HIV & DRUG USE IN ASIA
Australia’s response

PREVENTION IN AUSTRALIA
The big picture

LIFTING THE PROFILE OF ALCOHOL
NSW Summit outcomes

RESEARCH ON ILLICIT DRUG USE
Monitoring & reporting systems

QUITTING SMOKING in other treatment settings

RESEARCH ON INDIGENOUS ISSUES, NEWS, RESOURCES AND MORE...
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Managing Editors:
Julia Tesidder and Kate Pockley
Of Substance contact details:
Email: editor@ancd.org.au
Telephone: 02 6279 1650 or write to us:
Of Substance, PO Box 1552,
Canberra ACT 2601 Australia

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Recent releases.
Summary and highlights from the newly released Prevention monograph.
How this new report lifts the profile of alcohol-related harm, plus three perspectives on the future for alcohol services in NSW.
Australian partnerships help assess the crisis and meet the challenge.
Research and new guidelines to help clients undergoing treatment for opioid dependence.
Illicit drug data collection in Australia: a profile of two monitoring and reporting systems.
The prevention and treatment service needs in the ACT for the Aboriginal and Torres Strait Islander community.
Indigenous Australia and alcohol policy: meeting difference with indifference.
Prevention is a major theme in this issue of Of Substance. Two recently released reports, the Australian Government-funded Prevention monograph and the NSW Government’s Alcohol Summit Outcomes report, emphasise the need for both evidence-based and whole-of-government responses to maximize prevention outcomes. We outline the content of both reports and provide perspectives from a range of people in the alcohol, tobacco and other drugs (ATOD) sector.

The need for treatment services to think about polydrug use is highlighted by two articles about the high rates of tobacco smoking amongst people undergoing treatment for opioid dependence. Tobacco is the major cause of mortality in Australia, when all drugs are taken into account, and therefore more could be done to assist people who are stable on other drug treatments to quit smoking.

Asian countries are grappling with epidemics of HIV/AIDS and injecting drug use. As a follow up to our coverage on the South East Asian crisis in the April 2004 issue, we have included an article on how Australia is helping to contain these epidemics. Australia’s successful experience with harm reduction as a prevention measure to contain these epidemics is being shared with the region.

Regular population surveys document Australia’s alcohol and other drug use. The ATOD field also has two other monitoring and reporting systems to assist in the response to emerging trends in illicit drug use, and these are profiled in this issue. Indigenous research partnerships are important in highlighting where mainstream policy and programs are not adequately addressing the needs of our Indigenous communities; we continue to cover recently released research on this issue.

Of Substance fills a gap in the dissemination of research to the ATOD field. Another gap is being filled by a new online database of current ATOD research projects. We profile how this new database can assist stakeholders in the field to find out about current research.

We have also introduced a news and debate section, and we welcome your feedback about these pages. Finally, in this issue we present an index of all topics and articles published to date – this will be a feature of each October issue of the magazine.

Julia Tresidder and Kate Pockley
Managing Editors
Ph: (02) 6279 1650
Email: editor@ancld.org.au

GUEST EDITORIAL

PREVENTING RISKY SUBSTANCE USE AND HARM
TIM STOCKWELL, CENTRE FOR ADDICTIONS RESEARCH OF BRITISH COLUMBIA, CANADA

I am delighted that Of Substance is featuring the Preventing Risky Substance Use and Harm Monograph that was produced jointly by the National Drug Research Institute (NDRI) and the Centre for Adolescent Health for the Ministerial Council on Drug Strategy (Loxley et al. 2004). I was happy to help launch the final report in Melbourne with Wendy Loxley and John Toumbourou in my last week as Director of NDRI. This was the culmination of nearly four years of collaboration which also involved some 20 other researchers from Australia and North America.

The Australian Government Department of Health and Ageing had the vision to set some very large questions and I think the group responded well to the challenge. What emerged was not just a review of the evidence base for a wide range of interventions but also a new way of thinking about prevention in a much broader context. We considered issues of human development across the lifespan, social determinants of health and patterns of substance use, and how treatment can also be preventive. As well as the need for multiple interventions that can reduce population levels of harm, we also thought through whether there are effective strategies that simultaneously address other risk-taking behaviours and mental health problems.

A number of core themes emerged. One was the importance of harm reduction approaches for both legal and illegal drugs. Then there was the as yet unrealised potential for broad-based early and late childhood interventions with possible multiple benefits including reducing levels of risky substance use. For me, the overarching theme was the need to give greater priority to the legal drugs given that (i) tobacco and alcohol contribute over 90% of preventable death, disability and years of life lost from risky substance use (ii) ‘mainstream’ average young people contribute most of the incidence of risky use of these drugs and (iii) most of the effective interventions identified were for whole-of-population approaches to tobacco and alcohol.

It is quite striking how the investment in prevention is still at odds with these emerging patterns of evidence. A reduction in population-level deaths from risky substance use requires increased resources; it also requires political priority to be given to regulatory and law enforcement responses to legal drugs, as well as more investment in harm reduction strategies for illegal drugs. That there is such disparity is not just down to the difficulty of selling effective prevention to the voting public – there is clear evidence of popular support in Australia for some effective strategies. Effective prevention does not always have to be unpopular and I hope that the monograph will support Australian efforts to further narrow the gap between policy and research.

RELEASE OF THE NATIONAL DRUG STRATEGY 2004-2009


The Strategy follows from the National Drug Strategic Framework 1999-2003-04 and provides for the continuation of collaboration across sectors, and a balance between law enforcement and health, to address drug-related problems in Australia.

The Strategy’s three pronged approach of demand, supply and harm reduction has been maintained. Eight priority areas have been identified: prevention, supply reduction, harm reduction, improving access to quality treatment, development of the workforce, organisations and systems, strengthening partnerships, implementation of the National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2006, and responding to emerging trends.

The new Strategy was informed by the findings of an evaluation and a public consultation process that was undertaken in March/April 2004. The comments raised in submissions were mostly supportive of the key elements of the Strategy and many of the comments were useful in informing further revisions that were subsequently made.

The Strategy will be complemented and supported by supplementary documents that will provide more detailed information about activities and initiatives.

The Strategy is available at the National Drug Strategy website – www.nationaldrugsstrategy.gov.au

TOBACCO WARNING LABELS DECISION

Health groups have criticised the recent back down by the Australian Government on the introduction of new graphic health warnings on tobacco products, citing tobacco industry influence. Federal Treasury released a revised Regulation Impact Statement on May 26, 2004. The statement proposes that tobacco companies do not have to introduce new health warnings until early 2006. This represents a significant delay in warning consumers about the link between smoking and several diseases. The revised statement may also result in a reduction of the size of the mandatory warnings from the proposed 50% to 30% on the front of the packets.

A number of prominent organisations have spoken out against the decision:

- The Australian National Council on Drugs issued a press release expressing its dismay at the attempt by tobacco companies to delay and reduce the introduction of graphic warning labels on cigarette packets. The ANCD unanimously believes that any product that kills more than 19,000 people is responsible for over 142,000 hospital admissions each year should be regularly subjected to the introduction of extremely strong and prominently displayed warnings on its use.

- Anne Jones of Action on Smoking and Health (ASH) Australia says: ‘Smokers and potential smokers – especially children – deserve better protection. If just one per cent of the 19,000 lives lost prematurely to tobacco smoking in Australia could be saved by the increased quitting and reduced uptake strong effective warnings could produce, then for each month of delay more than 15 Australians are dying whose lives would otherwise be saved.’

- Andrew Ellerman of The Cancer Council Australia states: ‘All smokers have basic consumer rights to truth and safety. Yet both have been denied and fought by tobacco interest groups to protect their own commercial self-interests.’

- Maurice Swanson of the National Heart Foundation of Australia says: ‘We urge the government not to cave in to the interests of tobacco companies but to put public health and consumer rights first – without further delays.’

For more information about the INCB see www.incb.org

ANCC CHAIR ELECTED TO INTERNATIONAL BOARD

In May 2004, Major Brian Watters was elected to the International Narcotics Control Board (INCB). He will be a member of the INCB for five years. The INCB promotes compliance with the international drug control treaties and monitors the use of narcotics and psychotropic substances for research purposes. Prime Minister John Howard said in his press release about the election of Major Watters:

Major Watters is a leading and influential figure in the field of narcotics control, with almost 30 years experience as both a policy advisor to governments and a drug treatment practitioner. In 1996 Major Watters was appointed Chair of the Australian National Council on Drugs, the peak drugs advisory body of the Australian Government.

Major Watters was made an officer of the Order of Australia (AO) in 2003 for outstanding services to the Australian community in the field of drugs policy development and the provision of drug treatment.

For more information about the INCB see www.incb.org
Recent releases

LOCAL GOVERNMENT RESOURCE ON ALCOHOL

A new report showing how local governments across Australia are implementing projects to minimise the harms from alcohol misuse was released in July by the Federal Parliamentary Secretary for Health, Trish Worth.

In launching the report, Ms Worth said local governments are ideally placed to provide frontline programs that protect communities from the social and economic costs of alcohol misuse. Examples include the use of town planning schemes and Planning Acts to control the type, number and trading hours of licensed premises, and the use of ‘alcohol-free’ zones.

The report, titled ‘Australian Local Government: Alcohol harm minimisation projects’, includes a best practice guide for local governments to implement effective programs designed to minimise the harm associated with alcohol misuse.

Copies of the report are available from the Department of Health and Ageing and can be accessed at www.health.gov.au.

RISKY BUSINESS RESOURCE FOR INDIGENOUS YOUTH

‘Risky Business’, a new Streetwize Communications comic and Educator’s kit, was launched as part of National Drug Action Week 2004. The first of its kind in Australia, the resource provides education about substance misuse for young Indigenous people aged between 12 -16 years. The comic was launched in Adelaide, South Australia by Director of the Aboriginal Drug and Alcohol Council, Mr Scott Wilson.

Citing a lack of cross-cultural training for workers in the youth sector, Mr Wilson said, ‘The Risky Business Educator’s kit is a great tool for Indigenous and non-Indigenous workers to educate young people about the wider impact substance misuse has on the future of their communities.

Streetwize researchers conducted focus groups addressing the issue of substance misuse with Indigenous young people in South Australia, New South Wales and the Northern Territory in rural and metropolitan areas in May 2003. Research indicated that the substances most commonly used included alcohol, marijuana and cigarettes mixed with household prescription drugs.

Streetwize General Manager, Liz Skeleton said, ‘Risky Business explores protective behaviours, such as good family relationships and support networks, and harm minimisation is a key strategy. The comic depicts culturally relevant role models and scenarios young Indigenous people at risk may relate to.’

