

OF SUBSTANCE

JANUARY 2006 VOL. 4 NO. 1

THE NATIONAL MAGAZINE ON ALCOHOL, TOBACCO AND OTHER DRUGS

PETROL SNIFFING & ALTERNATIVE FUELS

Tackling a major health problem

DRUG TRENDS

The latest
Australian data

MULTICULTURAL COMMUNITIES

Informing about
drugs and alcohol

MEDICAL CANNABIS

Latest research and policies

ANTI-SMOKING CAMPAIGNS

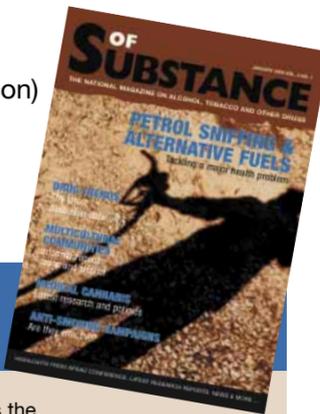
Are they effective?

ISSN 1449-0021

HIGHLIGHTS FROM APSAD CONFERENCE, LATEST RESEARCH REPORTS, NEWS & MORE ...

SUBSCRIBE TO OF SUBSTANCE

- *Of Substance* is now a **free** quarterly magazine
- Subscription forms are available at www.ancd.org.au (click on *Of Substance* icon)
- Back issues of *Of Substance* are available as PDF files at www.ancd.org.au
- Inquiries about overseas subscriptions and for bulk orders (over 10 copies) to distribution@ancd.org.au



Advertise in *Of Substance* – The magazine will consider full- or half-page advertisements. Current rates (excluding GST): • \$1000 for a full page • \$600 for a half page

Of Substance is governed by a Board of Management.

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

Members:
Trevor Fearnley AM, Chief Executive, AdPartners Group.
Robert Olney, Manager, Marketing and Communications, Australian Federal Police.

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

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

Dennis Young, Executive Director, Drug-Arm Australia.

Managing Editors:
Jenny McKey Tinworth and Kate Pockley

Of Substance contact details:
Email: editor@ancd.org.au
Telephone: (02) 9280 3240 or write to us:
66 Bay Street, Ultimo
NSW 2007 Australia

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

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

Members:
David Crosbie, Chief Executive Officer, Odyssey House Victoria.

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

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

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

Wesley Noffs, Chief Executive Officer, Ted Noffs Foundation.

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

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

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

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

acknowledgment of the source and no commercial usage or sale. Reproduction for purposes other than those indicated above, require the prior written permission from the Commonwealth. Requests and inquiries concerning reproduction and rights should be addressed to Commonwealth Copyright Administration, Department of Communications, Information Technology and the Arts, GPO Box 2154, Canberra ACT 2601 or email Commonwealth.copyright@dcita.gov.au.

© Commonwealth of Australia 2006

Front cover photograph courtesy of Photolibrary. The magazine is designed by Juliet Fisher, AdPartners Group.

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

The views and opinions expressed in the articles in this magazine are those of the individual authors and do not necessarily represent the views of the Australian National Council on Drugs (ANCD), the Australian Government Department of Health and Ageing, the Salvation Army or any other organisations associated or involved with the ANCD.

This work is copyright. It may be reproduced in whole or in part for study or training purposes subject to the inclusion of an

Contents

Editorials	2
News and recent releases	3
Letters	6
NADA conference report	7
Petrol sniffing and alternative fuels	8
Background to a major health issue.	8
A long-term commitment needed.	10
Another day, another battle.	10
Medical cannabis	12
New research highlights the legal dilemma faced by desperately ill people who have turned to cannabis for relief.	12
Towards a National Cannabis Strategy	15
Research techniques: focus groups	16
<i>Of Substance</i> explores the value of this research approach.	16
APSAD Conference	18
An overview of the 2005 conference highlights.	18
Drug trends	20
The latest research figures from the Illicit Drug Reporting System and Party Drug Initiative.	20
Culturally and linguistically diverse communities	22
Understanding and meeting their needs about drug and alcohol use.	22
Anti-smoking campaigns	26
Feedback from a recent Australian campaign.	26
Opinion piece on the future of campaigns and funding.	27
Homelessness and drug dependence	28
A group of Melbourne crisis accommodation services provides a holistic approach to people experiencing homelessness and drug use.	28

Access to references cited in *Of Substance*

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



Jenny McKey Tinworth



Kate Pockley

Editors' letter

Welcome to the first issue of *Of Substance* for 2006.

Petrol sniffing is a major health problem faced by both urban and rural/remote communities alike, yet there is no doubt that the Indigenous communities of Central Australia are some of the worst affected.

In the May 2005 Federal Budget, the government announced increased funding for the roll out of Opal gas, a non-sniffable fuel alternative. In this issue, we explore the background to this strategy, and speak to a range of people working directly with petrol sniffers and their communities to find solutions.

As we go to press, the Australian Professional Society on Alcohol and other Drugs (APSAD) conference has just ended. We are privileged to include convenor Dr Alison Ritter's conference highlights in this issue, plus the latest Australian research data on alcohol and other drugs (AOD) usage from the adjunct Drug Trends Conference. We will have further coverage of some of APSAD's many presentations in our April issue.

Culturally and linguistically diverse (CALD) communities make up a significant portion of Australian society, yet our AOD services focus mainly on the needs of the Anglo-Australian population. In our first feature coverage of this topic, *Of Substance* explores the need for better education and services to CALD communities, and highlights a range of resources currently available.

The 'Echo' television commercial campaign, which ran in NSW, Victoria and Tasmania in 2005, featured a range of smokers' excuses for not quitting, juxtaposed by sufferers of lung disease. We cover a recent evaluation of this campaign, plus discuss the history of anti-smoking campaigns in Australia.

As usual, we provide a run-down of the latest news and recent releases from the AOD sector. Our letters page continues in this issue, and we encourage you to send us more contributions to make for lively debate.

We hope you enjoy this issue, and of course look forward to your comments and feedback.

Kate Pockley and Jenny McKey Tinworth
Managing Editors
Ph: (02) 9280 3240
mail: editor@ancd.org.au

GUEST EDITORIAL

PETROL SNIFFING IN ABORIGINAL COMMUNITIES

DR NOEL HAYMAN, CLINICAL DIRECTOR,
INALA INDIGENOUS HEALTH SERVICE, QUEENSLAND



Petrol sniffing has been widely publicised in recent times, making headlines in national newspapers and television documentaries.

In a historical context, petrol sniffing dates back many years and was mostly confined to rural and remote communities, particularly in Central Australia. The prevalence of sniffing is increasing, but the numbers are very small when compared to alcohol and smoking rates.

However, sniffing is becoming more widespread which is surprising and alarming to me. Just recently a foster mother attended my clinic with a ten-year-old Aboriginal girl who has been sniffing petrol for the past three years. 'Can you assess her?' she asked, as both foster mum and her teachers have noticed a rapid decline in cognitive function at school. On questioning, the girl stated that she was sniffing with a small group of friends. This is happening in a large urban setting, which is rich in health service delivery but sadly poor on interventions to address young children sniffing petrol.

Why sniff petrol? It is easy to access, cheap, legal to buy, and coupled with peer group pressure and boredom makes its use recreationally entertaining for youth. Petrol is easily absorbed through the lungs and carried to the brain where it acts on the central nervous system causing the pleasant addictive effects that the young sniffers seek.

The sensation of euphoria and excitement, the feeling of numbness, help users forget the daily troubles of growing up in dysfunctional circumstances. Contrasting this is the severe health effects (sudden death from an arrhythmia – when the heart is not beating regularly – brain-related damage, seizures, mental health problems, etc.) and the social and economic disruption to Aboriginal communities.

To address the devastation from petrol sniffing, it is essential that all levels of government – Commonwealth, state and local – work effectively together with Aboriginal communities. Areas of potential gains include the use of Opal gas, better policing in communities, improving infrastructure (e.g. sporting venues and educational institutions having access to well trained recreational officers), and supporting community capacity to mobilise resources, strengthen leadership and community commitment in finding solutions.

The diversity of Aboriginal culture must be taken into account when any intervention is implemented, as local modification of programs may be needed for specific locations. A simple example of this cultural diversity is the use of language. Petrol resources developed for remote Northern Territory communities would use local Aboriginal language, and hence may not be suitable for use by Aboriginal people who grew up and live in large cities, unless resource modifications to suit local settings are carried out through community consultation.

NEWS

World Drug Report 2005

The United Nations Office of Drug Control's (UNODC) annual *World Drug Report* for 2005 (launched in October 2005) estimates that worldwide, 200 million people, or five per cent of the world's population aged 15-64, had used illicit drugs at least once in the last 12 months; the most widely-used illicit drug continued to be cannabis (160 million people), followed by 30 million people using amphetamine-type stimulants (ATS), 16 million people using opiates, and 14 million people using cocaine; in terms of treatment demand, opiates continued to be the main problem drugs worldwide.

Trends in the world's four main illicit drug markets indicate that:

- global opium production in 2004 had increased marginally by two per cent from 2003, but was still significantly lower than levels in the 1990s. The marginal increase reflected an increase in opium production in Afghanistan, which was not fully offset by the declines reported from Myanmar and Laos. The prospects for Afghanistan in 2005, however, were more positive
- global cocaine production in 2004 was two per cent higher than in the previous year, but still 26 per cent less than in 1999. Although cultivation in Colombia had decreased substantially in 2004, this was more than offset by increases in Bolivia and Peru
- cannabis continued to be the most widely produced, trafficked and consumed drug worldwide, and indicators suggested that the cannabis market at the global level was expanding further
- global production of ATS, excluding ecstasy, was estimated at 332 tonnes, which was less than previous estimates and less than production of cocaine or heroin. Production of ecstasy was estimated at around 90 tonnes.

The UNODC estimates that the retail value of the global illicit drug market was over US\$320 billion, and that the size of the world's illicit drug market was thus the equivalent of 0.9 per cent of the world's GDP. The full report is available in PDF format at: http://www.unodc.org/unodc/en/world_drug_report.html.

Substance abuse a factor in juvenile crime

Recent reports from the Australian Institute of Criminology (AIC) identify substance abuse as an important factor in the offending patterns of young people. Launched in October 2005, the reports, *Alcohol, drugs and crime: a study of juveniles in detention* and *Key findings from the drug use careers of juvenile offenders study*, focus on the drug and alcohol use and criminal careers of 371 young people aged between 11 and 17 years who were sentenced to or remanded in detention in 2004.

'The report found that in the six months before entering detention, 71% of youths had used one type of substance regularly and 29% used more than one type of substance regularly,' said Dr Toni Makkai, the Director of the AIC.

'One-third of the juveniles attributed their most recent offending to their drug and alcohol use.'

Seventy per cent of the juveniles reported that they were under the influence of substances at the time of committing the offence leading to their detention. This rate is higher than reported by incarcerated adult males (62%) and adult females (58%). The most common type of substance used regularly was cannabis (63%) followed by alcohol (46%) and amphetamines (20%).

The reports can be found at:
<http://www.aic.gov.au/publications/rpp/67/index.html>.
<http://www.aic.gov.au/publications/tandi2/tandi304.html>.

National treatment map

At the November 2005 Australasian Professional Society on Alcohol and Other Drugs Conference, the Australian National Council on Drugs (ANCD) released its latest research paper titled *Mapping National Drug Treatment Capacity*.

The ANCD has regularly heard the following questions during its national discussions:

- What is the current profile of alcohol and other drug (AOD) treatment services across Australia?
- Where are the alcohol and other drug treatment services across the country?
- Is there a way to better understand the types of AOD treatment services that are needed in Australia?

Commenting on the report, Co-Acting Chair of the ANCD Professor Margaret Hamilton said, '[It] provides a comprehensive listing of all the drug and alcohol treatment services across Australia.'

'This report provides policy bodies and funding providers with a framework to more effectively assess these questions when they are making decisions about the types of treatment that should exist in various locations.'

Mr Gino Vumbaca, Executive Officer of the ANCD, said, 'The list of services, accompanying set of maps and electronic mapping software linked to this project are excellent resources for organisations that are involved in funding or referral activities.'

To obtain a copy of the complete report please visit the ANCD's website: www.ancd.org.au.

NEWS CONTINUED

Australasian Liquor Licensing Authorities Conference

DR IAN CRUNDALL, OFFICE OF ALCOHOL POLICY AND COORDINATION, NT

Darwin hosted the 35th annual conference of the Australasian Liquor Licensing Authorities in September 2005. Licensing bodies were represented from all Australian states and territories, New Zealand and Papua New Guinea. The conference aim was to discuss issues of common concern, highlight new developments and share experiences about the control measures being used to address alcohol-related harm.

A variety of presentations included an outline of the new National Alcohol Policy, managing electronic purchases (e.g. via Internet), anti-discrimination considerations, development of the *Grog Book* as an Indigenous resource, recent court cases, and a study into rural communities by the National Drug and Alcohol Research Centre.

Each jurisdiction reported on operational and legislative developments. These ranged from outcomes of a legislative review conducted in Western Australia, through to the experience of lockouts in Victoria and Queensland, and the practicalities of social impact assessments in NSW.

Reports were received from the Education and Training, and the Indigenous Issues, Working Parties.

From the former it was decided to seek greater consistency in the content of Responsible Service of Alcohol courses and to give attention to the quality of course delivery.

The second highlighted greater information sharing and provided a checklist of harm minimisation strategies that might be applied in communities to control alcohol and negative outcomes. It will convene again in Victoria early in 2006.



Chemical Diversion Congress

The importance of partnerships was a key theme of the National Chemical Diversion Congress held in Darwin in October, 2005. Northern Territory Police Commissioner Paul White told the congress that the production of illicit drugs knew no borders; therefore 'global partnerships' were needed to combat the trade. With a theme of 'Working together to prevent the diversion of precursor chemicals and to reduce the supply of illicit drugs', the need for collaboration was a key topic of discussion among the 170 delegates from police, health, prosecution and the private sector from around Australia, Asia, Europe, Canada and America.

Speakers included Lisa Barnhill from the US Drug Enforcement Administration, Chan Yiu-wah from Hong Kong's Customs and Excise Department, Wang You Mei from China's National Narcotics Control Commission, Harold Trupish from the Royal Canadian Mounted Police and Liu Weiguo from the Criminal Investigation Bureau of Guangdong Province in China. There was a discussion of trends in the trafficking of precursor chemicals, intelligence on new precursors, and the importance of effective legislation in providing a coordinated response.

