HEPATITIS C
Improving access to treatment

INDIGENOUS PEOPLE IN PRISON
The role of drugs and alcohol

CULTURAL CHANGE
Tackling drinking habits in NZ

DRUG USE AND THE WORKFORCE
A risky mix

A DRINK, A SMOKE, A JOINT
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Welcome to the April 07 issue of Of Substance.

People who use drugs, particularly those who choose to inject, often have multiple struggles. For the clinicians and others who work with them, helping clients sort through all these needs can be an enormous task. The complexity of the challenge coupled with pressures on time and resources means that often there are areas in clients' lives which get less attention than is required.

Sometimes, one of these areas is blood borne viruses such as hepatitis C. We know that up to 80 per cent of hepatitis C cases occur from injecting drug use. Yet many people who receive drug and alcohol treatment are not accessing screening or treatment for the condition. In the first of a two-part series, we discuss the latest news about hep C and explore the need to better integrate treatment for blood borne viruses into drug treatment services.

Drug use occurs in all areas of society and among most age groups. In a collection of three articles, we explore two different settings for drug use. On pages 18-21, we discuss drug use in Australia's workforce, and on pages 22-24, we look at what tomorrow's workers – today's students. It is always useful to look beyond our shores to see how other countries are approaching alcohol and other drug issues. We go 'across the ditch' to New Zealand to understand what they're doing with 'doing something about alcohol'. When I presented my research I had the audacity to suggest that there was a need to examine the cultural place of alcohol in that community – its financial, symbolic, social, political and functional role in day-to-day life.

I had noted alcohol was the lucky envelope prize at the primary school fete; most households had a second refrigerator for the beer; the only place you could get air-conditioned relief from the 40+ degree days was in the pubs, clubs and one supermarket; and there was no other place where you could access a drink of water.

But surely I had been asked to examine 'the alcohol problem' some said, 'not just the way we live!'

When I used the word 'culture' many assumed I must be talking about the local Indigenous people's alcohol consumption that was sometimes visible in the dry creek bed, where small groups gathered to share a flagon of wine. This was clearly seen as curiously different, more dangerous and the proper topic of a study of culture; while the observations of the clustered groups of non-Aboriginal Australians engaged in shooting-in-rounds in one of the many hotel bars had nothing to do with culture.

My observations were not challenged but the reflections and commentary on them was strictly criticised by academic anthropologists who suggested that my use of the word 'culture' was intellectually inappropriate. However, I seemed to be readily understood at the 'coal face'. My observations fuelled thinking and program ideas among local government, health, welfare, police, education, the mine-side unions and even mine management. A tap was installed in the main street. Industrial negotiations included alcohol-related clauses. The local police developed protocols with the hospital. Alcoholics Anonymous' membership rose by 50 per cent. Schools exchanged alcohol prizes for games and food.

Many years on, I have spent a career working with alcohol issues at both local and national policy-making levels. It is rewarding to stay in a field long enough to explore, test and redevelop ideas and to see them taken up by others, including in February's national conference 'Thinking Drinking II: From Problems to Solutions'. It is reinforcing to see the new work on alcohol happening in New Zealand (see pages 25-7) and their key message: it is not always the drinking but the way we drink – the culture of drinking – that needs to be our focus. Which is just what I meant in 1980.
IN BRIEF...

Positive image website
The discrimination that can go with having hepatitis C or having injected drugs is a major community problem – and some of the worst discrimination occurs in the health sector, according to Anne Madden, Executive Officer of the Australian Injecting and Illicit Drug Users’ League (AIUFL).

People with a history of injecting drug use routinely experience poor and degrading treatment in the health sector, she said. Speaking at the launch of a new AIUFL website, ‘Positive not punitive’, Madden said the website aims to educate both the community and the media about hepatitis C and injecting drug use, and promote more compassionate and positive action rather than punitive and discriminatory attitudes.

The ‘Positive not punitive’ website provides personal stories from people affected by hepatitis C to convey the impact that discrimination can have on their lives. It also includes a ‘prejudice questionnaire’ that website visitors can fill in to evaluate their own attitudes to people who are HCV positive.


Public health activities – where the money goes
In 2004-2005 governments in Australia spent a total of $1436.3 million on public health activities – of that, $184.2 million (13.5 per cent) went on the prevention of hazardous and harmful drug use. These figures come from the National Public Health Expenditure Report 2005, the latest report on spending on public health activities in Australia, compiled by the Australian Institute for Health and Welfare. For more details on spending in this area, or to find out where the rest of the money goes, see the full report at www.aihw.gov.au/publications/index.cfm?title=10271.

Tackling AOD issues in the Pacific
A report into illicit drug issues in Asia and the Pacific commissioned by the Australian National Council on Drugs in 2005 found that there was a lack of information available to allow a good understanding of illicit drug use and its related harms in Fiji, Papua New Guinea, Samoa, the Solomon Islands, Tonga and Vanuatu.

In response to this, the Pacific Drug and Alcohol Research Network (PDARN) was established to tackle problems of drug and alcohol use in the region. The network aims to provide a good evidence base and research capacity to help develop appropriate responses and policies on drug and alcohol use. It will also work with government agencies, the private and public sector, and faith and community-based organisations to enable people to strengthen their communities and respond to the challenges resulting from drug and alcohol use.

For more information about PDARN, including a report from the network’s second regional workshop held last year, go to the website at www.pdarn.org.au.

Recent conferences – papers now available online
•  The Australasian Professional Society on Alcohol and Other Drugs (APSAD) conference held in Cairns, November 2006, drew a wide range of Australian and overseas speakers focusing on emerging alcohol and other drug issues in different settings including urban, regional and rural locations, and in Indigenous populations and the Asia-Pacific region. Papers from all three days of the conference are now available at www.apsad.org.au/index.php?menu=conf.

•  The success of the 2005 conference, ‘Thinking Drinking: Achieving Cultural Change by 2020’, which focused on solutions to risky drinking in Australia, has been followed by a sequel, ‘Thinking Drinking II: From Problems to Solutions’. Held in Melbourne in February by the Australian Drug Foundation, it looked at how to change attitudes, customs and policies to create sustainable change to Australia’s drinking culture. Papers from the conference, which had speakers from the areas of health, welfare and youth community development, law enforcement, research, policy, local government, mental health and education, are available at www.adf.org.au.

New school drug education award
The National Drug & Alcohol Awards have announced a new award category: ‘Excellence in School Drug Education’. The award will recognise the school that demonstrates innovation and successful outcomes in school drug education to address drug and alcohol issues. The award is open to Australian schools in all sectors: primary and secondary levels; and government and non-government schools.

Nominations for all awards are due in by 30 April. The Award ceremony will be held on 22 June. For more information visit: www.drugawards.org.au.

Launch of the Alcohol & Other Drugs Charter
The newly completed Alcohol and Other Drugs Charter was launched at the ‘Thinking Drinking II’ conference in Melbourne on 28 February. Following extensive consultation this document has been developed by the Australian National Council on Drugs (ANCD) for the drug and alcohol sector.

The Charter includes references to families, individual drug users, practitioners, key stakeholders and basic human rights such as shelter and safety, as well as citizen rights. It also provides a broad range of principles and goals to assist stakeholders within the AOD sector in the development and implementation of AOD policy. The ANCD also expects that the Charter will inform the general public on AOD-related policy issues as well as being included in a range of publications relevant to sectors such as law enforcement, public health and welfare.

A number of key stakeholders across the AOD and related sectors have already endorsed the Charter. Organisations and individuals are invited to become co-signatories via our collective websites. For more information on the Charter and how to sign up to the Charter you are invited to visit the ANCD’s website at www.anecd.org.au.

Reviewing Australia’s alcohol guidelines
The Australian Alcohol Guidelines are being reviewed by the NHMRC. Last revised in 2001, the updated guidelines are expected to be released by the end of this year.

One focus of the review is the guidelines relating to pregnant women and alcohol consumption – some experts suggest that the current guidelines (no more than seven standard drinks per week and no more than two on any one day) should be changed to recommend no alcohol at all during pregnancy. The review will also examine alcohol addiction, the impact of alcohol use on the length and quality of life, and Indigenous Australians’ alcohol use.

The review team will invite input from the community and health care practitioners through formal consultation later this year. Notices will be published on the NHMRC website closer to the time.

The Victorian Premier’s Drug Prevention Council hosted a community consultation forum in Melbourne in February to gather community views on the current alcohol guidelines which will be fed into the NHMRC’s review. Key issues discussed at the seminar included:

•  What is the purpose of alcohol guidelines? Do they encourage people to ‘drink up’ to meet them?
•  Can guidelines provide advice for everyone, including those with special needs?
•  Should zero drinking be recommended for women planning pregnancy and while pregnant?
•  Is it confusing to mix the benefits of drinking among the risks and harms?

Health professionals’ attitudes: resource

For people with alcohol and other drug (AOD)-related problems, one of the major barriers to accessing good clinical care is the stigma attached to their AOD use and to other problems related to their use of these drugs. This stigma is often reflected in negative attitudes of staff who provide services for these clients.

A new resource, from the National Centre for Education and Training on Addiction at Flinders University in Adelaide, is designed for use by trainers and educators to encourage health professionals to explore and evaluate their attitudes towards people who use drugs.

Some examples of judgments of deservingness used in the resource include:

• ‘people who use drugs don’t deserve medical treatment as much as other people’
• ‘it’s their fault that they are having problems’
• ‘they chose to use the drug – now they have to live with the consequences’.

The resource provides materials and activities designed to provide a template for educators and trainers which can be adapted to suit the needs of different courses or training.

To download a copy of the resource, go to www.nceta.flinders.edu.au/documents/AttitudesBookletFinal.pdf.