Over 25,000 copies of Risky Business will be distributed throughout Indigenous-specific youth, community and neighbourhood centres. For further information contact Kate Smith: kates@streetwize.com.au or phone (02) 9319 0220.

Drug and mental health booklet

‘Double Trouble: Drugs and Mental Health’ is a booklet jointly produced by the National Drug and Alcohol Research Centre and the Mental Health Services Conference Inc. of Australia and New Zealand.

One in five Australians will experience a mental illness. One of the factors that may trigger mental illness is the use of alcohol and other drugs. This booklet examines the link between drug use and mental health problems by firstly describing the most commonly reported mental illnesses – anxiety, depression and schizophrenia. It then gives specific information on what the research tells us about the link between specific drugs and mental health, including alcohol, cannabis, amphetamines, ecstasy and heroin.

This booklet is now available and the order form is accessible through the following website: http://ndarc.med.unsw.edu.au/ndarc.nsf/website/Publications.resources

The booklet is available at the cost of $1.80 each with a minimum order of 20 copies.

Policy debate

Alex Wodak, Director, Alcohol and Drug Service; St Vincents Hospital, NSW presents his case for… the need for fresh ideas in Australia.

The large number of people acquiring hepatitis C infections each year and other injecting-related health and social problems is a major concern in Australia. Two-thirds of female and more than one-third of male inmates in NSW prisons have hepatitis C. High rates of hepatitis C among injecting drug users is a growing concern in many countries. We can expect increasing numbers of people in the future with serious and costly health and other problems related to hepatitis C. HIV infection rates are still lower in Australia than among our neighbours in South East Asia, but with no vaccine or cure in sight, maintaining low infection rates will be a major challenge.

The number of drug overdose deaths is unfortunately increasing again after the welcome fall following the start of the heroin shortage. Property crime has increased substantially in recent decades only to fall somewhat in recent years. Police corruption linked to illegal drugs continues to surface frequently in one part of the country or another. Finding more effective ways of controlling the health and social complications of drug injecting is of utmost importance to the health and wellbeing of the nation.

Few people realise that Australia had few ‘heroin’ or injecting drug use problems when heroin was available legally. It is only since heroin was prohibited that Australia’s serious drug problems developed.

In May 1953, over a half century ago, the Commonwealth government overrode objections from the states and the medical profession and banned the importation and production of heroin. The Director-General of Health in New South Wales, the British Medical Association (later to become the Australian Medical Association), the Royal Australasian College of Physicians and the Royal College of Obstetricians and Gynaecologists were among those to declare that ‘the use of heroin should not be prohibited’. Nevertheless, the Commonwealth advised the state premiers in May 1953 that the production and importation of heroin was to be prohibited. Until the states and territories subsequently ran out of heroin, it was only prescribed by doctors and dispensed by pharmacists under careful controls, much as it had been for many previous decades and much as other drugs derived from the opium poppy are still used medically today.

The ban on the importation of heroin was introduced largely due to external pressure from the Permanent Central Opium Board, the forerunner of the International Narcotics Control Board. The involvement of the United States in this intervention has long been suspected but never confirmed.

Before heroin was prohibited, very few people used illicit heroin in Australia. Significant illicit heroin use in this country began a decade and a half after heroin was prohibited when US servicemen in the late 1960s, briefly visiting on leave from the Vietnam War, introduced the drug and the practice of injecting to young Australians. Once introduced, heroin injecting, and then later other illicit drug use, increased rapidly. Drug arrests in New South Wales grew fourfold from 173 in 1972 to 909 in 1977 while overdose deaths increased threefold from 14 in 1974 to 49 in 1976.

Australia’s experience with illicit drugs during the twentieth century was common to most industrialised and later many developing countries. Global drug prohibition had started slowly at the beginning of the twentieth century but included virtually all nations by the end of the century. The international community gathered at the United Nations in New York in 1998 to take stock of global drug prohibition and contemplate a new slogan (‘a drug free world, we can do it’). AIDS, the most serious global public health threat since the Black Death, is still gathering pace. In most countries, sharing of needles and syringes is either the major or the second most important risk factor for HIV infection.

In many countries, a deeply entrenched commitment to solving drug problems by relying on law enforcement rather than a more balanced health and social approach has tragically prevented or delayed the introduction of proven means of effectively controlling HIV infection, such as needle syringing and methadone programs.

In April 2003, the half term review of the 1998 UN commitment to eliminating or significantly reducing heroin, cocaine and cannabis use by 2008 was held at the UN in Vienna. The United Nations Office on Drugs and Crime declared improbably that ‘encouraging progress had been made to still distant goals’, even though global drug production and consumption showed no overall reduction from 1998 and even though drug-related problems had deteriorated substantially in many parts of the world.

The extent to which domestic law enforcement has contributed to the heroin problem shows that Australia is not isolated. While the dramatic reduction in overdose deaths is welcomed, there have also been some concerning negatives. The sustainability of the benefits is still uncertain. Heroin availability has increased from its post 2000 nadir but has not yet returned to pre-shortage levels.

When drug treatment becomes more accessible and more attractive to drug users than street heroin sold by criminals, real progress will be made. New treatment options are needed. A heroin prescription trial is required for those few severely dependent heroin users who do not benefit from multiple attempts at diverse treatment options. The evidence base for this approach continues to slowly improve. If improved treatment reduces the demand for heroin, then the supply of heroin will also diminish.

Law enforcement currently attracts the overwhelming majority of funding with little left for other options. More needs to be done to make drug treatment more attractive and more widely available. In Switzerland in 1997, 71% of voters in a national referendum supported retaining the option of heroin prescription for treating refractory, severely dependent heroin users.

A recent Australian Government commissioned report on HIV prevention (Loxley et al. 2004) found that mounting evidence supports a heroin prescription trial. Australia has had the political will for two decades to prevent an HIV epidemic through needle syringing programs and methadone programs in the community and in jails. It’s time for some fresh ideas to reduce our nation’s drug problems.
A new monograph highlights that drug misuse costs the Australian community $34 billion and causes the premature deaths of over 20,000 Australians annually.

According to the monograph, The prevention of substance use, risk and harm in Australia: A review of the evidence, much of this harm is preventable. Anyone wanting to further explore the notion of the prevention of drug-related harm will find this a useful reference.

There are three primary authors: Associate Professor Wendy Loxley and Professor Tim Stockwell from the National Drug Research Institute in Perth, and Associate Professor John Tournourbourou from the Centre for Adolescent Health in Melbourne. The monograph also acknowledges contributions from other Australian researchers. It was commissioned by the Australian Government Department of Health and Ageing.

The monograph addresses the three pillars of Australia’s current drug policy: supply reduction, demand reduction and harm reduction. All three are defined by the report as prevention: as they all contribute to the minimisation of harm. A key feature of the report is its overview of evidence indicating how supply reduction, demand reduction and harm reduction policies can be integrated to prevent drug-related harm.

An overview of the Prevention Monograph

The monograph is wide ranging and compiles information on:

- the prevalence of drug use in Australia and the harms associated with it
- theoretical approaches that can be used to explain drug use
- evidence for the success of prevention programs across sectors.

There is a useful summary document that accompanies the monograph; this provides an overview of the content and leads to a summary of the recommendations covered in the framework for action. The monograph itself is a useful reference and much can be gained from just reading the chapters that address specific areas of interest. The following is a brief overview of its structure.

The first six chapters outline what is known about alcohol and drug-related harm and how a range of social and cultural factors are associated with harmful drug use. The background chapters summarise complex social science perspectives about social disadvantage, cultural difference and the evidence from longitudinal studies that has been the basis for understanding the development of drug use across the life course and for defining what are referred to as ‘risk and protective factors’. These factors are used to help explain an individual’s risk of adverse outcomes including harmful drug use. The following is a short overview of some of these background chapters.

Social disadvantage

The monograph discusses the link between social disadvantage and poor health. It points out that the links between social disadvantage and alcohol and other drug use are not straightforward. Tobacco use is more prevalent amongst people who are socially disadvantaged and poor. This higher prevalence of tobacco use increases the poor health outcomes for this group. However the links between social disadvantage and poverty with alcohol consumption are less clear, as people with higher disposable income often consume more alcohol than those with less disposable income.

Cultural differences

The report highlights that cultural differences have an effect on the patterns of drug use amongst different communities. Some of the more recent migrant groups to Australia have a lower prevalence of drug use than the general population. Indigenous Australians however are a group that are considered at high risk. Much of this risk may be explained by the fact that many Indigenous Australians live in poverty. Other factors that have contributed to this disadvantage include the ongoing effects of both federal and state government policies after colonisation that displaced many Indigenous Australians from their traditional land and that undermined their traditional family structures and culture.

Risk and protective factors in developmental context

The monograph also summarises the literature on risk and protective factors that are useful for understanding children’s development. Protective factors can include for example resilient childhoods; resilience is a process that develops over time, and that may make people less likely to develop alcohol and other drug problems even when they are exposed to a high number of risk factors. An example of a risk factor is that families in which the parents choose to use drugs themselves may be more likely to damage their child development through maternal alcohol or tobacco use or to have adolescents who choose to use drugs.

Evidence also shows that those connected to their families and those with greater social support may also be less at risk of problem alcohol and other drug use. The notion of protective factors is used to bridge between childhood prevention frameworks aiming to improve community conditions for healthy child development and frameworks directed at harm minimisation for adults. From this perspective, programs that encourage sales of alcohol to intoxicated patrons are defined as adding a protective advantage to individuals within a community, reducing their likelihood of experiencing alcohol-related harm although not changing their overall exposure to risk factors.

A complex picture

The monograph outlines the complex associations that combine to make up the picture of an individual’s or community’s risk profile for drug use (as well as other behaviours that are likely to cause harm such as juvenile offending and risky sexual activity). There is no straightforward mathematical formula that can be applied to assess risk. However it is clear that the more risk factors that co-occur in an individual’s life the more likely they are to experience harm from drug use.

Reducing risk factors should therefore reduce the likelihood of harm. Of particular relevance to prevention is the variation across communities in the types of risk and protective factors that adversely impact healthy child and youth development.

In some communities prevention work may need to focus on early childhood by assisting parents who are in drug treatment or harm reduction programs. In other communities the greatest advantages may come from improving conditions across all primary schools. In others, working to eliminate the sale of alcohol to intoxicated patrons or to underage youth may be the first priority.