A series of resolutions from the congress covered a spectrum of issues from drug awareness campaigns, to quality prosecutions, sharing of intelligence and a national approach to legislative and policy reform. These resolutions were to be presented to the National Working Group on the Diversion of Precursor Chemicals in November.

Detective Superintendent Evans from the Northern Territory Police, Drugs and Intelligence Division said, 'The concept of the National Chemical Diversion Congress is quite unique, in that it brings together the majority of the key stakeholders involved in both licit and illicit drug control. With such a large gathering of people from a diverse range of fields, it was pleasing to reach positive outcomes.'

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 or visit www.sph.uq.edu.au



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



CPI/COS Provider Number 00028

RECENT RELEASES

New website about alcohol and work



The Australian Drug Foundation (ADF) launched a new website in October 2005 with information about 'Alcohol and work ~ what everyone should know'. The alcohol and work project is a partnership between the ADF and the Victorian Department of Human Services and is funded by the Alcohol Education and Rehabilitation Foundation (AERF).

Daryl Smeaton, CEO of AERF said, 'AERF is pleased with the results of its grant which has helped create an informative and user-friendly tool for employers and employees to deal with issues arising from workplace culture and alcohol use. Research by the National Drug Research Institute suggests that more than 25% of workers will experience an alcohol-related problem in any one year.'

Victorian Employers' Chamber of Commerce and Industry CEO, Neil Coulson welcomed the alcohol and work initiative. 'While alcohol is not a problem in every workplace, the alcohol and work website, provides employers, including small business employers, with information and advice to assist them in preventing alcohol-related issues and resolving them if they do arise,' he said.

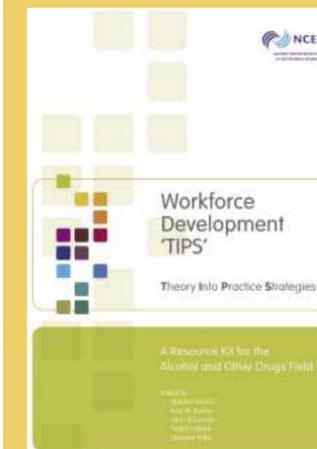
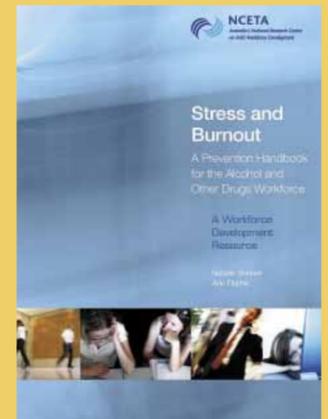
Deborah Vallance, National OHS Officer with the Australian Manufacturing Workers' Union said, 'The alcohol and work website is a useful base of information for workplaces on how to deal with alcohol-related issues, with an approach of harm minimisation for those affected by alcohol abuse and for their work colleagues, and is a step forward. The AMWU is sure the website will get lots of use.' Visit the website at: www.alcoholandwork.adf.org.au.

Workplace resources

Two resources for alcohol and other drug (AOD) sector staff were launched by the National Centre for Education and Training on Addiction (NCETA) in November.

Stress and burnout: a prevention handbook for the alcohol and other drugs workforce is designed to help members of the AOD workforce identify situations where staff are at risk of burnout. It also provides a range of practical strategies managers and their staff can use to minimise the negative impact of workplace stress.

Written by NCETA's Natalie Skinner and Ann Roche, the 46-page book also provides useful checklists for staff performance and further resources relating to stress and burnout.



The second resource released by NCETA provides a comprehensive overview of strategies which enhance workforce development. *Workforce development 'TIPS': theory into practice strategies* outlines key issues in staff development and provides practical step-by-step examples of how theory can be applied in the workplace. The *TIPS* resource is available in a ring-binder folder or as a booklet which includes a CD ROM.

Both *Stress and burnout* and *TIPS* are available in printed format from NCETA or can be downloaded by visiting www.nceta.flinders.edu.au.

Animated opiate action

A cartoon character called Opie has joined the ranks of alcohol and other drug (AOD) educators.

Opie is the star of a seven-minute animated movie, launched at the recent Australasian Professional Society on Alcohol and other Drugs (APSAD) conference in Melbourne. *The Adventures of Opie* depicts the life of an opiate molecule, from plant growth to injection into a person. Unfortunately for the person using the drug, Opie has been joined on his journey by Gino the hepatitis C virus. As well as explaining how opiates are produced, the movie also shows some of the effects that a depressant drug, such as heroin, has on the central nervous system. The movie is aimed at a post-secondary school aged audience.

Developed by Victoria's Turning Point Alcohol and Drug Centre, *The Adventures of Opie* is available as a free download for government-funded educational institutions and AOD agencies. It can also be purchased by other interested parties.

To view or download *Opie*, visit www.turningpoint.org.au





19/10/05

Drug Action Week – what impact?

I think we should look critically at the Drug Action Week (DAW) program. We should ask the following questions:

- Does the existing program reach the target audience?
- Who is the target audience?
- Does the impact on the target audience match the considerable input by government agencies and NGOs, both manpower and money?
- Are we largely preaching to the converted?

I suggest that our target audience should be school students and their parents. This year, Family Drug Support found it difficult to gain the cooperation of schools and access to school students, probably for a variety of reasons. This question may be best addressed by the schools themselves and the NSW Department of School Education.

The impact of an event in NSW might be judged by the coverage it receives from the *Sydney Morning Herald*. There was no reporting of any event during DAW that I could find even with daily fresh media releases from Canberra. (There was however a report on the ACT conference about young people and alcohol held in Parliament House, Canberra.) The *SMH* coverage may not be a valid measurement but in the absence of alternatives it is the one I use. I appreciate that there were worthwhile local events particularly in rural and regional areas this year, and I would not want to denigrate their efforts and local impact, having no way to assess this. However I think we should examine additional means of achieving statewide publicity.

My suggestion is that a significant drug/alcohol conference be held on the first day of DAW in Sydney. This could be either an international meeting about a popular issue such as cannabis or 'club' drugs, with announcements of new research findings etc., or an existing conference such as the NDARC annual symposium or the 'Club Health' event transferred to DAW. Maybe an event like the old ANZ scientific meetings could be arranged which would run for several days.

I would have to say that smaller NGOs are reviewing their commitment to participating in future DAWs because of the amount of work involved for an uncertain return.

Regards

Evan Thomas

Volunteer, Family Drug Support, Sydney; community member, Hornsby Community Drug Action Team.

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.

Club Health Conference 2005

PAUL DILLON, NATIONAL DRUG AND ALCOHOL RESEARCH CENTRE

Bars, nightclubs and other nightlife venues are a central element in the recreation and enjoyment of millions of people throughout the world. However, nightlife can also lead to a range of health and social issues including alcohol, tobacco and drug use, violence and criminal activity, risky sexual behaviour and safety issues. Tackling such issues involves not only a wide range of services protecting and promoting health at night, but also organisations and individuals involved in managing and regulating nightlife environments.

The 1st Australian National Conference on Nightlife, Substance Use and Related Health Issues was held in Sydney in September 2005. The program aimed to stimulate delegates to debate, discuss and develop strategies and interventions which would lead to better health outcomes in this increasingly popular leisure time activity. Club Health is not a drug conference – the organisers tried to ensure a wide range of speakers presenting on topics as diverse as clubbing and hearing problems, sexual behaviour of clubbers, harassment and the medical management of dance events. Speakers included members of the scientific community, medical professionals, researchers, law enforcement officers, promoters, as well as clubbers themselves.

Organisers believe that it is only through the pooling of such wide-ranging skills and resources that the topic of 'club health' can be covered adequately and, as a result, be better understood. One of the major hopes was that the conference would attract club owners and event promoters and a range of clubbers. However, this year we still had a great problem attracting this audience to the conference.

It would appear that because it cuts across so many sectors and can't be neatly pigeon-holed into a category, many potential delegates are unable to justify their attendance. It's not a drug conference, it's not a law enforcement conference and it doesn't even really fit into the 'young person' category, as a result it tends to find itself in the 'too difficult' category.

However, there was real support for Club Health to continue and the organisers are now looking at ways to make this happen. Hopefully, a series of Club Health Symposia will occur over the next two years looking at a range of issues in the area. One topic that has been raised as one that needs investigation is alcohol-related violence and the nightlife scene.



RISING TO THE CHALLENGES: NADA CONFERENCE 2005

LARRY PIERCE, NETWORK OF ALCOHOL & OTHER DRUG AGENCIES, NSW

The Network of Alcohol & Other Drug Agencies (NADA) hosts an annual conference for its members and others working in the drug and alcohol field in NSW. The 2005 conference focused on key service delivery issues and topics facing the non-government organisation (NGO) sector.

The conference was opened by the new NSW Health Minister, the Hon John Hatzistergos, MLC, who acknowledged the key role NADA and the NGO sector play in developing and delivering alcohol and other drug (AOD) services in NSW. The Minister also took the opportunity to make a number of funding announcements, including: to aid the greater involvement of NGOs in providing court diversion services; and to help with training and capacity development to address the needs of clients with concurrent AOD and mental health issues.

Tobacco addiction and the National Cannabis Strategy

The conference program featured a keynote presentation from Professor Margaret Hamilton, Co-acting Chair of the Australian National Council on Drugs, focusing on the current developments nationally across the sector. The next presentation focused on the issue of treating tobacco addiction in AOD treatment settings, a topic which raises particular issues and some difficulties for treatment services. The conference then provided an excellent opportunity for a wide-ranging consultation with the National Drug and Alcohol Research Centre (NDARC) on the development of the National Cannabis Strategy.

Residential rehabilitation and methamphetamine

NDARC also presented on the Australian Treatment Outcomes Study, its two-year treatment outcomes follow-up on clients from residential rehabilitation treatment services. This presentation was followed by a presentation entitled 'Methamphetamine use: recent trends and their impact on services'. Both these high quality presentations gave conference participants an opportunity to engage with the researchers, ask questions and make observations. This dialogue went to the heart of the current issues service providers have in relation to the deteriorating health and psychological profile of clients presenting to residential rehabilitation services, and the difficult issue of adapting treatment services for clients whose primary presentation is for methamphetamine.

Ethics in the AOD field

The conference also featured two sessions on the issue of ethics and addressing ethical dilemmas in the AOD field. The first was a presentation/consultation from the Alcohol and other Drugs

Council of Australia (ADCA) on its project to develop a code of ethics for the Australian AOD field. This was a great opportunity for NSW-based NGOs to provide input to this important national initiative. The second session was an interactive workshop, 'Boundaries for workers in AOD client services', where participants were taken through structured exercises to develop strategies to address ethical dilemmas in treatment settings. NADA will continue to promote the issue of ethics with its membership over the coming year.

AATOM project

Another interesting session looked at the issue of routine outcome measures for alcohol treatment. Dr Peter Lawrinson from NDARC and Max Brettagh from NADA presented on the development of the Australian Alcohol Treatment Outcome Measure (AATOM), a tool development project being conducted by NDARC, Turning Point and NADA. The workshop looked at building consensus and strengthening partnerships between practitioners, policy makers and researchers. The AATOM project is due to be completed by the end of next year.

NADA also took the opportunity to use the conference to gather additional editorial comment from treatment practitioners on the NSW Treatment Guidelines for Residential Rehabilitation Services. This initiative is being sponsored by NSW Health and the development is being managed by NADA. We will be presenting the guidelines to NSW Health at the end of this year for departmental endorsement, and implementation commences in 2006.

A regular feature of the conference is the presentation of workshops and research presentations by NADA member agencies; this year around 15 presentations covered topics like tobacco prevention and youth peer education, dual diagnosis treatment approaches, financial management and service evaluation, management mentoring, and training for illicit drug diversion treatment programs.

Overall the NADA conference gave our member agencies and other AOD workers an opportunity to exchange ideas and experiences in a relaxed and collegiate environment. I often hear it said that conferences aren't really good training and learning venues. I don't agree, and in our experience the NADA conference provides a way for NGO practitioners to meet, share ideas, synthesise research information, explore values and beliefs, and debate. Surely this reflects the basic principles of adult education. And we always make sure the conference dinner and entertainment activities are a real hit – after all, what's the point if you can't have a little fun!

PETROL SNIFFING AND

BACKGROUND TO A MAJOR HEALTH PROBLEM

ANGELA ROSSMANITH

On the Anangu Pitjantjatjara (AP) Lands, in the far north-west of South Australia, elders have expressed fear that some communities will no longer exist in the next 15 years. People are leaving in droves, they say, to escape being terrorised by those who wander the streets sniffing petrol (Siegel 2003). Such are the social costs of petrol sniffing, which is devastating many Indigenous communities.

In August 2005, an inquest was held into the deaths of three young sniffers, two from Mutitjulu and one from Willowra, NT, where petrol sniffing is entrenched. Following the inquest, coroner Greg Cavanagh chastised both state and federal governments for ignoring many of the recommendations from previous coronial inquiries. He called for the Federal Government to provide enough funds to roll out fuel alternatives across the entire central desert area. While such fuels are not a panacea, he said, 'comprehensive coverage of the region with un-sniffable fuel is an available strategy which will substantially reduce petrol sniffing and its associated harms' (Khadem 2005).

Fuel alternatives

Replacing petrol with a fuel alternative had its origins in the early 1990s. A community in Arnhem Land, in the Top End of the NT, where people sniffing petrol were causing havoc, noticed that the aviation fuel stored in drums at the airstrip remained untouched, even though it was very accessible.

The fuel, known as Avgas, did not provide the euphoria that petrol produced. The community installed Avgas at its petrol stations, but while there was an immediate drop in petrol sniffing, it gradually crept up again. There were too many other sources of petrol nearby. News of Avgas reached Maningrida, a very isolated community. They'd had no long-term success with various strategies to reduce petrol sniffing, and in December 2002, they replaced all tanks of petrol with Avgas.

'It took one day for the sniffing to stop,' says Blair McFarland, Coordinator of the Central Australia Youth Link Up Service (CAYLUS). 'There had been between 150 and 200 young people living in the mangrove swamps, sniffing petrol and creeping around the community, like a bunch of zombies. When they got rid of sniffable petrol, people found relations they thought had died. It was Avgas that made the difference, and the fact that the community was isolated from other petrol sources.'