Inappropriate alcohol advertising

How easy is it for consumers to protest against inappropriate alcohol advertising? Very easy – if they use this new postcard developed by the WA Community Alcohol Network, an initiative of the Injury Control Council of WA. Called Help us put a stop to inappropriate alcohol advertising, the resource is a reply paid postcard which goes straight to the Advertising Standards Bureau. It can be filled out if an alcohol advertisement doesn’t comply with the Alcohol Beverages Advertising Code. People fill in basic details about the product and when they saw/heard the ad, and tick the appropriate box as to where the ad contravenes the code. Anyone interested in copies can contact Sarah Jaggard of the ICCWA at sjaggard@iccwa.org.au.
The recent article on the management of drug-using pregnant women and their babies (January 2007) recalled to me the pioneering work of Dr Edith Collins. Edith Collins, who died in 2004, developed the specialty of maternal and neonatal addiction treatment in Australia almost entirely by herself.

After completing her medical degree in Edinburgh, Scotland, Edith trained as a paediatrician in England before moving to Australia with her family. She had a lifelong interest in the prevention of birth defects. Edith Collins and her colleague Gillian Turner were the first to describe fetal alcohol syndrome in Australian babies. She worked with Margaret Burgess to prevent congenital rubella through the institution of schoolgirl vaccination. She subsequently identified a number of babies who were small for gestational age due to maternal ingestion of salicylates. Her work led to the removal of caffeine from the common headache preparations of the day, resulting in fewer affected babies and fewer women with chronic renal failure.

Edith Collins took up the position of staff paediatrician at Crown Street Hospital in 1973. There she became aware of the large number of pregnant women attending the hospital who had significant drug consumption. At this time the principal illicit drug in the inner areas of Sydney was heroin. As a paediatrician, she noted a high incidence of irritability and feeding difficulties among many newborn babies and identified this as due to the neonatal opioid withdrawal (abstinence) syndrome.

Having established that injecting heroin use was common among some women in inner Sydney, she investigated the best methods to treat this population, and importantly to engage pregnant women in drug treatment and good antenatal care in the first place. She quickly appreciated that trying to secure and maintain abstinence from heroin and other opioids was difficult. Detoxification caused considerable fetal distress. Noting the work of Dr Loretta Finnegan in the USA, Edith established the first specialised drugs in pregnancy clinic in Australia. This offered pregnant women stabilisation and maintenance on methadone throughout their pregnancy and beyond. She also introduced systematic monitoring of neonatal withdrawal and developed treatment for the syndrome. She quickly developed a reputation for excellent medical treatment amongst this disadvantaged group of women and a highly empathic approach to them as people.

Edith secured NHMRC research funding for a cohort study of babies born to opiate-using women. She compared their physical, neuro-cognitive and psychosocial outcomes with those of a control group of babies born to non-drug-using, age-matched mothers. This research was pivotal in demonstrating that the outcome of babies born to mothers who had been commenced on methadone early in pregnancy was identical on all physical and neuro-developmental parameters to that in the control group of babies born to non-using women. The outcome was far superior to that seen among babies whose mothers had continued to use heroin throughout much or all of their pregnancy. She also identified the importance of nutrition and concomitant cigarette smoking as a cause of low birth weight.

The work that Edith Collins did was pioneering and to the immense advantage of a group of disadvantaged and disenchanted women and their babies. But it was not popular work amongst the medical establishment. When the drugs in pregnancy clinic relocated to King George V and Royal Prince Alfred (RPA) Hospitals, following the closure of Crown Street Hospital in the mid-1980s, there was consternation amongst many staff in these august institutions, as these women were viewed as ‘not our sort of patient’.

As well as the challenge of providing good treatment to this disadvantaged patient group, Edith also experienced the difficulties of being an advocate for the underprivileged. The proposal to establish a purpose-designed clinic for the drugs in pregnancy service was greeted with organised opposition by some of the medical hierarchy and local developers. Eventually a ‘temporary’ clinic in an unattractive building on the RPA campus was opened. When Edith retired in 1993, the specialist clinic that she had worked so hard to establish was subjected to ‘mainstreaming’. This led to a reduction in the numbers of patients, and the residual service no longer fulfilled the role of a statewide centre of excellence.

Nonetheless, Edith Collins’ pioneering spirit continues and it is encouraging that succeeding generations have taken up the challenge and are now providing a range of treatments that are evidence based, available and humane. Edith Collins would have been proud of their achievement.

Our January issue sparked plenty of discussion amongst readers. Here, we share two recent responses.

EDITH COLLINS: NEONATAL PIONEER

JOHN B. SAUNDERS*

The recent establishment of DrinkWise Australia has focused industry needed attention on the issue of industry influence upon the alcohol and drug research and policy agenda. DrinkWise is funded by the alcohol industry and the Australian Government, and half its board is from the alcohol industry.

DrinkWise describes itself as a ‘self-governing, independent, not-for-profit organisation focused on encouraging a healthier drinking culture in Australia’ (DrinkWise Australia, 2006). Others have called it an industry advocacy group (Hall & Room 2006).

A number of commentators are worried about the independence of DrinkWise in terms of what research it might fund and what alcohol policy and public ‘responsible drinking’ messages it promotes. Because of its relationship with the alcohol industry, some fear DrinkWise may be unable to lobby for evidence-based policies that the industry disagrees with, such as targeted alcohol taxation and availability restrictions that aim to reduce consumption (Hall & Room 2006).

Competing interests are inevitable

Concerns about industry influence and competing interests in public policy and research are not new or unique to Australia or DrinkWise. Nor are they restricted to the alcohol industry. We should accept that advocacy groups will always seek to influence research and policy agendas. These days many such groups strive to do so in direct partnership, or at least in some relationship, with industry, government, researchers and practitioners. Indeed, each of these stakeholder groups independently seeks to exert their own influence.

In this public policy environment industry involvement and competing interests are inevitable. Those closest to research and policy agenda making are likely to hold a number of professional roles. It is becoming increasingly difficult to balance the multitude of relationships, roles and obligations that co-exist for many professionals. We might rightly wonder if there is any such thing as independence, and if there is, how is it actually preserved?

Unfortunately, there is currently no authoritative national policy guideline for the alcohol and drug field dealing with the ethical limits of industry relationships and competing interests. Examples of varying practices are easy to find in relation to industry gifts and honorariums, hospitality, free samples, support for conferences and other meetings. Few national organisations in the alcohol and drug field have formal policies on this issue.

National policy on ethical limits needed

At the moment it falls mostly to individuals to reach their own conclusions about how to respond (if at all) when they feel ‘uneasy’ about a potential or existing industry relationship(s), or sense that there is tension between the interests and obligations of different professional roles.

The DrinkWise example is high profile. The debate about it is important and should continue. However, let us also harness the interest in this particular issue to address the broader ethical questions of relevance for the alcohol and drug field. For example, how do we tell when competing interests matter, and what should our response be? How should we balance the competing interests and obligations we have in our different professional roles? What stance should professionals working in this field adopt on relationships with the alcohol and pharmaceutical industries? Is tobacco industry funding for harm reduction research (e.g. smoke free products) really out of the question?

A nationally endorsed policy or guidelines on the ethics of industry relationships and competing interests that encapsulates the diverse alcohol and drug field should be viewed as an urgent priority. A useful starting point is the recently revised Royal Australasian College of Physicians guidelines for relationships between physicians and industry. National peak bodies such as the Alcohol and other Drugs Council of Australia, the Australasian Professional Society on Alcohol and other Drugs, and the Association for Prevention and Harm Reduction Programs have an important role here, as do the various state/territory networks (e.g. VAADA, NADA, WANADA, ADTC, SANDAS).

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Among people who had recently taken alcohol and other relieving (13%), cholesterol-lowering and indigestion (each was a trend towards greater recent use of alcohol and all was most common among those aged 65+ years, and there used alcohol and both types of medicines. Daily drinking number of medicines (median=4). In the last 24 hours, 25% Australians aged 65+ years were using the greatest level of stringent evaluation as pharmaceutical drugs and are not necessarily dispensed by trained professionals. While their relative safety is under-researched, adverse effects and physiological changes increase the risk of interactions between medicines and alcohol. Secondly, there is a trend for the oldest age group (65+ years) to have recently consumed alcohol and all medicine types. Given age-related physiological changes, these data indicate that older Australians in particular may be at risk of interactions between alcohol and their medicines. While we do not know the quantity of alcohol consumed, or whether alcohol was used at the same time as medicines, interactions can occur with low blood alcohol content among older people. Despite this, there were few concerns about the effects of mixing alcohol and the medicines people reported using. This illustrates the need for continued efforts to provide education on safe use of medicines.

**MEDICINE USE**

This poster presented preliminary unweighted data (n=815, response rate=75%) collected from a panel of Australian adults recruited by telephone using random probability sampling for the Pfizer Australia Health Report. It examined: (i) the prevalence and patterns of concurrent use of prescription and over-the-counter medicines, CAM and alcohol; and (ii) concerns about medicine-alcohol interactions. A diary was used to facilitate recall of all medicines used in the past 24 hours.

After adjusting for age, gender and drinking status, women and adults 45+ years were significantly more likely to have used conventional medicines and CAM in the past 24 hours. Australians aged 65+ years were using the greatest number of medicines (median=4). In the last 24 hours, 25% of adults had consumed alcohol and taken a conventional medicine, 18% had used alcohol and CAM, and 14% had used alcohol and both types of medicines. Daily drinking was most common among those aged 65+ years, and there was a trend towards greater recent use of alcohol and all medicine types among this group. Daily drinkers had used alcohol and a wide range of commonly used medicines in the last 24 hours including: blood pressure (25%), pain-relieving (13%), cholesterol-lowering and indigestion (each 12%) and blood-thinning (10%) medicines, vitamins and glucosamine (each 15%), fish oils (11%) and more. Among people who had recently taken alcohol and other medicines, one-half (49.1%) were ‘not at all’ concerned about potential interactions.

