HARM REDUCTION: A BEGINNER’S GUIDE

WHERE HAVE ALL THE PRESCRIBERS GONE?

INTERVIEW: PROFESSOR ROBIN ROOM

THE PROBLEM OF PAIN: Relief without opiates?

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Welcome to the November issue of Of Substance.

Earlier this year, a reader told me that as a trainer of non-AOD-specific health workers, she wished she had a simple handout that explained harm reduction and why the substance use sector used the term.

We’ve risen to her challenge and have produced Harm reduction: An overview. This article, which can be found on pages 26-29, explains the history of harm reduction and is designed as a simple guide for anyone who is new to working with substance use problems. This article can also be downloaded as a pdf from our website (www.ofsubstance.org.au) and used as a handy reference guide.

Last issue, we looked at the rapid increase in the use of prescribed opioids. Since these medications are often used to relieve pain, this issue we thought we’d look at the broader picture of chronic pain. Managing pain is a particular challenge for people who have been dependent on illicit drugs, and as this sector of the population ages, this issue is attracting attention. Writer Bronwyn Duncan has looked at some interesting advances in this area.

Earlier this year, the Australian AOD sector honoured some of its highest achievers at the National Drug and Alcohol Awards. Victoria’s Professor Robin Room was the recipient of the Prime Minister’s Award for Excellence in Drug and Alcohol Endeavours. We were privileged to chat with Professor Room, and have included the highlights of that interview in the magazine. However, our conversation with this ‘accidental expert’ was so interesting, that with Professor Room’s permission, we have included a transcript of the entire interview on our website. To read more, visit www.ofsubstance.org.au.

In closing I also want to thank the many readers who took time out to answer a survey about Of Substance earlier this year. The evaluation is now complete and a short summary of what you told us can be found on page 7. You liked what we do and also told us ways we can improve our service as we move into an increasingly digital age.

As always, I hope you will find this issue of Of Substance informative and thought provoking. Between issues, we like to keep readers informed electronically about news and opinions in the AOD sector. To receive our regular eBulletins, subscribe at www.ofsubstance.org.au.

Jenny Tinworth
Managing Editor

The challenge of chronic pain

Dr Bridin Murnion, Head of Department, Drug Health Services, Concord Repatriation General Hospital; Staff Specialist, Drug Health Services, Royal Prince Alfred Hospital; Clinical Senior Lecturer, Discipline of Addiction Medicine, Faculty of Medicine, University of Sydney

There is increasing appreciation of the individual and societal burden of chronic pain both in Australia and globally. Consequences for the individual include loss of employment and income, loss of self-esteem, depression, reduced mobility, obesity and increased cardiovascular risk. Costs for society are those of having large numbers of people unable to work and becoming dependent on social security payments, and health care costs. Chronic pain may be particularly problematic for people on opiate substitution treatment, with some studies reporting a prevalence of 50 per cent of this group.

In conjunction with increasing awareness of the problems of chronic pain, there has been increasing recognition of the limitations of treatment. Using acute pain or palliative care models to treat chronic non-malignant pain is often ineffective and may be damaging. There are long waiting lists for pain clinics, and rural and remote regions are often not serviced at all. There are limitations of knowledge around optimal treatment and the side effects of treatment. The role of opioids in chronic non-malignant pain is unclear, and there is significant evidence that increases in opioid prescribing are associated with increasing harms from these medications. The US experience over the last 10 years is of an epidemic of prescription opioid abuse. In some states, deaths from prescription opioid overdose now exceed those from motor vehicle accidents.

A number of strategies have been adopted or are suggested. To reduce waiting lists, some pain clinics ask that all patients referred undertake a course of non-pharmacological therapies (exercise and psychological). If pain persists despite this, a further review in a pain clinic is organised. This has been shown to be an effective intervention. Health care practitioner and consumer education is vital to improve outcomes, with greater understanding of and funding for non-pharmacological treatments.

No single strategy is likely to solve the burden of chronic pain. However, it is evident that a balance between access to opioids for those who need them, both within Australia and globally, and the risks of increased exposure to opioids has not yet been achieved.
News

Tobacco plain packaging gets green light

Australia now leads the world in anti-tobacco marketing and branding regulations, following the High Court’s decision in August to reject a challenge by British American Tobacco, Philip Morris Australia (PMA), Japan Tobacco International and Imperial Tobacco Australia that the Commonwealth Government’s Tobacco Plain Packaging legislation was in breach of the Constitution.

As a result, from December 2012 all tobacco products sold in Australia must be in standardised green-brown packs, including graphic health warnings increased to 75 per cent of the front of the pack.

President of the Australian Council on Smoking and Health, Professor Mike Daube said, ‘This is a massive win for the public. The global tobacco companies have opposed plain packaging more ferociously than any other measure we have seen. They know that plain packaging will have a major impact on smoking here – and that other countries will now follow.’

Three countries, including Ukraine, have already challenged Australia before the World Trade Organization (WTO) over the plain packaging legislation as contrary to Australia’s obligations as a WTO member. Trade Minister Craig Emerson said the Government would vigorously defend any challenges against it. PMA is also suing Australia for multiple breaches of its Bilateral Investment Treaty with Hong Kong.

FASD funding welcomed

Minister for Mental Health and Ageing Mark Butler announced new funding in August for projects aimed at reducing alcohol-related harm in the community, with a focus on reducing the misuse of alcohol during pregnancy. Part of this funding will provide more than $750,000 over three years for the National Organisation for Fetal Alcohol Syndrome and Related Disorders (NOFASARD) to support its work as the peak body.

‘The funding will enable us to continue the critical, ongoing support of individuals, carers and families who live every day with the impact of fetal alcohol exposure … Our new funding will assist us to launch new programs, including self-advocacy kits which will assist parents and carers to negotiate better outcomes for their children, and also help us develop more localised support networks,’ NOFASARD Chairperson Sue Miers AM said.

Additional funding will be provided to the Foundation of Alcohol Research and Education to work with health professionals in raising awareness with patients about the risks of harmful drinking – particularly to pregnancies. Funding will also be provided to DrinkWise Australia to work with industry to develop ‘point of sale’ information for consumers at liquor retailers, clubs and hotels.

ACT’s needle exchange trial

The ACT’s Chief Minister Katy Gallagher announced in August that prisoners at the Alexander Macarthur Centre (AMC) will be given clean needles to safely inject drugs, in Australia’s first trial of a prison needle exchange plan.

‘By halting the spread of blood borne viruses in the AMC we stop them spreading further in the community when prisoners are released and go back to their family and friends,’ the Chief Minister said.

Ms Gallagher said she would seek a trial of needle exchanges as early as next year, winning praise from human rights groups and public health advocates across the country, but strong opposition from guards, who have described the scheme as ‘dangerous’.

The government’s trial will address educating prisoners about the spread of blood borne viruses, take steps to cut off the supply of drugs in the prison, provide treatment and screening, as well as access to needle and syringe programs, which have been proven to be successful in the wider community.

Prisoners would only receive a clean needle by handing over a dirty one, in a ‘one-for-one’ exchange overseen by their doctor. An implementation group representing staff at the AMC and health and corrections officials will now be convened to provide advice on how this model could be applied.

There have been nine documented cases of in-custody transmission of hepatitis C at the AMC since it opened in 2008.

$24 million for drug and alcohol research

New funding announced by Health Minister Mark Butler in June will see $24 million invested over three years in alcohol and drug research, under the National Drug Strategy. The funding will focus on areas such as reducing harm from alcohol, Indigenous substance misuse and workforce development. It will also enable a new collaborative network to be built across three National Research Centres of Excellence – the National Drug and Alcohol Research Centre (NDARC), the National Drug Research Institute, and the National Centre for Education and Training on Addiction – to ensure better coordination of research.

The funding means that NDARC will continue its annual collection of Australia’s drug trends through the Illicit Drug Reporting System and the Ecstasy and Related Drugs Reporting System. As well, it will enable the Australian Institute of Health and Welfare to run the National Drug Strategy Household Survey and National Opioid Pharmacotherapy Statistics Annual Data, and the continuation of funding for the National Coronial Information System.

Of Substance, vol. 10 no. 3 2012
A new report commissioned by the Australian National Council on Drugs and prepared by the National Drug & Alcohol Research Centre at the University of NSW looks at the supply, demand and harm reduction strategies in Australian prisons.

The report, *Supply, demand and harm reduction strategies in Australian prisons*, highlights that the vast majority of current prison system efforts on alcohol and other drug (AOD) programs are being directed at reducing the supply of drugs in prisons, and that effective programs operating in the community to treat AOD use are either restricted or unavailable for prisoners.

The report provides the most recent snapshot of AOD strategies and programs currently available across Australian prisons. Through the report, the ANCD calls for the introduction of regular, transparent and independent reviews of every prison to determine the breadth and level of services available to address AOD problems and reduce reoffending.

The report calls for new approach to AOD in prisons

A study of teenagers has found that those who smoke cannabis weekly or more are twice as likely as non-users to have an anxiety disorder in their late 20s, even if they stop using. The findings are based on analyses of a landmark study of nearly 2000 Victorian secondary school students, led by Professor George Patton of the Centre for Adolescent Health at the Murdoch Childrens Research Institute in Melbourne, and lead author of the analysis, Professor Louisa Degenhardt from the National Drug and Alcohol Research Centre at the University of NSW.

The study found those who used frequently in their teens and continued to use on a daily basis at the age of 29 were three times as likely to have an anxiety disorder compared with non- or infrequent users. Those who used minimally in their teens but became daily users in their late 20s were two and a half times as likely to have an anxiety disorder. But the really striking finding say the authors is the persistent association between frequent teenage cannabis use and adult anxiety disorders up to a decade after cannabis use has ceased. The relationship between cannabis use and anxiety disorders was present even after the researchers took into account other possible explanations such as mental health problems in their teens or other drug use in their twenties.


UN report highlights Australian drug use

The 2012 World Drug Report was launched in June by the UNODC Executive Director Yury Fedotov. The report shows that global patterns of illicit drug use, production and health consequences largely remained stable in 2010, however opium production had rebounded to previous high levels in Afghanistan (the world’s largest opium producer). The report also noted the high levels of recreational drug use by Australians and New Zealanders – making us the world’s biggest.

