AA & NA: IN STEP WITH TODAY’S TREATMENT?

SUICIDE: THE ROLE OF ALCOHOL AND DRUGS

JUSTICE REINVESTMENT: STAYING OUT OF JAIL?

LOCKING UP LIVES: The incarceration of women in Australia

Find a new job! www.jobsofsubstance.org.au

ISSN 1449-0021
Advertise in Of Substance and reach 35 000 readers

The magazine will consider full, half or quarter page advertisements. Current rates (excluding GST):

- $1800 for a full page
- $1000 for a half page
- $600 for a quarter page. Discounted rates apply for non-profit organisations.

- Of Substance is a free magazine published every four months
- Inquiries about overseas subscriptions and for bulk orders (over 10 copies) to distribution@ancd.org.au

Of Substance contact details:
Level 9, 155 George Street, Sydney 2000
Tel: (02) 9018 8767  Fax: (02) 6162 2611  Email: editor@ancd.org.au
www.ofsubstance.org.au

Of Substance is governed by a Board of Management.

Chair:
- Dr Dennis Young, Executive Director, Drug Arm Australasia.

Members:
- Dr John Herron, Chairman, Australian National Council on Drugs.
- Mary-Lou Jarvis, PR Consultant.
- Ross Pearson, Senior Strategy Consultant.
- Gino Vumbaca, Executive Director, Australian National Council on Drugs.

An Editorial Reference Group advises the Managing Editor on the development of content.

Chair:
- Toni Makkai PhD, Dean, College of Arts & Social Sciences, Australian National University.

Members:
- José Acacio, Assistant Director: Illicit Drugs and International Policy; Drug Strategy Branch, Australian Government Department of Health and Ageing.
- Josephine Baxter, Executive Officer, Drug Free Australia.
- Alan Clough, School of Public Health, James Cook University.
- David Crosbie, Chief Executive Officer, Mental Health Council of Australia.
- David McDonald, consultant in social research & evaluation and Visiting Fellow, National Centre for Epidemiology & Population Health, Australian National University.
- Wesley Noffs, Chief Executive Officer, Ted Noffs Foundation.
- Larry Pierce, Executive Director, Network of Alcohol and Other Drugs Agencies.
- Ann M Roche, Director, National Centre for Education and Training on Addiction, Flinders University.
- Gino Vumbaca, Executive Director, Australian National Council on Drugs.
- Gideon Warhaft, Editor, NSW Users and AIDS Association.
- Dennis Young, Executive Director, Drug Arm Australasia.

Managing Editor: Jenny Tinworth
Contributing Editor: Kate Pockley
Business and Distribution Manager: George Hamilton

This work is copyright. It may be reproduced in whole or in part for study or training purposes subject to the inclusion of an acknowledgment of the source but for no commercial usage or sale. Reproduction for purposes other than those indicated above, require the prior written permission from the Commonwealth.

Requests and inquiries concerning reproduction and rights should be addressed to Commonwealth Copyright Administration, Attorney-General's Department, Central Office, 3-5 National Circuit, Barton ACT 2600 or posted at www.ag.gov.au/cca.

© Commonwealth of Australia 2011

The magazine is designed by Rebecca Horsburgh and printed by GEON.
Contents

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

News ...................................................................................................................................... 3

Letters ................................................................................................................................... 6

Research digest .................................................................................................................... 8
  What works in community prevention programs?
  We summarise some of the literature.

Locking up lives: Women in prison .............................................................. 10
  The number of women imprisoned is increasing rapidly, with devastating effects.

What is justice reinvestment? ................................................................. 14
  Justice reinvestment has been promoted recently as a way to slow
  the flow of people into our prisons. But what is it?

Outside perspective: Australia no longer leads ........................................ 16
  American drug law reformer Ethan Nadelmann visits Australia.
  His views will challenge many.

Building on the capital ................................................................................................. 17
  Report from the national conference of the Australasian Professional
  Society on Alcohol and Drugs.

Suicide in Australia:
Where do alcohol and other drugs fit in? .............................................. 18
  Why do people commit suicide? We look at the role of drugs and alcohol
  in the decision to end a life.

Interview: Long road home ............................................................................. 22
  AIVL’s Annie Madden talks about her personal journey
  through drug use and methadone.

AA & NA: In step with today’s treatment? .............................................. 24
  12-step programs have long been used by people recovering from alcohol
  or drug use. How do they fit with today’s more clinical-style treatments?

Addicted doctors: Finding a path to recovery ...................................... 28
  Specialised programs help doctors to recover from an addiction. Can their
  principles be applied to other people struggling with drug dependency?
Welcome to the March issue of *Of Substance*.

Our designer called this the ‘gritty’ issue. In many ways she was right. In this magazine’s pages, we look at some of life’s darker topics. Things like suicide, and the role that drugs and alcohol can play in a person’s decision to end their life. We also discuss the spiralling numbers of women entering Australia’s prisons.

While the reasons for this increase are complex, the effects on these women are absolutely devastating. That’s not to downplay the harsh impact of prison on men, but as author Libby Topp discovered, a woman trying to recover from a stint in jail has to overcome huge hurdles.

Every so often, a topic or person comes along that I mark as one of my personal highlights in more than a decade of writing about alcohol and drugs. This issue’s interview with consumer representative Annie Madden is one of those occasions. While I’ve known Annie for a long time, I wasn’t aware of the ongoing pain behind the scenes of the energetic human rights campaigner’s professional life. At my request, Annie has been brave enough to open up about her journey and talk about the enormous personal price she paid for being the public face of people who use drugs.

Please turn to page 22 for an interview which I hope will give many readers food for thought about the lives of the people they meet in their daily work.

These are just a few of the topics we explore in this issue of *Of Substance*. We also focus on prevention initiatives and on one of the best-known drug recovery programs, Alcoholics Anonymous and its sister Narcotics Anonymous.

We’re looking forward to a busy year ahead in the Australian drug sector. Within days we are expecting the announcement of the revised National Drug Strategy, along with senior appointments at a national level. As always, *Of Substance* will bring you the latest news. We’re proud to announce the launch of our on-line e-bulletin with the first edition due in May.

In NSW and other jurisdictions, children live with their mothers in purpose-built and/or child-friendly accommodation. In establishing Jacaranda’s full-time residential program for children up to school age and the occasional residential program for older children, Corrective Services NSW (CSNSW) aimed to ensure that children of mothers who have committed a crime are not disadvantaged and can grow in an environment reflecting contemporary community standards for child protection and development.

CSNSW recognises that continuity in the relationship between child and mother is of high importance to the child’s development. Children who have a parent incarcerated are at increased risk of developing behavioural and emotional problems and disorders owing to experiences of trauma and enforced separation.

The mothers’ eligibility is determined by their most serious offence, classification, drug use histories and behaviour in custody. The bottom line is the health and well-being of the children. In assessing applications, the capacity of women to live communally is a factor. Risks of any kind – child protection, offence history, drug use, disruptive behaviour – are considered against the child’s circumstances.

The CSNSW Mothers and Children’s Policy states that caring for their children while serving a custodial sentence does not preclude mothers from participating in programs that address offending behaviour. Living in a supportive, pleasant environment has assisted women to be compliant with medication, to participate in parenting and offence-related programs.

The major challenge is not the day-to-day management of the Program but the absence of post-release options for women with children, particularly those with drug use histories. Mothers and their children require post-release structured alcohol and other drugs treatment, stable accommodation and social, environmental and emotional support to assist them to avoid the circumstances that preceded their incarceration. In the absence of these supports, women with children return again and again to the criminal justice system.
A national alliance representing more than 40 leading Australian health organisations has supported the Federal Government’s plan to include alcohol taxation in the Tax Summit, to be held in 2011. The National Alliance for Action on Alcohol (NAAA), formed in March 2010, supports a push to apply tax to alcoholic drinks on an increasing scale, on the basis of the percentage volume of alcohol, with some of the revenue allocated to preventing and treating alcohol problems. Professor Mike Daube, Chair of the NAAA, said that the current alcohol tax system was a dysfunctional mess, and the Tax Summit would give the government an opportunity to act on recommendations.

‘Action is urgently needed because wine is being advertised at $2 a litre – as cheap as soft drinks and attractive to drinkers of all ages. We hope that a tax summit will result in a more sensible system that will play a major role in reducing the massive levels of harm caused by alcohol,’ he said.

New health prevention agency

In November, Parliament passed the Australian National Preventive Health Agency Bill 2010. The agency will lead campaigns targeting obesity and alcohol, tobacco and other substance abuse. The passage of the Bill was welcomed by numerous national health organisations. The government has allocated $17.6 million to establish and operate the agency which will be open from early 2011 and will be responsible for three specific programs under the National Partnership Agreement on Preventive Health:

- national social marketing programs relating to tobacco and obesity ($102 million budget over four years)
- a preventive health research fund focusing on translational research ($13.1 million over four years)
- a preventive workforce audit and strategy ($0.5 million over two years).

Dr Rhonda Galbally (AO) has been appointed as the agency’s transitional Chief Executive Officer.

Indigenous smoking workforce

A new national workforce to tackle Indigenous smoking and improve health was launched in December 2010 by the Minister for Indigenous Health, Warren Snowdon. The workforce features 82 new positions to help reduce smoking and help improve nutrition and physical activity in Indigenous communities across the country. The Tackling Smoking and Healthy Lifestyle Workforce will grow as it’s rolled out nationally over three years, increasing from 82 positions in 20 regions to 340 positions in 57 regions. The workforce will be led and mentored by the National Coordinator, Dr Tom Calma, and operate in regional teams, which feature a tobacco coordinator and action worker, and two health lifestyle workers.

Tobacco advertising restrictions

The government introduced into Parliament the Tobacco Advertising Prohibition Amendment Bill 2010 in November last year. The Bill proposes to bring restrictions on tobacco advertising on the internet into line with similar restrictions in other media and at points of sale, adding to the government’s plan for enforcing plain packaging for tobacco products in mid-2012.

New ADCA Board

The Alcohol and other Drugs Council of Australia announced its new Board of Directors late last year. Professor Robin Room and Adjunct Professor John Mendoza were re-elected unopposed as President and Vice-President respectively, along with Mr Tony Trimmingham, who was re-elected as a Board Director. Four new Board Directors are: Dr Alex Wodak, Associate Professor Alison Ritter, Associate Professor Lynne Magor-Blatch and Dr Stefan Gruenert. Mr Mick Palmer and Ms Violet Bacon have been confirmed in their roles of independent directors for a further two years.

Kakadu to get Opal

Opal fuel became available in Kakadu National Park for the first time, in December 2010. The Kakadu roll-out is part of an $83.8 million Australian Government commitment to tackle petrol sniffing, which includes the expansion of Opal fuel to at least 39 new retail sites across the Northern Territory, Western Australia and Queensland.
Alcohol treatment on the rise

Alcohol remains the most common drug Australians seek treatment for, making up almost half of all drug and alcohol-related treatment episodes in 2008–09, according to a report released in November 2010 by the Australian Institute of Health and Welfare. The report, Alcohol and other drug treatment services in Australia 2008–09: Report on the National Minimum Data Set, presents information on publicly funded alcohol and other drug treatment services and their clients in 2008–09. It shows that in 2008–09, there were more treatment episodes for alcohol than any other drug type, with this proportion having risen four years in a row. For the full report, visit: www.aihw.gov.au/mediacentre/2010/mr20101203.cfm.

Narcotics/cocaine use rising

Research released by the NSW Bureau of Crime Statistics and Research in October 2010 indicate that use of narcotics (e.g. heroin) and cocaine is increasing in that state. The Bureau examined trends in arrests for narcotics and cocaine possession and overdoses through use of narcotics and cocaine between 1999 and 2009. The number of arrests for narcotics use/possession and the number of opioid overdose incidents have doubled since 2006 but overall levels of both remain much lower than they were prior to the heroin shortage in 2000. For the full report, visit: www.bocsar.nsw.gov.au/Lawlink/bocsar/il_bocsar.nsf/pages/bocsar_index.