Among daily drinkers, there was a trend for the oldest age group (65+ years) to have recently consumed alcohol and all medicine types. Given age-related physiological changes, these data indicate that older Australians in particular may be at risk of interactions between alcohol and their medicines.

**Driving, Sexual and Injecting Risk Behaviours**

Rebecca Jenkinson1; Paul Dietzel3 & Damien Jolley1

Monash Institute of Health Services Research, Monash University1, Turning Point Alcohol and Drug Centre2,3

This paper examined the prevalence of driving, sexual, injecting and other risk behaviours among a sample of young psychostimulant users in Melbourne. A non-representative convenience sample of 150 participants was recruited to take part in the research. Eligibility criteria were: aged 18-30 years; and used ecstasy, methamphetamine or cocaine at least once a month during the previous six months. Participants were recruited through targeted advertising (on club/dance websites, in music street press, at events/dance parties) and through researcher contacts and ‘snowball’ sampling (participants referring friends and associates). Participants were young, well-educated, polydrug users. Just over half (52%) of the sample were female, with a mean age of 24 years. The majority reported being securely accommodated (96%), identified English as the main language spoken at home (93%), and nominated their sexual identity as heterosexual (88%). Eighty-nine per cent had completed Year 12 (VCE) and almost two-thirds had completed qualifications after school. Just over two-thirds (68%) were currently employed and 19% were currently full-time students.

Forty-three per cent reported ecstasy as their main drug of choice, followed by speed (15%) and cannabis (12%). The majority reported recent (past six months) use of alcohol, ecstasy, speed, cannabis and tobacco, while around half reported recent use of cocaine and crystal meth. Close to half (46%) of the sample reported binging on psychostimulants or party drugs during the past six months (for more than 48 hours continuously without sleep), while 9% reported that they had passed out and been unable to be woken or fallen into a coma due to using these drugs during that time. Ten per cent reported having ever injected a drug and 5% reported injecting a drug during the month preceding interview. Prevalence of needle sharing was low, although almost three-quarters (71%) of those who had injected during the past month were experiencing injection-related health harms in that time.

A significant proportion (85%) reported sexual activity while under the influence of psychostimulant (and other) drugs during the previous six months, and unprotected sex during that time was not uncommon. Less than half (47%) of the sample reported having ever had a sexual health check-up, and of those who had, 18% had been diagnosed with a sexually transmitted infection. One in three had not been tested for bloodborne viral infections such as HIV, and half (49%) had been vaccinated against hepatitis B. Close to half (47%) of those who had driven a car during the previous six months had reported having driven whilst under the influence of alcohol, 19% during the month, and 58% had driven within one hour of having taken an illicit drug (most commonly after taking speed, ecstasy, cannabis or crystal meth).

Given some of the risk practices identified amongst this group, continued monitoring of regular ‘club drug’ (psychostimulant) users is warranted. Education and harm reduction campaigns need to consider targeting this group with specific health promotion messages in regard to safer drug use, sex, injecting and driving practices.

**METHODONE TO ABSTINENCE: RESIDENTIAL HEALTH OUTCOMES**

Carla Janssen, Peter Connie & Garth Poppole

We Help Ourselves Methadone to Abstinence Residential Program

This paper examines the effect of the program on drug use, well-being, well-being and social functioning post treatment. All 68 clients included in the first study were approached mid-2005 to participate in follow-up research. Forty-eight clients (71%) were successfully interviewed. The interviews took place approximately one year after leaving the program.

The program was not abstinence based, but it was designed to help clients reduce their use of drugs and develop skills to maintain a drug-free lifestyle. The program was a modified therapeutic community model for clients on opioid replacement therapy who want to gradually withdraw from methadone or buprenorphine and pursue a drug-free lifestyle. The length of the detoxification process is often two to three months. The duration of the residential therapeutic program is four months and the extended program is two months, giving a total of six months of treatment. WHOS conducted an initial research study to examine the client and treatment profiles of those who seek treatment at WHOS MTAR. All 68 clients who entered treatment between July 2003 and December 2004 were selected for the study.

Sixty-three per cent of clients were male and the mean age was 33 (range 20-53). Many clients were self-referred (82%) and most others were referred via AOD agencies (20%) and through the courts (12%). The average methadone dose in admission was 72 mg. Sixty-six per cent of clients used illicit drugs (methadone 15%).

Fifty-four per cent of all clients who started treatment completed the detoxification process. Most of those who achieved this treatment milestone continued their treatment in the program with 22% of those originally admitted completing the extended (aftercare) program. See figure 1.
DRUGS, ALCOHOL AND INDIGENOUS IMPRISONMENT

DON WEATHERBURN*

Indigenous Australians make up less than two per cent of Australia's population but account for 22 per cent of all Australian prisoners. The problem of Indigenous over-representation in prison first came to public prominence in the late 1980s during the Royal Commission into Aboriginal Deaths in Custody. In the years that followed Commonwealth, state and territory governments made determined efforts to try to reduce the rate of Indigenous imprisonment. Tragically, those efforts have failed. The Indigenous imprisonment rate is now higher than it has ever been.

We are so accustomed to hearing depressing statistics on Indigenous disadvantage it is easy to become inured to them. This is an attitude we cannot afford. Prison is very expensive. Having a prison record substantially reduces an individual's subsequent employment prospects. Australia's high Indigenous imprisonment rate has been the subject of frequent criticism in international forums. The courts may have little choice but to imprison violent and persistent offenders but there has to be a better way of preventing crime than waiting for people to offend and then locking them up in cages for a substantial portion of their lives.

High-risk alcohol consumption and drug abuse were very strong predictors of prosecution and imprisonment

The popular view

As always with seemingly intractable problems, it helps to step back for a minute and review the assumptions on which our efforts to reduce Indigenous imprisonment have been based. The received wisdom is that Indigenous imprisonment is a reflection of Indigenous economic and social disadvantage. This was the view advanced by the Royal Commission into Aboriginal Deaths in Custody and accepted by the Keating Government. And at first blush it appears to make a lot of sense. Most people know that there is a relationship between disadvantage and crime. Aboriginal people are among the most disadvantaged of all Australians. Tackling Indigenous disadvantage therefore seems like a good way to reduce the number of Indigenous Australians who end up in court and prison.

If only it were as simple as this. Indigenous Australians experience poorer outcomes than non-Aboriginal people in a vast range of cultural, economic and social domains. They are less likely to be employed, less well paid, more likely to die young, more likely to abuse drugs and alcohol, less likely to complete school, more likely to have a physical or intellectual disability, less likely to own their own home, more likely to be the subject of a report of child maltreatment and more likely to become victims of domestic violence. Should we assume that progress in all of these areas is necessary if we are to reduce the rate of Indigenous imprisonment? Or are some areas of Aboriginal disadvantage more closely linked to Aboriginal imprisonment than others? This is a question that the Royal Commission never satisfactorily addressed.

A new focus

Recent research has started to shed some light on this problem. Common sense suggests that factors like poverty and unemployment should be the leading causes of Indigenous contact with the justice system but common sense may be wrong. Lucy Snowball, Boyd Hunter and I recently used the 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) to examine the relative importance of a variety of factors as predictors of arrest and imprisonment. We found that high-risk alcohol consumption and drug abuse were very strong predictors of prosecution and imprisonment, even after controlling for a wide range of factors associated with economic and social disadvantage. In fact, high-risk alcohol consumption and drug abuse were much more powerful discriminators of which Indigenous Australians end up prosecuted and imprisoned for an offence than factors like unemployment, school retention, financial stress or living in a crime-prone neighbourhood (though all these factors are important).

The criminogenic effects of drug and alcohol abuse in Aboriginal communities are probably much larger than this study suggests. Large-scale longitudinal studies in the United States have found that parents who abuse illicit drugs or alcohol are at much higher risk of neglecting or abusing their children. Child neglect and abuse have been shown in a number of studies to greatly increase the risk of involvement in crime and, by extension, the risk of arrest and imprisonment. It is no coincidence that drug and alcohol abuse, child neglect and abuse, and juvenile involvement in crime are endemic to many Aboriginal communities.

What do we need to do, then, in order to bring down the rate of Indigenous contact with the criminal justice system? Perhaps the first point to make is that, while drug and alcohol abuse appear to be the leading causes of Indigenous arrest and imprisonment, other factors such as unemployment, school retention and poverty are still important factors. It would be a mistake to abandon or scale back our efforts to improve Indigenous education and employment, just because other factors seem more important. The take-home message from our research is not that efforts to reduce Indigenous economic and social disadvantage are misguided but that much more needs to be done to reduce Indigenous drug and alcohol abuse. Indeed, given the insidious effects of drug and alcohol abuse on family life, reducing such abuse may be a precondition of reducing Indigenous economic and social disadvantage.

restricting supply

In its response to the Royal Commission, the Keating Government set aside $70 million to deal with Indigenous drug and alcohol abuse. None of this money appears to have been directed toward restricting the availability of alcohol or increasing its cost. Most, if not all of it appears to have been directed toward treatment. Aboriginal activist and commentator Noel Pearson has been a scathing critic of this approach. He argues that the key drivers of substance abuse epidemics are ready access to drugs (including alcohol) and substance abusing parents and peers. Treatment, he says, has only a small effect on the population of substance abusers and no effect at all on the number of new recruits to substance abuse.

The key to reducing substance and alcohol abuse, he maintains, lies in reducing the availability of alcohol and illicit drugs. Some of these claims are well supported by evidence. A number of researchers have shown that parental modelling, peer influence and substance availability are extremely potent influences on drug and alcohol abuse. A number of studies have shown that it is possible to reduce alcohol-related crime and violence through measures that increase the cost of alcohol, strengthen the capacity of Aboriginal people to restrict the sale of alcohol in their own community or ensure more responsible service of alcohol.