Evidence based interventions

After the first six chapters of scene setting, the monograph gives an overview of a whole range of prevention and early intervention strategies that may help reduce the risk of the negative effects of alcohol and other drug use across the life span. There is a systematic approach taken by the authors to their review of 159 prevention strategies with each intervention rated by the level of evidence based on the review of the evidence. There are many interventions outlined and the summary document gives a useful overview of what is covered in more detail in the monograph. The interventions are grouped under the following chapter headings:

- Interventions for children
- Interventions for young people (12 - 24)
- Broad based prevention
- Demand reduction
- Regulation and law enforcement: licit drugs
- Regulation and law enforcement: illicit drugs
- Judicial procedures
- Harm reduction strategies.

A framework for action

The final chapter presents a framework for action titled: ‘Increasing protection and reducing risk across the life course’. This chapter requires a broad understanding of the entire document. It suggests that the way forward is a whole-of-government approach. It also highlights the need for prevention initiatives to be implemented at community, family and individual levels across the life course.

The message in this chapter is clear that to minimise the harms from drug use there is no one strategy that can be implemented in isolation. Figure 1 on page 9 is taken from the report and summarises an integrated picture of the range of strategies that could be implemented to have the greatest possibility of success.

Reference

PERSPECTIVES ON THE PREVENTION MONOGRAPH

The following comments were provided by the three authors of the monograph.

Professor Tim Stockwell from the National Drug Research Institute (NDRI) in Perth says:

The report ranks the scientific evidence for 159 prevention strategies covering all drug types, all age groups and including law enforcement and regulation as well as education and persuasion.

...it is mostly alcohol and tobacco that is killing Australians prematurely... Alcohol-related death rates in the 1990s are responsible for around 90% of preventable disability and death from drug misuse worldwide, while illicit substances are responsible for less than 10%...the great bulk of government expenditure in the broad area of prevention is targeted at illicit drugs...

In terms of early prevention, Associate Professor John Toubourou, from the Centre for Adolescent Health in Melbourne, says the review encourages an integrated approach. There is a wide inclusion of all possible prevention and early intervention, including strategies that target young women, young children and adolescents right through to harm reduction approaches with active drug users. According to Toubourou:

Working together across different approaches will ensure better integration of services at the community level and large preventative impacts. We need to modify service systems so we can tailor the right mix of prevention programs to match the specific conditions in each community.

In communities where there are high rates of parental drug use and child abuse, effective prevention programs can be implemented to increase the prospects for healthy child development and reduce the numbers who go on later in life to illicit drug use and problems with alcohol abuse. There are opportunities to work more intensively within special populations such as parents participating in drug treatment or harm reduction programs. In many communities children are in great shape but start to get involved most specifically with harmful alcohol use and tobacco use as adolescents. In these communities prevention investment can be directed at encouraging stronger bonds in primary schools, increasing the age at which families introduce children to alcohol and on implementing and enforcing laws that discourage early alcohol and tobacco use.

The following comments were provided by two members of the Prevention Expert Committee. This committee advised the Australian Government Department of Health and Ageing on the development of the monograph.

Professor Ann M Roche from the National Centre for Education and Training on Addiction, Flinders University of South Australia says:

Australia has once again demonstrated real leadership in the alcohol and other drugs field, this time in relation to prevention. The prevention monograph is indeed a landmark document. It packages in a comprehensive and critical manner the key developments in the prevention field. It synthesises findings from over 1,000 references and provides a six-point scale indicating the strength of evidence for various interventions. Importantly, the authors did not focus exclusively on a developmental pathways approach that would have placed the emphasis of prevention primarily on the individual; rather, a broader and more comprehensive approach has been taken which incorporates crucial environmental and systemic factors that need to be addressed in any prevention effort. Readers should not be daunted by the size of the document as it is structured in a manner that makes it an accessible read, a ready reference and an essential tool in one’s prevention armament.

Dr John Howard, Director of Clinical Services, Training and Research at the Ted Noffs Foundation says:

The monograph is comprehensive and useful tool to guide policy makers, program developers and funders. In addition to providing the evidence base for a wide range of preventive activities, the sections on social determinants of health and drug use, and risk and protective factors predicting harmful drug use, take this report to where few others have gone, and strengthen the case for more comprehensive interventions that can be located in a variety of settings. For example, investing in home visitation to support selected populations of new parents can be associated with reduced risk for later substance use, as well as reduced risk for other negative health outcomes and involvement in criminal activity. The monograph also notes how ‘treatment’ has a significant role in prevention.

The following table provides examples of a number of areas where current policies and practices are discordant with an evidenced based approach to prevention.

Evidence based prevention strategies | The current situation
--- | ---
Good quality data systems enabling monitoring down to the community level of harms, risk and protective factors, patterns of substance use and prevention investment | Existing data provide a poor guide for prevention investment
‘Protection and Risk Reduction Approach to Prevention’ emphasising comprehensive community prevention (e.g., improving environments for healthy child development, enforcing liquor licensing provisions and ensuring access to treatment and harm reduction programs) | There are few communities implementing evidence based prevention approaches
A price disincentive for higher alcohol content products, specifically an alcohol content-based tax on wines | Very cheap bulk wines favoured by vulnerable groups and problem drinkers are readily available
Community trials to evaluate the longer-term effectiveness of alternative prevention approaches | There is little investment in evaluation

Source: Associate Professor John Toubourou

This soon to be released book is a comprehensive text on the scientific basis for preventing risky use and associated harm from drug use, both legal and illegal. There are 51 contributors drawn from leading research centres in North America, Australia and Europe. A broad view is taken of what constitutes prevention. The text incorporates supply, demand and harm reduction strategies applicable across the complete life span. A number of theoretical perspectives regarding social, developmental, economic and environmental processes underlying risky drug use and misuse are adopted. The emphasis of the book is on concise summaries of best available scientific evidence with clear recommendations for policy and practice.
RADAR: THE ONLINE DATABASE
OF ATOD RESEARCH IN AUSTRALIA

JANE SHELLING, ALCOHOL AND OTHER DRUGS COUNCIL OF AUSTRALIA, ACT

RADAR has helped to ensure RADAR makes a positive start, with over 200 records already submitted. In addition to these institutions and other ATOD specific organisations, it is hoped that researchers in other fields which impact upon ATOD areas will also contribute their research.

This will make RADAR as encompassing as possible, gathering up research from other adjoining areas which impact on the ATOD sector, such as criminology and sociology, into a central register. This broader ATOD viewpoint together with the inclusion of a range of types of research will help RADAR give a comprehensive look at the Australian ATOD research scene.

It is anticipated that the register could be used by funding bodies to identify researchers with expertise or interest in a particular area of study, so that tenders for specific projects could be brought to their attention. Those seeking research collaborations could also utilise the register for this purpose. It will make it easier to define projects to meet a unique area of research and to avoid unnecessary duplication as well.

Adding your research to RADAR

Adding records to RADAR is easy and researchers may add their own records using the interactive form on the website. Once submitted, RADAR staff proofread and where necessary correct the record, check and edit the keywords and add the record to the database. The researcher receives a confirmation and a password to use if they wish to make any changes later. Alternatively, you can simply email your record to the RADAR team, or advise us where the record is on the web and we will add the record for you. This may be particularly useful if you have a number of records to add.

RADAR has a strong search capability and a number of different ways of accessing records. In addition to the usual keyword searches, a subject browsing system called ‘textpert’ provides a hierarchical structure of subject categories, allowing you to search broadly initially, or progressively move to the more specific.

ADCA believes that RADAR will become a valuable tool in fostering research and improving the dissemination of research findings to the field. The RADAR team looks forward to working with researchers and other ATOD workers in building RADAR into such a tool.

Go to www.radar.org.au to access RADAR.

For more information about RADAR, please email jane.shelling@adca.org.au

RADAR RESEARCH FEATURE

Alcohol taxation and the low strength alcoholic beverage market

CHERYL WILSON, ALCOHOL AND OTHER DRUGS COUNCIL OF AUSTRALIA, ACT

The Alcohol and other Drugs Council of Australia (ADCA), in consultation with two private consultants – Mr Robert Preece, an expert on excise, and Mr Chris Murphy from Econtech – is currently undertaking research into alcohol taxation and the low strength alcoholic beverage market. The aim of the research is to develop a model of alcohol taxation for Australia that promotes the production and consumption of lower strength alcohol products without causing major consumption shifts between beverage types (i.e., between beer, wine and spirits) or major reductions in government revenue. Major shifts in revenue and/or consumption need to be avoided as they would make the changes unpopular with government and to particular industry sectors, thus reducing the likelihood that they would be adopted.

The research is comprised of:

- a review of the research literature around the relationship between alcohol consumption and the price, taxation and marketing of alcohol
- consultations with the alcohol industry on barriers and incentives for the production and marketing of lower strength alcohol products
- building an economic model of alcohol taxation utilising, amongst other things, consumption and expenditure data from the Australian Bureau of Statistics and industry sources such as the Liquor Merchants Association
- economic modelling of possible changes to the current alcohol tax regime to better understand what impact these changes would have on patterns of consumption and on government revenue
- if appropriate changes to alcohol taxation that meet the research aims can be identified, development of an advocacy framework to promote the approach to government, industry etc.

Why does alcohol taxation matter?

Taxation has been shown to be an effective way of influencing the consumption and production of alcoholic beverages. Studies of price and income elasticity of alcohol from around the world indicate that alcohol consumers do respond to price changes, although the extent to which this occurs varies between different types of alcoholic beverages and different categories of consumers.

Significantly, it would appear that both ‘binge’ drinkers and heavy drinkers are price elastic (that is, their consumption of alcohol will respond to changes in price. For example, if the price of alcoholic beverage goes up, they will drink less or not at all and vice versa).

This project seeks to explore how taxation can be used in Australia to exaggerate price differentials between low and full strength alcoholic beverages and influence shifts in consumption from full strength products to lower strength options – thus reducing overall consumption.

A good example of where this strategy has been effective in the past is in relation to beer.

Beer is taxed on a volumetric basis within a number of tax tiers that recognise the ‘light’, ‘mid’ and ‘full strength’ beer markets. Differential tax rates are applied to each of these tiers, with lower strength tiers treated more favourably than higher strength tiers.

Largely as a result of this taxation regime, there has been a significant shift by consumers towards lower strength beers (by 1999 over 41% of the total beer market was made up of low and mid strength beer sales) leading to a significant drop in alcohol consumption overall. Not only has this structure of beer excise lured consumers to lower strength beers, it has made the marketing and sale of low strength beers more profitable than marketing and selling full strength beers. Furthermore, it has resulted in brewers dropping the strength of full strength beer.

If a similar outcome could be achieved for products such as ready to drink spirits and wine it could have a significant impact on alcohol consumption and related harm in Australia.

