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Gideon Warhaft, Editor, NSW Users and AIDS Association.
Dr Dennis Young, Executive Director, Drug-Arm Australasia.

Managing Editor:
Jenny Tinworth

Of Substance contact details:
Telephone: (02) 9280 3240 or write to us:
Level 3, 439-441 Kent Street, Sydney NSW 2000 Australia.
Email: editor@ancd.org.au www.ofsubstance.org.au

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Editor’s letter

We are almost at the end of another year – a year which has seen substantial change in the Australian drug sector.

There has been a shift away from the community’s traditional focus on the harms of illicit drugs to a spotlight on a licit and equally, if not more so, dangerous one: alcohol. Prime Minister Kevin Rudd’s comments about youth ‘binge drinking’ early in the year have shaped much of public drug debate in recent months. This interest in the damage caused by a socially acceptable drug is very welcome.

Another issue in the spotlight recently is homelessness, which comes in many shapes and forms. In this issue, we look at the relationship between homelessness and substance misuse. How much do substance issues contribute to an individual becoming homeless, and when homeless, what role do drugs and alcohol play?

Mental health problems are also often linked to substance issues. We discuss a positive advance in the treatment of mental health problems among young people. The national Headspace initiative has been a popular addition to the suite of programs working in this area.

Another ‘addiction’ which commands attention is that of gambling. What are the similarities and differences between gambling and substance addictions? What can the substance field learn from the gambling field? Writer Carol Major provides us with some food for thought, starting on page 22.

And of course, few of the positive outcomes which occur in the alcohol and other drugs sector would occur without a dedicated workforce of clinicians, researchers, policy makers and law personnel, just to name a few. Each year, the ‘quiet’ achievers of the sector are honoured, and we share their stories from this year’s National Drug and Alcohol Awards.

There is much more in this issue of Of Substance, including our usual round-up of news, research and events. I hope you enjoy the information and as always, I welcome your feedback – email editor@ancd.org.au. All our past issues are also available by visiting www.ofsubstance.org.au.

Jenny Tinworth
Managing Editor

GUEST EDITORIAL

DRUGS, ALCOHOL AND HOMELESSNESS

CHRIS MIDDENDORP, COORDINATOR, CENTRAL DIVISION, SACRED HEART MISSION, ST KILDA, MELBOURNE

Homelessness is such a nebulous issue, it can be as difficult to define as it is to resolve. At the heart of this enigma is how profoundly the experience of homelessness varies between individuals.

Among those affected are children, young adults, the aged, the educated, the uneducated, people with mental illnesses, the unemployed, people with jobs, people with gambling or drug addictions and people for whom substances – legal or illicit – have never held any interest. It can include a 15-year-old girl living on the street for the first time, or a 40-year-old man just released from prison. In short, people who experience homelessness encompass diverse backgrounds and expectations and often don’t have a lot in common with each other.

The general public invariably view addictions to substances as one of the causes, if not ‘the’ major cause, of homelessness. And certainly among the 400 men and women who utilise our services at Sacred Heart Mission each day, over 50 per cent admit to wresting with substance abuse issues. This all leads us to the familiar, even hoary question: Do drugs cause homelessness, or does homelessness drive people to drugs? It seems pretty apparent that both pathways are well-trodden.

At a more practical level, the question of causes loses some of its significance. In attempting to solve or prevent homelessness it is clear that in many cases problematic drug and alcohol use will need to be addressed. Among the hard-core street people I have known (those who have been homeless and sleeping rough for some years), a dependence on substances is generally the most significant impediment to their obtaining and maintaining accommodation. For those who survive on paltry government benefits, their future is often predicated on a key question: Do I continue using and living chaotically, or do I commit to paying rent?

The underlying issue keeping many people on the streets is trauma (often through abuses experienced during childhood). For many people, in the absence of more effective therapeutic strategies, drugs and alcohol are viewed as a pragmatic anodyne; a way to soothe or distract from the enduring distress.

To this end, the most prevalent substance of choice may well be heroin. This existential dimension to the problem of homelessness and the concomitant abuse of substances is not addressed often enough. But I feel certain that it is out of these essential questions of meaning and identity that some of the more permanent solutions to homelessness and substance dependency may be found.
A $6 million advertising campaign has been launched, with the aim of reversing the trend of teenagers drinking at a younger age and of making 'drinking to get drunk' socially unacceptable for the next generation of Australians. It is the initiative of DrinkWise Australia, an alcohol industry-based organisation which aims to encourage Australians to use alcohol responsibly. It is seen as a 10-year social marketing campaign.

