| Potassium Ion | .. | .. | .. | 1 | .. | .. | 1 |
| Propanol | 1 | .. | 1 | .. | .. | .. | 2 |
| Quinalbarbitone | 5 | 1 | 3 | 1 | .. | 1 | 11 |
| Quinidine | .. | .. | .. | .. | 1 | .. | 1 |
| Quinine | .. | 1 | .. | .. | 1 | .. | 2 |
| Salicylamide | .. | .. | .. | .. | 1 | 1 | 2 |
| Salicylic Acid | 2 | .. | .. | .. | .. | .. | 2 |
| Sodium Diatrizoate | 1 | .. | .. | .. | .. | .. | 1 |
| Solvents | 1 | .. | .. | 1 | .. | .. | 2 |
| Strychnine | .. | .. | .. | 3 | .. | .. | 3 |
| Thiopentone | .. | .. | .. | .. | .. | 1 | 1 |
| Trimipramine | .. | .. | .. | 1 | .. | .. | 1 |

Appendix C

Form 5

NEW SOUTH WALES

No.

POISONS ACT, 1966, AS AMENDED

**LICENCE TO MANUFACTURE, SUPPLY OR SELL* DRUGS OF ADDICTION ON PREMISES LICENSED FOR THE PURPOSE**

Name: .....

of: .....
has been licensed by the Health Commission of New South Wales to manufacture the undermentioned substances to which Schedule Eight of the Poisons List applies. This licence also empowers the holder to supply or sell such undermentioned substances.*

The said substances shall be manufactured only on the premises situated at .....

.....
which premises are hereby licensed for the purpose, and such substances shall be manufactured in accordance with the terms of this licence and of the Poisons Act, 1966, as amended, and the regulations made thereunder.

This licence shall have effect until the thirtieth day of September each year unless sooner withdrawn or unless application for renewal is granted before that date.

The substances in respect of which this licence applies are—

This licence shall be subject to the following terms and conditions:

*(1) Any supply or sale of any such substances shall be only:

(a) to persons licensed or authorized to supply or sell, or be in possession of such substances under the Act or regulations and in accordance with the provisions of the Act and regulations;

(b) to the holder of a licence or authority to supply or sell, or be in possession of such substances under a law of the Commonwealth, Territory of the Commonwealth or other State of the Commonwealth;

(c) by way of export to any person or body located in any country or territory outside the Commonwealth and its Territories.

(2)

Dated this.....

day of ..... of .....

* Only applicable if licence is to be endorsed accordingly in the case of a manufacturer who is to be empowered to supply or sell substances manufactured by him.

Secretary,
Health Commission of
New South Wales.

Appendix D

Form 4—Reg. 16

HEALTH COMMISSION OF NEW SOUTH WALES

THERAPEUTIC GOODS AND COSMETICS ACT, 1972

(Sections 17, 20)

**LICENSE**

License No.

Name: .....

Address: .....
is hereby licensed to sell by wholesale therapeutic substances or prescribed cosmetics subject to the following conditions:

1. Therapeutic substances or prescribed cosmetics shall be sold only on or from premises situated at:

2. The storage, handling and sale of substances to which this license applies shall be in accordance with the provisions of the Therapeutic Goods and Cosmetics Act, 1972, and the Regulations made thereunder.

3. This license shall not authorize the sale by wholesale of the following classes of substances—

(a) poisons to which Schedule One, Two or Three of the Poisons List applies;

(b) restricted substances, being substances to which Schedule Four of the Poisons List applies;

(c) therapeutic substances to which Schedule Seven of the Poisons List applies.

Dated this eighteeenth day of August, 1976.

Delegate of the
Health Commission of
New South Wales.

Appendix E

Form 4—Reg. 16

HEALTH COMMISSION OF NEW SOUTH WALES

THERAPEUTIC GOODS AND COSMETICS ACT, 1972

(Sections 17, 20)

**LICENSE**

License No.

Name: .....

Address: .....
is hereby licensed to sell by wholesale therapeutic substances or prescribed cosmetics subject to the following conditions:

1. Therapeutic substances or prescribed cosmetics shall be sold only on or from premises situated at:

2. The storage, handling and sale of substances to which this license applies shall be in accordance with the provisions of the Therapeutic Goods and Cosmetics Act, 1972, and the Regulations made thereunder.

Dated this fourteenth day of October, 1974.

Delegate of the
Health Commission of
New South Wales.

Appendix F

HEALTH COMMISSION OF NEW SOUTH WALES

POISONS ACT, 1966

Form 7

No.

**LICENCE TO SUPPLY OR SELL DRUGS OF ADDICTION**

Name: .....

of: .....
has been licensed by the Health Commission of New South Wales to supply or sell substances to which Schedule Eight of the Poisons List applies.

The process of supplying or selling such substances shall be carried out on or from the premises situated at: .....

.....

This licence will expire on the thirtieth day of September each year unless sooner withdrawn or unless application for renewal is granted before that date.

This licence shall be subject to the following terms and conditions:

(1) any supply or sale of any such substances shall be only:

(a) to persons licensed or authorized to supply or sell, or be in possession of such substance under the Act or regulations and in accordance with the provisions of the Act and regulations;

(b) to the holder of a licence or authority to supply or sell, or be in possession of such substances under the law of the Commonwealth, Territory of the Commonwealth, or other State of the Commonwealth;

(c) by way of export to any person or body located in any country or territory outside the Commonwealth and its Territories.

(2)

Dated this ..... day of ....., 19....

Secretary,
Health Commission of
New South Wales.

Appendix G

Act No. 31, 1966

*Poisons*

21. (1) If any person—

(a) manufactures, supplies, sells, or otherwise deals in prepared opium or Indian hemp;

(b) has in his possession any prepared opium or Indian hemp;

(c) being the occupier of any premises permits those premises to be used for the purpose of the preparation of opium or Indian hemp for smoking or the sale, distribution, or smoking of prepared opium or Indian hemp;

(d) being the owner or lessee of any premises knowingly permits such premises to be used for the purpose of smoking opium, prepared opium or Indian hemp;

(e) is concerned in the management of any premises used for any purpose referred to in paragraph (c) or (d);

(f) has in his possession any pipes or other utensils for use in connection with the smoking of opium, prepared opium or Indian hemp or any utensils used in connection with the preparation of opium or Indian hemp for smoking; or

(g) smokes opium, prepared opium or Indian hemp or otherwise uses prepared opium or Indian hemp, or frequents any place used for the purpose of smoking opium, prepared opium or Indian hemp;

he shall be guilty of an offence against this Division.

(2) If any person has in his possession any drug of addiction other than prepared opium or Indian hemp, he shall be guilty of an offence against this Division unless—

(a) he is licensed or otherwise authorised under the regulations to manufacture, sell, distribute or supply the drug;

(b) he is otherwise authorised under the regulations to be in possession of the drug; or

(c) the drug was supplied or requested to be supplied, for the use of that person, by a medical practitioner or veterinary surgeon, or on and in accordance with a prescription complying with the regulations or was supplied or requested to be supplied by a dentist for the use in dental treatment, for a period not exceeding one month, of a patient in a hospital.

(2A) Any person who supplies or sells any drug of addiction other than prepared opium or Indian hemp shall be guilty of an offence against this Division unless—

(a) he is licensed or otherwise authorised under the regulations to supply and sell the drug; or

(b) he is a medical practitioner, dentist or veterinary surgeon and supplies or sells the drug for therapeutic use in the course of the practice of his profession.

(3) A person shall not be guilty of an offence under subsection (2) by virtue of his having in his possession, or attempting to obtain possession of, a drug of addiction, other than prepared opium or Indian hemp, if he proves that he had possession, or attempted to obtain possession, of the substance only for the purpose of delivering it to a person referred to in paragraph (a), (b) or (c) of that subsection.

(4) Any opium, prepared opium or Indian hemp or other drug in the order or disposition of any person shall, for the purposes of subsections (1) and (2), be deemed to be in his possession.

Appendix H

Authority to be in possession of and supply certain drugs of addiction

53. (1) Until in any particular case such authority is withdrawn—

(a) a medical practitioner;

(b) a pharmacist employed in dispensing medicines at any public hospital or other public institution;

(c) a dentist;

(d) a veterinary surgeon;

(e) the matron in charge of a public hospital where no pharmacist is employed as such, or in her absence the nurse acting in that capacity;

(f) the nurse in charge of a ward in a public hospital;

(g) a nurse employed by the New South Wales Bush Nursing Association; or

(h) a nurse employed by the New South Wales Ambulance Transport Board in aerial ambulance duties;

is hereby authorised to be in possession of and supply any drug of addiction (other than a drug of addiction to which regulation fifty-two applies) for the purpose of his or her profession or employment subject to the conditions and restrictions prescribed by these regulations, but such authority does not entitle any person to use any drug of addiction for any purpose other than that of his or her profession or employment.

(1A) Notwithstanding the provisions of paragraph (1) of this regulation, a medical practitioner, a pharmacist or a nurse whose authority to be in possession of and to supply, any drug of addiction was withdrawn pursuant to the provisions of Part VI of the Police Offences (Amendment) Act, 1908, as amended, and was not subsequently restored, is not authorised to be in possession of or to supply any drug of addiction until so authorised by the Commission.

(2) A person to whom a prescription for a drug of addiction has been issued in accordance with these regulations is hereby authorised to have possession of the drug of addiction to the extent specified in the prescription.

(3) Until in any further case such authority is withdrawn—

(a) a person in charge of a laboratory for the purpose of research or instruction who is approved by the Commission for the purpose of this paragraph; or

(b) an analyst appointed under the Therapeutic Goods and Cosmetics Act, 1972,

is hereby authorised to be in possession of any drug of addiction (other than a drug of addiction to which regulation fifty-two applies) for the purpose of his profession or employment subject to the conditions and restrictions prescribed by these regulations, but such authority does not entitle any person to use any drug of addiction for any purpose other than that of his profession or employment.

Authority for Pharmacists to Retail, Compound and Dispense

54. (1) Until in any particular case such authority is withdrawn a pharmacist engaged in the retail business of pharmacy is hereby authorised—

(a) to manufacture at his shop in the ordinary course of his retail business any preparation, admixture or extract of any drug of addiction (other than a drug of addiction to which regulation 52 applies);

(b) to carry on at his shop the business of selling by retail, dispensing or compounding that drug to or for persons licensed or otherwise authorised under the Act or these regulations to be in possession of that drug; and

(c) to be in possession of that drug for the purposes of subparagraphs (a) and (b).

(2) Any authority under this regulation does not entitle the holder thereof to use any drug of addiction for any purpose other than that of his business.

16. (1) A person shall not have in his possession or attempt to obtain possession of a prescribed restricted substance unless—

(a) he is a medical practitioner, pharmacist, dentist or veterinary surgeon;

(b) he obtains possession or attempts to obtain possession of it on and in accordance with the prescription of a medical practitioner, dentist or veterinary surgeon for its supply to him;

(c) he is a person or belongs to a class of persons authorised by the Commission for the purposes of paragraph (b) of subsection (1) of section 19; or

(d) he is a person authorised in writing by the Commission to obtain possession of the prescribed restricted substance for the purposes of his profession or employment and obtains, or attempts to obtain, as the case may be, possession of the prescribed restricted substance in accordance with any conditions subject to which he is so authorised.

(2) A person shall not forge or fraudulently alter, or utter, knowing it to be forged or fraudulently altered, any prescription of a medical practitioner, dentist or veterinary surgeon including any prescribed restricted substance.

(3) A person shall not—

(a) knowingly by any false representation (whether verbal, or writing, or by conduct)—

(i) obtain or attempt to obtain from any medical practitioner, dentist or veterinary surgeon any prescription including any prescribed restricted substance; or

(ii) induce or attempt to induce any pharmacist to dispense any forged or fraudulently altered prescription including prescribed restricted substance or any prescription obtained in contravention of this paragraph knowing it to be forged or so altered or obtained; or

(b) be in actual possession of any forged or fraudulently altered prescription including a prescribed restricted substance or of any prescription obtained in contravention of paragraph (a), knowing it to be forged or so altered or obtained;

(c) * * * * * *

(4) Any prescribed restricted substance in the order or disposition of a person shall, for the purposes of subsection (1), be deemed to be in his possession.

(5) A person shall not be guilty of an offence against subsection (1) by virtue of his having in his possession, or attempting to obtain possession of, a prescribed restricted substance if he proves that he had possession, or attempted to obtain possession, of the substance only for the purpose of delivering it—

(a) to a medical practitioner, pharmacist, dentist or veterinary surgeon; or

(b) to a person to whom its supply has been authorised by the prescription of a medical practitioner, dentist or veterinary surgeon.

17. (2) Subsection (1) of section 16 does not apply to a wholesale dealer who has in his possession, or attempts to obtain possession of, a prescribed restricted substance referred to in that subsection for the purposes of a wholesale dealing.

Appendix K

Barbiturates for Animal Destruction

32. A health surveyor nominated by the council of a city, shire or municipality or an officer nominated by an animal welfare organisation, who is authorised by the Commission pursuant to section 16 of the Act to obtain possession of the prescribed restricted substance pentobarbitone sodium for the purpose of animal destruction shall comply with the following conditions—

(a) the process of animal destruction shall be carried out by or under the direct personal supervision of such authorised health surveyor or authorised officer of an animal welfare organization;

(b) all stocks of such substance in the possession of such authorised health surveyor or authorised officer of an animal welfare organisation shall be stored apart from all other goods in a safe, cupboard or other receptacle securely attached to a part of the premises and kept securely locked excepting when stocks of such substance are actually being placed in or removed from such safe, cupboard or receptacle;

(c) such authorised health surveyor or authorised officer of an animal welfare organisation shall maintain, or cause to be maintained, a register in which shall be entered on the day the event occurs the following details, namely—

(i) in the case of the procurement of the substance—
(a) the date upon which it was obtained;
(b) the name and address of the supplier;
(c) the quantity of such substance obtained;
(d) the amount of such substance held following such procurement; and
(e) the signature of the person making the entry;

(ii) in the case of the use of the substance—
(a) the date upon which it was used;
(b) the number and species of animals for which it was used;
(c) the quantity of such substance used;
(d) the amount of the substance held following such use; and
(e) the signature of the person making the entry.

33. The register required to be maintained under paragraph (c) of regulation thirty-two shall be kept on the premises on which the pentobarbitone sodium is stored, and shall be at all times available for inspection by any member of the police force or person authorised by the Commission under section forty-three of the Act.

[*Published in Government Gazette No. 5 of 9th January,* 1976; *No.* 21 *of* 13*th February,* 1976; *No.* 103 *of* 13*th August,* 1976.]

Health Commission of New South Wales, Sydney,

22nd December, 1975

POISONS ACT, 1966

*Authorization of Certain Persons to Supply Restricted Substances on Medical Authority to Patients in Hospitals or Inmates of Institutions*

IN accordance with the provisions of section 19 (1) (b) of the Poisons Act, 1966, any person specified in the Schedule hereunder has been authorized to make the supply of a restricted substance on and in accordance with the prescription of a medical practitioner to a patient in a hospital or an inmate of an institution specified therein in respect of that person.

D. M. STOREY, Commissioner for
Environmental and Special Health Services.

SCHEDULE

A nurse employed by the Health Commission as an Aboriginal Health Nurse.

A nurse employed in any of the following Community Health Centres:

Bermagui Community Health Centre.
Carinda Community Health Centre.
Darlington Point Community Health Centre.
Enngonnia Community Health Centre.
Lightning Ridge Community Health Centre.
Mangrove Mountain Community Health Centre.
Merimbula Community Health Centre.
Moulamein Community Health Centre.
Perisher Community Health Centre.
Quambone Community Health Centre.
Smiggin Holes Community Health Centre.
Tambar Springs Community Health Centre.
Thredbo Community Health Centre.
Tullibigeal Community Health Centre.
Wanaaring Community Health Centre.
Weethalle Community Health Centre.

A nurse employed by the New South Wales Ambulance Board in aerial ambulance duties.

The matron in charge (or in her absence the person acting in that capacity) of a hospital specified in the Second, Third or Fifth Schedule of the Public Hospitals Act, 1929.

The nurse in charge of a ward of a hospital specified in the Second, Third or Fifth Schedule of the Public Hospitals Act, 1929, or a nurse working in such a ward who has been directed to administer medicines by the nurse in charge of that ward.

The nurse specified in a license to supply or sell drugs of addiction in a private hospital.

The nurse in charge of a ward of a private hospital registered under the Private Hospitals Act, 1908, in which a medical practitioner or pharmacist is employed as such or a nurse specified in a license to supply or sell drugs of addiction is employed.

The officer in charge of an institution conducted by the Department of Youth, Ethnic and Community Affairs.

The officer in charge of an institution conducted by the Department of Corrective Services.

The officer in charge of a ward, sick bay or similar section of an institution conducted by the Department of Corrective Services.

A nurse employed in the Narrabri/Wee Waa Community Centre and stationed in the Gwabegar/Pilliga area.

Appendix M

## HEALTH COMMISSION OF NEW SOUTH WALES APPROVED SYSTEMS FOR RECORDING PRESCRIPTIONS—TG 50

1. Where the use of a prescription book is required by the Poisons Regulations for recording prescriptions for restricted substances (Regulation 27 (4) (c)) or drugs of addiction (Regulation 64 (4) (d)), the "prescription book" must be—

1.1 A book in which prescriptions may be copied and in which pages are numbered consecutively and each prescription is given a consecutive letter or number which is incorporated in the prescription number; or

1.2 Any other recording system approved by the Commission.

2. Approval has been given for general use of the following recording systems, subject to the conditions set out in respect of each approved system—

2.1 *Duplicate or Photocopy*

The retention of a duplicate copy or photocopy of each prescription or a written copy of the essential details of each prescription, where each copy is given a consecutive letter or number which is incorporated in the prescription number and all copies are maintained in sequential order in bound form.

2.2 *Microfilm*

The retention of a microfilm copy of each prescription, where each copy is given a consecutive letter or number which is incorporated in the prescription number and copies appear in sequential order on the microfilm record.

2.3 *Patient Medication Profile*

The retention of a copy of the essential details of each prescription on a personal or family medication record card, with cards filed in alphabetical order according to patient or family name, provided that a Day Book which has the following features is also kept—

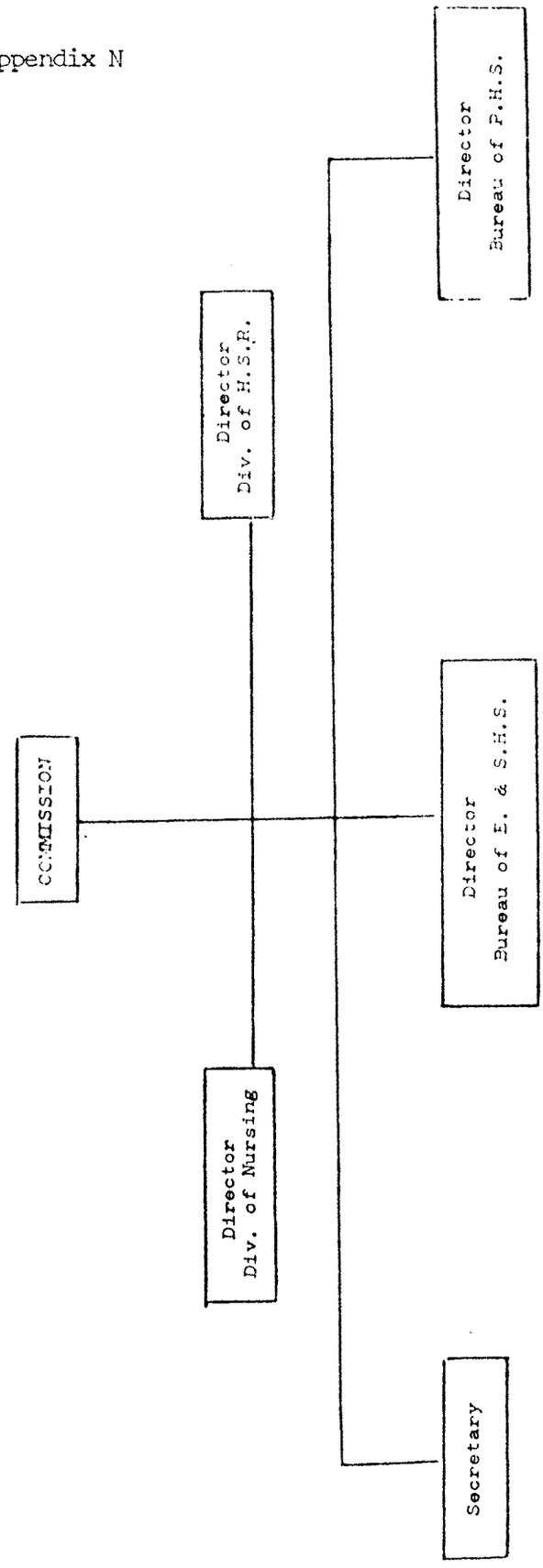
2.3.1 A separate page is used for indexing prescriptions dispensed each day;

2.3.2 Each line is given a sequential letter or number which is incorporated in the prescription number; and

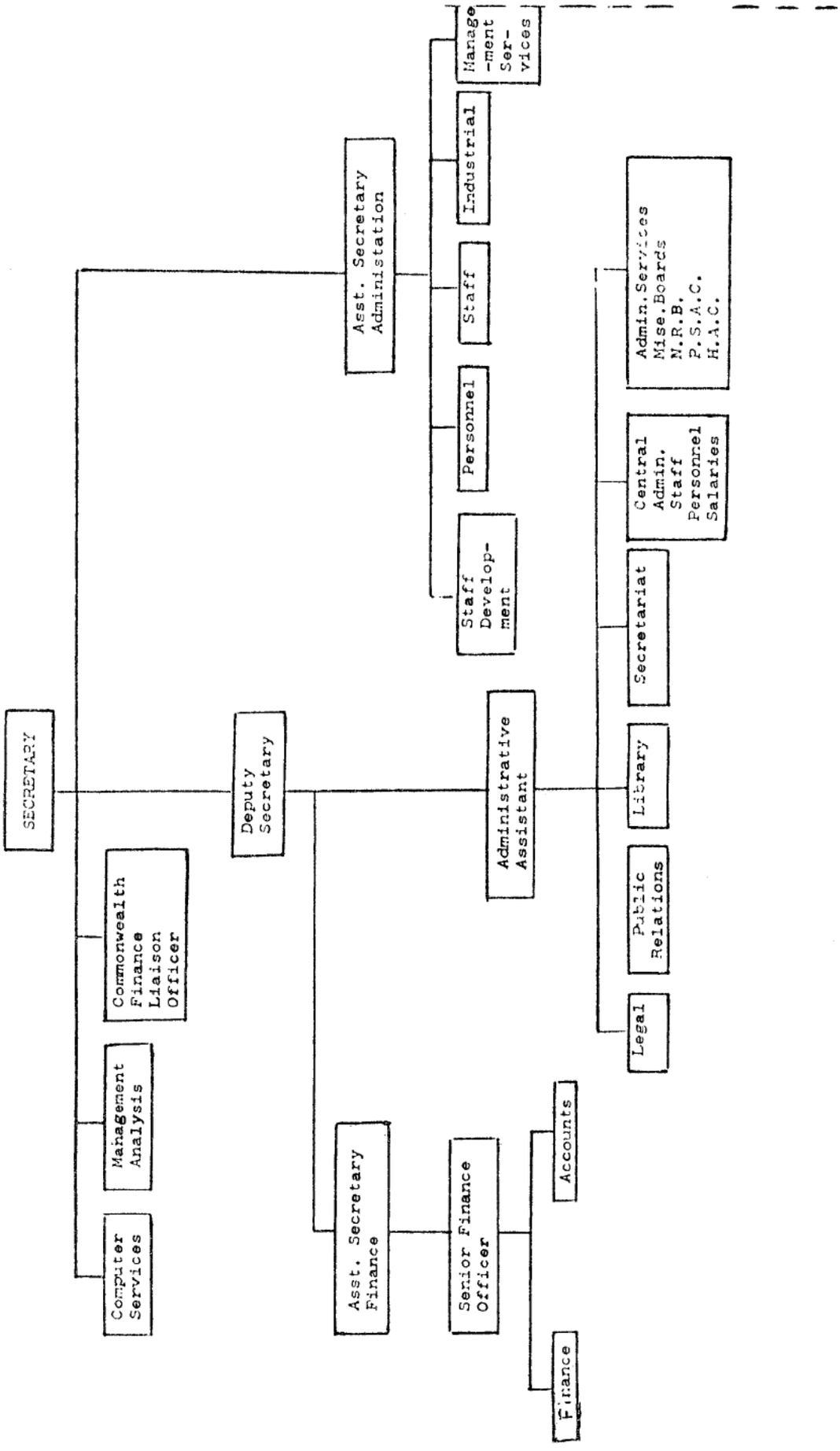
2.3.3 The name of the person for whom each prescription is dispensed and the reference number of the medication record card upon which full details of that prescription may be found are listed, one entry to a line.

3. The term "essential details" used in this advice means the details required by the Poisons Regulations to be written on the prescription by the prescriber, and any notations made by the dispenser.

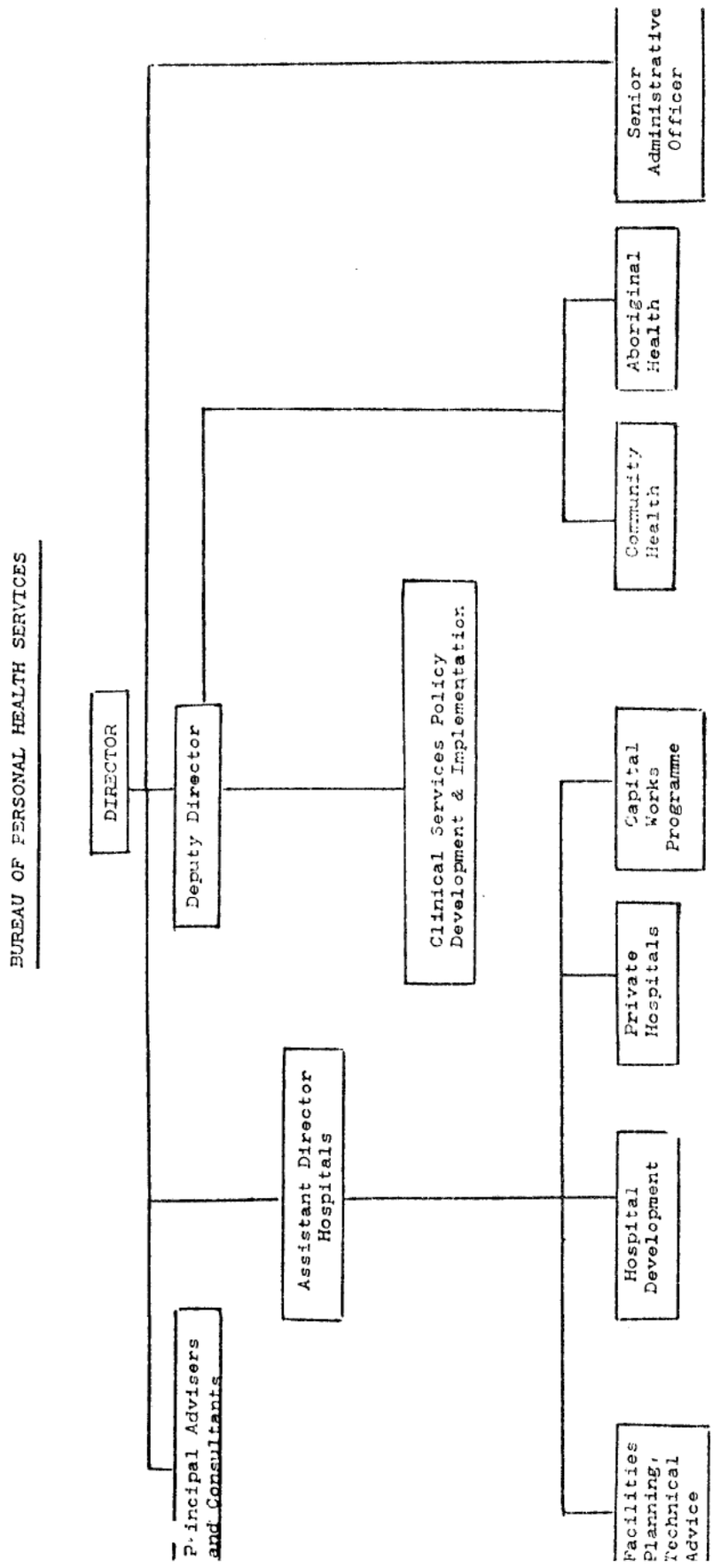
Appendix N



Appendix 6

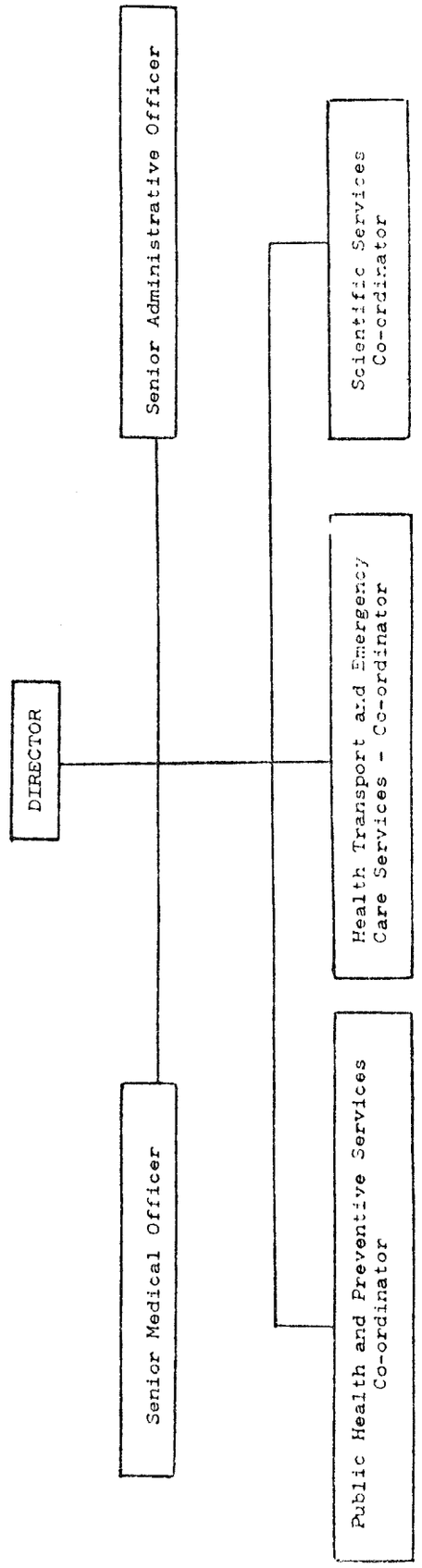

SECRETARY
Deputy Secretary
Asst. Secretary Administation
Staff Development
Personnel
Staff
Industrial
Management Services
Administrative Assistant
Central Admin. Staff Personnel Salaries
Admin.Services Mise.Boards N.R.B. P.S.A.C. H.A.C.
Secretariat
Library
Public Relations
Legal
Commonwealth Finance Liaison Officer
Management Analysis
Computer Services
Asst. Secretary Finance
Senior Finance Officer
Accounts
Finance

Appendix P

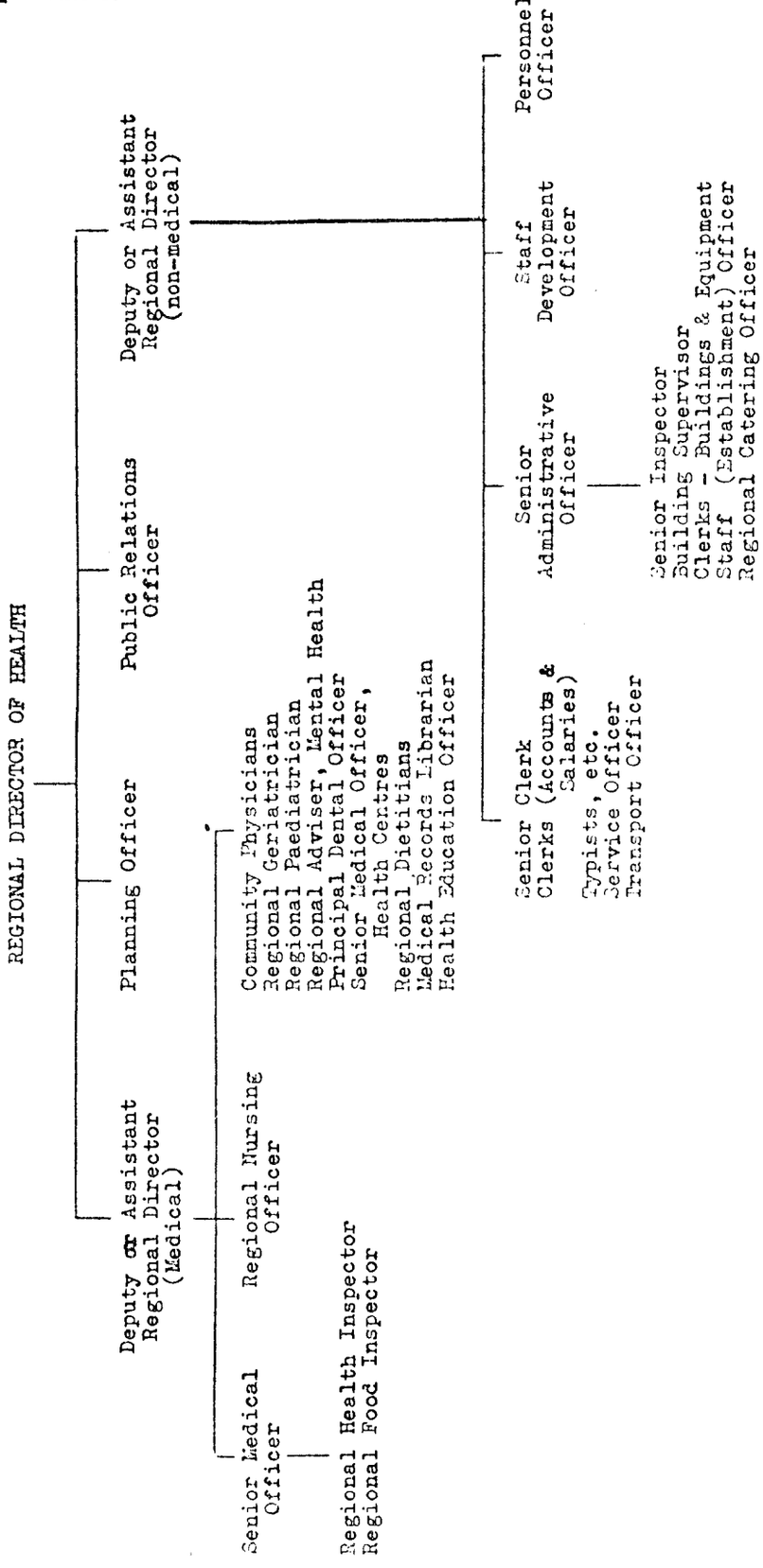

BUREAU OF PERSONAL HEALTH SERVICES
DIRECTOR
Deputy Director
Assistant Director Hospitals
Principal Advisers and Consultants
Clinical Services Policy Development & Implementation
Community Health
Aboriginal Health
Private Hospitals
Capital Works Programme
Hospital Development
Facilities Planning, Technical Advice
Senior Administrative Officer

Appendix Q

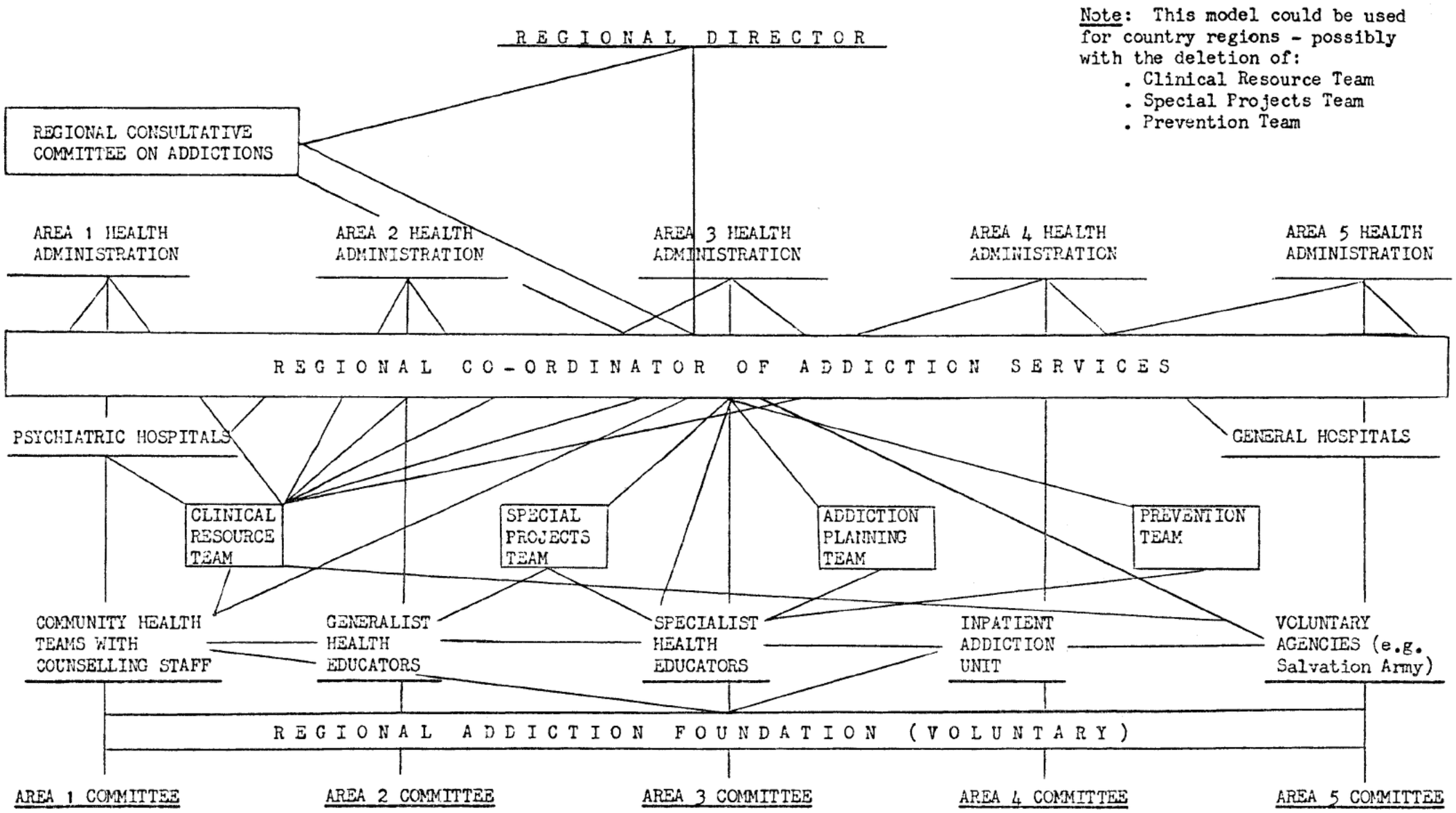
BUREAU OF ENVIRONMENTAL AND SPECIAL HEALTH SERVICES



Appendix R


REGIONAL DIRECTOR OF HEALTH
Deputy or Assistant Regional Director (Medical)
Planning Officer
Public Relations Officer
Deputy or Assistant Regional Director (non-medical)
Senior Medical Officer
Regional Nursing Officer
Regional Health Inspector
Regional Food Inspector
Community Physicians
Regional Geriatrician
Regional Paediatrician
Regional Adviser, Mental Health
Principal Dental Officer
Senior Medical Officer, Health Centres
Regional Dietitians
Medical Records Librarian
Health Education Officer
Senior Clerk
Clerks (Accounts & Salaries)
Typists, etc.
Service Officer
Transport Officer
Senior Administrative Officer
Staff Development Officer
Personnel Officer
Senior Inspector
Building Supervisor
Clerks - Buildings & Equipment
Staff (Establishment) Officer
Regional Catering Officer

