

# OF SUBSTANCE

OCTOBER 2006 VOL. 4 NO. 4

THE NATIONAL MAGAZINE ON ALCOHOL, TOBACCO AND OTHER DRUGS

## SCHOOL DRUG EDUCATION

Looking for direction



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Celebrating the sector

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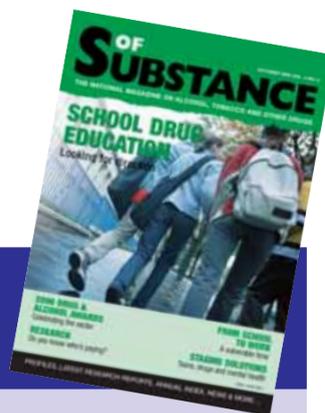
Teens, drugs and mental health

ISSN 1449-0021

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



Jenny Tinworth



Kate Pockley

## Editors' letter

Welcome to the October 2006 issue of *Of Substance*.

Schools have always provided something of a captive audience for our society to promote messages about everything from good nutrition to moral values. And drug education has been no different. For years, health workers, teachers and even police have used the venue to teach students about the potential dangers of alcohol, tobacco and illicit drugs.

In this issue, we explore what works in school drug education. We look at the trends in presentation approaches, as well as taking a moment to look at the lessons to be learnt from the way we have tackled drug education in the past.

And of course, the attitudes and decisions young people make both at home and school will influence the way they use alcohol and other drugs throughout their lives. Researchers Ken Pidd and Ann Roche follow this journey and write about a little discussed but vulnerable period in the lives of adolescents – their transition from school into the workplace and how this may impact on their substance use.

Keeping with the theme of drugs and young people, we also hear from a group of adolescents in South Sydney, who have turned their own experiences of substance misuse and mental health into a powerful drama.

Drug Action Week 2006 culminated in the prestigious National Drug and Alcohol Awards. This annual event honoured people and programs from across the country. It is inspiring to read about the work and dedication of so many individuals who work with drug and alcohol issues. Turn to page 10 for our coverage of this annual event.

As usual, *Of Substance* has many regular features which continue to be of interest to readers. We report on the findings of recent research studies, drug sector news and resources as well as continue our series on research methods, this time looking at action research. For your convenience, we are also publishing an index of all our 2006 articles.

As always, we welcome feedback from readers via email at [editor@ancd.org.au](mailto:editor@ancd.org.au). We also invite you to visit our website at [www.ofsubstance.org.au](http://www.ofsubstance.org.au). Here, you will find all the past issues of the magazine and a useful search facility which will allow you to access all our coverage of specific topics.

Jenny Tinworth and Kate Pockley  
Managing Editors

## GUEST EDITORIAL

# ADOLESCENTS AND SUBSTANCES

JOHN HOWARD, DIRECTOR CLINICAL SERVICES,  
TRAINING AND RESEARCH, TED NOFFS FOUNDATION, NSW



Substance use by young people is the product of many factors in their personal and social lives and the spaces in which they live. These spaces include the family home, schools, workplaces and more public places. Within a setting of social and peer influence and expectations, together with easy availability and variety, substance use can become one aspect of the developmental process. Most young people

who try substances do not continue their use or develop significant problems. Most of their use is not mindless or pathological, but functional. Curiosity, boredom and wanting to feel good (or better) tend to be the main reasons cited for trying substances.

However, the pathways for young people who develop patterns of regular and problematic or harmful use appear to differ from those who merely experiment or maintain irregular use. Personality characteristics, family difficulties, association with substance-using peers, different degrees of exposure to substances, and social disadvantage all play a role.

In the past, there were few positive outcomes of interventions to prevent or reduce substance use among young people, and the young people most needing the message were those least likely to be receptive to them or not where the messages were delivered – most often schools. The situation appears to be improving and studies presented in this edition of *Of Substance* yield more optimism, highlight some emerging success stories for prevention efforts within schools/education, and stress the role of other 'spaces' such as the workplace. Of significance are cautionary tales from the US and reminders to not ignore history, and the failure of more ideologically and politically driven programs.

Interventions which imply that adolescents are unable to resist negative peer influences, and which are simply based on a 'just say no' approach tend to miss the point, are naïve, simplistic, and out of context with the initiation and maintenance of many young people's substance use.

We know that the most effective interventions:

- provide accurate and unbiased information that challenges incorrect normative beliefs, and include harm minimisation strategies (e.g. safer using techniques) as appropriate
- build skills (e.g. decision-making and communication)
- provide counselling as necessary
- improve access to health services
- create a safe and supportive environment that can expose young people to satisfying and acceptable alternatives to substance use.

**Correction:** In our July 2006 issue we listed Margaret Hamilton's recent award as 'OAM'. It should read 'AO'.

# NEWS

## Alcohol and cannabis top treatment lists

A recent report, released in July by the Australian Institute of Health and Welfare, has found that when Australians seek treatment for substance use, alcohol and cannabis top the lists.

The report, *Alcohol and other drug treatment services in Australia 2004-05*, profiles 142 144 treatment episodes from 635 government-funded alcohol and other drug treatment agencies across Australia. One in three treatment episodes were for clients aged 20-29 years and the majority (two in three) were males. Alcohol was the main drug of concern in 37% of treatment episodes, a figure which has changed little over the last four years.

Cannabis was the next most common main drug of concern (23%), followed by heroin (17%) and amphetamines (11%). Many clients sought treatment for multiple drugs, with over half of all treatment episodes involving at least two drugs of concern.

A special chapter on cannabis shows that, of cannabis users who sought treatment, around two-in-five (41%) were aged 20-29 years – this is the age group most likely to have recently used cannabis.

Among clients who said cannabis use was their main concern, just over half (52%) of their treatment episodes involved at least one other drug that concerned them. Alcohol was the most common 'other drug' reported (36%), followed by nicotine (21%), amphetamines (20%) and ecstasy (6%). Counselling was found to be the most commonly provided treatment overall, followed by withdrawal management (detoxification).

*\*Agencies whose sole activity is to prescribe and/or dose methadone or other opioid therapies were not included in this national data set.*

For copies of the report, visit [www.aihw.gov.au/publications/index.cfm/title/10268](http://www.aihw.gov.au/publications/index.cfm/title/10268).

## New Hart for Drugs Strategy Branch

Ms Virginia Hart has recently begun work as the new Assistant Secretary, Drug Strategy Branch, in the Australian Government Department of Health & Ageing. Prior to her appointment, Ms Hart was the General Manager of the Water Programs Group in the National Water Commission; previously she also worked in the Department of Health & Ageing as Assistant Secretary of the Budget Branch and then the Aged Care Policy and Evaluation Branch.

## Drug use by police detainees

The 2005 annual report of the Drug Use Monitoring in Australia (DUMA) program, which surveys the drug testing of police detainees in seven sites across Australia, was released in July.

'The DUMA program highlights national and site-specific trends in illicit drug use and crime by police detainees, providing an evidence base for practitioners and policy making in this area,' Senator Chris Ellison, Minister for Justice and Customs, said.



The urinalysis results from over 3000 police detainees in 2005 indicate that:

- Cannabis continues to be the most commonly detected drug. Fifty-four per cent of adult detainees tested positive to cannabis. Among males aged 18-20 years, 65 per cent tested positive to cannabis, as did 41 per cent of males aged 36 or older.
- Methamphetamine use has remained at about the same level it was in 2003. Averaged across the sites, 39 per cent of females and 25 per cent of males tested positive to methamphetamine.
- The overall average proportion of detainees testing positive to heroin decreased from 2004, with a marked decrease in Bankstown, NSW of 10 per cent. Numbers testing positive in Parramatta, NSW remained similar to 2004. The overall average proportion remains much lower than pre-heroin shortage levels.
- Over all sites there was a slight decrease in the proportion of detainees testing positive for benzodiazepines. Compared with the previous year there were slight increases in the percentage testing positive in three sites and decreases in four sites.
- MDMA (ecstasy) detection remains low, but has increased over the past five years, from 0.5% in 2000 to 2.5% of all detainees in 2005.
- Cocaine is the least likely of all drugs to be used.

'In recognition of the importance of the information collected from DUMA, I recently provided funding to expand DUMA to Melbourne and Darwin, bringing the total number of DUMA sites to nine,' Senator Ellison said. The full report, and access to more information about the study, can be downloaded at [www.aic.gov.au/publications/rpp/70](http://www.aic.gov.au/publications/rpp/70).

## NEWS CONTINUED

### IN BRIEF...

#### Family Violence, Drug and Alcohol Use conference

The Australian Institute of Criminology held a conference, Family Violence, Drug and Alcohol Use in Remote Communities, in Darwin on 18 August. The aim of the conference was to identify family violence issues in remote settings with an emphasis on underlying factors which exacerbate family violence, such as illicit drug and alcohol use, and mental health issues. Conference papers will be available shortly via [www.aic.gov.au/conferences/](http://www.aic.gov.au/conferences/).

#### 6th Annual Colloquium of the International Centre for the Prevention of Crime

Australia hosted the 6th Annual Colloquium of the International Centre for the Prevention of Crime (ICPC) at the National Museum of Australia in Canberra, 14-15 September. The ICPC is an international non-governmental organisation established in 1994 to help countries and cities enhance safety and reduce delinquency, violent crime and fear of crime. Affiliated with the United Nations and based in Montreal, Canada, it provides a central location for the identification and distribution of effective crime prevention strategies internationally. More information on the colloquium can be accessed via [www.colloquium2006.info/](http://www.colloquium2006.info/).

#### Latest IDRS and PDI bulletins available online

Topics discussed by these bulletins are:

- The Illicit Drug Reporting System, which monitors trends and patterns of harm related to use of heroin, methamphetamine, cocaine, cannabis and diverted pharmaceuticals. The current IDRS examines gender differences among regular injecting drug users in Australia. Visit <http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/page/IDRSBulletins>.
- Party Drugs Initiative, (referred to on the website as the EDRS) which monitors trends and harms related to use of 'ecstasy and related drugs'. The current report examines patterns of other drug use among regular ecstasy users in Australia, focusing on cocaine, ketamine, LSD, GHB and MDA. Go to <http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/page/EDRSBulletins>.

For more information on the projects, go to the 'Drug Trends' section of the NDARC website: <http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/page/Drug%20Trends>.

#### Kava abuse

The Commonwealth Government has asked the Northern Territory Government to review its regulations on the use of kava, following evidence that it is being abused in some remote Indigenous communities. Pacific Islanders throughout Australia use kava, but in the NT it is consumed by some Indigenous communities at up to 100 times the usual rate. At least eight communities in Arnhem Land, comprising about 7700 people, have identified significant kava use as a problem. Heavy use of kava can cause weight loss, malnutrition, liver damage, hypertension and skin disorders. Current NT law allows kava to be consumed as long as permission is given by the Northern Territory Treasury's Racing, Gaming and Licensing Division and a community kava management plan regulates such matters as hours of sale. In Western Australia, by comparison, the sale and use of kava is banned except for specific cultural events, notably for ceremonies and celebrations by Pacific Islander peoples.

#### Recent symposiums

- The National Drug and Alcohol Research Centre's annual research symposium was held on 20 July in Sydney. For information about the full program, visit [ndarc.med.unsw.edu.au/NDARCWeb.nsf/page/Symposium](http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/page/Symposium).
- Turning Point's annual 'Work in Progress' research symposium was held on 18 August in Melbourne. The theme of this year's program was 'Translating research into practice: making services, research and development matter'. For more information visit [www.turningpoint.org.au](http://www.turningpoint.org.au).
- The National Drug Research Institute hosted a two-day research symposium, 'Responding to drug problems: Lessons from the past, future challenges and opportunities' in Perth on 25-26 September. The Symposium marks NDRI's 20th anniversary, and was designed to bring together experts on drug and alcohol policy, prevention and harm minimisation to reflect on the aims of the National Drug Strategy, the achievements of the drug and alcohol research sector in Australia, and to examine current challenges and chart future directions for the field. For more information visit [www.ndri.curtin.edu.au/home/ndri060925/index.html](http://www.ndri.curtin.edu.au/home/ndri060925/index.html).

