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Welcome to another issue of Of Substance.

In the past 20 years, society has increasingly placed restrictions on when and where people can smoke. While that might be fine for those of us who can move about freely, how does this translate for people who live in mandated settings, such as prisons or mental health facilities, where access to smoking areas is restricted? In this issue, we explore this dilemma from several perspectives.

One year after the devastating Victorian bushfires which claimed so many lives, we look at the impact of community disasters. For some people alcohol or other drugs will provide an escape from the trauma, but create a new set of personal problems. We discuss what people working with substance use need to know about recovery from a widespread disaster.

And while focusing on communities, we must recognise that most have residents who come from very diverse backgrounds. Each culture has its own unique preferences, customs and issues around substance use. Writer Bronwyn Duncan looks at engaging with Australia’s migrant population.

These are just a few of the many highlights of the latest issue.

A new year often means changes and this year, Of Substance is introducing a new publication schedule. We’ll now be publishing each March, July and November, rather than quarterly as we have in the past. We have attracted so many subscribers in recent years that this change helps us to responsibly manage these increased costs while continuing to provide readers with free access to a quality publication. We’re also investigating ways that we can keep all our readers up to date with the latest information by delivering additional content online.

As always, we welcome your feedback at editor@ancd.org.au.

Jenny Tinworth & Kate Pockley
Managing Editors

Guest editorial

Trauma and its link to substance use

Dr Katherine Mills
Senior Lecturer, National Drug and Alcohol Research Centre

In this issue, Bronwyn Duncan’s article on the impact of disasters on substance use portrays the myriad adverse consequences that stem from mass catastrophes. Substance use, both licit and illicit, is one way in which people may choose to cope with the physical and emotional outcomes they experience after such an event.

This response is understandable – alcohol and other drugs provide an effective means of alleviating both physical and mental pain. However, while it may be helpful in the short term, it can serve to prolong post-traumatic reactions in the long term. Substance use can interfere with the processing of the trauma and mask symptoms that require treatment. People may also find that they cannot cope with their feelings in the absence of substance use and may become dependent. Once this occurs, sufferers tend to be locked in a vicious cycle; many report great difficulty in achieving their goals to cut down or stop using, as the trauma symptoms they have been suppressing come back to haunt them. This presentation is one with which clinicians working in alcohol and other drugs (AOD) services would be all too familiar.

Exposure to trauma is almost universal among individuals with substance use disorders and approximately one-third suffer from post traumatic stress disorder (PTSD). Mass disasters are one of the many trauma types that clients present with. More common, however, are disasters of a more personal nature, such as physical and sexual assault. While these events may be on a smaller scale, their impact on the individual may be just as great, or even greater. People who suffer from these personal traumas do not have the extraordinary support that is offered by the community to those who have experienced mass disasters. Indeed, in most cases, nobody is aware of what they have been through and they are left to deal with the experience on their own.

Despite high rates of trauma exposure and PTSD among AOD clients, it is not unusual for these experiences to go unnoticed and therefore, untreated. Given their high prevalence, it is essential that AOD services provide training to their clinicians in the identification and management of trauma reactions, and implement routine screening. Identification is only the first step in a person’s journey towards recovery from trauma, however, without it they will be unable to take the remaining steps necessary to break the cycle they are in.
Illicit drugs federal funding package

A funding package of more than $4 million was announced in December 2009 by the Minister for Health, Nicola Roxon, for measures to support peak bodies, drug education, online counselling, data collection and law enforcement research.

The allocations include:
- $1.1 million in 2009-10 to the National Drug Law Enforcement Fund
- $750,000 in 2009-10 to the Turning Point Drug and Alcohol Service, to support web-based counselling for illicit drug users
- $747,000 over three years to extend the Illicit Drug Reporting System operated by the National Drug and Alcohol Research Centre
- $468,000 over three years for Drug Action Week activities
- $308,000 in 2009-10 for the Australian Drug Foundation to support the Australian Drug Information Network
- $250,000 in 2009-10 to the Alcohol and other Drugs Council of Australia
- $201,000 in 2009-10 to the National Coroners Information System
- $110,000 in 2009-10 to the Australian Therapeutic Communities Association.

National health reforms update

In December 2009, Prime Minister Rudd announced that action on national health reform would be delayed until the first half of 2010. The National Health and Hospitals Reform Commission report, A healthier future for all Australians, was delivered to the government in July 2009 with 123 recommendations, including the proposal that the Commonwealth Government assume control of all primary care and outpatient services.

Parallel reports – the Preventative Health Taskforce Report and the National Primary Health Care Reform in Australia Report were also delivered in 2009. The Preventative Health Taskforce was asked to advise on how to improve health by targeting the priority areas of tobacco, harmful alcohol consumption and obesity. Legislation was introduced in parliament in 2009 to establish a new National Preventative Health Agency, with a proposed allocation of $133 million over four years.

Extensive public and stakeholder consultation continued through the second half of 2009. Of Substance will report on the implications of health reforms for the alcohol and other drugs sector after the government’s decisions have been announced.

Advocacy award for Ian Hickie

Professor Ian Hickie, Executive Director of the Brain & Mind Research Institute at the University of Sydney, received the 2009 Advocacy Award for outstanding contributions to the health and medical research industry at Research Australia’s annual ‘Thank You’ Day awards. In making the award, Research Australia said that Professor Hickie has been instrumental in ensuring Australians understand the importance of addressing depression and nurturing their brains.

Australia Day honours for AOD sector

Many people who work in the drug, alcohol, mental health and related sectors were given highly deserved recognition in the 2010 Australia Day Awards. In particular, the announcement of Professor Patrick McGorry, Executive Director of Orygen Youth Health (OYH), as Australian of the Year was a tremendous honour for the health sector. OYH is a mental health organisation for young people that has put Australia at the forefront of innovation in the prevention and treatment of mental illness.

APSAD award winners

The Australasian Professional Society on Alcohol and other Drugs (APSAD) makes annual Awards for Excellence in Science and Research designed to provide peer recognition for those working in the drug and alcohol field in Australasia.

In 2009 the Early Career Award for excellence in research and practice relative to career opportunities went to Dr Frances Kay-Lambkin (pictured above, centre), an NHMRC public health postdoctoral research fellow with the National Drug and Alcohol Research Centre, University of NSW. Her expertise is the use of computerised psychological treatments for comorbid mental health and substance misuse problems.

The Senior Scientist Award for a scientist who has made an outstanding contribution to the field of substance use and misuse went to Professor Robyn Richmond (above, left). Professor Richmond is a leading researcher in smoking cessation and brief interventions for alcohol and has made a consistent and outstanding contribution to research over 28 years.

The Aboriginal and Torres Strait Islander Achievement Award for excellence – an award introduced in 2009 – was made to Kim Gates, Director of the Council for Aboriginal Alcohol Program Services in the Northern Territory (above, right). The award recognises her commitment to Indigenous health and management of substance use services across the Territory.
New aviation drug testing regime

More than 18,000 random tests were conducted across Australia in the second half of 2009 on staff in ‘safety-sensitive’ aviation jobs (including pilots, cabin crew, and maintenance, security and ground staff) under a new national drug testing regime introduced last year. There were seven positive results for alcohol out of 14,273 tests (equating to 0.05 per cent of those tested) and 17 positive results out of 4,091 tests for drugs (0.4 per cent of those tested).

Qld inquiry into alcohol-related violence


Supporting parents with AOD problems

The Federal Government will spend $9 million over the next three years on a new early-intervention program providing in-home parenting help and after-care support for parents who have left drug rehabilitation services.

National Drug and Alcohol Awards (NDAA) 2010

Now in their seventh year, the 2010 NDAA will be celebrated in Brisbane on Friday 25 June, co-hosted by the Ted Noffs Foundation and Drug Arm Australasia. More information available from drugawards.org.au.

‘Night Out into a Nightmare’ campaign results

Recent research conducted by the Australian Government to review its ‘Don’t turn a night out into a nightmare’ campaign to reduce harm associated with binge drinking among young Australians, has shown positive results. The research showed that 85% of people aged 15-25 (6,173 interviewed) and 80% of parents of 13-17 year olds (2,390 interviewed) were aware of the campaign, and that reduced drinking and increased protective measures for young people were among the reported behaviour changes. The full report is available at drinkingnightmare.gov.au.

Call for ban on alcohol marketing in the UK

A report on the damaging effects of alcohol marketing on young people by the British Medical Association has called for a comprehensive ban on alcohol marketing communications. According to the report, in 2007 alcohol sales nationwide were ‘high enough to put virtually every British adult over government guideline drinking levels’. The alcohol industry spends around £800 million (A$1.24 billion) annually promoting alcohol consumption, while committing only a small fraction of this to education campaigns.

The report is emphatic that UK governments must end partnerships with the industry on alcohol education, arguing that they serve the interests of the industry rather than public health. The alcohol-related death rate in the UK nearly doubled between 1991 and 2005 – from 6.9 to 12.9 per 100,000 people.

Under the influence – the damaging effect of alcohol marketing on young people can be viewed a bma.org.uk/images/undertheinfluence_tcm41-190062.pdf.

New report on drug issues in Europe

While cocaine and heroin remain at the heart of Europe’s drugs problem, polydrug use in conjunction with alcohol is now the defining element of the problem, across all age groups. These are among the key findings of the European Monitoring Centre for Drugs and Drug Addiction’s 2009 annual report The State of the Drugs Problem in Europe. European policy debate now focuses more on targeting supply rather than drug use. In some countries legal penalties for supply-related offences have been raised or minimum penalties introduced. However, while the number of supply-related offences has increased, the number of offences for possession or use has increased even more.

The report comments on the range of new substances available and aggressive marketing of intentionally mislabelled products. For example, the internet market for substances has grown rapidly, and now provides a wide range of plant-based products, in particular herbal mixtures marketed under the ‘spice’ label, as well as products containing synthetic compounds. Forensic analysis of some samples of ‘spice’ has found synthetic cannabinoids added to the mixtures. The full report can be accessed at emcdda.europa.eu/publications/annual-report/2009.
**Between the Lines youth and drugs website**

*Between the Lines* is an online community for young people to discuss drugs and find information and help, with the aim of informing themselves and reducing problematic use. Developed by young people and professionals together, it focuses especially on amphetamine-type substances, alcohol and cannabis.

The initial phase has been funded by the Department of Health and Ageing and is a joint initiative of Inspire Foundation and the Ted Noffs Foundation.

Website: betweenthelines.net.au/.

**New comorbidity resource for AOD workers**

To assist those working with clients who have co-occurring mental health conditions and alcohol and other drug (AOD) use problems, the Australian Government Department of Health and Ageing funded the National Drug and Alcohol Research Centre to develop guidelines on the management of co-occurring AOD and mental health conditions in AOD treatment settings.

The purpose of the guidelines is to provide AOD workers with up-to-date, evidence-based information on the management of comorbid mental health conditions in AOD treatment settings. They are based on the best available evidence and draw upon the experience and knowledge of clinicians, researchers, consumers and carers from around Australia.

In December 2009, hard copies of the guidelines were distributed to all AOD treatment services across Australia. *The guidelines, and other resources, are also available for download from ndarc.med.unsw.edu.au/NDARCWeb.nsf/page/Comorbidity+Guidelines.*

AOD workers may provide feedback on the guidelines via a short online survey at this site.

