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Contributors

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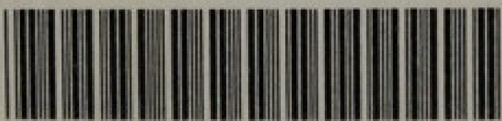
ROYAL COMMISSION INTO THE NON-MEDICAL USE OF DRUGS

SOME RESPONSES

South Australia
January 1978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Royal Commmission into the Non-Medical Use of Drugs

SOME RESPONSES

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INTRODUCTION

The Commission has been appointed by the Government of South Australia to inquire into the non-medical use of narcotic, analgesic, sedative and psychotropic drugs or substances of dependence not including nicotine or alcohol. The precise terms of reference are set out in Appendix A.

In April, 1977, we issued a small booklet entitled *Some Questions*. This booklet asked questions on matters on which we felt we needed advice, information and opinions. It was intended to stimulate interest in our work and to provide guidance (without in any way being binding) to individuals and organisations making submissions to us.

Following publication of *Some Questions* we received a large number of submissions and conducted an extensive programme of hearings, public meetings and informal discussions. Some submissions adopted the form suggested by *Some Questions*, while others adopted different approaches. A list of submissions received by us appears in Appendix B and a schedule of hearings and public meetings conducted is set out in Appendix C. We have also established a research programme to investigate in detail certain issues arising out of our terms of reference.

The purpose of this booklet, which follows the general framework of *Some Questions*, is to give an idea of the responses we have received to our public invitation to make submissions to us. We recognise that in summarising so briefly the substance of nearly 2000 pages of transcripts and perhaps another 1000 pages of submissions we are exercising our own judgment and this necessarily reflects our perception of the issues raised and the evidence presented. However, this booklet is not intended to express our views on the matters within our terms of reference, nor to commit us to any particular conclusions. We should add that the selection of quotations, which accompanies the text, is not representative of all responses in any precise sense—it could not be. The quotations do, however, provide examples of the range of opinions presented to us.

We hope that *Some Responses* will stimulate further debate on the issues related to the non-medical use of drugs. For this reason we welcome further comments on the matters discussed in the booklet. Comments should be addressed to the Secretary, Royal Commission into the Non-Medical Use of Drugs, P.O. Box 221, G.P.O., Adelaide 5001.

. . . I wish to express my astonishment and regret that the Government of South Australia has excluded alcoholism and alcohol-related problems from your investigations . . . I am very disturbed that a young drug abuser is labelled criminal and treated as such, while his alcoholic father, whose pathological drinking keeps many lives in turmoil, is considered to be a gentleman and a stalwart of our community.

Alcohol & Drug Addicts
Treatment Board, S.A.,
Dr J. W. Gabrynowicz,
submission, pp. 11-12

2.1. It is contended that there are dangers and difficulties in investigating the use of the range of drugs outlined without examining the use of nicotine and alcohol.
2.2. It is impossible to develop rational policies for "drugs" whilst excluding alcohol and tobacco from enquiry. . .
2.7. Over recent years progress has been made, against considerable resistance from the community in general and from those with a commercial interest in particular, towards general acknowledgement of the unitary nature of drug use and misuse in society. A partial approach by the Commission would set this back considerably.

Commonwealth Department of Health,
submission, p. 2

We regret the non-inclusion of nicotine and alcohol amongst the drugs to be studied, as we feel that these two drugs are probably the major killers and destroyers of the quality of life in our society.

The Way Back Committee, submission,
p. 1

. . . the terms of reference, 3, 4, 5, and 6 do in fact make quite implicit assumptions . . . that there is a significant problem of drug abuse, a significant problem does exist . . . The second assumption . . . is that . . . laws that currently exist do in fact affect drug use and one maybe needs to question that, whether there is any evidence that suggests that those laws which are currently in use and any laws which may . . . be envisaged as a result of the Commission's findings and recommendations will in fact make any difference to drug use. The third assumption seems to be that educational, preventive and treatment programmes are in fact relevant to drug abuse or use . . .

Meeting of members of ANZ
College of Psychiatrists S.A. Branch,
transcript, pp. 12-13

A drug user is "sick" when he/she cannot cope with normal living. Symptoms can be recognised by doctors and trained social workers.

Woman's Christian Temperance
Union of S.A. Inc.,
submission, p. 3

. . . the primary concern of the Commission should be with drugs which alter the perception of the user, so that he is no longer able to assess his own condition rationally.

Festival of Light—Community Standards
Organization (S.A.), Inc., submission, p. 7

TERMS OF REFERENCE

Terms of reference are the basis from which a Royal Commission works. They define the task to be undertaken. A Commission cannot itself alter its terms of reference, but it can request that the Government do this. Therefore, we thought it useful in the first place to seek comments from the South Australian public upon our terms of reference. Were they misleading in any way? Did they contain implicit assumptions which should be brought to light?

The exclusion of alcohol and nicotine from our terms of reference was indeed seen by many as undesirable, and by some as possibly dangerous. The point was made repeatedly that alcohol use creates social problems of enormous magnitude, which makes the abuse of such drugs as amphetamines, analgesics and narcotics pale into relative insignificance. The omission is taken by some respondents to reflect the social approval (or at least no disapproval) of drinking and smoking, while the Commission is required to investigate the "abuse" of other substances of dependence. Most submissions which deal with this matter point out that, on any analysis, alcohol and nicotine are drugs of dependence. While acknowledging the force of these comments, we have felt that the exclusion of alcohol and nicotine from direct consideration does not prevent comparisons being made with these substances and with their use and effects in the community whenever required in considering the non-medical use of other drugs.

Certainly the comments on our terms of reference have made us conscious of the need to place the question of drug use in context, and to make the appropriate social, historical and statistical comparisons. This can be done in relation to alcohol by comparisons in such areas as patterns of consumption, addictive potential, behavioural effects, and so on. Further, we have become aware of how far value judgments (including ours) intrude into the way in which issues are perceived, terms defined and solutions suggested. There are implicit and occasionally explicit assumptions within our terms of reference to which some people have objected. For example, it has been argued that the concept of "abuse" of drugs is not a valid one, since drug-taking can be seen as a response to certain pressures, psychological and social, which means that even heavy use of the drugs may not in itself be "abuse".

Similarly, one of the terms of reference requires us "to recommend such changes to . . . the provision of such education and preventive . . . programmes" as we think appropriate. The assumption implicit here is that educational and preventive programmes are important in reducing the incidence of non-medical drug use in the community. The assumption may of course be correct, but there were some who were not quite so sure. Similarly, the notion of treatment may be assuming too readily that drug dependence is an "illness", and that if so, it is "treatable".

The most common assumption is that drug use in our community is a problem, requiring, among other things, a Royal Commission to investigate it.

Every time since then I have taken Mandrax or nearly everytime, I have done stupid things and got caught. Or taken Mandrax and done stupid things and not got caught. That is one drug that should be taken off the market because they are sold freely and widely abused and you can buy it on the market easily for a dollar each.

Confidential submission no. 31

There is a great need to establish different names which will separate the two groups in the minds of the public at large. Often people in real need of care such as hypertension will stop taking a medication because of the attachment to the wide meaning word—"drug".

Australian Pharmaceutical Manufacturers Association, submission, p. 7

There is no honest information generally available as to the real nature of non-medical drugs. In particular illegal drugs are not readily distinguished between and the stereotype of the heroin addict becomes the fear held for the pot smoking adolescent.

Dr G. D. Wright, medical practitioner, submission, p. 2

Except for their terminology, there is no difference between a compound as introduced in the food supply and one that is licensed for use as a medicine, as a drug.

Dr Bernard Feingold, Allergist, public hearing, transcript p. 603

THE DRUGS

In general, as a result of public responses, we have become aware that the terms "drug" and "drugs" are used in very different ways by different people in the community. One way or another, all submissions define the term "drug", either explicitly or by implication.

Some people take the very broad basic definition that "a drug is any chemical or natural substance which changes the way the body works". This definition will include even oxygen and foods (or at least those components of food which are capable of chemical definition). A related point which has been put to us is that chemical food additives widely used by manufacturers for colouring, preserving or flavouring food products are in fact a non-medical use of "drugs" injurious to the health of some people, and should therefore be considered within our terms of reference.

Most of the definitions adopted in submissions are very narrow. Some assume that we are concerned only with the question of cannabis. Those with an organisational or individual interest in only one drug tend to confine their submissions accordingly. We can contrast such submissions with the very wide areas of concern proposed in our booklet *Some Questions,* which details the range of drugs which we see as needing consideration.

It is apparent that no simple view of "drugs" is possible, and this is where popular usage of words and distinctions are still very confusing to many, because they oversimplify the issues. The fields of biology and human behaviour, in which the consideration of drugs is set, are full of variables. We have received evidence that any one drug can have effects on a person that vary according to dose, time, social setting and expectations. The same drug can have different effects on another person under the same conditions. This is particularly true of the psychotropic drugs. In addition, people can experience effects associated with certain drugs (for example, the "high" associated with cannabis) when the substance they are consuming, unknown to them, has no psychoactive properties at all. This "placebo effect" is a common and well-documented phenomenon in medicine.

Confusion regarding the terms used in any discussion of drug use has resulted in definitions which are strongly influenced by the values of those making the definitions. For those who regard drug use as necessarily sinister or bad, the term is defined so as to reinforce that notion. Hence some submissions assume that the drugs with which we should be concerned are those which it is now illegal to cultivate, manufacture, distribute or possess. For people who are concerned to show that all of us take drugs of one kind or another, and that the label of illegality has been imposed arbitrarily on certain categories of drugs, the emphasis is on defining drugs as broadly as possible.

Some people see a difference between a "medicine" (or a "remedy") and a "drug", believing the first always to be good and safe, and the second always to be bad and dangerous. So simple a view breaks down when faced with the fact that there are many substances which must then be

As I was waiting for the bus this morning I got a neat perspective on the double standards this community has by looking in a chemist shop window, it said, on a very neat poster, "Any cough needs a serious cough mixture. Benadryl, raspberry flavoured, for all the family." Then you read on, in the small print it said, "May cause dizziness, don't drink alcohol, do not work machinery, do not drive while using this medication, it contains diphenhydramine hydrochloride etcetera, etcetera. And you can walk in there and you can get that just like that, and you can get as much of it as you like, and you can go and drink that bottle and you'll be bombed right off your head for about four days . . . well, that's one thing, the whole inquiry will take place in a double standard situation where crazy equals true.

Meeting of students,
University of Adelaide,
transcript, p. 10

considered as "medicines" in medical hands but as "drugs" if used without a doctor's advice, even though their pharmacological properties remain exactly the same. Some submissions confine their use of the term "drug" to those chemical substances which affect the organ of judgment—the brain—and do not apply it outside that category of psychotropic—mood-altering—substances. But here, too, there seems to be some confusion as to whether tea, coffee, cigarettes and alcoholic drinks, which all have psychotropic effects, are to be called drugs, particularly as some who do not regard them as drugs might apply the term to caffeine, nicotine or ethanol (ethyl alcohol). All this perhaps reflects a common opinion that drugs which are capable of altering mood or perception are intrinsically the most to be feared.

We are of course taking detailed expert evidence on all the drugs and substances which fall within our terms of reference: Dr G. B. Chesher, Reader in Pharmacology at the University of Sydney, is investigating the pharmacological aspects of cannabis, and Professor D. J. Birkett, Professor of Clinical Pharmacology at Flinders University, is investigating the pharmacological properties of other drugs with which we are concerned. In due course, this information will be published.

One distinction that has been made . . . for example, talks about medicine and drugs to define the two uses, medicine relating to a medical use of drugs, and drugs referring to a non-medical use of drugs.

Dr D. M. Phillips, Chairman;
Festival of Light—Community Standards
Organisation, (S.A.) Inc., public hearing,
transcript, p. 490

Medical use of the drug is the use by a medical man of a drug which is aimed to benefit a patient in some specific way . . . Non-medical use of the drugs must be considered when the drugs are used without the authority of a doctor, without regard to the possible consequences of the bad effects of repeated and long term use.

Dr W. S. Salter, Hillcrest Hospital,
submission, p. 1

When you go to a doctor and he says "What's your problem?" "What's wrong with you?" "I really don't know, I'm sort of feeling a bit flat." The minute he seems to find out that you're divorced or separated, "Oh, it's your nerves, so we'll put you on something or another, either Valium or Tryptanol and take those for a while and then you'll be fine." It's definitely always your nerves. I'm sure if you walked in there pregnant he'd say "It's your nerves".

Meeting, Parents without
Partners, transcript, p. 3

I would make a plea that barbiturates should be banned for anything other than epilepsy.

Meeting of members of A.N.Z.
College of Psychiatrists, S.A. Branch,
transcript, p. 7

. . . I suppose in the last three months I've had two people come in who were obviously addicts to hard drugs. One wanted palfium, one wanted morphia. These were fairly easily spotted and they didn't get either their palfium or their morphia, but, you know, I don't know what you do about this. I guess there are no answers, but it suddenly brings it home that in a fairly respectable suburban practice, you find these people just turning up with quite long, complicated and quite plausible stories but with one aim in mind. I presume they got it somewhere—I don't know —but one sees that they need help, and we never got to the stage of actually discussing that they were addicts. We got to the stage where they realised that we weren't going to play ball and they turned off and I think the interview was terminated on the part of the patient. I mean, they found there was no point in continuing the conversation.

General practitioner,
meeting of the A.M.A.,
transcript, p. 5

MEDICAL AND NON-MEDICAL USE

Most respondents seem to accept that the distinction between "medical" and "non-medical" use of a drug is clear enough in a general way. At first glance, too, it may seem that "non-medical" is pretty well the equivalent of "illegal", until one reflects that using alcohol, tobacco or coffee is non-medical but legal, and that medically prescribed drugs can be illegally used—for example, by people obtaining prescriptions from several doctors for the same drugs, or by a patient "conning" a doctor with a story in order to obtain a drug which that doctor might not otherwise prescribe. Also, legally available drugs can be used non-medically for suicide or attempts at suicide. Drugs commonly used for this purpose are barbiturates and analgesics. Although some mention was made at the hearings of the dangers of accidental poisoning from medical drugs, very little was said about the role of drugs in suicide.

It is not always realised that "medical" does not mean "scientific" or "strictly defined". There is considerable room in medical practice for differing opinions and judgments by doctors and, increasingly, for different relationships between doctors and patients, and between the medical profession and the public. It is difficult to say precisely what is "medical" in the sense of its being part of "accepted medical practice", particularly when dealing with the grey area of psychological stress in everyday life. For this reason, we have taken an interest in the fringe area between "medical" and "non-medical" use.

Drug-taking, according to many, is behaviour that is learned. Consequently on this view, the extensive, perhaps sometimes careless, use of drugs in official medicine may set a social example that is partly responsible for wide non-medical use of drugs. If that is true, then to reduce the non-medical use of drugs it might be necessary, as some submissions suggest, to try to reduce the level of drugs prescribed for medical purposes.

We have heard from doctors who believe that the prescribing patterns in general practice ought to change towards more counselling and fewer drugs for those patients experiencing difficulty in coping with life problems. At the same time they tell us that many of their patients have so great an expectation of receiving a prescription that without it the doctor/patient relationship does not continue. It was frequently said, both in submissions and in the hearings, that diazepam for example has been too readily prescribed by doctors in the past, and that the use of this drug by "patients", who are psychologically dependent on it, is non-medical. Yet other patients, alarmed by a rising public belief that drugs are undesirable, have to be persuaded that they should take a drug in circumstances where medical opinion is clear that treatment by drugs is required.

Again, we are told that many patients who obtain drugs on their doctor's advice do not then take them according to that advice. It is believed that about one-third of patients do not comply with their doctor's instructions. There may be reasons for this. A doctor may be unable or

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... 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?

Analgesics Subcommittee of the
Australasian Society of Nephrology
and the Australian Kidney Foundation,
submission, pp. 26-27

This Association submits that misuse or excessive use will not be controlled by merely restricting outlets.
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.

Proprietary Association of
Australia, submission, p. 13

... 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.

Proprietary Association of
Australia, submission, p. 7

I would like to see a government sponsored clinic if you like, where people can go to use the drugs of their choice, being served by their quality and purity, and they go to this government sponsored clinic and say, "I would like to use this drug", and that would be supplied to them . . . it would be a clinic . . . where you could go and drop your trip or have your hit or whatever. But I think that aside from consuming drugs of this type in the government clinic, they should be illegal.

Meeting of students,
University of Adelaide,
transcript, pp. 14-15

In fact I think that while marijuana is illegal it is far more likely to lead to people using harder drugs. That is because while a person is willing to break a law once, he is willing to break it again . . . While we have it illegal people will be mixing in a slightly different culture to that if you could use it much more openly. If, for a week or two, you are not able to get your grass, you might be tempted to try something else. You tried something illegal once and there was nothing wrong with it, you'll try something else which is illegal. "Look, society was wrong about this one . . . Society said marijuana's bad, now I've tried it, and it hasn't been harmful. I might as well try something else."

Meeting, Young Liberal Movement
of S.A., transcript, p. 10

may neglect to follow through his treatment by inquiries or visits designed to monitor the use of the drugs he has prescribed. The patient may not wish to pay for further care, or may live in a remote part of the country and therefore be unable to visit his doctor regularly. We are informed that people frequently themselves decide at a later stage to use some drug that a doctor has prescribed on an earlier occasion, or to give it to some other member of the family or to a friend. We see therefore a gap between the doctor's prescription and the patient making up his own mind as to how the prescribed drug is to be used. It may be that in this area medical practice is not sufficiently comprehensive in its cover, and that some members of the health team, not necessarily the doctors, should have a clearer role in taking care of the consequences of prescribing drugs.

Many of these questions revolve around the safe use of drugs, and the proposition that the clearer the knowledge concerning action and side effects available to a user or to his adviser, the safer will be the use of the drug.

A drug used illegally (and therefore "non-medically") may not cause harm if used with full technical knowledge. But illegality greatly complicates the safety question because a drug which comes from clandestine sources may be impure or of unknown strength. And there is also in that case much less reliable information about its effects, because the illegal status of the drug suppresses the open canvassing, testing, publishing and discussion of such information. This has led to one suggestion that, even assuming the continued legal controls on drugs such as heroin and cannabis, there should be a centre to which users could come, without fear of legal liability, to have the purity and strength of their drugs assessed.

Again, an illegal drug may be branded as "dangerous" by those who disapprove of its use; but those who may be using it secretly (and in their view and perhaps in their actual experience without danger) then feel that the disapprovers are uninformed and biased in their assessment.

Both medical and non-medical uses of drugs have risks associated with them, as do most of the activities people undertake in the ordinary course of life. The problem is to determine which levels of risk are acceptable, and which are so serious as to warrant close regulation or even prohibition of the risky activity. For example, we are told that the excessive use of compound analgesics, which are freely available, destroys the kidneys of about 15 South Australians each year, putting their lives in jeopardy, and significantly injures the kidneys of about 10 times as many again, though not to the point of being fatal. On the other hand, each year over 100 000 South Australians use compound analgesics, not necessarily excessively, presumably for some perceived benefits in their health or state of well-being. Kidney specialists recommend to us that these drugs should be withdrawn from open sale. Bodies such as the Proprietary Association of Australia claim, however, that the disadvantages resulting from restrictions on the availability of compound analgesics will far outweigh any likely advantages.