#### New monographs from NDLERF

The National Drug Law Enforcement Research Fund has recently released three new monographs:

- *The policing implications of cannabis, amphetamine and other illicit drug use in Aboriginal and Torres Strait Islander communities*, available via [www.ndlerf.gov.au/pub/Monograph\\_15.pdf](http://www.ndlerf.gov.au/pub/Monograph_15.pdf).
- *Good practice framework: Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities*: available via [www.ndlerf.gov.au/pub/Monograph\\_15a.pdf](http://www.ndlerf.gov.au/pub/Monograph_15a.pdf).
- *Policing, volatile substance misuse, and Indigenous Australians*: available via [www.ndlerf.gov.au/pub/Monograph\\_16.pdf](http://www.ndlerf.gov.au/pub/Monograph_16.pdf).



### LETTERS

#### Naltrexone: another clinician's view

I read Martyn Lloyd-Jones' article on naltrexone implants (*Naltrexone implants: a clinician's view*, July 2006) with interest. I have been using naltrexone implants for approximately seven years and have managed several hundred patients, and so feel qualified to comment.

Rapid opiate detoxification (ROD) is mentioned as a preparatory procedure. I no longer perform these as I believe a buprenorphine-medicated withdrawal is safer and utilises far fewer medical resources. However, if an ROD is to be performed, the patient should be closely monitored by staff trained in airway management, for at least 36 hours. The case of aspiration pneumonia cited by Lloyd-Jones implies this monitoring did not occur. The other significant potential complication is cross transmission of blood-borne viruses, between patients and staff. I believe ROD should, at a minimum, be performed in a high dependency unit. A transient psychosis is also often precipitated following an ROD. Personal experience has taught me to recognise and treat this condition.

After withdrawal, naltrexone is a useful adjunct to opiate abstinence. Patients on naltrexone maintenance must make a daily decision to take their medication. They must also undertake non-medical therapies to gain and maintain a healthy drug-free lifestyle. It is not surprising that many patients require more than one attempt at achieving this.

I have trialed several types of naltrexone implants, and currently use an implant prepared by a compounding chemist. All implants cause a lump. Those with a plastic polymer may have a significantly larger enduring egg-shaped lump. The complications cited by Lloyd-Jones include precipitate withdrawal. This only occurs if the patient has not withdrawn prior to inserting the implant. It is my practice to only insert implants into patients who have already completed the withdrawal process. My experience with naltrexone implants has led me to develop the following personal guidelines for helping patients:

- gastrointestinal symptoms respond well to a somatostatin analogue
- pain relief responds best to local blocking agents
- if generalised analgesia is required, ketamine is the drug of choice
- if the patient is in ICU and sedation is required, an alternative to opiates must be used, for example muscle relaxants and midazolam (a short-acting, parenteral benzodiazepine)
- the occurrence of emergent psychosis must be anticipated and managed aggressively.

Dr Michael Kozminsky, North Brighton, Victoria

*Of Substance* welcomes correspondence from all our readers on topics raised in the magazine, or subjects of interest to the field. Please submit letters of up to 150 words to [editor@ancd.org.au](mailto:editor@ancd.org.au).

### Pacific AOD research

As a result of a recently commissioned report on illicit drug issues in the Asia-Pacific region, the Burnet Institute, with the support of the Australian National Council on Drugs (ANCD) and AusAID established the Pacific Drug and Alcohol Research Network (PDARN). This group aims to provide a sound evidence base and research capacity to address the problems of alcohol and other drug (AOD) use in the region. Its second meeting held in Fiji in July, brought together Pacific country representatives from ministries of health, law enforcement agencies, community-based organisations, regional funding bodies, research and education institutions to further explore AOD issues.

Throughout the meeting, participants were able to relate the costs to health and society, and the emergence of risks such as the spread of HIV, to the growing use and abuse of AOD. In conjunction with this, all participants agreed on the importance of understanding and incorporating traditional culture in the development of responses to local needs.

The meeting identified research priorities to help address problems linked to drug use, encourage networking amongst the Pacific research community, as well as linking individuals with the broader international research community. With the continued support of the Burnet Institute and the ANCD it is hoped that PDARN will see Australia's drug and alcohol research relationship strengthen with Pacific countries.

## Alcohol and drug problems

### Are you ready to learn more?

Alcohol and drug misuse is a significant issue in today's public health practice. Would you like to learn more about this challenging area while gaining graduate qualifications from a highly respected university?

Courses in **addiction studies** are being offered by The Queensland Alcohol and Drug Research and Education Centre (QADREC) at The University of Queensland.

All courses are offered in distance education mode and students can study towards a graduate certificate, graduate diploma or master's degree. Students enrolling in postgraduate coursework at UQ may also be eligible for interest-free, deferred payment loans through FEE-HELP and tax concessions.

To find out more about addiction studies and QADREC, phone (07) 3365 5189, email [qadrec@sph.uq.edu.au](mailto:qadrec@sph.uq.edu.au) or visit [www.sph.uq.edu.au](http://www.sph.uq.edu.au)



A collaborative initiative of Queensland Health and The University of Queensland.



# RECENT RESOURCES

## National Comorbidity Initiative: family stories

*In my life*, a book that draws on real-life experiences to help families battling with drug addiction, was launched on 5 June by the Parliamentary Secretary to the Minister for Health and Ageing, the Hon Christopher Pyne MP. The book was funded by the National Illicit Drugs Strategy – National Comorbidity Initiative.

The idea for the book came from a research study conducted in 2002-2004 under the National Drug Strategy by LMS Consulting with the National Centre in HIV Social Research, the University of NSW and the Australian Injecting and Illicit Drug Users League. One of the recommendations of the research noted that governments at all levels and service providers should build on the relationships and strengths offered [by families] and recognise the needs of families who seek to help family members through drug treatment.

The Australian Government agreed that a book of family experiences would provide a valuable insight into the experiences of families who do just that – choose to continue, however hard, to support their loved ones through the sometimes tortuous journey of drug use and its treatment.

*In my life* will be widely distributed with strengths-based workshops also planned across three jurisdictions and broader dissemination following the workshops.

Copies of the book can be ordered by contacting Tania Browne at the Department of Health and Ageing: [tania.browne@health.gov.au](mailto:tania.browne@health.gov.au).



## 'On Thin Ice' booklet

Over the last few years Australia has seen the emergence of new forms of methamphetamine available on the illicit drug market; in particular, the importation of high purity crystalline methamphetamine, or 'ice', has been increasing.

There is an urgent need to inform users about ice and the risks associated with its use, but currently there are few resources available on ice use that are accessible to drug users. In 2005, the Australian Government Department of Health and Ageing contracted the National Drug and Alcohol Research Centre (NDARC) to produce a new resource on ice. *On Thin Ice: a Users' Guide* is now in print, and a downloadable PDF version is available on the NDARC website: [www.ndarc.med.unsw.edu.au](http://www.ndarc.med.unsw.edu.au).

## Amphetamine-related problems

The Western Australian Clinical Guidelines for the Management of Acute Amphetamine-Related Problems were recently developed by the Drug & Alcohol Office (DAO) in partnership with the Office of Mental Health. These guidelines have been developed to assist clinicians working in mental health settings, emergency departments, and drug and alcohol services to manage patients with acute problems resulting from amphetamine-type stimulant use, particularly acute mania and amphetamine-induced psychosis.



Electronic copies of the guidelines can be downloaded from the DAO website ([www.dao.wa.health.gov.au](http://www.dao.wa.health.gov.au)) under Publications – Manuals, Guidelines and Information Papers). The Clinical Guidelines are due for review in July 2007.

## Magazine matters

*Of Substance* has become an essential tool for people who work in the alcohol and other drugs sector.

The publication of this issue celebrates not only the magazine's third anniversary, but we also now distribute 10 000 copies to the sector. With many copies read by five or more individuals, that means *Of Substance* has a readership much greater than its print-run. In its short life, the magazine has become a vital tool in informing a diverse network of readers about the latest topics, news and research which impact on the sector. Recently *Of Substance* also launched its own website, which is attracting substantial online activity. Visit [www.ofsubstance.org.au](http://www.ofsubstance.org.au) to join our free subscription list and to see all our past issues.

# DRUG ACTION WEEK HEADS FOR MILESTONE

LISA A HORNSBY\*

Next year it will be 10 years since the inception of Drug Action Week.



In 1997, when the Alcohol and other Drugs Council of Australia's (ADCA's) then president, Professor Ian Webster conceived a way to promote to the Australian community what the alcohol and other drug (AOD) sector had known for many years – that treatment works – little did he realise its potential impact.

Drug Action Week (born as Treatment Works Week) is now held every June and aims to increase awareness of alcohol and other drug issues and to promote the achievements of those who work to reduce the harms associated with alcohol and other drug use.

Drug Action Week (DAW) has grown to become one of the major annual events on the national health calendar. DAW provides an opportunity for all individuals and organisations striving to reduce drug-related harm to raise awareness about issues and services, acknowledge the excellent work that is being done and involve members of their community to promote understanding.

Although the week is coordinated by ADCA, the success of DAW can only be attributed to those who give their time and energy to run events and to those who attend them.

In 2006, the 21st year of harm minimisation as a national policy, DAW was again highly successful. From Yam Island to Launceston, from Esperance to Mackay, Australian communities participated in a huge range of activities.

When reflecting on DAW's success over the years, Professor Ian Webster (chair of the Alcohol Education Rehabilitation Foundation) said that 'DAW serves to broaden the focus in the community on the achievements of the alcohol and other drugs sector. The pinnacle was celebrated at the National Drug and Alcohol Awards where leaders who have been successful in a range of settings such as research, prevention and treatment were honoured.' He added 'DAW is about celebrating and acknowledging what our communities do in recognising drug and alcohol problems and the responses they make.'

An example of one of the many DAW activities occurred in Johnstone Park in Geelong, Victoria. There, a memorial was constructed to commemorate all those who lost their lives in the region in 2004 due to alcohol, tobacco or other drugs. The local Drug Action Committee, consisting of police, drug and alcohol treatment services, the Salvation Army, Geelong Council, BATForce (the region's peak youth affairs body), the Department of Education and Training, and Deakin University have been involved in constructing

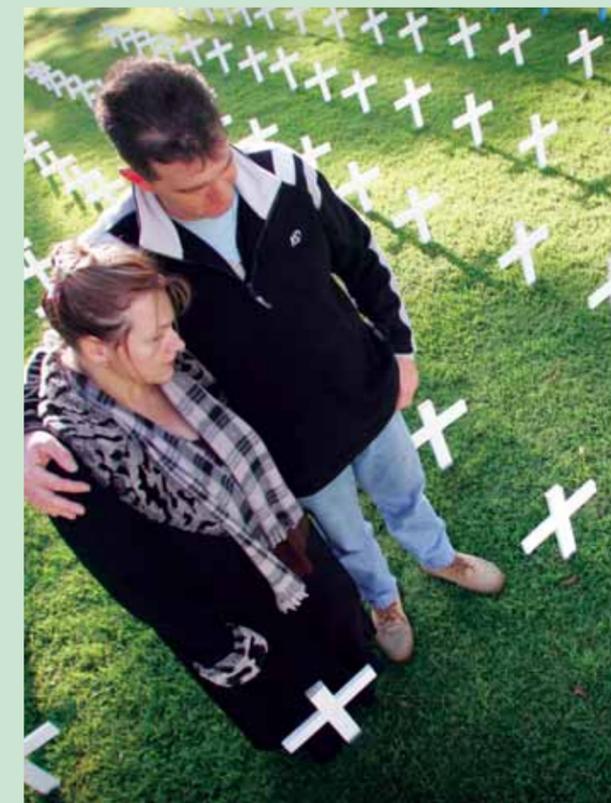
this memorial each year since 2000. This year, 172 crosses were erected representing 172 lost lives (27 for alcohol, 139 for tobacco and six illicit drugs).

An event such as this serves as a poignant reminder of how alcohol and other drugs affect so many. Each cross represents not only a life lost but also all those other lives affected by that loss – families, friends and workmates. It serves to focus attention on the human elements in a field which is too often subject to the vagaries of political support.

The success of DAW is that these messages reach beyond the halls of political process to touch urban, rural and remote Australian communities in a very real sense. These messages are ones we must foster.