Dr Ian Crundall, Director, Office of Alcohol Policy and Coordination, NT, agrees that Avgas had an impact, and points out that other initiatives influenced its effectiveness. '[These other factors] included community action and leadership, an increase in employment and recreation, and action by elders,'

The term 'un-sniffable fuel' commonly refers to fuel that contains either very low, or no, levels of aromatic hydrocarbons, which are attractive to sniffers. Aromatic hydrocarbons are additives used to replace lead compounds in unleaded fuel, a result of which makes it more 'sniffable'. Opal is an unleaded fuel specially designed to contain very low levels of these hydrocarbons.

he said, adding that a non-sniffable fuel provides respite and allows other strategies to take hold.

Introduction of the Comgas Scheme

Avgas was valuable as a harm-minimisation strategy, but it was expensive. Several communities, Indigenous organisations and the NT Government lobbied the Federal Government for a subsidy to allow them to purchase Avgas at prices comparable to unleaded petrol. The result was the Comgas Scheme, established in 1998 to subsidise the price of Avgas fuel to communities that applied for it.

'The subsidisation of Avgas is the responsibility of the Australian Government. Avgas only became expensive in about 1998, when the government added a levy to it as a disincentive for road users because of environmental concerns due to its high lead content,' notes Crundall.

An evaluation of the Comgas Scheme commissioned in 2003 saw 33 communities consulted, with six presented as case studies in the report. The clear conclusion was that 'the Comgas Scheme should be maintained and the role of the scheme expanded to promote and facilitate the use of Avgas so as to maximise participation' (Shaw et al. 2004).

From Avgas to Opal

Meanwhile, the aviation industry had been reducing the lead content of Avgas, making it more sniffable (see blue box above). The Office for Aboriginal and Torres Strait Islander Health



Janet Inyika, staff member of NPY Women's Council, at the launch of Opal in February 2005.

Photo courtesy of Mark Drake

ALTERNATIVE FUELS

lobbed for the development of an unleaded fuel to replace Avgas. The result was Opal, produced by BP and launched in February 2005 under the Comgas Scheme. Opal has low levels of the chemicals that produce a 'high', and it is safe for use in vehicles and boats. (For more information about Opal, visit http://www.bp.com.au/products/fuels/opal/opal_faq.asp?menuid=ed).

In its 2005 Budget, the Federal Government allocated \$9.6 million over four years starting in 2005-2006 to extend the Comgas Scheme to another 23 communities. In September 2005, the government announced an extra \$6.5 million over two years to roll out Opal across the central desert region of Central Australia (DOHA September 2005).

The Opal Alliance, incorporating CAYLUS, the Ngaanyatjara Pitjantjatjara Yankunytjatjara (NPY) Women's Council and the GPT Group (owners of the Ayers Rock Resort in Central Australia), strongly endorse a complete regional roll out of the new fuel. They point to statistics from the NT Department of Health and Community Services that show the cost of caring for each person disabled by petrol sniffing to be around \$200,000 each year. With an estimated 120 sniffers likely to acquire brain damage, care costs could run to \$24 million a year, whereas extending the subsidy for Opal to cover the entire region would cost between \$8 and \$9 million a year.

Effects on communities

Research indicates that sniffing causes 'serious health consequences including death or long-term brain damage, social alienation of sniffers, social disruption, vandalism and violence, increased inter-family conflict and reduced morale on communities, incarceration of sniffers and costs to the health system in terms of acute care and providing for the long-term disabled', and that most sniffers are males, between 8 and 30 years of age (d'Abbs and MacLean 2000).

Vicki Gillick, Coordinator of the NPY Women's Council, says sniffing has brought about a huge generational loss. 'The effects on families are devastating, because you have ageing parents looking after these younger people, when it should be the other way around.' Gillick says her members agree that parents need to take responsibility. 'But how can they have the capacity when their lives are ground down with the effects of petrol sniffing? When young people suicide, when they walk around with cans up their noses?' These are communities with fewer resources and less ability to control difficult problems than mainstream communities (Torzillo 2002).

NPY Women's Council members are very keen to see the introduction of Opal throughout the cross-border

region (Central Australia, taking in part of SA, the NT and WA). Gillick says that the use of petrol must be attacked first and foremost, and then followed by increased policing to deal with traffickers (including of cannabis), youth activity and diversion programs, and treatment and rehabilitation services.

Additional support needed

The *Comgas Report* recommended that, along with continued subsidy of un-sniffable fuel, communities need funding to implement whatever complementary interventions are appropriate for them (Shaw et al. 2004). Sarah MacLean, Research Fellow at the Youth Research Centre, University of Melbourne, agrees that 'interventions targeting the substance have been successful where they are part of a broad strategy that also addresses the needs of users and their families.'

In its advice to government, the National Indigenous Drug and Alcohol Committee called for a holistic approach to address the immediate, short-term problems, as well as the long-term issues. That includes removing sniffable fuel, establishing treatment services, and providing trained youth workers in the short term, and addressing the underlying causes of petrol sniffing in the long term (NIDAC 2005).

References

- d'Abbs, P & MacLean, S 2000. Petrol Sniffing in Aboriginal Communities: A Review of Interventions, *Drug and Alcohol Review*, vol. 21, no. 65:72.
- Department of Health and Ageing, May 2005. Health Budget, Fact sheet 5: Helping Aboriginal and Torres Strait Islander people to better health.
- Department of Health and Ageing, 2005. *Government announces an extra \$9.5 million to combat petrol sniffing*, Media Release, 12 September 2005.
- Federal Budget 2005. www.health.gov.au/internet/budget/publishing.nsf/Content/health-budget2005-hbudget-hmedia02.htm.
- Khadem, N 2005. *The Age*, 11 October. Access via: www.theage.com.au/news/national/coroner-damns-petrol-sniffing-inertia/2005/10/10/1128796469458.html?from=moreStories.
- NIDAC 2005. Advice to Government on Petrol Sniffing – Personal communication.
- Shaw, G, Biven, A, Gray, D, Mosey, A, Stearne, A & Perry, J 2004. *An evaluation of the Comgas Scheme: Report prepared for the Comgas Evaluation Working Group, Aboriginal Drug & Alcohol Council (SA) Inc (ADAC)*, Department of Health & Ageing, Canberra.
- Siegel, N 2003. The interaction between petrol sniffers and bush court in Aboriginal communities, *Paper presented at the Imbalanced Use and Disorder Conference*, Australian Institute of Criminology, Townsville, 7-8 July 2003, Canberra.
- Torzillo, P 2002. Petrol sniffing on the AP Lands: Report to the Coroner, Nganampa Health Council.

continued over page

Petrol sniffing and alternative fuels (continued)

A LONG-TERM COMMITMENT NEEDED

SCOTT WILSON, ABORIGINAL DRUG AND ALCOHOL COUNCIL OF SA

Over the past 50 years, remote Aboriginal communities have been dealing with an issue that plagues indigenous communities throughout the world: petrol sniffing, or volatile substance abuse (VSA). Coroners' investigations bring the issue to people's attention, otherwise mainstream Australia is unaware that a major social problem confronting many Indigenous youth and their communities is wreaking havoc in remote Australia.

Since the early 1970s, communities in Central Australia and other remote locations have been calling for a variety of measures to stop petrol sniffing. Unfortunately, governments at all levels tend to fund these cries for help with one-off pilot projects that come to an end as soon as funding comes to an end, usually after 12 months.

Any successful petrol sniffing projects are usually brought about by local community people taking action and setting up camps for sniffers to be sent to. These outstations have relied on older members of the community using their land and in some cases funding it with their own pensions.

In 2003, the Aboriginal Drug and Alcohol Council (SA) Inc (ADAC) won the tender to evaluate the Comgas Scheme. We were asked to advise on the safety and effectiveness of Avgas, identify the nature and extent of sniffing, assess community participation approaches, collect data on health impacts, identify what has worked in the past, and develop conclusions.

In early 2005, Federal Health Minister Tony Abbott launched the full report in Darwin, and BP also launched Opal. In the 2005 Budget, the Federal Government committed nearly \$10 million to expand the Opal fuel subsidy to allow more communities to introduce Opal to combat petrol sniffing. In my opinion this is all very well, but as the Comgas evaluation stated, if you only rely on fuel alternatives then you won't get the necessary sustainable outcomes. People seem to have lost sight of the fact that this is an issue of substance abuse and want magical ways of dealing with VSA.

Without developing a whole community approach, including youth specific programs, communities might have some success using Opal but I don't believe it will be sustainable. Petrol sniffing has been in Aboriginal communities for a number of years and I believe to help end this practice community projects need to be funded for at least a decade.

Given the track record of various tiers of government, as well as community perception, I don't see governments committing to the long term. But I believe the only way forward is if the Council of Australian Governments (COAG) commits sufficient funds over the next ten years to help plan and develop community infrastructure and programs that will eventually make petrol sniffing a thing of the past in rural and remote Australia.

ANOTHER DAY, ANOTHER BATTLE: BLAIR MCFARLAND & CAYLUS

ANGELA ROSSMANITH

A few weeks ago, in Papunya, Blair McFarland cut down a young man, a petrol sniffer, who tried hanging himself. At first he thought he was dead, but he revived him and took him to the clinic. He was rushed to Alice Springs, then to Adelaide Hospital into intensive care. After several weeks he's recovered enough to return to his community.

The irony of this is not wasted on McFarland, Coordinator of the Central Australia Youth Link Up Service (CAYLUS) in the NT. 'I saved a man's life so that he could go back to his community which has 60 petrol sniffers and one overworked rec (recreational) worker,' he said. 'Unless we do something, he'll continue sniffing and he'll end up like too many others: dead from respiratory failure or with burns or with a melted brain and disabled for life.' Papunya is one of the largest communities in Central Australia, and has been described as the petrol sniffing capital of Australia.

Petrol sniffing is a scourge, says McFarland, and replacement fuel is one of the most powerful tools in reducing inhalant abuse. 'Since Opal has been brought on line, every man and his dog thinks it's a great idea.' He points out that all the remote community councils support a universal roll out of Opal, as do their peak body, the Local Government Association of the Northern Territory (LGANT,) the NT Government, and the Alice Springs Town Council.

'They all endorse the idea of an un-sniffable fuel because it's such an obvious solution,' he says, 'but it's not out there because it will cost the Federal Government money. What they don't get is that it's already costing a lot of money, supporting people disabled by petrol sniffing.'

A few years ago, a photograph of a young sniffer in a wheelchair being pushed by his parents in front of Ayers Rock appeared on the front page of a national newspaper. It had a huge impact, and the Federal Government, pressured to do something about the extent of petrol sniffing in the region, diverted some of the money they were providing to the Northern Territory Government to give to Tangentyere Council. A steering committee made up of the youth organisations in Alice Springs and various remote community councils set up CAYLUS in 2002. McFarland, who has a legal background and had been working with remote communities in the NT for about 20 years, was invited to run the organisation.

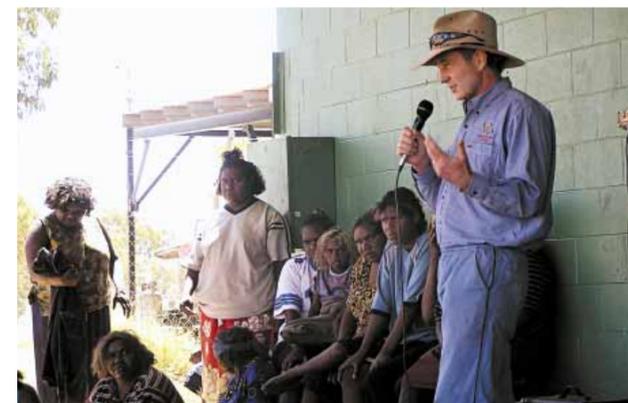
He has an associate, Tristan Ray, and they now have a caseworker, funded by the Alcohol Education and Rehabilitation Foundation for two years. 'So many people were coming to us and we couldn't in our hearts turn them away, but it was interfering with our ability to do the community involvement work because casework is very time consuming. When you're writing a submission for a \$¼ million and suddenly you have a suicidal petrol sniffer in your office, you have to attend to him, you can't send him away.'

The CAYLUS model is simple, says McFarland. 'You do supply reduction and demand reduction, then sniffers are reduced to small numbers, which the caseworker can deal

with. Supply reduction involves replacing all petrol with Opal, police enforcing no dealing laws and community meetings that shame sniffers. Demand reduction involves setting up recreation programs and employment programs. Ideally you'd bring these in at the same time, but without supply reduction you won't get demand reduction off the ground. The sniffers will all be off their faces.'

With this cluster of interventions, most of the sniffers will stop, he says. While some believe that sniffers will move on to another inhalant, McFarland says the anecdotal evidence does not support this. Petrol provides the effect of a combination of LSD and alcohol, said McFarland, and is very cheap. Other inhalants, such as deodorant, do not give the same 'kick', and a can lasts less than a couple of hours, while half a litre of petrol provides several days of inhalant use.

'People ask me if it breaks my heart to see all this, but it doesn't,' said McFarland. 'It makes me stronger. Some people get depressed because they feel powerless, whereas I don't feel at all powerless. That sniffer, I saved his life, and that gives me resilience. I feel I'm on the right side of the problem. I know what works, I've seen it work, and I'm doing it.'



Blair McFarland speaking about petrol sniffing at a community meeting at Mt Leibig, 300 km west of Alice Springs.

Photo courtesy of Tristan Ray

HEALTH FACTS ABOUT PETROL SNIFFING

- The term 'petrol sniffing' refers to the inhalation of petrol fumes from a container. Chronic users progress to 'huffing', holding a saturated cloth over the nose or mouth for greater concentration of fumes
- It takes between one and five minutes for the intoxicating effect, which can last from minutes to hours. A headache, or hangover, after sniffing can last for days
- The immediate short-term effects of petrol sniffing include a feeling of euphoria, numbing sensation, and a sense of invulnerability
- These effects are followed by giddiness, hallucination and loss of coordination
- The long-term and severe effects of petrol sniffing include permanent brain damage, severe mood swings, damage to body organs, high blood pressure, and/or sudden death from an arrhythmia (when the heart is not beating regularly). For women, miscarriage and birth defects have been linked to petrol sniffing
- Common, less severe effects of long-term petrol sniffing include coughs, colds, sleep disorders and nose bleeds
- Petrol sniffing is often associated with severe burns, because individuals who are intoxicated by the fumes stand too close to open fires
- Sniffers can asphyxiate if they fall asleep holding a petrol can to the nose because it creates a seal.

Sources:

The Public Health Bush Book, published by the Territory Health Services (now known as the Department of Health and Community Services, Northern Territory), 1999 & 2002.

National Centre for Education and Training on Addiction (NCETA) Consortium 2004. *Alcohol and Other Drugs: A Handbook for Health Professionals*, Australian Government Department of Health and Ageing.