Commissioned by DrinkWise, the National Centre for Education and Training on Addiction collated research that shows that over the past five decades, the average age of initiation to alcohol has dropped from 19 to 15.5 years, while the latest National Drug Strategy National Household Survey shows that 90 per cent of 14-year-olds interviewed had consumed alcohol at some time in their lives.

A key component of the 'Kids absorb your drinking’ campaign is a multi-generational television ad showing how parental drinking patterns and attitudes shape the way children will use alcohol. For more information about the DrinkWise campaign, visit www.drinkwise.com.au.

Boost in mental health support

In any year, nearly 20 per cent of Australians experience some form of mental illness; in response, the Australian Government is to invest almost $50 million in strengthening mental health services.

The funds include $20 million to help prevent suicide; $5.72 million for 209 community-based mental health organisations; $12.3 million for MindMatters to promote mental health in secondary schools; and $4.8 million to support KidsMatter activities in primary schools and preschools.

The Government is also refocusing the National Suicide Prevention Strategy (NSPS) to ensure that it better targets areas and groups at highest risk of suicide. It will strengthen psychological services, rural mental health services, services related to bereavement from suicide, and culturally appropriate suicide prevention activities in Indigenous communities.

Supporting these initiatives is the new National Advisory Council on Mental Health, to be chaired by John Mendoza, former CEO of the Mental Health Council of Australia. The Council will provide independent, expert and balanced advice to help drive national mental health reform.

FebFast alcohol awareness campaign

FebFast is an innovative education, awareness and fundraising program that asks people to commit to a ‘booze-free’ February. The program’s objectives are to raise community awareness of the impact of alcohol, help participants feel more in control of their own health and raise money to support the treatment of young people with drug use problems.

Based in Victoria, FebFast 2008 attracted 1400 participants and raised more than $330,000. This will fund grants for work in research, prevention and services for the youth alcohol and other drugs sector. Most participants completed a survey as part of their FebFast registration. Almost two-thirds were women and 59 per cent were aged between 30 and 50. More than 70 per cent reported reduced alcohol consumption after completing FebFast, both in frequency and amount consumed on each occasion.

Following its successful first year, FebFast 2009 hopes to achieve a national reach and broadened institutional support.

Indigenous logo a winner

Print and website design company, Dreamtime Public Relations, has won a national competition to design the logo of the National Indigenous Drug and Alcohol Committee. The award was announced at the National Drug and Alcohol Awards in June. The design by Dreamtime’s Toby Dodd was judged the best from a field of over 100 international entrants and 170 logos. Entries came from urban, rural and remote areas of Australia as well as overseas. Another South Australian Indigenous designer Karen Briggs was runner-up along with Tony Laplanche from Brisbane.

Toby, of Ngarrindjeri/Narungga/Kaurna descent, has been with Dreamtime since he left school at 17 years of age. He has since been given the opportunity to gain various qualifications and experience in graphic design, pre-press, multimedia and website development.
IN BRIEF...

Online course tackles binge drinking
AlcoholEdu, an online program from the USA that tackles high-risk drinking, is to be trialled in Australia. The program consists of information and a self-assessment exercise and will be trialled at Geelong Grammar, Melbourne University, Deakin University, the University of Queensland and the University of NSW. About one million students at over 450 campuses in the USA have used AlcoholEdu. Data analysed so far suggests that taking the program can curb binge drinking and reduce short-term harm.

Tasmania targets tobacco
New tobacco control measures in Tasmania costing $2.7 million over four years confirms the state’s lead in tobacco legislation. The funding will pay for both public education and smoking cessation programs. In addition, as part of its $4.3 million National Smoke-Free Pregnancy Project, the Federal Government is providing an additional $18 000 to Tasmania to train midwives at the North West Regional Hospital and Mersey Hospital. The most recent Australian Institute of Health and Welfare data shows 27.6 per cent of pregnant women in Tasmania smoke.

Protecting unborn children
In July the NSW Government introduced a six-month trial of a program aimed at protecting unborn children from harm by targeting parents with a history of drug abuse, mental health issues and domestic violence. The trial comes as a result of recommendations from the NSW Ombudsman to support mothers early in their pregnancies. Recent statistics show parental mental health issues and drug and alcohol abuse are the fastest-growing factors in NSW child protection reports.

