TACKLING THE STIGMA: Drugs and discrimination

RECOVERY: WHAT DOES IT MEAN?

PRESCRIPTION OPIOIDS: A RISING TIDE

HEPATITIS C: WAYS TO HELP YOUR CLIENTS

Find a new job! www.jobsofsubstance.com.au
Advertise in Of Substance and reach 79,000 readers

The magazine will consider full, half or quarter page advertisements. Current rates (excluding GST): $1800 for a full page, $1000 for a half page, $600 for a quarter page. Discounted rates apply for non-profit organisations.

Of Substance is a free magazine published every four months.

Inquiries about overseas subscriptions and for bulk orders (over 10 copies) to distribution@ancd.org.au

Of Substance contact details:
Level 2, Pier 8/9, 23 Hickson Road, Milers Point 2000 NSW Australia
Tel: (02) 9258 4473 Fax: (02) 6162 2611 Email: editor@ancd.org.au
www.ofsubstance.org.au

Of Substance is governed by a Board of Management.

Chair:
• Dr John Herron, Australian National Council on Drugs

Members:
• Ms Mary-Lou Jarvis, Media and Policy Advisor
• Mr Ross Pearson, Senior Marketing Strategy Consultant
• Mr Gino Vumbaca, Executive Director, Australian National Council on Drugs
• Dr Dennis Young, Executive Director, Drug-Arm Australia

An Editorial Reference Group advises the Managing Editor on the development of content. Members for the July 2012 issue are:

Chair:
• Professor Steve Alkso, Director of the National Drug Research Institute at Curtin University

Members:
• Mr Sam Biondo, Executive Officer, Victorian Alcohol & Drug Association
• Dr Roger Brough, General Practitioner
• Dr Neil Donnelly, Senior Research Manager, NSW Bureau of Crime Statistics & Research
• Dr John Herron, Chairman, Australian National Council on Drugs
• Dr Caitlin Hughes, Research Fellow, Drug Policy Modelling Program, National Drug & Alcohol Research Centre
• A/Professor Lynne Major-Blatch, Executive Officer, Australian Therapeutic Communities Association and Associate Professor, Centre for Applied Psychology, University of Canberra
• Mr David McDonald, Consultant in Social Research & Evaluation and Visiting Fellow, National Centre for Epidemiology & Population Health, Australian National University
• Professor Ann M Roche, Director, National Centre for Education and Training
• Mr Chris Tanti, CEO, Headspace
• Mr Tony Trimingham, CEO, Family Drug Support
• Mr Gino Vumbaca, Executive Director, Australian National Council on Drugs
• Ms Nicole Wiggins, Manager, Canberra Alliance for Harm Minimisation and Advocacy

Managing Editor: Jenny Tinworth
Contributing Editor: Kate Podbery
Business Manager: George Hamilton

© Commonwealth of Australia 2012

This work is copyright. It may be reproduced in whole or in part for study or training purposes subject to the inclusion of an acknowledgment of the source but for no commercial usage or sale. Reproduction for purposes other than those indicated above requires the written permission from the Commonwealth. Requests and inquiries concerning reproduction and rights should be addressed to The Managing Editor, Of Substance, Level 2, Pier 8/9, 23 Hickson Road, Milers Point 2000 NSW Australia or by emailing editor@ancd.org.au.

Cover and images on pages 1, 3-9, 12, 14-17, 20-23, 25-27 & 29 are courtesy of Shutterstock. Please go to the Latest Issue section of www.ofsubstance.org.au for further details. The magazine is designed by Rebecca Horsburgh and printed by GEON.

Visit www.ofsubstance.org.au and subscribe to Of Substance

Contents

Editorials ........................................................................................................................................ 2

News, Research and Resources ........................................................................................................... 3

Research digest ..................................................................................................................................... 8

Diss, discrimination and health care, We look at how stigma stops individuals from seeking adequate treatment.

Stigma: Why wouldn’t I discriminate? ................................................................................................. 10

Many people believe that stigmatising individuals who use drugs is a positive move for society. We explore stigma’s sting and look at innovative programs that change attitudes.

Recovery .............................................................................................................................................. 14

Everyone is talking about ‘recovery’, but what does it mean in an Australian context? We present a collection of short articles that seek to define it.

Interview: Christopher Kennedy Lawford .......................................................................................... 18

The author, activist and UNODC Goodwill Ambassador on Drug Dependence took time out to chat with Of Substance during his recent visit to Australia.

Prescribed opioids: A rising tide ......................................................................................................... 20

Opioid-based prescription painkillers are increasingly popular. We discuss the trend and a new approach to ensuring they are used appropriately.

AOD clinics: Stepping up to stop Hep C ............................................................................................ 24

Drug treatment providers have a responsibility to work with hepatitis C.

Barriers to success: What gets in the way of AOD project implementation? ................................. 27

Staff continuity, data collection methods and timeline issues all play a part in affecting how well a project proceeds.

Drug-Arm Australia

A/Professor Lynne Major-Blatch, Executive Officer, Australian Therapeutic Communities Association and Associate Professor, Centre for Applied Psychology, University of Canberra

Of Substance
Dr John Herron, Chairman, Australian National Council on Drugs

Australian National Council on Drugs

Dr John Herron, Australian National Council on Drugs

The Salvation Army (New South Wales) Property Trust has been contracted to provide financial and administration services for Of Substance.

© Commonwealth of Australia 2012

Of Substance is an Australian National Council on Drugs (ANCD) initiative and is produced with funding from the Australian Government Department of Health and Ageing. The Salvation Army (New South Wales) Property Trust has been contracted to provide financial and administration services for Of Substance.

The views and opinions expressed in the articles in this magazine are those of the individual authors and do not necessarily represent the views of the Of Substance Editorial Reference Group, the Board, the ANCD, the Australian Government Department of Health and Ageing, the Salvation Army (New South Wales) Property Trust or any other organisations associated or involved with the ANCD.

Some images used in this publication depict models rather than real-life circumstances.
Laws must change to challenge stigma

Jude Byrne, Senior Project Officer, National Hepatitis C and other BBVs/STIs Program, Australian Injecting & Illicit Drug Users League (AVL)

The impact of stigma and discrimination on the lives of people who inject drugs is profound, complex and multilayered. It encompasses every aspect of their lives from how they are treated in the street, to how they are treated at Centrelink, the courts and more problematically how they are treated by health care staff.

Over recent years a plethora of documents have been written purporting to delve into this mysterious ‘phenomenon’. Every document comes to the same conclusion: drug use is illegal and while it is illegal, the wider community believes it is incumbent upon them to ensure that the behaviour does not spread. The way the community responds to behaviours it deems unacceptable is to stigmatise and discriminate against individuals who indulge in those behaviours.

We all know some of the key reasons why drug users are not accessing health services – we have example after example of how injecting drug use is treated by the majority of mainstream health services. We have statistics to back up the anecdotal information that only 1.6 per cent of hepatitis C-positive people who inject drugs are bothered to undertake a treatment that may save their lives. That speaks volumes doesn’t it?

People who inject drugs would rather risk their health than voluntarily go through all the soul-destroying interactions a course of hepatitis C treatment involves.

This group is one of the few whose illnesses are perceived as ‘self-inflicted’ that are denied decent medical treatments – smokers are not denied chemotherapy for lung cancer and people whose heart disease stems from an unhealthy diet receive care. The language that surrounds us is pejorative and hurtful – ‘dirty junkie’ and ‘cheating scum’ – this only serves to encourage the marginalisation of our community. Essentially people who inject drugs are not seen as deserving of the benefits of society as we voluntarily challenged its nature and norms.

When you look beyond the rhetoric and the public hysteria to find that the drugs laws are a combination of historical accidents, racism and social control, you come to understand the stigma and discrimination faced by injecting drug users is part of a much larger agenda that we have little control over. Unless drug laws are changed and people do not feel that they have the right to deny us our human rights, the status quo will remain, even if we can articulate chapter and verse why it happens.

Editor’s Letter

Welcome to the July edition of Of Substance.

Some years ago, my son was hospitalised. Sharing the ward with my toddler was a very young baby. Staff identified her mother to other parents as a ‘drug user’. While I admired their care and concern for her child, I was horrified by the way the otherwise compassionate professionals openly and continually stigmatised this parent. When they searched her overnight bag I was uncomfortable about this action, and then disappointed that they did find stolen hospital equipment.

Ever since that experience, I have pondered the nature of discrimination. What creates it? How is it fuelled? Do negative expectations create the very behaviours that feed stigmatisation? What needs to happen for perceptions to change? While I still don’t have all the answers to those questions, our article starting on page 10 does explore the topic and highlights some interesting initiatives that tackle the way society perceives not only consumers of illicit drugs, but other marginalised groups.

In recent months, it seems ‘recovery’ has become the new buzzword of alcohol and other drug treatment, not just in Australia, but internationally, with the UK Government adopting a particularly strong policy not just in Australia, but internationally, with the UK Government adopting a particularly strong policy.

In the May Federal Budget handed down a number of key policy and funding changes that will impact on the alcohol and other drugs (AOD) sector. Most notably, many AOD services have been shaken by recent changes to their funding arrangements (see box for the latest update in this issue). Other Budget areas of interest to the sector include:

- General health Budget:
  - Key initiatives in the areas of dental health, rural health and aged care were the highlights of the 2012-13 health Budget.
  - Other areas of note include additional measures to ‘Close the Gap’ in health outcomes for Indigenous Australians.

- Over 10 years $173.5 million will be spent under the Stronger Futures in the Northern Territory initiative for better primary health care and allied health services for Aboriginal people living in rural and remote areas. A further $694.29 million will go towards community safety initiatives, including measures to address alcohol misuse.

- Tobacco:
  - The Government announced in the Budget that it would cut the duty-free importation limit on cigarettes.
  - Under the previous rules, inbound travellers aged over 18 were allowed to bring in 250 cigarettes or 250 g of tobacco products tax-free – this will now be cut to 50 cigarettes or 50 g.
  - The Government estimates it will raise an extra $600 million over four years from this measure. It is anticipated that some of the proceeds will help pay for the plain-packaging initiative, including the litigation by tobacco companies fighting the legislation.

In addition, in 2012-13 the Department of Health and Ageing will develop a new National Tobacco Strategy in partnership with states, territories and non-government organisations, which will provide the policy framework for activities aimed at reducing the health, social and economic costs caused by tobacco use.