**ANCD’s media briefing service**

The Australian National Council on Drugs (ANCD) has launched an informative and topical online monthly media briefing service that provides links to articles, media and other reports across the nation on a range of topics, including health and mental health, welfare, youth, Indigenous, AOD and related issues. Go to: ancd.org.au/drug-and-alcohol-monthly-media-briefing.

**Indigenous Services Database**

The National Centre for Education and Training on Addiction (NCETA) has produced a CD Rom of practical resources for workers in Indigenous health, alcohol and other drugs services. *An Indigenous services database and other resources* provides a database containing contact details of over 500 services across Australia; a list of relevant websites; and a list of training courses with Indigenous content and/or designed for Indigenous students.

For copies contact NCETA: ncesta@flinders.edu.au. Tel: 08 8201 7535.

**Cannabis – new resources**

The National Cannabis Prevention and Information Centre (NCPIC) has launched two new resources:

- Concerned about someone’s cannabis use: Fast facts on how to help, a booklet developed by Orygen and NCPIC.
- Making the Link, a school-based program aimed at teachers, to promote help-seeking for cannabis use and mental health problems.

Both are available at: ncpic.org.au.

**Letter to the Editors**

Tribute to the late Dr Michael Cohen, President, Palmerston Association (WA)

Many in the Western Australian and national alcohol and drug sector were saddened by the sudden and tragic death of Dr Michael Cohen in November 2009.

Dr Cohen was the President of Palmerston Association Inc. (WA) for six years. His professional appointments included Executive Chair of Narhex Life Sciences Ltd and Executive Chair of Advanced Diagnostic Concepts Pty Ltd. Dr Cohen was a trained pathologist with a long interest in drug and alcohol issues including both prevention and treatment and research into the nature and prevention of addictive states. A highly regarded member of the ANCD with a long involvement in the NGO residential and therapeutic community sector, as well as many other areas of need, Michael’s valuable contributions will be greatly missed by many in the sector.

Palmerston’s sense of loss of a wonderful leader, a great mind and a committed, caring man is deep. Michael’s leadership as President of Palmerston Association Drug and Alcohol Services WA over the last six years will leave a lasting legacy. His contribution to the national debate is also acknowledged.

Sheila McHale
CEO, Palmerston Association Inc.

Of Substance welcomes correspondence. Please submit letters of up to 300 words to editor@ancd.org.au.
New tools assess Indigenous substance abusers

Kylie Dingwall, Sheree Cairney
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Measuring cognition and social and emotional well-being for Indigenous Australians can be difficult, as conventional assessment tools are often based on concepts or experiences that are unfamiliar or irrelevant for them. Until we have appropriate psychological assessments that prove effective for use with Indigenous Australians, there will remain a poor understanding about the prevalence, course and aetiology of mental illness and cognitive impairment. Recently, our team has developed tests of cognitive function and social and emotional well-being that are based on concepts that may be more familiar to Indigenous Australians. Our research then investigated the utility of these assessments for detecting substance abuse-related impairments.

The cognitive assessment, ‘CogState’ (see CogState.com), uses computer-based games. Seven tasks measure attention, learning, memory, psychomotor and executive functions. The performances of a group of healthy Indigenous Australians were compared to a group of Indigenous Australians attending substance abuse rehabilitation facilities (N=387). Compared to healthy people, those in rehabilitation showed reduced cognitive performance on complex psychomotor, learning, memory and executive function tasks after controlling for age. The test was useful for detecting problems related to substance abuse and provided a basis for more detailed examination of the relationships between specific substances of abuse and cognitive function.

To assess social and emotional well-being, eight items were selected from the ‘Strong Souls Inventory’, which was developed after extensive consultation with Indigenous people and mental health experts (Thomas et al. 2010). These eight items assessed self-reported experiences of anxiety, depressive and psychotic symptoms on a four-point scale using plain English (i.e. ‘not much’, ‘sometimes’, ‘fair bit’, ‘lots’). A group of Indigenous Australians (N=416) attending Indigenous-specific secondary or tertiary education institutions or substance abuse rehabilitation facilities completed the eight items. Associations between demographic (age, gender, locality) or substance use (inhalants, cannabis, alcohol, cigarette use) variables and each of the items were investigated. Compared to non-users, frequent cannabis users were up to four times more likely to experience symptoms of depression or anxiety such as feeling worried, lonely, angry or worthless. Few associations between gender, locality, inhalant and alcohol use with psychological symptoms were observed. There were no associations for age. Symptoms of depression or anxiety may therefore be common for individuals seeking treatment for substance abuse and the selected items from the inventory may provide a useful screening tool for use by rehabilitation facilities.

Together these results demonstrate the utility of CogState and the Strong Souls Inventory for detecting substance abuse-related cognitive impairment and psychological symptoms for Indigenous people. Further research is required to elucidate the specific relationships between substance abuse behaviours, cognitive impairment, psychological symptoms and treatment outcomes.

Reference

Pharmaceutical misuse among drug treatment clients

Suzanne Nielsen1, Raimondo Bruno2, Susan Carruthers1, Jane Fisher3, Nick Lintzeris4, Mark Stooove4
1Turning Point Alcohol and Drug Centre, 2University of Tasmania, 3National Drug Research Institute, 4Queensland Health, 5Sydney South West Area Health Service, 6Burnet Institute
This study examined misuse of pharmaceuticals and associated harms among people who recently entered alcohol and other drug (AOD) treatment. It is well established that pharmaceutical drugs are used in a range of ways by people in AOD treatment samples. However, few studies have focused on the patterns and extent of use of pharmaceuticals among this group in detail.

Three hundred and five people who had recently entered withdrawal, residential rehabilitation and pharmacotherapy treatment and who self-reported use of pharmaceuticals were interviewed. The interview examined frequency of use, source of pharmaceuticals, and associated harms including impact of non-medical pharmaceutical use on AOD treatment.

Among this sample, a range of pharmaceuticals, particularly pharmaceutical opioids and benzodiazepines were very commonly used. Around 89% of the sample reported lifetime non-medical use of pharmaceutical opioids and a similar number (88%) reported non-medical benzodiazepine use. Smaller numbers reported lifetime non-medical use of pharmaceutical stimulants (49%), over-the-counter analgesics (such as codeine: 41%), antidepressants (24%) and antipsychotics (27%).

Non-medical use of pharmaceutical opioids and benzodiazepines in the four weeks prior to entering treatment was reported by around two-thirds of the sample for both drug types. Just over half the sample reported daily use of benzodiazepines prior to entering treatment, though only 7% of the sample were entering treatment for benzodiazepine dependence.

Common sources of pharmaceuticals used for non-medical purposes included GPs and purchasing from friends and dealers, though this varied by drug type. Benzodiazepines more commonly came from GPs while prescription opioids were often purchased from friends or dealers.

Harms most commonly reported in association with non-medical pharmaceutical use were dependence and withdrawal. Psychiatric comorbidity was common, with almost two-thirds of the sample experiencing moderate to severe levels of psychological distress. Untreated comorbidity and complications from benzodiazepine dependence were noted to negatively impact on treatment.

One interesting finding about harms was that while alprazolam was not the most commonly used benzodiazepine in the sample, it was the main benzodiazepine associated with harms such as traffic accidents, seizures and crime.

Comments from participants highlighted the role for health professionals in identifying problems early and facilitating treatment entry.

Some areas for further research and discussion highlighted by the study included the need for early intervention in pharmaceutical misuse by GPs and pharmacists; the need for better screening for pharmaceutical misuse and monitoring of medication adherence in AOD treatment, and the need for treatments addressing comorbidities such as chronic pain and psychiatric distress.


Screening for drugs in blood samples from injured drivers in Victoria

Edward Ogden1,2, Tania Frederiksen3, Martin Boorman1,2, Rebecca King4, Con Stough5

1Victoria Police, 2Brain Sciences Institute, Swinburne University

The road safety community is beginning to focus on the risks associated with driving under the influence of drugs other than alcohol. Data pooled from coronial investigations has shed light on the relative risk of fatalities. This project aims to document the relationship between responsibility for collision causing injury, and the presence of drugs in injured drivers in Victoria.

Methods

Any person over 15 years of age taken to hospital as a result of a collision in Victoria is required to provide a blood sample (Road Safety Act 1986 (Vic)). Blood samples are screened for the presence of alcohol, cannabis, stimulants and benzodiazepines. For this study, police collision reports (N=442) were examined to determine whether the driver responsible for the collision had any of these substances in their blood. Using drug- and alcohol-free drivers as the control group, an odds ratio gave an estimate of the relative risk associated with drugs.

Results and discussion

Nearly half the drivers were involved in single-vehicle collisions, which resulted in the vehicle or motorcycle hitting a tree, fixed object or road embankment. Seventy per cent of drivers were male with an average age of 35 years. Thirteen drivers were below the legal driving age, with all of these drivers responsible for the collision. Ten of the 13 drivers had a positive blood alcohol concentration (BAC). Cannabis, amphetamines and benzodiazepines were also detected in the underage drivers.

Alcohol was the most frequently detected drug. The alcohol group was predominantly male. Ninety-five per cent of injured drivers who tested positive for ‘alcohol only’ were responsible for the collision, with the majority of these drivers recording a BAC level ≥0.08%.

Fifteen per cent of the total samples contained a benzodiazepine only. Almost a quarter (23%) of these samples had levels in the toxic range. Most of the benzodiazepines were associated with relatively modest increase in collision risk. High-dose diazepam was associated with a large increase in collision risk.

Alprazolam (a benzodiazepine) has become popular as a recreational drug and is subject to misuse. All of the drivers with alprazolam present (N=12) were responsible for the collision and half of these drivers had levels in the ‘toxic’ range. Thirteen per cent of samples contained amphetamine, methamphetamine or ecstasy. Of these, 96% were responsible for the collision.

Conclusion

This study has established a methodology for performing responsibility analysis in non-fatal collisions using the same analysis technique that has been used for fatal collisions. It highlights the relationship between abuse of benzodiazepines and use of illicit drugs with increased risk of collision, and provides good evidence that drugs other than alcohol are associated with increased risk of injury collision.
One goes like this: drugs like morphine, cocaine and heroin are illegal because they are inherently dangerous. This argument focuses on the properties of the substances, their presumed dangerousness and the harm they cause.

The second argument is more recent. It recognises the different historical paths the substances have taken, but it argues that it’s now time to throw out that baggage and to classify the substances ‘rationally’ according to actual harms. If tobacco or alcohol were to have been discovered recently, so the argument goes, there is no way they would be legal substances now.

Both of these arguments have problems. The first one lacks historical depth. It focuses on the substance itself and fails to recognise the historical issues that have brought particular substances to the positions they occupy. It also separates the substances – illicit drugs, alcohol and tobacco – from each other.

The second argument implies that history can now be dismissed – just like that. This article will argue that we need to be more aware of the historical factors, which have framed the differing present-day situations. I’ll identify a mix of factors we need to think about: culture; economic interests and technological change; politics and social movements; medicine, the professions and public health; fear; and also national and international dimensions. These have impacted in different ways and crucially, at different times, on the substances, and continue to do so.

Cultural and economic influences
If a substance’s use is embedded in general culture, it’s difficult to regulate it strictly. If we look back to, say, the first half of the 19th century, our three sets of substances – opiates, alcohol and tobacco – were all more or less tolerated by society. But by the early 21st century, their positioning was different. Back in the 1950s, British politicians were very wary about intervening to curb smoking. Most of the (male) electorate smoked and the politicians did not want to lose votes. Sixty years later, smoking is much less central in mainstream culture and smoking bans, which would have once been unthinkable, could pass into law.