Annual use in both countries of all drugs, except heroin, ‘remain much higher than the global average’.

National Drug Research Institute Director Steve Allsop said the UN report did not necessarily provide an accurate comparison with other countries, as Australians were generally more forthcoming about their drug use.

Denmark legalises drug consumption rooms

As of July 2012, the establishment and operation of ‘safe drug consumption rooms’ has been made legal in Denmark, after a unanimous vote by the Danish Parliament. The new legislation also legalises smoking of drugs in such facilities; this includes heroin and other currently illegal drugs such as amphetamines, cocaine, crack and mixtures.
Chikritzhs wins top award

Western Australian researcher, Professor Tanya Chikritzhs, won the Commonwealth Health Minister’s Award for Excellence in Health and Medical Research in June. Professor Chikritzhs leads the Alcohol Policy Research team at the National Drug Research Institute, Curtin University. Her research focus is on the epidemiology of alcohol use as it relates to disease and injury, the prevention of alcohol-related harms, evaluating policy impacts and translating research into policy.

Inaugural Indigenous D&A Award winners

The winners of the inaugural National Indigenous Drug and Alcohol Awards were announced in June. These awards recognise the contribution of Aboriginal and Torres Strait Islander drug and alcohol workers to the reduction of AOD use among Aboriginal and Torres Strait Islander people, and the harm reduction that follows.

The awards presented were:
- Ms Gabrielle Sledge of the Winnunga Nimmityjah Aboriginal Medical Centre in the ACT received the Award for Excellence, Female Worker.
- Mr Paul Parfitt of the Drug and Alcohol Office in WA received the Award for Excellence, Male Worker.
- Mr Richard Burchill of the Alcohol, Tobacco and Other Drugs Service in Mossman, Queensland, received the Encouragement Award.

The inaugural inductees to the National Indigenous Drug and Alcohol Honour Roll were Ms Coralie Ober and Mr Steve Ella, who were acknowledged for their exceptional efforts as AOD workers and for their tireless contributions to this sector over many years.

Pioneer passes

Griffith Edwards, a leader of the modern AOD field, passed away in September aged 84. Professor Edwards was director of the UK’s Addiction Research Unit from 1968 until retirement and established the country’s National Addiction Centre. He was instrumental in the development of effective treatment approaches, especially for alcohol-related problems, and a strong advocate for evidence based prevention. He also inspired the development of the leading journal Addiction. Professor Edwards’ influence and ideas were unmatched, and they resonate in current Australian research, prevention and treatment efforts.
National AOD agencies standard

A new national standard for alcohol and other drug (AOD) agencies was launched in Perth in August. The Standard on Culturally Secure Practice (Alcohol and other Drug Sector) has been developed by the Western Australian Network of Alcohol and other Drug Agencies. The standard can be applied by services throughout Australia, including 90 services in WA. It is the first to require that services define and understand their target population, whether it be men, women, young people, people from culturally and linguistically diverse backgrounds or people from a particular location.

For more information, visit: www.wanada.org.au.

Helping more Australians to stop smoking

The Federal Government in conjunction with SANE Australia, a mental health non-government organisation, has produced resource materials to help people experiencing mental illness quit smoking. The materials will provide information to help people get started on the path to quitting smoking, as well as detail available support services, and how families and carers can help too. The resources are part of the Australian Government’s More Targeted Approach campaign which focuses on high need and hard-to-reach groups as part of the national QuitNow campaign. As many as 32 per cent of Australians with a mental illness smoke — increasing to between 60 and 73 per cent for those living with severe mental health conditions such as schizophrenia.

For more information, or to request free copies of any of the resources, visit: www.quitnow.gov.au.

AOD handbook for Indigenous issues

Aboriginal health professionals now have access to a plain English, up-to-date and evidence-based handbook with the launch of the Handbook for Aboriginal alcohol and drug work. The handbook is a result of a partnership between the University of Sydney and Aboriginal and mainstream alcohol and other drug (AOD) agencies, and has been written to help health professionals tackle AOD problems.

As well as advice on AOD treatment and prevention, the handbook contains sections to help with the many other complex challenges that clinicians face in the field, including the wide range of physical, mental, social and legal problems that many of their Indigenous clients experience. Many sections of the handbook were either written or reviewed by Aboriginal professionals who work in the AOD field, with a focus on plain language.


Support for Qld pharmacotherapy

QPAMS is the new Queensland Pharmacotherapy Advocacy Medication and Support Service. It is a peer-based service for people who are on pharmacotherapy treatment living in Queensland. QPAMS is a service of QuIVAA (the Queensland Injectors Voice for Advocacy and Action), that provides people with information and support about methadone or buprenorphine treatment. QPAMS can support people with accessing pharmacotherapy treatment by providing referrals to clinics and GPs. QPAMS also has a confidential free call number: 1800 175 889.

For more information, visit: www.quivaa.org/qpams.html.

New Addiction website

The research journal Addiction has launched a revamped website that makes the journal useful to a much wider readership than the academics and clinicians who are its regular subscribers. It offers features to help close the gap between pure research and its practical application.


Drug stigmatisation

The various opinions on the stigmatisation of illicit drug use reviewed in the July issue of Of Substance [‘Stigma: Why wouldn’t I discriminate] make two fundamental errors of assumption. The first is that stigmatisation can somehow be excised from the Australian community’s almost univocal disapproval of illicit drug use, where 93-97% disapprove of the regular use of heroin, cocaine, speed/ice and ecstasy, and 76% of cannabis, according to the 2010 National Drug Strategy Household Survey. To remove the stigma of illicit drug use, the community must approve of it. But why?

The second error is a kind of naive romanticism which believes that the illegality of illicit drug use causes this stigmatisation. But tobacco smokers and problem drinkers are stigmatised, yet are using legal drugs. A more searching analysis, in our view, would find that the compassionate within the Australian community will accept the drug user, while not accepting their drug use – a most basic distinction which appears to have been missed in the Of Substance reviews.

Jo Baxter
Drug Free Australia
Broadview, SA

OF SUBSTANCE WELCOMES CORRESPONDENCE. PLEASE SUBMIT LETTERS OF UP TO 300 WORDS TO EDITOR@ANCD.ORG.AU.
Between February and April this year, 1280 people contributed to an external evaluation of our magazine and eBulletins. The evaluation, conducted by LeeJenn Health Consultants, aimed to examine the reach, value, content and style of our publications, and to examine how the Of Substance website meets the needs of readers. LeeJenn used multiple methods to analyse the current readership and to elicit your views.

A total of 1135 people contributed to an online survey, of whom 90% (n=1023) were readers and 10% (n=112) were non-readers. A further 145 people were interviewed by telephone, of whom 76% (n=111) were readers, 9% (n=13) were opinion leaders and policy makers in the sector and 14% (n=21) were non-readers.

LeeJenn found that:

• the magazine is highly regarded, seen as high quality and containing well-written and easy-to-read articles on current issues
• 93% of readers in the telephone interview thought the magazine was as good as, or superior to, other industry magazines and 97% would (or do) recommend Of Substance to their colleagues
• 72% of online respondents read every issue and subscribers who receive a personal copy were most likely to be regular readers (85%).

What do readers think about the content?

Overall, readers are highly satisfied with the content of the magazine. There was a strong preference for content on subjects related to skills, practice and programs. Readers were also very interested in emerging issues, particularly new drugs, and for the magazine to offer a balanced view of controversial and ‘edgier’ topics. A quarter of reader respondents would also like more articles on prevention of AOD-related problems and harm reduction, and others would like more content on issues related to culturally and linguistically diverse communities and Aboriginal and Torres Strait Islander peoples.

What about the format?

While most people (92%) prefer the print version of the magazine, about 57% of online respondents would be likely or very likely to use some form of online interactive media, including participating in, or reading, an online discussion forum (47.8%), commenting on articles (48.2%) or receiving updates via Facebook (24.8%) or Twitter (13.5%).

Is the magazine reaching its target audience?

Results from the online survey suggest that it is.

• 32.5% of readers work in the AOD sector, mostly in a treatment setting.
• 67.5% work outside the AOD sector, predominantly in education, mental health, primary health, youth work, research and law enforcement.
• Of those who work outside the specialist AOD sector, 52.5% indicated that more than half of their work was AOD-related.
• The current readership is estimated to be approximately 79000.

What impact is the magazine having?

Ninety per cent of readers felt the magazine was relevant to their work and more than 60% of those interviewed by telephone said it improved their practice or changed their thinking.

What do readers think of the eBulletins?

Most readers are happy with the eBulletins but there is limited awareness of their presence.

• 23% of online survey respondents subscribed to the eBulletins.
• 75% of magazine readers do not subscribe to the eBulletins, primarily due to lack of awareness (70%).

Does our website fit with readers’ needs?

There has been a considerable increase in website user activity since the last evaluation in 2008:

• Downloads of current and past issues of the magazine have increased considerably. About 8% of readers access the magazine through the website exclusively
• Readers would like a more powerful and sophisticated search function to meet their needs. Readers would also like more opportunity for two-way interaction with the magazine and each other via the website, and others would like to use the website to manage their own subscriptions.

FROM THE CHAIR

On behalf of the Of Substance staff, Editorial Reference Group and Board of Management, I’d like to extend our sincere thanks to everyone who took part in the evaluation. LeeJenn has presented a range of timely recommendations for us to pursue, many of which we are excited to be progressing. As always, we’ll continue to strive to make the magazine an integral part of the sector, as well as work behind the scenes to further improve our accessibility and use to the work all our readers undertake.

Dr John Herron, Chair of the Of Substance Board of Management
Finding the balance


This paper argues that the availability of prescription opioids and public misconceptions about their addictive potential underlie recent increases in non-medical opioid use in many countries including the USA and Australia. Competing pressures on doctors to diagnose and treat pain syndromes, while identifying pain patients at risk of addictive disorders, make opioid use in pain management clinically challenging. Clinicians must strike a balance between minimising potential adverse opioid effects – misuse, respiratory depression, overdose, medication interactions – without diminishing legitimate access to opioids for analgesia.