The heroin shortage has shown that increasing the cost and reducing the purity of illicit drugs can reduce levels of drug-related harm. The number of Aboriginal people arrested for heroin use/possession in NSW is less than a quarter of what it was back in 1999, before the heroin shortage hit. Of course, efforts to control the cost and availability of alcohol and drugs are not without their risks and problems. Making one substance more expensive and/or harder to get prompts substance users to seek out potentially more harmful substances. Laws that allow Aboriginal communities to restrict the sale of alcohol have sometimes been inadequately enforced and at other times overzealously enforced.

These problems ought not to be seen as inevitable or as fatal flaws in supply-side policy. Even if raising the price and/or reducing the availability of alcohol and illicit drugs has counterproductive effects on some drug users it may produce net positive benefits, especially if price/availability changes lead to a reduction in the rate of initiation into drug and/or alcohol abuse. Policing of liquor and drug laws does not have to be insensitive, lax or excessive. State and territory law enforcement agencies appear to be working much more closely with Aboriginal people than they have in the past in developing strategies for tackling drug and alcohol trafficking in Aboriginal communities.

None of this should be seen as an argument for abandoning our efforts to entice Indigenous substance abusers into treatment or educate Indigenous young people on the harms associated with drug and alcohol dependence. The point is rather that past efforts to reduce Indigenous contact with the justice system have underestimated both the importance of tackling Indigenous drug and alcohol abuse and the importance of supply-side drug and alcohol policy achieving this outcome.

“Dr Don Weatherburn is the Director of the NSW Bureau of Crime Statistics and Research.”

Reference


H ave your say

The author suggests that alcohol and illicit drugs play a significantly greater role than previously thought in the high numbers of Indigenous people in Australian prisons. What do you think? Where do traditionally held views about Indigenous economic and social disadvantage fit into the bleak picture of Indigenous imprisonment? To have your say, please email editor@ancd.org.au or write to The Editors, Of Substance, 66 Bay St, Ultimo, NSW 2007. Responses should be a maximum of 400 words.
1 CLIENT, 2 NEEDS:
IMPROVING ACCESS TO HEP C SERVICES

LIBBY TOPP

First identified in 1990, the hepatitis C virus (HCV) is now estimated to infect 130 million people worldwide. In Australia, as elsewhere, people who inject drugs bear the majority of the burden of HCV infection. Retrospective testing of stored serum samples shows that prevalence of HCV infection among Australian injectors has declined from around 70% in the early 1970s to 50-60% in more recent years. HCV prevention programs targeting Injectors have undoubtedly contributed to decreasing HCV risk and infection among this population, but even so, among the estimated 264,000 Australians living with HCV infection in 2005, 80% of infections were attributable to injecting drug use, and 99% of the 9700 new infections that year occurred among Injectors (NCHER, 2006).

Some subpopulation groups appear especially vulnerable to HCV infection, particularly new Initiates to injecting, along with young women and Injectors from culturally and linguistically diverse backgrounds (Maher et al. 2007). Although detailed mathematical modelling of the HCV epidemic in Indigenous Australians has not been undertaken (Hepatitis C Virus Projections Working Group (HCVPWG), 2006), around 4.7% of the Aboriginal and Torres Strait Islander population are estimated to live with hepatitis C, markedly higher than the general population prevalence of approximately 1%. This is likely to be because Indigenous people experience social disadvantage at higher rates than the non-Indigenous population, including an over-representation in custodial settings which are often associated with significant HCV and other blood borne virus (BBV) infection rates.

Among the estimated 264,000 Australians living with HCV infection in 2005, 80% of infections were attributable to injecting drug use. Although only a minority of those with chronic HCV infection develop severe liver pathology, hepatitis C is still estimated to account for up to 27% of cirrhosis and 25% of hepatocellular carcinoma (liver cancer) cases worldwide. HCV-related morbidity is substantial; in Australia during 2005, HCV infection was estimated to account for the loss of 37,800 healthy years, also known as quality-adjusted life years (HCVPWG, 2006). Until we learn more about HCV transmission, and translate this into effective biological and behavioural prevention programs, management and treatment of HCV infection must be prioritised.

Yet only about 2000 Australians per year access treatment for chronic HCV infection, and under current conditions, the numbers of people living with chronic infection, advanced liver disease and cirrhosis are projected to increase by about 18% by 2015. At least a tripling of treatment rates would be required to decrease the burden on the health care system of these conditions (HCVPWG, 2006).

Government treatment for chronic HCV infection is funded by the Commonwealth Pharmacetical Benefits Scheme (PBS) Highly Specialised Drugs (section 100) program. Cost of treatment to the recipient is around $20 per month. Recently, two significant barriers to access to government-funded treatment have been removed. Prior to May 2001, a 12-month period of abstinence from injecting drug use was required; however, no exclusion criterion based on drug use has operated for nearly six years. Retraction in April 2006 of the prerequisite of a biopsy to ascertain extent of liver damage was a second considerable advance. Biopsy had been an obstruction to treatment uptake, due to the painful and invasive nature of the procedure, along with the fact that it must be performed in a hospital setting.

Even with such concerted efforts to increase treatment access, and improve treatment outcomes, treatment uptake for chronic HCV infection among former and current injectors remains low. Part of the explanation lies in the traditional lack of integration between the AOD and the BBV sectors. Stuart Loveday, Executive Officer of the Hepatitis C Council of NSW, explains, ‘by and large, in the past we haven’t seen fully effective collaboration between the two sectors. This was probably due to limited capacity resulting from insufficient resourcing, which led the AOD workforce to consider only AOD treatment their primary work focus. Clients’ secondary health concerns, such as hepatitis C testing and management, necessarily became matters for referral onwards.’

Currently, HCV treatment is provided largely through hospital- based liver and hepatitis clinics, and supervised by approved specialist physicians; treatment availability in other settings is extremely limited. Despite the close association between injecting drug use and HCV infection, few HCV treatment programs or clinical care is conducted by specialists with dual expertise in the care of both liver disease and drug dependence, or offer parallel treatment of drug dependence and HCV. Yet the high HCV prevalence among people receiving opioid pharmacotherapy, the required regularity of attendance at these clinics, and low rates of referral for HCV treatment clearly indicate that a major strategy to improve access to treatment and care among injectors would be the development of specific HCV treatment expertise, and associated BBV service provision in general, within AOD treatment settings (Hallinan et al. in press). Clearly, closer collaboration between HCV and AOD professionals and the AOD clinical workforce is needed.

Hepatitis C is estimated to account for up to 27% of cirrhosis and 25% of liver cancer cases worldwide. System preparedness (Litwin et al. 2005) must also be considered. Provision of BBV testing requires a sufficient degree of staff training such that education, support and referral services are in place to meet the needs of the patients identified as infected with BBV. Winstock et al. emphasise that enhanced funding is required for onsite service provision and to make testing part of the core business of more AOD agencies. Of 222 AOD agencies throughout Australia who responded to a postal survey conducted by Winstock et al., including pharmacotherapy clinics (27%), needle and syringe programs (25%), inpatient units (15%) and community-based units (12%), about 75% reported providing at least some access to testing, counselling and vaccination services for BBV; HCV and HIV, but only about a third offered them routinely (rather than on request) and onsite (rather than providing referrals elsewhere). Major barriers to service provision included costs, a lack of facilities and limited access to medical staff, mainly doctors. Where resources did not permit onsite service provision, many services referred on to, for example, sexual health services, but characteristics of drug-using lifestyles, along with often negative experiences of the health care system, can render these clinical pathways ineffective.

Hepatitis C Community Prescribing Pilot conducted by the Australian Society for HIV Medicine (ASHM), due to finish in May 2007. This program saw 82 ‘community prescribers’ (primary care and drug dependence treatment practitioners) trained, assessed and accredited to oversee much of the management of hepatitis C patients. Hepatitis C treatment is the same as that provided through specialist liver clinics, and accredited prescribers have full access to services provided by such clinics. Under the terms of the pilot, only a specialist can initiate treatment, but the community prescriber may write second and subsequent prescriptions for HCV antiviral therapy, and can also order diagnostic tests.

Primary health care settings are the other obvious location in which to target initiatives designed to increase access to HCV-related services. General practitioners (GPs) are well placed to provide interventions for current and former drug users for a number of reasons, including that about 85% of all Australians (including drug users) visit a GP in any one year, spending an average of 83 minutes with a GP. Moreover, drug use disorders are typically associated with a range of relatively complex health problems, and as GPs provide an entry point into the health care system, general practice represents a juncture at which a variety of services can be implemented and coordinated.

‘To this end, a significant advance with respect to increasing access to treatment for HCV infection has been the three-year Hepatitis C Community Prescribing Pilot conducted by the Australian Society for HIV Medicine (ASHM), due to finish in May 2007. This program saw 82 “community prescribers” (primary care and drug dependence treatment practitioners) trained, assessed and accredited to oversee much of the management of hepatitis C patients. Hepatitis C treatment is the same as that provided through specialist liver clinics, and accredited prescribers have full access to services provided by such clinics. Under the terms of the pilot, only a specialist can initiate treatment, but the community prescriber may write second and subsequent prescriptions for HCV antiviral therapy, and can also order diagnostic tests.

Community prescribing can facilitate treatment access, especially in rural areas, by reducing the need to regularly attend a liver clinic, and allows the development of dual AOD/HCV treatment expertise among methadone prescribers. By October 2006, 166 patients had been referred under the pilot.

In the July edition of Of Substance, we will present three case studies of AOD settings in which specific initiatives have successfully increased the number of BBV services provided to clients. Although the individual models differ, their results clearly indicate that achieving better integration is possible, and an outcome towards which the AOD sector should strive.
What happens when you are infected?

Among people who develop antibodies following exposure to HCV, around 25% clear the virus spontaneously, without requiring treatment. In the other 75%, infection becomes chronic, meaning they remain infectious and at risk of long-term secondary illnesses from their infection. HCV infection generally progresses slowly; an estimated 20–20% of those with chronic HCV infection develop liver cirrhosis within 20 to 40 years (Dore et al, 2002). Rates of liver failure and cancer following cirrhosis are estimated to be 4% and 2% per annum, respectively. However, even in the absence of severe liver pathology, chronic HCV infection impairs quality of life, suggesting that factors other than liver inflammation and damage are responsible. Impairment may be related to a direct effect of HCV infection or to other factors, such as drug dependence, psychosocial issues, and/or the psychological impact of HCV diagnosis.