PROPOSED ORGANISATIONAL MODEL FOR ADDICTION SERVICES IN A METROPOLITAN HEALTH REGION




Note: This model could be used for country regions - possibly with the deletion of:

- Clinical Resource Team
- Special Projects Team
- Prevention Team

Appendix T

HEALTH COMMISSION STAFF AVAILABLE FOR AND ENGAGED IN DRUG EDUCATION, COUNSELLING AND TREATMENT PROGRAMMES IN NEW SOUTH WALES

| | Health Education Staff | | | Drug and Alcohol Counselling and Treatment Staff | | | Total |
|---|---|---|---|---|---|---|---|
| | Full-time | Part-time | Not filled | Narcotic Dependency Programme | Training Officer | Planning Officer | |
| CENTRAL STAFF: | | | | | | | |
| 1. Central Drug and Alcohol Advisory Service .. .. | 4 | .. | .. | 4 | 1 | 1 | 10 |
| 2. Division of Health Education .. .. | 1 | 1 | 2 | .. | .. | .. | 4 |
| Total .. .. .. | .. | .. | .. | .. | .. | .. | 14 |

Appendix U

STAFF AVAILABLE FOR AND ENGAGED IN DRUG EDUCATION, COUNSELLING AND TREATMENT PROGRAMMES IN N.S.W.

| | Health Education Officers | | Drug and Alcohol Counselling and Treatment Staff | | | Total |
|---|---|---|---|---|---|---|
| | Specialist | Generalist | Full-time | Part-time | Not filled | |
| REGIONAL STAFF | | | | | | |
| I INNER METROPOLITAN | | | | | | |
| 1. Bellevue Street .. .. | .. | .. | 3 | .. | .. | 3 |
| 2. Bourke Street<br>3. Brisbane Street .. .. | .. | .. | 14 | .. | .. | 14 |
| 4. Burwood .. .. .. | .. | .. | 1 | .. | .. | 1 |
| 5. Campsie .. .. .. | .. | 1 | .. | .. | .. | 1 |
| 6. Glebe .. .. .. .. | .. | 1 | 1 | .. | .. | 2 |
| 7. Kalparin .. .. .. | .. | .. | 1 | .. | .. | 1 |
| 8. Marrickville .. .. .. | .. | 1 | 1 | .. | .. | 2 |
| 9. Rozelle.. .. .. .. | .. | 1 | .. | .. | .. | 1 |
| Total .. .. .. | .. | .. | .. | .. | .. | 25 |
| II SOUTHERN METROPOLITAN .. | | | | | | |
| 1. Advisory Service .. .. | 2 | .. | 3 | .. | 1 | 6 |
| 2. Bondi Junction .. .. | .. | 1 | 4 | .. | .. | 5 |
| 3. Boronia .. .. .. | .. | .. | 1 | .. | .. | 1 |
| 4. Botany .. .. .. | .. | .. | 1 | .. | .. | 1 |
| 5. Caringbah .. .. .. | .. | .. | 3 | .. | .. | 3 |
| 6. Cronulla .. .. .. | .. | .. | 1 | .. | .. | 1 |
| 7. Hurstville .. .. .. | .. | 1 | 2 | 1 | .. | 4 |
| 8. Lakemba .. .. .. | .. | 1 | .. | .. | .. | 1 |
| 9. Maroubra .. .. .. | .. | 1 | 2 | .. | .. | 3 |
| 10. Miranda .. .. .. | .. | 1 | .. | .. | .. | 1 |
| 11. Redfern House .. .. | .. | 1 | 1 | .. | 1 | 3 |
| 12. Rockdale .. .. .. | .. | 1 | 1 | .. | .. | 2 |
| 13. Sutherland .. .. .. | .. | 1 | 2 | .. | .. | 3 |
| Total .. .. .. | .. | .. | .. | .. | .. | 34 |

STAFF AVAILABLE FOR AND ENGAGED IN DRUG EDUCATION, COUNSELLING AND TREATMENT PROGRAMMES IN N.S.W.—*continued*

| | Health Education Officers | | Drug and Alcohol Counselling and Treatment Staff | | | Total |
|---|---|---|---|---|---|---|
| | Specialist | Generalist | Full-time | Part-time | Not filled | |
| III NORTHERN METROPOLITAN | | | | | | |
| 1. Chatswood | .. | 1 | 5 | 1 | .. | 7 |
| 2. Dee Why | .. | .. | 4 | .. | .. | 4 |
| 3. Gosford | .. | 2 | 1 | .. | .. | 3 |
| 4. Manly | .. | .. | 3 | 2 | .. | 5 |
| 5. Prevention Team | .. | .. | 7 | .. | .. | 7 |
| Total | .. | .. | .. | .. | .. | 26 |
| IV WESTERN METROPOLITAN | | | | | | |
| 1. Bankstown | .. | 1 | 3 | .. | .. | 4 |
| 2. Blacktown | .. | .. | 1 | .. | 1 | 2 |
| 3. Campbelltown | .. | 1 | .. | .. | 1 | 2 |
| 4. Fairfield | .. | 2 | .. | .. | 1 | 3 |
| 5. Granville | .. | 3 | 2 | .. | .. | 5 |
| 6. Katoomba | .. | 1 | .. | .. | .. | 1 |
| 7. Liverpool | .. | 3 | 1 | .. | .. | 4 |
| 8. Mt Druitt | .. | 1 | 1 | .. | .. | 2 |
| 9. Parramatta | .. | 3 | .. | .. | .. | 3 |
| 10. Penrith | .. | 1 | 1 | .. | 1 | 3 |
| 11. St Mary's | .. | .. | 1 | .. | .. | 1 |
| 12. Westmead | 1 | .. | 9 | 1 | 1 | 12 |
| 13. Wistaria House | .. | .. | 11 | .. | .. | 11 |
| Total | .. | .. | .. | .. | .. | 53 |
| V NORTH COAST | | | | | | |
| 1. Grafton | .. | 1 | .. | .. | .. | 1 |
| 2. Lismore (Richmond Clinic) | .. | .. | 1 | 1 | .. | 2 |
| 3. Port Macquarie | .. | .. | 1 | .. | .. | 1 |
| Total | .. | .. | .. | .. | .. | 4 |
| VI NEW ENGLAND | | | | | | |
| 1. Armidale | .. | .. | 1 | .. | .. | 1 |
| 2. Inverell | .. | .. | 1 | .. | .. | 1 |
| 3. Moree | .. | .. | 1 | .. | .. | 1 |
| 4. Narabri | .. | .. | 1 | .. | .. | 1 |
| 5. Tamworth | 1 | .. | 2 | .. | .. | 3 |
| Total | .. | .. | .. | .. | .. | 7 |

STAFF AVAILABLE FOR AND ENGAGED IN DRUG EDUCATION, COUNSELLING AND TREATMENT PROGRAMMES IN N.S.W.—*continued*

| | Health Education Officers | | Drug and Alcohol Counselling and Treatment Staff | | | Total |
|---|---|---|---|---|---|---|
| | Specialist | Generalist | Full-time | Part-time | Not filled | |
| VII ORANA | | | | | | |
| 1. Dubbo | .. | .. | 2 | .. | .. | 2 |
| 2. Mudgee | .. | .. | 1 | .. | .. | 1 |
| Total | .. | .. | .. | .. | .. | 3 |
| VIII FAR WEST | | | | | | |
| 1. Broken Hill | .. | .. | 2 | .. | .. | 2 |
| Total | .. | .. | .. | .. | .. | 2 |
| IX MURRAY | | | | | | |
| 1. Albury | .. | 1 | 1 | 3 | .. | 5 |
| Total | .. | .. | .. | .. | .. | 5 |
| X RIVERINA | | | | | | |
| 1. Griffith | .. | .. | 2 | .. | .. | 2 |
| 2. Narandera | .. | .. | .. | .. | 1 | 1 |
| 3. Wagga Wagga | .. | 1 | 2 | .. | .. | 3 |
| Total | .. | .. | .. | .. | .. | 6 |
| XI CENTRAL WEST | | | | | | |
| 1. Orange | .. | 1 | .. | 5 | .. | 6 |
| Total | .. | .. | .. | .. | .. | 6 |
| XII SOUTH EAST | | | | | | |
| 1. Goulburn | .. | 2 | 2 | .. | .. | 4 |
| 2. Narooma | .. | .. | 1 | .. | .. | 1 |
| 3. Queanbeyan | .. | .. | 1 | .. | .. | 1 |
| Total | .. | .. | .. | .. | .. | 6 |
| XIII HUNTER | | | | | | |
| 1. Maitland | .. | 1 | .. | .. | .. | 1 |
| 2. Nelson Bay | .. | 1 | .. | .. | .. | 1 |
| 3. Newcastle | 1 | .. | 5 | .. | .. | 6 |
| 4. Windale | .. | 1 | .. | .. | .. | 1 |
| Total | .. | .. | .. | .. | .. | 9 |
| XIV ILLAWARRA | | | | | | |
| 1. Corrimal | .. | 1 | .. | .. | .. | 1 |
| 2. Port Kembla | 1 | .. | .. | .. | .. | 1 |
| 3. Warrawong | .. | 1 | .. | .. | .. | 1 |
| 4. Wollongong | .. | 2 | 6 | .. | .. | 8 |
| Total | .. | .. | .. | .. | .. | 11 |

Total Drug and Alcohol Staff 197

Appendix V

Dr Helen Nowlis, in the 1975 UNESCO publication *Drugs Demystified,* acknowledges four prevalent drug abuse models, each with varying assumptions and emphases. The four models are:

The traditional moral-legal.

The medical or public health.

The psycho-social.

The sociocultural.

In more detail these models are:

1. *The moral-legal model*

The traditional moral-legal approach has placed major importance on the drug. Drugs are classified as safe or dangerous, where safe means not designated as dangerous or not socially or legally prescribed. The primary goal comes to consist of keeping specific drugs away from people. Drugs are assumed to be the active agent, people to be the uninformed, unwilling or deviant victims who must be protected via legal controls on cultivation, processing, manufacture, distribution, sale, sharing or possession of the substance, even in some instances, on possession of the paraphernalia or instruments for using. The principal deterrents are considered to be control of availability of drugs, increase in cost of drugs, punishment or threat of punishment, and warnings of great physical, psychological and social harm. Great emphasis is placed on the dangerous effects of drugs in an effort to deter use, and educational programmes based on these assumptions often consist primarily of dissemination of information about the dangers of specific drugs causing concern and about their legal status and the penalties attached to sale, use and possession. Just as drugs are dichotomized as legal or illegal, individuals tend to be dichotomized as users and non-users with regard to the kind of drugs used or pattern of use. Although distinctions are sometimes made between "soft' drugs and "hard" drugs, both drugs and individuals tend to be dichotomized on the basis of legal and illegal, medical or non-medical.

2. *The disease or public-health model*

In the public-health model or approach, which has been increasingly considered as an alternative to the moral-legal model, drug, individual and context are translated into agent, host and context following the infectious disease model. Although differences between these two models may seem subtle, they have an important influence on the nature of recommended action. An agent is by definition active, and in this model the drug as agent assumes, as in the previous model, the major role in the triad.

The drugs causing concern are defined as dependence-producing rather than simply dangerous as in the moral-legal model, but the two models share a major emphasis on drug or substance as the active agent. A major difference between the two approaches is that the public health view does not distinguish between legal and illegal and, therefore, often includes alcohol, nicotine, and caffeine as dependence-producing, but distinguishes them from other dependence producing drugs on the basis of the contextual (social) variables of social acceptability and increase in cost of dependence-producing substances thus become a means for possible reduction in use as well as control of availability.

The individual or host is viewed as vulnerable or not vulnerable, as infected and infectious. Since the identification of vulnerable individuals is far from perfect, there are various attempts to "vaccinate" by measures including prevention-oriented educational programmes that tend to rely on information about the risks involved in initiating use of designated substances and the personal and social harm caused by becoming dependent on these substances.

Although those adherents to the public-health model who are most experienced in dealing with drug use and drug users recognize inadequacies and seem to be moving in the direction of a psycho-social model, this model still represents their basic concept of the nature and relative importance of drug, of individual, and of context, and it determines to a major extent the manner in which they respond to problems associated with drug use. Drug users are to be treated and cured as a medical problem. Drug use is to be prevented as a public-health problem just as any infectious disease.

3. *The psycho-social model*

The psycho-social model tends to put major emphasis on the individual and the active agent in the drug-individual-context formulation. Drug use and drug user rather than pharmacological substances are the complex, dynamic factor and the major point for intervention. This model tends to be concerned with the meaning and function of drug use to the individual, with drug use as behaviour that, like other behaviour, would not persist unless it served some function for the individual. It tends to make distinctions among different amounts, frequencies, and patterns of drug use, the different functions that drug use may serve, the differential effects of different patterns of drug use in different individuals. It is concerned with context in terms of the influence of the perceived attitudes and behaviour of other persons individually or in social groups such as families, peer groups and communities. Context is seen as a contributor to both use and the problems associated with use via interpersonal definition of, and response to, drug use and drug users. Because of its emphasis on individuals and their behaviour, and on the role of social factors, this model often recommends non-drug-specific responses to drug use which turn out to be equally applicable to other destructive or deviant behaviours.

4. *The sociocultural model*

Those who view drug use and the problems associated with drug use from the sociocultural point of view tend to emphasize and recognize complexity and variation in the context factor of drug-individual context. Specific drugs gain their meaning and significance, not so much from their pharmacological properties, but from the way in which a given society defines and responds to their use and their users. Socially proscribed drug use is seen primarily as deviant behaviour to be viewed and treated along with other deviant or, if excessive, destructive behaviours. As in all deviant behaviours, harm may come to the individual either from the behaviour itself or from his society's response to that behaviour. This point of view recognizes that such behaviour will of necessity vary from culture to culture, from subculture to subculture. It goes behind the social and psychological factors emphasized in the psychosocial model to stress what is present in socio-economic and environmental conditions as the reasons for psychological stress and therefore, as the basic, if not essential, locus of intervention. Poverty, poor housing, discrimination, lack of opportunity, industrialization, urbanization are seen as the breeding ground of the more personal factors that the psycho-social model emphasizes—factors such as broken homes, lack of parental guidance, large, impersonal educational and work institutions and breakdown in social controls. This view also recognizes that, despite the tendency to see undesirable behaviour always as the result of undesirable aspects of the social system, much that it disapproved of is initially linked with things that are approved of and valued. Conformity, competition, achievement, productivity may be two-edged swords.

Appendix W

## POISONS ACT, 1966

### Some Observations on its Present Construction and Proposed Modifications

1. *General Construction of the Act*

1.1 Legislation leading to the Poisons Act, 1966, followed two quite distinct paths. A line of development from the original Sale and Use of Poisons Act, 1876, can be shown for Part III of the present Act, which deals with poisons and restricted substances. In fact, sections 11 to 15, which deal in some detail with the conditions of sale of Schedule One poisons, follow almost word for word the corresponding provisions of the 1876 Act.

1.2 Much of Part IV of the Act, which deals with drugs of addiction and prohibited drugs, is derived from the Police Offences Amendment (Drugs) Act, 1927. Prior to that time, what little control there was over the sale and use of opium and its preparations was contained in the Poisons Act, and it was not until the late 1930's that synthetic substitutes for opium, such as pethidine and methadone, started to make their appearance.

1.3 The wheel turned full circle by 1966, when the control of opium, its derivatives and its synthetic substitutes was once more a function of the Poisons Act.

1.4 At this time, the use of other classes of drugs was becoming identified as a social problem. Hallucinogens, of which lysergide (LSD) was the most common example, were becoming more readily available and a cult was developing around their use. Cannabis had been known in other countries for centuries, but was beginning to be smuggled into and used in this country. There had been sporadic interest in cocaine, but this was overshadowed by interest in and use of other drugs.

1.5 The Poisons Act, 1966, was a marriage of two previously unrelated Acts, the Poisons Act, 1952–1961, and the Police Offences (Amendment) Act, 1908–54. Some new provisions were enacted in 1966, notably control over the supply (as distinct from sale) of poisons and restricted substances, control over the possession of certain prescribed restricted substances, and provision for the issue of authorities to doctors prescribing drugs of addiction under certain circumstances.

1.6 This marriage of two different Acts has produced an Act which lacks internal consistency. Drugs of addiction and prohibited drugs are dealt with in quite different terms from poisons and restricted substances. The availability of new drugs with novel properties and changing community attitudes to the use of drugs and the conditions under which they may be used are factors which have led to the application of provisions of the existing Act in ways that were probably not originally envisaged. The way in which the Act specifies in considerable detail the conditions of sale of Schedule One poisons, while being almost silent on the conditions of sale of Schedule Seven poisons for example, also shows some lack of consistency.

1.7 While some reorganization of the Act and the Poisons List is highly desirable, it is difficult to find an arrangement which is clearly better than any other approach. Some countries, such as U.S.A. and Britain, have three separate Acts, a Controlled Substances Act which deals with the distribution, possession and use of drugs of dependence, a Medicines Act which deals with the evaluation of medicines, prescribing of standards for medicines, and restriction of medicines to sale by pharmacists only or sale on prescription only, and a Hazardous Substances Act which deals with the packaging, labelling and sale of non-medicinal poisons and hazardous substances. We already have a Therapeutic Goods and Cosmetics Act which deals with many of the matters covered by the British Medicines Act and the U.S. Food, Drug and Cosmetics Act. There is no need to modify the Therapeutic Goods and Cosmetics Act, provided account is taken in the Poisons Act of those matters not covered by it, particularly restriction of the sale of certain medicines to sale by pharmacist only or sale on prescription only.

1.8 It is suggested that the Poisons Act be divided into seven parts (instead of five as at present, disregarding amendments to the Crimes Act and the Motor Traffic Act), as follows:

Part 1—Preliminary.
Part 2—Poisons Advisory Committee and Poisons List.
Part 3—Poisons.
Part 4—Restricted Substances.
Part 5—Drugs of Addiction.
Part 6—Specified Drugs.
Part 7—General.

1.9 Part 1 would be similar to part 1 of the present Act.

1.10 Part 2 would also be similar to part 2 of the present Act, with one significant change to the Poisons List. An additional Schedule, Schedule Nine, would comprise Specified Drugs which would be drugs of dependence available on special authority only. Drugs in this category would include amphetamines, hallucinogens and Cannabis.

1.11 Part 3 would deal only with poisons, and would comprise relevant clauses from sections 9, 10, 17 and 19. Sections 11 to 15 contain far too much detail about the conditions of sale of Schedule One poisons, and would be replaced by a subsection requiring regulations to be made on the form of record of sales of Schedule One poisons to be maintained.

1.12 Part 4 would deal with restricted substances, and would comprise relevant clauses from sections 9, 16, 17 and 19.

1.13 Part 5 would deal with drugs of addiction. The Act should be more specific regarding licences to manufacture and distribute drugs of addiction, and provisions relating to supply of drugs of addiction should be constructed more along the lines of the provisions relating to supply of restricted substances. Section 21 (1), which deals with prepared opium and Indian hemp, should be omitted from this Part altogether.

1.14 Part 6 would deal with specified drugs, which would be a new class of drugs of which the manufacture, supply or possession without written authority would be prohibited. There could be a section specifying the kinds of circumstances in which authorities could be issued. It is envisaged that drugs to which this Part would apply should include amphetamines, hallucinogens and Cannabis.

1.15 Part 7 would include those provisions in Part 5 of the current Act, together with all penalty provisions.

2. *Schedule Three*

2.1 The National Health and Medical Research Council has for some time been considering a proposal for amending Schedule Three of the Uniform Poisons Schedules, including in that Schedule only the more potent substances at present in Schedule Three and transferring from Schedule Four to Schedule Three a number of substances at present restricted to supply on prescription only. It is envisaged that Schedule Three would become a list of substances that would not be advertised to the general public, but could be supplied by a pharmacist (without any delegation to assistants acting under his control or supervision) without prescription provided:

2.1.1 the pharmacist is satisfied that the substance is appropriate for treatment of the person for whom it is being obtained; and

2.1.2 a record of details such as the name and quantity of the substance and the name and address of the purchaser is made.

3. *Poisons Licences*

3.1 Section 10 of the present Act provides for the issue of a licence to sell Schedule One, Two or Three poisons to persons who keep open shop for the sale of goods more than 6.5 km from the nearest pharmacy. This provision has remained unchanged over the past 100 years, and was originally intended to provide for the sale of poisons in areas not served by a pharmacy. With improved methods of transport and communication, the distance of 6.5 km (originally 4 miles) is outmoded and should be extended to at least 20 km.

4. *Exemptions for Substances for Pesticide or Photographic Use*

4.1 Section 19 (4) of the present Act exempts substances prepared for pesticide or photographic use from the restrictions on supply of Schedules One, Two and Three poisons. The remaining conditions, mainly packaging and labelling, are those applied to Schedule Six poisons. However, current practice is to specify pesticides and photographic chemicals that are hazardous or poisonous in Schedule Five or Six, and the general exemption has become redundant. There are a few Schedule One poisons, such as cyanide, which should not be exempted from Schedule One requirements even when prepared for pesticide use, and these substances are in fact prescribed as provided for in section 19 (4) of the Act. Nevertheless it would simplify the Act and Regulations if section 19 (4) were to be omitted.

5. *Dispensing Interstate Prescriptions*

5.1 Section 19 (1) (a) authorizes pharmacists to supply restricted substances on prescriptions of medical, dental and veterinary practitioners. Most prescriptions are written by medical practitioners, and all prescriptions for Pharmaceutical Benefits under the National Health Act are written by medical practitioners.

5.2 The term "medical practitioner" is not defined in the Poisons Act, but the Medical Practitioners Act states that any reference to "medical practitioner" in that or any other Act means, unless otherwise specified, a person registered as a medical practitioner under that Act. This means that a prescription for a restricted substance written by a doctor in another State cannot be dispensed by a pharmacist in New South Wales unless the doctor is registered in New South Wales as well as in the State in which he practices. This can be at the very least inconvenient to patients travelling interstate, but they may be required to make an otherwise unnecessary visit to a strange doctor to obtain a valid prescription.

5.3 This could be overcome by including in section 19 (1) of the Act a clause to the effect that "medical practitioner" for the purpose of that subsection includes a person registered as a medical practitioner in any other Australian State or Territory.

6. *Forfeiture of Appliances*

6.1 Section 26 (1) provides for forfeiture of articles in respect of which an offence involving a drug of addiction was committed. However, no similar provision is made in respect of articles associated with an offence involving a prescribed restricted substance or prohibited drug. Such articles can include containers, pipes, syringes, raw materials and apparatus used for the illicit manufacture of drugs and so on. It would be highly desirable to extend provisions regarding forfeiture to articles associated with offences involving prescribed restricted substances and prohibited drugs (and specified drugs if such a class of drugs is included in the Act).

7. *Penalties for Trafficking Offences*

7.1 The National Standing Control Committee on Drugs of Dependence (N.S.C.C.) has recommended increased penalties for drug trafficking offences. The maximum penalties proposed are imprisonment for 25 years and/or a fine of $100,000 for trafficking offences involving drugs of addiction or prohibited drugs. At the same time, the N.S.C.C. has reviewed the quantities of drugs prescribed as "traffickable quantities", possession of which is presumed to be possession for the purpose of supply unless the contrary is proved. The new quantities recommended are about four times greater than the present "traffickable quantities".

7.2 While the proposed maximum penalty has been compared with penalties for murder and rape, drug trafficking can have equally devastating results. The proposed increase in maximum penalties for certain drug trafficking offences should be considered in this light.

8. *Cultivation of Drug Plants*

8.1 The only drug plant dealt with specifically in the Poisons Act at present is Cannabis. Reliance is placed on the declaration of other drug plants as noxious weeds under the Local Government Act to control their cultivation.

8.2 A new section should be included in the Poisons Act to deal with the cultivation of drug plants. The cultivation, harvesting, possession or processing of opium poppies, coca bushes or Cannabis plants should be prohibited without a special authority.

4152. CHAIRMAN: In evidence before this committee reference was made several times to restrictions imposed by the Public Service Board. Members of the committee would like this aspect clarified. Is it correct that the establishment, conduct and management of the Health Commission services in this State are functions of the Crown, regulated substantially by statutes and assigned to the administration of a Minister responsible to the Parliament?——W. Yes.

4153. Is it correct that as the Health Commission, subject to the direction of the Minister and the statutes of the general law, has the care, direction, control and management of health services, it is for the government of the day through the Minister to determine and direct policy and practice within those services?——W. I should have to qualify that answer by saying yes, subject to the oversight of the Commission by the Public Service Board and the Treasury.

4154. In what way would the Public Service Board oversee the Commission?——W. The Minister may wish us to do something or may direct us to do something and we may not have the staff to do it because the Public Service Board has placed a ceiling on the staff of public servants of the Health Commission.

4155. Does the authority and power carry with it a corresponding responsibility of good management?——W. Yes, of the Commission it does.

4156. Does section 52 of the Public Service Act state unequivocally that the direction and control of officers and the work in a department are matters for the Minister and the permanent head, subject to the overriding control already mentioned?——W. The short answer is yes, but I think that again must be qualified by saying that the Minister and the Commission may believe that something is a matter of health and therefore lies within the decision of the Minister to direct the Commission.

The Public Service Board may take a legitimate view that the matter also concerns the activity of a public servant and therefore the Board would have an input into whatever decision was made.

4157. Presuming that that aspect has been clarified, does this mean that the Public Service Board has no executive authority whatever in regard to the matters I have been speaking about?——W. That is a difficult question to answer. I think in effect the Board has an executive authority in that it is responsible for the actions of public servants and if the Health Commission set out to perform a task on its own decision or at the direction of the Minister, if it involved the activities of a public servant the Public Service Board would feel that it had an input into that action.

4158. But the board does not normally control the actions of public servants simply as public servants, does it?——W. It is difficult to answer that question directly yes or no.

4159. If it is not a matter of conduct or discipline or anything of that nature but only a matter of the provision of health services as such?——W. Yes, I think that is true, but the Public Service Board has a charter for efficiency and economy of public servant operations. Therefore, when efficiency and economy are concerned the Board may consider—rightly, I suppose—that it has a charter to consult with the Health Commission about the decisions that the Commission has taken. A recent example was the question of the use or overuse of motor cars within the Health Commission. The Public Service Board felt that the use of motor cars was not sufficiently well controlled and a joint operation was mounted by the Board and Commission to inquire into this matter and see whether the criticism was valid or not.

4160. What was the result?——W. The result was that the criticism was valid and the Health Commission's fleet of motor cars was reduced by 405. This was a joint decision by the Commission and the Board. In my view it was a little harsh and I believe that it is now the Commission's task to go back to the Board and say, "You made this decision on the basis of economy but you have intruded into efficiency. We now wish to argue with you that some of those cars were taken away without good reason and we want to advance individual cases to you which indicate a need to return the cars so that the effectiveness of the staff can be improved."

4161. Did the Board tell you where the 405 cars were to be removed from?——W. No. The cars were identified by two persons, one from the Health Commission and one from the Public Service Board.

4162. Did the Public Service Board decide that the Commission's cars should be marked?——W. No, that was a Health Commission decision.

4163. Does the Public Service Board determine the hours of work of Commission employees?——W. Yes, of public servants.

4164. In the broad frame?——W. Yes, in the broad frame, but the Board leaves it to the department concerned to decide whether the hours should be worked on flexitime or not. The hours of work are covered by an award and the Public Service Board is involved in the negotiations leading to that award.

4165. In other words, the Public Service Board does not say to the Commission, "All the employees in one section of your Commission must work between 9 a.m. and 5 p.m. on five days a week".——W. No. The Board would say that the award provides the number of hours to be worked each week and it may say that they shall be worked between certain hours.

4166. Apparently one of the results of the recent investigation was that a lot of the Commission's vehicles which were not previously compounded at night are now compounded?——W. That is correct.

4167. Was that a Public Service Board decision or a Health Commission decision?——W. It was really a joint decision between the person who at that time was the Secretary of the Commission, Mr Eagleton, and the Public Service Board inspector who worked on the matter of whether the Commission was oversupplied with motor cars.

4168. Is it correct that the Public Service Board delegates to all departments many aspects of their general organization?——W. Yes.

4169. I think it covers something like twenty different classifications?——W. Yes.

4170. The matter of hours of duty would be one?——W. Yes, in the broad. I think you may be referring to the fact that some of our drug services operate only from 9 to 5. If we wanted them to operate until 10 in the evening or perhaps at weekends we could negotiate with the Public Service Board to obtain that result if the award allowed.

4171. Why would you have to do that if the hours of the person concerned were staggered in such a way that he or she would be working only the normal number of hours per week?——W. We would have to consult the individual award to discover whether it allowed us to ask the person concerned to work different hours in the evening or at weekends. Traditionally this has been a matter that we have usually referred to the Board before taking a decision.

4172. Does your delegation of power include the working of overtime? Do you not have the power to decide that employees may work overtime?——W. Yes, overtime. I was taking your question a different way. I was assuming it meant that we might ask someone to work from 4 in the afternoon until midnight, rather than overtime. Yes, the working of overtime lies within the authority of the Health Commission.

4173. What would be entailed for you to try to cover these critical hours, say, between 4 p.m. and midnight, in an area where at present they finish at 5 p.m.?——W. I think the overwhelming problem is not the relationship between the Board and the Commission or the rules that apply from whatever source on the Commission, but the availability of staff. I mean, our ability to employ people under the ceiling imposed upon us by the Public Service Board.

4174. In addition to the normal delegations, which are common to all departments, is it correct that most departments have been granted specific delegations in relation to matters peculiar to their particular functions and activities?——W. Yes.

4175. That would apply particularly to the Health Commission?——W. Yes.

4176. Is it true that the board has no general policy of discrimination against ex-addicts, as implied in evidence by one senior member of the commission?——W. For employment purposes?

4177. Yes.——W. Yes, I think that, for employment purposes, we refer the papers of potential employees to the Board if there is a doubt. I am not aware of the Board's attitude towards ex-addicts. I would have thought the question would be resolved on a general matter of health and suitability. Certainly within the Commission there would be no restriction or there would be no attitude towards non-employment of ex-addicts. As you know, we employ many such people.

4178. In other words, the person who gave us that evidence, although senior, really was not quite *au fait* with commission policy if he gave that evidence.——W. I simply put this: I do not believe the Commission has any wish not to employ ex-addicts. I think we would employ ex-addicts if they were in good health; that is, had a period of freedom from being addicted to drugs, and otherwise were in good health. I know of no directive from the Board that we should not employ such people. The Board has other rules about previous criminality and so forth, which may apply in some cases.

4179. Does the commission take advantage of specialized accommodation divisions within the Public Service Board to assist in acquiring suitable accommodation for its activities?——W. Yes, we are bound to do that.

4180. What is the policy concerning the need for provision of referral centres and halfway houses?——W. When we wish to rent premises for occupation by public servants, we have to have this space agreed by the Public Service Board, and their view is that they want to see that the rent is paid and the accommodation provided is of reasonable standard.

4181. What would be the policy of the commission in regard to such accommodation for the employees and staff where it means that the hours of duty would have to be varied in the way we indicated earlier—or rostering staff to be on call to meet crisis situations?——W. Our view is that this is one of the areas in which we do not perform well, in that the person who is addicted to drugs usually needs help out of ordinary business hours. Apart from certain minor exceptions, we do not supply such a service. We would wish to do so, but it is difficult to do it, chiefly I think because of the numbers of staff we are allowed to employ, rather than for other reasons.

4182. Do you feel that some people requiring treatment might be embarrassed by having marked cars appearing at their place, when it would be better if they were unmarked cars?——W. Yes, I am sure that would be so. But there is a provision in the rules applying to the labelling of cars, so that some cars are not marked.

If a situation arises in which it would be better to use an unmarked car—say, in the case of venereal disease, drug addiction or anything else—an unmarked car is used. That is the instruction, but I would not guarantee that it always applies.

4183. Would you see some value in making available a vehicle for officers on night work, as distinct from the wholesale release of cars?——W. Yes, I think we should now go back to the board—indeed, we are doing this—and ask that, having tightened up the whole area, we should now examine specific cases where the circumstances suggest that the staff could be used more effectively if they had a vehicle.

4184. On more than one occasion we have been told of the difficulties relating to obtaining equipment and services for the provision of drug services. What is your opinion in regard to this? Should there be any difficulties associated with obtaining equipment?——W. There should not be. Of course, we are limited by our budget, but our budget is not unreasonably low for the provisions of equipment. Consistent with the times we find ourselves in, I think our major inhibiting factor is the availability of staff, because of staff ceiling.

4185. Do you have a separate budget for the drug addiction service, or is it lumped together as alcohol and drugs?——W. No, it is divided in other ways—into staff, equipment, buildings and so forth, under different headings. But usually we talk about alcohol and drugs as one unit.

4186. Therefore, neither you nor any member of your staff would be able to tell us what particular amounts have been spent in regard to drug addiction services in the past three or four years?——W. No, but may I first confirm that with Mr Dash and Mr Diehm? (*Mr Diehm*) No, there is no division.

4187. I am not pressing you on that; I just wanted to find out whether any differentiation is made. The green book, the consultative document, which was published in April this year referred to regionalization, management and structure of the Health Commission. That document is well known and has been circulated. Is it correct to say that virtually no reference is made in it to the problems of providing drug services?——W. That may be true, but that consultative document should be seen for what it is. It is a report of a working party that was formed partly from Commission initiatives and partly by direction from the Premier. The Commission wished to examine itself, to see whether it was operating efficiently and achieving the objects the government had set for it. Second, the Premier required an examination of regionalization, to see whether or not it was successful. By permission of the Premier, the two matters were merged, and the task force took evidence from a great number of people in order to find the answers to those questions.

The consultative document is part of their report; their total report was taken and some matters were removed from it; they were of little account. The rest was supplied as a consultative report, for examination by the public and interested people. It does not have the blessing of the Minister or the Government, and after the public have offered their reactions to that document—which were due on 31st August—they will be collated, and the Commission will then put to the Minister the various matters in that consultative document. If drugs and alcohol did get too small a mention, you would be aware I think of activities within the commission in the past two or three months, in which there has been greater emphasis on the resources of the drug and alcohol service.

4188. On page 12 the consultative document refers to the provision of services including drug addiction treatment. It says that these services have been taken up by the various parts by the public hospital system. Do you feel that there should be some drug addiction treatment and service at most public hospitals?——W. Yes.

4189. At page 13 the document says that preventative and therapeutic community health services of this kind had been falling behind the growth rate of the State, but that with the infusion of Commonwealth funds, most of these problems had been overcome. Can you explain how this has affected the provision of drug treatment services in this State?——W. Yes. There is a list of our staff, which we can provide for the Committee; that is, the staff involved in drug and alcohol services, centrally and within the regions. In addition to that, there is another list of the perhaps more desirable staffing that we would like to achieve.

4190. The first matter to which you have referred appears in appendix 2, which we have?——W. Yes.

4191. One point of clarification. Apparently there are four full-time members of the central health education staff, and one full-time member and one part-time member of the division of health education staff. Who are they?——W. (*Mr Diehm*) Dr Webb, who is a psychiatrist, and Mr Chapman, who is a senior health education officer. The third position is for a health education officer, but that is vacant following a resignation. The fourth position is that of a stenographer. In the Division of Health Education, the full-time position is that of a research officer and the part-time employee is a librarian.

4192. There are four full-time members of the drug and alcohol counselling treatment staff, narcotic dependency programme. Who are they?——W. With the advisory service we have Dr Waddy, who is the clinical supervisor, Mr Lambert, a programme co-ordinator, Mr Magro, a planning officer, and Dr Egger has succeeded Mr McCulloch.

4193. There appears to be one specialist health education officer at Westmead. What is the difference between that officer and an ordinary health education officer?——W. The specialist health officer is concerned exclusively with drug addiction. The other health education officers have a drug education function, but it is only one part of their responsibility.

4194. How many people live in the western metropolitan area?——W. (*Dr McEwin*) 1.1 million to 1.2 million.

4195. You have only one specialist drug education officer for the whole of that area?——W. Yes.

4196. Are you aware of the manner in which the drug authorities in South Australia and Western Australia work under special Acts of Parliament?——W. Yes. I do not have a deep knowledge of it.

4197. Do you see any virtue in setting up in New South Wales a separate authority to cater exclusively for drugs and alcohol?——W. I think this might be done partly by the Drug Authority, which the Government recently formed, but that is not a complete answer.

4198. Perhaps my question is not fair because it could be a matter of policy. Do you see it that way?——W. I would not like to see a separate body. My personal opinion is that all health matters are better retained in the one unit. The Health Commission was formed so that there would not be a duplication, an overlapping, or a lack of services. With drug and alcohol services it may well be that there should be much more effort in some ways, but that is not an answer to your question because you are asking me whether the problem should be dealt with by legislation.

4199. You have answered my question. You have said that you would prefer to see all these services within the one organization. Is that so?——W. Yes.

4200. Is that commission policy or your personal opinion?——W. I think I can be certain in saying it is commission policy. In the consultative document that led to the formation of the Health Commission following the two committees of inquiry in the late 1960s and early 1970s the central theme was the merging of three or four departments concerned with health matters.

May I go back to staffing, which raises an important point? It has been suggested that not enough staff are involved in drug services within the commission. That criticism is made frequently. The ceiling for public servants in the Health Commission is 13 857. Our establishment is 14 564, so the ceiling is 707 below our establishment. We find it difficult to operate beneath the ceiling. We are not aware of restrictions imposed on other departments but I understand—I do not know—that the Health Commission absorbed about 36 per cent of all cuts when the ceilings were imposed. Therefore we are in a difficult situation knowing that drugs, for instance, need extra staff, as do baby health centres, and as do psychiatric hospitals, which have been criticized by the Letts committee, and as do other services. We recognize that in some areas we are not doing enough, but we must balance that fact against the fact of the staff ceiling.

4201. The staff ceiling is imposed by the Public Service Board, is it?——W. Yes, and that is the greatest restriction on our capacity to give service in the drug field and in other fields.

4202. I take it you have made approaches to have the ceiling lifted?——W. Yes.

4203. Unsuccessfully?——W. So far.

4204. Do you foresee the Health Commission acting in co-operation with the recently formed Drug Authority of New South Wales in order to provide the necessary services to people who are dependent on drugs?——W. Yes, very much so.

4205. Is it proposed that there should be some amendment to the structure of the Health Commission in order to incorporate those special services?——W. Yes. A proposal, which has the agreement of the Commission and the Minister, is to form a division of drug and alcohol services within the commission.

4206. Which will be under the control of somebody responsible direct to the commission, or to the Minister? ——W. To the Commission. That, I hope, would be a senior psychiatrist with experience in the field, and it would have an overriding authority to advise the Commission and the Minister.

4207. That person would not be a member of the authority?——W. No, he would not be a member of the Drug Authority, but he will be an employee of the Commission.

4208. Do you see any possibility of conflict between the Drug Authority and that person?——W. There is a possibility, but it is remote. One person who would be very suitable for the post of director of drug and alcohol services is in North America. If we are successful in obtaining him for the post, his personality is such that I think you could say there would be no difficulty between him and the Authority. Certainly there is a great spirit of co-operation between those on the Drug Authority and the Health Commission. I do not forsee any difficulty.

4209. Do you think it would be possible for such conflict to occur in the future?——W. I suppose it is possible, but that possibility, I think, has been covered in the Authority's charter, which is different from the Commission's charter. The Drug Authority is likely to work more with voluntary agencies, and in the field of funding voluntary agencies and research, leaving treatment to the Health Commission. As the charters are different, even if difficult persons were involved, which I do not think will be the case, there should not by any conflict.