Research suggests that patients with no prior history of opioid misuse who are treated with opioid analgesics over extended periods do not experience euphoria and are therefore unlikely to become ‘addicted’ – that is, to use compulsively, experience cravings and continue to use despite harms. Nevertheless, some of these patients may develop addiction, complicating the management of chronic pain. The Royal Australasian College of Physicians recently published clinical guidelines for managing pain recommend a comprehensive assessment of a patient’s risk of addiction, particularly individual or family history of drug misuse, before chronic opioid therapy is initiated. High-risk pain patients prescribed chronic opioid therapy should be referred to an addiction medicine specialist from the outset, and treatment providers must liaise closely to ensure continuity of care. Cases where pain clients have their opioid prescriptions terminated after they exhibit escalating doses, for example, are not uncommon. Referral to an addiction specialist at this stage may lead to detoxification, and the patient may be discharged from all treatment suffering both ongoing pain and opioid cravings. Multimodal, individualised care plans are essential to meet each patient’s unique treatment needs.

These authors identify buprenorphine as the preferred pharmacotherapy for patients with comorbid pain and opioid dependence due to its relative safety and analgesic effects. Non-opioid medication treatment options include non-steroidal anti-inflammatories, tricyclic antidepressants, anticonvulsants, muscle relaxants and interventions such as nerve blocks or steroid injections. Non-medication adjunctive treatments should be considered for all patients, including cognitive behavioural therapy, massage, relaxation and physical therapy.

Innovative research approaches to the pain/addiction nexus include development of abuse-deterrent opioid formulations that prevent the release of active opioids when pills are crushed or chemical extraction is initiated. Another approach investigates genetic predisposition to opioid addiction. A patient identified as genetically susceptible could be targeted for prevention; and clinicians could use genetic information to accurately assess risk and to individualise care plans. Although a genetic screen for all pain patients may be impractical, it may be justified in cases where other risk factors are apparent. Current research also investigates opioid-induced hyperalgesia (OIH), the increased sensitivity to pain that can arise as a consequence of long-term use of opioids. The mechanisms underlying OIH are unknown and its roles in pain and opioid addiction remain unclear. Researchers hope to develop new drugs that can prevent OIH, provide analgesia without inducing hyperalgesia and reverse established OIH.

A different clientele


The past decade’s marked increase in prescription and non-medical use of pharmaceutical opioid analgesics (POA) in Australia has been accompanied by health practitioner reports of different ‘types’ of POA users. These include people who inject heroin but use pharmaceutical opioids as substitutes for heroin or as their primary drug in regions with poor heroin availability; and a ‘hidden population’ of POA users who initiated use for therapeutic purposes, but continued on POAs for longer and at higher doses than...
initially intended. The latter group is perceived as largely absent from traditional treatment services, possibly due to stigma attached to attending these services. This study recruited a convenience sample of 192 recent treatment entrants from public and private detoxification (17%), residential rehabilitation (10%) and pharmacotherapy (73%) services in Victoria, Western Australia, Queensland and Tasmania. Most participants reported histories of injecting and use of both heroin and POA. Researchers divided participants into those presenting with either primary heroin (61%) or primary POA (39%) problems; and used the statistical technique of latent class analysis to differentiate the two groups.

Most POA users were similar to heroin users in terms of demographics, health status and drug use patterns, suggesting that most people seeking treatment for primary POA problems resemble traditional heroin injectors; and indeed may prefer heroin but choose to use POAs for cost and/or availability reasons. However, the analysis defined 12% of participants as highly distinct from the remainder of the sample. These primary POA users were older and more likely to be treatment-naive than other participants; typically did not inject; commonly initiated prescribed opioid use for pain; and experienced elevated physical and mental health disability relative to other participants. The characteristics of this group resemble those of non-injecting POA treatment seekers described in North America, and are consistent with Australian health practitioner descriptions of an emerging ‘type’ of problematic POA user. Yet this distinct group currently makes up only a minority of Australian treatment seekers, suggesting that they are not attracted to contemporary treatment services. The authors propose that this may reflect the treatment system’s current orientation towards injecting drug users, and suggest that the system’s responsiveness to changing patterns of drug use warrants consideration.

In the case of pain and addiction, common treatment goals include increased self-efficacy and decreased reliance on drugs, decreased depression and anxiety, increased functional enjoyable activities, enhanced capacity to endure boredom, increased distress tolerance (e.g. cravings, pain), increased behavioural activation relating to life goals and increased stable support for a functional lifestyle. These shared goals provide a platform for developing a comprehensive integrated treatment program for comorbid pain and addiction. On this basis, the authors proceed to review the evidence for the effectiveness of a range of psychosocial treatment approaches in treating addiction, pain management and the integrated treatment of both.

Multiple techniques familiar to the drug and alcohol clinician, including motivational interviewing, cognitive behavioural therapy, and contingency management (which shapes behaviour through rewards for appropriate behaviours from patients), have all demonstrated some effectiveness in evaluations of their utility in pain management. Relaxation therapy, biofeedback and meditation are all effective tools to reduce the subjective pain experience and related distress which increase the patient’s self-efficacy related to their pain management. There are obvious parallels between the use of these techniques in the context of pain and their use in drug treatment as an addition to the coping repertoire. Nevertheless, despite the intuitive overlap between treatment goals, no psychosocial treatment individually validated for the treatment of either pain or addiction has ever been subjected to rigorous evaluation as part of an integrated treatment program for comorbid pain and addiction.

In the absence of evidence-based direction for best practice treatment approaches, the authors argue that integrated treatment of both comorbidities within the same treatment context is likely to have the greatest impact. Simultaneously addressing both pain and addiction should allow the patient to learn the skills needed to achieve the mutual goals of treatment, while reducing the risk that focusing on just one disorder will increase the risk of relapse to the other. A drug treatment-only approach that advocates detoxification without addressing pain issues will lead to relapse as patients attempt to treat their pain. Likewise, pain-only treatment cannot address the secondary gain of maintaining the appearance of a pain disorder to maintain access to opioids. A cohesive, unified treatment model is clearly the next step to developing effective treatments for this debilitating pattern of comorbidity, but remains, to date, lacking.

**The case for combined treatment**


This broad-ranging literature review highlights the lack of research into effective psychosocial treatments for comorbid chronic pain and opioid addiction. Patients suffering this comorbidity are difficult to treat, and are more likely to have serious medical, psychological or social issues compared with individuals in drug treatment and with non-comorbid chronic pain patients. Drawing on psychosocial treatment models for comorbid mental health and drug use disorders, the authors categorise treatment approaches as sequential, in which each of the comorbidities is addressed separately and one at a time; or parallel, in which each of the comorbid issues is addressed simultaneously but separately. The authors advocate for integrated treatment, where comorbid issues are treated simultaneously, by the same treatment provider, within a single treatment model. They argue that integrated treatment allows a focus on the treatment goals shared by the treatment model for each condition, rather than focusing on the specific treatment techniques designed for each of the individual disorders.
Although pain has always been part of human experience, the scientific study of pain management and relief is a very recent phenomenon.

A revolutionary change in understanding pain began with the publication in the mid-1960s of ‘Gate Control Theory’, and with the transformative work of John Bonica, who discovered the effectiveness of multimodal pain management when treating injured soldiers after World War II. Bonica established the world's first multidisciplinary pain clinic in 1974 in the United States.

In just the last two years there have been global moves to make pain management a high priority within health care policy and practice, driven by both human rights and economic concerns. The Declaration of Montreal, released by the first International Pain Summit in 2011, calls for access to pain management as a fundamental human right.

Professor Michael Cousins, Chair of Australia’s National Pain Strategy (NPS) states, ‘Pain is Australia’s third most costly health problem and arguably the developed world’s largest “undiscovered” health priority.’

A 2007 report by Access Economics and the MBF Foundation found that chronic pain costs the Australian...
economy $34 billion per annum. The largest share of costs is borne by the sufferers themselves (55 per cent).

While chronic pain is today recognised and treated as a disease entity in itself, delivery of care is inefficient and haphazard. There is, however, some cause for optimism. In 2010, Australia was the first country in the world to develop a national approach to improving the lives of people living with chronic pain. Through the NPS, a coordinated approach to policy reform is being developed. Several countries are following in Australia’s footsteps.

**How widespread is chronic pain?**

Access Economics estimates the number of Australian adults experiencing chronic pain at around 3 million (1.4 million males and 1.7 million females, excluding children and adolescents) (2007). Of these, around 20 per cent (5 per cent of the national population, or over 1 million people) experience significant persistent pain that reduces their quality of life, and almost two-thirds of sufferers report that pain interferes with their daily activities. Associated problems are mood changes such as anxiety and depression, which share neurotransmitters with chronic pain.

Research suggests that some 20 per cent of chronic pain sufferers in Australia receive no treatment at all, and that under-treatment is widespread, particularly for vulnerable sufferers, such as the elderly, people with dementia and people with substance use issues.

The underlying causes of chronic pain can be very difficult to determine. However, the leading identifiable cause is injury, commonly resulting from playing sport, or accidents.

**Obstacles to effective treatment**

One of the chief obstacles to treatment is stigma. ‘I always acknowledge to patients that I believe their pain is real,’ says Dr Penny Briscoe, Head of the Pain Management Unit at Royal Adelaide Hospital, highlighting one of the most distressing features of chronic pain. When pain and associated limitations continue long after an injury has healed, family, friends, employers and even medical professionals may respond with scepticism or misunderstanding.

Other obstacles are long waiting periods to access pain clinics and specialists; the complexities of multiple medications and unanticipated side effects; lack of access by GPs to proven pain-relieving drugs because they are unavailable on the
Pharmaceutical Benefits Scheme for that purpose (e.g. antidepressants and anticonvulsives); and a funding climate not conducive to innovative research.

Importantly, many patients experience a variety of personal circumstances that limit their motivation or capacity to engage in long-term pain management. Nicole Wiggins, Manager of the peer-based drug user group Canberra Alliance for Harm Minimisation and Advocacy, cautions that it is simply not practical for most of their clients to take on multiple therapies.

What works?

In spite of great strides over a short time in treating chronic pain, there is as yet no ‘magic bullet’. Pain management is an emerging field of study and practice, and firm positions on the best modes of treatment are difficult to defend.

Mild to moderate chronic pain is commonly treated with oral analgesics such as over-the-counter paracetamol and non-steroidal anti-inflammatory drugs, with vitamins, minerals, herbal and natural preparations also widely used. Drugs have limited usefulness. While most people reach for painkillers as a first resort, over time these are unlikely to provide relief because of increasing tolerance, and may cause harm at high doses.

