

# OF SUBSTANCE

JANUARY 2005 VOL.3 NO.1

THE NATIONAL MAGAZINE ON ALCOHOL, TOBACCO AND OTHER DRUGS

## ALCOHOL

Culture of the workplace

## SCHOOLIES WEEK

Research & interventions

## DIVERTING PHARMACEUTICALS

Health & police  
perspectives

## METHADONE & BUPRENORPHINE

Costs of treatment

# VOLATILE SUBSTANCES

Research & interventions

RESEARCH ON TREATMENT SERVICES, NEWS, RECENT RELEASES & MORE ...



# SUBSCRIBE TO OF SUBSTANCE

- *Of Substance* is a quarterly magazine
- Subscription rates are \$50 per year (\$70 for overseas subscribers)
- Subscription forms are available at [www.ancd.org.au](http://www.ancd.org.au) (click on *Of Substance* icon)
- Oct '03, Jan '04 and April '04 issues are available in PDF at [www.ancd.org.au](http://www.ancd.org.au)
- Inquiries about bulk orders (over 10 copies) to: [editor@ancd.org.au](mailto:editor@ancd.org.au)
- *Of Substance* is a GST-free product. ABN 39 008 455 525



**Advertise in *Of Substance*** – The magazine will consider full- or half-page advertisements.  
Current rates (excluding GST): • \$1,000 for a full page • \$600 for a half page

*Of Substance* is governed by a Board of Management.

**Chair:**

Professor John Saunders, Professor of Alcohol and Drug Studies, University of Queensland.

**Members:**

Kirk Coningham, Manager, Marketing and Communications, Australian Federal Police.

Trevor Fearnley AM, Chief Executive, AdPartners Group.

Tim Trumper, Consultant Advisor. Tim has an extensive career in publishing.

Gino Vumbaca, Executive Officer, Australian National Council on Drugs.

Brian Watters AO (Major), Chairman, Australian National Council on Drugs.

Dennis Young, Executive Director, Drug-Arm Australia.

**Managing Editors:**

Julia Tresidder and Kate Pockley

*Of Substance* contact details:

Email: [editor@ancd.org.au](mailto:editor@ancd.org.au)

Telephone: 02 6279 1650 or write to us:

*Of Substance*, PO Box 1552,  
Canberra ACT 2601 Australia

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

**Chair:**

Professor Margaret Hamilton, Chairperson, Multiple and Complex Needs Panel, Victoria.

**Members:**

David Crosbie, Chief Executive Officer, Odyssey House Victoria.

Jenny Hefford, Assistant Secretary, Drug Strategy Branch, Department of Health and Ageing.

Annie Madden, Executive Officer, Australian Injecting & Illicit Drug Users League (AIVL).

David McDonald, Alcohol & other Drugs Council of Australia, Representative.

Wesley Noffs, Chief Executive Officer, Ted Noffs Foundation.

Larry Pierce, Executive Director, Network of Alcohol and Other Drugs Agencies.

Professor Ann M Roche, Director, National Centre for Education and Training on Addiction, Flinders University.

Professor John Saunders, Professor of Alcohol and Drug Studies, University of Queensland.

Gino Vumbaca, Executive Officer, Australian National Council on Drugs.

Brian Watters AO (Major), Chairman, Australian National Council on Drugs.

*Of Substance* is an Australian National Council on Drugs initiative and is produced with funding from the Australian Government Department of Health and Ageing.

The magazine is designed by Caroline Butler and Juliet Fisher, AdPartners Group.

The views and opinions expressed in the articles in this magazine are those of the individual authors and do not necessarily represent the views of the Australian Government Department of Health and Ageing, the Australian National Council on Drugs or the Alcohol and Other Drugs Council of Australia.

© Commonwealth of Australia 2005

This work is copyright. It may be reproduced in whole or in part for study or training purposes subject to the inclusion of an acknowledgment of the source and no commercial usage or sale. Reproduction for purposes other than those indicated above, require the prior written permission from the Commonwealth. Requests and inquiries concerning reproduction and rights should be addressed to Commonwealth Copyright Administration, Department of Communications, Information Technology and the Arts, GPO Box 2154, Canberra ACT 2601 or email [Commonwealth.copyright@dcita.gov.au](mailto:Commonwealth.copyright@dcita.gov.au)

Front cover: Courtesy of Fairfax Photos

## Contents

Editorials	2
News	3
Recent releases	4
New data on national AOD treatment services.	5
Volatile substance misuse	8
An update on current issues, national and state/territory government initiatives, Indigenous resource and treatment programs, and urban users' perspectives.	
Hepatitis C	12
Recent information on new infections, and an analysis of Australia's approach to hepatitis C prevention.	
Opioid substitution therapy	14
A policy debate on whether there should be government subsidy of retail pharmacy outlets' dispensing and recording fees.	
Alcohol and the workplace	18
A focus on how workplace culture impacts on individuals' and organisations' attitudes to alcohol consumption.	
Diversion of pharmaceuticals	22
An overview of the recent government initiatives including prescription shopping, and a case study on the harms of misusing temazepam capsules.	
Policing perspectives on the dangers of clandestine laboratories and regulation of non-prescription medications.	24
Queensland's Schoolies Week	26
A recent cross-sectional study investigates alcohol and other drug consumption, and risk-taking behaviour, on the Gold Coast; plus a snapshot of different intervention strategies.	

### Access to references cited in *Of Substance*

A photocopy of any journal article cited in *Of Substance* required for the purpose of research or study can be ordered from the ADCA National AOD Clearinghouse by contacting [aodclearinghouse@adca.org.au](mailto:aodclearinghouse@adca.org.au) or by phone to (02) 6281 1002 or fax to (02) 6282 7364. The charge per article is \$5 for members of ADCA and \$11 for non-members.





Julia Tresidder



Kate Pockley

## Editors' letter

In this issue of *Of Substance* we focus on young people and different risk-taking behaviours. Volatile substance, or inhalant, use is a high-risk activity that can be difficult for frontline workers to respond to; we provide some background information to this issue, plus outline a range of current government and non-government sector programs dealing with volatile substance abuse. We also hear some urban users' perspectives.

Alcohol is also a major theme of this issue, and its role in celebrations is highlighted in the article on Schoolies Week. This annual celebration occurs in many locations around Australia; the Queensland Gold Coast is one particular destination that attracts around 50,000 young people from Queensland and interstate. Since the 1980s, the Gold Coast celebrations have been identified as a place where school leavers may be at risk of harm when they experiment with alcohol and other drugs, and engage in risky behaviours. We cover a series of cross-sectional studies that have looked at these risks over a number of years.

Alcohol and workplace culture is discussed in another article; it examines how alcohol use is entrenched in our culture, especially in specific settings, and how this creates difficulties in developing successful interventions.

An area of concern is how pharmaceutical drugs can be diverted for purposes other than those intended. The potential harm of misusing such drugs is illustrated by a case study of how temazepam capsules came to be withdrawn from the market; several government initiatives to investigate and prevent aspects of this diversion are also outlined.

Continuing from our article in the October 2004 issue on data collection, we highlight another national project that records aspects of treatment provision in Australia – the National Minimum Data Set. On the treatment front we present a 'policy debate' about the cost to consumers of methadone and buprenorphine. Finally, our regular news and new releases pages aim to keep you up-to-date on recent happenings in the AOD sector.

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

## GUEST EDITORIAL

### VOLATILE SUBSTANCES: THE NEED FOR COMMUNITY - WIDE SOLUTIONS

ANNE MOSEY, DIRECTOR, ALCOHOL EDUCATION AND REHABILITATION FOUNDATION LTD



The level of volatile substance abuse (VSA) has increased dramatically in urban and regional areas of Australia in the last five years. Previously, solvent or inhalant abuse was believed to belong 'out there' in Central Australia – mainly petrol sniffing in Indigenous populations. Recently readers of the major city dailies have been shocked to read of the deaths of young people

while 'chroming', and the increasing levels of crime and public behaviour problems that are attributed to 'sniffers'.

Frontline alcohol and other drug (AOD) workers in urban situations have been expressing confusion and frustration while attempting to support these young (and not so young) people. It might be useful, therefore, to discuss some possible community-based strategies for working with chroming and other forms of VSA. While there have been very few evaluations of these strategies, it appears from anecdotal evidence that there are some factors that need to be taken into account when planning community-wide VSA programs.

Firstly, AOD workers need to consider all levels of VSA, and to plan separately for each target group. Users can be divided into never-used (approx 80% of young people nationally), occasional or opportunistic use (once every few months), social use (once a month to once a week) and chronic use (every day, all day/night, constantly seeking out the substance). While many of the occasional and social use group will respond to fun diversionary activities, the chronic user may benefit from a different approach – for example, working intensively with the family (if there is one), case management, time out in another environment, and counselling to deal with any underlying issues. Initially, he/she may also need housing, money and food.

The more successful strategies involve several programs at the same time. It doesn't seem to matter what the mix is, as long as there are at least three or four running at the same time. These can include pleasant activities, as well as strategies such as reducing supply by working closely with local retailers and retail bodies, setting up a community or night patrol, and working with police to use state and federal legislation.

It is also important to consider plans for the short-term (1-3 months), the medium-term (3-6 months) and the longer term (6+ months). Service providers can fall into the trap of seeking funding for major events or amenities works, and forget the value of simple, cheap, short-term ideas such as regular discos, sport, art, etc. The key word here is regular. Occasional big event concerts are less effective than a small local disco, BBQ or video workshop held every weekend.

While the above ideas are not in any sense a recipe, they may be useful to AOD workers struggling with how best to work with VSA in their region.

## NEWS

### INDOOR SMOKING: NEW BANS ANNOUNCED

In October 2004, NSW and Vic. announced total indoor smoking bans in pubs and clubs by mid-2007. The bans will be phased in, with restricted inside smoking in licensed premises starting from July 2005.

The bans bring the two states into line with most others in Australia. Tas. will have a total indoor smoking ban from January 2006, followed by Qld in July 2006 and the ACT in 2007. SA will phase in a total ban by 2008.

A few international jurisdictions – including three US states, New Zealand and Norway – have also announced or implemented similar bans. A NSW Health survey reported that 23 per cent of respondents would go to pubs and clubs more if smoking was banned – countering the protests from the Hotels Association that bans would lead to job losses. Figures released by the NSW Premier's Office claimed that since a similar ban was imposed in New York, business has grown by 8.7 per cent.

'It is disappointing that after ten years of debating the issue there is still a need [in NSW and Vic.] to have a partial ban introduced before the full ban is implemented. We are concerned for the workers and patrons who will be exposed to high levels of carcinogens in the smoking rooms – they are being denied a safe and healthy environment unnecessarily,' said Ms Anita Tang, Director of Health Strategies, Cancer Council NSW.



### 2004 FEDERAL ELECTION

Following on from the recent Federal election, The Hon Christopher Pyne will be taking over responsibility from Ms Trish Worth for national alcohol and drug concerns.

*Of Substance* notes that Trish was especially interested in and committed to furthering the Australian response to drug use during her term as Parliamentary Secretary of Health. Her interest in pursuing prevention, her sensitive personal involvement in the development of drug response initiatives and her genuine pursuit of evidence in seeking answers was

### FINDINGS FROM THE 2004 IDRS

The Illicit Drug Reporting System (IDRS) is a national illicit drug monitoring system that monitors the price, purity, availability and patterns of use of heroin, methamphetamine, cocaine and cannabis. The information gathered is not representative of illicit drug use in the general population nor is the information representative of all illicit drug users, but is indicative of trends that warrant further examination. Preliminary findings of the 2004 IDRS are presented below; detailed national and state reports will be available in March 2005.

- The majority of people who inject drugs in all states but Tas. and the NT reported recent heroin use. The frequency of heroin use decreased in NSW, the ACT, Qld and SA. Heroin was reported to be 'easy' or 'very easy' to obtain except in Tas. and the NT. Heroin was cheapest in NSW, Vic. and the ACT at \$300 a gram.
- Recent use of speed remained lowest in NSW and recent use of ice was highest in WA. Recent use of base varied by jurisdiction; highest in Tas. and lowest in Vic. All forms were considered 'easy' to 'very easy' to obtain in all states, except the NT where ice was reportedly 'difficult' or 'very difficult'. All forms remained cheapest in SA.
- The proportion of people who inject drugs that reported recent cocaine use remained low (15% or less) in all jurisdictions except NSW (47%). The frequency of cocaine use has decreased in NSW in recent years; every second day in 2001, to weekly in 2002 and now once a month in 2004. Use remained sporadic in all other jurisdictions.
- Cannabis remained easy to obtain in all jurisdictions. Hydroponically-grown cannabis continued to dominate the market and potency continued to be rated as high.

For more detailed results go to the National Drug and Alcohol Research Centre website:

<http://ndarc.med.unsw.edu.au/ndarc.nsf/website/IDRS.bulletins>

impressive. Trish was also a strong advocate for exploring better ways of dealing with those affected by dual mental health and drug dependence problems, personally attending day-long meetings and forums in an effort to find workable and better responses. As Parliamentary Secretary, she was a well-informed and experienced contributor to national alcohol and drug campaigns, and she ensured that an appropriate level of respect and use of independent research informed their development. Trish's cooperative approach and work with the states and territories will also be recognised for some time. *Of Substance* wishes her well in her future endeavours and acknowledges the valuable contribution she has made to the ATOD and related sectors.



## RECENT RELEASES

### National training package

Medical practitioners and AOD clinicians are the primary target audience for a new resource on illicit drug issues, launched by the National Centre for Education and Training on Addiction (NCETA) in November 2004. Nurses, counsellors and education-sector workers may also find it relevant. The National Training Package for Medical Practitioners on Illicit Drug Issues has three components: an AOD handbook, a CD ROM resource kit for GP trainers and a website for GPs.

The handbook for health professionals is the third edition of this resource and the new version has expanded to cover topics such as polydrug use and coexisting mental health problems.

The resource kit for GP trainers provides evidence-based strategies and perspectives that are practical to assist GPs in their day-to-day practice. There are many materials to choose from to use in training.

The website provides useful information for GPs to use both with patients and for their own professional development.

The handbook can be downloaded from [www.nceta.flinders.edu.au](http://www.nceta.flinders.edu.au) and hard copies of both the handbook and the resource kit can be ordered by calling 1800 020 103 (ext 8654) or by emailing [nmm@nationalmailing.com.au](mailto:nmm@nationalmailing.com.au)

### Australian prisons report

The Australian National Council on Drugs released their latest report, *Supply, demand and harm reduction strategies in Australian prisons: implementation, cost and evaluation*, at the annual Australian Professional Society for Alcohol and Other Drugs Conference in November 2004.

The report is authored by Emma Black, Kate Dolan and Alex Wodak, and is the result of a collaboration between the National Drug and Alcohol Research Centre, the University of New South Wales and St Vincent's Hospital, Sydney.

The report outlines what is known about the diverse array of supply-, demand- and harm-reduction strategies that have been implemented in Australian prisons. It concludes that many strategies have been poorly documented, their costs were largely unknown and their benefits and adverse consequences have rarely been defined.

The report notes that supply-reduction strategies (such as sniffer dogs and drug testing) were widespread, relatively expensive, had not been evaluated and possibly had unintended negative consequences. Demand-reduction strategies (such as methadone treatment) had a reasonable level of implementation, were relatively inexpensive and evaluation had been favourable. Harm-reduction strategies (e.g. the provision of bleach and condom distribution) were least likely to be implemented, were relatively inexpensive and evaluation had been favourable.

The report makes a number of recommendations to improve the effectiveness of supply-, demand- and harm-reduction strategies in Australian prisons. The report is available from the ANCD website: [www.ncnd.org.au](http://www.ncnd.org.au)

### ADIN website updated

The Australian Drug Information Network (ADIN) website – [www.adin.com.au](http://www.adin.com.au) – has been completely redeveloped and re-launched.