No deaths at all have been reported to us as having resulted solely from the use of marijuana, but it is suggested by some that the heavy and prolonged use of marijuana has harmful effects on the health of the user

The evidence indicates that any harmful results of marijuana will be less serious than those associated with other, more popular drugs such as alcohol, tobacco, birth control pills, analgesics, and a growing list of drugs, the use of which is tolerated by our communities and sanctioned by our governments.

Cannabis Research Foundation, submission, p. 4

. . . current medical knowledge . . . indicates that the health risks associated with cannabis use are insignificant in comparison with the health risks involved in the non-medical use of licit drugs, particularly alcohol, and . . . the community is prepared to tolerate non-medical use of drugs having health risks of significantly more consequence than cannabis use.

Cannabis Research Foundation, submission, p. 1

I don't drink but I wouldn't prohibit alcohol, even though it does a lot of harm. Knowing the harm that prohibition can do, I can see that decriminalisation could have some advantages, although I'm totally against it.

Public meeting, Pt Lincoln, transcript, p. 19

and that this danger warrants continuance of the legal prohibition on the drug. The number of deaths in South Australia each year from lung cancer which might be attributed to tobacco smoking is about 300, while the number of deaths in Australia resulting one way or another from the use of alcohol is, according to the Senate Standing Committee on Social Welfare (*Drug Problems in Australia—An Intoxicated Society?*, AGPS, 1977), over 30 000 during the last 10 years.

A prohibition approach has not been applied in Australia to alcohol or tobacco, although of course prohibition of alcohol was attempted with unhappy results in the United States for a time. The lesson may be that, just as the legal availability of drugs creates dangers for the users and the community, so restriction and prohibition create their own difficulties.

. . . in my own experience . . . a marijuana smoker today is the heroin smoker of tomorrow, and the heroin smoker of tomorrow is a dead subject in less than five years, in the usual sense that they are a derelict.

Meeting of members of
the Police Association of S.A.,
transcript, p. 22

Most of the stuff from the chemist break I either kept for myself or gave away. I was a social junkie. I liked to see people stoned if I was stoned.

Confidential submission no. 31

It is our belief that we are beginning to accumulate evidence that drug giving by the parents is for them a learned behaviour, that children are exposed to parental modelling of drug taking behaviour from an early age and we wonder whether in this way children are being conditioned to "non-medical" use of drugs that may establish life-time patterns in which drugs may be a preferred method of coping.

Prof T. G. C. Murrell and
Dr J. R. Moss, submission, p. 3

Our original studies show a correlation between mothers taking drugs and giving their babies drugs. The other correlation is that mothers who bottle feed their babies give their babies significantly more drugs than babies who are breast fed.

Dr J. R. Moss, public hearing,
transcript, p. 1087

THE USERS

Submissions concerning the characteristics of users of drugs have been made to us by persons identifying themselves as users, by educationists, social workers, medical practitioners and health authorities. However, no evidence has been given to suggest that it is possible to make useful predictions about the likelihood that a particular person will become dependent upon drugs. Neither have respondents contended that genetic factors play an important part in determining a predisposition to dependence on drugs, including alcohol. On the other hand, there is evidence that vulnerable groups can be identified. For example, there are said to be familial tendencies which probably operate by way of upbringing, and psychological example. Children of heavy drug takers, including alcohol and tobacco, are, we told, more likely to become habitual drug users themselves. Analgesic-taking mothers tend to pass the habit on to their daughters. Alcoholic fathers have children who may be more likely to use alcohol and, these days, other drugs along the way. Introduction to drug use and the establishment of drug-taking habits may therefore be seen as a part of the total drug behaviour of our society.

Submissions point out that the path to "harder" drugs is often opened through the use of analgesics, prescribed drugs (such as sleeping tablets), alcohol and tobacco, in the sense that people who have got into the habit of taking these substances may find it easier to move on to "harder" drugs. The cannabis debate raises the claim that cannabis use leads to "harder" drugs, usually heroin or other narcotics. The connection between the use of these drugs—and it is said that most heroin users have used marijuana—is claimed by many to have been greatly exaggerated, since the vast majority of cannabis users do not proceed to the narcotics and most narcotic users have experienced more drugs than just cannabis. There is no cross-tolerance or pharmacological or chemical similarity between cannabis (or its derivatives) and the opiates. It is also said that insofar as there is any relationship between cannabis use and narcotics, it is more closely related to the illegal status of both drugs than to any intrinsic pharmacological attribute of cannabis.

The reasons for non-medical use of drugs are said to vary greatly from user to user. Moreover, the explanations for drug use tend to be different according to the perspective of the observer: the psychiatrist's explanation tends to be different from that of the churchman, and the criminologist's different from that of the police officer.

Some people will use a drug in an attempt to exchange disagreeable feelings for agreeable ones, or simply to undertake a new experience altogether; others perhaps in an attempt to escape from working in situations which they find intolerable or to overcome the stresses associated with difficult personal relationships.

Many who use medically prescribed drugs or tobacco or alcohol for just the same reasons may not, so we are told, see themselves as being "on drugs" at all. This highlights the great differences between "using" (and therefore between "the users" of) drugs which are socially approved, and

It is the belief of the pharmacists of the Department [of public Health] that drug consumption or "taking", as a human behaviour, is a norm in our population. That is, if we include alcohol, nicotine and medicines under the classification "drugs" we are, most of us, of all ages and sex, "takers" of one sort or another. *Not* to be a drug taker is the exception, and to see the characteristics of the drug takers in our Society, we need only look at *ourselves*.

South Australian Department of Public Health, submission, p. 12

Categorising addicts as all being "dependent personalities" or in need of "psychiatric assistance" simply will not stand up under careful analysis. One is in fact dealing with a group of people with a broad range of personalities whose only real area of communality is their addiction.

M. A. Griffiths, psychologist, submission, p. 3

The medical approach directs intervention in problems at an individual level. Such a perspective views the individual as the primary source of problems, whereas the socio/political perspective concentrates on various elements in the person's environment as the primary source of problems.

ACOSS Secretariat, submission, p. 23

This [psychosocial] approach emphasizes the individual as the active agent and not the drug. The person using the drug and the reasons for this rather than the pharmacology of the drug itself is the major point of intervention. The meaning of drug use is its major concern. . . Owing to its emphasis on the person and his behaviour and the effect of social factors, this approach recommends non-drug specific responses to drug use, which can in fact be applied to another destructive or deviant behaviours.

Mr B. Goldberg, pharmacist, submission, p. 3

using those that are not approved. It was explained to us that if a community, or a group within a community, defines the use of a particular drug as "dangerous", "forbidden", or "destructive to self", then those who wish to protest or deviate from the general views of that community or group may well use that drug as a symbol of their protest rather than for its own sake. Or again, those who through curiosity or disposition are attracted to taking risks may use the drug if it is available in a situation perceived by them to be risky. In this way, social or legal disapproval may actually induce some people to use drugs which otherwise would be unattractive to them.

It is apparent to us then, from the responses that have been made so far, that unless the term "drug" is given an unduly restrictive meaning, the category "drug user" can be applied to almost everybody in the community. It is not possible to classify "drug users" as psychologically or socially abnormal, and they certainly cannot be distinguished as groups, or as psychological types from the rest of the community in any practical way. At the same time there are others, though not a majority, who either because of prolonged compulsive use of a particularly active drug which has chronically affected their mental health, or because drug use is merely an aspect of an otherwise deviant, destructive, violent or psychopathic personality, can be classified to some extent as psychologically or socially "abnormal". Even here, it is necessary to be cautious. We have been reminded by, among others, the visiting American psychiatrist, Dr Thomas Szasz, of the need to consider the implications of the "mental illness" label, whether applied to drug users or to others. Also during the hearings witnesses who attributed personality disorders in patients within their clinical experience to the patients' use of drugs usually accepted that it was not easy to determine that the drug use had *caused* the personality disorder, or whether other circumstances may have been the cause of both the mental disorder *and* the drug use, or indeed whether the mental disorder itself caused the drug use.

We have become aware that any view of "drug users" is coloured by whether the observer believes drug-taking to be a "drug problem" or a "people problem". The first view puts greater stress on the properties of drugs and on control of their distribution and availability. This view forms at least part of the basis for the criminal model of dealing with the "drug problem" which directs sanctions at persons possessing, distributing or dealing in certain drugs. The second view considers it a problem of human behaviour and sees solutions in either the pragmatic adjustment of human relationships, or the application of the social and behavioural sciences. This view forms the basis of what is often described as the psychosocial model for dealing with the problem.

Not every drug user, of course, uses the same drug or drugs, nor at the same rate. Too simple a view of drug use can be unfortunate, if for example, it places in the same category a school child who has once smoked marijuana or once taken a supposed mood-altering tablet, and a person who has been dependent on heroin administered intravenously for ten years. Many of the submissions to us, understandably enough, do not appear to realise the differences in intensity and quality of the behaviour

Some people would argue that they have been "spoilt" by our easy, high standard of living and expect more than normal working people. Possibly they are simply lazy people. They expect things to be served up on a silver platter and if they cannot obtain material possessions easily they refuse to work, get apathetic and use drugs.

Confidential submission no. 151

I know over a dozen people who have died from drugs because they have become psychologically dependent on grass, and when there has been a drought on they have had to go to others like I have.

Confidential submission no. 31

Many of the people we see are the heavy abusers and abuse all sorts of drugs. They will smoke 60 cigarettes a day and drink more alcohol than the average person drinks. They will take far more analgesics than the average person too. As well as that they are taking heroin and other things. You find a person is abusing whatever he can get that is abusable.

Mr W. D. Crews, Wayside Chapel,
public hearing, transcript, p. 642

I have never met an alcoholic or an addict and scientifically no-one can prove the existence of these things as diseases. What I meet are ordinary people with more than their fair share of problems from their use of alcohol, narcotics and other drugs. The other danger with labelling people is that you do label them out of society.

Dr G. Milner, Health
Department, Vic. public
hearing, transcript, p. 931

or experiences resulting from the use of different drugs or from the same drugs in different quantities or on different occasions.

The question of multi-drug use arises here, too. We are told that this is an increasing phenomenon within the drug "scene". It means that heavy drug users are not necessarily confined to one drug, or one category of drug, and that they may move from one drug to another quite readily, particularly if supplies of their drug of choice are cut off. We have heard evidence that narcotics users switch to hypnotics or barbiturates if narcotics supplies are hard to obtain, or of poor quality. We are also told (although this is more difficult to assess) that some marijuana users may turn to heroin if there is a "drought". It appears that the change from drug to drug occurs across the spectrum of all the drugs which have been brought to our attention—from alcohol and nicotine through other legally available (and acceptable) medically prescribed or over-the-counter drugs, to illegal drugs.

A set of categories of non-medical users of drugs, taken from *Drugs Demystified,* by Helen Nowlis (Unesco Press, 1975), a booklet which was recommended to us by the Education Department of South Australia in its submission, divides users into four groups, based on rate of usage:

- 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". We are informed that

. . . a reasonable estimate from surveys of drinking in Victoria, a reasonable estimate, would be that on any one night, 10 000 men would be totally drunk.

Dr G. Milner, public hearing, transcript, p. 924

The younger drug users attract more attention in the mass media because the drugs they use are more likely to create drug dependence over a short period and because the life-style they often adopt also attracts the attention of the mass media. The drugs more likely to be used by the young are marijuana, narcotics and LSD—in that order—with the emphasis on marijuana.

Church of England, Adelaide, Social Questions Committee, submission, p. 2

. . . for example I work on the understanding that 10 per cent of adult Australian males at any one time are actually damaged by their use of alcohol.

Dr G. Milner, public hearing, transcript, p. 933

by far the largest number in this group are alcoholics, who are using a socially approved drug that falls outside our terms of reference.

Various administrators in different parts of Australia who deal with both alcohol and other drug dependencies have explained that the social effects of alcohol, measured in various ways (number of persons, social and administrative costs, etc.) are from five times to twenty times greater than the effects of other drug dependencies.

We think it is of considerable importance to determine fairly precisely the level in the community of the actual use of any drug such as cannabis whose approval status is perhaps in an uncertain stage of social transition. Such information can help a changing society which has a problem of "retreating from an entrenched moral position" (as a Christian very experienced in drug problems expressed it to us). Putting it another way, most people do not use a substance their culture prohibits; users of such a substance represent a threat to the consensus of that culture; but if the number of users is so great as to constitute a real threat to the consensus, the culture may have to change to accommodate the use of the substance, rather than risk the threatened break. In any event, information of this nature is important if we are to answer our terms of reference, and accordingly we have undertaken a detailed empirical study of the extent of drug use in South Australia, which covers a range of drugs, both legal and illegal. The results are not yet available.

Generally, the evidence we have so far indicates that heavy use of drugs in Australia, measured by the harm to the individual users themselves and to the community as a whole, 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 devasting 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 tranquillisers 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 20s, and a larger group using opiates experimentally. Estimates of just how many in either of the groups vary enormously. The discrepancy

One thing which is not generally appreciated is that the active ingredient of cannabis is like morphine in chemical structure except that it lacks nitrogen as a base that makes it an alkaloid. One way of classifying cannabis is to say that it is a non-alkaloid opiate.

Prof H. B. Jones, public hearing, transcript, pp. 63-64

[Cannabis] is not structurally like the opiates. It does not act on the opiate receptor, and in fact this was one of the first things I did when we first began looking at THC, we studied and compared the pharmacology of morphine, pethedine and THC and they are quite different . . . there is no doubt structurally they are quite dissimilar and if you make a molecular model of narcotics and THC they are quite different shapes.

Dr G. B. Chesher, Reader in Pharmacology, public hearing, transcript, pp. 268-269

So far these studies . . . have found very little evidence of serious medical harm and no evidence of any neurological damage or brain damage [from cannabis].

Dr G. B. Chesher, public hearing, transcript, p. 241

. . . pretty careful examination of . . . perhaps approaching 200 heavy users [of cannibis], and I am including now some recent studies in the United States, have not disclosed any evidence for serious neurological or brain damage . . .

Dr G. B. Chesher, public hearing, transcript, p. 242

may result from a failure to differentiate between experimental, occcasional and regular use.

- Heavy multi-drug use involving some or all the drugs already referred to, together with other psychotropic drugs including barbiturates, other hypnotics and amphetamines.

It is worth remembering here that there is experimental, casual and regular use of all the drugs mentioned above. Evidence also indicates that the use of drugs within these categories is widespread in the community, but that, relatively speaking, few people use narcotics either singly or in combination with other drugs of dependence.

In addition, many respondents see the extent of use of cannabis as the major problem. The indications to us so far are that cannabis is regularly (rather than heavily) used, and approved, in South Australia by people in their teens and 20s, and casually used by older people who are usually professional, educated and well-to-do. Experimental use occurs in both groups. As already mentioned, we are undertaking a random sample of the population of Adelaide, which will in due course determine with reasonable precision the extent to which cannabis is used in South Australia, and the regularity of its use.

Cannabis use is a good example of behaviour which is seen as "deviant" by non-users. Thus there is wide social disapproval of cannabis use, particularly by the middle-aged and elderly who have little or no direct experience of it, and who do not distinguish between experimental, occasional and regular use. On the other hand, heavy and regular users of the drug do not see themselves as engaging in reprehensible or deviant behaviour and resent both the law's characterisation of their conduct as illegal, and the labelling by others of their behaviour as deviant. Indeed the same view is taken by experimental and casual users. Yet it is interesting to note that regular users of marijuana often describe users of hard drugs in terms similar to those employed by opponents of marijuana when describing the marijuana-using population.

As has been the experience of other Commissions concerned with this issue, we have conflicting evidence as to whether cannabis, a psychotropic drug, has itself caused serious harm to Australian users. Evidence has been put to us that prolonged cannabis use may cause serious harm to the user. For example, some opponents of cannabis assert that prolonged use of cannabis leads to brain damage. Other witnesses attack these conclusions and interpret the available scientific and medical evidence in a very different way.

Much of this conflicting evidence reflects the fact, which other Commissions have noticed, that the cannabis debate provokes passionate advocates on either side of the controversy and that not all the material presented as "scientific" evidence withstands close examination. This is not to say that cannabis is free of risk. Its relatively recent popularity in Western communities, its slow elimination from the body, and its effects on the psychomotor performance of some, must all qualify any estimate of the risks associated with its use. Some submissions, however, argue that the greatest risks to the user of cannabis are those associated with its illegality.

There was a drug scene in a particular school for a while and they were doing things like taking grandpa's sleeping tablets to school and swallowing a couple of those for kicks, which was quite hilarious. They were sleeping through school and the teachers couldn't work out what was going on.

Meeting, Parents without Partners, transcript, p. 8

A further point about cannabis, often overlooked, is that in the form in which it is usually available, it is almost impossible for any user to absorb a lethal dose, and in this way cannabis differs from most other drugs that are used legally and illegally.

Some parents and teachers inform us that they are very fearful about the possibility of drugs being used by school children. While they do not provide us with direct evidence of this happening, others assert that this kind of drug use is common. We have, for example, received many suggestions that experimental and occasional use of alcohol and cannabis among school children in South Australia is quite common.

It can be said that if a substance of whatever kind has an effect on the central nervous system which is *enjoyed* by somebody then that substance will be abused by some people and it will be capable of producing dependence (i.e. psychic dependence with or without physical dependence) in some of the abusers of that drug. This aspect is illustrated by the wide range of products that are abused.

S.A. Department of Public Health, submission, p. 4

We felt it very difficult as psychiatrists to come up with any clear definition of issues of dependence as against habituation or addiction, or, as you referred to, compulsive repetitive behaviour.

Meeting of members of ANZ College of Psychiatrists, S.A. Branch, transcript, p. 15

I think a lot of people have the impression that once a person's had a shot of heroin, that was the end of them—there was just no way they could be cured—there may be a lot of people who think the same way.

Meeting of members of the Apex Club Burnside, Inc, and Lions Club of Adelaide Flinders, transcript, p. 19

Fear of withdrawal is also very important because so many [addicts] have been conditioned by the press, by the mass media, by doctors, by everybody, about the withdrawal symptoms and they are afraid.

Dr J. W. Gabrynowicz, Alcohol & Drug Addicts Treatment Board, S.A., public hearing, transcript, p. 99

It seems that withdrawal for some addicts is relatively painless, physically and psychologically, and for others it is physically—words cannot describe—although I think so-called withdrawal symptoms have been grossly exaggerated by some people, but it is amazing how a narcotic, a synthetic narcotic, such as methadone will replace all those cravings but not give that euphoria that heroin will give them.