So how does that mix of issues I identified impact on such cultural change? Economics and changes in technology can serve to restrict or to amplify markets. For alcohol and tobacco in the 19th century, they did the latter. The Bonsack machine, which turned out mass-produced cigarettes, helped underpin the rise of a mass smoking market. The hypodermic syringe, and the discovery of the opiate alkaloids, on the other hand, brought previously openly available opiates under more restrictive medical control. This became a professional activity only doctors could do. Industrial interests can pull in different ways.
The alcohol industry wanted wider availability of their products, whereas the pharmaceutical industry in the UK and Germany argued for restriction of trade in the opiates and cocaine prior to World War One (WWI) as a means of maintaining the market.

**The role of politics, society and medicine**

Politics and social movements are also important. Whether a substance becomes the focus of negative public sentiment, and the ways in which alliances are reflected politically, can determine subsequent controls. The temperance movement, with its religious and moral overtones, was widely supported in 19th century northern European countries; in Britain, it initially had major political impact through the Liberal Party. But its political pull was on the wane before WWI and support for it died away. Anti-opium sentiment was never as strong and focused primarily on opium in the Far East, with little by way of a political alliance. But the very absence of political interest in fact made such drugs easier to regulate and control in the UK – there was no political interest in defending them, no equivalent to the brewers and their alliance with the Conservative Party, which protected alcohol.

The medical professions including public health personnel have also played a significant role. Ideas of disease, inebriety or addiction became common currency in medical discussions of excessive consumption of alcohol and opiates from the 1870s. Public health doctors were involved in treatment, but this primarily involved quarantining patients – a practice then in vogue for infectious disease. Tobacco was never considered an issue of disease and treatment, nor the province of psychiatry and mental health, as drugs and alcohol became in the 20th century. Rather, it fell within the remit of public health epidemiology, the new science of the ‘risk factor’, which emerged in the 1950s. Treatment and hospital beds were far from this model.

Public attitudes are also important and it is here that our next issue – fear – comes into play. If substances are connected with feared or despised minorities, or embody some threat, then regulation and cultural change are not far behind. In the 19th century, it was the Chinese with their opium smoking, which embodied a threat with both racial and sexual overtones. Alcohol was also seen as threatening — in Britain in the 19th century, opium use was often seen as preferable to beer drinking because it made the consumer placid. But drinkers never became associated with a minority in the way opiate drug users were. For smoking too we can see this process at work – but much later. As smoking became less central to middle-class culture, it became associated with the modern equivalent of the lower class.

**Global factors**

The ways in which our substances have fitted into international agendas has made an impact in a differential way. The opiates and cocaine became subject to a system of international control just after WWI, which grew out of concern about opium use in the Far East, but was also the result of US trade and strategic objectives in that area. This became a worldwide system, way beyond its original intention, because of the strategies adopted by pharmaceutical companies and the impact of WWI. Pharmaceutical companies argued for a more widespread control system before the war, thinking that there would never be global agreement on this. The delay ultimately brought a greater degree of control. Alcohol has had no such global restrictions placed on it, and control was limited in the same period to a regional system, which just covered Africa. For tobacco, the idea of internationalism came on the agenda much later and in line with public health objectives. The World Health Organization’s Framework Convention on Tobacco Control (adopted in 2003) now embodies the global focus of the anti-tobacco movement of the second half of the 20th century.

And finally we need to remember different national trajectories; for example, alcohol may have lacked political support as an issue in the UK after WWI but it certainly had that support in the US, hence prohibition passed into law.

**Converging paths?**

These factors have operated historically to direct our substances down different routes, but are they now drawing closer together? There are elements of convergence in the current situation. Medical/penal systems of control are in play for all three – albeit in different ways. You will be fined for smoking in a bar; or for drinking in a restricted public area; sent to prison, or into treatment for taking illicit drugs. The public health approach is trumpeted for all three sets of substances. Harm reduction is on the agenda for drugs, to some extent for alcohol and is even beginning to be discussed again for tobacco. A disease model of addiction is also on the agenda for all three.

Activists in the alcohol field look to the history of anti-tobacco activism for ideas about how to achieve cultural and legal change. Internationalism is important. Both alcohol and tobacco activists argue for greater international control, with the model of international narcotics control in the background. Some have argued for a ‘brave new world’ in which drugs of all types can be used by the whole population. But one thing is certain – the rise and fall and the reconfiguration of substances, will remain a complex matter. History, rather than rationality, will determine the future.

**References**

For references, email editor@ancd.org.au.

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Three poor men burdened with barrels of alcohol, being freed by a man from the Temperance Society, c. 1840. Image courtesy of the Wellcome Library, London.
The trend is also being seen in Australian prisons. In 2008, Western Australia trialled a smoke-free policy in all enclosed areas in Greenough Prison. A year later, it introduced a Smoking Reduction Plan with the aim that all WA prisons would eventually have smoke-free indoor areas. The ACT has recently grappled with the issue, while in NSW, Justice Health has opened a partially smoke-free prison hospital and a clean-air (totally smoke-free) forensic hospital.

All these settings serve segments of the population which have significantly higher rates of smoking than the wider Australian community. According to a literature review conducted by the Cancer Institute NSW (2008), one Australian study has shown smoking rates were as high as 92 per cent among people admitted to an inpatient psychiatric unit, while there is a smoking prevalence of around 75 per cent among clients of drug and alcohol treatment facilities. The same review shows that in NSW prisons, 78 per cent of men and 83 per cent of women smoked. In comparison, smoking rates in the wider community are below 20 per cent.

Yet introducing a smoke-free strategy is not simply about health benefits. Policy makers and administrators grapple with the tension between applying initiatives which will benefit the health of clients, inmates, visitors and staff members and the civil rights of mandated residents who, for much of the time, do not have the freedom to smoke elsewhere. Questions must also be asked about the purpose of smoking bans and their effectiveness.

In the following pages, Of Substance shares the perspectives of some of the people closest to the action on tobacco bans in healthcare and prison settings. But first, it is worth briefly considering some of the key issues and what the research literature says about smoking bans in drug and alcohol treatment facilities, psychiatric settings and prisons.

What is a smoking ban?

The terms ‘smoke-free’ and ‘smoking ban’ are often raised in this discussion. However, does ‘smoke-free’ really mean that, or is smoking banned in enclosed spaces, but permitted in outdoor settings? A total ban on any smoking significantly influences staff and client attitudes, quit attempts and has different legal implications to a policy where outdoor smoking is allowed. In Australia, there are currently no completely smoke-free adult prison facilities, although some jurisdictions have smoke-free buildings. Mental health facilities are grappling with similar issues, while there are examples of residential drug and alcohol treatment facilities that have adopted total smoking bans within their premises and grounds (see page 14-15).

Enforcement of any non-smoking policy is also an issue. Many community organisations, workplaces and health settings have smoke-free policies, but in reality, they are not applied or breaches are overlooked.

Why ban smoking?

Historically, smoking has been restricted in the community because of concerns about the health impact of cigarettes, both on the smoker and those around them. However, it seems that, particularly in international prisons, a significant driver of smoking restrictions has been the fear of legal action by non-smoking staff and inmates over health-damaging environmental tobacco smoke (Butler et al. 2007).

The motivation behind a smoking ban may influence the outcomes administrators seek and the evaluation of those bans. For example, if the purpose of a policy is to avoid legal action, it is possible that policy might not place a
strong focus on providing smokers with adequate cessation treatment or on the smoking habits of residents or inmates once they leave the facility. Whereas, the effectiveness of a policy driven by concern for the health of residents will include measures of the number who quit smoking and maintain a non-smoking lifestyle long after their release. In addition, provision of smoking cessation programs to residents and ongoing evaluation of smoking behaviours can be a significant cost to already stretched resources.

Legal issues

While the threat of legal action by non-smoking staff and residents who are affected by environmental tobacco smoke may be a driver for non-smoking policies, those very policies increase the likelihood that mandated residents of mental health facilities or prison inmates will be successful in legal action to maintain their right to smoke, as they do not have the freedom to continually access outdoor areas where smoking is allowed. The rights of prison inmates were further boosted last year when the Federal Court of Canada ruled that a total smoking ban in Canada’s penitentiaries violated inmates’ rights unnecessarily and that outdoor smoking should be permitted.

Research

In a 2008 literature review, Smoking and mental illness, other drug and alcohol addictions and prisons, the NSW Cancer Institute examined the available literature to assess the impact of smoking bans in three settings: psychiatric inpatient facilities, drug and alcohol centres, and prisons. It found:

Psychiatric inpatient facilities
• on average, no change in aggression, the use of seclusion, the use of ‘as needed’ medication or discharge against medical advice, particularly if bans are total rather than partial (where smoking is permitted in certain areas)
• some evidence that total bans are more effective than partial bans in increasing residents’ motivation to quit smoking
• very few studies explored residents’ smoking behaviour post-discharge. The only available study showed all 100 participants resumed smoking within five weeks of discharge.

Drug and alcohol facilities
• tobacco dependence treatment can be fully integrated into addiction treatment programs
• the use of nicotine replacement therapy is more likely to reduce smoking prevalence among participants
• staff have greater resistance to implementing a tobacco-free policy than patients
• thorough staff preparation and training is important
• most studies have found smoking cessation treatment has either no effect or a slightly positive one on treatments for the use of other substances
• concurrent treatment for smoking and other substance use is likely to be more effective than sequential treatment for another drug dependency followed by nicotine dependence treatment.

Prisons
• there are few published studies of interventions to reduce smoking in prisons, and the available data for most of those studies is poor, either lacking control groups, having low sample sizes or excluding inmates who are in withdrawal from substances or on psychotropic or antidepressant medication
• only one Australian prison has ever introduced a total ban on smoking. In 1997, 120 inmates at Woodford Prison (Queensland) rioted after the introduction of the policy. It is not clear to what extent the ban was the riot’s trigger or cause (Butler et al. 2007). Internationally, there is little evidence of riots related to smoking bans.

Other writers note that the banning of smoking in prisons has occurred in the absence of evidence that it influences inmates’ smoking behaviour after release (Butler et al. 2007). The authors say the major adverse impact of smoking bans appears to be the creation of a black market in tobacco. They recommend any prison smoking bans should be implemented in tandem with cessation programs.

References
Cancer Institute NSW. Literature Review. Smoking and mental illness, other drug and alcohol addictions and prisons, Sydney, Cancer Institute NSW, September 2008.
Tobacco plays an important role in Australian prisons, where it has increasingly been restricted by authorities.

In deciding how to handle smoking, prison administrators should consider the following issues:

- the possibility that a smoking ban will threaten prison security by triggering riots
- concerns about passive smoking – the rights of the non-smoker to a smoke-free environment are not trivial
- evidence that tobacco cessation programs are more common among prison systems with indoor tobacco bans (86%) than those with complete tobacco bans (39%) (Kauffman et al. 2008).

Prison security and public amenity

Prisoners have minimal discretionary funds – a large proportion is commonly spent on tobacco. The most popular tobacco product is a 30 gram pouch which costs approximately $16 – the average prisoner who smokes uses one to three pouches per week.

Some researchers argue that a smoking ban creates a black market for tobacco. If so, this deprives some inmates and also places institutional security at risk, creating opportunities for prison staff to engage in illegal trade (Thompkins 2009).

