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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 or by phone to (02) 6239 1002 or fax to (02) 6282 7364. The charge per article is $5 for members of ADCA and $11 for non-members.
Editors’ letter

Welcome to the October issue of Of Substance.

Research – we’re constantly quoting it. But where does it come from? How do we get the data that is so often talked about? In this issue, we’ve decided to explore the mystery of ‘research’. David McDonald provides some insights into the purpose of research and what kind of methods are appropriate for drug and alcohol research; in the first of a series on different study techniques, Alison Ritter also explains the secrets of randomised controlled trials.

Still on the topic of research, we discuss a practical example of just how important field studies are. Recently, the Federal Government announced the cancellation of the retractable syringes trial for injecting drug users. This carefully monitored trial quickly revealed that the current technology actually increased the risk of harm to injectors.

During the past quarter, the alcohol and other drug sector has had the chance to celebrate just a few of its success stories. In six pages of inspiring reading, we share the stories of the people, organisations and programs which were among the winners at June’s National Drug and Alcohol Awards.

Enhancing the skills of the drug workforce is always important. This feature discusses the dual and why an important tool in the alcohol and drug counsellor’s bag of tricks – motivational interviewing. As well as highlighting the basics of this useful technique, we explore two examples of how this cognitive-based model has been used.

In July, we looked at the term ‘peer education’ and what it could mean. We continue this theme, with a further article focusing on developing successful peer education programs with young people.

And finally, we are very pleased to publish our first modest letters page. We hope this will become a permanent feature of the magazine – but we need more contributions. So please get writing!

We also welcome Jenny McKey Tinworth who joins Of Substance as co-managing editor. Jenny has a long history of publishing in the alcohol and other drug sector.

Kate Pockley and Jenny McKey Tinworth

Managing Editors
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GUEST EDITORIAL

PROUD RESEARCH TRADITION
IAN W WEBSTER, EMERITUS PROFESSOR, UNIVERSITY OF NEW SOUTH WALES

Two decades ago when the National Campaign Against Drug Abuse started, alcohol and drug research was in a poor state. Epidemiology was just emerging as a discipline looking beyond infectious diseases towards chronic disease and population screening for diabetes, coronary heart disease, hypertension and cancer. Alcohol, tobacco and other drug use was starting to be described as well.

There had been rare examples of biomedical research into alcohol and the liver, alcohol and the brain and the health problems of heroin addicts. There were psychological studies of addictive behaviours, much theorising about addiction and anthropological studies of the origins and social mechanisms of addiction. There were no studies of effectiveness – certainly none which could stand modern tests of evidence.

The funding of two national centres in the universities of New South Wales and Curtin in Western Australia signalled new directions in research. Other dedicated centres have followed, with the National Centre for Education and Training on Addiction in South Australia, Turning Point in Melbourne and the Queensland Alcohol and Drug Research and Education Centre, and new research centres for the sociology, epidemiology and clinical treatment of blood borne virus infections.

Other research has been funded by governments needing data and advice for policy and evaluation of programs. This need for policy, new directions and thinking, were driven by the social and public health imperatives of burgeoning societal harms. Had research been left to the conventional paradigms and funding agencies, alcohol and other drug research would have had strained growth.

To the credit of the national centres and others, and to those who lead the research effort, the narrow keyholes of specific disciplines have been eschewed in favour of an aggressively maintained multidisciplinary approach. And to their greater credit, the objectivity and independence of their research has been protected.

We can be proud of our research effort – it has brought good sense to policy and program development; it has provided international benchmarks for how societies can respond to these problems. Our key people write influential editorials in major relevant international journals, they directly assist other countries and their work contributes strategies and policies to the World Health Organization.

What next then? Assuming that epidemiological surveillance and intervention/outcome studies will continue their trajectory, the new emphasis should turn to pain and addiction, addiction and mental function and the social meaning of alcohol and substance use. We need new ways of conceptualising the bodily, mental and social predicaments of substance use to allow their promising intersections to be explored. In a short time research has come a long way, and there is more ahead.

NEWS

1st National Illicit Drug Diversion Workshop
GINO VUMBACA, AUSTRALIAN NATIONAL COUNCIL ON DRUGS

Recently in Sydney, the 1st National Illicit Drug Diversion Workshop was hosted by the Australian Government Department of Health & Ageing, the Inter-Governmental Committee on Drugs (ICGD) and the Australian National Council on Drugs (ANCD). The workshop brought together over 80 delegates from around the country to discuss the successes, challenges and future for the Diversion Initiative.

With presentations from the non-government, justice and health sectors, it became clear that despite some early testing protocols, the Diversion Initiative had evolved into a wide variety of programs across the country. The strongest message was that success happens when all the sectors truly cooperate, the positive impact on many people’s lives was also often recounted by delegates.

However, there were of course many challenges, including the lack of treatment availability and reach in many areas, as well as the potential for net-widening (capturing more people into the criminal justice system than before). Some of the key recommendations for the future involved a reworking of the Diversion framework to take into account how the programs operate today and will do into the future.

The need for a more targeted evaluation of the outcomes of the Initiative also became a focal point for discussion after a comprehensive presentation by the Australian Institute of Criminology on the currently known impacts of the Diversion Initiative. A report on the workshop proceedings and recommendations will be forwarded to the ANCD and the ICGD for consideration and made publicly available on their respective websites (www.ancd.org.au and www.analdrugstrategy.gov.au/councils/icgd.htm.)

ANCD CHARTER – feedback invited

The Australian National Council on Drugs (ANCD) has developed an Alcohol and Other Drugs (AOD) Charter. The Chart outlines the principles and goals that all stakeholders within the sector in Australia can draw upon in the development and implementation of AOD policy. The Charter provides a mechanism to formally recognize the principles and aspirations that are implicit in the contributions that we all make to prevent and reduce drug-related harms.

The Charter has been informed by United Nations’ Charters, such as the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the UN Convention on the Rights of the Child and the various UN Conventions on Narcotic Drugs, including trafficking and Psychotropic Substances, in addition to the mission of Australia’s National Drug Strategy 2004-2009. To ensure the Charter reflects the goals of the sector, and is reflective of a range of AOD issues affecting our community, the ANCD seeks your views as part of its second-stage consultation process.

You are encouraged to view the draft Charter at www.ancd.org.au and provide comments by the end of October 2005. The ANCD aims for the Charter to be acknowledged within international and domestic arenas to further strengthen Australia’s policy response to AOD issues.

UN’s new-look website

The United Nations Office on Drugs and Crime has re-launched an expanded and revitalised version of the Asia and Pacific Regional Office (APRO) of the United Nations Information Centre website: http://www.apaic.org. The website is an extensive information source on the trafficking and use of ATS in the Asia and Pacific region. Enhancements to the site include updated regional ATS trends and ATS trends for eight countries, weekly ATS news article, new annual report, links section, FAQ section, expanded searchable library, improved navigation and site search.

EU drugs action plan (2005-2008)

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is one of the European Union’s decentralised agencies. Based in Lisbon, it is the central source of information on drugs and addiction in Europe. The Council of the European Union recently endorsed a new drugs action plan (2005-2008) put forward by the EMCDDA in June 2005.

The action plan follows the structure and the objectives of the EU drugs strategy (2005-2012). It focuses on two policy domains – demand reduction and supply reduction – and two cross-cutting themes – international cooperation and research, information and evaluation. It lists around 100 specific actions to be implemented by the EU and its member states by the end of 2008. Assessment tools and indicators, responsibility for implementation and deadlines are clearly indicated for each action.

On the basis of the work of the EMCDDA and Europol, an impact assessment will be carried out in 2008 with a view to proposing a second action plan for the period 2009-2012. For more information, and links to the action plan, go to: http://www.emcdda.eu.int/index.cfm
Drug Action Week® 2005

ANNE ROSENZWEIG, NATIONAL COORDINATOR

More than 720 events were held across Australia as part of Drug Action Week® 2005, making it the biggest Drug Action Week yet.

Drug Action Week (DAW) is a national week of activities to raise awareness about alcohol and other drug issues and to promote prevention and early intervention for drug-related harm. It is hosted annually by the Alcohol and Other Drug Council of Australia (ADCA).

DAW 2005 was launched on 20 June at Parliament House in Canberra by Dr Neal Blewett AC, Parliamentary Secretary to the Minister for Health and Ageing. The event was hosted by ADCA’s President Dr Neal Blewett AC. Both Mr Pyne and Dr Blewett gave engaging and informative speeches which recognised a number of the sector’s extensive achievements to date and outlined some of the challenges that lie ahead.

Merchandise

In 2005, ADCA launched a range of DAW merchandise to help promote the week. The range featured the DAW logo and included stickers, balloons, magnets, badges and show bags. The merchandise proved to be very popular with event organisers, with the magnets, small stickers and balloons being the biggest sellers. Given the success of the merchandising initiative, ADCA hopes to make DAW promotional material available again next year.

Rural Communication Initiative

An exciting enhancement for DAW this year was an initiative to increase awareness of the harms associated with tobacco use and the misuse of alcohol and other drugs among rural and regional Australians. ADCA aimed to achieve this through boosting the number of DAW 2005 events held in rural and regional areas of Australia. This is an increase on last year which saw approximately 50 per cent of events being held outside the major metropolitan centres.