Why undertake economic modelling?

Taxation of alcohol is a complex balance of competing policy interests. A review of alcohol taxation changes over the past 30 years suggests that there are a number of competing policy considerations that have been shaping Australia’s alcohol system, including:

- the health and social costs of harmful alcohol consumption
- maintenance and growth of government revenues
- recognition of alcohol as a contributor to the economy in the manufacturing, hospitality, tourism, retail and export sectors
- recognition of the importance of alcohol to rural and regional economies in the agriculture and tourism sectors
- other factors such as World Trade Organisation treaties on taxation, reducing complexity, ease of compliance etc.

The differences in taxation methods and rates between beer, wine and spirits, lie in these five broad areas of competing policy interests. Economic modelling will provide us with an assessment of how changes might impact on government revenue and on particular groups or industries. It provides necessary data to allow us to formulate rigorous, fully costed arguments to support change. This will put the health lobby on a more equal playing field with the alcohol industry (at least in terms of data, if not financial resources) when advocating to governments.

The project is expected to be completed by the end of 2004 and the project partners gratefully acknowledge the financial support of the School Education and Rehabilitation Foundation that has made this project possible.
LIFTING THE PROFILE OF ALCOHOL

OUTCOMES FROM THE NSW ALCOHOL SUMMIT

KATE POOLLEY

The NSW Government set itself a public policy challenge to respond to its 2003 Summit on Alcohol Abuse (the Summit). The ‘Outcomes of the NSW Summit on Alcohol Abuse: Changing the Culture of Alcohol Use in NSW’ report, released in May 2004, contains a raft of commitments and strategies to tackle the cost of alcohol misuse.

The feedback from the alcohol, tobacco and other drugs sector has been largely positive: at last, alcohol has a profile to match that of illicit drugs. The next challenge appears to be whether the new approaches will have a lasting effect.

In this article we outline some features of the Outcomes report, as well as issues surrounding their implementation, following this Of Substance presents the views of three Summit participants.

Overall approach

The Summit was convened as a response to widespread concern about alcohol and its effects in communities — including intoxication, violence and injury. It followed on from the similar-styled NSW Drug Summit, held in 1999.

The Outcomes report distills all but 14 of the Summit’s 318 recommendations, and 100 public submissions, into initiatives that are categorised in relation to the main Summit working groups, including ‘The Community’, ‘Preventing Abuse and Harm’, ‘Dependence Disease and Treatment’ and ‘Service Delivery – Health’.

The report features a combination of existing measures, ideas implemented since the Summit and new initiatives. As John Della Bosca, NSW Special Minister of State, has outlined: [The report] requires each public sector agency to review what they’re doing and, if necessary, reshape services and create new services. It calls on agencies and departments to better target and coordinate services and programs and promote greater community awareness and responsibility (AcNow Bulletin, June 2004).

It is this reshaping required by the public sector and alcohol-related services that has some in the field concerned that initiatives may not be matched by additional funding. However it is acknowledged that the Government’s approach needed to be quite different to that adopted following the 1999 Drug Summit, because it is dealing with a legal product, an established industry, and significant programs are already in place.

It is conservatively estimated that the NSW Government alone spends over $190 million per year on alcohol programs. Its new response includes specific funding of $12.5 million over four years. By comparison, the government is spending $230 million over four years on its drug programs.

As Professor Ian Webster, Chair of the Alcohol Education and Rehabilitation Foundation has commented: ‘The costing is thorough, the [real] expenditure [on initiatives] is likely to be much greater. However, while some in the alcohol and other drugs field are disappointed about the actual new dollars, especially when compared with the expenditure by governments on illicit drugs, the processes and public statements so far have indicated that alcohol policy, services and broad social and health interventions is firmly implanted in NSW, and especially in the operational departments.

Report highlights

The NSW Government has highlighted some of the major initiatives contained in the Outcomes report as including:

• The establishment of a Liquor Accord Unit, which will further develop the Accord Program already underway across NSW (see John Green’s article, opposite, for more discussion).

• Strategies to improve community awareness, with a key role being delegated to Community Drug Action Teams across the State to tackle the issue of alcohol abuse in their local communities.

• A retailer alert system, that will be designed by the alcohol industry and the NSW Government to ensure alcohol products which encourage under-age and binge drinking will be quickly identified and removed from retail outlets.

• The Rural Alcohol Diversion pilot program that will target adult offenders whose criminal behaviour can be clearly linked to their alcohol abuse.

• Random breath testing on NSW Waterways.

• A legislated definition of intoxication.

• Increasing penalties for repeat offending in relation to supplying intoxicated/aggressive persons alcohol or serving/ supplying minors with alcohol.

• Improved “Move along” legislation to include antisocial behaviour.

• Review of alcohol free zones.

Liquor Accords

Liquor Accords are underpinned by a focus on local solutions to local problems. Accords entail local licensees, police, council and community representatives coming together to seek a consensus on solutions to alcohol-related issues within a geographic area. Significant debate occurred both during and after the Summit as to whether Liquor Accords should be mandatory. NSW Police were committed to ensuring an overarching system was in place so that the community is able to have their say in local issues through the Accord process. As a result, Liquor Accords will be mandatory throughout NSW, although membership will remain voluntary. This process may also see licensed premises with extended trading hours subject to greater regulation, including closed-circuit TV coverage of external areas.

More information

The NSW Government has established an alcohol information website, developed in response to recommendations from the Alcohol Summit. The Outcomes report and the ‘AcNow Bulletin’ are reproduced on this site: www.alcoholinfo.nsw.gov.au

NEW SOUTH WALES POLICE PERSPECTIVE

JOHN GREEN, ALCOHOL RELATED CRIME PROJECT, NSW POLICE

For NSW Police, the Alcohol Summit was an opportunity to work with government and the community to seek ways of reducing the harms associated with the irresponsible consumption and supply of alcohol, and alcohol fuelled anti-social behaviour. Police Commissioner Ken Moroney said during an address to the Summit: ‘Alcohol-related crime has no single cause or solution. A balanced and multi-tiered approach at all levels – local, regional, state and Commonwealth – with community and industry involvement is required.’

Implementation of strategies arising from the Outcomes Report, some of which are listed here, will ensure police are equipped to better manage alcohol-related crime, through a range of increased training, improved intelligence systems, focused enforcement and improved legislation.

Alcohol Linking Program

For many people, responsible consumption of alcohol is an accepted part of life. Similarly, licensed premises and licensees that promote responsible service and consumption are part of society. However, studies show that a minority of licensed premises are associated with a disproportionate amount of alcohol-related crime. The Alcohol Linking Program targets licensed premises with irresponsible drinking practices.

The program involves the routine collection and recording of data by police at every incident attended, recording the last place of consumption of alcohol prior to the incident by offenders and victims.

This ‘links’ licensed premises to the incidence of crime, and possible irresponsible serving practices. Police work collaboratively with licensees to identify where reduction in harm can occur. Continued indication of irresponsible serving practices by licensed premises can then result in police conducting overt/covert licensing enforcements. Roll-out of the program will continue during 2004, with relevant government and industry stakeholders kept informed.

Legislative amendments

The significant message arising out of the Alcohol Summit is one of shared responsibility by individuals, by licensees and their staff, and by friends and family members who supply alcohol to others. Legislative amendments that will assist in the reduction of alcohol-related crime or fear of alcohol-related crime in the community have been recommended by the Alcohol Summit. NSW Police will promote legislative amendments that impact upon the cause of alcohol-related crime rather than the effect. An interagency Alcohol Related Offences, Penalties and Law Enforcement Taskforce will be established, implementing legislation targeting:

• random breath testing on NSW Waterways.
• increasing penalties for repeat offending in relation to supplying intoxicated/aggressive persons alcohol or serving/ supplying minors with alcohol.
• improved “Move along” legislation to include antisocial behaviour.
• review of alcohol free zones.

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(continued over page)
Alcohol and young people
Supply of alcohol to young people and underage drinking was a constant issue throughout the Summit. Whereas an interagency Education and Information Taskforce will be established to examine community education issues, NSW Police will expand the ‘Supply Means Supply’ (SMS) program to priority areas.

This program, commenced on the Central Coast, targets the secondary supply of alcohol to minors through a combination of in-school education, signage around licensed premises, TV and print media advertising and police enforcement. Assistant Commissioner Bob Bates, NSW Police Corporate Spokesperson on Alcohol Crime says, ‘Laws regarding purchasing alcohol and its current role as a member of the Council from its work

PERSPECTIVES FROM THE NGO SECTOR
LARRY PIERCE, NETWORK OF ALCOHOL AND DRUG AGENCIES (INC.), NSW

There are some in the drug and alcohol field in NSW who see the recent NSW Alcohol Summit as a disappointment in priority terms - the government’s plan of action and recently released key initiatives report. This principally relates to the lack of additional funding, programs and resources, in comparison to those allocated after the 1999 Drug Summit.

In terms of the NADA perspective, additional new monies for the funding of prevention, education and workforce development programs, early identification and intervention programs and expanded treatment services for people with alcohol dependence would always be welcome. However we understand that in the context of recent substantial enhancements to these programs from 1999 and the overall constraints of the NSW Government’s budget, it is not always possible to tip new buckets of money to the drug part of the drug and alcohol program.

Strategic planning
Contained in the key initiatives document are a raft of excellent projects and programs that build on a lot of work that has been progressively developed over the past five years in particular the emphasis, by both state and commonwealth governments, has been on illicit drugs. This has largely been to the exclusion of alcohol in terms of the funding priorities of both governments and has led to the absurdist situation of drug and alcohol service providers having to at best mask, or at worst ignore, the alcohol component of their service delivery if the funding came from the National Illicit Drug Strategy or the NSW Drug Summit.

Thus while alcohol disease prevention is a goal which has been exploited by the NSW Alcohol Treatment Services Development Plan Reference Group that is charged with the development of a ten year plan for NSW. This is another example of the continuing integration of the NGO sector in the governance and management of the drug and alcohol statewide program, a trend that started with the 1999 Drug Summit.

The action plan will promote the further development of clear agreed case management guidelines and a policy framework for drug and alcohol management services. It will see the development of formal interagency agreements or memorandums of understanding between government and non-government services, which in turn will see more comprehensive and better managed treatment services for clients.

Improving the workforce
With regard to the skills development and related workforce issues faced by the field, the establishment of the NSW Drug and Alcohol Workforce Development Council is a progressive move. It will bring government departments and experts together to establish a comprehensive workforce development agenda for the specialist drug and alcohol workforce. NADA has been involved in the development of the Council from its work on the Alcohol Summit Working Group and its current role as a member of the Council. Non-government organisations have particular workforce needs; we believe that our involvement at the senior levels of planning will help NGOs be involved in the broader workforce initiatives arising from the work of the Council.