Role of GPs

After trying over-the-counter products the next port of call for chronic pain sufferers is usually their GP, but patients also seek help from medical specialists, allied health professionals and/or alternative practitioners.

‘Psychological therapy, such as mindfulness, meditation and cognitive behaviour therapy, has been shown to work,’ says Penny Briscoe. ‘But we also need to upskill GPs on pain management.’

A promising initiative in this respect is the forthcoming online education program for GPs in pain management, developed jointly by the Royal Australian College of General Practitioners and the Faculty of Pain Medicine, and supported by a $200 000 grant from the Bupa Health Foundation.

Multidisciplinary models

The causes of chronic pain can be very difficult to diagnose. Pain specialists advise that patients should be thoroughly assessed by a team of health care professionals before a treatment regime is planned. The treatments that work for acute pain may not work for long-term chronic pain and may even exacerbate it.
A majority of people with chronic pain experience psychological and environmental changes that they cannot overcome without support, even when their pain diminishes. Pain management experts support a multimodal approach to guide treatment. Associate Professor Lynne Magor-Blatch, Executive Officer of the Australasian Therapeutic Communities Association points out that ‘better results come from psychological interventions such as acceptance commitment therapy, often in combination with medication, whereby a person comes to accept pain as part of their life and the resulting limitations, and then puts in place strategies to reflect their new level of functioning.

‘A holistic approach is key, but we must also be flexible. If medication helps someone to exercise, to have a life, then it’s useful. But we also encourage them to work with a physiotherapist or exercise therapist, because masking pain with medication can result in unknown physical damage.’

Taking control

A proven approach supported by many pain specialists, including Professor Cousins, is reflected in the title of a widely used Australian manual, Manage your pain. The intensive ADAPT program outlined in the manual does not promise to ‘fix’ pain, but to make it much less troublesome to live with through a long-term approach in which the sufferer takes an active part. The program draws upon many scientific studies and over 20 years of clinical experience and is particularly relevant to people whose pain is unresponsive to treatment.

Opioids and pain management

The National Prescribing Service (NPS) recommends that opioids should only be prescribed as part of a broader pain management plan and introduced on a trial basis. Patients should be carefully selected, clearly understand the goals of opioid therapy, be instructed about proper use and be closely monitored.

This is a crucial message. The past 25 years have seen a marked rise worldwide in the use of prescription opioids to treat moderate to severe chronic pain but evidence suggests that only one in three suffers benefits. Opioids can be very effective in treating cancer pain and some other types of chronic pain, but for some people and some conditions they are either ineffective or may actually aggravate pain. Adverse side effects from combining different drugs, and individual reactions, such as skin intolerance to morphine patches, can further limit the effectiveness of opioids and other pain relief medicines.

Some patients report being prescribed high doses of opioids from the outset, which over time have no effect in controlling the pain, as well as impairing their ability to function normally.

‘We’ve learned only recently that opioids taken long term at high dosage are implicated in serious physiological damage,’ says Penny Briscoe. ‘They act to suppress hormones such as testosterone and impact upon the hypothalamic pituitary function. Testosterone gives us drive and energy, so without it we become lethargic and unmotivated.

‘Long-term side effects can include compromised immune systems, fluid retention, osteoporosis and infection risk. As you might expect, patients who have managed to reduce or come off high dose opioids report feeling much better.’

Future directions

Much of the current research into pain and its management focuses on the role of the brain in both physical and emotional dimensions of pain, and in the action of drugs of dependence and the negative side effects of painkillers. Studies are also underway into disease-modifying drugs, novel therapies and biomarkers to guide drug development and clinical practice.

The most fruitful way forward would seem to be a three-way marriage between the special needs of each patient, a multidisciplinary coordinated approach to treatment and research, and an adequate allocation of resources to meet these significant challenges.

References

For a full list of references used in this article, visit: www.ofsubstance.org.au.
Nothing in Robin Room’s upbringing hinted that he might one day make a career in the field of alcohol and other drugs (AOD). Growing up near Sydney in a middle-class family, he spent much of his teenage years in boarding school, using his spare time for extracurricular activities rather than drinking or partying. Drugs were simply unheard of.

When Room finished school he suddenly found himself in New York after being chosen as a delegate for a youth forum run by the *New York Mirror*. Room remained in the United States and along the way he found himself admitted ‘more or less by accident’ to Princeton as an undergraduate in physics, only to change later to English literature after realising ‘that you really had to concentrate’ in physics and that his interests ranged more broadly.

In 1960, Room moved to the University of California, Berkeley, which was already a hotbed of student politics, and soon found himself involved in the budding student movement. ‘There’d been a hearing of the House Un-American Activities Committee earlier that year and a lot of students demonstrating against it got washed down the steps of City Hall with fire hoses. So it had become a siren call that everyone should head for San Francisco.’ He became a member of the student left movement at that time. ‘It was a very broad church. About half the folk in it were what we called red diaper babies – that is, their parents were lefties – and the rest were from wherever else we came from.’

By the time Room obtained his Masters in English Literature, he had decided that he really couldn’t see himself as an English professor. So he switched to sociology in pursuit of a deeper understanding of the mechanics of social change, in particular why social change is so difficult and why it happens so rarely.

In 1963, Room started on what he thought would be a two-month summer job in a project called the California Drinking Practices Study, which was surveying alcohol consumption in the general population. ‘It was a kind of new idea then. When I first worked there I thought it was as far away from my interests as it could be, because at that time we thought of alcoholism as something that never changed. At that point, until 1962 or so, the consumption of alcohol in the US had been quite stable. So it was only five years after I wandered into the field that I discovered that, boy there’s a lot of change that’s happened historically in AOD, and that it really is a wonderful place to study social change.’

Robin Room is a sociologist and researcher widely regarded around the globe as a pioneer in alcohol and drug research. After nearly 50 years working and living in the United States, Canada and Scandinavia, Room returned to Australia six years ago to become Director of the Centre for Alcohol Policy Research at Turning Point Alcohol & Drug Centre and a professor in Population Health at the University of Melbourne. Room is this year’s recipient of the Prime Minister’s Award for Excellence and Outstanding Contribution in Drug and Alcohol Endeavours. In conversation with Gideon Warhaft, he reflects on his accidental and eventful career.
people who were alcoholics and those who were social drinkers. Instead, there was a continuum. Also, ‘if you looked at people over time then people dropped into and out of having alcohol problems. It wasn’t something that people had for life necessarily.’

In 1991, looking for a new challenge, Room accepted an invitation to head the research section of the Addiction Research Foundation (ARF) in Toronto, Canada. ‘As a provincial agency we had a responsibility to be advising the government about alcohol policy. And so that brought me much closer to the coalface in terms of, “We’ve been doing all this research, what should we be advising people to do?” So I was involved both in policy research and also how that research relates to reality.’

While Room acknowledges that his time at the ARF brought a new role for him as an advocate, ‘fundamentally my view is that I’m a researcher and if someone asks me a question about what happens if you jiggle this lever, then it’s my job to tell them whether I agree with doing this or that. It’s my job to tell them honestly what the literature says and what it doesn’t say. I tried to distinguish my role as a technician, rather than as a relatively knowledgeable citizen, so I can tell you this is what happens if you do that.’

Room’s next move, which he describes as another ‘happy accident’, was to Scandinavia: first to Norway for six months and then to Sweden to set up and head the Centre for Social Research on Alcohol and Drugs (SoRAD). Unlike other Nordic countries, Sweden up until that point had no permanent AOD research department. During his time in Canada and at SoRAD, Room became an expert in alcohol control, particularly alcohol distribution monopolies. Room argues that alcohol control is essentially harm reduction for alcohol. ‘A simple way of putting it is that the alternative to prohibition was harm reduction in alcohol as well as drugs. In setting up these monopolies, or the Australian equivalent, liquor licensing laws, the argument was that we can have legal alcohol but we’ve got to control the harm. And there’s an awful lot that drugs can learn from alcohol about these models of control.’

After another seven years and facing Sweden’s mandatory retirement age, Room was lured back home (albeit to Melbourne, not Sydney) by Margaret Hamilton, the then director of Turning Point. By this time, of course, Australia had changed markedly from that time nearly 50 years earlier when Room last lived in his homeland. ‘I remember when I was 40, telling my mother that there was no job in Australia, because at that point it was true. It really wasn’t an environment for social scientists interested in alcohol research until after the National Drug Strategy in 1985. So Australia got a slow start, you might say, from that point of view. But I think Australia now really pulls its weight, or comes close. There’s some real success stories, around HIV/AIDS particularly. And no-one can take that away.

On the other hand, it went part way down the road of decriminalising personal use and possession of drugs and then got stuck, and it still seems stuck at this point, in fact.’

For young people coming into the AOD research field, Room’s advice is to do something you really enjoy doing. ‘I still stick to the rule that yes, there’s things that I’m paid to do and I’ll damn well do the other things that I think are important to do as well. It’s true, it doesn’t make for a very balanced life. But I think if you do good work then you’ll come out okay in the end as a researcher, even if it isn’t exactly what you’re being paid for. There are things that you think are important to get said, or to be studied. Often you can find a way that you can do it within the funding. If you can’t then it’s still worth doing.’

Room also believes it’s important not to become frustrated when the evidence derived from research work doesn’t swiftly translate into policy. ‘Evidence is only a part of the policy process. It’s no use imagining that there’s this mechanical thing where you go and settle it with an experiment and that’s what’s going to happen. Quite properly the political process is taking into account a lot of different considerations. There are two kinds of effects that research can have on policy. One of them is immediate – if you wiggle this lever then this happens, and that’s what everyone thinks of when they’re talking of evidence-based policy. But in some ways the more important effect is much longer term, which is around changing paradigms or changing ways of thinking about things. And as I’ve described to you I’ve been part of that for alcohol, in terms of that big shift in paradigm that happened, since the 1970s.’

To read more of Professor Room’s interview with Of Substance, visit: www.ofsubstance.org.au.

Professor Robin Room presents the Excellence in Media Reporting Award to SBS’s Luke Waters at this year’s National Drug & Alcohol Awards
Imagine the headlines if people with type 2 diabetes were denied medication to manage their condition because of a shortage of GPs to prescribe it. Yet that’s the reality for thousands of people unable to access opioid substitution therapy (OST).