The new easy-to-use layout includes links for treatment services, information for multicultural and Indigenous communities, teachers and researchers. Organisations can now incorporate ADIN onto their own webpage allowing the user to access ADIN from other websites.

The new website brings together over 1300 alcohol and other drug-related websites, each of which is critically reviewed by an alcohol and other drug professional, before being included in the ADIN database. The reviewer checks each site for accuracy, bias, currency, security and accessibility before ranking it according to the content provider's credibility. The aim of this is to provide the user with the best selection of information in one place, so they can avoid the inconvenience and nuisance of searching numerous unverified sites.

ADIN is funded by the Department of Health and Ageing under the National Illicit Drug Strategy, and managed by the Australian Drug Foundation.

## Alcohol and other drug treatment services in Australia 2002-03

JULIA TRESIDDER

The latest report on the Alcohol and Other Drug Treatment Services National Minimum Data Set (NMDS) from the Australian Institute of Health and Welfare (2004) gives a national snapshot of a specific set of government-funded treatment services. This is the third report in this series; the first report was published in 2002.

### Development of the current NMDS

The need for an NMDS was first discussed at a national forum held in 1995 by the Alcohol and other Drugs Council of Australia (ADCA). The Federal Government funded the special invitation-only workshop to develop strategies that could bridge the gap between research and drug treatment practice. The gathering of leading researchers, government representatives, and managers of drug treatment agencies from around Australia spent a full day listening to brief presentations, discussing options and agreeing to recommendations.

David Crosbie, who was the CEO of ADCA at the time, notes that:

One of the most important outcomes of this workshop was a shared commitment to establishing accurate data about drug treatment across Australia. The major barrier to establishing this data was the way different states and territories not only categorised and funded drug treatment agencies in different ways, but also recorded vastly different levels of information about drug treatment in their jurisdiction.

The establishment of the NMDS was seen as a way of beginning to standardise some of the basic information needed to gain a picture of drug treatment across Australia. Even getting agreement on the way things as simple as the age of the person in drug treatment was recorded was more difficult than most people would imagine. Some states and territories used four figures for the year of birth while others used only two, some used a three letter abbreviation for month while others used two figures, etc. Imagine trying to standardise all the drug treatment records from every jurisdiction?

After gaining agreement to work towards a standardised data set, a joint feasibility study was undertaken by the National Drug and Alcohol Research Centre and ADCA. Further development was facilitated by an interim working group in 1998 set up by the Intergovernmental Committee on Drugs (IGCD). In December 1999 the Commonwealth and state and territory governments, through the National Health Information Management Group, endorsed the NMDS and data collection commenced on 1 July 2000.

The NMDS for alcohol and other drug (AOD) treatment services is still a national project of the IGCD, and its working group has state, territory and Australian Government representatives, as well as a representative from NDARC.

In looking back over the process started in 1995, David Crosbie notes that:

The NMDS has come a long way in the last nine years, and although it still has a long way to go, there is no doubt it represents an important step forward in providing accurate

## RECENT RELEASES CONTINUED

and reliable data about the extent and nature of drug treatment across Australia.

### Current sample and limitations

Five hundred and eighty-seven government-funded AOD treatment agencies participated in the collection of data in 2002-03. The overall response rate was 94%. Fifty-five per cent of these agencies are non-government organisations.

Treatment services participating in the NMDS are most likely to be in major cities (56%). A quarter of these services are located in inner regional centres. Almost one in five are located in outer regional, remote or very remote locations.

### 'NMDS excludes agencies that only provide opioid maintenance treatment'

While the NMDS provides much useful data and information, it has some limitations. It excludes a number of agencies involved in AOD service provision, including prisons and other correctional services. Accommodation services such as halfway houses or sobering-up shelters are also excluded, as well as those agencies that only provide prescription for or dosing of methadone or other opioid maintenance pharmacotherapy. This means that the NMDS excludes many clients receiving treatment for heroin use. Finally, the majority of Indigenous government-funded AOD services in Australia and Indigenous primary care services that offer AOD treatment, provide data through alternative avenues and are not included in the NMDS.



### Treatment episodes

The minimum data set counts 'closed' treatment episodes, which are periods of contact with defined start and end dates, between a client and an agency. A treatment episode may be for a specific treatment, such as information and education only, that is not part of a larger treatment plan, or for a specific treatment, such as withdrawal management (detoxification) that is part of a long-term treatment plan. Treatment may cease for a variety of reasons including treatment being completed, loss of contact with the agency for a period of three months or more, change in main treatment type or the client ceasing treatment against the advice of

### In the eye of the needle

DR INGRID VAN BEEK, ALLEN AND UNWIN 2004



Dr Ingrid van Beek recently released her personal account of how Australia's first medically supervised injecting centre came about. Facts, emotions, politics and perspectives are interwoven throughout the book; it also documents interactions between key players bringing the personal and the political aspects into the picture, as well as the policy outcomes and implementation.

After the first three chapters set the scene and give an overview of early negotiations, the rest of the book is a diary and documents the more memorable events that have occurred day-to-day. Both media-driven crises and client-centred incidents illustrate the complexity of being at the centre of a controversial and highly politicised service. Overall the book is an interesting account of a controversial and contemporary trial of an innovative health service.

Photo courtesy of Relationships Australia, Canberra and region: re-enactment of a counselling session

(continued over page)



(continued from page 5)

the agency. The report is based on analysis of data from 130,930 closed episodes of treatment.

### 'closed treatment episodes are periods of contact with AOD services with defined start and end dates'

In 51% of cases, treatment episodes ceased because they were completed. Other cases were closed for different reasons, for example when clients ceased to participate (16%) or when clients transferred to other service providers (7%).

Non-residential treatment services accounted for just over two-thirds of treatment episodes. About one in five treatment episodes were conducted in a residential treatment service and seven per cent were in an outreach setting.

### Demographics of people seeking treatment

The majority of treatment episodes were for clients aged between 20 and 49 years of age. One third were for clients aged between 20 and 29 years. Almost two thirds of treatment episodes were for male clients. Most closed treatment episodes were for clients seeking treatment for their own drug use (94%). The majority of treatment episodes had clients who were born in Australia (85%) and spoke English as their preferred language (95%).

Nine per cent of the treatment episodes had clients who identified as Aboriginal and/or Torres Strait Islander. This is a higher proportion than identifies in the general Australian population (2.4%). As the majority of Aboriginal and Torres Strait Islander specific health services are not included in this data set this proportion should not be treated as representative. It does however indicate that some Aboriginal and Torres Strait Islander people use mainstream services.

### Treatment types

**Counselling** was overall the most common form of treatment provided (42% of closed treatment episodes). Women (47%) were more likely to receive counselling than men (39%). Counselling accounted for the highest median number of treatment days (44 days) and was the most likely treatment type to occur in non-residential treatment settings (56%).

Half of the treatment episodes for clients older than 49 were for counselling while only a third of treatment episodes for clients aged 10-19 years of age were for counselling. A quarter of counselling treatment episodes ended because the client failed to turn up to a session without notifying the service.

**Withdrawal management (detoxification)** was the second most common type (19%). Withdrawal management had a median time frame of seven days. Withdrawal management was the second most likely treatment type to occur in a residential setting (27%). Less women (18%) underwent withdrawal management than men (20%).

**Assessment only** was the third most common treatment type (13%) and almost three quarters of these treatment episodes were completed.

**Information and education only** was also defined as a treatment type and had a median length of one day. As many of these people

## RECENT RELEASES CONTINUED

attend information and education sessions as a penalty for a minor cannabis offence, close to two thirds of these treatment episodes ended because the client had completed the required penalty. Where information and education only was the main treatment type, cannabis was the principal drug of concern in 77% of all treatment episodes.

**Support and case management only** was the second longest treatment type (a median of 43 days). This treatment type accounted for a high proportion of treatment episodes that occurred in an outreach setting (45%).

**Rehabilitation** had a median time frame of 32 days. This treatment type had a relatively low proportion of treatment episodes ceasing due to completion (35%). Rehabilitation was the most likely treatment type to occur in a residential setting (56%).

### Drugs of concern

Records are kept of which drugs people stated as their drug of concern (both in terms of their 'principal' drug of concern and 'other' drugs of concern). Alcohol was nominated as the principal drug of concern in 38% of treatment episodes, followed by cannabis (22%), heroin (18%) and amphetamines (11%). For 20-29 year olds the treatment episodes were fairly even across the four main drugs, with younger people more likely to nominate cannabis, and older ones alcohol. Just over half (51%) of clients of AOD services reported at least one other drug of concern.

**Alcohol** was the most common drug people sought treatment for (38%). Forty four per cent of treatment episodes for alcohol problems involved counselling. Residential treatment settings were most likely when the drug of concern was alcohol (43%). Men were more likely than women to seek treatment for alcohol-related problems (39% males and 35% females). For those over 29 years of age half of the treatment episodes were for alcohol. Proportionally the younger groups were less likely to say alcohol was their drug of concern, with only 17% of treatment episodes for the 10-19 group being alcohol-related and 22% of treatment episodes for the 20-29 age group.

### 'the younger groups were less likely to say alcohol was their drug of concern'

**Cannabis** was the second most common drug of concern for people seeking treatment. Many of these people only come for treatment because attending an information or education only session is the penalty for some minor cannabis offences. Just over one in five treatment episodes were for cannabis problems, and in a third of these episodes counselling was provided.

More males sought treatment for cannabis (24%) than females (19%). Cannabis treatment was most common amongst the youngest age groups with half of all treatment episodes amongst the 10-19 year age group being for cannabis and a quarter of those for people between 20 and 29 years of age.

Cannabis was different to other drugs in that most people only attended treatment for information or education sessions. Many of these people attended because it was required as a penalty for a minor cannabis offence. Nearly a quarter (24%) of treatment sessions for cannabis ceased when the client satisfied the specified time of treatment stated in the penalty. In comparison only

one per cent of treatment episodes for heroin or amphetamine treatment ceased for this reason. When interpreting this information it should be noted that in the Queensland data, which accounts for a high proportion of the data relating to police diversion processes, the principal drug is automatically recorded as cannabis (and all clients are recorded as ceasing once they complete the penalty imposed by completing a required information and education session).

**Heroin** was the primary drug of concern for one in four closed treatment episodes in a residential setting, second only to alcohol. Treatment for heroin use accounted for 18% of closed treatment episodes. It is important to note that opioid maintenance is not included as a treatment type in the NMDS and is therefore not represented in this data set. Of the treatment types included in the NMDS, counselling was the most common form of treatment; this was provided in a third of closed treatment episodes. When regional differences are taken into account, there were more treatment episodes for heroin than for cannabis in major cities.

**Amphetamine** was the principal drug of concern in 11% of closed treatment episodes. Counselling was the most common form of treatment with 43% of all treatment episodes being coded this way.

### Summary

The report on the NMDS gives the field a clearer picture of what AOD treatment services are provided in Australia. It points to the fact that clients of AOD treatment services are most likely to be getting help with alcohol-related problems; treatment for problems with cannabis, heroin and amphetamines is also prominent, particularly among younger clients. National diversion programs for cannabis also appear to have had an impact on treatment providers by referring people to treatment services as a consequence of minor cannabis offences.

### Reference

Australian Institute of Health and Welfare Canberra (AIHW) 2004. *Report on the National Minimum Data Set, Drug Treatment Series No. 3*, AIHW cat. No. HSE 33, Canberra.

## National Drug and Alcohol Awards 2005 NOMINATIONS OPEN

Following the success of the 2004 National Drug and Alcohol Awards, the Ted Noffs Foundation, the Alcohol and other Drugs Council of Australia, the Australian Drug Foundation and the Australian National Council on Drugs are pleased to announce that nominations for the 2005 Awards are now open. **Nominations close on Friday 4 March 2005.**

This prestigious annual event provides the opportunity to encourage, recognise and celebrate Australian achievements to prevent and reduce alcohol and other drug use and associated harms, with the ceremony to be held at the Four Seasons Hotel, Sydney, on 24 June 2005.

#### Awards will be presented in the following categories:

- Prime Minister's award for excellence and outstanding contribution in drug and alcohol endeavours
- Excellence in prevention
- Excellence in treatment
- Excellence in research
- Excellence in services for young people
- Excellence in alcohol and drug media reporting
- Excellence in law enforcement (new category)

Generous prize money of \$2000 will be awarded to each winner, with the winner of the Prime Minister's Award receiving \$5000.

For further information about this event or to submit a nomination form, please visit [www.drugawards.org.au](http://www.drugawards.org.au) or contact Ms Helen Thearle on (02) 8383 6715.

Principal Sponsor: Alcohol Education and Rehabilitation Foundation  
Major Sponsor: Australian Government Department of Health and Ageing  
Sponsor: NSW Government



Photos courtesy of Joseph Lafferty



# VOLATILE SUBSTANCE MISUSE AN ONGOING CONCERN

KATE POCKLEY

Only a small percentage of people engage in volatile substance misuse (VSM) with many ceasing their use very quickly. Despite low user numbers VSM is still of concern to health and welfare workers. This is particularly due to the very young age of many users, the harmful, sometimes fatal health effects and the relative lack of information regarding these effects.

This article outlines information that may be useful to workers in the alcohol and other drugs field. It includes common types of volatile substances and terms used. It also covers statistics on use, some management options, and gives a snapshot of recent policy and legislation changes in Australia. Sarah MacLean, University of Melbourne, writes about users' perspectives; Scott Wilson, Aboriginal Drug and Alcohol Council of South Australia Inc, outlines his organisation's petrol-sniffing resource; and Karissa Preuss and Jena Brown, Mount Theo Program, Northern Territory, talk about the Yuendumu community's treatment service.

## Commonly used substances

Inhalants are a range of products which, when vaporised or inhaled, may cause the user to feel intoxicated. Many inhalants are known as 'volatile substances' because they include aerosol and gas fuels as well as glues and other forms of solvents. Amyl nitrite and nitrous oxide, found in canisters, are also used.

Major volatile substances	Sources
Benzene	Petrol, varnish, resins, lacquer
Toluene	Adhesives, spray paints, glues, paint thinners, petrol
Xylene	Lacquer, thinner, wood glues
Propane	Bottled fuel
Butane	Cigarette lighter fuel
Acetone	Nail polish remover
N-hexane	Model glues, rubber cement
Trichloroethane	Dry cleaning agents, degreasing agents
Trichloroethylene	Dry cleaning agents, stain removers, degreasing agents
Trichlorofluoromethane	Aerosol propellant
Dichloromethane	Paint stripper
Butyl nitrite	Room air freshener

Source: Alcohol and Other Drugs: A Handbook for Health Professionals, 2004 (NCETA)

Some common forms of use include:

- 'sniffing': vapours are inhaled directly from a container
- 'bagging' or 'chroming' (as in the use of chrome paint): vapours are inhaled from a plastic or paper bag held firmly over the mouth and nose
- 'huffing': a piece of saturated material is held against the mouth or nose and inhaled
- 'spraying': a substance is sprayed into a balloon and then the balloon implodes inside the user's mouth.

## Inhalant use in Australia

The Australian National Household survey in 2001 found that 2.6 per cent of Australians aged 14 years and over had used inhalants at some time in their life. Other statistics such as the 1999 National Secondary School Students survey found that:

- 26 per cent of students had used inhalants at some time in their life
- younger students (aged 12-13 years) were five times more likely than older students (17 years) to have ever used inhalants
- boys tended towards longer, heavier or more regular use.

Various other studies have examined VSM in particular parts of Australia. For example, Brady (1992) and d'Abbs and MacLean (2000) found petrol sniffing to be a significant problem in some remote Indigenous communities. However, VSM is not confined to such communities; pockets of urban use occur throughout Australia.

## Detection and management

There are no clear signs or symptoms of VSM, but some indications are:

- possession of unusual amounts of glues, solvents or aerosol cans
- chemical smells on clothes or breath
- unexpected and rapid 'drunken' behaviour
- bloodshot eyes, sores around nose and mouth.