Anonymous general practitioner, public hearing, transcript, p. 222

DEPENDENCE

We have been surprised to discover from much of the material presented to us that the concepts of "addiction" and "dependence" are not at all specific or capable of simple definition. For some, the term "drug addict" means pretty well the equivalent of social outcast. Others often loosely (and wrongly) apply the term "addict" to experimental users of opiates and to regular marijuana users, neither of whom suffer physical withdrawal symptoms if they cease using those drugs. Similarly, people "addicted" to minor analgesics can withdraw, on their doctor's advice, without suffering any physical discomfort whatsoever.

We have heard "addiction" used as a synonym for habit, compulsion and mild dependence. However, certain substances, particularly caffeine, nicotine, alcohol, barbiturates and opiates when used in sufficient quantities at sufficient rates apparently produce physical changes in a human or other organism so that its behaviour for a time becomes unusual if that drug is not continually used. This is the "withdrawal syndrome". This process in a human being is a disturbance of the reflex nervous system accompanied by a felt hunger for the drug. How long such physical "addiction" and craving then lasts (in the sense that, like sexual hunger, it can thereafter readily be re-awakened) seems to be unknown. It varies with the drug and the person and the route of administration to the body. Just as drugs can be graded roughly in a range of potential addictiveness, so evidently can different people be ranged for their addictability. But this can be done in retrospect only, and thus cannot yet be forecast. This varies according to the drug and the personal and social situation of the individual. Addictiveness is a complex phenomenon, relating not only to the pharmacological properties of the drug, but also the characteristics of the user, his beliefs, and the expectations of his group. Merely using a drug once, even heroin, is not in itself capable of producing compulsive addiction. On the other hand, many people would be surprised to learn of the addictive potential of certain drugs. In recent years it has become clear that even minor tranquillisers can produce dependency, and certainly terminating the heavy use of barbiturates creates a withdrawal syndrome.

Varying opinions have been expressed to us about the severity of the "withdrawal syndrome" associated with narcotics. Dr J. W. Gabrynowicz, Medical Director of the Alcohol and Drug Addicts Treatment Board of South Australia, says, for example:

> It is rare nowadays to see a case of even mild withdrawal sickness from drugs (apart from alcohol, diazepam and tobacco). It is an estabilished clinical fact that no-one has ever died due to uncomplicated withdrawal from narcotics . . .

Dr W. S. Salter, then Superintendent of Hillcrest Hospital, puts forward another view:

> . . . it's easy to get off drugs, quite easy. It is a matter of covering the withdrawal symptoms with non-addictive drugs and then gradually reducing them . . . but that isn't just the problem. Many addicts are taken off them forcibly, cold turkey in prison, if they happen to get there, which means that

The problem is not so much the drug but the drug subculture, and there is real difficulty for people to give it up when they are closely connected with other drug users.

Miss Rosemary Taylor, social worker, public hearing, transcript, p. 866

We take the view very strongly that the overcoming of the physical dependence on drugs is a fairly straightforward matter and that the most difficult matter . . . is the dependence on the drug sub-culture and the supports they get from that sub-culture.

Mr A. P. Diehm, N.S.W. Health Commission, public hearing, transcript, p. 1270

In Adelaide, in Osmond Terrace Clinic, in the past two years 200 young drug users claiming to be withdrawing from heroin or heroin-like substances were admitted and not one single one of them showed any signs of withdrawal sickness. That is our experience here.

Dr J. W. Gabrynowicz, public hearing, transcript, p. 97

I have definitely been psychologically dependent on grass and up to date I am still not sure of the damage it has done, but I believe it has been responsible for my long periods of unemployment, financial debts, using other drugs, making me less of a person, offences committed under the influence of it, definitely unstable, and my inability to lead a normal life.

Confidential submission no. 31

If you can keep young people alive, by the time they are 30 you can hope that one-third of them will have graduated out of drugs.

Dr M. S. Y. Dalton, Way Back Committee, public hearing, transcript, p. 697

The concept of "maturing-out" . . . suggest[s] that between the ages of 30-35, about one-third of narcotic cases tend spontaneously to give up their drugs and settle down to a more normal drug-free existence. The evidence for this process is admittedly somewhat tenuous, but it does suggest there may be limits to methadone maintenance set by the natural history of narcotic addiction. In that case, for a percentage of clients, a modest success in terms of freedom from drugs might be achieved provided one is prepared to wait for the spontaneous change in attitude to occur.

Prof F. A. Whitlock, Univ. Qld., submission, p. 18

they just suffer it out. I don't know if you can die from it . . . but they go through a very unpleasant time.

Discussions with narcotics users indicate that even after the withdrawal phase has been completed, a craving for the drug often remains, perhaps for years. This, coupled with the lifestyle and reinforcing friendship patterns of users and the conditioned responses to old scenes and signals, contributes to the extraordinarily high "relapse" rate by users who seem otherwise determined to abstain from narcotics.

The term "dependence" tends to be used as a synonym for "psychological dependence" in regular users who nevertheless do not suffer physical withdrawal symptoms if they cannot use their drug. For them the drug meets some strong psychological need, and inability to obtain it may lead to extremely strong feelings of disappointment.

Medical use of drugs shows that dependence on a drug may not necessarily be a bad thing. Drug use may play a long-term, perhaps permanent part in the medical management of blood pressure, epilepsy, diabetes, schizophrenia, depression and neurosis, and the individuals so treated are in many cases physically or psychologically dependent on the drugs prescribed. Psychological dependence, when well established, may for some drugs progress from a habit to a compulsion, and then to physical dependence (as described above), which makes the drug more desirable still to the user because of its now added ability to relieve the unpleasant physical sensations associated with withdrawal. Physical dependence may also precede, or not be accompanied by, psychological dependence.

There is a poorly understood phenomenon known as "maturing out", where at least some who from their youth have been compulsive users of narcotics, will, providing they stay in good health and avoid complications such as infection and malnutrition, more or less spontaneously cease to use the drug when they reach an age of about thirty to forty years. Sometimes "maturing out" is associated with a change in lifestyle or companions. "Maturing out" may be related to the fact that some delinquent behaviour patterns are known to be a phenomenon of youth which disappears with age or "maturity". So far as narcotic addiction is concerned, "maturing out" indicates that for some, at least, the natural history of addiction is that it need not be lifelong or fatal.

Another aspect of drug use which we are required to examine is tolerance. "Tolerance" to a drug means that larger and larger doses are needed for the same effect to be obtained, and that tolerant individuals can survive doses of a drug that would otherwise prove fatal. Tolerance disappears if an individual stops using the drug for a period. Some addicted heroin users deliberately withdraw from the drug for a time, even though this causes unpleasant symptoms, for the sake of returning to a pre-tolerant state where they can experience desired effects from smaller doses.

Cross-tolerance means that tolerance to one drug produces tolerance to another, even though the second has not been used. There is cross-tolerance among the opiates, and cross-tolerance between alcohol and the

Because the problem is interpreted as being internally generated the medical profession supplies a medical agent—the psychotropic drug—as the solution which reinforces the patient's perception of his problem being of an individual nature. The patient uses the drug to control or prevent a recurrence of this illness. Gradually he may become drug dependent.

ACOSS Secretariat,
submission, p. 22

A very high proportion of the people who come asking for methadone and seeing themselves as addicts show no sign of physical dependence at all and I think it becomes a pretty subjective sort of judgment in many cases as to whether a person is an addict or not.

Mr A. P. Diehm, public hearing,
transcript, p. 1305

barbiturates. This is the basis for the so-called methadone "blockade" treatment, in which very large doses of the synthetic opiate methadone are given to heroin addicts. The doses are so large that the methadone is said to block the euphoric effect of all other opiates. There is no cross-tolerance between cannabis and the opiates, and furthermore, regular users of cannabis may experience a "reverse tolerance" effect, in that they require less of the drug to obtain the desired effect.

It was about the middle of 1973 when I had my first bad trip, and started asking myself a lot of questions about myself, and started having bad feelings about myself. I suffered paranoia, afraid of being with people, felt my life was worthless and wondered why I was on this earth and felt I hadn't achieved anything with my life. Then I returned to the use of narcotics.

Confidential submission, no. 31

The drug scene is full of myths and legends. The first thing I learnt was that drugs have two effects; the physical effect and the effect that society has told us that a drug has on us. The latter is the biggest problem.

Mr W. D. Crews, Wayside Chapel,
public hearing, transcript, p. 650

With LSD I have experienced telepathy for the first time, experienced music as a 3D movie, realised failings in myself I can now (at least partially) correct, achieved total rapport with fellow trippers, become suffused with hilarity, tragedy, tasted strawberries with my eyes, heard paintings explain themselves etc. I have also experienced acute paranoia—mostly of getting busted.

Submission no. 44

The hallucinogens, particularly LSD do assist people to expand the consciousness and the user may have a sense of undergoing a spiritual experience. They appear to facilitate the functioning of different parts of the brain in that a sense of increased awareness and increased sensitivity to all sensory phenomena is experienced.

Dr W. S. Salter, Hillcrest
Hospital, submission, p. 3

The medical profession needs to continue to remind itself that social problems do not have medical solutions and the continued use of such drugs may sap vitality and may prejudice the ability of a person to cope positively with his problems.

Dr G. D. Wright, medical
practitioner, submission, p. 1

Finally I would like to say I enjoy taking drugs (my choices are marijuana, opium, mescaline and mushrooms, nicotine + wine + beer) and do not feel degraded, irresponsible, unhealthy, insane, impotent, doomed to an early death, bored or depressed. I do not feel these drugs are necessarily good for everyone, and have no wish to force anyone to take any of them. I do not see why I shouldn't be allowed to take any of them.

Submission no. 44

By their very nature, drugs designed to alter experience or behaviour must also affect the psychological and social processes connecting the individual to his physical and social environment. These two kinds of costs—both to the individual and to his relationships with others—may involve fundamental alterations that change the level and pattern of relationships with others, so that the use of drugs takes on a regulatory function in the relationship . . . By using drugs the possibilities for interaction and reaction are severely reduced. It is therefore necessary to question the validity of such practices as automatically using tranquillisers in order to calm the bereaved so that they can fulfil their social obligations at the funeral. This deprives them of the full feelings of grief which many . . . are now claiming have an important psychological function.

ACOSS Secretariat,
submission, p. 35

EFFECTS OF THE USE OF DRUGS

As already mentioned, we are arranging a compilation of the pharmacological effects of those drugs which are used non-medically in South Australia. Such knowledge, however, is unlikely to cover all the "effects" with which the use of such drugs may be associated, either in respect of an individual user or of the society of which he is a part.

The effects directly desired by drug users are, variously, the relief of pain by dulling it or eliminating the perception of it; a reduction of mental activity or experience such as anxiety or aggressiveness; an increase of mental activity or experience to provide feelings of energy or capacity, or to counter fatigue or depression; a change in the ways of perceiving the self or the environment; and inner subjective experiences of joy, certainty or ecstasy. We have been assured that similar experiences and effects can usually be obtained without chemical mediation by a range of practices and activities such as holidays, scientific discovery, games, sleep, group interactions, isolation, yoga, social achievements, rewards, discipline, artistic experiences or achievements, hypnotism, psychiatric treatment, transcendental meditation, acupuncture, prayer, fasting, religious experience or conversion, twirling, over-breathing, going without sleep, and falling in or making love.

Generally we are aware that this area "beyond pharmacology" is difficult and confused. It contains clouded concepts and generalisations. When any claim is made on a basis of personal experience it can be hard to counter or confirm. The placebo effect, mentioned earlier, is one explanation for this difficulty.

The direct effects of the drugs used are for the most part not dangerous. It is true that some psychotropic substances are very toxic, that is to say that the dose which will provide the psychotropic effect is very close to a higher dose which will provide undesirable and dangerous effects. And all drugs (alcohol is a good and familiar example) will, in sufficient doses, produce effects beyond those that are desired by the individuals or those that will perhaps be tolerated in him by the community. In practice though, the toxic dose has to be many times greater than the effective dose if the substance is to be use safely without expert technical supervision.

Therefore, highly toxic drugs cannot be used widely by the illegal drug culture, and never for very long, for the simple reason that their toxicity eliminates the users through death or disability and the reputation of that drug then falls. Such drugs as are generally used illegally will for that reason not usually have acutely toxic properties at the doses used because the users will be seeking psychotropic rather than toxic effects. Whatever undesired side effects these users will experience, they are therefore likely to be of the kind that develop slowly, inconsistently, later, or as a result of social or accidental consequences that are not part of the scientific pharmacology of the drug. Of course, some may use either legally or illegally available drugs specifically for their toxic effects—in suicide attempts or gestures.

The psychotropic effects of drugs may, according to the drug used, alter the mood and the mental processes of the user. This does not have to be for the worse: it may mitigate the impact of personal problems created by bereavement, loss, failure, unemployment or peer pressures, all of which

People who see others using marijuana and marijuana only will notice that there is nothing extraordinary happening—much different to what alcohol does. In fact, a lot of people who use marijuana use it interchangeably with alcohol. They often use marijuana because it is cheaper—and that is not a joke, I'm serious, but the same effect is cheaper, and that is one of the reasons why a lot of people use it. In fact some people don't like what alcohol does to them and people act very strangely when they use alcohol too—perhaps stranger than when they use marijuana.

Meeting, Young Liberal
Movement of S.A.,
transcript, p. 10

With more frequent use, the user becomes better adjusted to the state of being "high" and therefore is able to cope better with emergencies (as in driving a car) or changes in situation.

Confidential submission no. 151

. . . of course there's the question of driving when you're stoned. I think most people I know don't really want to have an accident when they're stoned so if they don't think they can handle it, they sit around for a while until they're straight—able to drive. I don't think most people would drive a motor vehicle when they're really stoned.

Meeting of students,
University of Adelaide,
transcript, p. 14

I think there are enough studies to show that the effect of acute intoxication with cannabis is such that it will adversely affect the ability of driving a motor car. In much the same manner as alcohol, it is a dose-related effect.

Dr G. B. Chesher, Reader in
Pharmacology, public hearing,
transcript, p. 243

. . . I told her that I wanted to try some grass. She arranged a joint for us. I got a very good effect out of it. I was very happy and couldn't stop laughing, and both of us got very stoned and were in very high spirits.

Confidential submission no. 31

What I would like to see the Commission do is a follow-up study on people who had been busted for marijuana . . . because the courts simply suck in people that the cops have busted, and spit out the bones, and that's it as far as they are concerned. . .

Meeting of students,
University of Adelaide,
transcript, p. 10

As far as Western society is concerned, cannabis psychosis, if it exists, is so rare as to warrant single case reports of patients alleged to be suffering from the disorder. Despite the claim that cannabis is being widely used in Australia, I have never seen a case of psychosis which could be attributed wholly to the use of the drug.

Prof F. A. Whitlock, Univ. Qld,
submission, p. 4

Once you have prohibition, you'll find that there's a market, and the price can go up. I don't see how you can stop it when the adults are drinking and smoking, which are both drugs. Probably the only reason governments are concerned about it is because they're not getting any income out of it.

Hypnotherapist, public meeting,
Whyalla, transcript, p. 10

are a natural part of the social environment and interpersonal relationships. It may increase, though it may also decrease, an individual's capacity to perform certain tasks, depending on what they are. The effects of a drug upon the ability to drive a car, and the consequences of this, are familiar to everyone because of the community's experience with alcohol. Most depressants of the central nervous system could be expected to have similar effects according to dose, but the same does not apply necessarily to all psychotropic drugs. There is evidence that acute cannabis intoxication significantly impairs driving skills, and this is suggested to us as a major argument for retaining the prohibition of cannabis use. The state of knowledge relating to the effects of cannabis use on driving performance is imperfect and we are gathering as much information on this topic as we can.

A drug may increase, or indeed decrease, an individual's tendency to act destructively or aggressively. Submissions point out that drug use may uncover, or as some argue, bring about psychotic or other mental activity that inhibits an individual's capacity to continue as an accepted co-operating member of his social group or of society. Generally speaking, this applies to all psychotropic drugs (including alcohol) whether used medically or non-medically. Non-medical use, however, has associated effects that are specially related to drugs that are illegal and socially disapproved.

Illegality and social disapproval make the drugs available only on a black market where they become scarce, highly priced and of doubtful purity. People seeking and using them may suffer social "effects" not associated with the drugs' chemical properties—arrest and social stigmatisation for possession of the drugs; blackmail; the results of committing other crimes or going without food in order to obtain drugs or money to buy them at black market prices, and so on. The small bulk of the drugs, which makes them easy to conceal, and the strong compulsions of some individuals to use them has made it impossible for Western countries to police their communities to the point where the substances can be totally excluded, and we have been informed that as a general rule in such countries only about 5 per cent of illegally used drugs are likely to be seized and destroyed by police or customs officials. Such are the dilemmas and personal and social consequences of "prohibition", which were thoroughly exemplified by the United States' experience in relation to alcohol over forty years ago.

Intravenous administration ("mainlining") of a drug in an illegal setting has associated "effects" related to inexpert use of substitute or unsterilised needles and syringes. Septic, irritant, foreign or lethal material can be introduced into veins, leading to effects such as thrombosis, phlebitis, infection of the heart valves or general virus infections of the hepatitis type. Such complications can cause rapid deterioration in the well-being or health of the user of illegal drugs, and may occasionally cause death. In general, these socially created effects on users of illegal drugs are as great a cause of ill-health as the direct toxic effects of the drugs themselves.

There are also the "mental" effects of the dangers, consequences, threats and narrow escapes that often surround illegal drug-taking. These are themselves a thrilling attraction for certain personalities, though for many they must become, sooner or later, disincentives.

I think if you say experience in any way, tried it once or smoked it continuously, I think it would be at least a quarter, perhaps at least 30%, I'd say, but I'm only just saying that off the top of my head without having thought about it a great deal.

Public meeting, Pt. Lincoln, transcript, p. 9

. . . the Victorian Young Liberals have collected a view from . . . 6000 young people [in Victoria], and this was conducted in late August through to the beginning of September. That poll, which had some statistical significance . . . indicated that up to 50% of young people under the age of 30 had had access and tried, or experimented with the drug marijuana, and that the maximum age range of people acknowledging that they had experimented with marijuana was 20 to 25.

Meeting, Young Liberal Movement of S.A., transcript, p. 6

Our society has always been a drug using one and we should learn to understand and accept ourselves in that context . . . The root of the problem of drug abuse would appear to be with some people's inability to cope with the sophisticated lifestyle our society has conditioned us to adhere to, rather than our inability to use drugs correctly.

Confidential submission no. 151

The one factor which is present in every person who becomes drug dependent (and, to some extent, in all of us) is emotional or personal immaturity. That is, the immature, under-controlled desire to feel good or to avoid suffering at all cost, often coupled with the immature, undercontrolled desire to please or go along with "friends" at all costs, rather than making mature choices and seeking healthy pleasure-fulfilment, and healthy ways of living and wholesome relationships.

Dr C. Sprague, GROW, submission, p. 5

I have . . . seen a remarkable change in the drug scene in Adelaide in the last two years. From when there was only a handful of junkies to the present stage where narcotics are being sought after by many people from as young as 16 and 17 years old.