HCV management

(i) Screening and surveillance

Most acute HCV cases are asymptomatic, and therefore elude clinical observation. Combined with the generally slow progression of the disease, this characteristic means that many people who become infected may remain unaware for some years, and regular blood screening of injectors is the most reliable way to identify new cases. Enhanced surveillance of newly acquired HCV infections has the potential to provide valuable information on current transmission pathways, which could be used to develop more effective prevention campaigns. Early identification also allows infected individuals to promptly implement health-related behaviours, such as ceasing their alcohol use, and decreasing morbidity from HCV infection; as well as behavioural change to reduce the risk of infecting others.

(ii) Vaccination against hepatitis A and B

Chronic hepatitis B (HBV) infection or acute hepatitis A infection are generally thought to increase the risk of severe liver disease in people infected with HCV, so that vaccination against the two are not only important public health goals in their own right, but also central components of HCV care. People who inject drugs are among those at highest risk of HBV infection through both the sharing of injecting equipment and sexual activity. Vaccination of injecting persons against both hepatitis A and hepatitis B infection is widespread and unambiguously advocated in national and international health strategies, yet rates of vaccination uptake among injecting persons are low. The addition of HBV vaccination to Australia's national childhood immunisation schedule, and the current implementation of ‘catch up’ vaccination programs among adolescent populations will in future greatly reduce rates of infection among injecting persons; however, the potential that primarily school-based catch-up programs may miss some adolescents most at risk of HBV infection means that the targeting of injecting persons for HBV screening and vaccination will remain essential for some years yet.

(iii) Monitoring

Monitoring provides the basis for informed clinical decisions regarding treatment for chronic HCV infection. Treatment is not indicated for everyone with HCV infection, and should particularly be targeted at those at higher risk of progressive liver disease, including those with a longer duration of infection, heavy alcohol intake, co-infection with other BBVs, and consistently elevated liver function tests; and who were older (40+) at the time they acquired the infection. Therefore, regular assessments of clinical indicators such as liver function must underlie integrated HCV care.

To increase the likelihood of both cost-effective service provision and good treatment outcomes, decisions about when to initiate treatment must be based not only on monitoring of disease progression, but also promoting patient stability in order to maximise adherence to the rigorous and extended medication regimen. That Australia's treatment program allows individual patients access to government-funded treatment on only one occasion heightens the imperative for sound clinical judgment about the best time to start treatment, to maximise the likelihood of successful outcomes from that single opportunity.

(iv) Antiviral therapy

Antiviral therapy for chronic HCV infection has improved considerably in recent years. Treatment success is generally defined as a sustained virological response or an absence of HCV genetic material in the blood six months after the end of treatment. This is considered a probable cure and is associated with improved liver functioning and quality of life.

The most effective treatment appears to be a combination of interferon and ribavirin.

Treating people who inject

Improved treatment outcomes have been shown in randomised controlled trials that excluded people who currently inject drugs; however, smaller, non-randomised trials of treatment for chronic HCV infection among current injectors and those in opioid replacement treatment have produced encouraging treatment outcomes (Dore & Thomas 2005). Although more rigorous research with longer follow-up periods is required, several important findings have already been reported:

- It is possible to successfully and safely use combination antiviral therapy in current and former injectors.
- HCV treatment can be successful when initiated during opiate detoxification or opioid replacement programs.
- HCV treatment can be successful among people who continue to inject illicit drugs, although more frequent illicit drug use is associated with poorer outcome, mainly because of its effects on adherence to treatment.
- HCV treatment does not have a major impact on drug dependence treatment requirements; nor does it appear to increase injecting drug use, as was predicted by some commentators who believed that the similarities between symptoms of opiate withdrawal and common side effects of combination therapy, including nausea, insomnia, myalgia, depression and irritability, may trigger drug use among patients either seeking to self-medicate the side effects, or mistaking them for withdrawal.
It's an obvious but largely overlooked fact that most people who use drugs or alcohol in a risky manner do so outside the paid workforce. There are significantly more illicit drug users in the paid workforce than not in the workforce. Workers' use of illicit drugs is most notable for cannabis, ecstasy and amphetamines. In relation to alcohol, fewer people in employment are abstainers (10.6%) compared to the total population (17.5%) (NDSSH 2001).

Illicit drug and risky alcohol use can have a detrimental impact on the workplace. Absenteeism rates for both illicit drug users and risky drinkers and risky drinkers is significantly greater than for non-users, and is particularly prevalent among young workers. Certain industry and occupational groups have higher proportions of risky drinkers and drug users, most notably the hospitality industry. There is also evidence to suggest that the culture of a given workplace may be conducive to workers using alcohol or other drugs (AOD) in a risky manner.

To date, there has been relatively little attention directed to the AOD use of the paid workforce. From the treatment sector's perspective, many clients are not in the paid workforce; rather they are often ill, unemployed, on pensions, have faced imprisonment and in general are often struggling to cope with chaotic lifestyles. Their perspective is therefore shaped by the experiences of users with severe and chronic problems, and not the majority of drug users who are not in treatment.

Little is known about the AOD consumption patterns of Australian workers and the impact these patterns have on workplace safety, workplace productivity and worker well-being. The National Centre for Education and Training on Addiction (NCETA) recently undertook a comprehensive analysis of AOD use by the Australian workforce using National Drug Strategy Household Survey (NDSHS) data from 2001 and 2004 that has shed some light on the patterns and correlates of workers' AOD use. Examination of drug use patterns of the workforce is important as it allows us to plan more effectively for preventive and early intervention strategies, and to get high-risk groups more efficiently. It also opens up opportunities in terms of new and different partnerships in this area.

Our interest in workers' drug use involves both on-site and (more frequently) use before or after work. Any pattern of use that may impact on an individual's capacity to work safely, productively and with proper 'duty of care' for others is relevant. AOD use can affect an individual's performance in the workplace in relation to productivity, work relationships, and health and safety of individuals. Productivity may be reduced by illness and absenteeism and compromised work quality. Unpredictable actions, violent and abusive behaviour and criminal activity may also contribute to a breakdown in relationships with other workers.

Ann M Roche*

AOD USE BY AUSTRALIAN WORKERS: A RISKY MIX

Illicit drugs and the Australian workforce

The 2004 NDSHS surveyed 29 445 Australians of whom approximately 50% over 14 years of age were employed. Among those employed, 17.3% had used illicit drugs in the previous 12 months compared to 11.8% not in the paid workforce (p=0.0001). That is, nearly one in five workers reported using an illicit drug in the past 12 months. Significantly more male (20.3%) than female (13.4%) workers reported using an illicit drug (p=0.0001). Illicit drug use peaked in the 18-29 years age group (32.4%), but the youngest age group (14-17 years) had the highest level of use for cannabis (29.0%) and hallucinogens (2.9%). For amphetamines, 12.4% of male and 9.1% of female workers, aged 18-29 years, reported use. Use of illicit drugs varied significantly across different industries (p=0.0003), with use of all drug types most prevalent in the hospitality industry. Over 31% of hospitality workers had used at least one illicit drug in the past 12 months. Construction industry workers were the second heaviest users of drugs (24.1%), followed by the retail industry (20.7%). Industries reporting lower levels of use were education (9.2%), mining (12.0%) and administration (12.3%). Across all industries, cannabis was the drug of choice, followed by ecstasy, amphetamines, painkillers and cocaine. Amphetamines use in the hospitality industry was nearly double that in any other industry group.

Using the Australian and New Zealand Standard Industrial Classification codes to examine more narrowly defined industries, workers in commercial fishing (40.5%) had the highest level of use of at least one illicit drug. Other groups reporting relatively high levels of use (30-37%) included employees in motion picture, radio and television services; accommodation, cafes and restaurants; libraries, museums and the arts; and construction trade services.

Absenteeism

There is a strong association between use of illicit drugs and absenteeism. Almost 1% of the workforce (1.2% males; 0.7% females) reported taking days off due to their drug use. This was most prevalent among 14-17-old workers, and more common among males than females. Among amphetamines users, absenteeism levels were particularly high with 11.4% of amphetamine users reporting a drug-related day off in the past three months, compared to 4.5% among users of any drug.

Workers who use illicit drugs were also significantly (p=0.0001) more likely to report days off due to any illness or injury in the past three months (48.1% of drug users overall and 56.8% of amphetamine users) compared to workers who report no drug use (29.2%).

Alcohol and the Australian workforce

Our most current data on workers' drinking patterns comes from the 2001 NDSHS data. It comprises responses from 26 744 Australians aged over 14 years of whom 51% were employed. Key findings are as follows:

- 90% of the workforce were drinkers and half these workers drank, at least occasionally, at levels associated with risk of harm, and 11% drank at long-term risky or high-risk levels
- 1 in 10 employed drinkers drank at least weekly at short-term risky or high-risk levels, 1 in 3 drank at short-term risky or high-risk levels at least monthly or at least yearly
- risky patterns of consumption were most prevalent among young workers (14-29 year olds)
- country employed drinkers were more likely than capital city workers to drink at short- and long-term risky or high-risk levels
- consumption patterns varied between male and female employees.

In particular:
- a larger proportion of males drank at short-term risky or high-risk levels compared to females
- a larger proportion of females drank at long-term risky levels compared to males
- tradespersons and unskilled workers were occupational groups with the largest proportion of workers that drank at risky levels
- the hospitality, agricultural and mining industries had the largest proportion of workers that drank at risky levels.

Consequences for the workplace

Risky patterns of alcohol consumption are associated with negative work-related behaviours (e.g. attending work under the influence of alcohol) and work absences.