Alcohol and Other Drugs: A Handbook for Health Professionals, (2004) advises that most volatile substance intoxication resolves spontaneously. If a person appears intoxicated, some initial steps can be taken:

- remove affected clothing and clean their skin
- observe the person in a well-ventilated and safe environment
- call for medical advice or an ambulance if unsure.

## Harm minimisation and resources

Guidelines and resources are available for people working with VSM, including DrugInfo Clearinghouse's 'Prevention of harms associated with volatile substance abuse' report (2004) which contains a detailed list of resources, plus an up-to-date reading list on the topic. In their Fact sheet 2.3 on inhalant use, some strategies suggested for volatile substance users include:

- do not sniff alone or in dangerous places
- smaller bags reduce the risk of suffocation
- substances are flammable – don't smoke
- using alcohol or other drugs with volatile substances can increase the chances of accidents and overdoses
- advice on what to do in an emergency.

Information from 'Inhalant use (for workers)' is reproduced with approval from the Australian Drug Foundation © ADF www.druginfo.adf.org.au

## GOVERNMENT RESPONSES TO VSM

### National Taskforce on Inhalant Abuse

In August 2003, the Ministerial Council on Drugs Strategy (MCDS) endorsed the development of a national approach to inhalant abuse. As a result, a National Inhalant Abuse Taskforce was established to make recommendations for such an approach. The Taskforce includes representatives of a number of Commonwealth and State departments as well as the Central Australian Cross Border Reference Group on Volatile Substance Use, National Drug and Alcohol Research Centre and the Australian National Council on Drugs.

The Taskforce is investigating current national and state approaches to inhalant abuse, with a view to identifying best practice and gaps. For example, it is exploring the feasibility of, and process for, modifying products subject to VSM, including petrol, butane gas lighter fuel and aerosol spray paint products. The Taskforce will report to the MCDS in May 2005, with recommendations for a national approach to inhalant abuse.

### State and territory examples

#### Northern Territory

In October 2004, the Northern Territory Legislative Assembly released its long awaited report, 'Petrol sniffing in remote Northern Territory communities'. Compiled over three years, the report found that over 350 young people are sniffing petrol in remote Aboriginal communities, and details the extensive health problems and social damage caused by sniffing. The report said sniffing was directly related to socio-economic factors – poverty, boredom, lack of services and facilities, and parents who abused alcohol and other drugs.

The report recommends an overarching body be established to coordinate a petrol-sniffing strategy in the Northern Territory. It also recognised that communities cannot be expected to solve VSM problems by themselves; the report recommends establishing culturally responsive teams on a regional basis. Such teams would move quickly into a community when a problem is identified, and deal with issues of intervention, assessment, treatment and diversionary programs, plus community training.

The report also calls for the Territory and other state/federal governments to look at developing fuel that would not appeal to petrol sniffers. The Territory Government has also announced \$10 million for extra programs, services, and legislation to ban petrol sniffing.

#### Victoria

In September 2002, the Victorian Drugs and Crime Prevention Committee tabled its final report on its Inquiry into the Inhalation of Volatile Substances. This extensive inquiry produced one of the most comprehensive studies into VSM in Australia to date,

and led to the Victorian Government introducing the Drugs, Poisons and Controlled Substances (Volatile Substances) Act 2003. This act provides police with new powers to search and detain people under 18 years of age if he/she has inhaled or is likely to inhale a volatile substance, and is deemed likely to cause harm to him/herself or others. The legislation does not criminalise inhalant abuse.

Other Victorian Government responses to the Inquiry have included:

- Establishing a Volatile Substance Abuse Protocol Advisory Committee, which includes representatives of peak bodies, youth, police, alcohol and drug workers, Indigenous and legal sectors. The Committee's work includes supporting a statewide protocol and local agreements between police and agencies in the response to inhalant abuse in their communities.
- Contracting the CSIRO to assess the feasibility of adding a bittering agent to volatile substance products. The CSIRO report concluded that: it is technically feasible to add a bittering agent to only some common substances subject to abuse (fuels, correction fluids and glues/adhesives) without affecting their performance; the addition of bittering agents may discourage occasional and beginning abusers; there would be value in modifying aerosol-based fuels such as butane gas. An inhalants modification project, exploring technical and industrial feasibility, is being developed.

#### Queensland

The Queensland Government has passed new laws to help people who endanger their health and their lives through VSM. The new laws are concerned with reducing access to and use of substances, and improving the immediate help and longer-term support that users of volatile substances receive. As of April 2004, it became an offence for retailers to sell volatile substances to people who they reasonably suspect may misuse the substances, and in July police were also given the power to search people for substances and items used to inhale volatile substances, and to seize such items.

In addition, under a trial of new laws from July 2004 in inner-Brisbane, Logan, Townsville-Thuringowa, Cairns and Mount Isa, police will be able to temporarily detain people misusing volatile substances for the purpose of taking them to a 'place of safety' such as home, a friend's or relative's home, hospital, or to a designated, funded safe place currently being trialled during 2004-2005.

Queensland Health has also commenced a project to develop and evaluate an integrated VSM treatment package for clinicians in a range of settings, including urban, rural, regional and remote areas.

## References

National Centre for Education and Training on Addiction Consortium 2004. Alcohol and Other Drugs: A Handbook for Health Professionals, Australian Government Department of Health and Ageing. Downloadable from www.nceta.flinders.edu.au

d'Abbs, P & MacLean, S 2000. Petrol sniffing in Aboriginal communities: a review of interventions, Cooperative Research Centre for Aboriginal and Tropical Health, Darwin.

Brady, M 1992. *Heavy metal: the social meaning of petrol sniffing in Australia*, Canberra, Aboriginal Studies Press, 1992.

Australian Institute of Health and Welfare (AIHW) 2003. *Statistics on drug use in Australia 2002*, Cat. No.PHE 43. Canberra, AIHW (Drug Statistics Series No. 12).

Toumbourou, JW, Dimsey, L & Rowland, B 2004. Preventing harms associated with volatile substance abuse, DrugInfo Clearinghouse prevention research evaluation report 11, Australian Drug Foundation, Melbourne, pp. 1-19.

White, V 2001. *Australian secondary students' use of over-the-counter and illicit substances in 1999*, Monograph series no 46, Canberra: Commonwealth Department of Health and Aged Care.

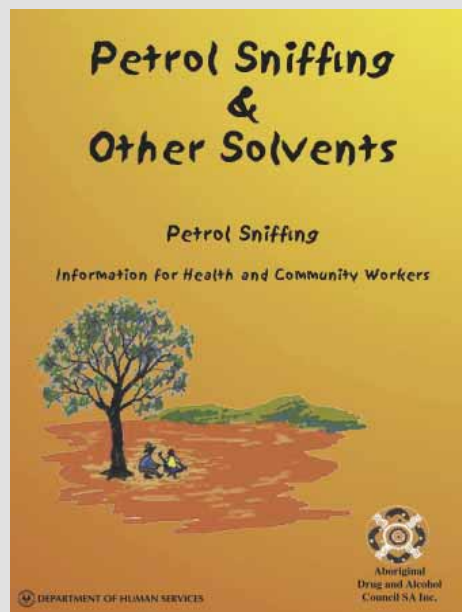
(continued over page)



(continued from page 9)

## INDIGENOUS RESOURCE TACKLES PETROL SNIFFING

SCOTT WILSON, ABORIGINAL DRUG & ALCOHOL COUNCIL (ADAC), SOUTH AUSTRALIA



The idea arose from the Healing Our Spirits Worldwide Conference in 1996. Sniffing was a major issue in both Canadian and American Indigenous communities, and we originally intended to adapt North American resources for Australian usage. Surprisingly, there was little useful material available. ADAC therefore set about researching the issues and secured funding to begin to develop this resource.

A small grant by the SA Department of Human Services started the project. Consultations with many Indigenous communities and organisations were conducted during the process to ensure the content and style would be appropriate for Aboriginal people.

ADAC has produced a comprehensive manual about petrol sniffing and other solvent use in Indigenous communities. Four illustrated booklets are used to target family members, community members, community decision-makers, and health and community development workers. Basic health information, examples of successful programs, community intervention strategies as well as resource and contact lists are included. Although petrol sniffing has been in our communities for over 40 years and many reports and much research has been conducted, this is the first practical manual to come out with information specific to Aboriginal communities.

While the manual doesn't pretend to offer any magic solutions to petrol sniffing, it does provide much practical information about what has and has not succeeded in the past.

After extensive consultation, research and trials of drafts, the Office of Aboriginal and Torres Strait Islander Health (OATSIH) funded the printing of 500 copies of the manual. These were distributed free to all OATSIH-funded organisations across Australia. A new report by Dr Peter d'Abbs and Sarah MacLean from the Cooperative Research Centre for Aboriginal and Tropical Health (CRC), NT University, came out at the same time. This report 'Petrol Sniffing in Aboriginal Communities' which reviews interventions over a number of years

in this area is included in the manual's resource kit.

The four booklets that make up the kit include:

- a 'Plain Language Summary' for community members and other people interested in learning about petrol sniffing
- 'Information for Health and Community Members' contains more detailed information about petrol sniffing and is for workers who are helping communities to deal with sniffing issues
- 'Community Development' is for workers and includes a workshop outline
- 'Other Solvents' is for communities where sniffing of other solvents (paint, glue, etc) is an issue.

We also received permission from the Territory Health Services to reproduce 'The Brain Story' into an A4 format for inclusion in the kit. Over 1500 copies have now been distributed nationally. OATSIH is now funding a national evaluation of the kit.

The package can be obtained from ADAC for an at-cost price, plus postage.

Contact ADAC on:  
Phone (08) 8362 0395  
Fax (08) 8362 0327  
or email [adac@adac.org.au](mailto:adac@adac.org.au)

## INHALANTS AND SOCIAL STIGMA

SARAH MACLEAN, YOUTH RESEARCH CENTRE, UNIVERSITY OF MELBOURNE, VICTORIA

In the hierarchy of drug use, chroming (inhalant use usually involving aerosol paints) does not enjoy much status. Like all kinds of drug use, however, chroming is a complex social experience. It can be both intensely pleasurable and a source of great shame for young people (MacLean, 2004). In this article I draw on interviews with young people from Melbourne with chroming experience, conducted as part of a larger research project, and consider some of the effects of the stigma associated with inhalant use (all the names used are pseudonyms suggested by interviewees).

*'Chromers are the lowest people on Earth' (Pedros, 19)*

Some of the young people I have spoken with describe highly meaningful and enjoyable experiences while chroming. Spray paints are effective hallucinogens. Users describe intense experiences of intoxication and feelings of personal power. The common perception that inhalants are 'gutter drugs' may make it more difficult for adults to acknowledge that chroming can be deeply pleasurable.

Chroming is a particularly hidden form of drug use and young people talked about how poorly understood it is. A couple of the young people (who were already engaged with a drug and alcohol service) told me they felt too embarrassed to discuss inhalant use with workers. Whereas some of the younger users in their early teenage years reported enjoying chroming in public places, the older users went to great lengths

to hide their use, particularly due to a fear of being assaulted. They spoke about the importance of scrubbing their faces to remove paint from around their mouths. The silence and secrecy around chroming appears to be protective for young people who do not use inhalants (Bellhouse et al., 2001) but it is also problematic for those who do.

The young people I spoke with described various graphic and frightening risks they believe to be associated with chroming. Star (21) thought her lungs would explode, Michelle (15) told me that a friend's eyeballs had popped out, Ned (19) feared a bubble would burst in his brain. Everyone mentioned death as a likely consequence. It is possible that the fear surrounding chroming leads young people to hold particularly alarming views about the health effects, seeing chroming therefore as more risky and exciting than other kinds of drug use.

Much of the stigma attached to chroming relates to its smell and messiness (it is difficult for users to avoid becoming covered with paint). It is cheap and easy to access: 'just three dollars and you're gonna get high as a kite for a day' (Jade, 19). Many of my interviewees commented on the link between chroming, youth and homelessness. These associations do appear to help some people 'grow out' of chroming but for those who do not they are a continuing source of shame.

Rather than seeing chroming as an understandable response to extremely difficult life circumstances, many

(particularly the older users) felt that only they were to blame for their drug use. They spoke with remorse about violence to others, ruined relationships, time spent in correctional facilities and damage to their bodies and brains. Ann (19) told me ruefully that 'it just makes you become a different person'. This anger and sense of impairment seemed to compound an already poor self-image for some of the young people.

The stigma attached to inhalant use has implications not only for the young people who use these drugs, but also for the development of policy. Unlike most drugs, spray paints are not developed for human ingestion. This is surely part of what makes chroming so unsettling and distressing. The young age of users and the risks it is seen to produce also make it a great subject for alarming media coverage. With attendant images of death and destruction – images that are also internalised by young people who use these drugs – the stigma against chroming makes compassionate policy responses particularly difficult to achieve.

[s.maclea@pgrad.unimelb.edu.au](mailto:s.maclea@pgrad.unimelb.edu.au)  
Ph: (03) 8344 9642

*I am grateful for scholarship support for this research from VicHealth and the Alcohol, Education and Rehabilitation Foundation.*

### References

Bellhouse, R, Johnson, G & Fuller, A 2001. A Report on Volatile Solvent Use for the Victorian Department of Employment, Education and Training.

## MOUNT THEO PROGRAM

SARAH MACLEAN, YOUTH RESEARCH CENTRE, UNIVERSITY OF MELBOURNE, VICTORIA

'Mount Theo' is an outstation 160 km north-west of Yuendumu, which is itself 300 km north-west of Alice Springs, in the Northern Territory. This remote place has been the setting for a remarkable success story, which has transformed the lives of numerous Walpiri youth in the region.

Around 1993-94, the level of petrol sniffing amongst adolescents in Yuendumu was reaching a crisis point. Up to 70 young people were active 'sniffers', and this was having a devastating effect on their health, as well as the wider community. Community meetings were held to discuss the

issue, but no clear solutions were found. Sensing the need for immediate action, Peggy Brown, a Yuendumu elder, volunteered to take users to the Mount Theo outstation, her children's traditional country. Two weeks later, Mount Theo had its first intake of Yuendumu's worst users, including the local ringleaders, who it was felt were negatively influencing younger children.

'Getting [the users] away from the community was very important', says Jean Brown, Peggy's daughter and Chairperson of the Mount Theo Program. 'Once they were at Mount Theo, we took them hunting, went around country, gathered bush food. They learnt stories about the land and their dreaming. We gave them skills to bring back to town.' The Mount Theo program has been so successful that Yuendumu now has only two known regular sniffers.

It has since extended its services to all young Walpiri in the region, including Alice Springs. And, fortunately, intake numbers have dropped steadily [at the time of this interview, only one girl from Alice Springs was a resident].

Valuing Walpiri ways of doing things has been the key to the program's achievements. 'Mount Theo is known as a special healing place, so it's a really appropriate location to help young people stop sniffing', says Karissa Preuss, manager of the Mount Theo Program. 'It complements other, newer, Yuendumu community initiatives, such as cultural mapping, learning stories and building personal strength.'



Photo courtesy of Mount Theo Program, Northern Territory



# HEPATITIS C

## Hepatitis C: increase in new infections to 2003

ANNIE MADDEN, THE AUSTRALIAN INJECTING AND ILLICIT DRUG USERS LEAGUE, ACT

Australia led the way in 1990 by developing the first National Hepatitis C Strategy in the world. Following on from that groundbreaking work, the Australian Government is currently in the process of developing the 2nd National Hepatitis C Strategy to continue building a national strategic response to the epidemic.

Recent surveillance reports have estimated that more than 240,000 Australians are already living with hepatitis C, and in the past four years there has been a 45% increase in the number of new infections each year, from 11,000 per year in 1998 to 16,000 a year in 2003. Given that more than

75% of people with newly acquired hepatitis C infections report a history of injecting drug use, the alcohol and other drugs sector in Australia has a major role to play in both the prevention and treatment of hepatitis C amongst this population group.