Drug Action Week should continue in all of us just as it did in 1997 – with a vision to inform our communities. Future impact and confluence events will ensure this.

\*Lisa A Hornsby was coordinator of Drug Action Week 2006 for the Alcohol and other Drugs Council of Australia. For more information visit [www.drugactionweek.org.au](http://www.drugactionweek.org.au) or contact ADCA on (02) 6281 0686.



In Geelong, DAW highlighted the deaths of 172 people who lost their lives to alcohol, tobacco and illicit drugs in 2004.

Photo courtesy of the Geelong Advertiser

## RESEARCH DIGEST

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### COMORBIDITY RATES FOR PTSD AND SUBSTANCE USE

#### Featured study:

Mills, K et al. 2006. Trauma, PTSD, and substance use disorders: Findings from the Australian National Survey of Mental Health and Well-Being, *American Journal of Psychiatry*, vol. 163, pp. 651-8.

#### Findings:

This study analysed data drawn from the Australian National Survey of Mental Health and Well-Being to examine the relationships between post-traumatic stress disorder (PTSD) and alcohol/drug use disorders among a large (N=10 641) sample of the general population. Although it is recognised that comorbidity exists between PTSD and alcohol/drug use disorders, this study extends our current knowledge, most of which is based on studies of people seeking treatment, rather than among the general population.

The findings of this study were consistent with the clinical literature in demonstrating significant comorbidity between PTSD and alcohol/drug use disorders; along with substantial impairment experienced by those suffering this comorbidity. The paper reports that 1.3 per cent of the Australian general population was diagnosed with PTSD, and 7.9 per cent with an alcohol/drug use disorder; whereas alcohol/drug use disorders plus PTSD was experienced by 0.5 per cent of the population. One-third of those with PTSD also had an alcohol/drug use disorder, most commonly an alcohol use disorder (24 per cent). Indeed, people suffering from PTSD were five times more likely than those without PTSD to have an alcohol use disorder. Similarly, people diagnosed with an alcohol/drug use disorder were 6.5 times more likely than those without, to receive a diagnosis of PTSD. Among two-thirds of those with both PTSD and an alcohol/drug use disorder, their most traumatic event (e.g. witnessing a death or serious injury) occurred before or simultaneously with the onset of their alcohol/drug use disorder, suggesting that many people suffering this comorbidity may be self-medicating their PTSD symptoms.

Compared to people diagnosed with either PTSD or an alcohol/drug use disorder alone, those suffering both conditions experienced significantly poorer physical and psychological health, and social and occupational functioning. Mood, anxiety and personality disorders were also more common among those with both conditions. Interestingly, people with comorbid PTSD and alcohol/drug use disorders were more similar to those with PTSD alone than to those with an alcohol/drug use disorder alone. This suggests that the additional morbidity seen in those with both disorders may be attributed largely to PTSD. Consequently, treating alcohol/drug use disorders without addressing PTSD is unlikely to be successful for comorbid clients, highlighting the need to treat both disorders concurrently.

The findings of this study clearly indicate that individuals with PTSD plus an alcohol/drug use disorder constitute a significant challenge to service providers and are likely to require substantial clinical resources.

### ALCOHOL AND DRUG ABUSE LINKED TO HOMICIDES

#### Featured study:

Shaw, J et al. 2006. The role of alcohol and drugs in homicides in England and Wales, *Addiction*, vol. 101, pp. 1117-24.

#### Findings:

The data for this study was drawn from psychiatric assessments of the perpetrators of almost three-quarters of the 1594 homicide convictions in England and Wales between 1996 and 1999. These assessments contained information regarding psychiatric disorders and alcohol and drug misuse and dependence among perpetrators; and their mental state at the time of the offence, including the extent to which alcohol and/or drugs were judged likely to have influenced the homicide.

Consistent with previous research, the paper demonstrates significant associations between homicides and alcohol/drug use across two domains: homicides involving alcohol/drugs; and/or homicides committed by perpetrators with a history of alcohol/drug problems. Forty-two per cent of homicide perpetrators had a history of alcohol misuse or dependence as described by ICD-10; and 40 per cent had a history of drug misuse or dependence (note that these two groups are not mutually exclusive; many perpetrators had a history of both). In England and Wales, a total of 205 homicides per year were estimated to be committed by people with a history of alcohol/drug misuse. In addition, alcohol and/or drug misuse was judged to have contributed to 45 per cent of all homicides, which equates to 152 murders per year. In particular, alcohol was considered to have influenced a large number of homicides.

Whereas in general, homicides are often the result of escalation of private conflicts between friends, family and spouses, alcohol- and drug-related homicides were generally committed by male perpetrators on victims who were strangers, a pattern which may provide unique opportunities for prevention. Perpetrators had frequently misused both alcohol and drugs; were likely to be unemployed; and were likely to have a history of personality disorders, convictions for violence, and contact with mental health services. As noted by Graham (2006), this research suggests that those committing alcohol- or drug-related homicides are marginalised from mainstream society – unemployed, unmarried, psychiatric disorders, conflicts with strangers – and this is particularly true for drug-related homicides. Graham emphasises the high rates among perpetrators of previous contact with the health and criminal justice systems, highlighting the need for the development

of more effective rehabilitation programs for alcohol/drug offenders to prevent re-offending. In particular, marginalised offenders will benefit from being better integrated into mainstream society.

#### Further reading:

Graham, K 2006. The relationship between homicide and alcohol, drugs and psychiatric disorder: Some directions for prevention, *Addiction*, vol.101, pp. 1071-72.

### STABILITY THE KEY FOR HEROIN TREATMENT

#### Featured study:

Teesson, M et al. 2006. One year outcomes for heroin dependence: Findings from the Australian Treatment Outcome Study (ATOS), *Drug and Alcohol Dependence*, vol. 83, pp. 174-80.

#### Findings:

The Australian Treatment Outcome Study (ATOS) is designed to examine the outcomes of treatment for heroin dependence. It is a study of entrants to treatment for heroin dependence who were followed up 12 months after entering treatment; and a comparison group of 80 heroin users not in (or seeking) treatment, recruited from Sydney needle and syringe programs. Treatment entrants were recruited from randomly selected treatment agencies in Sydney, Melbourne and Adelaide, and included 277 people entering maintenance therapy; 288 entering detoxification; and 180 entering residential rehabilitation units. This paper examines (i) drug use, criminality, and physical and mental health of ATOS participants 12 months after they entered treatment; and (ii) the role of treatment in the achievement of improved outcomes.

Compared to the non-treatment group, those who entered treatment at baseline demonstrated a range of positive outcomes over the 12 months. Across all treatment groups, there were significant reductions in heroin and other drug use, heroin overdose, criminal behaviour, needle risk-taking and injection-related health problems, but less marked reductions in the non-treatment group. Among treatment groups, indicators of mental health dramatically improved, and in particular, diagnoses of major depression were significantly reduced at 12-month follow-up. In contrast, psychopathology remained stable among the non-treatment group.

Importantly, the benefits of treatment were demonstrated regardless of which particular treatment modality participants entered. Rather than revealing significant advantages of one form of treatment over others, this study showed that positive outcomes were associated with (i) a higher cumulative number of days spent in treatment over the 12-month period (the treatment 'dose'); and (ii) fewer treatment episodes undertaken in that time (treatment 'stability'). Even though three-quarters of the non-treatment control group did access some form of treatment during the 12-month follow-up period, they spent fewer days in treatment over the year than those who entered treatment at baseline. They evidenced some improved outcomes over the 12 months, but not to the same extent as the treatment groups. In short, this study clearly indicates that longer and more stable exposure to treatment, no matter which treatment that may be, significantly enhances positive outcomes for

heroin-dependent people. To improve clients' health and welfare, therefore, our goal as treatment providers should be to help our clients achieve longer retention in fewer treatment episodes.

### PARENTS HELP DEFINE PREVENTION TOOLS

#### Featured study:

Beatty, S et al. 2006. Investigating parental preferences regarding the development and implementation of a parent-directed drug-related educational intervention: An exploratory study, *Drug and Alcohol Review*, vol. 25, pp. 333-42.

#### Findings:

Parental practices powerfully influence the likelihood that children will engage in many hazardous behaviours, including alcohol and other drug (AOD) use. Many parent-targeted educational interventions have difficulties in recruiting and maintaining substantial parental participation. In this Perth study, 51 parents (predominantly mothers) of Year 6 students completed a questionnaire and/or participated in structured, small group discussions designed to identify parental needs with respect to (i) communicating with their children about AOD use; (ii) preferences regarding a parent drug education intervention; and (iii) strategies to recruit and engage parents in parent-directed interventions.

Participating parents reported that they worried about the potential harm associated with AOD use by children; yet underestimated their own children's vulnerability and AOD-use experiences. They wanted to be involved in the planning of parent-oriented AOD educational interventions, but identified numerous barriers to their participation in educational programs. They nominated flexibility and convenience regarding intervention delivery as being essential, and greatly preferred home-based interventions.



The types of programs preferred by parents included helping children with their homework where parents learn at the same time, and at-home learning activities that are especially designed for parents to complete independently of their children. Parents reported that any parent-oriented interventions should be supported by parents, non-judgmental, simple, time-efficient, fun and interactive. They advised that practical communication skills (such as how to talk with children; how to raise the topic; what topics to talk about) should be addressed in the intervention, rather than factual information about drugs themselves.

# CELEBRATING THE SECTOR

## THE 2006 NATIONAL DRUG AND ALCOHOL AWARDS

GINO VUMBACA, AUSTRALIAN NATIONAL COUNCIL ON DRUGS

On Friday, 23 June 2006, the alcohol, tobacco and other drugs sector celebrated the third 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 providing an award for excellence and outstanding contribution adds to the prestige of the evening.

There were more than 250 people present for the gala event in Sydney at the Four Seasons Ballroom, with guests being entertained by the MC for the evening, Dr Norman Swan. This year's Awards also saw the induction of six people into the newly created Drug & Alcohol 'Honour Roll', which is our

equivalent to the various sporting Halls of Fame. There was also a viewing of a video montage of drug and alcohol campaigns and issues over the past 30 years, plus the presentation of the awards in the various categories of excellence.

You can visit the website to check out the winners and view photos from the 2006 National Drug and Alcohol Awards event at [www.drugawards.org.au](http://www.drugawards.org.au). We also profile the major award winners on the evening over the following six pages.

The organising committee would also like to thank the Awards sponsors for 2006 – the Alcohol Education & Rehabilitation Foundation (principal sponsor), the Australian Government Department of Health and Ageing (major sponsor), as well as the NSW and SA Governments – for their support.

### National Drug and Alcohol Awards 2006 – winners and finalists

#### PRIME MINISTER'S AWARD FOR EXCELLENCE AND OUTSTANDING CONTRIBUTION IN DRUG AND ALCOHOL ENDEAVOURS

**Winner:** Cynthia Morton, CEO, Emotional Fitness Foundation – Qld

#### EXCELLENCE IN SERVICES FOR YOUNG PEOPLE

**Winner:** Youth Outreach Program, Geelong – Vic  
**Finalist:** Youth Withdrawal & Respite Service – WA  
**Finalist:** RRISK Committee – NSW

#### EXCELLENCE IN TREATMENT

**Winner:** East Perth Neuropsychology Clinic – WA  
**Finalist:** Odyssey House McGrath Foundation – NSW  
**Finalist:** Moreland Hall Intensive Support Service (ISS) – Vic

#### EXCELLENCE IN PREVENTION

**Winner:** 'Keep It Simple' Manly Drug Rehabilitation and Counselling Centre – NSW  
**Finalist:** Good Sports Program – Vic  
**Finalist:** Youth Solutions – NSW

#### EXCELLENCE IN ALCOHOL AND DRUG MEDIA REPORTING

**Winner:** triple j – Steve Cannane – Hack Team

#### EXCELLENCE IN LAW ENFORCEMENT

**Winner:** Cairns City Beat Police, Homelands Project – Qld  
**Finalist:** City Watch Community Nursing Service – SA  
**Finalist:** NT Police Drug Enforcement Section – NT

#### EXCELLENCE IN RESEARCH

**Winner:** National Drug Research Institute Indigenous Research Team – WA  
**Finalist:** NDARC UNSW – NSW  
**Finalist:** NDRI Alcohol Policy Research Team – WA

#### DRUG & ALCOHOL HONOUR ROLL

Rev Ted Noffs (posthumous), Mr Milton Luger (posthumous), Major Brian Watters, Dr Alex Wodak, Prof Margaret Hamilton, Prof Ian Webster

The AOD sector celebrates its night of nights



### Drug and Alcohol Honour Roll

## RECOGNITION FOR YEARS OF OUTSTANDING SERVICE



L to R: Prof Ian Webster, Major Brian Watters, Roz Luger (wife of Milton Luger), Superintendent Frank Hanson (on behalf of the late Ted Noffs) and Prof Margaret Hamilton at the Awards presentation.