Figures on pharmacotherapy use in Australia show that while the number of clients treated with methadone or buprenorphine rose from 39 000 in 2007 to almost 46 500 in 2011, prescriber numbers inched up by only 149 (NOPSAD, 2012).

This gap in the medical staff who prescribe is one reason why an estimated 10 000 to 30 000 people in Australia can’t get treatment for opiate dependence and why some areas have lengthy waiting lists for pharmacotherapy treatment. Travelling long distances or moving to other locations may be the only way some clients can access services – including clients recently released from prison and needing continuing pharmacotherapy.

It’s not just regional and rural areas that struggle to provide pharmacotherapy either. In her Sydney practice, Dr Kate Conigrave has one client who does a round trip of 300 kilometres to collect prescriptions because he lives in the Hunter New England Local Health District where the waiting list for local prescriber services is up to two years.

‘It’s not acceptable in a country like Australia that people are dying because of a lack of services,’ says Professor Conigrave, a spokesperson for the Royal Australian College of Physicians’ Chapter of Addiction Medicine.

One effect of the ‘drought’ of medical staff who prescribe is misuse of prescription opioids, she adds.

‘Having more “prescribers” would also reduce doctor shopping. We see a lot of deaths from opiate painkillers.’

So why aren’t more GPs involved in a treatment that helps stabilise clients and encourages long-term engagement in treatment?

‘Many GPs have heard stories of clients who are aggressive or manipulative. Some worry about the impact it might have on other patients in their practice, or they’re concerned they’ll be swamped by clients on pharmacotherapy and the practice will become focused on them,’ she explains. ‘For others, an experience with relapsing drug users in Accident and Emergency while working as a junior doctor is enough to put them off – or maybe they’ve seen clients at a public pharmacotherapy clinic who are disruptive perhaps because they’re taking benzodiazepines or have mental health issues.

‘But they don’t see the stable clients who get jobs – in my practice I see clients who’ve been in full-time employment for years. Clients with a GP prescriber who get their dose through a private pharmacy are usually getting on with life,’ says Conigrave who believes work as a pharmacotherapy prescriber carries real job satisfaction.

Wariness of chaotic clients is only one barrier to engaging more GPs. There are no financial incentives to encourage GPs to become prescribers, and pharmacotherapy patients don’t attract much income, says Dr Cameron Loy, a spokesperson for the Royal Australian College of GPs (RACGP).

‘Most patients will be bulk-billed and on a fee basis all you get is the Medicare rebate for a Level B consultation [$4.30],’ he says. ‘You make the most money in general practice by having as many patients as possible, but in the early stages of treatment a pharmacotherapy patient may be time consuming.’

Imagine the headlines if people with type 2 diabetes were denied medication to manage their condition because of a shortage of GPs to prescribe it. Yet that’s the reality for thousands of people unable to access opioid substitution therapy (OST).
It’s not just about money. Loy believes lack of peer support is why some GP prescribers discontinue the work and why many doctors who complete the six-hour Opioid Treatment Accreditation Course don’t opt to become prescribers despite accreditation.

‘The work can be isolating. You’re not always surrounded by other GPs who are also prescribers and there may be no-one to bounce off – or you may be working in a practice where pharmacotherapy is frowned on,’ he points out.

But Loy, a member of the Special Interest Group in Addiction Medicine at the RACGP’s Victoria Faculty, is a staunch supporter of integrating addiction medicine into general practice.

‘Addiction is common, yet there’s a reluctance to engage in it, even though GPs would come across someone with an addiction in their practice every day, although they may not realise it.’

His personal view is that knowing how to recognise and treat people with problems of dependence – whether it’s prescription opioids, benzodiazepines, alcohol or illegal drugs – is an essential skill for GPs and one that can be honed as a pharmacotherapy prescriber.

‘Addiction medicine is nuts and bolts general practice and should be a priority in our skill set,’ he says. ‘A GP practice is also the best place for an OST client to be. I would prefer a methadone patient to have a normal GP experience than go to a clinic with a security grille over the dispensing area and where they may feel marginalised. There will always be a small cohort of pharmacotherapy clients who are hard to manage but they can be seen by a public clinic.’

Attracting GPs

So what’s being done to persuade more GPs to prescribe pharmacotherapy?

If Kate Conigrave had her way, training to prescribe Suboxone would be integrated in the medical school syllabus and GP training, without the need for further accreditation. This would spread the workload, increase access to treatment and be good for clients because they wouldn’t all be clustered together, she says.

Although that’s not a reality, a policy change by Drug and Alcohol Services South Australia last year does allow medical practitioners to prescribe Suboxone for up to five opiate dependent clients without accreditation (although prescribers still need to obtain an authority from the Drugs of Dependence Unit). As a result, there are now over 100 Suboxone non-accredited prescribers. The choice of Suboxone (a buprenorphine/naloxone combination) reflects its better safety profile and reduced potential for diversion.

Expanding similar options in other states would shrink waiting lists and ease pressure on public clinics, says Dr Jeremy Hayllar, Clinical Director Alcohol and Drug Service, Metro North Health Service District in Brisbane.

‘In Queensland, two out of three pharmacotherapy patients are seen in public clinics, but some clinics are now closed to new patients for long periods. Supporting more-stable patients to transfer to their GPs would make room for new, less-stable patients in clinics,’ he says. Limiting patient numbers to less than five could also help make OST prescribing more acceptable to more-cautious GPs, Hayllar adds.

Shared care

Another approach which places small numbers of clients with a GP – and provides professional support to doctors – is a shared care program between a public clinic and local GPs in South Brisbane which has modestly increased prescriber numbers without any need for accreditation.

The project, managed by clinical nurse Mandy Woodbury from Peel Street Clinic, identified stable clients and asked them who their GP was. With the clients’ consent, the GPs were asked if they’d write pharmacotherapy scripts for these patients as part of their GP care. The Drugs of Dependence Unit provided authorisation for them to sign the scripts under the GP shared care model, while the clinic assured the GPs that patients could return to Peel Street if there were any problems or if a GP moved to another practice. As a result, 15 stable clients were moved to the care of nine GPs, freeing up more clinic places – before the funding for the project ran out.

A bonus of this program, soon to be rolled out by the Sunshine Coast and Gold Coast ATOD services, is that some of these GPs are now interested in becoming accredited prescribers. It’s a result that’s flowed from the shared care approach that gives GPs support and a safety net if things go wrong, says Woodbury.

Like Peel Street, Western Australia’s Drug and Alcohol Office (DAO) has recognised that GP prescribers need back-up. Community Drug Service Teams in regional areas support GPs by providing counselling and case

REGISTERED PRESCRIBERS, BY PHARMACOTHERAPY TYPE, AND STATE AND TERRITORY, 2011

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<th>NSW</th>
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<td>–</td>
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<td>0.6</td>
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management to clients on pharmacotherapy, allowing GPs to focus on medical assessments and treatment, says a DAO spokesperson. The hope is that this team approach will encourage more GPs to participate as prescribers.

Meanwhile in Victoria, Pharmacotherapy Development Officers Barbara Taylor and Maureen Chesler identify the state’s greatest areas of need and then headhunt GPs to fill the service gaps. Last year they recruited 120 GPs to do the opioid accreditation course, although not all have become active prescribers.

‘We’re like sales reps for the program and it’s mainly cold-calling. The Opioid Treatment Accreditation Course gives GPs 40 professional development points so that’s the “carrot”,’ says Taylor from the Victorian Department of Health’s Harm Reduction and Pharmacotherapy Services.

‘We also explain to them that there are likely to be drug-dependent people already in their practice who need pharmacotherapy.

‘We get a lot of “no’s”. The GPs we recruit are the ones feeling it is not appropriate to intervene.

As for the need for peer support, the RACGP is working to fill the gap. The RACGP’s Specific Interest Group in Addiction Medicine provides mentors for GPs prescribing pharmacotherapy, says Cameron Loy, while the RACGP’s Victoria Faculty has a Special Interest Group in Addiction Medicine providing professional support for high-volume prescribers.

Furthermore, the Victorian Government is embarking on a reform of the state’s AOD treatment services. Pharmacotherapy has been identified as one of six treatment interventions, and has been under the spotlight in discussions this year.

Tackling stigma starts in med school ...

Recruiting more GP prescribers also depends on changing attitudes among some doctors, says Kate Conigrave, who is also Professor of Addiction Medicine at the University of Sydney’s Medical School.

‘Drug dependence is often not recognised as a chronic condition, even though the literature and clinical experience suggest that a chronic relapsing pattern is typical,’ says Conigrave who believes that de-stigmatising drug dependence should start in medical school.

‘The University of Sydney has funding for this so that medical students spend time at a drug and alcohol service where they talk to clients having treatment. Typically the students’ jaws drop and their response is “but they’re ordinary people”,’ she says.

‘A lot depends on what’s on offer at different medical schools. Although Medical Deans Australia and New Zealand have an agreement to include drug and alcohol education in the curriculum, we don’t know how well this is implemented.’

Meanwhile in the Hunter New England Local Health District, which has seen a 200 per cent increase in pharmacotherapy patients in the last decade, interns now do rotations through the Newcastle clinic to provide early career exposure to addiction medicine.

... and with practice nurses

It’s not only GPs who need education about drug dependence – it’s important for practice managers and nurses too, says Cheryl Sobczyk, General Manager of Primary Health and Integrated Care at Bendigo Community Health Services in Victoria.

‘There have been cases where a GP has done the training to prescribe pharmacotherapy, but the practice nurses and practice manager have said “were not having those people in here”. It’s not enough to tackle the doctor – the doctor isn’t the first person the client sees,’ says Sobczyk, a former nurse herself.

‘We have to take away the stigma with drug and alcohol dependence like we have with mental health,’ Sobczyk adds. ‘It’s taken ten years but we’ve changed attitudes among the general public as well as health professionals – now we have to do the hard yards and change attitudes around the misuse of illegal and prescription drugs.’

For a full list of references used in this article, visit: www.ofsubstance.org.au.
Australia has one of the highest levels of methamphetamine use in the world, and drug and alcohol clinicians have often found the treatment of methamphetamine dependence challenging. In the early 2000s, there was an increase in both community concerns about methamphetamine-related violence and in the number of people seeking treatment for their use of the drug.