ADCA would like to thank all those who participated in DAW 2005 – those who held events, those who attended events and those who encouraged others to host or participate in DAW activities. We would also like to thank our generous sponsors – the Australian Government Department of Health and Ageing, the Alcohol Education and Rehabilitation Foundation and the NSW Government.

implemented a two-stage strategy. The first phase encouraged rural and regional organisations and groups to hold DAW events. It included targeted media relations as well as a direct marketing campaign. The second phase of the initiative focused on encouraging people to attend events by increasing awareness of DAW activities among people in rural and regional areas.

A key component of the second phase was the airing of the DAW television commercial featuring the jigsaw puzzle theme. This theme was also reflected in the 2005 kit, poster and launch invitation. The commercial aired as a paid advertisement on the Prime Network in New South Wales/Australian Capital Territory, Victoria and Queensland on a demonstration project basis. It also screened on a number of other networks as a community service announcement.

To support the Rural Communication Initiative, ADCA developed a fact sheet on alcohol and tobacco use in non-metropolitan Australia. By all reports the fact sheet was useful to event organisers and also to rural and regional media who wanted a local angle for their stories. You can download copies of the fact sheet from: www.drugactionweek.org.au/facts.html.

Early figures show that over two-thirds of 2005 DAW events were held in rural and regional areas of Australia. This is an increase on last year which saw approximately 50 per cent of events being held outside the major metropolitan centres.

ADCA would like to thank all those who participated in DAW 2005 – those who held events, those who attended events and those who encouraged others to host or participate in DAW activities. We would also like to thank our generous sponsors – the Australian Government Department of Health and Ageing, the Alcohol Education and Rehabilitation Foundation and the NSW Government.

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Drug Action Week® 2005

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Alcohol and cannabis top drug treatment list

Alcohol and cannabis account for more than half of the drug treatment episodes provided in Australia, followed by heroin and amphetamines, according to a report released in August 2005 by the Australian Institute of Health and Welfare (AIHW).

The report, Alcohol and Other Drug Treatment Services in Australia 2003–04, profiles 137,000 closed (completed) treatment episodes across 622 government-funded alcohol and other drug treatment agencies. It shows that alcohol was the most common principal drug of concern in 38% of these treatment episodes, with cannabis accounting for 22%, heroin 18% and amphetamines 11%. It appears many clients are seeking treatment for multiple drug problems, because over half of all treatment episodes involved at least one other drug of concern, in addition to the principal drug.

The report’s co-author Chrysanthi Psychogios said although the overall results were very clear, there were also important differences between the various age groups: “It seems that there are ‘ages and stages’ when it comes to seeking drug treatment services. Cannabis and heroin are the drugs the under-30s are presenting to treatment services for, while in the over-30s, alcohol becomes the predominant drug of concern,” she says.

For example, among 10–19 year olds, cannabis was the principal drug of concern in 49% of treatment episodes, while in the 20–29 age group cannabis at 27% was closely followed by heroin at 26%. Alcohol was the third most commonly reported principal drug of concern amongst 30–39 year olds (40%), rising to 82% for those aged 60 years and older.

In relation to amphetamines, nearly half of amphetamine users who sought treatment – male and female – were aged 20–29. The 2004 National Drug Strategy Household Survey also showed that this age group were the most likely to have ever used amphetamines (21.1%).

Men were more than twice as likely to receive treatment for amphetamine use as women were. Ms Psychogios said that counselling and withdrawal management (detoxification) were the most common types of treatment overall, with counselling accounting for the highest proportion of closed treatment episodes for most principal drugs of concern. Counselling was most commonly amongst female clients, and clients in the older age groups.

(Agencies whose sole activity is to prescribe and/or dose methadone or other opioid maintenance therapies are excluded from the national data set.)

Practical approach to treatment

First published in 1995, Treatment approaches for alcohol and drug dependence: an introductory guide, proved something of a bestseller in the alcohol and other drugs sector.

So much so that a second, updated edition of the book has just been published. Written by National Drug and Alcohol Research Centre (NDARC) researchers, Treatment approaches offers an easy-to-use, easy-to-read approach to treating and managing issues as diverse as pharmacotherapies, young people’s care and management, and dual diagnosis. A number of additional chapters reflect the latest research findings and current practices within the AOD field.

The book can be ordered by phoning NDARC on (02) 9385 0335.

LETTERS

Re: drinking study in July 2005 issue

Dr Lindsay,

I have just read your article in the latest Of Substance, and note with interest your key finding that: ‘The large proportion of men (60%) and women (87%) drinking spirits, particularly white spirits such as vodka, is a cause for concern’, and your intervention suggestion that ‘we also need to monitor ... consumption of white spirits’. Although I’ve not had a chance to read your full study, given that the vast weight of evidence shows ‘alcohol is alcohol’, and all alcohol having the same benefits in moderation and negative effects in excess, and there being similar amounts of alcohol in the common servings of different alcohol beverages, I am keen to understand on what basis you single out spirits – particularly white spirits – as a cause for concern and requiring ongoing monitoring.

The summary article suggests there is much else in your paper that we would be strongly supportive of – encouraging the consumption of food and the provision of water, understanding drinking cultures, contexts and patterns and framing strategies accordingly – hence my interest in understanding your findings and rationale for singling out white spirits.

Regards,

Clayton Ford,
Manager, External Affairs, Diageo Australia

25/5/05

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Of Substance evaluation - reporting back

Earlier this year, research consultants Siggins Miller undertook an evaluation of Of Substance. The key questions we wanted answered were:

- what is the current reach and readership of the magazine?
- how do readers rate the magazine’s appearance and content?
- what are your personal stories and profile pieces.

The results indicate that you think the magazine is successful in developing and presenting content that is meaningful and relevant, particularly in regard to up-to-date information, information on practice and training, and research. However, the level of awareness of the publication and the rate of subscription among drug and alcohol agencies needed to improve.

Some of the key recommendations we received were to:

- broaden our distribution and promotion
- follow up subscriptions, to ensure appropriate staff members receive the magazine
- email a contacts page to subscribers and AOD listen to highlight new issues, and distributing PDF versions of the magazine
- broaden the content of the magazine to be more inclusive, or to reflect the issues of particular groups more effectively
- establish feedback loops (such as publishing reader’s letters) so that readers can respond to the magazine

Thank you

On behalf of the magazine’s Editorial Reference Group and Management Board, we would like to thank everyone who participated in the evaluation.

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Of Substance

DRUGS AND RESEARCH
AN OVERVIEW

Research
In the alcohol and other drugs field, we’re always quoting it. But what is it? How is it done? Who does it and how do they decide which way to tackle a research project? In this issue, Of Substance introduces a new series which explores the types of research techniques applied to alcohol and other drugs. We provide an overview of the topic, and discuss randomised controlled trials. Subsequent issues of Of Substance will include articles by other expert research practitioners on more of the diverse approaches used to investigate drugs, their use and misuse, and societal responses to the issues they create.

RESEARCH IN THE DRUG AND ALCOHOL SECTOR
DAVID MCDONALD, NATIONAL CENTRE FOR EPIDEMICIOLOGY AND POPULATION HEALTH, THE AUSTRALIAN NATIONAL UNIVERSITY, CANBERRA

Of Substance aims to be an accessible and independent magazine that discusses current research and practice, in Australia and overseas. Each issue reports on research findings that apply directly to the sector. To fully evaluate their soundness and applicability, however, readers need to understand the underlying rationale for the research approach chosen and have some understanding of the specific methods used.

In various articles in Of Substance you will have seen statements such as these:

- ‘The effectiveness of the treatment has been demonstrated in three randomised controlled trials’
- ‘Ethnographic research has helped us to understand the impacts of street level policing’
- ‘Although the condition is rare, case-control studies have shown that a relationship exists between exposure to the risk factor and the probability of contracting the disease’
- ‘The convenience sampling approach used in the IDRS limits its generalisability’

This series of articles will explain and clarify just what researchers are talking about when they use these kinds of labels to identify their research methods.

Research designs
The research design is what connects the research question to the data. And by definition, research data are empirical. What do we mean by empirical? No, not quantitative (numerical), a common misapprehension. ‘Empirical’ means observable. A count of the number of people who complete treatment is an example of empirical data. So does documenting a case study of the process of developing and implementing a new policy. Studies are often classified as being either observational studies or intervention studies.

1. Observational studies
In the first category, the researcher only observes something of interest. Attention is paid to describing and understanding variables associated with the person, place and time.

a) Descriptive observational studies:
The most common observational study design is descriptive; examples include cross-sectional surveys and case reports. They identify the population groups that have a condition of interest (e.g. that have experienced childhood trauma), the locations where the condition is found (e.g. rural vs urban), and how the frequency of occurrence changes over time (e.g. between two surveys).

b) Analytic observational studies:
These include planned comparisons, cohort studies and case-control studies.