The following article by Professor Robert Batey, Chair of the Australian Government's main advisory committee on hepatitis C, discusses the development of the 2nd National Hepatitis C Strategy and outlines some of the major challenges facing Australia in responding effectively to this enormous public health issue.

## Is Australia heading in the right direction?

ROBERT BATEY, CHAIRMAN, NATIONAL HEPATITIS C SUBCOMMITTEE OF MACASHH

Australia has been responding to the hepatitis C epidemic since the virus was discovered in late 1989 and the Australian Government has taken a leading role in defining the Australian response to this epidemic. For much of the 1990s the government led the field worldwide in defining policy and approaches to the epidemic and this was a very exciting period. It is appropriate, at this stage of the epidemic, to review where Australia is heading, as we are now about to see the release of the 2nd National Hepatitis C Strategy.

### Structural progress

Australia has established a national body which functioned initially as Australian National Council on AIDS and Related Diseases (ANCARD), then as Australian National Council on AIDS, Hepatitis and Related Diseases (ANCAHRD), and now as the Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis (MACASHH). During the life of ANCARD the Hepatitis C Sub-Committee was formed; this body was responsible for overseeing the development of the 1st National Hepatitis C Strategy and many of the responses to this epidemic, including the very valuable Projections Committee Reports which have defined the extent of the problem in this country. The Australian response to hepatitis C has included the involvement of the National HIV Centres for Epidemiology and Clinical Research, Social Research and Virology in hepatitis-related activities. As a result of national enthusiasm, state bodies have been established to provide advice on hepatitis C and a number of states have produced their own hepatitis C strategies, which have directed the evolution of hepatitis C services and prevention strategies in each of the Area

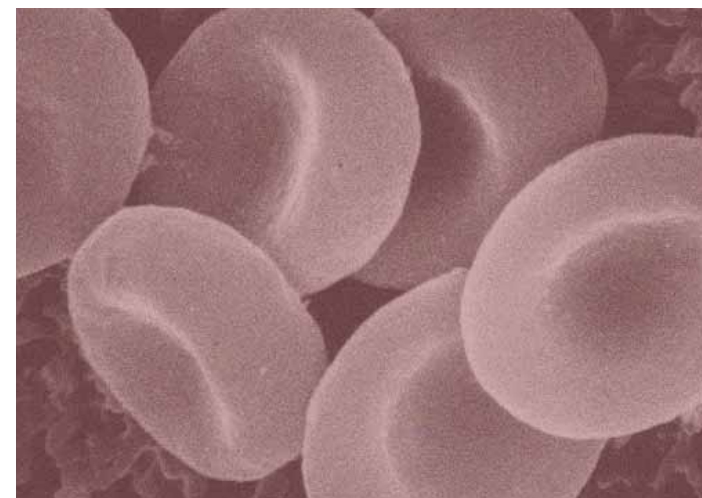
Health Services. Hepatitis C Councils have been established and they have taken a very important role in directing how this country has responded to hepatitis C over the last ten years.

The question must be asked whether these structural responses have been appropriate. It is also important to stress that whilst many would suggest more should have been done for hepatitis C, very few diseases have specific ministerial advisory committees at a state or federal level and hepatitis has at least achieved that. Most diseases do not have national centres funded to undertake research in relation to those diseases and most diseases certainly do not have consumer representation to the degree that hepatitis C has.

However, despite these significant structural activities the ANCAHRD review of the 1st National Strategy did identify failures of the previous structures including ANCARD itself, and recommendations have been made on ways to improve the structural response in the years ahead. It has been pointed out that the structure as it has evolved has failed to deliver increased treatment availability and increased research funding for hepatitis C-related activities. However, whilst criticism has been directed towards the failure of the Strategy to decrease transmission, more recent data suggest that transmission is falling and one can only hope that this continues.

### Strategic progress

The government has sought to establish a strategy which would optimise the Australian response to hepatitis C at a variety of



levels. It has overseen the development of national guidelines on the diagnosis and treatment of hepatitis C, on testing for hepatitis C and models of care have been developed for people with hepatitis C in the general community and within the prison setting. The 1st National Strategy was a world first, and whilst it may not have achieved all that might have been hoped, it has certainly directed the national approach to this disease. The 2nd National Strategy will pick up on the successes and criticisms of that 1st Strategy.

Most criticism of the strategic approach to hepatitis C is directed towards the fact that hepatitis C has been linked to HIV funding and structures. This has been seen as unfair by the HIV lobby and inappropriate by the hepatitis C lobby, in that both bodies felt that funding was not really being directed adequately towards hepatitis C. Despite these criticisms, much has been achieved in relation to hepatitis C, which would not have been achieved if the linkage had not been made. A 'stand-alone' disease strategy these days is unlikely to attract significant federal funding.

Strategically, Australia had led the world but currently we are lagging behind in relation to providing equitable access to optimal treatment. Strategically we need to increase efforts to reduce transmission of this disease.

### Epidemiology and clinical practice

The Australian approach has focused on prevention from the very early days of the Strategy. Efforts have been directed towards educating the highly at-risk groups and to providing access to clean injecting equipment to reduce risk of transmission. Work was undertaken in the very early days of the epidemic to ensure the blood supply was made safe, and whilst the occasional case of hepatitis C following a medical procedure is still reported, the risk of contracting hepatitis C from the blood supply has been reduced to almost zero. Most recent data do suggest that prevention strategies are leading to a reduced risk of acquiring hepatitis C by new recruits to drug injection.

Testing for hepatitis C has been defined clearly in the recently released testing policy for hepatitis C. Australia has led the world in recommending that patients who are undergoing testing for hepatitis C should have pre- and post-test counselling to make them more aware of the significance of this disease.

The management of hepatitis C has included the counselling of patients about their disease and about the possible need for treatment, recognising that many patients do not need treatment for their disease at an early stage. Treatment of hepatitis C has been of a world class standard and the Australian Government funded hepatitis C treatments began long before many other countries in the western world. Currently, there is debate underway seeking to increase access to treatment, and that may include taking the need for a liver biopsy for at least genotype 2 and 3 patients out of the absolute requirements for this highly expensive drug protocol.

Overall the direction has been correct but more needs to be done to improve the evaluation and treatment of patients with hepatitis C in this country.

### Scientific approach

The scientific approach to hepatitis C in Australia has been led by individual groups who have placed an enormous priority on this disease. The fact that a number of centres are now receiving funding from the United States National Institutes of Health for hepatitis C work is a testimony to the tremendous effort that has been made by our own researchers, despite the lack of identification of hepatitis C as a priority area by our own major funding bodies (the National Health and Medical Research Council and the Australian Research Council). These bodies have funded a number of research projects which have delivered excellent results over the last decade but more funding should be directed towards this major epidemic in our community. Australia has been very active in undertaking clinical trials in relation to the treatment of hepatitis C; information from some of the Australian-based studies have informed the Federal Drug Administration in relation to the release of the anti-hepatitis C drugs in the USA. It would be fair to say that researchers in this country still feel under-supported by the Australian system.

### Ethical issues

There is no doubt that this disease evokes inappropriate responses in many people within the community, including those working in the health sector. Discrimination is a real issue confronted by individuals infected by hepatitis C; once again, the Australian community needs to do a lot more to reduce inappropriate responses to hepatitis C by informing the community more effectively about this disease and the risks of contracting it from casual contact.

### Are we heading in the right direction?

The answer to this is mainly yes but at times no. Why no? We are still linking hepatitis C to HIV despite major differences between these viruses. Australia is still regulating treatment access when outcomes of treatment have improved markedly and we are still depending on Needle and Syringe Programs for prevention and not supporting such programs when they come under threat. If we do address all of these issues in the 2004-07 period, during the life of the 2nd National Strategy, we should see a fall in new infections per annum, more patients treated per annum, better informed health care workers and ultimately more funding directed towards hepatitis research.

It has been an interesting journey and hopefully, it will continue in the right direction in the next four years.



# OPIOID SUBSTITUTION THERAPY CONSIDERING THE COSTS TO CONSUMERS

PETER MUHLEISEN, DR NICO CLARK, AMANDA TEO AND DAMON BROGAN,  
TURNING POINT ALCOHOL AND DRUG CENTRE, VICTORIA

Considering the costs involved to the community of heroin dependency, it is sensible to publicly fund most, if not all, the costs of providing opioid substitution treatment (OST) to people who may benefit from it.

This article outlines the issues that need to be considered in developing policy that will give clients access to optimal, convenient and affordable treatment. For example, there are strong arguments in favour of further government subsidies to fund the costs to pharmacists of dispensing methadone and buprenorphine.

Long-term opiate substitution with methadone is a cheap and effective treatment for the majority of opioid-dependent people. Approximately one-third of dependent heroin users are in substitution treatment (it is estimated that one in four of these people are taking buprenorphine). OST plays an important role in reducing overdose deaths, preventing HIV and reducing criminal behaviour (Loxley et al. 2004).

The misuse of heroin in Australia has been associated with:

- a high proportion of the annual cost of illicit drugs to the Australian community of \$6 billion (Collins & Lapsley 2002)
- a peak of around 1000 overdose deaths per year between 1998 and 2000
- up to 20 000 non-fatal overdoses with ambulance call-outs to overdoses costing around \$8 million each year
- an over-representation of drug users in the justice and correctional system
- significant ongoing costs to health and welfare services, with drug users being often impoverished, unwell and in crisis; in particular, there are significant potential health costs related to drug use via infection with blood-borne viruses (hepatitis B & C, and HIV), plus other infections, accidents, injuries, violence and diseases of poverty and neglect
- significant social disruption, distress and costs to users, their families, friends and society as a whole.

Once established, drug dependence is a chronic condition characterised by remissions and relapses often over a period of decades. Effective treatment for chronic diseases involves both acute and maintenance interventions. To meet individual needs it is useful to have a range of options available.

Clinical evidence consistently shows that people who remain in treatment tend to do better than those who do not. People leaving treatment tend to relapse back into drug use. All treatments have improved outcomes for people retained in treatment. However, the maintenance treatments retain clients for longer and have less risk of mortality if clients relapse.

## Treatment methods: some of the issues

While some states and territories do have publicly funded clinics where people can get their treatment for free, increasingly clients get their treatment through community pharmacies and have to pay for this service. Moving clients to the pharmacy program, once they are stable on methadone, frees up publicly funded places and allows more people into treatment.

The ACT has a system of partial government subsidy, while in Victoria people have to pay for methadone at clinics as well as those using community pharmacies. This standardised payment system helps ensure there is no barrier to moving people when appropriate to the community, thus only a small proportion of people on methadone maintenance therapy are in the public system in Victoria. The Victorian Government also pays for training and recruitment of practitioners, administration of the scheme and the referral to specialist clinics that treat less than ten per cent of OST clients. A recent scheme has fully funded the treatment of clients 18 years and under.

While other states have more publicly funded treatment places, the use of community pharmacies to dispense methadone and buprenorphine is seen as increasingly desirable (for largely financial reasons) in most states and territories.

## Consumer costs

From a consumer point of view, there are few medication regimes that cost the person being treated as much as opioid substitution treatment. In Australia, most medicines are subsidised under the Pharmaceutical Benefits Scheme (PBS) and are usually dispensed in monthly quantities and have a patient co-payment of \$23.70 per month (or \$3.80 for concession-holders). The PBS pays the balance to the pharmacist. PBS payments include a dispensing fee of \$4.66 per item as payment to the pharmacist for the dispensing of the medication and an additional \$2.66 to the pharmacist for drugs of dependence, due to the additional paperwork required. Prescription costs to patients for most medications are also capped under the PBS safety net at \$726.80 per year, or \$197.60 per year for low-income earners.

For methadone and buprenorphine, however, there are no concessional or safety net benefits. In addition the dispensing and recording fees are covered by the consumer. Only the cost of methadone and buprenorphine are subsidised under section



Turning Point, Victoria, pharmacy dispensing methadone (staff used in photo).

## Treatment options

### Substitution treatment

Substitution treatment, sometimes called 'maintenance treatment', involves using a long-acting opioid medicine to control a person's drug use on a long-term basis (months to years). The idea behind the treatment is to substitute an illegal, short-acting, expensive drug (heroin), which is usually injected, with a legal, longer lasting, inexpensive drug, which is taken orally (methadone or buprenorphine).

Substitution treatment works really well for many people as it gives them the chance to improve their health and social situation, and reduce the risks related to heroin use without having to deal with withdrawal. People can focus on other areas of their life, for example, finding stable accommodation, getting work or further education, as the time and stress involved in 'scoring' heroin is reduced. Dependent users who have failed at detoxification or who have unstable social circumstances may be better suited to substitution treatment.

Substitution treatment is provided by specialist clinics, private clinics, medical practitioners and community pharmacies. The first step to entering a program is to see a medical practitioner who is an approved methadone or buprenorphine prescriber (people should contact the alcohol and drug service in their state or territory for referral). In some public programs there will be no cost, whereas in other settings – such as pharmacy or private clinic – a dispensing fee will be charged.

### Benefits:

- it holds a person stable while they get control over their drug use and life
- a person will not experience withdrawals if they are on the right dose
- it costs less than heroin, removing the need for crime to support a habit
- people do not need to detoxify first to start substitution treatment
- it gives people time to focus on improving their lifestyle
- it reduces the risk of HIV and hepatitis
- it offers access to other health and support services.

### Considerations:

- a person is still dependent on opioids during this treatment and there will be withdrawal symptoms at the end of treatment (reducing the dose slowly will minimise symptoms)
- people will need to attend a clinic/pharmacy daily or several times a week for dosing
- travel can be difficult (especially interstate and international) and must be organised well in advance
- methadone and buprenorphine can be dangerous when used incorrectly (e.g. injected, mixed with other drugs, in high doses)
- there may be side effects from treatment.

**Methadone** is a long-acting opioid that has been used to treat heroin and other opioid dependence in Australia for about 30 years. A single daily dose of methadone will stop withdrawal and cravings for heroin for 24 hours or longer. Methadone typically comes as a liquid that is swallowed.

**Buprenorphine** is also a long-acting opioid and can be used instead of methadone in a substitution program. Buprenorphine became available in Australia in 2001.

Compared to methadone, buprenorphine:

- is easier to withdraw from
- is longer lasting – at higher doses its effects can last up to two or three days, and
- is in the form of tablets (made in three strengths) that are taken sublingually, which means, placed under the tongue until they dissolve. Some states may either break or crush the tablet before it is placed under the tongue.

### Reference

This text is extracted from:  
O'Brien, S 2004. *Treatment options for heroin and other opioid dependence: a guide for frontline workers*, Canberra, Commonwealth Department of Health and Ageing for National Drug Strategy, Australian Government.

[www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-publicat-drugpubs.htm-copy4](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-publicat-drugpubs.htm-copy4)

100 of the PBS. This means these drugs are supplied free for administration at state government-run hospitals and by extension to pharmacies.

In most states and territories dispensing fees are not charged in government-funded clinics. This makes it difficult to convince clients to switch to community pharmacies as there is then a cost involved. Victoria is an exception to this and clients at government-funded treatment clinics are charged a fee to facilitate them moving on to community pharmacies, thus freeing up places for new clients.

An evaluation of community-based methadone programs in Victoria in 1996, found that payment for the program was a significant irritant to both those being treated as well as those dispensing the medication. Cost of treatment was associated

with high treatment dropouts. For those who pay treatment fees and are unemployed, the cost of treatment is over 15% of their total income. Pharmacists may not be offering this service due to concerns about being paid (Lintzeris 1996).

### Victoria: the costs of OST

The costs to consumers of OST vary around Australia. In Victoria, it costs each client about \$4.80 per day for the dispensing fees. Buprenorphine (while more expensive to the Commonwealth to subsidise) is potentially less expensive as many clients do not need to be dosed every day.