**A National Honour Roll was created this year for persons who have made a significant contribution, over a considerable time period, to the drug and alcohol field. The goal of the Honour Roll is to acknowledge and recognise the exceptional work which is done by some people who have worked tirelessly over many years in this sector. Congratulations to the six inaugural members of the honour roll.**

#### Rev Ted Noffs (posthumous)

The Reverend Ted Noffs first came into contact with young people using heroin in 1964 when he discovered someone overdosed underneath one of the pews in the Wayside Chapel, in Sydney's Kings Cross. Ted first created the Crisis Centre in 1965, then the Drug Referral Centre in Rushcutters Bay in 1967. By 1972 he had developed a preventative concept called Life Education, which continues to this day. Ted and his team also developed early adolescent treatment approaches with programs such as the TRACA (Treatment of Adolescent Chemical Abusers). He also set up family self-help groups such as RAIN (Relatives Against the Intake of Narcotics).

#### Mr Milton Luger (posthumous)

In 1980, at an age when many of us think about retiring, Milton Luger left his home, and successful career in public life, in

the United States and came to Australia to establish new drug treatment options. In the 25 years Milton actively worked in the Australian AOD field, he was a beacon of practical common sense to people with significant drug problems. He established the Odyssey House programs in Australia, and throughout his career, was a great educator and mentor to many workers in the field, as well as constantly engaging with clients and directly counselling them about their lives. Milton also made a real contribution to drug policy through his advocacy of people-centred responses.

#### Major Brian Watters

Major Brian Watters has worked tirelessly in the AOD field in a variety of capacities for over 35 years, including a previous role as the Chair of the Australian National Council on Drugs. Brian has been an advocate for the rights of those affected by drugs and alcohol and has advocated for additional services to meet their needs. In his capacity as a Salvation Army officer, Brian has also helped countless numbers of people, both alcohol and drug users, and their families, cope with the negative impact of drugs and alcohol.

#### Dr Alex Wodak

Dr Alex Wodak, Director of the Alcohol and Drug Service, St Vincent's Hospital, Sydney, has a distinguished career in research, treatment and advocacy. He

has published over 200 scientific papers, is President of the Australian Drug Law Reform Foundation and was President of the International Harm Reduction Association 1996-2004. He lobbied for and helped plan the development of the first national institute of alcohol and drug studies, which opened as the National Drug and Alcohol Research Centre (NDARC). Alex has long been an advocate for needle and syringe programs, helping to establish Australia's first (pre-legal) program in 1986. He co-authored Australia's first scientific paper on HIV testing among drug users in treatment. Alex was also instrumental in establishing the first medically supervised injecting centre in Australia.

#### Prof Margaret Hamilton

Professor Margaret Hamilton has over 30 years experience in the AOD field including clinical work, education and research. She has a background in social work and public health and has conducted research in epidemiology, policy, evaluation (prevention and treatment), young people and drugs, women and alcohol, alcohol problems in remote Australia, and was the founding director of Turning Point Alcohol and Drug Centre in Victoria. Margaret now chairs the MACN Panel, a statutory body in Victoria and serves on various boards and policy advisory groups.

#### Prof Ian Webster

Professor Ian Webster is a physician and Emeritus Professor of Public Health and Community Medicine of the University of NSW and Patron of the Alcohol and other Drugs Council of Australia. Among his many current commitments, he is Chair of the Alcohol Education and Rehabilitation Foundation, National Advisory Council on Suicide Prevention, the NSW Expert Advisory Group on Drugs and Alcohol, and a member of the Australian National Council on Drugs.

Since 1976, Ian has been honorary visiting physician to the St Vincent de Paul Society's Matthew Talbot Hostel for the Homeless; he is also a consultant physician in the South Western Sydney and Shoalhaven areas.

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

### PERSONAL JOURNEY HELPS THOUSANDS

JENNY TINWORTH

At the age of 14, Cynthia Morton was homeless, dyslexic, traumatised by years of sexual abuse and domestic violence, and about to embark on a 19-year journey into severe substance misuse.

The young teen could never have imagined that one day she would receive one of the nation's top honours for her work with people experiencing drug and alcohol problems. And yet, now 44, Cynthia has helped thousands of Australians heal from abuse, either self-imposed or at the hands of others. Their abuse ranges from substance misuse, sexual abuse and domestic violence through to eating disorders, gambling and workaholism.

Using a peer support approach, Cynthia and her Emotional Fitness Foundation have for the past seven years provided a resource which complements professional services such as counsellors and medical treatment. The Foundation has helped more than 7000 Australians to work with issues of abuse and/or addiction.

#### Life experience

'The worst part about my story is that it is so common,' Cynthia says of the journey that brought her to the national drug and alcohol awards night.

Born into a 'perfect Ken and Barbie' household where domestic violence and incest were common behind closed doors, the young Cynthia chose life on the streets as preferable to the abuse she suffered at home. Dyslexic and lacking a formal education, she quickly moved into experimenting with drugs and by the age of 15, a cocktail of substances had become her medication to dull the daily pain of living.

At 19, Cynthia met her first husband and together the couple embarked on a 'party life' – full of drink, drugs and sex. The birth of two sons did not slow them down, but for Cynthia, their existence would one day give her a reason to break the cycle. 'One day in 1995, I hit rock bottom. I contemplated driving off a bridge to end my life, but could not cope with leaving both my boys, who were seven and nine at the time, so I even toyed with the idea of taking them with me. I was insane,' she says.

Instead she chose to live a new life. Her decision to change signalled the end of her marriage and the beginning of an unpleasant reality of facing emotional pain without drugs. The switch was almost too much. Fifteen months later, Cynthia was admitted to a psychiatric hospital suffering from post-traumatic stress disorder. There she began to use art and writing as powerful healing outlets which offered her a non-judgmental method of exploring her feelings and continuing her recovery.

She also self-published a book, *A helping hand*. It quickly became a top 10 bestseller. She later wrote a second book, *Emotional fitness*.

#### Helping others heal

Cynthia is now a sought-after public speaker and the chief executive officer of the Emotional Fitness Foundation, a national charity which since 2000 has operated from the Royal Brisbane Women's Hospital. Its purpose is to provide peer support and emotional growth for people recovering from abuse and addiction.

'We're a peer support program which is not just abstinence-based,' she explains. 'We've found that there is not a lot of support out there if you are at a stage where your focus is on cutting down your use or just reducing the harm you are causing yourself.'

'We are based on abuse and addiction, rather than just focusing on addiction.' This important distinction comes from Cynthia's own experience of finding that the pain of abuse was so great once she had addressed her own addiction problems.

'Our aim is to help people stop the inner verbal abuse that they put themselves through,' Cynthia explains. 'I believe there are three factors which are important to recovery – professional help, peer support and finding a spiritual element you can connect with. That spiritual factor might be God, Buddha, nature – whatever works for the individual. Often people will combine their work here with yoga classes, traditional therapy or reiki.'

#### Looking to the future

Winning the Prime Minister's award has given Cynthia's vision a boost. She plans to increase the availability of the Emotional Fitness program nationally and is hopeful that the award will help secure recurrent funding for the Foundation. Until now, it has operated on one-off grants from Queensland Health.

And for a woman who has journeyed from life on the streets to CEO, the award is more than just an acknowledgment of professional achievement.

'The moment that the Prime Minister announced my name and spoke about the value of my work, was one of the highlights of my life,' she says.

For more information about Cynthia Morton and the Emotional Fitness Foundation, visit [www.emotionalfitness.com](http://www.emotionalfitness.com) or phone (07) 3666 0722.



Cynthia Morton ... a long journey

Photo courtesy of Encapture Photography

## Excellence in services for young people

### PUTTING CARE WITHIN REACH

PAUL WEIGHT, BAYSA, VICTORIA

The Barwon Association for Youth Support and Accommodation (BAYSA) program began as the result of a significant drop in treatment access occurring in 2001–2003, when the number of young people participating in youth residential withdrawal was as low as two in south-west regional Victoria.

BAYSA, with the support of the Barwon South West Youth Alliance, was granted \$250 000 over two years by the AER Foundation, with the first team of regional youth AOD outreach workers starting work in September 2004. Within only six months of operation, the three youth outreach workers had engaged with up to 315 young people, resulting in 140 episodes of care, and access into withdrawal services increased to 18 admissions.

BAYSA established outpost and service protocols with regional services like Glenelg Southern Grampians Drug Treatment Services, and the co-location of youth outreach workers with Western Region Alcohol and Drug Centre – a base for outreach operations from Warrnambool. During 2004–06, outreach workers travelled up to 3000 kilometres each week – one in every seven episodes of care being for Indigenous youth – and provided treatment to 247 young people. Around 480 young people in total were engaged through outreach functions,

which is a huge measure of the success of the program. An external evaluation in September 2005 indicated that the following service types were accessed through outreach:

- 17% – youth residential withdrawal
- 47% – AOD counselling
- 15% – drug education
- 9% – drug diversion
- 7% – mental health
- 4% – supported accommodation
- 1% – home-based withdrawal.

The evaluation identified that 15–19 year olds were the largest group engaged in the program and the primary drugs of concern were alcohol (86%) and cannabis (83%) followed by tobacco and illicit substances.

A regional youth outreach model is to be released this year. Further information is available from BAYSA Drug Prevention and Treatment Services – [dtp@baysa.org.au](mailto:dtp@baysa.org.au) or telephone (03) 5244 7372.



Paul Weight, Josie Taylor and Tony Harrison from BAYSA receive their award

Photo courtesy of Encapture Photography

## Excellence in treatment

### THE EAST PERTH NEUROPSYCHOLOGY CLINIC

DR KYLE DYER, SCHOOL OF MEDICINE & PHARMACOLOGY, UNIVERSITY OF WESTERN AUSTRALIA



Kyle Dyer (R) and Mathew Albrecht analyse the saliva drug test results of a client.

Each patient receives a neuropsychological screening battery that has been specifically designed for the WA treatment population.

On the basis of the screening results, patients may require a comprehensive neuropsychological assessment which is conducted in subsequent sessions. Next Step clinicians are provided with detailed summaries of the neuropsychological functioning of their patients, as well as suggestions for their treatment regimen. Drug-induced neurological harm may significantly impact on the effectiveness of drug-dependence treatment, either by

The East Perth Neuropsychology Clinic (EPNC) was established in 2004. The clinic, based at the Next Step drug treatment service in East Perth, is a collaboration with the Schools of Psychology at the University of Western Australia and Murdoch University; it is operated by volunteer postgraduate psychology students under the supervision of senior academics.

The clinic assess the cognitive functioning of patients before they receive treatment at Next Step Drug & Alcohol Services.

reducing the retention of patients in treatment or by requiring additional interventions for neurological impairments. However, neuropsychological assessment and interpretation requires trained psychologists, and is not usually possible within the budget and workload constraints of drug-dependence treatment services. The EPNC is unique as it incorporates a clinical service within tertiary education, workforce development and research frameworks. Students are able to develop knowledge, skills and experience with patients receiving treatment for drug dependence, as well as receive training from clinical psychologists, neuropsychologists and pharmacologists. Clinicians receive information and support to assist them to design effective treatment.

In the first year of operation the clinic assessed over 100 patients, provided over 2000 hours of student supervision and numerous training sessions for Next Step clinicians. Importantly, it was found that over half of those people with alcohol dependence, and all of those who used methamphetamines, demonstrated some level of cognitive impairment.