- Examples of planned comparisons include case studies, where the cases are compared to identify common and differing features.
- In observational cohort studies, the investigator typically follows a group of people over time, observing how they change, and sometimes comparing different cohorts which have different life experiences.
- In case-control studies, the investigator starts by identifying a group of people with a condition (e.g. lung cancer) and a control group without this condition, and then compares the two groups’ amount and/or frequency of exposure to possible causes of the condition (e.g. smoking cannabis).

c) Correlational or ecological studies:
The investigator studies whole population groups, looking for relationships between a matter of interest (e.g. criminal offending) and characteristics of the population with the condition (e.g. poor school performance). These studies have both descriptive and analytic components.

2. Intervention studies or randomised controlled trials
These compose the next broad category of research designs. They are often called experimental studies, as their designs closely match the experimental methods used in basic science. The key feature is that the things being studied (e.g. people with a given health condition) are randomly assigned to the ‘treatment’ or to a comparison condition. The comparison might be a different ‘treatment’, no treatment or a placebo.

I have placed ‘treatment’ in inverted commas to draw attention to the fact that experimental designs are also used in non-medical settings including the criminal justice system, education and social welfare. In those settings, the ‘treatment’ might be a new type of community policing or a drug education program or providing additional social supports to disadvantaged families. Randomised controlled trials have been conducted in each of these areas, and many others.

Qualitative and quantitative research
You may be wondering why I have classified research designs as observational and intervention studies, rather than the more familiar ‘qualitative’ and ‘quantitative’ studies. The reason is that, in discussing the many approaches to psychoactive drugs research, qualitative and quantitative are terms describing types of data, as well as research methods. One authority (Punch 1998) put it very directly:

‘Quantitative research is empirical research where the data are in the form of numbers.

Qualitative research is empirical research where the data are not in the form of numbers’.

Clearly, some research methods primarily use quantitative data (e.g. cross-sectional surveys and experimental designs) whereas others primarily use qualitative data (e.g. document content analysis and ethnography). Some studies, particularly in evaluation research, use mixed methods, that is, both qualitative and quantitative methods (Stufflebeam 2001) producing particularly rich and comprehensive results.

Taking this further...
This article has presented a brief overview of research methods used in the psychoactive drugs field. It should be clear that the issue is not which research methods are best. Rather, the issue is which research method or combination of methods is most appropriate for answering a particular research question or set of questions. For example, experimental designs are particularly useful for determining causality under tightly controlled conditions whereas ecological studies are particularly useful for describing populations of interest and drawing hypotheses for testing using other research designs.

The following article by Alison Ritter on randomised controlled trials honed in on this powerful research design, explaining what it is, how it is used, where it is most useful and its strengths and limitations.

References and further reading


Wadeworth, Y 1997. Do it yourself social research, 2nd edn, Allen & Unwin, St. Leonards, NSW.

What is a randomised controlled trial?

A randomised controlled trial (RCT) is an experimental research technique used to compare two or more types of treatments or other interventions. It is used to test the efficacy or effectiveness of an intervention. ‘Efficacy’ refers to the success of an intervention under research or trial conditions, whereas ‘effectiveness’ refers to the success of an intervention under usual practice conditions. RCTs are most frequently used in a clinical setting (e.g. comparing two forms of treatment) but are also used in community settings (e.g. comparing communities with responsible alcohol server programs with communities not having this intervention).

How does an RCT work?

Studies that use simple ‘before-after’ comparisons evaluate the changes that occur in a group of people from before to after an intervention occurs. This type of study has limitations in identifying whether one intervention is better than another. Improvement may occur because of the therapeutic relationship or other variables in the environment, not necessarily because of the intervention.

The before-after design does not fully answer the question of relative efficacy or effectiveness. This is where an RCT can be of benefit – by comparing one treatment (the experimental condition) with another (the control condition). The comparison could be with existing practice (like comparing buprenorphine with methadone) or it could be comparing it to doing nothing. When you compare the experimental treatment with nothing, it is called a placebo controlled trial.

In an RCT the experimenters try to control all the possible variables that impact on the likely outcomes. Random allocation deals with these problems. In an RCT clients are randomly assigned to either the experimental or the control condition. Each client has an equal chance of receiving the experimental treatment or the control treatment and, in this way, any differences between the two groups will be randomly distributed, and any variables that systematically affect outcomes will be found equally in both groups.

It is very important that the randomisation order is ‘concealed’, that is, that the person assigning clients to the two groups does not know which group is coming up. It is possible that, if a trial is done by having the clients randomised into the two groups, that is, that the person assigning clients to the two groups does not know which group is coming up. It is possible that, if a trial is done by having the clients randomised into the two groups, the clients will elite the different groups differently (e.g. the clients in the buprenorphine group. Randomisation usually takes place at a different centre, and the allocations are sealed (in envelopes, or you ring up for the allocation), so that there can be no interference in the process.

‘Blinding’ – another RCT technique

The other aspect of RCTs is whether or not the clients are ‘blind’ to treatment allocation. Clients may have beliefs about treatments – especially if they enter a trial hoping to get a new treatment because they believe it will work for them. This may have a profound effect on their outcomes. For this reason, it is preferable to keep clients unaware of the treatment they receive. So, in the case of a trial of two different tablet drugs, one drug is a placebo and the other is active. They still don’t know which group they are in.

In an RCT the experimenters try to control all the possible variables that impact on the likely outcomes. These variables include the participants’ backgrounds, demographic variables, and reasons for participating in the trial. In comparing the interventions, whether they are treatments or community interventions, you are trying to make sure that the comparison is as ‘clean’ as possible and that all the known variables that might make a difference are managed or controlled in the study. This is where random allocation becomes very important.

Random allocation

Randomisation is a technique to ensure that the comparison is fair and accommodates background variables. Comparing two interventions as they occur in real life – for example, clients in buprenorphine maintenance compared to those in methadone maintenance, or one community which had school-based drug education with another that did not – does not address the background variables issue. There may be systematic differences between those clients or groups in the first place, introducing bias into the study.

RCT. When the drugs take two different forms as well, it is called a double dummy, double blind RCT. (Yes, we are all blind dummies doing this work!)

So, the strongest test of whether drug A is better than drug B is to randomly allocate clients to two groups (using a concealed process) where neither the clients nor the clinicians know which treatment they get. It is also regarded as good RCT practice to make sure that the interviews measuring the outcomes (e.g. drug use or social functioning) are done face-to-face and by an independent researcher, not by a member of the clinical team.

There are a number of other aspects to conducting a good RCT (such as the statistical analyses one should use) and international standards exist which control how RCTs must be conducted.

Effectiveness trials

In community trials, you cannot achieve the above criteria of blinding intervention allocation. So these studies (such as school-based drug education or responsible server programs) are usually effectiveness trials, rather than efficacy trials. Importantly, the RCT design should be applied to community interventions, as they are still superior to before-after designs and no-comparison evaluations if you want to test effectiveness. Randomisation remains the key, comparing the outcomes between the intervention and control groups.

When to use an RCT

RCTs are best used when you want to directly compare two or more interventions and you want to test efficacy. It is not useful if you do not want a direct comparison between two interventions, or between an intervention and nothing.

What population would you use it with?

Efficacy trials are generally conducted with clinical populations and effectiveness trials with community interventions.

What are the limitations?

RCTs, especially double dummy, double blind RCTs, are best used with medication trials. Unfortunately, trials of psychological treatments are much harder to keep blinded (especially to the clinician providing the therapy).

Another limitation is cost – RCTs are expensive to run. You need to establish the appropriate sample size (through a statistical technique called power analysis) and it may take a long time to recruit the required numbers in order to test the efficacy.

RCTs are not technically complicated, but take a lot of attention to detail and precise procedures. If any aspects of the randomisation, blinding, treatment of participants or statistical analyses are compromised, the trial cannot answer the efficacy question.

Some people criticise RCTs because they have strict inclusion and exclusion criteria (usually because of the blinding and the hypothesis being tested). This means they are less applicable to those in methadone maintenance clients randomly allocated to buprenorphine or methadone in 19 treatment sites who were followed up over 12 months. Our findings revealed no significant differences between the methadone and buprenorphine groups on either clinical or cost-effectiveness outcomes.

An example of a community-based effectiveness study is an RCT investigating police targeting ‘hot-spots’, that is localities where criminal behaviour (including drug-crime) is concentrated. In Minneapolis, USA, Sherman and Weisburd (1995) randomly allocated over 100 high crime places to receive either increased police patrolling or not, testing the proposal that increased police presence would deter offending. The experiment showed that increased patrolling caused decreased crime in the experimental sites.

References


Further reading


What sort of findings will be produced?

Generally RCTs report a direct comparison between two interventions on a set of variables. In clinical trials in the substance abuse field, the usual outcome variables of interest are drug use, retention in treatment, social and psychological functioning and risk behaviour. The statistical question is: Is there a ‘significant’ difference between the two interventions on these variables?

Recent examples of RCTs

Turning Point has completed an RCT of methadone and buprenorphine (Lintzeris et al. 2004). We did not blind the clients or clinicians to the treatment allocation as we wanted to compare the two treatments under real-world conditions. The participants were 119 Victorian heroin-dependent people and methadone-maintenance clients randomly allocated to buprenorphine or methadone in 19 treatment sites who were followed up over 12 months. Our findings revealed no significant differences between the methadone and buprenorphine groups on either clinical or cost-effectiveness outcomes.
S
et against the late 90s background of increasing heroin use and rising community angst over the health risks of carelessly discarded needles, some saw the Federal Government’s 2001 election promise of a trial of retractable syringes as a good idea at the time.