Compared to workers who drank at low levels of short-term risk, workers who drank at short-term risky or high-risk levels at least weekly were:
- 19 times more likely to have missed a work day in the past three months due to their alcohol use
- six times more likely to have attended work under the influence of alcohol.

Those who drank at short-term risky or high-risk levels at least monthly were:
- seven times more likely to have missed a work day in the past three months due to their alcohol use
- three times more likely to have attended work under the influence of alcohol.

Approximately one in five workers reported being put in fear, verbally abused or physically abused by a person affected by alcohol and/or drugs. Over three-quarters of these incidents involved alcohol. While the majority of these incidents occurred in public places, 13-17% of all reported incidents occurred in the workplace. In most cases, perpetrators of workplace incidents were not co-workers, but customers, clients, or other persons encountered in the work context.

High levels of workplace abuse or intimidation by persons affected by alcohol were also found in certain occupations and industries, with highest prevalence among health and welfare professionals in particular, and workers in the health and hospitality industries in general.

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Early in 2005, I commenced work at the Alcohol and other Drugs Council of Australia (ADCA) after a period working with the Australian Defence Force (ADF) setting up their alcohol and other drugs (AOD) program. Soon after I was greeted by a senior member of the AOD field with the sentiment ‘Welcome back to the sector, Donna’. I was dumbstruck. Where did this person think I’d been, or what did they think I’d been doing? Why was my work with the ADF, establishing the largest workplace AOD program in Australia, not regarded as an AOD activity? Is it because the workplace is a prime area for intervention, but has been generally neglected by the AOD sector? For some time now, I have argued that there has been a level of inertia among AOD professionals in relation to the workplace. Around 90% of the Australian workforce regularly uses alcohol. Just short of one in three regularly drink at levels that place them at risk of harm. Around 15 per cent of Australians report using illicit drugs. In general, we spend a third to a half of our waking hours at work on most days of the week. We know that there are particular occupation groups that are more likely than others to engage in harmful substance use, and we also know that they can be a population group that doesn’t traditionally access the usual AOD services. It isn’t the case that people go to work, come home, and then have their substance use problems neatly and conveniently occur separately to their work.

The impact of AOD in the workplace is a complex issue, and there doesn’t exist a great deal of research on the topic. The perception of balance between effort and reward is an important factor influencing AOD use. The workplace culture includes all of the ritual and tradition surrounding the use of alcohol (more so than other drugs), and defines what is regarded locally as acceptable or unacceptable use. Traditional workplace AOD programs that focus on managing individuals with problems have had minimal impact on influencing the AOD culture of an organisation, because they fail to foster attitudes and behaviours that minimise alcohol-related harm. Good, evidence-based education and training programs to prevent AOD problems have been proven to greatly reduce drug-related harm in the community. Often, however, education and prevention activities are assigned a low priority or are ill-informed and divorced from the evidence base, and this appears evident in the current appraisal of many workplace responses (where workplace drug testing is often the extent of the ‘program’). The messages that are used and the means by which the message is conveyed to the target group are of critical importance to the credibility of the program. For this reason, involvement of people from the target group in the development of specifically designed activities leads to more effective outcomes.

Increasingly, the attention of the sector has turned to early detection, early intervention and brief intervention strategies in response to problematic AOD use. I must point out, here, that early detection does not mean drug testing. Rather, it is early detection of problematic substance use by valid, reliable screening tools such as the Alcohol Use Disorders Identification Test (AUDIT) or the Severity of Dependence Scale (SDS). It is widely accepted that one of the most effective strategies for reducing alcohol-related harm is for individuals with drug use to intervene at an early stage to prevent problems from progressing further. There is a steadily increasing emphasis on brief intervention as a treatment method, and its role as an effective and cost-effective method has been acknowledged internationally.

The public health model encourages community-based early and brief interventions delivered by generalist workers, however intensive specialist treatment may still be required for individuals with serious and complex issues. Some specialist interventions for individuals with more severe problems are best conducted by specialist AOD professionals, through appropriately accredited provider agencies. Specialist treatment might include withdrawal services, psychological counselling, and/or rehabilitation services.

**An opportunity not to be missed**

It is time for the AOD sector to recognise the legitimacy of the workplace as an appropriate setting for intervention and the opportunities that exist in linking with business and industry to develop high quality, evidence-based, multi-level programs. Involvement in workplace AOD programs presents opportunities not only for business growth and access to a non-traditional source of funds, but also for the sector to have an unprecedented level of influence over the development and implementation of AOD policies and service delivery initiatives that result. Through the provision of specialist technical advice from the sector, based on sound evidence, the likelihood that recipients of workplace programs will receive a good health outcome from intervention is enhanced.

Expert advice from the sector is sometimes sought by business and industry via a tender process or direct approach when commencing development of a workplace AOD policy or program. More frequently however, workplaces will develop their policy or program in-house, using little if any specialist input (other than a trip through Google!). Appropriately knowledgeable AOD agencies should be taking advantage of their marketable skills and technical expertise to assist and advise workplaces. Local Chambers of Commerce and Industry usually offer education seminars and these provide a good starting point for AOD agencies to build relationships with local workplaces. Another tactic is to review the literature available, and this enhances risk and protective factors for substance use in the workplace, and the occupation groups that are most at risk. Are any of these industries local to your area? Consider preparing a document that makes use of this literature and introduces your agency, with a view to a meeting with their Human Resources or Occupational Health & Safety managers.

There are considerable rewards or benefits associated with the introduction and delivery of a good evidence-based workplace AOD program. Firstly, there are the organisational benefits. There are benefits such as providing a commitment to workplace health programs, which are a key component of workplace culture, and to the health and safety of the workforce. Benefits may also include improved physical and long-term health potential, and improved OH&S environments. There are benefits to mental health, and social benefits from enhanced capacity for establishing and maintaining functional relationships. Finally, there are other benefits such as increased awareness about the impact of substance use on the workplace, and improved skills for identifying and managing AOD issues.

The AOD sector has an enormous amount to offer business and industry in order to assist workplaces to get their programs into place, and take advantage of these rewards. Hopefully, our neglect of workplace AOD issues — an approach of ignoring the situation instead of assuming responsibility for managing or improving it — is beginning to turn around.

*Donna Bull is the CEO of the Alcohol and other Drugs Council of Australia*
A DRINK, A SMOKE, A JOINT: NEW STATS ON STUDENTS’ USE

In 2005, 21805 students aged between 12 and 17 years across Australia were surveyed about their use of alcohol, tobacco, cannabis and other illegal substances as part of the Australian Secondary Students’ Alcohol and Drug Survey (ASSAD). The survey is conducted every three years and has monitored students’ use of tobacco and alcohol since 1984, and their use of cannabis and other substances since 1996. The survey method and questions used to assess substance use have been the same in each survey, enabling trends in use of the different substances to be determined.

Similar to the results found in previous years, in 2005 the most common substances used by secondary students were alcohol, tobacco and cannabis. Figure 1 shows the proportion of students aged 12-13 years, 14-15 years and 16-17 years indicating they had ever used each of the different substances. Overall, 86% of 12- to 17-year-old students had consumed alcohol, 35% had had at least a puff of a cigarette and 18% had tried cannabis at some time in their lives. As Figure 1 shows, use of all substances becomes more common as students grow older. However, fewer students had used these substances recently, with 43% reporting to have consumed alcohol, 13% smoking cigarettes and only 6% reporting to have used cannabis in the month before the survey.

Alcohol use in 2005

The proportion of students drinking in the week prior to the survey (defined here as current drinkers) increased with age from 10% of 12 year olds to 49% of 17 year olds (see Table 1). The Australian Alcohol Guidelines (2001) recommend that adults and adolescents should not drink seven or more standard alcoholic drinks in one day for males, and five or more standard alcoholic drinks in one day for females. The proportion of students drinking at or above these levels increased with age and was around 20% of all 16 and 17 year olds. Among current drinkers, 44% of 17 year olds had consumed alcohol above the recommended levels at least once in the week before the survey. Because of the difficulty in estimating a standard drink, it is possible that students underestimate their consumption, e.g. considering a can of beer to be one ‘drink’, rather than the 1.5 standard drinks it actually measures. These findings suggest that on occasions when older students drink, many place themselves at increased risk of being either the perpetrators or recipients of verbal and/or physical abuse, unwanted sexual advances, drink driving, brain injury and liver damage.

Trends

Long term trends in the proportion of current drinkers and the proportion drinking at levels that risk short-term harm among all students are shown in Figure 2. The proportion of current drinkers has fluctuated between 29% and 35% over the 21-year period of the study. The proportion of current drinkers in 2005 was significantly lower than the proportions found in 2002 and 1999. However, the proportion of students drinking at levels that risk short-term harm has increased from 6% in 1990 to around 10% in 1999, 2002 and 2005.

Figure 2: Trends in the proportion of students aged 12 to 17 who drank alcohol in the week before the survey (current drinkers) and the proportion who drank at levels that risked short-term harm on at least one occasion in the week before the survey, Australia 1984-2005.

CURRENT DRINKERS ONLY
Drank at levels that risk short-term harm on at least one occasion in past week
(Males: 7+ drinks; females: 5+ drinks)
Male .5 2 5 11 19 23 9
Female .5 1 7 10 18 20 9
Total .5 2 6 11 19 21 9

Table 1: Percentage of students reporting different levels of drinking experience by age and gender, Australia, 2005

**Figure 1**: Percentage of students who had used different substances in their lifetime, Australia 2005

Decreases over time in consumption in the week before the survey are somewhat encouraging, as they suggest that fewer students are current users of alcohol. However, the increase over time in the incidence of harmful drinking among all students is of concern, as it suggests that if students do drink they are increasingly likely to consume alcohol at excessive levels. As teenage alcohol use is predictive of harmful usage levels at older ages, these findings suggest a need for access-reduction and educational programs to be increased.