Against this background, the three-year Methamphetamine Treatment Evaluation Study (MATES) was established. Its aim was to find the most effective community-based treatment models.

One finding of interest was the role of residential rehabilitation in treatment. The study found residential rehabilitation produced a large but time-limited reduction in methamphetamine use, with very few people showing long-term recovery. That is, results were initially glowing, showing large improvements among people attending residential rehabilitation clinics. However, these improvements did not appear to outlast rehabilitation, with longer-term outcomes not much different to what we saw when people didn’t go to treatment.

Specifically, for every 100 people entering residential rehabilitation, there was a gain of 33 people being continuously abstinent three months after starting treatment compared to methamphetamine users who did not go to treatment or who only received detoxification.

This benefit fell to a gain of 14 people for every 100 treated having remained abstinent at one year after having started treatment, and six people at three years. Less stringent reductions in methamphetamine use (frequency of use and remission from dependence) yielded similar results.

These findings are challenging in many respects, but they have important implications for community-based drug treatment options. In this article, I explain how we arrived at these findings and their implications for providing drug treatment.

About the research

The findings mentioned above were derived from the Methamphetamine Treatment Evaluation Study (MATES). MATES is a prospective longitudinal cohort study of methamphetamine users who we tracked over three years, with follow-ups at three months after entry to the study, and again one and three years later.

Most of the cohort were recruited on entry to community-based drug treatment services in Brisbane and Sydney. Forty-one drug treatment agencies supported the project, and we have reported on data from clients recruited from residential rehabilitation facilities (n = 15) and detoxification units (n = 11). Unfortunately we received too few referrals from outpatient counselling services to report robust treatment outcomes for this mode of treatment.

The cohort also included a comparison group of methamphetamine users who were not receiving treatment, who were recruited from advertisements, needle and syringe programs and various other health and community services, and who screened for methamphetamine dependence, to ensure that they had similar levels of methamphetamine use to the treatment clients. We referred to this group as our quasi-control group.
We assessed levels of drug use, health and social functioning in treatment clients for the period immediately prior to their starting treatment, and then did follow-up assessments at three months, one year and three years after the clients had started treatment. We compared reductions in methamphetamine use that we saw among residential rehabilitation clients (n = 248) and detoxification clients (n = 112) to what we observed among the methamphetamine users who were not in treatment (n = 101).

In order to accurately compare treatment outcomes for the residential rehabilitation clients, detoxification clients and our quasi-control clients, we needed to account for any differences in the characteristics of these groups at the start of the study which might impact on their subsequent levels of drug use (e.g. severity of methamphetamine dependence, psychiatric comorbidity). To do this we used a novel statistical procedure called ‘inverse probability-of-treatment weighted estimators’. This method effectively matched the groups on a range of pre-treatment characteristics, including their level of methamphetamine use, polydrug use, motivation levels and psychiatric morbidity at the baseline assessment.

What we found

The first clear finding was that there was no difference in outcomes between the detoxification clients and our quasi-control group. This was true at each of the follow-ups, showing that methamphetamine users who attend detoxification do not do any better than methamphetamine users who did not receive treatment (from at least three months onward). Because there was no difference between the detoxification and the quasi-control clients, we combined these groups of clients to form a larger group, against which we compared the residential rehabilitation clients.

Residential rehabilitation clients, when compared to the quasi-control and detoxification clients combined, showed a large reduction in methamphetamine use three months after treatment. This reduction manifested as high rates of abstinence among the residential rehabilitation clients. Among residential clients, 53% had remained abstinent since starting treatment, compared to only 18% in the quasi-control and detoxification group. Once we adjusted these outcomes for differences in baseline (pre-treatment) characteristics, the level of continuous abstinence fell slightly in the residential rehabilitation group to 48%. Against the quasi-control and detoxification clients, this was a gain of 33%, or 33 in every 100 residential rehabilitation clients being continuously abstinent at three months. Similar results were seen for other patterns of use (i.e. dependence on methamphetamine and frequency of use), but the largest effect of residential rehabilitation was seen for abstinence.

Examining the outcomes for clients at one and three years showed that methamphetamine use patterns among residential rehabilitation clients tended to merge with that seen for the detoxification clients and the quasi-control group. The gains seen for residential rehabilitation were substantially diminished at one year, with the adjusted
rate of continuous abstinence being 20% for residential rehabilitation clients (cf. 7% in the control group), or a gain of 13 people in every 100 residential rehabilitation clients remaining continuously abstinent. This fell further at three years to a gain of seven in every 100 residential rehabilitation clients remaining abstinent (adjusted rates of 12% vs. 7% continuous abstinence).

An interesting observation was that there was an overall reduction in methamphetamine use in the quasi-control and detoxification groups over time. This reduction occurred most conspicuously between the baseline interview and the first (three-month) follow-up interview, and was largely due to a reduction in the frequency of methamphetamine use.

What does this mean for community-based treatment?

One clear implication from our findings is that detoxification should be provided in tandem with ongoing treatment rather than as a stand-alone treatment option. Detoxification, when provided alone, did not reduce rates of methamphetamine use compared to no treatment. The vast majority of clients attending detoxification were highly motivated to reduce their methamphetamine use and reported that they wanted to achieve abstinence. While detoxification may be necessary to manage the withdrawal syndrome that occurs on cessation of methamphetamine use, clients seeking detoxification need to be informed that detoxification alone is unlikely to alter their methamphetamine use in the longer term, and they should be linked into other treatment options after they complete detoxification.

A second clear implication is that although residential rehabilitation produces very large improvements in the short term, particularly in terms of abstinence, it is unlikely to produce long-term reductions in methamphetamine use for the majority of clients. Therefore, while residential rehabilitation is beneficial as a means of temporarily alleviating the harms from heavy methamphetamine use, efforts need to be put into developing strategies that will produce more durable reductions in methamphetamine use. To this end, we noticed that very few clients attending residential rehabilitation received follow-up care. Follow-up care may assist clients in transferring their skills to a real-world situation, beyond the drug-free environment provided in residential rehabilitation, and reduce their risk of relapse.

Finally, there were strong reductions in methamphetamine use regardless of whether treatment was provided. In the context of our study, these are likely to be due to participating in the study itself, with clients undergoing an intensive interview and follow-up. However, these changes are likely to also reflect background shifts in the availability of methamphetamine, as there were reductions in the availability of crystalline methamphetamine during the study period, which were anecdotal reported by participants. To some extent, these shifts in methamphetamine use were also likely to reflect natural remission from methamphetamine use, either the natural ebb and flow in the cycle of use, or a maturation out of drug use as people age. Indeed, the point at which people are recruited into studies, particularly if they are recruited from health services, is likely to reflect a peak in the cycle of methamphetamine use, as they are seeking health support for this reason. The subsequent interviews are likely to reflect a more typical or naturalistic picture of this population. We also excluded participants who had received treatment in the month before the baseline interview, whereas a proportion of participants were in treatment at the time of follow-up, which would have reduced their relative levels of drug use.

Regardless of the reasons behind the apparent remission from methamphetamine use, these findings highlight the need to include quasi-control groups in observational treatment outcomes studies, as exposure to drug treatment is clearly not the only factor influencing levels of drug use. Uncontrolled before-after run the risk of attributing changes in drug use due to other extraneous factors to drug treatment itself, and in doing so may overestimate the benefits that we gain from drug treatment.

In closing, community-based residential rehabilitation alleviates heavy methamphetamine use in the short term, but there is much scope for improving treatment outcomes in the longer term. To do this we need a better understanding of what specific elements of treatment are necessary to facilitate long-lasting reductions in methamphetamine use. We also need to ensure that detoxification is provided in conjunction with other treatment modalities, and not as a stand-alone treatment, as it does little if anything to alter the natural trajectory of methamphetamine use. This research has also highlighted a need to better understand the environmental and contextual factors that impact on drug use over time (e.g. availability of drugs, maturation out of drug use), as these factors appear to have a substantial impact on drug use in their own right.

Reference


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In 2011, the Australian National Council on Drugs (ANCD) identified the need to increase employment participation for people in the alcohol and other drugs (AOD) treatment system. Subsequently, Ms Wilma Gallet was appointed by Prime Minister Julia Gillard as Special Advisor on Employment Participation to the ANCD.

Gallet has worked for more than 30 years in employment services. She established The Salvation Army’s Employment Plus, developing it to become the largest community provider of employment services. She continues to work as a consultant to The Salvation Army, providing strategic advice on social policy and practice issues. She has also authored reports such as Finding my place, which addresses youth homelessness, and Turning off the tap, an approach to prevention and early intervention in homelessness.

In her current role, Gallet assists in preparing ANCD advice for the Prime Minister, ministers and relevant departments on how to better assist people with AOD issues into work. Announcing the appointment of Gallet, Dr John Herron (Chair of the ANCD) said it was necessary to overcome the barriers to employment that stigma and discrimination created for people with a history of substance use. It was also essential to address the bureaucratic complexity that can complicate the development of new programs and access to current assistance programs.

Here, Gallet talks to Of Substance about the challenges facing people recovering from AOD-related problems who want to enter the workforce.

**Stumbling blocks**

‘There are many issues that can impact on people with AOD use histories,’ says Gallet. ‘They include lack of confidence, low self-esteem, a poor or patchy employment history, lack of vocational skills, possibly a criminal record, poor physical health, and sometimes poor mental health.’

The ‘work first’ approach that is central to the current employment services framework can present specific challenges for people with AOD-related problems, particularly in relation to the participation requirements. ‘People are required to undertake certain activities when they are receiving income support benefits. If the person doesn’t do that activity, which might include turning up for an interview with their employment service, or attending a training program, they risk losing their unemployment benefits. In some situations, people are unable to comply with the participation requirement because of personal circumstances and this needs to be dealt with sensitively by case workers who are able to recognise and understand that people with complex needs require additional support and encouragement.'
The current employment services system also tends to focus on immediate placement and can take a one-dimensional approach rather than focusing more broadly on the biopsychosocial issues that impact on individuals. This means taking into consideration emotional health and wellbeing needs, physical health issues, relationship issues as well as the social context. People with AOD issues need special support from people who have a good knowledge of the complex issues associated with addiction, and who can assist them in understanding their addiction patterns and in developing coping strategies. This is the type of supportive relationship that can develop within AOD treatment programs.