In the case of methadone the \$4.80 per day in dispensing fees equates to \$1752 per person per year, or over \$15 million per

(continued over page)



(continued from page 15)

annum for the whole of Victoria. There is currently no mechanism for subsidising dispensing fees. The cost paid by the client is significantly more than that borne by either the Victorian or the Australian Government.

### What is the impact of dispensing fees on patients?

The problems with patients bearing the cost of OST are that:

- a high proportion of patients are low-income earners. Fees for OST can be over 15% of welfare benefits, which increases poverty and its associated problems in this population
- high treatment costs (\$1752 per annum) can thus represent a significant disincentive for clients to enter OST
- the argument that OST is 'cheaper than heroin' assumes that patients will have the same disposable income when in treatment as out of treatment. Usually this would necessitate continuing their heroin-funding activities which most have entered treatment to discontinue
- patients who are not good at managing their finances often find themselves unable to afford ongoing treatment. Interruptions to treatment may lead to physical withdrawal symptoms of variable severity and increase the chances of other drug use, contributing to dropping out of treatment. It is also arguable that it is inhumane to deny life saving treatment and to allow people to suffer opiate withdrawal due to their inability to afford treatment. While charitable organisations often cover the cost of other medicines, they will not usually cover opioid substitution therapy fees due to the high and ongoing cost.

The relationship between treatment fees and treatment retention has been demonstrated in a number of studies. Maddux et al. (1994) conducted a randomised trial of fees (US\$2.50 per day) versus no fees for methadone treatment. At one year, 54% were retained in the no fees group as compared with 34% in the fees group. Similar differences in retention have been reported in non-randomised trials (Gerstein 1994).

### Pharmacotherapies Advocacy and Complaints Service (PACS)

Evidence from PACS, a project of the Victorian injecting drug users group VIVAIDS indicates that dispensing fees are the main problem reported by people in OST (about 40% of all contacts with the service) (Thompson 2003).

### Whole-of-society perspective

Methadone has repeatedly demonstrated its cost effectiveness as a treatment (Ward, Mattick et al. 1998). When all the costs to society are taken into consideration – such as crime, health care and lost productivity – investment in methadone treatment results in net financial benefits to society (Gerstein 1994). A study conducted in Victoria found that each person in methadone treatment specifically costs society \$5000 less per year in attributed health and crime costs than an illicit drug user not in treatment, or in other forms of treatment (Clark 2003).

A recent report to the Australian National Council on Drugs (Muhleisen & Brogan 2003, Teo 2004) used these data to economically model the effects of applying a number of government subsidy schemes to methadone dispensing.

The study compared different levels of subsidies, and then projected the flow-on effects to program starts and retention rates. These were then compared to the health and legal costs to the community of heroin users not in treatment.

The study found that if the government partially subsidised treatment by \$3 per day with clients paying \$2, then a projected ten per cent increase in retention would make the intervention cost-neutral and would still save clients around \$1000 per year.

The study also recommended that it is essential to fund OST for particular needs groups through specialist agencies even if only for critical periods. Important examples where treatment disruption is particularly unacceptable include pregnant clients, HIV positive clients and clients with an active major psychiatric or medical condition.

### Study conclusions

Even a partial government subsidy would:

- increase the support for the program from community pharmacies
- reduce the difficulties and stress associated with fee collection
- reduce interruptions to client's treatment regimes because of lack of finance
- increase retention in treatment and further reduce illicit drug use, crime, health and social damage caused by drug users outside the treatment system.

Other benefits included:

- more clients can be treated by more pharmacies with less pressure on waiting lists
- more time to be spent on the therapeutic relationship
- less concentration of clients at pharmacies

- more stable clients will be able to be treated conveniently and more locally
- treatment spaces at clinics can be used for clients who need more extensive resources rather than clients trying to stay there to save money.

### Conclusion

The benefits of at least partially subsidising the dispensing fees are great. In most states and territories the financial barrier to moving into a pharmacy scheme is limiting the new places available, and therefore reducing the number of people in treatment. Even in Victoria, where this barrier does not exist, the cost of methadone or buprenorphine treatment to the client is a disincentive to treatment. Therefore methadone and buprenorphine dispensing should be subsidised either partially or fully as the benefits to the community in reducing the amount of illicit injecting drug use are well documented.

### A national snapshot of methadone/buprenorphine treatment provider options and costs to consumers

Methadone/buprenorphine treatment programs vary around Australia. In 2001 the Australian Injecting and Illicit Drug Users League (AIVL) researched what was offered in all the states and territories. This information is presented in the Table below and has been updated to reflect the costs and availability of methadone in 2004.

	ACT	NSW	NT	QLD	TAS	VIC	SA	WA
<b>Public clinic</b>	Yes	Yes	Yes (only one)	Yes	No	Yes	Yes	Yes
<b>Pharmacy dispensing</b>	Yes	Yes	Yes (limited)	Yes	Yes	Yes	Yes	Yes
<b>GP prescribing</b>	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
<b>Private clinic</b>	No	Yes	No	No	No	Yes	No	No
<b>Weekly cost of treatment</b>	\$15- \$30	\$0- \$53	\$35	\$0- \$28	\$24	\$10- \$35	\$21 up per week	\$0- \$28

Information courtesy of AIVL

### References

- Clark, N, Gospodarevskaya, E, Harris, A & Ritter, A 2003. *What's the deal? The cost of heroin use in Victoria*. Report for Premier's Drug Prevention Council, Department of Human Services.
- Collins, D & Lapsley, H 2002 *Counting the cost: estimates of the social cost of drug abuse 1998-9*, National Drug Strategy, Canberra.
- Doran, C, Shanahan, M, Mattick, RP, Ali, R, White, J & Bell, J 2003. Buprenorphine versus methadone maintenance: a cost-effectiveness analysis, *Drug and Alcohol Dependence*, vol. 71(3), pp. 295-302.
- Gerstein, D, Johnson, R et al. 1994. *Evaluating recovery services: the California Drug and Alcohol Treatment Assessment (CALDATA) General Report*. Department of Alcohol and Drug Problems, California.
- Lintzeris, N, Koutroulis, G, Odgers, P, Muhleisen, P, Ezard, N et al. 1996. *Report on the evaluation of community methadone services in Victoria*, Turning Point Alcohol and Drug Centre, Melbourne.
- Loxley, H, Toumbourou, J, Stockwell, T et al. 2004. *The prevention of substance use, risk and harm in Australia: reviewing the evidence*, Commonwealth of Australia, Canberra.
- Maddux, J, Prihoda, T & Desmond, P 1994 Treatment fees and retention on methadone maintenance, *The Journal of Drug Issues*, vol 24(3), pp. 429-443.
- Muhleisen, P & Brogan, D 2003. *Fairer options for payment for opioid pharmacotherapies*, paper for ANCD briefing.
- Peterson, GM 1999. Drug misuse and harm reduction: pharmacy's magnificent contribution, but at what cost? *Journal of Clinical Pharmacy and Therapeutics*, 24, pp. 165-169.
- Teo, A 2003. *Should the government pay for methadone dispensing fees in Victoria? A policy perspective*, Economics and Commerce Issues Seminar.
- Thompson, N 2003. *The Pharmacotherapy Advocacy and Complaints Resolution Service (PACS) Report for the period 1 July 2002 to 30 June 2003*, VIVAIDS, Melbourne.
- Ward, J, Mattick, R, Hall, W (eds) 1998. *Methadone maintenance treatment and other opioid replacement therapies*, Harwood Academic Publishers, Netherlands.



# WORKPLACE CULTURE AND ALCOHOL USE

DR KEN PIDD, NATIONAL CENTRE FOR EDUCATION AND TRAINING ON ADDICTION, ADELAIDE

The workplace is one setting where attempts have been made to prevent or minimise problems associated with alcohol. However, most of the work concerning alcohol use and the workplace has focused on drinking that occurs within work hours or 'on the job'. Less attention has been focused on how the workplace setting interacts with a broader notion of 'culture' and how this interaction impacts on the behaviour of individuals and organisations with respect to alcohol.

Culture plays an important role in determining our patterns of alcohol consumption, and contributes to our definitions of 'problematic' and 'non-problematic' drinking. This makes it important to understand how workplace culture can impact on the drinking patterns of workers when attempting to minimise alcohol-related risks in the workplace.

All workplaces set formal and/or informal rules and norms regarding appropriate work behaviour. Workplaces also have procedures, developed from these rules and norms, to regulate work behaviour. These rules, norms and procedures extend to alcohol, including defining what constitutes problematic and non-problematic drinking in the workplace.

Each workplace culture is usually quite unique. Some workplaces have established rituals, for example, workers may be pressured to join co-workers in regular 'end of week' drinking rituals. Some of these workers may not normally drink in their own leisure time but may find it expected of them at work or in work-related situations. Recent research has highlighted the pressure that women often experience in relation to conforming to workplace drinking norms (Ames & Rebhun 1996).

## Cultural dimensions relating to alcohol in the workplace

Four main cultural dimensions have been outlined by Ames and Janes (1992) that influence alcohol use in the workplace:

- normative regulation of drinking
- the quality and organisation of work
- drinking subcultures
- factors external to the workplace.

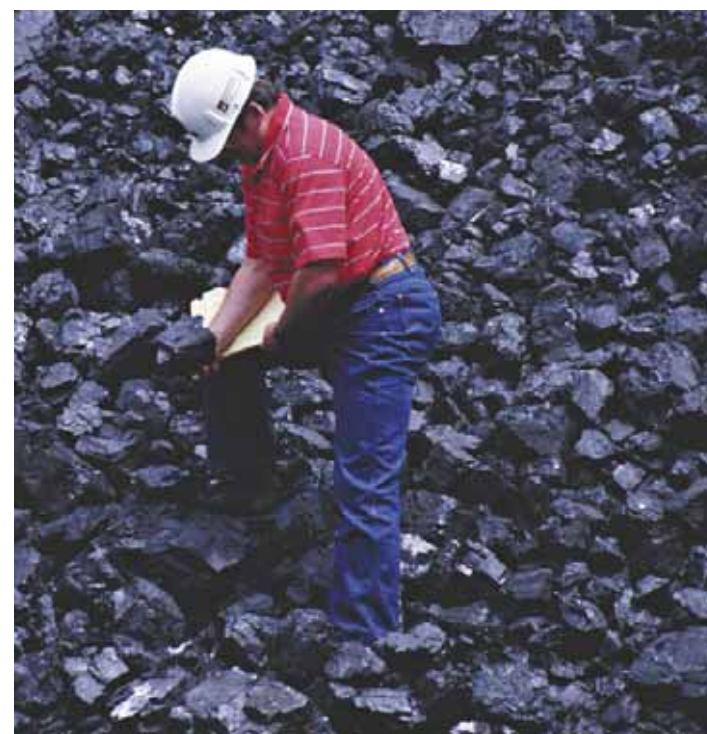
**Normative regulation of drinking** is the most important dimension of workplace culture regarding alcohol use. Normative regulation involves elements of the workplace that form and maintain beliefs, values and behaviours related to drinking including both formal and informal social controls regarding alcohol use. Formal social controls include workplace policies and procedures concerning alcohol use at work. Informal controls involve attitudes and expectations concerning alcohol use in specific work contexts. These attitudes and expectations may vary between work groups within a work organisation. They may be consistent, or inconsistent, with the organisation's formal policies. Formal and informal social

controls determine the degree to which alcohol is available, or perceived to be available, in the workplace.

**The quality and organisation of work** concerns factors that contribute to work stress such as dangerous or high-risk work, shiftwork, task complexity, and lack of control over the planning or pace of work. Workers often consume alcohol as a coping strategy for dealing with stress particularly if the cultural norm supports drinking as an appropriate coping strategy. This has been highlighted in high stress occupations such as policing (Davey, Obst & Sheehan 2001).

**Drinking subcultures** can occur when a category of workers forms a subculture that has distinctive beliefs about their drinking. These drinking practices continue because they are informally defined as appropriate and expected in certain circumstances. These drinking practices can serve functional work-related purposes. For example, drinking subcultures may consider frequent and heavy drinking as an acceptable method for dealing with work conditions, expressing social solidarity between workers, or celebrating work-related achievements. Thus, within drinking subcultures, drinking becomes defined as a normative behaviour that can influence the overall workplace culture regarding alcohol use.

**Factors external to the workplace** relate to the interaction between work and social life. While workplace culture is distinct from the culture of the wider community, there is a large degree of overlap and interaction between the workplace and the wider community. The values and norms gained within the family unit and the wider community interact with workplace norms and values concerning alcohol use. Thus, workers bring to the workplace their existing values, norms and behaviours concerning alcohol use and these can influence workplace values, norms and behaviours concerning alcohol use.



## Sharing leisure activities with co-workers

Employees spend many hours together and therefore significant social relationships can develop leading to shared leisure time after work. This sharing of leisure activities off the job often shapes workplace culture. The involvement of alcohol in these activities can lead to development of work-based drinking networks. Worker participation in these networks may result in the development of occupational drinking subcultures which, as outlined above, are a cultural dimension of the workplace that can influence workers' alcohol use.

## Workplace culture and drinking initiation

For many young Australians, socialising with work colleagues is one way in which they 'learn to drink'. Drinking norms are often established in these settings and levels and patterns of risky drinking are often shaped by workplace cultural norms in relation to alcohol. For example, a recent series of Australian workplace studies (Pidd 2003) found the behaviours and expectations of supervisors and co-workers had a significant influence on the drinking patterns of adolescent or new entrants to the workforce.

## The role of supervisors and managers

The way in which direct-line supervisors and senior management deal with alcohol use in the workplace can impact on workplace culture in regard to alcohol. Often there is:

- alcohol use at business lunches
- alcohol use at conferences and office parties
- the use of alcohol for team and morale building
- alcohol use in ritual ceremonies that celebrate work-related events.

Other management practices can influence higher levels of work-related drinking, including emphasising the importance of production quotas over dealing with alcohol issues and relying on informal as opposed to formal measures to deal with alcohol issues. Workplaces that have poor management/union relations

also tend to have higher levels of work-related drinking (Ames, Grube & Moore 2000).

## Recent research on workplace culture and alcohol use

There is very little Australian research concerning prevalence of alcohol use in the Australian workplace (Phillips 2001), or the relationship between the Australian work environment and alcohol use (Allsop & Pidd 2001).



In order to address this issue, the National Centre for Education and Training on Addiction recently analysed data collected as part of the 2001 National Drug Strategy Household Survey to identify the alcohol consumption patterns of the Australian workforce and to determine if these consumption patterns were associated with aspects of workplace culture. A total of 13 582 Australians, working for pay on a full-time or part-time basis, completed the survey.

The measurements of alcohol consumption patterns used in the Survey allowed for respondents to be classified according to three 'risk levels' of alcohol consumption (see Table 1 below).

The Survey also asked respondents to record their occupation and the industry within which they worked.

Analysis of the Survey data indicated that the alcohol consumption patterns of Australian workers varied considerably according to industry classification. There was evidence that these consumption patterns were associated with negative workplace outcomes. The results also indicated that workplace culture may play a role in influencing workers' consumption patterns.