European report

The European Monitoring Centre for Drugs and Drug Addiction’s annual report is a valuable reference for anyone seeking the latest findings on drugs in Europe. The 2010 report highlights changes in the supply and use of established drugs and the emergence of a record number of new substances. For the full report, visit: www.emcdda.europa.eu/publications/annual-report/2010.

Burma's opium trade grows

Opium production in Burma is eclipsing that in all other South-East Asian countries and trending ‘relentlessly upward’, according to the United Nations’ East Asian drugs and crime representative. In a speech in October 2010, the regional head of the UN’s Office on Drugs and Crime, Gary Lewis, revealed that Burma’s opium growing has spiked in the last four years, and he called on law enforcement and governments to do more to tackle the threat of trans-national organised crime.

California marijuana ballot fails

Californian voters soundly rejected a ballot measure in November 2010 that would have made it the first US state to legalise marijuana for recreational use. Just a month before the election, Governor Arnold Schwarzenegger signed legislation that made possession of up to an ounce of marijuana the equivalent of a traffic ticket, subject to no more than a $100 fine and no arrest or criminal record.

Substance link with child abuse

Adults Surviving Child Abuse (ASCA) and the University of New South Wales released new qualitative research in November 2010 revealing the high cost of alcohol and drug (AOD) abuse among adult survivors of child abuse. The study, Use and Abuse: Understanding the intersections of childhood abuse, alcohol and drug use and mental health found that the negative emotions experienced by survivors of child abuse are the main contributing factor to their alcohol or drug use. AOD services are highlighted in the report as failing to address the role of childhood trauma in the substance abuse problems of many clients.

New teen drug use stats

The National Drug Strategy Monograph: Australian secondary school students’ use of tobacco, alcohol, and over-the-counter and illicit substances in 2008, was released in January. The survey is conducted every three years, with this most recent survey taking place during 2008 with around 24 000 secondary-school students participating. The report contains many welcoming trends in terms of decreased use of licit and illicit substances, however, it also highlights that risky behaviour still exists around young people’s levels of binge drinking and use of ecstasy and inhalants. The full report is available at: www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/school08.
Try to avoid these reminders you felt when you were drinking or using. It’s important to distract yourself with new things that don’t remind your brain of drugs or alcohol. Before you are aware of it, people, places or smell anything to do with using or drinking. By delaying an urge to drink or use, you’re switching on your prefrontal cortex to help you stay in control. Use a structured psychological intervention such as salmon). Antioxidants (green tea, fruit and vegetables), protein (meat, eggs and dairy), carbohydrates (bread, rice, pasta), and don’t drive whilst affected by drugs or alcohol.

Healthy brain tips

- Learning, hobbies and doing new things helps create new brain cells.
- A good night’s sleep is important for your brain to learn and remember things.
- To work well, your brain needs carbohydrates and omega-3 fatty acids (found in oily fish).
- Exercise helps your brain stay active and healthy.
- A well balanced diet is important for your brain to work well. Avoid the risk of over dose, stay out of fights or risky substance use, and is now available on the Drug and Alcohol Services SA (DASSA) website. Visit www.dassa.sa.gov.au and go to ‘Health Professionals and Researchers’.

WHO screening test available

The World Health Organization’s Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) is a clinically validated questionnaire that screens for all levels of problem or risky substance use, and is now available on the Drug and Alcohol Services SA (DASSA) website. Visit www.dassa.sa.gov.au and go to ‘Health Professionals and Researchers’.

Victorian GPs portal

The Victorian Drug and Alcohol Clinical Advisory Service (DACAS) is a 24-hour, 7-day specialist telephone consultancy service. In October 2010 it launched the DACAS PACT Program portal – a service that provides GPs across Victoria with readily accessible counselling for patients with problematic alcohol use, including the option of a telephone-based structured psychological intervention. The service will provide a viable alternative pathway for those who can’t easily access face-to-face services. For more information, visit: www.dacas.org.au.

Young people and alcohol

Produced by the youth division of the Australian Drug Foundation, Your Shout is a DVD conversation-starter to help young people talk about alcohol and the role it plays in their lives. Visit: www.bookshop.adf.org.au.

Drugs and the brain

When was the last time you thought about your brain?

Isis Primary Care and the Florey Neuroscience Institute have created an educational pamphlet for AOD clients called Drugs, alcohol and your brain – explained. The easy-to-read pamphlet explains the fundamental aspects of addiction neuroscience and neuroplasticity alongside PET and MRI images of substance-affected brains. It also features relapse prevention and brain health tips. For copies, email: David.Eckel@isispc.com.au.

Focus on families

The National Centre for Education and Training on Addiction has launched a new resource entitled For Kids’ Sake: A Family Sensitive Policy and Practice Toolkit, which aims to minimise cases of child abuse or neglect by increasing collaboration between child and adult service agencies. The toolkit aims to improve the safety and welfare of children with parents who misuse alcohol or drugs. Visit: www.ncca.flinders.edu.au to download the kit.

Tuning in youth

A new youth-focused website – www.tuneinnotout.com – is a youth initiative of the Australian Lions Drug Awareness Foundation Inc. and the Drug Education Network, and is supported by the Tasmanian Community Fund and Handbuilt Creative. The site features information on alcohol, drugs, mental health, exams and relationships using videos, clips, informative fact sheets and blogs.

New AIVL website

The Australian Injecting & Illicit Drug Users League (AIVL) has launched its new website, to allow greater access to information for people who inject drugs, people on pharmacotherapies, people working in the AOD sector, policy makers, researchers and others interested in the work AIVL does and issues surrounding people who inject drugs. Visit: www.aivl.org.au.
Dr Frances Kay-Lambkin (left) received a Young Tall Poppy Science Award in October 2010. Dr Kay-Lambkin, from the University of NSW, won the award for work on developing the SHADE program (Self-Help for Alcohol/other drug use and Depression) which helps those suffering co-occurring depression and substance use problems.

The Community Council of Australia (CCA) has appointed high-profile not-for-profit executive, David Crosbie (right) as its new CEO. Crosbie leaves his role as CEO of the Mental Health Council of Australia for the position; he was previously CEO of Odyssey House Victoria, and CEO of the Alcohol and other Drugs Council of Australia.

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 2010, the Early Career Award for excellence in research and practice went to Michael Livingston (far left) from Turning Point Alcohol and Drug Centre, Victoria. The Senior Scientist Award for a scientist who has made an outstanding contribution to the field of substance use and misuse went to Professor Amanda Baker (left) who is the Deputy Director, Priority Research Centre for Brain and Mental Health Research, School of Medicine and Public Health, Faculty of Health, University of Newcastle.

Reduce federal tobacco addiction

I have been reading with interest the recent articles regarding tobacco and smoking in your magazine. I feel I must point out what I believe to be one of the largest factors that contributes to smoking in Australia – the Australian government’s own addiction to the tax profits it makes from the sale of this highly addictive drug.

This tax income is worth many millions per annum to the government. I am sure the citizens of Australia will happily accept an increase in personal and business taxes to cover this income if it means we can eliminate this drug from sale. According to statistics and research, eliminating tobacco products will greatly reduce health care costs therefore there may be no need to increase taxes at all.

One solution to the current tobacco market is to limit the access to nicotine, whereby tobacco or nicotine replacement therapies are only made available to addicts. A GP would be required to write a prescription for clients that are addicted; it is filled by a pharmacy, thus severely limiting the supply of tobacco products available.

But first we need to cure the biggest addict in the entire scenario. Once the government is free of its tax addiction it will be much easier to get rid of tobacco for good. So lobby your politician to make tobacco a controlled substance available only through prescription. They can then remove the tax for this drug and free themselves from the cycle of addiction. With no more motivation to perpetuate the tobacco addiction in society, the government will then be able to institute the measures noted above to hopefully eliminate tobacco use.

Kevin Lyons
Adelaide, SA
Overcoming benzos

With regard to the recent article entitled ‘Benzo dependence: The case for substitution’ (November 2010), it should be noted that although the aims of treatment have been abstinence, the methods used to achieve abstinence generally involved the use of benzodiazepine (BZD) agonists, e.g. dose-tapering or substitution with a BZD that cases the withdrawal associated with cessation. To go through withdrawal from BZDs – whether through rapid or gradual detoxification, requires a strong commitment from the individual. For many heavy users, dose-tapering may take up to a year before abstinence is achieved. It is therefore not surprising that many high-dose, problematic or poly-drug dependent users do not complete their treatment or achieve long-term abstinence following cessation.

In a similar way, the treatment of opiate dependence was originally centred on agonist drugs such as methadone. However, recent literature suggests that while minimising harm and mortality associated with injecting, maintenance therapy may prolong the overall duration of dependence (Kimber et al. 2010). For this reason, many countries have decided to look to antagonists as an alternative, e.g. naltrexone and buprenorphine.

Perhaps antagonist pharmacotherapy could be the next step in developing treatment for BZD addiction. A study by Gerra et al. (2002), found that the BZD antagonist flumazenil immediately reversed BZD effects and reduced withdrawal symptoms associated with ceasing BZD use as compared to those given tapered doses of oxazepam, a slow-onset BZD. In addition, individuals treated with flumazenil had a significantly lower relapse rate and did not display other paradoxical symptoms associated with oxazepam dose-tapering. More recently, flumazenil administered subcutaneously at a low dose by continuous infusion has shown promising results in reducing the severity of withdrawal symptoms (Hood et al. 2009).

Alternative treatments for BZD addiction have long been overlooked in research. Interest in BZD research is slowly growing with the recognition of the prevalence of BZD addiction, but much work still needs to be done before more treatment options become available to those seeking to help. In order to decrease the harm of BZD dependency, the full range of treatment options should be offered. People wishing to cease BZD use without replacing it with another BZD would be more likely to recover from their addiction.

Dr George O’Neil
Fresh Start Recovery Program, WA

Another side to MSIC research

Drug Free Australia’s Board would urge that Of Substance, when reporting on any contentious drug intervention or policy, ensure that the credible views and findings from both sides of the debate are well represented in its pages.

Drug Free Australia refers to the articles in the November 2010 [issue] of Of Substance which uncritically reproduced questionable arguments from a UK drug lobby group and a privileged perspective on the assumed success of the Sydney injecting room in causing a reduction of crime in Kings Cross since its opening. Our analysis of the KPMG evaluation however, which coordinated the input of international drug experts including the first President of the US National Institute on Drug Abuse, Dr Robert DuPont, found that the claim of reduced crime in Kings Cross fails on two counts.

Firstly, the claim fails to mention that crime in Kings Cross reduced only in line with crime reductions for the rest of Sydney postcodes as a result of the heroin drought of the last decade and secondly the injecting room evaluators made no mention of the significant impact of sniffer dog policing since 2002 on drug users in the Kings Cross postcode and its relationship to reductions in local crime. The failure of exploring obvious and significant causal factors was also found to relate to reduced ambulance call-outs in Kings Cross, where such policing clearly obscures any real clarity on the impact of the injecting room.

Drug Free Australia’s academic analysis found weaknesses in the KPMG evaluation. For example, using the same methodology by the two major international evaluations of injecting rooms, it found that the injecting room had saved just four lives in nine years at a cost of more than $23 million, that it had no measurable impact on blood-borne diseases, that it had referral rates to drug interventions well below what might reasonably be expected, and that needle counts and public injecting in Kings Cross reduced only in line with the impacts of the heroin drought and tougher policing.

Gary Christian
Secretary, Drug Free Australia
Adelaide, SA

Thanks for the recognition

I receive Of Substance magazine and really enjoy reading it. As I was reading the November 2010 issue I saw the website that I created as part of your story on page 12, regarding drug help online for young people. The ‘What’s the Rush’ website was developed by myself, in consultation with some of the students at the Launceston College and a professional web company a couple of years ago. We think the site has great value for young people and have received much positive feedback. So thank you for using the site as an example.