4210. On page 39 of the consultative document, the task force points out that it was always the intention of community health programmes to have a high degree of involvement by voluntary agencies in special programmes but this intention does not appear to have been fully realized in New South Wales. What plans has the commission for involving voluntary and private organizations in the provision of drug addiction services?——W. Whenever we look to a new activity in the Commission we think of voluntary agencies, including religious and other charitable groups, and ask ourselves whether they could do the job better than we could. Often the answer is, yes, because people will relate to a voluntary agency much more freely than to a government agency. That applies particularly in sensitive fields such as those concerned with drugs and alcohol. The Commission's philosophy would be to co-operate to the maximum extent and to seek the maximum achievement of its programme through voluntary agencies —which have other advantages also, in that they can work 24 hours a day, seven days a week, something that we find it difficult to do.

4211. Would you do that by giving financial assistance? ——W. Yes. This will change a little with the establishment of the Drug Authority because it will be funding voluntary agencies. We would wish to co-operate in treatment to the maximum extent possible.

4212. The task force recommended the creation of district boards. I know that this proposal has been given much consideration. One of the suggestions was that a board would be appointed to control Westmead hospital, Parramatta psychiatric hospital, Marsden and Parramatta hospitals and all associated health services. How would that affect Wisteria House and Jacaranda House?——W. I do not think that will be achieved, but if it were, all of those services would come under the control of that district board.

4213. What about the other drug addiction service in the western metropolitan area, which extends from Bankstown to Mt Druitt and Katoomba to Granville?——W.

The idea of an area board is that if you have a hospital at Mt Druitt and community services operating from, say, the Mt Druitt polyclinic, all of these services would come under the area board. The idea is that you get better co-ordination between community services and hospital services. The reaction to the proposal concerning area boards has not been popular. I think the scheme would be achieved only to a minor degree, and only where hospital boards wished to be involved in the running of community services. A good example is Hornsby, which is very much involved in the running of community services.

4214. You say in your submission that there is close co-operation between law enforcement officers and your department. Does that mean you have regular conferences on drug problems?——W. Yes. An interdepartmental committee on this matter has operated for some time but perhaps Mr Diehm could answer this better than I. (*Mr Diehm*): There is an interdepartmental drug and alcohol advisory and liaison committee on which the Commission, Police Department and a number of other departments are represented. In addition there are project committees on which the same Commission representatives and the same police representative meet in common with the Board of Magistrates and representatives of the police Prosecuting Branch. The contact happens regularly in four quite different committees.

4215. The submission by Mr Liddy referred to dramatic increases in the number of deaths in New South Wales and the Australian Capital Territory, especially since the middle of 1975. The figures supplied by the Police Department show that they rose dramatically for opiate narcotics and cannabis offences early in 1974. It seems strange that if there is so much co-operation with the police that either he should not be aware of it or you would not be aware of the way in which these offences were increasing?——W. (*Dr McEwin*): I think we would have been aware of that. The matter of recording deaths due to the use of heroin particularly is not easy and I am not sure that we can make statements with great validity. We do say that the increase has been of the order of 200 per cent.

4216. We have been told that between 1973 and 1976 the apprehensions for offences involving opiate narcotics and cannabis have multiplied four times?——W. Yes, and there might be other deaths from other illnesses which are not written up as due to heroin but due to hepatitis and other secondary manifestations. We could not say our figures are valid. From the Coroner's figures and the police figures there is no doubt that the problem has multiplied quite considerably.

4217. What action has the Health Commission taken to adapt itself to these obviously changing circumstances? ——W. We are aware from experience in America that if we follow North America, as we seem to do, the worst of the drug problem has yet to come. The Commission has therefore formed the Division of Drug and Alcohol Services and the Government has formed the Drug Authority. We are seeking extra staff. We have formed views as to where we should have our input and that is in prevention rather than treatment.

(*Mr Diehm*): To pick up your preceding question, we did have information from the police relating to convictions and for our purposes we have been concerned to discriminate between cannabis and opiate convictions because there is little the Health Commission can do for cannabis users. In relation to narcotics we have been following the trend in convictions and the presentations to treatment centres as closely as possible since 1973. The trend is increasing. In relation to services to meet those trends, the major developments have been through community health centres and the number of centres and locations at which we have specialist counsellors has been extended considerably over the past eighteen months. I would not suggest that the services we are offering are adequate for the needs or are even in the locations where the needs are greatest. In addition to a re-distribution of our staff on the basis of those trends we have become involved with a diversionary programme for convicted offenders. We keep a close watch on the changing characteristics of clients who present themselves. Because of the nature of the treatment service we need to provide we have been able also, during the past couple of years, to offer greater access to in-patient beds for the management of withdrawals. We have been able to overcome in substantial part our previously almost exclusive reliance on methadone for the treatment of addicts. We now have a number of alternatives to methadone. We are aware of the geographical spread of addiction. The fact that there are numbers of people using drugs in areas where we had previously not any reason to believe there was any significant drug use is known. That causes us some concern as we do not have specialist staff or services in those areas. We have discussed this with the Commission and there is a report suggesting the needs in terms of future development to keep pace. The development you have intimated is envisaged only in paper planning. We do not have the resources or the agreement on priorities for getting extra resources.

4218. Have you noticed any change in the type of drug abuse in recent years?——W. (*Dr Egger*) I do not think we have any real difficulties in suggesting what the changes are. From my own research I get the feeling that we have been suffering over the past two or three years a vast upsurge in the use of alcohol particularly among young children, and the use of harder drugs such as heroin. Researchers in the field believe that the softer drugs such as cannabis have stabilized in the past two or three years with the trend going more towards harder drugs and alcohol. In looking at this we have set out to re-do the alcohol and adolescent study, combined with a study on drug abuse in school children. The alcohol and adolescents study was in 1974 and the Bell and Rowe studies were in 1971 and 1973. We are now combining those. We have received permission from the Department of Education to repeat those studies combined into one, in October and November of this year. We hope to have some more specific data on that in the near future.

4219. Have you had any problems in the supply of therapeutic researchers in recent times?——W. (*Mr McEwin*) We have an overall problem in that we are severely short of staff over the whole range of services of the Health Commission. We are often criticized in various areas such as lack of good apparatus in psychiatric hospitals particularly for long-term patients, withdrawal of some community health services, lack of expansion of services, failure to accelerate sufficiently rapidly our services to non-English speaking people, for which there is a great demand, and other things. With the ceiling that has been imposed upon us we find it difficult to expand our services to the degree we believe necessary.

4220. Have any extra staff positions been allotted to the drug addiction service in the past three years?——W. The community health programme is between three and four years old and there has been a great increase in community health programmes. There are now 2 331 people employed in the community health services. In those services are many of the people who work in drug and addiction services. There has been an expansion in the past three years though not in the same order as the increase in the number of people needing help.

4221. In answer to an earlier question you said there was provision for in-patient withdrawal. Could you tell what extra provisions have been made?——W. (*Mr Diehm*) In the past couple of years there has been an opening of a unit at the Mosman community hospital. The Langton Clinic has been operating for a number of years and has recently increased the number of beds available. The McKinnon Unit which previously excluded the treatment of narcotic cases has agreed to take some withdrawal patients. Banks House has been opened at Bankstown hospital for in-patient withdrawals. At the psychiatric unit of Liverpool Hospital there is provision for in-patient withdrawals. I would mention also a matter that relates to beds for withdrawal patients. The number of persons who come to the clinics who are not physically addicted seems to be greater than we were aware of. Since we have been using Narcan in some of the centres it has been amazing to learn that so few people who come forward seeking treatment are now physically dependent. At Liverpool where Narcan was first introduced, out of the first 30 people applying for methadone only five were found to have a physical dependence.

4222. Unless it is shown that they are physically dependent on it the methadone programme is not adopted for those people?——W. Not unless there is a particular reason.

4223. The recent work of Ingrid Reynolds and co-workers has concluded that the programme for narcotic dependence has deteriorated from a closely monitored and effective one to a very second rate programme? What is your comment in regard to that statement?——W. The number of prescribers of methadone has increased considerably and the area over which they are located has increased considerably. With any treatment programme individual views creep in. I think that is quite reasonable. Rather than what you have said with regard to Mrs Reynolds' paper I would say that the whole methadone programme seems to be under some cloud as to whether it is effective or not. I think in any treatment programme for whatever disease you must recognize that there will be individual points of view between various therapists.

(*Mr Diehm*) For a number of reasons the methadone programme was rather seriously abused or misused because there were not any alternatives to the use of methadone on an out-patient basis. Methadone was used in cases where it was later discovered to be quite inappropriate. The supervision of the programme has always been difficult because of the spread of prescribers and the use of part-time prescribers who were not subject to any particular supervision. As regards the observance of the criteria laid down by the medical committee, there was no opportunity for supervision of the prescriber to ensure that those criteria had been met. This has changed significantly over the past eighteen months, since the Commission set up a consultative committee to supervise the narcotics dependency programme. During that period a number of alternative programmes have been introduced, so that we have got away in a large part from the problems of not having an alternative to methadone and using methadone when it was not altogether appropriate.

4224. Could you tell the committee the origin of the drug methadone?——W. (*Mr Dash*) I believe that it originated in Germany immediately prior to the last world war. I suspect that it was developed as alternative to morphine. At the time Germany was looking for alternatives for various things. Subsequently it came into use throughout the world as a narcotic analgesic, and its use was purely as a narcotic analgesic for quite a number of years. Methadone programmes in the sense that we are talking about them here—that is for addict maintenance—I think first developed in the United States of America. Their history goes back to some time shortly after the second world war. Use in Australia for this purpose goes back to about 1970. (*Dr Egger*) Methadone, like heroin was first synthesized as the non-addictive answer to morphine.

4225. I was surprised to hear somebody say—I think it was Dr McEwin—that there had been a big increase in the number of people prescribing methadone?——W. (*Dr McEwin*) Yes.

4226. Normally methadone can only be prescribed for an addict by somebody authorized by the commission?——W. That is correct.

4227. Do you feel that a lot of medical practitioners are prescribing methadone for non-addicts, or people who claim that they are non-addicts?——W. No. I should have been more specific. It has gone from ten in 1972 to thirty now. That is what I mean by a big increase, but they are all authorized under the Poisons Act, which is administered by the Health Commission.

4228. Do you have any suspicions that there are other doctors prescribing methadone when they should not be?——W. (*Mr Dash*) We have more than suspicions that there are other doctors who are prescribing methadone. Quite a deal of time of the officers of the Therapeutic Goods Branch is taken up in following up cases and stopping this wherever it is found to occur. The pattern is generally fairly characteristic: an increased usage of methadone is found in a particular area and when it is followed up it is found that one doctor is prescribing rather more liberally than previously he had. On interview he says that he was approached by a number of people who said that they were addicts and who for various reasons did not want to go to regular addict management programmes, and he was talked into giving prescriptions. As soon as he started doing this he found a number of other addicts descended on him, and very quickly he ceased the practice. Usually it has started and stopped by the time we have found it. There are exceptions to that general rule.

4229. I come back to the work done by Ingrid Reynolds and her co-workers. I have listed five of the conclusions that they arrived at before they came to their findings. I should like your comments on each of them. The first conclusion was that there was a breakdown in the strict monitoring of the principles and rules for the use of methadone?——W. (*Dr McEwin*) I think that is a reasonable finding and that it results largely from the increase in the prescribers from ten to thirty. Mr Diehm might have more specific comment on that. (*Mr Diehm*) Before regionalization we had only two addict management centres—Brisbane Street and Wistaria House. With the regionalization of the community health services it became necessary to set up services in the outer metropolitan regions and at several centres in those regions, which meant bringing in new staff who had not previously had any experience in the methadone programme. It meant bringing in new prescribers to provide the service in each region. It is at that time of the expansion that the strict and direct supervision of the principles started to break down.

4230. The second reason given is the poor training programmes for workers in this field?——W. That is a valid criticism. The programme has improved but it is still not nearly as effective as it should be because we have very slender training resources for the staff. Two years ago the commission approved the setting-up of an addiction staff development centre and training programme to cover the needs of the State. The funds for that were at first approved and then withdrawn by the Commonwealth. This was before the block-grant system was introduced.

4231. The third reason was lack of skilled workers in the field of behavioural science to act as consultants to the counsellors?——W. (*Dr McEwin*) That is also true but I think the stronger reason is our lack of ability to employ such people.

4232. They do not come easily?——W. Because of our ceiling.

4233. Another conclusion is insufficient staff to carry out a meaningful and effective programme. You have already answered that. Then there is reference to the lack of monitoring of the prescribing habits of doctors in general practice?——W. That is a difficult thing. If I could speak superficially about it, we can indeed monitor the prescriptions written by doctors in general practice because we have access in a limited way to the computer run by the Commonwealth Department of Health. However, this is a fairly sensitive area; it is a matter of privacy the doctors' records and their care of their patients. It is a thing that should be handled with great sensitivity. Mr Dash may wish to amplify that. (*Mr Dash*) There is a monitoring programme in which the States participate. It is a joint Commonwealth-State venture from manufacturers down to the level of supply of drugs from wholesaler to retail level, and the results from it tend to be six to eight weeks late. It relies upon weekly returns from manufacturers and wholesale distributors. There is the coding of these, the running at four-week intervals of all the coded data and then the printing out of reports. This system will highlight changes in usage in particular areas through increased purchases of drugs by individual pharmacies or hospitals. It then requires a physical follow-up to look at the records maintained at that hospital or pharmacy to find out what is the cause of the increase. Dr McEwin was referring to the records of prescriptions dispensed as pharmaceutical benefits, which is a very sensitive area. These are Commonwealth documents to which we do not have any right of access, as distinct from the documents which are obtained as part of the monitoring system of wholesale transactions.

4234. Has the Commission a particular policy in regard to the use of methadone?——W. (*Dr McEwin*) Yes, we rely on the advice from the committee appointed. Mr Diehm might wish to elaborate on that. (*Mr Diehm*) The policy of the committee is that there is a valid use of methadone but that much more stringent controls need to be introduced and the criteria for prescribing methadone needs to be much more rigidly adhered to. There is a programme now that will bring about that supervision. It becomes possible now for a compliance with that policy because there are alternatives in every region to the use of methadone. That situation did not exist before the committee undertook a revision of the principles suggested by the medical committee.

4235. It is possible that in some regions no methadone would be available because the regional director would not approve of the programme?——W. Yes. This is one of the problems that relates to every aspect of the drug treatment programme. Every region can determine unilaterally what it will or will not do or what priority it will give to drug services in general. The nature of the drug service can be determined by each region separately. We have had instances of people coming from one region to another because in their own region there was either no drug service or appropriate services were not offering.

4236. Your experience suggests that methadone should be given only under very close supervision?——W. Yes.

4237. You are quite satisfied by the Brisbane Street supervision?——W. That is applied now, yes.

4238. And Wisteria House?——W. Yes. I would think that the supervision over the last twelve months leaves little to be questioned. The questions that have been raised relate to periods before that.

4239. Do you consider that patients who are given on Friday sufficient dosages for the weekend are being closely supervised?——W. (*Dr McEwin*) We have a document here from the consultative committee on narcotic drugs and one of the deficiencies that they point out is that there is not a seven-day service. If I may go back to something you mentioned about what exists in each region is the decision of the Regional Director. It is not quite as simple as that. That is true within the overall policy of the Commission but if a Regional Director decided to have no drug and alcohol services that would not be acceptable to the Commission because it breaches Commission policy.

4240. I was not referring to alcohol and drug services but to the use of methadone. If the regional director decided that there would be no methadone programme in his area, what would be the position?——W. That would be unacceptable to the Commission.

4241. I go back to ask Mr Diehm a further question. Do you believe that when methadone is used for the withdrawal from opiates the period of use should be short rather than protracted?——W. (*Mr Diehm*) It depends entirely on the individual circumstance. If it is used from the outset only for withdrawal then certainly a short period—that is not longer than twenty-one days—is desirable. There is now an alternative. Where withdrawal cannot be accomplished within twenty-one days with the outpatient use of methadone there are inpatient alternatives quite readily available. If methadone is used for longer than twenty-one days I would not see it as a withdrawal programme but as a maintenance programme.

4242. Are progress reports supplied to the drug and addiction service in regard to patients on a methadone programme?——W. Progress reports or notes are maintained at each of the centres where the client is registered. They are not reported regularly to any central authority, except on a six-monthly basis. There is a report to the Therapeutic Goods Branch. Also the other report that comes centrally is when a client leaves the programme, an exit report comes to the Therapeutic Goods Branch.

4243. When you say they are supplied at six-monthly intervals, they would only be figures?——W. Not detailed clinical notes. (*Mr Dash*) There are some details supplied at six-monthly intervals. The Therapeutic Goods Branch uses a set of three questionnaire forms. One is for patients being admitted to methadone maintenance; there is a progress report form which is required to be completed at intervals of six months while they remain on the programme; and there is an exit report form which gives details of the reasons for termination.

4244. What procedures are used to follow it up when no reports are received?——W. The clinic is asked to submit the reports.

4245. Do you always get them in?——W. We do not always get them in as we would like. (*Dr McEwin*) At the beginning of 1977 the Commission acknowledged that, with the expansion of services the methadone problem had come into some disrepute. It asked the committee for advice and the committee gave it, much of which has been covered by Mr Diehm. There are about four pages of it here and I do not think you would want to go through it. It covers many of the points raised by Mr Diehm and tries to put the programme in better order.

4246. Mr Diehm, you mentioned the drug diversion programme that was set up on 1st March of this year. One of the things to be done was the preparation of case histories of the people who came to the clinic or were referred to it from the courts. Have any case histories been prepared during the time that that place has been in operation and, if so, what consideration has been given to them?——W. (*Mr Diehm*) There are two separate records. There is the clinical history taken by the staff at Bourke Street, and there are two parts of that; three, rather. In addition to that there is the report compiled jointly by the health staff of the probation service—more of a social history with some inclusion of the medical aspects in the programme. Every month the clinical records that are maintained by the health staff are reviewed by the staff. At the time of the person leaving the programme at the end of the eight weeks' remand, there is a review of those records jointly between the counsellors and the probation officers and frequently the client is asked to attend that review. It is at that stage that a report to the court is made. In addition to that practical use of the clinical report, we look at the profile—the social characteristics and the drug-use characteristics—of the people coming into the programme.

4247. Mr WOTTON: Dr McEwin, do you feel there is a resentment or an objection basically in public hospitals to patients being hospitalized for withdrawal?——W. (*Dr McEwin*) By the staff?

4248. By the hospital generally?——W. Yes, I think there is.

4249. I am not sure whether you said this earlier, but I think it is general knowledge, that the American drug situation has improved considerably, yet we are always likely to catch up with the situation over there. Have any efforts been made to find out their experience so that perhaps we never do catch up but beat the problem before it actually arrives?——W. Yes. Much of the work the Commission has done is based on the American experience and much of Dr Webb's work, which has been reported to you, is based on that experience. Our difficulty is that we get some variation of opinion from North America. We had Dr Hardin Jones here recently and he holds a fairly pessimistic view about the drug scene in North America and about the future of it in Australia. He said they had two million people on heroin in the United States and ten million people taking marihuana on a daily basis. He had strong views about the damage—particularly brain damage —that marihuana does to people. Other people give us quite a different viewpoint, so it is hard for us to decide which is the proper path to follow.

4250. Which times do you consider are the most important times for referral centres or half-way houses to be staffed?——W. In the evenings is the most important time. Perhaps Mr Diehm could qualify that answer, but I think that is when the people need the service most. (*Mr Diehm*) Yes, evenings and weekends are of particular importance. May I pick up the answer I gave to Mr Durick earlier about weekend use of methadone? I do not think there is a proper supervision of the issue of methadone. The question you asked related to prescription. That is fine, but the issue of it leaves a lot to be desired. One of the recommendations of the consultative committee was that there should be no weekend issues and that at least one centre in every region should be open for seven-days-a-week use of methadone. Most of the use that occurs, even in relation to addicts, seems to be in the late afternoon and fairly late into the evening. An evening service—perhaps not at every centre, but certainly at one or two centres in a region—is very important.

4251. Mrs DAVIS: This question follows on from Mr Wotton's. We visited some of the regional health centres and saw that they are in close proximity to general hospitals. We have been told by members of the staff that it is hard to find beds in clinics to detoxify clients. Why cannot general policy be that one or two beds in general hospitals be made available for the period needed—four to five days—to detoxify these people?——W. (*Dr McEwin*) It is true that there is often resistance to taking a person who has an alcohol or drug problem into a general hospital. The reasons for this are multiple. One is that sometimes the staff are not trained in handling these patients and they feel threatened and insecure in their handling of them. There are beds that are specifically held for people with drug problems; Mr Diehm has mentioned this. There are other beds, such as at inpatient services at Griffith Base Hospital—that is not a good example. There are psychiatric beds in general hospitals that are available for all patients, but even in respect of those beds you sometimes get resistance to the admission of a patient with an alcohol or drug problem. This is because the staff involved do not regard the treatment of these people as—rewarding is not quite the right word; but they are not attuned to the needs of the people. What is needed is an educative programme for the staff and for the general community.

The question of keeping beds specifically for these patients is difficult because some of the places mentioned are under considerable pressure for beds and they tend to let a bed go to the next person who turns up, whatever his problem may be. If it is a psychiatric unit they tend to let the bed go to the next patient who arrives, no matter what his problem is. I have said that some beds are specifically used for drug and alcohol patients, but where you have a general psychiatric unit there is sometimes this regrettable reluctance to take the patient with a drug or alcohol problem.

4252. Mr Dash, has it been drawn to your attention that there are certain doctors in various areas of Sydney who are prescribing, with monotony, opiates and mandrax, and this is increasing? What is the department doing about those doctors?——W. (*Mr Dash*) I am not aware of the opiates. I have heard of Mandrax being prescribed with great frequency. When I say I am not aware of the opiates, I am not aware of this being a continuing problem. The Commission's approach where this has been found has been—because with opiates we have a monitoring system and we are able to monitor prescribing habits—where a doctor is found to be prescribing at an

unusually high level and where it appears that his prescribing is for addicts, and where this continues in spite of any warning or advice he may get, we have two alternatives. One is to prosecute, and the second is in some way to take away his authority to prescribe. The usual procedure has been to take away the doctor's authority to prescribe by asking him whether he is prepared to surrender his authority. We have not yet had a case of this kind where the doctor, after some discussion, has not been prepared to surrender his authority. We have not reached the stage of prosecution. In any case, I could foresee difficulties if we did. The section of the Act appears to work quite well at the moment but it has not really been tested legally and I think we could run into a bit of difficulty if we tried to question it.

4253. CHAIRMAN: You said that inspectors could be sent out in these cases where you suspected methadone was being prescribed in excess of requirements. How many inspectors have you?——W. We have an acting senior pharmacist and six other pharmacists, of whom really only three are regularly engaged in inspections of pharmacies and visiting doctors. They have other duties as well. If I could continue with the matter of Mandrax, there has been a proposal put to the Poisons Advisory Committee, and on the advice of that committee it is now proposed to make methaqualone, which is one of the principal active ingredients of Mandrax, an accountable drug. It is proposed to retain it as a restricted substance but to make it an accountable drug so that all distributors will have to keep records in the form of a drug register. By that means we should be able to monitor usage much better than in the past.

4254. CHAIRMAN: It would not become a schedule 8 drug?——W. Not at this stage.

4255. It is in Queensland. What is the position in other States?——W. I do not know about the Australian Capital Territory. It is in Queensland, and it is effectively a drug of addiction in Tasmania; in other States it is still a restricted substance.

4256. It was put to us by a senior officer of the Australian Department of Health that methaqualone and mandrax are not quite the same, for reasons which have been mentioned. It was said that methaqualone is not abused to anywhere near the same extent as mandrax? ——W. I would not quite agree on that.

4257. You are quite satisfied that if you make mandrax an accountable drug, it will have the same effect?——W. I think that is so, but I do not quite understand the point you are trying to make about methaqualone and Mandrax. Methaqualone is the addictive part of Mandrax. Banning methaqualone would be banning Mandrax, wouldn't it?

4258. I am quoting what was said by an expert in Canberra. He said that methaqualone is not as dangerous as mandrax mainly because of the combination of the two drugs.——W. We would have to agree that there is probably a synergistic effect between the two, and perhaps there is greater abuse potential with Mandrax than with methaqualone separately, but I would disagree that methaqualone on its own is not a drug of significant dependence.

4259. Mr McGOWAN: What is narcane and how does it work?——W. (*Mr Diehm*) If a person has a physical dependence on heroin, for example, with a simple injection of Narcan. within half an hour you would expect to see positive signs of physical withdrawal. It seems to happen frequently that people have been using fairly small amounts of heroin over a period of months and they assume they are addicted when in fact they may be dependent. The psychological dependence may be difficult to resolve, but there may be no physical addiction and no sign of withdrawal if their intake of heroin is withdrawn. One of the things that helps to explain that is the low quality of street heroin at present, and people who claim to use up to three capsules a day show no signs of physical withdrawal.

4260. Is Narcan injected?——W. Yes.

4261. Is there any ethical or other objection to its use? ——W. As long as the client consents to the injection, I do not see any objection.

4262. You would have to get the client's consent first? ——W. I would say so. I do not know if there is an absolute legal requirement. (*Dr Egger*) There are some objections to the use of methadone treatment in the United States of America. The objections come mainly from addicts on the ground that it is an infringement of their liberty.

4263. Who makes the decision to prescribe methadone? ——W. (*Dr McEwin*) We get advice from the consultative committee on narcotic drugs, and the authority is vested in the Health Commission under the Poisons Act, 1966.

4264. Does the regional director make the decision? ——W. (*Mr Dash*) It is essentially a controlled system of approval. The application is received by the Therapeutic Goods Branch and a recommendation is made by an officer in that branch. The actual authority is given by a medical officer delegated by the Commission.

4265. No one prescribes methadone on the Central Coast. Who would make the decision that somebody was needed there to prescribe methadone? Would it be the regional director?——W. We would expect an approach to come from the Regional Director or the community services that they are seeking approval for someone to become an authorized prescriber. I think the initiative would have to come from the services. We do not normally go out and ask whether they have an authorized prescriber at a centre. Unless we have a circumstance where there is already a programme and a prescriber is leaving a centre, we would not take the initiative. In such a circumstance we would tell the service to make sure that there is continuity there and ask who was intended to be nominated as an authorized prescriber. That person would then be checked out.

4266. Have comparisons been done to compare the use of methadone with supportive therapy, acupuncture or any other treatment, to see how effective the methadone programme is?——W. (*Dr Egger*) No. One of the reasons for that is that research into the actual therapy of drug treatment has been sparse because of the lack of personnel involved in such research. At present in New South Wales two people are doing that sort of work, myself and one research officer. A lot of our time is spent in setting up monitoring systems, not actually looking at therapeutic procedures. Little work has been done on looking at actual therapeutic procedures and even less on comparing different therapeutic procedures. (*Mr Diehm*) Methadone is one element of the treatment programme. The recommendation of the consultative committee was that methadone should be seen as an adjunct to the treatment.

4267. What would happen if the methadone programme were done away with altogether? Who would suffer?——W. (*Dr Egger*) Certain information and evidence is coming out from the experimental literature in the United States of America to the effect that methadone may be counter-productive in some circumstances. I think that doing away with methadone—provided there were rational alternatives—would probably have minimal effect. The success rate of methadone is among a small percentage of people and they can probably be catered for with other techniques.

4268. I am worried about whether we should be providing people with a drug which may be more addictive than heroin in order to get them off heroin?——W. (*Mr Diehm*) I think there is no single answer to that question. Provided the selection of personnel is adequate, I would say that on balance there is a moral justification for its use for a particular few persons. I do not think there is justification for its blanket use for anybody coming in with narcotic addiction. The selection is really the critical factor in making a decision.

4269. CHAIRMAN: Somebody would not get methadone just because he came along and said he was an addict?——W. No, it is difficult for people to get methadone if an alternative can be provided. Since Bourke Street opened, and all the assessments in the inner metropolitan region are done away from Brisbane Street, out of 60 clients, only 5 were recommended for methadone. The same sort of picture is developing in other regions. The percentage of persons coming for treatment and being given methadone is decreasing significantly. One effect of that is that the number of clients in this respect fell from 130 four months ago to 72 last week, that is at Brisbane Street.

4270. Mr MacDIARMID: Do you think more research should be done on methadone to determine whether it should be used? There seems to be a great division among the medical profession about the use of methadone?———W. Research is always valuable but the real issue has been philosophical rather than clinical. I think the argument has become confused at that level because of the different goals people are trying to achieve with their clients. To illustrate that problem, one prescriber might take the view that his concern is to reduce the criminal behaviour of a client which relates to getting the money for his methadone, and to use blockade doses of methadone which take away the heroin hunger. His expectation is that by doing this he will reduce or control in some way the criminal behaviour of that person. Another person confronted with the same client would see his concern not so much to control the client's criminal behaviour but to make it possible for him to live without drugs so he would use methadone in small doses. The clinical goals they are trying to achieve are different. Therefore, their attitudes towards the use of methadone must necessarily be different. I think that the argument is now being resolved because methadone was once seen as a drug of choice, a treatment of choice, for heroin users. Now prescribers are becoming a little disillusioned.

4271. Do you feel the commission is understaffed right across the board or only in certain areas such as drugs and alcohol?——W. (*Dr McEwin*)I think it varies. I think that we are understaffed in the drug and alcohol areas, and the problem has become worse in recent years. We have been unable to keep our staff up to the mounting problem. Also, I believe, particularly in our psychiatric hospitals, that our staffing levels are insufficient to supply the services that we would like to supply and the public would like to receive.

4272. Mr MacDIARMID: Is your comment that Australia has not seen the worst of the drug problem yet based on statistical evidence or a philosophical view that we generally follow the trend in America? Having spoken to some younger people I was under the impression that the drug problem may be lessening in certain areas in Australia?——W. (*Dr McEwin*) I think my remark was based on philosophical lines that we usually follow North America and, secondly, following the visit of Professor Hardin Jones I had the impression, and it is certainly his view, that we have yet to see the worst of the drug problem; it may be four to six years before we see the worst of it. On the other hand there is a small amount of annecdotal evidence coming in that the drug problem is lessening in some areas. There is a little bit of evidence to suggest this in Wollongong.

4273. Mr HEALEY: I wish to go back to the methadone problem. I am a little confused by what has been said. On the one hand it is said that the number of part-time prescribers has increased and it has been agreed that this has broken down to a certain extent the control of the methadone programme. Mr Diehm has said that there has been a remarkable decrease in the number of persons on methadone treatment. The commission's original submission in October, 1975, included a table of current patients and patients on the methadone treatment. In July, 1975, the Commission had 577 patients under treatment, of whom 400 were on methadone, which seems to have been a high proportion at that time. Have you any up-to-date figures that would give us the situation today? I notice it is not included in your second submission?——W. (*Mr Diehm*) I do not have the figures here but certainly we could obtain for the Committee the numbers of persons under treatment and the proportion of those who are receiving methadone. It is quite clear that the proportion of clients under treatment who are on methadone has declined since that first report. However, the number of prescribers is not related to the number of persons on methadone. It relates more to the geographical distribution of our services. For example, in the southern metropolitan region we may not have many people on methadone but we have more prescribers because one centre is at Sutherland and one at Bondi and we cannot use one prescriber to cover the region. So the number of prescribers relates to the geography of the region rather than the number of clients.

4274. What happens to the monitored reports that you get from the federal body every four weeks regarding the movement of drugs generally, and how much reliance do you place on them?——W. (*Mr Dash*) They are only an indication to us in terms of usage. They are reliable data so we can put quite considerable reliance on them. The main problem is in making adequate use of the data. We get a number of tables, the most useful of which is the exception report. We establish what we consider to be a normal purchase level for any pharmacy or hospital over a period of four weeks. There are different levels for pharmacies and hospitals and the level will vary from one drug to another according to the general rate of usage of each drug. The exception report will tell us which pharmacies and hospitals have purchased quantities of drugs in excess of those normal levels.

4275. Is this information given to your regional directors?——W. No, it is not.

4276. When the Committee was in Canberra talking to the federal people it was given information, quite unsolicited, that a methadone problem exists in a certain area in New South Wales. The committee had been to that area a couple of weeks previously and had been told by the Health Commission director there, that there was no methadone problem in the whole of that region. That prompted me to ask what happens to these reports when they are received. You say that irrespective of what is in the report, it is not passed on to your local director?——W. That is true, because all that the report gives us is the usage of drugs through legitimate channels. It does not tell us anything about illicit drug distribution.

4277. I am not speaking of illicit use. I am speaking of licit use?——W. The staff who follow this up are in the central branch. They are not attached to regions.

4278. Would you not think it wise at least to alert the regional director that you had reason to believe that a problem existed in a certain area so that he could keep his eyes open and be a little more vigilant than usual?——W. Yes, this would be advisable.

4279. Coming now to the question of drug educators and counsellors, what qualifications does a person have to hold to become an educator or counsellor and what facilities are available to train them?——W. (*Dr McEwin*) In the broad, the people chosen for those tasks come from two groups, those with a university degree and those without. Those with a university degree usually have it in the social or behavioural sciences and they are committed to a programme of training within the Commission. In addition, other people are taken into the programme from quite a wide background. They may be ex-addicts. I remember one who worked as a receptionist in a drug clinic and became expert at dealing with patients. That, I think, reflects the world pattern of staff selection. Broadly they are the two groups that are trained within the Commission.

4280. Who trains them and what is your training programme?——W. (*Mr Diehm*) The training programme is very limited. We have two programmes. Each region is responsible for its own staff training programmes. Most metropolitan regions work on the apprenticeship system, under which new counsellors are placed with experienced counsellors who look after their instruction on an apprenticeship basis. This is supplemented by a supra-regional seminar-type instruction. The only departure from that is that this is not possible in the country regions because there are no experienced staff there to whom new people can be apprenticed. The central drug and alcohol advisory service has a training officer and that service sets up central training programmes, usually of two to three weeks' duration, to which any region can send its new staff. These courses are held more frequently than once or twice a year. In addition there is occasionally a one-day or two-day seminar in alternate months of the year. That is the only supplementary training we are able to give.

4281. In effect, no standard training method is used in all regions throughout the State and no standard qualifications are laid down for people who wish to become counsellors or drug educators, so a counsellor or educator trained in one region could be transferred to another region and find that different criteria and differtnt methods were in use. In other words, everyone is doing his own thing and there is no overall co-ordinating body that says "This is what we believe is required by an educator or counsellor and this is what it should be throughout the whole of New South Wales?——W. (*Dr McEwin*) The short answer to the question is no, I would not agree with Mr Healey. I think Mr Diehm may qualify this but I would qualify it first by saying, with respect, I believe the question goes to far. I believe there it a degree of co-ordination. There are two groups of people chosen. They come from distinct groups of people. I believe the training is to a degree uniform. I do not believe it is ever the case that one gets uniform training in health services. One medical school trains in a different way from another medical school. One nursing school trains in a different way from another nursing school. I do not believe it is as disparate and disorganized as the question seems to suggest.

4282. There are different methods of training in different hospitals but there is one standard that all trainees are required to meet before they are recognized. But from what we have been told I gather there is not one standard required for educators or counsellors to conform with and each individual region sets up its own training and standards. Should there not be one overriding standard or qualification for all educators and counsellors to meet?——W. (*Dr Egger*) Taking the two things separately, there is one overriding standard for drug educators. They are all trained by the Health Education Division of the Health Commission. They all have the standard qualification of a university degree. Dr McEwin's comment about the two different types applies, I believe, more to the counsellors. (*Mr Diehm*) The other part of the answer is that the very problem Mr Healey has raised was the justification for the proposal we made two years ago to set up an addiction staff development centre which would have led to uniform training and a recognizable qualification for all people working in the drug services. Since funding for that project was withdrawn by the Commonwealth what we have been able to do has been very much piecemeal. There is no way that we are able to offer training that would lead to an acceptable qualification.

4283. Do you receive any funding at all from the federal health body now?——W. It was given the highest priority by the Health Commission in the State's submissions to the Commonwealth. It was in fact approved by the Commonwealth and the cheque for the first $50,000 was received in Sydney, followed two days later by a telegram withdrawing the cheque. That was the end of that effort to establish a substantial training programme that would lead to a recognizable qualification.

4284. How often do people from the central office of the Health Commission go out and inspect Wistaria House and Jacaranda House?——W. (*Dr McEwin*) That would be on a sporadic basis but more constant inspections would be done from the region. Visits to Wistaria House by central people would be in two categories; on demand when a problem occurred or discussion was necessary and scheduled visits which might be reasonably infrequent.

4285. CHAIRMAN: Would you take important visitors from overseas to show them those institutions?——W. Not to Wistaria House I do not think.

4286. What about Jacaranda House?——W. That is a difficult question to answer. We believe that Wistaria House could do with an injection of funds to tidy up the toilets and bathrooms and so forth. I suppose if one were showing people honestly what one's programmes are one could take them. We would hope they would not see some of the toilet facilities while they were there, perhaps.

4287. Mr HEALEY: Does the Commission consider itself extremely fortunate to get trained staff to work in the conditions that they have to at Wistaria House and Jacaranda House?——W. It does.

4288. CHAIRMAN: Could you tell us how many patients have been through the Bourke Street drug diversion programme in the six months it has been operating? ——W. (*Mr Diehm*) Until last week it was either 76 or 78.

4289. Have you made any estimate of the success of the programme at this stage?——W. Yes. I think of those who have gone back to court—which is about 23 or 24—most have profited substantially from their treatment. I expect about 14 or 15 of those to continue in the programme for some little time. I think it has been successful also from the viewpoint of involving a great number of voluntary agencies working with the same client. For example, a number of people coming from the diversionary programme have been closely identified with Bourke Street, and I expect that this identification will continue. I think the most pleasing improvement is that of the first 60, five were prescribed methadone, and I think of the others a number have, since leaving Bourke Street, identified themselves with the voluntary agencies like the Drug Referral Centre and the Wayside Chapel. I think there will be a continuing association between the client and that centre, but more important between Bourke Street and that centre; and the interchange of information about these clients is very good.

4290. Do you feel that there are any of these people, who are not committed to prison, who would profit by some type of residential accommodation? Have any of them been referred that way?——W. From memory, I think only two have sought residential accommodation. The information we get from all the centres is that very few addicts are interested in residential programmes. Whether they would profit by it is a separate question. However, few are prepared to volunteer for residential programmes. I suspect—and my impression is only from talking with many addicts who have come through the diversionary programme—that there would need to be strong legal sanctions for them to accept such a programme by choice, rather than an out-patient programme.

4291. Dr McEwin, both Wistaria House and ward 18 at Morisset are associated with the psychiatric centre. Do you think that a psychiatric centre is a desirable situation for the treatment of drug addiction?——W. (*Dr McEwin*) Ideally they could be isolated from a psychiatric centre, but there are difficulties. One is getting a physical facility in which to treat a patient; the other is to make the greatest use of available staff. Psychiatrists in the public sector are hard to get, although I believe there is an excess of psychiatrists in New South Wales, most of them being in private practice. Also, people who work in the drug programme are hard to get. I suppose we would argue that you make better use of staff by having the centre at a psychiatric hospital, because you can call upon other people. However, philosophically, I think a person who needs treatment because of drug abuse would be better treated outside a psychiatric hospital.

4292. If I were to ask you how many people are being treated in New South Wales today for some form of drug addiction, in either official hospitals such as Wisteria House or Morisset, or in public hospitals, could you tell me how many?——W. No, I could not. I could tell you with some degree of accuracy about in-patients, and from some other source about out-patients, from health centres and so on. But I think other people would be treated from other sources, and I could not quantify them.

4293. Do you feel that some good purpose would be served by trying to organize information along those lines? ——W. Yes. On an in-patient basis we tabulate all discharges from hospitals in New South Wales. They are computerized in the form I show you, under various headings, with numbers. We have there the numbers for drug dependents, and which show whether they are addicted to opium, synthetic analgesics, and so on. We can tell the number of people in hospital for those problems. Other people would be in hospital for personality disorders and may have a drug problem as a secondary matter. This system has been developed by Dr Adams of the Division of Health Services Research, Health Commission of New South Wales. It is probably ahead of anything in the world. Information is starting to flow back from it, but it relates only to people in hospital.