New cannabis clinic for Lismore
The NSW Government is setting up a cannabis treatment clinic at Lismore, adding to the five clinics operating in Sydney, Orange and on the Central Coast. An independent evaluation has found that 50 per cent of people treated at the clinics give up cannabis. The separation of cannabis clinics from the rest of the drug and alcohol treatment system is one of their strengths, as people who use cannabis generally do not see themselves in the same category as people who use other illicit drugs.

Improving Indigenous health
The National Indigenous Health Equality Council, to be chaired by Professor Ian Anderson, a leading researcher in Indigenous health, was launched in July. The Council will advise the Government on health-related goals and targets to support its commitment to closing the 17-year life expectancy gap between Indigenous and non-Indigenous Australians, and to reducing unacceptably high rates of child mortality in the Indigenous population.

The Government has committed $19 million to a plan to boost the Indigenous health workforce.

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**ADVERTISEMENT**

**Thanks from FebFast**
FebFast would like to thank the Australian Alcohol and Other Drugs sector for its interest, support and enthusiasm during our first year of activity.

FebFast invites Australians to forgo alcohol in February, and simultaneously raise funds to support organisations working in alcohol and other drug research, prevention, treatment and service delivery for young people.

Our 2008 education, awareness and fundraising campaign achieved excellent health and wellbeing outcomes for participants and financial outcomes for the sector.

Interestingly, 16 per cent of FebFast participants were motivated to join the program in order to show support for youth alcohol and other drugs services.

Our inaugural grants program commenced in July to distribute the funds generated from the February campaign. Grant submissions are currently under consideration, and we are working towards distributing the funds across Australia before the year ends.

FebFast 2009 will be promoted nationally. We seek your continued support as we strive to engage the public through awareness and education, contribute to cultural change and raise funds for this sector. We hope you’ll encourage peers and stakeholders to participate next year.

Our Constitution requires FebFast to fund alcohol and other drug research, prevention and service delivery for young people, enabling us to work collaboratively with others towards the reduction of alcohol and other drug related harms in Australia.

Yours sincerely,
The FebFast Team
www.febfast.com.au
Illicit drugs report

The Illicit Drug Data Report released by the Australian Crime Commission (ACC) in June shows that increased detection of cocaine and heroin by law enforcement agencies is having an impact.

Border detections of cocaine by weight increased by more than 600 per cent in 2006–07 and border detections of heroin were the highest on record. In 2006–07 total cocaine seizures by weight increased by around 1300 per cent, the total number of seizures increased by 68 per cent, and national cocaine arrests increased by more than 75 per cent. The largest number of detections for cocaine and heroin were through ‘scatter’ importations (air cargo and postal streams).

The number of clandestine laboratories detected continued to decrease, which the report says is related to initiatives to combat amphetamine-type stimulants (ATS) production. The report can be found at www.crimecommission.gov.au

NSW councils ban outdoor smoking

More than half Sydney’s metro councils and 22 of 109 NSW regional councils now have policies banning smoking in certain outdoor public spaces, according to a recent Heart Foundation survey. Of the 43 metro councils, 24 (56%) have smoke-free policies that ban smoking in specific areas, such as children’s playgrounds, playing fields or alfresco dining areas.

Twenty of the metro councils and 21 of the regional councils have banned smoking at children’s playgrounds and playing fields, making these the most common smoke-free areas. Seven metro councils ban smoking at alfresco dining areas and the same number has made their beaches smoke free.

A coalition made up of the Heart Foundation, the Cancer Council NSW, the Australian Medical Association (AMA) NSW and Action on Smoking and Health (ASH) Australia is calling on remaining NSW councils to follow this lead.

Windana Drug and Alcohol Recovery, based in St Kilda, Melbourne, has won a 2008 Victorian Children Communities’ Award in the Drug and Alcohol Services Category. The Award acknowledged Windana’s SAFE at Home Program, led by Karen Efron.

SAFE at Home supports families where a parent or caregiver is affected by harmful drug or alcohol use. It allows the extended family, particularly children, to receive support, develop a sense of connectedness and move together as a family with improved quality of life.