- Alcohol:
  - The Australian Government has added to the National Binge Drinking Strategy by providing an additional $50 million for community-focused activities that address harmful consumption of alcohol by young people.
  - Funding will also support the Australian Drug Foundation’s Good Sports program which addresses the adverse aspects of alcohol-related culture while encouraging sporting participation.

Research spending:

- Funding for health and medical research has been largely maintained in the Budget. The Government made an ongoing commitment to medical research, with the allocation of $760.5 million for the National Health and Medical Research Council (NHMRC) Medical Research Endowment Account. While this amount is comparable in terms to the $746 million allocation in 2011-12, the response from the research sector has been positive.

Mental health:

- The area of mental health received a welcome boost in the Budget. With a forecast funding increase of over $100 million, in 2012-13 the Department of Health and Ageing will continue to implement a National Partnership Agreement with states and territories to support mental health reform.
  - The Australian Government has added Australia’s first National Mental Health Commission, within the Prime Minister's portfolio. Among other activities, the Commission will continue the development of the annual national report card on mental health and suicide prevention. In 2012-13, among a range of new or existing measures, the Government plans to:
    - continue expanding the Access to Allied Psychological Services (ATAPS) program
    - increase funding to the headspace program. A total of 90 headspace centres will be funded by 2014-15
    - provide further support for mental health services for teenagers and young adults by working with states and territories to establish up to 16 youth early psychosis services based on the Early Psychosis Prevention and Intervention Centres model.

Diversion of proceeds of crime funding:

- A measure that escaped much attention in the Budget was the Government’s announcement that it would return all the money from its Confiscated Assets Account – funded from assets seized under the Proceeds of Crime Act – to consolidated revenue. This savings measure, worth $60 million over four years, will come at the expense of community crime prevention and drug and alcohol diversionary programs.

- Last year, the recipients of this fund included The Salvation Army Drug & Alcohol Services, Mission Australia and Barnardos Australia.

AOD SECTOR IN FUNDING TURMOIL

Since May, the Federal Government has announced major changes to the way alcohol and other drugs services are funded.

Follow the latest developments through our e-Bulletins.

Subscribe at www.ofsubstance.org.au

Jenny Tinworth
Managing Editor

Of Substance, vol. 10 no. 2 2012
A database system developed in Tasmania to prevent the abuse of painkilling prescription drugs has been so successful it will be rolled out across Australia. People buying drugs of dependence from pharmacies will be tracked electronically in real time across the nation. The $5 million system will cover scripts for pethidine, morphine, methadone and oxycodone (known as ‘Hillbilly heroin’). The crackdown on prescription drug sales follows evidence that people are doctor shopping for multiple scripts, stealing script pads from doctors and forging prescriptions for drugs. The information gathered through the database will be available to doctors, pharmacists and state and territory health authorities.

Record drug seizures

According to Australian Crime Commission (ACC) data released in May, Australian authorities made almost 70,000 illicit drug seizures in the 2010-11 financial year, the biggest number in a decade. More than 93 tonnes of illicit drugs were seized nationally – a 19 per cent increase on seizures in 2009-10, and more than 84,700 illicit drug arrests – the second highest in the past decade.

The Illicit Drug Data Report reveals that cannabis is still the most dominant illicit drug in Australia in terms of use, arrests and seizures. Seventy-two per cent of seizures by number were for cannabis, while the drug accounted for almost 84 per cent of seizures by number. Seizures by number. Heroin (2.8 per cent of seizures) and cocaine (1.7 per cent) were relatively stable.

Synthetic cannabis banned nationwide

Since May, a nationwide ban on synthetic cannabis has become effective. Eight groups of synthetic cannabinoids and all synthetic cannabinomimetics are now illegal. Once considered a substitute for cannabis, these products, commonly known as ‘legal herbal/high’ mixtures are often marketed as ‘safe’ and ‘legal’ drugs. This new law follows on from bans made last year by a number of states and territories, starting in Western Australia, to prohibit the sale and use of products such as ‘Kronic’ and MDPV. Both these substances are included in this national ban.

Alcohol advertising board to challenge industry

The United Kingdom’s Department of Health (DH) announced in January that Injectable Opioid Treatment (IOT) is a ‘clinically effective second-line treatment’ for people with chronic heroin additions. IOT involves the prescription and dispensing of injectable diamorphine (pharmaceutical heroin) or injectable methadone in a supervised clinical setting for opiate misusers who have not responded to other types of treatment. The results of a randomised IOT trial initiated by the DH, were published in The Lancet in 2010; as a result of this study and other international research, IOT is now evidenced as a clinically effective second-line treatment for the small number of people who have repeatedly failed to respond to standard methadone treatment. The DH has now been given approval by the UK Government to commission Phase 2 roll-out of the IOT program, including inviting potential service providers to host supervised injecting clinics.

WA celebrates its Indigenous workers

Julie Woods, from Ngnowar Arawar Aboriginal Corporation in Wyndham, Western Australia, has been recognised for her decade-long dedication in assisting Wyndham’s Aboriginal community with drug and alcohol and mental health related issues, by being awarded the ‘Strong Spirit Strong Mind’ Aboriginal Alcohol and Other Drug Worker of the Year.

Other WA Indigenous alcohol and other drug (AOD) workers were also recognised with awards in March at an annual two-day forum in Perth. The award for Innovative and Culturally Secure Aboriginal AOD Program was given to equal winners – the Midwest Community Drug Service Team for their ICARE program (Improving Client–Agency Regular Engagement) and Ngnowar Arawar Aboriginal Corporation for their Improved Services Initiative Program.

The forum was organised by the WA Network of Alcohol and other Drug Agencies in partnership with the Drug and Alcohol Office, which also provided funding in conjunction with the Federal Department of Health and Ageing.

Drug (AOD) abuse. The new funding aims to help these communities work with Government and non-profit organisations to develop and implement AOD abuse management plans. The initial locations were chosen on the basis of their high need for assistance to combat alcohol abuse and alcohol-related harm and for the commitment which community leaders and members have to taking action:

- Bourke, Brewarrina, Murthi Paski region and Condobolin in New South Wales
- Doomadgee and Mornington Island in Queensland
- Ceduna and region in South Australia
- Laverton and Goldfields region in Western Australia.

Pharmaceutical heroin to be rolled out in UK

In Scotland, the Government has taken a stronger than anticipated line on alcohol problems by fixing the planned minimum price at 50p a unit. Nicola Sturgeon, the Scottish Health Secretary, announced in May that she plans to deal with the alcoholism and binge-drinking endemic in some parts of Scotland by introducing a minimum price which is higher and more wide-ranging than the 45p she had previously planned.

It means the cost of cheap vodka will be pushed up by nearly 50 per cent, a bottle of wine will cost at least £4.69 and four cans of lager £3.52.

It is the first time minimum pricing has been tried in the European Union, and the policy is expected to be passed overwhelmingly by the Scottish Parliament after the Tories and Liberal Democrats agreed to support the proposal earlier this year. UK Prime Minister David Cameron confirmed his Government will also look at minimum pricing across England and Wales in a consultation due out later this year.

Minimum alcohol price set in Scotland

The New Zealand Government announced in April that it has agreed in principle to introduce plain packaging of tobacco products, subject to further consultations around the country to be held later this year. This follows on from the British Government’s announcement in the same month that it is announcing to hold public consultations about whether to introduce plain packaging.
Pregnant women ignore safe drinking guidelines

Research released in February shows that one in five Australian women continue drinking once they know they are pregnant. The study, Alcohol consumption during pregnancy: Results from the 2010 National Drug Strategy Household Survey by the Centre for Alcohol Policy Research and commissioned by the Foundation for Alcohol Research and Education, has led researchers to urge the Commonwealth Government to do more to promote safe drinking guidelines.

The study highlights the continued confusion and a lack of knowledge about the harms of drinking while pregnant, but also the urgent need for major changes to people’s attitude towards alcohol. The study found that almost half of all pregnant women drank before knowing they were pregnant and 19.3 per cent continued to drink once they became aware of their pregnancy. For copies of the report, visit: www.fare.org.au.

Benzodiazepine update

Data collected as part of the national Illicit Drug Reporting System (IDRS), which undertakes annual monitoring in all Australian states and territories, has highlighted an increase in the use of benzodiazepines among those surveyed. In 2011, 870 people who regularly injected drugs participated in individual face-to-face interviews. Participants were residents of Australian capital cities. Frequency of use had increased, with median use in 2011 being approximately three times a week. The study found that benzodiazepines have poorer physical and mental health and are more likely to have been involved in violent crime. Further details are available on the NDAIR website under Drug Trends: www.ndair.med.unsw.edu.au.

Grants announced for preventive health research

Almost $4 million in research funding has been allocated nationwide to 13 new projects that will investigate ways to prevent the harms caused by obesity, tobacco and harmful use of alcohol. It includes funding for three major alcohol research projects to be undertaken by Professor Steve Allsop, Dr Tanya Chikritzhs and Professor Robin Room. The Government said that the ‘...projects stood out because the results from these key areas of research will help inform everyone looking to prevent chronic disease and promote good health’.

The funding allocated to alcohol research will focus particularly on risky drinking by young people, as this is a-known community concern. This research will help define the contexts in which this drinking occurs, the factors contributing to risk and how we can better target prevention and treatment efforts.

Pharmaceutical drug misuse strategy

The National Centre for Education and Training on Addiction (NCETA) is developing Australia’s first National Pharmaceutical Drug Misuse Strategy. A preparatory report focuses primarily on prescription opioids, benzodiazepines and codeine-containing analgesics and is structured in three parts. Part A examines the extent and nature of pharmaceutical drug misuse problems in Australia and internationally; Part B outlines the broader policy context and key stakeholders, paradigms, strategies and activities of relevance to the topic; Part C explores potential responses to pharmaceutical misuse problems. Copies of the report can be downloaded from the pharmaceutical section of the NCETA website: www.nceta.flinders.edu.au.

Rise in crystal meth ambulance calls-outs

Research released in May by Eastern Health’s Turning Point Alcohol & Drug Centre has revealed an alarming increase in metropolitan Melbourne ambulance attendances due to crystal methamphetamine (ice) use. Figures released show a 107 per cent increase in crystal methamphetamine-related ambulance call-outs, with 282 incidents in 2010-11 compared with 136 in 2009-10.