Nonetheless, by incorporating the results from cognitive assessments to develop individualised treatment approaches, the EPNC significantly increased the effectiveness of the treatment provided at Next Step.

## Excellence in prevention

### KEEPING PREVENTION SIMPLE

KRISTINA DEVLIN, KIS COORDINATOR, MANLY DRUG EDUCATION AND COUNSELLING CENTRE, NSW

The idea for Keep It Simple (KIS) was developed in mid-2003. A conversation between Kerri Lawrence, manager of Manly Drug Education and Counselling Centre (MDECC), and Michael Gordon, a young, forward-thinking clubber, revealed his concern for the health and welfare of many of his clubbing pals. He was concerned that young people regularly using 'club drugs' had little access to credible information and that some worrying myths were circulating through the dance scene.

Funding was acquired and the first steering committee convened in April 2004. Michael was contracted as the peer coach; he had great contacts within the club scene and was responsible for developing quality partnerships with club owners. The project aims of delivering credible drug information with harm prevention messages, as well as informally monitoring the club scene, were established.

Three months later, I was recruited to KIS after attending the Club Health 2004 conference in Melbourne. (I was there representing 'Crew 2000' from Scotland, one of the peer education projects on which KIS is modeled.) In true peer education form, we completely modified the Crew 2000

and other models to best suit the Sydney clubbing context.

We recruited 15 fantastic young people who were mostly at university and also working part time. Their energy, dedication and input ensured that KIS stayed innovative and accessible to their peers. For example, KIS peers requested mental and sexual health training on top of the drug education because these issues were cropping up and seemed to dominate the flipside of drug use.

That the peers were deemed highly approachable by the target group is a major outcome of the project. We spoke to over 2000 young people in clubs, and had 650 hits to the peer-created website. We cultivated relationships with rave/event promoters and club owners to foster a culture of more responsible clubbing environments for their patrons. The project is highly sustainable, and further peer intakes will mean that a large network of highly trained and credible young people can dispel myths and shape attitudes 'on the dancefloor' where it is most needed.



The KIS team in action (L to R): Ashleigh Stitt, Elisha Richards, Anthony Yong, Che Walsh Kemp and Hannah McHugh

Photo courtesy of Kristina Devlin

## Excellence in alcohol and drug media reporting

### TRIPLE J AND DRUG REPORTING

STEVE CANNANE, TRIPLE J 'HACK' TEAM

I believe good reporting on drug and alcohol issues can save lives. At triple j, we've considered it our responsibility to give out straightforward information about the dangers of drugs – both legal and illegal. We know a certain proportion of our audience will ignore these warnings. With this in mind we also see it as our duty to give out information that can minimise harm to those who decide to take drugs.

Some of the topics we've covered on the 'Hack' program include:

- a cannabis and mental health special
- drug testing in schools – does it reduce harm?
- ecstasy – is it addictive?
- drink spiking – how to avoid it
- increased methamphetamine use – and increased meth psychosis.

Earlier this year I spent a Saturday night reporting from the Emergency Department of St Vincent's Hospital in Darlinghurst, Sydney. I saw a stream of alcohol casualties and one incredibly disturbed patient with crystal meth-induced psychosis. But the image that stayed with me the most was that of a man in his twenties on life support. He looked like any other young bloke you'd see out on a Saturday night. The

difference was he'd overdosed on GHB at home, had gone into a coma, and had no-one around to wake him up. A day later this young man died. His family and friends were devastated.

This young man's death was avoidable. If you get someone who's 'dropped' from GHB into hospital on time, you can save their life. Do not take this drug alone at home, or without a friend present who is not taking it. We've been telling our listeners this since we first found out about this drug. Maybe if he'd heard one of our shows he would still be alive.

Just as I believe good reporting can save lives, I believe bad reporting can cost lives. Sensationalism and hysteria does not sit well with cynical young people who use, or are thinking about using drugs. Why should they believe these beat-up merchants? It becomes a lost opportunity for good information. Bad reporting prevents a serious and rational debate about harm minimisation policies that could help save lives. Watch the attack dogs of the press jump on anyone who questions current government drug policy.



L to R: Ali Benton, Cath Dwyer, Steve Cannane, Ronan Sharkey and Alice Brennan

Photo courtesy of Encapture Photography

## Excellence in law enforcement

### ONE STEP AHEAD ON THE BEAT

SUPERINTENDENT MIKE KEATING, CAIRNS POLICE DISTRICT

A police-led program is helping to reduce homelessness and alcohol-related problems in the Cairns central business district. The Homelands Partnerships is not only boosting the health and welfare of the homeless but improving the perception of safety in Cairns. The program seeks to help people – primarily from the Cape York and Lockhart River areas of Queensland – who become displaced after moving to Cairns. It provides them with the support they need to return to their communities.

"The program has allowed homeless people to be treated with dignity and has broken down the cycle of alcoholism and homelessness in the central business district of Cairns," says Assistant Commissioner Peter Barron, from the Far Northern Police Region.

Since Homelands was introduced in July 2004, 28 people have been housed in temporary accommodation, 17 people have entered alcohol rehabilitation and 149 itinerants have voluntarily returned home to their communities. As many homeless people feel trapped in a cycle of mounting debt, Homelands has also helped 282 people pay off outstanding fines by assisting them in structuring an automatic payment from their fortnightly pension.

Cairns City Police Beat also initiated the Homelands Partnership to identify the reasons behind people becoming homeless. Police, liaison officers and government

representatives spoke with homeless people and identified that the majority were Indigenous and many had arrived in Cairns from surrounding communities for medical treatment, or had been released after serving prison sentences in Cairns.

Many wanted to return to their communities but did not have the knowledge or provisions to organise a trip home. Senior Sergeant Owen Kennedy, Officer in Charge of the Cairns City Police Beat, says many homeless people were circulating through the criminal justice system. 'It was important to tackle the issue at street-level, to break the cycle and bring about long-term change,' he notes. A number of other related issues had to be considered, such as poor mental or physical health due to alcoholism, communicable diseases or substance abuse.

The program was greatly helped by the Department of Aboriginal and Torres Strait Islander Policy, Centrelink, Queensland Health, Department of Communities, Corrective Services (Jails) and Cairns City Council. Community organisations and local businesses also played a key role in providing support including reduced airfares and transport, temporary accommodation, food and clothing assistance, and medical services.



The Homelands Partnership Project Team

## Excellence in research

### INDIGENOUS RESEARCH: MAKING A DIFFERENCE

DENNIS GRAY, NATIONAL DRUG RESEARCH INSTITUTE, CURTIN UNIVERSITY OF TECHNOLOGY, WA

The NDRI's Indigenous Research Program was established in 1992 and has undertaken over 30 projects in conjunction with 27 Indigenous community-controlled organisations in Western Australia, South Australia, the Northern Territory and Queensland. Among these projects are:

- an evaluation of the Tennant Creek liquor licensing restrictions
- a study of the harm reduction needs of Indigenous people who inject drugs
- the policing implications of volatile substance misuse
- mapping the distribution of substance misuse intervention projects for Indigenous Australians
- identification of elements of best practice in Indigenous substance misuse interventions.

Indigenous capacity building has been an important focus of the team's activities. Positions have been established for Indigenous people and provisions for training, mentoring and support have been put in place – including employment of a staff member whose sole role is that of Indigenous staff support. The team has also established a joint research internship with Aboriginal Alcohol and Drug Services in Perth and, perhaps most importantly,

has helped Tangentyere Council in Alice Springs to establish its own research unit.

A third focus of the team's activities has been disseminating information about Indigenous alcohol and drug misuse, and measures for its prevention. Some of our activities have included establishing a web-based bibliographic database on Indigenous substance misuse, the publication of several review articles, circulation of publications to agencies working in the area, and presentations on substance misuse to Indigenous community-controlled organisations and government agencies.

The team's research has had positive impacts at regional, state and national levels. However, the team is particularly proud of its work with local Indigenous organisations. Commenting on this, an independent review of NDRI reported: 'Having built long standing relationships with many Aboriginal communities there are now many examples of NDRI's work having resulted in structural changes and policy interventions in specific Aboriginal communities.'



Dennis Gray (L) and Anna Stearne (R) from NDRI, with Dr Neal Blewett at the Awards

Photo courtesy of Encapture Photography

## SCHOOL DRUG EDUCATION:

Australia has a commendable history of drug education programs in schools, dating from the late 1960s. Many of these programs were informed by the prevailing government drug policies of the day, as well as by overseas influences, which has led to overall mixed results. In this *Of Substance* feature, we outline the different tensions currently existing with drug education in Australia, plus review past policies and some recent successful programs. Further on, US education expert Rodney Skager talks about a new approach to drug education there.

### Harm minimisation vs zero tolerance

Australian school-based drug education has had varied results, with some programs reporting reduced drug use, some showing no impact, and others associated with an increase in drug use. Part of the problem is a lack of clarity about the precise aims of drug education, says Professor Ann Roche, Director of the National Centre for Education and Training on Addiction (NCETA) at Flinders University, South Australia. She points to the great divide between different discipline perspectives.

'People from the health field, specifically the alcohol and drug field and politicians, are interested in particular behaviour outcomes. They don't want people to use drugs at all, or they don't want young people to use alcohol in a risky manner. It's very specific behaviour. But teachers will tell you very directly that they are interested in pedagogical issues, in what students learn and think about. So the goals of those who are expected to implement drug education are very different from what those in the health field want. These are dilemmas that are not well understood or articulated.'

Another issue is the ambivalence of the Federal Government regarding a harm minimisation approach, says Judy Pettingell, lecturer in the Faculty of Education and Social Work, University of Sydney. 'Most governments see the pragmatic benefits of harm minimisation, but community attitudes are still not in support

of any strategy as broad as that. There's wide public support for abstinence and the government overtly aligns itself. Until as a society we've sorted that out, it will be difficult for drug education to really move ahead.'

Zero tolerance simply doesn't work, says Roche. A number of Australian schools have addressed drug issues with strong exclusion policies, but a body of evidence shows it's the last thing you want to do. 'I did some work in the rural areas of Queensland where kids were excluded from school, but there was nowhere else for them to go. That makes a young person very vulnerable and increases their chances of getting into difficulties with alcohol and drugs.' Young people need to stay on at school, and be kept engaged and rewarded, she says, because this approach is the best kind of prevention.

### A long-term commitment

The broad purpose of drug education is to equip students with the skills to make responsible decisions about drugs in different settings, says Dr Richard Midford, Associate Professor at Australia's National Drug Research Institute. He laments the government's lack of commitment to the development of effective programs, and the emphasis on short-term, palatable outcomes that fit prevailing political rhetoric.

'For example, if you look at the current National Drug Education Strategy, the goal is "no illicit drugs in school". I immediately have a problem with that, firstly because the drug that causes young people most harm is alcohol, and secondly because the focus is on a particular setting. We need to give young people skills to make better, safer decisions not just while they are at school, but into adulthood.'

Drug education is targeted at school-age youths because they are a naturally captive audience, says Helen Cahill, Deputy Director of the Australian Youth Research Centre in the Faculty

## LOOKING FOR DIRECTION

ANGELA ROSSMANITH

of Education, University of Melbourne. 'However, the group taking most risks with alcohol, cigarettes and illicit drugs are 18-27 year olds, but we don't have a way to access them.'

Effective programs would result in reduced uptake in this group, says Midford, but what's needed is a long-term commitment to develop such programs and provide funding for training. Cahill points out that professional development is critical for teachers delivering drug education programs, to show them ways to engage students in problem solving and critical thinking within a broad health and personal development curriculum.

### A role for schools

School is an important setting for drug education, despite the limited success of past approaches, says Roche. But as part of a drug prevention strategy, schools can be very powerful in a different

way, by improving social capital and social connections. 'If young people feel strongly valued, have good social support mechanisms and a sense of purpose, they are less likely to have problems around alcohol and drugs.' Many schools are already doing this very well, but there may be no formal recognition that their approach contributes to the prevention of drug problems, she says.

Certainly, best practice sees schools embed drug education in their more general wellbeing and welfare policies, but the perception of drug education as a separate issue persists, says Cahill, who has developed many programs. 'With drug education as part of the health curriculum, teachers can feel pressed for time and end up delivering just the knowledge-based component which we know from research doesn't work. Young people need those other interactive elements to develop their skills and understanding.'