(Sitting suspended from 12.36 p.m. to 2.15 p.m.)

*Upon resumption*:

BARRY THOMAS MEWES, Acting Senior Pharmacist, Therapeutic Goods Branch, Health Commission of New South Wales, residing at 8 Riviera Avenue, North Rocks, sworn and examined:

4294. CHAIRMAN: Mr Mewes, you are joining this afternoon the witnesses from the Health Commission of New South Wales who have already been sworn. Did you receive a summons issued under my hand in accordance with the Parliamentary Evidence Act, 1901?——W. I did.

4295. This afternoon we shall deal mainly with analgesics and with the controls that are exercised on the production and distribution of drugs. First, has any witness any further thoughts to add on what was said this morning?——W. (*Dr McEwin*) There is only one matter, and that is the official view of those known as Alternative Life Style. You may wish to leave this until another time.

4296. Yes. One of the matters discussed at some length with the Commonwealth Department of Health during our visit to Canberra was controls on some drugs that are becoming a problem in the community. It was pointed out to us that although the Commonwealth had fairly good information about some drugs, it was not fully conversant with all of the details that we sought. You have said something already about the drug methaqualone, or Mandrax, being followed up. It was said that the Commonwealth's computer could give the States information on the production and distribution of drugs of dependence, and of drugs generally under schedule 8, and that the monitoring of those drugs would indicate doctors and pharmacists who might be prostituting their profession in respect of them. We were told that it would be possible to isolate unusual purchases. I think Mr Dash has indicated that it would not be possible to isolate them quickly. Is that so? ——W. (*Mr Dash*) There is a delay of six to eight weeks between the supply at retail level and the monitoring return which would give us the ability to follow up that supply.

4297. If the Commonwealth gives you information about a particular pharmacist, whose responsibility is it to follow up that information?——W. It is a State responsibility. We have the responsibility under the Poisons Act for following up those transactions.

4298. Have you had any complaints from the Commonwealth that the follow-up action is not as speedy as they would like?——W. (*Dr McEwin*) I am not aware of any complaints. (*Mr Dash*) When you speak of complaints about action not being as speedy as they would like, whom do you mean when you say they?

4299. The follow-up of supposed over-prescriptions or over-supplying by pharmacists?——W. The Commonwealth would not be aware of any follow-up action that we took. We may on occasion go back to them for some information but normally once they have given us the monitoring data, that is the end of their interest in it.

4300. The Commonwealth would have no opportunity of monitoring analgesics unless they contained a drug like codeine, would they?——W. (*Dr McEwin*) That is correct.

4301. Does the Commonwealth supply you with any statistics of drugs that might be used in minor analgesics other than codeine?——W. (*Mr Dash*) No, other than the overall statistics contained in the annual report of the Commonwealth Director-General relating to the level of prescribing of drugs under the pharmaceutical benefits scheme. They attempt to monitor prescriptions of methaqualone and pentazocine, but their ability to do that is limited to the extent that the data is available, and the data is not available unless the drugs are classified as drugs of addiction or accountable drugs. The proposal to make them accountable drugs in New South Wales will improve the ability to monitor the movement of those drugs.

4302. It was put to us that a tremendous amount of methadone was being used in one area of New South Wales and in answer to a question from me about whether it would be obtained on a prescription from a doctor not authorized to prescribe it, I was informed that the computer would not show who the prescriber was, or whether the drug was prescribed by somebody who was authorized. Can you suggest any way in which it might be possible, apart from internal measures that you would take, to cut down the prescription of methadone by unauthorized prescribers?——W. I can tell you what we have done and what is proposed. The fact that what has been done has not been entirely successful might indicate the degree of the problem. Doctors have been circularized by a number of means and on a number of occasions about their obligations under the Poisons Act, and about the limitations that are placed on the prescribing of drugs of addiction, in particular methadone and Palfium, which is another drug that causes us a deal of concern. The doctors have been circularized by direct letter, by insertion in the Newsletter for medical practitioners published by the Health Commission, by insertion in the A.M.A.'s monthly bulletin, and, on one occasion by insertion in the *Medical Journal of Australia*. In spite of that we are still getting quite a number of doctors telling us that they have never seen anything advising them of their obligations in this respect.

Also, over the past couple of years we have attempted to get at graduating doctors annually by getting information to them at the start of their residencies. Again there is a difficulty here in that they are hit with so much material at the time that this material does not stand out. So we have a difficulty in communication. There is no doubt that the most effective means of getting information to doctors is by direct contact with those who have already fallen foul of the provisions in respect of this matter, but it is then too late regarding the prescriptions that have been written. A proposal has been made that certain drugs, particularly methadone, be restricted to supply only on special authority, in the same way as amphetamine is already restricted. I do not know what stage this proposal has reached, or whether it is still a proposal. Perhaps Mr Mewes could give you more information in that respect.

There is a third means which has been used and that has been by notation in the handbook for medical practitioners issued by the Commonwealth Department of Health. It is a handbook on the pharmaceutical benefits scheme showing what items are available for prescription as benefits, the number of tablets or what have you that might be prescribed at one time and so on. One of the reactions we have had in approaching doctors is that they say the pharmaceutical benefits handbook does not show any restriction. So it has been quite obvious that they take a lot of notice of that handbook whereas they appear not to take notice of quite a lot of other material that reaches them. Some time ago we asked the Commonwealth to include in the pharmaceutical handbook a note to the effect that there were limitations to prescribing particularly methadone and dextromoramide. The department agreed but the note found its way only into the introductory section which is rarely read and did not appear against the particular entries for methadone and dextramoramide. The Commonwealth has since modified the book to include a note to the effect that there are State restrictions that should be observed. They cannot include full details as the restrictions are not necessarily identical from State to State.

4303. They are provided free under special provisions of the National Health Act. If the Commonwealth were to put a restriction on them it would apply nationwide would it not?——W. Yes, but it would be only to those cases in which it were prescribed as a pharmaceutical benefit.

4304. And it would not stop a doctor from prescribing as many as he might like?——W. (*Dr McEwin*) It would only affect payment. (*Mr Dash*) We did find that people obtaining methadone by forged prescriptions were forging them not as pharmaceutical benefits so they did not enter the Commonwealth monitoring and checking system.

4305. Would it surprise you to learn that chemist dispensed 10 000 tablets of methadone in one weekend though it did not happen in New South Wales?——W. I would be surprised as that would be an extraordinary number of tablets. That would be an extraordinary occurrence whether it would come immediately to attention or not I do not know. It would depend upon the pharmacist. A number of pharmacists become concerned about what is occurring in their area and they ring up and report the matter, which gives us a shortcut.

4306. Do you have much evidence of co-operation between pharmacists in a particular area where they decide to gang up against the prescribing of particular prescriptions?——W. This would depend a lot on the area.

4307. Have you any evidence of pharmacists who have decided to co-operate in this way and stop doctors from prescribing these things?——W. No, I do not have evidence of that kind. I do have a knowledge of pharmacists approaching doctors to draw their attention to the restrictions that apply. I do not have evidence that pharmacists as a group have done this.

4308. The blue book on pharmaceutical benefits to which you have referred, is it possible for the committee to get copies of it?——W. (*Dr McEwin*) Yes, that will be arranged. With regard to Commonwealth–State relations, to complete an answer given by Mr Dash, we do have informal lines of communication between the Commonwealth department and the State authority and sometimes we get information on these informal lines which allows us to recognize unusual patterns of prescribing.

4309. Doctors are required to keep a book of dangerous drugs prescribed, by law are they not?——W. (*Mr Dash*) Not of dangerous drugs prescribed but supplied.

4310. And if they prescribe them?——W. They are not obliged to keep a record.

4311. If they supply them they must keep a record? ——W. Yes.

4312. Are those books inspected regularly?——W. I would not say regularly. (*Mr Mewes*) Not on a regular basis because of the shortage of staff. We find it generally unprofitable to spend long periods waiting to see doctors. They usually keep little in the way of stock. Sometimes they keep records of prescriptions on patient record cards but it would be an enormous task to go through those cards to find out what had been prescribed. If there is reason to believe that a doctor might be using more than the normal amount of drugs we would ask to see the drug register. (*Mr Dash*) On the matter of communication, I have here copies of a recent *Newsletter for Medical Practitioners* which features the matter of obligations in respect of prescribing for addicts. I make copies of the newsletter available to members of the committee.

4313. Thank you. It was put to us that some doctors who had been visited, presumably by Commonwealth inspectors, had not made an entry in their books for more than two years. Would you find that exceptional?——W. (*Mr Mewes*) No, I would not be entirely surprised if some doctors are not keeping records as they should. In most cases usage is confined to, say, ten ampoules of methadone or morphine per month. Some doctors are lax in keeping records.

4314. But legally they should do so?——W. Yes.

4315. Single drug tablets of aspirin or paracetamol alone are preferred to combined preparations by about a quarter of the people who take them frequently. Would you agree that a single agent tablet can be just as effective as a one containing two or three compounds?——W. (*Dr McEwin*) We believe that and that is one of the recommendations from the National Health and Medical Research Council, that the most freely available analgesics should be the single substance analgesics.

4316. Do you believe that patients may have headaches and withdrawal systems caused by caffeine?——W. Yes.

4317. Phenacetin?——W. Yes.

4318. Do you believe that recurring headaches are often the result of rather than the cause of dependence upon analgesics?——W. Yes.

4319. Are you aware of any education programme carried out particularly by the drug companies to counteract this situation?——W. It depends what you mean by educational campaign. They do advertise in some of their literature that if your symptoms persist you should see a doctor.

4320. Are you aware that on 26th April a statement was issued by the acting chairman of the National Health and Medical Research Council regarding recommendations in the use of analgesics?——W. Yes.

4321. Do you know the main recommendation?——W. Yes.

4322. Do you agree with those recommendations?—— W. Yes and we support them strongly and believe that it is very much in keeping with the health of the people of New South Wales that these recommendations should be adopted by the Government.

It has been submitted to us that the answer to excessive usage of analgesics by a minority group in the community lies in consumer education rather than restrictive legislation. You would not agree with that opinion?——W. No, not really. I think it would be fine if we could educate people not to use analgesics, but I do not think that is a practical solution.

4323. Obviously such a proposal would be an inconvenience to some people?——W. Yes.

4324. You think it would be more profitable generally if the restrictions were imposed?——W. Yes. The work we have done does not suggest it would be of great inconvenience to many people. The renal physicians have given opinions that it is possible to get people off compound analgesics without very much difficulty and without the people concerned having any problems. In fact, Mr Mewes has a paper here suggesting that only about 10 per cent of such patients have any difficulties getting off compound analgesics.

4325. One of the suggestions in the recommendation was to do with special packs. Do you think the extra cost involved in preparing special packs would be justified? ——W. Yes. There was some debate about this at the National Health and Medical Research Council. The council tended to wish to change the unit of 20 tablets, to increase it to 25, because there was evidence that the manufacturers' equipment was more suited to 25 tablets. The cost to the manufacturers of doing what the NHMRC suggested would be small compared with the savings—that is talking of money alone—in the treating of people with renal failure.

4326. We have been informed that interested parties are willing to co-operate with the Health Commission in any education programme designed to achieve an enlightened use of analgesics. Have any approaches been made to the commission with regard to the production of such programmes in relation to non-opiate analgesics?——W. Yes, we have had approaches from people concerned in the manufacture of these substances. We have not thought that that really is the best answer to solving the problem.

4327. Could I press that a little further by finding out what type of suggestions they made, or is it confidential? ——W. No. The discussions did not get down to the fine detail of what would constitute an educational programme. The NHMRC solution has been under discussion for a considerable period—two or three years as far as I know, and perhaps longer. During that time it has been the opinion of the Commission that the answer to this problem is the recommendation produced by the NHMRC rather than an educational programme.

4328. In your submission you pointed out that most regular consumers preferred compound preparations. Have you any idea why that is so?——W. I think it is because of their availability. They are usually available and advertised as compounds rather than single substances.

4329. Is it the availability or the slick advertising campaign?——W. I find that hard to answer. (*Mr Mewes*) It is probably because of the caffeine content. That would not initiate the use of these things but I would think that it would certainly perpetuate it.

4330. Build up a dependency?——W. Yes, people get a lift from taking these things, as you mentioned earlier about the rebound headache problem. (*Mr Dash*) If you want to look at specific advertising campaigns, the advertising campaign for one of the analgesic powders might be described as anything but slick whereas some of the advertising campaigns for some of the single substances, analgesic substances, are quite slick campaigns. I would think there is more to it than just the advertising.

4331. We have been talking about rebound headache that occurs with the effect of caffeine and when the effect of caffeine begins to wear off. Professor Merton, whom you may know, when giving evidence on behalf of the Proprietary Association claimed that there is no scientific evidence to suggest that this is so?——(*Dr McEwin*) I would just have to say that we do not agree with that.

4332. You are acquainted with the work done by Dr Nanra at Newcastle?——W. Yes.

4333. Has Dr Nanra the full support of the Health Commission in the work that he has undertaken?——W. Yes. (*Dr Egger*) He is working with the Health Commission at the moment on a project that we have set up.

4334. Do you agree with his assessment that of the 300 new patients seen every year about 100 go to him because of abuse of headache powders?——W. (*Dr McEwin*) I think we would have to take his word for that. He sees the patients, we do not. His figures are a little higher than figures from other places, but he maintains that he has a greater analgesic problem in the population that he is treating than in the other places where a rather lower figure is sometimes suggested.

4335. That would be the general consensus of opinion in regard to the Hunter River area?——W. I think so.

4336. What do you regard as abuse of analgesics?——W. The regular taking of analgesics for their effect rather than for a symptom. I think you are probably looking for a quantification of that?

4337. Yes, I am looking more for an expression of opinion from some experts?——(*Dr Egger*) We have certain evidence that this sort of kidney abuse we are talking about can occur after 20 years of taking one tablet a day or after one year of taking 20 tablets a day. I think that is within the order or magnitude that we are talking about.

4338. Mr Dash, do you agree with that?——(*Mr Dash*) I am not in a position to comment on that quantification. I have seen a report which takes the consumption of analgesic powders at a level of more than three powders a day regularly as being habitual use and probably misuse or dependence.

4339. In arriving at your opinions you would be depending to a great extent on people like Dr John Stewart and Dr Nanra and the work they are doing?——W. (*Dr McEwin*) Yes. It is a hard question to answer because they are seeing the patient only in an advanced stage of renal failure, and there is a great period in time between the commencement and the end failure. So it is difficult to answer.

4340. I asked you a general question, which perhaps is not fair. In forming your own opinions you would not be doing so necessarily from your own experience?——W. That is right.

4341. You would be dependent on people you regard as experts working in the commission?——W. That is true.

4342. The committee has found it impossible to obtain figures indicating the quantities of analgesics sold in particular areas of New South Wales. At page 3 of your submission it is stated that for the year ended 30th June, 1974, New South Wales with 35.7 per cent of the national population consumed 41.5 per cent of minor analgesics. Why is it not possible to obtain regional figures if we can get the State figures?——W. (*Mr Dash*) It has actually not been possible to get either State or regional figures. These figures are based upon community surveys and extrapolations from a questionnaire on a sample population rather than from any monitoring of sales. The people who distribute them are not required to keep detailed records of what they supply. The quantity that might be sold is not available directly from the inspection of records. Presumably the information could be obtained by requesting it from the manufacturers or distributors. We then run into two types of problems. First, there is the purpose for which we are getting the information. Second, if we are looking at manufacturers in particular we are looking at a market that is not necessarily confined to New South Wales. We believe that New South Wales has something like 70 per cent of the pharmaceutical manufacture in Australia. A person or firm manufacturing in New South Wales manufactures for the Australian market. They will have estimates of what their sales are in various parts of that market, but again that is their estimate based on their own internal figures and they would not necessarily be available to us.

4343. What you are telling the committee is that there is no way in which you can find out the number of particular analgesic tablets or powders that could be distributed in any particular part of New South Wales?——W. I would not say that it is impossible to get it, but I would say it is extremely difficult. I would have difficulty in justifying the collection of that type of information for purposes for which we have the power to collect information. (*Dr Egger*) Two commercial organizations collect this information, both on a State basis and now on a regional basis. Am I allowed to name them?

4344. Yes.——W. A. C. Nielsen & Company, the data people, and Intercontinental Medical Statistics. They both have figures on this. I am in the position of getting material from them for the study we have proposed for the Newcastle region. That will be available of course to the Health Commission. (*Mr Dash*) I have seen figures from the IMS organization. These figures that I have seen cover only sales through pharmacies.

4345. They would only be a fraction when compared with some of the other retail outlets?——W. Yes. (*Dr Egger*) A. C. Nielsen only have figures through retail outlets and not pharmacies. It is a matter of putting the two together to get the total figure.

4346. At page 4 you say that in recent years people suffering from analgesic nephropathy have accounted for at least one-third of the renal disease in Australia. Who decides whether it is analgesic nephropathy?——W. (*Dr McEwin*) It is decided by the physician in charge of the case. These figures would come from units which have a high interest in analgesic renal failure. They would take a history from the patient and examine tests made on the patient and form a judgment as to the cause of the disease.

4347. If I were to refer to figures from the coroners' court, which I have here, I do not think I would find for the last year that disease mentioned anywhere as the cause of death.——W. That would be a reasonable statement.

4348. So you are dependent exclusively on the reports from the doctors who are working in this field?——W. Yes. I think the coroners' figures cover only deaths reported to the coroner, which are only a small proportion of deaths. These figures are subjective, they are not hard data figures; they are formed on the judgment of people who are expert in the treatment of kidney disease.

4349. Members of the proprietary association when giving evidence were insistent that any renal nephropathy so far evident was directly attributable to phenacetin. They claim that now that phenacetin has been removed from the two most commonly used analgesics, that is Bex and Vincents, there will be a gradual diminishing in the number of renal failures. Do you agree with that?——W. No, that was not agreed, and that was not agreed by the experts who advised the National Health and Medical Research Council. (*Mr Dash*) In fact phenacetin was deleted from one of the analgesic powders several years ago. If there were truth in that I would think that there should have been already seen some decline in the acute end stage of renal failure.

4350. At this stage it is not evident?——W. Apparently not. (*Dr McEwin*) No. (*Dr Egger*) The idea for removing caffeine was similar to that suggested for removing water out of alcohol on the occasions when people found they had a hangover the day after drinking either Scotch and water, Brandy and water or something else and water—it was the water that caused it.

4351. Evidence has been supplied regarding the difference between phenacetin and paracetamol once they have been absorbed into the body. Can anybody enlighten the members of the committee in regard to this matter?——W. (*Mr Dash*) That is really for an expert clinical pharmacologist to comment upon. (*Dr McEwin*) Paracetamol is one of the breakdown products of phenacetin when taken into the body and it was introduced because it was said to be less damaging than phenacetin. I do not know anything more about the pharmacology than that.

4352. How would you compare an analgesic containing aspirin, phenacetin and caffeine with one containing aspirin, paracetamol and caffeine?——W. The one with paracetamol would be preferable.

4353. But you have no idea as to the difference in the effect on the body?——W. No. I think we could say that they would both be bad.

4354. Do you believe people can become physically dependent on analgesic powders or tablets?——W. It has been shown that 10 per cent of people counselled to get off analgesics found difficulty in doing so. (*Mr Mewes*) I do not get the impression that there is physical dependence but that people like the effects that they derive from it. With the remaining people, it was found that 90 who could be dissuaded from using compound analgesics were switching to something else. They accepted this change and used a single substance as an alternative. It was found that their use of this tended to diminish with time. They did not seem to have the same need to take the preparation, as compared with a compound form, and ultimately their health improved and their consumption became less as a result of that. It is psychological rather than physical dependence. It has been said that there is such a mild form of physical dependence that people are able to overcome withdrawal symptoms by taking increased coffee or tea.

4355. More than once we have been told that people —particularly housewives—might have half a dozen powders before a breakfast. Do you think that would be physical or psychological dependence?——W. I think, psychological. (*Dr McEwin*) I would support that.

(*Mr Dash*) Could I refer to one of your previous questions about the difference between aspirin, phenacetin and caffeine, and aspirin, paracetamol and caffeine? It was said that the difference between the effects of phenacetin and paracetamol would probably require the opinion of an expert in clinical pharmacology. Could I add to that by saying that there is considerable evidence that phenacetin is metabolized in the body at least partly to paracetamol, and therefore it would be reasonable to assume, unless there is evidence otherwise, that the effects of aspirin, paracetamol and caffeine might be very similar to those of aspirin, phenacetin and caffeine.

4356. Dr Nanra conducted a number of experiments with rats and compound analgesics, of which you are probably aware. The validity of those experiments has been hotly contested. Do you think the experiments are a worthwhile scientific exercise?——W. (*Dr McEwin*) I do not see the necessity for proving the relationship between the rat and the human. I think it has been shown in the same way as smoking and lung cancer has been shown, not to be of direct cause and effect but as a sequential thing. The body of evidence would suggest to me that the causal relationship is proven in the human being.

4357. You feel therefore that the Commission has a responsibility to advise the public of the dangers of analgesics abuse?——W. Very much so. We hope that the Government might bring in legislation to control the sale of analgesics in the way that the National Health and Medical Research Council has proposed.

4358. Have you given consideration to any concerted advertising campaign, say on television?——W. No, we have not gone as far as a concerted advertising campaign. There has been material released from our health education unit, but we are hopeful that legislative control would be the answer. (*Dr Egger*) There was an education campaign planned for the Hunter Valley region, until the National Health and Medical Research Council made its recommendation. Then it was shelved temporarily to see whether new legislation would be brought in and probably the education programme would become redundant.

4359. You have carried out various education campaigns in regard to harder drugs. What makes you optimistic that one for analgesics will be more successful?——W. I do not think we had that optimism. We think the quickest answer is to control their sale by legislation.

4360. Mr WOTTON: What sort of legislation do you visualize?——W. We hope the legislation would repeat what the National Health and Medical Research Council said. It said three things: that aspirin, paracetamol and salicylamide and their derivatives should be available only as single substances in child-resistant containers and limited to 25 tablets or 12 powders; that when combined with not more than 1 per cent of codeine they should be limited to 25 tablets or 12 powders and in child-resistant containers, and available from chemists only; and that a mixture of two or more drugs should only be available on prescription by a doctor.

4361. You think the benefit to be gained would compensate for the habits that people have got into?——W. Yes. I think the opinion given by Mr Mewes is that 90 per cent of the people would not have a problem in getting off compound analgesics.

4362. Mr MACDIARMID: If you relate Dr Egger's statement about women breaking down through taking analgesic tablets and powders, it follows that the advertising conducted by pharmaceutical firms is not accurate?——W. (*Dr Egger*) If a substance is taken often enough, as has been proven with rats—if you give them enough of any substance they can form some sort of carcinoma or it can have a deleterious effect. It is difficult to say that an advertiser could provide for all contingencies under all forms of abuse.

4363. Do you think there should be some limits to advertising analgesics?——W. Certainly. I go along with the rest of the Commission's proposals—that compound analgesics be restricted. Then I do not think the advertising aspect becomes an issue. We are collecting figures at this moment, but I think the feeling that we have is that advertising for compound analgesics has increased markedly since the NHMRC proposal in April, and particularly in the Hunter Valley region. I suggest that is a somewhat insidious basis, and that the rationale being that they can sell as many compound——

4364. CHAIRMAN: They have the stocks and have to get rid of them?——W. Quite. It might be appropriate to add here that we have a research programme to look at the habits of people taking compound analgesics, if and when the restrictions are brought into being. Starting this week we are going into the field to test analgesic habits in the Newcastle–Hunter Valley region. Then at a later stage we hope, if the restrictions come in, to test to see just how this has affected analgesic use and also general habits in compound analgesic users. In other words, are they just compensating for an analgesic habit by going to harder drugs? I think this is of particular interest.

4365. Mr MACDIARMID: We have had evidence placed before us by one witness in that area who said that she was taking as many as 17 Vincent's a day. She worked in a clothing factory. The end result was renal breakdown. Has not someone a responsibility to counter this by advertising the adverse effects? Would the Health Commission consider that area?——W. I think the Commission is considering this. We have put out information on this and we are also considering it within the context of the research programme I mentioned, as to what is going to be needed in terms of education and information in the Hunter Valley region for people who are likely to suffer withdrawal symptoms because of the lack of compound analgesics available.

4366. Someone has a responsibility to point out to these people the dangers inherent in taking Vincents and Bex?——W. The Health Commission has taken that responsibility. We have put out literature on it and it is being widely circulated in the Hunter Valley region through the health education programmes that are going on, in the Hunter Valley region, in particular, specifically related to analgesic use and to use in factories. Of course, then, the easiest solution is to have the restriction that we are talking about.

4367. Mr WOTTON: Why the emphasis on the Newcastle–Hunter Valley region?——W. I think we know that the Hunter Valley region probably has the world's highest rate of analgesic nephropathy. Something like 33 per cent of all cases of nephropathy in the Newcastle region are attributed to analgesics. The figure is 8 per cent in England, 7 per cent in the United States—which is quite prone to drug abuse problems—and it is down as low as 2 per cent and 1 per cent in some Scandinavian countries. Newcastle is unique in the world. It is also unique in Australia, from the point of view of analgesic nephropathy. There are a number of reasons why this may be so, but they all seem to come together in the Hunter Valley region.

4368. CHAIRMAN: Dr Duncan told us he has been trying for ten years to get figures on the number of analgesic powders and tablets sold in the area but he has found that he is running into a brick wall all the time?——W. I have found that, too.

4369. I suppose it is a fair assumption that, if all these people have been taking powders, that is the cause; but evidence has also been given here that there is no scientific basis for these opinions?——W. As Dr McEwin said, there are a lot of people who would suggest there is no scientific basis for a link between cigarette smoking and carcinoma of the lung; but we get to the point where we can say there is no scientific basis, philosophically, for anything. We cannot prove anything philosophically. We can certainly say that the correlated links are strong. I think the onus should be on the manufacturer rather than on us to prove it.

4370. You are saying that if Dr Nanra has 100 patients who all eat and drink different things but take the same sort of powders, it is fair to assume that the powders are the cause of the problem?——W. Not just in the case of Dr Nanra. We know from all round the world that a lot of other correlated causes have been produced and analgesics always seem to be the major one. Their demand would also suggest that there is a physiological reason for analgesic association with kidney abuse, which I think most people would agree we do not have as much detail about as with the cigarette and lung cancer situation.

4371. Mr HEALEY: What steps, if any, does the commission take when foreign doctors apply for registration in New South Wales and are granted it? Are they given any instruction as to their responsibilities in respect of prescribing such things as methadone or are they set out in the main stream and have to rely on literature?——W. (*Dr McEwin*) In short, they go out into the main stream. One of the benefits of decentralization is that the regional director and his staff are close to the community and they know the shortcomings in training or a new doctor's lack of understanding with our language or culture, that is, in regard to people who come from other countries. These things are notified to the commission in Sydney. The Medical Board also is notified and it may suggest to a doctor that perhaps he needs more training in some fields or that he needs some certain information. That is done quite often.

4372. Would it not be better if he were given this information before being granted registration? Should he not then be given instructions as to things he must not do and cannot do?——W. We have done that. The suggestion is a good one. We have done that in one instance. (*Mr Dash*) We did that at one stage. Foreign graduates who come in for registration are required to be interviewed by the Registrar of the Medical Board before being granted registration. At one stage we arranged for him to have supplies of the material we produced, explaining the requirements of the Poisons Act for doctors. I cannot say whether this is still being distributed.

4373. If such a person had that material given to him he could not come back later and claim that he did not understand the position?——W. (*Dr McEwin*) The matter has been discussed at the Medical Board, and while I may not necessarily agree with its conclusion, its view was that it was the responsibility of the doctor to know the law and the customs of his new country and become familiar with them.

4374. In your original submission in October, 1975, dealing with movement reports, you said:

> These reports facilitate the reconciliation of manufacturers', wholesalers', pharmacists', and medical practitioners' records. All reported inward and outward transactions together with computer stock balances for each manufacturer, importer, exporter and wholesaler are printed every four weeks and forwarded to the appropriate State Health Authority.

Your submission states also:

> The monitoring system also gives estimated consumption figures on a State-by-State basis. This report, also available each four weeks, lists total drug quantities moved from the reporting authorities to non-reporting authorities (e.g., supplies to retail pharmacies, hospitals, medical, dental and veterinary practitioners). Figures for the last six four-weekly report periods, plus a year-to-date figure, are also printed so as to observe seasonal trends.
>
> Reports of nominated drugs covered by the system on purchases by retail pharmacies, hospitals, medical practitioners, etc., can be provided on request. These describe all purchases by form, strength, brand, and packsize, as well as the date of purchase and from whom. They can cover any period within the two years preceding the current date.

That would cover things like methadone and the restricted drugs. If that coverage was extended to cover minor analgesics, would that make the job of the Health Commission easier?——W. (*Mr Dash*) Not really, because it would be a major exercise to introduce that sort of monitoring system to cover analgesics. It was a major programme to introduce the monitoring system to cover drugs of addiction. It took about nine months to introduce the programme. New South Wales, the largest State, was the last on the computer. We had the largest number of reporters because we had the largest number of manufacturers. It is a major programme even within the range of drugs of addiction. I would say it would be almost impossible to extend it to other groups of drugs, just from the point of view of providing the resources to run the system.

4375. CHAIRMAN: Are there other renal units in the country apart from the one at Newcastle?——W. (*Dr McEwin*) There are several units in the city of Sydney. There are renal services and renal units. The renal service is usually taken to mean a dialysis service, an artificial kidney service, whereas the renal unit is usually taken to indicate a much more exotic and complete facility often involving transplantation as well. There are several such units in the city of Sydney.

4376. Are there any other units in the country?——W. Not a renal unit. A renal service has been contemplated for the Wollongong area and a service has been contemplated for Bathurst, but it is only for dialysis.

4377. You do not think that perhaps this has operated in reverse, that the spotlight has been put on to Newcastle because there is a unit there?——W. That could help but I do not think it obscures the main cause which we discussed. The service at Newcastle is not as advanced as most of the units in Sydney. The service in Newcastle might hang largely on the enthusiasm and dedication of the doctor we discussed.

4378. I think Dr Nanra was critical of the booklet prepared by the Commission. He has said that the problem of analgesic abuse and analgesic nephropathy was related almost entirely to analgesic mixtures and not individual compounds. I think he wrote to you in those terms?——W. Yes.

4379. What was your reaction to that?——W. I think that is a reasonable opinion but an idealistic one, in that I do not think it is possible to stop the use of analgesics and the recommendation of the National Health and Research Medical Council does not seek to do that; it seeks to restrict access, particularly to compound analgesics, so that they are harder for people to get.

4380. He has said that terminal renal failure due to analgesic abuse has shown no decline. Apparently that is an opinion that you agree with?——W. Yes. (*Mr Dash*) We would have to rely on the reports that the doctor and other renal physicians give us. (*Dr McEwin*) I was present at all the discussions at the National Health and Research Medical Council and that was the opinion there.

4381. Do you think it is fair for the doctor to say that the booklet places the entire blame of nephrotoxicity on phenacetin alone and appears to support the views of the pharmaceutical industry?——W. I think it might be overstating it a bit.

4382. Have you had the opportunity to read the evidence given to the committee by the Proprietary Association?——W. Not in full. I have read some of it.

4383. That association contests a number of the opinions that have been expressed?——W. Yes. It has also discussed these matters with the Commission and advanced its views to the Commission. Having listened to those views we are still strongly of the opinion that analgesics should be controlled by legislation.

4384. Are there any other matters that you would like to draw to the attention of the committee?——W. No, not on analgesics.

(The witnesses withdrew.)

(The Committee adjourned.)

*AT SYDNEY ON THURSDAY, 29 SEPTEMBER, 1977*

(Held in the St James Road Court, Sydney)

**Present:**

Mr V. P. DURICK, B.A., M.L.A. (in the Chair)

| *Legislative Council* | *Legislative Assembly* |
|---|---|
| The Hon. MARGARET DAVIS | Mr B. McGOWAN, B.A. |
| The Hon. C. HEALEY | Mr R. C. A. WOTTON |
| The Hon. F. M. MacDIARMID | |

DAVID MAXWELL STOREY, member of the Health Commission of New South Wales and Commissioner for Environmental and Special Health Services, of 50 Barker Road, Strathfield;

GARRY ANDREWS, member of the Health Commission of New South Wales and Commissioner for Personal Health Services, of 78 Kent Street, Epping; and

ROBERT ARTHUR JOHN WEBB, officer of the Health Commission of New South Wales and Senior Psychiatrist in charge, Drug Education, of 26 Sherwin Street, Henley, were sworn and examined.

ROBERT MACDONALD DASH, an officer of the Health Commission of New South Wales, Co-ordinator of Scientific Services, of 4 Blair Place, St Ives;

ANDREW PETER DIEHM, Director of the Central Drug and Alcohol Advisory Service, of 17 Virginia Street, Blacktown; and

GARRY JAMES EGGER, Senior Research Officer, Division of Health Services Research, of 29 Bay Street, Mosman, were further examined:

4385. CHAIRMAN: You gentlemen have each received a summons under my hand issued under the Parliamentary Evidence Act?——W. (*All witnesses*) Yes.

4386. Dr Storey, is it correct that you are responsible for the preparation of medical plans in the event of a natural disaster in New South Wales?——W. (*Dr Storey*) Yes.

4387. How many victims must there be before an accident is classified as a disaster?——W. According to our present plan, thirty.

4388. So if an aeroplane, a tourist bus or a train crashed and there were thirty victims, that would be regarded as a disaster?——W. If they were significantly injured, yes.

4389. Do you believe the use of heroin is often hidden from public gaze so that the physical effects are not obvious for all to see and the results of its use are more insidious?——W. I think there must be a great deal more use of heroin than we ever get to know about.

4390. A witness before this committee gave a list of thirty-four young people who were known to have died during the previous twelve months. This list had been drawn up by three people whom he was treating. He advised the committee that he knew of ten others. Would you regard that as a social or medical disaster?——W. I think it is certainly a social disaster.

4391. Then do you feel it is necessary to organize some sort of plan to meet such a situation in the same way as you plan to cope with a physical disaster?——W. I think a plan is required. I would not care to draw too close an analogy between the two.

4392. Are you aware of the terms of reference of this committee?——W. I would have read them originally. I could not call them all to mind with complete accuracy today.

4393. Have you given any consideration to particular sections of the terms of reference that might apply to your own work?——W. In my relationship to the control of the administration of the Poisons Act, legislation would be my main involvement. I have considered that constantly.

4394. Have you any particular recommendations, or have you given consideration to any particular recommendations that you may make to this committee to help it in the preparation of the report that will ultimately be submitted to Parliament?——W. It is important that the Commission does have an alcohol and addiction service whose responsibility it is to co-ordinate our efforts in that regard and to maintain a close liaison with the body recently set up by the Government in this area.

4395. What action has the Health Commission taken, with the Minister for Health, about restriction of analgesics offered, following the recent National Health and Medical Research Council recommendation or at any earlier stage?——W. We have given the matter a good deal of consideration both within the Commission and in association with our representation on the National Health and Medical Research Council, a role which is usually fulfilled by our chairman, Dr McEwin. I represent the commission on the Public Health Advisory Committee of the National Health and Medical Research Council, which receives recommendations in this area.

4396. You are fully conversant with the terms of the recommendation of that committee?——W. I have read them. I could produce them.

4397. Dr McEwin said he supported the recommendations. Do you support them also?——W. Yes.

4398. Is that an official view of the commission?——W. I do not know that the Commission at this stage—as a corporation—has given consideration to the recommendations. The normal course of events would be that the recommendations would be conveyed in the first place to our Poisons Advisory Committee, which is the State body responsible under the Poisons Act for advising the Minister and the Commission in these areas. Then it would come to the Commission by way of suggested regulation, to be conveyed to the Minister.

4399. That is the procedure in regard to the legislation that you mentioned just now. You would regard those regulations as part of the legislation under the Poisons Act?——W. Yes, but I might say that the Minister has directed that we should stay action in this regard pending the outcome of the deliberations of your Committee.

4400. Has any serious consideration been given—supposing these regulations and the recommendations were accepted—to the social and psychological consequences that might flow from them to people who rely greatly on compound analgesics?——W. I think that in the vast majority of cases they could be withdrawn without any undue harm to these people. Some may need assistance, but I would think it was a very small percentage.

4401. What sort of assistance would they require?——W. They may need psychological or psychiatric help during the period of withdrawal. (*Dr Egger*) I may have mentioned before that we have a research programme set up to look specifically at this problem of the help that people may need if compound analgesics are not available.

4402. Do you think it would be necessary to mount an education campaign to acquaint people of the problems that they may meet and to convince them that what is being done is for their physical good?——(*Dr Storey*) I think that would be very desirable.

4403. Has the commission any plans to mount such a campaign?——W. I will refer that to my colleagues, but the commission quite recently produced a pamphlet on the dangers of misuse of analgesics. (*Dr Egger*) There was an educational campaign set up originally to do just this, in the absence of any restriction being brought down. When the restriction was mooted by the National Health and Medical Council in April of this year it was decided that educational campaign be held over and instead to look at the effects of the restrictions and to build in a specific educational programme in different areas—in particular, the Newcastle region—to examine the new types of education that might be needed if and when the restrictions are brought down. The answer to the question is really that there is no overall plan for an educational programme, but each specific region is looking into the education that might be needed if and when the restrictions are introduced.

4404. Talking about education in regions, the pamphlet that you mentioned did not meet with the full approval of some of the people in the Hunter region, did it?——W. (*Dr Storey*) We are aware that Dr Nanra made some criticism of it. We did not take quite such a serious view of the material that he criticized. I do not think it was really as counter-productive as he suggested.

4405. It has been said in evidence before this committee that the figures relating to prescriptions issued under the pensioner medical service for APC powders for the years 1961 to 1967 dropped from approximately 390 000 to 250 000 in the first two years; then in 1964–65 to 21 000; in 1965–66 to 17 000 and in 1966–67 to 14 000. So in a period of six years the drop was from 390 000 to 14 000. In 1963–64 there was a major publicity campaign about the harmful effects of compound analgesics, particularly about nephropathy. It has been concluded that as a consequence of that campaign the number of prescriptions dropped from 390 000 to 14 000. Dr McEwin seems to think that education does not work effectively in this field. Would you not consider that these figures would be fair evidence that an education campaign of that nature can be effective?——W. Before answering that I would like to see if any of my colleagues, particularly Mr Dash, could remind us whether there were any financial constraints that may have had some effect. For instance, were pensioners being required to meet some part of the cost of their PMS prescriptions?? (*Mr Dash*) No, pensioners were not required to meet some part of the cost. On the other hand the way in which benefits have been listed and the components that have been available as benefits have changed quite considerably over that period. I would think that could have had quite a fair influence. On the other hand it is the prescriber that controls in most cases —we hope—the amount of any particular drug that is prescribed, and not the patient. So if an education campaign had been successful I would think that it would have been successful amongst doctors rather than amongst the general public. But I still feel those other factors, particularly the formulations that were available for prescribing as benefits would have had a major influence on what was being prescribed. (*Dr Egger*) In my view—and I add that it is my view—there is a range of substances, addictive substances, ranging from the complete non-addictive consumer-type product to the very highly addictive substances such as heroin. Along this continuum there are things like compound analgesics. I feel that education and banning of substances at one end of the consumer substances will completely eliminate that. It is something that is not absolutely necessary, that somebody is not psychologically dependent on. At the other end of the scale banning or restricting that substance has little or negligible effect. Compound analgesics are more towards the non-addictive end, and banning of the substance is not likely to reduce the problem that we have.