Confidential submission no. 29

The reason kids end up taking drugs is the lack of communication and common interest in the family unit.

Women's Discussion Group, Lutheran Church, public hearing, transcript, p. 634

In all a pattern seems to be developing whereby any uneasiness or change in lifestyle (such as a bereavement or menopause) is immediately dealt with by the use of drugs. Were drugs not so readily available, pressure for the creation of constructive alternatives might be forthcoming. At the moment drugs are being used to cover up unfavourable social and interpersonal arrangements that often generate anxiety and unhappiness.

ACOSS Secretariat, submission p. 36

Marijuana if overused can lead to a lack of drive and ambition. People who are unemployed are highly susceptible to the habitual use of the drug to find pleasure. People normally find pleasure through activities which usually require more money than smoking marijuana. Hence it is necessary to be working so as to have enough money to enjoy life without resorting to drugs for pleasure.

Confidential submission no. 151

I was getting into a lot of trouble because I became disinterested in school and sport and was knocking around with a crew that were pretty much the same as myself. I think a lot of my trouble was that my father did not show much attention to me, and I was out to get attention, which I didn't know at the time. The kids I was associating with were either from broken homes, divorced homes, etc.

Confidential submission no. 31

EXTENT AND CAUSES OF THE USE OF DRUGS

Determining the extent of use of drugs in this country with any degree of precision requires very careful examination of published figures from a variety of sources and, given the lack of data in Australia, the conduct of extensive empirical surveys. As mentioned elsewhere, the survey being undertaken by the Commission should provide more detailed information on the extent of the use of certain drugs within South Australia. The submissions and hearings did include estimates from people with expertise in the field, although necessarily these often involved a substantial element of guesswork. The imprecision of the estimates is increased by the difficulty of distinguishing between casual and moderate and heavy use of drugs.

It has been suggested, for example, that perhaps one in 700 of the South Australian population has had some fleeting or occasional experience with heroin, but that only about one in 3500 is currently dependent on the drug. These figures need to be treated with special caution because of the inevitable clandestine nature of the activity and the mobility of the drug-using population. In contrast, estimates of the proportion of the population having had at least occasional experience of marijuana vary from 1% to as high as 30%. Our survey, in addition to producing more reliable figures, is likely to indicate substantially different patterns of use among different age groups in the community. It has also been suggested that as much as 10% to 16% of the adult population uses simple or compound analgesics daily—that is, at a level which is seen by some commentators as amounting to abuse. As the recent report of the Senate Standing Committee on Social Welfare shows, the evidence of published surveys indicates that the patterns of consumption of analgesics vary considerably from region to region in Australia and care must be taken not to assume that the level of use in one place reflects behaviour elsewhere. The report of the Senate Committee is valuable because (among other reasons) it gathers together the available empirical research in Australia on extent of use of marijuana and analgesics. The report also provides figures on the consumption and effects of alcohol and tobacco, which provide a basis for comparison with other drugs. The report indicates, for example, that over one quarter of a million Australians can be classified as alcoholics, and that tobacco, particularly in the form of cigarettes, contributes each year to the death of perhaps 8000 people from heart disease and 3500 from lung cancer.

Relatively few submissions concentrate on the causes of drug use, perhaps reflecting the fact that no single theory is likely to provide a satisfactory explanation for the phenomenon and that the causes will vary from one individual to another and from one group to another. Moreover, explanations for drug use tend to vary according to the perspective of the observer. For example, some submissions make the point, implicitly at least, that people who use drugs non-medically, on a regular basis, do so essentially because there is something wrong with them—that is, they are

The message I get is that we are taught from the earliest age that if you feel bad you should take a drug. People are not being told what feeling bad is. I believe it is psychological and physical. If you feel really terrible inside, and you find that a drug makes you feel better, it will not matter whether or not that drug is legal or illegal. We are getting people using drugs to make them feel better.

Mr W. D. Crews, Wayside Chapel, public hearing, transcript, p. 642

One of the reasons people take drugs which act on the central nervous system (i.e. the drugs which are often the focus of abuse) is that it is fun, it gives pleasure or they enjoy it.

It seems logical to propose that if we wish to reduce the level of drug taking overall (except for legitimate medical purposes) our Community needs to develop methods of obtaining fun, pleasure and enjoyment which are healthier than just consuming drugs.

S.A. Department of Public Health, submission, pp. 25-26

Doctors reflect society and society takes some credence from doctors, so one of the effects has been, I believe, to increase the general population's view that drugs are a useful means of coping with all sorts of illnesses for which in fact drugs are not a good agent.

Dr G. D. Wright, medical practitioner, public hearing, transcript, p. 160

They [parents] might find tobacco or half an aspro in their [child's] pocket. They seem to fly off on a tangent and they think it is a drug. They tend to think it is marijuana, they have found that their teenager has been smoking it, that "they are hooked for life", "it is the end of the world". But without exception when I say "why don't you talk to the boy?" they have all said that they have lost communication with their teenager.

Mr D. J. Call, counsellor, public hearing, transcript, p. 1235

But we wonder whether the other side of it has been considered, as to whether in fact sometimes those drugs may prevent other effects, and whether the removal of all drugs from the community, which again is Utopian, might not result in the appearance of a greater . . . degree of psychosomatic illness or some other behavioural problem in the community . . . We wonder . . . how much that in fact may have the paradoxical effect of increasing the drug dependence and . . . one would wonder if no case of drug dependence or charge against anyone using a drug, was ever publicised, whether in fact that would not lead to a lessening, rather than increase, in the incidence.

Meeting of members of ANZ College of Psychiatrists, S.A. Branch, transcript, pp. 4-5

If doctors tend to use drugs mainly as a symptom of relief where there is no obvious pathology detected to account for these symptons then it is clear that these attitudes may lead to similar patterns of behaviour within the general community.

Dr R. Chynoweth, Reader in Psychiatry, Univ. Adel., submission, p. 2

. . . we would like to see more research in this amotivational syndrome in the present unemployment situation where there continues to be conflicting comments. One reads in the paper and hears on the radio people saying that unemployment is very high, but other employers say they cannot get people who are willing to work or answer advertisements . . . we would like the Commission . . . to look specifically at the question of whether there is any connection between unemployment and the lack of incentive to find jobs, and increasing marijuana in our community.

Dr D. M. Phillips, Festival of Light—Community Standards Organization (S.A.), Inc., public hearing, transcript, pp. 506-507

thought to be suffering from a physical or mental disorder of some kind. Others, particularly people identifying themselves as drug users, reject this proposition, contending that the major factor in the use of certain drugs (marijuana is most frequently mentioned) is simply the pleasure derived from the experience. Sometimes the pleasure argument is taken further, users contending that the drugs allow them, for example, to reach a capacity for self-awareness and for the appreciation of objects and experiences that otherwise they would not have.

Emphasis was laid by some on the pressures of everyday life as a principal cause of heavy drug use. These respondents, while perhaps acknowledging that no simple cause could be identified, point to such factors as unemployment, repetitive and soul-destroying work, loneliness, boredom and frustration. Peer group pressure is regarded by many as an important cause of drug use, (and not merely for the young) both in relation to the initial foray into drugs and the continued use after the stage of experimentation. To some the whole society is geared towards drug use —as indicated by the consumption of large quantities of alcohol, and the reliance on legally available drugs to alleviate unpleasant feelings. On this view a successful approach to drug use requires fundamental changes in community attitudes.

A common theme was that the level of drug use is directly related to the availability of drugs. On this approach, if a drug is readily available, whether through legal or illegal sources, more people will tend to use it and more people will use it heavily than if the drug is difficult to obtain. The implication, in relation to drugs obtainable only through illegal sales on the "black market", is that if the police, customs authorities, public health officials and other law enforcement agencies are sufficiently strengthened, the consumption of those drugs can be reduced. The argument is, however, not confined to illegal drugs. Some contend that the heavy use of legally available drugs is encouraged by the ease with which they can be obtained and the effects of advertising—whether directed to the public (as in the case of analgesics) or to the medical profession (as in the case of prescription drugs). Accordingly, it has been suggested that the availability of drugs which are prone to heavy non-medical use should be limited, for example, by changing their legal classification and therefore the applicable controls (as was done some years ago with the amphetamines, apparently with the result that the level of use fell dramatically), or by restricting advertising. These suggestions are resisted by some respondents, usually because a different view is taken of the relationship between availability and advertising, and patterns of consumption. Sometimes it is also argued that limiting availability is not a complete answer, since the forces that encouraged the use of the (now) restricted drug will simply produce an increase in the consumption of other drugs.

I suppose it depends whether one sees addiction as a bad thing in itself or whether one can take a fairly non-judgmental attitude on it and say it is a form of behaviour that exists and if we can control it and it does not damage the individual's health, we are doing as much as we can. That is my view.

Prof F. A. Whitlock,
Univ. Qld., public hearing,
transcript, p. 801

A drug addict says "I am the worst addict in the world, I am number one, I am in need of help." He always exaggerates the degree of his addiction.

Dr J. W. Gabrynowicz,
Alcohol and Drug Addicts
Treatment Board, S.A.,
public hearing, transcript, p. 88

It must be remembered that heroin use can lead to social alienation, as easily as social alienation can lead to heroin use. It is the role of a clinic to discourage the young addict's use of heroin from dividing him from the mainstream of society.

Mr M. A. Griffiths,
psychologist, submission, p. 15

We happily accept the treatment of the consequences of the complications of syphilis, gonorrhoea, excess drinking, any number of diseases that could be termed self-inflicted and yet we turn our backs on the drug addicts who are no more self-inflicted wound sufferers than people suffering from the complaints I have mentioned.

Dr B. Taylor, Hillcrest Hospital,
public hearing, transcript, p. 138

Many young drug addicts enjoy their addiction, they just do not want treatment of any kind . . . Many enjoy it, very few suffer from it.

Dr J. W. Gabrynowicz,
public hearing, transcript, p. 101

If I label one of my clients, if I called him a patient and say "you are an addict" he can then say "O.K. Doc. I'm sick, you get me better". Whereas our approach is to say "You have come to us for advice as a client". Just as someone goes as a client to an architect to have a design for a house, but the house is really their problem, their business. We lead them to a recognition of the nature and extent of their problems and then say "Well do you want help with this". If they say "no", fine. If they say "yes" we can give them certain advice and crutches like methadone.

Dr G. Milner, Health
Department, Vic., public
hearing, transcript, p. 931

TREATMENT

We have already referred at the beginning of this booklet to the assumptions about drug dependency which are implied in the notion of "treatment". Does this imply "sickness"? Are all users of illegal drugs "sick"? If so, is the sickness treatable?

There seems to be a quite widespread attitude which lumps together all users of illegal drugs as "addicts". Against this is set the professional view of workers in the treatment areas who tend mainly to see narcotics users, especially heavy users, and who take a much narrower view of the scope of treatment. It seems clear that if *all* illegal drug users had to be "treated", as some comments to us suggest, the treatment services would be inundated by thousands of cannabis users who, we understand, have neither withdrawal symptoms nor signs of disease.

On the other hand, there are also very many people who have become dependent on certain legally available drugs, such as analgesics, tranquillisers, sedatives and hypnotics, and who are being treated within the general medical services, not in specialised drug clinics or institutions. They are therefore not stigmatised as drug users or addicts in need of treatment any more than those who are addicted to tobacco.

It is against this background that we have received evidence regarding "treatment", most of which has concerned narcotics users and the range of treatment facilities available to them. The variety of these facilities and the differing opinions expressed as to their quality perhaps indicate that none of these facilities is particularly effective. Increasingly it is seen that drug dependency, like alcoholism, is not a simple medical "disease" for which some straight-forward medical "treatment" may be suitable. We are advised by workers in the field, and by others who are in contact with drug dependency, that the community should look primarily to prevention and early detection of drug use rather than late treatment, and to rehabilitation methods that are more socially supportive of the drug-dependent person and less purely "clinical". Looking at "treatment" from a broader perspective, it seems that treatment of drug dependence may move to include education of children and adults concerning the use of drugs, community prevention, personal care and social support for the dependent person, and rehabilitation with no stigmatisation.

If the priorities for treatment programmes relating to drug use were to be determined by the costs to society and the costs to the physical and psychological well-being of the user (and of those close to him), then it seems from what we have heard so far that the problems warranting attention in order of priority are:

1. heavy use of alcohol;
2. heavy use of analgesic, tranquillising, sedative and hypnotic drugs;
3. heavy use of narcotics;
4. heavy use of other illicit drugs.

As mentioned earlier, most of the evidence we have heard about present treatment practices has concerned the treatment of narcotics users, rather

In our training we were told that these people could only be handled within a unit set up to handle drug addiction. Now in the surgery you have a problem as to where to send that person. I know there's the Drug and Alcoholic Treatment Board and that's where, in practice, they should go. Now you physically have to get them from your surgery to that Board. It's a bad name. They resent that name . . . I think just the coldness of it—the Drug and Alcoholics Board. When you mention that name, you see a barrier come up, particularly amongst these younger groups . . . you're not sure that they're going to get there. Also, when they get there . . . obviously the people treating them are not sure, either, that their treatment is going to be successful . . .

General practitioner, meeting of the AMA, transcript, pp. 6-7

The real goal of any therapeutic procedure should be really modification of [the addict's] behaviour, and that really means it involves teaching him a completely new way of life, new way of coping with society . . . his own personal difficulties which he never verbalises . . . He always projects the blame on someone else. Unless he accepts this and comes to terms with his own problems, he is never safe.

Dr J. W. Gabrynowicz, public hearing, transcript, p. 95

One of the things that drug-addicted people need to know is that the person they are going to see is actually committed to helping them, because if there is not the commitment there, then why should there be a commitment on the part of the person going for help?

Mr W. D. Crews, Wayside Chapel, public hearing, transcript, p. 656

In the field of addiction the single most important criterion or tool to make a prognosis is not the actual drug that the person is dependent on or the actual physical severity, but his social stability which can be measured in the past.

Dr J. W. Gabrynowicz, public hearing, transcript, p. 91

If we see a need of medical treatment of any kind, particularly of drug users, we will do everything we can to see they get that treatment and by whatever means we can, by persuasion, by what other means are available to us. We recommend them as people who are in trouble and need help.

Assistant Commissioner E. L. Calder, S.A. Police Department, public hearing, transcript, p. 223

The end point in heroin addiction is so damaging to the person that there is a very good argument for gaining early access to the user and in my mind I can justify doing that because although it may transgress the civil liberties of the person the gains to the person are so great.

Dr R. G. McEwin, Chairman, N.S.W. Health Commission, public hearing, transcript, p. 1307

Whatever is offered to the addict, it has to present to him an alternative to the drug culture and his dependence on it. It is a mistake to think that we are trying to assist an individual against an addictive chemical. We are offering an alternative to the sub-culture of which the addict is a part.

Mr M. A. Griffiths, submission, p. 10

than of the numerically greater number of people who are dependent upon legally available drugs. In part this reflects the exclusions from our terms of reference. It also may reflect the fact that heavy narcotics users, like alcoholics, are treated in clinics separate from other patients in treatment. These treatment facilities are socially stigmatised to a certain extent, through popular association with "skid-row" alcoholism and the image of the "drug addict" as a dangerous or crazed person. Indeed those who run drug dependency clinics sometimes give them neutral names so that people needing help with a drug problem are not deterred from seeking assistance.

Two of the questions which particularly interest us are these: when is a drug user seen as sick and needing treatment, and why does such a person seek treatment?

Some have told us that drug users require treatment as soon as their use of drugs interferes with their day-to-day functioning, measured by their capacity for work and their ability to maintain personal relationships, as well as their physical and mental well-being. The user himself may realise his need for treatment in these terms, or the need may first become apparent to a spouse, relative or some other person close to him. Another view is that a drug user is sick only when suffering from a medically classifiable condition, such as hepatitis or a drug-induced psychosis. Again, some reject altogether the "sick" label for a drug-dependent person, and prefer to see drug dependency as a behavioural problem, maybe a learned response, or just another way of coping with a life situation. A related theme is that heavy drug users are essentially bad people who are not in need of treatment at all, but rather deserving of punishment, although this view seems to be less prevalent than it once was.

We understand there are at lease three main ways in which a heavy drug user may come into contact with a treatment facility. He may himself decide that his drug use is beyond his control, or is interfering with his life to an intolerable extent, and so he seeks help. He may suffer from a complication associated with his drug use, for example hepatitis or kidney damage, and seek treatment for that side effect, or his use of an illegal drug may cause him to come into conflict with the authorities and to be referred for assessment to a treatment centre by a court or the probation service. Alternatively, the user himself may seek treatment at that stage in an effort to minimise any penalty that may be imposed by a court, or to avoid threatened action.

More than one person involved in treatment has suggested to us that a person dependent on drugs changes his habits or seeks treatment only when he faces some crisis in his life that forces him to make a decision about the drug use. This crisis may be precipitated by a criminal charge, marital disharmony or an obvious threat to his work or health. It has also been suggested that if laws concerning illegal drug use were relaxed there would be less motivation for drug-dependent persons to consider and to seek treatment. On the other hand, some respondents contend that users in need of assistance may not seek treatment because they fear that the police will hear of their illegal drug use and take action against them at

The longer a person meditates, the greater the diminution in drug usage over time.

Mr V. V. L. Lorenzon,
teacher of transcendental meditation,
public hearing, transcript, p. 420

Acupuncture has certain advantages over drug treatments ... The acupuncture techniques operate analgesically only. Thus the detoxification is able to be demystified, with the addict himself regulating the acupuncture ... However, the most important point I should make about a number of addicts treated by this method is that acupuncture *does* work. I have seen a number of addicts treated by this technique and have been very impressed by the results ...

Mr M. A Griffiths,
submission, pp. 6-7

It seems to me in my limited experience, that the prognosis for a narcotic addict at this stage is very low and some people will talk in the order of less than 10% and others will talk of up to 30%. It all depends on how long you take. If it is a five year cure rate if they are talking of cure the relapse rate would be extraordinarily high. I have read a statement somewhere that "once an addict always an addict", it seems to me that such a euphoria effect would be very difficult to get rid of when one has had that experience.

Anonymous medical practitioner,
public hearing, transcript, p. 1214

The Department of Public Health perhaps knows—I don't know exactly how much they do know about the pathogenesis of heroin addiction. It seems that they—it is almost an ivory tower type of attitude. They decree that certain people shall not, except with written authority, which is infrequently granted, prescribe methadone or take over the management of heroin addicts. I think that attitude should be changed.

Anonymous medical practitioner,
public hearing, transcript, p. 1230

I think it was a complete waste of time trying to treat under threat, under penalty. It's exactly the same as the alcoholic. They have got to be motivated themselves to do something about their problem and recognise that they have got a problem and look for help. If you try to help them against their own inclinations, you are just knocking your head against a brick wall. They have got to have psychological support, because the greatest thing about the alcoholic, when he comes for treatment, is his loss of esteem, loss of face and loss of confidence and if one can help a person to regain these three points in his character, then ... he'll ... do something about re-establishing himself as a citizen.