Parents are encouraged to discuss their strengths and concerns in parenting and receive information and peer support. The children’s wellbeing is paramount: their resilience is promoted, and they receive support for their education, their physical, emotional and behavioural development, health connectedness, and with minimising risk-taking behaviour. Over 25 families, with a minimum of 50 children, access the program in any one month.

No resources to develop staff

In relation to your article Where have all the staff gone? (July 2008), I think that an additional factor in recruiting difficulties in rural areas is that there are not enough resources to develop new staff.

As a mature age student, I completed a Graduate Diploma in Counselling. While studying, I found it extremely difficult to get a work experience placement, because agencies’ staff were too overloaded with work to take on a student, and spare office space was also unavailable. Other students had similar problems obtaining placements. Agencies which take on students seem to be generally in the larger cities. In the end I found a series of short-term places, which allowed me to finish my course, but the education and learning was not as good as it otherwise could and should have been.

Now as a qualified counsellor, I have been offering unpaid services as a probationary to increase my hands-on experience, but again, no one takes me on. Agencies seem to have too much workload and a lack of resources to provide the extended supervision and training needed by a newly qualified person. An additional factor, exacerbated by resource restraints, might also be that inexperienced staff constitute a risk in relation to high performance requirements for accreditation and receiving government funding.

Name supplied, Victoria

Of Substance welcomes correspondence from all our readers on topics raised in the magazine, or subjects of interest to the field. Please submit letters of up to 300 words to editor@ancd.org.au.
International attack on alcohol

Policy changes to curb binge drinking and alcohol misuse are taking shape in other countries as well as Australia.

The US Government has increased ‘alcopop’ taxes, and England is considering increasing alcohol prices in supermarkets. The most extensive changes however are being planned in Scotland. Citing the ‘health time-bomb’ of rising alcohol misuse among people of all ages, the Scottish Government is planning initiatives to limit binge drinking that go further than any so far proposed.

Proposed changes in Scotland would include: raising the minimum age for off-sales alcohol purchases to 21; setting minimum retail prices per unit of alcohol; ending bulk-purchase discounted promotions; charging a ‘social responsibility fee’ to help pay for the consequences of alcohol misuse; and introducing alcohol-only checkouts in large off-sales premises.

Health effects of cannabis use

Take a closer look: Cannabis and your health 2008 is a new brochure from the Australian Medical Association (AMA) about the short- and long-term effects of cannabis use.

It relates the facts objectively and gives information on mental health effects and sources of advice. The brochure also covers the effects of short-term use of cannabis in small and large doses; long-term use; smoking cannabis during pregnancy; how long the effects last; psychological dependence; and driving or operating machinery under its influence.


Crack cocaine and treatment

Two British drug workers have joined forces to write Crack cocaine: the open door, a book that explores myths around cocaine addiction and its treatment.

Christopher Robin and Kenneth Jordan draw on their experience working with cocaine treatment services in Britain to discuss models of practice and to challenge the approach taken by many substance clinicians. While specifically focusing on crack cocaine, the book’s concepts are transferable to other drug types.

For information, visit www.janussolutions.co.uk.
STRONG SUPPORT FOR DRUG ACTION WEEK

Drug Action Week is an initiative of the Alcohol and other Drugs Council of Australia (ADCA) with the dual aim of raising public awareness of alcohol and other drug issues as well as promoting the efforts of people who work to reduce drug-related harms.

ADCA established the idea of a yearly awareness week in 1997 and for the early years it was carried out under the name of ‘Treatment Works Week’. In 2002, the name was changed to ‘Drug Action Week’.

This year’s Drug Action Week (DAW) was held from 22-28 June. A record of 630 events were registered on the DAW website and tens of thousands of people throughout Australia joined in activities to raise awareness of the harm alcohol misuse can cause for individuals, families, and communities, promoting this year’s DAW tag line that ‘Alcohol is a drug – Too!’

Table 1: 2008 Drug Action Week activities per state/territory

<table>
<thead>
<tr>
<th>State</th>
<th>Number of activities</th>
</tr>
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<tbody>
<tr>
<td>Tasmania</td>
<td>51</td>
</tr>
<tr>
<td>South Australia</td>
<td>98</td>
</tr>
<tr>
<td>Western Australia</td>
<td>61</td>
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<tr>
<td>Queensland</td>
<td>128</td>
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<tr>
<td>NSW</td>
<td>129</td>
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<tr>
<td>Victoria</td>
<td>99</td>
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<tr>
<td>Northern Territory</td>
<td>36</td>
</tr>
<tr>
<td>ACT</td>
<td>28</td>
</tr>
<tr>
<td>Total</td>
<td>630</td>
</tr>
</tbody>
</table>

Activities were held in each state and territory, in both metropolitan areas and in more remote rural communities (see Table 1). These ranged from information stalls, barbecues and sausage sizzles, to trivia nights and concerts.