Prison smoking bans are common in the United States. A 2007 survey of 52 US departments of correction showed 60% of prisons reported a total tobacco ban on prison grounds, while 27% had indoor bans on tobacco use (Kauffman et al. 2007). Such partial bans also pose challenges, with the need for designated smoking areas. Usually these areas have to segregate staff and prisoners, including different classification groups of prisoners. In the above US study, there were no reports of prison riots resulting from implementation of stricter tobacco policies, but multiple respondents reported that tobacco products became the dominant contraband item following ban implementation.

In 2008, the Orsainville Detention Centre (Canada) withdrew its smoking ban following a riot; a similar event may have occurred in 1997 at Woodford Prison (Queensland), although the connection to banning tobacco has been contested.

Human rights

It could be argued that the need for tobacco control includes the human right to a safe and healthy environment for everyone without any discrimination based on nationality, gender, economic status or residence. The limitation that is raised is that the prisoner’s cell is his ‘home’.

In the community, the application of rights to health is not an attempt to outlaw smoking; that is still up to the individual’s decision. But there are restrictions and consequences to this social behaviour, such as cigarette taxes and restrictions on smoking areas.

These human rights issues have been demonstrated in prisons, with the US Supreme Court ruling in 1993 that a prisoner’s exposure to second-hand smoke could be regarded as cruel and unusual punishment (which would be in violation of the 8th Amendment of the US Constitution). In 2004, tobacco was banned from US federal prisons.

Moving forward

Banning tobacco outright, at this time will entrench a black market, and will not contribute to prisoner and staff safety. Harm reduction offers some guidance through this complex issue.

A moderated approach towards tobacco restriction – rather than an outright ban of tobacco – could be achievable. This approach, unlinked to any punitive restrictions would promote pre-contemplation and contemplation among detainees, with a view to attempting to quit smoking. Equally, there would be an acceptance that not all detainees want to stop smoking at this time.

This approach may have the best chance of NOT establishing an illicit market in tobacco. Acknowledging ‘non-smoking’ as the normative (even rewarded) behaviour, over the current situation where smoking is allowed to be the normal accepted condition, would go a very long way to redress the imbalance of non-smokers to smokers in Australian prisons – for example, access to Quit programs should be enhanced, provision of free tobacco at the time of reception should cease, non-smoking in cells should be ‘celebrated’. The success of this approach may only be achieved once 51% of prisoners and custodial staff are non-smokers!

I would support a restrictive, but not an abolitionist, regime which would be under constant review – reflecting changing positions in the community at large. Additionally consultation with detainees and staff in creating a health-promoting environment should strike the best balance between government intention and acceptable restriction of tobacco.
Key references and further reading


For a full list of references used in this article, email editor@ancd.org.au.

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As complete smoking bans in mental health inpatient facilities are being rolled out around the country, the first moves towards similar bans in our prisons are being made.

On 30 June 2009, the Western Australian Government implemented partial smoking bans in all its prisons, limiting smoking to designated areas and banning it in all cells and units.

The move follows a recent trend in the United States where 11 states have banned smoking entirely in all their prisons.

The issue is a major one among prisoners. Figures show that over 80% of prisoners smoke. Over the years, smoking has developed as one of the few ‘joys’ a prisoner can have. In fact, in most prisons, tobacco has become an unofficial currency.

The issue therefore raises considerable passion among prisoners. In Quebec, where several years ago smoking was completely banned in all its prisons, the ban was recently overturned after widespread unrest and violence occurred in the prisons as a direct result of the bans.

The move to entirely ban smoking in prisons raises a number of medical and social justice issues.

Do compulsory bans work?

This question is important not only from an outcomes perspective but also from a financial perspective. This is because in every jurisdiction where bans have been imposed, large sums of money are spent on gums, patches and other smoking cessation medications to assist people to quit.

By imposing smoking bans on inmates, those who are forced to give up smoking do not get the opportunity to ready themselves for change.

In New South Wales, NSW Health has published a smoking intervention guide to assist smokers to kick the habit. The guide refers to four stages of readiness to change – the pre-contemplation stage (not ready), the contemplation stage (not sure), the determination stage (ready) and the action and maintenance stage (already quit).

By forcing inmates to forgo the first three of these stages, will this in the long term mean inmates will quit? Research on this topic has been performed mainly with those mental health patients who were forced to give up smoking in mental health units. In 2006, Prochaska and colleagues studied the effects of compulsory quit programs on the smoking habits of 100 mental health patients, forced to give up smoking while they were in an inpatient facility. All returned to smoking within a month of their discharge from the mental health unit. The median return time to smoking of all patients in the group was 15 minutes.

Are the bans fair?

There are two dimensions to this question.

The first relates to the fact that for prisoners, prisons are their homes. From any objective viewpoint, it would appear indefensible that a ban be imposed on prisoners in what is effectively their home when the rest of society is not subject to such a ban. Prisoners are imprisoned as punishment not for punishment. Such bans would be discriminatory and may well form the ground for legal action challenging the validity of the bans on that basis.

The second dimension relates to the often-heard cry from health authorities that the bans are necessary to protect non-smokers, including staff, from the dangers of passive smoking. In NSW, that state’s smoke-free legislation demonstrates the paucity of this argument. Nowhere in the Smoke Free Environment Act 2000 is smoking banned per se – it is only banned in ‘enclosed spaces’ and not in ‘unenclosed spaces’. This unMASKs total smoking bans for
what they are – creatures created by health departments having no legislative basis. Even worse, research shows they have no long-term positive effect of helping inmates quit the habit and they cost substantial amounts of money to implement.

Conclusion

The move to impose smoking bans in prisons reflects a top-down approach from government. It takes advantage of the vulnerability and dependency of inmates to impose bans which do not work and have no long-term health benefits. Against that background, any bans would add another layer of punishment on this group of very disadvantaged individuals.

Importantly, prison officers’ unions in Victoria and the ACT have recently expressed opposition to the bans.

Our view is that in prisons, inmates should be encouraged to quit smoking – but it should be a voluntary process involving a choice made by the inmate. Once that choice is made, the inmate should be given extensive access to smoking cessation medications. To impose bans would be totally counterproductive.

Reference


*Michael Poynder is the Coordinator of the criminal justice activist group Justice Action.

Realising an impossible dream

Matthew Frei*

Smoking in residential drug treatment settings has long been accepted, under the unsupported assumption that it is too hard, unreasonable and unrealistic to expect treatment consumers to cease smoking while undertaking other drug withdrawal. The view has been ‘one drug at a time’, and smoking is given a low priority, despite some associations between smoking and other drug use.

On 31 May 2009, World Tobacco-Free Day, Victoria’s Southern and Eastern Health networks went smoke-free. We had some opportunity to exempt our community residential withdrawal units (CRWUs) but decided we should be consistent with our auspicing services’ policies. Ten months later, we have found that with the right strategies in place, a smoke-free inpatient detoxification unit can work.

In our CRWU model of care, clients leaving the unit unaccompanied during their seven-day stay are discharged. This means, with smoking banned in the unit, clients who stay cannot smoke for the week. As CRWU treatment includes staff-supervised offsite activities, we had to decide whether they could smoke while offsite. On deciding that clients could not smoke (onsite or offsite) while involved in the program, we also had to consider how to respond to breaches of this policy.

Our services anticipated the change by informing treatment consumers about to enter residential withdrawal of the smoke-free status in a specific section of the treatment agreement. Our medical staff formulated clinical guidelines for nicotine withdrawal and secured a stock of nicotine replacement therapy (NRT) medication.

Prior to the change, staff were anxious about client behaviour. Was the detoxification process going to become unpleasant or even dangerous? Were the units going to empty as potential clients declined admission to smoke-free services? Should we ask for an exemption, believing the whole idea was a disaster that would inevitably need to be abandoned?

Some months down the track we analysed the response to the transition among clients and staff.

Our surveys showed the staff considered the change hadn’t been as difficult as they had anticipated. There were incidents of aggression to staff and some discomfort about the transition, but these were outweighed by the positives the staff reported. These positives included the ease of involving clients in groups and other activities, and the ‘cleaner’ smoke- and butt-free work environment.

Users of the service continue to voice some disquiet about the policy, which is recorded in some of the feedback forms. Clients have also commended the policy and some have entered community residential withdrawal with the aim of ceasing both cigarette smoking and other drug use. The likelihood that an inpatient would cease smoking in a unit where the small courtyard area was invariably filled with smokers would have been very low.

A few clients have reported smoking as the primary reason for early self-discharge from the unit. However, self-discharge prior to completing withdrawal from other drugs is common in drug treatment. We hope to clarify whether the smoke-free policy is associated with increased early discharge in further research.

All smokers are assessed for severity of nicotine dependence, and most are prescribed NRT as a patch and intermittent therapy as needed. We do not use NRT gum, but have a variety of forms and strengths of short-acting agents including lozenges and microtabs. We also use the more expensive inhalers, as some clients seem to benefit from them.
The process of going smoke-free has raised some major issues for our treatment service. Victorian CRWUs are not region-specific, and at least four still allow smoking. This has meant significant drops in bed occupancy numbers for our units with consumers choosing to undertake detoxification where they can smoke. This may not be resolved until smoke-free policies are consistent across the state (likely to happen in the near future).

Observers have questioned enforcing nicotine withdrawal in consumers not ready to quit. This is reasonable, given most research suggests the best outcomes for sustained nicotine abstinence occur where a motivated patient undertakes a long-term well-structured plan. With this in mind, we are supplying clients with NRT on discharge and organising follow-up with their GPs as well as other supports.

We will have to meet these ongoing challenges. Opportunities for cigarette smoking in health services will continue to be squeezed. Reduction of harm from substance use remains a primary focus of drug treatment, and this should include tobacco use. We hope that our positive experience in inpatient smoking cessation is a realisation of ‘the impossible dream’ of having a smoke-free detoxification service.

*Dr Matthew Frei is the Clinical Head, Addiction Medicine Units, Southern and Eastern Health, Victoria.

Truly therapeutic: ban supports holistic approach

Kamira Farm is a 19-bed modified therapeutic community for women and their accompanying children, offering residential rehabilitation for six to nine months. In early 2008, the centre adopted a smoke-free policy. Staff are smoke-free during all shifts and residents are smoke-free while members of the program.

The policy is a complete change from the approach of the early 1990s, where both staff and clients smoked freely, including in counselling and group therapy sessions.

In 1995, Kamira followed the lead set by other health services and adopted a smoke-free workplace environment, banning indoor smoking and establishing designated outdoor smoking areas which were out of sight of visitors, residents and staff. The areas did not have furniture, were open to the elements and were child-free, a significant issue because Kamira provides accommodation for residents’ young children.

The partial smoking ban posed a number of problems, with clients who smoked running late for programs because they were outside smoking, and staff finding that the last 10 minutes of group therapy sessions were less productive due to clients’ focus on going outdoors to smoke. Cigarettes became a commodity to be traded and outdoor smoking areas also became venues to socialise, gossip and avoid interactions with their children.

By 2007, none of Kamira’s staff smoked and they became concerned about the health effects of residents’ smoking, along with the cost of smoking contributing to poverty and nicotine dependence leading to residents showing neglect in other areas, such as their children’s needs, taking care of themselves, building relationships and focusing on rehabilitation. They felt that continuing to allow residents to smoke contradicted the holistic approach to rehabilitation that the centre promoted, which included regular daily exercise, yoga, nutritional support and lessons in stress management and relaxation.