Now just a few short years later, the trial has been aborted as it became increasingly evident that the health of people who inject drugs was being compromised in the search for improved public safety.

In a single-line item, the May 2005 Federal Budget listed the abandonment of the retractable syringe trial, saving the Government more than $51 million.

The simple entry hid a fascinating story.

The trial

In 2001, it was hypothesised that if people who injected drugs were to switch to retractable syringes, there would be public health benefits to the entire community, including those who injected. Advocates suggested that any used syringes which had been publicly disposed of would no longer pose the risk of HIV or hepatitis C transmission to members of the general public.

For people who injected drugs, it was believed that the one-shot nature of retractable syringes would stop the risky health practice of sharing needles.

But for the concept to become reality, more information was needed and challenges had to be met. Could retractables truly offer the public health and safety benefits sought by the community?

Could they actually reduce the health risks for people who inject drugs? Would they choose a retractable syringe in preference to what they already knew? And what were the cost implications of widespread retractable syringe use?

Funding was committed for the trial in the 2002 Budget. With $17 million per year to invest, it was crucial that the first step be to find a retractable syringe of a standard which could be approved by the Therapeutic Goods Authority. Several syringes and prototypes were explored. Most were suitable for use by trained staff administering intramuscular medication in health care settings. But how would they go in the hands of others, injecting into veins in often less than ideal settings?

Gino Vumbaca, Executive Officer of the Australian National Council on Drugs, and a member of the trial implementation reference group, says one of the benefits of the trial was the research and development opportunity it offered for improving the available technology.

‘Initially, we needed more information about what was out there, whether it was suitable and if not, whether it could be adapted for use by injecting drug users’, Mr Vumbaca says. ‘In the end, two syringes were approved for the trial. However, only one model was ever used’.

Research, syringe selection and the establishment of the study took many months. However, by early 2004, the implementation phase was in its initial stages, with several needle exchanges on the eastern seaboard offering retractables to injectors who were willing to be part of the trial.

Once it appeared that these pilot sites were running smoothly, there were plans to expand to other sites, with the study to run until late 2005. An independent evaluation team was appointed to monitor and review the trial.

Many drug sector experts expressed concerns that injectors would not be interested in the new technology. However, these fears proved unfounded as initial reports from the trial were favourable and people joined the trial. Plans were made to launch the next pilot site. However, within months, reports began to filter back that all was not well with retractables. There were tales of blood splatters as the syringes were retracted, posing a greater risk of virus transmission between injectors. Increased needle damage to veins was also reported.

A halt was called by the Australian Government Department of Health and Ageing, and the 2005 Budget entry was a formal statement about a research study which had already ceased operation.

Consequences and decisions

So what came out of the initiative and what knowledge has been gained?

‘From the beginning, there was a question of balance that had to be explored’, Mr Vumbaca says. ‘We know that the actual risk, as opposed to the perceived risk, of contracting a blood borne virus such as HIV or hepatitis C from a used needle discarded in a public place is very low. To date, I have only heard of one report of possible transmission, and that is yet to be officially confirmed.

‘So, given the very low risk, we had to determine the best use for available funds. A retractable syringe costs up to five times more than the syringes currently supplied to injecting drug users. That had major implications for needle and syringe program budgets and the number of syringes they could supply. The consequences of introducing a program that could undermine Australia’s pre- eminent position as a country that had successfully contained an epidemic of HIV amongst its injecting drug users to extraordinarily low levels also had to be taken into account’, Mr Vumbaca notes.

Important lessons have also been learned about the need to understand how drug injectors’ use of syringes differs to individuals being treated in health care settings.

‘The Government is to be praised for the way it quickly stopped the trial once it was realised that the current technology in retractable syringes threatened the safety of injecting drug users and thus the wider community’, Mr Vumbaca says.

‘I have talked to syringe manufacturers since the trial was aborted and they are aware that the onus is now upon them to come up with a design that is safe and able to compete in both cost, safety and acceptance with other needles that are currently available’.

About the technology

Accidental needlestick injuries pose a risk of virus transmission to health care workers and others who may come into contact with a recently used syringe.

A spokesman for a retractable syringe manufacturer said, in an effort to reduce this risk, medical device companies have been developing protective technologies such as needleless systems and retractable syringes since the 1990s. These technologies are varied and have different degrees of effectiveness. New products are continually coming on to the market that may reduce injury rates from sharps, and these can vary in shape, size and intended clinical application.

Retractable action

A retractable syringe enables the needle to retract into the housing, or barrel, of the syringe at the end of the injection, thus providing protection from accidental needlestick injuries. Retractable syringes can be divided into two main categories – manual or automatic – which are determined by the type of retraction mechanism.

The Unilock Safe Syringe® is one example of a retractable syringe. It was developed with controlled retraction of the needle with the aim of preventing blood splatter and tissue damage. This product was not involved in the retractables trial discussed in this article.

Early generation retractable syringes were designed with a manual retraction feature where the operator must manually activate the retraction mechanism. This is typically achieved by pulling the plunger back once it has locked onto the needle, or applying further force on the end of the plunger after the injection stroke.

Manual retraction requires a conscious decision by the operator to engage the safety mechanism and therefore limits its effectiveness.

More recent retractable syringe technologies have been designed with automatic or passive retraction. The needle is retracted and enclosed at the end of the injection without a secondary action required from the operator. Consequently, automatic retraction does not require any change in standard injection practice.

The most advanced retractable syringes incorporate a passive action and the ability for the consumer to control the speed of needle retraction.

Controlled retraction allows the operator to have power over the retraction process, enabling needle retraction from the body and reducing or preventing blood splatter and additional tissue damage.
On Friday, 24 June 2005, the alcohol, tobacco and other drugs sector celebrated the second year of the National Drug & Alcohol Awards.

The Awards are a collaborative effort of the Ted Noffs Foundation, the Australian Drug Foundation, the Alcohol & Other Drugs Council of Australia and the Australian National Council on Drugs. They provide a unique opportunity, for us all to celebrate the work and achievements of the sector with some style and glamour. Certainly the continued support of the Prime Minister in again providing an Award for Excellence and Outstanding Contribution in Drug and Alcohol Endeavours; adds to the prestige of the evening.

The support of the Alcohol Education & Rehabilitation Foundation’s principal sponsorship, and major sponsorship from the Australian Government Department of Health and Ageing, as well as sponsorship from the NSW Government, for a second time permitted the Awards to be a formal event at a prestigious Sydney venue, with entertainment and significant prize money for each award winner. Based on the growing response to the Awards from last year, it is clear this has quickly become an anticipated event for the sector.

This year, the Awards included a new category to honour the work undertaken by law enforcement agencies in the sector. On the evening, the Awards Organising Committee also announced the establishment of a new ‘Roll of Honour’ for the sector as part of the Awards ceremony in 2006 and beyond. This Roll will become a place to permanently honour all those people who have worked for many years in the sector. Details on nominations and processes for inclusion in the AOD Sector’s Roll of Honour, as well as for all 2006 Awards, will be available via the National Drug & Alcohol Awards website in coming months. For now you can visit the website to check out the winners and view photos from the 2005 National Drug and Alcohol Awards event at www.drugawards.org.au. We also profile the major award winners over the following five pages.

Prime Minister’s award for excellence and outstanding contribution in drug and alcohol endeavours

BARRY ABBOTT: RECOGNITION FOR AN OUTBACK HERO

Kate Pockley

Not many of the people gathered at the Awards ceremony had heard of Barry Abbott before he climbed the stage to receive his Prime Minister’s award. However his remarkable story, told by Major Brian Watters – and their engaging conversation on the podium – left no one doubting Mr Abbott’s worth in taking away the night’s highest accolade.

Treatment services don’t come much more remote than the Ilpurla Aboriginal Association’s outstation, in a south-west corner of Central Australia. It’s here that Mr Abbott and a small team of paid staff and volunteers take in young people from mostly Piritjantjarra-speaking traditional Aboriginal communities. The geographical area covers 500,000 square kilometres to the south and west of Alice Springs, with an at-risk population of about 10,000 people. The client age can range from 8 to 25 years, and the service takes in up to 15 clients at a time.

The outstation has petrol, glues and sprays in use all the time – I don’t lock them up. People often ask me why not, and I tell them that I trust the young people not to abuse them while they’re here, and they don’t let me down,” says Mr Abbott.

Mr Abbott and his family model behaviour that may have been missing from the life experience available in the Aboriginal settlements. He relies on the isolated setting of the outstation to remove the clients from influences that exist in their home settings towards substance abuse. His program links them with another way of life, in which there is valuable work to do, and a group that relies on their contribution to that work.

‘I’d like to involve the parents in the program, so that we break the habits of whole families, not just one generation’

Mr Abbott ran this service to the community for many years without any funding, using his own money. In the mid 1980s he began to receive recurrent funding from the Office for Aboriginal and Torres Strait Islander Health, a funding source that is shared with the client’s family, and getting an outline of any medical conditions is addressed, nor are clients who have behavioural problems that are beyond the capacity of the outstation program. This phase involves talking with the client’s family, and getting an outline of the support that that family will provide.