AUSTRALIAN GOVERNMENT'S EIGHT-POINT STRATEGY

From an Information Paper by the Department of Health and Ageing for the National Indigenous Drug and Alcohol Committee, 2005

In September 2005, in response to increased community concern, the Department of Health & Ageing announced \$6.5 million over two years for a regional roll out of Opal fuel in the central desert region of Central Australia to combat petrol sniffing. Central desert regions that will benefit from this include Yulara Resort and Mutitjulu, down the Stuart Highway from Henbury to Erdunda and Kulgera Roadhouse to Marla.

The Australian Government Department of Health and Ageing, together with the Office for Indigenous Policy Coordination, has recently gained the agreement of the Western Australian, Northern Territory and South Australian

Governments on an eight-point plan of action to combat petrol sniffing. This eight-point strategy aims to: tackle petrol sniffing through consistent legislation; appropriate levels of policing; a further roll out of Opal fuel; alternative activities for young people; treatment and respite facilities; communication and education strategies; strengthening and supporting communities; and evaluation.

Through the Department of Health and Ageing, the Australian Government has committed funding of \$20.1 million over the next four years to reduce the incidence of petrol sniffing. This funding will allow additional remote Aboriginal and Torres Strait Islander communities, mainstream roadhouses, and pastoral properties to register onto the Comgas Scheme, bringing the total number of sites to more than 70 over the next four years.

MEDICAL CANNABIS LOST IN POLITICS

LIBBY TOPP

Together, a variety of data sources suggest that the average Australian cannabis user is a young male who buys cannabis 'heads' from a friend or acquaintance, and smokes them through a 'bong' to get stoned on between a daily to weekly basis. So when, desperate for pain relief, 70-year old Margaret abandoned her dreams of access to pharmaceutical cannabis, obtained a seed from a relative, grew a plant, rolled a shaky joint and took her first ever puffs of cannabis, she couldn't have been more different to the stereotyped 'stoner'. Yet, to many policy makers, these two types of cannabis user are inextricably linked.

Margaret had read anecdotal accounts of the therapeutic benefits of cannabis in support magazines for multiple sclerosis (MS) sufferers, but her reluctance to do anything illegal, and a specific dislike of cannabis caused by her children's smoking, prevented her from experimenting. She says she was at her 'wit's end' when she finally succumbed to the temptation to seek relief from pain caused by MS and rheumatoid arthritis. The effect of those four puffs on her home-grown joint was 'virtually magic': for the first time in three years, she descended the stairs of her two-storey home without arthritic pain. So instantaneous and dramatic was the relief that she told her specialist, who responded positively. 'He knew that telling me to have a Bex, a cup of tea and a good lie down wouldn't work,' she said, 'so he had no reservations in supporting anything that helped me feel better.'

NDARC survey of medical cannabis users

New research by Dr Wendy Swift of the National Drug and Alcohol Research Centre (NDARC) confirms what many clinicians and patients have long known: Margaret is not alone in finding that cannabis provides greater relief, and fewer side effects, than her multitude of conventional, prescribed medications. Among the 128 medical cannabis users in Dr Swift's survey, the first published Australian research of its kind, multiple, chronic medical conditions were the norm. Participants used cannabis to relieve an average of three symptoms, particularly chronic pain (57% of the sample), depression (56%), arthritis (35%), persistent nausea (27%) and weight loss (26%). Cannabis was most commonly administered by smoking of either bongs or joints, and was perceived by respondents to provide either 'great' (86%) or 'a little' (14%) relief. No one reported that cannabis had been detrimental to their condition or symptoms.

Almost three-quarters (71%) of participants experienced a return of their symptoms when they ceased cannabis use; and close to two-thirds (62%) reported a decrease in or discontinuation of prescribed medicines when they started using medical cannabis. For some, this was a substantial change, representing a shift away

from chronic, high-dose medication. Eighty-two per cent of participants considered that cannabis provided 'a bit' or 'much better' relief than other medications, or was their only source of relief. The majority reported either that the side effects of their other medications were 'somewhat' (13%) or 'much worse' (32%) than those produced by cannabis, or that they had no undesirable effects from cannabis at all (24%).

Overwhelmingly, participants' greatest concerns were that their cannabis use was illegal, they risked being arrested and its cost on the black market. One-quarter (27%) claimed to have been arrested, cautioned or convicted for their medical cannabis use. Several participants commented that they had no alternative but to use an illegal drug, noting that other medicines with negative and toxic effects, such as opiates, were legally prescribed; and made pleas for medical cannabis to be treated as a medical rather than a legal issue, because their quality of life was at stake.

For Dr Swift, a striking aspect of her results was the age of her sample; like Margaret, many respondents did not fit the demographics of the 'average' pot smoker. They ranged in age up to 88 years, with one-third aged 50 years or more, and one in ten aged 60 years plus. The age at which they had first tried cannabis for medical purposes ranged up to 77 years, with an average age of 31. She describes many of the participants as 'older, law-abiding citizens with debilitating medical conditions, who never used drugs in their life, being forced to break the law to obtain some relief'.

Recent history of medical cannabis in NSW

It was patients like these that prompted the Australian Medical Association (AMA) and the Law Society of NSW to advocate that cannabis be made available on prescription for those in genuine medical need. The NSW Government responded in October 1999 by establishing an expert working party to advise whether cannabis and cannabinoids (the active ingredients of cannabis, which may be found in the plant, or synthesised in a laboratory) had any therapeutic uses, and if so, to suggest how they could be made available for medical use without decriminalising recreational cannabis use.

The working party included eminent scientists and representatives from the AMA, Law Society, Royal Australian College of General Practitioners, NSW Cancer Council, AIDS Council of NSW, and government agencies including NSW Police, NSW Health and the Attorney-General's Department. Chaired by the then NDARC director Professor Wayne Hall, the working party reviewed the available evidence and presented its report to the Government in August 2000. It found that cannabinoids may have value in the treatment of a limited range of medical conditions

and for pain that is unrelieved by conventional treatments. It said that the best chance for establishing the medical use of cannabis lies in the development, testing and registration of synthetic cannabinoid drugs. It recognised that the research required for this process would take considerable time, and until then, patients who use cannabis for medical purposes risk criminal prosecution if detected by the police.

The working party's view was that the law should not compound the predicament of seriously ill patients. Accordingly, the report recommended that specific classes of patients who wished to use cannabis for medical purposes should be given a limited exemption from criminal prosecution until pharmaceutical cannabinoids were registered.

The report was released for public comment in November 2000. Submissions into the findings were invited by February 2001, and in July 2001, a report on the consultation process was released. Almost two years later, in May 2003, NSW Premier Bob Carr announced that a draft exposure bill would be introduced 'at the earliest opportunity' to allow a four-year trial of medical cannabis. The trial would include the establishment of an Office of Medicinal Cannabis within NSW Health, with which participants would register annually.

In terms of source of cannabis supply for registered medical users, the then Premier stated that the government would work with medical, pharmaceutical and research institutions to examine various options, including decriminalising the growing of cannabis plants; government regulation and supply; and obtaining Commonwealth approval to import synthetic cannabinoids if and when they became available overseas.

Two and a half years later, the trial announced by Bob Carr is yet to commence. As recently as September 2004, John Della Bosca, then Special Minister of State responsible for drug policy, affirmed in the NSW Legislative Council that 'this Government remains committed to a compassionate principle... that seriously ill or injured people receive all the assistance that is available, even if that includes access to medicinal cannabis'. The Minister added that significant medical, legal and constitutional issues must be resolved; but that Prime Minister Howard and Premier Carr had agreed that Minister Della Bosca and Commonwealth Health Minister Tony Abbott would be meeting within the week to begin working together to progress the trial. More than a year later, however, the comment provided by NSW Health for this article was:

Discussions are ongoing between the NSW Government and the Commonwealth regarding the establishment of a medicinal cannabis trial in NSW. An interview cannot be provided at this time, as any comment regarding the outcome of discussions would be speculation.

Regulatory difficulties?

Government spokespeople imply that difficulties relate to the intricate web of international, federal and state laws under which any trial would be conducted. Although undoubtedly complex, according to Graham Irvine, a doctoral candidate in the School of Law and Justice at Southern Cross University, the legal and regulatory issues surrounding the introduction of a medical cannabis scheme are not insurmountable. His research indicates that there is 'no real impediment' to any state introducing medical cannabis legislation. Even Australia's international treaty obligations allow the importation of prohibited drugs for medical or scientific purposes.

continued over page

Medical cannabis in the international context

Netherlands Purchasing cannabis for personal use has been legally possible in the Netherlands since the 1970s. In 2003, the Dutch were the first to legalise cannabis on prescription for patients suffering serious illnesses. With a doctor's prescription, patients can buy five grams of dried cannabis from pharmacies. The Office of Medicinal Cannabis in the Ministry of Health, Welfare and Sport licenses selected companies to grow cannabis on its behalf, and distributes it to hospitals and pharmacies.

Canada In 1999, the Canadian Government began granting permits to individuals to possess and cultivate cannabis for medical use. Following legal challenges to this scheme, the Marihuana Medical Access Regulations were introduced in 2001 administered by the Office of Cannabis Medical Access in Health Canada. Applicants must provide a doctor's statement to obtain an Authorization to Possess a maximum of 30 days supply of dried cannabis.

USA There is no federal approval of medical cannabis in the US. Beginning with California in 1996, 12 states have introduced legislation that effectively removes state-level criminal penalties for growing and/or possessing medical cannabis, with the process underway in a thirteenth. Patients can possess specified quantities of dried cannabis and cannabis plants. These laws give patients, caregivers and doctors protection from state penalties, but some participants have been prosecuted and even imprisoned under the federal Controlled Substances Act (1970).

UK The UK does not have a specific medical cannabis program, but has been active in conducting clinical trials of cannabinoid medications. GW Pharmaceuticals developed the sublingual cannabinoid spray Sativex® and applied for regulatory approval in 2003, although a decision is yet to be reached by the Medicines and Healthcare Products Regulatory Agency.



Medical cannabis (continued)

Although the level of cynicism about the perceived lack of political will is high, some experts are hopeful that Canada's registration in April 2005 of the sublingual cannabinoid spray Sativex® may provide renewed impetus for Australia's medical cannabis lobby. Specifically, under the Special Access Scheme of Australia's Therapeutic Goods Administration (TGA), approval can be granted for access to unapproved therapeutic goods, and success is most likely for products approved for use in countries with equivalent regulatory systems to Australia's. Moreover, if and when Bayer, the pharmaceutical company which holds the licence to market Sativex® in Australia, applies to the TGA for the drug's approval, much of the research necessary to establish its efficacy and safety has already been conducted in Canada and the UK, which should greatly facilitate the TGA's processes.

On the other hand, GW Pharmaceuticals, the UK company which developed Sativex®, first applied for its approval to the UK therapeutic goods regulatory agency in March 2003. Approval is yet to be granted.

For Laurence Mather, Professor of Anaesthesia and Analgesia (Research) at the University of Sydney, and a long-time proponent of clinical research into alternative methods of delivering cannabis (other than smoking), delays such as these constitute the real mystery of medical cannabis. 'The true story,' he says, 'is to get the polities to 'fess up to their real intentions in announcing and then sandbagging (the medical cannabis trial) – after raising the hopes of patients and researchers alike. Every time there is something in the press, we get calls from desperate patients ... it is pretty tragic.'

Whether those 'real intentions' will ever be clarified is uncertain. Political will has been distinctly lacking with respect to medical cannabis, even though household surveys show that the majority of Australians support the concept. Although most experts believe the issue has disappeared from the political landscape, surveys such as Dr Swift's, and international developments such as in Canada, may re-ignite the public commitment made almost three years ago by Bob Carr that the NSW Government would meet its 'obligation to minimise human pain and distress wherever we can'.

In the meantime, patients like Margaret, the 127 other medical cannabis users in Dr Swift's survey, and thousands of others in genuine medical need, wait ... and hope. As Margaret, in her gentle, quavering voice, says, 'We just have to hope that there will be some enlightened politicians who are broadminded enough to look at the big picture and not tar everyone who uses cannabis with the same brush.'

Further reading

Australian Institute of Health and Welfare 2005. *2004 National Drug Strategy Household Survey: First Results*, Canberra: Australian Institute of Health and Welfare.

Carr, B 2003. Cannabis medical use, questions without notice, NSW Parliamentary Hansard, 20 May 2003, p. 697.

Della Bosca, J. Cannabis medical use, NSW Legislative Council, 1 September 2004, p. 10570.

Drug Policy Alliance (USA) website: www.drugpolicy.org/marijuana/

Griffith, G & Swain, M 1999. *The medical use of cannabis: recent developments*. NSW Parliamentary Library Research Service Briefing Paper No. 11/99.

Hall, W, Degenhardt, L & Currow, D 2002. Allowing the medical use of cannabis. *Medical Journal of Australia*, no. 175, pp. 39-40.

Canada's approval of Sativex®

The pharmaceutical company Bayer has an exclusive licence to market the sublingual cannabinoid spray Sativex®, developed by GW Pharmaceuticals, in the UK and Canada, with an option to expand the licence to include Europe, Australia and New Zealand. In Canada in April 2005, Sativex® was granted a 'Notice of Compliance with conditions', a form of market approval granted by Health Canada on the basis of promising evidence of clinical effectiveness. (Follow the 'Pharmaceuticals' then 'Sativex®' links at www.bayerhealth.ca for information on Canada's approval of Sativex®; and see www.gwpharm.com for information about Sativex®.)

The legal situation in Australia

The possession, use and supply of cannabis are illegal in Australia, but offences are dealt with differently across states and territories. Some jurisdictions enforce 'prohibition with criminal penalties', meaning that criminal penalties apply for even minor cannabis offences, which may result in a criminal record for the offender. In jurisdictions with 'prohibition with civil penalties', cannabis offences attract infringement notices and fines, similar to parking tickets. All jurisdictions have programs where non-violent and minor cannabis offenders are diverted from the legal system, so that even where cannabis offences are criminally punishable, first-time minor offenders are unlikely to receive a criminal record.



Johns, R 2004. *Medical cannabis programs: a review of selected jurisdictions*. NSW Parliamentary Library Research Service Briefing Paper No. 10/04.

Medical Cannabis Information Service website: www.medical-cannabis-information-service.com.

Medical Marijuana Pro Con website: www.medicalmarijuanaprocon.org.