**Table 1: Risk levels of alcohol consumption**

Levels of risk	Definition
1. NHMRC short-term risk	7 or more (males), 5 or more (females) standard drinks per day
2. NHMRC long-term risk	5 or more (males), 3 or more (females) standard drinks per day 29 or more (males), 15 or more (females) standard drinks weekly
3. Risk due to infrequent but high level consumption	More than 10 standard drinks (on each occasion) monthly or less for males and more than 7 standard drinks (on each occasion) monthly or less for females

(continued over page)



(continued from page 19)

**Table 2: Percentages of workers drinking at risk levels grouped by industry**

Short-term risky or high risk (%)	Long-term risky or high risk (%)	Infrequent high consumption (%)
Average 13.9%	Average 9.7%	Average 25.3%
Hospitality (24.1)	Hospitality (13.7)	Mining (34.6)
Retail (19.6)	Construction (11.6)	Hospitality (31.5)
Agriculture (16.5)	Retail (11.2)	Wholesale (28.5)
Manufacturing (15.4)	Agriculture (10.9)	Construction (28.2)
Transport (15.1)	Manufacturing (10.8)	Financial (28.2)
Financial (13.8)	Transport (10.5)	Transport (27.3)
Construction (13.4)	Wholesale (9.2)	Admin/Defence (26.6)
Wholesale (11.8)	Financial (8.7)	Retail (25.9)
Admin/Defence (11.7)	Services (8.6)	Manufacturing (25.4)
Services (11.1)	Education (7.5)	Agriculture (25.1)
Mining (7.7)	Mining (7.0)	Services (22.4)
Education (6.7)	Admin/Defence (6.4)	Education (15.2)

## The hospitality industry

The hospitality industry had the largest percentage of workers who reported short- or long-term risk drinking (see Table 2). Several possible reasons may account for this pattern:

- within the hospitality industry alcohol is readily available
- a culture of alcohol promotion exists within the hospitality industry
- the hospitality industry traditionally attracts younger workers (across all industries, younger workers were more likely to engage in at-risk alcohol consumption).

Further support for a culture of alcohol use in the hospitality industry was evident when data concerning alcohol-related incidents in the workplace were examined. Compared to other industries, the hospitality industry had the highest percentage of workers:

- missing a work day due to their alcohol use (7.2%)
- attending work under the influence (13.3%)
- usually drinking at their workplace (17.7%).

## The mining industry

While only relatively small percentages of workers reported drinking at risk levels for short- or long-term harm, the mining industry had the largest percentage of workers who engaged in infrequent high consumption.

Many mines now have clear policies on the use of alcohol at the mine site and management actively discourages the use of alcohol – which was not the case a decade ago. Even on mine sites that serve alcohol in their canteens, this is usually restricted to low alcohol beverages, or they limit the number of full strength alcoholic drinks an employee can purchase each day. However, mining industry workers are often employed on a roster system for two to three weeks on site, then they have one week of recreational leave.

Therefore, workers may consume only a small amount of alcohol on site and then engage in heavy alcohol consumption during leave periods. From this perspective, normative regulation of drinking in mining workplaces restricts workers' consumption of alcohol while at work. However, these

restrictions do not extend to employees' recreational leave away from the mine site. This may account for workers engaging in infrequent high consumption.

## Drinking more than intended

Further support for the impact of workplace culture on workers' consumption patterns was evident from respondents' experiences of drinking more alcohol than intended and unsuccessfully trying to cut down on alcohol use. Respondents who reported that they usually drank at their workplace (such as those employed in the hospitality industry) were 1.4 times more likely to also report occasionally drinking more alcohol than they had intended. This may indicate social pressure to consume more alcohol than intended in workplaces with a culture of alcohol use (typified by workers who usually drink at their workplace).

## Unsuccessfully tried to cut down

Similarly, respondents who reported that they usually drank at their workplace were 1.4 times more likely to also report having unsuccessfully tried to cut down on their alcohol use. This may indicate that these workers recognise that they may be drinking more than they should. However, due to social pressure to consume alcohol at their workplace, they may find it difficult to reduce their alcohol intake. Conversely, these findings may also indicate that certain occupations or industries attract people with a propensity to develop alcohol problems.

## Implications for harm minimisation in the workplace

The relationship between the workplace culture and alcohol use has important implications for responding to alcohol-related harm in the workplace. Many traditional approaches to dealing with workplace alcohol problems, such as Employee Assistance Programs (EAPs), focus on the treatment of individual workers with alcohol problems. In addition, more workplaces are adopting drug and alcohol testing as a method of detecting individual workers with alcohol or other drug problems.

These individualistic approaches are no doubt important for detecting and dealing with individual workers who represent

a risk to safety and productivity. However, strategies that focus on individual 'problem' workers have little impact on the cultural aspects of the workplace that can influence the consumption patterns of a much larger number of workers. Individualistic approaches are of little benefit to the much larger number of workers who are not problem drinkers, but whose drinking patterns also represent a risk to safety and productivity.

Similarly, unless alcohol education and training strategies target workplace culture they are unlikely to have any substantial impact on minimising the risk of alcohol-related harm in the workplace. A recent study that evaluated the effectiveness of a drug and alcohol training program (Pidd 2004) provides an example of how the success of this type of training depends on workplace culture. This study indicated that training:

- had a significant long-term impact on the *attitudes and beliefs* of trainees
- but a limited impact on alcohol-related *behaviour*.

The strongest change, in terms of reducing work-related drinking, occurred only for trainees employed in workplaces where the workplace culture reflected an intolerance of work-related alcohol use.

Effective minimisation of alcohol-related harm in the workplace requires innovative strategies that go beyond traditional approaches that focus on individual workers. In many cases, these individual workers are merely a symptom, or indication, of a workplace culture of alcohol use. Thus, focusing on these workers is treating the symptom rather than the cause.

Strategies aimed at minimising alcohol-related risk to workplace safety and productivity need to be multifaceted and acknowledge the cultural dimensions of the workplace that influence the consumption patterns of all workers. These strategies need to target normative regulation of drinking, the quality and

organisation of work, workplace drinking subcultures, and alcohol-related factors external to the workplace. It is unlikely that strategies such as EAPs, drug and alcohol testing, or education and training alone will have any substantial impact on minimising alcohol-related harm in the workplace unless they also acknowledge and target the cultural dimensions of the workplace that influence workers' alcohol use.

## References

- Allsop, S & Pidd, K 2001. The nature of drug-related harm in the workplace. In Allsop, S, Phillips, M & Calogero, C (eds), *Drugs and work: Responding to alcohol and other drug problems in Australian workplaces*, Melbourne, IP Communications, pp. 5-19.
- Ames, GM, Grube, JW & Moore, RS 2000. Social control and workplace drinking norms: A comparison of two organizational cultures. *Journal of Studies on Alcohol*, vol. 61(2), pp. 203-219.
- Ames, GM & Janes, C 1992. A cultural approach to conceptualizing alcohol and the workplace, *Alcohol Health & Research World*, vol. 16(2), pp. 112-119.
- Ames, GM & Rebhun, LA 1996. Women, alcohol, and work: interactions of gender, ethnicity and occupational culture, *Social Science and Medicine*, vol. 43(11), pp. 1649-1663.
- Davey, J, Obst, P & Sheehan, M 2001. It goes with the job: Officers' insights into the impact of stress and culture on alcohol consumption within the policing occupation, *Drugs: Education, Prevention and Policy*, vol. 8, pp. 141-149.
- Phillips, M 2001. The prevalence of drug use and risk of drug-related harm in the workplace. In Allsop, S, Phillips, M & Calogero, C (eds), *Drugs and work: Responding to alcohol and other drug problems in Australian workplaces*, Melbourne, IP Communications, pp. 20-41.
- Pidd, K 2003. *The work-related drug use of adolescent apprentices: Testing a revised theory of planned behaviour*. Unpublished doctoral dissertation, Flinders University, Adelaide.
- Pidd, K 2004. The impact of workplace support and workplace identity on training transfer: An Australian case study. *International Journal of Training and Development*, vol. 8(4), pp. 274-288.

## THE BUILDING TRADES DRUG AND ALCOHOL PROGRAM

The building and construction industry is the second most dangerous industry in Australia (mining is the most dangerous). It is also widely acknowledged that the industry has had a culture of alcohol use, with many building and construction workers regularly drinking at high levels. According to the building industry drug and alcohol program, at least one in four people in the building industry drinks at a high or moderate risk level.

The combination of a high safety risk industry and a culture of alcohol use can be a dangerous mix. The World Health Organization estimates that one in four of all industry accidents worldwide can be attributed to drugs and/or alcohol.

To address this, the Building Trades Drug and Alcohol Program take a nationally consistent, whole-of-industry approach to the prevention of alcohol use (as well as other drug use) on worksites. The program works with the three main stakeholders to ensure it addresses the culture of the building industry effectively. These three groups are the workers, the employers and the unions. The program is peer-based and

encourages workers to improve safety on building sites, as well as informing workers of available treatment options. To achieve cultural change in the industry, the program utilises a range of strategies including consultation, education, training and referral.

While the program is ongoing, it has been successful in achieving cultural reform regarding alcohol use. An example of this is a change in managerial support for work-related alcohol use. As outlined, alcohol was a pivotal part of the culture of this industry for many years. It was used in important work-related rituals, such as site barbeques, which were traditionally used to mark completion stages of the job. These events usually involved the free supply of alcohol by the employer.

The introduction of the program has altered this managerial support. Barbeques are still conducted to celebrate the completion stages of the job. However, they are now either alcohol free, or the worksite is officially closed and the barbeque is conducted with alcohol away from the workplace.



# DIVERSION OF PHARMACEUTICAL DRUGS

JULIA TRESIDDER

In 2002 the Australasian Centre for Policing Research prepared a discussion paper for the Police Commissioners' Drugs Committee (2002) that outlined the major issues and challenges for Australia in regards to the diversion of pharmaceutical drugs into the illicit market. Two of the major issues they identified-were:

- 1) diversion from the pharmaceutical market to the illicit market directly (usually involving prescription drugs, e.g. benzodiazepines)
- 2) diversion of pharmaceuticals to be used for the manufacture of illicit drugs (usually involving non-prescription drugs that contain pseudoephedrine).

There are many aspects to, and perspectives on, the diversion of pharmaceuticals. Of Substance has chosen to highlight just a few of the current initiatives that are being implemented to

reduce the misuse and diversion of pharmaceuticals for purposes other-than those intended by the pharmaceutical companies and-prescribers.

When people obtain pharmaceutical drugs for their own purposes by visiting a range of doctors, the practice is referred to as 'prescription shopping'. The Health Insurance Commission writes about their Prescription Shopping Project, below. Following this, Dr Michael Dobbin writes about the harmful effect of temazepam capsules if injected and the subsequent withdrawal of these from the market.

## Reference

Australasian Centre for Policing Research 2002. The diversion of pharmaceutical drugs onto the illicit market, Adelaide, Commissioners' Drugs Committee. [http://www.acpr.gov.au/research\\_drug.asp](http://www.acpr.gov.au/research_drug.asp)

## Prescription Shopping Project

The Health Insurance Commission (HIC) administers the Pharmaceutical Benefits Scheme (PBS) on behalf of the Australian Government. The Prescription Shopping Project is one of a number of initiatives being managed by HIC to ensure the proper and efficient use of the PBS. The project aims to identify and reduce the number of people who are obtaining PBS medicines in excess of their health needs.

A range of strategies is being used to identify individuals found to be obtaining excess PBS medicines, to intervene, and also to educate and prevent others who may be at risk of this activity. Various education materials about the project have been produced both for consumers and for health professionals.

### How are doctors involved?

When an individual is identified by the project, he or she may-be contacted by HIC to discuss the PBS medicines they have obtained.

Additionally, under legislation relating to the project, HIC has the authority to contact an individual's doctor/s to discuss their PBS information if the person appears to be obtaining PBS medicine in excess of medical need. The purpose of contacting the doctor is to bring to their attention the individual's suspected excess use of PBS medicine to assist the doctor in more informed prescribing to that person.

### Limitations of the project

In administering the PBS, HIC is limited to collecting only information about medicines claimed under the PBS. As a result of this limitation, the Prescription Shopping Project does not collect information about:

- over-the-counter medicines
- items that have not qualified for a pharmaceutical benefit, e.g. private prescriptions
- Department of Veterans Affairs patients and their associated PBS history
- prescriptions rejected for payment
- items dispensed by pharmacists using emergency Medicare numbers
- visits to doctors where no PBS script was subsequently provided
- doctors' bag medications.

### Future of the project

HIC is currently liaising with peak bodies to explore the possibility of establishing an information service to enable doctors to obtain information about a person they suspect is obtaining PBS medicine in excess of therapeutic need. Doctors will be advised on the development of this service.

## Case study: the withdrawal of temazepam capsules in Australia

DR MALCOLM DOBBIN, DEPARTMENT OF HUMAN SERVICES, VICTORIA

Temazepam belongs to the benzodiazepine group of drugs. These drugs are used to treat anxiety, insomnia and epilepsy. Diversion of mood-altering (psychoactive) prescription drugs from licit to illicit use is common, and benzodiazepine misuse and injection have been endemic among people who inject drugs for many years (Ross et al. 1996). Most people who want benzodiazepines for their own use obtain prescriptions from doctors, but an illicit market in which the drugs are trafficked, or exchanged for heroin also exists. Benzodiazepine use amongst those who inject drugs is associated with increased HIV risk as a result of needle/syringe sharing, increased injection frequency, poorer health and higher risk of drug overdose death.

Temazepam was unique among prescription hypnotics as it was supplied in a readily injectable form: a soft gelatin, liquid-filled capsule. The harm caused by the injection of the contents of these capsules is documented in the medical literature from 1987 on, and was first identified in the United Kingdom (Stark et al. 1987). Serious harm from such injection has been reported in numerous articles (e.g. Farrell & Strang 1988). Serious injury includes gangrene as the result of unintentional injection into arteries (Bhabra et al. 1994).

Injection of the liquid from capsules became established during the heroin drought in late 2000. There were subsequently many reports of serious damage to blood vessels and tissue, similar to that documented in the United Kingdom before prescribing temazepam capsules was banned in 1996.

In Australia, temazepam capsules were one of the ten most frequently prescribed drugs on the Pharmaceutical Benefits Scheme (PBS), accounting for 2.2 million prescriptions in 1999-2000. Temazepam tablets became available several years after the capsules, and there was a slow, steady trend towards tablets being prescribed instead of capsules. However only 25 per cent of temazepam PBS prescriptions in Victoria in September 2001 were for tablets (Health Insurance Commission 2001). In response to the serious harm caused by temazepam injection, the Department of Human Services Victoria developed an education and information initiative for general practitioners, pharmacists and injecting drug users in Victoria: the Temazepam Injection Prevention Initiative (Department of Human Services 2001).

Subsequently, representations to national committees resulted in severe restrictions on the availability of a PBS benefit for temazepam capsules. This resulted in a 99 per cent reduction in PBS supply of the capsules. In late 2003 and early 2004 the pharmaceutical companies supplying temazepam capsules withdrew them from the Australian market because of concerns about the injection of the liquid contents, this put an end to the serious harm caused by temazepam injection.

### Questions about limiting availability

Many people believed that if temazepam was removed from the market, people who inject drugs would substitute another benzodiazepine, with no net benefit in preventing serious harm. This was not the experience in the United Kingdom.

While users did substitute other benzodiazepines, they either did not inject the drugs or injected less frequently. The use of other benzodiazepines did not cause serious harm, and a substantial net public health benefit was documented (Donaldson 2001). Anecdotal evidence suggests the experience in Australia since removal of the capsules from the market is similar: injecting drug users have not shifted to injecting temazepam tablets, and there appears to have been a marked decrease in the serious tissue and vascular harm caused by injecting benzodiazepines.

Concerns were raised that insomnia patients would be disadvantaged, though this was not the case in the United States where the capsules were never widely prescribed (or in the United Kingdom since 1996) therefore insomnia can be satisfactorily managed without them. Temazepam is still available as a tablet.

Following the Victorian initiative, the Victorian Department of Human Services was told that drug-seeking patients were requesting and misusing other soft gelatin, liquid-filled capsules, including Unisom® (diphenhydramine), Hemineurin® (chlormethiazole) and Dozile® (doxylamine). People were also reportedly asking doctors to prescribe 20mg of temazepam or asking specifically for a brand (Euhypnos®) that was only available as a capsule, and not as a tablet, without specifying the dose form.

### Strategies to minimise misuse

This placed pressure on pharmacists to dispense capsules because there are no 20mg tablets (or Euhypnos®). Doctors could specify tablets on temazepam prescriptions to counter this tactic.