A medical assessment is organised through the Kings Canyon Clinic (the closest medical facility – 258 km away).

Any medical conditions are addressed, and the outstation staff is made aware of any drug or treatment programs. When a client is first referred to Ilpurla, a medical assessment is organised through the Kings Canyon Clinic (the closest medical facility – 258 km away). Mr Abbott, and is brought into regular work patterns. The clients exit the program 8 to 25 years, and the service takes in up to 15 clients at a time.

A long tradition of care

A stockman by trade, Mr Abbott has opened his door to hundreds of young Aboriginal people and has given them guidance to get back on track at the outstation on the Finke River. He has been looking after people in this way since 1964. He has ‘grown up’ literally hundreds of young people over this time, and is a locally known resource that families call on when their young people have problems with all kinds of substance abuse, including volatile substances.

‘The problems with the petrol sniffing and the harder drugs is only getting worse out here. It’s frustrating to see the government spend money on things like the Opal fuel [a non-‘unifyable’ fuel alternative], when communities out here are so needy. I see kids all the time that are hungry, that don’t have good schools or community resources – this is what’s leading to their drug taking’, says Mr Abbott.

Speaking openly about Indigenous living standards

Mr Abbott sees a bleak future for the conditions of local Indigenous youth.

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‘The next phase of treatment includes a stay at the outstation. This phase can run for a couple of months to a couple of years, depending on the client. The outstation has a range of station work going on, including stock handling, mechanics and some housing/ construction activities. The client undertakes this work alongside other residents including Mr Abbott, and is brought into regular work patterns. The clients exit the program when they and Mr Abbott agree that they are ready.

Barry Abbott accepting his award from Major Brian Watters.

Speaking openly about Indigenous living standards

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Excellence in prevention

TEMPAZEPAM INJECTION PREVENTION INITIATIVE – A PREVENTION CAMPAIGN

GLENNE ZIMMER, DRUGS POLICY AND SERVICES BRANCH, DEPARTMENT OF HUMAN SERVICES, VICTORIA

Detecting a health issue

Temazepam is a drug commonly prescribed to treat insomnia. A serious problem with the diversion of Temazepam gel capsules was first identified in 2001 when a shortage of heroin saw an increase in people who inject drugs experimenting with a range of other drugs. This included injecting the liquid from Temazepam gel capsules into veins in arms, legs and groins.

The capsules soon became greatly prized, fetching a high price on street drug markets or being traded for heroin. Medical practitioners and pharmacists were experiencing aggressive and threatening behaviour from drug-seeking patients. There was also an increase in ‘ram raids’ and burglaries on pharmacies.

The result was a high number of people who inject drugs presenting to hospital emergency departments with serious vascular and tissue harm including abscesses, necrotic ulcers, and gangrene. The loss of fingers, toes and even limbs was a serious threat facing people who inject drugs who were injecting the contents of Temazepam capsules.

Extensive research by the Department of Human Services, the public health physician Dr Malcolm Dobbin and consultation and collaboration with a broad range of key stakeholders, confirmed that an epidemic of Temazepam injection harm was occurring. This resulted in the Victorian Drugs Policy and Services Branch establishing the Temazepam Injection Prevention (TIP) Initiative.

Developing a strategy

Two reference groups were formed to work with a Drugs Policy and Services Branch team on a strategic response. A professional reference group including medical and pharmaceutical peak bodies, and a reference group including people who inject drugs and frontline workers assisted in developing resources and a broader response. Consultations were held with representatives of pharmaceutical companies and their industry association, to alert them to the evidence of harms and criminal activity associated with the diversion of the capsules.

The result was an information kit – ‘Injecting Temazepam: the facts’ – which gave advice about the severe health risks associated with injecting the content of Temazepam capsules. The kits were distributed to 1236 pharmacies, 146 drug treatment agencies and 174 needle and syringe programs in Victoria.

A key campaign strategy was entailing the support of medical and pharmaceutical professionals to discontinue prescribing and stocking Temazepam gel capsules in favour of other treatments for insomnia. The campaign received wide support, effectively halving the Pharmaceutical Benefit Scheme (PBS) supply of Temazepam capsules in Victoria within eight months.

National response

It soon became apparent that injecting Temazepam wasn’t confined just to Victoria. Other jurisdictions were having the same problem with its diversion. The Victorian Drugs Policy and Services Branch brought the campaign to the attention of the Australian Health Ministers Council (AHMC).

The Council acknowledged the outstanding success of the Victorian campaign and facilitated the national introduction of the campaign materials developed by the Victorian team.

Defining moment

A defining moment in the campaign was the Australian Health Ministers’ Conference’s recommendation to the Australian Pharmaceutical Advisory Council that Temazepam capsules be restricted as a PBS item. This occurred in May 2002 and led to a dramatic 99 per cent decrease in PBS supply of Temazepam capsules nationally.

The domino effect, which started when doctors and pharmacists supported the campaign and stopped prescribing and dispensing Temazepam capsules, was completed when all pharmaceutical companies manufacturing the gel capsules withdrew them from the market.

In 2004 a letter was received from Sigma, the last company to market Temazepam capsules, advising that it would be withdrawing them from sale because of the serious health concerns. The last of the capsules were finally removed from the market in early 2005. This effectively ended the criminal activity and epidemic of serious harm caused by the diversion and injection of the contents of Temazepam capsules.

The campaign has been referred to as one of the most significant outcomes in preventing drug-related harm nationally in the last five years. No government department, either state or national, had previously won a national drug and alcohol award, and given the awards are judged by leaders from the not-for-profit sector and related peak organisations, the achievement of a government department winning such an award is not only significant, but well deserved.

Excellence in treatment

THE MILTON LUGER WITHDRAWAL UNIT – A JOURNEY TO EXCELLENCE

JAMES PITTS, ODYSSEY HOUSE, NSW

The name Odyssey is a reference to the Greek hero Odysseus, who encountered a long and difficult journey before returning to Ilahia eventually triumphant. Odyssey House characterises each individual’s rehabilitative experience within this context. The fact Odyssey House has provided services to the drug misusing population in NSW for the past 27 years is another testament to our ability to navigate the often troubled waters of service provision within the alcohol and other drugs field. The establishment of the Milton Luger Detoxification Unit at Odyssey House is a prime example of such a successful journey.

Identifying a need

Some years ago it became evident that the gap in our service delivery was the ability to provide detoxification services. These services were provided mainly through the Langton Clinic in Sydney, Basement 82, the McKinnon Unit and others. Clients of Odyssey House’s residential rehabilitation program who needed medically assisted detoxification were referred to one of these agencies.

This was based on the proviso that at the completion of detoxification the individual would return to our centre to begin rehabilitation. However, people almost never came back for admission. Being the forward-thinking organisation we were, we decided to develop our own detoxification service. That was in 1986.

As a contributing member to the South West Sydney Area Health Services Drug and Alcohol Strategic Plan, I lobbyed along with others to have detoxification services included in the plan as a priority, and it was. Buoyed by this recognition of the need for such a service, we thought that within a short time we would have one up and running within our area.

Red lights and green lights

For some reason, a detoxification service did not eventuate. There were other more pressing issues to deal with such as the proliferation of methadone services, the advent of performance indicators and their application, research that showed residential rehabilitation was not needed as it provided no more benefit than a one-hour session with a counsellor, and there was more. Despite this, and similar to our namesake who overcame the Siren’s call, we never lost sight of our goals.

In 1993, Professor Ian Webster chaired a committee which reviewed the need for detoxification services within NSW. The report stated there were far too few such services for the drug misusing population. We at Odyssey learned long ago not to wait for government subsidy once the legitimate need for a service has been established.

In 1996 we secured a grant from a private trust to establish a six-bed detoxification facility within the residential rehabilitation facility. Any time you have a new service which operates within an established, and more dominant, service there’s bound to be trouble. The detoxification unit was blamed for everything from a fall in drug program census to the fact dinner was burned the night before!

Fortunately for us, in March 1997 the Prime Minister, John Howard announced the establishment of a new initiative, ‘Tough On Drugs’. We received funding to establish and expand our detoxification service. The funding, through the National Illicit Drugs Strategy, provided a mechanism to recruit more nursing staff, and along with a commitment from our Board of Directors, to construct a purpose-built facility in the grounds of our assessment and referral centre.

A proud history and bright future

The unit has had outstanding outcomes. These can be attributed to its unique location on the grounds of our short-term (four to six weeks) rehabilitation program. People who complete the detoxification process cite the fact they are able to realise there is life after ‘detox’. This is due to the peer counselling provided by senior residents to detoxification clients.

In addition, we have been able to attract and retain a dedicated staff contingent who have worked tirelessly to provide the highest standard of care. The staff are to be commended for their commitment to excellence despite the fact the unit is funded far below what comparable facilities in the public health system receive.

We are proud of our accomplishments within the unit, which last year (2004) saw 87 per cent of people complete the detoxification process, and 56 per cent of those entered our rehabilitation service. The unit has assisted people to withdraw from drugs successfully and acted as a conduit to longer term treatment. The recognition of these achievements by our peers and colleagues within the field through the award for ‘Excellence in treatment’ is truly worth it, as has been the long and difficult journey to get there.