Susie Dewis
Counsellor
Launceston College, Tas
Drugs, prevention and youth

Midford, R 2009. Drug prevention programmes for young people: where have we been and where should we be going? *Addiction*, vol. 105, no. 10, pp. 1688-95.

In this paper, Australian researcher Richard Midford comprehensively reviews drug prevention for young people. Early programs that sought to prevent drug use through education about associated harms failed to change drug use behaviour. Prevention programs of the 1970s, predicated on the notion that young people who were emotionally strong and had good decision-making skills would be able to resist drug use, likewise failed in their prevention objectives.

In the 1980s, school drug education programs were based on social learning theory. These more rigorous programs assumed that young people are susceptible to social influences to use drugs, and must therefore be made aware of these influences and equipped with the skills to resist; and were the first to demonstrably change drug use behaviour. The approach was subsequently elaborated with two additional components: general social skills; and provision of normative data on young people's drug use to validate conservatism.

Contemporary prevention programs have extended social influence models. Parenting programs acknowledge parents’ major influence on their children’s drug use through modelling, attitudes and family relationships. Some evidence indicates their effectiveness, particularly in combination with social influence programs. Whether parenting programs can be considered primary prevention is debated: whereas a classroom or whole-of-school program can be delivered in a consistent manner to all students, parents do not face this obligation. Parenting programs also have difficulty recruiting and retaining participants, raising questions about selection bias.

Whole-of-school and community elements combined with social influence approaches recognise that what occurs within the limits of classroom-based prevention programs is unlikely to have lasting effects unless reinforced by ongoing contextual influences. Community-based programs for alcohol might include, for example, strategies to reduce availability and perceived acceptability of youth drinking. Generally, evidence suggests that combined school and community programs are more effective than school programs alone. The additional benefits of such components must be weighed against the considerable extra resources they require.

Other prevention programs target risk and protective factors prior to the onset of problem behaviours. The theory is that certain factors in a child's life predict a range of health and social problems including drug use. Accordingly, if risk factors are reduced and protective factors are enhanced, drug use can be prevented. These programs are likely to endow youth with the resilience to make better choices. Whether they can be considered stand-alone drug prevention programs is contested because they target mediating variables which improve general pro-social behaviour, rather than drug use specifically; and seek effects years before young people's exposure to drugs.

Developing an evidence-based approach

Two major, generally incompatible, forces have shaped the development of youth prevention programs: ideological beliefs about how young people should behave, and evidence of effectiveness. Governments have gradually acknowledged that prevention must be underpinned by demonstrated effectiveness. The community may wish to deliver strong anti-drug messages, but programs which do not change behaviour beneficially are a waste of resources and a failure of responsibility towards young people.

Accordingly, governments have established criteria that prevention programs must meet to receive funding. Most commonly, programs must have undergone experimental evaluation; and resulted in statistically significant drug
use reductions. Despite these commendable efforts to implement evidence-based decision-making, the evidence used to demonstrate effectiveness raises concerns. Few independent evaluations exist, and numerous examples document non-independent evaluators manipulating their analyses to more readily demonstrate change. Follow-up periods are typically short (1-2 years), but as follow-up is extended, programs’ effects wane and attrition becomes problematic. A 2003 systematic review concluded that findings were unconvincing due to both significant and non-significant effects in the one program; small effect sizes; and significant short-term changes that tended to disappear after lengthier follow-up.

Such evidence suggests that even the ‘best’ prevention programs are methodologically flawed, achieve limited changes to drug use, or reach only a select population. Consequently, some conclude that primary prevention for young people is a waste of resources and cannot achieve its goals. Others respond that preventive education is our responsibility towards young people, particularly to counter alcohol industry marketing. Some raise concerns about assessing school programs in isolation rather than as a component of a broader response that shapes community attitudes. Others argue that data limitations preclude strong conclusions about effectiveness, with the field characterised by ‘absence of evidence’ rather than ‘evidence of absence’ of effectiveness.

Nevertheless, several meta-analyses show that school-based prevention programs have small but measurable effects on drug use. Moreover, economic modelling demonstrates that the most effective drug education programs result in a saving of $5.60 from every dollar invested. Midford therefore argues that as part of a broader public health approach to drug use, universal prevention benefits society. Prevention does not eliminate drug use swiftly or comprehensively, but it does contribute to incremental reduction in use among young people.

What should prevention programs prevent?

Prevention programs’ relatively limited effects on drug use raise the question of whether harm, rather than use, would be the more worthwhile prevention target. To evaluate effectiveness, we must be clear about a program’s prevention objectives. Most aim for abstinence, but is this realistic for widely used drugs such as alcohol? Moreover, most assume that drug use occurs because the individual lacks something – knowledge, social competence or refusal skills – and seek to prevent uptake by remedying these deficits. Is this appropriate when some forms of drug use are normative?

For Midford, prevention programs must acknowledge that drug use is attractive to young people and does not necessarily equate to drug abuse; and must be integrated into a broad approach that addresses systemic factors such as alcohol marketing. Programs must specifically target problematic use, and employ measures of success other than use reductions. If a prevention intervention fails to convince a teenage boy not to drink a six-pack at a party, but succeeds in convincing him to sleep over and not drive home, abstinence-oriented approaches would deem it ineffective despite the beneficial outcome.

Harm reduction concepts are important in setting realistic prevention goals and selecting outcome measures directly related to program activities, both of which are essential to meaningful evaluation. An intervention strategy should be chosen on the balance of evidence that it is likely to prevent harm, and its effectiveness should be evaluated in terms of reductions in actual harm or risk of harm, even if consumption remains unchanged. Seventeen-month follow-up of one Australian harm reduction intervention found that students who received the intervention were just four per cent less likely than others to drink alcohol at risky levels, but were 23 per cent less likely to experience alcohol-related harm.

Nevertheless, some strongly resist the application of harm reduction to prevention. United States federal guidelines have mandated since 1989 that prevention programs emphasise ‘zero tolerance’ and abstinence. Even in settings supportive of harm reduction, including Australia, the approach must be carefully handled to avoid potential misunderstanding and public backlash. In a national survey of Australian teachers, more than 90 per cent considered harm reduction as important to effective prevention, but were also concerned that they could be represented as condoning drug use, thus undermining both their professional judgement and the credibility of school-based prevention. Although harm reduction is often considered a value-neutral approach, it has a moral dimension because it values the individual’s wellbeing over an ideology opposed to all drug use. This allows harm reduction programs the flexibility to select evidence-based strategies likely to reduce harm, whereas abstinence-based programs cannot move away from abstinence goals no matter how strong the evidence that they are ineffective.

Improving future prevention programs

Four decades of research have demonstrated the superiority of prevention based on the social influence model, which includes up to four program elements: information on drug-related harm combined with training in decision-making and self-efficacy; resistance training to counter pressure to use drugs; normative information on the acceptability and prevalence of youth drug use to validate conservatism; and broader training to improve self-esteem and social skills. Several studies demonstrate that general social skills and drug resistance training do not improve the outcomes of social influence programs; the elements that directly mediate change focus directly on drug use. Thus, not all social influence programs are effective; and not all elements within these programs contribute to behaviour change.

Directions for future research

Future research should identify the elements that maximise the effects of social influence programs; and should compare the effectiveness of harm reduction prevention approaches with traditional abstinence approaches. The additional effects of whole-of-school, parent and community components also require further examination. Holistic, multi-element programs seem to offer considerable advantages, but these must be weighed against the substantial costs of implementing them.
Locking up lives

Libby Topp

OF SUBSTANCE EXPLORES THE COMPLEX WEB OF CAUSES AND EFFECTS OF WOMEN IN PRISON, INCLUDING THE ROLE PLAYED BY ALCOHOL AND OTHER DRUGS.

Australia’s first women’s prison opened at Long Bay in Sydney in 1909. The number of women incarcerated around the country has increased relentlessly since then. Whereas between 2000 and 2010, the number of men imprisoned across Australia rose by 35 per cent, the number of incarcerated women escalated by 60 per cent over the same period (ABS 2010).

Nevertheless, women constitute just seven per cent of Australia’s incarcerated population: in June 2010, of Australia’s 29 289 full-time prisoners, 2188 were women (ABS 2010). The imprisonment rate for adult women is almost 13 times lower than among men. Commentators argue that consequently, the corrections system is based on a model that is more responsive to men’s needs, and has too often been inappropriately adapted for women. They suggest that until corrections programs and services are gender-responsive – that is, until they are designed specifically to meet the needs of women, and the role of gender in the patterns and causes of women’s offending is acknowledged – the system will fail to reduce both the numbers of women entering prison and women’s high recidivism rates.

Women’s drug-related offending

Reasons for the increase in women prisoners are complex and ill-defined. Nevertheless, a rise in drug-related offending is thought to underlie a substantial proportion of the increase. Rates of alcohol and other drug dependence and associated offending are disproportionately high among imprisoned women. But drug-related offending must be considered in the context of the enmeshed social and structural disadvantages that underlie women’s pathways to offending, incarceration and recidivism.

Violence, trauma and victimisation

The majority of imprisoned women have histories of substance dependence that directly impact their offending. In turn, imprisoned women’s drug dependence is often a response to their experience of violence and victimisation. The majority of imprisoned women are survivors of family violence and sexual and emotional abuse, having endured childhoods of indescribable trauma.

As a former woman prisoner interviewed for an ACT Women and Prisons Group report entitled Invisible Bars: The Stories Behind the Stats (Wybron & Dicker 2009) described: ‘My uncle was my first abuser when I was 10; there ended up being so many. My mother, aunty and uncle were sexually abused in their childhoods. One of my mother’s abusers came to live with us and became one of my abusers. All of my sisters have also been abused ...’

Graph: Source: Australian Bureau of Statistics, 2010
Childhood violence can lead to patterns of adulthood trauma and other mental health problems, which are themselves closely related to women's offending. Too often, domestic violence follows a history of childhood victimisation. In the *Invisible Bars* report, one woman revealed: 'At 17 I believed the domestic violence would stop when I gave birth to our child. It did not and I thought I would never get out of that relationship other than being dead.'

**Women with children**

Around 80 per cent of imprisoned women have children; the vast majority are primary and sole carers of children. Many contend with housing, financial hardship and family violence issues that increase the likelihood of state intervention and place them at risk of removal of their children, itself a highly traumatic event, which may precipitate psychiatric distress, substance use and related offending. Many such issues are inter-generational: as one ACT service provider reported in *Invisible Bars*: ‘We now see young women who were born in institutions; their parents were institutionalised and some of them are even staying in the same refuges as their parents.’

If on release mothers are reunited with their children, the prior physical separation can have repercussions for parenting. Children who have grown up during their mother’s imprisonment may resent her resuming the parenting role; and she may be dealing with her own guilt issues and parent inappropriately as a result. Such parenting pressures can precipitate women’s post-release relapse to drug or alcohol use.

Eileen Baldry, Professor in the School of Social Sciences and International Studies at UNSW, and one of the few people to systematically investigate the experiences of people released from prison describes women prisoners’ ‘... sense of utter hopelessness, driven by their belief that they won’t regain custody of their children after release. Many women with dependent children consider it virtually impossible to meet the requirements to be granted custody – achieving stable, secure housing and addressing her drug issues can seem insurmountable to a woman who knows little else ... [women can] feel defeated before they even start.’

**Housing**

Relationships between lack of housing and women’s offending, and re-offending, are strongly linked. Safe accommodation is the foundation for successful transition into the community post-release, and homelessness strongly predicts recidivism. Far higher proportions of men than women expect to live with their partners or parents on release; and limited public housing and long waiting lists result in inadequate accommodation options for women in contact with the criminal justice system. Transitional and emergency housing may be located in areas of high drug use or poor service availability; and accommodates many ex-offenders and people with substance and mental health problems, facilitating ongoing contact with high-risk people and situations.