Partnerships and profiles
From the NGO sector’s point of view, the Alcohol Summit and its outcomes have provided considerable ongoing impetus to the development of better and more significant partnerships in service planning, development and delivery between the government and non-government sectors in NSW. It has also been significant for the ‘re-positioning’ of alcohol within the drug and alcohol field.

For the past five years in particular the emphasis, by both state and commonwealth governments, has been on illicit drugs. This has largely been to the exclusion of alcohol in terms of the funding priorities of both governments and has led to the absurdist situation of drug and alcohol service providers having to at best mask, or at worst ignore, the alcohol component of their service delivery if the funding came from the National Illicit Drug Strategy or the NSW Drug Summit.

Thus while alcohol disease prevention is a goal which has been exploited by the NSW Alcohol Summit for what they will engender in terms of systems development in the drug and alcohol field, rather than focus on what the Summit failed to deliver in terms of dollars.

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The NSW Alcohol Summit has been a wake up call to the wide disquiet about alcohol and its effects in neighbourhoods – including intoxication, violence and injury. It also responded to a strong community feeling that young people were being exploited by the marketers of alcohol.

Service providers’ input
It was the hope of service providers that the Summit would galvanise and improve services. For example, the Royal Australasian College of Physicians, with university, health promotion and public health interests, advocated strongly for a public health approach. Their submission identified an urgent need for a strong skill base – informed and updated by education and training of front-line and professional personnel.

Two of the working groups at the Summit – ‘Dependence, Disease and Treatment’ and ‘Effective Health Care Service Delivery’ – together made 53 recommendations. The guts of their proposals were to amplify the current services for illicit drugs to include alcohol. The principal ideas were about comprehensive approaches, case management, early intervention, guidelines for residential programs, setting treatment standards and building interventions around high risk and special need groups in the population.

Prevention
There are many points in the spectrum of alcohol use, misuse, problems and dependence where prevention can work. Alcohol disease prevention is more relevant to the prevention of, and more advanced effects of alcohol on the body or mind. But in reality, intervention at any point in the continuum can lessen the harms of alcohol misuse.

Thus while alcohol disease prevention is a goal which makes sense for medical practitioners, every discipline and approach – from health promotion to psychological counselling – is relevant to preventing alcohol harms. The Action Plan will build a matrix for prevention and show where and how different skills and techniques fit in and contribute to the health of the whole.

Benefits to treatment services
In the treatment area, the NSW Department of Health has set in train the following plans:

- NSW Drug and Alcohol Treatment Services Development Plan 2006-2015 (Treatment Plan)

Better late than never: a view of treatment outcomes
IAN WEBSTER, ALCOHOL EDUCATION AND REHABILITATION FOUNDATION LTD, ACT

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- NSW Drug and Alcohol Treatment Services Development Plan 2006-2015 (Treatment Plan)
QUITTING TOBACCO USE WHILE BEING TREATED FOR OTHER DRUG DEPENDENCE

Julia Tresidder

There is a growing interest in treatment for polydrug use. People who are dependent on alcohol or opioids are also often dependent on tobacco as well. Reviews of the literature also claim that smoking-related medical conditions are responsible for the deaths of many people who have been treated successfully for other drug dependence (Richter et al. 2001).

While smoking prevalence rates in Australia have declined to around 20%, surveys in the United States of people in other drug treatment show that over two-thirds smoke (Richter & Ahluwalia 2000). Therefore it is timely to look at what could be done to encourage people in treatment for other drug dependence to also quit their tobacco use.

This article provides a brief review of three recent research articles on this topic. On page 17 we profile the guidelines that Turning Point has developed in Victoria.

Clients’ attempts to quit smoking

A recent US study by Richter et al. (2001) surveyed clients at two public methadone programs, two private for profit programs and one private not for profit program about their tobacco use and intention to quit. They had responses from 550 out of 655 clients (84%). This study found that 77% of those surveyed were current smokers. Of the smokers, three-quarters had stopped smoking at least once for 24 hours. On average they had tried to quit five times; over a third of those who had tried to stop smoking had maintained abstinence for over six months and just under a third had only managed abstinence for a week. Most of those surveyed (80%) were interested in quitting and almost two out of three said that they would think about quitting through the methadone clinic they attended. Of those who had successfully quit 10% had used nicotine replacement therapy which they considered to be similar to the proportion of the general population who use this method. The study authors recommend that, as this group is already using pharmacotherapy for opioid dependence, a combination of pharmacotherapy and behaviour therapy should be trialled to help them quit their tobacco use at the same time.

Treatments during pregnancy

Also in the US, Huang et al. (2001) studied a group of 50 pregnant women who were being treated with methadone and were attending a comprehensive drug treatment program. Amongst this group of women only 40% even contemplated quitting their tobacco use. Forty women were followed up during pregnancy and the study found that none of the women had quit smoking and that few had even reduced their smoking despite knowledge of the personal and foetal health risks of tobacco use. The authors recommend that more research into quitting smoking interventions with this high-risk group of methadone clients be undertaken.

Another US study trialled nicotine replacement therapy (using patches) by itself, as well as in combination with relapse prevention and contingency management treatment, to help clients undergoing treatment for heroin and cocaine use also quit their tobacco use (Shoptaw et al. 2002). The results showed that the groups who received contingency management (which involved rewarding abstinence) were more likely to abstain from smoking tobacco during the 12 week treatment phase, but they were no more likely to have maintained abstinence from smoking tobacco at the six month follow up than the group who only received nicotine replacement therapy.

Relapse prevention behavioural therapy (group counselling) combined with the nicotine replacement therapy showed no greater benefits during the treatment phase than just receiving the nicotine replacement therapy alone. The study concluded that nicotine replacement therapy alone is as successful as combining this with the behavioural therapies trialled. The study however does back up the results from other studies that show that nicotine replacement therapy during treatment for other drug dependence does not erode the effects of that treatment.

More research needed in treatment

There is extensive literature about programs to assist people to quit smoking, however more research is needed in multi-treatment settings. The clinical guidelines that have been prepared by Turning Point will be of use to clinicians in assessing the different treatments available to help people to quit smoking.

More work is still needed here in Australia to help people who want to quit tobacco smoking while they are on methadone maintenance treatments.

References


Guidelines for AOD treatment services

Nicole Lee, Turning Point, Victoria

Smoking rates among alcohol and drug service clients are upwards of 80-90%, which is three to four times higher than the rates in the general population. This group is therefore at greater risk of tobacco-related morbidity and mortality and more needs to be done to address this.

A team headed by Dr Nicole Lee at Turning Point Alcohol and Drug Centre have developed clinical treatment guidelines with a specific focus on smoking cessation treatment within alcohol and drug treatment (AOD) services. These guidelines will be published in late 2004.

In reviewing the literature, the researchers found that quit rates for those in AOD treatment are similar to those of the general population of people who smoke tobacco. Despite this, treatment providers rarely address the potential to assist their clients to quit smoking while they are being treated for other drug dependencies. Some reasons for this may be:

- AOD workers themselves have high rates of tobacco smoking and may model smoking behaviour in front of their clients. They may be unwilling to address the issue of quitting smoking for their clients whilst they are still smoking themselves.
- AOD workers often believe that clients in AOD treatment cannot or do not want to quit smoking, and there are few studies specifically looking at quitting smoking interventions among this group and few guidelines specifically for this group.

However, there does not appear to be an adverse effect of quitting whilst in other drug treatment, and in fact quitting may actually assist some clients to avoid relapsing into use of their primary drug.

Guideline features

The guidelines were developed to reflect the success of mainstream QUIT’s “Fresh Start” program. They have however been adapted to be more consistent with alcohol and drug treatment, and contain a detailed program that can be used to help clients quit smoking. The program takes into account the stages of change model and has several levels of intervention that are responsive to clients’ readiness to change their smoking. It highlights the interaction between smoking and other drug use and focuses on skills that are already available to clients through their other drug counselling, such as relapse prevention. Key components were also compressed into four sessions to more easily fit within drug treatment services. The program can be conducted as individual or group sessions.

Guideline trial

A small trial (Dunlop et al. 2003) was conducted to examine clinician and client smoking and uptake of the guidelines by clinicians. Staff were trained in the use of the guidelines and encouraged to offer a smoking cessation program to their clients. A number of group sessions were also scheduled.

Around 80% of staff asked a median of three clients about smoking during assessment at the beginning of the study. Although around 75% of clients who were asked if they were interested in smoking cessation said yes, clinicians were pessimistic about their chances of quitting. Around 16% of clinicians did not ask their clients at all because they thought that they would not be interested and about 35% said that it was ‘not appropriate’ at the time. By the eight week follow-up, two clients had stopped or reduced smoking without intervention and five had attended some form of intervention (quit group, individual counselling or nicotine replacement therapy).

Targetting staff smoking

The study found that around 25% of clinicians were current smokers, 25% were current occasional smokers and 25% were ex-smokers, but this did not appear to be correlated with whether they addressed smoking with their clients or not.

In addition to the research, some policy changes were also introduced to reduce the potential impact of staff smoking on client smoking rates. Staff were asked not to smoke with clients or in view of clients. A series of Fresh Start programs were conducted in a format with a reduced length (four sessions) to provide support for staff to reduce smoking. Outcomes were good for staff taking up the program with an 80% retention rate and around 30% of staff participants not smoking after the four sessions.

The Turning Point guidelines outline recommendations by Bowman & Walsh (2003) to address staff issues by making smoking cessation among staff a priority, introducing smoking restrictions for staff and clients, providing staff with education and training to dispel myths and encourage uptake of smoking cessation strategies and management support of policy changes and training. There is a lot more to be done in assisting alcohol and drug clients to reduce or quit smoking, only some of which is about introducing smoking cessation programs for clients.

References


HIV/AIDS & DRUG USE IN ASIA:
CHALLENGES AND RESPONSES
GARY REID, THE CENTRE FOR HARM REDUCTION, MACFARLANE BURNET INSTITUTE FOR MEDICAL RESEARCH AND PUBLIC HEALTH LTD, VICTORIA

Background to a crisis
The two interconnected epidemics in Asia of injecting drug use and explosive HIV rates were identified by a review in 1997 (Reid & AHRN 1998). This review covered sixteen countries and documented the HIV risk among, and transmission from, people who use drugs in various parts of the region. Yet, the public health response to this specific problem was woefully poor and there was little recognition of its nature and existence. This was reflected by its near absence in national AIDS policies and strategies. The focus by Asian governments at the time was on traditional supply and demand reduction approaches with minimal responses addressing the escalating HIV transmission spread by people who inject drugs.