Tobacco use in 2005

The proportion of students who smoked on at least one of the seven days preceding the survey (defined as current smokers) increased from 2% among 12 year olds to 18% among 17 year olds. The proportion of current smokers doubled between the ages of 13 (5%) and 15 (11%). Students who had smoked on three or more days of the preceding week were defined as committed smokers. The proportion of committed smokers among all students increased with age from a low of 1% among 12 year olds to 12% among 17 year olds. Current smokers smoked an average of 23 cigarettes a week. Although the legal age for purchasing cigarettes in all Australian states and territories in 2005 was 18 years, 23% of students who smoked in the past week bought their last cigarette themselves. However, friends were the most common source of cigarettes (41%). Based on these data, it is estimated that just over 140 000 students across Australia smoked on average over 3 450 000 cigarettes between them in the week before the survey.

**Figure 3**: Trends in the proportion of students aged 12 to 17 who smoked cigarettes in the week before the survey (current smokers) and the proportion who smoked cigarettes on 3 or more days in the week before the survey (committed smokers), Australia, 1984-2005.
behaviour among younger students. Long-term trends in the proportion of current smokers and committed smokers among all students are shown in Figure 3. Since 1984 there have been several marked decreases and increases in the prevalence of smoking among adolescents. Smoking decreased between 1984 and 1990, and then started to rise again between 1990 and 1995. While the prevalence of current smoking was stable between 1993 and 1996, prevalence declined sharply between 1999 and 2005. A similar pattern of declines and increases is seen for the prevalence of committed smoking. The prevalence of current smoking and committing smoking in 2005 was lower than at any other point in the survey series. The decrease in the prevalence of smoking coincides with a period of increased funding for tobacco control at both a state and federal level, a change in the price and method of levying excise on tobacco that resulted in a real increase in the cost of cigarettes and increases in restrictions on smoking in public spaces. The results of the 2005 ASSAD study suggest that promoting anti-smoking messages through strategies that target the whole population can be effective at reducing smoking among Australian adolescents.

Cannabis use in 2005

Cannabis was the most commonly used illicit substance among secondary school students, especially among those in the older age groups. As time periods became more recent, fewer students reported having used cannabis. In 2005, age was a significant factor in use, with use in the past year ranging from 3% of students aged 12 to 25% of 17-year-old secondary school students, while use in the past month increased from 2% of 12 year olds to around 11% of students aged 16 and 17. Among the 14% of students who reported using cannabis in the previous year, 35% of males and 43% of females had used it only once or twice. Among those that had used cannabis in the past year, bongs were the most common way of using it (around 58%), followed by joints (36%). The vast majority of students using cannabis in the previous year used it with others (86% of males and 90% of females) and generally used it at a friend’s place (31% of males and 38% of females) or at a party (29% of males and females).

Regularity of use: Students who had used cannabis 10 or more times in the previous year were categorised as regular users and those who had used cannabis between 1 and 9 times were categorised as occasional users. Among the 14% of students who had used cannabis in the previous year, 34% of males and 25% of females were classified as regular users. Regular use increased with age from 2% of males and females aged 13, to peak at 9% among males 15 years and older and 6% among females aged 16 years. Compared to occasional users, regular users differed in their method of cannabis use, with whom they used cannabis, and where cannabis was used. While occasional users were more likely to smoke cannabis as a joint, regular users were more likely to use a bong. In addition, more regular users (22%) than occasional users (4%) reported that they used cannabis about equally often by themselves and with others. Occasional users were more likely than regular users to use cannabis at a party. These findings indicate that for the majority of adolescents who use cannabis use is irregular and largely confined to social occasions. However, there are a small minority of adolescents who use cannabis more regularly and their use is becoming less social. This pattern of use may lead to long-term cannabis use, as research shows it is easier to stop using cannabis if it is being used only in a social context.

Trends

Students in 2005 were less likely to have used cannabis than were their same age counterparts in 1996, 1998 or 2002. Among all 12 to 17 year olds at school, the proportion reporting use of cannabis in their lifetime decreased from 35% in 1996 to 18% in 2005, while the proportions using cannabis in the previous month decreased from 18% to 7%.

Victoria White and Jane Hayman write from the Centre for Behavioural Research in Cancer, The Cancer Council Victoria.

Figure 4: Trends in the proportion of students aged 12 to 17 who had ever used cannabis and who had used cannabis in the month before the survey, Australia, 1996-2005

Acknowledgments

The ASSAD study is a collaborative project between state and territory cancer councils across Australia and health departments at the federal, state and territory levels.

For details of findings from the 2005 ASSAD study see:


Reference


This major piece of research enabled us to group adults and young people according to both their attitudes and behaviour. What we see is large numbers of adults and young people drinking large amounts per occasion and thinking it’s okay. When ALAC released this research, the response was indignant, and a sad reflection of the denial they were in: ‘that’s not me’ – ‘it’s the kids’ – ‘my drinking’s okay’. The majority of Kiwis certainly drink. Yet the total amount we drink is not a problem. Spread evenly, it wouldn’t be too much of an issue. It’s our acceptance of drunkenness that’s the problem because this is where those acute harms occur. We set out to get drunk. We tolerate getting drunk. We celebrate getting drunk.

And if that is the problem, then what is the harm? It’s the billions it costs our country: the impact on weekend policing and crime, on the hospitals, on relationships and families, the lost productivity, not to mention the embarrassment and loss of our dignity. With a drinking culture where everyone generally accepts drunkenness as a social norm, it’s hardly any wonder we’re having problems with young people.

CULTURAL CHANGE

TACKLING NEW ZEALAND’S DRINKING HABIT

SANDRA KIRBY*

The Alcohol Advisory Council of New Zealand (ALAC) – the leading advisor to the New Zealand Government on alcohol issues – has taken an innovative approach to the problem of binge drinking.

Like many similar western countries, New Zealand has employed a range of policy interventions to reduce alcohol-related harm, focusing on reducing total consumption. However, despite declining consumption over 20 years, the harm associated with drinking has not reduced in ways traditional modelling might suggest.

A few years ago, youth drinking emerged as an issue, highlighted by young people getting very drunk – very publicly. In 2003, ALAC extensively researched the youth drinking issue to find out how best to tackle it. This included international literature reviews, as well as in-depth research into our own young people’s drinking patterns and attitudes. The research showed some alarming statistics: 59% of young people (aged 12-17 years) thought it was okay to get drunk as long as it wasn’t every day. Although 48% of the young people surveyed were non-drinkers – of those who did drink a quarter said they drank to get drunk. Most of the non-drinkers were aged 12 and 13 years therefore, comments on drinking for young people are taken from the 14-17 year age group. One-third of 14 to 17 year old current drinkers (or 23% of all 14 to 17 year olds) reported they had consumed more than five ‘glasses’ of alcohol on their last drinking occasion (a ‘glass’ in our survey was roughly more than a standard drink – 10 g of alcohol).

This was no great surprise but what also came through strongly were messages from youth that ‘there’s no harm in what we’re doing’ – it’s a rite of passage – adults are doing it anyway – and it’s what we do in New Zealand’ ALAC then shaped and tested a new hypothesis: ‘That adults are drinking the same way as young people. We looked at adults’ attitudes and behaviours and what motivated and stopped them drinking. The hypothesis proved correct, and indeed young people were learning their drinking ways from their role models – their parents and other adults in their lives. Some of this further research showed that:

• 19% of adults (aged 18 and above) are non-drinkers
• 24% of adults who currently drink report they consumed 7+ glasses on the last drinking occasion
• 39% agree: ‘It’s okay to get drunk as long as it’s not every day’
• 9% agree: ‘I drink to get drunk’.

In population terms this equated to:

• 450 000 people binged on their last drinking occasion
• 275 000 people set out to get drunk on their last drinking occasion

*Victoria White and Jane Hayman write from the Centre for Behavioural Research in Cancer, The Cancer Council Victoria.

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Changing our drinking culture

On the basis of this research, we took a hard look at ALAC’s strategic plan and made a marked change to it. An ambitious new goal was set and a comprehensive program developed to achieve it – to address the causes, not just the harm. Our aim became nothing short of changing the whole drinking culture in New Zealand.

Our approach focuses on achieving cultural change by aligning a balance of programs across the pillars of supply control, demand reduction and problem limitation. It relies on a commitment to a full range of reinforcing activities, not just one or two approaches such as policy or treatment. It is also not about delivering a social message simply by mass media. It is about an integrated program of complementary strategies that the marketing messages are designed to stimulate.

Supporting activities range from achieving better compliance with and enforcement of existing laws such as the Sale of Liquor Act (1989), controlled purchase operations to identify breaches of the Act, parents’ programs, policy measures such as tax/price, outlet density, advertising and purchase age, community programs, to strategies that focus on the group of dependent and hazardous drinkers who need support and assistance to reduce or stop their drinking.

Some people will be provided with simple facts – ‘this sort of drinking leads to this sort of harm’. Others will need more direct help such as a GP of prosecution or the inability to consume alcohol due to price drinking leads to this sort of harm’. Others will need to be supported activities range from achieving better compliance with and enforcement of existing laws such as the Sale of Liquor Act (1989), controlled purchase operations to identify breaches of the Act, parents’ programs, policy measures such as tax/price, outlet density, advertising and purchase age, community programs, to strategies that focus on the group of dependent and hazardous drinkers who need support and assistance to reduce or stop their drinking.

Additionally, a fairly relentless media relations program was critical. We’ve had an excellent response from the media as they understand of what can be a complex issue sharpens, following many briefings and repetition of messages. We’re delighted that our messages are being repeated word for word, again and again.

The New Zealand Government and ALAC have carried out an intense program of briefings with a vast number of stakeholders to ensure full understanding of the model, to achieve support and enable them to clearly see where and how they could contribute.