Hypnotherapist, meeting of
members of the A.M.A.,
transcript, p. 19

some stage. The point is not so much whether or not the fear is justified (the police contend that it is not) but that it exists. Many respondents point out that users who seek treatment for narcotic addiction often do so, not to stop using drugs, but either to reduce the level of tolerance so that it does not then cost so much to maintain the habit, or to tide them over periods when street drugs are in short supply.

In practice, as noted earlier, "treatment" for drug users is organised on an institutional basis only for alcoholics and narcotic addicts. There are several such treatment facilities available in South Australia. They include the out-patient methadone programme of Hillcrest Hospital, which was recently catering for about 60 narcotic addicts, each attending daily. There are also the various facilities of the Alcohol and Drug Addicts Treatment Board (St Christopher's, St Anthony's, Osmond Terrace Clinic and Elura). Hillcrest Hospital and the Treatment Board are both State Government agencies and together handle the largest number of narcotics users. General hospitals also see many users, who, while perhaps not wanting assistance to stop their drug use, need medical help for related conditions such as drug overdose or hepatitis.

There are also several non-government agencies and practitioners who may not see many drug users but who feel they have something to offer in this area and who have given evidence to us. These include hypnotherapists, teachers of transcendental meditation, psychiatrists, psychologists and members of agencies such as Grow and Narconon. The role of private medical practitioners in this field is limited basically to treatment other than with narcotics since they are prevented by law from prescribing narcotics (such as methadone) without permission from the Department of Public Health. Most doctors who have spoken to us think that this restriction is reasonable and are happy to leave the treatment of narcotic addicts to specialist agencies. However, some general practitioners have put the view that they should be able to prescribe narcotics to addicts during the course of treatment if they consider this appropriate for their patients.

In addition, we have been told that a significant proportion of the prison population has a history of heavy use of illegal drugs, although not all of these imprisoned drug users have necessarily been convicted of offences directly related to drugs. The role of prisons as "treatment" agencies should not, therefore, be overlooked.

We have been told that there are several criteria by which the effectiveness of treatment of narcotic addiction may be measured. The area is contentious, but some of the criteria put forward include decrease or cessation of illicit drug-taking, decrease in criminal or antisocial behaviour, improved work record, improvements in relationships with non-drug users and an increased feeling of well-being by the user.

The effectiveness of programmes in Australia and in other comparable countries in "curing" narcotic addicts of their drug-taking seems to be very low. From what we have been told, the programmes in South Australia are no different from those elsewhere. However, there appears to have been no thorough long-term evaluation of the effectiveness of any programmes available here and assessments of the "success" rate appear to be based only on anecdotal reports or the impressions of staff.

The suggestions I propose [for limiting the use of a methadone clinic] are firstly, that patients who attend here provide proof of identity and also provide a signed photograph. Secondly that we establish a clear state of physical dependence before methadone is considered, and at the minimum this would mean the administration of a Narcan test. Thirdly, that initial physical examination and appropriate investigations be done and that provision of repeat physical assessments at regular intervals occur . . . there is quite a lot of literature . . . about the medical status of opiate addicts, and how their health profile would be similar to that of a man in his late middle age. Fourthly, I suggest that we should really have only daily attendance for receiving methadone rather than have them taking methadone away from the hospital. Fifthly that all new patients were to have an adequate trial of drug-free management before being considered for methadone management. Sixth, that there be a temporary banning from treatment if they were found to be using or trading in illicit drugs, or trading in our prescribed drugs. Seven, that patients be managed under a contract system where they are aware of treatment policies and know the consequences of breaking that contract. Eight, random urine tests with no appeal against the results. Just expanding on this, there is, apparently, a means where urine tests can be done with an instantaneous result given on the premises . . . Nine, that provision of inpatient treatment be perhaps obligatory for new patients. Ten, geographical separation of patients attending for methadone medication and those endeavouring to become drug-free.

Meeting, Hillcrest Hospital
medical staff, transcript, pp. 5-6

Methadone has become a replacement treatment based on the fallacious assumption that some drug abusers cannot live without synthetic opiates. It is common knowledge that many young drug abusers, who might never have been really addicted to any drugs, have become addicted to methadone, which has become the panacea for the addict and has been grossly misused.

Dr J. W. Gabrynowicz,
submission, pp. 7-8

My own personal view of methadone is that if you look at variables such as future employment and arrest rate, then methadone is a clear winner, and I think people who object to it seem to be objecting more on ideological grounds that these people are remaining addicts. Well, so what? If their addiction is not causing them problems and they are able to maintain a job and stay out of gaol, that's a plus.

Meeting, Hillcrest Hospital
medical staff, transcript, p. 11

I would like to point out that as a drug of treatment [methadone] is a compromising second choice—with the logical first choice being the drug to which the individual is addicted.

Mr M. A. Griffiths,
submission, p. 10

Methadone is often used as a kind of bait to keep [the addict] in some kind of therapeutic relationship with the treatment agencies.

Miss Rosemary Taylor,
social worker, public
hearing, transcript, p. 686

There is no such thing as [methadone] blockade. . . It is analogous to giving somebody with a drinking problem a bottle and a half of Scotch a day. If he then goes out and thinks "I will sneak up and have a glass of beer that they don't know about". . . he is unlikely to notice any effect from it.

Dr G. Milner, public
hearing, transcript, p. 944

My feeling about [methadone] is that what it is doing is providing a drug for people who are saying they want to get off drugs, and that seems to be a contradiction in terms.

Miss Rosemary Taylor,
public hearing, transcript, p. 868

Each method or programme seems to be successful with a small percentage of narcotic-dependent people and it has been suggested that having a wide choice of programmes is desirable, since it maximises the chance that each patient will find his way to a programme suited to his particular needs. From what we have been told the choice of the general method of treatment to be used in each case of narcotic addiction is made by the individual concerned. Most narcotic addicts in South Australia know, or know how to find out, what treatment is available at each agency and they select accordingly. Thus if a narcotics user wants a methadone programme he goes to Hillcrest rather than to St Christopher's; if he wishes to attempt a drug-free regime he is more likely to contact St Christopher's. It has been suggested that a more effective use of resources might result from coordination between agencies, especially if there were a central assessment panel which, in consultation with the user himself, could determine which method of treatment would be appropriate for that user.

There are several areas of controversy in the treatment of narcotic dependency, and submissions to the Commission have reflected this.

There is the question of the use of methadone. Methadone is a synthetic narcotic, which is given to narcotic addicts in controlled doses and which is said to remove the need for other narcotics (including heroin), thereby providing an opportunity for the user to stabilise his life. Opponents of methadone tell us that it only re-emphasises to the user his need for drugs if he is to lead a "normal" life; that if methadone is used incorrectly it can create addicts where there were not real addicts before; and that it is difficult to modify anyone's behaviour when they are under the influence of a psychoactive drug. On the other hand, supporters of methadone say that it is not meant to be a curative agent but a stabilising *legal* drug which can be taken while addicts consider and improve other areas of their lives without having to worry about obtaining supplies of *illegal* drugs.

Another controversial issue that has been raised is whether facilities for the treatment of drug users should be segregated from those for alcoholics or from those provided for general health care. Supporters of providing integrated facilities say that a segregated facility tends to isolate and stigmatise the users, reinforcing group behaviour and the negative self-image that many of them have. They also say that if a drug user can go for treatment to a general health facility he is less likely to be socially stigmatised as an addict and may therefore present for treatment at an earlier stage. Supporters of segregated services suggest that treatment of drug users requires special skills and so should be regarded as an area of specialisation. They also suggest that drug treatment may receive a higher priority in funding if it is not viewed as part of an overall health care programme.

We have been told about the so-called "diversion" programme that is operating experimentally in some Magistrates' Courts in New South Wales. Under this programme, which began as a new approach to the problem of drinking drivers and was extended to narcotics users, persons convicted of certain offences related to narcotics are given the choice of either being sentenced in the usual manner or being remanded after conviction for eight weeks. During this remand period the offender is

Our policy should be more concerned with integrating services for addicts within the general health services, so that they are not isolated and stigmatised.

Mr A. P. Diehm,
N.S.W. Health Commission,
public hearing, transcript, p. 1269

There's a lot of bitterness between drug addicts and alcoholics. Alcoholics think drug addicts are the scum of the earth—that's a general attitude—and drug addicts think alcoholics don't understand, and they just don't get on together. As one [drug addict] out of a group of 30 people, he just didn't get on, he was different and if he tried to bring up his problems in groups, he either felt funny doing it because his problems were different, or the alcoholics didn't want to help him or consider his problems because he was a drug addict . . .

Meeting of Hillcrest Hospital
medical staff, transcript, p. 15

The fact that drug addicts want to segregate themselves from other clients is part of their desire to reinforce their own negative self image; they want to establish their identity as being a social, as being a different group, and what they want in the treatment is simply a reflection of what they want in society. They want to see themselves as being shut off as an elitest group.

Mr A. P. Diehm, public
hearing, transcript, p. 1274

The people who are coming to those integrated centres show a tremendous concern to disassociate themselves from the drug scene, the drug subculture and once they have experienced this integrated programme they are very reluctant under any circumstances to go near those centres that rely on methadone; because as I say, the pressures there are for them to keep using, to be tightly associated with the drug scene.

Mr A. P. Diehm, public
hearing, transcript, p. 1271

We saw [the N.S.W. Drug Diversion Programme] as an opportunity to fit in with our early intervention philosophy and it is very encouraging to find this has happened.

Mr A. P. Diehm, public
hearing, transcript, p. 1300

The fundamental philosophy is to avoid penalties altogether and to offer treatment as an alternative to penalties . . . We are not, and have been quite determined from the beginning, not making this an easy way out for the pushers to avoid punishment.

Mr A. P. Diehm, public
hearing, transcript, p. 1302

"diverted" to a treatment centre where he is given an intensive assessment as to the extent of his drug use and his motivation to cooperate in its treatment. At the end of the remand period the court is provided with a report from the treatment centre which is considered when passing sentence. The sentence is usually an unconditional discharge or discharge on a bond to continue treatment. The remand period may also be extended for another eight weeks so that further assessment may take place.

We are told that offenders coming within the scope of the diversion programme tend to be different from those who would otherwise attend for treatment. They have more social resources, are more often employed, have a shorter history of drug use, and are more likely to choose to go on a drug-free regime that a methadone programme. It appears that many continue in treatment even after they have been given an unconditional discharge by the court. According to the evidence presented to us by the Health Commission of New South Wales, the response to that diversion programme has been favourable from the point of view of both the offenders and the relevant authorities. The evidence relating to the programme has raised a number of interesting and important questions that require careful consideration. For example, is the participation of offenders in the programme truly voluntary, in the light of the alternatives realistically before them? If not, is a policy of involuntary treatment consistent with the proper objectives of the criminal law?

A related area of concern to us is whether treatment should always be on a voluntary basis or whether compulsion can be justified in some circumstances. Some evidence suggest that only voluntary treatment programmes are likely to be successful in attaining their goals; others contend that compulsory treatment (sometimes called civil commitment) has a role to play. While there would seem to be a clear-cut distinction between the two alternatives, in practice it often may be difficult to distinguish between them, in that a person who is apparently appearing for treatment voluntarily in fact may be under economic or social compulsion. This may be because of pressure from his employers or family. An impending court appearance may not be very different. One person has suggested that the concept of voluntary treatment is in fact a myth and that all people are coerced in some manner to accept help. If civil commitment is to be comtemplated questions are raised about the means of safeguarding the rights of the patient both at the stage of commitment and during the period of treatment.

The system requires all reporting authorities (i.e. those drug firms licensed to import, export, manufacture, formulate or distribute specified drugs) to report their transactions each week. The system extends to an outgoing wholesale level. The information provided by these sources is the basic data which is routinely gathered for their internal record-keeping and invoicing procedures.

Based on this information a variety of routine and special reports are produced by the Department of Health's computer for the State health authorities and other interested bodies for information and analysis . . . One report details all inter- and intra-State movements between reporting authorities and non-reporting authorities . . . also shown are imports and exports, loss, larceny, controlled and accidental destruction, manufacturing and formulating processes.

Another report lists all those hospitals and pharmacies whose purchases of a particular drug from all sources exceed a pre-determined level.

Commonwealth Department of
Health, submission, Appendix X, pp. 3-4

Although there is a licit supply of Narcotic Drugs in Australia, it does not represent a problem as:—

(a) The writing of prescriptions is controlled.
(b) The distribution system is also controlled, down to separate security storage at each stage of movement with appropriate signatures to establish responsibility.
(c) The total system is monitored by the Australian Health Department on a weekly basis and all issues are checked.

Australian Pharmaceutical
Manufacturers' Association
submission, p. 2

The Commonwealth Government and the Minister of Health are adequately advised in relation to therapeutic goods and their uses . . . In fact it could be said that there is over-control, over-use of manpower and resources, which could be either used more effectively or reduced in the public interest, especially the taxpayer—without increasing the likelihood of any health hazard.

Australian Pharmaceutical
Manufacturers Association,
submission, p. 15

Control is so easily abused because it presumes that the people who have the responsibility for this control are responsible, and they are most certainly not. I can cite instances of abuse through warehouses where someone goes into a warehouse, gives the name of a doctor and they are supplied with prescription preparations. It's very simple and no one thinks any more of it but it is happening, and I heard only today of one medical practitioner who had his car serviced free, permanently, because his service station proprietor was able to go to a particular warehouse, quote the doctor's name, get as many amphetamines as he wanted and then supply them to the truck drivers.

Pharmacist,
meeting of members of
Lions Club of Adelaide Flinders,
and the Apex Club of
Burnside, Inc., transcript, p. 30

SOURCES AND DISTRIBUTION OF DRUGS

The Commission is advised that drugs and substances of dependence that are used in the ways envisaged in our terms of reference come mainly from the following sources:

- Drugs prescribed in good faith by doctors but then diverted to non-medical use, including use to maintain a dependency created by the prescribed drugs.
- Drugs legally available for open sale.
- Drugs obtained by forged or otherwise fraudulently obtained prescriptions.
- Drugs improperly supplied by doctors or pharmacists.
- Drugs stolen from doctors, pharmacists, wholesalers or manufacturers' stores, or while in transit.
- Drugs illegally manufactured within Australia.
- Plant materials illegally grown in Australia.
- Plant materials growing naturally in the wild in Australia.
- Substances (such as petrol or solvents) that are legally available for the purposes of industry or commerce.
- Drugs or substances (particularly cannabis and heroin) that are illegally imported into Australia.

We have considerable evidence on the legal and administrative controls which apply to the importing and distribution of pharmaceutical substances that are used medically in Australia. These controls are managed through a combination of Commonwealth and State agencies and committees. Apparently, the controls have served to limit large-scale losses or pilfering at the wholesale level, although some claim that the controls are insufficient.

We are informed that narcotics, cannabis, amphetamines, barbiturates and psychotropic drugs are smuggled into Australia. For the most part these do not enter through South Australia because it is not the first port of call for overseas ships, neither does it have an international airport, nor is it near enough to South-East Asia for the purpose of illicit visits by small aircraft or boats. The main source of illegal opium is an area of Burma, Thailand and Laos, and it is illegally processed into heroin in the same area or in other parts of Asia. A few illicit heroin manufacturing laboratories have been found in Australia, but none in South Australia.

Heroin is distributed in Australia and in South Australia by clandestine organisations that cannot readily be penetrated by the conventional law enforcement and police methods. But the drug passes to the lower levels of illegal distribution by street dealers who are more open to police detection and arrest. Heroin is "cut" or adulterated with inert powders or other impurities as it passes down the lines of illegal dealers, and what was a

It is extremely difficult to secure evidence sufficient to show the true magnitude of any trafficker's illegal activities. Consequently the charges relate only to what can be proved against the offender. The Defence has a further advantage in that it can lead in mitigation almost any material which cannot be disproved by the Prosecution. Consequently, traffickers receive penalties which are disproportionately low when related to the tremendous profits which they receive from their illegal transactions.

South Australian Police
Department, submission, 8.02

Where the big key source is, if only we knew and it's so hard to get to them because they're very careful, these big drug scenes. Like Indian hemp they're not quite so careful, but with heroin, there seems to be, like half the time, the main pusher that's actually distributing it, he doesn't know who he is getting it from, it's a very sinister sort of middle-of-the-night arrangement, and he couldn't tell you himself.

Meeting of members of
the Police Association of S.A.,
transcript, p. 17

We have had a number of students come to us in Sydney with a sample of marijuana that they claim must be "spiked" because they have an adverse reaction, and they describe the adverse reaction. On analysis this has proven not to be adulterated in any way, but really to be a higher concentration than that to which they are accustomed. Most of the marijuana seized in Australia is of the order of 1% THC, 1 to 2% THC. These samples that were brought to use were of the order of 3 to 4% THC, from memory, and this just like someone who is accustomed to drinking a middy of beer without being told suddenly drinking a middy of sherry . . . So I think the variation in the potency of the available samples of THC may be responsible for some of the adverse effects.

Dr G. B. Chesher, Reader
in Pharmacology, Univ. Sydney,
public hearing, transcript, p. 252

fairly pure product may finally reach the street at only 5% to 15% of its original strength. Because of this enormous variation in strength when it reaches the street level, the dangers of overdosing through ignorance of the true strength of the drug are increased; on the other hand, many people have bought "heroin" which contains little or no heroin.

Practically all users of heroin are dealers to some extent—they buy a small amount and sell it, sometimes at a profit, sometimes not, to support their own habit. However, they cannot be classified as pushers in the sense in which that word seems to be commonly used. This distinction is a difficult one to apply, particularly in terms of legislation, and the figures of arrests and convictions given by the police here probably do not match the true situation. As noted elsewhere, the police point out that it is difficult to distinguish between the user/dealer and the true pusher at street level, and doubly difficult to prove a trafficking offence to the satisfaction of a court.

We are informed that some cannabis leaf and other cannabis products such as hashish oil are smuggled into Australia, but that most cannabis used in this country is grown here. The Australian climate is very suitable for it. There have been major cultivations detected in all States, including South Australia, though the largest crops are believed to be in New South Wales and Queensland. There has been no direct evidence given to the Commission that "lacing" of marijuana occurs, although it is frequently alleged by users that some marijuana has been adulterated with foreign substances, ranging from heroin to rat poison. However, the evidence from State and Federal government analysts does not appear to support the allegations. Other evidence suggests that variation in the strength of the active constituents of the drug might account for most of these claims.

Some submissions to the Commission have assumed that the traffickers of narcotics are the same people who sell marijuana. Consequently they argue that users of marijuana are likely to become users of narcotics because the supplier is the same, and pressure will be brought to bear, if there is a shortage of marijuana, for heroin or other narcotics to be bought instead. Others dispute this, claiming that, for the most part, illegal dealing in cannabis is largely through organisations separate from those dealing in narcotics. There is some evidence that the black markets which handle prohibited substances tend to be surrounded by the types of crime (bribery, standover tactics and violence) that were associated with the period of prohibition of alcohol in the U.S.A. However, the scale of these activities in South Australia seems to be small compared with some other Australian States, even taking account of differences in population.