(*Mr Dash*) I draw an analogy with what happened with the bromoureides and I recall the considerable concern a number of years ago about the dependence on Relaxa-Tabs. This concern was expressed at various committees, through the media and amongst the professions. Regardless of the expressions of concern, the use and abuse of Relaxa-Tabs continued fairly unabated. When bromoureides were restricted to sale on prescription only their use practically died overnight. I would think that there is a fair analogy between what happened with bromoureides and what we might expect to happen with compound analgesics.

4406. Dr Andrews, how long have you been a member of the Health Commission?——W. (*Dr Andrews*) Almost twelve months.

4407. What was your appointment in the commission before you became a commissioner?——W. Regional Director of Health for the Western Metropolitan Region.

4408. For how long did you hold that position?——W. Approximately three years.

4409. Did the Parramatta Psychiatric Centre come within that area?——W. Yes.

4410. Is Wistaria House regarded as part of the Parramatta Psychiatric Centre?——W. Yes.

4411. And Jacaranda House?——W. Yes.

4412. You probably had the opportunity to see these buildings quite often during the period you were regional director?——W. Yes, I would have. I would have made formal inspections on at least three occasions, as that was an annual event.

4413. Were you satisfied with the buildings and with the equipment there?——W. No.

4414. Do you know of any action that was taken in the last three years to improve the conditions there?——W. There were submissions made to the Hospital and the hospital makes its submission to the Region for funds to update the facilities, and for maintenance and so on. Except for routine maintenance—that is painting and general refurbishing which took place in that period—there were no major works undertaken on Wistaria House or Jacaranda House. However, I must say that the general maintenance work and the painting made a considerable difference. It was an improvement on what it was before that.

4415. Are you talking about Wistaria House, or Jacaranda House, or both?——W. Both.

4415A. Have you had the opportunity to study alcohol and drug centres in Victoria, South Australia and Western Australia?——W. I visited South Australia and Western Australia with the Minister fairly recently to look at what was happening there.

4416. What was your impression of the centres that they had available?——W. I thought they were very reasonable. They were mostly in older type buildings. There were exceptions to that. From memory, in Perth they had quite a new facility that had been recently constructed. In most cases they were in refurbished cottage-type facilities and they were of very reasonable standard.

4417. You said that you are the Commissioner for Personal Health Services. Would you tell the committee what that broadly covers in terms of the Health Commission's charter?——W. In very general terms it covers all of the areas of delivery of health care to the community. So it includes responsibility for the provision of general hospital services, mental health services, community health care, liaison with professional groups and the general issues associated with the delivery of medical and paramedical services.

4418. Within the commission itself you would be the one responsible ultimately for the alcohol and drug dependence services?——W. Yes. It is rather difficult to define precise line responsibility for individual Commissioners. We have a general responsibility as defined in the appointment as individual commissioners, who are appointed by position. That responsibility is generally defined in the structure of the Health Commission so that the areas are divided up. There is not a great degree of specific delegation. So there is a corporate responsibility for the general affairs and operations of the Commission in all its areas, and the individual commissioners exercise authority and responsibility over broadly defined areas. It is not terribly clear-cut. It would be a responsible statement to say that that would fall within my ambit.

4419. I will approach it in another way. Mr Diehm is responsible for alcohol and drug services—he is in charge of that particular section?——W. Yes.

4420. If he had a specific submission to make does he make it to the commission as a whole or to you?——W. In many areas if it is a matter of general policy it would go to the Commission as a whole through the medium of a business paper presented to a Commission meeting. That business paper would go to me in the first instance for approval to go on the Commission agenda and for any further information that I might require to put to the corporate body.

4421. On one occasion the members of the committee were at Wistaria House on a day when the weather was most unfavourable. We were told on that occasion that when there was an overflow there they had to shelter for the night in Jacaranda House, which is on the other side of the river. The only way that those people could get there was to walk in the rain from Wistaria House to Jacaranda House. No official transport was provided. Do you think that is a satisfactory condition?——W. As stated, no. I would not have been aware that that was a common problem or indeed that it was a situation that had occurred.

4422. How do the people normally get into Jacaranda House? Are they not the overflow from Wistaria House? ——W. Do you mean on an emergency basis when there is simply no further accommodation in Wistaria House?

4423. Yes?——W. My understanding was that it was used as an adjunct to Wistaria House but I was not aware that it was used purely for overflow purposes.

4424. At Wisteria House treatment is given, but members of the Committee did not see any evidence of that at Jacaranda House?——W. (*Mr Diehm*) That would be correct. There is a distinction between the functions. Wisteria House is the treatment centre. Persons ready for discharge, or for work, may use Jacaranda House for a short period, during that transition period from Wistaria House to the community. It is not intended as an active treatment unit. I should have thought there would have been little occasion for traffic between the two places in the circumstances you have mentioned. My impression was that they ran substantially independently of each other. (*Dr Andrews*) That was also my impression.

4425. There seems to be an administration in charge of Wistaria House: Who is in charge of Jacaranda House? ——W. (*Mr Diehm*) The same administration and the staff of Wistaria House would have a supervisory responsibility for Jacaranda House which has never been intended to operate as a sepatate unit. It is part of Wistaria House, but part of which the people living in and responsible for have a much greater personal responsibility.

4426. Is it not a fact that one of the male staff has to go there every couple of hours during the night to check that everything is all right?——W. I think that is simply part of the regulation of the Hospital as a whole. I do not think that is a particular arrangement between Wistaria House and Jacaranda House. I think that supervision at that level is necessary, but that applies to every ward within the Hospital.

4427. Coming back to the provision of alcohol and drug dependency services, are regular reports made to the commission in regard to the provision of such services?——W. (*Dr Andrews*) There is a reporting system which works throughout the whole of the Commission's operations so that on a regular basis reports are made by individual psychiatric hospitals and then by regions in a number of forms—monthly reports from the Region to the Commission on matters of concern relating to new developments and so on—an annual reporting system—two annual reports—one under the public service regulations and the other in relation to the formal Health Commission's annual report. In addition, reports are called for from time to time through the Commission's advisers but, except for the annual reporting provision, that would not be a regular event—only as issues arise.

4428. On page 12 of the most recent submission from the Health Commission under section 7.3, Central Services, this appears:

> The Central Drug and Alcohol Advisory Service, now administered through the Inner Metropolitan Health Region, has responsibility to the Commission and to all Health Regions in the following areas:
>
> policy formulation in relation to both treatment and prevention services;
>
> staff training programmes;
>
> forward planning for development of services;
>
> monitoring of regional services.

Could you tell us what part you play in that part of the organization?——W. I have no direct involvement in that operation but in relation to those areas, that is policy formulation, recommendations for staff training, forward planning for development and monitoring, where there are matters of policy the Director of the unit would refer those matters of policy to me through the Director of the Bureau of Personal Health Services to whom he is responsible for that function. If they were matters that could be dealt with by the Bureau or by individual Commissioners they would be dealt with in that way but if they were matters going beyond that they might be put forward in the business paper form I have mentioned.

4429. You may have had the opportunity to have a look at the terms of reference of the Committee. What particular section of the terms of reference would apply to your own work?——W. I think the very general areas that relate to education, to preventative counselling treatment and rehabilitative services, particularly 4 (c) preventative counselling treatment and rehabilitative services. In other words, the delivery of services to the community.

4430. Are there any particular recommendations that you feel should be put before the Committee that it would not be aware of already?——W. I should really like to strongly endorse the brief comment Dr Storey made about the need within the Commission's structure for the creation of a division. There are a number of reasons why I believe this should happen. The Commission works under a system of fairly complex organization with a central corporation with both bureaux and regions. As the Committee will be aware from the discussion this morning, the direct line of responsibility in relation to a number of areas is not very clear in many instances since a great degree of delegation is made to individual regional directors for the provision of all services in their areas and most of the central responsibility is of an advisory nature in respect of the bureau and the Central Drug and Alcohol Advisory Service of the commission has available to it information that comes through only that regional system, in any detail. Indeed, the Regional Director, given his broad responsibilities for the delivery of the whole of the health services, very often to large areas of population like the Western Metropolitan Health Region with one million people, is not in a position to have detailed information and knowledge of all the services for which he is responsible and is dependent on various mechanisms for reporting. In an area like drugs and alcoholism there is need for special advocacy. There is a number of such areas—mental retardation, mental health services generally, geriatrics and, for instance, rehabilitation. The reason that the division is needed, headed by somebody with considerable status, and given specific responsibility and delegation, to see that the objects of the Commission are carried out, is that I believe it is the only way that can be effectively exercised in areas that tend to get a low priority in the minds—not necessarily consciously—of people who have responsibility on a day-to-day basis for administering the service. Those matters may tend to be over-shadowed by some of the other major areas of activity like the operation of the general hospitals which consume vast quantities of resources and funds. I think by virtue of it being a division headed by a responsible, authoritative and respected person, the Commission can be assured that real attention is given to those important areas and that, through its regional system, through the authority that will be delegated to the director of such a division, its objects can be carried out, through the regional system, and in relation to the operation of individual units. I believe that the Commission could also be assured that it has drawn to its attention special areas of need, or gaps, which might occur from time to time in relation to the delivery of services which is not so easy to achieve now, as part of the broader system.

I further endorse the remarks of Dr Storey about the creation of a drug and alcohol authority, of which I have been appointed interim deputy chairman. In the broader areas of drug and alcoholism services, which go beyond the areas that the Health Commission has direct responsibility for, particularly in the organization of areas of general education and the promotion of voluntary effort and the over-all co-ordination of drug and alcohol services, including perhaps an approach to community education generally and linking with the media and with the efforts of voluntary organizations, the fact that there is such a body and that there is a parallel body, not in the sense of duplicating services but with a responsibility in the specific area of delivery of treatment and rehabilitative services, means that there can be a far more comprehensive approach to tackling this particular issue rather than as part of the general system.

4431. How often are you able to visit Health Commission treatment centres for alcohol and drug addiction?——W. In my capacity as Commissioner?

4432. Either in hospital or out of hospitals?——W. I would say not on a very regular basis in the past. Given the size of the State, the number of regions, the fact that I have a responsibility also in relation to public hospitals, community health centres, mental health centres, psychiatric hospitals and drug and alcohol services—regular visits to specific centres would not be feasible.

4433. Is it possible for you to visit any of the voluntary organizations supplying these services?——W. It is my intention, in my new role as deputy chairman of the interim body, to pay at least an annual visit to the major —and some of the minor—centres for drug and alcoholism services within the public hospital system and the community health programme and the voluntary organizations. To that end I have undertaken such a programme fairly recently where I had a look at a number of the services in the inner metropolitan health region and the northern metropolitan health region. I see that as important but, more in relation to my new responsibility, than as commissioner.

4434. Mr Diehm, are you able to visit the Health Commission's treatment centres?——W. (*Mr Diehm*) Yes.

4435. What about the voluntary health centres?——W. Many of them—not all. I work closely with the Salvation Army and the Sydney City Mission and, to a lesser extent, with drug referral centres. WHOS I have not visited in some eighteen months but I visit regularly those agencies of the Government service in all the health regions.

4436. What are your views on the treatment offered at the William Booth Clinic?——W. For the particular group of people for whom it seeks to operate I think it is excellent. The clinic provides a specific and self-selecting programme so those undertaking the programme are likely to do well. By the same token, it is not a programme of value to every person. In relation to narcotic addicts I think it has limited value. In relation to alcoholics, it has a great value for those who have reached a particular stage in their drinking career. As part of an early intervention programme, for example, in relation to clients we send to drug community centres, it would not be appropriate but for the group at whom it aims its services it is very good indeed.

4437. Could you explain why they should be successful in one field and not in the other?——W. Yes, like many services, they have tried to draw too close a parallel between different alcohol programmes and narcotic programmes and in some instances they fail to take into account significant differences in the needs and resources of individuals. There is a significant difference between the young narcotic population and the middle-aged alcohol population.

4438. Have you had the opportunity to study drug abuse in other parts of the world?——W. Yes. I visited centres in the United States of America, Canada, Austria and Sweden.

4439. Are there any particular aspects of treatment in operation in other parts of the world which you regard as feasible in New South Wales but not yet in operation here?——W. Yes, in minor areas. My first impression, which has been confirmed by recent attendance at international congresses on addiction, is that in relation to general services New South Wales is more advanced than most countries, particularly in the development of community alcohol and drug services. The particular areas where we might profit are in relation to programmes that seek to establish contact with people outside the formal structure of health services, by getting at people in the streets, like the detached worker programmes I have seen elsewhere. We could profitably explore this area in relation to narcotic problems and adolescent drinking problems.

4440. Have you had the opportunity to see what is being done in South Australia and Western Australia, where they operate under a special Act of Parliament?—— W. Yes, I have.

4441. Do you see that as an advantage?——W. Possibly, because of their small population, the small scope of their services and the limited geographical distribution of those services. I do not think that approach would be of value here where the situation is much more complex.

I think the approach in New South Wales should rather be to the integration of alcohol and drug services within the context of the general community health services, rather than trying to isolate things. There is more opportunity here than perhaps in any other State to take advantage of a range of general health services and if the addiction services were isolated they could be denied to people.

4442. What is the situation in Victoria?——W. There is a much greater reliance there on institutional services than community services. I think that the ultimate goal in both States is much the same but we started in different directions. In New South Wales we are concerned with established community services, without being too preoccupied with building up major institutional services to start with. In Victoria their concern in the first three years of the community programme was to build up the institutional base and to extend from that base into the community. I think the move into the community is now starting to gain some momentum in Victoria. In that State there is a much heavier emphasis on institutions than there is here.

4443. In Victoria they work within the Health Department?——W. Yes, but they do have a special section.

4444. That is envisaged here, is that not so?——W. I think our division covers the same area but I think they have a rather different structure.

4445. The drug authority that Dr Andrews mentioned, of which he is deputy-chairman, will be more or less an advisory body that will make decisions and recommendations about grants to voluntary associations but will have nothing to do with the treatment of people; is that correct? ——W. (*Dr Andrews*) That is the assumption at this stage. Until the authority makes recommendations to the Government through the Minister for Health about the legislation under which it will finally be created, that is still an open question.

There is a certain amount of consensus that that is the way it should be. In think that it would be fair to say that it is also the view of the Health Commission although it has not been laid down so far. It has been our assumption that that has been the Government's view to date.

4446. Mr Diehm, you heard Dr Andrews say that if they wanted to improve the physical circumstances at Wisteria House or Jacaranda House, an approach would have to be made through the hospital there?——W. (*Mr Diehm*) Yes.

4447. Do you know of any approaches that have been made to improve the physical circumstances of those places?——Yes.

4448. Have they been unsuccessful?——W. Yes, to date. I am not sure whether they have been brought into this year's estimates or not. Last year an approach was made by Dr Edwards, Medical Superintendent at Parramatta. A submission was made for half a million dollars to upgrade those two places. That submission was made to the western metropolitan region. I am not sure whether that has been included in the estimates. A copy of that submission went to the commission. I do not know of any decision about it.

4449. You do not think it would be better to put a bulldozer through Jacaranda House and construct a completely new building?——W. If that were a possibility, I think there would be some real advantage in looking outside a psychiatric hospital for a unit of that kind; within the psychiatric hospital, perhaps quite a different sort of unit would be more appropriate.

4450. What is serepax?——W. (*Mr Dash*) It is one of the benzodiazepines. It is a minor type of tranquillizer.

4451. Have you had any experience about its excessive use?——W. Yes, I think there has been some concern about the extent of use of all benzodiazepines, not just Serepax, which has had some proliferation in its use since it came on to the market a few years ago. I do not think you can really separate the use of Serepax from the use of other drugs of that kind, such as Valium and Mogadon which, although it is promoted for a different purpose, is a related drug in structure and activity.

4452. Would you like to see restrictions on those substances?——W. Yes. That is a personal opinion. In fact, it did have some limited restrictions placed on its use in that it was classified as a prescribed restricted substance under the Poisons Act and its unauthorized possession was an offence. That did not limit the way it could be prescribed by doctors or the extent to which it could be prescribed. On the other hand, the federal Government has taken some action under the pharmaceutical benefits scheme to limit it by the conditions under which it can be prescribed or the number that can be prescribed at one time. The net effect of that is that often prescribers, instead of writing prescriptions for it as a pharmaceutical benefit, write a prescription outside the scheme. It then ceases to be an economic advantage to patients to have it dispensed for them as a pharmaceutical benefit. They can have fifty or a hundred dispensed as a private prescription for the same cost or a smaller cost than they can have multiple prescriptions for twenty-five, which is the maximum quantity allowed under the pharmaceutical benefits scheme.

4453. Are you aware that valium is available over pharmacy counters in Hong Kong and Singapore?——W. I have heard that.

4454. And apparently there is no restriction on bringing it into Australia?——W. I think the customs people would have something to say about that. (*Dr Storey*) I think they would have something to say about that. When I was away recently I carried a couple of capsules of a mild substance to help me sleep on aircraft. A great flurry was caused when I brought them back into Australia (*Mr Dash*) Of course, the Customs people would have a considerable number of problems trying to search every person coming into the country to see whether they were carrying quantities of these substances.

4455. Mr Diehm, could you give the committee an indication as to whether the methadone programme revealed that methadone clients use other drugs heavily? ——W. (*Mr Diehm*) Yes, the evaluations carried out to the end of the 1975–76 year indicated that a high proportion of clients on methadone at that time used other drugs as well on occasions. I do not know with what frequency they were used. The random urine testing just identified that on particular occasions they were using other drugs.

4456. Who did that evaluation?——W. The Division of Health Research.

4457. Dr Chegwidden indicated that many people on methadone programmes were heavy users of alcohol?—— W. That is a well-known fact. That represents a change over the past five years. About five years ago it was unusual to find a methadone user also a drinker. Now most of the people who are on methadone, drink and a significant number of them drink heavily. (*Dr Egger*) We often ignore the fact that addiction is not a drug problem but a personal problem. It is not so much a matter of the substance but often it indicates an addictive type of personality. If he prefers some substance that is unavailable, he will go to the next preferred substance. Most addicts are poly-drug users.

4458. In the memorandum tabled in Parliament on 30th March it was recommended that a full-scale review be made of the Poisons Act. What action has been taken to implement that recommendation?——W. (*Dr Storey*) As you are aware, a revision—not yet a full-scale revision —was made and the Minister for Health recently presented legislation in relation to penalties.

4459. That concerned the growing of certain prohibited plants? Apart from that you do not know of any procedures that are in train to amend the Act?——W. (*Mr Dash*) I do not think any procedures are in train right now other than consideration of proposals related to schedule 3 substances which came under review as a result of a recent submission to the National Health and Medical Research Council and a recommendation subsequently made by the Council.

I must confess that I saw the recommendation which the committee made as a suggestion rather than a confirmed recommendation. I anticipated you would have something more to say about this when the final report was brought down.——W. (*Dr Storey*) There is a high desirability for uniform legislation as much as possible between the States. It is not entirely achievable but it is desirable that these matters be handled through the appropriate committees of the National Health and Medical Research Council so that we can get as close as possible to uniformity, otherwise it throws the trade into confusion.

4460. Could you tell us what the procedure would be to bring in an amendment to the Act? Suppose a firm recommendation is made by this committee, what would happen? ——W. (*Mr Dash*) The procedure would be that a proposal would be prepared for the Commission to consider— in the form of a business paper setting out the principles that it wished to incorporate in new or amended legislation. Subject to the Commission agreeing with that, the Commission would then make a recommendation to the Minister seeking an approach to Cabinet for Cabinet approval to prepare a bill.

4461. The Premier announced the Government's intention to set up a drug authority on 27th April of this year when he opened the Bourke Street establishment. Can anyone tell the committee why a further five months elapsed before it was set up?——W. (*Dr Andrews*) I am not sure whether I can give you the whole background, but from what I know of it the Premier's announcement at the opening of Bourke Street was the first intimation that the Health Commission had formally of the Government's decision to set up such an authority. Following that announcement by the Premier a consultative committee was set up by the Commission consisting of a number of Commission officers and a couple of other people from other States who had some knowledge and experience of this issue and who could advise us. As a result of that consultative exercise some advice was given to our Minister as to what the Commission's views were about the creation of an authority and making some suggestions about the terms of reference in relation to the Commission itself, staffing and other matters. I think the way the Commission saw it then was that it was a matter for the Government. The Government had made the decision, we had offered some advice, and the question of the creation of such an authority, its membership, terms of reference and so on was a matter for further consideration by the Government. We really awaited that action.

4462. Do you see the possibility of conflict between the authority and the supply of medical and hospital services through the commission?——W. We see the potential for it, but I think that proper consideration being given to this at the outset will avoid conflict. In relation to Western Australia, I know that the health authority there is most concerned about the separate body that is providing services, and is most critical of that approach. That has been specifically expressed to me by Dr Jim McNulty, the chief of the Hospital and Public Health Services.

4463. Is that because they are outside the commission? Is he jealous of the role they are playing or is he critical because of the quality of the services they render?——W. No, his view is that the fact that they are not integrated with the general health services creates a number of problems. They are isolated and do not have the benefit of the back-up services of the various related health and hospital services needed to provide a comprehensive approach. It is primarily in this area of treatment that he is concerned that there should be integration. With a separate authority responsible for treatment as well as the other issues, this is non-achievable. If we recognize that in New South Wales and define precisely the Commission's responsibility and the responsibility of the Authority at the outset, we can avoid any conflict. As a model the State Cancer Council might be an interesting comparison. Indeed, that council goes further; there is a demonstration unit set up within one of the hospitals. We even foresee the possibility that the Drug Authority might be responsible for sponsoring pilot projects or demonstration projects, in co-operation with the Health Commission. So I do not see their being totally excluded from involvement in this area. I certainly see them making recommendations to Government concerning the allocation of resources for treatment in this area.

4464. I do not think we have any hospital for the treatment of alcohol or drug dependence similar to the one that they have in the West?——W. They have a detoxification unit. The nearest we come to it is the Langton Clinic, which is not dissimilar.

4465. One of the aims of the new drug authority is the establishment of a data collection unit to gather information and draw conclusions on the size of the drug population in New South Wales, the ages and geographical locations of the offenders, the class and quantity of drugs of addiction, new trends and the use of various drugs for addiction purposes and the source of all drugs available in New South Wales, either local or imported. That sounds more like the terms of reference for a Royal Commission, but perhaps if I could go through each of those in turn and those of you who are interested in a particular matter might give the committee some information. What information is available in New South Wales in regard to the size of the drug population in this State? Have we any reliable estimate?——W. (*Dr Egger*) I do not think we have a reliable estimate, although we have several different ways of measuring the size of the problem. One is monitoring surveys of drug abuse. We have another one of those coming up in the near future. Another one, which the Commission is at present investigating and which we are holding off until the new division of drug services is set up, is monitoring the use of services available throughout the State. Then again, a third level is spot surveys at different periods of time, which are not followed up or monitored at other periods. I do not think we could say we have definite knowledge, or even non-accurate knowledge of the size of the drug problem in New South Wales.

4466. Apart from the figures available to us from the courts, have we any idea of the ages and geographical locations of offenders?——W. (*Dr Storey*) We are aware of those on the methadone programme. There a number of bases from which one can extrapolate to try to get an idea of the overall problem.

4467. Of course, there are a number of areas where methadone is not used?——W. Indeed, but then if there is a programme that is not using methadone we can get figures from the clinics in some areas about estimates of the number of patients they are treating. (*Mr Diehm*) Persons who are convicted and come into the diversionary programme, in those courts where such a programme is available, provide some information. As that programme is extended to other courts this will provide a useful source of information to give us an indication of the spread, location and social profile of users.

4468. I understand that only about fifty people have gone through the programme in six months?——W. Yes.

4469. You do not suggest that there are only fifty people in the area involved in this—?——W. No. I would suggest that any information we get is a very vast understatement, because we are getting information, quite informed—

4470. There is no reliable way in which we can collect data at the present time in regard to the problem?——W. (*Dr Egger*) There is a standard survery technique, which is reliable.

4471. But is it being used?——W. Yes, but only within specific segments of the population; like the Bell and Rowe studies conducted in 1971 to 1973 and my study of alcohol in 1974. They are being combined next month and we will then have an indication of the drug problem within the population that is still at school, up to eighteen years, I think. It does not cover eighteen years and over, but it gives us an indication of the drug problem up to that age.

4472. Mr HEALEY: Might that not be only the figures up to 1974?——W. No. That is being repeated now. The figures will be for 1977.

4473. CHAIRMAN: What use was made of the other studies done?——W. Quite a deal. Originally my own personal view was that I was loathe to repeat the study I did in 1974 until I was sure that some action was taken on it. I am satisfied that a good deal of action has been taken on it. There has been a working party set up to examine the proposals put forward in the original study and that has made a number of recommendations. It has just issued an interim report. The Department of Education I understand has introduced a number of specific proposals that were recommended in the report. So I think there has been some action taken. There are encouraging signs that the study has been put to practical use.

4474. In what way would the Department of Education have used the findings?——W. Specifically I cannot say which proposals they have taken up. I know there was a lot of interest by the Department of Education in the proposals. There was a research study carried out immediately following the original study looking at the different types of education and their effects. The effect of this, I think, was looking at three different types of education—the didactic approach, the group-centred approach and the control approach, and examining the relevance of these areas. As a result of that—and before that, as a result of the proposals of the original alcohol report—I believe the Department of Education has written into its personal development courses some of the recommendations. (*Dr Storey*) Dr Webb has had opportunities to study the management of addiction overseas and has read widely about it. He has brought with him a series of contributions in the form of literature, some by himself and some by others, which I think he would like to tender to the committee at a convenient time.

4475. That is acceptable to us, Doctor, but it might be better to leave it for a little while. I wanted to follow up what Dr Egger said because it has been submitted to the committee that people are riding their own hobby horses in regard to some programmes but findings that are made are pigeon-holed and nobody does anything about them. You mentioned some of these things being written into the personal development programmes, but the use of the programme depends on the principal of the high school. We have been told that, although programmes are available, they are never used, so there is obviously some weakness in that regard?——W. (*Dr Egger*) The working party that has been set up has made a number of specific recommendations which, hopefully, will be followed through more specifically than the recommendations in the original report, particularly in relation to alcohol advertising and education. I hope that these recommendations will be taken up more thoroughly. I agree entirely with your surmise that a lot of research reports are written up but then pigeon-holed. I have been critical of this in the past but I am quite satisfied that some action has been taken on the report that I prepared. That is one reason why we are doing the follow-up and I hope recognition will be taken of it.

4476. I deal now with new trends in the use of various drugs of addiction. Is there any way that we can monitor those at the present time?——W. We will be getting an indication of new trends in use at least in the younger age groups from the study that will be carried out in October. (*Dr Storey*) Do you refer in your question to licit or illicit drugs?

4477. I am quoting from the proposed terms of reference of the drug authority.——W. (*Dr Egger*) We are covering licit and illicit drugs to the extent that tobacco and alcohol are licit, and also other drugs in the stimulant line such as amphetamines and mandrax—I cannot think of any more offhand. (*Mr Diehm*) Experience of the community drug clinics has to be taken into account. It is not documented as formally as the studies that Dr Egger mentioned, but the amount of information that they get from clinics in relation to drug trends is something that we can use as a guide. Whether it could be documented formally enough to be used by the authority I am not sure. But it is an important source that should not be overlooked.

4478. I refer now to the source of all drugs in New South Wales, whether local or imported. Is there any way you can obtain that information?——W. (*Mr Dash*) There is considerable information about licit drugs, but illicit drugs present something of a problem. I think the Commonwealth recognized this some time ago when they were framing some sections of the Customs (Prohibited Imports) Regulations and the Narcotic Drugs Act where they made provision for a presumption that certain drugs were imported. One of the major moves in this area was the prohibition in 1955 of the manufacture and possession of heroin in this State. Subsequently this has been adopted in other States as well. The reason for this basically at the time was the potential for illicit use and the fact, even at that stage, it was recognized that illegal importation could occur and possibly was occurring. It was hoped at that time that by this move it would be reasonable to assume any heroin found in someone's possession would have been imported. We know subsequently that there has been some illicit manufacture of heroin in Australia. I think a couple of cases were discovered by the police in New South Wales, where people used as starting material codeine, in one case, and I am not sure what it was in the other case. It can no longer be assumed that all heroin found on someone's person has necessarily been imported. On the other hand there are analytical techniques which can show fairly conclusively whether one particular lot of material is related to another lot which has been found elsewhere. For instance, if some heroin is found and it is known to have been imported and some other heroin is subsequently found which has been shown to have very similar properties, it can then be fairly satisfactorily demonstrated that the second lot must have been imported.

4479. But it would not tell you how much came in in the original consignment?——W. No, and I do not think there is any way of knowing how much. (*Dr Storey*) It might be pertinent to say in respect of heroin as a prohibited drug that from time to time there is an upsurge of representations from sections of the medical profession to reinstate it as an available drug. There are some who believe that there is no drug which really substitutes for heroin in terminal illnesses, and some obstetricians believe that it has an application not filled by other drugs. I am afraid I cannot subscribe to that view, but there is such a view in the medical profession.

4480. Mr Diehm, in how many health regions is methadone prescribed?——W. (*Mr Diehm*) Six.

4481. Who normally determines whether methadone is to be used in a particular area?——W. The psychiatrist who is responsible for the administration of drug services. If he wants to use methadone he must apply through the Regional Director to the medical committee under the Poisons Act for authorization to prescribe. The process is initiated in the region by the psychiatrist responsible for drug services, through the Regional Director and if authorization for him to prescribe is granted by the medical committee then the use of methadone is permitted.

4482. Is it true that the Hunter Addiction Service believes that methadone should be used only in the treatment of acute withdrawal?——W. The Hunter Addiction Services takes that view. The Newcastle Psychiatric Centre takes a slightly different view.

4483. To where would most addicts go in the first place?——W. The majority of those who have been in treatment up to now have gone to the Newcastle Psychiatric Centre. Only very recently has there been a substantial or even a significant move towards new clients coming to the community addiction service.

4484. Are the members of that service of the opinion that severe withdrawal is a very rare phenomenon? Would you know that?——W. Yes, I know that. I think that view is shared by a number.

4485. It is also supported by findings from the United States of America?——W. Yes, but for slightly different reasons. Here the withdrawal phenomenon is rarely seen and this is accounted for mainly in terms of the low quality of the street heroin. Also, there is a trend for people to look for assistance much earlier in their drug-taking career than was the case five years ago, when withdrawal with a rather serious phenomenon, or more frequently encountered.

4486. Do you believe that the provision of methadone in an area has a honey-pot effect by attracting and spreading illegal narcotic use like an epidemic of an infectious disease?——W. It can have that effect if its use is not carefully controlled. When the use of methadone was first introduced into Sydney there was a concern to attract narcotic addicts to treatment services by the use of methadone. That was abandoned fairly quickly, but there have been a few instances where the use of methadone had not been controlled with sufficient care. The method in which it is prescribed and the failure to observe the criteria recommended for the use of methadone has created this honey-pot impression. The Commission is well aware of this now and is doing quite an amount to overcome that possibility by introducing throughout the State much more stringent criteria for the use of methadone.

4487. A statement has been made before this committee that the increase in the illegal narcotic use in New South Wales in the past few years can be directly related to the extension of the methadone treatment programme. Would you agree with that statement?——W. No, I would think that was a little bit fanciful. I would say that methadone centres have been identified as places where a certain amount of trading goes on. I would think also that it is possible for people who were not in fact physically addicted, to have come to the centre to go on to methadone and to be involved in the drug culture in that way. I would not think that the use of methadone has had any significant relationshlp to the increased usage of narcotics.

4488. Are you aware of the case in Wollongong—and I am talking about people who have come for treatment —that has been the subject of a coronial inquiry?——W. (*Dr Storey*) Are you thinking of a patient who developed type B hepatitis?

4489. I understand that somebody who went to Wollongong Hospital claimed he was an addict and subsequently he died. He was not supposed to be an addict. Perhaps we had better not tread on that ground.——W. I am not aware of such a case. (*Mr Dash*) If I may add something to what was said about the use of methadone and its contribution to the number of addicts, I think that quite a lot of the methadone which has been available and used by addicts has been either prescribed illegally—that is without the authority of the Health Commission—or, more particularly, obtained by means of forged prescriptions. Over the past day or so I have made inquiries to ascertain the current situation. I found that forged prescriptions continue to be a serious problem in relation to methadone. It highlights the need for some tighter control over the authentication of prescriptions for certain drugs of addiction.

4490. If what you say is true should not it be possible to find evidence that people who are not receiving methadone illegally but are receiving it legally through the treatment service show some recovery rate? Would not that be the aim?——W. (*Mr Diehm*) Methadone of itself is not a treatment programme. It is an adjunct to treatment. Often it has been seen as the programme in itself—the beginning and end of the whole deal. A number of persons have come along to get methadone simply to make their continuing use of heroin possible.

4491. Is it not true that there is no convincing evidence that the use of methadone will increase the addict's chances of coming off narcotics?——W. It depends entirely how the methadone is used. It is the safest drug to be used for outpatient withdrawal from heroin and if it is used over a 21-day period for that purpose it does make a most valuable contribution. In relation to the high dosage maintenance programmes, it may not succeed in getting people off drugs. There is substantial evidence that it brings about quite considerable change in their criminality, in their anti-social or asocial behaviour. In between those two I do not think that there is much evidence that methadone alone achieves very much.

It is notorious that a lot of the Americans who served in Vietnam were heroin addicts?——W. Yes.

4492. Those people returned to America after the war. Has any extensive survey been done to follow up those people?——W. (*Dr Egger*) Yes, some work was reported recently which shows a large proportion of those people who were classed as heroin addicts during their stay in Vietnam have since been able to get off the drug quite successfully.

4493. Without any chemical help?——W. I do not think it has been defined which technique was used for them to come off the drug. But the implication was, as I mentioned before, that addiction is a person problem. The people who were using heroin in Vietnam were using the drug because of the circumstances they were in. They were not necessarily the same sort of people who would have taken up heroin while they were in the United States. Therefore, when they returned to the United States it was possible for them a lot more easily to get off the drug than those people who would have taken it up in the United States.

4494. Has the American Medical Association expressed the view that continued administration of drugs for the maintenance of dependency is neither a bona fide attempt to cure nor an ethical treatment?——W. I think that is correct.

4495. One medical witness advised that some English-speaking countries had put their patients on to pure heroin rather than allow them to use the dreadful drug methadone. Has the commission any official opinion with regard to that statement?——W. (*Dr Andrews*) I think the view is that there is still a place for methadone but in a very

controlled way, under strict conditions. One of the reasons for looking at the creation of a drug and alcohol division was the need for much tighter control over the policies and for the application of methadone treatment and the need to have those controls fairly stringently maintained.

4496. The first part of my statement was that a witness had given evidence that people had been put back on pure heroin rather than use that dreadful drug methadone? ——W. (*Mr Dash*) I saw some heroin maintenance programmes in the United Kingdom in 1973. At that stage the treatment system was under some re-organization because the United Kingdom authorities were quite disturbed at the way their system was going. Several people to whom I spoke were moving away from heroin maintenance towards methadone maintenance in those cases where they saw maintenance as desirable. I do not know whether the trend has continued but at that stage heroin maintenance was viewed generally with considerable disfavour. On the matter of methadone maintenance, there is a deal of work from the United States which claims quite considerable benefits, particularly the work of Nyswander and Dole and, more recently, the work of the New York City Methadone Treatment Programme. Whether we can simply convert that to local conditions and say that because it works there it will work here, I do not know, but I should have thought that while in the work of Ingrid Reynolds there was considerable doubt about the outcome of many of the maintenance programmes here, I do not think she completely threw cold water on it. She was more concerned that there were benefits provided the programme was adequately controlled.

4497. I shall ask other members of the Committee who wish to ask questions to do so now. Mr Diehm is not available this afternoon?——W. (*Dr Egger*) I shall be here but I may be half an hour late. (*Dr Andrews*) May I go back to some matters. In relation to our physical facilities at Parramatta Psychiatric Centre, I should mention that there was a study undertaken of the facilities, I think a couple of months ago, by the physical resources department of the Health Commission and some recommendations made about refurbishing and the cost involved to bring them up to an adequate standard. Myself, and Mr Boylan, in his capacity as Commissioner for Finance and Physical resourses, have been looking at the recommendations in the light of what we appear to be getting in the Budget for maintenance and capital works, to see what might be done in that area. I should correct the impression I gave that the level of maintenance in the past few years particularly in relation to Jacaranda House—I said that a significant amount of painting has been done. That would be true of Wistaria House but far less true of Jacaranda House which remains pretty inadequate for accommodation. I did not want to leave members of the Committee with the wrong impression.

4498. Mr WOTTON: Mr Diehm mentioned centres such as Wisteria House and Jacaranda House. Do you believe that is the venue, the area they should be in, or should they be right away, like WHOS at Cronulla?——W. There is a case for some of the work done at Wistaria House to be done in the setting of either a general hospital of a psychiatric hospital but I feel that a sort of half-way house development, the person who is largely over the immediate de-toxification and immediate treatment phase and in the process of rehabilitation, I think that is much better done outside the setting of a general hospital or psychiatric hospital.

4499. Does the Health Commission have any sort of standardized treatment? It seems to have come through to the Committee in discussion with various organizations that everyone seems to want to do their own thing. We cannot find any standard sort of treatment. Would you give your view on that?——W. (*Dr Storey*) It is fair to say that the Commission, over the past several years, has been increasingly concerned at lack of uniformity. Doctors, in their training and practice, have always been rabid individualists. They believe that, as between doctor and patient, it is the doctor's right to decide professionally what is the best approach to the patient's particular problem. There is always therefore difficulty in laying down standard treatments in a programme. The Army did it successfully in the Second World War. There were technical instructions from the Director of Medical Services outside of which individual medical officers were not allowed to move. That tends to be accepted in the disciplined atmosphere of army service. It is far less well accepted in civilian practice but it is my personal belief that we do need somebody, and we have referred to the director of alcohol and addictive services whom we hope to recruit as soon as possible—not necessarily to say that everyone shall use programme A, but to decide, as we are in an experimental field and are all feeling our way, it is highly desirable that somebody have the authority to say that clinic A should use programme A and clinic B should use programme B and so on and then to critically assess the values of the programme, contrast and compare them. If a programme emerges that seems to be more satisfactory in local conditions, a decree is issued that for the moment that shall be the programme used. I am speaking now of methadone. There are schools of thought that methadone is at least—we accept that it is only an adjunct with a great deal of other treatment and support has to be available at the same time. (*Dr Andrews*) I agree with that entirely. It is much easier to lay down fairly strict guidelines and strict standards where the outcomes of treatment are clear and where the results can be anticipated. In this area that is not so. We have heard in the discussion today how difficult it is to measure outcomes in these areas and know whether the methods currently used are truly successful in the final analysis, so that there is room for experimentation and variation, but it should be controlled experimentation and variation and have built into it some system of evaluation so that we make progress in our knowledge about the relative efficacy of different approaches and this kind of arrangement for some sort of successful oversight, of a much more direct nature than at present. (*Dr Egger*) Because I feel that addiction is a person problem which cannot be treated with a needle or pill in the typical medical way—it is psychological—there is no one set treatment for that sort of psychological problem and therefore there is always bound to be a number of different programmes.

4500. Would it be fair to say that because we have entered into a fairly new era in the drug scene, which has only been with us for a decade or so, we could do more to get the message through by publicity or education to the people to inform them of the very thing that Dr Egger has said, that there are reasons for experimentation. Perhaps everybody is expecting results overnight?——W. (*Dr Andrews*) Yes. I think there might tend to be in the community a level of expectation of what government and health services can do in this area. This might be particularly true of people who have addicts in their families—as to their expectations of what can be done. That is expressed to some extent in the sort of voluntary organizations which are now more and more active, particularly those associated with people who have had the problem in their families and believe that a great deal more effective things can be achieved by one or other approach and they tend, almost with missionary zeal, to

promote particular approaches. There is some risk that there will be a considerable let-down when, in spite of considerable effort, some of the measures will not be effective in the overall picture.