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## A historic perspective

Drug education began formally in Australia in the late 1960s, after a surge in illicit drug use by young people. Until then, the use of drugs was confined to medical and scientific purposes, and drug education was discouraged because it was believed to encourage experimentation.

In the early 1960s, the trend towards the use of cannabis and LSD in overseas countries was reported in Australia, with politicians assuring that the trend would not spread here. But when the media reported an incident in Sydney involving teenage girls taking LSD, drug education was incorporated into the health education syllabus.

This early approach to drug education was based on 'no substance use', an approach that still informs the purpose and practice of drug education in schools in the United States (Beck, 1998). The harmful effects of drug use were emphasised, together with the threat of legal consequences.

'It was in Sydney that much of the illicit drug use was going on,' says Judy Pettingell, whose PhD thesis explores the history of drug education policy in NSW between 1965 and 1999. 'During this time there was a lot of fragmented education in schools, with police and churches involved. Then the first health education unit was set up in the NSW Department of Public Health, and they developed a curriculum based on discussion and information, rather than on scare tactics.'

A National Drug Education Program was established by the Commonwealth Government in 1970, with funding to be shared by the states and territories. Apart from the covert goal of abstinence, many other principles of the program continue to inform drug education in Australia: a low-key approach;

integration into health education curriculum; countering the myth that drug use is the norm; interactivity and evaluation as important elements (Midford et al. 2006).

A turning point came in 1985, when a national drug policy emerging from the Drugs Summit focused on harm minimisation rather than abstinence. There were calls for drug education to be part of the core health curriculum in schools. Drawing on the modest successes of new American programs, Australia developed drug education programs that was aimed at teaching young people to resist social pressure.

In 1994, the Federal Government established a new initiative, the National Initiatives in Drug Education (NIDE) program, with the aim of increasing the involvement of the education sector in the national drug strategy (Midford et al. 2006). Harm reduction was prominent as a goal in the program. However, a spate of overdose deaths among young people in the mid-1990s led to a call for abstinence, and governments publicly committed to that goal. In 1997 the Federal Government launched the 'Tough on Drugs' campaign, and increased funding for drug education. They also transferred responsibility for drug education from the health department to the education department, with an attendant shift in emphasis.

Helen Cahill notes that the history of drug education in Australia is multi-layered, and that while national initiatives are referred to, it is the state initiatives that play the greater role. 'It is in the states that most of the work goes on,' she says.

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## Success with harm minimisation: SHAHRP

Although most drug education has been focused on abstinence, driven by similar policies in the United States, an approach based on harm minimisation has shown promising results. Dr Nyanda McBride, Senior Research Fellow at the National Drug Research Institute, Curtin University, established the School Health and Alcohol Harm Reduction Project (SHAHRP) to experiment with a harm minimisation approach to alcohol in particular. SHAHRP is the first study of its kind in the world, and won the 2004 Excellence in Research Category of the National Drug and Alcohol Awards. It was built on practitioner information, focus groups with young people, and a systematic literature review of research evidence. 'A lot of information went into the development of the program to give us the best chance of success,' says McBride. 'By success we mean change in behaviour — less risky use of alcohol and less harm experienced from use.'

The approach incorporates non-use and delayed-use strategies, as well as strategies to reduce harm from young people's own use of alcohol, and to reduce harm from other people's use of alcohol.

'In Australia, the number of young people who drink alcohol from a young age is increasing and getting younger and younger so we had to cater for those who were drinking and those who weren't,' says McBride. 'We looked at ways of providing them with strategies based on what they told us in focus groups, and contextual issues like what kind of parties they attend, where they get their alcohol, and what type of alcohol, and we talked about strategies for minimising problems they might encounter. They could be problems with parents or with friends, or exposure to physical violence, or sexual advances. Many different things were discussed within the program. It's a very practical program. We've incorporated "utility knowledge", information young people can use. For example, one of the foundations of the program was learning what a standard glass of alcohol was, and how long it takes to digest. Young people often have no idea.'

The program was conducted in two phases: eight lessons delivered in Year 8 (13 year olds), and then five lessons in Year 9 (14 year olds). A baseline survey was followed up for 32 months to detect changes in behaviour.

'We had strong behavioural findings from the students involved in the program compared to others involved in normal drug education in their school. During the first and second phases, the students involved consumed 31% less alcohol than their counterparts. Risky drinking was cut by 26% after the first phase and 34% after the second phase. This is significant, because risky drinking is probably the key behaviour we want to change.'

The success of the program has attracted national and international interest. 'The last stage of the research involved dissemination to the government, Catholic and Independent school sectors in four states of Australia. South Australia in particular has a coordinator whose primary role is to train teachers in SHAHRP,' says McBride. 'And Canada, Scotland and Ireland have started using the material. We've proved that we can create behavioural change in kids that means less harm from alcohol, and it's been picked up.'

For more information about SHAHRP visit:  
www.ndri.curtin.edu.au/shahrp/index.html

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### Research

Most published research comes from America, and this is problematic, says Cahill. 'Their context is very different. Our rules are different. We have a much more practical, less sensationalist, less emotive approach to drug education.'

The area is dominated by American research, says Midford, so the tendency is to look there for models that work well, yet world-class drug education research has been conducted in Australia, such as the School Health and Alcohol Harm Reduction Project (SHAHRP) (see left panel).

Roche believes that the SHAHRP program is the most significant piece of research that's been done in Australia. 'It was very successful in countering (American) criticisms that young people would not understand concepts like "harm reduction". That study showed that they do have that level of finesse.'

'Research in Australia suffers from a lack of funding and a lack of prioritising,' Midford says. 'There is funding for treatment and for epidemiological work, but not for drug education. One of the issues is that research is expensive and can take years to complete, but he also questions whether (education) policy makers value research on drug education. Producing evidence of behaviour change is not that relevant in the education context, where the focus is more about learning processes.'

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www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-publth-strateg-drugs-illicit-index.htm

Australian Government National Drug Strategy:  
www.nationaldrugstrategy.gov.au

## Effective education

Recent studies of the relevant drug education literature have revealed 11 critical components of effective drug education programs.

1. **Demonstration of program effects:** the most successful programs are those based on evidence of effect.
2. **A comprehensive approach:** whole-of-school and community-wide support for classroom messages provides a broader social context.
3. **Based on students needs:** programs are more effective if the content is based on the experiences and interests of students.
4. **Timing of the intervention:** drug education should start before initial experimentation and continue as young people mature.
5. **Realistic prevention goals:** harm reduction programs provide broader benefits than those based on abstinence and delayed-onset.

6. **Interactive teaching:** it is important to actively engage students in the learning process.
7. **Role of the classroom teacher:** training in drug education should be provided to classroom teachers, who are in the best position to coordinate the provision of drug education to students.
8. **Role of peers:** where possible, peer leaders should be used in place of, or in combination with, adult leaders.
9. **Social-influence approach:** programs based on the social-influence approach are the most effective.
10. **Content:** certain program content is essential.
11. **Coverage:** drug education programs should provide adequate coverage of the central issues.

**Source:** Midford, R 2006. Looking to the future: Providing a basis for effective school drug education, in *Drug Education in Schools: Searching for the Silver Bullet*, IP Communications, East Hawthorn, Victoria.

## The Gatehouse Project

JENNY TINWORTH

A landmark project developed by Victoria's Centre for Adolescent Health pioneered a new approach towards health promotion activities in schools. The project was based on attachment theory which suggests that positive psychological and social development occurs when young people have a secure emotional connection to key people such as parents, teachers and peers.

The project involved a randomised controlled trial (conducted in 1997-2000) with 12 schools, and a control group of 14 schools. It targeted key areas in the schools' social environment: a sense of security, communication, and positive regard through valued participation. Key elements of the project included:

- collection of a survey and other information about each school's social environment, used to set priority areas relevant to that school, such as preventing bullying or increasing participation
- a school adolescent health team which coordinated the project and developed school-specific strategies
- ongoing consultation with a member of the Gatehouse Project team.

Given that strategies were developed by each school rather than by the Gatehouse Project team, the work of the project was slightly different in each of the intervention schools. The Gatehouse Project used whole-school strategies to encourage strong connections between staff and students, including altering classroom structures, professional development for teachers, extra-curricular activities and recognition of academic, sporting, social and other achievements. It promoted a positive classroom climate and developed curriculum activities to help students deal with life's challenges.

### Evaluation

Evaluation was carried out via student surveys, first in Year 8 and then in Years 9 and 10, and post-Year 12. Students were questioned about school, friends and others in their lives. The surveys also asked questions relating to emotional wellbeing and behaviours such as alcohol, tobacco and other drug use. Both across the years of the trial and in two subsequent Year 8 groups surveyed, rates of reported smoking, drinking and cannabis use were reduced in students from the intervention schools, compared with those in the control schools.

### Prevention literature

The Gatehouse Project is a good example of the drug education principles revealed by an extensive literature review exploring the prevention of substance use and harms. Published in 2004, the monograph *The prevention of substance use, risk and harm in Australia: A review of the evidence* explores the three pillars of Australia's drug policy: supply reduction, demand reduction and harm reduction.

The monograph provides an overview of risk and protective factors and interventions from birth to 24 years. It notes that school drug education has been one to the most commonly evaluated strategies and that programs which have a social influence approach, like that of the Gatehouse Project, are likely to be more effective than programs which only target the provision of information and education.

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Gatehouse Project website: www.rch.org.au/gatehouseproject

## AN UN-AMERICAN PERSPECTIVE on drug education for young people

RODNEY SKAGER\*

### Zero tolerance doesn't work

After 20 years of monitoring the ways in which the USA has addressed drug use among young people I am convinced that zero tolerance is bad policy. If anything is to be learned from our example, this is it.

The national Monitoring the Future Study has never shown a consistent downward trend in overall illicit drug use among youth. Neither has the California Student Survey which I have directed since 1985-86. The percentages for specific substances fluctuate from year to year, but overall prevalence remains constant.

How have we tried to stop substance use among young people? Favoured educational strategies include negative drug information in a traditional, didactic process; practising saying 'no' to peers who offer drugs; and being assured that most peers disapprove of use. On the dark side there is deterrent punishment for those who break the rules. Banning students from extra-curricular activities or suspending them from school are assumed to deter others from making the same mistakes. Wouldn't prevalence have declined significantly if these strategies were really effective?

### Make it interactive

It is widely agreed that drug education for young people should be interactive (Tobler & Stratton, 1997). On topics that intersect with personal lifestyle, young people want to share experience and air issues raised by that experience. A traditional instructional process in which teachers deliver information limits the degree of interaction.

Deterrent punishment for offenders is a second downside of zero tolerance. Following a public health (as contrasted to criminal justice) approach, schools would identify and assist young people whose lives are troubled by problematic drinking or using. Problematic use of substances can be reduced by harm minimisation information (McBride et al. 2004).

### Assisting students

Finally, humane intervention for troubled students is a form of prevention (of current and later problems). Some US schools do offer student assistance programs (SAPs) to help troubled youths. Unfortunately, Pennsylvania is the only state currently mandating these programs in all high schools. The flaw in our SAPs is their separation from drug education. It is as if there were no relationship between knowledge and personal experience. Intervention and assistance at the secondary school level should be incorporated into drug education. To achieve this, a learning climate that promotes more authentic relationships between adults and students is required.

I learned how this is done by observing students in an urban high school participating in the UpFront program (Skager, 2005). UpFront staff adopt the clinical role of facilitator rather than the didactic role of teacher. I saw high school students respond enthusiastically in a guided discussion that allowed them to feel involved and valued. The experience is educational, but by being flexible and personally relevant it encourages students to reveal how they feel about issues. Equally important, students who need help realise that it is safe to tell the facilitator about their alcohol or drug problem.

### Restorative justice

What about deterrent punishment, the true face of zero tolerance? The answer for me came from a Canadian school counsellor who sent me Australian writings on restorative justice. I later read the seminal book in this field (Braithwaite, 1989). Restorative practice starts when people affected by misbehaviour confront wrongdoers with the harms they have caused. These ideas had already arrived in my country. I soon discovered the International Institute of Restorative Practices (IIRP) in Pennsylvania (see references). The IIRP offers training in specific strategies for conducting restorative processes in schools. Interactive education, student assistance, and restorative practice are the three components of a model that I believe can and should replace didactic education and zero-tolerance punishment.