Members of the TIP Initiative team: L to R: Malcom Dobbin, Irene Tomaszewski, Richard Adzeiz, Paul McDonald and Glenne Zimmer.

James Pitts (second from right), Odyssey House, with friends (L to R) Kris Asghipole, Larry Pierce, Lynne Magen-Blatch and Holly Magen-Blatch.

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Excellence in services for young people

STREETWISE AND SAVVY

KATE POCKLEY

Streetwise Communications is a successful, nationally recognised not-for-profit social communications agency. This self-funding organisation conducts research across a wide variety of challenging social issues and produces creative campaigns to raise awareness and enable informed choice.

2005 marks the 21st anniversary for Streetwise Communications who are renowned for their research methods in reaching those hard to reach about social issues, in particular disadvantaged young people. Streetwise has produced several innovative resources addressing drug and alcohol issues affecting young people. These resources have been distributed nationally and have covered topics including substance misuse amongst young Indigenous people, dual diagnosis and Hep C. Streetwise is currently working on projects tackling issues such as performance- and image-enhancing drugs and support information for Aboriginal families and carers of those with drug and alcohol problems.

One reason Streetwise Communications successfully communicates with young people is its unique qualitative research process, which involves young people in every step of a campaign. Streetwise works in focus groups and interviews with young people to determine their perspective on the issue at hand. For example: On The Edge is a comic dealing with dual diagnosis – substance misuse and mental health issues facing some young people. Young people aged between 12 and 18 years were consulted about this issue – their thoughts, opinions and concerns were creatively expressed in the draft comic, created by the Streetwise artist and writer/researcher. The draft is circulated for feedback to the target audience and service providers to ensure that the culture, language and style of the target group is reflected in the story. The final draft is circulated for feedback to ensure that messages are being understood, particularly for those with literacy problems.

Jo Taylor, General Manager of Streetwise says: ‘It is the young people who courageously take part in Streetwise projects, who share their stories and volunteer their honest opinions, who ensure that the resources are credible with the target group and are effective. This award reflects that in order to tackle social issues effectively, organisations should involve young people in the development and implementation of solutions.

‘Another reason for Streetwise’s success is that we partner with key stakeholders for each project that we undertake. As an expert in communication rather than specific issues Streetwise works with a diverse range of agencies to ensure that the information campaigns are based on current best practice in each field. This award is also an award for our partners and we thank them wholeheartedly for their support. For example Risky Business, a resource aimed at young Indigenous people, which was also nominated for an award, was completed in partnership with the Aboriginal Drug and Alcohol Council of South Australia.’

Excellence in law enforcement

THE ALCOHOL LINKING PROGRAM – A POLICE/HEALTH TEAM EFFORT

DEBORAH CHURCH, ALCOLOH LINKING PROGRAM, HUNTER NEW ENGLAND POPULATION HEALTH

Background

The Alcohol Linking Program (Linking) which is now routine police practice in NSW, started as an idea between some health promotion staff in the (then) Hunter Area Health Service, around 1996.

How is it, they asked, that with the advent of responsible service of alcohol (RSA) provisions within the Liquor Act, there were still highly intoxicated people pouring out of licensed premises and onto the streets?

Discussions with local police indicated there were limits on what they could do, simply because they could not be at all licensed premises on all occasions to enforce the law. Improved intelligence and low cost, targeted, but systematic, strategies were required by police to work with licensees to better manage RSA practices.

A search of the available literature indicated that up to 70 per cent of incidents attended by police are alcohol-related, and approximately 75 per cent of street offence incidents (assault, offensive behaviour and offensive language) are linked to alcohol. Almost half of all alcohol in NSW is sold through licensed premises. There is evidence that over 50 per cent of those charged with drink-driving offences last drank at a licensed premises and that 60 per cent of alcohol-related street offences occur on or near a licensed premises.

Trialling the project

Thus a pilot project in the Hunter region of NSW began to provide intelligence about the levels of intoxication of people involved in police-attended incidents, and where they had consumed their last drink. This intelligence allowed police to provide licensees with educational feedback about people linked to their premises. Together, police and licensees could identify strategies which would assist with RSA and in doing so, reduce the level of and number of intoxicated people on licensed premises.

As a result of that pilot project, and a regional trial in Western NSW, it was decided, with support from the Alcohol Education Rehabilitation Foundation, to roll-out Linking throughout NSW Police. Linking became mandatory practice for all police in August 2004, and management of the program passed to NSW Police from the partnership arrangement with Hunter New England Population Health in June 2005.

Alcohol intelligence gathering

The overall goal of the Alcohol Linking Program is to reduce crime associated with excessive alcohol consumption on licensed premises. This is achieved through an increase in the compliance by licensed premises with the Liquor Act as a result of the police’s increased capacity to collect alcohol-related intelligence and apply it to the education of licensees on RSA.

A POLICE/HEALTH TEAM EFFORT

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Police now systematically record – for ‘persons of interest’, victims and witnesses involved in a police-attended incident – the following information:

1. Did this person consume alcohol prior to the incident?
2. If so, police then assess their levels of intoxication (not, slightly, moderately, well or seriously affected)
3. Where did the person have their last drink?
   a) if at a licensed premises, then the name of that premises is recorded
   b) if at a private residence, public place or BYO restaurant, then that is recorded
4. Who purchased the alcohol? (Asked only if they answer ‘yes’ to 3b)

Partnerships with licensees

This information is entered into the police database (COPS) and reports are produced regularly which can identify the number of intoxicated persons ‘linked’ to particular licensed premises.

Licensed premises then receive written feedback about the number and nature of the offences linked to their premises and also information regarding the level of intoxication of the people questioned. Those with high numbers and/or a consistent trend of linked incidents are informed that they will receive a covert police audit. Feedback from that audit provided by the local licensing officer provides opportunities for the licensee to improve their RSA management practices.

These reports and any feedback from an audit provide an important educational opportunity for police and licensees. Licensees generally welcome this feedback and use it to positively inform their management practices. An average of 13 per cent reduction in some has been recorded.

Associated with premises that have received a covert audit are informed that they will receive a covert police audit. Feedback from that audit provided by the local licensing officer provides opportunities for the licensee to improve their RSA management practices.

NSW Police have a range of enforcement strategies for use when appropriate with licensed premises. Linking complements enforcement activities and has proven to be an effective, educational strategy available for use by NSW Police and licensees to reduce alcohol-related crime.
MOTIVATIONAL INTERVIEWING
NUTS AND BOLTS

Motivational interviewing (MI) is a popular technique used by drug and alcohol counsellors. Over the following four pages, Of Substance presents a summary of the key features of MI and snapshots of the technique. Further on, we outline some practical examples of MI at work in Australia and Canada.

The keynote presentations and workshops on MI by US clinicians Mark and Linda Sobell at the recent Winter School in the Sun conference drew large numbers of delegates. Below is a paper that summarises the main points of the MI presentations made by the Sobells.

The key elements of motivational interviewing
LINDA CARTER SOBEll AND MARK B SOBEll, CENTRE FOR PSYCHOLOGICAL STUDIES, NOVA SOUTHEASTERN UNIVERSITY, FLORIDA

Motivational interviewing (MI) was first developed in the 1980s by Dr William R Miller as a way of interacting with persons who have low-level drinking problems. These individuals are unlikely to accept the label ‘alcoholic’, and are often highly resistant to traditional confrontation. Rather, they may be ambivalent about whether they need to change. Designed to minimise resistance, motivational interviewing is based to some extent on Carl Rogers’ client-centred therapy, but whereas Rogers’ therapy was non-directive, motivational interviewing is explicitly directive.

Resolving ambivalence
The goal of MI is to get people to resolve their ambivalence (conflict) about changing their behaviour, while not evoking resistance. MI is a directive, patient-centred counselling style which elicits behaviour change by helping clients explore and resolve ambivalence about harmful practices. This is achieved by increasing clients’ awareness of the discrepancies between their current behaviours and their stated goals. With a strong focus on personal choice, the techniques used minimise resistance while exploring those discrepancies. Those techniques can help people to change by recognising their high-risk behaviour, evaluating how much of a problem their behaviour is for them and so on.

Handy tools
1) Readiness to change ruler
- People come into treatment with different levels of motivation (or readiness) to change.
- At the assessment first session ask: ‘On the following 10-point scale from 1 to 10 where 1 is “not ready” and 10 is “ready” where are you now in terms of changing your behaviour?’
- People move forward and back along this readiness to change scale.
- A health worker needs to operate at the same level of change where the client is in order to minimise resistance and gain cooperation.

On the following scale (show client) from 1 to 10, what number best reflects how ready you are at the present time to change (the behaviour)? CIRCLE ONE.

Not ready to change Thinking of change Underlying uncertainties Somewhat ready Very ready to change

2) Scoring
It can be helpful to ask clients to rate the urgency of the problems on a scale of 1 to 10, with 1 being the least urgent and 10 being the most urgent. 