Homelessness can aggravate poor physical and mental health, exacerbate drug problems, and reinforce social isolation and financial hardship. Even prisoners who were homeless before their imprisonment are not deemed homeless while incarcerated, and are consequently ineligible for public housing. Women on remand or serving short sentences may lose their housing. Homeless offenders are more likely to be remanded in custody than granted bail and may be ineligible for diversion programs. Lack of secure and stable accommodation can jeopardise women’s reunification with their children; and decreases their capacity to comply with community-based orders.

**Breaking cycles of poverty**

Imprisoned women report low education levels, and high proportions were unemployed before their incarceration. Poor educational attainment and unemployment are deeply entangled, creating long-term poverty that leads to offending and re-offending. Education and training that leads to meaningful employment both inside and outside prison is essential to provide income-generating options that help break the poverty cycle.

‘[IMPRISONED WOMEN] GREW UP WITH THE SAME CHILDHOOD DREAMS AS ANY OTHER WOMEN. WE DREAMT OF LOVING HUSBANDS AND HOMES WITH PICKET FENCES AND BEAUTIFUL, HAPPY CHILDREN ... WHO WEREN’T FORCED TO FACE THE SAME HARDSHIPS THAT WE WERE BORN INTO.’
Social exclusion and the recidivism cycle

Post-release, the issues women faced prior to imprisonment – housing, mental health, trauma, drug dependence, poverty, child custody, social stigma – remain central to their lives. To refer to post-release ‘reintegration’ is paradoxical, as it assumes that women are integrated into their communities prior to entering the criminal justice system. Isolation is a constant reality and a key factor in offending and re-offending. In the *Invisible Bars* report, one woman described her release from prison as ‘... just so overwhelming ... you come out and it is so loud and everyone is doing their own thing. New coins had come out and it was like “wow”; it felt like I had been on another planet.’

In addition, many commentators emphasise the potential contribution of systemic factors to increasing numbers of imprisoned women, including possible changes in policing practices; the sentencing options available to magistrates; and the availability and quality of rehabilitative care and treatment for women with mental health and substance use problems, both in prison and post-release.

Indigenous women in prison

A SMALL BUT SIGNIFICANT POPULATION IN OUR PRISONS IS MADE UP OF INDIGENOUS WOMEN, REPRESENTING COMPLEX PERSONAL HISTORIES AND REPERCUSSIONS OF IMPRISONMENT.

Indigenous women are the fastest-growing prison population (Bartels 2010). Across Australia, Indigenous women’s imprisonment rates increased by 10 per cent between 2006 and 2009. In 2007-08, 29 per cent of all incarcerated women were Indigenous, compared to 24 per cent of all incarcerated men. The same factors that underlie the broader increase in women prisoners are fundamental to Indigenous women’s high imprisonment rates, yet their experiences are also uniquely defined by economic disadvantage and systemic racism (Baldry & McCausland 2009). Indigenous dispossession; multiple interventions including the removal of children, institutionalisation and discrimination; inter-generational social disadvantage; diminished ties to traditional cultures; and continuous cycles of grief and trauma resulting from the premature deaths of family and friends, fundamentally contribute to Indigenous peoples’ over-representation in custody.

Data suggests that systemic factors account for much of the increase in numbers of imprisoned Indigenous women. Over-policing of Indigenous women is likely to be compounded by under-utilisation of diversionary options such as community service orders, probation, or court-mandated drug treatment (Bartels 2010). Indeed, across Australia, non-Indigenous offenders are 2.2 times more likely to enter community corrections than prison, compared to a rate of 1.5 times for Indigenous offenders (SSCRC 2010).

Indigenous prisoners tend to receive shorter prison sentences than their non-Indigenous counterparts (at June 2009, 24 months and 42 months, respectively), suggesting that they are imprisoned for less-serious offences. Indigenous prisoners are also more likely to have undergone previous adult imprisonment (74% versus 50% in June 2009) (ABS 2009). Previous imprisonment histories, even for relatively minor offences, generally result in harsher sentences. Indigenous and non-Indigenous women tend to be imprisoned for different offences (ABS 2009). The most serious offence (MSO) of 31% of imprisoned Indigenous women is an ‘act intended to cause injury’ (mainly assault). Offences against justice procedures (e.g. breaches of parole orders) are the next most common MSO (14%), followed by burglary/break and enter (10%); robbery and extortion (9%); and theft (9%). Imprisoned non-Indigenous women’s MSOs are most likely to be illicit drug offences (22%); fraud (15%); homicide (11%); theft (11%); or acts intended to cause injury (10%).

Forming the context of Indigenous women’s offending are the much higher rates of violence and victimisation to which they are subject (Bartels 2010). Indigenous women’s rates of offending for homicide, acts intended to cause injury and dangerous/negligent acts are higher than among both men and non-Indigenous women. But, compared to non-Indigenous women, Indigenous women are 38 times more likely to be hospitalised for assault, and 10 times more likely to die from assault (Bartels 2010). Some authors suggest that aggression may be seen as the sole measure available against domestic violence due to the high levels of brutality to which many Indigenous women are subject; their perception that they would not receive police protection; and kinship and community ties are so strong that they are unwilling to fragment their identity by leaving their community, family or partners. Less petty crimes committed by Indigenous women, such as social security fraud, are often crimes of necessity motivated by poverty.

With fewer prisons for women, Indigenous women may be detained far from their families and communities. Some speak English as a second language, compounding their isolation. Many Indigenous women have primary care responsibilities for children other than their own and for extended family members. Combined with low education and employment levels, such familial obligations may motivate significant proportions of Indigenous women’s offending.
Systemic factors

Imprisonment – no longer the ‘last resort’?

Distinct gender differences in sentencing practices traditionally resulted in less severe sentences for women. More recently, however, women are receiving short sentences of imprisonment (under three months) where once they may have received suspended or community-based sentences. Despite national and international research indicating that women’s offending rarely results in significant harm, the severity of sentences handed to women offenders has also increased (DCPC 2010).

Increasing imprisonment in response to women’s offending does not address the issues underlying offending; and custody may be particularly counterproductive for the many women with short sentences. Short sentences may increase women’s vulnerability through disruptions to rental accommodation, childcare and employment, thus potentially contributing to re-offending. A series of short sentences may cause greater disruption to an offender’s life than a longer, continuous prison term, cumulatively accruing to a form of serial institutionalisation (DCPC 2010). Prisoners serving short sentences may not be eligible for prison therapeutic and rehabilitation programs; and may be released to the community with limited support. Advocates propose the complete avoidance of short custodial sentences for women.

Increased use of remand

Prisoners on remand are those who have been refused bail after their arrest. They have not been convicted of an offence and are awaiting trial. Increases in the proportion of suspected offenders placed on remand, together with longer periods spent there, have been documented (e.g. Fitzgerald 2009). The number of women placed on remand has contributed significantly to the increase in female prisoners. Remand status has the same negative impact as short sentences on accommodation, employment and custody of children. Long-term implications can be disproportionate, particularly where women ultimately are not convicted of any crime, which limits access to post-release support services.

Lack of diversion options

Women may be detained for minor crimes due to the lack of availability to the courts of more creative sentencing options. Diversionary programs, including those where offenders are diverted into drug treatment, are invariably expensive; few have been subjected to rigorous evaluation; and the systems on which they depend may be overstretched and under-resourced. For example, men are more likely than women to enter drug treatment following a court order because women are more likely to encounter a lack of available places (Loxley & Adams 2009).

Post-release planning and service provision

Successful integration into the community post-release is fundamental to addressing women’s high rates of recidivism, yet the post-release period is one of extreme vulnerability for women. Alcohol and other drug treatment availability, social isolation and loneliness, and the hardships associated with survival – particularly issues around securing housing and family reunification – all contribute to women’s greatly increased risk of death post-release. A study of more than 85 000 prisoners released in NSW indicated that specific risks of death by drug overdose, suicide and homicide are much higher among women recently released from prison than among women in NSW’s general population (Kariminia et al. 2007).

Holistic approach needed

As the earlier discussion of the complexity of issues underlying women’s offending illustrates, attempting to address one concern (e.g. AOD dependence) in isolation from others (e.g. housing or domestic violence) is likely to be ineffective; and an holistic approach to women’s multiple needs is required. As Professor Baldry describes, ‘A truly holistic approach to addressing substance issues among women who have been imprisoned is fundamental to changing their futures. You simply can’t treat drug dependence in a woman who is homeless, with no job skills, who suffers PTSD – how can she prioritise addressing her drug use under such circumstances?’ Yet existing support services often operate within discrete frames of reference, creating a ‘silo’ mentality that can result in failure to address the full range of women’s needs. Resource constraints often dictate that pre-release planning is rudimentary at best; and continuity of service provision as women transition from prison to the community can be sorely lacking (DCPC 2010).

While acknowledging the imperative to provide holistic pre- and post-release support, Professor Baldry argues that the fundamental answer lies in avoiding imprisoning women in the first place. ‘Every parliamentary inquiry ever held in this country has recommended that changes be made to the criminal justice system that would see fewer people locked up. Yet our prison populations continue to grow, and particularly the number of women we imprison.

‘My experience when dealing with the general public through forums like talkback radio is that once the extreme disadvantage suffered by women who end up in prison is described to them, they are generally sympathetic. It’s not the average Australian who opposes changing the system; it’s our policy makers and legislators who think that continuing to refuse low-level offenders bail will send the “right message” about their own “tough on crime” credentials.’

Deb Wybron is convenor of the ACT Women and Prisons Group and herself the veteran of 29 years’ lived experience of institutionalisation. In 2009 she graduated from the Australian National University with a social work degree, and is now a passionate advocate for the rights of incarcerated women. She poignantly notes, ‘Imprisoned women are all just human beings, the same as any other woman. We grew up with the same childhood dreams, and they definitely didn’t involve being an addict or a criminal or in prison. We dreamt of loving husbands and homes with picket fences and beautiful, happy children ... who weren’t forced to face the same hardships that we were born into.’

For a list of references cited in this article please email editor@ancl.org.au.

Of Substance, vol. 9 no. 1 2011 13
Between 2000 and 2010, the proportion of the Australian population in prison increased by 15 per cent to 170 in every 100,000 people, and now includes nearly 30,000 people, one-quarter of whom are Indigenous (Australian Bureau of Statistics 2010).

Accompanying this increase has been an even greater rise in the costs to governments of building new facilities and staffing and servicing existing ones. Australian governments now spend close to $3 billion per year imprisoning their citizens (Steering Committee for the Review of Government Service Provision 2010).

In the United States (US), where prison populations have been growing at an unsustainable rate, some state governments have begun to reform the way they treat incarceration and public expenditure by employing evidence-based strategies to reduce the prison population and improve public safety by investing in disadvantaged communities.

Collectively some of these strategies are called ‘justice reinvestment’, and they provide an example of an evidence-based process that can potentially help reduce rates of imprisonment, reduce spending, reduce crime and strengthen communities.

What is justice reinvestment?

The idea of justice reinvestment (JR) was developed in 2003 by a think-tank in the US called the Open Society Institute, in response to concerns about predicted growth in prison populations and skyrocketing costs.

The Council of State Governments Justice Center (CSGJC), a non-profit organisation in the US working with state governments to implement JR programs, describes JR as ‘a data driven approach to reduce corrections spending and reinvest savings in strategies that can decrease crime and strengthen neighborhoods’. It involves two primary components: cutting costs to the prison system by reducing growth in the prison population and reinvesting some of the savings into communities from where large numbers of prisoners originate.

If a prison population grows at a slower rate than is predicted, there is usually less need to spend money on building new prisons and staffing existing ones at the same rate as was initially allocated. Examples of measures to reduce growth in prison populations include increasing rates of parole and probation (rather than prison sentences), increasing drug treatment for prisoners and those on parole or probation, vocational education programs for prisoners, and appropriate housing for inmates upon release.