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\*Rodney Skager is Professor Emeritus at the Graduate School of Education and Information Studies, University of California, Los Angeles, consultant to the Drug Policy Alliance, and Co-Director of the California Biennial California Student Survey. This article is based on a presentation given at the Drugs and Young People Conference in Sydney in May 2006.

# STIGMATISED: TACKLING PERCEPTIONS OF DUAL DIAGNOSIS

MICHELLE L GIFFORD AND JANE BARTON\*

Can young people with drug and alcohol issues make an impact on service providers? When the production of *Stigmatised*, a group-devised piece of theatre was shown at a session of the 5th International Conference on Drugs and Young People in May, the standing ovation it received, the tears, questions and accolades it produced were an indication of the heartfelt response to the piece.

Initiated by the South Sydney Youth Services' Dual Diagnosis Team, the play was the result of an initial 12-week program that was extended at the request of the young people. Using a combination of tools including drama, community development, group therapy and peer education, the group met once a week for six months. One of the participants described the development process and production for *Of Substance*:

'For months we had worked hard to come up with a play that would allow others to look into the lives of people suffering from dual diagnosis. A piece of work that would make people tear apart their previous misconceptions and stereotypes and leave them with a whole new perspective on the subject.

'This was our third performance and we were performing in front of a large group of industry professionals. This was to be our biggest performance and I will happily divulge that I was on the verge of passing out from fear and anxiety. Our wonderful psychologist Julie Anne Geddes took the floor and gave a brief talk about South Sydney Youth Service and the work that they have been doing with people suffering from dual diagnosis. This was received with applause and then Julie Anne introduced our magnificent director James Winter.



### TREATMENT REALITIES

The performance is a group-devised piece. It starts off with one of the performers, quite chillingly, playing the role of a psychiatrist.

'So you're back in here again? Are you hearing voices again? Are there people chasing you?'

Then it continues: 'Fine then, if you aren't going to speak to me ...'

From this beginning, a series of small vignettes unfold illustrating young people's interactions with mental health services, and their relationships with drugs and peer groups. The overall sense conveyed is a realistic portrayal of lives lived in the shadow of drug use and mental health. It is not without hope. The genuine understandings and the honesty that the performers bring to the piece give it a strong integrity.

'Before I go on further with what happened on that day I would like to tell you what a wonderful job James Winter has done with our drama group. With his help and guidance and persistent positive attitude he has turned a disorganised motley crew into a group of professional actors. You see, this drama group really means a lot to us who are involved. To us it is a safe, fun environment where we are free to express our ideas, opinions and be ourselves without the fear of being criticised. Some of us who are involved do not have a lot going in our lives so it's very fulfilling for us to feel as though we are contributing to something which may make a difference.

'So, back to the performance day. After the first words, it seemed as though we were floating outside of our bodies watching ourselves perform. We were so caught up in trying to give the best performance possible that there was no time to have stage fright and worry about what the audience was thinking.

'Even when one of us forgot the lines the play still seemed to flow. It wasn't till we took our bow and heard the applause that I remembered where I was. We went to go and take our seats and the audience members started to stand up and cheer. I can't really describe the effect that it had on us, the best I can hope to come up with was we were in a state of delirium. When one of the audience members told us that she cried, I knew that the play we had worked on for so long had had the desired effect.'

\*Michelle L Gifford and Jane Barton write from the South Sydney Youth Service

## FROM SCHOOL TO WORK: A VULNERABLE TIME

KEN PIDD & ANN ROCHE\*

For many years we have struggled with ways to prevent risky alcohol use and the uptake of illicit drug use among adolescents. Much of our prevention effort has focused on school-aged children (with only modest success at best).

Virtually no attention has been directed to the more crucial school-to-work transition phase of a young person's life. As young adolescents mature, they pass through transition phases that often place them at risk of initiating and maintaining harmful alcohol and other drug use behaviours. Understanding how these behaviours develop during these transition periods is important.

### Social influence

Developmental explanations of adolescent drug use focus on the role of social influence and propose that as adolescents mature, they are exposed to a wider circle of peer and social groups. Thus, the influence of the social group is likely to increase at a time when alcohol and other drugs are more readily available. Supporting this perspective is research indicating that social influence plays a central role in explanations of adolescent drug use. For example, the drug-related behaviours and attitudes of both parents and peers have been shown to be consistent and significant predictors of adolescent alcohol and other drug use (Duncan et al. 1995).

**'Employed adolescents are more likely than their unemployed peers to use alcohol and drugs'**

It is often assumed, however, that this influence occurs only within family, school and social environments. While this may be the case for many teenagers, a substantial proportion are also exposed to powerful social influence in the workplace. Each year, large numbers of adolescents enter the workforce by engaging in part-time employment while still at school, leaving school for full-time employment, or leaving school for occupational training. Research concerning the occupational transition of adolescents consistently demonstrates a relationship between employment and drug use (Bell et al. 1999; Mihalic & Elliot 1997). Contrary to what might be expected, employed adolescents are more likely than their unemployed peers to use alcohol and drugs. The extent of harm associated with this use is unclear.

### Work and drug use

The increased substance use of employed adolescents is likely to be due to a number of factors including work stress or the stress of combining part-time work with secondary or tertiary level education. However, reinforcement for use and exposure to use by others are also more likely in the workplace compared to the school environment. In addition, older adolescent and adult

co-workers have the potential to be potent role models and their drug-related behaviours and attitudes can have a strong influence on younger workers.

The workplace is likely to be a particularly salient source of influence on adolescent workers' alcohol and drug-related behaviours and attitudes. The transition from school to work signifies a shift from childhood to adulthood and accompanying this transition is a release from parental controls and exposure to new workplace social and peer groups. These changes coincide with working adolescents gaining increased disposable income and increased choice in where, when, and with whom, they socialise.

### Workplace lessons

Starting work also means that adolescents begin to learn the skills, attitudes, values and behaviours necessary to integrate into the workforce as valued and effective members of the organisation (Feij 1998). Much of this adjustment occurs by observing the behaviours of others and conforming to workplace policy and controls that stipulate and regulate expected workplace behaviour. In many cases, these workplace behavioural norms and controls also extend to behaviours and attitudes concerning alcohol and other drug use.

This workplace socialisation process is consistent with social learning explanations of alcohol and other drug use. For example, it has been argued that alcohol use is essentially a learned behaviour that is subject to social and cultural influences (Roche 2001). Similarly, if we apply Bandura's theory (1977) that social behaviours are learnt by observing role models such as parents and other adults, it is logical that adolescents learn to drink by imitating the behaviour of parents, friends and peers.

In addition, for most adolescents workplace socialisation occurs at a crucial stage of identity development. The initiation of a career or full-time employment can have a substantial impact on both the development of an individual's identity (i.e. through a process of occupational training, education, and work experience, the person becomes a doctor, electrician, accountant, plumber, etc.) and social category (e.g. social status, income level). Therefore, as new entrants to the workforce, adolescents are particularly susceptible to influences evident there.

The importance of social influence on working adolescents' alcohol use was highlighted in a series of recent studies involving more than 300 young male apprentices (Pidd 2003). This research indicated that the pressure to belong to the work group and to be socially accepted by co-workers were important influences on young apprentices' work-related alcohol use. For example, while the majority of apprentices surveyed believed that their supervisors and co-workers would disapprove of alcohol use during work hours, they also believed that supervisors and co-workers

would not only approve of, but actively encourage, drinking with co-workers after work. It should come as no surprise that while less than 25 per cent of these apprentices reported drinking during work hours (including lunchtime), more than 70 per cent reported drinking with co-workers after work.

The alcohol and other drug consumption patterns of many adolescent workers not only places them at risk of alcohol and other drug-related harm, but may also affect safety and productivity in the workplace in general. Recent research by the National Centre for Education and Training on Addiction identified that young workers aged 14-19 years were the age group most likely to drink at risky levels, most likely to have taken a day off work due to their alcohol use, most likely to have consumed alcohol in the workplace, and most likely to have attended work under the influence of alcohol (Pidd et al. 2006).

**'Older co-workers have the potential to be potent role models'**

### A duty of care

These findings have important implications regarding employers' duty of care toward adolescent staff. Employers need to be aware of the potential influence of older workers and supervisors, and factors such as workplace policy on adolescent workers' consumption patterns. In particular, while the alcohol and other drug-related behaviours and attitudes of older workers and supervisors can have a negative impact on adolescent workers' consumption patterns, they can also be role models for low-risk alcohol and other drug use behaviours. The support of older workers and supervisors is often crucial to the success of workplace initiatives, such as policy or training, designed to minimise the risk of alcohol and other drug-related harm among adolescent new entrants.

However, despite evidence indicating the workplace is likely to be a significant source of influence on the initiation and maintenance of alcohol and other drug-related behaviours among adolescent workers, it remains a largely under-utilised setting for alcohol and other drug prevention and early intervention strategies that target adolescents.

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- \*Ken Pidd and Ann Roche write from the National Centre for Training and Education on Addiction.



## A DAY IN THE LIFE OF...

SUSIE COLLINS, YOUTH SUBSTANCE ABUSE SERVICE, VIC

The alcohol and other drug workforce covers a wide spectrum of people and jobs. In this series, *Of Substance* introduces you to some of the personalities who work in this field and the work they do.

**Of Substance:** What do you do?

**Susie Collins:** I am the senior outreach worker at the Youth Substance Abuse Service (YSAS) in Dandenong. I work with young people aged 12-21 who are experiencing significant issues due to problematic substance use.

**OS:** Describe a typical day on the job.

**SC:** There is no typical day! One of the reasons I love it is because it is so varied. A day could begin with picking up a client to take them to residential withdrawal. I might talk to their family about what to expect. On the way, I would attempt to ease the client's anxiety, as going to detox can be a fairly intimidating experience. Once there, I would help them to settle in.

After providing staff with handover information, it's off to see another client. This could be meeting someone at TAFE while they are having lunch. If they have reduced or ceased their drug use, relapse prevention education and general support would be provided. Then it might be back to the office to meet a Juvenile Justice client who is mandated to attend treatment.

Often these clients are ambivalent towards me, so I might spend some time building a relationship by taking them out for a meal or a recreational activity. Later, I might see a client who injects drugs, so I would educate them about safe injecting practices and vein care.

**OS:** Do you have any other duties?

**SC:** Part of my role is to do street outreach, which means going to areas where young people are known to congregate, such as train stations and shopping centres, and attempting to engage with young people who wouldn't access a service from an office-based setting.

I'm often known by some young people in the area, so I'll meet new clients through them. I'll also approach young people who I don't know if I believe they are in need of assistance related to alcohol and other drug use. I will sometimes give out lollies or glow sticks when doing outreach at a particular event such as Battle of the Bands.

As well as helping clients with issues around drug use, I might need to help them in other areas such as accessing Centrelink payments, accommodation, help to access education and training, or mental health assistance, just to name a few.

**OS:** What challenges do you face?

**SC:** At a grassroots level, the biggest challenge is the lack of low-cost housing and emergency accommodation for clients. I spend a lot of time trying to find somewhere for young people to stay, and often come up with nothing.

**OS:** How long have you been at YSAS? Where have you worked previously?

**SC:** I have been with YSAS for over five years. I was lucky enough to do my third year social work placement with the Box Hill outreach team, and now they can't get rid of me! I initially began as a casual outreach worker after my placement, and then a home-based withdrawal support worker. Then I became an outreach worker. Last year I moved over to the Dandenong team. Before YSAS, I worked at Coles! I also did volunteer work at the Sacred Heart Mission in St Kilda.

**OS:** What kind of training have you done?

**SC:** I have a Bachelor of Arts (Psychology), a Bachelor of Social Work and Master of Social Work. I am a little obsessed with studying.

**OS:** Any advice for people entering the AOD sector workforce?

**SC:** Remember that you are not God, and can only do your best. Don't let the weight of the world fall on your shoulders. The other piece of advice is to make sure that you take the time to stand back and appreciate what a privilege it is to be part of the lives of the people you work with.