This strong support was a massive increase from last year when 172 events were held nationally.

Chief Executive Officer for ADCA, David Templeman, said the huge response has shown that drug problems are of vital importance to our communities: ‘The misuse of alcohol and other drugs is becoming a clear problem in many communities, and people are recognising that we must all work together to address it.

‘We are pleased to see support for change in attitudes towards alcohol arising from the grassroots level. Although we need leadership from our governments on this issue, it’s really a community-wide problem which all of us must contribute toward solving.’

Mr Templeman said there were a number of reasons why this year’s week had received so much support, including a strong promotional drive, televised community service announcements, the involvement of Surf Life Saving Australia and The Salvation Army, mailouts to a number of secondary schools and the provision of free promotional packs for activity coordinators.

After a busy week of activities, Drug Action Week ended with a celebration to acknowledge the frontline workers who continue to make a difference in the alcohol and other drugs sector. This celebratory event was the 2008 National Drug and Alcohol Awards which were held in Melbourne on Friday, 27 June.

The Awards were a joint initiative of ADCA, the Ted Noffs Foundation, Australian Drug Foundation and Australian National Council on Drugs and recognised the work of some of the country’s most dedicated professionals, researchers, community organisations, volunteers and media representatives. For more information about the Awards, turn to page 26. To be a part of Drug Action Week 2009, log on to www.drugactionweek.org.au when registrations open in January next year.

Where events were held

Metropolitan areas held 183 events (29%) and regional areas hosted 447 (71%).

In recent years there has been an increased focus on problems associated with methamphetamine use and discussion about appropriate treatment methods. A recent issue of the *Drug and Alcohol Review* journal (vol. 27, no. 3) profiled a number of key Australian studies on the subject. Here, we briefly summarise four of these.

## TOXIC IMPACT


This paper authoritatively reviews the major physical and psychological health effects of methamphetamine use, and the associated risk factors. Methamphetamine is cardiotoxic, burdening the cardiovascular system by increasing heart rate and blood pressure. Serious cardiovascular and cerebrovascular complications can occur regardless of route of administration. Chest pains, palpitations, tachycardia and hypertension are the most common symptoms in emergency department presentations for acute amphetamine intoxication. Concomitant use of alcohol, opiates, and cocaine with methamphetamine all increase toxicity, a concern given this group’s extensive polydrug use. Multiple drugs are detected in half of methamphetamine toxicity cases, most commonly alcohol (with studies indicating proportions ranging from 10-25%), cocaine (12-25%) and morphine (20-30%).

Psychostimulant overdose is less clearly defined than heroin overdose. Symptoms of methamphetamine overdose vary among individuals, and do not necessarily entail a loss of consciousness. Physical symptoms include nausea, vomiting, chest pain, tremors, increased body temperature, increased heart rate, breathing irregularities and seizures. Psychological symptoms include extreme anxiety, panic, extreme agitation, extreme paranoia, hallucinations and excited delirium. Deaths are typically caused by seizures, cardiac arrhythmias or respiratory failure, with cardiovascular complications causing the majority. The toxic threshold for fatal reactions varies widely and toxic reactions can occur irrespective of dose, frequency of use or route of administration. There were 68 fatal methamphetamine toxicity cases in Australia during 2005.

Psychological harms of methamphetamine use include psychosis, a typically transient phenomenon involving delusions of persecution and auditory and visual hallucinations, possibly accompanied by emotional swings, agitation and irrational hostile behaviour. Usually lasting hours to days, psychosis generally remits rapidly following detoxification. More chronic symptom profiles suggest the triggering of a vulnerability towards psychotic disorders. Symptoms of psychosis are remarkably common among people who use regularly, and are most likely to occur among chronic, dependent and injecting users of the drug.

Other forms of psychopathology associated with methamphetamine are more common, more chronic and potentially more debilitating than psychosis. Depressive and anxiety symptoms are particularly common, and rates of suicidal ideation and attempted suicide are also high. As with psychosis, higher levels of depression, suicide and anxiety have been associated with longer methamphetamine use careers, more frequent use, dependence and injecting.