Other people claimed intolerance to the minute amount of lactose in the tablets. Doctors could advise the patient that temazepam is indicated for short-term use only (two to three weeks) and use leaflets from the kit to offer help for sleep problems without prescribing drugs. Doctors could also avoid chronic prescribing of hypnotics, as recommended by therapeutic guidelines. If temazepam is necessary for short-term use, then tablets were an effective alternative that were less likely to be trafficked and eventually injected.

More information is available on the Department's website: <http://www.drugs.vic.gov.au/temazepam>

### References

- Bhabra, MS, Meshikhes, AM, Thomson, GJL et al. 1994. Intra-arterial temazepam: an important cause of limb ischaemia in intravenous drug users, *European Journal of Vascular Surgery*, vol. 8, pp. 240-242.
- Donaldson, L 2001, Chief Medical Officer, Department of Health, London. Personal communication. 27 November 2001.
- Farrell, M & Strang, J 1988. Misuse of temazepam. *BMJ*, Nov 26, 297, p. 1402.
- Ross, J, Darke, S, Hall, W 1996. Benzodiazepine use among heroin users in Sydney: patterns of use, availability and procurement. *Drug and Alcohol Review*, vol 15 (3), pp. 237-243.
- Stark, C, Sykes, R & Mullin, P 1987. Temazepam abuse (letter), *Lancet*, Oct. 3, 2, pp. 802-803.



(Diversion of pharmaceuticals to the illicit market continued)

## REGULATION AND POLICING CHALLENGES

### Policing and methamphetamine production in Australia

JULIA TRESIDDER

The continued growth in methamphetamine production in Australia has been a challenge for law enforcement agencies. The increasing number of clandestine laboratories detected across Australia was outlined in the Australian Illicit Drug Report in 2001-02 and last year's Illicit Drug Data Report. These hazardous operations, which vary significantly in size and method, represent a danger to the community, police investigators and the offenders themselves.

Chemicals used to manufacture illicit drugs are referred to as 'precursor' chemicals. Restrictions on the availability of precursor chemicals used in the manufacture of illicit drugs in Australia have been successful in limiting the extent of manufacture. However, law enforcement agencies stress that continued vigilance and proactive policing is required. Domestic restrictions on these chemicals could also potentially lead to increased attempts to import precursors.

In the case of non-prescription pharmaceuticals, people sometimes visit many pharmacies to obtain large quantities of tablets that contain pseudoephedrine hydrochloride (e.g. Sudafed). Pseudoephedrine is used to manufacture methamphetamine and is relatively easy to extract.

Information is provided below on a collaborative initiative of federal/state governments (both health and law enforcement sectors) and private sector peak bodies on this issue. The NSW Police Service also provides their perspective about two issues arising from the illicit manufacture of methamphetamine in Australia.

#### References

Australian Crime Commission 2003. Australian Illicit Drug Report 2001-02, Commonwealth of Australia, Canberra.

Australian Crime Commission 2004. Illicit Drug Data Report 2002-03, Commonwealth of Australia, Canberra.

### National Working Group on the Prevention of the Diversion of Precursor Chemicals

LEITH WATSON, SENIOR LEGAL OFFICER, ATTORNEY-GENERAL'S DEPARTMENT

The National Working Group on the Prevention of the Diversion of Precursor Chemicals ('the Working Group') was established in September 2002 by the Minister for Justice and Customs at the Chemical Diversion Congress. The Working Group brings together 42 members from law enforcement, health and industry and has met six times since its inception on 4 December 2002.

The Working Group is assisting with the development and implementation of the National Strategy to Prevent the Diversion of Precursor Chemicals into Illicit Drug Manufacture ('the National Strategy') from 2003-04 to 2007-08. The National Strategy provides national leadership and coordination to better inform and target efforts to prevent the diversion of precursor chemicals into illicit drug manufacture. The National Strategy will benefit pharmacists, industry, Customs, police, intelligence officers and policy analysts by improving their capacity to share information and by enhancing intelligence on the diversion of precursor chemicals.

Measures being developed under the National Strategy include:

- a national clandestine laboratory database
- enhancements to the National Industrial Chemicals Monitoring Scheme
- enhanced training for Customs, law enforcement officers and forensic chemists

- a Crime Stoppers awareness-raising campaign to alert the public to the indicators and dangers associated with illicit drug manufacture and how to report it
- an awareness campaign for industry and occupations that may come into contact with clandestine laboratories.

The Working Group is addressing the issue of decontaminating properties previously used as clandestine laboratories. The Group also facilitated the development of the Model Criminal Code drug endangered children offences, which target the exposure of children to the dangers of clandestine laboratories.



A seizure of 18 500 pseudo tabs made from a single 'pseudo runner'. This quantity of tablets could be used to produce in excess of 10 kg of street level methylamphetamine.

Photo courtesy of NSW Police Service

## A POLICE PERSPECTIVE

### CLANDESTINE DRUG LABORATORIES

DETECTIVE INSPECTOR PAUL WILLINGHAM AND DETECTIVE SERGEANT NICHOLAS IORFINO, DRUG SQUAD (CHEMICAL OPERATIONS) STATE CRIME COMMAND, NSW POLICE

#### Safety issues associated with clandestine drug laboratories

Clandestine drug laboratories are hazardous. In addition to the detrimental effects illicit drugs have on the community, clandestine laboratories are toxic and can cause explosions. There are numerous examples of people being seriously injured as a direct result of clandestine drug laboratories.

In July 2003, a drug laboratory exploded in Western Sydney, NSW, causing serious burns to the offender who later died in hospital as a result of these injuries. In 2004, a 20 year old man was critically injured after receiving severe burns from a clandestine drug laboratory fire in Sydney. Similar to the death in July 2003, this person was involved in the extraction of pseudoephedrine from cold and flu tablets readily obtained from retail pharmacy outlets.

Clandestine drug laboratories have been found in houses, units, factory units, hotels/motels and even in remote bushland. Often the sites are left contaminated with future tenants unaware of the contamination. People residing near or occupying premises next to illegal drug laboratories may be in danger.

Most illegal drug laboratories are operated by amateur 'chemists' who do not engage in quality control and often resort to improvised equipment to avoid detection by the law enforcement sector. These laboratories are often found after an explosion and/or fire.

There has been a substantial increase in detection and use of methylamphetamine and other synthetic drugs. The number of clandestine laboratories discovered has risen. The consequences of this translate to large financial costs when law enforcement, decontamination and in the case of accidents, medical expenses are taken into account. The police therefore encourage the pharmaceutical industry and the community to cooperate to help to prevent the manufacture of illicit drugs.

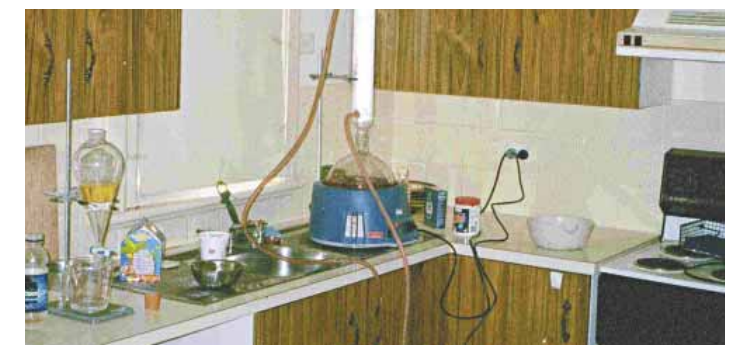
#### Preventing the diversion of pseudoephedrine-based products

The majority of drug laboratories seized across Australia involve the reduction of pseudoephedrine into the illicit drug methylamphetamine. Due to the restrictions on this precursor ingredient, illicit manufacturers source pseudoephedrine from cold and flu products available through retail pharmacy outlets. The people who buy non-prescription medications that contain pseudoephedrine and divert these to illegal drug manufacture engage in an activity commonly referred to by the police as 'pseudo running'. Illicit drug manufacturers are often highly organised and engage a network of 'runners' to accumulate large quantities of tablets.

Currently, there are only limited restrictions on pseudoephedrine-based products and, despite the ongoing strategies deployed jointly by the police and retail pharmacy outlets, they remain relatively easy to obtain. As 'gatekeepers' for pseudoephedrine-based products, retail pharmacy outlets are advised by the police to be vigilant in relation to suspicious persons who are not regular

or local customers, request multiple packets or whose reason for purchase is not consistent with the stated purpose of the product. Some 'pseudo runners' travel interstate and use maps indicating the location of retail pharmacy outlets. Some of these runners take detailed notes about layout and stock levels of each pharmacy, the attitude of retail pharmacy outlet staff and whether identification was requested.

The police are therefore addressing this issue. Currently, in NSW, a proactive strategy exists whereby retail pharmacy outlets can report suspicious persons buying, and attempting to buy pseudoephedrine-based products. Retail pharmacy outlets are advised by the police to display notices so that customers can be aware that questions can be asked of them when buying pseudoephedrine-based products.



A typical clandestine laboratory set up in a suburban kitchen. The contamination generated during these 'cooks' pose immediate risks to the community.

The police have been assisted in a number of investigations by information supplied about pseudo runners. This intelligence has, on a number of occasions, resulted directly in the discovery of clandestine drug laboratories. The police are currently conducting training and awareness sessions for the staff of retail pharmacy outlets to assist them in identifying suspicious purchasers.

One successful strategy is for retail pharmacy staff to ask people buying pseudoephedrine for identification. Earlier this year, in Oklahoma (US), legislation was introduced requiring that identification be produced and recorded for purchases of all pseudoephedrine-based products. It has been reported that Oklahoma subsequently had a 70% drop in the number of clandestine laboratories located after the introduction of this legislation. In NSW, only those who purchase single entity tablets have to produce identification. This has caused a shift in demand and people are now purchasing combination tablets that can also be used in the manufacture of methamphetamine.

Ongoing cooperation between pharmaceutical companies and retail outlets and police is necessary to find effective strategies that can successfully prevent pseudoephedrine being diverted for the manufacture of illicit substances. It is hoped that with the cooperation of staff at retail pharmacy outlets that it will not be necessary to bring in legislation requiring staff to ask for identification when consumers purchase combination tablets containing pseudoephedrine.



# SCHOOLIES WEEK IN PERSPECTIVE

## STUDIES OF ALCOHOL, DRUG AND RISK-TAKING BEHAVIOUR

CAROLINE SALOM<sup>1</sup>, MICHAEL WATTS<sup>1</sup>, STUART KINNER<sup>2</sup> AND DENNIS YOUNG<sup>3</sup>

### Introduction

Each year young people gather in various locations around Australia to celebrate the end of the school year. Traditionally, the revellers are Year 12 students who are celebrating the end of their schooling and the beginning of their independent 'adult' life. These celebrations are often seen as a rite of passage and a time for young people to experiment with adult behaviours. However, some of these behaviours have been a cause for concern among other members of the community.

In South East Queensland, the Gold Coast (GC) has long been a favoured destination for these celebrations. It has become known as the Schoolies Week Festival (Schoolies Week), and each year more young people travel to the GC at this time.

In the face of media reports of excessive drug use and the absence of consistent long-term data, DRUG ARM instituted a cross-sectional study of the drug- and risk-taking behaviours of young people at Schoolies Week. This study examined the use of licit and illicit drugs, and risk-taking behaviours during Schoolies Week from 1999-2003.

The patterns of use and associated behaviours are a cause for some concern. The results gathered also provide some evidence for a link between the use of drugs, both licit and illicit, and risk-taking behaviours. This paper compares some of these results with other relevant research, and also examines any changes in behavioural patterns over this time and compares these with other reports.

### Studies of Schoolies Week and other festivals

A number of studies have looked at the consumption of alcohol and other drugs by young people in Australia, including during Schoolies Week. These vary enormously in their scope, longevity and detail, making comparisons across subsequent years sometimes difficult.

Smith & Rosenthal (1997) discussed data from a street intercept study with 1795 respondents ('schoolies' only), looking at how the young people's expectation of their behaviour at Schoolies Week determined that behaviour. Their finding was that expectations were largely fulfilled: 82% of males and 68% of females expected to be drunk most or every night, and 75% of males and 60% of females achieved this. Twenty-seven per cent of males and 16% of females expected to be stoned most or every night/day, and 25% of males and 13% of females were stoned most days.

Sexual behaviour was also expected, though not as frequently fulfilled: 65% of males and 31% of females expected to have sex during Schoolies Week, with 39% of the whole cohort (gender breakdown not reported) reported having sex. Although around 80% expected to use condoms, only approximately 55% used them, with 10-20% not knowing whether any contraception was used.

Winchester et al. (1999) discussed observations and a number of semi-structured in-depth interviews of schoolies during 1996. Overall the perceptions of the young people reflected their expectation of surf, sex and sun as part of the rite of passage from school and enforced behaviour to freedom and adult behaviour. There was a sense of 'sanctioned misbehaviour', that behaving outside the usual social norms was 'expected' of schoolies. Although there was some perception of the harms associated with drug use, such as overdose, there was a sense of being dissociated from the consequences.

Zinkiewicz et al. (1999) compared substance use and risk-taking behaviour of 658 young people at Schoolies Week between several South East Queensland locations and with that of Year 12 students still at school. In the comparison with school students, 55% of students had consumed alcohol in the last seven days, while at Schoolies Week, 84% had consumed in the last 24 hours. Reported levels of use of alcohol, marijuana and ecstasy among schoolies were higher than levels in the general population of similar age. Risk-taking behaviours examined included drunkenness, vomiting, drink driving, drug use, fighting, sexual harassment and injury. Schoolies at the Gold Coast were more likely to have been involved in such behaviours than those at other Queensland locations. Curd (1998) and Curd & Parker (1995) noted the success of diversionary activities in festivals of smaller scale, e.g. the Sunshine Coast.

### Literature summary

Overwhelmingly, previous studies indicate that amongst young people who have just completed their last year of school and are celebrating at an event, alcohol is the drug of choice. This reflects the strong association in Australian culture between alcohol and celebration. It is also not peculiar to leaving school. In some cases, it reflects increased accessibility, via the newly legal status of drinking for students who have turned 18 (commonly those from Victoria or NSW). In others it is a reflection of the semi-ritual rebellion against social controls that is part of this stage of adolescence.

Concerns, however, arise with the linkages seen between alcohol consumption, particularly at risky levels, and the association with risk-taking behaviours, including violence and public disturbance. Also of concern is the establishment of patterns of consumption that may remain and cause damage to the individual in the long term. In the next section, some results from the DRUG ARM study are discussed in light of recent research across similar populations.

### DRUG ARM's cross-sectional study

This study, covering the years 1999-2003 (to date), is the first of its type. From a total of 7328 surveys collected, responses were gained from 4848 young people who had just left school and were aged 16-20 years. Alcohol and other drug use over the last 12 months, month, week and day were recorded, along with participation in risk-taking behaviours. Analysis yielded patterns of use over the five-year period, with comparisons between gender, and also between schoolies (those who have just left school) and non-schoolie attendees. These data were collected over a time frame encompassing several public safety and harm minimisation campaigns.

### Alcohol: the drug of choice

Of the schoolies sampled, alcohol appeared to be by far the 'drug of choice'; 88% of young people having consumed alcohol in the last seven days in the 2003 sample. This was consistent across years. Students still at school reported similar preferences, but lower levels of consumption over the last seven days (Gillespie et al. 1991; Wibberley & Price 2000). Uni students also preferred alcohol but indulged slightly less (Roche).

While almost 90% of schoolies used alcohol, only 27% used cannabis, 6% used ecstasy, 5% amphetamines and 2% LSD, cocaine or heroin. Again, figures for 2003 are similar to those from other years. Smith & Rosenthal report comparable figures in 1995.

### Risk-taking behaviours at Schoolies Week

Behaviours regarded as risky are common during Schoolies Week. Of those surveyed in 2003, 73% had been drunk and 37% had

experienced a hangover. Seventeen per cent of the young people had been in a car where they believed that the driver was under the influence of alcohol and/or other drugs. Twenty-one per cent of respondents reported that they had vomited due to drinking or taking drugs, while 19% indicated that they had passed out due to drinking or taking drugs. In 2003, there was no significant difference between males and females for vomiting; this seems to indicate an escalation of female drinking as Zinkiewicz et al. (1999) reported 22% for males and only 11.7% for females. This tallies with national reports of increases in incidence of binge drinking amongst young females.