NSW Government DrugInfo Medical Cannabis website: www.druginfo.nsw.gov.au. All the NSW Working Party documents can be accessed by following the Medical Cannabis NSW links; plus there are useful links to a range of other relevant documents and websites.

Rickard, M 2003. *The use of cannabis for medical purposes*. Department of the Parliamentary Library Research Note No. 13. 15 September.

Swift, W, Gates, P & Dillon, P 2005. Survey of Australians using cannabis for medical purposes. *Harm Reduction Journal*, no. 2, p. 18.

TOWARDS A NATIONAL CANNABIS STRATEGY

JENNIFER MCLAREN AND PROFESSOR RICHARD MATTICK, NATIONAL DRUG AND ALCOHOL RESEARCH CENTRE

The National Drug and Alcohol Research Centre (NDARC) has recently been engaged by the Australian Government Department of Health and Ageing to work on the development of what will be Australia's first National Cannabis Strategy. Cannabis is by far the most widely used illicit drug in Australia; this widespread use means that the National Cannabis Strategy will be a particularly important component of the National Drug Strategy.

The current National Drug Strategy aims to prevent the uptake of harmful drug use and minimise drug-related harm. In keeping with this underlying philosophy, the National Cannabis Strategy (the Strategy) will need to focus on reducing the harm associated with cannabis use in this country; a wide variety of issues will also need to be addressed that involve a range of sectors in the community.

For example, the education sector has an important role to play in preventing the use of cannabis by informing young people about the harmful aspects of the drug. The law enforcement sector plays a role not only in disrupting the supply of cannabis, but in reducing demand through diversion programs. The health sector needs to be involved in providing adequate treatment to those who are dependent on cannabis. Additionally, researchers provide reliable and up-to-date information on a wide variety of cannabis-related issues that help inform government policy and initiatives.

Project Management Group and reference groups

Professor Richard Mattick, Director of NDARC, has been appointed as the chair of the Project Management Group (PMG), which has been established to lead the development of the Strategy. The PMG includes members of the Australian National Council on Drugs, and representatives from the health, education and law enforcement sectors.

Four reference groups have also been established to provide advice to the PMG throughout the development of the Strategy. These groups include people with knowledge and experience in four areas that are particularly relevant to cannabis: mental health; treatment; law enforcement; and research.

Existing research

A background paper has been developed by staff at NDARC that provides an overview of the current cannabis situation in Australia. This paper provides the context for the National Cannabis Strategy. It draws on existing research and policy documents and is guided by input from the reference groups.

Consultations

Given the range of issues that need to be addressed, the development of the National Cannabis Strategy has included a broad consultation process. Representatives from a range of sectors attended consultation forums that occurred around the country between September and November 2005. Attendees expressed their views on what should be considered when developing the Strategy.

The consultation forums were broad and inclusive, and were held in all capital cities as well as in at least one regional area in each state and territory. Invitations to attend the forums were extended to: drug and alcohol workers; criminal justice professionals including police; representatives from all levels of government; researchers; educators; Indigenous representatives; drug user groups; health professionals; parent groups; and other relevant stakeholders. Special forums for canvassing the views of cannabis users, young people and Aboriginal and Torres Strait Islander peoples were also run.

Issues discussed in the forums included: concern that the age of initiation of cannabis use seems to be getting younger; the social and economic causes of cannabis use in certain communities; the recent increase in the use of cannabis in remote Indigenous communities; the involvement of organised crime; and the lack of up-to-date research on patterns and harms associated with cannabis use in Australia. Some of the strategies suggested included: parent-focused education; community education campaigns; support and expansion of the illicit drug diversion initiative; clinical guidelines for cannabis treatment; and improved partnerships between the drug and alcohol, and mental health sectors.

National Cannabis Strategy – the document

At the present time, the Strategy is being drafted by the Project Management Group. It draws on: existing policy and research presented in the background paper; the expertise of the reference group members; the views of the public provided in the written submissions; and the opinions of key individuals and organisations gauged through the consultation forums, feedback forms and the written submissions. The final National Cannabis Strategy will be presented to the Ministerial Council on Drug Strategy in May 2006 for their consideration.

Further information about the National Cannabis Strategy can be found at the following website: <http://ndarc.med.unsw.edu.au/ndarc.nsf/website/News>. To discuss the Strategy development process, email: cannabis.strategy@unsw.edu.au.

FOCUS GROUPS

JEREMY NORTHCOTE, NATIONAL DRUG RESEARCH INSTITUTE, WESTERN AUSTRALIA

Last issue, we began a series exploring different research techniques and how they can be used to increase our understanding of alcohol and other drug issues. This month, *Of Substance* looks at the use of focus groups.

What is a focus group?

A focus group is a qualitative research technique that uses group consultation to produce in-depth information about a particular topic or issue. Focus groups have been commonly employed by marketing companies to canvass opinions from general community members or niche groups regarding the effectiveness of marketing campaigns and/or to understand issues surrounding consumer preferences. A marketing company might, for example, conduct a focus group on behalf of a beverage company to find out why people choose to drink certain types of beer and to determine why they like or dislike certain beer commercials. Researchers or evaluators often employ focus groups for the same types of purpose – evaluating the effectiveness of interventions (including advertisements) and exploring the issues surrounding their success or failure. Beyond their evaluative function, focus groups are also widely employed as a gathering tool for obtaining data on people's views and opinions on certain topics, such as issues surrounding alcohol or drug use.

How does a focus group work?

Focus groups ideally involve five to ten participants, who are guided through a group-based discussion typically lasting one to two hours. One or more moderators are usually present to coordinate the discussion. The degree to which the moderator directs the course of the focus group discussion varies depending on the aims of the research. For exploratory focus groups that seek to investigate general types of issues relating to a topic, a more free-flowing type focus group might be preferable. In these cases, participants are left largely to themselves to raise matters of interest, with the role of the moderator being to ensure the involvement of all participants and possibly highlight emerging issues for further elaboration. For focus groups that seek to gain information on specific questions, the moderator may take more of a steering role in which he or she directs group members to discuss particular items of interest identified by the researchers. In these cases, the moderator may follow a semi-structured question guide and exercise considerable control over the course of the discussion.

The importance of group dynamics

Focus groups rely on the effect of group dynamics to produce information. The use of group dynamics is what distinguishes this method from, say, one-on-one in-depth interviews. While other approaches endeavour to minimise group dynamics so that interpersonal constraints do not bias the views and opinions expressed, focus groups seek to benefit from the way in which

participants 'feed off' each other's comments and thereby obtain greater depth about issues.

When to use a focus group

As a qualitative method, focus groups are intended to produce in-depth data on participants' views and opinions, and therefore are best employed when little is known about a topic, or when depth or scope of understanding is being sought. It is in this respect that focus groups differ from close-ended surveys, which aim to uncover the generalability of views and opinions among sub-groups or the wider community based on pre-defined knowledge categories. However, focus groups can be employed as part of the pre-survey design phase in order to determine the appropriate structure, content and form for questionnaires. Alternatively (or additionally), they can be employed to 'flesh out' the issues and findings that emerge through surveys and other forms of quantitative and qualitative data collection.

What population would you use focus groups with?

The type of participants chosen depends on the aims of the research. For example, everyday individuals, either drawn from sub-groups (such as young people or beer consumers) or a cross-section of the community, might be chosen for a focus group that seeks to understand the impact of commercial advertising on the general public. In another case, a group of specialist medical practitioners and health workers might be chosen for a study that seeks to



understand issues surrounding the delivery of particular services or treatments, which only specialised experts might be qualified to comment on.

Unlike quantitative methods such as surveys or controlled trials, participants in focus groups are not usually randomly selected. Participants are selected on the basis of their value for providing in-depth information or understanding about a particular matter. Given the amount of time and effort involved in being a participant in a focus group, it is normal for incentives to be offered to participants in order to compensate for their surrendered time.

What sort of findings will be produced?

Focus groups produce verbal data in the form of a group conversation. The discussions can be documented by either electronic recording or note-taking.

Direct recording using a cassette recorder or video camera is arguably the preferable form of data-gathering. The advantage of direct recording is that the data is verbatim and so does not suffer gaps or distortion through summarisation. The disadvantage of direct recording is that recording devices may inhibit participants, and transcription (which most analysts will desire for ease of examination) may be expensive or time consuming.

The second method of recording is through note-taking. Good note-taking ideally requires someone skilled in shorthand writing, otherwise the notes will tend to be too generalised and vague, and important details or concepts may be lost.

Like other forms of qualitative research, focus-group analysis revolves around the interpretive capacity of the analyst to identify key themes in the data. The data can be analysed in qualitative software packages such as NUD*IST or N-Vivo, which allow data to be readily coded into the key themes.

What are the limitations?

The main limitation of focus groups is that, much like other qualitative research, the results are not statistically indicative of the wider population or sub-group. Although it is possible to increase the representativeness of focus groups by ensuring a selection of participants from a broad cross-section of the community (or sub-group) and by increasing the number of focus groups held, the purposeful nature of the sampling method and the constraining effects caused by the moderator and group dynamics mean that the results will have limited applicability to the wider population. Remember, the aim of focus groups is to understand the depth, rather than the numerical extent, of issues.

In terms of group dynamics, the challenge for the moderator is to ensure that the problematic aspects of group dynamics do not dominate. Aspects to be avoided include ridicule and hostility; excessive dominance of certain participants in discussion; and participants feeling shy in front of others.

Recent examples of focus groups

Researchers from the MORI Social Research Institute employed focus groups in their study of alcohol consumption among UK club-goers (Engineer et al. 2003). Their choice of a focus-group method

was determined by their desire to learn more about the social context that surrounds problematic drinking among young adults. A total of 16 focus-group discussions were carried out by the research group across eight locations in England and Wales, involving between five and 11 participants per focus group. Participants were aged 18-24 years and were deemed high-risk alcohol consumers. A cross-section of young adults based on age, gender and occupation were selected. The discussions explored various issues related to attitudes, relationships and behaviour surrounding binge drinking and related harms. Participants were also asked to suggest a range of interventions and messages for minimising alcohol-related harms. The findings indicated that young adults drink excessively in order to maximise the effect of intoxication or because they have difficulty judging their limits, with social influences and features of the setting also salient factors. The impact of awareness-raising campaigns was seen to be minimal. The MORI study is a good example of focus groups being employed for primary data gathering.

'The challenge for the moderator is to ensure that the problematic aspects of group dynamics do not dominate.'

De Crespigny et al. (1998a; 1998b) used focus groups in a quite different way in their study of drinking amongst young Adelaide women. After preliminary data analysis of observational notes and semi-structured interviews, a focus group consisting of ten female drinkers was held to assess the accuracy of the findings (De Crespigny et al. 1998a, p7). The outcome of the focus group consultation was a refinement of the results prior to compilation of the final report. The investigators also used a focus group to assess the appropriateness of a survey that they planned to administer to young Adelaide women who patronised selected hotels (De Crespigny et al. 1998b, p9). The focus group consisted of nine pub-going young women who discussed the survey in a tape-recorded session lasting 45 minutes. The suggestions made by participants resulted in various refinements of the survey design. This is an example of focus groups being employed as a verification method for primary data collection instruments and preliminary findings, and demonstrates the diverse ways that focus groups can be employed in research design.

References

- De Crespigny, C, Vincent, N & Ask, A 1998a. *Young Women and Drinking: Volume 1: Young Women's Decisions, Drinking and Environment* (second edition), School of Nursing, Flinders University of South Australia.
- De Crespigny, C, Ask, A & Vincent, N 1998b. *Young Women and Drinking: Volume 2: Development of a Survey for Young Women in the Hotel Environment* (first edition), School of Nursing, Flinders University of South Australia.
- Engineer, R, Phillips, A, Thompson, J & Nicholls, J 2003. *Drunk and disorderly: a qualitative study of binge drinking among 18 to 24-year-olds*, Home Office Research Study 262, Home Office Research, Development and Statistics Directorate, available online at www.homeoffice.gov.uk/rds/pdfs2/hors262.pdf.

Further reading

- Krueger, R & Casey, M 2000. *Focus groups: a practical guide for applied research*, 3rd edn, Sage Publications, Thousand Oaks, California.
- Sharma, M 2004. Tapping into the Potential of Focus Groups for Research in Alcohol and Drug Education, *Journal of Alcohol and Drug Education*, vol. 48, no. 3, pp. 3-6.

SCIENCE, PRACTICE, EXPERIENCE APSAD 2005

ALISON RITTER, CONFERENCE CONVENOR

The Australasian Professional Society on Alcohol and other Drugs (APSAD) 2005 Conference, held in Melbourne in November, showcased outstanding science, clinical practice and experience in alcohol and other drugs. The topics covered by the program were wide ranging and included: young people; neurosciences; criminal justice; pharmacotherapies; hospitals, doctors and GPs working with addictions; families; epidemiology; prevention; Indigenous issues; drug treatment; comorbidity; blood borne viruses; inhalants; ethics; workforce development; and drugs and driving.

The diversity of topics was matched by the diversity of presentations: plenary sessions with notable international and national experts; symposia; clinical workshops; oral sessions; and a dedicated poster session.

Over 650 delegates participated in the conference, representing Australia, Bangladesh, Canada, Finland, France, Ghana, Malaysia, Nepal, New Zealand, Nigeria, Norway, Singapore, Sweden, the UK, USA and West Africa. The daily opening plenary sessions were followed by seven parallel streams across the three days.

Opening keynote speakers

In the first plenary session, Nichola Hall and Jimmy Dorabjee spoke from personal experience. Nichola, a founding member of the Canadian advocacy group, From Grief To Action, has been working since 1999 to improve the lives of drug users and their families. The mother of two sons who are currently on the methadone program, Nichola has also been involved in lobbying on behalf of drug treatment centres and working with schools on education and prevention. She outlined the work of her group for families of drug users and spoke of the importance of acknowledging families and the relief that can ensue from engaging with parents in similar circumstances. This can lead to powerful advocacy.

Jimmy Dorabjee is currently based at the Macfarlane Burnet Institute in Melbourne, but for many years lived in India where he began the first oral buprenorphine substitution program in Delhi in 1993. He gave delegates a graphic account of the status of drug users and drug treatment in Asia. Whilst noting differences between countries in their approaches, he emphasised the need to move from punitive treatment models to humane and caring responses that incorporate the latest medical and psychological advances. The opening keynotes grounded the conference in the world of experience and practice.

Keynote speakers on following days

On the second day, we heard from Tim Rhodes, who is the director of the Centre for Research on Drugs and Health Behaviour, Imperial College, London. He leads a program of work focused on the social aspects of HIV prevention associated with injecting

drug use. He reminded us of the stressful life circumstances of addiction, and highlighted the importance of social and structural change in effective responses.