4501. It possibly gets back to a basic education programme?——W. (*Dr Egger*) It would be most useful to inform the public, to change the views about addiction—that addiction is not specifically a drug problem but a person problem and also that the big problem is not addiction, but the sober state for the addict. The addict can quite usefully cope with himself in the drug state but, putting up with himself in the sober state, both before he becomes addicted and after—to a drug—that is the problem—solving the sober state, not the drug state. It would be useful to get that sort of information across to the public.

4502. It was said that recommendations made by various organizations would go before the commission, and, if they agreed, they would make a recommendation to the Minister. What happens if the members of the commission do not agree?——W. (*Mr Dash*) The Commissioner would probably be able to answer that. (*Dr Storey*) The findings of this Committee could come to the Commission in a number of ways. No doubt the report will be made to the Parliament and it may be adopted by formal motion. If so, the Minister for Health might well direct us to get on and do what the Committee says. That would be one way in which, quite logically, it could come about. Other than that I would think the least that would happen would be that the Minister would say that the Commission must forthwith consider the recommendations of this Committee or any other committee and let him have a report. (*Mr Dash*) My earlier comments were directed to a situation that the Chairman envisaged, where proposals originated from within the Commission. The question was asked as to what the Commission would do to promote change rather than what would happen about recommendations generated from outside.

4503. Mr MACDIARMID: Do you think enough is being done to educate people about the dangers of drugs to health?——W. (*Dr Storey*) I think the answer to that question must inevitably be, no. On the other hand I add a note of caution that an education programme must be carefully conceived and implemented. Many so-called drug education projects can be counter-productive. (*Dr Webb*) Your question contained the word "danger", which is commonly used by concerned people in the community. They say that if people are told that something is dangerous to their health or their life, they will behave in the appropriate way. We know from some other educational programmes that this is not so. About ten per cent of people behave appropriately if they are told something is dangerous; the other ninety per cent behave according to their mood or how their peers are behaving. Informing people, particularly about dangers, could be counter-productive. The Americans coined a phrase about this. They said that peril is the law. They have found that their drug education programme, into which they leapt with great enthusiasm and in respect of which they told people that some things were certain to lead to a bad future life, caused some personalities to take that risk.

4504. CHAIRMAN: I do not want to intrude on this interesting discussion, but I purposely did not ask about educational aspects as that matter will be dealt with after lunch. Mr MacDiarmid, are you willing to leave this matter until this afternoon? It is almost lunchtime and Mr Diehm will not be here this afternoon.

4505. Mr MACDIARMID: I am satisfied with that arrangement. I have certain other questions to ask on this subject after lunch.

4506. Mr MCGOWAN: I wish to deal with the use of methadone in withdrawal. Would it be true that most addicts would go through withdrawal from heroin fairly frequently?——W. (*Mr Diehm*) Physical withdrawals are becoming an increasingly rare phenomenon. It is fairly unusual to encounter a withdrawal that is more substantial than discomfort. I shall illustrate that by dealing with the two centres where Narcan is used to establish whether there is physical dependence. Only a small proportion of people who come asking for methadone show any reaction to Narcan. In the major centres where people are brought in for assessment, they have been kept under observation for eight hours without showing any real discomfort, so that withdrawal is seen less frequently and less severely than was the case a few years ago.

4507. Of those people who do react to narcan, would they not, as part of their life style, go through the process of withdrawal quite frequently because they have run out of a supply?——W. I think that also would be a fairly unusual thing. It might happen on occasions but people have learned skilfully how to manage their withdrawal. In a number of areas illicit methadone is readily available. Many addicts now use illicit methadone as a means of spacing their heroin use and also managing their own withdrawal. There is a certain competence among addicts to get hold of Hemineurin to treat their own withdrawal, either by prescription or on the market. I think the number of people who go through a severe withdrawal without assistance would be very few.

4508. Would we be better off restricting the prescription of methadone, taking it away from the use in withdrawal, if we have other things that can be used for that; in other words, taking it away from doctors?——W. That would create a considerable number of management problems. There are few drugs as reliable as methadone for use with an outpatient. That is in the area of heroin. Hemineurin is normally used on an inpatient basis.

To achieve what you want it would probably mean that more people would have to be admitted to hospital for at least several days to reach what can be accomplished with a three-week outpatient programme, using methadone. I would expect two problems to arise. First, there could be an objection by the addict to accept hospital admission for withdrawal. Second, a burden would be put on the hospital facilities. Additional facilities would have to be established.

4509. In other words, by the introduction of methadone over the years we are now in the position where we cannot do without it?——W. I am not sure whether that is the case. The question is whether there is anything better for particular people. I accept the criticisms that have been made both here and elsewhere about the use of methadone for long periods of time. I do not think the same objections have been made in relation to methadone for a short withdrawal. Criticism has been made that people who started out on a 21-day withdrawal course are still on methadone after several months. I think that is a management problem that is perhaps more the fault of the clinician than of the methadone.

4510. Do you think the addicts are smarter than we are because they have a greater drive and they can find their way around any barriers that are put up?——W. Yes. I think it could be said that they wrote the textbooks on manipulation.

4511. Mr HEALEY: Mr Diehm, you expressed some rather strong reservations about the treatment given at the William Booth Hostel. What treatment does the Health Commission provide which differs greatly from that given at the William Booth Hostel? How successful is that treatment, and where is it being used?——W. I think you are reading more than should be read into my comments about the William Booth Hostel. In relation to the narcotics problem at William Booth, I thought it was modelled too closely on an alcohol programme without taking sufficient account of the differences between alcoholics and narcotic addicts.

4512. The Health Commission does not do that? ——W. I think it does in some centres. I think in comparison with the William Booth narcotic services, some of our services would compare very favourably.

4513. What region would you say has the most successful programme for the narcotic addict?——W. I find it difficult to establish this positively. I have impressions and in the absence of a follow-up measure, I can only give my impressions. I think those centres that have good programmes are located in the Western Metropolitan, the inner metropolitan, the northern metropolitan and at two centres in the Southern Metropolitan Region, and Wollongong. I would say that the approach is substantially different from that used at the William Booth Hostel.

4514. Is methadone a common treatment in most of those regions?——W. It exists in the regions but not in all the centres. We are trying to restrict the use of methadone to one centre in each Region. There are many centres where methadone is not used, where drug-free programmes are used for most of the clients. The percentage of new clients for whom methadone is being prescribed is going down significantly; it is probably about half the rate it was twelve months ago; in percentage terms the use of methadone is decreasing.

4515. Dr Egger, you mentioned you have research under way in regard to analgesics withdrawal. Where is that being conducted and in respect of whom?——W. (*Dr Egger*) I have to correct that slightly. It is not specifically looking at analgesic withdrawal; it is related to the effect of any restriction that might be brought down on the present consumers of compound analgesics. The study being carried out is in the Hunter Valley region. The reason why we selected that region is that Newcastle is known as the nephritis centre of the world, and it is supposed to have the largest incidence of analgesic use in the world.

4516. How many people will be involved in that study? ——W. The study is to be conducted originally on 1 000 households. Fifty per cent of the households to be selected are from a high risk area, in respect of which we have specific information that it contains a large proportion of analgesic users. The other fifty per cent is from a sample of the rest of the Newcastle region. The results will be weighted according to the population samples in those two areas. The early part of the study is to select analgesic users, not just abusers. We are interested in what happens to the user of compound analgesics. After consulting 1 000 households, we hope to follow up with about eighty to a hundred other households some eight months later, after the restriction, hopefully, has been brought in, and that is largely dependent on this committee. We will then go back to those households that are users and study the effects of the restrictions. To my knowledge this is the first time that such a research project is being based round any type of restriction and in my view it is a necessary adjunct to any programme like this. It will provide valuable information as to the effectiveness in lots of different dimensions of the restrictions, if and when they are brought down.

4517. Mrs DAVIS: Mr Diehm, Mr McGowan made the point that the methadone programme commenced about four or five years ago more out of concern for wealthy addicts. Do you think it would be better to discontinue the programme altogether bearing in mind that drug addicts are abusing it?——W. (*Mr Diehm*) Not unless something very substantial in terms of resources were introduced to replace it: If it were possible to introduce resources to meet the demands that are presently being met by the use of methadone, which is something of a short cut, it may be possible to withdraw without using the alternative, which is to withdraw use of methadone. It could be quite destructive. It would need careful planning and some additional resource, to be a realistic possibility. But, given that, it could be.

4518. Have you ever thought how long it might take to phase out this programme?——W. Yes. It would vary. I think there would be two groups of persons concerned and they pose different problems. Those on methadone maintenance could be withdrawn, I think, within a period of six months—that is, withdrawn from the use of methadone but established in alternative management programmes. For the group who are on a high dose of methadone and have been for some little time, the withdrawal period or transition would be very much longer. I would think in terms of probably two or three years in some instances. That is if it is done in a community-based programme on their present outpatient regime. The alternative, if that time was not available, would be hospitalization. Under those circumstances it could be achieved in a much shorter period.

4519. Do you think addicts prefer to visit voluntary centres such as WHOS, which we have seen are not nearly as affluent as some of the health centres? They say the regional centres are too impersonal. Would you care to comment on that?——W. Yes. I think the treatment programme is not withdrawal from the drugs as such; that is bread and butter medicine. The real concern is making it possible for people to survive without their dependence on the drug subculture. What needs to be provided is the social competence for the person to be able to survive outside the drug scene, which is an area where non-government agencies have a big contribution to make. There are problems when organizations are concerned with providing immediate treatment, medical services and social services. To an extent some community health centres are providing that kind of social support but it is almost outside the capacity to provide the counselling service within the situation they have to provide it. This is an area where inter-relationship between government and non-government services can be used to the greatest advantage.

4520. CHAIRMAN: Mr Diehm, have you any suspicions that methadone programmes have got out of control in any areas?——W. I am not sure how to interpret that. If you mean out of control in the sense that there has not been adequate supervision of prescribers, it is possible. If you suggest out of control as meaning too great a number of people being taken into the programme, I would not think that is so on the numbers of clients who are being taken into official methadone programmes. The area of prescribing by unauthorized people—general practitioners—is a separate problem. Although what they would prescribe is probably out of control, it is not——

4521. I had in mind both aspects. Take the first, where you have unauthorized prescribers. Whose responsibility is that, yours or Mr Dash's?——W. It is Mr Dash's. (*Dr Storey*) We become aware from a number of different sources that a general practitioner is prescribing methadone for addicts. Sometimes it shows up in the first instance from the computer print out. At other times, pharmacists see it as their duty to tell one of the inspectors what is going on. Almost inevitably the inspector will go out to check the prescribing at the pharmacy and will submit a report through the Therapeutic Goods Branch. We usually invite the doctor concerned to come in to talk to us. Sometimes it seems that the doctor may not have been fully aware that he was not supposed to prescribe for addicts. Sometimes he will say he did not know the patient was an addict. Sometimes it is a misplaced sympathy. Some of my colleagues lend themselves to manipulation by addicts. An addict will come along and say, "I have got a problem". He seems a nice young man, and he says, "I don't like to go to the Brisbane Street Clinic because the pushers wait up the street or you meet other addicts and become involved. You don't get away from the drug scene". That is a plausible argument and one or two of my colleagues have been sympathetic and have provided the methadone contrary to the legislation. Sometimes they get themselves into real trouble because the addicts are not genuine. But the word spreads like wild fire that Dr X is an easy mark and in no time he has a string of addicts on his doorstep, some of whom are aggressive. I have had some doctors come to me almost in fear and say, "Please take my authority. It is my only chance of survival". We always acquiesce in that regard.

4522. Have you any evidence of people standing over pharmacists in some way?——W. Not personally. (*Mr Dash*) No.

4523. Or even pharmacists being held up if they do not supply?——W. I can recall a couple of cases some years ago. I am not aware of recent cases.

4524. The chairman, in his evidence on the 12th of this month, said: "If the situation arises in which it would be better to use an unmarked car, an unmarked car is used. In cases such as venereal disease or drug addiction—that is the instruction." I do not want you to feel responsible for what the chairman has said, but could you advise the committee of any places where unmarked cars are used for drug work?——W. (*Mr Diehm*) My own car is unmarked.

4525. Mr HEALEY: How often would you call on an addict at his home?——W. I would not call on an addict at his home. I would meet addicts in public situations very frequently. (*Dr Andrews*) There was a decision taken by tthe Commission that cars should not be marked with large and obvious insignia but with a much smaller logo similar to the one used, I think, by the water board and some other statutory bodies. It just sits on the front of the bonnet and if you look for it you find it but it is not very obvious. There are many borderline instances where just the presence of an official-looking car in a neighbourhood gives people cause for concern. (*Dr Storey*) There is authority for inspectors who are going out to police the law in respect of pharmacists. If one of our therapeutic goods branch inspectors—or two of them, as a rule —go to see whether a pharmacist would indeed sell narcotics or schedule 4 drugs, as had been alleged on information, it would be pointless to arrive in a marked car. So there is authority to use unmarked vehicles in that circumstance.

4526. That answer arose out of a question in regard to treatment rather than inspection procedures. Mr Diehm, do you have any feeling that the drug and alcohol service has been a poor relation as far as the Health Commission is concerned?——W. (*Mr Diehm*) Yes, I think there is a lot of support for that view. The situation is different in different regions but by and large it has not had the same advocacy within the regions as have other specialist services. Over the past two years there has been some change of attitude, some increasing awareness of the need to give priority in this area. At the time this recognition was being achieved a number of other problems such as staff ceilings and cuts and budgets and what-have-you were imposed.

4527. Who determines the priorities?——W. Substantially each regional director, or each administration, independently. (*Dr Andrews*) The Commission exercises significant control of overall State priorities. Regions are given budgets which reflect those priorities at any time and they are constrained to stay within the budgets, though it is not always within the Commission's power to make major shifts in priorities, say, between the operations of the public hospitals system and community health care. A significant proportion of the funding in both cases comes from the federal Government and policies are determined and budgets allocated in consultation with federal bodies through a number of committees that are set up. Then our own State Treasury responds to the federal allocations rather than our being able to determine the major areas. I would put the drug and alcoholism services in that general area of health care services, which have not been given nearly as much attention as the general hospital services in the past. This would include mental retardation, geriatrics, rehabilitation, chronic disease services, preventative services and so on. Seen in that context, the areas that are perhaps not socially attractive to either members of the health profession or the community, areas that are very difficult in terms of achieving obvious results, where there are few rewards, as it were, for the people involved, and areas where the methods of treatment are not as effective in a dramatic way as the more acute areas, have tended not only here but all over the world not to get as much attention.

4528. Should not that be a challenge to the commission to allocate more funding to such a situation?——W. It is indeed, and it constitutes a lot of discussion at Commission level, and a lot of examination in terms of what we might be able to do in that respect. One of the barriers in the way of doing anything dramatic is that a very large proportion of the budget available to the Commission each year is tied into ongoing operations of services. Although we might feel that we should shift from the services provided, say, in the teaching hospitals or within the general hospital system, into areas of prevention of chronic disease, or drugs and alcoholism, it could not be done in any dramatic way without considerable trauma of an administrative, political and every other nature. You would disrupt in a major way the continuing services in the area you wanted to shift from. One could quote many examples. If you look at the difficulties that have been experienced over examining the role of Sydney Hospital, which we see as a special instance of this, it is not something that is easily achieved by any kind of administrative decree.

(Luncheon Adjournment.)

*Upon resumption*:

4529. CHAIRMAN: Dr Storey, can you tell the committee when staff ceilings were introduced into the New South Wales public service?——W. (*Dr Storey*) I think it is a recurrent phenomenon. I cannot give you a precise date. My colleague may be able to assist. (*Dr Andrews*) From memory I cannot give a precise date. It would be close on six or eight months ago. (*Dr Storey*) I think that is so. If I may go back beyond that, in the days of the previous Government, for a while there were constraints on staff.

4530. I am talking about present staff ceilings. As I understand the position, at the present time you have an establishment, but then you have been given ceilings which, in some cases, are well below the establishment?——W. That is true. (*Dr Andrews*) There is a total ceiling for the whole of the operations of the Health Commission. There is a total staff establishment and then the Public Service Board says that you will not recruit beyond a certain level.

4531. That is for the whole commission?——W. Yes.

4532. Can you give us some broader details of the way in which these constraints operate within the commission? ——W. For each Region there is a limit on the number of people who can be employed at any one time. Therefore, it is necessary at any point in time to look at the current recruitment patterns and ensure that the recruitment of people never goes above the level that is set. It means looking at priorities and so on.

4533. Were any staff cuts made in the Health Commission at the time when the 1976–77 ceilings were set?—— W. No, no one was dismissed to bring the level below the staff ceiling. At any point of time as a result of resignations or transfers there is always a certain level of positions that are not filled. At the time that staff ceilings were imposed we were slightly over the ceiling but the Public Service Board approved of that continuing and to just come back to the staff ceiling level by the process of attrition.

4534. In effect, the alcohol and drug addiction service should not have been affected by these ceilings set?——W. (*Dr Storey*) Perhaps I could read a paragraph from a submission prepared by our Assistant Secretary, Administration, one of our experts in this field: "The Board's instructions in regard to staffing for 1976-77 included advice that the Commission should only recommend the establishment of additional positions providing it nominated the deletion from the establishment of existing positions of a near equivalent value". (*Dr Andrews*) In effect it eliminates expansion.

4535. You can take them out here and put them there? ——W. Yes, and there is no room for expansion beyond adjustment within the total staff ceiling level. (*Dr Storey*) But you could not exchange a medical officer for an office assistant; you would probably need two office assistants.

4536. Has the commission made application to the board for increases in its staff establishments and staff ceilings since the imposition of the ceilings?——W. (*Dr Andrews*) Yes. Soon after the imposition of ceilings a submission was made to the Board to have all community health positions outside the ceilings as they were largely federally funded and represented a development programme in a single programme of community health. In fact there was an agreement by the Public Service Board to allow us to recruit up to a higher level in community health than applied generally throughout the Commission's services, but the total ceiling remained—it was moved slightly in response to the submissions that we made.

4537. The total ceiling remained?——W. The total ceiling remained. It moved somewhat as a result of our representations. It was agreed that we could recruit within the community health programme up to a higher level than was the case for the other parts of the commission's operations. But we still had restrictions on even the community health programme.

4538. These increases in the community health programmes were not at the expense of some other aspect of the commission's activities?——W. In as much as everything had to be contained within the total ceiling.

4539. That is what we were talking about before: There was no real change at all; all you were doing was obtaining approval from the Public Service Board to increase the numbers working in the community health services at the expense of some other aspect of the commission's activities?——W. They did raise the ceiling somewhat as a result of the representations, but not to a great degree.

4540. Do you know whether the commission has ever employed staff in excess of the ceilings set?——W. From time to time we have gone over the ceilings. It can be difficult, if you are close to the ceiling, with people leaving and then recruitment of essential positions and the ebb and flow that takes place.

4541. It would not be any significant number over the ceiling?——W. No. (*Dr Storey*) With several on leave, unexpected sick leave and others granted leave without pay it constitutes a problem but strictly speaking one is not supposed to fill those positions.

4542. Is there any prospect of staff ceilings being increased for 1977–78?——W. (*Dr Andrews*) The total staff establishment was increased by three and the result, in effect, was that staff ceilings remained, for all intents and purposes, at the same level.

4543. Mr HEALEY: Three, in a total of how many? ——W. In the order of 13 500.

4544. CHAIRMAN: In effect there will be no prospect of any improvement in the alcoholism and drug service unless people are taken on or there are some new activities?——W. Accompanying the Public Service Board decision was an instruction to the Commission to reduce the central office staff by 205 in lieu of positions to be created in the field of health service delivery. We are seeking advice from the Board as to precisely what it intends and what positions it has agreed to in the 205 field people, some of whom may be drug and alcoholism positions that we have sought. (*Dr Storey*) I think it was 205 less 3, a net 202. That is the adjustment we have to make, by reallocating staff to other positions. (*Dr Andrews*) It is difficult to be precise because we are looking at information that has just come from the Board in relation to staff ceilings in head office positions and approvals from the Commonwealth Government for funding under the community health programme, and attempting to put those figures together to find out exactly where we stand at the moment. The general indications are that staffing will be very tight in the coming financial year.

4545. Have you any idea what effect the reduced spending by the Commonwealth Government will have on the field of community services and alcohol and drug dependency service?——W. It should not cause any reduction. This is a complex matter. The federal Government did not decrease its allocation to community health,

it changed the formula and required a greater contribution from the State. Whereas the on-going expenses were previously funded 90 per cent by the federal Government they now fund them 75 per cent. Whereas capital expenditure was funded to 75 per cent it is now funded to 50 per cent. The net result is that provided the State Treasury is prepared to pick up the additional costs and the Public Service Board is prepared to approve of additional positions there would in fact be room for some expansion.

4546. The Commonwalth has reduced its expenditure in this field and is expecting the State to take up the leeway? ——W. Yes.

4547. Have you any indication as to whether the State is going to make up the leeway and, second, if not, do you see any way in which the alcoholism and drug addiction services will be affected?——W. Our present indications are that the State will, in the main, pick up the additional contribution for on-going services so that we do not expect there will be any reduction in services. What we are uncertain about at the present time is the question of degree of expansion or the development of new projects that will be allowed.

4548. In evidence before the Committee earlier the chairman said that if drugs and alcohol got too small a mention the Committee would be aware of the activities of the commission in the past two or three months in which there has been a greater emphasis on the resources of the drug and alcohol service. Could you give some indication of the changes that have taken place in the past two or three months that would cause him to make the statement?——W. I did not quite understand the statement. (*Mr Dash*) That was in relation to the consultative document.

4549. Yes?——W. (*Dr Andrews*) I am sorry, could you repeat Dr McEwin's statement.

4550. It is perhaps a little unfair, as the chairman is not here, but I was wondering whether you might be able to help. He said:

> If drugs and alcohol got too small a mention you would be aware I think of the activities in the commission in the past two or three months in which there has been a greater emphasis on the resources of the drug and alcohol services.

——W. I wonder whether the activity he mentioned might have occurred at the planning stage. I mean the initiative in relation to the proposed advisory body chaired by Mr Farquhar and our own initiatives in regard to the setting up of a drug addiction division in the Commission. I think it would be fair to say that it is more at the planning stage than in the implementation, except of course that Mr Farquhar's organization is well under way.

4551. When the first regional director's office of the Department of Education was established it was suggested —mainly by teachers—that whereas all applications and reports were previously in triplicate, they now had to be sent with either six or seven copies. Is there any parallel between that experience and the commission's experience with the drug and alcohol service?——W. In the main, I do not think so. The regional officers of the Commission have a much greater degree of delegated authority than would have been the case with the creation of the area officers in the Department of Education. Often, matters were referred back to the head office of the Department for a decision. They may have related to appointment to promotional positions and approval of staffing and establishment in the public service sector. There is a limited delegation of the Public Service Boards' authority in those areas. In many cases the regional office merely refers back to the Commission and it goes then to the Public Service Board.

4552. We have been talking abut reallocation of staff. You mentioned the possibility of people from head office being redistributed. Who would ultimately make that decision?——W. The Commission as the corporate body, on advice.

4553. Dr Webb, could you give the Committee some idea of your average working week and the type of work you would be engaged in?——W. (*Dr Webb*) At this moment I should like to say that I am advisory rather than a doer, and I have been so since regionalization. It is mainly consultative work with education officers who either ring up or come in for resources material or for advice on what techniques to use with particular community groups, children or teachers or whoever it is. I would say that is a fairly large part of my duties. Another large part is attempting to collect on a mateship network information about what is going on in the Region as there is no obligation on them to report or to inform us as to what is happening. This is mainly supporting work. There is another responsibility in training that is in running fairly continuous workshops for our Health Commission staff and we are asked to help Commission staff run workshops in their areas for other professions. For instance, yesterday the Inner Metropolitan Health Region was running a teacher workshop and they asked three of us to help them out with this work. This would be a smaller part of the week's work but I would guess it would probably be the most important work in terms of doing things. Another part of the work is writing policy statements and submitting them. Meetings are held by the dozen. They would be meetings with our own people and with the Department of Education; there would be meetings also with other government department officials. There seem to be more of those in the form of committees and working parties or groups trying to make up policy statements between the Department of Education and the Health Commission. They are also trying to prepare a joint drug education programme. That is roughly the sort of work I am doing.

4554. Would you spend much time visiting the various regions in the Health Department?——W. Not very much. I prefer to be invited because of the peculiar position of being neither fish nor fowl, being advisory without the sort of authority to say that I am making a visit. We do visit but usually for a specific job rather than to see what is going on. It would be a visit to consult with them.

4555. What particular part of our terms of reference applies to your work?——W. I think the educational parts, that is 4 (a), (b) and (c), the last one being the prevention part. We have been involved in 4 (a), (b) and (c).

4556. You have had the opportunity to look at the Health Commission's submission and the most recent submission of the committee, I presume?——W. Yes, I recognize some of this document.

4557. Have you any particular ideas which you would like to put before the committee for its guidance, which are not embodied in that report?——W. This might be an appropriate time to ask for this document to be made an exhibit ("Exhibit 8"). I have written submissions that are probably newer than this, stating that I believe that we are facing a dilemma whether to go on providing treatment services for drug dependent people whose numbers seem

to expand year by year. The public demands that we should do this; also we are mounting a preventive programme which the public cannot see. I have been arguing for prevention, but that is my argument to my own Commission.

4558. In appendix "U" of that submission, which I referred to earlier, the northern metropolitan region is the only region where there is any specific reference to a prevention team. Are we right in concluding that this is the only area where there is any emphasis on prevention? ——W. No, there are about six health education officers designated drug and alcohol education officers. They would be prevention officers. I know that number is very small but they are in the Southern Metropolitan Region, Newcastle, Wollongong and Western Metropolitan Region. All of those regions would have nominated manpower to do preventive work.

(*Dr Andrews*) The Northern Metropolitan Region would be the only one where they have brought all those resources together into one central unit within the region. It differs from the other regions where the drug education officers and drug counselling officers are scattered throughout the health centres of the region.

4559. I think I referred previously to the fact that in the western metropolitan area there is only one drug education officer and the population is roughly 1 250 000 people. Would that be a fair sample of the type of task that is allocated to a drug education officer?——W. (*Dr Storey*) To say that there is only one person for that area would give a false impression. It would be fair to say that not only all the general duty education officers but also some of the community health teams would be taking part in the general approach to drug education as part of their general day-to-day task. (*Dr Andrews*) There would also be a number of drug counsellors attached to health centres. The drug education officer was originally a member of the Wistaria community drug team and was part of that establishment in the submission that went up to create that team as part of the community health programme. He was subsequently detached from that team and located centrally in relation to the regional office because of the difficulty of working in a pure prevention and advisory role while attached to a team that had major emphasis on treatment services.

4560. According to the western metropolitan table there are only seventeen people listed as education officers in the whole area?——W. Yes. In 1973, there was one person called a generalist health education officer who did the whole of education in the whole western metropolitan Health Region, so there has been a 1 700 per cent increase.

4561. Those seventeen people would be engaged mainly on education in regard to alcohol, not so much the use of drugs?——W. (*Dr Storey*) They are concerned with all types of health education: education in relation to trying to alter life-style, trying to discourage smoking, trying to discourage analgesic abuse—any message at all to the public which has a bearing on their health.

4562. At page eleven of the submission it is stated that the authority and responsibility of the regional director, under the direction and control of the commission, spreads over the whole of the services and the whole of the regional resources needed by those services in giving effect to the commission's policy. We touched on this earlier today: Has the commission a drug policy?——W. (*Dr Andrews*) Perhaps I could begin to answer that. I know that Bob Webb has something to add. There is embodied in the general structure and organization of the drug and alcohol services of the community health services of the Commission an inherent policy. There is no absolute statement of that policy laid down in concrete form, though there have been documents produced from time to time which set out the general directives of the Health Commission in regard to drugs and alcoholism and addiction services. These statements, mainly in the form of discussion documents, have been distributed to regional directors' conferences and incorporated into those conferences, which are held once a month. They are discussed by the Regional Directors with people working in the field. It must be said that these policies are evolving and are not in any way absolute or fixed or enshrined in any absolute sense. But there are statements of Commission policy which could be referred to by Regional Directors.

4563. Although we have been told that regional directors have a fair amount of autonomy, there are directives and controls issued periodically in regard to drug policy?——W. Yes. They are mainly guidelines and so long as the regional directors stay within their budget allocations and within Public Service Board staff requirements and the general structure and policy of the Commission, they have a fair amount of freedom within that sort of structure.

4564. How would this be first communicated and then effected, accounted for and audited?——W. There are regional directors' meetings held once a month when the papers that develop the Commission policy are distributed and discussed and sometimes amended, brought up again and then agreed to as Commission guidelines or standards, depending on the nature of the instruction. Then there are the central advisers to the Commission. In this respect Mr Diehm has a particular role of visiting regions and looking at the services provided there, either at the request of the Commission itself or at the request of a Regional Director, to comment on the services provided and make any recommendations for their alteration or development.

4565. It has been stated that each region has substantial autonomy in determining the nature and extent of treatment and preventive services. In those circumstances how can it be assured that services in the drug area are consistent with the problem all over the State?——W. I think we would say that is a problem, and we have experienced it after four-and-a-half years in this sort of organization with the regional system. We come back yet again to the concept of a central division which has very well-defined responsibility for monitoring what happens on a State-wide basis and ensuring that State-wide policies are adhered to. There is a need in those areas of special advocacy, of which drugs and alcoholism is one. We have something of that sort of system at present in respect to the position of advisers, as Mr Diehm would point out if he were here. The position of an adviser can be somewhat equivocal, whereas the position of a director of a division, who has defined responsibility and authority in relation to regions, regional directors and services being provided, is far less equivocal. (*Dr Storey*) The Committee might reasonably ask, if there is a problem with the term adviser and the role of adviser, why did the Commission from the start not have directors who can get out into the regions and lay down the law about various subjects. This was seen as being foreign to the concept of a regional administration. The regional director was to be the man who was to have the authority and to determine the overall programme for his region. If he then had five or six or ten directors who could go out and tell him what to do it would be quite foreign to the regional concept. Although we are now coming back to a compromise situation, in the early days

of our regionalization we eschewed any suggestion that there would be directors. (*Dr Andrews*) Part of the reason for being able to do that was that the regional structure is well established. In recent discussions with regional directors they select that as a welcome level of advice and guidance in areas that they might feel unfairly accountable for. It is our impression that in the development of the commission's organization the time is appropriate to introduce this sort of approach in this and other areas.

4566. On page 16 of the submission, paragraph 10 (1) (3), it is indicated that the commission collects data in respect of drug abuse, yet recognizes the need for a standardized and more comprehensive data collection procedure. On page 8, paragraph 4 (5), it is indicated that many regions have implemented their own system of data collection and there is no agreement on one standardized method?——W. (*Dr Storey*) I think page 8 refers to the present position. 10.1.3 acknowledges what we think it ought to be and what it must be.

4567. Why the delay in some agreement?——W. (*Dr Egger*) There was some problem. An overall data collection procedure was planned some time ago—I think it was approximately two years ago it was set up, we had the forms running—it was not me specifically because I was not involved in that section of the Commission at that stage—and for various reasons it broke down. We were not getting the full collection from the different centres. The centres then opted to provide their own information for the regional offices—information on drug and alcohol services. Now the situation is that they each have their own monitoring systems which cannot be put together as a total scheme because they are all on different computer systems. We are now in the process of formulating a scheme whereby we can co-ordinate these different areas into the one scheme.

4568. Are you saying that the present system would inhibit the collection of meaningful material?——W. For the whole State. (*Dr Storey*) I think it would be fair to say that the development of a State-wide morbidity or data collection programme has been constrained to a degree by the need for us, under the terms of the Commonwealth–State agreement in relation to census and statistics, to rely on the services of the Commonwealth Bureau of Census and Statistics for some of our programmes. Our ability to get programmes on line has depended on the availability of resources within the Bureau of Census and Statistics. I do not advance that specifically in relation to this programme but it is only recently that we have completed the implementation of the inpatient data collection programme.

(*Dr Egger*) And that was no mean feat. The collection of this sort of data is fraught with a multitude of problems. That was the reason the first one broke down. We have overcome most of those problems for the institution of the next global collection of data.

4569. 10.1.5 mentions that the Commission provides staff for drug education and has a programme of pharmacy inspections but recognizes the need for more frequent inspections. In 65 on page 10 the benefits to be derived from routine inspections are stated. Yet in the previous section on page 10 it is indicated that routine inspections have practically ceased to be undertaken.——W. (*Mr Dash*) That is a matter of history and the availability of staff. When the Therapeutics Goods Branch was first established with this responsibility it was envisaged that inspections would be made at regular intervals and that there would be coverage of the State at reasonably frequent intervals. It was found that each inspection produced the need for follow-up, that in quite a number of cases things were not right and the only way of ensuring that they were put right was to return, perhaps once, perhaps twice, perhaps three times, to follow up and make sure that deficiencies that had previously been observed were corrected. This put the inspection programme back. Then in more recent times the problems of following up complaints about prescription forgeries, imposition upon doctors and pharmacists and doctors themselves becoming addicted have added a further burden which has prevented pharmacists, whose original job was to do routine inspections, from getting on with that job.

4570. Would you regard this section of the branch's work as probably one of the most important?——W. The routine inspection part of it?

4571. Inspections generally.——W. I would certainly regard inspections generally as being very important—probably the most important as far as preventive work is concerned, but one which tends to be pushed back as urgent problems such as a sudden rush of prescription forgeries or something of that nature crops up.

4572. Would one solution be the appointment of more inspectors?——W. That would certainly be a help.

4573. Has any effort been made to obtain the services of more inspectors?——W. Submissions for additional staff have been made, but again we ran into the problem, where the lies within the resources available to the Commission, of competing priorities elsewhere.

4574. Are you saying that the Public Service Board would not agree to the appointment of more inspectors unless they were taken from another department?——W. That is generally the case, yes. (*Dr Storey*) That is the way the matter stands at the moment. I think it would be fair to say that there are quite a number of areas in which the Commission feels that to do the job it would like to do it needs more inspectorial staff. Therapeutic goods is one such area. Pure foods is another. There are quite a number of areas where the Commission has to determine priorities. In pure foods we could do with a considerable number of outside inspectors if we were to do the job as we would like to do it.

4575. Dr Webb, could you explain to us in general terms what you believe is the part played by the education services in the drug and addiction services division?——W. (*Dr Webb*) Yes. Basically I think we are apt to and do attempt to collect from our own experience and all over the world what is going on in drug education and the results of various drug education programmes and then to see that Health Commission staff know about these techniques and the disastrous results of some of them. It fits in with what I was saying. To do that one has to consult, to meet and to run training workshops with Health Commission staff. In summary I should say that I see our main job as ensuring that as many Health Commission staff as are engaged in educating know the guidelines that we are putting out and how to do this job.

4576. Has the drug addiction division any fixed opinions in regard to the effectiveness or efficacy of the drug education services?——W. In this State or all over the world?

4577. In this State.——W. Three years ago we were told that we were one year ahead of England and were possibly in the lead in the world. This was at an international conference. Where we failed I think is in pene-

tration. The ideas, the techniqupes, what not to do, are all good and can all be defended. I do not think that enough Health Commission staff, enough education department staff, enough key community leaders and groups know what they should and should not be doing or even know the dangers of doing anything. So I should say that the quality is good but the delivery or penetration is poor.

4578. On 12th September the Chairman of the Health Commisison said in answer to a question from me about analgesics that while he had some reservations about consumer education he felt legislation was far more effective. What is your reaction to that?——W. My personal reaction is I am always pleased when chairmen of my Commission say that they believe in education. Our approach has not been to educate by drug but by behaviour. Dr Egger was saying it is a people problem. I would not like to mount an analgesic specific education programme. I would like to include analgesic abuse in part of the general education programme which looks at the reasons for the use of any drug, including analgesics.

4579. His opinion was that it would be fine if we could educate people not to use analgesics, but he did not think that was a practical solution?——W. (*Dr Storey*) I think Dr Egger made the point this morning that analgesics are at the end of the spectrum, away from physical dependence. Therefore, probably—and in my view, certainly—the most effective way of dealing with this is by way of a legislative programme, backed up by the reasons why we are doing it, and trying to ease the problem for the very small minority who might be adversely affected by legislative action.

4580. Do you agree that the same criteria would apply to barbiturates?——W. I think they would be half way in between. We are moving across the spectrum now. (*Dr Egger*) With the compound analgesics we have an alternative that is just as effective in medical terms, that is, the single analgesic. The only property lacking is the addictive property. That is, the extra caffeine. With the barbiturates I think there is probably a case to be made for some of the more harmful ones being restricted, in the same way as the compound analgesics. There are still some benefits to be gained by certain of the barbiturates, the same as with single analgesics.

4581. Mrs Davis has drawn my attention to the note in the pharmaceutical benefits book that authorizes any increase in the maximum quantities of diazepham. It says, "Authority for increased maximum quantities and/or repeats of diazepham will be granted only for the treatment of disabling spasticity, and malignant neoplasia (late stage)." Yet we have had evidence before this Committee that some people seem to be able to get valium tablets without a great deal of trouble. Has the Commission had much experience of this? Have reports come to the commission of doctors prescribing great quantities of Valium? ——W. (*Dr Storey*) I think the statistics show that Valium is the most prescribed single drug. I think it is at the top of the list. (*Mr Dash*) The fact that it is listed in the pharmaceutical benefits notebook does not prevent its being prescribed for other conditions in increased quantities outside the scheme.

4582. CHAIRMAN: Dr Webb, will you agree that television documentaries, properly used, could be a powerful educational tool?——W. (*Dr Webb*) It depends on "properly used". The evidence in front of you there is that media warning campaigns can be catastrophic. I think that is the word that is used in a report. The whole business about the glue sniffing epidemic in the States was said to be due to a warning in the media against sniffing glue. We have just started our campaign here, judging by this week's television. I know of no television programme that has been successful. I have heard of media campaigns that have been written up that have been unsuccessful. I am not sure that I can truthfully, or even authoritatively, answer that question at all.

4583. Are you familiar with the British documentary "Gail is Dead"?——W. No.

4584. Are any of the other witnesses?——W. (*Dr Storey*) No.

4585. What has been the impediment to generating documentary programmes for use by people in television time?——W. (*Dr Webb*) I think one thing has been that where the media has been used overseas it has boomeranged, and rather than have the blame laid on our own educational efforts, it has been deliberate policy to adopt a low key, small-group process rather than a media campaign.

4586. Would you agree that television can be a powerfully educational tool, used properly?——W. I would hope so. We are going to try a radio programme in the country, and it will be evaluated before it is used anywhere else. We have no plans for television, largely I think because of the cost involved. (*Dr Egger*) One big problem with all these things is getting the personnel who have the skill and experience to put the theoretical knowledge into practice. Most of the people who are skilful in television promotions come from commercial advertising and television. Unfortunately, they have not been involved in drug education. The only people we have had involved in drug education, largely because of the funds available, are people who have a basic behavioural science background. It is unfortunate that we have not used their skills.

4587. Seminars have not been organized with Commonwealth representatives, with the idea of getting them to purchase documentaries as a community service?——W. (*Dr Webb*) Yes. The national government organized one in Canberra. That was about three or four years ago.

4588. Do you know anything about its success?——W. It led to committees, sometimes advisory committees, being formed in some States, on which the Health Commission and the media were represented. This would be one of the things they will look at; that is, the use of the media.

4589. Do you know anything about any productive results?——W. Not as a campaign, but as a system whereby newspaper reporters would consult with the Health Commission on the facts of the data they were going to publish. But the fact that we were able to contact the reporters and say, "What you are doing is counter-productive" and be listened to, it was effective. In terms of producing a programme, I do not know.