The Trends in alcohol and drug-related ambulance attendances in Melbourne: 2010-2011 report also revealed large increases in ambulance attendances due to alcohol and cannabis. Alcohol continues to record the highest figures compared with any other drug, with 6946 incidents in 2010-11 – up 12 per cent from 2009-10. After alcohol, the next highest number of call-outs was for benzodiazepines, a drug commonly prescribed for sleeping and anxiety issues, with 3135 ambulance attendances. On a positive front, there has been a significant drop in the use of illegal drugs, including ecstasy (down 41.7 per cent from 343 incidents in 2009-10 to 200 incidents in 2010-11) and cocaine (down 22.2 per cent from 90 incidents in 2009-10 to 70 incidents in 2010-11).

Case notes made simple

Developed by Turning Point researchers and tested by alcohol and other drugs (AOD) clinicians, Take Note! A Practical Guide to Writing Case Notes is an evidence-based guideline designed to assist AOD clinicians and managers with all aspects of case note writing from structure and details, to the management and consistency of case note models and templates, through to the legal considerations that apply to case notes in Victorian AOD services. Available in two formats – the full length guideline and the quick reference version. These resources are available through the Turning Point website: www.turningpoint.org.au.

Reduce your cannabis use

The National Cannabis Prevention and Information Centre (NCPCIC) has launched an online intervention program – Reduce Your Use: How to Break the Cannabis Habit – an evidence-based program aimed at assisting cannabis users to quit or lower their use of the drug. It is the first fully self-guided online treatment for cannabis use to be tested and supported in a randomised controlled trial. The program is largely based on a face-to-face brief treatment previously found to be effective for problem cannabis use. The website contains six core modules covering feedback and building motivation; managing withdrawal symptoms; withdrawal; changing thinking, coping strategies and skill enhancement; activities and interpersonal skills; and relapse prevention and lifestyle changes. The program can be accessed at https://reduceyourcannabis.org.au/sign-up/.

New hepatitis C treatments

The new treatments for hepatitis C, which will become available in Australia over the next few years have great potential to offer the chance of a cure for many people with chronic hepatitis C. It is an ideal time for people living with chronic hepatitis C to reconsider treatment options and start to plan for a cure. To assist those people who do not have a scientific or clinical background to learn more about the emerging treatments, Hepatitis Australia has produced a guide to current and emerging treatments for hepatitis C. To download the PDF, visit: www.hepatitisaustralia.com/data/assets/pdf_file/0010/23500/Guide-to-hepatitis-C-treatments.pdf.

Online tool for schools

The Australian Drug Foundation (ADF) has launched its new educational shop website, highlighting an extensive range of drug educational tools designed for educators, health workers and parents.

New and popular products include:

- Be Careful of S.D.D. (Seemingly Irrlevant Decisions)
- Take Care of Your Drinking and You May Not Need to Quit
- What Drug is That?
- The Safer Injecting Handbook
- Standard Drinks Kit.

For copies of the report, visit: http://bookshop.adf.org.au/

Governance tools

The NADA Governance Toolkit has been developed to assist organisations within the NSW non-government alcohol and other drug (AOD) sector to improve governance knowledge and practice. The Toolkit is aimed at voluntary Board members, paid CEOs, and other staff working in non-government AOD organisations, however it is applicable across the range of non-government and community service sectors. The Toolkit is divided into three sections: i. Board responsibilities; ii. Governance processes; and iii. Characteristics of effective boards. The Toolkit also highlights governance practice from the non-government drug and alcohol sector, provides practical resources, and refers readers to external sites for further information and other resources. The Toolkit is available free to download at: www.nada.org.au/resource.nadapublications/resourcetoolkits/nada-governance-toolkit/.

The Australian Drug Foundation has launched its new educational shop website, highlighting an extensive range of drug educational tools designed for educators, health workers and parents.

New and popular products include:

- Be Careful of S.D.D. (Seemingly Irrlevant Decisions)
- Take Care of Your Drinking and You May Not Need to Quit
- What Drug is That?
- The Safer Injecting Handbook
- Standard Drinks Kit.

For copies of the report, visit: http://bookshop.adf.org.au/.

Governance tools

The NADA Governance Toolkit has been developed to assist organisations within the NSW non-government alcohol and other drug (AOD) sector to improve governance knowledge and practice. The Toolkit is aimed at voluntary Board members, paid CEOs, and other staff working in non-government AOD organisations, however it is applicable across the range of non-government and community service sectors. The Toolkit is divided into three sections: i. Board responsibilities; ii. Governance processes; and iii. Characteristics of effective boards. The Toolkit also highlights governance practice from the non-government drug and alcohol sector, provides practical resources, and refers readers to external sites for further information and other resources. The Toolkit is available free to download at: www.nada.org.au/resource.nadapublications/resourcetoolkits/nada-governance-toolkit/.

The National Centre for Education and Training on Addiction (NCETA) has launched its new Indigenous Worker Wellbeing Resources Kit. The kit is an extension of a broader program of work undertaken by NCETA on alcohol and other drug (AOD) workers’ stress, burnout and wellbeing. This resource addresses the specific needs of Indigenous workers in the AOD sector. It identifies high levels of demand and sources of stress, but it also notes the commitment of Indigenous workers and the rewards associated with the work they do. The resource provides practical strategies to improve Indigenous worker wellbeing at the individual, group, organisational and community levels. The Resource Kit contains three separate documents plus a CD ROM with electronic copies of the documents. It includes: Indigenous Alcohol and Drug Workforce Challenges: A literature review of issues related to Indigenous; AOD workers’ wellbeing, stress & burnout, Indigenous AOD Workers’ Wellbeing, Stress and Burnout: Findings from an online survey, and Stories of Resilience: Indigenous Alcohol and Other Drug Workforce. The publications include case studies, speakers notes, and templates, through to the legal note writing, from the nuts and bolts of complex legal documentation, togetIDATo a CD ROM plus a CD ROM with electronic copies of the documents. It includes: Indigenous Alcohol and Drug Workforce Challenges: A literature review of issues related to Indigenous; AOD workers’ wellbeing, stress & burnout, Indigenous AOD Workers’ Wellbeing, Stress and Burnout: Findings from an online survey, and Stories of Resilience: Indigenous Alcohol and Other Drug Workforce. The publications include case studies, speakers notes, and templates, through to the legal note writing, from the nuts and bolts of complex legal documentation, to the nuts and bolts of complex legal documentation, to...
One of ‘them’: stigmatising labels lead to inequalities


People who inject drugs (PWID) often suffer poor physical and mental health. This is because PWID are highly stigmatised because their behaviour is heavily stigmatised due to media portrayals. Once loaded, the marker becomes negatively ‘unloaded’ through general society’s experience of the marker (e.g. damaging media portrayals). Once loaded, the marker becomes a stigma, and discrimination follows. Discrimination leads to disadvantages for the stigmatised individual (e.g. poorer access to health care). Such setbacks impair self-esteem, causing stress and greater disability. Consequently, the labelling of PWID as one of ‘them’ and not ‘us’ leads to social exclusion, thus leading to self-imposed exclusion (e.g. from mainstream healthcare). Accordingly, the labelling of PWID as one of ‘them’ and not ‘us’ leads to social exclusion, thus significantly impacting this group’s poor health.

A public health framework for understanding stigma identifies several interdependent components working together: (i) people first identify then label human differences; (ii) mainstream cultural beliefs link the labelled difference to undesirable characteristics, thus creating negative stereotypes; (iii) categories of ‘us’ and ‘them’ are used to separate people; and (iv) labelled individuals experience loss of status and discrimination resulting in unequal outcomes. Stigma thus affects health through various pathways, including by causing psychological stress. Enacted stigma (discrimination) causes individuals to internalise stigma and expect to be discriminated against (felt stigma). Felt stigma reduces people’s involvement in drug use as more credible and able to genuinely understand the ways that stigma operates to impede healthcare access. For instance, staff predicted treatment completion is important. Most clients perceived staff with histories of drug use as more credible and able to genuinely understand the treatment even after other relevant variables such as felt stigma. These expectations can influence what people pay attention to in social settings and the inferences that are drawn about others. Clients perceived staff with histories of drug use as more credible and able to genuinely understand client issues, particularly of real or perceived discrimination. Staff recognised the importance of reflecting on their interactions with clients to ensure that staff behaviours (e.g. enforcing rules of the service) were not misinterpreted or negatively construed. Results demonstrate that to enhance treatment programmes, staff should consider past history of discrimination and negative healthcare experiences that could shape clients’ perceptions of current treatment staff.

Negative attitudes to HCV in healthcare settings


Discrimination related to hepatitis C virus (HCV) is reportedly common, and is suggested to occur because of society’s equation of injecting drug use with HCV, and generally poor knowledge about transmission risks. Ancillary evidence suggests that HCV-related discrimination is common in healthcare settings, where it may alienate people with HCV and people who inject drugs (PWID), impede access to bloodborne virus (BBV) testing, drug treatment and general health services, and reduce exposure to BBV prevention resources. This paper presents findings from a self-completed survey of people living with chronic HCV infection recruited through a hepatitis C magazine (n=450) or a Sydney needle syringe program (n=54).

Perceived discrimination was assessed by asking participants if they had ‘ever been discriminated against... because you have hcv c or... because you were an injecting drug user’ by nine categories of people including doctors, other healthcare workers, employers, family, friends or insurance companies. Sixty-five per cent of participants reported having experienced discrimination in at least one setting. Those who experienced discrimination were significantly more likely to agree with items such as ‘his problem is caused by a reckless lifestyle’ and ‘the poor choices he made’; and ‘he should be given a jail sentence to serve as a wake-up call’. These clinicians were more likely to endorse items which together conveyed personal culpability, suggested he had voluntary control and should be given a punishment such as jail time and therefore deserving of punishment. Results thus suggest that even among highly trained clinicians, referring to an individual as a ‘substance abuser’ may elicit negative perceptions of the individual and lead to negative judgements, inadvertently encouraging people to assume ‘it’s his own fault’, rather than, ‘he can’t help it’.

A SELECTION OF RECENT STUDIES LOOKS AT THE ISSUE OF STIGMA IN RELATION TO PEOPLE WHO USE ILLICIT DRUGS, AND HOW IT CAN IMPACT ON THEIR INTERACTIONS WITH HEALTH CARE PROFESSIONALS.
People who use drugs are members of just one group in society who face ongoing stigma and discrimination. Discerning attitudes exist across the spectrum, including ethnicity, socio-economic status, gender and other health conditions, to name just a few targets. The mental health sector is one of the closest areas to intersect with the alcohol and other drug sector. It is worth looking at that sector’s efforts to tackle long standing stigmatisation.

The stigma associated with mental illness is a barrier to optimal recovery, and many people report that the stigma associated with their illness is as distressing as the symptoms themselves (Hocking 2003).