This keynote was complemented by the presentation from Rajita Sinha, outlining the relationship between stress and addiction, and providing the latest research on neurobiology, including hormonal changes and brain-imaging studies demonstrating the relationship between brain structures, hormones, stress and cravings, and drug use.

Eric Strain also spoke at this session. Eric is a professor of psychiatry and behavioural sciences at the Johns Hopkins Medical Center in Baltimore. He outlined the new medications for opiates, cocaine and alcohol, new formulations, and the potential issues for the field.

Later in the day, Westley Clark summarised the latest work on knowledge transfer. He is the director of the American Center for Substance Abuse Treatment and leads a national effort to provide Americans with effective and accessible treatment for addictive disorders.

Final day highlights

On the final day of the conference, the first keynote speaker was Professor Keith Humphries, who is based at Stanford University's School of Medicine in the Psychiatry and Behavioral Science Department. In addition to researching self-help programs for substance abuse and psychiatric disorders, he is actively involved in teaching addiction treatment methods. He outlined the efficacy and effectiveness of 12-step programs in treating addiction.

He was joined by Annie Madden, Executive Director of the Australian Injecting & Illicit Drug Users League (AIVL), which



Left to right: Conference delegates Sharon Dawe and Ann Roche with Annual APSAD Award winners Alan Clough (Early Career Award) and James Bell (Senior Scientist Award).



Left: James Bell accepts his award. Right: Conference convenor Alison Ritter.



is the national peak body representing consumers. Annie gave an overview of the ethics of drug research from the consumers' perspective. She reminded us that 'your work affects our lives'.

Clinical workshops and more

The keynote speakers and the many parallel sessions throughout the three days highlighted the importance of integrating research with experiential knowledge and practice wisdom.

The clinical workshops, a new innovation this year, were very well received. Aimed at skills acquisition rather than being didactic presentations, the workshops included mindfulness; alcohol withdrawal in hospital settings; developing partnerships between police and drug treatment services; workforce development; guidelines for the management of drug use during pregnancy; clinical supervision; young people and mental health screening; integration of Gestalt and art therapy; brief interventions for alcohol; and acquired brain injury.

A unique Indigenous workshop (Snake dreaming) was very well-received (see panel at right for a delegate's account of this presentation).

Five Indigenous travel awardees talked about their work with their

own Indigenous communities and addictions.

Another innovation this year was the dedicated poster session held on the second day. With over 60 posters, delegates were able to spend over an hour talking one-on-one with poster presenters, networking and gaining new knowledge through interaction, rather than sitting and listening to speakers. The feedback on the poster session was very positive and we hope to maintain this session in future APSAD conferences.

In a plenary session on the heroin shortage, experts outlined the potential explanations for the shortage, the health, crime and social consequences. It was apparent that it is very difficult to interpret the data (with some indicators running counter to intuition and substantial variations between jurisdictions). Key points raised during the session were: the impact of research on politics; the role of evidence in the political processes; and how to communicate equivocal findings.

The APSAD Conference is always an opportunity for the alcohol and drug community in Australia to meet, and various satellite business meetings, formal and informal networking meetings and organisational meetings were held throughout the conference.

Snake dreaming

Muningah Djumba Teamayea Bunjilaka

To begin with, we sang the above lyrics in the spirit of Bunjil – the wedge-tailed eagle – in the sand at Port Melbourne Beach.

Facilitator Bea Edwards taught us the dance of the Snake Mindi, and we danced in front of the playground as we looked out on the calm water of grey Port Phillip Bay.

Bea told us of the problem-solving that she used in her work with Koori clients and acknowledged that we all suffer at one time or another. She drew a big totem snake around us and gave us our own section of the snake in which to draw our feelings in the sand. We each stood in our own section of the snake's body and Bea spoke to us of what she saw through our drawings. It rained gently on us and we all led the snake and danced in formation on the beach.

Use of dance, song and drawing the many totems as part of problem-solving has been used by the Kulin peoples for thousands of years. The snake dreaming creates harmony that is needed to discuss things within families and many totems are used to approach different issues. The snake dreaming assists people to bring order to their life when they are out of control. Bea also introduced us briefly to the turtle which is a symbol of 'self-protection' and we saw how she used it as a method for resolving conflict, especially within families.

At the end of the session we thanked the water, the mother earth and because we were on Bunerong land we thanked the spirit of their land for allowing us to dance there.

Meina Mungoolgali gali gali gali tyep tyep

Anne-Marie Laslett, conference delegate

2005 DRUG TRENDS

JENNY TINWORTH

Heroin use has not returned to the levels at which it was being used before the 2001 heroin shortage, however cocaine use, particularly in NSW, is increasing in popularity.

These are among the findings from the 2005 surveys conducted for the annual Illicit Drug Reporting System (IDRS) and the Party Drugs Initiative (PDI). Findings from both the IDRS and the PDI were presented at the Drug Trends Conference held in Melbourne in November, 2005.

THE STUDIES

Both the IDRS and PDI are conducted by researchers in capital cities across Australia. While neither study is representative of Australian illicit drug use in general, both are designed to monitor drug trends and provide early warning systems for issues that may require further investigation. The results may help inform both future health treatment and law enforcement policy. Both surveys have similar methodologies. Information from three sources is pooled to provide information about drug trends:

1. People who use illicit drugs – the IDRS interviews people who regularly inject illicit drugs, while the PDI interviews people who regularly use ecstasy. Each study interviews about 100 people in each capital city.
2. Key experts – the IDRS interviews people who work in the illicit drug sector or have a good knowledge of the illicit drug market (e.g. health workers, police officers) while the PDI interviews people who have regular contact with people who use ecstasy (e.g. entertainment venue staff, DJs, youth workers).
3. Analysis from routine data sources – including treatment data collections, ambulance calls to drug overdoses, customs reports and police operations.



The aim of both surveys is to provide a broad overview of use of all illicit drug types, however each draws on the knowledge of distinctly different groups of people who use drugs. The IDRS taps into markets where individuals generally list heroin or methamphetamines as their primary drug of choice, while the PDI sources people who are more likely to nominate ecstasy as

their preferred drug. Other important differences between the two groups are that IDRS respondents are likely to be older, unemployed, to have been in prison and currently receiving treatment for their drug use (see Table 1).

Table 1. Demographics of IDRS and PDI respondents

	IDRS (n=943)	PDI (n=810)
Mean age (years)	34	24
Male (%)	64	59
Aboriginal or Torres Strait Islander (%)	12	3
Mean years of school education	10	12
Unemployed (%)	73	14
Prison history (%)	50	5
Currently in drug treatment (%)	48	3

THE 2005 IDRS FINDINGS

Across all capital cities, survey findings and drug trends varied. Here, *Of Substance* provides an overview of the general national trend for key drugs, in terms of levels of use, availability and purity.

Heroin

The national heroin market generally remained stable during 2005, and there was not a return to the high frequency of use seen prior to the heroin shortage in 2001 (in 2005, heroin users had used on a median of 70 days in the previous six months, compared to 2000 where they had used on a median of 120 days in that time period). It was generally considered that heroin was very easy or easy to obtain in most jurisdictions, while purity was seen as low to medium.

Methamphetamines

Methamphetamine use was reported in three forms:

1. Speed – use was seen as increasing or stable, it was very easy to obtain and purity was considered low to medium.
2. Base – use was varied, it was generally very easy to easy to obtain and purity was medium to high.
3. Ice – use was decreasing or stable, and obtaining it varied from very easy to difficult, while purity was generally high.

Cannabis

The cannabis market remained stable across Australia, with hydroponic and bush varieties being the most popular forms of the drug. It was considered very easy to easy to obtain, while

the strength of hydroponic forms was rated as high and bush strength as medium.

Cocaine

The cocaine market remained stable, with the exception of NSW where use increased from an average of once to twice per month and it was considered very easy or easy to obtain, and of medium quality. In most states, use was low and sporadic, with respondents saying it was difficult to obtain.

Other pharmaceuticals

Diversion and injection of pharmaceutical drugs continued to be an issue of concern, with injection of illicit methadone remaining stable nationally (26% of respondents had injected it in the last six months). Overall, the use and injection of diverted pharmaceuticals such as morphine, methadone and benzodiazepines remained most evident in areas such as the NT and Tasmania where heroin has traditionally been less available. The exception to this is buprenorphine diversion and injection, which was highest in WA and Victoria. With the exception of the NT where rates remained stable, there has been a declining trend in benzodiazepine injection – attributed to the discontinuation of temazepam gels in 2004. Use of diverted oxycodone was highest in WA and Tasmania.

Health problems reported by users

Scarring or bruising and difficulty in injecting were the most commonly reported injection-related health problems, while 43% of people who injected drugs also reported mental health problems, particularly depression.

THE 2005 PDI FINDINGS

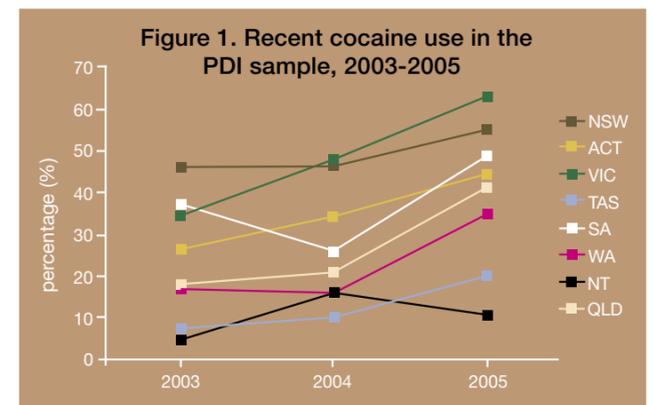
The PDI provides an overview of ecstasy and related recreational drugs such as methamphetamines, cocaine, ketamine, GHB, MDA and LSD. While these drugs are often associated with the party and rave scenes, they are used in a variety of settings, including private homes.

Fifty-one per cent of PDI respondents nominated ecstasy as their drug of choice. Responses indicated ecstasy was generally consumed in a pill form and used with other drugs. The majority of respondents also reported using other drugs while they were coming down from ecstasy. See Table 2 for an overview of the way in which ecstasy was used by regular users.

Table 2. Ecstasy use among regular ecstasy users

Mean age first used ecstasy	19
Median days used ecstasy in past six months	15
Use ecstasy weekly or more (%)	35
Median tablets in 'typical' session	2
Recently binged* on ecstasy (%)	40
Use other drugs with ecstasy (%)	93
Use other drugs to come down from ecstasy (%)	83

*Binging defined as the use of ecstasy for more than 48 hours continuously without sleep.



Ecstasy was regarded as very easy to easy to obtain and friends were the usual source (nominated by 86% of respondents), followed by known dealers (56%) and acquaintances (30%). Perceived purity fluctuated from medium to high.

The PDI also explored ecstasy purchasing patterns. The study revealed people who used ecstasy were more likely to buy the drug for themselves and their friends and to buy in bulk once or twice a month. The data revealed:

- prices ranged from \$30 to \$50 for a pill
- 77% of respondents purchased for themselves and others at the same time
- on average, respondents had purchased ecstasy from four people in the last six months
- the median number of pills bought at one time was five.

The survey also revealed that ecstasy dealers provided something of a one-stop drug shop for people who wished to buy drugs. The following drugs were also available from ecstasy dealers: speed (69% of respondents could purchase this drug from their dealer), cannabis (64%), ice (42%), base (34%), cocaine (29%), LSD (29%), ketamine (20%) and pharmaceutical stimulants (10%).

Issues for further research

Cocaine use was also flagged as an issue to be watched. While the IDRS showed an increase in use only in NSW, the PDI reported a slight increase in use in almost all jurisdictions (see Fig 1). Conference organisers highlighted the dynamic nature of the Australian drug market. 'When there is low availability of a drug or quality is poor, you will see a shift towards the use of other drugs, including pharmaceuticals,' Dr Louisa Degenhardt said. 'So it is important that we continue to monitor what we already monitor, including any harms which are associated with use.'

References

Stafford, J, Degenhardt, L and state/territory coordinators (forthcoming). *Australian Drug Trends 2005: Findings from the Illicit Drug Reporting System (IDRS)*, Sydney.

Stafford, J, Degenhardt, L and state/territory coordinators (forthcoming). *Australian Trends in ecstasy and related drug markets 2005: Findings from the Party Drug Initiative*, Sydney.

Further reading

For further information, visit <http://ndarc.med.unsw.edu.au>, where bulletins which further analyse the 2005 data will be published.

DRUGS AND DIVERSITY ISSUES FOR A MULTICULTURAL SOCIETY

PAULA GOODYER

Although we live in one of the world's most multicultural societies, with around 16 per cent of Australian residents speaking a language other than English at home, alcohol and drug services are still largely geared to an 'Anglo' population. Workers in the AOD sector say there are large gaps in our knowledge about the use of drugs among people from culturally and linguistically diverse (CALD) backgrounds, and that more needs to be done to educate their communities about alcohol- and drug-related harm, and availability of services.

A key issue is training. Service providers need to be better informed on how to engage clients from CALD communities – not just people working in alcohol and other drug services, but other community workers who may be the first point of contact for someone needing help with a drug problem, says Matt Stubbs, manager of the Ted Noffs Institute in Sydney. 'Like the wider population, people from CALD communities aren't necessarily going to look up drug and alcohol services in the phonebook because they may not know these services exist, or they may not want to admit there's a drug problem. In many cases, it's people like GPs, religious leaders, teachers, youth workers, the police and providers of legal services who also need training to understand the issues of people in CALD communities, and then assist them appropriately or refer them to drug and alcohol services.'

Lack of awareness is one reason people from CALD communities may not access help. Most young people from CALD backgrounds don't know about drug and alcohol services or local youth health services that may provide confidential services and information, according to research by NSW's Drug and Alcohol Multicultural Education Centre (DAMEC, 2001), while some others perceive health and community services as too unfriendly, busy or impatient. There's also some evidence that people from CALD communities don't seek help from AOD services until there's a real crisis.

While language might be one barrier, another is that, in some communities, there's a trend to keep problems within the family rather than seek help from outside. For some people of CALD backgrounds, the idea of seeing a counsellor is unacceptable

– not only because counselling services may not exist in their own country, but because it may be culturally inappropriate to talk about personal or family problems to strangers. There may also be fears that confidentiality may be breached if problems are disclosed. Another hurdle to accessing services for some people may be distrust of government authorities because of past experiences – including persecution – with authorities in their country of origin. This may make some clients wary of authorities in Australia, especially if their problem involves illicit drugs, points out Tony Jackson, Program Manager for Opiate Treatment and Community Detoxification with Drug Health Services at South Western Sydney Area Health Service.