4590. Recently the Minister for Planning and Environment announced that, instead of a Government control, a lot of people involved in producing cans for soft drinks and beer had agreed to run their own anti-litter campaign. They were going to finance it. Do you see any chance of a parallel campaign being organized by people like yourself?——W. Using the money, yes; I think that is a real possibility. The brewers are already offering large sums

of money for research rather than for campaigns. But I think that is a way of funding a campaign; that is, to tax the drug or one of the drugs.

4591. If it were to be taxed, it would have to be probably by way of a Commonwealth tax. But you have not had any approach on a State basis for drug companies to come into the education field?——W. No. (*Mr Dash*) When you look at media campaigns, there are problems. You are talking about media use as a means for promoting a barrier against drug abuse and dependence, whether the media is not better attuned to promote some procedure? Some of them do something else. It is really the message that you are trying to get across, and it is difficult to promote in that way.

4592. I am not trying to suggest how a campaign should be run; I am wondering whether any great thought has been given to organizing a campaign?——W. (*Dr Egger*) I was the convener for the working party on adolescents and alcohol and it made specific recommendations which may be worthwhile submitting to this inquiry. There were two major recommendations. One was that a media advisory panel be set up specifically for this purpose, for advising on aspects of the media that could be used for campaigns for promotion of drug education, the prevention of drug addiction and so on. The second one was that an equivalent amount of money spent for advertisements on alcohol could be sought from the manufacturers for drug education in the alcohol field and specifically that the voluntary code on advertising set up for the advertising of alcohol be disbandoned as such because it is a don't-do-this code, which is really just a guide to creative advertisers to try and get around this. The recommendation was that the code be made—not proscriptive—(*Dr Storey*) Voluntary? (*Dr Egger*) No, that the advertisers be made do certain things in advertising rather than not do certain things. In every advertisement they have to include a certain amount of health advertising.

4593. Mrs DAVIS: You do not feel that might be a negative approach in that they would immediately decrease the amount of money available for advertising?——W. I do not think it would be a negative approach; that would be a positive approach because decreasing alcohol advertising has the positive benefit—at least we assume so—of reducing the consumption of alcohol, otherwise they would not advertise in the first place. You win on both counts. You may get less money for advertising but you also reduce overall advertising. There is a practical problem here. Any form of restriction on advertising is difficult to implement. The cigarette campaign was indicative of that. We have to be realistic in any restrictions that we place specifically on alcohol advertising, and not say that we are going to ban advertising in the short term, but work towards making it more effective and more helpful for drug and alcohol education as well as for promotion of drug and alcohol use.

4594. Dr Andrews, do you see drugs being a separate entity in your department from alcohol, rather than drugs and alcohol being run together?——W. (*Dr Andrews*) There are several areas where special approaches need to be made to the problem of drugs and to the problem of alcohol, not necessarily at a clinical level. You cannot always effectively deal with the two problems together. In the education area you need sometimes people with special skills in one or other aspects. In terms of the overall organization within the committee, it is all part of the one problem of addiction to substances, and alcohol of course, as we all hear continually, is the major problem in numerical and consequential terms.

4595. Drugs and alcohol consistently are tied together. Because we are consistently told also that one seems to outnumber the other by ten to one, it seems that what we are setting out to do about the problem of drugs might get swamped because of the enormity of the other problem?——W. Yes, I guess one has to recognize that risk. Somehow one has to strike a balance. The other thing one must recognize is that it is not a steady state situation; it changes. We are all aware of the rapid increase in the drug problem in recent times, and therefore the emphasis that needs to be placed at this point of time. While one can argue that the alcohol problem is increasing in various ways, it has been with us for a very long time and it is in a more steady state. I can see some argument logically being put forward for some emphasis being given at present to the problem of drug abuse because of its increase in the community.

4596. CHAIRMAN: The problem of alcoholism has not increased at anywhere near the same rate as the drug problem?——W. Not at the same rate. I believe it is increasing but not nearly at the same rate. Some people might well argue that whatever we do we can expect to see in the drug area something of a swing back in the future. It may be that our priorities in the future will need to shift.

4597. Mrs DAVIS: I wonder if I might show this container to members of the commission. We are looking at the question of licit and illicit drugs. That is one of the few child-proof containers on the market. The members of the commission will observe that one has to twist it and fiddle with it before it can be opened. I think we should bear in mind that a lot of the drugs we are talking about, whether licit or illicit, ought to go in this type of container. What do you think about implementing this type of thing in the licit drug trade?——W. (*Mr Dash*) I can make a few comments on that. First, I am familiar with that particular pack and with several similar ones. There are three ways of achieving some degree of child resistance. One is to lock medicines up in a cupboard so that children cannot get at them. Unfortunately if they do get them it is because someone has got one of them out to use, put it on a table and walked away for a few minutes. It is the experience of the Poisons Information Centre that this is what most frequently happens. The second method is to use a container with a child resistant closure, something similar to the one produced here. There are problems in adopting that type of closure. The first one is that in designing a closure that is resistant to children but can still be opened by adults, particularly adults whose manual dexterity is not that good, some trials have shown that once people manage to work out how to open it they leave off the cap rather than put it back on. They become frustrated. So you finish up with something that is worse than no closure at all. The other problem is in designing a test method of determining whether a particular closure is child resistant. A test method has been developed by the Standards Association of Australia which follows similar test methods adopted in the United States of America, Canada and Great Britain. It involves using panels of children, adults and elderly people. There are two criticisms. First, it is difficult to get these panels together under the test conditions to perform the necessary tests to see whether children cannot open it and the adults can. Second, there is the legal problem of what happens to those children who, as a result of that test, may have been taught to open those closures and subsequently poison themselves.

(*Mr Dash* continuing) That problem remains unsolved. The third approach is to use something which is perhaps not impossible but a little slower to open, the blister or

strip packaging. That method has been favoured generally by the industry because it is accustomed to package a number of products in that way. The machinery has been developed and is in use. Controls have shown that with, particularly the impulsive pseudo-suicidal type of person, blister or strip packaging can be effective because these are impulsive things; usually a young girl takes a handful of tablets, regrets it subsequently and is raced to the hospital for a stomach pump-out or something like that. With blister or strip packaging it does take some time to get through them and, by the time she has got them out, she has probably had second thoughts. This seems to have had some success particularly with the tricyclic anti-depressants which were a particular problem a few years ago. That is the sort of comment I should have to make on child resistant closures.

4598. Two weeks ago you were talking about definite action being taken: Can you give the Committee any idea when that is about to take place so that the production of Mandrax will cease?——W. I cannot give a date. I believe that it will be in the next couple of weeks.

4599. Dr Storey, with the facilities available through computer printouts are you checking with manufacturers and wholesalers as to the number of hypodermic syringes being sold? Wholesalers' print-outs?——W. (*Dr Storey*) I do not think they are shown on the print-out that comes to us from the Commonwealth. (*Mr Dash*) You are talking about wholesalers' records of transactions?

4600. Yes, not particularly where they are going, but how many are being sold?——W. (*Dr Storey*) We have not followed up hypodermic syringes. It has been suggested from time to time and it has been suggested also that they should not be issued without a doctor's order or prescription. I think that could be counter-productive in one way. If you deny them access to disposable syringes you might add the problem of hepatitis to their already-existing difficulties.

4601. I would not argue with you on that. I brought it to attention because I do not believe that we have any idea of the number of heroin addicts there are. I have worked in pharmacies where hypodermic syringes are sold. It is nothing for a person to ask for 10 or 12 of them. I have worked in other pharmacies where they are not sold. We rang the Guild and the Health Commission and they said that they would rather we sold hypodermic syringes if asked for them as that would stop hepatitis but if we could get across to computer print-outs of wholesalers we might get a glimmer of how many are being sold? ——W. (*Mr Dash*) The figures would be available. You would, however, have to take into account the quantity used by doctors, hospitals, diabetics and others. You would still be making a guess as to what quantity went into the administration of illicit drugs. It is one possible indication about some extent of the use of illicit drugs. (*Dr Storey*) It would an interesting figure, as a one-off, three month figure but one would have to be careful about what inferences one drew from the figures. It should not be that hard to obtain.

4602. Mr HEALEY: One of the things that has struck me is that witnesses can all tell us what is not the right education programme, that it is counter-productive, but no-one has been able to say what they think is the right programme. Has the Health Commission anything which it is prepared to say it thinks is the right approach and programme or that what it has done over all the years has been wrong?——W. (*Dr Webb*) You are quite right: more people know about what not to do than what to do with drug education. With drug education—and drug education alone—that is probably the right way around. The Health Commission has produced guidelines recommending about fourteen different techniques it feels are the right ones to use in drug education. I am not sure whether I have included them or not. They are in the draft policy statement on prevention. Health Commission staff largely know them and Dr Egger and I have included them in a paper we have written. Local ideas on what are the right things to do have been published.

4603. Dr Storey, on 14th July the Committee visited Canberra and spoke to your federal counterparts. The Committee was told that the federal Government sponsors drug education to the extent of $750,000 a year, mainly in the form of subsidies to the States and that New South Wales gets about $150,000. Last week, representatives of the Health Commission told the Committee that New South Wales does not get one cent. The Committee was told that New South Wales got a cheque for $50,000 which was cancelled by telegram two days later?——W. (*Dr Storey*) I think there must be some confusion between the programmes. (*Dr Webb*) That is not so. (*Mr Dash*) That was in response to a comment about a programme for training counselling treatment personnel.

4604. No?——W. (*Dr Storey*) I think the question must have been not understood for some reason.

4605. Do you get money from the federal Budget and, if so, how much?——W. (*Dr Webb*) $208,000. (*Dr Storey*) Dr Webb might tell us when the federal money was first allocated. (*Dr Webb*) 1970. (*Dr Storey*) There was a clear understanding—the Commission's view then was that our health education programme would be on a broad front, directed towards life styles of people rather than specifically towards drugs. It might therefore be difficult to identify salaries to personnel whose whole time is directed to drug education or as drug resources perssonnel. That was accepted by the federal authorities at that time. One of our difficulties has been, not that the federal programme has been withdrawn, but that it has not been indexed. It showed promise when it was first made available six or seven years ago but we have had to reduce even the staff available because the federal grant was not indexed to keep pace with the consumer price index and the average wage. (*Dr Egger*) That $208,000 spent on promoting life styles conducive to non-drug abuse is in competition with at least some part of $900 million a year spent in commercial advertising to promote the opposite effect.

4606. I realize that. I wanted to clear up whether any federal money was being received by New South Wales? ——W. (*Dr Storey*) Yes.

4607. Mr McGOWAN: Dr Andrews, do you feel any conflict of interest between your position in the Health Commission and being on the Drug Authority? Do you feel that as the Health Commission has a certain policy, it is your job on the Drug Authority to put a particular point of view, or do you think you should act independently on the Drug Authority?——W. (*Dr Andrews*) In the fairly early days of the Drug Authority, I consider that the idea of having a member of the Commission as a senior member of the Drug Authority to be a good one. Clearly, there will need to be the closest working relationship and the closest communication in this area. I believe that the best way to achieve that is by some overlapping membership. On the question of what one's responsibilities

are, I believe that when all the people on the Drug Authority, myself included, take part in the activities of the authority they are acting independently of any other associations they might have. I would not feel constrained to limit myself to Commission policy. On the other hand, I might well advise the Drug Authority on what Commission policy is.

4608. I am getting back to the question whether a separate organization should be looking at this problem. From what I can see of the Health Commission, it was established to overcome the problem of fragmentation. However, it has run into another problem now that it has been all put together, that is competing interests. I think you pointed out that we do not have the people to go to the chemist shop and to do all the counselling and that we have institutions that cannot change quickly enough as the drug problem changes?——W. I think you are right, in that the primary objective of the Commission was to integrate health services. The drug problem is one that goes beyond the ambit of health. Education has a part to play in community services and another part to play with various forms of voluntary organizations which are not concerned wholly with health. Therefore, it seems worth while to have some body with a responsibility for the overall co-ordination and I think that is what was envisaged.

4609. CHAIRMAN: What would you see as the principal criteria of subsidizing voluntary organizations?—— W. I think they provide a needed service that is not being provided. The service is oriented to an area of the community that can be defined, in other words a defined problem. The services they provide can be integrated with all the other services in the area and generally. I think the most important thing the authority will have to do in relation to recommending funds for voluntary organizations is to draw up a general set of objectives as to the contribution the voluntary sector can make.

4610. You are dividing the geographical areas from the area of treatment?——W. I think both the geographical area and the range of services available across-the-board.

4611. Do you know why the Commission resisted for so long any subsidy to the WHOS organization?——W. It was purely lack of funds. When WHOS made an application to the Commission the difficulty was that there was simply not a ready amount of money that could be allocated to that source. It was only after considerable juggling and discussion with the Treasury that an amount was able to be found which was not used in other ways. Another difficulty is that voluntary organizations often ask for their funds halfway through a financial year when a public authority is probably over-committed as to where its money is going. Finding ready cash is not easy at that time. That happened in the case of WHOS. (*Dr Storey*) I do not know whether WHOS was the organization that operated in Wollongong at one time but about four years ago we refused a grant to one body because we were not satisfied as to its capacity satisfactorily to see to the application of the money. I have in mind that was an organization at Wollongong, but I am not sure. (*Dr Andrews*) I was thinking of more recently when WHOS made an application. It took several months before funds were able to be made available. They were found then only with some difficulty. A previous application was made under the community health programme. That was approved but withdrawn because of a lack in the organization to account for its financial affairs. They improved considerably in that respect and the problem was removed.

4612. Mr McGOWAN: My assessment as a layman has been that the voluntary agencies do a better job than the Health Commission in regard to what I have seen of the commission. I am talking about Jacaranda House and Wistaria House, both depressing places although they were manned with excellent staff who are doing the right thing. Comparing that with the situation we saw at WHOS, where there was an enthusiasm among the addicts in an attempt at rehabilitation, at Wistaria House there was a general air or institutionalism and depression. That was probably brought about at least by a lack of funding. That leads me to think that probably throughout the Health Commission there is an attitude towards drug addicts, that these people are suffering from self-inflicted wounds. We have come across this attitude at hospital level. I wonder whether it goes through to administrative level. ——W. I do not think so. You have raised a complicated issue. Wistaria House has been in the business a long while and there are a number of problems associated with it. One problem is that it was set up within a psychiatric hospital and earlier there was some discussion of the problem of providing positive, outgoing and high-morale type services in that kind of setting. I think that is a real issue. The other is that it tended, as most public institutions do, to turn to more difficult and resistant problems of drug and alcoholism because they are the problems that tend to be referred to that kind of setting. Voluntary organizations get perhaps more than their fair share of the easier-to-deal-with issues.

You mentioned lack of funding generally, and that is a problem. Large sums of money have not been made available to that sort of service and that is evident in the physical facilities they work with. That has been a factor within the psychiatric hospital system in recent years. The other thing was the question of attracting staff to work in that kind of setting and to work within the public sector. That is rather in contrast to some of the things that happened in the community health programme where there has been a positive attitude by staff generally to the issue of community health, drugs and alcoholism. I think the answer to your question is that there is a need for a proper balance between the public sector and the voluntary sector in all these areas. The public sector does some things better and there are undoubtedly some things, because of their flexibility and positive approach, that voluntary organizations do better. I think that in any given area what we need to be looking at is a framework where the public and voluntary sectors contribute in a complementary way. This is fairly philosophical, but it is a basis for looking at this sort of issue rather than taking the view that the public sector does not seem to have done very well so we should shift all our emphasis to the voluntary groups. I think there is need for a balance here. *Dr Storey*) I would be reluctant to adopt that as a generalization. There must be some areas where voluntary groups do better, and there are some where even we do not do so badly. As regards this idea of a punitive attitude or an attitude of let them be because it is self-inflicted, I have heard the Commission criticized the opposite way. It has been said that in our attitude to drug addiction we are too permissive. We get it both ways. It is simply a reflection that this is an extremely difficult problem, a satisfactory answer to which has not been found anywhere in the world. If we have not succeeded in this, we are in pretty world-wide company. (*Dr Andrews*) If you look beyond the Health Commission's activities into the public hospitals sectors and the general health care sector, the attitudes of professional groups such as doctors and nurses, what you say has a great deal more credence in that general theme, whereas people in the Commission, by virtue of working in a public health setting, tend to be people who have sympathy towards those problems. (*Dr Storey*) My own

view would be, in relation to our philosophy and particularly in relation to education, to encourage the population into thinking that their life-style with all its sequelae is each man's own affair. We should perhaps be trying to inculcate in the community a sense of responsibility for their own health and life-style rather than let them think they can get themselves into trouble and then necessarily have someone who can rescue them.

4613. Mr WOTTON: Do you know how much of your funding from the Health Commission is channelled into the alcohol and drug addiction sphere? Have you any idea?——W. I do not think I could provide a figure. It would be split up among so many headings. (*Dr Andrews*) There are available some figures based on estimates of the number of people admitted to hospital with drug or alcohol problems. I would have thought that they were already made available to the Committee, but if they are not we will arrange——

4614. CHAIRMAN: We had some discussion about it with Dr McEwin. He said funds are divided so many ways in regard to salaries—?——W. There is a breakdown available which may be useful to the Committee.

4615. There is nothing in regard to what is expected on the drug problem?——W. (*Dr Storey*) There is no specific heading "drugs" or "drugs and alcohol programme" with the elements costed out. We will refer that to our finance branch to see if there is anything that would assist the Committee.

4616. Mr WOTTON: In relation to funding from the Commonwealth Government it was mentioned that it had come down from 90 per cent to 75 per cent in one sector and in another from 75 per cent to 50 per cent. I forget the actual figures?——W. Those figures apply specifically to the dental programme. (*Dr Andrews*) And general community health. (*Dr Storey*) They are figures that are familiar to us. What their application is in this context I cannot imagine. (*Dr Andrews*) The drug and alcoholism programme, which is funded through the health and community services, suffered the same change.

4617. How long ago were they up to 90 per cent?——W. Up to the current financial year.

4618. Do you mean for ever and a day?——W. The programme commenced in 1973. It is a little complicated because the community mental health programme, which was funded by the federal government originally, was funded on a 100 per cent or 90 per cent overall basis, but the general community health programme was funded from 1973 on the basis of 90 per cent operating and 70 per cent——

4619. And that was cut back?——W. Yes. We anticipate it will be cut back again next financial year. I think there is good reason to surmise that it will become fifty-fifty basis overall and a tie in to the hospital cost sharing agreements.

4620. CHAIRMAN: In the evidence given by Mr Diehm at the last hearing of this Committee there was discussion about training in drug services leading to an acceptable qualification. In answer to a question as to whether any funding was received from federal health authorities in this regard, Mr Diehm said that a cheque for $50,000 had been received in Sydney but was followed two days later by a telegram withdrawing the cheque, and that was the end of ever trying to institute training in drug services leading to an acceptable qualification. Dr Storey, it is a fact that all cases of tuberculosis must be notified to the Health Commission?——W. (*Dr Storey*) Yes.

4621. And the same applies to the treatment of venereal disease?——W. Yes.

4622. Do you see any objection to the compulsory registration of all suspected addicts, irrespective of the drug involved?——W. I can see pros and cons while drug addiction remains an offence, or while the taking or possession of drugs remains an offence under the law. (*Mr Dash*) About twelve months ago in Victoria there was an attempt to develop a uniform method of acquiring data on the number of drug offenders in that State. It relied upon collection of data from a number of different sources including community health services, drug and alcoholism treatment services, law enforcement agencies, voluntary agencies and so on. They found quite considerable difficulty in acquiring that data and in reconciling information obtained from different sources. They felt constrained to apply some limits on the nature of the data they collected to try to preserve the privacy of the people concerned. As a result they lost the facility of being able to identify people who appeared in three or four different places. Their programme pointed up the difficulties of doing this. On the other hand, notification has been tried in Great Britain over a number of years and my impression when I was over there was that only a small proportion of addicts were actually being notified.

(*Dr Storey*) May I amplify my answer? I had assumed that you meant notification by name. Under the Venereal Diseases Act as long as the patient continues to attend, the name is not a compulsory part of the notification; simply the disease and certain other data. That would get over that problem but it straight away raises the problem that Mr Dash mentioned, that a patient could be notified a number of times. Concerning the notification of tuberculosis, a pension is involved there and the patient has to be notified to qualify for it. The accuracy of the notification of tuberculosis would be very high. On the other hand, in relation to venereal disease, some ten years ago we were getting only about 10 per cent in the ordinary course of business. A special survey was done which strongly suggested 10 per cent was the figure, so we are dealing only with the tip of the iceberg. That has been the experience in other countries. The same applies to notification of other infectious diseases. We have the greatest difficulty in collecting data. We have had to go to the backdoor, and Parliament agreed to our amendment to the Venereal Diseases Act requiring laboratories to notify positive tests for syphillis. But it is difficult to persuade a doctor that he has an obligation, both morally and legally, to notify infectious diseases. The same attitude, or perhaps even more so, would probably prevail in relation to drug addiction.

4623. You would be fairly confident that you know most of the tuberculosis sufferers in Sydney or in New South Wales?——W. The diagnosed cases—yes, I would. But there again there is a strong incentive in that the patient will not get his pension unless it is known.

4624. Most of the people in the drug field today are on sickness benefit or unemployment benefit?——W. Yes.

4625. Would it not be preferable for them to become eligible for a pension, similar to the tuberculosis payment, provided they were notified and put on a register?——W. That would involve notifying them by name. In my view while it remains an offence under the law there would be

considerable reluctance on the part of the patient to put himself in a position where he would be notified to the authorities. I believe while that is the attitude of the patient there would be a significant proportion of the medical profession that would probably not be co-operative in relation to notification. If the patient had something to gain the situation might alter a little. I understand in England—and Mr Dash may correct me on this—this started, as I recall, in association with a morphine or heroin maintenance programme, that unless a person was registered as a drug addict he did not get his free heroin. I could be wrong in that but I believe that was the situation under which notification and registration commenced in England. I would see many difficulties in such a programme. (*Dr Egger*) I believe if the addict has something to gain from registration we will have the opposite problem of inducing people who are not really addicts to own up, in the same way as we have with the methadone programme, maybe making them become addicts.

4626. But it would not be a matter of someone simply coming along and admitting that he was an addict. He would have to be proved to be an addict and that is where a test such as the narcan test would come in.——W. That brings out another difficulty. The Narcan test is not 100 per cent successful in determining addiction. It is only a stopgap measure.

4627. How do you know it is not 100 per cent successful?——W. For a start, if someone has a shot of heroin immediately before coming in for the Narcan test, he can elicit some sort of withdrawal. He does not have to be fully addicted to elicit withdrawal from Narcan.

4628. You are saying that medical officers can detect that people are not really addicts or they are addicts and they do not respond positively to the narcan test?——W. In some cases they can from Narcan, but there are other cases where Narcan is not a discriminate of addiction. We still do not have a 100 per cent sure way of telling whether a person is an addict and how long he has been an addict. It may be that he has been using the drug for some time but is not classically addicted to the drug.

4629. Let us hop over that stage and come to the next stage. Assuming that medical authorities can evolve a successful method of determining whether a person is addicted or not, do you see any advantage in evolving some sort of pension scheme so that provided a person who is addicted submits to treatment he is paid but if he does not submit to treatment he gets nothing?——W. (*Mr Dash*) I think you would have to tie in with that the removal of criminal sanctions against possession and use of drugs of dependence. Control over possession in particular has been one of the bases of control over illicit drugs and it would require a considerable change, I believe, in our general philosophy of drug control and in our method of enforcement of prohibitions on illicit manufacture, distribution and use if we wanted to treat use under the criminal law before you could successfully introduce a pension scheme of the type you have in mind.

4630. The present system has not been a success, has it?——W. (*Dr Storey*) No. (*Dr Egger*) The whole thing hinges on your statement, provided we can determine a 100 per cent sure method of detection. Until we do I believe by introducing such a scheme you may simply exacerbate the problem that we have with methadone.

(The witnesses withdrew.)

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CORNELIUS BRENDON KEOGH, D.D., Ph.D., Catholic Priest, sworn and examined:

4631. CHAIRMAN: What is your full name and address?——W. I am Cornelius Brendon Keogh, I am a Catholic Priest, Archdiocese of Sydney and I am honorary programme director of Grow, which is of Australian origin, and is a community mental health movement which was formed here about 20 years ago under the name of Recovery, and changed its name about four years ago to Grow. I have been working full time as the national programme director, although still a priest under the Archdiocese of Sydney. My private address is 29 Juliett Street, Marrickville.

4632. We have a submission from you here, do you wish it to be incorporated as part of your evidence?——W. Yes. The submission reads:

DECRIMINALIZATION OF MARIHUANA IS A SPURIOUS ISSUE

by C. B. Keogh, D.D., Ph.D. (29th September, 1977)

By this I mean that it is:

(1) superficial in the whole present-day social context;
(2) hypocritical if made primary and most urgent, and
(3) predictably disastrous if introduced prematurely.

Decriminalization concentrates on the removal *of a cause of real harm and suffering to a small minority of people, but one of immeasurably less importance to all concerned* (including the individuals *affected in this way*) *than the vital values of personal and community health* which are, in the nature of the case, being widely jeopardized and sacrificed. For through increasing marihuana use the health and lives of countless persons and the culture that has created our very identity as a people are gravely at risk: they could be damaged in a wholesale and probably irreparable way at this point of time if community authorities were to indulge in misplaced priorities in handling the drug problem.

Any real harm which our society might be doing to persons through disparity in the application of the law should, of course, be removed, and eventually (i.e. as soon as is possible without creating greater evils) must be removed; but it would be unwise and treacherous to tidy up a legal anomaly which causes disadvantage at a surface level to a small number if in the process multitudes were to suffer far worse harm through the removal of what is still a meaningful warning and relatively effective deterrent against the involvements and behaviour which bring on that more notable harm. Indeed, it would be truly criminal to contribute to the removal of such a legal safeguard against larger and worse evils if in doing so one was knowingly clearing the way for the freer and more destructive action of many people's own self-defeating immaturity and the cynical forces which systematically exploit their vulnerability for selfish material advantage.

(1) *Decriminalization is a superficial issue in the whole present-day social context*

It is superficial in giving disproportionate importance to what is an extrinsic disadvantage of the small number of persons concretely brought under the force of the law, as compared to the profound and intrinsic harm to the real health of much larger numbers.

The *deprivation of liberty* through imprisonment is obviously extrinsic and negligible in comparison to the loss of liberty which results from serious dependence on a drug like marihuana. And surely *the effect of an individual's career and future* which may come from a court conviction of this kind and resulting social discredit in the eyes of peers or potential employers is as nothing when compared to the real ruination of personal growth and prospects of success in life which regular and increasing marihuana use causes.

In other words, it is one thing to be relatively prevented from a career by a less attractive appearance to others and their unfavourable way of looking at you, when you are still able for and desirous of pursuing that career yourself; but it is an altogether different thing—an incomparably worse thing—to have contracted, in the reality of your personal life, an internal condition which makes you no longer able for, nor even able to desire, such a career.

There lies the essential and radical difference between the harm, on the one hand, which our society does to individuals by continuing to permit a state of law which punishes a small number of marihuana users simply for possession and use, and the harm it does, on the other hand, by continuing to permit social, cultural and administrative conditions which lead to widespread marihuana addiction (for there is such a thing) or even serious marihuana dependence.

To be chiefly concerned about the external hindrance to the individual who is a user but is not yet hooked, and to disregard or treat as less important the ruined health and prospects of the individual who is hooked, is either mindless or heartless.

It is the natural effect of marihuana to produce pleasure by artificial means, that is, unearned by the natural exercise of one's faculties. It thereby tends to lessen any user's drive towards achievement and personal development, and it substantially undermines the activation, concentration, coherence and effectiveness—in a word, the fulfilment and prospects—of regular and dependent users. Moreover, there are far more lives ruined in this way by the spreading use of marihuana than by the application of the law which makes its use a criminal offence. Therefore, it shows a distorted sense of values to be agitating for the removal of a legal and social disadvantage to the few and not to be chiefly campaigning for the more real and permanent harm to the greater number.

Moreover, if one were concerned about the greater problem of those who get hooked on this drug, it would still be a sign of unrealism and ignorance to be making a fuss about the harm that could come from arrest and imprisonment. Anyone close to the problem knows that there is little or no hope of rehabilitation from serious drug dependency unless the person who is hooked can be got out of circulation for long enough to survive the long period of psychological need which remains and has to be painfully unlearned long after physical withdrawal has been got through. (Marihuana dependency is particularly relevant here ,owing to the rather unique property of its active element (THC) of being stored for long periods of time in different parts of the body, especially the brain. The fact that it takes months for this mind-altering material to be eliminated accounts both for the tapered withdrawal which masks the addictiveness of marihuana and for the extremely slow return of the necessary insight and purposeful self-activation which are the essential condition of rehabilitation.)

Every drug programme which is at all effective involves strict and long-term, voluntary or involuntary, enclosure of the individual in an environment where drugs are not available. Indeed, if there has been no substantial breakthrough in drug rehabilitation programmes in Australia, it is precisely because there is as yet no strictly controlled long term live-in system where the inmates are able to learn or relearn healthy attitudes and personal control away from their twin enemies: The availability of their drug and the social inducement to take it. The institutions in the U.S.A. which have achieved good results (e.g., Synanon, Daytop Lodge, Odyssey House, Teen Challenge) all lay down strict isolation from the outside world as an absolute must. The term of this isolation, in the case of heroin addicts, can be anything from 18 months to 4 years (with strong inducement, in the case of Synanon, to make the separation from outside life permanent).

The simple fact behind this stark reality of drug rehabilitation is that there are only three factors involved in drug enslavement:

(i) the immature pleasure inclination which eventually becomes an obsessive need;

(ii) social inducement; and

(iii) availability of the drug.

With only those three variables, you haven't much room to move. Well then, faced with an inevitably long struggle to reorient his mental, emotional and physical system to manage without the drug, the addict needs to be physically unable to get the drug when his resolution temporarily fails him, as it often will on the way up. And he needs to be out of the reach of false friends from the drug scene who would both undermine his new thinking and supply him with more drugs.

For this reason many a mother, father or marriage partner often sees jail, when it comes, as a blessing in disguise, and will even, in order to give their loved one that last desperate hope, report him to the police and pray that he will be put away. Speaking as a former chaplain to Long Bay Prison, I know how often I shared with an alcoholic or drug addict in prison the restoration of his genuine humanity and personal dignity in contrast with the pathetic shambles we knew he had been outside—and sadly anticipated that he would become again soon after his release. So realistic is the understanding in Japan of this need of the addict for isolation from both drugs and the drug scene that the standard treatment there for addicts is jail for several months, followed by compulsory resettlement in another city away from their previous environment.

That is the approach of people who realize that drastic evils call for drastic remedies. By contrast, to ignore that drastic and spreading evil in our country, for which the only hope is the voluntary or involuntary deprivation of liberty, and to give all attention to the lesser evil of such deprivation for a small number who have been caught playing on the fringe of it, so to speak, is a clear case of grossly inverted priorities.

Note that I am not suggesting that prison is the answer to drug addiction, or that every drug user who is hooked—much less those who are not—should be put away for their own good. Prison programmes have been found, on the whole, to be a failure, though they have here and there been the salvation of particular individuals. (Some addicts even found a twisted advantage in a prison term which afforded them the chance of reducing the tolerance they had built up to their drug: As a result they could take up their habit again later and get better kicks at much less cost.) The fact is that nobody can be changed who doesn't really want to change; nor will anyone be likely to perseveringly want to change if he is not strongly encouraged by healthy-minded people about him. There is something to be said for the isolation of a regular marihuana user in a strict live-in rehabilitation centre where there is a positive programme of authentic rehabilitation—for in such a place, as the accumulated marihuana was slowly eliminated from his system, he could in a month or two learn to want to change—which would have been impossible for him on first entry into the programme. But such a programme would necessarily entail a lot of built-in leadership by addicts who had changed and others who were in the process of changing.

There is, on the contrary, little or nothing to be said for the compulsory attendance of drug users, however far gone, at any of our typical drug centres, where there is no strict isolation and users come and go—for, in the prevailing complete absence of education and leadership for drug-free living which characterizes them, these places serve mainly the reinforcement rather than the reversal of the drug habit. Finally, for the non-hooked user who is caught, there is clearly no gain to be anticipated from sending him to prison, and everything to be said for obliging him, instead, to attend compulsory classes on drug effects and personal health care—but where in this State is one going to find such a healthy programme? Certainly not in anything run by the State at present, nor in any of the voluntary drug referral centres which are State funded or subsidized. These are emphatically more a part of the increasing problem than of its solution: Which brings me to the second of the three observations I made and promised to elucidate.

(2) *Decriminalization is Hypocritical if Made Primary and Most Urgent*

It is hypocritical, I submit, to be urging decriminalization of marihuana possession and use when one is conspicuously (and perhaps studiously) doing nothing about the far greater cultural and social problem—which is the setting up of vigorous anti-dependency rehabilitation programmes for those who are already hooked, and convincing anti-dependency educational programmes for all users and potential users in the community. I say this is just as hypocritical as the present practice of sending that pathetically unrepresentative token group of offenders to prison and taking no strong action against the real criminals at large, who are set to make the big gains in power, prestige and profit out of their exploitation of the weak and immature members of the community who finish up on the addiction end of drug use or on the wrong end of the law. Parallel to the obvious *down-and-outs* of the drug culture, the sick and the suckers, there is always the parallel group, correctly described as the *"up-and-outs"*, who exploit them and prey on them, and who are the real propagators of the drug anti-culture. These are people who originate the policies, and some of them (usually narcissistic ego-tripping intellectuals) are the ones who frame the arguments, for the legalization or the decriminalization of drugs such as marihuana.

It is pleaded that there is unfairness and objectionable disparity in giving a criminal record to some hundreds of people, and even a jail term to a portion of these, when many times more are allowed to get off scot free with exactly the same kind of behaviour. Unquestionably this is a case of blatant inconsistency. But it is not the only inconsistency nor by any means the most blatant or the most harmful. Moreover, the way you choose to be consistent in the midst of numerous and competing inconsistencies reveals only too clearly to a perceptive observer your deep underlying consistency and what you are really aiming at.

Let me return to my earlier point concerning the three variables involved in the spread and control of marihuana dependency:

(i) the *immaturity* of the vast majority of marihuana users and *potential users;*
(ii) the *availability of the drug;* and
(iii) the *social inducement towards using it.*

Now, the drug users themselves are not mainly law-breakers, for most of them are not law-breakers in any other way at all: at the most, the offences they commit are in connection with the maintenance of their habit. This fact is taken up and urged as an obvious argument for not treating them as law-breakers—in other words, for decriminalization of the use of marihuana.

I concede that this would be the case, and this reasoning could be acquiesced in as genuine, if you were continuing to treat marihuana as a dangerous drug, and were still bent on keeping its production, sale and use illegal. For it *is* possible to maintain the illegality of the drug and to use the force of law against its extended use in the community without treating the mere user (especially the first offender) as a criminal: the condition that makes it possible is that you are convinced of the grounds for maintaining its illegality, and determined to be consistent in keeping it illegal and using all the necessary means against its extended use.

Two factors, then, stand out here as integral to a sincere case for the decriminalization of marihuana as distinct from and opposed to its legalization. They are (i) the firm conviction that marihuana is a dangerous drug, far too dangerous, in fact, for its use to be allowed to become common in society (and in the event of real doubt over this fact, at least the firm conviction that the probable or threatening dangers are too great for society to risk incurring, and therefore such as to justify strict anti-marihuana legislation and control until such time as the worst suspected dangers are proved unreal and there is reliable assurance as to its overall safety)—then (ii) thorough consistency in controlling the other two factors which account for the spread of marihuana use (availability and social inducement). For it is the State's duty to use the necessary educational, administrative, legislative, judicial and even punitive steps to enable people to take the proper care of their own health, and to protect them against those who, for base purposes of their own would persuade or cheat them into doing the opposite.

Let us look a little more closely into what is involved in the control of the other two variables in the case. I refer to our practical attitudes towards *those who make the drug available*—the growers and the sellers— and *those who positively induce people to use the drug.* We are dealing, in fact, with *two different kinds of pushers*: there are the pushers or providers of the drug, and there are the pushers of people towards the practice of drug-taking.

First, *the pushers of the drug* and the factor of *availability.* Of course, as is well known and often said, "every user is a pusher". It is friends or peers in the individual's natural environment who are the main immediate source of drugs for the vast majority of those who become users. This fact must never be lost sight of or underestimated; and it will need to be tackled thoroughly in terms of due education and leadership, and the trend it represents will need to be effectively reversed, if success is finally to be won against the mental, physical and social disease of drug abuse. At the same time this is by no means the most powerful factor or the most guilty cause of drug abuse. Because of the high degree of spontaneity and immaturity, and the lack of calculation, malicious intent, exploitation or breach of community trust, this kind of drug pushing is, though still illegal, the least illegal. Those concerned are arguably more victims than perpetrators of the wrong of spreading an agent of harm.

The more real or deeply involved pusher is either the *grower* or the *seller* of the drug. This includes *any* grower or seller. As such, a grower or seller has a different level of effectiveness for harm than a mere user, or than one who merely invites another to use a harmful drug—in this case to share a "joint". Even one who privately grows the plant, ostensibly or really for his own sole use, is a more real and active violator of the law than a mere user. For he introduces the harmful drug into society—as surely as anyone who smuggles it in past the customs.

In proportion to the *quantity of growth* and the *quantity of selling* the law should be increasingly severe, and the punishments greater. If *all* growing (even in small quantity and complete privacy) and *all* selling, even at peer group level, were punished as a greater wrong than mere use, the law would be seen to be consistent and would be both more respectable and more respected.

The tragedy of Don Mackay's disappearance and assumed killing in Griffith, and the shock to people there and throughout Australia, brought to light and to community realization the spectacular anomaly that we had no law against the *growing* of marihuana. To condemn and punish use without condemning and punishing production is obviously irrational and grossly unjust. This anomaly is now being remedied. In addition, the law has been strengthened in this State so as to inflict severer penalties (heavier fines and longer terms of imprisonment) on the worst kind of pusher—not the one-to-one user-pusher, but the far more destructive one-to-many exploiter-pusher or profiteer.

So much for the *material* aspect of drug-pushing. The epidemic spread of marihuana use will only be prevented if growing and/or selling are dealt with as criminal offences, and the penalties for either of these are made of greater or less magnitude according to the greater or smaller quantities of the drug or of the growing or selling practice that is involved. It is manifestly inconsistent and damaging to respect and trust for the law that a grower of marihuana should receive less punishment than a seller. The amount of marihuana made available for harmful use and the degree of profit hoped for from either form of behaviour, producing or selling, should be the measure of the harmfulness and the criminality involved, and should be punished accordingly.