With a new purpose-built building on its way, the time proved right for a change in policy. After a period of consultation with residents, Kamira adopted a total smoking ban, supporting clients through information sessions and the provision of eight weeks’ free nicotine replacement therapy (NRT).

The new policy was supported by an increase in Kamira’s fees, with the centre now charging 80 per cent of residents’ welfare payments, rather than 75 per cent. This increase helps cover the provision of a course of NRT for any new resident who is a smoker.

The transition to a total smoking ban has been surprisingly easy. The key to its success could be attributed to a well-informed and supportive team of staff and the support they provide for clients before and after they enter treatment.

While some people may choose not to come to Kamira on this basis, generally the reaction is quite positive. Comments commonly include ‘I have tried to give up before and not been successful, so that’s great’, ‘I’m giving up everything else so why not this too’ and ‘Wow, no-one smokes, so it should be easy’.
We could count on one hand the number of people who have left early because of the policy and, anecdotally, we know that many residents continue a smoke-free lifestyle after they leave. It seems that generally clients treat it as being just like maintaining abstinence from the drug of choice they came into rehab for.

What we can say definitively, is that the women and their children leave Kamira in far better health than when they arrived. They also leave with an understanding of how nicotine has impacted their lives and their relationships as did their drug of choice, and with far more money in their pockets.

*Kate Hewett is the director of Kamira Farm. For more information about Kamira Farm, visit www.kamira.com.au.

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**Just ask:**
the answer is ‘no’

Isabell Collins*

The issue of smoking bans on all psychiatric inpatient units and longer-stay psychiatric residential accommodation facilities has been a topic of concern for many consumers for some time.

People with a serious mental illness (schizophrenia, bipolar affective disorder or psychosis) also have a 25-year less life expectancy than other folk (Lawrence et al. 2001).

Given the above statistics, no-one who cares about people with a mental illness would argue that something positive needs to be done about the high level of smoking and poor physical health of these people. However, is forcing someone to give up smoking at a time when they are at their most distressed state the time to do it? I would argue it is not.

The concerns of consumers are many in regard to the cessation of smoking in inpatient units and longer-term psychiatric residential units. For the most part, to ban a person from smoking at a time when they are at their most vulnerable and distressed is cruel and inhumane. Most people who find themselves in psychiatric inpatient units are there as involuntary patients, thus their level of mental unwellness is so serious they require immediate treatment and care (often against their will) with many patients being suicidal and in a state of extreme distress.

Very few health service organisations have sought the opinion of people with a mental illness who use the service about whether a ban should occur or exemptions should apply. Exemptions are needed, particularly for people who are involuntarily detained in acute inpatient units, secure extended care units or other residential facilities where people are required to reside. This lack of consultation occurs despite various Mental Health Acts and the Commonwealth and State/Territory Health Ministers’ Statement of Rights and Responsibilities which articulate clearly the responsibility to consult consumers.

Notwithstanding the above, the ease with which health services have imposed their will on consumers reflects a deeper issue of the negative organisational culture and attitudes that exist towards people with a mental illness.

While the physical health of people with a mental illness is well known to be of major concern, the approach to lessening the number of mental health consumers who smoke should be done in a respectful, dignified, holistic manner at a time when the person is not in an inpatient facility at their most vulnerable and distressed state of their life, or an involuntary patient in a secure extended care facility where they do not have the option to leave.

**Reference**

Lawrence, D, Holman, CDJ & Jablensky, AV 2001. Duty to Care – Preventable Physical Illness in People with Mental Illness, Perth: The University of Western Australia.

*Isabell Collins is the Director of the Victorian Mental Illness Awareness Council.*
Being arrested and remanded in custody can be psychologically traumatic. The sudden loss of liberty and change in social status can be very challenging. For the 70% of people who enter custody with an alcohol or other drug (AOD) problem, incarceration may result in unintended detoxification.

The complexity of this target population has been highlighted by recent clinical research. Currently, Victoria Police are conducting a five-year, $3.5 million project in conjunction with Monash University and Forensicare to explore the nature, purpose and outcomes of police contacts with people with a mental illness. The early findings of the project confirm that 70% of the people surveyed in police custody had a current problem with substance use, and 23% were on a pharmacotherapy treatment (such as methadone or buprenorphine). Adding complexity to this is the finding that 55% of the study group had prior contact with mental health services and 25% were currently undergoing mental health treatment.

The Custodial Risk Management Unit was established in response to the recognition of these health needs of people in police custody, and to make the transition from the community into custody safe. The unit works proactively with Victoria Police to improve health outcomes and reduce risks for people in police care. It is staffed by a doctor and a team of nurses, and supported by a network of GPs.

**How it works**

Custodial nurses are based in metropolitan and regional police stations in Victoria to meet the challenge of keeping people safe and healthy in police custody. The nurse offers a comprehensive health assessment to everyone held in custody. The assessment considers aspects of each person’s welfare, medical, psychiatric and AOD issues. The focus is on managing the health risks of being in a place where there is restricted access to health services.

Once the person has been assessed and their issues identified, a care plan is devised in consultation with a medical officer and the police. The nurse works closely with the local medical officers. The doctors prescribe medication when it is required to continue regular treatment and they may initiate treatment for alcohol or drug withdrawal. Any medical or psychiatric conditions that are identified are actively managed.

The nurses liaise with community agencies to ensure they understand the individual’s needs. They can help people find pharmacotherapy prescribers, pharmacies, withdrawal services, court-based services or arrange access to the Mental Health Court Liaison Service. If the person is going to prison, referral is made to the appropriate services in the jail.

The custodial nursing service has been well supported by police. Many police say that since the commencement of the current program in 2002, there has been a dramatic reduction in the number of health and welfare issues in custody.

**AOD and mental health issues**

In the past year, the custodial nursing service performed 4086 nurse consultations – one-third of these were for general medical problems, one-third were for drug withdrawal, and a quarter were for psychiatric problems. The most common drugs that required detoxification were opiates (mostly heroin) and alcohol. The most common mental health issues treated were depression, stress and anxiety disorders.

**Challenges**

The balance between the physical and mental health of people in custody and the workings of the justice system can present challenges. The unit attempts to manage the tensions and liaise with external agencies such as case managers, the courts and doctors to determine the best approach for each individual.

**A model for other organisations?**

The key success of this unit has been the collaboration between health professionals and the police. By working together in police stations and being involved in the unit’s plans for health care, police have come to recognise some of the complexity of the physical and mental health needs of the people in their care. The result is better care for all people in custody. It is a collaborative model that could be applied in a range of community health and care environments.

If you are interested in knowing more about the Custodial Risk Management Unit please contact (03) 9247 6988 or email custodialmedicineunit-OIC@police.vic.gov.au.

*Dr Edward Ogden is the Principal Medical Advisor, Operations Coordination Department, Victoria Police.*
Published by the National Centre in HIV Epidemiology and Clinical Research, Return on Investment 2 examines needle and syringe program (NSP) provision for the past decade, concluding it is highly cost-effective and has had an enormous impact on reducing the spread of both the hepatitis C and HIV viruses.

In launching the report last October, Chair of the Australian National Council on Drugs Dr John Herron reminded people that ‘Australia enjoys one of the lowest, if not the lowest rates of HIV infection among injecting drug users, largely due to those who had the foresight in the 1980s to introduce needle and syringe programs to protect people from the then little known but fast spreading human immunodeficiency virus (HIV).’

The primary aim of NSPs is to prevent the shared use of injecting equipment, thus reducing the risk of people who inject drugs acquiring blood borne virus infections. Injecting equipment includes needles and syringes, swabs, sterile water, and sharps bins for the safe disposal of used equipment.

NSPs around Australia now distribute more than 30 million syringes each year – up from 27 million a decade earlier. As well as providing injecting equipment, NSP services include education and information on reducing drug-related harms, and referral to drug treatment, medical care, legal and social services. They also provide condoms and safer sex education to reduce the potential for sexual transmission of infections.

Expenditure on NSPs over the past decade increased by 36 per cent (adjusted for inflation). While spending on sterile injection equipment remained stable, there were increases in funding for primary sites and staffing. A significant proportion of the increase was for measures to increase client referrals to drug treatment and other services.

There are now more than 3000 NSP sites across Australia, consisting of:
- primary outlets, which provide a range of services focusing on safe injection and drug use
- secondary outlets, located in facilities that have a different core business
- mobile and outreach services
- syringe vending machines
- a significant number of pharmacies.

The distribution of these outlets varies considerably between states and territories.

**SNAPSHOT OF REPORT FINDINGS**

**Effectiveness of NSPs**
- It was estimated that over the last decade (2000–2009) NSPs have directly averted:
  - 32 050 new HIV infections
  - 96 667 new hepatitis C infections.

**Economic analysis of NSPs during 2000–2009**
- During 2000–2009, gross funding for NSP services was $243 million. This investment yielded:
  - health care costs saved of $1.28 billion
  - approximately 140 000 disability-adjusted life years gained
  - net financial cost-saving of $1.03 billion.
- It was estimated that:
  - for every one dollar invested in NSPs, more than four dollars were returned (additional to the investment) in health care cost-savings in the short term (ten years)
  - the majority of the cost savings were found to be associated with hepatitis C-related outcomes.
- If patient/client costs and productivity gains and losses are included in the analysis, then the net present value of NSPs is $5.85 billion; that is, for every one dollar invested in NSPs (2000–2009), $27 is returned in cost savings.
- NSPs are very cost-effective compared to other common public health interventions.
Support for NSP expansion

The report argues that, from a public health perspective, further expansion of NSPs across Australia is warranted, and that this could be achieved in various ways, with different cost implications.

The current coverage of injections with sterile syringes is about 50 per cent. Viral transmission still occurs among people who inject drugs, with at least 30 to 40 new HIV infections and 8000-10 000 hepatitis C infections occurring each year through sharing syringes.

Expansion options identified in the report include:

• establishing NSPs in settings where there is demand and where they currently do not exist
• considering alternative ways of supplying clean injecting equipment, such as extending operating hours of NSPs
• removing impediments to secondary exchange, where people who inject drugs can supply clean equipment to their peers
• increasing availability of syringe vending machines.

With respect to decreased levels of NSP funding, the report estimates that a decrease of just 10 per cent could cost more in the next decade in HIV and hepatitis C infections: loss of health and life and associated extra health care costs would lead to a reduction in the return on investment greater than the immediate NSP expenditure savings.

While HIV remains low and stable among people who inject drugs, the report argues that even relatively minor reductions in current levels of NSP coverage could result in an important increase in incident infections. The situation is more severe for hepatitis C.

Need for evidence-based responses

The results of this study support the need for a range of evidence-based public health responses to prevent both primary and secondary HIV and hepatitis C transmission among people who inject drugs.

These responses include:

• biomedical and behavioural prevention interventions which target injecting-risk behaviours
• interventions designed to encourage early uptake of treatment
• increasing access to hepatitis C treatment.

Conclusion

The report points out that the study results are conservative estimates of the true return on investment, as they are based on the effectiveness of NSPs in averting HIV and hepatitis C infections only among people who inject drugs, and not on the wider benefits of NSPs, such as avoided mental health episodes and injecting-related injury, psychosocial benefits, and the benefits of referral, education and prevention.