Since stereotypical images in the media reinforce the stigma of mental illness, the media is regarded as an important player in changing perceptions of people with mental illness. To this end, the Australian Government’s Department of Health and Ageing established the Mindframe National Media Initiative, a comprehensive strategy that aims to influence how issues related to mental illness and suicide are reported in the media to ensure responsible and sensitive representation.

Part of the Initiative is StigmaWatch, a web-based program run by the national charity SANE Australia to promote accurate and respectful reporting, expose cases of media stigma to public scrutiny, and educate those responsible for stigmatising.

Members of the community are invited to send reports of media content, and if they are judged as stigmatising they are posted on the site with responses from the professional or organisation concerned. Positive and appropriate reporting of mental illness and suicide are also reported and appear in the Good News Section.

The Mindframe National Media Initiative also provides journalists with the resource Reporting Suicide and Mental Illness which gives practical advice and information about sensitive and appropriate reporting of suicide and mental illness. In a separate initiative by the South Australian Government, the recommendations made by the state’s landmark report Stepping Up: A Social Inclusion Action Plan for Mental Health Reform (2007-2012) led to a media campaign aimed at ending the stigma of mental illness. The report recommended that a ‘slow stream’ public health campaign be developed to educate the community about mental illness and promote positive messages about people dealing with mental illness.

The ‘Let’s think positive’ campaign, launched in February this year, is a series of advertisements aimed at improving perceptions the general community holds of people with a mental illness by challenging common assumptions. The ads show three real-life scenarios of a person’s work, social and family life in three distinct television commercials. The campaign also includes radio commercials, online and outdoor ads, and brochures. ‘This campaign’s intended to get people thinking about how our actions, attitudes and language can really affect others’, said Mental Health Minister John Hill.

‘One in five of us will be affected by mental illness this year and we want to shine a light on the stigmatisation and discrimination that can accompany it.’

For information about StigmaWatch visit SANE Australia at: www.sane.org.

The television commercials can be viewed at: www.sahealth.sa.gov.au/thinkpositive.
Judgments of whether people who use drugs deserve a high or low level of care influence the quality of treatment by healthcare workers (Skinner et al. 2007). Such attitudes are contrary to expectations concerning professional ethics in the health sector, the researchers write, and it is essential to identify what lies behind the negative and discriminatory views some health professionals hold towards people with stigmatised conditions.

Addressing stigma and discrimination

The AIVL report calls for discrimination against people who use drugs, and particularly those who inject, to be tackled on numerous levels. These include the expectation of ethical treatment by the medical profession, changes in perception and representation by the mass media, and the education of the general public. One of the recommendations of the report was the development of a national training module dealing with stigma and discrimination against people who inject drugs for inclusion in university courses in the areas of medicine, nursing, pharmacy and dentistry, and in police training.

‘Addressing stigma is a complex, multi-dimensional, multi-layered thing,’ says Professor Treloar. ‘For one thing, we need to ensure there is always a healthy critique of how drug use, drug users, and health services for people who use drugs are constructed and portrayed in the media. If we see anything that does harm in terms of stigmatising or reinforcing stigma, we need to have the opportunity and the courage to say it’s not acceptable.’

When a Western Australian study dispelled the stereotype of people who inject drugs, showing, for example, that more than 46 per cent were employed and that many were not physically dependent on the drugs they were using, the story was reported in the Australian media (Lenton et al. 2000). This did a lot to challenge public perceptions of people who inject drugs, says Professor Simon Lenton, Deputy Director of the National Drug Research Institute at Curtin University in Perth, WA.

‘Afterwards I had a number of people come up to me and say the coverage helped them explain to family members and others, who had simply seen them as “the stereotype”, that they were individuals and contributing members of the community like anyone else,’ he says.

In a step towards educating and changing perceptions, AIVL employed an advertising agency to produce a short film that tackles discrimination against people who inject drugs, and presents a different way of responding to people who inject. “We are planning to distribute the film to schools and medical facilities,” says Byrne. ‘We’re also developing a module on stigma and discrimination that will go with the film.’ AIVL’s film was launched in late May.

For a list of all references cited in this article, email editor@andc.org.au.
What’s in a word? Suzanne Helfgott and Celia Wilkinson*

From our professional workforce development experience in the alcohol and other drug (AOD) field, it appears that the term ‘recovery’ has become increasingly popular in both the research literature and in clinical practice. Despite this, there appears to be little consensus on how the term should be defined. Recovery has been variously described as ‘remission’, ‘resolution’ and ‘abstinence’, and also of ‘recovering’ oneself (Laudet 2008). However it has also been described as ‘characterized by voluntarily-sustained control over substance use which maximizes health and wellbeing and participation in the rights, roles and responsibilities of society’ (UK Drug Policy Commission 2008). As language can either enlighten or obscure an issue, it is timely that views on what recovery can mean are discussed to ensure that we develop a shared understanding of the meaning of the term. It is important that the term is reflective of the diverse shifts that individuals make when embarking on change, and does not just focus on abstinence or cessation of drug use.

Definitions over time

Historically, the term ‘recovery’ was used in relation to the disease models of dependence, in which the development of alcohol-related problems was viewed very much as a medical or ‘diseased’ condition. In the 1980s, recovery became a common term in the ‘spontaneous remission’ literature, which refers to a treatment approach at the time in which people changed drug use behaviour without the aid of formal treatment (Tuchfeld 1981; Biernacki 1986). However it has also been described as ‘characterized by voluntarily-sustained control over substance use which maximizes health and wellbeing and participation in the rights, roles and responsibilities of society’ (UK Drug Policy Commission 2008). As language can either enlighten or obscure an issue, it is timely that views on what recovery can mean are discussed to ensure that we develop a shared understanding of the meaning of the term. It is important that the term is reflective of the diverse shifts that individuals make when embarking on change, and does not just focus on abstinence or cessation of drug use.

Lifelong recovery

A reflection on recovery in terms of a comprehensive biopsychosocial perspective is needed when, in both the AOD and mental health sectors, there is growing evidence of a shift from an intervention focus to a focus on long-term lifelong recovery journeys (White 2007). This trend has also seen the design of drug dependence treatment shift from a model of acute biopsychosocial stabilisation to a model of long-term management (White 2007).

While in these treatment models recovery often appears synonymous with abstinence, such a narrow definition ignores that severe problems of dependence are often inextricably bound with other ‘life problems’. Abstinence without resolution of physical, psychological, social and family problems, would not sit well with the view of recovery as equivalent to achieving personal autonomy. In addition, viewing recovery as achieving a drug-free state may not be feasible or even desirable for some people. If drug use is a response to intolerable circumstances, as it sometimes is, pursuing a drug-free option may not necessarily help and may even increase symptoms, especially post-trauma symptoms. An emphasis on encouraging people with drug problems to become drug free might also lead to an intolerance of, and sanctions against, those who do not immediately attain abstinence, for whom recovery is a long term process (Carlin 2011).

Towards a holistic definition

While remission or abstinence from drug use conveys only what is absent from one’s life, the notion of recovery should include what is present, i.e. a more meaningful and fulfilling life. The need to effect a paradigm shift from a disease or pathological view of addiction, to wellness and global health, from acute to continuing care models is advocated by a number of researchers (White 2007; Laudet 2007). This notion of recovery is similar to mental health definitions which state that recovery is not synonymous with a cure, but having opportunities and choices, and being empowered to lead a meaningful and fulfilling purposeful life (Mental Health Commission WA 2011). In this view of recovery, the use of substitute pharmacotherapy as an adjunct to treatment is judged, not by their presence or absence, but rather by the impact they have on reducing harms to the individual, their family and the community. The significance in terms of recovery is in the role these medications play in resolving severe AOD-related problems (Miller 1996 as cited in White 2007, p. 238). For example, as Murphy and Irwin (1992) stated, ‘… denying medically and socially stabilised methadone patients the status of recovery is a particularly stigmatizing consequence’ (as cited in White 2007).

Recovery as a process

White (2007) defined recovery as ‘the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe AOD problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life’. Depicting recovery as a process conveys that initiating and sustaining recovery are quite different processes (Snow, Pruchnicki & Ross 1994, cited in White 2007). Including families and communities in this definition affirms the interconnectedness between the individual and the environment in which they reside. This type of model assumes that the ‘process involved in fostering and sustaining change may occur gradually over multiple, linked service interventions that unfold over years’ (Hser et al. 1997 as cited in Laudet 2008). A holistic view of recovery is developed further by Whiteley and Drake (2010) who proposed five dimensions of recovery:

1. clinical recovery, as in improvements in symptoms
2. existential recovery, as in having hope, being empowered and achieving well-being
3. functional recovery, in terms of stable employment, education and housing
4. physical recovery, as in better health and lifestyle
5. social recovery, leading to improved and meaningful relationships with family, friends and community.

As Whiteley and Drake suggested, viewing recovery in this broader framework, allows for person-centred, meaningful and holistic care. Although the Australian National Drug Strategy 2010-2015 (Commonwealth of Australia 2010) does not define recovery, the document nonetheless suggests that recovery from AOD problems should involve not just recovery from dependence, but reconnection with the community. The strategy notes that ‘recovery is most effective when the individual’s needs are recognized at the centre of their care and treatment’ (Commonwealth of Australia 2011).
THE DEFINITION TRAP

David Best, Turning Point Alcohol and Drug Centre / Monash University

Despite an established recovery paradigm for mental health (enshrined in the National Mental Health Action Plan), the advent of a ‘recovery movement’ for AOD has provided both confusion about its nature and purpose and anxiety about its consequences. The concerns can be summarised in three main questions:

- What is recovery all about?
- Who are the likely beneficiaries (and the corollary of who will lose out)?
- What is different from what we do already?

The issue around defining personal recovery – and existing attempts at definition – are well articulated in the companion article by Helfgott and Wilkinson, and I will deal with these only by explanation of why definition is problematic for those from a recovery perspective. Many recovery definitions are deliberately vague (‘a sense of hope, a sense of purpose, a sense of belonging and a positive identity’, Best 2011) or deliberately inclusive (‘you are in recovery if you say you are’, Valentine 2011), because the aim is to move away from something that could be ‘diagnostic’ – recovery is an experiential process, and something that emerges over time and it will vary markedly over time. However, it is important to say that the philosophical roots (the user empowerment and involvement models, among others) do not require such a clinical determination of ‘you are in recovery.’