Once governments have started to save money, they have the opportunity to reinvest some of those savings into programs and services in the identified communities. JR will usually focus on programs and services that address the underlying causes of crime such as poverty, education, housing, health care and public amenities.

This approach differs from other, more traditional ways of investing in areas of high crime, such as increasing spending on law enforcement – more patrols, stricter enforcement or simply more police on the ground – measures that tend to respond to crime or shift crime to other locations. JR takes a different approach; it supports spending money in communities where offenders live, in order to break the cycles (often inter-generational) that spawn crime.

How does JR work?

A majority of prisoners come from a relatively small number of disadvantaged communities, and these communities tend to be characterised by poor economic, social and physical conditions that collectively contribute to crime. In a reciprocal manner, high rates of imprisonment in an area damage the economic, social and political bonds that are the basis for neighbourhood cohesion, social inclusion, and health and well-being.

JR purports that if the money that would have been spent on keeping individuals in prison is spent on rebuilding the human resources and physical infrastructure – schools, support services, public spaces and housing – of neighbourhoods affected by high levels of incarceration, not only will those particular communities benefit, but so too will governments, the prisoners themselves and the wider population.

JR in practice: Texas

In 2005, Texas had the second highest rate of incarceration in the US. It saw a 300 per cent increase in the prison population between 1985 and 2005, resulting in nearly one per cent of the total Texas population being imprisoned. Prison overcrowding and massively increasing costs of housing inmates resulted in a bipartisan agreement to pursue JR.
Detailed mapping of the prison population found that five counties accounted for more than half of the people imprisoned. It also identified that ten of Houston’s 88 neighbourhoods accounted for more than $100 million per year in prison costs. Additional analysis found that a decrease in funding for community-based substance use and mental health services and low rates of parole among eligible inmates were major contributing factors to the increase in the prison population.

In response to these findings and a comprehensive process of consultation, in 2007 the State of Texas implemented a raft of policies aimed at reducing the prison population. These included new AOD treatment places in prisons and for offenders returning to the community, new guidelines limiting caseloads for probation and parole workers, and incentives for local courts to use measures other than prison for parole and probation violations.

These initiatives slowed the growth in the prison population and resulted in a US$241 million savings from in-prison treatment programs and improved probation and parole services. This, in turn, saved Texas US$210.5 million in 2008–09, some of which was reinvested into communities with a high proportion of prisoners.

Two years after this JR initiative was implemented, the prison population in Texas had stopped growing for the first time in decades. The Texas Department of Criminal Justice attributes this plateau to the policies implemented to reduce the prison population as part of its JR initiative and now plans to continue and extend these programs (CSGJC 2009).

**JR in Australia**

Australia has yet to adopt the JR model into its criminal justice systems. The Australian Human Rights Commission, in its Social Justice Report 2009, has proposed that JR may be one method whereby the over-representation of Indigenous Australians in the criminal justice system could be addressed. The Senate’s Legal and Constitutional Affairs Reference Group in a 2009 report on Access to Justice (Senate Legal and Constitutional Affairs Committee 2009) recommended that JR be trialled in Australia. JR now forms part of the criminal justice policies of the Australian Greens.

While JR is still an emerging strategy, it offers potential opportunities to reduce rates of imprisonment in Australia and translate these savings into initiatives that promote public safety through reinvesting in social services, job creation and infrastructure.

**Key reference**

www.justicereinvestment.org/states/texas/pubmaps-tx ‘Presentation March 2010’ (see page 3).

*For a list of references cited in this article please email editor@anecd.org.au.*

**DROPPING OFF THE EDGE:**

**MAPPING AUSTRALIAN DISADVANTAGE**

*Dropping off the Edge* is a 2007 report of the Jesuit Social Services and Catholic Social Services Australia, authored by Tony Vinson, Emeritus Professor at the University of Sydney’s Faculty of Education and Social Work. The report used data from the Australian Bureau of Statistics, Centrelink, the Health Insurance Commission, and state and territory authorities and services to map the distribution of disadvantage around Australia.

The report ranked geographical areas on indicators of social distress, health, community safety, socio-economic status and community participation. By counting the number of times an area ranked in the top 5 per cent for an indicator, the report was able to identify the areas characterised by the greatest number of disadvantaged characteristics.

1.7 per cent of localities accounted for nearly seven times their share in the number of top ranked positions.

**AUSTRALIA’S MOST DISADVANTAGED AREAS**

The report also lists the most disadvantaged areas in each jurisdiction according to a single disadvantage factor. These lists, as well as interactive maps showing the distribution of disadvantage across Australia, are available online at www.australiandisadvantage.org.au.

Of the 170 most disadvantaged areas identified in the report, about half were considered rural or remote.

**CHARACTERISTICS OF DISADVANTAGED LOCALITIES**

The report identified features of the most disadvantaged localities, including:

- low income families
- early school leaving and lack of post-school qualifications
- low work skills and unemployment
- limited computer use and internet access
- disability/sickness support
- long-term unemployment
- criminal convictions and prison admissions
- confirmed cases of child maltreatment.

**WHAT NEEDS TO BE DONE?**

The report recommended that governments focus on building social cohesion in disadvantaged communities by resourcing the following strategies:

- Education and training
- Employment opportunities and income generation
- Improving health
- Promoting parenting skills
- Developing local leadership capacities.

The report also recommended that programs to address disadvantage need to be long term (at least eight years) otherwise there is a risk of problems re-emerging.

**Reference:**

Australia no longer leads
Jenny Tinworth

Executive Director of the US’s Drug Policy Alliance, Ethan Nadelmann, visited Australia late last year. A guest of the Drug Law Reform Foundation, Nadelmann toured the country, promoting his view that Australia needs to re-assess its approach to illicit drugs. He briefly spoke with Of Substance.

OS: Where do you think Australia is in its approach to drug policy?

EN: In the 1980s, Australia led the way in embracing and adopting needle exchange and other harm reduction measures. It was successful in keeping the HIV rates among people who injected drugs under 2 per cent, while in my country we hit rates of 40 per cent and 50 per cent in some places, essentially writing off a quarter of a million people. Clearly, Australia was seen as a global leader in terms of innovative methods to reduce the harms of drugs and to experiment with new policies. It was also true with the conversation on heroin maintenance in the early 1990s. Once again, people like drug law reformer Alex Wodak and (then ACT Health Minister) Michael Moore started the discussion, while Gabriele Bammer’s research played an important role in informing the discussion that emerged in Europe about initiating heroin prescription trials.

However, your Prime Minister John Howard nixed the whole thing here in 1997, and Australia now seems to have lost its leadership in taking an innovative approach to drug problems.

OS: What are four key drug policies you believe Australia should focus on?

EN: The first is heroin maintenance for people who are dependent on opiates. The evidence of its effectiveness in other countries is truly overwhelming.

Secondly, you need to ask the basic questions about what sort of return Australia is getting for its investment in a prohibitionist strategy. This would be invaluable in the area of cannabis enforcement. Your Productivity Commission could look at this and compare it with other regulatory options.

Thirdly, I’ve been curious about why the issue of medical cannabis has never moved forward in Australia, even though in the US, Israel and a host of other countries it is progressing. I don’t believe the answer is because Australia is already effectively dealing with pain management and other conditions in the absence of this medication. There was a moment in Australia in the late 1990s when this issue was on the agenda but it has dropped off.

Finally, naloxone should be more readily available to prevent opioid overdose deaths. This shouldn’t just be in the traditional injecting drug user community but more broadly in the whole pain management world. It appears that there are substantial benefits and relatively low risk in expanding naloxone availability and training people how to use it.

OS: How can people working in the drug sector advance drug policy?

EN: First, they need to ally with those working in advocacy and those who are involved in actual use. Australia is impressive in the extent to which it has done this. People working with drug problems also need to embrace the notion that the role of criminalisation and the criminal justice system in drug control should be reduced as much as possible, consistent with public safety and public health. While there is support for this notion, you need to push forward with the implications of this objective.

Finally, workers must be driven by the evidence which emerges from around the world, rather than by premature and pessimistic assumptions about what is politically possible.

OS: There are tensions within the sector about where we should be on the continuum between criminalisation and legalisation. How do we manage these tensions?

EN: The first step is to establish a consensus on actions which the evidence conclusively says are low risk. Things like heroin maintenance, wider distribution of naloxone, the expansion of supervised injecting facilities, a needle exchange in the ACT prison. Virtually none of these strategies present a threat of increased levels of drug use.

Then there are the strategies where you can’t prove the evidence of risk, such as cannabis regulation versus prohibition. That’s where one has to demand just a willingness to debate all options. There needs to be a consensus to look at the variety of regulatory models with the same thoroughness that we’ve looked at enforcement models over the last 40 or 50 years. Even if one comes down in favour of continuing prohibition, say cannabis prohibition, those arguments will be better grounded if they have been tested by comparison with the arguments in favour of regulatory strategies.

For further information, visit: www.drugpolicy.org.
Over the period 28 November to 1 December 2010, some 550 delegates descended on Canberra for the 30th Annual Conference of the Australasian Professional Society on Alcohol and other Drugs (APSAD). It was certainly appropriate to hold it in the national capital, as APSAD’s first annual conference was held there way back in 1981.

As I said in my welcome to delegates, the conference title ‘Building on the Capital’ emphasised the breadth and strength of the alcohol, tobacco and other drug workforce, the ‘capital’ that is applied to helping individuals, families and communities prevent and deal with substance abuse problems. The title also refers to the location of the conference in the national capital, reminding us of the importance of both national and international alcohol, tobacco and other drug policy work, much of which takes place in Canberra.

The conference began on the Sunday with meetings of the Australasian Chapter of Addiction Medicine and the well-attended Reckitt Benckiser Symposium on ‘Treatment strategies for opiate dependency’. The conference proper ran over the following three days.

It was a full program, including seven Australian and international keynote speakers; the annual James Rankin Oration; 124 proffered papers, symposia and workshops; and 71 posters.

The wide scope of the topics covered is illustrated by those addressed by the keynote speakers:

- ‘Australia’s medicines reimbursement system – its strengths and challenges’ – Professor Lloyd Sansom AO
- ‘Identifying and managing risks for drug users on entering and leaving prison’ – Professor Michael Farrell
- ‘The intertwined nature between trauma and drug and alcohol use: the self-medication hypothesis’ – Professor Sandy McFarlane
- ‘Cape York, crime prevention, alcohol management plans and innovation’ – Professor Marcia Langton AM & Stephen Isles
- ‘Treatment of opioid dependence during pregnancy and the post-partum period: current findings and future horizons’ – Professor Hendree Jones
- ‘Reducing harmful use of alcohol: global public health priority and call for action’ – Dr Vladimir Poznyak
- ‘Fetal alcohol spectrum disorders: the legacy of alcohol use in pregnancy and the challenges for health professionals and society’ – Professor Elizabeth Elliott AM.

The 2010 James Rankin Oration was delivered by Professor David Penington AC. His title was ‘The politics of illicit drugs: the war on drugs can never succeed; where should we go?’. Professor James Rankin, in whose honour the Oration is given each year, was APSAD’s first president. He was able to attend the conference, speak at the opening ceremony and introduce the 2010 James Rankin Orator.

Members of consumer organisations were prominent in the 2010 conference. AIVL and CAHMA had a booth and quite a few consumers presented papers and posters, chaired sessions and made other valuable contributions.

Emerging issues and research findings received attention in the program. These included the possible impacts of the new national health reforms; challenges facing mothers (and babies) who use alcohol, tobacco and/or opioids, and what can be done about it; and the effectiveness and cost-effectiveness, in terms of reduced levels of heroin use and crime, of providing unsupervised buprenorphine/naloxone (Suboxone) to people on waiting lists for entry into methadone/buprenorphine programs. Also important was new information about vicarious traumatisation among Australian alcohol, tobacco and other drugs (ATOD) workers whose service users are themselves traumatised, and a thorough discussion of the need for an Australian trial of bystander-administered naloxone (Narcan®), building on positive experiences abroad with this intervention, which helps prevent opioid overdose deaths.