As Dr Herron said at the launch last October, ‘Drug use occurs for many reasons, but everyone is entitled to have their health protected. Don’t ever think that it could never be your child, brother, sister or friend who will need this help.

‘As the Federal Government focuses on preventative health issues there can hardly be a better example of the value that prevention brings to the community.’

Further reading


VOICES OF CONCERN

Senior figures in the Australian alcohol and other drug sector have warned that Australians must not become complacent and think that the NSP program has completed its work.

Executive Director of the Australian National Council on Drugs, Gino Vumbaca says, ‘The program needs greater investment to adjust, expand and move to meet the changing trends in drug use, and to help slow the hepatitis C epidemic; it needs to be made far more available and accessible with governments needing to look at removing the unnecessary barriers that were put in place when the program was introduced at the height of controversy.’

Vumbaca is supported by John Ryan, the CEO of ANEX, a national organisation of health service providers committed to reducing drug-related harm. He has raised a number of concerns about current NSP provision and advocates a number of changes. His thoughts include:

• the need for a much greater investment in campaigns to changing public attitudes to and understanding of the value of NSPs, including accurate and responsible media coverage and the placement of ’good news’ stories
• more investment in workforce development, including a national workforce development plan for NSPs, with the aim of establishing a fully professional workforce and consistent training standards across jurisdictions
• greater effort is needed to reach ’hidden’ populations in need of NSP services
• NSPs should be available to prisoners, to improve their health and safety and the safety of prison officers, and there should at least be an initial trial
• greater attention on female injectors, who are particularly vulnerable to infection through injection and sexual transmission
• NSP services generally operate on a working hours (9am – 5pm) model, whereas drug use does not. Access should be improved, including an increase in the number of vending machines
• many NSP sites are very basic and cramped, with no space for confidential discussions. These should be upgraded.

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Research findings and clinical observations suggest that most people who have been psychologically damaged by disasters recover over time and return to ‘normal’ functioning. But a significant minority do not. Research also suggests that in some survivors and witnesses, post-disaster health – particularly mental health – is connected with substance use and patterns of misuse (Boscarino et al. 2006).

Survivors of, and witnesses to, disasters and emergencies include people directly in their path, emergency and frontline support workers, and people outside the affected areas with strong emotional connections to them.

The key messages on the psychological effects of disasters are:

• many people who survive or witness the impact of disasters will have experienced shock, fear, the prospect of their own sudden death and the reality of death around them
• generally, the greater the exposure, the more likely it is that a survivor will also experience severe reactions, which may linger for years if not properly treated
• people whose history includes experience of previous trauma or psychological disorders are more at risk of severe ongoing psychological or social dysfunction following exposure.

Australian disasters
Most major disasters in Australia have been so-called ‘natural’ ones – including cyclones, bushfires, floods and earthquakes. The most severe natural disasters of recent memory are conjured up by certain dates: Black Friday 1939, Cyclone Tracy 1974, Ash Wednesday 1983. And, just a year ago in Victoria, one of the worst, Black Saturday 2009.

Australians have also suffered several man-made disasters with their attendant grief and loss of life, for example the Granville rail accident in 1977. And although it occurred offshore, many regard the 2002 Bali terrorist attack as one of the worst of these, because so many Australian citizens were killed or maimed. ‘Bali anger’ often resurfaces on the anniversary date, 12 October.

Exposure and mental and physical health
Individual responses to disasters vary widely but some reactions are almost universal. Most people directly in the path react initially with fundamental survival behaviour: they fly into action and do what they can to meet the threat.

Most survivors who experience post-exposure shock, grief and loss resume the basic activities of their lives usually...
within a few weeks. But a significant minority experience lingering or late-onset symptoms of post-traumatic stress disorder (PTSD), clinical depression or anxiety disorders, each of which requires specific treatment.

The causes and symptoms of, and risk factors for, post-disaster trauma are complex, and need much more study. Much research on post-disaster health focuses on mental health, but there is also evidence of long-term physical health and social problems, with significant implications for population health and clinical practice (Galea 2007; Camilleri et al. 2007).

‘Exposure to disasters is really exposure to a toxin – in this case a psychological toxin; as such it should be seen as a public health issue,’ says Professor Sandy McFarlane, specialist in post-disaster mental health and PTSD.

A month after the World Trade Center Disaster (WTCD) in Manhattan, studies found that the rate of PTSD among New Yorkers was 7.5% (20% for those who were in ‘Ground Zero’) and for depression 9.7% (Boscarino et al. 2004; Galea 2002). In other studies, around a third said their lives had not returned to normal even two years later (Boscarino et al. 2008).

For many who lose loved ones in a disaster, ‘complicated grief’ may become a persistent condition. Psychologist Dr Richard Bryant suggests that, while complicated grief affects 10-15% of bereaved people, the rate is likely to be much higher when the death occurs in a traumatic way, as occurs in disasters. As with PTSD, complicated grief can result in various health problems, including increased smoking and alcohol consumption (Bryant 2008).

Long-term impacts

McFarlane’s study of 800 affected children after the 1983 Ash Wednesday fires in South Australia found, surprisingly, that, while their rates of psychological distress were initially lower than those of the control population (who had not been exposed to any fires), concentration problems and disruption at school, and other problems, were much greater 29 months later. Moreover, his follow-up of these children as adults in 2004 found that many still suffered from intense distress and anxiety more than 20 years on (McFarlane 2009).

Similarly, a 2007 report on the 2003 bushfires in the ACT found that one in five survivors were still distressed more than three years after the tragedy, and that significant numbers were experiencing alcohol and other drug problems, mental illness or emotional crisis, and serious illness, two to three years later (Camilleri et al. 2007).

Substance use after disasters

Some people exposed to disasters try to manage or blunt severe emotional reactions by reaching for the bottle, the pills or the cigarettes. Studies after the WTCD found that, within the New York City precinct, in the 5-8 weeks afterwards, smoking rose by 9.7%, alcohol consumption by 24.6% and cannabis use by 3.2% (Vlahov et al. 2002).

It has been widely acknowledged that alcohol is the most commonly used substance within Australian communities impacted by disasters. It is widely available, is part of the culture in which many emergency workers, police officers and volunteers operate, and may be used by them to cope with repeated stress. For survivors, alcohol use may simply equal a few drinks with colleagues, friends and family while going over the experience.

‘Moderate drinking to cope with short-term stress is not necessarily bad,’ says McFarlane. ‘The important concern is to monitor consumption, together with psychological symptoms, particularly in vulnerable survivors. If a pattern of increased drinking develops, it may be symptomatic of an underlying untreated mental health disorder.’

In his longitudinal study of 469 firefighters exposed to the Ash Wednesday bushfires, McFarlane found that PTSD was associated with either an increase or decrease in alcohol consumption. In addition, this study found that sometimes symptoms did not surface until years after the event (McFarlane 1998).

Treatment for PTSD and substance abuse

As Dr Katherine Mills and others have pointed out, comorbid PTSD and substance use problems have
typically been treated in separate services, and so one or other problem is often missed or untreated as people are referred back and forth between mental health and drug and alcohol services (Mills 2008).

Randomised control trials of psychological treatment for PTSD and substance use problems are currently underway at the National Drug and Alcohol Research Centre, to examine whether treatment known to be highly effective for PTSD sufferers with no substance use problems is as effective for those with comorbid alcohol or other drug use problems.

Lessons from post-disaster interventions

Stages of community recovery

In the days and immediate weeks following a disaster, the common experience of survival and loss brings a community very close. But over time it becomes clear that individuals have been very differently affected. The united front fractures, and sometimes the resulting conflict causes lasting social and psychological problems. Typically, a lot of resources are allocated immediately after a disaster, but recovery policies have not always recognised the need for longer-term interventions. In recent times this has improved. In bushfire-affected Victoria, support services and activities are well publicised, and are planned to continue for at least two years.

Family and individual recovery

Disaster psychology expert Dr Rob Gordon worked throughout 2009 with communities affected by the Black Saturday fires in Victoria to help them understand and manage their reactions.

‘Survivors may continue to run on adrenaline for months, but then they slow down and exhaustion sets in, often coinciding with the need for difficult long-term decisions,’ he explains.

Family conflict and individual anxiety and depression may follow. ‘Patterns of substance abuse and stress have been reported anecdotally to peak at around six months after impact. The second six months is often a time of

SUBSTANCE USE AFTER THE WORLD TRADE CENTER DISASTER

Professor Joseph Boscario, senior investigator at the Geisinger Clinic in Pennsylvania, has completed several studies of substance use among people exposed to the World Trade Center Disaster (WTCD) of September 11 2001.

A random population sample survey of 1681 New Yorkers by Boscario and colleagues found that alcohol consumption, binge drinking and alcohol dependence were associated with exposure to WTCD events up to two years after the event. There was also an association between problem drinking and mental health disorders. Follow-up studies strongly suggest that the increased use has lasted over time (Boscario et al. 2006).

Boscario says that the results of the WTCD studies confirmed his findings for Vietnam veterans in the 1970s. ‘Substance use was associated with the level of exposure. People were self-medicating to deal with stress, using common legal substances and sometimes illegal ones.’

Around 10 per cent of New York City workers exposed to the WTCD attacks (around half a million people) received brief multi-session (one to three sessions) interventions conducted at the worksite by mental health professionals and provided by local employers for their employees shortly after the September 11 attacks. The content of these sessions varied, but they generally included psycho–educational interventions and information about available treatment services.

By tapping into a substantial random sample of this large cohort, Boscario and colleague Dr Richard Adams were able to evaluate the effects of these sessions on a range of typical post-disaster symptoms. The findings of a treatment outcomes study conducted a year after the WTCD were unexpected and remarkable, says Boscario. Of a range of post–disaster treatments, these brief worksite interventions were the most effective, producing substantially reduced symptoms, particularly with respect to alcohol use. Surprisingly, those who received more conventional post-disaster interventions, such as psychotherapy, seemed to have poorer outcomes.

In addition, a follow-up study found that people who had received these brief interventions experienced:

- a decrease in PTSD, anxiety and depression symptoms, that lasted for two years
- a greater decrease in alcohol problems and dependency symptoms than among those who did not have treatment.

‘Many survivors and witnesses surveyed after the WTCD also reported benefiting from informal support networks,’ says Boscario. ‘This was especially so for symptomatic members of minority communities, who tended not to seek post-disaster treatment.’

Other research has consistently shown that social support helps protect people exposed to traumatic stress from psychological harm, and that it can influence effective treatment, although the reasons for this are unclear (Boscario et al. 2006).
high stress, lowered health and emotional resilience, and depression.’

For bushfire survivors, the onset of the next summer can bring stress and heightened arousal. ‘Many readily recognise the problems when they are described, and decide to increase recovery activities,’ says Gordon.

What works

Interventions need to be guided by the different stages of recovery. Signs of distress can endure for years or emerge much later. ‘Research shows that the most effective recovery services are low-key, informal, community-based, outreach-oriented services built on local agencies,’ says Gordon. He recommends that recovery teams:

- establish communication with affected people (including emergency workers) as soon as possible
- identify those likely to become isolated and more affected
- provide clear information as soon as possible on all aspects of the emergency
- encourage opportunities to share experiences.