'But good health services can help overcome this by building good relationships with these communities that strengthen trust,' he says, adding that word of mouth can be an effective way of promoting drug and alcohol services in the community. 'People talk to each other and if you have a quality service that's sensitive to people's needs, then word will get around.'

'We can also be more effective if we educate key people from CALD communities such as community leaders, religious leaders or GPs about drugs and alcohol, and about treatment services. If they're educated themselves they can educate their communities,' he says, adding that it's also good to have representatives from CALD groups on community-based drug action teams.

A growing problem?

As for what's known about patterns of alcohol and drug use among CALD communities, the limited research available suggests that although people from CALD backgrounds generally use less alcohol, tobacco and drugs than other Australians, the use of these substances in these communities is growing, according to DAMEC, which was established to help AOD service providers work more effectively with CALD clients. However, results of DAMEC's new research into the knowledge, attitudes and use of alcohol and other drugs among the Arabic, Chinese, Italian, Spanish, Vietnamese and Pacific Island communities may shed more light on current trends. Some findings were due to be released in late 2005.



The notion that drug use is generally lower among CALD communities was challenged in a 2003 Victorian report, *Prevention issues for communities characterised by cultural and linguistic diversity*. Feedback from practitioners working with CALD clients to reduce drug-related harm indicated that illicit drug use was probably higher among Australians from CALD backgrounds because they were exposed to more risk factors.

There are two aspects of the immigration experience that may increase the risk of drug use (Sowey 2005). One is that as people adjust to their new country, they adopt its social norms of alcohol and drug use. If these norms are more tolerant than in their home country, then there may be an increased risk of alcohol or drug abuse. The other is that the stress of adjusting to life in a new country – loss of family support in the country of origin, homesickness and problems with language and acculturation – may also increase the risk of mental health problems, and in turn the risk of substance abuse.

Yet the most significant contributors to drug abuse in CALD communities are likely to be the same as those for other Australians – social and economic disadvantages. Problems like unemployment, low income, mental health problems, low self-esteem, and poor parenting can make people vulnerable, regardless of background (Beyer & Reid 2000). There's also some evidence that people from culturally and linguistically diverse backgrounds are more likely to be unemployed, and that poverty

Alcohol, tobacco and other drug use in CALD communities

There's little research available on trends in drug use in different CALD communities, especially in new and emerging communities, but this DAMEC snapshot suggests the following:

Alcohol

There's some evidence that people from CALD communities use less alcohol than the general population. In 2001, 58% of people whose main language is not English had consumed alcohol in the last 12 months (up from 50% in 1998). In comparison, 84% of people whose main language is English had consumed alcohol in the same period.

Tobacco

Although people whose main language is not English are less likely to use tobacco – 18% had used tobacco in the last 12 months compared to 24% of people whose main language is English, according to 2001 figures – there's evidence that some sections of some CALD communities use more tobacco than the general population, while some use significantly less. In 1998, 42% of Vietnamese men and 49% of Arabic-speaking men in the central Sydney area reported using tobacco, following on from earlier studies which found similarly high tobacco use amongst males in the Greek and Chinese communities. In Arabic communities, for instance, smoking is socially acceptable and cigarettes are traditionally offered to visitors. For men, smoking is seen as a mark of manhood and maturity. While it's less acceptable for women to smoke, factors that increase their risk of smoking include feelings of isolation and beliefs that smoking helps keep their weight down. However, with the exception of the Arabic community, females from CALD communities smoked significantly less than females in the general population.

Cannabis

There's evidence that people from CALD communities use lower levels of cannabis than the general population. In 2001, 5% of people whose main language was not English had used cannabis in the last 12 months (up from 3% in 1998). In comparison, 13% of people whose main language is English had used cannabis in the same period.

Other illicit drugs

Research shows that people from CALD communities use similar levels of any illicit drug (other than cannabis) to the general population. In 2001, 7% of people whose main language was not English had used other illicit drugs in the last 12 months (up from 3% in 1998). In comparison, 8% of people whose main language spoken was English had used other illicit drugs in the same period.

*Information from the Drug and Alcohol Multicultural Education Centre's website: www.damec.org.au.

continued over page

Free forums on CALD youth drug issues

The Ted Noffs Institute and DAMEC are running a series of forums in Sydney in 2006 to help workers in the field gain more insight into the issues of young Australians from different backgrounds, including Arabic speaking, Pacifica and Vietnamese. These forums will focus on a hypothetical presentation of a young person from a CALD background looking at issues relating to their drug and alcohol use.

'There will be input and comments from a panel of respected community and religious leaders, as well as experienced service providers, and the hope is that workshop participants will gain a unique view on how AOD and related services may better respond to other cultures,' says Matt Stubbs of the Ted Noffs Institute.

Workshops will be held in a number of locations across the greater Sydney region. For more information, contact Matt Stubbs on (02) 9310 0133.

Where to find information and resources in other languages

These websites have translated information on alcohol and other drugs. However, the lack of printed translated material is a major gap in resources, with a particular need for more resources for emerging communities from Africa and the Middle East.

- **NSW Multicultural Health Communication Service (Multicultural Communication)** provides information and services to help health professionals communicate with CALD communities in NSW. Multilingual resources on health issues, including alcohol and other drugs are available at www.mhcs.health.nsw.gov.au.

- **Multicultural DrugInfo Website.** Part of the Australian Drug Foundation's service, DrugInfo Clearinghouse. Lists over 670 resources in 50 community languages, a multicultural drug and alcohol service directory for Victoria, and research relating to CALD communities and drugs and alcohol. www.druginfo.adf.org.au/multicultural.

Some services develop their own translated material if nothing suitable is already available, but never assume that just translating an existing English resource is good enough – it may not be culturally sensitive, and the level of the language may not be appropriate. Both of the above websites have information on developing appropriate translated resources.

and low income are more common in CALD communities (Beyer & Reid 2000). The extra pressures that are part of settling in a new country can compound this.

Resilience

For some young people, growing up in a culturally and linguistically diverse background can boost resilience and help protect against substance abuse. In a position paper in 2001, DAMEC described these factors as:

- close family relationships
- strong rules at home which prohibit excessive use of all substances
- strong spiritual values and discipline
- gender-based values which prohibit women from smoking tobacco and drinking alcohol
- a highly developed sense of obedience to family, community and the law
- a healthy fear of illicit drugs and of bringing shame to the family
- striving for and maintaining hard work or business interests.

While it's likely that young people from CALD backgrounds who do use alcohol and drugs do so for the same reasons as other young people – to socialise, have fun and test the limits – another reason may also be that it's a way to be accepted by their Australian peers.



While the experience of migration can strengthen the bonds within families, there may be extra problems for some young people from CALD communities because of extra stresses related to migration. Relationships with parents can come under pressure because of conflict created by the 'culture clash' between parents with traditional values, and children drawn to the values of their new country, or possibly because in some families where children are the most fluent in English and have to speak for their parents, parents may feel their authority is undermined.

Young people with mental health problems in Australia are three times more likely to become drug dependent, and some young people from a CALD background are especially vulnerable to mental illness either because of exposure to traumatic experiences or other stresses within the family.



Resources have been developed by the Australian Drug Foundation in a number of languages. To access a range of CALD resources, visit www.druginfo.adf.org.au.

On top of this, the general community's lack of recognition and respect for diverse cultural identities can have an impact on CALD young people's feelings of self-worth and identity.

Working with CALD communities

Taking the time to consult with CALD communities and understand their needs is essential for working effectively with them, says Nancie-Lee Robinson, Manager of the Centre for Culture, Ethnicity and Health in Melbourne. She advises:

- Attitudes and behaviours vary from one community to another – service providers need to have a good idea of how a community views a particular health issue before they can implement health promotion. If you don't understand a community's approach to a particular behaviour such as the use of alcohol, tobacco or other drugs, you're likely to draw on the attitude of your own culture and this may be inappropriate.

- When it comes to getting information across to the community, the community itself is your best source of advice. Translated pamphlets left in GPs' surgeries may seem like a good idea, but some people feel that picking up a pamphlet on drugs and alcohol identifies them as having a problem – information in their language on community radio programs or through newspapers in their language might be better.

- If someone doesn't speak or read English well, they need an interpreter at all critical points of service – it's not appropriate to rely on family members to act as interpreters because service providers then have no way of knowing how accurate the communication is.

- Some clients may have concerns about confidentiality – it's important to stress that service providers, including interpreters, have an obligation to keep information confidential.

- Employing bilingual workers rather than using interpreters can be an advantage – there's evidence that people are likely to travel to a centre that has a staff member who speaks their language. But, again, check with the community – some people may be reluctant to trust service providers (including interpreters) from their own community because of fears about confidentiality.

References

Bennett, D, Chown, P, Kang, M 2005. Cultural diversity in adolescent health care, *Medical Journal of Australia*, vol. 183, no. 8, pp. 436-438.

Beyer, L & Reid, G 2000. *Drugs in a multicultural community. An assessment of involvement*, Victorian Government Department of Human Services, www.druginfo.adf.org.au/multicultural.

Drug and Alcohol Multicultural Education Centre position paper, 2001 *NESB young people and substance abuse*, www.damec.org.au/resource

Houseman, D 2003. *A framework for working with alcohol and other drug clients from diverse communities*, Southcity Clinic, www.druginfo.adf.org.au/multicultural.

Kotze, B 2005. Challenges faced by CALD young people and their families, *Synergy*, the magazine of Multicultural Mental Health Australia, edition 2.

Rowland, B, Toumbourou, J & Stevens, C 2003. *Prevention Issues for communities characterised by cultural and linguistic diversity*. DrugInfo Clearinghouse.

Sowey, H 2005. *Are refugees at increased risk of substance misuse?* Drug and Alcohol Multicultural Education Centre, Sydney.

Young, S 2005. Working with CALD families: learning from the experience, *Synergy*, the magazine of Multicultural Mental Health Australia.

Improving cultural competency

- **The Drug and Alcohol Multicultural Education Centre (DAMEC)** provides training to help service providers acquire the knowledge and skills to work with CALD communities. The NSW Directory of Alcohol and Other Drugs Services Programs and Resources for People of Culturally and Linguistically Diverse Backgrounds is also available from DAMEC. Contact (02) 9669 3552, email project@damec.org.au, or visit www.damec.org.au.
- **Centre for Culture Ethnicity and Health** provides information and training to help Victorian health service providers work effectively with clients from CALD communities. Visit www.ceh.org.au.
- **Success Works (1998).** *Cultural Diversity Workbook*, Department of Human Services, Victoria. A practical tool to help organisations plan and promote culturally sensitive and inclusive services. Copies are available for loan through the DrugInfo Clearinghouse Library or contact the Department of Human Services to order a copy.

AUSTRALIAN ANTI-SMOKING CAMPAIGNS

'ECHO' CAMPAIGN STRIKES A CHORD WITH SMOKERS

TRISH COTTER, CANCER INSTITUTE NSW

The 'Excuses' (Echo) anti-smoking campaign, run in April, May and June 2005 in NSW, featured a remake of the successful Californian television commercial (TVC) 'Echo'. It's the first of a series of major mass-media campaigns developed by the Cancer Institute NSW and is the signature campaign for its concerted effort to drive down the prevalence of smoking in NSW.

The campaign targeted adult smokers of different ages and backgrounds. Its objective was to tackle smokers' self-exempting beliefs by balancing their excuses with the certain consequences of continued smoking. Key messages were to acknowledge that quitting smoking is difficult, while providing health information (as a motivator to quitting) and support for smokers making that decision to quit.

Our pre-campaign focus testing of the US version of the TVC showed it had huge potential application for Australian smokers.

Campaign echoes smokers' excuses

The creative concept of the TVC focuses on the excuses smokers use and consequences of not quitting. It sets up a number of scenarios such as 'I can't go more than a few hours without a cigarette' and presents the flip side or *echo* 'I can't go more than a few feet without the oxygen tank'. The final scenes are 'I don't think I can quit' with the echo delivered by a surgeon, 'I don't think I can operate'. This is then followed by the end tag 'Quitting is hard, not quitting is harder. Call Quitline 137 848'.

Building on the original TVC from California, two 30-second TVCs were produced for Australia. They ran continuously for an unprecedented three-month period in NSW at a total media cost of just over \$1.4 million. They have now also been shown in Victoria and Tasmania.

Initial research shows positive results

It's too early to know if there has been a significant impact on the prevalence of smoking in NSW as a result of this campaign. However, our tracking research, conducted with smokers to evaluate the campaign objectives, has provided great insight into the effectiveness of the creative material and the extent to which the campaign has resonated with the target audience.

The campaign was seen by a very high proportion of smokers in NSW. At its peak, between 80 and 90 per cent of smokers in NSW had seen an 'Echo' TVC on television. Three-quarters of those who saw the advertising perceived it to be believable; two-thirds agreed it reminded them of the dangers of smoking; and just under half found the advertising to be very relevant.

Smokers also saw clear messages in the advertising about the negative effects of smoking (two-thirds of those who had seen the advertising). The advertising's motivational ability appears to have an emphasis in the longer term – encouraging smokers to think about quitting. Of those seeing the advertising, around two-thirds were more likely to stop smoking or to think about quitting as a result of seeing the advertising.

Younger and lifetime smokers harder to reach

While the results from the advertising are positive, there are some smokers for whom the advertising has not worked as strongly – those who are less likely to quit (i.e. the 28 per cent of smokers with a low quitting salience – primarily younger or lighter smokers and those who are lifetime smokers).

Despite these differences in how smokers with different quitting salience related to the advertising, all smokers – irrespective of their quitting salience – saw and remembered the advertising at similar levels. There is evidence here that it is relatively straightforward to reach all smokers at different stages of quitting through the media. However, it is more difficult to effectively communicate with them all at once – some will take greater heed of the messages than others.

Maintaining a focus on health effects

So, do we cater for people at different stages of quitting with different messages? Not necessarily, but it would be an easy trap to fall into. This research, and lots of other research, tells us that messages about the negative health effects of smoking motivate smokers the most. Closing down the smoker's opportunity to self-exempt is an important part of this communication and providing the reassurance and support for smokers attempting to quit will help smokers succeed. What we need to focus on is a three-pronged approach of health effects messages, countering self-exemption and support to quit. And just as important, we need to ensure that all smokers see all three types of messages as often as possible.