Example:
Health care practitioner (HCP):
Let’s say 10 means how much trouble you want your life to be when you solved the problem that brought you here, and 1 means how bad things were when you picked up the phone to schedule an appointment; how would you rate your problem today?

Client: I would say a 4.

HCP: So, what would it take to go from (4) to (9)?

Different types of reflective listening
Simple reflection: reflects exactly what is heard, for example:

HCP: ‘I don’t want to quit.’
Client: ‘You don’t think quitting will work for you.’

Double-sided reflection: reflection presents both sides of what the client is saying; this a useful method for pointing out ambivalence.

HCP: ‘There is no question that my children come first. However, after I put them to bed I don’t really want to quit.’

C: ‘I don’t want to quit.’

HCP: ‘I just can’t relax anymore and I find I am drinking more after work.’

C: ‘What kinds of things have you done in the past to relax? (OE)’
C: ‘Read, walk, but lately I’m too tired.’

Verbalising ambivalence:
- In what ways has your behaviour been a problem?
- ‘If it is not viewed as a problem now, how might your use eventually become a problem?’
- ‘In what ways has it been inconvenient for you?’

Recognising ambivalence (decisional balance):
- ‘What are the things you like about your use of drugs?’
- ‘What are the less good things about your use of drugs?’
- ‘If you keep stepping over the line that you’re on what can you imagine happening?’
- ‘What would be the best outcome you could see for yourself?’

Looking forward:
- ‘If you keep going the way you are going where will you be five years from now?’
- ‘Where would you like to be five years from now?’

Advice on training
If you are interested in gaining a better understanding of MI, and training, you can visit www.acar.net.au.

References

Basic motivational interviewing skills
1. Ask open-ended questions (OE):

Some examples of OE questions include:

- Health care practitioner (HCP):
  ‘Do you mind if we talk about …?’ or ‘Tell me a bit about your health and how it is affecting your work’.

2. Reflective listening (RL):

Paraphrase clients’ comments and make reflections as statements where the inflexion goes down at the end. This style can also incorporate OE. For example:

HCP: ‘It sounds like your work is quite stressful. (RL)’
Client (C): ‘Yes, but it is quite challenging, pays well and I like it.’

HCP: ‘So even though your work is stressful, you find it rewarding.’ (RL)
C: ‘Well most of the time, but lately I wonder where it is all going.’

HCP: ‘What other concerns do you have?’ (OE)
C: ‘That’s a good question. Actually there have been cutbacks lately – downsizing they call it. I just can’t relax anymore and I find I am drinking more after work.’

HCP: ‘What kinds of things have you done in the past to relax?’ (OE)
C: ‘Read, walk, but lately I’m too tired.’

3. Developing discrepancy

Another important skill is to highlight discrepancy between the client’s stated goals and where they are currently at, with the goal being to resolve the discrepancy through a change in behaviour.

Strategies:

- Tell me some of the good things and less good things about your behaviour/concern.
- What will your life be like (5 years from now) if you don’t make changes and continue to use?
- Explore how a client’s life would be different if he/she did not have the problem or were not engaging in the behaviour.

If you are interested in gaining a better understanding of MI, and training, you can visit www.acar.net.au.
The program

Interested participants call a tollfree number and are screened for eligibility. People who have been advised by their GP that they should cut down on drinking due to health problems are not accepted. Nor are minors, pregnant women or people on medication where alcohol is contraindicated. Where appropriate, these people are referred to other services.

‘It's important that participants can understand, benefit and apply the principles of motivational interviewing and cognitive behavioural therapy on their own’, Professor Thiagarajan says.

‘The material provided offers tips on self-recording drinking and coping with high-risk situations such as low mood, cravings or social situations’.

The future

Professor Thiagarajan and his team are developing an Internet-based treatment for problem drinking which will be available in the near future. Next year, ACAR also plans to launch a nationwide Comorbidity Management Program, which will enable participants who are depressed or anxious and who drink excessively to receive treatment by mail.

For more information, visit www.acar.net.au or phone 1800 006 577 tollfree.

GOOD NEWS ABOUT GROUPS

JENNY TINWORTH

Group work is a popular form of therapy in many alcohol and other drug treatment centres. Often it is complemented by clients having individual sessions with counsellors.

With this in mind, researchers at the Addiction Research Foundation in Toronto, Canada, found themselves asking questions: ‘How effective is group therapy?’ and ‘How does group therapy measure up against individual therapy?’ To find answers, the team established Project GRIN, a randomised control trial which compared group therapy to individual therapy sessions.

Former University of Toronto professors Linda and Mark Sobell, now based at Nova Southeastern University in Florida, were the researchers. Mark recently presented the study and its findings at the Winter School in the Sun conference in Brisbane. ‘We knew that it was more cost effective to provide group therapy than individual therapy, however there had been very little evaluation of group therapy’, he says.

Study design

Through the usual centre intake and additional newspaper advertisements, 287 clients were attracted to the study. Alcohol misuse was the challenge for 212 clients, with another 52 clients seeking treatment for their use of other drugs, predominantly cannabis or cocaine. All were randomly allocated to either group or individual therapy sessions.

Those in the group sessions received four two-hour structured group therapy sessions. Those in the individual pool were allocated four one-hour individual sessions.

The researchers’ initial concerns included that there might be a high drop-out rate by group members, so group members were given handouts which explained the benefits of group work. They were also contacted the day before each session to confirm their attendance. Those attending individual sessions also received a reminder call, but were allowed to rebook their sessions if they could not make an appointment.

Findings

The participants were generally socially stable and well educated, and their drug use reflected a not so severely dependent population. While two-thirds of the participants had not received prior treatment, about 70 per cent rated their drug problem as major or very major.

At the end of the study, it was found that there was no difference in attrition rates between treatment types, and that those in group treatment did as well as those in individual treatment on multiple measures. There were no major differences in results between the two groups. There were significant changes in alcohol and drug use at the end of treatment, and a small number of clients had changed goals, some switching from a moderation goal to abstinence, while others changed from abstinence to moderation.

See Figure 1 for details of post-treatment alcohol use.

Researchers conducted a follow-up 12 months after the project, and successfully contacted 87.3 per cent of the participants. Generally, behaviour change was maintained at 12 months.

Implications

‘This study shows that group therapy can be as effective as individual therapy’, Mark Sobell says. ‘Even though our groups only ran for four sessions, participants reported high group cohesion by the end of treatment. This is important if group work is to be effective.

‘From a cost perspective, we found that there was a 41 per cent saving for the group condition, so in a climate where the cost of treatment is important, group work is a good place to start. I believe guided self-change motivational group work could be incorporated into a stepped care approach. This is a base for not severely dependent people, and if they were not successful in switching to their desired behaviour, they could then be moved into more intensive treatment’.

TREATMENT: IT'S IN THE MAIL

JENNY TINWORTH

‘Only a fraction of the people who have problems with alcohol will ever walk through the door of a drug treatment service’.

This is the belief of Associate Professor Sitharthan Thiagarajan, of the Australian Centre for Addiction Research (ACAR). And to support his statement, Professor Thiagarajan turns to figures from the 1992 National Campaign Against Drug Abuse which estimated that only one in ten individuals who needed treatment for alcohol issues would ever receive it.

‘Further, we know that for every person that is physically dependent on alcohol, there are another four people who are problem drinkers’, he says. So for the ACAR team, the challenge was to widen their service to take treatment beyond clinics and into people’s homes.

For this new style of therapy to be effective, it required special attributes: it must be cost effective and its style must be such that individuals who applied it would be motivated enough to be able to change their drinking habits with very little physical support from clinicians.

The postal system was quickly identified as an effective and inexpensive method of delivering treatment to a wider audience, while Professor Thiagarajan and his team designed a program which drew heavily on the principles of cognitive behavioural therapy and motivational interviewing.

Throughout the mid-90s, the team refined the program through a series of randomly controlled trials. Today, NSW-based ACAR offers a statewide correspondence treatment program which last year treated 1000 people.

‘Of that group, participants generally reported more than a 50 per cent reduction in drinking, while there were significant reductions in other alcohol-related problems, such as relationships, problems at work and health problems’, Professor Thiagarajan says.

‘Another positive element is that the Controlled Drinking by Correspondence Program has a high number of female participants. Currently, 59 per cent are women. In traditional treatment programs, females usually account for only seven to 15 per cent of participants’. 
Peer education essentially involves sharing and providing information about alcohol and other drugs to individuals or groups. It occurs through a messenger who is similar to the target group in terms of characteristics such as age, gender or cultural background, has had similar experiences and has sufficient social standing or status within the group to exert influence (McDonald, Roche, Durbridge & Skinner, 2003).

Peer education is popular, widely used and intuitively appealing. What constitutes best practice in peer education, however, is a difficult question to answer. Despite its popularity in practice, there is very little consensus in the research literature regarding:

- the definition of peer education (i.e. what it is and is not)
- strategies to ensure maximum impact (i.e. what works best)

Therefore, instead of presenting a step-by-step approach of ‘how to do peer education’, in this article we highlight four key issues for consideration when setting up peer education programs:

1. developing program aims and objectives
2. identifying and training effective peer educators
3. designing credible and effective messages
4. strategies to conduct peer education activities

Developing program aims and objectives

Identifying clear program aims and objectives is a crucial step that informs other important decisions such as the type of information to provide and the education strategy(s) to be used.