**The difficulty of disclosure**

A major difficulty for people who have experienced AOD use problems is the stigma attached to their history. ‘Often when people have been through treatment programs they don’t want to disclose their addiction issues, either from personal embarrassment, or a fear that they might be judged and they don’t want employers or even Centrelink and employment service providers to know about it,’ says Gallet.

At Odyssey House Victoria, which offers treatment for substance use issues, residents are counselled to be discerning about revealing that they’ve completed a program there, says Eric Allan, Executive Manager of Residential Services. ‘We explain that there is a stigma attached, and that understandably employers are looking for people they can trust. We talk to them about appropriate disclosure.’

Allan knows former residents who waited until they had been working for a while before disclosing their history. ‘They were told point-blank by their employers that if they’d known at the first interview about their history they wouldn’t have taken a chance on them.’

One of the problems about not disclosing history is that clients can miss out on the additional employment services support that they need to help them to transition back into the labour market. The current employment services framework involves a tiered or streamed service system: Stream One services provide limited assistance to people who are assessed as job ready; Streams Two and Three provide more in-depth services for people with some barriers to employment; and the Stream Four service level provides additional support for people with significant needs. Job seekers are assessed through the application of the Job Seeker Classification Instrument to determine the level of service that best suits their needs.

‘The Job Seeker Classification Instrument relies on responses to a series of questions around age, education attainment, ethnicity, language, literacy skills, employment history, health issues and so on,’ says Gallet. ‘If a person does not disclose treatment for substance addiction, they may be directed into a Stream service that does not enable the level of service provision that they need to support them into employment. There are examples of some people with complex issues such as homelessness and alcohol problems who have not disclosed their history and so find themselves in the Stream One or Two services. This means they get only limited levels of help.’
THE TOLL GROUP AND THE SECOND STEP PROGRAM

In 2000, the Toll Group, Australia's largest logistics provider, was approached by the 'First Step Program' in St Kilda, Victoria. Impressed by the low cost and effective treatment provided, Toll committed to providing financial, administrative and IT assistance to the clinic.

Subsequently, Toll established the 'Second Step' supported program, designed to offer opportunities for employment for people with a history of addiction or criminal conviction. Each year Toll offers 35 positions through the Second Step program.

‘Although clients came through the treatment program at First Step brilliantly, they had nothing to replace their old lifestyle with. They found it difficult to find employment because of poor CVs and often criminal convictions as well,’ says Ruth Oakden, Senior Chaplain and Second Step Manager for Toll Group. ‘We saw that Toll could help by providing jobs to people who came through the program, people who were ready to join the workforce but couldn’t simply because of their addiction history.’

Roger Antochi, National Coordinator of the Second Step program and a former Second Stepper himself, understands firsthand the struggle of recovery. ‘Everyone deserves a second chance. These people need the opportunity to work, they have to survive. They want a roof over their heads, they want to put food on the table and not depend on benefits. Helping them gain meaningful employment is a way to prevent relapse.’

For more information about the Second Step program, visit: www.firststepprogram.org/home/services/employment-services.

THE BUSINESS OF EMPLOYMENT

The Australian Institute for Corporate Responsibility reports that although it may not often be publicly known, many companies employ people with criminal convictions. Strategies vary across Australia, but in Queensland, for example, two programs support ex-offenders into employment: Advance2Work and the Offender Reintegration Support Service. Advance2Work is an employment assistance program run through Queensland Corrective Services and the Department of Employment, Economic Development and Innovation and delivered in all correctional centres across the state. The Offender Reintegration Support Service offers a range of programs such as 'Bridging the Gap' and 'Stepping up Stepping Out', to help those transitioning back into the community.

The organisation Whitelion, a partner program to the Second Step program, works with young people who have had dealings with youth justice. One of the ways it provides ‘lifetime opportunities’ is to find employment for them.

‘These young people have a range of multiple and complex issues,’ says Jeff Hamilton, who runs Whitelion's employment program. ‘Most of them have current or past substance use issues. We create employment options and help them with training and work readiness and preparation. The Toll Group is one of our leading employers.’

The requirement for young people to be found employment by Whitelion is that they have their addiction managed, Hamilton says. Anyone still struggling with AOD-related problems is referred to specialist services. ‘But if the young person is on some sort of pharmacotherapy treatment, or if they engage in recreational AOD use that’s not going to impact on their work or their workplace, we’d look for employment for them.’

However, those employed by Toll Group must be totally abstinent. ‘A company like Toll operates a range of heavy equipment, so if someone is under the influence they would place themselves and their colleagues at risk,’ says Hamilton.

Reference

‘Employment provides an opportunity for people to enhance their life experience,’ says Gallet. ‘It provides an income and a sense of meaning and purpose, but we need to recognise that not all jobs are good jobs and not all jobs provide a positive benefit.

‘That's where understanding the individual is particularly important. If we place a person in the wrong kind of work it can have disastrous outcomes. The stress of the work, together with the pressure of juggling health issues or family commitments, can prove impossible. We also know there are sometimes negative workplace relationships, there may be a culture of workplace bullying, so if we place someone who's just been through a treatment program in a workplace where they feel under pressure and the environment is not healthy, it can set them right back.’

Gallet tells the story of a person who, having gone through a treatment program for alcohol dependence, went to an employment service provider for assistance in finding a job. The person had been a chef, and the employment service provider insisted on referring him to a chef's job. They couldn’t understand why he resisted taking the position. What the employment service didn’t know was that it was in his job as a chef that his problems with alcohol began.

Educating employers

Educating employers with respect to a range of target groups including those with AOD issues is critical, says Gallet.

‘These people need an employer who understands the issues and can offer flexibility in the workplace, particularly during the early months as the individual regains his/her confidence in the job. That’s not to say the employer shouldn’t expect the best from their employee. It simply means that employers need to give people a chance to prove themselves. In fact, most long-term unemployed people really want an opportunity to work, they want that sense of achievement and accomplishment that comes from being productive in the workplace.

‘There are some employers with a strong sense of social justice who are prepared to give people a chance. They’ve developed pathways in their companies for people who are ex-offenders and for people with AOD-related problems. Toll Group is a great example of a company that takes the time to provide on-the-job training and understand individual needs, and there are many others.’

A further challenging area is the issue of drug testing in the workplace. A person who is receiving pharmacotherapy treatment is at risk of failing some drug tests and therefore being excluded from potential work opportunities, Gallet says.

Building a trusting relationship

The central, essential element in delivering services to a person with AOD issues is the development of a trusting relationship with a support worker, says Gallet.

‘This is not always available through employment services – this is very much dependent on the Stream service that the person has been referred to, time constraints, and the skills and abilities of the employment case worker.

‘Trusting relationships tend to develop between the client and support worker more naturally within treatment programs, essentially because of the nature of these programs. They are usually longer term and involve frequent interaction between the support worker and the client and this facilitates the development of a supportive and trusting relationship. The support worker comes to understand what the particular stresses and triggers are for that individual. They can work with them to develop strategies to avoid those as they arise.’

A preferred approach would be to provide employment assistance concurrent with the treatment service, Gallet says. The job preparation or skill development activities could be interwoven into a treatment plan and provided within the AOD service setting.

‘If that’s not possible, at the very least we need to encourage stronger collaborative approaches that include a joint servicing arrangement where the employment services worker works very closely with the AOD support worker so they get a real understanding of how to address the significant barriers and individualised needs of that person.’
The term ‘harm reduction’ refers to the theory and practice of trying to reduce the harms of drug use rather than attempting to reduce or eliminate the behaviour. Although the term has been in use for many years, and can refer to activities other than drug use (see box), it is most often associated with illicit drugs, particularly the attempt to reduce or eliminate the spread of HIV and other blood borne viruses among people who inject drugs. Applied in this way, the principles and practices of harm reduction have also been referred to as ‘risk reduction’, ‘risk minimisation’ and ‘harm minimisation’ (the latter term often used in Australia to refer – somewhat confusingly – to the country’s broad drug policy principles rather than the specific practices of harm reduction). Harm reduction is regarded by some people as an evidence-based and public health-focused alternative to the moral or criminal prism through which drug use and addiction is largely viewed.

Although there has never been consensus on the exact definition of harm reduction, the UK-based organisation Harm Reduction International defines it as the ‘policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Harm reduction benefits people who use drugs, their families and the community … It is based on the recognition that many people throughout the world continue to use psychoactive drugs despite even the strongest efforts to prevent the initiation or continued use of drugs. Harm reduction accepts that many people who use drugs are unable or unwilling to stop using drugs at any given time’ (2010).

History

The origins of harm reduction practices dealing with drug use are widely thought to have sprung from the HIV epidemic in the 1980s, but they can in fact be traced back to the Rolleston report in Britain in the 1920s. The Rolleston Committee comprised a group of leading British physicians who argued that maintaining drug-dependent people on drugs might be necessary to help them lead normal and healthy lives.
useful lives. The Committee decided that addiction must be seen as a disease rather than a vice and recommended physicians should not be restricted in prescribing morphine or heroin to addicted patients. Known as the ‘British System’ of drug control, to this day there is a limited number of people who obtain legally prescribed heroin from their doctors.

But it was the HIV epidemic of the 1980s that ushered the term ‘harm reduction’ into the general vernacular. In 1985, Liverpool in the United Kingdom pioneered what became known as the Mersey Harm Reduction Model. An influx of cheap heroin had earned Liverpool the moniker of ‘Smack City’. With an estimated 20,000 people using drugs in a population of 2,500,000, and the realisation that HIV could be contracted through contaminated injecting equipment, the Mersey Regional Health Authority decided to follow the Netherlands’ example, which had introduced a needle exchange service the previous year. It set up the Mersey Drug Training and Information Centre and began operating its own needle exchange.

This model established many of the harm reduction principles that have informed programs in other jurisdictions, including Australia. Services had to be easy to access, staff had to be non-judgmental and user-friendly, and interventions had to be tailored to the specific population at risk. Methadone and outreach programs were also offered.