A follow up review in 2001 by Reid & Costigan (2002) covered more than 20 countries, and illustrated the dynamic nature of illicit drug production, trafficking and consumption. It also highlighted the ongoing risk behaviours that gave rise to a continuing epidemic of HIV/AIDS amongst people who inject drugs. Some policy development to tackle the use of illicit drugs was shown to have occurred, but most countries continued repressive law enforcement approaches.

By 2004, various harm reduction approaches have been implemented but overall they are minor in size and scale, and the technical capacity of organisations on the ground is still inadequate. Adding to this daunting challenge is that harm reduction approaches are still widely misunderstood and/or rejected in Asia, and consequently the prevalence of HIV remains tragically high. The Centre for Harm Reduction (CHR), along with AusAID and other organisations, has been involved in the collective effort to bring attention to, and reduce the health and social consequences of, drug use in Asia. The task ahead is to greatly expand the various educational and technical capacity building programs and projects in this region.

Patterns of drug production, trafficking and use
Since 1997, Myanmar (Burma) has remained the epicentre of the opium industry of South East Asia’s ‘Golden Triangle’ and the second largest producer of illicit opium and heroin. Afghanistan produces around 75% of the world’s illicit opium supply. Opium production in Afghanistan slumped in 2000 under the reign of the Taliban but the collapse of this regime and ongoing socio-economic hardships currently provide the incentive for Afghan farmers to resume commercial opium cultivation in most provinces.

The most significant change in drug production from 1997 to 2004 has been the massive increase in methamphetamine production, led by Myanmar. Labs in various areas of the country produce hundreds of thousands of methamphetamine tablets each day at a cheap price and most are trafficked across into Thailand, but also through to China, Laos, Cambodia, Vietnam and India (UNAIDS & UNDCP 2006; US State Department 2004).

Heroin still remains the drug of choice and the major problem drug in the region, dominating treatment demand and drug-related offences. Availability, affordability, physical addictive qualities and, following administration an intense feeling of euphoria explain heroin’s ongoing popularity. Heroin generally was initiated by smoking but because of cost, peer pressure or the desire for instant effect the transition to injecting often proved inevitable. The most significant change in Asia has been the dramatic rise in and popularity of the use of amphetamine-type stimulants (ATS), in particular methamphetamine. Use of methamphetamine either in pill or crystalline form has swept the entire region. Other drugs like ecstasy and ketamine have gained popularity in selected countries of the region, as did cannabis but the latter was not highly associated with problematic use patterns (UNODC 2004).

Risk practices and trends in behaviours
Favoured administration routes for illicit drugs vary from place to place, over periods of time and in different cultural settings. Heroin is commonly first smoked or inhaled, but users inevitably begin injecting heroin after a period of use. The transition period of moving from non-injecting to injecting varies from one country to another, but in some countries there is a narrowing timeframe. In China, younger people who use drugs often commence injecting relatively quickly with those who use heroin injecting within eight months to as little as a few months (Lai et al. 2001).

In 1997 the HIV prevalence rates among people who inject drugs in Asia were some of the highest recorded globally, often reaching 60-90% six months to a year after the appearance of the first case. The situation today remains bleak. An increasing number of people inject drugs, the rate of sharing injecting equipment with often multiple partners remains exceedingly high, and with mobility and the mixing with other people who inject drugs on the rise, several countries continue to experience serious HIV epidemics amongst this group. The countries most severely affected include Myanmar, Vietnam, China, Thailand, Malaysia and Indonesia. The further spread of HIV infection to current non-HIV infected people who inject drugs and to the wider community appears inevitable. For example is Manipur, India, where the transmission of HIV infection from people who inject drugs to their non-injecting wives increased from 6% in 1994 to 45% in 1997 (Sarkar et al. 1993; Panda et al. 2000). According to UNAIDS, Asia is likely to have the largest number of injecting drug-related HIV cases in the world.

Government response to drug use and HIV
Long established epidemics of HIV among people who inject drugs are found in most of Asia, yet the response among governments is either dangerously slow or the approach is inappropriate. Addressing the use of illicit drugs in response to the legal implications of drug use rather than the public health implications of HIV/AIDS. Consequently most countries in Asia remain years away from creating or implementing specific policies that address issues of HIV/AIDS among people who inject drugs. However, there are recent signs of optimism as shown in Indonesia where the National AIDS Commission (NAC) launched a revised National AIDS Strategy (2001-2007) in which harm reduction approaches are to be implemented in the prevention of HIV amongst people who inject drugs. Additionally the NAC is also developing a Memorandum of Understanding with the National Narcotics Board, outlining areas of work that can be undertaken by government agencies (Atmosukarto 2004).

HIV/STI transmission amongst people who inject drugs
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HIV/STI transmission amongst people who inject drugs
In 1997 the HIV prevalence rates among people who inject drugs in Asia were some of the highest recorded globally, often reaching 60-90% six months to a year after the appearance of the first case. The situation today remains bleak. An increasing number of people inject drugs, the rate of sharing injecting equipment with often multiple partners remains exceedingly high, and with mobility and the mixing with other people who inject drugs on the rise, several countries continue to experience serious HIV epidemics amongst this group. The countries most severely affected include Myanmar, Vietnam, China, Thailand, Malaysia and Indonesia. The further spread of HIV infection to current non-HIV infected people who inject drugs and to the wider community appears inevitable. For example is Manipur, India, where the transmission of HIV infection from people who inject drugs to their non-injecting wives increased from 6% in 1994 to 45% in 1997 (Sarkar et al. 1993; Panda et al. 2000). According to UNAIDS, Asia is likely to have the largest number of injecting drug-related HIV cases in the world.

Government response to drug use and HIV
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The need for more harm reduction in Asia
Drug production continues to flourish in Asia, many people who use drugs inject and this risky behaviour is ever more creating new HIV threats. Currently it is not possible to reverse the HIV epidemic trend among people who inject drugs in Asia, when only 10% of these people have access to harm reduction programs (Global 2003). Consequently, the urgency to increase the capacity of those in Asia to respond more appropriately remains.

There are various harm reduction approaches that require implementation if the HIV situation amongst people who use drugs is to be addressed, including:

- scaling up prevention activities to tackle the size of the epidemic
- educating people who use drugs not to share injecting equipment and to practice safer sex (e.g. use condoms)
- making outreach workers and peer educators deliver health messages that can help prevent the spread of HIV
- establishing needle and syringe programs
- creating primary care health services for people who use drugs, and to help long term drug users into treatment
- making wider availability of drug substitution therapy programs to lower the risk of HIV transmission by decreasing injecting behaviour
- encouraging counselling and HIV testing to assist those currently HIV infected, and prevent further HIV transmission to others by reducing risky behaviours.

Links between health and law enforcement
Just as important for harm reduction to progress in Asia, is the need to improve, but adopting this strategic approach has been good for both sectors and for the community as a whole. Both health and law enforcement agencies, and over time such cooperations have been able to become more effective in tackling drug issues.

Strengthening the links between health and law enforcement to ensure that injecting drug use is to be addressed, including:

- encouraging counselling and HIV testing to assist those currently HIV infected, and prevent further HIV transmission to others by reducing risky behaviours.
- educating people who use drugs not to share injecting equipment and to practice safer sex (e.g. use condoms)
- making outreach workers and peer educators deliver health messages that can help prevent the spread of HIV
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- encouraging counselling and HIV testing to assist those currently HIV infected, and prevent further HIV transmission to others by reducing risky behaviours.

ACTIVITY CASE STUDY: India
In 2002, The Centre for Harm Reduction (CHR), The Burnet Institute undertook a field assessment of HIV/AIDS transmission in India. The assessment identified various inputs required to increase the ability of both government and non-government organisations (NGOs) working with people who inject drugs to respond effectively to the problem of HIV/AIDS transmission.

After the field assessment, CHR, in consultation with local NGOs, developed a training module covering various technical aspects of local field workers. The principle focus of the modules is to increase knowledge and to consider various issues, rather than implementation of a specific approach. A broad range of topics are covered in the training module including an understanding of peer education and outreach programs to an overview of harm reduction. As of 2004, five ‘train the trainers’ workshops have been completed using these training modules with positive feedback from the participants. One of the greatest advantages of the training modules is that they can be run independently of CHR, as demonstrated recently by a group of Indian trainers with CHR trainers playing a secondary role in the proceedings.

Funding for this work has been provided by USAID/Family Health International.

References


UNAIDS & UNDCP 2000. Drug Use and HIV Vulnerability: Policy research study in Asia, Regional Centre for East Asia and the Pacific, Bangkok, Thailand.

United Nations Office on Drugs and Crime 2004. Amphetamine-type Stimulants in East Asia and the Pacific, UNODC, Regional Centre for East Asia and the Pacific.

CASE STUDY: Asia Regional HIV/AIDS Project
The Asia Regional HIV/AIDS Project (ARHP) commenced in July 2002 for a period of four years. It is funded through AusAID, with technical expertise provided and sourced by the Centre for Harm Reduction, Burnet Institute. The aim of the project is to reduce HIV-related harm associated with injecting drug use by taking a more strategic and evidence based approach to policy making, planning and programming in the Asian region. Specifically, the project is targeted towards Myanmar (Burma), Vietnam, and the Yunnan Province and Guanzhi Zhuang Autonomous Region located in southern China. All of these areas have been harshly affected by injecting drug-related HIV transmission. The results and experiences within the three countries can then inform other countries in the region, and facilitate regional cooperation to help address the epidemic.

Building the capacity of institutions to deal with these issues is a key component of the project. The development of a series of educational training materials targeted at both public health and public security personnel has been a major focus. The production of five video trainers’ guides, with a focus on broad aspects of harm reduction, has been completed and covers the following topics: guidelines for safer injecting, effective approaches for peer educators and outreach workers, effective approaches for the health sector, HIV awareness raising and community based effective approaches, and effective approaches for law enforcement. They have all been translated into three languages and will soon be available to local trainers who have previously received educational capacity building training by ARHP technical staff.

A major achievement has been incorporating training on issues related to HIV/AIDS and injecting drug use into regular police/public security training activities. Introductory training at one leading police academy in four project sites has begun, and training for both narcotics control police and general duties police on the topic of harm reduction has been provided. The effects of these training packages have proven significant. For example, the Yunnan Police College is a national centre for the training of anti-drug police. It is also a regional police training centre training anti-drug police from Laos, Vietnam, Myanmar and Thailand. This college is now developing a training resource with one chapter devoted to harm reduction approaches and HIV. To assist in this process and to continue the support for such initiatives, a police academy curriculum has been developed through the Asia Regional HIV/AIDS Project.