The conference was held in the National Convention Centre in Canberra, a venue ideal for a conference the size of APSAD. The conference dinner took place in Parliament House, with ‘The Smooth Operators’ providing dance music – after all, APSAD conference-goers have a well-earned reputation for dancing up to the point when the lights go out!

APSAD acknowledges with thanks not only the speakers and poster presenters, but also the conference sponsors: Reckitt Benckiser, the Commonwealth Department of Health and Ageing, AER Foundation Ltd and ACT Health.

As conference convenor, I was brilliantly supported by the Scientific Program Committee, the national and local organising committees and by volunteers from Canberra-based ATOD agencies.

* David McDonald was the convenor of the 2010 APSAD Conference.
Suicide in Australia: Where do alcohol and other drugs fit in?

Suicide is a complex issue; we know that alcohol and other drugs have strong links to suicidal behaviour, yet gathering accurate suicide data is problematic. What do people working with drug issues need to be aware of? What can and should you do to help your clients with suicidal issues? In this Of Substance feature, we explore some of these key concerns.

Substantial Australian and international evidence clearly demonstrates strong and consistent relationships between suicide and alcohol and other drugs (AODs), particularly among young adults. Coronial post-mortem investigations reliably find substances at detectable levels in between 30 per cent and 50 per cent of suicides, and in two-thirds of violent suicides. Alcohol is the most common substance detected post-mortem, followed by polysubstance use. The robust associations between suicide and substances arise because alcohol or other drug use functions as both a chronic risk factor for suicidality, and an acute precipitant of suicidal behaviour. Chronic drug use substantially increases the risk of experiencing mental health problems such as depression or psychosis, which are themselves significant risk factors for suicide, particularly when they co-occur with substance use disorders. Moreover, independent of the influence of mental illness, substance use disorders themselves increase the risk of suicide, possibly due to alterations in neurotransmitter levels. Acute intoxication, particularly with alcohol, is associated with disinhibition, impulsivity and aggression; and reduced cognitive function, decision-making capacity and pain perception, all of which may increase the risk of self-destructive behaviour and provide the ‘courage’ to initiate or continue a suicide act. In addition, although relatively uncommon, some individuals choose overdose as their method of suicide. Substance use is also a common response to the grief of a loved one’s suicide.

Broadening responsibility

In June 2010, a 200-page report of a nine-month Senate Inquiry into suicide prevention made 42 recommendations intended to prompt sweeping reform in Australia’s response to this crucial social issue (Senate Affairs Committee 2010). The Senate committee identified a wide variety of groups at increased risk of suicide to be targeted with specific programs, including men; young people; Aboriginal and Torres Strait Islander communities; children; individuals who have previously attempted suicide or self-harm; people suffering mental illness and Australians living in regional, rural and remote areas as examples. The inquiry report drew on expert knowledge from around the country to touch on close to every conceivable perspective on suicide prevention. Yet there was no specific mention of substance users as a priority target group. Perhaps this is a reasonable approach, given many people who use alcohol or other drugs would fit into at least one of the categories identified. Indeed, substance use disorders are classified as mental disorders by...
the current psychiatric diagnostic system, so all sufferers of substance disorders are included in the list by default. Or is the omission of AOD users as an independent priority group symptomatic of a broader absence of alcohol and other drugs from Australia’s contemporary suicide discussion?

For Emeritus Professor Ian Webster, Chair of the Australian Suicide Prevention Advisory Council, the issue is that suicide is seen by many as exclusively a mental health problem. While acknowledging that individuals who suffer mental ill health are clearly among those at highest risk of suicide, Professor Webster considers that a more comprehensive and useful conception of suicide would include not only a mental health perspective, but would also relate to broader public health and social well-being, and would incorporate many risk factors beyond the mental health paradigm, of which drugs are but one. He argues that although ‘... suicide is the worst outcome for mental illness; it is also the worst outcome of chronic physical illnesses such as unremitting pain, progressive disablement, diminishing mental capacity, from alcohol and drug problems and from social sequestration’. For Professor Webster, suicide is not a problem confined to mental illnesses or disorders, therefore suicide prevention must involve all branches of the health, welfare and social systems.

Drug clinicians’ role in suicide prevention

‘Gatekeepers’

The implication of a broad conception of suicide that seeks to link inter-related and overlapping risk factors is that suicide prevention is not the domain of mental health alone: many individuals, services and organisations can and should contribute to suicide prevention. AOD workers are fundamental to this list because of the strong and complex relationships between suicide and drug use. Along with many other professions including police, emergency workers, GPs and other health care workers, staff of government agencies such as Centrelink, teachers and even coaches of young sports teams, AOD workers can be classed as ‘gatekeepers’ – frontline workers who respond to, deal with or witness suicidal ideation or attempts, or interact with suicidal individuals, who may have the potential to prevent suicide.

Yet many drug workers, from case managers to addiction medicine specialists, do not fully grasp the high probability that they will encounter suicidal clients, including among those with whom they are already engaged. Much evidence supports the effectiveness in reducing suicide of training and support for frontline health and community workers. Like all gatekeepers, drug workers must be trained to accurately identify and confidently respond to clients at risk of suicide. All AOD services should include suicide risk assessments in every intake assessment and treatment review assessment, with the ultimate goal of referral to evidence-based treatment options.

Continuity of care

A second way evidence suggests this sector can help to prevent suicide is by contributing to better continuity of care. The lack of coordination between services such as AOD, mental health, hospital emergency departments (EDs), law enforcement, community organisations and telephone crisis support services means that people at high risk of suicide may be in contact with many service providers, but do not receive appropriately integrated and holistic care. Transitions between residential and community-based care are particularly high risk periods, with the onus of responsibility on services to develop and implement care plans which include communication with other professionals. This includes, for example, care plans devised by residential AOD services when discharging their clients back to community care. But comprehensive continuity of care must also include somewhat less well-developed communication and referral channels. For example, drug workers whose clients present to EDs after a suicide attempt would usefully make contact with ED staff to ensure the collaboration of everyone involved in responding to the incident to protect the client’s safety. Communication with families, friends and carers, to whom the burden of responsibility often devolves, is also an important component of ongoing support and care.

Follow-up

Some evidence suggests that the period prior to suicide may be marked by disengagement from services, such as missed appointments or self-discharge. AOD clinicians should persist in their attempts to set follow-up appointments and to ensure that referrals to other services are taken up by clients at risk of suicide. Evidence is also accumulating regarding the role that simple follow-up measures including postcards, letters and phone calls can play in preventing further suicide attempts, even among individuals who refuse follow-up. Apparently working to enhance social connectedness and a sense of personal value, the potential difference that these relatively inexpensive approaches may make to a client at risk of suicide should not be underestimated.

Treat the whole person

Continuity of care and holistic suicide prevention must also recognise that the interventions required to effectively prevent suicide often fall outside the health care system.
The tendency of many health care professionals, including both AOD and mental health workers, is to treat the presenting illness rather than the person. Although this is understandable given the burden on and constraints of the health care system, the social circumstances and life events that may trigger and exacerbate suicidality, mental health problems and substance use disorders typically remain unaddressed. Interventions which aim to diminish and counteract life stress by addressing the range of social, situational, genetic, emotional and interpersonal life factors that can trigger development of suicidality are likely to be equally important in suicide prevention as effective treatment of a substance use disorder. For effective suicide prevention, appropriate referrals to address risk factors such as sexual abuse, domestic violence, homelessness, unemployment, relationship breakdown and social isolation must be considered the core business of the AOD clinician in much the same way as is achieving the right dose of opioid substitution medication.

Support for staff
To play their part in holistic suicide prevention, individual clinicians must receive appropriate support from management. Frontline staff encounter confronting and stressful situations involving the threat of, or actual, suicidal behaviour. Services must take responsibility for ensuring that adequate debriefing and counselling services are available to these key personnel.

Facts and figures about suicide
Although largely preventable, approximately one million suicide deaths occur worldwide every year. According to the 2007 National Survey of Mental Health and Wellbeing, 3.3 per cent of Australian adults have attempted suicide. Disproportionately affecting young people, suicide is the leading cause of death among men and women under the age of 34 years and men under the age of 44 years. Following review of statistics collated by the Australian Bureau of Statistics, current estimates suggest there were around 2500 suicide deaths in Australia in 2007, significantly exceeding the combined number of fatalities from motor vehicle accidents and homicides. Suicide attempts are 10–30 times more common than completed suicides: every day, 60–140 Australians attempt suicide, and more than 80 are admitted to hospital for self-harm. Men are four times more likely to die by suicide than women, whereas suicide attempts and self-harm are more common among women: in NSW, women accounted for 62% of hospitalised self-harm cases in 2003–04. Gender differences are thought to arise because men use more lethal self-harm methods than women; when suicide deaths are combined with suicide attempts requiring hospitalisation, gender differences decline.

Mindful of the difficulties inherent in placing a financial value on human life, economists conservatively estimate the annual costs to Australia of suicide and suicidal behaviour at $17.5 billion, or $795 per person (Suicide is Preventable Joint Submission 2009). Yet many of the profound individual, familial, social and economic costs of suicide cannot be reliably measured. As Tatz (1999) describes, suicide ‘... utterly rejects all of us – everything we can offer by way of love, family, a sense of belonging or of identity, learning, progress, creativity, leisure, pleasure, societal feelings, civility and civilisation and, not least, a belief in a future’ (p. 37). Suicide and suicide attempts can cause not only immense distress to individuals, but also vicarious trauma to the wider community. Among those bereaved, grief, guilt and remorse can linger for years and even for lifetimes; and the emotional toll on first responders, such as police or emergency services personnel, should not be underestimated. Suicide may result in financial stress as a result of job loss or inability to return to work; or financial imperative to do so too soon. Estrangement from social networks, relationship breakdown and family conflict (particularly relevant to ethnicity and cultural beliefs about suicide) can also contribute to the
enormous, far-reaching and seemingly unquantifiable losses of suicide attempters and those bereaved by suicide (Suicide Prevention Australia 2009).

Accuracy of suicide data

Recently, concerns emerged regarding the under-reporting of suicide deaths in Australia and the associated impact on understandings of risk and protective factors, policy formulation, prevention interventions and service provision. The Australian Institute of Health and Welfare’s preliminary comparisons of National Coronial Information Service and ABS data reveal up to 30 per cent under-reporting. Many factors contribute to this happening. The ABS reports annually on all registered deaths where sufficient information exists to code cause of death. In the past, the number of suicide deaths reported was affected by the number of open coronial cases with insufficient information available for coding at the time of ABS processing, to which less specific cause-of-death codes were assigned. All coroner-certified deaths registered after 1 January 2007 are now undergoing revision to enable the use of results of finalised coronial cases, a change from previous years when ABS processing of cause-of-death data concluded approximately 13 months after the end of the reference period.

References


ANNIE MADDEN HAS THE AIR OF A WOMAN WHO IS CONTENT WITH WHERE SHE’S AT IN LIFE. BUT IT HASN’T ALWAYS BEEN THAT WAY. MADDEN IS THE FIRST TO ADMIT THAT THE JOURNEY TO REACH THIS POINT OF PERSONAL SATISFACTION HAS BEEN A LONG AND DRAINING ONE.

For a decade, Annie Madden has headed AIVL, Australia’s peak body for people who use illicit drugs and those in drug treatment. Nationally and internationally, she is known and respected for the grit and energy she puts into representing the rights and interests of a marginalised and disadvantaged community. As a member of the Ministerial Advisory Committee on Blood-borne Viruses and Sexually Transmitted Infections and other national bodies, she plays a key role in advising the Federal Government on issues affecting people who use or have used illicit drugs.

For Madden, that passionate campaign to fight for the well-being of consumers is totally intertwined with her personal story.