While . . . it seems clear that there is no intrinsic reason why users of [the opiates, heroin and L.S.D.] cannot lead socially useful lives provided use of the drugs is decriminalised it may be that full legalisation of these drugs should await the forging of stronger social controls to govern their uses. Hence [it is suggested] that, again as an interim measure, possession and use by competent adults of the opiates (including heroin) and L.S.D. be decriminalised immediately, and on-going social and pharmacological research be carried out to ascertain the feasibility of further changes to the law.

Mr D. Brown, Univ. N.S.W., submission, p. 30

I don't think we have any right whatsoever to stop people from growing it, or possessing, or using marijuana . . . There is nothing to be gained whatsoever by continuing its illegality. In fact it is hypocritical to make it illegal while we allow alcohol which is certainly more destructive than marijuana.

Meeting, Young Liberal Movement of S.A., transcript, p. 8

It is an illogical practice prohibiting commercial dealings, yet permitting use and possession of small quantities. Unless one has a marketing board or a government distribution system, one will create the demand and yet prohibit the supply.

D. G. Letcher, barrister, public hearing, transcript p. 667

. . . I can only say that marijuana is an extremely harmful drug. If you are going to decriminalise it and allow people to have it, ultimately you are going to destroy the psyche of these individuals.

Dr H. B. Kildea, general practitioner, public meeting, transcript, p. 410

I think that alcohol's become socially acceptable now, and we are stuck with that. Why put this other burden on us of, say, marijuana? You are only . . . opening another avenue and we know how much it costs Australia in the workforce alone by the use of alcohol and how it's affected the workers and the time and the manhours lost per year. Is this marijuana only going to lead to more people becoming involved? Most of us agree that alcohol is bad, why legalise marijuana and add another avenue, another tangent?

Meeting, Young Liberal Movement of S.A., transcript, pp. 12-13.

The goal of government should be the enhancement of the opportunity of each person to grow to full responsibility and maturity not only as an individual but also as a contributing citizen in the community, recognising the pitfalls that keep people from realising this goal, such as the taking of harmful drugs and other harmful influences which the weak and the young and immature so easily succumb to.

Dr C. Sprague, GROW, submission, p. 9

. . . I don't care which way you look at it, if it is decriminalised, to me it's encouraged. I don't care how you wrap it up, what parcel you put it into, . . . it's being encouraged. In other words, it's getting virtually the stamp of approval. Even though it's against the law, they're making it a lesser thing than it was. It's not serious any more, so automatically you're going to have more people smoking it.

Meeting of members of the Police Association of S.A., transcript, p. 13

GOVERNMENT POLICY

Most people would say that the principal justification for establishing a Commission such as ours is the need to formulate a coherent government policy relating to the non-medical use of drugs. Indeed the fact that so many governments in the Western world have in recent years established similar Commissions is itself evidence that governments everywhere are searching for more satisfactory drug policies.

Very few of the submissions made to us direct their attention to the basic questions of the goals that the South Australian Government should seek to achieve in framing its policies on drugs. The reason for this is clear enough. It is extraordinarily difficult to make sense of existing government policies relating to drug use and perhaps even more difficult to develop a philosophy which is capable of being applied consistently in practice. Time and again we are told that it is inconsistent for governments to forbid the sale and use of marijuana on the ground that the substance is harmful to the user, yet at the same time actually tolerate the heavy consumption of alcohol and tobacco which can be very much more harmful both to the individual user and, ultimately, to other people in the community. Others argue that it makes little sense for governments on the one hand to act as though narcotic addicts are sick people in need of sympathetic and supportive treatment and on the other to impose harsh penalties on them for conduct which is the direct product of their addiction. Professor F. A. Whitlock of the University of Queensland points to a paradox created by the suppression of narcotics use.

> If opiates are taken regularly in known dosage, and if injected with proper aseptic precautions, the risk to life and health is remarkably small. But the more government restricts the supplies, the greater is the need for the addict to obtain them illegally; with far greater hazard to his health as a consequence.

Most submissions suggest changes in particular aspects of government policy. Many are detailed and well reasoned. However, not surprisingly, they do not always fully analyse the consequences of their proposals in the broader context. Proponents of the decriminalisation or legalisation of marijuana rely on the importance of protecting the freedom of the user but sometimes appear willing to limit the freedom of users of other substances, such as analgesics, in order to curb abuse. Those who argue that the solution lies mainly in applying more severe criminal penalties to "pushers" and users tend to overlook the difficulties of enforcing the criminal law, the failure of imprisonment as such to "cure" addiction, and the fact that an almost limitless variety of substances can be abused by anyone who is sufficiently determined to do so. Submissions emphasising the treatment approach are sometimes unsure about the proper relationship between treatment programmes and the criminal justice system, and the role, if any, of compulsion in the treatment of drug users.

The objective of reducing the availability of *all* drugs, which is seen as an appropriate social response (since the overuse of *all* drugs is linked to the *abuse* of some drugs) would require tighter drug laws governing the type, amounts, and channels of availability of drugs.

S.A. Department of Public Health, submission, p. 24

The Cannabis Research Foundation recommends that a discouragement policy be adopted towards the recreational use of all drugs, including alcohol, tobacco and marijuana. This policy should be implemented by a public education campaign aimed at warning users and potential users of the risks involved with the use of all recreational drugs. Such warning should reflect honest scientific and medical concern. Similarly advertising which encourages the recreational use of drugs should not be permitted.

Cannabis Research Foundation, submission, p. 11

Aims:

(2) To resist influences that lower moral standards and threaten human dignity.
(3) To research the social implications of biblical ethics and the effects of modern trends on family and community life.

Festival of Light— Community Standards Organisation (S.A.) Inc., submission, p. 13

Libertarians would argue that self-regarding acts, i.e. acts not harmful to other people, as distinct from other-regarding acts, should not be sanctioned by the law, even if these self-regarding acts are physically or morally harmful to the individual concerned.

> "He cannot rightly be compelled to do so or to forbear because it will make him happier, because in the opinion of others, to do so would be wise, or even right."
>
> *On Liberty*, ch. 1.

. . . I fully recognise the difficulties of the other-regarding/self-regarding distinction. Sufficient to say now that I treat it rather as a practical imperative than as an inviolable distinction. Furthermore, there is no doubt an archaism about the individualism of Mill in our more collectivist age. Finally, he clearly underrates the forces of a paternalist argument based on physical harm.

S.A. Council for Civil Liberties, submission, pp. 2-3

We believe "the effective discharge of the Commission's responsibilities" . . . requires the frank recognition that philosophical assumptions and opinions cannot easily be dissociated from any submissions, however factual, and that these assumptions frequently colour our judgment. For instance, [the] Festival of Light/Community Standards Organization supports the absolute moral standards of the Judaeo-Christian ethic. This position distinguishes us from others whose ethic is described by themselves as "relative".

Festival of Light—Community Standards Organization (S.A.), Inc., submission, p. 2

Despite the difficulties, there seems to be a measure of agreement on some important questions. No one seriously argues that J. S. Mill's famous dictum, that the

> only purpose for which power can be rightly exercised over any member of a civilised community, against his will, is to prevent harm to others,

should be used as the sole basis for government policy, without some qualification. It seems to be generally accepted that restrictions can and should be placed on the supply and use of substances sufficiently dangerous to the user, although not necessarily by means of the criminal law. On the other hand few express support for an absolutist moral position which implies that the criminal law should be used to enforce moral standards, without the need for further justification.

A common positive theme in submissions is the desirability of achieving a reduction in the level of drug use in the community. Some express this narrowly, confining their concern to the illegal consumption of drugs. Others put the argument more broadly, relying on overseas studies suggesting that the level of use of all drugs may be related to the degree of abuse of drugs, legal and illegal. The belief that drug use should be reduced is not necessarily linked with an expectation that government action of itself could or should bring about this result. It is frequently suggested that the drug "problem" is basically one of human behaviour responses to particular social or psychological pressures—which can be controlled only by changes in attitudes to drug use and to the accepted means of meeting the needs now served by drugs. This approach places less importance on government policies relating to the availability of drugs, law enforcement and treatment, than on changes in lifestyle, in which education programmes may play an important role.

Most of the submissions which focus on a single drug concern themselves with cannabis. Here there is much confusion of language, submissions employing the terms legalisation and decriminalisation in a variety of senses. Not all sought reform, but those that did had suggestions that ranged as follows:

- Allowing cannabis to be produced, sold and advertised commercially in the same way as alcohol and tobacco.

- Establishing a government-controlled production and distribution system designed to achieve quality control and to avoid the dangers of commercial exploitation of the drug.

- Removing criminal penalties attached to the cultivation or possession of marijuana for personal use and to the limited distribution of the drug without financial gain.

- Removing criminal penalties for the conduct referred to above, but imposing standardised "civil penalties", such as relatively small fines, instead. This appears to be what most submissions refer to as decriminalisation, and, broadly speaking what is advocated by the Senate Standing Committee on Social Welfare, in its 1977 report, mentioned previously.

We strongly believe that if someone's life is damaged because of a certain product, then the people who manufactured that product should be forced to contribute towards rehabilitation of the person they have, in a sense, destroyed.

Mr W. D. Crews, Wayside Chapel, public hearing, transcript, p. 647

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.

Australasian Society of Nephrology and the Australian Kidney Foundation, Analgesics Subcommittee, submission p. 5

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.

Proprietary Association of Australia, submission, p. 14

A number of submissions were concerned with the need for change in the regulation of certain other drugs, principally compound analgesics (preparations containing more than one analgesic drug) and certain prescription drugs. Kidney specialists argue for implementation of the NH & MRC recommendation that compound analgesics should be available on prescription only, and not over the counter. The Proprietary Association of Australia contends that such a step is unnecessary in view of what they say is the relatively small number of heavy users of compound analgesics. It is also suggested that certain hypnotic drugs presently available on prescription should be more rigidly controlled, because of the possibility of abuse.

The unsatisfactory aspect of drug searches is related more to the inability of the searching officers to find the drugs than to the inadequacy of the law itself.

S.A. Police Department,
submission, 8.01

. . . one bloke I arrested who was trafficking —most of them traffic, most heroin users end up trafficking because it's the only way they can support their habit. . . See, you buy it in bulk, you cut it, and if it cost him $500 to buy, he'd sell it for $1000, so half of it would be sold, the other half he would be looking after his own habit, so virtually he wasn't making any profit, but he was making enough to support his own habit.

Meeting of Members
of the Police Association of
S.A., transcript, p. 16

Let's face it, we've got virtually no assistance, and we've got all the rules in the world which we've got to abide by for our own protection, our individual protection. There's no rules for them at all, no boundaries, no financial problems. They've got everything going for them.

Meeting of Members
of the Police Association of
S.A., transcript, p. 18

. . . it is obvious that drug offences cannot be combated by merely responding to reports which come to the notice of the Police by conventional means. This is because there are no victims of crime in the usual sense. Furthermore, the information which comes to the Department through the medium of informers and the like has been found frequently to be unreliable. Sometimes this is contributed to by lack of precision or genuine mistake on the part of informers, but on other occasions can be attributed to maliciousness. Whatever the causes it is necessary to make preliminary enquiries to reduce risk of embarrassment or harassment.

S.A. Police Department,
submission, 7.03

. . . the defence can tell the Court anything they like in relation to mitigation, they can tell all sorts of sob stories which many times are complete lies but the Crown is very loath to ever challenge what the defence says in relation to penalty. I can only ever recall it happening once when the Crown did get a bit upset about what was said, but they tell some tremendous sob stories which are pure fabrication nine times out of ten and we've got to sit there and listen to it. It's just an unfortunate thing, but the penalties—well, that's the way the Courts are handling penalties at the moment, but that reflects their attitude to marijuana.

Meeting of members of
Police Association of
S.A., transcript, pp. 7-8

ENFORCEMENT OF THE LAW

Some submissions make comments on the difficulties of detecting and successfully prosecuting persons involved in the illegal cultivation, production, distribution, possession and consumption of drugs. Both South Australia and the Commonwealth have legislation governing these matters; the principal South Australian legislation is the Narcotic and Psychotropic Drugs Act 1934-1977, and the principal Federal legislation is the Customs Act 1901. Mostly the legislation concerns itself with illegal possession of, or other dealings with specified drugs, including the forging of prescriptions. But there are also offences such as theft from pharmacies, or unlawful attempts to obtain money in order to buy narcotics, while although directly related to drug use are in fact covered by other general areas of the law. These are all important and within our area of interest.

The South Australian Police Department made a detailed submission to us, but the authorities directly responsible for enforcing Federal legislation did not. The problem of law enforcement from a national perspective is one of the matters now under consideration by the Australian Royal Commission of Inquiry into Drugs, chaired by Mr Justice Williams.

The South Australian Police point out that it is very difficult to detect those primarily responsible for illegal trafficking in drugs of dependence, particularly narcotics. This is partly because of the relative ease with which valuable but not bulky consignments can be smuggled into the country and transported within it, and partly because of the difficulty in distinguishing between dealer and user at lower levels of distribution. The network of distribution is said to be structured so as to make it very difficult to pinpoint the key persons, whose identities vary over time, engaged in trafficking. Since there are no "victims of crime" in the usual sense the police cannot rely on complaints to give them leads, and information provided by informers tends to be unreliable. "Covert observations" are undertaken, and information exchanged between law enforcement agencies, but the South Australian Police Department indicates that these practices are not as successful as they would like.

The police, while recognising that their powers are reasonably extensive, suggest that they would be asisted by rather broader powers to search for drugs. They also contend that it is difficult to persuade the courts to impose suitable penalties on offenders known to the police to be engaged in extensive trafficking. This is because the police only rarely apprehend a person with a quantity of drugs sufficient to demonstrate that person's role as a dealer. Consequently, in the opinion of the police, a person known to be a dealer is treated by the courts as a mere user, since the quantity of drugs detected is relatively small. Individual police officers also complain, sometimes with feeling, of the ability of offenders at the time of sentencing to claim mitigating circumstances, which the police believe to be false but cannot disprove.

One theme in submissions, not confined to the Police Department, is that the "drug problem" has grown to its present proportions precisely because courts do not impose sufficiently severe penalties on offenders.

On the face of it the powers appear to be exceptional and comprehensive, whereas in fact the requirement to obtain a warrant is restricted to a specific time and place, and can result in delays which render the subsequent search ineffective.

S.A. Police Department,
submission, 8.01

However, we are not satisfied necessarily that the Courts make the best use of the punitive provisions. The Police, as a class, tend to be critical of the Courts for what they claim to be unreasonable leniency in sentencing some offenders. One of the motivators is that the Police are influenced by knowledge or suspicions which cannot be proved or led in evidence. However, we wish to draw a distinction between this attitude as it applies to crime generally and drug offences. It is acknowledged as being unreasonable for the Police to expect that a Court could, or should, infer any regularity in conduct when an accused is convicted of an isolated crime. For example, a conviction for one charge of rape ought not to be regarded as evidence that a person is a practising rapist. Conversely, unless there is specific evidence to the contrary, a proven charge for possess, use or supply drugs ought properly to suggest regularity in use, possession or supply.

S.A. Police Department,
submission, 8.02

Our operational units also believe that people are less cautious in terms of concealing their use of Indian hemp now than they used to be and it is a prevailing thought amongst police officers that this is attributable in part to the leniency shown in courts.

Superintendent R. McAuley,
S.A., Police Department,
public hearing,
transcript, p. 190

An additional factor which must be taken into account in evaluating the present situation is the extreme difficulty experienced by police in discovering and successfully prosecuting illicit drug possession and use. These difficulties render it most unlikely that any individual drug user will be caught and punished, and it is widely accepted by criminologists that such deterrent effect as a sanction may have is directly related to the perceived certainty, from the point of view of the offender, that he will be caught and punished, rather than to the size of the sanction itself: that is a relatively small sanction which is almost certain to be applied to all offenders will tend to prove more effective than a severe sanction applied in a random or capricious manner.

Mr D. Brown, Univ.
N.S.W., submission, p. 10

So many young drug offenders who are apprehended and brought to courts are let out on probation and the courts have become a laughing stock because they are on good behaviour bonds for a year or two during which time they do what they like.

Dr J. W. Gabrynowicz,
Alcohol & Drug Addicts
Treatment Board, S.A., public
hearing, transcript, p. 90

Law enforcement is said to be hindered by the knowledge, shared by the authorities and law-breakers alike, that certain kinds of offences attract lenient treatment in the courts. As always the submissions contain counter-themes. Some argue that certain offences, like dealing in small quantities of marijuana, simply do not warrant harsh penalties, since the social harm caused is minimal. Others argue that the more serious offences are often committed by narcotic addicts whose long-term patterns of behaviour would not be changed by a term of imprisonment or the threat of imprisonment. The scepticism about imprisonment as a means of reforming addicts brings up the difficult question of whether courts should use their powers to "divert" drug-takers to treatment agencies, a matter referred to earlier.

The responsibility for law enforcement is not confined to the South Australian and Commonwealth Police forces. We have been given detailed information concerning other bodies involved. The South Australian Department of Public Health, for example, enforces restrictions on the freedom of doctors to prescribe narcotics to patients, thus limiting the possibility of diversion of drugs to improper purposes. The Commonwealth Department of Health, following a 1969 recommendation of the National Standing Central Committee on Drugs of Dependence, has established a computer-based system to collect, collate and disseminate information on all interstate and intrastate movements of drugs covered by the United Nations Single Convention of Narcotic Drugs 1961, to which Australia is a signatory. This is known as the Drugs of Dependence Monitoring System and is designed, among other things, to identify losses of drugs and unusual trends in drug consumption. There are other forms of control exercised over people, such as manufacturers, doctors and pharmacists, authorised to handle drugs of dependence, suggesting that the criminal law is not the only means of preventing improper diversion of drugs intended for medical use.

. . . obviously a person who is on heroin is at the stage where they're getting pretty damn close to being addicted, so I think all we can do is for the Government to help them overcome the problem, hopefully, but if you get the guy that sold it to him, and most of them aren't users, they're just straight out pushers, if you can get to them, they're the ones to crucify.

Meeting of members of Lions Club of Adelaide, Flinders and the Apex Club of Burnside Inc., transcript, p. 14

Four important new trends are developing in the definition of, and response to, socially disapproved and destructive drug use. These have occurred primarily in those countries and parts of countries that have struggled longest and hardest to modify unacceptable drug use and only after other approaches have been tried. The first of these new trends is to define the problem in psycho-social terms rather than pharmacological, legal or medical terms, to place increasing emphasis on drug use as behaviour. The second is, often reluctantly, to adopt as a primary goal not the prevention of use but the reduction of the problems associated with destructive drug use. The third is an increasing though not dramatic willingness to put socially disapproved drug use by youth in the context of use of all drugs, legal and illegal, by persons of all ages. The fourth, closely associated with the third, is a willingness to include alcohol as a drug and to consider the implications of its use by adults and by youth.