The capacity building of key stakeholders at the district/local level to understand and respond to drug use and the related HIV/AIDS in the community has also been increased through the implementation of rapid assessment and response (RAR) training. Briefly, RAR is a series of methods to identify, report, describe and plan responses to drug use associated issues. The RAR process is designed to address problems and this becomes a response. While the RAR training has yet to be implemented in Vietnam due to project implementation delays, it has been conducted in 16 sites: six in Myanmar and ten in China. As a result of the training rapid assessments have been conducted in all RAR training sites and the results of this exercise will soon be disseminated. In conclusion, the project has made good progress in developing partnerships between health and public security agencies, and introduced the concepts and systematic approaches to harm reduction to various parts of the Asian region.
T

he National Drug Strategy Household survey and the National Secondary Schools survey are perhaps the most comprehensive and broad-based of our sources of data on drug use in Australia. In addition, there are other sources of data available in Australia to inform us about drug availability, price, specific drug use behaviours, and other population groups not captured by these surveys.

This information can then be used by those with an interest in alcohol, tobacco and other drugs issues to inform such things as policy, advocacy, funding decisions and research; it can also guide treatment and law enforcement interventions, and can assist the field in staying on top of, and responding to, emerging trends.

As part of a new occasional series, Of Substance profiles in this article two important data collection programs focusing on illicit drugs. Drug Use Monitoring in Australia (DUMA) and the Illicit Drug Reporting System (IDRS).

Background to DUMA & IDRS

The Drug Use Monitoring Australia (DUMA) program, which is coordinated by the Australian Institute of Criminology (AIC), monitors national illicit drug trends by interviewing recent detainees in a number of police stations or watchhouses. This methodology provides a specific source of information on drug trends and criminal activity, and is compiled quarterly.

Its strengths include its capacity to help police and other agencies identify emerging drug crime problems, and to target police operations; its data can also help treatment providers assess the needs of this section of the population who use drugs. DUMA data has application at the strategic intelligence level for Commonwealth law enforcement and also provides a market snapshot that complements other data sources such as the Illicit Drug Reporting System (IDRS) and as such is very useful in informing policy research and development.

According to the AIC, one of the main reasons for focusing on the offender population rather than people who use drugs per se is that those who engage in both criminal activity and illicit drug use have greater impact on the quality of life of ordinary Australians than other groups of people who use drugs.

The IDRS is coordinated by the National Drug and Alcohol Research Centre (NDARC). It also monitors national illicit drug trends, and is conducted annually by participating research institutions throughout the country. The IDRS monitors the price, purity, availability and patterns of use of the main illicit drugs, as well as identifying emerging trends in illicit drug markets; it analyses data from sources such as people who inject drugs, key informants who are experts in the field, and other sources such as Customs seizure data.

By specifically surveying people who inject drugs, the IDRS can provide an early warning system for governments, law enforcement and health workers. It is this early warning aspect, gained through researching the drug market from the perspective of imitated and market-immersed injecting drug users, which is arguably of the most value to law enforcement and health professionals. While it is not an accurate picture of population patterns of drug use, the IDRS is highly useful for looking at emerging trends and potential harms within the major using communities.

Other Australian data sources

A principal source of information on drug use in the general population is the National Drug Strategy Household Survey (NDSHS), the last two of which have been managed by the Australian Institute of Health and Welfare. Four other key data sources include:

• National Health Survey (for tobacco and alcohol use in the adult population)
• Australian Secondary Schools Alcohol and Drugs Survey (for patterns of drug use among students aged 12-17 years)
• National Alcohol Indicators Project
• Illicit Drug Data Report (previously the Australian Illicit Drug Report, for law enforcement drug seizure and clandestine laboratory detection data).

All of these, and other, data sources serve to complement each other. Together they provide useful information on trends and behaviour in Australian illicit drug markets. For example, both the 2001 NDSHS and the IDRS independently highlighted the decline in heroin availability and use which first began in late 2000.

The results of the IDRS survey for 2004 will be available later this year and Of Substance will continue to report on these and other data sources in future issues.

The following pages contain more information about the methodology and recent findings of both DUMA and IDRS.

Drug Use Monitoring in Australia

LEE MILNER, AUSTRALIAN INSTITUTE OF CRIMINOLOGY, ACT

Background history

Prior to 1999, there was little empirical data on the link between drug use and crime, which meant that policy initiatives in the field of illegal drugs often relied on anecdotal information. DUMA was established to address this issue by collecting legal drug prevalence data from offenders, and providing aggregate data to state law enforcement agencies, drug and alcohol services and national such as the Australian Federal Police, Australian Customs, the Australian Crime Commission, the Department of Health and Ageing and the Australian National Council on Drugs.

DUMA data collection began in 1999 at four sites – East Perth Lockup (WA), Southport Watchhouse (Qld), Parramatta and Bankstown police stations (NSW) and was extended in 2001 to include Adelaide City Watchhouse, Elizabeth police station cells (SA) and Brisbane City Watchhouse (Qld). In 2003 the Australian Government committed funding until 2008.

How does DUMA work?

Trained local staff conduct interviews with adult male and female detainees who have been arrested and have been held in custody for less than 48 hours. Juveniles are only interviewed in the NSW sites. There are two components to the data collection – an interviewer administered questionnaire and a urine sample. Both are strictly confidential and voluntary so that the information cannot be linked back to individuals. The urine analysis tests for six different classes of drugs – cannabis, opiates, methadone, cocaine, amphetamines and benzodiazepines. Further tests are run on the positive screens for amphetamines and opiates to determine the actual type of drug used.

Interviews are conducted quarterly for three to four weeks in each site. The data is collated at the Australian Institute of Criminology and fed back to stakeholders in each jurisdiction within two to six weeks following collection. Since 1999, 88 per cent of detainees approached have agreed to be interviewed; of those, 78 per cent provided a urine sample. At the end of 2003, almost 13,000 questionnaires had been completed. (continued over page)

The Illicit Drug Reporting System

COURTNEY BRENN, EMMA BLACK & LOURIS DEGENHARDT, NATIONAL DRUG AND ALCOHOL RESEARCH CENTRE, NSW

Background history

The IDRS is a national illicit drug monitoring system, funded by Australian Government and the National Drug Law Enforcement Research Fund. The IDRS is conducted each year in every state and territory by participating research institutions throughout the country, and is coordinated by the National Drug and Alcohol Research Centre.

The IDRS commenced as a trial in NSW in 1996. After successful piloting, it was expanded to three states (NSW, Vic and SA) in 1997. The complete IDRS methodology was conducted for the first time in every jurisdiction in 2000. Comparable data on drug purchase prices, drug use patterns, availability, health, criminally and policing are obtained from at least 100 people who inject drugs in each capital city of each jurisdiction.

How does IDRS work?

The IDRS monitors the price, purity, availability and patterns of use of the main illicit drugs, as well as acting as an early warning system for emerging trends in illicit drug markets, via three data sources: a quantitative survey of people who inject drugs; a semi-structured interview of key informants (experts who work in the field of illicit drugs); and other sources such as Customs seizure data, seizure purity data and arrest data.

The IDRS informs us of what is new in drug markets, and gathers information from people active in the market about:

• what is being used; i.e. if there is a new drug or a new form of a drug being used
• the harms associated with use and the extent of these harms.

As the IDRS is conducted annually we can examine trends over time and look at what has changed (or remained the same) from the previous year. It also provides information on the similarities and differences between states.

It is also important to note what the IDRS cannot do. The survey of people who inject drugs is not intended to be representative of all people who inject drugs, and different trends may exist elsewhere. It is not a population survey and so cannot tell us about the proportion of the population that are using different drugs, nor can the IDRS give us an indication of how many users of a particular drug there are. (continued over page)

(continued over page)
DUMA data

LEE MILNER, AIC, ACT

Drug and alcohol prevalence data

The DUMA questionnaire is designed to elicit data on a number of key areas. Standard socio-demographic questions are asked and data on social issues such as gambling and mental health are also collected. The main components of the questionnaire are discussed in more detail below.

The drug and alcohol use component of the questionnaire is designed to provide data on the detainee’s drug and alcohol use histories, the age of first and regular use, a measure of dependency, and in the case of illegal drugs, injection practices. Originally the questionnaire focused on alcohol and eight different types of illegal drugs – cannabis, cocaine, heroine, street methadone, methamphetamine, benzodiazepines, ecstasy and hallucinogens. Morphine and inhalants were added in 2004.

The DUMA questionnaire also focuses on heavy drinking by asking male detainees if they have drunk five or more drinks on the same day in the past 12 months and how often they have done so in the past 30 days. For females the questions relate to three or more drinks. Over half of males and 44 per cent of females had used alcohol at this level in the past 30 days. Of those who had used alcohol at this level in the past 30 days, 21 per cent self-reported being dependent on alcohol.

DUMA validates the self-report data with urine testing. This is important as a subgroup of detainees do not self-report recent use when in fact they have used; in addition some self-report recent use when in fact they do not. A subgroup of detainees do not have urine testing positive in the Sydney sites have been indicated of a downturn in heroin use, the heroin shortage, the proportions not observed until mid 2001. Since the heroin shortage, the proportions testing positive in the Sydney sites have dropped and are now comparable to all other sites.

Who is using DUMA data?

Treatment services

Multiple drug use is prevalent among police detainees. Approximately 40 per cent of detainees tested positive to two or more drugs. This means that offenders are using a range of drugs and there is not necessarily a clear cut connection between particular types of offending and particular types of drugs. Such high rates of multiple drug use have implications for treatment providers who need to be capable of dealing with the potential problems multiple drug use can cause.

The Drug and Alcohol Services Council in South Australia has been involved in the DUMA project in SA from the beginning and uses the information from DUMA in conjunction with other data sources such as IDRS to develop policies.

Drug market information

Law enforcement has a particular interest in local drug markets, but this is also of interest to those who seek to locate treatment services in areas where there is the greatest need. Detainees provide information about their involvement in the illicit drug market as well as their perceptions on the market. For example, detainees are asked about the perceived risk of buying and selling illegal drugs in their local area. This information has been used by police to evaluate targeted operations on local drug markets.

For a full list of references relating to the DUMA information compiled here, please contact the Of Substance editors.