Injecting activist

As the second youngest of six children growing up in Brisbane’s northern suburbs, Madden was the family’s activist from a very young age. ‘I was always fighting for somebody’s rights,’ she remembers.

She was also injecting illicit drugs. After high school she went on to complete a Bachelor of Arts in political science and Asian studies at Griffith University. It was here that injecting and activism came together in the student union, whose members included a number of people who had used, or were using, illicit drugs.

‘It was the late 1980s. We were just starting to hear about HIV/AIDS and injecting, and how it was killing people in the United States,’ she says. All too soon, the threat became personal. People she knew contracted the virus. ‘This was about our lives and the lives of our friends. There was a real energy to be active.’

Madden became involved in the Queensland Intravenous AIDS Association, first as a volunteer and later as a staff member. ‘People don’t know about the HIV epidemic among people who injected drugs in Australia,’ she says now. ‘We managed to keep rates low, but low infections doesn’t mean no infections. People died before the introduction of needle exchanges; and because they were already disconnected from treatment services, they did so very quickly.’

In the mid ’1990s Madden moved south to join the NSW Users & AIDS Association, initially as an HIV peer support worker, then later as its coordinator. It was there in 1999 that she made a decision that would have a very high personal cost.

‘I was one of only two people representing consumers who were invited to the NSW Drug Summit,’ she says. ‘Over the first day of the summit lots of negative things were being said, and it looked as if positive interventions such as the methadone program might be rolled back. I decided to stand up in Parliament House and admit that I injected...’
drugs and I was on the methadone program, yet I had a university degree and held a responsible job.’

Madden’s admission was one of a number of events which ultimately changed the mood and direction of that historic summit. But on a personal level, the impact was devastating.

‘While I would do it again, I was naïve and I wish I had thought it through more,’ she says now. ‘I wish I had gone to my family first and talked to them. Until then my use had been the family’s “dirty little secret” and suddenly it was all over the national media.

For most of the next decade Madden and her partner, also on methadone treatment, were estranged from both their families. They have only healed those rifts recently, and have just celebrated their first Christmas in many years with her family.

**Stigma and the journey**

‘If, with my personal and professional background, I can experience that kind of fall-out from admitting drug use, just imagine what it is like for someone who has had much less opportunity in life,’ Madden says. ‘If I didn’t work in this sector, I wouldn’t take the risk of identifying as someone who has used illicit drugs.’

Stigma and discrimination are constant themes in Madden’s conversation. ‘Now that I’m older, I can understand what it was like for my family – the shame that is associated with illicit drug use and how it must have been for my mother to wonder where I was when we were out of contact. Although it is a stereotype, she has said that her biggest fear was that I was dead on a street corner somewhere. We’re able to talk about these issues now, which is good for both of us.

‘The journey is a long one, so it’s important not to be disappointed in people, not to give up on them. Everyone has its ebbs and flows, and some things will work at different stages of the journey. People have to know they can walk back in through the door if the first time they’ve tried something hasn’t worked.’

A veteran of many different forms of treatment and rehabilitation, Madden is on her second stint of methadone maintenance, with this current treatment lasting 14 years. ‘This works for me, but everyone is different.’

To this end, she is saddened that so often people who are dependent on drugs feel they can’t afford to be honest with their clinicians, and thus miss out on receiving optimal treatment. ‘People know that often if they admit to the prescribers or other clinicians that they’re having a problem or they’ve used illicits again, they will be punished. They’ll lose a takeaway dose that’s vital to their ability to be at their shiftwork job or to get their kids to school on time. Or they’ll be kicked out of treatment. So they can’t take that risk. When in fact, that’s the time they most need the clinician to work with them to improve their treatment.

‘Often the only people who you can be honest with are other people who use drugs. They become your only family and your only friends because with everyone else, you have to pretend to be something you’re not.’

**More treatment options**

Ask Madden if she supports the legalisation of drugs and she pauses. ‘Once I would have answered that really quickly, but as I’ve gotten older I’ve become more reflective and better understand the complexity of this issue. I’m absolutely an advocate of regulation and prefer to think about it that way. We need a legal, regulatory framework rather than the chaos of criminality, corruption, death and disease we have now. The cost of allowing certain drugs to be run in an illicit market – the cost to the individual, their families and the community – just seems too much to bear.’

Ready accessibility to a wider variety of treatment options is a must, in Madden’s view. ‘At the moment, people often have to be absolutely desperate before they get some of the available treatment options – wouldn’t it be nice if they didn’t have to be in a really bad way before they could access treatment?’

She believes these options must include the introduction of a heroin prescription program. ‘A heroin program means that some people would need to go into a clinic up to four times a day, so that’s just not going to be an acceptable option for many. We must let people decide that for themselves however, rather than discounting such programs before people are even given the option or designing programs for those who have “failed” all other forms of treatment. We’re seeing an increasing number of older drug users who are suffering terribly – their many years of drug use and all of the consequences of an illicit market are taking an increasingly higher toll on them, coupled with the usual health issues older people have. A heroin prescription program would allow them some dignity.’

**Looking to the future**

Along with healing the rifts with her family, Madden has other reasons to be in a good place personally. Her partner of 20 years has recently completed fine arts studies. Already, he has sold artwork and the future looks promising. Madden is halfway through a part-time postgraduate law degree with a view to continuing her work in the human rights arena.

And like so many busy professionals, she is forcing herself to take time out with a hobby, teaching herself to sew on the machine which was a gift from her partner. ‘Now, talk about patience with people’s journeys,’ she jokes. ‘That’s definitely one I’ve got to work on!’

‘But really, it all comes down to that issue of not giving up on anyone. It’s taken me a long time to get to a place in life where I feel pretty settled. Some people get there quickly and some of us take a while. That’s not something that is exclusive to people with a history of injecting drug use – everyone’s lives involve some kind of journey.’
In step with today's treatment?

Angela Rossmanith

THERE WAS A TIME WHEN THE SELF-HELP ORGANISATIONS ALCOHOLICS ANONYMOUS (AA) AND NARCOTICS ANONYMOUS (NA) WERE CENTRAL TO ALCOHOL AND OTHER DRUG TREATMENT IN AUSTRALIA. OFTEN THEY WERE THE FIRST, AND ONLY, PORT OF CALL FOR ANYONE WITH DRUG AND ALCOHOL PROBLEMS.

Attitudes have changed over the last three or four decades, and an increased understanding of alcohol and drug issues has led to new treatment approaches, but the practice of referring clients to 12-step programs continues. In 2003, in the Federal Government’s guidelines for the treatment of alcohol problems, AA was described as ‘the mainstay of the self-help approach to alcohol problems in Australia’, with participation predicting ‘more positive long-term outcomes for many clients’ (Shand et al. 2003). In an update of these guidelines, published in 2009, involvement in AA was recognised as playing ‘a major role in improving a variety of long-term physiological and psychological outcomes, including abstinence rates, employment status, interpersonal functioning and overall wellbeing’ (Haber et al. 2009).

Raising questions

AA says that worldwide there are more than two million ‘recovering alcoholics’, a term used to highlight the ongoing process of healing, which according to AA is never fully completed.

This is an impressive number of people purported to be benefiting from AA, but questions have long been raised about the real effectiveness of the 12-step program. The tenet of anonymity means that neither AA nor NA keeps records or case histories, and they do not engage in research. Because they are not government funded, the organisations are not required to provide evidence of success, and critics complain that the organisations remain free of proper scrutiny.

They point to severe limitations in reports of success rates (Johnson 2010). One review of studies on alcohol treatment conducted between 1966 and 2005 reported that none of the studies clearly showed the effectiveness of AA or related 12-step approaches in reducing problems with alcohol (Ferri, Amato & Davoli 2006).

However, Professor Ian Webster, Director of the Alcohol Education and Rehabilitation (AER) Foundation, believes that the notion of evidence-based practice is ‘inappropriate for a community organisation that has created fellowship and continuity and connections’. AA and NA are outstanding organisations in that they have arisen out of the community, he says, and the scientific paradigms of medicine and other disciplines are not useful in this context.

‘We need to remember that when people have problems (with alcohol and drugs) they fracture their friendships and connectedness, becoming marginalised and alienated from relatives and friends and the workplace. AA and NA provide what is often lacking elsewhere in treatment: great fellowship and acceptance,’ he says.

The spiritual factor

Central to the 12-step philosophy is the concept of a higher power, or God ‘as we understand Him’. While the first of the 12 Steps is to admit to being powerless over alcohol, the second is to believe that only ‘a Power greater than ourselves could restore us to sanity’.

AA professes not to be a religious organisation, yet its dynamics and ideology have been described as religious in nature (Rudy & Greil 1988). This perception can be a stumbling block for those seeking help. ‘You come in with that resistance, but over time it shifts,’ says Sarah*, a member of AA. ‘I started praying and got some relief, and I wanted more of that relief.’

‘AA AND NA PROVIDE WHAT IS OFTEN LACKING ELSEWHERE IN TREATMENT: GREAT FELLOWSHIP AND ACCEPTANCE.’
Tony*, another AA member, says that for those who are agnostic or atheistic, this spiritual dimension can present problems initially. ‘But people who don’t believe in God have said they find the collective fellowship itself a power to draw on,’ he says. ‘Usually when people come to us they’re so desperate that they’re prepared to drop any prejudices they have about a spiritual approach.’

On its website, NA does not use the term ‘higher power’, but states that it teaches ‘basic spiritual principles such as honesty, open-mindedness, faith, willingness and humility that may be applied in everyday life. The specific practical application of spiritual principles is determined by each individual.’

This emphasis on spirituality in the 12-step program has attracted attention, especially as interest in spirituality has become a social phenomenon worldwide. Researchers are looking to AA and NA to better understand the role of ‘spiritual fellowship’ in recovery (Galanter 2008).

Abstinence and harm minimisation

While Professor Webster praises the work of AA and NA, he does acknowledge that there are many people for whom their ideology doesn't work. A group from St Vincent’s Hospital in Sydney began looking for alternatives in 2003 because AA and NA did not suit everyone. The following year, a cognitive behavioural therapy-based group program, Self Management and Recovery Training (SMART Recovery) was introduced to Australia from the United States (see page 27).

While SMART Recovery’s harm minimisation approach is seen as an alternative to AAs abstinence model, either program can function as a supplement to the other. SMART Recovery coordinator Josette Freeman says that while ‘quite a few’ people have come to SMART because AA or NA did not suit them, there are others who learn practical skills from SMART and attend AA or NA for the fellowship.

A BRIEF HISTORY OF AA AND NA

Alcoholics Anonymous (AA) was founded in the United States in 1937. Its early members developed a 12-step program (12 Steps), based on their own experiences, which offered suggestions for recovery from alcoholism. These steps include:

• admitting powerlessness over alcohol
• believing in a Higher Power
• making a fearless moral self-inventory
• asking God to remove shortcomings
• making direct amends to anyone harmed
• spreading the word to other alcoholics to help them recover.

As the membership grew, the 12 Traditions of AA were formulated to provide guidelines for dealing with each other, other groups and the public. The Traditions were first published in 1946, and advocate principles such as AA unity; no opinion on outside issues (so as to avoid public controversy); and the importance of anonymity in developing genuine humility.

Alcoholics Anonymous began officially in Australia with a meeting in NSW in 1945. The following year a clergyman from the Brotherhood of St Laurence started a group in Victoria, and before long groups were also running in other Australian states. The first office opened in Sydney in 1952, and the first national convention for AA was held in Melbourne in 1959.

Narcotics Anonymous was modelled on AA and its program is adapted from the 12 Steps and 12 Traditions. It was founded in California in 1953, and its first Australian meetings were held in 1971.

For more information about Alcoholics Anonymous, and for the complete text of its ‘Big Book’, visit www.aa.org/bigbookonline.