And then the bulk of our population will need to be sold a better proposition than getting drunk, and will need convincing. This is where a high-profile advertising program sits. Most people will need a mix of these approaches, and we hope that the combination of approaches together, will be powerful and effective.

Through our new model, we have been able to see where there have been gaps in our past investments. For example, we recognised the gap in the demand reduction area and secured funding through a small increase in an ALAC levy to address this. This funding is largely applied to our advertising program. We are confident this balance has now been adjusted.

Believing the messenger

Before we could begin work on our new approach, New Zealanders had to have confidence in the messenger. The emphasis ALAC has placed on building its own credibility and brand cannot be underestimated. ALAC was choosy about the issues it engaged in and the way it spoke out. In the main, the organisation is seen as sensible and in touch with the New Zealand drinker, and people appear receptive to our messages.

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The ‘see’ stage was launched in March 2005 using television, radio and press advertising. An ‘alter-ego’ device (a drunk person talking to their own self) was used for the advertisements with statistics to demonstrate that intoxication causes harm. This has proved appealing as it does not point the finger, engages the viewer, and allows them to judge the behaviour for themselves.

In April 2006 the ‘think’ stage began with three new television advertisements, continuing the use of the successful alter-ego. Realistic and likely situations that draw on the core fears associated with binge drinking are portrayed. These include fears around work performance, relationships, embarrassment and perceptions around good parenting. Parallel with the ‘think’ stage we ran what we called an ‘enhanced see’ to reach adults who were seeing the problem but not linking it to themselves and their peer group. Magazine and ‘tactical’ advertising were instigated. Photographic imagery is used to arrest readers’ interest and statistics used to make the point that ‘it is not the people I’d have thought it was’, thus extending the scope of the binge-drinking problem (see images reproduced on pages 25-27).

Where to from here?

The advertising component has been running since March 2005. Progress is tracked through tri-monthly market research. Key results of the campaign show there is:

- 96% prompted awareness of ‘national discussion’ about New Zealand’s drinking culture (65% unprompted) (June 2006)
- 90% prompted recall of television advertising
- 88% prompted recall of the message ‘it’s not the drinking it’s how we’re drinking’ and 45% unprompted (June 2006).

This has translated to attitudinal changes (which must precede behavioural change):

- people acknowledge that drunkenness causes serious harm – 68% (June 2006)
- very importantly, there is increased awareness of the range of harms caused by alcohol, such as violence, domestic violence, accidents, relationships issues and embarrassment/regret
- approximately one in five drinkers (19%) have thought about cutting back the amount they drink, with binge drinkers more likely to have thought about it (28%) and Māori (22%) and Pacific people (25%) than other adult drinkers.

* Sandra Kirby is the Deputy CEO of ALAC

References


ALAC’S ADVERTISING CAMPAIGN

The program is informed by two theoretical models: the stages of change model, which identifies that consumers move through stages of behaviour change towards being committed to a recommended behaviour (Prochaska & DiClemente 1983; Andreason 1995) and the theory of planned behaviour, which suggests that human behaviour is guided by three kinds of considerations, behavioral, normative and control (Ajzen 2002).

ALAC has paraphrased this as taking New Zealanders on a journey whereby people will:
- SEE there is a problem between risky per occasion consumption and harm
- THINK that their behaviour is a contributor to these harms, and there is something they can do about it
- ACT to moderate their drinking behaviours in ways that reduce the risk of harms to themselves, their families and communities.

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References

FUTURE OF NOT-FOR-PROFITS: INEFFICIENCY ON A GRAND SCALE?

DAVID CROSBIE*

‘The trouble with not-for-profit organisations is that they are not focused enough on finding efficiencies. The bottom line is less important to their work, so there is little incentive to make savings.’

This quote is from a very senior and experienced leader in the Australian business community, a director of several major corporate companies who also has an extensive academic background in management. He was speaking at a closed forum about the effectiveness of not-for-profit organisations where these views were widely supported.

As the name implies, the not-for-profit organisations (NFPs) I have been involved with over the past 25 years have all been primarily focused on achieving a mission, not a profit. Their reason for existence is to make a positive difference in the lives of individuals, families and the broader community. Financial considerations are important to NFPs primarily because they determine the capacity to provide programs and services. In reviewing what makes a good NFP, the touchstone of effectiveness should always be achievement of the mission.

In practice, this commitment to the mission of an organisation also means NFPs put as much as they possibly can into actual program and service delivery. It is this commitment to service that is often at the basis of a key not-for-profit dilemma, achieving efficiency while striving to achieve the mission.

Service dilemma without support

This dilemma has been compounded by the policies and practices of governments and other funding bodies. For over a decade, NFPs have been under relentless pressure from the purchasers of their services to provide ‘more for less’. The performance emphasis has been strongly upon reducing service costs and increasing outputs. Governments in particular, seek increased efficiency, not in the way the organisations run, but in the cost per unit of service.

However, this ongoing focus on low-cost service delivery has left many NFPs with poor infrastructure and limited capacity to effectively manage the day-to-day administration of a modern organisation. Most NFPs are incredibly efficient at providing services, particularly the broad range of tasks undertaken by even the most senior managers. That is not to say there is a lack of good management in the sector, but there is a lack of time, dedicated roles and management support to enable efficient and effective management practices to be put in place.

Moving forward

Most NFPs operate on the basis that the only way to increase management support would be to reduce service provision, but other options are emerging as important alternative approaches.

Funding for administration

One response that may go some way to addressing the efficiency dilemma is to build a level of management and infrastructure support into all not-for-profit service costs and contracts. For example, if a government is tendering or seeking proposals from NFPs to provide services, a set percentage of the funding might be pre-allocated to management, infrastructure and program or service evaluation. This set percentage allocation would apply to all tenders or proposals. This approach ensures that not only are services underpinned by a level of organisational support, but also that those competing for services do so on the basis of the actual program or service provision and do not achieve a financial benefit by undercutting in key areas like management, administration and evaluation. The Australian National Council on Drugs is currently seeking to have this form of set percentage allocation included in some future funding rounds under the Australian Government’s National Illicit Drugs Strategy.

Working together

A second possibility is to look at reducing costs and inefficiency through mergers and collaboration. In an environment that openly promotes competition between NFPs, it takes some strength of purpose to suspend the need to gain an immediate advantage for each organisation. Working collaboratively or in partnership with other organisations is never a quick fix, but it can provide real long-term benefits.

There are many models of collaboration emerging in Australia and internationally. They range from a simple back office merger (sharing costs for computers, stationery, printing, vehicles and travel) to larger mergers of program management, evaluation, fundraising and staffing. All mergers and sharing of infrastructure require a significant initial commitment of time and energy, as well as the building of trust between organisations that might previously have viewed each other with a measure of suspicion.

Other options

There are numerous other ‘efficiency’ options emerging in the drive to better support NFPs including the creation of various forms of investment bonds to underwrite not-for-profit efficiency and infrastructure; the linking of NFPs with for-profit companies providing low-cost infrastructure and skilled volunteers in the area of management, human relations, marketing, evaluation and finance; and the social-ventures model of independent income creation for not-for-profits.

ANCD project

The Australian National Council on Drugs is currently funding a project on the future of NFPs in the alcohol and other drugs field. Other organisations, including the Alcohol and other Drugs Council of Australia, have maintained a strong interest in promoting improved practice within the NFP sector. Outside of the alcohol and other drugs sector, several key groups including Nonprofit Australia and Philanthropy Australia are working hard to increase support and capacity within not-for-profit organisations.

New way of operating

The ‘more for less’ approach that has eroded NFP organisational infrastructure and capacity is now becoming untenable. The future challenge for NFPs may require atypical behaviour: moving beyond the ever pressing program and service provision needs, and embracing the requirement to improve organisational capacity and infrastructure. Only then can we establish organisations that are truly efficient and effective. Only then can we uphold the mission at the heart of all not-for-profit organisations.

*David Crosbie is the former CEO of Odyssey House Victoria. He is now CEO of the Mental Health Council of Australia.
Upcoming conferences & events

27-29 April 2007
First International Conference on Drug Abuse
convened by Drug Free Australia
‘Exposing the Reality – a National and International Perspective on Illicit Drug Use’
Stamford Plaza, Adelaide
www.drugfree.org.au

1-4 May 2007
17th National Conference of Australian Health Promotion Association
‘Grass Roots to Global Action: Health Promotion in challenging Environments’
Convention Centre, Adelaide

1-2 May 2007
National Youth Affairs Conference 2007
‘Are we there yet?’
Melbourne
www.yacvic.org.au

13-17 May 2007
19th International Conference on the Reduction of Drug Related Harm
‘Harm Reduction: Coming of Age’
Warsaw, Poland
www.harmreduction2007.org

10-15 June 2007
50th International ICAA Conference on Dependencies
‘ICAA Jubilee Conference – Stockholm 2007’
Stockholm, Sweden
www.icaaconference.se

14-15 June 2007
Health in Difference Conference 2007
‘Changing Spaces, Changing Faces: 6th National LGBT Health Conference’
Rydges Conference Centre, Brisbane
www.healthindifference07.org.au

27-28 June 2007
Family Alcohol & Drug Network 3rd Annual Conference
‘Drugs. Families. Solutions’
Darebin Arts Centre, Melbourne
www.oddyssey.org.au/fadnet

28-29 June 2007
Altering States, Creating Futures Conference
‘A Mental Health System for the 21st Century’
Sofitel Hotel, Brisbane
www.qldalliance.iamevents.com.au

2-4 July 2007
2007 Australian Winter School
‘The Way Forward’
Carlton Crest Hotel, Brisbane
www.winterschool.info

11-13 July 2007
Australian Social Policy Conference 2007
‘Social Policy through the Life Course: Building Community Capacity and Social Resilience’
UNSW, Sydney

11-13 July 2007
Drug & Alcohol Nurses of Australasia 2007 Conference
‘Regional Perspectives in Practice’
University of SA, Whyalla, SA
www.danaconference.com