Indeed, the emergence of a recovery movement as a grassroots drive for social inclusion, social justice and community participation assumes that recovery is something that exists between people as much as something that exists within them. The Recovery Academy Australia (RAA) has developed to provide a forum for recovery awareness raising and to provide a pluralistic voice to those who wish to champion hope and to belong and engage in visible recovery activities that are inclusive. Our aim is to engage in activities that supplement treatment endeavours, to create local targets and goals, and to celebrate the success of recovery as a mechanism of challenging stigma and discrimination.

In the US, no less a figure than President Obama has made proclamations endorsing Recovery Month. ‘Recovery promotes health, safety and success for people who have been affected by mental illness and substance use disorders. Recovery is a voluntary self-determined process toward wellbeing through minimisation or cessation of drug-related harms. This involves fostering healthy supported connections, such as with self, family, peers and community, and is premised upon fair access to pre-requisites for wellbeing.’

Anex: Towards an Australian understanding

Anex is a leading national voice in the public health sector. It proposes the following definition of recovery for the Australian context:

‘Recovery is a voluntary self-determined process toward wellbeing through minimisation or cessation of drug-related harms. This involves fostering healthy supported connections, such as with self, family, peers and community, and is premised upon fair access to pre-requisites for wellbeing.’

For a full list of references cited in these articles, please email editor@mdc.org.au.

A MENTAL HEALTH PERSPECTIVE

Debra Rickwood, Professor of Psychology, Faculty of Health, University of Canberra, and Head of Clinical Leadership and Research, headspace.

In the mental health field, recovery is a term that has been promoted by people with lived experience of mental illness, supported by a growing body of evidence about the positive long-term outcomes for people who have been seriously affected by mental illness (Harding, Zuhn & Straus 1992). The term is partly a reaction against a mental health service system that previously treated people as if there was no hope of living a full and meaningful life after diagnosis. The term has been used to mean recovery from the catastrophic effects of diagnosis with a psychiatric disability (Anthony 2000). What is recovered is hope and opportunity. Outdated beliefs regarding the inevitable adverse impacts of mental illness should no longer be perpetuated, and a recovery orientation needs to be prioritised in policy and practice related to treatment and continuing care.

Importantly, the term recovery does not mean being recovered, as in no longer experiencing any symptoms of mental illness. Recovery is a journey not an outcome. The journey of recovery accommodates the often fluctuating nature of the experience of mental illness; it acknowledges that some people will not have a recurrence of illness, others will have some further episodes; and a minority will experience longer-term repeated episodes of illness. Consequently, recovery is affected by risk and protective factors that are unique to each person. Regardless of the longer-term course, however, maximising hope, opportunity and well-being is essential for all. Recovery, therefore, recognises the fundamental importance of self-determination. A person’s recovery journey must be self-determined to be meaningful; goals and aspirations change over time as a person grows through, and potentially beyond, the experience of mental illness.

The role of services in recovery is to provide effective support when and where required, within an integrated system that enables people with mental illness to put in place the supports they need to maximise their wellbeing. Requirements for support will change over time, and services need to be responsive to different needs at different times.

Many common factors have been identified that impact on people’s recovery journeys. A large national consultation undertaken by Rickwood summarised some essential elements as comprising (Rickwood 2006a, b):

- awareness and acceptance of having a vulnerability to mental illness and being aware of risk and protective factors
- anticipation and planning related to personal risk and protective factors and putting in place plans to address these at all levels
- availability of alternatives to ensure there is a range of effective clinical, therapeutic, psychosocial, community support and illness self-management opportunities to meet people’s varied and changing needs
- access to services that are flexible, timely and responsive to the needs of people with mental illness and their families.

Finally, recovery fits within a broader spectrum of interventions for mental health. This spectrum spans prevention (for those at different levels of risk of mental illness) through to continuing care (for those who experience recurrent illness), underpinned by a foundation of mental health and wellbeing of all people regardless of current illness status. Investment in interventions across the entire spectrum is essential to improve the mental health and wellbeing of Australians and to reduce the individual, family and community impact of mental illness.
Christopher Kennedy Lawford was eight years old when his uncle, President John F. Kennedy, was assassinated in 1963 and 13 when another uncle, Senator Robert Kennedy, was murdered during his own presidential campaign. With his family’s turmoil rehashed constantly in the media throughout his adolescence and both parents — British actor Peter Lawford and Patricia ‘Pat’ Kennedy — battling alcoholism and drug addiction for most of their adult lives, it is perhaps no surprise that Lawford himself began using drugs and alcohol in his early teens. After years of near-fatal substance abuse, Lawford went into treatment and embraced 12-step recovery programs AA and NA.

As a prince in the nearest thing America has to royalty, Lawford’s own story is one of money and privilege, but this was no antidote to the chaos that enveloped his family. ‘I started using drugs at 12 years old because I couldn’t deal with life. Life sucked.’ They were killing people in my family. My parents divorced. I grew up around alcoholism. As well as being passionate about recovery, Lawford clearly possesses the talents and potential of people who have benefited from recovery should stand up and take a leadership role. He argues that the tradition of anonymity within 12-step programs is misunderstood. ’Most people say I can’t talk about recovery. No, you can. Bill Wilson [the co-founder of Alcoholics Anonymous] said, “talk about recovery, don’t talk about your association with AA.” I live in a community with a bunch of celebrities who are well-known drug users. They believe all the things we believe in, that people who are in trouble with drugs deserve treatment opportunities, but they just keep their mouths shut because they use drugs. They think, “I’m going to get killed by the recovery movement. I’m going to get killed by the people who are anti-drug.”'

Lawford has another view: that the recovery movement can carry its message loudly and boast of its achievements beyond just getting people sober and clean. ‘The message from the Co-Founders of Alcoholics Anonymous is that we’re powerless, that our primary purpose is to stay sober and help another alcoholic or drug addict and that we do it for free and unnoticed. All good stuff, but not everybody has to do it that way. You can do it out here, you can do it with a public face and with an attitude that we have something positive to offer the world.’

‘Amazing people’

As well as being passionate about recovery, Lawford clearly has a lot of time for people who are dependent on drugs or alcohol. ‘I want to be around them. I prefer them. They’re amazing. They have a vibrancy and a lust for life and all of this stuff that’s interesting about the human condition. My friend [Oscar-winning actor] Richard Dreyfuss said, “All addicts are trying to touch the hand of God. We’re running from pain, and we’re searching. I think we’re amazing people.” This is what I believe, that we’re amazing people and we have a lot to give the world.’

Lawford laments that the talents and potential of people who overcome their addiction are often wasted. ‘My uncle Jack, who also had issues with this stuff, used to say that people who achieve great things in the world overcome great things. We have millions of people who have overcome some of the hardest things you can ever overcome, this 800-pound gorilla of addiction. And then they’re shut to the side like they have nothing to offer. It’s a mistake.’

Taking recovery seriously

Lawford argues that policy makers should help remove some of the barriers to drug and alcohol treatment. ‘One of the concerns I have is that treatment isn’t available to people without a lot of money, for the most part. In the United States you need to have money to get treated for this disease, even with insurance. You’ve got to pay $1000 a day for 30 days of primary care, and then another $500 a day for extended care. You’re talking 60 grand to go to a treatment centre for 90 days. I mean it’s insane. It can’t be that just the top one per cent can afford it.’

Although Lawford acknowledges that the health system in Australia is structured entirely differently from that of his own country, he agrees that Australia would benefit from a change of emphasis from supply reduction towards harm reduction and recovery. ‘The data shows that if you spend money on treatment and prevention it saves money on other costs: health care, law enforcement, criminal justice. And if you spend money on demand reduction versus source eradication it’s also money better spent. The data’s there, but the politicians won’t do it because it’s a hard sell.’

Another hard sell, in Lawford’s view, is the belief that people with drug and alcohol dependency can ever really recover. Studies by Hazelden and A Drug Free America on American attitudes towards substance dependency suggest that people believe addiction is an illness and that, although they feel people who are dependent on drugs are competent in their addictive behaviour, they also believe that they deserve treatment. ‘But they don’t believe that they’ll ever recover,’ laments Lawford. ‘They don’t believe in recovery. That’s a problem, because until you believe there’s a solution, it’s hard to find political will. Treatment isn’t perceived as a solution, it’s perceived as a revolving door. Nora Volkow, director of the National Institute on Drug Abuse, said to me: “We spend a lot of money on prevention, we spend a lot of money on treatment, we do it fairly well. But we spend no money on recovery. We know nothing about recovery. We don’t know why people go there, what keeps them there, what’s going on, what can we do.” So I would like to see an investment by government in recovery.’

Employment: A weapon against stigma

Discrimination, in Lawford’s view, is still one of the biggest barriers towards recovery. ‘In my country if you have a drug conviction you don’t get a student loan, you don’t get student housing, you can’t vote in some states, you can’t drive in some states. It’s insane. This is the wreckage from our zero-tolerance policy.’ He argues that providing employment for people in early recovery is the most important thing you can do. ‘In 12-step programs, self-supporting through your own contributions is not negotiable. When you go into an AA meeting or an NA meeting the first thing is “don’t use”. The next thing is “Do you have a job?” Because you’re going to build your self-esteem if you can take care of yourself with a pay cheque. It’s a big deal for us.’

Speaking out

Lawford’s biggest message is that more people like himself who have benefited from recovery should stand up and take a leadership role. He argues that the tradition of anonymity within 12-step programs is misunderstood. ‘Most people say I can’t talk about recovery. No, you can. Bill Wilson [the co-founder of Alcoholics Anonymous] said, “talk about recovery, don’t talk about your association with AA”.’ I live in a community with a bunch of celebrities who are well-known drug users. They believe all the things we believe in, that people who are in trouble with drugs deserve treatment opportunities, but they just keep their mouths shut because they use drugs. They think, “I’m going to get killed by the recovery movement. I’m going to get killed by the people who are anti-drug.”'

Lawford has another view: that the recovery movement can carry its message loudly and boast of its achievements beyond just getting people sober and clean. ‘The message from the Co-Founders of Alcoholics Anonymous is that we’re powerless, that our primary purpose is to stay sober and help another alcoholic or drug addict and that we do it for free and unnoticed. All good stuff, but not everybody has to do it that way. You can do it out here, you can do it with a public face and with an attitude that we have something positive to offer the world.’
A rising tide

IN THE LAST FEW YEARS, BOTH IN AUSTRALIA AND INTERNATIONALLY, CONCERN HAS BEEN BUILDING ABOUT A MARKED INCREASE IN PRESCRIPTIONS FOR OPIOID ANALGESIC PREPARATIONS, PARTICULARLY TWO MAIN PRODUCTS ON THE MARKET, MORPHINE AND OXYCODONE.