## THERAPEUTIC APPROACHES


This is an impressive review of the efficacy of cognitive and behavioural therapies for methamphetamine dependence. Much of the limited methamphetamine treatment knowledge has been extrapolated from studies of people who use cocaine, so the review’s focus on methamphetamine-specific studies is a great strength. The authors also concentrate on randomised trials, which are rigorous research methodologies that produce accurate results.

The lack of success in identifying a pharmacological agent to effectively treat methamphetamine withdrawal, or that would assist in achievement or maintenance of abstinence, increases the importance of psychological treatments as intervention options.

This review focuses on cognitive and/or behavioural therapies, including cognitive-behavioural therapy (CBT), cognitive therapy (CT) and contingency management (CM). CBT is a form of ‘talk therapy’ based on learning principles, and encompasses a range of interventions different in application and focus, including relapse prevention and coping skills therapy. CT is very similar, but emphasises the cognitive components of therapy, that is, processes associated with thoughts and mental functioning. CM is a behavioural technique based on the systematic application of principles of positive reinforcement. Typically, incentives for meeting treatment goals, such as attendance at sessions or clean urines, are provided in the form of vouchers exchangeable for goods, privileges or cash. Researched extensively in the US with people who use cocaine, CM is not widely practised in Australia.

Only a small number of randomised intervention trials examine cognitive/behavioural interventions for methamphetamine dependence. The most rigorous and relevant were conducted in Newcastle by Amanda Baker and colleagues. These studies show that CBT is associated with reductions in methamphetamine use and other positive changes, even after only short treatment periods (two and four sessions). They also indicate that CBT-based self-help materials can help
some people reduce their use. CM studies – some of which have included results for both cocaine and methamphetamine use – consistently demonstrate efficacy in reducing drug use, although long-term follow ups are uncommon, and there is some reduction in treatment benefits once the contingencies are removed.

This review clearly demonstrates that effective treatments for methamphetamine dependence exist; that AOD clinicians are familiar with these types of interventions; and that they could thus be implemented within existing services. Clinicians should therefore use these interventions, and convey to their clients that they are effective. Services and policymakers should support their implementation to ensure their accessibility.

INJECTING VS. SMOKING


This study recruited treatment seekers in Sydney and Brisbane who nominated methamphetamine as their primary (78%) or secondary (22%) drug of concern. Participants were mostly male (75%) with an average age of 31 years, had used methamphetamine for an average of 12 years, and 77% had used three or more days per week in the preceding year.

To examine whether methamphetamine smokers seeking treatment represent a ‘new’ cohort of treatment entrants for whom attractive treatment options are required, or former injectors who have taken up smoking, drug use and associated harms were compared among three groups defined by their route(s) of methamphetamine administration in the preceding month: (i) those who had only injected (n=179); (ii) those who had only smoked (n=73); and (iii) those who had both injected and smoked (n=90). Participants who had both smoked and injected typically nominated injecting as their preferred route (82%), whereas 68% of those who had only smoked had never injected any drug.

People who both injected and smoked were similar to those who exclusively injected in terms of their demographic and polydrug use characteristics. On the other hand, people who only smoked were more likely to be female; tended to be younger; had shorter drug use careers; and were more likely to use ecstasy. All groups reported similar frequency of methamphetamine use in the preceding month, and equivalent levels of harm on a range of measures including general physical and mental health, psychological distress and psychotic symptoms such as paranoia and hallucinations. Despite their comparable frequency of use, however, the three groups differed in terms of their severity of methamphetamine dependence as assessed by the extent of their preoccupation with obtaining and using it. People who only injected were more likely to describe severe dependence than those who both injected and smoked, or those who only smoked.

These findings indicate both a treatment demand among a younger cohort of non-injecting methamphetamine smokers; and the uptake of methamphetamine smoking among people who have been injecting long term. The different characteristics of these two groups emphasise the need for multi-faceted responses that address a range of needs among methamphetamine treatment seekers.

WORKPLACE SNAPSHOT


The demographic groups most likely to use illicit drugs are concentrated largely within the paid workforce. Use of all illicit drugs is higher among people in employment than among those not working. Drugs play a role in Australian workforce fatalities and traumatic injuries; impact on workers' productivity; and cost business in the form of absenteeism. The workplace environment and culture can reduce or exacerbate problematic drug use. To examine the impact of workforce variables on drug use, this analysis of the 2004 National Drug Strategy Household Survey data examined methamphetamine use among the 14 851 respondents in paid employment.