**OS:** How do you relax?

**SC:** I'm a pretty relaxed person and don't really need any help to relax. I have recently started doing yoga five times a week. I'm a bookworm, too, and need to read to remain sane. Spending time with my husband, family and friends is my greatest way to relax.

**OS:** When was the last time you took a holiday?

**SC:** I went to Malaysia and Borneo last year. We are planning on heading overseas again at the end of the year. Because I love my job so much I don't ever feel that I need a holiday, just that I want a holiday.



## RESEARCH: THE NEED FOR TRANSPARENCY

IAN WEBSTER, DAVID CROSBIE & GINO VUMBACA\*

As information becomes a more powerful commodity, we need to look beyond what is being said and consider who paid for the message, what they want us to believe and why.

This is particularly true when considering the role of research in the development of public policy on alcohol and other drugs. Two recent examples where conflicts of interest have, or could, occur include the UK organisation Arise, and the newly established Drinkwise in Australia.

### Shining light on Arise

An article in the UK's *Guardian* newspaper earlier this year (February 2006) raised important issues for transparency of research in this area. The article describes the organisation Arise (Associates for Research into the Science of Enjoyment):

'Arise... described itself as "a worldwide association of eminent scientists who act as independent commentators". Its purpose... was to show how "everyday pleasures, such as eating chocolate, smoking, drinking tea, coffee and alcohol, contribute to the quality of life". It maintained that there were good reasons for dropping our inhibitions and indulging ourselves. "Scientific studies show that enjoying the simple pleasures in life, without feeling guilty, can reduce stress and increase resistance to disease... Conversely, guilt can increase stress and undermine the immune system... This can lead to, for instance, forgetfulness, eating disorders, heart problems or brain damage".'

Arise secured a high level of media attention, but the *Guardian* article shows all was not what it seemed:

'In 1998, as part of a settlement of a class action against the tobacco companies in the US, the firms were obliged to place their internal documents in a public archive... one memo suggests Arise was run not by eminent scientists but by tobacco companies. This impression is reinforced by another document in the tobacco archive, which explains how the group began. "In 1988 the US Surgeon General said: 'Nicotine was as addictive as heroin or cocaine'. The industry responded. A group of academics was identified and called together to... review the science of substance abuse... separate nicotine from these substances".'



### Wise spending on Drinkwise?

The Federal Government's May budget announced a \$5 million grant to Drinkwise, a new organisation set up by the alcohol industry. It remains to be seen whether Drinkwise will act independently, but its initial choice to tackle binge drinking amongst young people through a major media campaign is not a good omen. Such campaigns have a questionable history of success. As yet it is not clear how Drinkwise will work with other leading alcohol and other drug organisations and alcohol strategies around the country. A similar concern is expressed in an article which showed that as much as 48.8% of the alcohol industry's revenue in the US came from underage and pathological alcohol consumption in 2001 (Foster et al. 2006). It recommended:

'The financial interests of the alcohol industry appear to be antithetic to the public health interests of the nation in preventing and limiting pathological drinking... because of this apparent conflict of interest, the alcohol industry is not a good candidate to regulate its own marketing and sales practices, particularly as they relate to underage drinking.'

There is an uneasy and potentially unhealthy relationship between the 'alcohol industry' and the research community when the alcohol industry funds research. This is compounded when groups which receive funding from the alcohol industry, like Drinkwise, are responsible for not only research, but also developing and promoting messages about drinking.

### Whose wellbeing?

The issues are not always about who funded the research, but also about how it is interpreted. It is imperative that alcohol research, and indeed all research with potential to impact on public health, be conducted under the auspices of independent groups whose sole interests are the community or public health benefit. Research can be a powerful tool in debates and decisions on drug and alcohol public policy. There is often big money to be made and lost, particularly with licit drugs – alcohol, tobacco and prescribed medications. The need to ensure that our research is transparent and clearly identifies and declares any limitations or conflicts of interest is imperative in the public interest.

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\*Ian Webster and David Crosbie are members of the Australian National Council on Drugs (ANCD). Gino Vumbaca is the ANCD Executive Officer. Drinkwise has been invited to respond to this article.

## LEARNING THROUGH ACTION

BOB DICK\*

*Of Substance* continues its series exploring some of the different research techniques used to study alcohol and other drug issues. In this issue we look at action research.

**H**ow do you do good research when you don't know enough to frame a precise research question? When the situation is changing all the time? When you hope to bring about some change as you do the research? When the outcomes depend on the commitment of the people involved? It is precisely these situations that action research was designed to address. Using action research you can bring about change. You can research the change as you do so. So you could say that action research is action *and* research, integrated within a cyclic process involving continuous planning, action and review.

Action research can look disorganised. It may not be conducted by people who would traditionally be seen as 'researchers'. They may be known as frontline health staff, youth workers, service managers or even as people who use the substances which may be being discussed. Action research will evolve out of meetings which will bring some, or all, of these people together to contribute ideas and strategies about a situation they want to change.

The action research meeting provides a forum for the group to decide strategies or 'actions' they want to take to address the challenge they are working on. After those actions have taken place, group members can observe any changes which occur and report back to the next meeting.

In other words, much action research alternates between meetings and community action. The meetings review what has happened since the previous meeting and plan what will happen before the next meeting. Figure 1 summarises the cyclic process (see below).

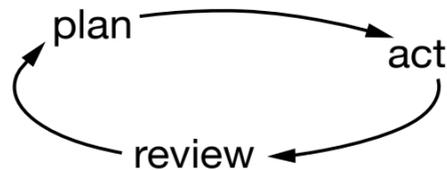


Figure 1. *The action research cycle alternates between action, and critical reflection consisting of review and planning.*

In the article which began this series, David McDonald (2005) subdivided research into observational studies and intervention or experimental studies. Different research approaches suit different purposes. For instance you might use observational studies when you don't wish to influence the situation, and where experimental studies are not justified. Action research on the other hand deliberately sets out to *change* the situation; it is an intervention study. But it is not 'experimental' in the sense in which that word is commonly used.

Suppose you have a precise research question such as 'Does treatment T produce outcome O?'. A randomised control

trial, where a treatment group is compared to a control (or 'no treatment') group, is the approach most likely to give you a reliable answer. That's the sort of question experimental methods are intended to address with assurance. Certain conditions must be met, however. Experimental methods require precise research questions and control groups. People in the sample don't know if they are receiving the treatment or a placebo. Quantitative measures are used, and the people doing the measuring don't know whether the people were from the treatment group or the placebo group.

Suppose instead your question is 'How can we design a treatment that will work best *in practice* with this particular group of clients?'. Randomised control trials may then serve you less well. We know that in practice people often do not carry out a treatment exactly as prescribed. As soon as you have to take people into account the outcomes of a treatment become much less predictable. We also know from the Boston Consulting Group Study of 2003 that about two-thirds of the time this compliance problem isn't forgetfulness or an inability to carry out the treatment; it is the result of a conscious decision by the clients to vary or discontinue their treatment. How then do you develop a treatment which people will *want* to follow?

Often we want a treatment that will work in practice as well as in theory — a treatment that will lead to successful action even when people are behaving as they sometimes do. A treatment that will be acted on. That's where action research can be effective.

### The 'action' in action research

Involving clients in planning the treatment is more likely to develop a treatment that is feasible in practice. For example compared to health workers, substance users are likely to bring a very different perspective to the research. This may allow the action research team to consider issues which are important, but which non-users may not know about.

More than that, clients tend to be more committed to decisions which they have helped to make. It is for reasons like this that action research is increasingly being used in the field of community health generally, including substance use. The Oxford House project (Jason et al. 2006) provides an example. It is an ongoing 13-year collaborative relationship between DePaul University, Chicago, and a system of democratically operated homes for addiction recovery. It uses action research as its overall research strategy.

Most action research is participative. As with the Oxford House project, the participants are likely to feel affirmed by being given more control of their own destiny. For many action researchers this is an important ethical reason for their choice of action research.

At this point, I imagine some of you are thinking that you can understand how action research increases the likelihood of action. You may also like the practical emphasis and the way in which all participants are treated as equals in the research process. But what about the research? Where does it come in?

### The 'research' in action research

It's true that action research can't achieve a research rigour in the same way that a method such as a randomised control trial can. Community action tends to be an ever-moving kaleidoscope of events. Experimental control isn't easy. Action research therefore tends to be qualitative or descriptive. (It can also accommodate quantitative methods when that's useful.)

Action research therefore needs its own sources of research rigour:

- Being participative, it takes into account a wide range of views from different perspectives. In their planning and review, people reconcile these differences. They learn from one another.
- Using action research you can fine tune the research methods as well as the treatment strategies as you proceed. You don't have to get everything right at the beginning. If something doesn't work in practice, you and the other participants can amend it until it does.
- Importantly, in each turn of the action research cycle (*plan » act » review » plan ...*) the plans are immediately tested in action. Each turn of the cycle is a miniature experiment. The *review* in each cycle builds in an ongoing evaluation of what you are doing and how well it is working.

The rigour of action research can be further increased by working with very diverse groups, being explicit about the theoretical assumptions which underpin your plans, and encouraging a climate of openness. Most importantly you can make it part of your regular practice to seek out evidence and opinions which don't fit with current preconceptions. This will lead you to a deeper understanding of what is happening and what you can do about it.

For example, some years ago I was working with the Student Services Unit at a Queensland university. The purpose was to help them improve the services they offered. I met regularly with the students who were involved in doing the research. In these meetings students would report the patterns emerging in the data

they collected in their interviews of other students. Whenever they did so, we would then probe in our interviews for exceptions to these patterns.

### Action and research

Different research methods serve different purposes. Observational methods, especially descriptive studies, allow you to research a situation without requiring a great deal of prior understanding and without having an influence on what happens. Experimental methods, and especially randomised control trials, let you determine with some assurance if a certain carefully prescribed treatment produces certain clearly defined outcomes.

However, perhaps that's not your situation. Perhaps you don't yet know enough to have a precise research question and a precise treatment regime. Perhaps the situation is too complex for you to be able to control everything. In particular, perhaps the effectiveness of a treatment depends as much on the commitment of the people involved as on the treatment itself. A research approach that combines action and research may then be an effective choice. You might choose action research for this purpose. It has its own sources of rigour — including the testing of assumptions in practice. As it combines action and research within each turn of its cyclic process, it integrates theory and practice both within each cycle, and overall.

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- \*Bob Dick is the editor of the *Action Research International* journal and writes from Southern Cross University, NSW.

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## Upcoming conferences

9-10 October 2006

**NADA Conference 2006**  
**'Mental health in non government alcohol and other drug services'**  
Manly Pacific Hotel, Sydney

For more information visit [www.nada.org.au](http://www.nada.org.au)

11-14 October 2006

**18th Annual Conference of the Australasian Society for HIV Medicine**  
Carlton Crest Hotel, Melbourne

For more information visit [www.ashm.org.au/2006\\_conf/](http://www.ashm.org.au/2006_conf/)

22-25 October 2006

**3rd International Conference on Alcohol and Harm Reduction**  
**'Creating Realistic and Concrete Solutions'**  
Cape Town, South Africa

For more information visit [www.ihra.net](http://www.ihra.net)

5 November 2006

**National Drug Trends Conference**  
Cairns Convention Centre, Queensland

For more information visit <http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/page/Conference>

5-8 November 2006

**2006 APSAD Conference**  
**'Drugs: Meeting New Challenges'**  
Cairns Convention Centre, Queensland

For more information visit [www.apsad.org.au](http://www.apsad.org.au)

13-15 November 2006

**Youth Health 2006**  
**'Young People's Health: What's it going to take?'**  
Olympic Park, Sydney

For more information visit <http://www.youthhealth2006.org/>

22-24 November 2006

**The Australasian Therapeutic Communities Association's Annual 'Research and Practice'**  
Auckland, New Zealand

For more information visit <http://www.odyssey.org.nz/ATCA-Conference.htm>

26-28 February 2007

**Thinking Drinking II**  
**'From Problems to Solutions'**  
Melbourne

For more information visit [www.adf.org.au](http://www.adf.org.au)

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

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