This article focuses firstly on the role of opioids in relieving suffering, and available statistical information on the rise in prescriptions, both in Australia and overseas. We describe what is known about their different uses and the problems arising from misuse, and the evidence concerning both use and misuse, and where more information is needed. We then look at some reasons for the substantial increase in use, in terms of both supply and demand, and the problems arising from misuse. Lastly, the article outlines potential responses to these and the need to raise public and practitioner awareness of the dangers of overuse and misuse.

Trends in opioid use

Over the past 30 years the therapeutic use of opioids has increased significantly in many developed countries, including Australia, both for managing pain and in treating opioid dependence.

Australia’s total consumption of opioid analgesics is now ranked tenth internationally. Out per capita consumption of oxycodone ranks third, and morphine preparations fifth, internationally (Roxburgh et al. 2011).

Opioids are one group of pharmaceutical drugs. These drugs can be obtained over the counter by prescription, or illicitly. Prescribed opioids may be used as intended, or misused, either by the person for whom they are prescribed, or by others. The development of longer-acting and sustained-release oral opioids over the past two decades has improved the management of pain, especially acute and malignant pain, for millions of sufferers.

When used as intended, prescribed opioids play an important clinical part in alleviating suffering for many people. Nevertheless, the rise in prescriptions has been accompanied by some disturbing evidence of increasing misuse (both unintentional and deliberate).

A 2011 report by Nicholas, Lee and Roche from the National Centre for Education and Training in Addictions (NCETA) cautions:

‘The central issue is not the level of use per se, but rather the extent to which that level is consistent with the quality use of these medicines. It is imperative that this distinction is understood. Otherwise, there is a risk of introducing measures that aim to achieve a generalised reduction in use, rather than measures which seek to promote their quality use.’

International experience

Global consumption of pharmaceutical opioid analgesics has increased by more than two and a half times during the past decade, mainly in North America and Europe.

The National Centre for Education and Training in Addictions (NCETA) was appointed by the Victorian Department of Health, on behalf of the Intergovernmental Committee on Drugs to lead the development of the National Pharmaceutical Drug Misuse Sub-Strategy. The strategy is due for public release in September this year. Its primary focus is prescription opioids, benzodiazepines and anxiolytics containing codeine, categories where drug use is overlapping and polydrug use appears to be common.

This article draws heavily on NCETA’s preparatory report, Pharmaceutical drug misuse problems in Australia: Complex issues, balanced responses. Published early this year, the report provides the first comprehensive overview of what we know about the use and misuse in Australia of pharmaceutical drugs, and argues for a range of strategic responses.

Reference


The International Narcotics Control Board (INCB) has reported that prescribed drugs have become a first choice for many people who use illicit drugs, substituting them for their usual drugs (INCB, cited in Flinders, Lee & Roche 2011).

Prescription drug abuse has been described by the US Office of National Drug Control Policy as of epidemic proportions, in what is believed to be the largest per capita problem of non-medical use, injection and diversion of pharmaceutical opioids. In 2005 the US accounted for half the world’s estimated morphine consumption, while comprising 4.7 per cent of the world’s population.

While levels of consumption of pharmaceutical opioids in Western Europe are lower than in the US and Canada, they appear to vary, country to country, from significant levels to negligible. Misuse and diversion are known to be occurring, but there are problems of data reliability and inconsistencies in reporting.

A region of significant concern is South Asia, where there are reports of diversion of pharmaceutical opioids on a large scale, for example in India, primarily because of limited enforcement of pharmaceutical regulations.

In many developing countries access to opioid medication is very low; indeed their populations experience high levels of unmet legitimate medical need for opioids, principally because people cannot afford them.

Australian opioid supply

Various sources of data on prescription opioids in Australia reveal a steady increase in recent years in morphine prescriptions. Particular opioids showing a substantial increase include tramadol, oxycodone and fentanyl.

In the past five to six years, prescriptions of oxycodone in particular have soared: the Pharmaceutical Benefits Scheme (PBS) reported a 20 per cent increase between 2003–2004 and 2007–2008. Supply increased from 95.1 kg in 1999 to 1270.7 kg in 2008 – a more than 13-fold increase.

Drug Monitoring System (DRUMS) data between 1995 and 2003 showed an 89 per cent increase over the period in the average number of milligrams of morphine prescribed per person aged 15-54 years. These figures almost certainly underestimate supply because they exclude some kinds of prescriptions, such as private (non-subsidised) prescriptions, hospital prescriptions and other sub groups.

While increased supply may be largely attributable to appropriate prescribing for legitimate medical conditions, it is also a factor associated with increasing misuse, and thus needs to be considered in public health policy responses.

Who is using prescribed opioids?

Like other pharmaceutical drug users, people who take prescribed opioids are not a homogeneous group. Two well-identified groups are clinical patients in older age brackets, and people in opioid substitution treatment (OST) programs – also increasingly representative of older age groups.

Our ageing population is a significant factor in the rising use of prescription opioids. Broadly speaking, older people need pain relief and management more than younger people for acute or severe post-operative pain, cancer-related pain and other chronic non-cancer pain (CNCP). CNCP is more prevalent among older people and its treatment with opioids is increasing – often because of the availability of, or ignorance about, potentially more effective treatments.

With respect to people receiving OST, numbers have grown strongly since a decade ago, and many more of them are older (12.5 per cent were 50-59 years of age in 2009, compared to 7.6 per cent in 2006). There is evidence that OST clients suffer more from chronic pain than the general population, and are likely to experience pain treatment issues associated with long-term opioid substitution therapy, or with illicit opioid use. They also have a high prevalence of pharmaceutical drug misuse.

The high cost of OST can provide an incentive for this group to seek cheaper PBS opioid medications instead. Dr Alex Wodak, Director of the Alcohol and Drug Service at St Vincent’s Hospital Sydney, argues that a contributing factor to increasing use of prescription opioids is the growing difficulty of accessing methadone and buprenorphine programs.

The INCB has reported that misuse of and trafficking in prescription drugs exceeds that of illicit drugs in some countries (INCB, cited in Flinders, Lee & Roche 2011).

The NCETA report suggests this is a likely scenario in Australia. The subsidised prices of PBS medicines make them relatively cheap, especially for health and pension card holders. This provides an incentive to some people to obtain prescription opioids (and other pharmaceutical drugs) wholly or partially to profit from non-selling them.

People with no history of injecting drug use are taking pharmaceutical drugs, including opioids, at levels above recognised therapeutic doses, but they are not captured in traditional data sets and are not in treatment, so are difficult to quantify. In studying these populations Dr Suzi Nielsen, a Research Fellow in the Discipline of Addiction Medicine at the University of Sydney, has found that these ‘non-traditional’ users are reluctant to seek help from alcohol and other drug services (AODs) and tend not to identify as AOD clients. ‘People who take codeine above safe doses, for example, have been identified through research examining codeine dependence, but few seek treatment and may only come to notice through hospital presentations due to severe side effects from taking high doses of these products,’ she says.
PRESCRIBED OPIOIDS

Evidence gaps
At present in Australia there is only a patchwork of evidence to guide effective approaches to reducing misuse of opioids and associated harms. Evidence of misuse comes from general population surveys, surveys of illicit drug users, drug treatment data and data concerning offenders. The NCETA report describes several factors that hamper our understanding of what is going on. They include limitations in the coverage, consistency and timeliness of medium of monitoring systems; lack of timely access for police to relevant data; jurisdictional differences; inability to distinguish between use and misuse of pharmaceutical drugs in drug-related death records; and very limited research into pharmaceutical misuse.

While data on misuse is neither comprehensive nor unambiguous, what we do know from the available evidence is that, intentionally or not, opioids are sometimes misused by people with medical conditions for which the drugs are prescribed. Roxburgh et al. (2011) point out that non-medical use and diversion are complex behaviours, and ‘may occur among different groups of consumers’.

Supply, marketing and demand
It has been argued that, when heavily promoted and prescribed, controlled drugs with potential for misuse and diversion pose different and more problematic public health risks than do uncontrolled drugs. OxyContin has been cited as a case study in this regard (Van Zee, cited in Flinanders, Lee & Roch 2011).

Following its release in 1996, OxyContin was aggressively marketed and promoted, resulting in rapid and sustained sales increases. By 2004 it had become a leading drug of misuse in the United States. The period coincided with increases in prescription, acceptance of, and treating pain, particularly for chronic non-cancer pain – a much larger market than the market for treating cancer-related pain.

As mentioned, slow-release opioids can be highly effective in alleviating severe acute pain and pain from malignant conditions. However, the lack of relief in the belief and management of moderate and chronic non-cancer pain is being debated by some as the available evidence supporting their use for this condition is of variable quality. The effectiveness of management conditions related to nerve damage is also in question.

Misuse and associated harms
There is wide acceptance today that a primary objective of policies to address problematic use and misuse of drugs should be to minimise harm. Although the increase in opioid prescribing is not necessarily a concern in itself, as with other pharmaceutical drugs it has been associated with an increase in harms. Concerns include problematic administration, higher levels of overdoses, poly or multiple drug use, and an increasing demand for treatment, which is likely to be an indicator of increasing misuse and dependence.

Problematic administration
Some people are using pharmaceutical drugs including prescription opioids in ways unintended by their makers or medical professionals. For example, they may be chewed, or crushed for snorting or injection with the intention of bypassing slow-release formulations and increasing rate absorption. They may also be stockpiled to enable users to take large doses.

Diverse research strongly suggests that some consumers are highly vulnerable to harms because they do not understand the possible dangerous consequences of taking prescription opioids with other drugs, including alcohol, or of taking them at levels above the prescribed dose. Thus there is a strong case for education of patients and other users, and of the health professionals who prescribe, dispense and monitor their use.

Deaths involving drug toxicity
Drug-related mortality is an important indicator of drug-related harm. However, changes in Australian Bureau of Statistics methodology in 2006 have made it impossible to provide comparable year-by-year data on the number of drug-related deaths in Australia. A recent study by Roxburgh et al. (2011) found that the number of deaths attributable to opioid overdose nationwide fell to 269 in 2006 (from 174 in 2005). At the same time, there were high numbers of ‘open’ coronal findings in jurisdictions where high numbers of opioid overdose deaths had previously been recorded.

Oxycodeone-related deaths
One of the complications in extrapolating causes of death involving drug toxicity is poly or multiple drug use. Both licit and illicit drugs may be implicated, including prescribed opioids and other pharmaceuticals.