Helen Nowlis, *Drugs Demystified,* Unesco Press, Paris 1975, p. 17 (submitted by Ed. Dept. of S.A.)

I think that one of the things that any community has got to take some sense of responsibility for is that if it has been alright for us who are older to try tobacco and alcohol, what sort of rights have we got to say that the young people of today haven't got any choice, that they mustn't be involved in drugs.

Public meeting, Whyalla, transcript, p. 22

I would make a suggestion that if we are simply going to legalise one set of drugs and not another, then it's a fairly ridiculous situation. Surely the idea of freedom to virtually choose your own poison must include the right to everybody to have whatever drugs they will.

Meeting of students, University of Adelaide, transcript, p. 24

An obvious result of application of the criminal law to drug users is that all such users become, by definition, "criminals"—with all the stigma, expectations and resultant difficulties both in the mind of the user himself and in the minds of the rest of the community which still accompany that label in modern communities . . . there is still a very real stigma among major sections of the general community (including employers) attaching to conviction (indeed, even arrest) for illicit drug use . . .

Even in terms of their postulated benefits, the social and economic costs of the present criminal system are thus far too high . . .

Mr D. Brown, Univ. N.S.W., submission, pp. 16-17

It is far too easy to push drug dependence out of the public mind, as something unpleasant and best kept under the rug. It is a community responsibility, and this responsibility should be shared.

Mr M. A. Griffiths, psychologist, submission, p. 9

ATTITUDES IN THE COMMUNITY

We took evidence and held public and private meetings in different parts of South Australia. A list of the public meetings and the hearings held by us appears in Appendices B and C. We used informal meetings and arrangements so as to be as accessible as we could to the public, and to any individuals or groups who wished to see us.

Some general attitudes were expressed to us many times. Inevitably these represent the views of some members of the community, and it is difficult for a Commission like this, with limited resources, to become aware of the whole of the community's views on so wide and diverse an issue as the proper use of drugs.

The views we have regularly encountered are:

- A widespread belief that medical drugs are good and non-medical drugs are bad, although this is often combined, somewhat inconsistently, with a belief that doctors tend to over-prescribe.

- A reluctance to recognise that alcohol and tobacco are as harmful or more harmful than presently illegal drugs. Of course this view is not universal, as indicated by the comments concerning the exclusion of alcohol and nicotine from our terms of reference.

- An anxious concern about illegal drug use among the young, most often expressed by thoughtful middle-aged people, usually with children of their own. Mostly the people expressing concern have not come into contact with illegal drugs and do not believe that their children have, although they fear this may happen. These worries of parents are accentuated by media stories concerning drug use.

- A belief, particularly among younger people, that cannabis has been incorrectly classified as a dangerous drug and that this classification should be corrected.

- A willingness to distinguish between the users of illegal drugs, who are usually regarded with some sympathy, and the "pushers", who are seen as the real cause of the drug problem.

We have also heard many minority attitudes. In fact we think we have encountered almost every possible belief, ranging from the view that drug traffickers should be summarily shot, and users transported to offshore islands, to the opinion, not really pressed, that there should be no legal restrictions on the supply and use of any drugs. But such beliefs are held by the few.

Some respondents conclude that the imposition of criminal sanctions, by forcing the user outside the ordinary limits of society and labelling him a criminal, may be counterproductive. Once labelled as a criminal the user may find it extraordinarily difficult to retain or regain employment and to function as a "normal" member of the community; after a time he may acquire a self-image as a criminal and act accordingly. In other words, on this view, to impose criminal sanctions on the drug user, because the

If the addict is young, sociopathic and living in a drug culture environment, he can rapidly become the scapegoat for our own short-comings. This increases his sense of alienation and confirms his adherence to his addict companions. The outcome in terms of poor health and total estrangement from society with involvement with the criminal world, are features which we are quick to condemn, but rarely make much attempt to comprehend.

Prof. F. A. Whitlock,
Univ. Qld, submission, p. 12

I think we've got a problem, and it's here to stay. We're not going to overcome it in the short term or in the long term. We've got to accept that people will use drugs and perhaps some people will make some monetary gain off of the use of those drugs. But let's be sensible about the whole issue—let's educate the public, let's educate the users, let's control the use of drugs so that those people who do use them are using them in a controlled situation that we all know about; perhaps do away with those entrepreneurs . . . who are making a fast buck, and hopefully make sure that the users of the drugs don't kill themselves in the long run.

Meeting of members of
Lions Club of Adelaide,
Flinders and the Apex Club
of Burnside Inc.,
transcript, pp. 20-21

If the use of marijuana in particular . . . is as prevalent as we've been told by people . . . it would be far better to bring it out in the open where it could be handled socially than to continue making it a crime . . .

Public meeting, Whyalla,
transcript, p. 16

I think that society has more or less accepted the fact that marijuana exists and that it is being smoked, why in heaven's name make it a criminal conviction when he's caught? So I would be in favour of more stringent penalties being applied to that particular case, but not a criminal conviction.

Meeting, Young Liberal Movement
of S.A., transcript, p. 8

community is threatened by his conduct, may actually encourage deviant behaviour. Similarly, a medical or treatment approach to the user also labels him—as a patient who is sick or disturbed. This labelling process may have the effect of persuading the user that his troubles are beyond his control and that, being sick, he is helpless to do anything about his addiction or dependence.

It has been suggested to us that society might be more successful in dealing with heavy drug users by developing social responses designed to encourage them to accept responsibility for their own behaviour. It is said that the use of alcohol, particularly, is partly controlled by a set of mixed social attitudes which tolerates "reasonable" use, but frowns upon excessive consumption. While definitions of "reasonableness" vary enormously, the social attitudes may serve positively to limit consumption. Excessive use of alcohol—and increasingly of nicotine—is regarded within certain groups as unacceptable behaviour. Conduct induced or influenced by alcohol is disapproved of to various degrees, depending usually on the extent to which others are harmed. Thus driving under the influence (also a criminal act) is strongly condemned, especially if another person is hurt, whereas drinking to the point of unconsciousness in an hotel and then going home in a taxi tends to be tolerated.

On this approach it has been suggested that it may be possible through education and community awareness to extend the social sanctions, which operate to control excessive use of alcohol, to the use of other drugs, including those presently illegal. The effect might be to characterise the user as perhaps foolish, misguided or irresponsible, but not necessarily as a criminal or as a person in need of extensive medical treatment. The argument is that the user would not be regarded as someone who has irretrievably stepped over the line and who, by implication, is no longer a useful member of the community.

A major goal of drug education should be to ensure that young people have the knowledge to weigh the consequences of their actions, and some skill in weighing.

Commonwealth Department of Health, submission, pp. 31-32

. . . I think it is very important for us to suggest that the most important preventive measure in this area [of drug abuse] is probably much more attention to the aspects of life of young married people and to premarital counselling and to support of the very young married, and to support of young parents. In other words, educational and supportive services in these areas.

Meeting of members of ANZ College of Psychiatrists, S.A. Branch transcript, p. 38

I belong to a service club and . . . earlier this year it was decided by the governing body that we should embark on an educational programme amongst the service club members and their children . . . and the thing which has surprised me is how little the people of my age . . . actually know about drugs. The ones they're particularly interested in, of course, are marijuana, L.S.D. and heroin. Most people tend to equate them all together and to equate them with . . . violence, and when you point out that this isn't so, they're quite staggered. Now, how useful this programme is, I don't know. One of the other things which has come across is that the club members' children know far more about the drugs than the club members do, and really what we're doing, I think, is educating the club members . . . the children don't learn anything, but I'm sure the parents do learn something—perhaps a little bit of demystification about it.

Meeting of members of ANZ College of Psychiatrists, S.A. Branch, transcript, p. 33

We must face the issue that if people are to change then they must *value* the change and be able to face and deal with the consequences of change. This implies that we must develop programmes which help people understand and identify values and provide the skill and opportunity for decision making in changing values . . . If we expect students to change their behaviour we must develop the expertise and opportunity for them to work out action programmes and provide the necessary support and counselling while these are being implemented.

S.A. Department of Public Health, submission, p. 30

It would . . . seem necessary in order to be consistent and effective that drug education information be not only provided to young people but also to the community at large, which encourages the young to adopt its standard through social, legal and economic pressures.

Commonwealth Department of Health, submission, p. 32

11.5.4 Ideally, drug education information should not be directed at a particular problem in isolation, or with undue emphasis on certain aspects of the problem. Such an approach will give the subject undue interest and may have the opposite effect to that desired.

Commonwealth Department of Health, submission, p. 33

EDUCATION

As we have examined the submissions made to us, and listened to the divergent views of witnesses in public and private, it has become apparent that many firmly and widely held attitudes to drugs are irreconcilably inconsistent with one another. These differences are particularly marked in relation to the role of drug education in the community. Some contend that it might take a generation or more for the drug-taking behaviour of different groups to change sufficiently to eliminate many of the problems associated with drug use and for a consensus to emerge on the currently controversial issues. Until then, it is argued, the drug question will continue to be clouded. Others firmly believe that an expanded education program can speed the resolution of the matter. The supporters of this view seem to accept, either explicitly or implicitly, that there are relatively simple answers to the drug question, even though a strong case can be made for the proposition that education is the now third major social agency from which a simple cure-all for the drug problem is being sought—the law and medicine having already had their turn.

The discussion about education raises many of the same difficulties concerning terminology that we have experienced elsewhere. It is partly a question of the implicit goals of drug education. We have heard directly or by implication that these should be:

- to promote total abstinence from all drugs
- to promote abstinence from illegal drugs
- to promote "wise" use of any drug and the avoidance of drug dependency, rather than abstinence
- to allay public anxiety about the drug "problem"
- to give general information about drugs
- to give information about the dangers of drug use
- to give only "reliable information" about drugs (presumably stating clearly the pharmacological effects and the risks realistically associated with use)
- to show the young how to make any decisions (including those about drugs) in relation to health and social behaviour
- to help people develop personal resources which enable them to cope constructively with life stresses and problems
- to foster exploration and assessment of personal values and the development of satisfying lifestyles.

The Commonwealth Department of Health, in a very valuable submission, suggests to us that reference to drug use should be placed in the context of alternatives. The submission, quoting from the *WHO Report Committee on Drug Dependence: Twentieth Report* (Technical Report Series 551, WHO, Geneva, 1974), states:

> Among the important needs served for some persons by their drug-taking behaviour are a recognised or unrecognised desire for adventure, risk-taking, new experience, self-understanding, creativity, acceptance by and identification with others, new social relationships, assertion of independence, and escape from a variety of physical and psychic discomforts.

11.8.6 A number of reports including that of the WHO Expert Committee on Drug Dependence have pointed out that scare tactics are generally ineffective, and should only be used under certain very limited conditions . . . Often the people for whom the health message would be most beneficial are the most anxiety prone. Hence the use of fear may alienate the very group at which it is aimed.

Commonwealth Department of Health, submission, pp. 36-37

11.8.8 In terms of the content, a disquietingly common failing of drug education information is the failure to place legal drug use in the same context as illegal drug use and the tendency to differentiate between drug use by youth and all drug use.

Commonwealth Department of Health, submission, p. 37

If one of our sons had tried drugs, say once or twice, and we had found out about it, firstly we wouldn't know how to find out, or whether they were, but if we had, what would we do? It's a terrible dilemma for the parents or the friends or relatives of that person. They feel lost, they wouldn't know where to go . . .

Meeting of members of Lions Club of Adelaide, Flinders and the Apex Club of Burnside Inc., transcript, p. 18

11.5.2 Drug education information may be presented in a direct manner in the form of factual and objective information or in an indirect manner in which attention is focussed on non-drug specific information, such as values clarification, the development of decision-making and problem solving skills, and alternatives. The latter approach is probably more easily and usefully pursued in a school setting particularly as this involves young people in their formative years. Inclusion of this information in a broader school curriculum, such as in a sociological or health context, at least theoretically has the advantage of adapting the material to the developmental level of the student. Concepts can be introduced and eleborated over a number of years providing a sequential development of information in relation to maturity and needs.

Commonwealth Department of Health, submission, p. 33

Drug education is in a laughable state concerning marijuana—at least it would be laughable if it didn't create dangerous stupid situations. There still tends to be an attitude prevailing that dictates the official attitude is that marijuana is unremittingly evil, like all illegal drug use. One puff and you'll become a leper, fit only for an acid bath. The trouble is that when people discover that marijuana doesn't rot your soul, in fact it's even enjoyable and stimulating, maybe even inculcates a greater "moral" awareness—that they assume the warnings about other illegal drugs are also hogwash—which is a dangerous situation. Drug education should only be given by people with first-hand knowledge—otherwise lecturers will be laughed at.

Submission no. 44

This carries with it, perhaps, the implication that if there were no drugs the people satisfying their needs through drug-taking might have to find other outlets.

If it is accepted that education may provide a solution, one must then ask to whom this education should be directed. Many submissions see the drug problem as one affecting only youth, and so for them drug education means solely the education of young children. In this connection school teachers tell us that currently they have special difficulty with two issues when discussing drug-related questions with their classes. On each they suspect there is divided opinion among the parents and indeed among teachers themselves.

The first issue is whether total abstinence, or simply care and wisdom in relation to the opportunity to experience drugs, is the better approach to encourage. The second is whether to state that alcohol and nicotine are drugs too, and that attitudes to them should be consistent with attitudes to other drugs.

The South Australian Education Department is developing a health education program for schools which is structured around ten areas: Ourselves and Others; Consumer Health; Work and Leisure; Use and Abuse of Drugs; Mental and Emotional Health; Sex and Family Life; Disease and Disability; Safety; Environmental Health; and Food, Rest and Activity. This program is still being developed and tested, and given sufficient funding, will be taught generally in South Australian State schools by 1980. The Department is conducting an evaluation of its health education curriculum in terms of its "success" from the point of view of both teachers and students.

A question facing the Department, and us, is whether the health education program should be confined to school students, or should be extended to the wider community. One view is that such topics as drug education and sex education should at least be extended to parents of school children, to inform them of the objectives of the school program and to assist them in understanding their own responsibilities in health education. However, it has been pointed out that the extension of drug education into the community is no easy task, as the issues involved in drug use are complex and controversial. By the same token there are education programs designed to reach all groups within the community. One such program is conducted by a sub-committee of the National Standing Control Committee on Drugs of Dependence. This National Drug Education Program is currently funded at the rate of $1 000 000 a year, which is, as has been pointed out, a very small sum compared with that spent by the advertisers of alcohol and tobacco.

Another approach to community education involves lectures or group discussions for special groups with an important role themselves to play in educating the public. For example, the pharmaceutical inspector in the South Australian Department of Public Health spends quite a large portion of his time providing information for medical and pharmacy students, nurses, trainee teachers and other target groups. At the Commonwealth level, a National Drug Information Service is being developed by the Department of Health to provide computerised information retrieval about drugs, including poisons and narcotics, for

Education isn't three hours a week drug education—education is the full 25 hours. For the full week at school you're educating them for a way of life. If a teacher is not doing that in every subject, he is failing. Now you've got drug education in biology and drug education in mathematics if you're doing it properly, because you're teaching them a way of life and if you're not teaching meaningfully then you're letting the kid down. And, in fact, it's probably a big mistake in having a special subject of drug education, if that ever happens, because then the kids are seeing it as a special thing put up on a stool and in fact it might have the reverse effect. In fact, if you have a total education programme educating towards a meaningful life drugs are just one thing that is mentioned.

Meeting, Young Liberal Movement of S.A., transcript, pp. 28-29

I think an education programme differentiating between boredom and depression could reduce unnecessary heavy use of . . . drugs.

Submission no. 44

11.8.1 The dangers of making information about drugs available may arise from stimulation of an unhealthy interest in drugs and may be caused through the inappropriate nature of the information and/or the manner in which it is presented.

Commonwealth Department of Health, submission, p. 35

doctors and chemists in all States, linking up with the information about the effects of drugs held by the Australian Drug Evaluation Committee. A matter that has not yet been explored in depth is the possible part that can be played by the media in providing information and shaping attitudes towards drugs, perhaps supplementing the role of formal educational institutions.

What, in fact, should be the techniques employed in a drug education program? It seems to be a fairly general opinion among educationists that the use of drugs is not reduced by programs which give only plain information, however accurate; indeed it is possible that the use of drugs may actually increase because of such information. Much the same may happen, so we have been told, if scare tactics are used. One suggestion is that drug use can be reduced only by long-term participatory education programs, although it is acknowledged that there is little agreement yet as to their design.

There has been a good deal of support for the kind of observations made recently by the Senate Standing Committee on Social Welfare:

> There is considerable variability in the type, content and quality of education programs and it is likely that they have differing effects on behaviour. It is wrong to assume that every education intervention is in itself desirable. All education programs should be evaluated and those which cannot demonstrate a positive effect should be abandoned.

COMPARISONS WITH OTHER COUNTRIES

Relatively few submissions make any detailed reference to the experience of overseas countries in relation to drugs. Consequently, most of the information we have is in the form of printed documents and reports, primarily from English-speaking countries. However, mention is frequently made, and different interpretations offered, of the actions of nine American States in decriminalising the possession of marijuana for personal use. Some of the more detailed contributions also refer to the British approach to narcotic use, under which registered addicts have been able to obtain, through treatment centres, supplies of the drugs to which they are addicted. Again interpretations vary. Some argue that the British "medical" model is a far more civilised and effective method of tackling the problem of addiction than the punitive/criminal law approach exemplified by the United States. Others contend that although the British treatment centres were relatively effective for a long time in keeping the level of addiction under control, there is now a continuing, serious and slowly worsening problem.

Material from other countries must be applied with caution to Australia, since the social, legal and political structure may be different. Nevertheless, the work of eminent Commissions and other bodies inquiring into the non-medical use of drugs is often extremely helpful and we have been assisted by the approach and conclusions of some of those bodies. One of the earliest reports was the Indian Hemp Drugs Commission Report of 1894, which should have dispelled some of the myths which later grew up concerning the effects of marijuana. More recently, the extremely thorough report of the Canadian Commission of Inquiry Into the Non-Medical Use of Drugs (the Le Dain Commission) has provided us in its series of reports (1970-1973), with a sound starting point for many of our inquiries. The First Report of the United States National Commission on Marijuana and Drug Abuse (the Shafer Commission), *Marijuana: A Signal of Misunderstanding* (1972), provides some important material on marijuana. Of course Australia, too, is building up a body of reports on drug use, including the Report of the Senate Select Committee of Drug Trafficking and Drug Abuse (1971), the interim report of the New South Wales Joint Committee of the Legislative Council and Legislative Assembly upon Drugs (1977) and the report of the Senate Standing Committee on Social Welfare, *Drug Problems in Australia—An Intoxicated Society?* (1977). All these reports are proving to be very helpful to us.