For further information about the campaign research, contact Trish Cotter: trish.cotter@cancerinstitute.org.au.



MASS MEDIA WORKS IN THE FIGHT AGAINST SMOKING

PROFESSOR DAVID HILL, CANCER COUNCIL VICTORIA

A break in the funding drought

When the Federal Treasurer announced in the Budget speech in May 2005 that a campaign 'to tackle youth smoking' would be handsomely funded, a buzz of excitement tinged with a frisson of concern went around the tobacco control community in Australia.

It is exciting news that substantial new and ongoing funding for anti-tobacco campaigning will be available. Mass media-led campaigns are among the most potent, cost-effective and equitable means to drive down the prevalence of smoking. Evidence from Australia (Donovan et al. 2003) and from the USA (Biener et al. 2000) supports the use of persuasive advertising complemented by accessible cessation services such as the Quitline (13QUIT).

Cessation or prevention?

The break in the federal tobacco campaign drought is very welcome. Size counts – so more money should achieve a bigger effect. But the targeting and quality of the advertising also matters. A debate has raged in tobacco control circles for some time about whether the best place to spend precious campaign dollars is in prevention of uptake or cessation. Admittedly, there is much common sense and logic to support prevention – which, as we all know, is better than cure. But the evidence is stronger that cessation-focused campaigns have more impact on prevalence and would reduce tobacco-related disease levels sooner. As well, there is a collateral benefit of adult-oriented cessation messages – they seem to rub off on kids, possibly having a greater prevention effect than ads crafted for kids (White et al. 2003).

There is a difference between doing, and being seen to be doing something about teenage smoking. Hence the concern about exactly how the new campaign will be executed. As I know from my own and others' experience, there can be many a slip between cup and lip when trying to influence a socially-determined teenage activity such as smoking.

A history of effective campaigns

Fortunately in Australia we have a good record of innovation and effectiveness in mass media-led campaigns on tobacco. In the early 1980s, truly pioneering work was done in the Quit For Life campaign. This was tested on the north coast of NSW, and was subsequently implemented statewide. Remember the 'Sponge' ad in which cigarette tar is squeezed into a jar, as if from human lungs? It is the most enduring image of anti-smoking campaigns. As good as the sheer quality of the communication itself was the fact that these early campaigns



were subject to careful evaluation, thus enabling informed judgments to be made here and overseas about investing in such campaigns.

In 1996, the then Federal Health Minister, Dr Michael Wooldridge, gave a small group of us in his Ministerial Tobacco Advisory Group the chance to research, develop and test what came to be known as the National Tobacco Campaign. This was the campaign that brought you the 'Artery' advertisement. Remember those fatty deposits being squeezed from the aorta? The scene was modelled upon the actual amount of atherosclerotic deposit on the aorta of a young smoker.

The highly visceral NTC was comprehensively evaluated and was associated with a 1.8 per cent drop in adult smoking prevalence over a 12-month period, following a period when prevalence had ceased to fall. It was estimated that just the first six months of the campaign would not only lead to substantial health status improvements but pay for itself more than twice over in averted health care costs.

The campaign was picked up quickly overseas. Massachusetts was first to use it, followed by other US states. The countries that have either used it 'as is' or have adapted it now number over 40. My favourite adaptation was done in Cambodia where the Australian opening scene showing a smoker waiting anxiously for a Sydney bus was replaced by a scene in which an elderly peasant smoker views a passing water buffalo in a paddy field.

While there are lessons in history, we certainly should not get stuck in the past. What worked before may not work now. Modern campaigns can utilise well-honed qualitative and quantitative techniques to pre-test for effectiveness. And there is now considerable literature on the field regarding the effectiveness of types of advertisement. There is time and money available to get this new campaign right to liberate many more tobacco addicts who will otherwise die from their costly addiction.

References

- Donovan, R, Boulter, J, Borland, R, Jalleh, G & Carter, O 2003. Continuous tracking of the Australian National Tobacco Campaign: advertising effects on recall, recognition, cognitions and behaviour, *Tobacco Control*, 12 (Suppl II), pp. ii30-ii39.
- Biener, L, Harris, J & Hamilton, W 2000. Impact of the Massachusetts tobacco control programme: population based trend analysis, *British Medical Journal*. August 5, 321(7257), pp. 351-4.
- White, V, Tan, N, Wakefield, M & Hill D 2003. Do adult focused anti-smoking campaigns have an impact on adolescents? The case of the Australian National Tobacco Campaign, *Tobacco Control*, 12 (Suppl II), pp. ii23-ii29.

*An extensive reading list for this article is available on request from the editors.

HOMELESS DRUG USERS CHANGING THE WAY WE DO THINGS

KIM RAYNER, CONSULTANT TO THE HOMELESS AND DRUG DEPENDENCY PROGRAM

A three-year trial program has changed the way services are offered to people who use Melbourne's inner-city Crisis Supported Accommodation Services (CSAS).

Background

In the late 1990s, CSAS staff were becoming increasingly concerned by the changing profile of the residents using their services. Many of the homeless men and women were presenting with problematic drug use and complex health and welfare issues.

Staff also reported a significant shift in the behaviour of residents. There were increasing incidences of overdose, injecting drug use, drug dealing, violence and intimidation, poly-drug use and the commencement of illicit drug use by previously non-drug using residents.

Research conducted at the time by crisis accommodation provider Hanover Welfare Services (Horn 1999), also reported that heroin use among Hanover's clients had increased by 40%, to the point that clients had a prevalence rate of heroin use ten times greater than that of the general community.

Another frustration for CSAS staff was that many of the homeless clients using their services weren't able to readily access drug treatment services. These delays often resulted in a loss of motivation to make changes or seek help, further compounding the situation of homelessness, drug addiction and poor health experienced by residents. While many people had stayed in crisis accommodation in the past, they often received limited assistance to effectively address their drug addiction.

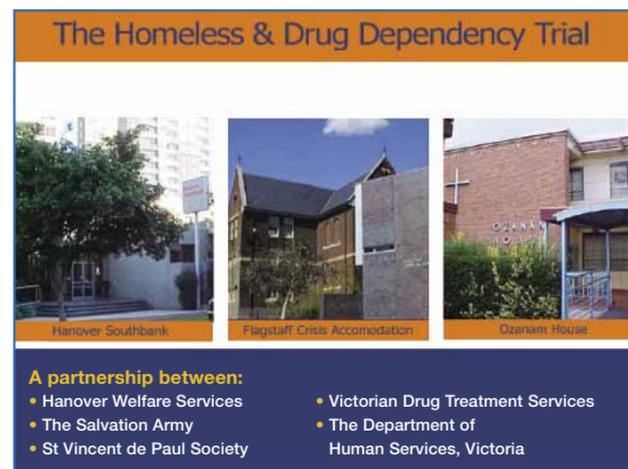
A new approach to care

Against this background, the Homeless and Drug Dependency Trial (HDDT) was developed and implemented as a three-year trial, starting in July 2001. Funded by the Victorian Department of Human Services (DHS), \$7.6 million was provided to work with presenting issues within three of Melbourne's major crisis accommodation services – Hanover Southbank, The Salvation Army's Flagstaff and St Vincent de Paul Aged Care and Community Services Ozanam House.

A partnership was formed between CSAS, the DHS (Drugs Policy and Services Branch and the Office of Housing (SAAP)), drug and alcohol services, and health and housing services. This partnership enabled the provision of an integrated service for drug dependent homeless individuals, 'with the aim of reducing their drug dependence, minimising the harm they do to themselves and building pathways out of homelessness and drug addiction toward secure accommodation and stable lifestyles' (Interagency Working Party, 2000).

Profile of the homeless population

Initially, a comprehensive survey of 95 homeless residents was conducted, confirming that a very high level of social, economic and health disadvantages existed amongst clients of CSAS (Rayner 2003). The majority of respondents had not progressed beyond secondary education, were unemployed and were a highly transient group, having moved an average of 11 times in the previous 12 months. Cycling in and out of crisis accommodation was common, with 72% of respondents reporting that they had stayed in a crisis shelter in the past.



All participants were using illicit drugs and/or alcohol at the time of the survey and drug dependence was one of the main reasons reported (63%) for currently being homeless. Rates of use in the six months prior to the survey for the four most used drugs were cannabis (92%), alcohol (68%), amphetamines (65%) and heroin (64%). Further, poly drug use was widespread as was injecting drug use, with 77% having done so in the past month. Forty-one per cent of residents in the study had hepatitis C. This combined with the injecting behaviour of the group meant there was a high risk of blood borne virus transmission among residents and the community.

Mental health disorders were also prevalent, with 79% of residents in the survey having been diagnosed in the past with clinical depression, anxiety disorder (47%), psychosis (42%) and schizophrenia (23%). Also of concern were the rates of attempted suicide, with 41% having made an attempt in the past.

Trial model

The HDDT adopted a broad approach to service provision for this complex client group. The aim was to trial strategies which addressed both the housing and drug treatment needs of participants, as well as other health and social problems. Thus it was essential that participating services and government sectors adopted a collaborative approach.

Two simultaneous approaches were implemented. The first was the introduction of activities and services designed to build CSAS' capacity to help and assist drug dependent clients. This resulted in significant changes to the CSAS environment and included:

- professional development for all staff, providing extensive training, mentoring and formal AOD qualifications
- active daily monitoring and discussion among staff in relation to residents' drug use patterns and harms
- improved health care with increased on-site nursing clinics for clients
- provision of CSAS-based diversionary activities for residents, including computer training, literacy and life skills courses, recreation activities and peer education.

The second approach involved the introduction of a new service directed at engaging drug-using residents and then providing continuous case management and support as they moved on from crisis accommodation. This approach included addressing clients' needs for housing and social support, funding treatment places (residential withdrawal and rehabilitation) and access to alcohol and drug supported accommodation programs established as part of the trial.

Crucial to the program was the employment of primary case managers within CSAS. A primary case manager was appointed to each client who took part in the trial. Their job was to resolve the client's initial crisis and then provide a supportive and counselling role, working with each client in developing a recovery pathway most suited to that individual and for the time period required. The case managers provided an ongoing point of contact for clients after they had moved away from CSAS and started their tailored program, whether that involved the community reintegration day program, a residential detox or treatment program, or in supported public housing.

Outcomes

The trial's continuous primary case management and pathways response delivered continuous care to 213 drug dependent homeless clients. The median age of participants was 33 years, with a high number of clients in the 25-29 age bracket. On average, clients stayed in the trial for 13 months.

Evaluation findings indicate that the program successfully engaged and retained participants in treatment (Rayner, Batterham & Wiltshire, April 2005). Substantial improvements in housing stability occurred, with greater levels of access to and maintaining of transitional and public housing.

There was a reduction in the harms associated with participants' drug use, and a reduction in the levels and patterns of drug use.

Continued involvement in the trial by participants significantly reduced the number of arrests, evictions, physical health problems and suicide attempts. At the end of the trial, many participants had improved health, had reduced or were abstinent from problematic drug use, were employed or involved in educational pursuits such as TAFE and had reunited with family and friends.

The accommodation services and their staff also experienced significant benefits from the trial. The comprehensive professional development program offered to staff has introduced a high level of AOD knowledge and casework skills to Melbourne's homeless accommodation sector. The daily monitoring of residents' drug use also resulted in health promotion strategies being introduced and this improved staff members' ability to identify and assess problematic drug use. This was complemented by opportunities to help residents access treatment and other welfare options.

Some people need more help

While the trial enabled many people who were homeless and drug dependent to adopt more stable lives, it also identified a sub-group of trial participants that require long-term and possibly indefinite support to remain stable and to prevent a deterioration in their health and wellbeing. Many of these have a co-occurring mental illness. An important finding is that future programs will need to accommodate the different levels of support required among homeless clients if they are to remain flexible and effective in supporting and treating complex clients.

Moving on

The Homeless and Drug Dependency Trial was a finalist in the Victorian 2005 Awards for Innovation and Excellence in Primary Health Care, Direct Care Category. It has resulted in an ongoing program funded jointly across three separate Victorian government departments. Additional funding has also been attached to the program in order to more effectively address the needs of homeless clients with a concurrent substance use and mental health disorder.

More information

To learn more about the current service or to read the full evaluation findings of the trial, contact Bill Couche – bcouche@hanover.org.au.

References

- Horn, M 1999. *Drugs and homelessness: the prevalence of alcohol and drug dependence among people experiencing homelessness*, Hanover Welfare Services, South Melbourne.
- Inter-Agency Working Party 2000. *Overview of the Homeless and Drug Dependency Trial*, Hanover Welfare Services, South Melbourne.
- Rayner, K 2003. *Making change possible: sharpening the focus on homelessness and substance use within crisis supported accommodation services in Inner Melbourne Victoria*, Hanover Welfare Services, South Melbourne.
- Rayner, K August, 2004. *Building capacity, final-year evaluation report of the Homeless and Drug Dependency Trial's capacity-building activities*, Report 8, Hanover Welfare Services, South Melbourne.
- Rayner, K, Batterham, D, Wiltshire & R, April 2005. *Rebuilding lives, final year findings on the Homeless and Drug Dependency Trial's continuous primary case management and pathways response (part B)*, Report 9, Hanover Welfare Services, South Melbourne.

Upcoming conferences

7–8 February 2006

Victorian Alcohol and Drug Association (VAADA) Conference '06

Rydges Riverwalk, Melbourne

For more information visit www.vaada.org.au

7–9 February 2006

19th Annual Conference of the Australian and New Zealand Society of Criminology (ANZSOC)

Wrest Point Convention Centre, Hobart

For more information visit www.cdesign.com.au/anzsoc2006/

20–22 February 2006

5th Australasian Viral Hepatitis Conference

The Sydney Masonic Centre, Sydney

For more information visit www.conferenceinfo@hepatitis.org.au

30 April–4 May 2006

17th International Conference on the Reduction of Drug Related Harm

Vancouver, Canada

For more information visit www.harmreduction2006.ca

24–26 May 2006

5th International Conference on Drugs and Young People

AJC Convention Centre, Randwick, Sydney

For more information visit www.adf.org.au

3–5 July 2006

Australian Winter School in the Sun

Brisbane

For more information visit www.winterschool.info

10–13 September 2006

2006 World Congress on Alcohol Research

International Society for Biomedical Research on Alcoholism

Sofitel Wentworth Hotel, Sydney

For more information visit www.isbra2006.com

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

Email: editor@ancd.org.au

Telephone: (02) 9280 3240

Or write to us:
Of Substance
66 Bay Street
Ultimo NSW 2007
Australia