Some recent studies, together with evidence from coroners’ reports, show that deaths involving oxycodone are increasing – even though it is not possible to be precise about its contribution in each case.

In their research on the prescription of opioid analgesics and related harms, Roxburgh et al. (2011) reported a three-fold increase in oxycodone-related deaths nationwide. One may assume that there is a significant increase, again, because it is a drug that has been widely promoted and marketed for use in alleviating severe acute pain and pain from malignant conditions. However, their value in the relief and management of moderate and chronic non-cancer pain is questionable and is well documented, but the extent to which it impacts on prescribing practices is unclear.

What should be done?
Prescription opioids comprise a large proportion of total pharmaceutical drug supply and consumption in Australia.

The National Pharmaceutical Drug Misuse Strategy, in development since 2010, is likely to reflect the range of suggested policy responses advocated in the NCETA report. These aim to strengthen infrastructure, research, monitoring and systems issues; clinical responses; workforce development responses, including guidelines; consumer responses; harm reduction responses; technological responses; and controls on the marketing and promotion of pharmaceutical drugs.

National Electronic Real-time Monitoring System
The first nationwide initiative, the new National Electronic Real-time Monitoring System, being implemented in July this year, is designed to improve monitoring of the supply of controlled substances. It will allow clinicians and pharmacists to check in real time on prescription and dispensing records for patients within their own and from other jurisdictions. It will replace slow and inconsistent recording methods currently used in the ‘boutique’ option of pharmacy provision, and is likely to be more widely available in the future.

What is the evidence?
Research published last year supports concerns about its contribution to drug toxicity and at least half of these were unintentional (Rintoul et al. 2010).

Research published last year supports concerns about the use of combinations of pharmaceutical drugs or pharmaceuticals with other drugs. In NSW between 1999 and 2008, oxycodone was present (among other drugs) in 70 deaths that fell into two main groups: younger people who injected drugs, and chronic non-cancer patients in their 50s (Dr. Dufo & Tórók, cited in Flinders, Lee & Roch 2011).

Intimation of prescribers
A damaging by-product of misuse is intimidation of prescribers and dispensers, particularly of GPs, by patients demanding inappropriate supplies of pharmaceutical drugs. Intimidation can range from verbal harassment to violence and is well documented, but the extent to which it impacts on prescribing practices is unclear.

What should be done?
Prescription opioids comprise a large proportion of total pharmaceutical drug supply and consumption in Australia.

The National Pharmaceutical Drug Misuse Strategy, in development since 2010, is likely to reflect the range of suggested policy responses advocated in the NCETA report. These aim to strengthen infrastructure, research, monitoring and systems issues; clinical responses; workforce development responses, including guidelines; consumer responses; harm reduction responses; technological responses; and controls on the marketing and promotion of pharmaceutical drugs.

National Electronic Real-time Monitoring System
The first nationwide initiative, the new National Electronic Real-time Monitoring System, being implemented in July this year, is designed to improve monitoring of the supply of controlled substances. It will allow clinicians and pharmacists to check in real time on prescription and dispensing records for patients within their own and from other jurisdictions. It will replace slow and inconsistent recording methods currently used in the ‘boutique’ option of pharmacy provision, and is likely to be more widely available in the future.

What is the evidence?
Research published last year supports concerns about its contribution to drug toxicity and at least half of these were unintentional (Rintoul et al. 2010).

Some recent studies, together with evidence from coroners’ reports, show that deaths involving oxycodone are increasing – even though it is not possible to be precise about its contribution in each case.

In their research on the prescription of opioid analgesics and related harms, Roxburgh et al. (2011) reported a three-fold increase in oxycodone-related deaths nationwide. One may assume that there is a significant increase, again, because it is a drug that has been widely promoted and marketed for use in alleviating severe acute pain and pain from malignant conditions. However, their value in the relief and management of moderate and chronic non-cancer pain is questionable and is well documented, but the extent to which it impacts on prescribing practices is unclear.

What should be done?
Prescription opioids comprise a large proportion of total pharmaceutical drug supply and consumption in Australia.

The National Pharmaceutical Drug Misuse Strategy, in development since 2010, is likely to reflect the range of suggested policy responses advocated in the NCETA report. These aim to strengthen infrastructure, research, monitoring and systems issues; clinical responses; workforce development responses, including guidelines; consumer responses; harm reduction responses; technological responses; and controls on the marketing and promotion of pharmaceutical drugs.

National Electronic Real-time Monitoring System
The first nationwide initiative, the new National Electronic Real-time Monitoring System, being implemented in July this year, is designed to improve monitoring of the supply of controlled substances. It will allow clinicians and pharmacists to check in real time on prescription and dispensing records for patients within their own and from other jurisdictions. It will replace slow and inconsistent recording methods currently used in the ‘boutique’ option of pharmacy provision, and is likely to be more widely available in the future.

What is the evidence?
Research published last year supports concerns about its contribution to drug toxicity and at least half of these were unintentional (Rintoul et al. 2010).

Some recent studies, together with evidence from coroners’ reports, show that deaths involving oxycodone are increasing – even though it is not possible to be precise about its contribution in each case.

In their research on the prescription of opioid analgesics and related harms, Roxburgh et al. (2011) reported a three-fold increase in oxycodone-related deaths nationwide. One may assume that there is a significant increase, again, because it is a drug that has been widely promoted and marketed for use in alleviating severe acute pain and pain from malignant conditions. However, their value in the relief and management of moderate and chronic non-cancer pain is questionable and is well documented, but the extent to which it impacts on prescribing practices is unclear.

What should be done?
Prescription opioids comprise a large proportion of total pharmaceutical drug supply and consumption in Australia.
HEPATITIS C VIRUS (HCV) PREVENTION AND CARE IS NO LONGER THE SOLE DOMAIN OF LIVER CLINICS AND PUBLIC HEALTH UNITS, ARGUES ROBERT BATEY. ALCOHOL AND OTHER DRUG (AOD) CLINICS ARE JUST AS INTEGRAL TO BREAKING THE CYCLES OF INFECTION, AND TO INTRODUCING CLIENTS TO THE NEW RANGE OF EFFECTIVE TREATMENTS.

Discovered in 1989, the hepatitis C virus (HCV) has now been characterised in detail. Research has defined the natural history of the infection and produced drugs which can eradicate the virus in a growing percentage of people. Worldwide prevalence figures vary and transmission pathways also vary (Figure 1).

In Australia, the overall prevalence of HCV in the community is approximately 1%, but in the population attending alcohol and other drugs (AOD) clinics this rate can be as high as 70%; similar figures are reported in studies of prison inmates (Ferguson & Batey 2010; Grebely & Dore 2011). Currently it is estimated that around 270,000 Australians are living with chronic HCV infection and, 11,000 new infections occur each year. To date, it is fair to say that AOD clinics have not given HCV the priority it deserves. This brief paper aims to highlight the issues for AOD clinicians in relation to HCV.

**Why should AOD services take a positive approach to HCV care?**

In the past five years, a growing number of reports have shown that HCV treatment can be delivered to people on methadone or buprenorphine programs and those with a controlled use of heroin, with efficacy equal to that in non-opioid using people. New drugs, currently in phase two and three clinical trial investigation, also promise to provide a much more convenient (once a day dosing), acceptable (fewer side effects) and efficacious treatment for all infected individuals.

Most Australians who have chronic HCV infection were infected because they used contaminated injecting equipment. A vast majority (90%) of new infections occur in people who inject drugs, despite a 10+ year effort to minimise shared use of injecting equipment. Each year, Australia provides in excess of 30 million clean needles and syringes and a smaller quantity of other equipment used while injecting, a per capita rate which exceeds any other Western nation. Despite this, our new infection rate is greater per capita than in the United States or Britain. While most initial HCV infections occur in the first year or two of injection use, and before many people come into contact with treatment services, the prevention of HCV transmission is very much the responsibility of AOD services.

HCV transmission is much more the responsibility of AOD clinicians. Reinfection and superinfection with different genotypes occur. Individuals on opioid treatment attend AOD services regularly, providing clinicians repeated opportunities to discuss HCV transmission, risk behaviours for its acquisition and the assessment process pre-treatment. Thus, AOD clinicians should be aware of the latest treatments for HCV, their ability to cure and their toxicity profile.

**HCV transmission**

- Most AOD clients carry multiple drug-resistant HCV genotypes.
- Many AOD clients have used contaminated injecting equipment.
- HCV transmission is not linked to the number of new infections, it is more closely linked to injecting equipment practices.

HCV transmission is very much the responsibility of AOD services, with some acknowledged reasons for not dealing with HCV:

- ‘The individual’s GP should look after their medical problems’
- ‘Treatment doesn’t work, so why test for the disease?’
- ‘Opioid treatment staff are too busy delivering methadone or buprenorphine to be diverted from these activities by other consequences of opioid dependence.’

A new understanding of HCV treatment is required. The focus is now on treatment efficacy, and a life-long health perspective.

**Changing perceptions of HCV care**

For the first decade of our awareness of HCV (1989–2000), those affected by the disease were referred to liver clinics for assessment and management because treatments were primitive, relatively ineffective (overall 20% cure rate) and the natural history of the disease was still being defined. When it came to prevention strategies, Public Health Units (PHUs) became involved and in many services, needle syringe programs (NSPs) were sited in PHUs. AOD services now prescribe for HCV. Fortunately, there has been a shift in focus and in recent years a number of clinicians have forged links with liver services and are offering HCV clinics in opioid treatment settings, with visiting specialists or with trained AOD doctors who now prescribe for HCV.
A best practice guide for HCV care in AOD clinics

Enough is known about HCV infection to allow a clear approach to this disease in AOD clinics across Australia. AOD medical practitioners can be trained to assess, co-manage and initiate treatment for defined subgroups of HCV-infected individuals, using the following best practice methods:

1. All staff should be up to date with HCV management pathways.
   a. Training can be provided by local liver clinic staff, and
   b. The Australasian Society for HIV Medicine (ASHM) provides regular HCV training days for staff across Australia.

2. Informed staff should discuss blood-borne viruses (HCV, HBV, HIV) with all patients regularly attending the service at an appropriate time after first contact.
   a. All clinics should offer testing for HCV (and HBV, HIV) to all individuals (see Figure 2). Optimally, this should be offered onsite to maximise the likelihood of attendance.

3. Results should be provided, in person, wherever possible and the significance of a positive or negative HCV Ab test explained to each individual.

4. Where treatment is requested or considered to be warranted, clinics should have a referral mechanism defined and functioning.