Thirty per cent of respondents in 2003 indicated that they had had sex and half of these (15%) indicated that they had not used a condom during one or more of their sexual encounters. Similar results were reported by Smith & Rosenthal (1997) for Schoolies Week in 1995. This is disappointing, considering public education campaigns regarding safe sex practices, but may reflect the unplanned nature of many encounters: as reported by Smith & Rosenthal, although 65% of males expected to have sex during the week, around 30% of females had similar expectations. The coexistence of diminished decision-making due to alcohol or drug consumption may account for lack of precautions.

With other significant individual risks, only 3.3% of those who responded indicated that they had injected a drug. However, at least half of these reported they had shared a needle. This may also reflect the unplanned nature of this behaviour, rather than a failure of safety messages. It has been suggested by a number of authors that young people's refusal skills are somewhat lessened during Schoolies Week.

Although there was no significant age difference for risk-taking behaviours there were significant gender differences. Males were significantly more likely than females to have driven under the influence of alcohol or other drugs, and significantly more likely to have been a passenger in a vehicle where the driver was under the influence. Eleven per cent reported that they had been in a fight. Again, males (14%) were significantly more likely than females (9%) to report this. Similar patterns were reported (Roche & Watt 1999) for university students. As mentioned above for binge drinking, changes in resulting behaviours such as vomiting due to drinking, fighting and driving under the influence in females (increasing toward 'male' levels) may reflect changing attitudes among the young people to what is acceptable.

### Changes in behaviour over time

Interestingly, as shown in Figure 1 on page 28, prevalence of these behaviours is remarkably stable over time. Comparisons with data from 1995 support this observation.

It appears that despite the efforts of the government and its associated community partners to provide diversionary activities and support mechanisms for young people at Schoolies Week, the behaviours we regard as risky have not shown significant reduction over time. A number of arguments are relevant to this observation.

One is that young people's behaviour at Schoolies Week reflects their expectations of the event. Until the young people's expectations are changed, behaviour is unlikely to differ. There is some suggestion that by interviewing young people on the streets at night, there is a self-selection of drug and risk-

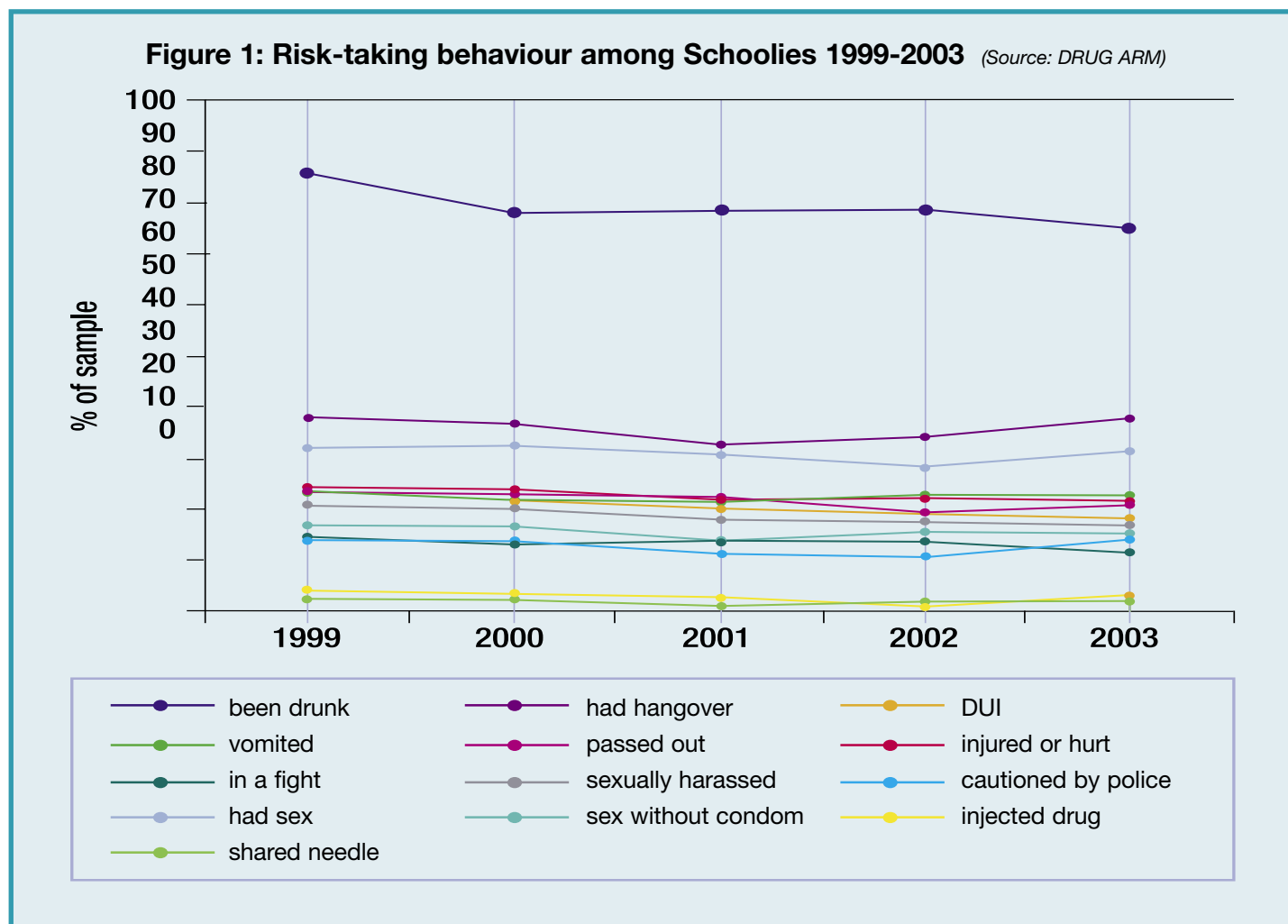


Image courtesy of Queensland Health and Community Solutions Inc.

<sup>1</sup>Centre for Addiction Research & Education, DRUG ARM <sup>2</sup>Queensland Alcohol and Drug Research and Education Centre <sup>3</sup>DRUG ARM Australasia



Figure 1: Risk-taking behaviour among Schoolies 1999-2003 (Source: DRUG ARM)



taking participants. However, with restrictions on gathering in accommodation, and centralisation of activities by event coordinators, this is where the young people 'hang out'. It is also worth noting that other studies (Zinkiewicz et al. 1999, Winchester et al. 1999, Roche & Watt 1999) also used street intercepts, but in the daytime, often at alcohol-free events, and obtained very similar results.

There is also the issue of whether behaviour at the GC is indicative of all young people celebrating the end of school. There has been some suggestion that over time, there has been a self-selection of the population at the GC: those intent on a quieter celebration are now exploring alternative venues such as Stradbroke Island or the Sunshine Coast (Zinkiewicz et al. 1999). Any changes to activities at the GC will thus depend on a major shift in the perception among young people of the event, what to expect and what is acceptable.

Schoolies Week is an entrenched phenomenon. The implementation of public support and diversionary activities has shown positive results in smaller, less entrenched festival destinations – it may be that these measures require longer to take effect at the GC. Extreme caution should certainly be exercised in considering any reduction of the infrastructure and support provided. As noted in other festivals (McKey 1997), relaxation of the support and structure in other events over time has resulted in increases in undesirable behaviour – far more quickly than the emergence of positive changes. Perception change is a very long-term objective: initiatives currently being implemented may take another five years to show results. However, it is in the interests of both the personal safety of our young people and public safety in the communities that host such large scale events that we work towards that goal.

DRUG ARM is a community-based organisation operating under Christian principles that provides support for individuals and their families experiencing harm due to alcohol and other drugs. Thank you to CARE's Resource Centre staff for their research help with this article.

## References

- Curd, D 1998. The Meaning, Madness & Magic of Schoolies Festival [Paper presented at Addictions: Challenges and Changes Conference (1998)], *Winter School in the Sun*, Conference Papers, pp. 58-63.
- Curd, D & Parker, T 1995. Sunshine Coast Schoolies Week Project 1994, *Dealing with Drugs: Ethics, Economics and Efficiency: the Proceedings of the Second Window of Opportunity National Congress*, 10-14 July 1995, pp. 105-112.
- Gillespie, A, Davey, J, Sheehan, M & Steadson, D 1991. Thrills without spills: the educational implications of research into adolescent binge drinking for a school-based intervention, *Drug Education Journal of Australia*, vol. 5, no. 2, pp. 121-127.
- McKey, J 1997. Celebrating safely, *Connexions*, December 97/January 98 pp16-18.
- Roche, AM & Watt, KA 1999. Drinking and university students: from celebration to inebriation, *Drug and Alcohol Review*, vol. 18, no. 4, pp. 389-399.
- Smith, A & Rosenthal, DA 1997. Sex, alcohol and drugs? Young people's experiences of Schoolies Week, *Australian and New Zealand Journal of Public Health*, vol. 21, no. 2, pp. 175-180.
- Wibberley, C & Price, JF 2000. Young People's Drug Use: Facts and Feelings – Implications for the Normalisation Debate, *Drugs: Education, Prevention and Policy*, vol. 7, no. 2, pp. 147-162.
- Winchester, HPM, McGuirk, PM & Everett, K 1999. Schoolies Week as a Rite of Passage: a study of celebration and control, in E. Teather (ed), *Embodied geographics: Spaces, bodies and rites of passage*, London, Routledge, pp. 59-77.
- Zinkiewicz, L, Davey, J & Curd, D 1999. Sin beyond Surfers? Young people's risky behaviour during Schoolies Week in three Queensland regions, *Drug and Alcohol Review*, vol.18, no. 3, pp. 279-285.

## QUEENSLAND SCHOOLIES WEEK INTERVENTIONS

JULIA TRESIDDER

Adolescence is a time when young people begin to experiment with alcohol and other drugs. Other risk-taking behaviours are also common and research has shown associations between all these behaviours. The research presented on the previous pages indicates that high-risk behaviours are also common amongst school leavers who visit the Gold Coast, despite the various prevention and intervention strategies that have been employed over the years.

While legislation prevents young people purchasing alcohol in licensed clubs and pubs until they turn 18, many young people

(as documented by the regular National Secondary Schools survey) begin to drink alcohol regularly from the age of 15. It is therefore not surprising that alcohol features prominently in end-of-school celebrations as well as other risk behaviours. However, there is legitimate concern about the harms associated with these risk behaviours.

Many different individuals, community groups and government agencies over the years have tried to help young people celebrate safely. The following is a brief description of this history, and of other work being done in Queensland.

### Gold Coast

JULIA TRESIDDER

The Gold Coast has attracted school leavers since the late 1970s. As the numbers of young people visiting the area increased (now up to 50 000 each year) so did community concern about young people congregating in the area with no appropriate and planned activities.

Community and charitable groups began providing refreshments and safe venues in the 1980s; the Gold Coast Council (GCC) added to this in the 1990s by providing alcohol-free entertainment.

In 2002 the Queensland Government put together a Schoolies Festival MPs Taskforce, which built on previous work done by the GCC. In May 2003 a three-point plan was developed to encourage all participants – young people, parents, accommodation providers, tourism operators, councils and state government agencies – to act responsibly to minimise the risks.

A Gold Coast Schoolies Festival Board now oversees and coordinates diversionary activities. Initiatives include:

- a professional event organiser who develops a program of entertainment and activities
- an increased police presence and improved coordination of security staff and volunteers
- extra temporary lighting on the beach and in areas where there is festival entertainment
- an increased liquor licensing presence
- a voluntary Code of Conduct for both accommodation managers and young people. A training program for the managers and a complaint-handling mechanism have also been established.

The challenge presented by the influx of young people celebrating the end of their schooling at one place over a short period of time has required a whole-of-community approach. The evaluation of such prevention initiatives will be needed to assess their impact over time.

### Sunshine Coast

JENNY MADDEN, COMMUNITY SOLUTIONS INC

On Queensland's Sunshine Coast, up to 5000 young people, predominantly Queenslanders, gather to celebrate the completion of Year 12.

Since 1994 Community Solutions Inc, a Sunshine Coast-based community organisation has developed and coordinated the Sunshine Coast Schoolies Week (SCSW) strategy. This is in conjunction with government departments, service agencies, business groups, sponsors and volunteers. It has been important that the strategy retains the meaning of the actual celebration while reducing associated risks.

Two years ago a Schoolies Week Taskforce comprised of government and community organisations was introduced.

A number of strategies have been implemented, including:

- a week long program of appropriate events limited to 16-18 year olds, e.g. underage alcohol-free nightclub parties, movie nights, themed parties and bands
- daytime entertainment, e.g. go-karting, surfing, movies and canoeing
- a transport strategy to maximise attendance at supervised events and minimise risk associated with travel
- an enforcement strategy that targets non-schoolies.

Schoolies Week celebrations generate economic benefit for accommodation providers, food outlets, retailers, travel agents and others. On the Sunshine Coast, minimising negative impacts and promoting positive impacts has resulted in significant support for the strategy. Similarly, it has also been important to engage the local media as partners.

## Queensland Schoolies Education Strategy

This Queensland Health-funded prevention project, managed by Community Solutions Inc (see box above right) provides Year 12 students with health and safety information, with the aim of reducing the harms associated with Schoolies Week. Now in its sixth year, the project has distributed around 43 000 student

booklets to Queensland secondary schools. Information covers drug and alcohol prevention issues, consumer information, sun safety, sexual health and party tips from past Schoolies. The project also includes professional development workshops that have been conducted in different areas of Queensland over the past four years.



## Upcoming conferences

9-11 February 2005  
**18th annual conference of the Australian and New Zealand Society of Criminology (ANZSOC) Crime, Community and the State**  
Hosted by the Institute of Criminology at Victoria University of Wellington, New Zealand  
[www.vuw.ac.nz/anzsoc/](http://www.vuw.ac.nz/anzsoc/)

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](mailto:thinking.drinking@adf.org.au)

10-13 March 2005  
**8th National Rural Health Conference**  
Alice Springs  
[www.ruralhealth.org.au/nrhpublic/](http://www.ruralhealth.org.au/nrhpublic/)

20-24 March 2005  
**16th International Conference on the Reduction of Drug Related Harm**  
Theme: Widening the Gap  
Belfast, Northern Ireland  
[www.ihrcbelfast.com](http://www.ihrcbelfast.com)

## Upcoming events

20-24 June 2005  
**Drug Action Week®**  
2005 Theme days:  
Monday 20 June: Young People  
Tuesday 21 June: Treatment  
Wednesday 22 June: Prevention  
Thursday 23 June: Indigenous Australians  
Friday 24 June: Consumers and Carers  
[www.drugactionweek.org.au](http://www.drugactionweek.org.au)

24 June 2005  
**2005 National Drug & Alcohol Awards Sydney**  
Hosts: Australian National Council on Drugs, Ted Noffs Foundation, Alcohol & other Drugs Council of Australia and the Australian Drug Foundation.

Awards will be presented in the following categories:

- Prime Minister's award for excellence and outstanding contribution in drug and alcohol endeavours
- Excellence in prevention
- Excellence in treatment
- Excellence in research
- Excellence in services for young people
- Excellence in alcohol and drug media reporting
- Excellence in law enforcement (new category)

Principal Sponsor: Alcohol Education and Rehabilitation Foundation  
Major Sponsor: Australian Government Department of Health & Ageing  
Sponsor: NSW Government  
[www.drugawards.org.au](http://www.drugawards.org.au)

We welcome your feedback about this issue of *Of Substance*.

Email: [editor@ancd.org.au](mailto:editor@ancd.org.au)  
Telephone: 02 6279 1650

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