CONCLUSION

Where do we go from here? We intend to publish working papers on important topics within the next few months. These will cover such matters as the treatment of drug dependence, the controls over the distribution and use of drugs and the approach to the regulation of cannabis. The working papers will set out background information (although not in exhaustive detail), pose what we see as the alternatives before us and make *tentative* recommendations. The working papers will be available to interested groups and individuals and opportunities will be available to comment on the tentative recommendations put forward. Comments received will be taken into account in the preparation of the Commission's final report.

APPENDIX A

The terms of reference of the Royal Commission into the Non-Medical Use of Drugs are to make inquiry into the factors underlying or relating to the non-medical use of narcotic, analgesic, sedative and psychotropic drugs or substances of dependence, not including nicotine or alcohol and in particular:

1. to marshal from available sources in South Australia, Australia and abroad information concerning such drugs or substances and their use;

2. to inquire into and report on current scientific, medical, social and other knowledge on the effects of such drugs or substances;

3. to inquire into and report on the extent and character of the use or abuse of such drugs or substances in South Australia, the types of persons engaging in such use or abuse, sources of supply, and the medical, social and economic factors underlying or associated with such practices;

4. to inquire into and report on the effects of the existing law and its administration in relation to the use of such drugs or substances in South Australia;

5. to inquire into and report on the provision of educational, preventive, treatment and rehabilitation programmes in South Australia for persons using or abusing such drugs or substances; and

6. to recommend such changes to the law in relation to the use and abuse of such drugs and the provision of such education, preventive, treatment and rehabilitation programmes as you think appropriate.

APPENDIX B

Written submissions were presented by the following individuals, organisations and departments:

Allison, H., M.H.A., Mt Gambier, S.A. (150)

Andrew, Mr J. F. & Mrs M., Mt Gambier, Springfield, S.A. (145)

Association of Principals of Catholic Secondary Schools. (66)

Auricht, Dr C. O., Medical Officer, Student Health Centre, University of Adelaide, S.A. (93)

Australasian Society of Nephrology and the Australian Kidney Foundation, Analgesics Sub-Committee. (116)

Australian Capital Territory Police, Canberra, A.C.T. (46)

Australian College of Allergists (S.A. Branch), Adelaide, S.A. (169)

Australian Council of Social Service, Sydney, N.S.W. (105)

Australian Pharmaceutical Manufacturers Association, Sydney, N.S.W. (83)

Australian and South Pacific Temperance Council, Mt Hawthorn, W.A. (132)

Bilney, Mr B., Kensington Gardens, S.A. (173)

Broadhurst, Dr N. A., Eden Hills, S.A. (25)

Brown, Mr D., Faculty of Law, University of New South Wales, Kensington, N.S.W. and others (40)

Burgess, Mr F., Elizabeth East, S.A. (143)

Cannabis Research Foundation of Australia, Prahran, Vic. (135)

Capital Territory Health Commission, Alcohol & Drug Dependence Unit, Canberra, A.C.T. (133)

Carington Smith, Mrs D., Sandy Bay, Tas. (148)

Ceduna Community Health and Welfare Centre, Ceduna, S.A. (96)

Chesher, Dr G. B., Reader in Pharmacology, University of Sydney, N.S.W. (174)

Chrisakis, Mr N., Seaton, S.A. (3)

Church of England, Social Questions Committee, Adelaide, S.A. (89)

Chynoweth, Dr R., Reader in Psychiatry, University of Adelaide, S.A. (130)

Clayer, Dr J. R., Deputy Director of Mental Health Services, S.A. (128)

Commonwealth Department of Health, Woden, A.C.T. (153)

Costello, Mr B. R., Millswood, S.A. (21)

Council of Social Service of the A.C.T., Social Aspects of Health Services Committee, Canberra, A.C.T. (82)

Council of Social Service of Tasmania, Hobart, Tas. (99)

Crews, Mr W. D., Wayside Chapel, Kings Cross, N.S.W. (49)

Dickins, Dr J. A., Unley, S.A. (55)
Diocese of Willochra, Gladstone, S.A. (167)
Duggan, Dr J. M., Royal Newcastle Hospital, N.S.W. (54)
Education Department of South Australia, Adelaide, S.A. (110)
Elura Clinic, North Adelaide, S.A. (124)
Festival of Light and Community Standards Organisation (S.A.) Inc. Adelaide, S.A. (101)
Finlayson, Ms G., Glenside, S.A. (113)
Fotheringham, Dr B. G., Medical Superintendent, Modbury Hospital, S.A. (136)
Franklin, Mrs A. M., Parafield Gardens, S.A. (170)
Furnass, Dr S. B., Director, University Health Service, Australian National University, Canberra, A.C.T. (12)
Gabrynowicz, Dr J. W., Medical Director, Alcohol and Drug Addicts Treatment Board, Adelaide, S.A. (13)
Gale, Dr A. E., North Adelaide, S.A. (154)
Goldberg, Mr B., Vaucluse, N.S.W. (65)
Gold Coast Drug Council, Burleigh Heads, Qld. (45)
Graham, Dr J. R., Panorama, S.A. (76)
Griffiths, Mrs G., Mt Gambier, S.A. (146)
Griffiths, Mr M. A., Glebe, N.S.W. (74)
GROW, Marrickville, N.S.W. (80)
Hancock, Mr H. R., O.B. Flat, S.A. (144)
Hansen, Mr H. C., Salisbury East, S.A. (63)
Harvie, Mr P. J., Laura, S.A. (48)
Heddle, Dr R. C., Director, Student Health Service, University of Adelaide, S.A. (93)
Hennessy, J. H., Mt Gambier, S.A. (142)
Higgins, Mr J., Parkside, S.A. (137)
Hyperactivity Association of South Australia Inc., Highbury, S.A. (14)
International Meditation Society, North Adelaide, S.A. (51)
Investigator Clinic, Pt Lincoln, S.A. (157)
Jones, Prof. H. B., University of California, Berkeley, California, U.S.A. (87)
Kidman, Ms M., Kalangadoo, S.A. (140)
Kildea, Dr H. B., Glen Osmond, S.A. (111)
Kurtze, Ms G., Glen Osmond, S.A. (122)
Lane, Mr W., Senior Tutor, Latrobe University, Bundoora, Vic. (176)
Lavers, Mr L. A., Medindie, S.A. (104)
Lawson, Dr W. S., North Adelaide S.A. (61)
Lee, Ms K., Mt Gambier, S.A. (139)

Lilly Industries Ptd Ltd, West Ryde, N.S.W. (85)

Live-a-Long Workshops, Norwood, S.A. (11)

Magic Group, Adelaide, S.A. (161)

Maranatha Drug Rehabilitation Centre, Ardrossan, S.A. (156)

Medical practitioners, Drs V. Tottman, G. Wright and J. R. Graham (109)

Medical students, Department of Community Medicine, University of Adelaide, S.A. (106)

Merritt, Mr M., Mt Gambier, S.A. (91)

Mills, Mr L., Adelaide, S.A. (131)

Milner, Dr G., Inspector and Director, Alcoholic and Drug Dependent Persons Services Branch, Department of Health, Melbourne, Vic. (4)

Moreton, Mr. T., Senior Lecturer in Psychiatry, Student Health Service, University of Adelaide, S.A. (93)

Moss, Dr J. R., Department of Community Medicine, University of Adelaide, S.A. (123)

Murrell, Prof. T. G. C., Department of Community Medicine, University of Adelaide, S.A. (123)

Nanra, Dr R. S., Royal Newcastle Hospital, N.S.W. (64)

Narconon Inc., S.A. (177)

New South Wales Health Commission, Rozelle, N.S.W. (95)

Nicholas Pty Ltd, Chadstone, Vic. (94)

Occupational Health Nurses Section of the R.A.N.F. (S.A. Branch), Kent Town, S.A. (127)

Orroroo Area School Council, Orroroo, S.A. (92)

Pang, Dr H., City Health Centre, Canberra, A.C.T. (43)

Pharmaceutical Society of Australia, Canberra, A.C.T. (125)

Pharmaceutical Society of South Australia, in Association with the Society of Hospital Pharmacists of Australia (S.A. Branch) and the Pharmacy Guild of Australia (S.A. Branch), Adelaide, S.A. (70)

Port Lincoln High School Parents and Friends Association, Pt Lincoln, S.A. (72)

Proprietary Association of Australia, Sydney, N.S.W. (108)

Randall, Mr R., Washington D.C., U.S.A. (6)

Roberts, Mr J. (160)

Royal Australian Nursing Federation (S.A. Branch), Kent Town, S.A. (166)

Royal District Nursing Society of South Australia Inc., Norwood, S.A. (171)

Salter, Dr W. F., Superintendent, Hillcrest Hospital, Gilles Plains, S.A. (67)

Scott, Mr A., Berri, S.A. (10)

Sherman, Dr D., Glen Iris, Vic. (7)

Sidebotham, Mr N., Athelstone, S.A. (147)

Snowtown Area Parents Club, Snowtown, S.A. (162)

South Australian Association of Hypnotherapists Inc., Adelaide, S.A. (8)

South Australian Council for Civil Liberties, St Peters, S.A. (100)

South Australian Department of Public Health, Adelaide, S.A. (62)

South Australian Foundation on Alcoholism and Drug Dependence, Adelaide, S.A. (141)

South Australian Police Department, Adelaide, S.A. (107)

St Christopher's Drug Referral Centre, Joslin, S.A. (134)

Stevens, Dr T. B., Pleasant View Assessment Centre, Department of Health, East Preston, Vic. (78)

Storer, Dr T. B., Loxton, S.A. (165)

Streaky Bay Area School Welfare Club, Streaky Bay, S.A. (164)

Stuart, Mr C. K., Stipendiary Magistrate, Adelaide, S.A. (159)

Sturt College of Advanced Education, Department of Health Studies, Bedford Park, S.A. (68)

Tasmania Police Force, Hobart, Tas. (79)

Taylor, Dr B., Medical Officer, Hillcrest Hospital, Gilles Plains, S.A. (67)

Temperance Alliance of South Australia Inc., Adelaide, S.A. (168)

Tennant, Mr B. G., Subiaco, W.A. (41)

Uniting Church in Australia, Adelaide, S.A. (57)

Way Back Committee, North Parramatta, N.S.W. (75)

Western Australian Police Department, East Perth, W.A. (47)

Whitlock, Prof. F. A., Department of Psychiatry, University of Queensland, Brisbane, Qld. (77)

Willis, Mr J., Lecturer, La Trobe University, Bundoora, Vic. (176)

Wilson, Mr E., Fullarton, S.A. (126)

Winthrop Laboratories, Ermington, N.S.W. (69)

Woman's Christian Temperance Union of South Australia Inc., Adelaide, S.A. (90)

Women's Discussion Group, Para Vista Lutheran Church, Modbury, S.A. (60)

The Commission received confidential submissions from Beckers Pty. Ltd., Mediscience Laboratories, Toorak, Vic., and the Northern Territory Police, Darwin, N.T.

The Commission received 56 other confidential submissions.

Discussions were recorded at special meetings arranged with these groups:

Students from the University of Adelaide

Students from Flinders University

South Australian Council of Churches

Parents without Partners

Members of the Australian Medical Association

South Australian Council of Social Service

Royal Australian Nursing Federation (S.A. Branch)

Members of the South Australian Institute of Teachers

Lions Club of Adelaide Flinders and the Apex Club of Burnside (Inc.)

Members of the Police Association of South Australia

Members of the Australian and New Zealand College of Psychiatrists, S.A. Branch

Hillcrest Hospital medical staff

Young Liberal Movement of South Australia

The Commission held a number of private meetings, and also conducted public meetings at the following country centres: Whyalla, Mount Gambier, Port Lincoln, Maitland, Berri and Renmark

The Commisssion sat on the following days in 1977:

July 20
July 21
August 15
August 17
August 21
August 23
August 24
August 25
August 31
September 1
September 7
September 8
September 13
September 14
September 15
September 20
September 21
September 22
September 27
September 28
September 29
October 4
October 7
October 13
October 14
October 18
October 19
October 20
October 24
October 25
October 26
October 27
October 28
November 2
November 3
November 7
November 10

APPENDIX C

The Commission conducted formal hearings at the Nurses Memorial Centre, Kent Town, S.A., and at the College of Law, St Leonards, N.S.W. The following people and organisations appeared before the Commission:

Australian Council of Social Service
  Joan H. McClintock, Deputy Secretary-General
  Fiona R. Hollier, placement student
  Ngaire S. Chant, placement student

Anonymous medical practitioner, Adelaide

Australasian Society of Nephrology and the Australian Kidney Foundation (Analgesics Subcommittee)
  Dr T. H. Mathew, Director, Renal Unit, Queen Elizabeth Hospital
  Dr A. R. Clarkson, Director, Renal Unit, Royal Adelaide Hospital

Australian Pharmaceutical Manufacturers Association
  Mr N. R. Kelly, Executive Director

Baldwin, Mr R. J., psychiatric nurse, New South Wales Health Commission

Broadhurst, Dr N. A., medical student, S.A.

Chesher, Dr G. B., Reader in Pharmacology, University of Sydney

Church of England, Adelaide, Social Questions Committee
  Rev H. Morrow
  Mr C. Lawton

Chynoweth, Dr R., Reader in Psychiatry, University of Adelaide

Clayer, Dr J. R., Deputy Director of Mental Health Services, South Australia

Costello, Dr R. A. H., psychologist, S.A.

Crews, Mr W. D., Director, Crisis Centre, Wayside Chapel, Sydney

Davis, Mr J. L., Senior Pharmacist, S.A. Department of Public Health

Dickens, Dr J. A., psychiatrist, S.A.

Education Department of South Australia
  Mr J. R. Steinle, Director-General of Education
  Dr B. C. Lindner, Assistant to the Director of Research and Planning
  Mr N. R. Wadrop, Coordinator, Health Education Project

Elura Clinic, Outpatient Clinic of the Alcohol and Drug Addicts Treatment Board, S.A.
  Ms R. Warmington, Senior Social Worker
  Mr M. Robinson, Social Worker
  Dr R. M. Jadhav, Medical Officer

Festival of Light and Community Standards Organization (S.A.) Inc.,
  Dr D. M. Phillips, Chairman

Gabrynowicz, Dr J. W., Medical Director, Alcohol and Drug Addicts Treatment Board, S.A.

Graham, Dr J. R., specialist physician, S.A.

Goldberg, Dr B., pharmacist, N.S.W.

Griffiths, Mr M. A., psychologist, N.S.W.

GROW, Marrickville, N.S.W.
Dr C. Sprague, Physician, Leadership Training Coordinator
Fr C. Keogh, Catholic Priest, Archdiocese of Sydney

Heddle, Dr R. C., Director, Student Health Service, University of Adelaide

Hillcrest Hospital, S.A.
Dr W. S. Salter, Superintendent
Dr B. Taylor, Medical Officer, Alcohol and Drug Dependence Unit

Hyperactivity Association of South Australia
Dr B. Feingold, Kaiser Permanente Medical Centre, San Francisco
Mrs E. G. Attwood
Mr B. S. Attwood

International Meditation Society
Mr N. A. Roberts, Chairman
Mr V. V. L. Lorenzon, teacher, transcendental meditation

Jones, H. B., Professor of Medical Physics and Physiology, University of California, Berkeley, U.S.A.

Kildea, Dr H. B., general practitioner, S.A.

Lambert, Mr W. G., Coordinator, Drug and Alcohol Service, Southern Metropolitan Region, N.S.W. Health Commission

Letcher, Mr D. G., barrister, N.S.W.

Medical students, Department of Community Medicine, University of Adelaide
P. S. Barratt
J. J. Beilby
D. Broadbridge
J. Munckton
M. Sutherland
N. J. Williams

Milner, Dr G., Inspector and Director, Alcoholic and Drug Dependent Persons Branch, Health Department of Victoria

Moss, Dr J. R., Foundation for Multidisciplinary Education—Community Health, Royal Adelaide Hospital

Murrell, Professor T. G. C., Department of Community Medicine, University of Adelaide

Narconon Inc. of South Australia
Mr A. Scott, Chairman

New South Wales Health Commission
Dr R. G. McEwin, Chairman
Mr R. M. Dash, Coordinator of Scientific Services
Mr A. P. Diehm, Director, Central Drug and Alcohol Advisory Service

Para Vista Lutheran Church, Women's Discussion Group
Mrs F. H. Kempe
Mrs R. R. Lehmann
Mrs R. E. Thiele
Mrs E. J. Traeger

Pharmaceutical Society of South Australia, in association with the Society of Hospital Pharmacists of Australia (S.A. Branch) and the Pharmacy Guild of Australia (S.A. Branch)
Mr T. J. Maloney, Senior Pharmacist, Royal Adelaide Hospital
Mr P. J. Bayly, pharmacist
Mr J. Warden-Flood, pharmacist
Mr G. A. Ingerson, pharmacist

Proprietary Association of Australia
Mr A. D. Glover, Managing Director, Richardson Merrill Pty Ltd, N.S.W.
Prof K. J. Murton, Vice President of Research and Development, Nicholas International, Vic.
Mr P. N. Daddo, Vice President and General Manager, Nicholas Pty Ltd, Vic.
Mr C. J. Tucker, Assistant General Manager, Nyal Winthrop Division of Sterling Pharmaceuticals Pty Ltd, N.S.W.

Pyne, Mr D. M., Acting Director, Probation and Parole Service, Department of Corrective Service, N.S.W.

Royal Australian Nursing Federation (S.A. Branch), Occupational Health Nursing Section
Sister P. A. Moller
Sister P. G. Smith
Ms S. O'Leary
Sister J. A. Pearson

Sidebotham, Mr N., rehabilitation officer, S.A.

South Australian Association of Hypnotherapists
Mr B. J. Perry
Mr A. P. Franklin

South Australian Council for Civil Liberties
Prof. N. Blewett
Mr M. Steele, President
Mr A. Van Rood

South Australian Department of Public Health
Dr P. S. Woodruff, Director-General of Public Health
Mr R. C. McCarthy, Principal Pharmacist, Senior Pharmaceutical Inspector
Dr C. O. Fuller, Acting Deputy Director-General of Public Health
Dr J. Moffatt, Medical Officer, School Health
Dr M. Rugless, Principal Medical Officer, School Health
Mr J. L. Davis, Senior Pharmacist
Sister S. Harper, Community Nurse, School Health

South Australian Foundation on Alcoholism and Drug Dependence
Mr D. J. Call, Director of Counselling and Education

South Australian Police Department
Assistant Commissioner E. L. Calder
Superintendent R. McAuley
Detective Sergeant J. F. Silverblade

St Christophers Drug Referral Centre, South Australia
Miss Rosemary Taylor, social worker
Miss Linda Zvirgzdins, psychiatric nurse

Stuart, Mr C. K., Stipendiary Magistrate, S.A.

Tottman, Dr V. D., psychiatrist, S.A.

Wayback Committee, N.S.W.
Dr M. S. Y. Dalton, Medical Director
Mr D. W. Duncan, Vice President

Whitlock, Prof F. A., Department of Psychiatry, University of Queensland

Wooler, Dr H. O., Medical Director, Lilly Industries Pty Ltd

Wright, Dr G. D., medical practitioner, S.A.

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