IDRS data

COURTNEY BREEN, EMMA BLACK AND LOUISA DEGENHARDT, NDARC, NSW

Illicit drug prevalence and use

The IDRS has shown that the availability of heroin has continued to increase since the shortage of 2001, although the prevalence and frequency of use has not returned to the levels seen as 2000. Use of all forms of amphetamine remains high and an increase in the use and availability of crystal methamphetamine has been observed in most jurisdictions. Recent cocaine use decreased in all jurisdictions and remains relatively uncommon outside NSW. In NSW the frequency of cocaine use decreased among people who inject drugs. Hydropically grown cannabis continued to dominate the cannabis market.

The IDRS research has provided valuable information on the misuse of prescription drugs including benzodiazepines, morphine, methadone and buprenorphine. In particular information provided on the injection of temazepam capsules contributed to the removal of this form of the drug from the market.

The use of diverted pharmaceuticals remains an issue of concern, and the IDRS will continue to provide information on changes in use and harms. This year the IDRS also included questions on instances of aggressive behaviour following use of alcohol and/or other drugs, as this has been highlighted as another area of concern.

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For a full list of references relating to the IDRS information compiled here, please contact the Of Substance editors.

How is IDRS data used?

Information from the IDRS can be used by ATOD workers to give an indication on trends in drug use patterns and new drugs that may emerge. It provides a context for issues which are relevant to their clients such as injection related problems due to certain drugs or frequency of injection (e.g. benzodiazapines and cocaine respectively).

The IDRS also provides information on what policy makers, health and law enforcement personnel should look out for and areas where further, or more detailed research is required.

The IDRS has demonstrated that it can provide information on changes in drug markets. It has contributed information to the investigation into the recent heroin shortage and changes in drug use associated with it. The IDRS has also provided information on the different forms of methamphetamine being used across the country and the recent increase in the availability and use of crystalline methamphetamine (ice).

The value of a monitoring system has been demonstrated over time. The IDRS has collected consistent information on the price, purity and availability of illicit drugs in all jurisdictions nationwide and therefore provides information to examine illicit drug markets within and between the states and territories of Australia.

For a full list of references relating to the IDRS information compiled here, please contact the Of Substance editors.

For more information

The study findings are presented every year at the Drug Trends Conference in November. Summary information can be found on the NDARC website. Annual reports are produced and are disseminated through NDARC. In addition, quarterly bulletins are produced and can be downloaded from the NDARC website: http://ndarc.med.unisw.edu.au/ndarc/mhwebsite/IDRS_bulletins
NEW RESEARCH ON ILLEGAL DRUG USE

ADDRESSING THE NEEDS OF ABORIGINAL AND TORRES STRAIT ISLANDER ILLEGAL DRUG USERS IN THE ACT AND REGION

JULIA TRESIDDER

Responding to community concerns

The ‘I Want to be Heard’ study, released in June 2004, is a response to concerns from Aboriginal and Torres Strait Islander people in the ACT and region about the impact of both licit and illicit drug use on their community.

Research partnership

The research was the result of a partnership between Winnunga Nimmityjah Aboriginal Health Service and the National Centre for Epidemiology and Population Health (NCEPH) at the Australian National University (ANU). A reference group, composed mainly of Aboriginal people, guided the investigation. This collaborative research was funded by the National Health and Medical Research Council (NHMRC) in a grant round funded by the National Illicit Drugs Strategy.

The ‘Darwin Criteria’ (which were established by the NHMRC to ensure community participation, as well as sustainable and transferable research results) informed the research methodology. A two-way ‘transfer of skills training’ between NCEPH and Winnunga Nimmityjah researchers took place throughout all phases of the research.

Methods

The researchers gathered both qualitative and quantitative data on drug use histories, behaviours and needs, as well as information related to social, physical and emotional health needs. The interviews were conducted over a 17 month period. Ninety-five Aboriginal and Torres Strait Islander people who use illicit drugs were interviewed. The researchers estimated that there are about 500 Aboriginal and Torres Strait Islander people in the ACT and region who use illicit drugs, so they therefore interviewed about 20% of this sub-population. Both an Indigenous and a non-Indigenous researcher were present at each interview. Participants were also encouraged to bring a support person with them to the interview. Health education and referrals were provided as an integral part of the research methodology.

Respondents

Respondents’ ages ranged from 16 to 50 years (average 29 years); forty four were aged 25 years or less. Two-thirds were men.

Illicit drug use

A vast majority of respondents were current tobacco smokers (95%). This is way above the national average. Most were also current drinkers. Three-quarters of those who consumed alcohol were at risk of alcohol-related harm (as defined by the NHMRC) and over half of these people had some level of dependence on illicit drug use.

The mean age of initiation into illegal drug use was 14. This is much younger than the general Australian population of people who have used illegal drugs. The first illicit drug used was most commonly cannabis. Nearly all participants had at some time used this drug; 70 were currently using it weekly, and 54 of these were assessed as being dependent. Just over a quarter of participants identified cannabis as their most problematic drug.

Sixty one people had ever injected. The mean age for first injecting was 20 years. Fifty four people had injected in the 12 months prior to the interview. The remaining 47 had used other routes of administration. Heroin was the drug first injected by two-thirds of the people who had ever injected. An amphetamine was the first drug injected by the remaining people who had ever injected. Forty nine people were currently using heroin and two-thirds were assessed as being dependent. About half of all participants were currently using benzodiazepines, and the same proportion was currently using amphetamines. Current use of hallucinogens was limited to four people. Polydrug use was the norm.

Drug treatment

Most of those interviewed had accessed some form of drug treatment. Over two-thirds had accessed outpatient services at an Aboriginal Community-Controlled Health Organisation. Mosch had also accessed mainstream services such as Alcoholics Anonymous, residential rehabilitation or withdrawal services. Some would have preferred these services to have Aboriginal staff. Some opioid users had also tried methadone or buprenorphine treatment.

A majority of the injecting drug users obtained clean injecting equipment from a mainstream service such as a needle and syringe program, but some also accessed pharmacies for this service.

Recommendations for improved service provision

The need for Aboriginal services, and mainstream services with Indigenous staff, is highlighted by the report. Waiting periods and inflexible rules within treatment centres were also seen as barriers to treatment. Holistic education within the treatment setting is recommended, as many people wanted to learn more about their culture and many also expressed a need to improve their education whilst in residential treatment.

A booklet for Aboriginal and Torres Strait Islander people is being produced as part of the study to fulfill, for example, needs for information about treatment services, and preventing and treating overdoses.

Other contributing factors

The report also details other related factors including cultural needs, low levels of education, high unemployment rates, dissatisfaction with housing situations and Stolen Generations stress as factors contributing to rates of illegal drug use that exceed those of the non-Aboriginal population.

Conclusions and recommendations

The report sets out 22 recommendations that would contribute to making a difference to the lived and opportunities this disadvantaged group. These include providing more opportunities for cultural education, the establishment of an Aboriginal residential treatment centre, multifunction services, better programs for young Aboriginal people at school who are not doing well in the education system, better employment services and a better understanding of the barriers to employment, including early age of school leaving, racism and criminal histories.

The report has application outside the ACT as it highlights the importance of family and cultural identity for Aboriginal and Torres Strait Islander people, as well as the importance of providing culturally appropriate and responsive treatment services.

Reference

Dunne, P., Torpey, J., Guthrie, J., McDonald, D., Donner, R., Caballo, C. & Bannister, G. 2004. ‘I want to be heard’: an analysis of needs of Aboriginal and Torres Strait Islander illegal drug users in the ACT and region for treatment and other services, NCEPH, ANU and Winnunga Nimmityjah Aboriginal Health Services, Canberra.

Copies of the report are available from NCEPH, phone 02 6225 2378. An electronic version can be found at: http://nceph.anu.edu.au/Publications/Indig_docs/I_want_to_be_heard.pdf

Book review

MARGARET HAMILTON

Indigenous Australia and alcohol policy: meeting difference with indifference – Maggie Brady – UNSW Press 2004

Maggie Brady has long been respected for her knowledge, experience and interest in Aboriginal communities, as well as individuals’, struggle with alcohol. In her earlier books about ‘grog’, her sensitivity and her commitment to finding ways of achieving positive outcomes for those affected, she provides insights that most of us rarely have access to. Notwithstanding this, Aboriginal health indicators are deteriorating and generally the situation for Aboriginal people remains a matter of shame for all of us.

The intellectual effort involved in researching this book, her most recent contribution, has been considerable and helps to explain the context of this situation.

When I first read it this was my reaction:

I confess to becoming swept up in the story told in this book of how Indigenous alcohol issues can fall through the cracks, both in the mainstream thinking and analysis of health and alcohol policy, and in the development of Indigenous perspectives. It is a walk through history. It also brings together a rich and extensive analysis of the Aboriginal policy and administrative structures over the last three decades, and an understanding of the conceptual and pragmatic contexts of drug and alcohol studies.

For those concerned enough to want to understand more about Australia’s Aboriginal people and grog – this book will tell you much.
Upcoming conferences

27-29 October 2004
Australasian Therapeutic Communities Association conference
‘Soaring To New Heights’
Surfers Paradise, Queensland
Phone: (07) 5576 7971 or (07) 5591 6871
Email: charlie@goldbridge.com.au
or mary@gcdrugcouncil.org.au

14-17 November 2004
APSAD 2004 National Conference
Incorporating the National Methadone Conference
Beyond the drug: Exploring individual, political, social and other contexts critical to effective prevention and treatment.
Esplanade Hotel, Fremantle, Western Australia
www.apsad.org.au

21-23 November 2004
National Indigenous Juvenile Justice conference
co-hosted by the Indigenous Law Centre of the University of NSW and Aboriginal Legal Service and the Aboriginal Legal Services (ALSWA), Perth, Western Australia
Email: conventionsinfo@westnet.com.au

25-26 November 2004
National Conference for Indigenous Peoples Issues in Custody
Perth, Western Australia
co-hosted by the Indigenous Law Centre of the University of NSW and Aboriginal Legal Service and the Aboriginal Legal Services (ALSWA).
Email: conventionsinfo@westnet.com.au

6-7 December 2004
Victorian Alcohol and Drug Association (VAADA) conference
Are we doing a good job? Exploring the public image and quality of services for people with alcohol and drug problems.
The William Angliss Conference Centre Melbourne, Victoria
Email: vaada@infoxchange.net.au

21-23 February 2005
Thinking Drinking: Achieving Cultural Change by 2020
Thinking Drinking 2020 brings together international futurists and alcohol experts to determine how we can change Australasia’s binge drinking culture.
Rydges, Melbourne
Email: thinking.drinking@adf.org.au

We welcome your feedback about this issue of Of Substance:
Email: editor@ancd.org.au
Telephone: 02 6279 1650

Or write to us:
Of Substance, PO Box 1552
Canberra ACT 2601
Australia