Interventions and services that have attracted positive evaluations from professionals and/or users include:

- early screening to identify, monitor, and where necessary refer, individuals at high risk of mental and physical health problems, including problematic substance use
- community outreach, both immediate and ongoing. The evidence suggests that long-term, creative and flexible outreach is the bedrock of good recovery strategies
- brief interventions at the worksite (see panel on World Trade Center Disaster)
- informal support networks, especially in the early stages
- web-based information and guidance.

Internet-based interventions

There is increasing research into the effectiveness of internet-based interventions for substance use disorders, for which a demand has been demonstrated (Copeland et al. 2004).

One pilot study of New York City residents explored the feasibility of internet-based intervention for mental health and substance use problems in disaster-affected populations (Ruggiero et al. 2006). The study focused on longer-term risk rather than the acute post-disaster context. The results were promising, warranting further investigation.

Some issues

Medical vs. social model of recovery

While informal support networks are reportedly helpful to many survivors, some argue that recovery professionals should monitor them to ensure high-risk survivors get access to professional intervention.

McFarlane believes there is a lack of empirical evidence for the social model of recovery, and that it may not change individual outcomes. On the other hand it has been argued that reliance on a medical model can lead to ‘over-medicalised’ attitudes to the reactions to trauma. Professor Joseph Boscarino (see panel) says more work is needed on factors affecting post-disaster resiliency. He submits that the traditional clinical focus of post-disaster interventions on psychopathology, rather than on wellness and positive psychological factors, might be misplaced.

The tendency to import static medical-model health and mental health services into disaster communities has been documented for over 40 years, says Gordon. At the same time, experience shows these are often mobilised early, under-utilised and then withdrawn after some months, when stress responses and their consequences are developing.

Training and expertise

In Gordon’s view, better recovery strategies flow from understanding the complex social processes that follow disasters. ‘People in support roles need the skills to recognise and respond to the changing needs and emotions of survivors,’ he says.

An evaluation of the UK’s July 7th Assistance Centre recommended that volunteers should be appropriately trained, and that counsellors be fully trained and individually supervised (Trickey 2007).

Galea and McFarlane have emphasised the critical role of GPs and other primary care providers, who need support, training and encouragement to look for underlying disorders in patients who are increasing their use of drugs, and to diagnose and treat specific disorders.

References


For the full reference list, email the editors: editor@ancd.org.au.
Outback crusade: Indigenous licensing officer drives alcohol reform

Sergeant Michael (Mick) Williams, an Aboriginal (Ngemba) police officer, is the Licensing Officer for the Darling River Local Area Command in NSW. Based in Bourke – his traditional community and home town – he knows remote communities well. For most of his 20 years with the NSW Police, he has served in the river towns of far western NSW – including Wilcannia, Walgett, Brewarrina and Bourke.

The Bourke local government area has the highest rate of alcohol-attributed hospitalisations in NSW – over three times that of the state as a whole. As well, over a third of mental health admissions from far western NSW are linked to alcohol intoxication and withdrawal.

In an effort to tackle the scale of local alcohol abuse at a ‘whole of community’ level, in 2008 Sergeant Williams formed the Bourke Alcohol Working Group (BAWG). The group is a collaboration of police, the Bourke Community Drug Action Team (CDAT), health, council, liquor accord and community members. Its first major initiative was the Bourke Alcohol Forum, held in July 2008. The forum identified specific alcohol products as major contributors to alcohol-related problems: four-litre cask wines, long-neck beer bottles and fortified wine.

Following the forum, Sergeant Williams tried to get a voluntary accord with licensees to cease selling these products, but licensees argued they would lose too much money. Subsequently, Sergeant Williams organised a local group to apply directly to the Director of the NSW Office of Liquor, Gaming and Racing (OLGR), Mr Albert Gardner, seeking a range of licensing restrictions. After visiting Bourke in January 2009 for a community meeting, Gardner imposed the current conditions on licensed venues in Bourke township (see panel below).

Since February 2009, Sergeant Williams and his colleagues have been enforcing these conditions. He spoke to Of Substance about the long road to these reforms, and what drives him to continue in a role that often means he must ‘walk between two worlds’.

Photo above: Mr Albert Gardner, Director of the OLGR (left), and Sergeant Mick Williams survey the debris of bottles outside a party house in Bourke.

IN 2008 SERGEANT MICK WILLIAMS BECAME THE FIRST NSW ABORIGINAL POLICE OFFICER TO BE AWARDED AN AUSTRALIAN POLICE MEDAL – AN HONOUR HE CALLS ‘OVERWHELMING AND SURPRISING’.

License restrictions in Bourke since February 2009 include:
• no fortified wine in containers greater than 750ml
• no beer in 750ml glass bottles (longnecks)
• only mid-strength alcohol to be sold between 2pm and 8pm
• no wine casks greater than two litres
• only low alcohol-content drinks can be sold in glass containers between 10am–2pm (non-residents living more than 50km away exempt)
• display health information approved by the Darling River Local Area Command.

Additional voluntary undertakings by licensees:
• Alcohol sold for consumption off premises will be loaded into a motor vehicle, with the purchaser present (bona fide travellers to Bourke who on the day of purchase have stayed or intend to stay at recognised tourist accommodation are exempt).
I was born and bred in Bourke but went away for a few years after I finished school. When I returned as a police sergeant in 1997 the town was in the throes of an alcohol epidemic. Domestic violence was rife. We saw every problem from fetal alcohol spectrum disorder (FASD) to extreme antisocial behaviour and total lack of respect for others. There were huge brawls in and around some of the pubs, all fuelled by alcohol.

The change began when new licensing regulations in 1997 prohibited sales of bottled alcohol after 8pm with no takeaway after 9pm and stronger security measures. It was a start, but it didn’t go far enough.

I moved into licensing from general policing about two years ago when Brett Greentree (now my boss) asked me to get alcohol awareness going. I’ve been given this opportunity and have all the police support I need. But the major obstacle has been a ‘not my problem’ attitude. Many people saw alcohol abuse as affecting only one part of the community, but my response is, even if only a minority are damaged, it’s still your problem if you live in this community. The reality is, everyone is affected.

Many locals don’t want me to rock the boat. But hard decisions need to be made. Alcohol causes endemic family dysfunction in these river towns. To get people to see it as a community-wide issue I just kept stating the facts, I confronted them, I even used subterfuge when I had to. I kept chipping away.

The grog parties were particularly brutal affairs. There were streets where everyone was drunk from 10am. Taxis would deliver cartons of grog but no food. The only way out was to break up whole families, as big as 30-plus members, and relocate them. We demolished public housing stock that was vandalised or uninhabitable. There are whole streets now with no houses.

Dramatic improvements

The licensing conditions we finally achieved last year were all based on facts. And they’ve had a dramatic effect on the health and well-being of a lot of community members. Some couldn’t walk or hold a conversation after long-term drinking of moselle. Now they drink mid-strength alcohol and move about the community without issue.

Alcohol-related domestic violence appears to have slowed dramatically, and anecdotal evidence from health services indicates more alcohol-withdrawal patients are attending Bourke Hospital. We also have a project officer funded for two years to roll out a five year Alcohol Management Plan.

Some people don’t like what I’m doing but I’ve had letters of support and congratulations from others. Lots of Aboriginal people affected by the new conditions are happy.

The restrictions impact on users but also on their families, especially children – the 10am grog parties have stopped.

We’re moving into smoother waters now, but the issue has become very political, and it’s uncharted territory for alcohol reform in these communities.

Bridging the divide

My inspiration is my grandfather, Tracker Sergeant Frank Williams. He worked with Bourke police in the early 1900s and is celebrated in Bourke’s Hall of Legends. He passed away before I was born, but he left learnings through my mother, that the divide between black and white could and should be bridged. Before he passed away, he was awarded the Imperial Medal from the Queen for his service to Police and Community.

Being Aboriginal is an issue for me in my work because I’m often pulled in opposite directions: ‘You’re black, help us, don’t lock us up’ – or ‘You’re white, look at your skin’. I hate custody duties because they can involve my own family members. As an Aboriginal person it’s my obligation to give and help. My colleagues try to shield me from custody duties for that reason.

Membership of the BAWG includes a wide range of government and community members – Europeans and Aboriginals working together. This type of challenge draws the best from both cultures.

I’ve been invited to give presentations in Walgett after they heard what’s happening here. Walgett tried voluntary alcohol restrictions, but the licensees believed they were losing money and reverted back – that’s the risk of the voluntary concept. I’m also asked to give cultural awareness training to other Local Area Commands. No one’s doing it in the western region. It can’t be given by just any officer, you need to be an Aboriginal officer, have personal credibility and knowledge.

Building the future

When I first left school I worked in an abattoir and ended up in the Northern Territory boning buffaloes. Back in Bourke, before I joined the police I trained as an Enrolled Nurses’ Aide. I worked in the children’s ward most of the time and saw firsthand the babies with symptoms of FASD – with that haunted look from alcohol withdrawal. Those babies are adults now and having their own FASD babies. I’m driven by the hope that this will change if we continue in this direction.

I want to go beyond the alcohol issue, though, to find solutions for unemployment, other health and social problems, and to focus on children and youth. I’d like us to have another forum where our youth tell us what we can do for them, so we can build a future with them.

Sometimes I feel like the Lone Ranger, even though I have good support. There’s lots of covert pressure on me but I’m hanging in there because I really want to see these improvements. Sometimes I ask myself, am I making a good impact or just treading water? If it turns out to be the latter, maybe I’ll quit and go play golf.

Reference

Presentation to Bourke community groups by Sergeant Michael Williams, Bourke LAC, July 2008.
In January 2006, Of Substance published an article discussing substance use among people from culturally and linguistically diverse (CALD) backgrounds. Four years on, what progress has been made in engaging CALD communities about substance use issues?

Who are our CALD communities?

It is worth reminding ourselves that our culturally and linguistically diverse (CALD) communities are, indeed, very diverse. While for some purposes they may usefully be grouped under an umbrella term, they also differ significantly from one another in a number of ways.

For example, some CALD communities are well established in Australia, with second and third generations born here; but others are as newly arrived as last week. There are business migrants, but also refugees. Some, particularly young people from established communities, are comfortable with the English language and more attuned to mainstream Australian culture than to that of their parents or grandparents, who may use only their language of origin and regularly practise their community’s cultural traditions. And so on.

As might also be expected, increasing length of time in a new country is generally associated with adoption of prevailing norms (e.g. in Australia, drinking alcohol). However, the available data does not show a clear-cut correlation between length of time in Australia and rates of substance use among members of CALD communities.

Communities’ origins are also implicated in substance use. Many people of refugee origin, for example, experience psychological problems and post-traumatic stress disorder (PTSD), and may be highly susceptible to substance misuse.

On the other hand, they may also be protected to some extent by higher than expected levels of resilience, and may draw great strength from family and peer networks; such characteristics can temper their vulnerability.

Recent research

From those in the field who provide targeted services and interventions, a recurring message is that more systematic research into substance use in CALD communities, including collection of demographic data, is needed to build a body of reliable evidence on which to direct efforts to those most in need.

Research remains patchy, but recent findings suggest a complex picture, with variations depending on cultural traditions, ethnic background, age, gender and other factors.

The most comprehensive recent data comes from two major studies into Sydney-based CALD communities, first in the mid-1990s, then a decade later in 2005, by the NSW Drug and Alcohol Multicultural Education Centre (DAMEC). The centre’s role is to reduce the harm associated with the use of alcohol and other drugs within CALD communities in NSW, and research is one of its chief activities.