Now, it does appear to be, and on the face of it it should be taken as, a sign of sincerity on the part of the government, that it has increased the legal penalties for large-scale selling of marihuana, and at the same time is bringing in new legislation to make marihuana growing a criminal offence. It is, of itself and so far as it goes, an objective sign that the government is not giving primary importance and urgency to its proposed decriminalization measure (which has yet to be enacted), and that it is therefore sincere in its professed resolve not to legalize marihuana but, on the contrary, to enforce the law severely against those who propagate the use of this harmful and therefore illegal drug. *There would be no grounds for thinking any differently*—i.e. *for thinking that decriminalization was hypocritical and a sly first step to legalization—if there were not strong evidence for believing that the other far more constant, subtle and ultimately effective type of pushing was not being discouraged, but on the contrary was being aided, abetted and even systematically organized by the government*: I mean *the intellectual, cultural or educational form of drug pushing.*

If the government were doing all within its sphere of influence to counteract intellectual drug-pushing, and specifically marihuana pushing, and if it were doing what was directly in its power to remove from official positions the active promoters of marihuana use, the *pro-marihuana or neutral-to-marihuana educators*, you could believe that it was genuinely trying to enforce the illegality of this drug. If, however, there were significant evidence of vacillation or incidental inconsistency in this respect, you would be inclined to think that it was yielding to some degree of doubt as to the harmfulness of the drug and the cogency of the grounds for its continuing to be held to be harmful, and for its use to be maintained illegal. Indeed, if there were indications of a consistent leaning in the opposite direction—viz. towards positively pro-marihuana education, towards support of various kinds for the pro-marihuana propagandists in various departments of public life, and towards wholesale failure to encourage genuine anti-marihuana health educators and even to positive discouragement of these, then there would be grounds for thinking that the other legislative gestures made and just now acknowledged, however appreciable in themselves, were little more than insincere window-dressing and temporary measures—measures that could be and would be ultimately revoked when the social status of marihuana had been substantially changed and the time was ripe for its full legalization. In short, if the State were not evidently implementing a vigorous educational programme to warn people at all levels of life of the serious hazards for health and even for life which marihuana use entails, and especially if there was evidence of large scale and determined educational influences maintained by it to favour the general conviction of its relative harmlessness and even positive acceptability, one could be justified in thinking that decriminalization *was* in fact the more important and cherished of its legislation projects, as being the necessary first step and the thin edge of the wedge for the social propagation of marihuana use and the inevitable demand for its full legalization. If legalization is indeed the cherished hope and chiefly intended objective of the proposed legislation for decriminalization, then the measure would deservedly be called hypocritical.

I suggest that the above considerations outline the only logical and realistic perspective in which the Joint Parliamentary Committee on Drugs can consider and discuss the question

of marihuana use in this State and the issue of its decriminalization. Everything will depend on what it concludes, after full investigation, that people in responsible positions and with government acceptance or even positive support have been doing and are currently doing in regard to anti-marihuana or pro-marihuana education. *Only strong and obvious anti-marihuana educational measures, extending throughout the whole community* (in the schools, through the media, and especially in the health education and drug education services, and in the marihuana-research, and the drug counselling and effective drug rehabilitation programmes which the government sets up or subsidizes) *will give real evidence of a sincere intention on the part of the government* (and especially its Health and Education Departments) *to maintain the status of marihuana as an illegal drug and to prevent the spread of a marihuana epidemic throughout the State and eventually, of course, the nation.* If, on the other hand, the mass of evidence shows *a marked neutral-to-marihuana or a pro-marihuana bias,* it will be obvious that the government is either weakly succumbing to the strong commercial, cultural and political forces which are working against the people's health for the all-too-obvious selfish purposes of identifiable people or the concealed and all the more sinister evil ends of other agents who are hostile to our country and our culture.

Moreover, besides the past and present government attitudes and policies, there are also the future ones to be considered: In other words, the effective educational policies and programmes which the Premier has promised to launch and have in operation before proceeding to the legislative step of decriminalization. For it is quite possible, and even likely, that many members of the legislature, on both sides of the House, have not had a clear picture of what has been involved, and even what trends the government has been effectively encouraging or discouraging up to now; and many can be expected to take up their own conscientious stand on the basis of what this Joint Parliamentary Committee brings to light concerning the reality of the present position and the unpleasant and urgent choices with which it may confront them.

It is not my intention, or within the scope of this brief paper, to plunge in detail into the factual part of that inquiry into the educational issue, for I believe the Joint Committee must earnestly search them out and decide what they show after due investigation. May I, however, briefly indicate what I consider can hardly avoid being the outcome of any thorough investigation that may be conducted by the Committee on this question? My remarks will, of necessity, be summary and schematic.

There is a marked trend in our affluent western capitalist society, and therefore in Australia, towards the progressive and ever more rapid disintegration of our life and civilization through an uncontrolled drug culture and in particular an epidemic of marihuana and heroin use. Part of this trend is spontaneous development, being the resultant of so many new forces and so much rapid change in a culture in which heavy emphasis is placed on freedom, feelings and artificial helps, and no importance is given to their vitally important counterparts, which are reason, respect for nature, laws of health, sound tradition and competent authority. Another and perhaps the more decisive part in the trend is the consequence of an anti-cultural movement deliberately mounted by a new breed of radical intellectuals who seem dedicated to change for the sake of change or for the chance it affords them to strike a destructive blow against the traditional culture and its values. It is well known and documented that the marihuana culture which multiplied the number of marihuana users in the U.S.A. from 50 000 in 1965 to an estimated 30 000 000 at present was consciously conceived and produced by a small group of determined intellectuals following in the wake of Aldous Huxley on Berkeley Campus about 12 years ago. Without doubt the movement in Australia is stimulated and directed by a similar cultural group with its own definite intellectual, financial, and even political components.

Succeeding governments in recent years have not been earnest and careful in their efforts to combat this trend and to protect the citizens of this State from the impending disaster. On the contrary, they have gone on taking the line of least effort and least trouble and employing opportunist policies—i.e., policies motivated by short-term considerations of pleasure and advantage, token problem-tackling and solutions in appearance rather than in reality—in short, anything but the real issues of truth and the objective demands of community health. As a result, the State's relevant health-education and drug programmes are at present almost entirely favourable or neutral to the extension of marihuana use in society, and are positively hostile to any genuine educational programmes with an unambiguous prior emphasis on health (as distinct from cultural and political manipulation). In short, the system paid for by the people's money is doing some good, of a token rather than a substantial nature, in the field of rehabilitation, but in the field of preventive education it is mainly obstructive and destructive—in short, considerably more harmful than helpful, and a positive menace rather than a service.

The plan or programme this systematic anti-health trend is implementing can be summarized along these main lines:

(i) Encourage at all costs the belief that marihuana is not a grave problem for the physical and mental health of people and the future of our country. *Make people think of it as "no more harmful than alcohol or tobacco", and therefore to be accepted* as these are in everyday use and legality, with only the ordinary precautions against immoderate or excessive use. For this purpose, suppress obscure or discredit the drastic evidence which has been coming to light, especially in the last three years, concerning the long-term effects of regular use of this drug.

(ii) Get into people's minds, subtly or blatantly, *that education on drugs and their effects on health has been tried and found not to work—indeed, even to be counterproductive,* especially when there is any appeal to motives of fear. This strategy has been very successful, for the belief in question is very widespread. In fact, it is a pernicious half-truth woven out of three elements of truth and two complete falsehoods.

The first part of truth in it is that education based on *information* about the effects drugs have, without constructive *motivation* for a healthy life-style, usually has the adverse effect of creating a morbid fascination which encourages drug experimentation. The second element of truth is that education based on highly dramatized and extreme cases (such as the agonies and the worst tragedies of heroin addiction) are of more harm than help to the general run of people, who need rational instruction concerning the severe damage to health and happiness that comes from the much more current and unsensational forms of drug use. And the third element of truth is that education based on fear for one's physical health in the context of an apparently meaningless and hopeless personal life-situation does not work, nor does education based on fear rather than love of the persons or authorities from which it emanates.

The first complete falsehood is that education based on the effects of drugs such as marihuana, as an ordinary appeal to persons having or coming to adult responsibility for their own, their friends' and the community's health, does not work. It *does* work wherever it is tried, and it is especially effective when it includes (in the context of a sound philosophy of life and a caring and sharing community) fear for the consequences of one's own actions, for what one does to oneself by irrationally following mere feelings or peer-group pressures. Wherever there has been factual and objective education on the effects of drugs on health (as, for instance, during the years preceding prohibition of alcohol in the U.S., and in the years following the U.S. Surgean-General's grave warnings on the dangers of tobacco smoking) there were marked improvements in people's self-discipline for health, as measured by the considerable reduction of abuse of alcohol and tobacco recorded at the times in question. And for a sensational and continuing proof of the effects of education against marihuana abuse, what could be more cogent than the results achieved year after year by Professor Hardin Jones in his course on drug use and drug abuse on Berkeley Campus in California? (Out of some two or three hundred students each year, mostly committed marihuana users at the very well-springs of the marihuana culture in the western world, the majority have given up the use of marihuana before the course has ended.) Professor Jones stated, while here in August:

> ". . .I find, in my large classes in drug abuse at the University of Californa, Berkeley, that education does work. Most people, especially young adults, do not want to harm themselves or impede their development. When my students understand the scientific facts about Cannabis use, most give it up, especially in recent years with the appearance of the results from cellular studies to confirm and explain the clinical observations. I tell my class that if they do not believe what I am telling them, there is one test they can do for themselves. Give up Cannabis use and watch the recovery. After several weeks of abstinence

the users report their memories improve and their minds become markedly cleared. Many describe it as a 'lifting of the fog'. Even those who use Cannabis only occasionally report some improvement. They notice functions return they hadn't missed; for the heavier users, this includes return of sexual functions.

It is still not too late in Australia for parents, teachers, doctors and responsible Government leaders, to become informed and to organize to reverse the tide of destructive drug use in Australian society".

The second faleshood is that objective education on the consequences of drug abuse has been carried out in Australia and been found to be a failure. The truth is that, in the case of alcohol and tobacco, nothing positive has been done—literally nothing of even the slightest significance or impact—to match and counteract the insidiously false persuasion in the opposite direction which is carried out unremittingly by the breweries, the tobacco companies, the advertising agencies and the media. The same applies to drugs of medication, and especially analgesics, for the abuse of which the Australian people have the worst record in the world. And, as for marihuana education, no one with any knowledge of the facts and without a cynical or sick sense of humour, would even venture the suggestion that we have tried it. The only noteworthy education on the effects of marihuana that has been carried out in this country in recent years was done during the four weeks' visit and the tour of Dr Hardin Jones and Mrs Helen Jones during the month of August last. It was eloquent indication of where we stand on this kind of education that, in marked contrast to the spontaneous gratitude and enthusiasm of people of every type of background everywhere, there apparently could come forth from the health educators and those entrusted with drug programmes, at best a wholesale coolness and at worst consistent and spiteful endeavours to trap or discredit this eminent scientist.

(iii) I am listing the strategies that characterize the organized approach to drug education in this State. The first was to encourage the belief that marihuana is no more harmful than alcohol or tobacco. The second was to spread the idea that education against harmful drugs doesn't work, anyhow. The third strategy, as I see it, is this: *whenever marihuana is under discussion, shift the spotlight away from it at all costs, and emphasize that alcohol is the great problem which we as a people have to contend with —or, if you wish, alcohol and tobacco.* But having done that, and made sure that no anti-marihuana education is allowed to get off the ground, don't take the reasoning any further than that. Let is be clearly understood that there is to be no concerted effort, let alone any official campaign, against the increasing use of alcohol or tobacco.

(iv) *Make sure that all the existing so-called drug-education is never person-centred or health-oriented.* In other words, never let the talk be about what drugs do *to* you, and what you may be doing to yourself by incautiously getting into the habit of using them. On the contrary, emphasize only what people use drugs *for*, and what they can do *for* you, or as a means of expressing attitudes *against* someone else or some other group or class of people in society. In short, treat the drug problem as primarily a *social* issue, and an object of *political manipulation.*

Above all, pretend, and try to get people to believe, that the question is a case in which all the young (as a single homogeneous class) are divided against all the old (also fictitiously represented as homogeneous). Don't ever let the facts be known that the marihuana culture is being foisted on the younger generation principally by calculating oldies for extrinsic and purely exploitative ends of their own. Having established this partisan polarization, the way to play the young off against their elders is like this: keep sowing this thought, that while ever the older generation continue to use and abuse alcohol and tobacco, the young—almost as part of their own striving or authenticity and in order to preserve their independent identity, to register their protest, and to express their own greater integrity and spirituality—have to use dope as their cultural symbol of rebellion. Certaintly, it must be brought home to parents that while ever they have not made the world a perfect world for their offspring to grow into and cleansed it of every vestige of materialism and adult drug dependency, they must not embark on any attempt to tell the young that marihuana dependency is wrong or sick or a losing game in life. (Above all, nobody, in dealing with this education policy, must have the temerity to suggest that two wrongs don't make a right, and that there is a crass and grotesque a materialism in a drug dependent reactionary drop-out as there is in any drug dependent, time-serving functionary in the work-oriented world.)

Obviously, the only winners in this stupidly naive or calculatingly cynical approach are *the commercial exploiters of both the older and the younger generation,* that is to say, the voracious money interests at the back of all three industries—alcohol, tobacco and marihuana—with the most monstrous and greedy of all—the heroin industry—waiting in the wings to take eventual control of the finally generalized drug scene.

The *causes* behind this whole sell-out of humanity are complex, and for the most part not clearly grasped, let alone maliciously endorsed, by most of the people involved, who nonetheless support and further the new drug culture in various and converging ways. I think they can be roughly identified as follows:

(i) In the first place, I list *the tendencies inherent in liberal capitalist democracies, to emphasize freedom rather than wholeness, health and welfare*—as distinct from totalitarian socialist countries which emphasize a pseudo wholeness, health and welfare at the cost of freedom (yet, under that head do manage to completely eliminate hedonistic culture trends and drug abuse as obviously inimical to an effective work force).

(ii) Next, I place the well-nigh universal adoption, in the caring professions, of *the method of non-directive counselling* which originated with Carl Rogers. This method has degenerated into a generalized philosophy of non-involvement and an utterly *non-caring neutrality to all life-styles,* whether healthy or sick, constructive or destructive to the persons concerned and to the community. Above all, it has developed in the official mental health and drug education world a totally spurious agnosticism or scepticism about what is objectively healthy and what constitutes sick behaviour and sick lifestyle. It has mongrelized the word "normal" so that it no longer means healthy but rather "what you feel like" or what is prevalent or even trendy; and it obscures the existence of *two diametrically opposite and constantly operative processes,* for all persons and for the community—viz., processes of *growth* towards health and civilization on the one hand, and of personl *breakdown* and the disintegration of hard-won culture on the other.

(iii) In third place, there is the habit of all governments, irrespective of the party in power, of *building up the bureaucracy at the expense of the community*—and the ridiculous policy of entrusting programmes of personal and community health and education to officials in the public service—as if these people could, as such, be expected to have the slightest competence in the complex matters entrusted to them —or as if their clients in the community could be expected to produce their problems, and wait on solutions for them, during the conventional times of 9 to 5, and from Monday to Friday.

In all honesty, what rhyme or reason is there in thinking that functionaries of the Health Commission would be the best ones to perform as health educators, any more than that functionaries of the Ministry for Defence would make the best soldiers? With all their costly back-up support in buildings, transport, equipment, administrative and other help, what do these people do except occupy the ground and the resources which rightfully belong to those voluntary bodies which, at the level of the problem and its authentic solution, have the essential answers but cannot develop and apply them through sheer lack of means? Having no special basis in experience, reason or authority for spinning out educational or rehabilitative attitudes and programmes on intrinsic grounds of personal and community health, what else *can* these officials do but ignore the health dimension altogether and push mere liberty of opinion—with the destructive implication that the health standards,

consensus and authorities of the existing culture are to be rejected in the name of independence and laudable rebellion, and the complementary madness that all opinions have equal validity and an equal claim on the community's acceptance? Individual officials, without an intrinsic health message to communicate, are inevitably left to choose their line of thought and influence on extrinsic motives—which can only be motives of an opportunist type, with their own pleasure, convenience or advantage being naturally the most prominent. But, as for the Commission's overall orientation—since nature will not tolerate a vacuum and the community's own positive health programmes were not given priority at the outset, the neutrality stance which may, with quite sincere stupidity, have been originally adopted had to give way sooner or later to an organized anti-health counter-culture. The employees themselves, being without any community cohesion of their own, were sitting ducks for this type of outside influence, and there would surely have been no lack of vested political, commercial and intellectual interests to coalesce towards this organized counter-programme of specious drug-culture promotion.

(iv) Finally, I note and blame *the historical inconsistency which affects both the major political parties at the present day*. On the one hand, the *liberal* party, which should be favouring innovative community programmes of private enterprise in the field of health and welfare, is, instead, affected with a status quo conservatism which is favourable to little else than vested financial interests. As a result, it is rigidly unimaginative and insensitive to those creative programmes of a genuinely healing, educative and progressive nature which the community is generating. On the other hand, the *labor* party, which has shown itself favourable and somewhat generous towards voluntary innovative programmes, seems to have got itself launched on a course of radical social change, which turns all life-styles, however destructive, into valid alternatives, and consequently hands over the whole field of personal and community health to the most extreme *laisser-faire* liberalism. Was anything ever so unfaithful as this is, to the lessons labor had learned in the past from its harsh experience of *laisser-faire* liberalism in the economic sphere? Is anything, at the same time, so completely antithetical to the educational policies and the legislative and penal practice concerning drug use and abuse in the countries of totalitarian socialism? And finally, what is still more to the point—is anything so alien as this to the nature of a truly democratic society, which has to combine respect for people's rights and liberty with the positive organization and protection of community health and welfare?

From that series of causal or conditioning influences behind the New South Wales Government's proposed legislation to decriminalize marihuana one must pass to a consideration of the *more immediate background of behaviour in government itself towards drug abuse*. The Government seeking to decriminalize marihuana needs to be seen in the context of the governments which have preceded it in this State as well as against the broader background of State and Federal governmental attitudes and practice in regard to drug abuse and the people's health. The record is not a good one; indeed, from almost every point of view it is deplorable, with only here and there some mitigating or redeeming feature.

Five main drugs or drug-types are currently working havoc on health in this country: they are alcohol, tobacco, the analgesics, valium and marihuana. In regard to the first four, what has been done to counteract and overcome abuse and to educate people against misuse? Very belatedly (as compared to other countries, such as the U.S.A.) the advertising of cigarette brands was removed from television and radio, thus ending the prevailing insult to people's intelligence and the demoralizing influence on motivation which were contained in the brand's highly persuasive encouragement to smoke, accompanied by a contradictory and pathetically impotent warning from the health authority to the effect that smoking was a health hazard! Then the late Federal Minister for Health, Dr Dough Everingham sounded a warning on the alarming and totally unwaranted 4½ millions of valium prescriptions which doctors had issued in one year. And there has been some attempt to discourage smoking in certain public places and means of transport. Beyond these gestures or token measures, nothing has been done. The overall attitude of government can only be gauged from figures such as those of 1975 according to which profits from taxes on alcohol and tobacco sales amounted to $1,000,000,000. The amount put back into overall drug education was $1,000,000—which (apart from its being nullified by an almost equal grant to subsidize the tobacco industry) conveys eloquently the relative priorities of government on this whole subject—when it has to choose between promoting health on the one hand and consulting for departmental convenience and the politicians' popularity on the other. Without any doubt, *this country's biggest drug-pusher is the Australian Government, aided and abetted in wholesale fashion by all the State governments*. Whether the party in power is liberal or labor, it makes no difference whatsoever: there is no courageous leadership and no effort of any significance, to reverse the progressive degeneracy of a once vigorous people whose health is being rapidly destroyed by the deadly combination of hedonistic immaturity and capitalist exploitation.

Coming still closer to the N.S.W. Government and the evaluation of the community's chances of getting healthy attitudes from its trusted representatives on this vital issue of health, one is reminded that a Joint Committee of the Legislative Council and Legislative Assembly was appointed and has been meeting for two years, to investigate the question. But is it the whole question? By no means. Conspicuously omitted are the most abused drugs of all—alcohol and tobacco—on the grounds that their inclusion would make the inquiry too broad. On this fact Rev. Ted Noffs commented: "That is precisely the same thing as discussing the question of traffic pollution but leaving out cars and trucks so that the subject would not be too large". ("Drugs and People"—Ure Smith, Sydney, 1976, p. 44.) It is to be noted also, as having the same disheartening implications, that the Royal Commission Inquiry into Drugs, recently announced by the Premier, has been given no authority to investigate the whole grave question of drug abuse, including the abuse of alcohol and tobacco.

Finally, and surely intended to be taken as indicative of the Government's intentions behind its legislation to decriminalize the possession and use of marihuana, there was the so-called "Victimless Crime" Seminar held earlier this year at the Government's instigation and expense. What must be made of the invitation of those three radical *laisser-faire* extremists to Sydney on that occasion: David Kaplan, Stanley Cohen, and especially that anti-social ego-tripping intellectual drug-pusher who at the last moment did not turn up—I refer to Jock Young, author of the book "The Drugtakers?" (See GROW Magazine, Nos 3 and 4, 1976, for a review of Young's book, entitled "Can a Community be Neutral on Drugtaking?") What other effect could that gesture have had but the one it did have—viz. to show the present State government plunging (to the dismay and resentment of many of its own members and the general body of the community) on a course of wholesale support for the trendy marihuana culture? In short, *in the existing context*, the Government's policy of decriminalization of marihuana can hardly be interpreted in any other light than as preparing the way for the full legalization of a new and most deleterious drug, and the implicit promotion of the epidemic or marihuana use which must follow in a few short years, once decriminalization has become law.

4633. CHAIRMAN: Have you any further comment to make, Dr Keogh?——W. I would point out that my submission is in three parts, and I shall supply the third part to you shortly. We are dealing with quite a study. Further to my statement, I might say that I have been with the Grow organization ever since it started in April, 1957, over twenty years ago. We have been involved with drug dependency, with probably the main complicating feature of mental illness, all that time. We have 350 branches of the organization throughout Australia, at the last count there being 154 in New South Wales. The very beginnings of Grow were that there were a couple of severe mental patients; I was one and Mrs Renee Ryan was the other. Both of us were drug dependent. I had a very severe mental breakdown when teaching philosophy in the seminar at Springwood in 1954. I was out of action for just on twelve months—deluded, halucinating, and quite refractory, and had quite a lot of the coersive treatment that was common in those days. But the point is that at the origins of our organization—then known as Recovery and now know as Grow—there were two mental patients whose mental sickness was very much affected by drug dependency. I had what was diagnozed as toxic confusional state, largely due to amphetamine effect, which I was taking in totally irregular quantities, in the form of inhalers. It was something like a simulated schizophrenia, diagnozed by Dr

Nowland, brought on mainly by the way I had wrecked my metabolism over the previous couple of years with these inhalers and so forth.

I was out for nearly twelve months, coming out of the Parramatta Mental Hospital where I was after being certified insane. I went to Alcoholics Anonymous for a couple of years, and they got me well. I met there other people, like myself, who were former mental patients, and were using AA groups to get over mental breakdowns. One of these was Mrs Renee Ryan, whose story is told in this issue of our magazine on drug dependence. She left home at thirteen years of age, got on to marihuana, and became a morphine addict. That was in the old days when drug rings were totally secret, but they were still active in that small, restricted environment. She was a morphine addict for ten years. Between the two of us we got the idea of these special groups for the rehabilitation of mental breakdown. We had our first meeting in 1957, and it snowballed. From there on we have been working in rehabilitation for years.

4634. Would that be rehabilitation for mental illness? ——W. Yes, mental illness. But as we went along we found that there was no clear line of demarkation between the mad and the bad, as you might put it. I was the chaplain at Long Bay Prison for a few years; that was the job to which I was appointed when I got back into circulation properly. I met there a Presbyterian minister, and also an Anglican minister in Pentridge, as well as a Church of England sister in Fairlea in Victoria. We got groups of Recovery going in the prisons. We found that the same type of need was being made by the offenders and by the former mental patients.

As time went on we found that we had to broaden our work to include not merely mentally disturbed people but maladjusted people of any kind. A further factor was as time went on and the groups became more numerous and better known, many people wanted to come for help who had not had breakdowns but just had problems. Consequently more of these began to come for what might be called prevention reasons rather than rehabilitation reasons.

4635. How are your branches organized in New South Wales?——W. From an administrative centre in Essex Street, Sydney. Each group has a group organizer approved by State executive and the groups are mutual help groups. So far as is possible a different and committed member of the group will lead the group each week. It is on the same principle as AA mutual help. Over the years we have gone into the development of a whole programme of rehabilitation and personal growth after any kind of personal collapse.

4636. How many people would normally be active at any one time in these branches?——W. The average group would be 8 or 10 people. At present our groups are a little bit over because we have not enough group organizers. Some in the city would have 20 or sometimes 30 and we are stuck with the problem of dividing them into two. Normally the group would be 8 or 10. Over New South Wales they meet every week and there would be something like 1 500 people being helped each week. In the course of a year each group would be helping not exactly the same numbers, but between 20 and 30 people, so about 4 000 people in the course of a year in New South Wales would be helped by the GROW groups as they stand at present.

4637. You are acquainted with the terms of reference of our committee?——W. Yes, and that is why we really had a lot to contribute—for the simple reason that there is no organization in the State that has both the numbers and variety of drug dependent people. Alcoholics Anonymous has 300 groups but short of that there is no voluntary organization with the number of drug-dependent people who are being constantly helped. In any of our GROW groups, of the 8 or 10 the majority would have at present or have had some drug problem. Drug dependency is unquestionably the commonest feature.

4638. How widespread is your organization throughout the State?——W. There are 60 groups in the metropolitan area and the rest, just over 90, are spread throughout the whole of the State, as far north as Grafton, in the New England area and as far west as Broken Hill, also in the Riverina area and in Albury.

4639. Is there any drug problem in Broken Hill?—— W. There is a drug problem along with the mental health problem, consequently we are dealing with it wherever we find it. I am not acquainted with each particular group in New South Wales and I have not personally visited the Broken Hill group. We have quite a number of alcoholics who go to AA to combat alcoholism and then come to GROW for further education. It is in the area of personal growth that we have developed more than any organization. We have the backing of all the health authorities. We are State-supported and federal Government-supported.

4640. Mr McGOWAN: On page 10 of your submission you say that without doubt the movement in Australia is stimulated and directed—you are talking about the pro-marihuana movement, I take it?——W. Yes.

4641. By a similar cultural group with its own definite intellectual, financial and even political components?—— W. Yes.

4642. What do you mean by political in that sense?—— W. I mean that there is a kind of tolerance or backing of people in government and in departments of government. For instance, the main area in which one would find this would be in the health education area, the drug programmes and approval of these, research programmes and health educators, where there is certainly some overall dominance of pro-marihuana or neutrality to marihuana orientation in all that goes on in health education in New South Wales. There is no question of that. It is a question of finding out who is at the back of it. I would not be able to tell you that. All you need do is go to any community health centre and you will find the approach is definitely soft on marihuana, that it is as harmless as alcohol or tobacco. There is definitely a strong opposition and resentment to anybody coming through with the idea that there has to be something wrong with it.

4643. If I may stop you there, there is a lot of difference between saying it is as harmless as alcohol and tobacco, and the reverse proposition, which is the way it is usually put, which is that it is no worse than or as bad as. Then one looks at the problem of alcohol within our society and of tobacco and observes the tremendous social damage they do. To make the statement that marihuana is as bad as is to condemn it out of hand?——W. To condemn what?

4644. To condemn marihuana by comparison with alcohol and tobacco?——W. But they do not say that it is as bad as alcohol and tobacco; they say that it is no more harmful than tobacco and alcohol and therefore, since we have suggested tobacco and alcohol, we should not have a different approach. What we are doing by that is arousing the opposition of the younger generation who see it as their drug compared with the oldies. On page 13 I mention the whole educational approach to this.

4645. I wish to clarify what you mean by decriminalizing. Are you in favour of people who have been found guilty of a marihuana offence incurring a further penalty in relation to their job, say in the Public Service, or as a teacher?——W. No, I am talking about the removal of the restrictions against marihuana in a context in which all the cultural influences are organized drug pushing. I am saying that there are two kinds of drug pushing. The person who grows marihuana and sells it. There is the intellectual or cultural drug pusher who is simply fomenting, organizing and paying. In that context I am saying that the removal of what is at present a legislative protection is more than a symbol than anything else.

4646. CHAIRMAN: You make that point further on in your submission. That is not answering the question that was posed?——W. You are asking me whether I am in favour of them being punished by being removed from the Public Service. No, I am not, nor am I in favour of their being imprisoned. Unless you are careful of what you are doing you will remove what in the minds of so many young people represents the social and community attitude and they will simply believe that marihuana use is safe legally and in terms of health.

4647. Would you give us your interpretation of the meaning of the word decriminalization?——W. I understand it to mean that irrespective of just how far persons are hooked, the fact they have marihuana in their possession and using it can mean that they can be given a criminal conviction and sent to prison. I am in favour of that not being the case if we are leaving the far more grievous criminal offenders in the community to get away. They are the great causes of the drug dependency of the poor little token-type individual.

4648. I found that confusing. I asked you to give your interpretation of the meaning of the word decriminalization?——W. From the discussion at the victimless crime seminar I understood it to mean removal of the possession and use of marihuana from the criminal code so that persons arrested could be fined just as with a parking offence—a civil offence—and would not be given a criminal conviction.

4649. Mr McGOWAN: In other words, the situation that applies in Canberra?——W. Yes—Canberra is a tiny place—but around the whole country. I think we have to see the whole thing in context. The first part of my submission is in its context. It is a gross misplacement of priority to emphasize the problem of individuals who are simply incapacitated by extrinsic circumstances. They look worse because they have had a criminal conviction and might be prevented from having a career. That is nothing if you consider individuals who cannot want a career any more because they have been put out motivationally and deprived of their liberty as a person whereas the others have been deprived of a social right. To make a big issue of the punishment of a small number of individuals on lesser matters and to introduce something that is going to involve—already involves many thousands more and will eventually involve many thousands more than that, especially the young, in the loss of personal liberty and the chance to grow, because the one thing that marihuana does is destroy self-activation and motivation. It destroys the developmental attributes of the individual. Our big problem is that we can talk about marihuana for the simple reason that it is the one thing we cannot do much with. But, it is most heartbreaking and frustrating because they do not present themselves anywhere for help for the simple reason that the more they get incapacitated the better they feel and, they lose insight. Marihuana dependency is mental sickness. One of the greatest problems is that a person getting mentally sick does not know it and, mostly, cannot be told.

4650. Mr HEALEY: On page 17 of your submission to the Committee you say—

> five main drugs or drug-types are currently working havoc on health in this country: they are alcohol, tobacco, the analgesics, valium and marihuana.

You do not consider heroin or the narcotics to be of any probem?——W. I do but not to the level—just as you can say with marihuana—heroin is far less harmful than tobacco and alcohol now. Of course it is: alcohol is doing far more damage than heroin but, given time, heroin will do far greater damage than alcohol and tobacco. In five years marihuana will be doing more harm than alcohol and tobacco. The figures in America are definitely demonstrative.

4651. CHAIRMAN: In what way?——W. The helpless derelicts who use the federal clinics around America are by far in the greatest majority heroin addicts. The next number are the marihuana addicts—the utterly helpless skid row types. After that, but less than half the number, are the alcoholics. In Australia we have the totally opposite picture. You could not tell people here that you are going to get a lot of marihuana addicts dependent on the live-in rehabilitation clinics because they are utterly helpless and cannot run their own lives. Skid row marihuana users are unknown here because of the kind and frequency and length of time that people have been dependent on marihuana are totally different from in the United States. Give us five years and we will get skid row marihuana users and one in five heroin addicts around the country, mostly young people. If we do not consider the time factor it is totally unreal. This is where everybody is coming through on the here-and-now feeling trip and feeling good and looking good. They are the kind of people who are running their lives but the people pushing it to them are the intellectual drug pushers, the narcissistic ego trippers in the educational spheres and through the media. They look good, they are saying that all life styles are equally valid and they could not give a damn about the people in the community but they bring about a state in which people just look to the present and what appears all right now. Consequently, anybody can be completely misled by marihuana. You can take a marihuana joint and get no effect—you have to have at least five before you get the high. The addiction—it is a real addiction—because you develop tolerance and have withdrawal, but it is tapered, for the simple reason that the THC is stored in the brain and eliminated gradually over a period of months. People say: I am enjoying it, why the fuss? Consequently, that is the type of thing that gets by but in the long term, in a matter of two or three years of use of marihuana, you get people totally de-activated, completely without interest, utterly bored with life at twenty years

of age and incapable of activating themselves. These are the ones who, if brought for help by parents or brought to a meeting, it is of no use whatever, they cannot get the insight. They were as bad as I was some months before I went mad and had to be boarded out.

4652. If you look at the coroner's court findings you will see that the decision of the coroner is that somebody died from an accidental or purposeful overdose of heroin or other drug but you do not see anybody whose death was recorded as due to marihuana?——W. I do not know anybody whose death was caused by marihuana, either.

4653. Do you know any who may have been involved in accidents where you suspect marihuana might have been involved?——W. I think a lot of the young types——

4654. I am not asking you for your opinion, I asked do you know of any where you suspect marihuana might have been the cause of an accident?——W. Yes, I do but I cannot say—I can simply quote the person—I know the person to be a marihuana user.

4655. One case?——W. Yes. I am thinking of one particular case right now but, from the testimony of people using it, they are affected in their vision, perception of time, co-ordination and so forth and have a fear of driving because they know they cannot control—these factors are important. I have seen figures quoted from America where as many as twenty-four per cent of accidents in Los Angeles were attributed to marihuana as either the sole or major factor—there is a combination.

4656. Do you know where the figures would be available?——W. In the *Sydney Morning Herald* of about three or four weeks ago. I can get them for you. I shall submit them to you.

4657. You do not know their original source?——W. It would be quoted in the *Sydney Morning Herald*, I am sure.

4658. The Committee has been trying to get reliable figures for a long time. Though some figures have been promised we have not received them?——W. I remember cutting it out of the paper at the time.

4659. Mrs DAVIS: Do you remember the figures that Professor Hardin B. Jones gave about marihuana and heroin use in the United States?——W. He said that in 1965 there were about 50 000 marihuana users; within five years the figure had gone up to 3 million and it went up to 30 million in the next six years. There are about 3 million heroin users in the United States. He said the ratio was about one in ten but it is about one in five in respect of regular marihuana users. There would be 3 million heroin users and 30 million marihuana users, of whom about half would be regular users. The big problem with marihuana is that we cannot say we are getting any success. People get a mental sickness and they have no insight.

4660. CHAIRMAN: Have you any idea how long the third section of this submission will take?——W. I think it would consist of between six and eight pages.

(The witness withdrew.)

(The Committee adjourned.)

## LIST OF EXHIBITS

| Description of Exhibit | Produced by | Designation | Date |
|---|---|---|---|
| 1. Table of Research Projects by the National Institute on Drug Abuse (U.S.A.) | Dr R. E. Willette .. | National Institute on Drug Abuse, Division of Research. | 18–2–1977 |
| 2. Report by the National Institute on Drug Abuse entitled "Cannabinoid Assays in Humans". | Dr R. E. Willette .. | National Institute on Drug Abuse, Division of Research. | 18–2–1977 |
| 3. Report by the National Institute on Drug Abuse entitled "Narcotic Antagonists: Naltrexone". | Dr R. E. Willette .. | National Institute on Drug Abuse, Division of Research. | 18–2–1977 |
| 4. Cassette tape of talk-back programme on Radio 2NX on 29th April, 1977, entitled "Session on Analgesics". | Dr P. O'Neill .. | Co-ordinator of Addiction Services, Hunter Region, Health Commission of N.S.W. | 4–5–1977 |
| 5. Photographs of slides arising from evidence given on analgesic nephrology and gastric ulceration. | Dr R. S. Nanra .. | Head of Division of Nephrology at Royal Newcastle Hospital. | 5–5–1977 |
| 6. Photographs of slides arising from evidence given on analgesic nephrology and gastric ulceration. | Dr J. M. Duggan .. | Director of General Medicine, Royal Newcastle Hospital. | 5–5–1977 |
| 7. Paper on Drug Education used in industry for Personal Development Programmes in the Illawarra Region. | Mr G. Lake .. | Health Education Officer, Health Commission of N.S.W. | 26–5–1977 |
| 8. Graphs of female and male overdose cases in the Illawarra Region from 1973 to to 1976. | Dr B. Willis .. | Regional Psychiatrist, Illawarra Health Region, Health Commission of N.S.W. | 26–5–1977 |
| 9. A. Research Report on Early Adolescent Antecedents of Narcotic Abuse prepared by Dr G. Egger, Dr R. A. J. Webb, and Ms I. Reynolds of the Health Commission of New South Wales. | Dr R. G. McEwin .. | Chairman, Health Commission of New South Wales. | 12–9–1977 |
| B. Health Commission of New South Wales Report on Prediction and Prevention of Drug Abuse. | Dr R. G. McEwin .. | Chairman, Health Commission of New South Wales. | 12–9–1977 |
| C. Paper on the Psychotropic Drug Use in the Elderly prepared by Mr S. F. Chapman, Health Commission of New South Wales. | Dr R. G. McEwin .. | Chairman, Health Commission of New South Wales. | 12–9–1977 |
| D. Paper on an Evaluation of Relaxation Courses produced by the Health Commission of New South Wales. | Dr R. G. McEwin .. | Chairman, Health Commission of New South Wales. | 12–9–1977 |
| E. Paper on Alcoholism and Drug Dependence – A Survey of General Practitioners' Opinions prepared by Ms I. Reynolds, Health Commission of New South Wales. | Dr R. G. McEwin .. | Chairman, Health Commission of New South Wales. | 12–9–1977 |
| F. Pamphlet on Health Education – Use of Drugs produced by the Health Commission of New South Wales. | Dr R. G. McEwin .. | Chairman, Health Commission of New South Wales. | 12–9–1977 |
| G. Paper produced on Alcohol Education by the Health Commission of New South Wales. | Dr R. G. McEwin .. | Chairman, Health Commission of New South Wales. | 12–9–1977 |
| H. Pamphlet entitled "The Drug Issue" produced by the Health Commission of New South Wales. | Dr R. G. McEwin .. | Chairman, Health Commission of New South Wales. | 12–9–1977 |
| I. Paper on Drinking and Drug Taking Patterns of 8516 Adults in Sydney, 1976 prepared by Ms I. Reynolds, Ms J. Harnas, Mr H. Gallagher and Mr D. Bryden of the Health Commission of New South Wales. | Dr R. G. McEwin .. | Chairman, Health Commission of New South Wales. | 12–9–1977 |
| J. Health Commission of New South Wales Report on Recent Statistics on the Use and Abuse of Alcohol and Drugs in New South Wales. | Dr R. G. McEwin .. | Chairman, Health Commission of New South Wales. | 12–9–1977 |
| K. Health Commission of New South Wales Report on a Review of New South Wales Health Commission Treatment Services for Narcotic Dependent Persons. | Dr R. G. McEwin .. | Chairman, Health Commission of New South Wales. | 12–9–1977 |
| L. Paper on Drinking and Drug Taking Patterns of 23000 Sydney Adults: A Comparison between two samples —1975 and 1976 produced by Ms I. Reynolds, Ms D. Harnas, Mr H. Gallagher and Mr D. Bryden. | Dr R. G. McEwin .. | Chairman, Health Commission of New South Wales. | 12–9–1977 |
| M. Report produced by the Health Commission of New South Wales on Monitoring Drug Use in New South Wales, 1971 to 1973. | Dr R. G. McEwin .. | Chairman, Health Commission of New South Wales. | 12–9–1977 |
| N. Health Commission of New South Wales Report on Trends in Marihuana Use in New South Wales, 1971 to 1973. | Dr R. G. McEwin .. | Chairman, Health Commission of New South Wales. | 12–9–1977 |

LIST OF EXHIBITS—*continued*

| Description of Exhibit | Produced by | Designation | Date |
|---|---|---|---|
| O. Health Commission of New South Wales Report on Monitoring Drug Use in New South Wales, Part 3, Correlations of Trends, Deviance and Attitudes. | Dr R. G. McEwin .. | Chairman, Health Commission of New South Wales. | 12–9–1977 |
| P. Report to the Child Health Committee of the New South Wales Health Education Advisory Council on Adolescents and Alcohol in New South Wales. | Dr R. G. McEwin .. | Chairman, Health Commission of New South Wales. | 12–9–1977 |
| 10. Drug Addiction Treatise .. .. | Dr R. A. J. Webb .. | Senior Psychiatrist in Charge, Drug Education Health Commission of N.S.W. | 29–9–1977 |
| 11. Audiotape of talk-back programme "Wednesday Town Meeting" dealing with Drugs on Radio 2NCR-FM. | Mr G. Irvine .. | Broadcaster and Lecturer, Lismore. | 15–10–1977 |