The challenge for all AOD services is to rise to the task of managing a disease which affects a large percentage of their patients and which can be cleared by appropriately delivered treatment.

**TABLE 2: TREATMENT OPTIONS**

Current treatment with pegylated interferon/ribavirin results in viral clearance (cure) in 45–50% of genotype (G) 1,4 infections (48 weeks treatment) and 70–80% of G2,3 infections (24 weeks treatment).

Treatment response is predicted by IL 28B genotype CC in G1 infections. This test assesses the individual’s response to interferon. A CC result indicates a good outcome with interferon.

New oral direct acting antiviral agents (DAAs): telaprevir and boceprevir will be available on the PBS in Australia in 2012/13 for G1 patients. Effective cure rates will increase to 70–80% and treatment may be shortened to 24 weeks.

More effective, less toxic drugs are in development and will radically change treatment efficacy and acceptability in the next 10 years.

For further reading and references cited in this article, email editor@ancd.org.au.

Sarah MacLean and Lynda Brennan*

---

**HEPATITIS C**

**IN PRACTICE**

---

**Positive partnerships are needed for the successful implementation of alcohol and other drug projects, a new report has found.**

The challenges of project implementation

We all know that getting a project up and running is challenging and that many things can go wrong along the way. In this article we describe the eight most frequently reported barriers to project implementation identified within a sample of 127 projects that operated between 2002 and 2008. This research is part of a larger study that was commissioned by the Alcohol Education and Research (AER) Foundation (now known as the Foundation for Alcohol Research and Education) and all projects in the study sample were funded by the AER.

Projects in the study sample involved a range of activities, each designed to reduce alcohol- or licit drug-related harm. Table 1, right, describes the types of projects included in the sample.

**Table 1: Types of projects in the study sample**

<table>
<thead>
<tr>
<th>Project type</th>
<th>Inclusion criterion</th>
<th># Projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhancing organisational systems and processes</td>
<td>Projects which primarily aim to improve organisational responses to AOD through introducing enhanced systems and processes</td>
<td>39</td>
</tr>
<tr>
<td>AOD training and workforce development</td>
<td>Projects which primarily aim to improve AOD service delivery or awareness through provision of training to the AOD workforce or to other service providers, for instance teachers or pharmacists</td>
<td>18</td>
</tr>
<tr>
<td>Community education and prevention</td>
<td>Projects that attempt to raise AOD awareness or effect policy change by influencing the population or a large group within the population, or through local community development and planning interventions</td>
<td>37</td>
</tr>
<tr>
<td>Engagement and treatment</td>
<td>Projects designed primarily to engage and influence individuals and groups who misuse AOD or who are at risk of doing so, or to provide treatment and aftercare</td>
<td>33</td>
</tr>
</tbody>
</table>

---

**Barriers to success: What gets in the way of AOD project implementation?**

Sarah MacLean and Lynda Brennan*
**IN PRACTICE**

- reviewing reports, evaluations and other documentation for these projects to identify barriers to project implementation
- identifying 46 barriers and counting how many times each of these was reported within the sample of 127 projects
- calculating the percentage of projects that each of the top eight barriers were reported in. Percentages have been rounded to the nearest whole number.

**What we found**

Figure 1 below shows the eight most commonly reported barriers to project implementation. The most frequently mentioned barrier to project implementation concerned staff continuity and retention, identified in over a fifth of projects in the study sample (23%; 29 projects). When staff resigned or moved to a different role within the organisation, projects often slowed down or in some instances ground to a halt. This was particularly a problem when key staff had developed relationships with clients, communities or other agencies that were critical to project implementation.

We were surprised that data collection problems and difficulties in conducting evaluations emerged so frequently within the study sample, which like staff continuity and retention was reported in over a fifth of all projects (22%; 28 projects). Under this category we included reports of difficulty getting staff to collect data about their activities and their service users on an ongoing basis. Problems conducting evaluations frequently involved staff having insufficient time and/or expertise to review and document their project activities.

It is difficult to anticipate how long project activities will take. In almost a fifth of projects (19%; 24 projects) project activities took longer than anticipated and the time budgeted for implementation of activities was insufficient. In 17% of projects (21 projects), evaluations and reports showed that the project design did not fit the setting in which it was implemented. Agencies are encouraged to model potential activities on other ‘best practice’ examples. Some projects that borrowed a project design developed in other rural or remote settings. In some instances difficulty in staff recruitment delayed project implementation significantly or led to the eventual appointment of staff who lacked the skills necessary to implement projects.

The last two barriers, each reported in 13% of projects in the study sample, concerned relationships with partner agencies. While working with partner agencies is essential for many projects, it can also lead to a range of difficulties for project implementation. Documentation for 17 projects recorded that partner agencies were unreliable or did not fulfil commitments to the project (such as being consistently late to meetings or not making previously promised resources available to the project such as meeting rooms). Serious breakdowns of relations with partner agencies were noted in relation to 16 projects. This included instances where partner agencies refused to refer clients to the project concerned or even decided they no longer wanted to be involved in the project in any way.

**Implications for AOD funding and services**

This study suggests that:
- recruitment and retention of qualified staff remains a major issue in the AOD sector
- AOD service staff should be supported to minimise resignation due to workplace dissatisfaction, and succession planning should be implemented, particularly where staff leaving will present significant difficulty to project implementation
- where service staff are expected to collect and collate service data, time efficient systems should be developed and data collection should be monitored throughout the project. Funding agencies should consider engaging an external evaluator to assess a range of similar interventions, thus supporting the development of a rigorous evidence base on AOD interventions.
- maintaining good working relationships between partner agencies involved in projects is critical to successful implementation of project activities. Disagreements that emerge in relationships between agencies should be addressed as a matter of priority to avoid compromising project implementation.

**How to find out more about the project**

This is a brief overview of findings from our study. We have published a more comprehensive analysis of data collected for this study that groups individual barriers discussed here into broader categories (MacLean et al. 2012) and also investigates enablers to implementation. In this paper we show that projects where relationships with partner agencies break down were statistically significantly more likely than other projects not to meet all funding objectives. An additional paper compares AOD project implementation in capital cities with experiences in other locations in Australia (Berends et al. 2013). A further article describes characteristics of AOD interventions that were able to be sustained after funding ceased (MacLean et al. in press). A detailed report on the project is also available for download (MacLean et al. 2010).

"Sarah MacLean is Research Fellow in Alcohol and Other Drug Studies and ARC Postdoctoral Fellow (Industry) at Turning Point Alcohol and Drug Centre and the Centre for Health and Society, University of Melbourne; Lynda Berends is Program Leader, Treatment and Systems, Turning Point Alcohol and Drug Centre, and Adjunct Senior Research Fellow, Monash University.

**References**


---

The Parents Under Pressure (PuP) program is based on an integrative model of maltreatment drawn from attachment theory and behavioral family therapy, combined with contemporary approaches to affect regulation based on mindfulness. The program is home-based and designed for families in which there are many difficult life circumstances that impact on family functioning such as depression and anxiety, substance misuse, family conflict, child maltreatment and severe financial stress.

**TRAINING AND CLINICAL SUPERVISION: A MODEL OF APPLIED LEARNING**

Training combines intensive training in the underlying theoretical background of PuP, and clinical supervision (conducted by phone or face to face). Learning is consolidated by the process of clinical supervision which focuses on how to put the PuP program into practice. Accreditation as a PuP Therapist requires completion of a case study demonstrating competency in the PuP model and a minimum number of hours of practice.

**SUPPORT OF A PURPOSE BUILT DATABASE**

The PuP program is supported by a purpose built database that allows for the automated scoring of key measures used to evaluate the effectiveness of the PuP program. A feedback form is generated for each measure with suggested treatment options for Therapists.

**PuP Program**

Promoting a stable environment for children

The Parents Under Pressure (PuP) program is based on an integrative model of maltreatment drawn from attachment theory and behavioral family therapy, combined with contemporary approaches to affect regulation based on mindfulness. The program is home-based and designed for families in which there are many difficult life circumstances that impact on family functioning such as depression and anxiety, substance misuse, family conflict, child maltreatment and severe financial stress.

**TRAINING AND CLINICAL SUPERVISION: A MODEL OF APPLIED LEARNING**

Training combines intensive training in the underlying theoretical background of PuP, and clinical supervision (conducted by phone or face to face). Learning is consolidated by the process of clinical supervision which focuses on how to put the PuP program into practice. Accreditation as a PuP Therapist requires completion of a case study demonstrating competency in the PuP model and a minimum number of hours of practice.

**SUPPORT OF A PURPOSE BUILT DATABASE**

The PuP program is supported by a purpose built database that allows for the automated scoring of key measures used to evaluate the effectiveness of the PuP program. A feedback form is generated for each measure with suggested treatment options for Therapists.
### Upcoming Events

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Australian Drug and Alcohol Conference</td>
<td>6–8 August</td>
<td>Perth, WA <a href="http://www.makingithappen2012.com">www.makingithappen2012.com</a></td>
</tr>
<tr>
<td>The Mental Health Services Conference</td>
<td>21–24 August</td>
<td>Cairns, Qld <a href="http://www.themhs.org">www.themhs.org</a></td>
</tr>
<tr>
<td>2nd National Cannabis Conference</td>
<td>19–21 September</td>
<td>Brisbane, Qld <a href="http://www.ncpic.org.au">www.ncpic.org.au</a></td>
</tr>
<tr>
<td>7th World Conference on the Promotion of Mental Health and the Prevention of Mental and Behavioural Disorders</td>
<td>17–19 October</td>
<td>Perth, WA <a href="http://www.perth2012.org">www.perth2012.org</a></td>
</tr>
</tbody>
</table>

### ATCA Symposium

**ATCA Symposium**

**27–30 August 2012**  
**Hotel Grand Chancellor**  
**Launceston, Tasmania**

Creating an inclusive system provides challenges – this year’s ATCA Symposium explores the barriers to treatment, addressing stigma and discussing the need for change within the treatment environment. The Symposium program features:

- **Dr Nicole Lee**: What do we know about brain impairment and what does it mean for treatment?
- **Mark Lamont**: Coping with identity crisis – insights from an ABI perspective
- **Rodney Croome**: Homophobia and mental health
- **Connie Donato-Hunt**: Finding the right help: Barriers and pathways to treatment for culturally diverse clients
- **Dr Richard Chenhall & Dr Peter Kelly**: Client progress and assessment in alcohol and other drug therapeutic community treatment
- **Associate Professor David Best**: Recovery and stigma

**Details and Registration forms available at:**  

**Register your interest now!**