The 2006 Of Substance article reported on the findings of DAMEC’s mid-1990s study. The 2005 study, published in 2008, confirmed the main finding of the earlier one,
that alcohol, tobacco and other drug use remains less prevalent within these communities than in the general NSW population.

Both studies examined the prevalence of substance use in six communities in the Sydney region. The first study covered Chinese, Vietnamese, Spanish, Italian, Greek and Arabic communities. In response to emerging health concerns about substance use in the Pasifika community, it was decided to include this community in the 2005 study in lieu of the Greek community. Most Pasifika people who reside in Australia were born in New Zealand, Fiji, Australia, Samoa, the Cook Islands and Tonga.

Alcohol and tobacco emerged as the substances most commonly used, with rates varying considerably between and within individual communities. Smoking is prevalent in many migrant and refugee communities, according to Veronica Ramos, Multicultural Project Coordinator at Quit Victoria. Its research suggests that, in some cultures, smoking symbolises maturity or masculinity, while in others it is believed to stimulate thought and relieve stress.

The multiple barriers to engaging CALD communities include the stigma and shame, and fear of ostracism, that keeps sufferers and families silent; unrealistic expectations of treatment; language barriers; and for many, the alien idea of seeking help and counselling outside immediate family or trusted community members.

Service providers who are working successfully with CALD communities have found that building trust is the key to building capacity on both sides. They point out that engaging families is a key to success in many communities. In communities that work collectively, and in many recently arrived groups, engaging their leaders is an essential first step.

They have also learned that interventions and services that are proactive, flexible and targeted to the needs and profiles of different sub-populations are those most likely to succeed.

Veronica Ramos counsels that no one strategy works for all communities: targeting specific groups and getting the timing right is crucial: for example, members of newly arrived communities normally have more urgent priorities, while established communities may present changing needs.

Preliminary results from an evaluation of Quit Victoria’s approach suggest that its culturally and linguistically specific strategies are highly effective. An increased proportion of smokers from CALD backgrounds are now accessing Quit services: calls to the Quitline via the interpreter service during the same period in 2007-8 in conjunction with an intensive ethnic radio campaign in December 2006 to January 2007 increased by 316% in December 2006 to January 2007. Distribution of multicultural resources in 20 languages almost doubled from 2007 to 2008.

### DAMEC: KEY FINDINGS, 2005

- Rates of weekly drinking and short-term high-risk drinking were lower across all the CALD groups studied compared to the total NSW population. However, in the Pasifika community, while drinking occurred less frequently, short-term high-risk drinking emerged as a health concern.
- More than half of current smokers in Chinese, Arabic and Pasifika groups had tried unsuccessfully to quit smoking in the last 12 months. Eighty per cent or more of the quitters in the Chinese, Arabic and Spanish groups did not seek any assistance to quit smoking. Vietnamese men and Pasifika men and women reported the highest daily smoking rates.
- Recent illicit drug use was substantially lower across all the CALD groups than the NSW rate of 15 per cent (AIHW, 2005).
- There were high levels of knowledge of common health problems associated with tobacco and alcohol use, but limited knowledge of the full range of health problems.
- Across all groups there was lower confidence in knowledge of other drugs (illicit drugs, sedatives and analgesics) than was the case with tobacco and alcohol.
- Across all groups, the doctor/GP was an important source of information and help for problems associated with alcohol and other drugs (AOD); community language media and SBS television and radio were well used information sources.

### Key recommendations

- Alcohol education campaigns should target Pasifika communities, and aim to increase knowledge in all communities of what constitutes a standard drink.
- Tobacco education and quit-smoking programs should target Vietnamese men, Pasifika men and women, Italian men, and men and women from Arabic-speaking communities; and aim to increase the proportion of smokers in all communities who seek help to quit.
- Education programs should aim to increase confidence and awareness in all communities of sources of help for AOD-related problems, in addition to GPs.
- Current programs supporting and training GPs in AOD issues should be expanded.
Successful interventions

DAMEC works closely with area health services and community organisations in managing targeted projects supported by funding. Its current projects are:

• The Vietnamese Transitions Project in Sydney’s South West region – provides intensive case management support for 3–6 months following release from prison for Vietnamese drug offenders and their families.

• The Hoa Binh Families Talk Project – a community outreach program to help families prevent and limit the harm caused by alcohol and illicit drugs within the Vietnamese community.

• The Young African Companions Project – which works with active members of African refugee communities aged 16–25 years. Companions undertake training in drug and alcohol issues, and are supported to share knowledge with their peers and communities and be a contact point for people seeking information and assistance.

• The Amphetamine-Type Stimulants Project – will develop informational resources for amphetamines users from Arabic, Vietnamese and Filipino backgrounds.

Use of ethnic media

Dr Stephen Li, Chair of Community Health for the Australian Chinese Medical Association, says the use of ethnic media can be quite effective. ‘We can capture close to 100 per cent of the ethnic media market in the Chinese Australian community with talk shows on 2AC, 2CR and SBS Radio and health columns in the two major Chinese language newspapers.’

Such media strategies may not reach the younger generation of established communities, however, especially those whose English language skills are well developed. They are more likely to tune in to messages via the internet and interactive communications, and the mainstream media that target young people generally.

Recent arrivals, including refugees, may be best served by culturally and linguistically specific strategies involving members of their own communities. Examples are DAMEC’s Young African Companions peer education project, mentioned above; and the weekly program, led by young Africans, on Edge Radio in Hobart – called Image of Africa – that broadcasts health, education and cultural messages.

Training

Training programs that bring communities together with health and AOD professionals have been found to break down barriers, foster trust and mutual learning, and build networks. They educate community representatives about the risks and harms of different substances and explain treatment options and outcomes; and help AOD and health professionals appreciate differing community expectations, circumstances and cultural complexities.

One such project, funded by the Victorian Department of Human Services, was run over three years in 2007–09 by the Turning Point Alcohol & Drug Centre, in conjunction with the Victorian Multicultural Centre for Women’s Health. Free courses were widely promoted through AOD agencies and health professionals, a refugee network website and other CALD networks. Getting the message to the right people can be challenging, however. ‘We rely on interested people promoting it heavily in their own communities,’ says Coordinator Phoebe Spry-Bailey.

Changing role of GPs

For many members of CALD communities, the family GP is likely to be the key professional practitioner they know and trust, and who may speak their first language. DAMEC’s research shows people from CALD backgrounds usually identify their GP as their primary source of help for AOD issues should they arise, so it recommends that programs supporting and training GPs in AOD issues need to be expanded. But the reality is that few GPs have the time to invest in training and, given the pressure of their caseloads, most have very limited capacity to identify CALD substance users before they are seriously at risk, to inform them fully of related harms or refer them to appropriate services.

Despite the apparent wide use of GPs as the first point for assistance and referral, some research has found that often assistance is not sought until there is a medical emergency or criminal justice intervention (Beyer & Reid 2000; Reid, Crofts & Beyer 2001).

Conclusion

While there have been some encouraging improvements in engaging CALD communities through targeted interventions and training programs, the DAMEC 2005 findings reveal that a high proportion of members of these communities in need of help are still not accessing support services for problematic substance use. Increased investment in research is vital to better understand the scope and nature of substance use within these communities, and so to guide effective responses.

Editor’s note: Subsequent articles in this series will explore in more depth aspects of the use of alcohol, tobacco and other drugs within specific CALD communities, and the challenges these present for the planning and delivery of intervention and support services.

References

To obtain a list of references cited in this article, email editor@ancd.org.au.
Refugees in Australia, recently arrived or well established, have almost always survived horrific experiences that would leave most people reeling. Demeaning torture, gang rape, losing parents or children, are just some of the traumatic experiences that can negatively affect people for years or even decades.

Despite the enormous resilience and courage shown by refugees, the effects of multiple traumas can lead to problems ranging across the biological, psychological, physical and social – particularly when combined with settlement difficulties and other life events. Common among refugees are symptoms of stress, anxiety, disassociation and numbing.

The work of the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) over the last 20 years suggests that some survivors of torture and refugee trauma turn to alcohol and other drugs to deal with painful memories.

Many try to avoid situations that remind them of what they have been through. Often, they try to numb their feelings and forget.

**Building trust**

Also common are issues of safety and trust; trust of themselves, of family, of community, and of government and other institutions. State terrorism and organised violence in their own country target the very essence of a community: relationships between individuals, families and other social groups. When relationships are affected, a severe lack of trust pervades social interactions (Martín-Baró 1989, 1993; Kordon et al. 1988).

Developing relationships is therefore crucial, with individual clients and with communities, who can encourage and support their members to access a service. Community education may form part of this, but it depends on what is appropriate for the community and what kind of relationship already exists.

‘The community needs to see it as a problem first. Once they trust you, they’ll approach you for help,’ says Jasmina Bajraktarevic Hayward, STARTTS’ Community Services Coordinator.

‘It’s the same when working one-on-one. The client needs to feel safe, to feel you are genuine and trustworthy. People might not talk about their drug and alcohol issues straight away, as there might be stigma associated with those.’

Asked how best to develop trusting relationships, Jasmina replies, ‘Being client-centred, working with what they bring to you. Once they trust you, then they will open up.’

Sejla Tukelija, a trauma counsellor with STARTTS, reinforces that message. ‘Trust grows as their relationship with you grows. It happens through the process of therapy. Once the client feels they can get support from you, that their children are supported, then that feeling of safety increases.’

Strategies for developing trusting foundations early in the counselling process, says Sejla, include ‘explaining who you are, what your role is, ensuring they understand confidentiality and that confidentiality extends to interpreters, that they understand they can have a male or female counsellor. A sense of choice is important. They can begin to feel in control and understand what is happening to them.’

**References**


* Rebecca Hinchey writes from the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors.
18-20 March
Asia Pacific behavioural and addiction medicine conference
Singapore
www.apbam.org

19 March
Training needs analysis for ATOD and mental health service CSOs workshop
Launceston, Tas
Email: Lindas@atdc.org.au

14-17 April
4th national biennial conference on adolescents and adults with Fetal Alcohol Spectrum Disorder
Vancouver, Canada
www.interprofessional.ubc.ca

25-29 April
Harm reduction 2010: IHRA’s 21st international conference
Liverpool, England
www.ihra.net/liverpool

30 May-2 June
Australian Health Promotion Association 19th national conference
Melbourne, Vic

7-9 June
Diversity in health 2010
Melbourne, Vic
www.ceh.org.au

7-9 June
Club health 2010: The 6th international conference on nightlife, substance use and related health issues
Zurich, Switzerland
www.clubhealthconference.com

16-18 June
Inaugural national Indigenous drug and alcohol conference: Listening, learning and leading
Adelaide, SA
www.nidac.org.au

21-23 June
2010 Winter School. Back to basics: A commonsense approach
Brisbane, Qld
www.winterschool.info

23-25 June
Connections 2nd European conference. Drugs, alcohol and criminal justice: ethics, effectiveness and economics of interventions
London, England
www.connectionsproject.eu/conference2010

25 June
National drug and alcohol awards
Brisbane, Qld
www.draa.org.au

14-16 July
Drug and Alcohol Nurses of Australasia 2010 conference
Gold Coast, Qld
www.danaconference.com.au

30 August-1 September
17th Western Australian drug and alcohol symposium
Fremantle, WA
Email: aline@eecw.com.au

28 November-1 December
APSAD 2010 conference
Canberra, ACT
www.apsad.org.au