Program aims may be as simple as increasing knowledge about drug-related issues so that the target group is able to make informed decisions, or as complex as attempting to change attitudes and behaviour.

It is important that the design of the program is in line with the stated aims. For example, if the intention is to change young people’s knowledge, a classroom-based approach may be sufficient. However, if the aim is to change attitudes and behaviour, then more informal approaches may have a greater impact.

Identifying and training effective peer educators

Peer educators are people who are considered by themselves and other group members to be fellow peer group members, or to have similar characteristics but differ in some way (e.g. they may be a few years older).

For peer education to be effective, intended recipients must believe that the person providing information is a trustworthy and credible source of information. A person who is a leader or respected within the peer group is more likely to be influential (Prendergast & Miller, 1996). The credibility of a peer educator can also be influenced by their personal characteristics, role, experience and knowledge (Shiner, 2000). For example, participation in drug education programs, contact with people who use drugs, and good communication and presentation skills may increase perceptions of a peer educator’s credibility and trustworthiness.

The meaning of ‘peer group’ may be as narrow as a group of friends or as broad as the more generic group regarded as ‘drug users’.

Careful consideration should be given to the way in which a peer educator is recruited. To maximise credibility with a peer group it may be preferable to seek volunteers or nominations from the group, rather than recruit on the basis of the preferences of health workers, teachers or community leaders.

In regard to training peer educators, most programs provide information and training regarding social, psychological, health and legal issues associated with alcohol and other drug use, and skills training in areas such as communication, planning and presentation. Peer educators’ knowledge, skill and confidence is likely to benefit most from interactive methods with an emphasis on modelling of techniques and practice.

Designing credible and effective messages

The credibility of the message will be increased if it is culturally relevant, targeted and non-judgmental. Keep in mind that drug use is increasingly seen as normal behaviour, both by users and non-users and many people see drug use as fun, social and functional.

It is important to target peer education strategies to the particular group in terms of drug type (licit or illicit), type of user (experimental, recreational, regular or problem user), and readiness of users to change their behaviour (Coggans & Watson, 1995; Tobler, 1992). Those with some experience of drugs are unlikely to respond to scare tactics, for example ‘all those who experiment with drugs will become addicted’ or ‘use of softer drugs will lead to addiction to harder drugs’. People with little or no experience of drugs are more likely to listen to information about the negative consequences of drugs (Bloor, 1999), whereas those who currently use drugs are more likely to respond to information about how to minimise risks associated with drug use.

Messages that are non-judgmental and based on accurate facts are generally more credible (Tobler, 1992). Messages based on fear- aroused or those advocating abstinence are less convincing because they are seen as biased and contradict people’s experience and knowledge of drug use (Coggans & Watson, 1995; Shiner & Newburn, 1996).

Peer education strategies

Peer educators may act in different roles, such as facilitators, counsellors, sources of information, support workers or tutors (Prendergast & Miller, 1996). They may work alone or with others present. Alternatively, they may simply pass on information in informal, everyday situations (Gore, 1999).

One peer education strategy is the Peer Teaching model, where the peer educator prepares and conducts an education session much like a teacher in a classroom. Unfortunately, this approach does not differ much from traditional teaching which creates a ‘hierarchy of power’, and its content is usually imposed from outside the peer group (Gore, 1999).

More informal approaches based on opportunistic interactions may be more effective in reaching a particular audience. Informal approaches can be as simple as everyday conversations, handing out information leaflets and answering questions at a music event such as the Big Day Out, or presenting a play which raises and deals with drug-related issues.

Conclusion

Peer education has the potential to be a highly successful approach to informing people about issues associated with alcohol or other drug use, and supporting behaviour change. However, to be effective peer education programs must be designed with the specific target group in mind. Involving representative numbers of the target group in the design, implementation and evaluation of a program can help to maximise the credibility and impact of a peer education initiative. This approach is also likely to result in creative and interactive approaches that take peer education out of the textbook and into real life.

References


The revised second edition
The revised 2005 version of the book has benefited from the original testing, along with the experience we had of researching and producing a similar book in South Africa: Tackling Alcohol Problems: Strengthening Community Action in South Africa.

While the basic layout of the new edition is much the same as the previous one, there is a wealth of new material, including more on foetal alcohol syndrome (which is increasingly arousing concern) and the making of home-brew beer (and illegally selling it in dry areas). We have included material on the link between playing the pokies and drinking; new case studies of permit systems, ways of managing public intoxication and unwanted social behaviours, and how to motivate small communities by collecting statistics that tell about their own town and the impact that alcohol is having.

We included an example of a group of women at La Perouse, Sydney, who had established a family support group for carers of alcohol- and drug-afflicted family members. We updated case studies to follow up strategies eight or ten years later, finding for example that in Elliot (a small Northern Territory town) alcohol sales restrictions had been voted in again, and that a nascent men’s group in Lismore, northern New South Wales, had grown into a fully fledged program with more staff. Another addition is a section with useful ‘handout’ pages which can be easily copied.

Ways to use the book
In order to show readers how to use the book, each chapter begins with a quote from a variety of people (nurses, outreach workers, a hospital program manager, AOD workers) saying how they had used the earlier edition. We know that the book has been used in some of the following ways:

● as a catalyst for discussions with community members and service providers
● for personal professional development
● as a text in tertiary courses
● as a reference to guide setting up resource collections
● as a means of encouraging service providers in new approaches to AOD issues
● to support open access by communities to statistical information relevant to them
● to provide a template for designing a new AOD strategy
● as a supporting resource for workforce development
● to provide ideas for what programs to start for clients in rehabilitation programs
● in the training of health workers
● to develop policies for night patrols
● to generate ideas in workshops to contextualise alcohol issues
● to contribute to discussions about restricting opening hours of licensed premises
● used in men’s group to talk with Aboriginal men about their past behaviours
● to counteract ‘redneck’ attitudes in the town by learning about the history of alcohol and different drinking patterns
● as background reading for police, liquor licensing authorities and new health staff.

References


To order a copy
The revised Grog Book has been released together with a reprint of an earlier book that takes a positive, action-oriented perspective on drinking problems. Giving Away the Grog: Aboriginal accounts of drinking and not drinking is a collection of interviews (first published in 1995) I conducted with individuals who had managed to quit their previous heavy alcohol use, who told of their motivations to change and the strategies they used to stay out of trouble. This book is also designed with discussion questions and a guide to the issues raised in the interviews, so trainers and teachers can make practical use of it. Both books are available free of charge by phoning 1800 020 101, extension 8654.

STORIES FROM THE GROG BOOK
A community educator in Tennant Creek has discovered a great teaching aid. ‘DW Eyes’ are special goggles that are designed to mimic what it feels like to have different blood alcohol levels. He has taken the goggles out to a number of communities and to rodeos and shows to demonstrate how strongly alcohol can distort senses and judgment. With the DW goggles on, he gets people to try a couple of exercises.

‘I get people to do the heel to toe line walk. They lose balance and about 99% drift to the right. I get them to pick up a ball and throw it at me – it goes about a metre and a half, about 99% drift to the right. I get them to throw a ball at a target – it goes a metre and a half. I get them to throw two balls at a target – it goes a metre and a half. I get them to throw three balls at a target – it goes a metre and a half. I get them to throw four balls at a target – it goes about a metre and a half. I get them to throw five balls at a target – it goes about a metre and a half. I get them to throw six balls at a target – it goes about a metre and a half. I get them to throw seven balls at a target – it goes about a metre and a half. I get them to throw eight balls at a target – it goes about a metre and a half. I get them to throw nine balls at a target – it goes about a metre and a half. I get them to throw ten balls at a target – it goes about a metre and a half.’ – Lloyd Brooks and Carol Watson, p. 107.

‘The day workers from CAAPU (a residential treatment and outreach program) visit Amoonguna School. We can only be a listening channel for those little kids. We only see them once a week. We have caring and sharing sessions. The CAAPU workers sit in the circle with the kids, and the children talk about their feelings about violence and the effects of grog in the family. The workers take a small treat, such as oranges, to share with the children. This is part of sharing and caring. Some kids pour their hearts out to us.’ – CAAPU worker, p. 181.
Upcoming conferences

14 October 2005
National Conference on Injecting Drug Use
Victoria Park Plaza Hotel, London
For more information visit http://www.exchangesupplies.org

4 November 2005
National Drug Trends Conference
Melbourne, Hilton on the Park
For more information and registration
visit http://www.apsadconference.com.au

6-9 November 2005
2005 APSAD Conference
Melbourne, Hilton on the Park
For more information and registration
visit http://www.apsadconference.com.au

10-11 November 2005
4th Annual Australian and New Zealand
Adolescent Health Conference
‘Challenge, Debate, Inspire, Survive’
University of Melbourne, Victoria.
For more information visit www.rch.org.au/cah
Phone: +61 3 9345 4835 Email: cah.conference@rch.org.au

9-10 March 2006
National Drug Treatment Conference
Glasgow Radisson, Scotland
For more information visit http://www.exchangesupplies.org/
conferences/2006_NDTC/intro.html

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