Another feature of the Mersey Model that would be reflected in other programs was the attitude of the police, who had become tired of continuously arresting the same people. Agreeing to a new approach, they stayed away from the vicinity of drug user services, referred those they arrested to the needle exchanges and refrained from arresting people for possessing drug-using equipment. This practice of police operating within a ‘grey zone’, of using discretion rather than following the strict letter of the law, has been an important (and sometimes controversial) aspect of harm reduction models.

The success of the Mersey Model was that there was ‘a reduction in sharing of needles and syringes and use of street drugs. Many more people were attracted into services who had never been before. Some people who had been injecting heroin for 25 years made their first appearance at a drug service. A range of physical problems relating to injecting drug use were found and dealt with. The drug-using population of Merseyside became healthier and more knowledgeable. In the late 1980s, Liverpool was responsible for about one third of the methadone prescribed in England. An HIV epidemic did not happen amongst injecting drug users in Mersey’ (O’Hare 2007).

The Swiss model

At around the same time as the Mersey Model was developing in the UK, in Switzerland HIV had hit the injecting drug user population with a vengeance, precipitating a rapid move away from abstinence as the only goal of drug policy. People were encouraged to stop injecting in toilets and instead use public parks, where injecting equipment was provided. The Swiss authorities provided easy access to the services, thus spreading HIV-prevention messages and helping some people get off drugs altogether.

In 1986, Switzerland took the next step in establishing harm reduction as the basis of its drug policy, opening its first injecting room. In 1993, this was followed by the introduction of a heroin prescription program, which still operates.

Australia embraces harm reduction

In Australia, harm reduction strategies were first flagged in 1985, when the Government’s National Campaign Against Drug Abuse stated: ‘The aim [of the campaign strategy] is to minimise the harmful effects of drugs on Australian society.’ The following year, the Director of Drugs and Alcohol at St Vincent’s Hospital, Alex Wodak,
HARM REDUCTION

became so alarmed at the prospect of HIV spreading through the sharing of injecting drug equipment that he began dispensing needles and syringes illegally to people who injected drugs in Darlinghurst. The Hawke Labor Government, supported by the Opposition of the day, responded by setting up a national needle and syringe program (NSP). It wasn’t until the Ministerial Council on Drug Strategy’s National Drug Strategic Plan in 1993, however, that the term ‘harm reduction’ was officially used and the three pillars of Australia’s drug strategy were formulated: Supply Reduction, Demand Reduction and Harm Reduction. Unique to Australia, these three pillars collectively have become known as ‘Harm Minimisation’.

Although NSPs in Australia continued to evolve with support from the public (and admiration from harm reduction advocates around the world), it wasn’t until 2001 that Australia saw its first injecting centre. In 1999, in the midst of a glut of cheap, high-purity heroin and a spate of fatal overdoses, the Wayside Chapel in Sydney’s Kings Cross set up an illegal injecting centre on its premises, forcing the New South Wales Government to act, which it did by hosting the NSW Drugs Summit. The main recommendation from the Summit was to begin an injecting centre trial in Kings Cross, and after a period of legal wrangling, Australia’s only legal injecting room, the Medically Supervised Injecting Centre (MSIC), was established. Unlike NSPs, the MSIC’s primary aim is to prevent drug overdoses rather than reduce blood borne virus transmission. To date the centre has treated thousands of overdoses without a single fatality.

For many harm reduction advocates, the next step is for Australia to establish a heroin prescription program, similar to those currently operating in Switzerland, the Netherlands, Germany, the United Kingdom and Denmark.

HARM REDUCTION: PROS et CONS

The effectiveness of harm reduction programs in Australia, particularly NSPs, is perhaps best demonstrated by the fact that all major political parties have either maintained or increased the program’s funding, often while at the same time espousing zero-tolerance, anti-drug rhetoric. This is because study after study shows that HIV prevalence in countries with NSPs is much lower than those without. By 2010, for example, the estimated HIV prevalence in Australia was 96 per 100 000 population, compared with 469 per 100 000 in the United States. HIV prevalence among people who inject drugs in Australia remained at around 1 per cent by 2010, whereas in the US injecting drug users accounted for 9 per cent of new HIV cases (Kirby Institute 2011).

In the first 10 years of the Medically Supervised Injecting Centre (MSIC) in Kings Cross, nearly 4000 drug overdoses were managed without any fatalities, and ambulance call-outs for overdoses in the area were reduced by 80 per cent. In addition, more than 9000 referrals to health care services and drug treatment centres were accepted by people using the centre (Jauncey 2011).

There is also strong evidence of the cost-effectiveness of harm reduction programs. Australia, for example, invested $243 million in NSPs between 2000 and 2009, resulting in an estimated 32 050 cases of HIV prevention, 96 667 cases of hepatitis C prevention, and an estimated saving to the health system of $1.28 billion (ANEX 2009).

CRITICSMS

The main criticisms of harm reduction are that it encourages people to continue using drugs and that it sends a message of tolerance to the community. There is no evidence that either NSPs or injecting centres increase injecting drug use: the estimated number of people in Australia who have injected drugs has remained at about 2 per cent for decades (Dolan, MacDonald et al. 2008). Governments across Australia continue to promote zero-tolerance messages about drugs and there is no evidence that harm reduction programs dilute the effectiveness of these messages.

Another criticism of harm reduction is that it forces the police to apply discretion towards illegal activity in certain areas and therefore weakens the absoluteness of the rule of law. However, NSPs across Australia and the MSIC in Kings Cross have operated without impinging on police operations, and many police acknowledge that the community is safer and their work more manageable because of harm reduction programs.

Philosophy and practice

Harm reduction refers to both a philosophical approach and to practical interventions in dealing with illicit drug use. Although there are no agreed principles underpinning the term, many harm reduction advocates accept that drugs are a part of society and will never be eliminated, oppose the stigmatisation of people who use drugs, believe that tolerance and respect should be shown towards people who use illicits, and believe that social determinants such as class, race, income and education make some people who use drugs particularly vulnerable to unjust treatment. They argue that harm reduction should be evidence-based, cost-effective and easy to implement, and have a high impact on both individual and community health. There is disagreement, however, about the extent to which harm reduction should be framed within a broader human rights agenda, with some advocates arguing that harm reduction should become an extension of the drug user rights movement, or even progressive political movements more generally.

It is in the United States where the philosophy underpinning harm reduction is perhaps most energetically challenged. The US has traditionally focused on reducing the prevalence of drug use as its top priority and harm reduction has been seen by many as tacitly endorsing drug use (‘sending the wrong message’) and an inappropriate use of taxpayer money. The US has been notable for its lack of leadership or innovation in the harm reduction
HARM REDUCTION HAS BEEN SO SUCCESSFUL BECAUSE PEOPLE WHO USE DRUGS HAVE EMBRACED AND OWNED THE STRATEGIES.

field. Only some states have government-sanctioned NSPs, and these are often stiffly regulated and limited to major cities. Although President Barack Obama repealed the decades-old ban on federal funding of NSPs in 2009, the US Congress reinstated the ban in 2011. This lack of commitment to a nationwide NSP has resulted in an average of 23 needles and syringes being distributed per person who injects drugs in the US, compared to 202 in Australia, and a correspondingly much higher rate of HIV infection among people who inject drugs (Harm Reduction International 2012).

The US does have one harm reduction program yet to be implemented in Australia, however, which is the distribution of naloxone to injecting drug users to help revive their peers in the event of overdose. In 2010, the country had 50 community-based naloxone programs operating in 15 states and Washington DC, and since the program began in 1996, over 50 000 naloxone kits have been distributed. Although in Australia harm reduction has largely been associated with NSPs, the MSIC and the methadone program, there has been a variety of other harm reduction strategies in other countries. For example, in Europe and the United Kingdom, ‘party safe’ strategies have included pill testing whereby ecstasy can be tested for unsafe or undesired ingredients. In some areas where methamphetamine is widely used, clean pipes have been promoted as a safer alternative to needles and syringes. In several provinces in Canada ‘safer crack kits’ consisting of clean pipes and mouthpieces have been distributed to help prevent cuts and burns to a user’s lips that might cause the spread of diseases.

Ownership by people who use drugs

One reason harm reduction strategies have been so successful in countries such as Australia is that people who use drugs have embraced and owned the strategies. When NSPs were launched in the 1980s, consumers were quick to embrace the scheme, educating themselves and their friends about how to use the equipment properly and why it was important. Many people argue that this peer model of information exchange, where one consumer educates another, has been central to the success of harm reduction in Australia.

New adopters of harm reduction

Until the last decade or so, harm reduction programs have largely been confined to Western Europe, North America and Australia. However, in recent years many countries in Asia, Latin America and Eastern Europe have started rolling out their own programs, particularly NSPs. Countries such as Vietnam, Indonesia and Malaysia have cautiously embraced NSPs to tackle their growing HIV infection rates — often with the guidance, encouragement and experience of Australian harm reduction practitioners.

Referral to other services

One of the benefits of harm reduction programs is the ability to refer people to health care facilities or drug treatment programs. Many harm reduction advocates argue that the social marginalisation experienced by people who use drugs is as damaging, or even more so, than the effects of the drugs themselves. Harm reduction programs can provide these people with access to services such as health care, dental care, accommodation services and so forth that they would not ordinarily come across.
upcoming events

9–10 November  
Australian Drug Court Conference  
Melbourne, Vic  
www.aija.org.au

13–15 November  
Family & Relationship Services  
Australia National Conference  
Darwin, NT  
http://familyservices.squarespace.com

14–15 November  
Congress Lowitja: Knowledge Exchange and Translation into Practice  
Melbourne, Vic  

15–16 November  
NSW Health Promotion Symposium  
Sydney, NSW  

15–16 November  
Connecting with Families: Through Community, Culture and Collaboration  
Melbourne, Vic  

16–17 November  
Children Communities Connections Conference  
Adelaide, SA  

17–18 November  
Profound Healing: Sustainable Wellbeing Conference  
Melbourne, Vic  
www.gawler.org/speakers

18–21 November  
APSAD Conference 2012  
Melbourne, Vic  
www.apsadconference.com.au

21–23 November  
Australian and New Zealand Third Sector Research Inc Conference  
Hobart, Tas  
www.anztsr.org.au/conferences.html

22–24 November  
Youth Cultures, Belongings, Transitions: Bridging the Gap in Youth Research  
Brisbane, Qld  

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