For more information about Narcotics Anonymous, visit www.na.org.au.
There is a need for a broad group of treatment approaches for clients, says clinical psychologist Dr Chris Lennings. ‘Total abstinence is not helpful to many clients who need a harm minimisation approach,’ he says. ‘On the other hand, for some people, long-term drinking or the use of drugs has caused physical damage to those parts of the brain used in making decisions and controlling behaviour, and they can only cope with clear and definite rules. This is what AA or NA offers them.’

Consumer perspectives

It was the idea of having to attend meetings indeﬁnitely that convinced Meg* to turn to SMART rather than to NA for help. ‘I’d lost custody of my child because of using drugs, and I wanted her back,’ she says. But she saw having to go to meetings for the rest of her life as a trap.

She was also drawn to SMART because its philosophy did not view her problem with drugs as a disease. ‘We don’t use labels, so you’re not an addict unless you want to label yourself that way,’ she says. ‘It’s all about changing your thinking.’ Since attending the program, Meg has trained to become a facilitator with the organisation.

For Sarah, AA and NA’s disease model is helpful. ‘You have the physical craving, the mental obsession, and behind it all is a spiritual malady,’ she says. Knowing she has a disease motivates her to follow the 12 Steps and attend meetings, and to work at ‘becoming a better person’.

‘AA doesn’t profess to be the only solution,’ says Tony, echoing the stance of NA, and holding to one of the 12 Traditions that no comment is made on issues outside the 12-step program.

Treatment or support?

AA and NA may have been the only options available in the early days, but things have changed. ‘The group support of AA and NA makes them very useful adjuncts to therapy, but they are not a substitute for therapy,’ says Dr Lennings.

‘What they offer can be a great help. For example, when someone is desperate for a drink at four in the morning, they wouldn’t call their therapist, they’d call their sponsor [an experienced member] at AA.’

The biggest problem in attending meetings, says Dr Lennings, is that members are talking about drugs and alcohol. ‘When I tell you about the last time I used and what happened, I’m also remembering how good it was,’ he says. The irony is that members are focusing on the very thing they are trying to overcome.

Only others who are recovering from alcohol or drug use can provide support within AA and NA. The idea is that you are less likely to feel judged and more likely to feel accepted by recovering alcohol and drug users because they’ve done what you’ve done and they understand. ‘But I don’t believe you have to have been there, done that, to be able to provide effective therapy,’ Dr Lennings says. ‘While other former addicts may offer

---

IN AUSTRALIA, AA ESTIMATES IT HAS AROUND 18 000 MEMBERS AND HOLDS ABOUT 2000 AA MEETINGS EVERY WEEK AROUND THE COUNTRY. NA ESTIMATES IT HOLDS ABOUT 400 MEETINGS EVERY WEEK.
hope of recovery, the danger is that they are not trained to pick up on any serious underlying problems in those who come along to meetings.’

Sarah offers some interesting insights here. ‘I came from a background of early trauma,’ she says, ‘and I did ten years of somatic psychotherapy. It didn’t help my alcoholism, and eventually I joined AA, which restored me. By then I’d done a lot of work on myself and through the therapy I’d digested my family history, got a lot of trauma out of my body. But I’ve seen a lot of people traumatised in the 12-step program. They get sober and all of a sudden their world comes crashing down around them.’

A challenge for therapists

Despite questions about the short-term and long-term effectiveness of the 12-step program, some in the alcohol and other drug sector are looking more closely at how they can incorporate some of the elements into therapy. For example, Smale (2010) explored what it was that kept people sober and found the AA approach helped build hope, self-esteem and satisfying relationships. ‘In AA there is a body of evidence showing that addicts can change their behaviour based on their relationship with another human being and a “higher power”. As therapists our challenge is to make sense of that experience and use it to help our clients,’ he writes.

Problems with alcohol and drugs are complicated predicaments related to a person’s experience of life, says Professor Webster. ‘The problem generally arises out of unsatisfactory life experiences and views of yourself; it involves the way the brain works; it involves the predispositions people have and the way they think, as well as the fact that the drug itself can have an effect on the brain. It’s a constellation of things, and requires a constellation of approaches.’

* All first names mentioned have been changed to protect anonymity.

References


An article in the *Journal of Substance Abuse Treatment* (2009), titled ‘Setting the standard for recovery: Physicians’ Health Programs’, summarised the outcomes for 904 addicted doctors admitted to 16 state Physicians’ Health Programs (PHPs) in the United States (US). These programs are abstinence-based – a universal requirement of US medical licensing boards. The report discusses possible reasons for the very high ‘success’ rates, measured in part by return to medical practice following chemical dependency (with 78 per cent of the participants having no positive test for alcohol or drugs over the five-year period of intensive monitoring).

Abstinence-based programs are at one end of the harm minimisation spectrum. They are not for everyone, but should be discussed with alcohol and other drug (AOD) clients as a management option. For those who are willing and able to participate in these programs, the rewards can be great. Such programs foster ‘recovery’ – loosely defined as an enduring lifestyle characterised by the resolution of AOD problems along with the progressive achievement of optimal health and good citizenship. They require a commitment by the client to sustain abstinence and broader behavioural change.

**Help for the helpers**

Doctors comprise a small but important group within the addict population. While the incidence of AOD problems in the medical profession is similar to that of the wider community, distinctive methods of treatment management have been developed, with remarkably successful outcomes. Although the details differ, Australian doctors’ health programs follow similar principles to the US (and Canadian) PHPs, almost always requiring abstinence as an outcome.

There are six key elements of PHPs that contribute to their high success rate, and to their possible application in the general population.

1. **Contingency management**

   Under the PHP model, doctors are rewarded for treatment compliance and ongoing recovery by the ability to resume their medical practice, usually with conditions attached. As they progress in their recovery, these conditions are reduced, and pending legal matters or medical board disciplinary action, may be dropped. Alternatively, non-compliance can result in the loss of medical registration, often requiring doctors to leave the profession in disgrace.

   To some extent, these positive and negative consequences are similar to the functions of drug courts, where compliance and ‘clean’ urines over time can lead to charges being dropped, and lack of compliance can lead to incarceration.

   PHP experience supports the view that compulsory systems like this improve the outcomes of addiction treatment. Perhaps we should be looking at creative ways of exploiting this management component in individual clients.

2. **Linkage with 12-step programs**

   The US PHPs place great store in the efficacy of 12-step programs for their clients. In theory, the requirements for ongoing PHP compliance can be met by any ‘recovery program’ that is ‘intense, high quality and enduring’. In practice, however, the vast majority of participants choose Alcoholics Anonymous or Narcotics Anonymous. There
are many reasons for this, including program content, frequency and accessibility of meetings, and lack of financial obligation.

Combining AA or NA with professionally directed addiction treatment has been shown to generate better recovery outcomes than either treatment alone or AA/NA alone.

3. Active management of relapses

Doctors who relapse are not typically discharged from the PHP (either here or in the US). They are reassessed and retreated, and usually re-enter work with additional therapeutic and monitoring requirements.

This approach is directly transferable to the general population. Most people who undertake abstinence-based programs require more than one treatment episode – as is the case with many other chronic relapsing disorders. The article suggests that relapse should be approached as a more-or-less normal course of events rather than a ‘treatment failure’, and upon which the client’s previous recovery experience can be built.

4. A continuing care approach

Chronic disorders require chronic care. This is a fundamental principle of PHPs, which insist on long-term involvement – typically for a minimum of five years. In these programs participants are engaged in a case management, aftercare and monitoring agreement, which incorporates a number of therapeutic components. These include a weekly ‘Caduceus group’, which provides professionally facilitated mutual support for medical professionals.

The article supports the notion that continuing care should be a key feature of community-based programs. Facilitated groups are effective and should be supplemented with individual sessions on a needs basis. These ongoing programs complement AA /NA; they are not regarded as a substitute. Family support should also be provided.

5. Focus on lifelong recovery

Abstinence is a key objective of PHPs, but is not regarded as an end in itself. PHPs support doctors to significantly improve the quality of their lifestyles, both personally and professionally. ‘Recovery’ involves personal development and the enhancement of physical, mental and emotional health, along with satisfactory relationships and community participation.

This approach is also transferable to the general community, with the proviso that adequate resources are in place to encourage and deliver the appropriate services. The 12-step fellowships incorporate lifelong recovery into their programs.

6. Frequent random drug testing

This is a universal requirement of PHPs, both in the US and Australia, and many workers regard it as the most effective component of these programs. It is tied to the contingency management discussed earlier, but in addition it serves as a behavioural intervention, regularly reminding the recovering doctor of his or her disorder and the potential consequences of relapse into substance use.

This type of drug testing is seldom used in the general population unless it is a workplace or court requirement. This is probably the only component of PHPs that may be difficult to apply to a large proportion of the general addict population, however in combination with contingency management there may be room for wider use.

Discussion

There are cultural differences between the US and Australia at both societal, treatment and professional levels that influence attitudes to management of substance use disorders. In North America, the ‘recovery’ paradigm has broad acceptance, and dominates the approach of PHPs. Accordingly, 12-step programs usually play an important role in recovery management. In Australia, harm reduction is the prevailing paradigm, and abstinence-based programs are not given as much encouragement.

In spite of the findings of the article, and a large body of other research, there are still legitimate questions regarding efficacy of 12-step programs at a population level. However, even a cursory look (that is, attendance at several meetings) at AA or NA provides convincing evidence that these fellowships can achieve remarkable transformations of individual lives, based on periods of total abstinence from days or weeks, to many decades.

Speaking from experience

I was the inaugural Medical Director of the Victorian Doctors Health Program (VDHP), from 2001 to 2007. During that period I managed over 80 doctors with substance use disorders, following the general principles of the US and Canadian PHPs (to several of which I am indebted for my training). Our outcomes at the VDHP were in the same order of those in North America.

I now work privately with people with severe substance use disorders from the general population (albeit limited to those with health insurance or the capacity to afford private treatment). Our treatment program at Malvern Private Hospital in Victoria is abstinence-based, and commences with a 28-day inpatient detoxification and recovery initiation program. It is suitable for people who genuinely desire abstinence, and are open-minded to actively participate. It utilises AA and NA as core components of ongoing recovery, along with our own weekly aftercare program. Our objective is to utilise the key elements described above (with the exception of drug testing).

We view the PHPs as setting the gold standard for recovery, and are attempting to present this type of program to the broader community. We freely acknowledge that this program does not suit all clients, but for many it represents an opportunity to completely transform their lives from that of an active addict or alcoholic to a productive and content member of society.

*Dr Jack Warhaft is the Medical Director of the Addiction Recovery Program, Malvern Private Hospital, Victoria and a member of the Chapter of Addiction Medicine.

Disclosure: The writer is in recovery from addiction, and attends and a member of the Chapter of Addiction Medicine.

Reference

upcoming
events

4 March
Victorian Addiction Medicine Nurses Education Forum (VAMNEF) conference
East Melbourne, Vic
www.vaada.org.au

7-8 March
Young people, risk and resilience: The challenges of alcohol, drugs and violence conference
Melbourne, Vic

13-16 March
National Rural Health conference
Perth, WA
http://11nrhc.ruralhealth.org.au

3-7 April
IHRA conference
Beirut, Lebanon
www.ihra.net/conference

6-7 April
Reconnexion: National Anxiety and Depression conference
Melbourne, Vic
www.reconnexion.org.au/conference

11-15 April
Kettil Bruun Society conference
Melbourne, Vic

18-20 April
27th ACHPER International conference
Adelaide, SA
www.achper.org.au/conferences-events

2-4 May
6th International Conference on Drugs and Young People
Melbourne, Vic
www.adf.org.au/6dyp

20-22 May
General Practitioner conference
Sydney, NSW
www.gpce.com.au

30 May – 2 June
ATCA conference
Fremantle, WA

8 June
Australian Winter School Conference Workshop
Surfers Paradise, Qld
www.winterschool.info

Jobs of Substance
LOOKING FOR WORK THAT HAS MEANING?
check out
www.jobsofsubstance.com.au

A jobs website for people working in the health, welfare, community and non-profit sectors.
An initiative of Of Substance magazine.