Four per cent of workers had used methamphetamine in the preceding 12 months, compared to 2.2% of respondents not working. Use was most prevalent among workers in WA (6%), the ACT (6%) and SA (5%). Employed males (5%) were more likely than employed females (3%) to report recent methamphetamine use, and use was most common among workers aged 18-29 years (11%). Employed people who used methamphetamine reported swallowing (83%), snorting (77%), smoking (26%) and injecting (18%) the drug.

Compared to people who were employed and used other illicit drugs, those who were employed and used methamphetamine were more likely to report working, driving, operating heavy machinery, verbally abusing and physically abusing someone while under the influence of illicit drugs in the preceding 12 months. They reported higher rates of recent drug-related absenteeism and illness/injury-related absenteeism. Risky drinking and working under the influence of alcohol were more common, and they had higher psychological distress scores. They also showed more extensive polydrug use.

Methamphetamine use was most prevalent among workers in the hospitality (9.5%), transport (5.4%) and construction (5.4%) industries. It is in these workplaces that the well documented physical and mental harms associated with methamphetamine use may have their adverse impact. Workplace safety, including operation of machinery, sharps disposal and infection control require consideration, and policies on verbal and physical abuse, bullying and harassment may be warranted. Workplaces also offer unique opportunities for intervention and prevention programs that are currently largely under-utilised, including education and training, counselling and treatment, and health promotion and brief intervention strategies.
NO HOME, NO HOPE?
DRUGS AND LIFE ON THE STREETS
BRONWYN DUNCAN

Like alcohol and other drugs, homelessness has always been part of our community. Together, the two are a potent mix, often trapping people in a lifestyle that robs them of hope and a secure future.

Recently, the public spotlight has focused on homelessness, with the new Federal Government calling for a total re-think of our efforts to solve it. In part one of our series, we explore the issue and ask what role substance abuse plays in homelessness.

What we know about homelessness

‘100 000 Australians are homeless on any given night. Half are under 24 years old, and 10 000 are children.’

Federal Minister for Housing, The Hon Tanya Plibersek, Foreword, Which Way Home? A New Approach to Homelessness (Green Paper)

‘Our response to homelessness is not nationally coordinated or strategically focused. While there are excellent programs, many lack sufficient scale or coordination to adequately address the multiple causes and effects of homelessness.’


The experience of homelessness can last a day, a month, or be recurring. It can be highly visible, as in rough sleeping in the streets, or invisible, as in temporary refuge in caravan parks, boarding houses and ‘couch surfing’.

The primary, urgent goal of homeless people is getting and keeping a decent roof over their heads; achieving long-term solutions to the national homelessness issue is, however, much more challenging.

A variety of research findings and rich anecdotal evidence support the proposition that homelessness is a complex social issue, with multiple causes and effects, that penetrates all strata of our society. Both economic and individual factors are in play. These facts are widely acknowledged in policy discussions and decisions, in interpretations of service delivery data, and even in recent media reports.

The main data on homelessness comes from the national Census of Population and Housing every five years, and from Australia’s largest homelessness funding program, the Supported Accommodation Assistance Program (SAAP), which annually collects statistics on clients of its services.

These sources are valuable but limited. They cannot capture the full picture, including the dynamic of homelessness over time.

Since the release in 1989 of the landmark Burdekin Report Our Homeless Children – a report that shocked the nation – there have been many substantial initiatives aimed at reducing homelessness in Australia. However, despite significant funding and years of cross-sectoral efforts to prevent homelessness and help the homeless, the nation has little to celebrate. Indeed, it seems indefensible that, almost two decades since Burdekin, and in a wealthier society, the crisis is in fact worse.

Just as in 1989, this year the homelessness issue has come to national prominence, galvanising public opinion and raising private consciences. As before, pledges and promises have been made, alongside exhortations to pursue long-term solutions. There’s a sense of revitalised energy and commitment, and indeed, of hope. This time, the commitment to the long term is embedded in the new Federal Government’s social inclusion agenda. Weeks into its first term, in January 2008 it announced it would tackle homelessness as a matter of national priority. In its ‘new bold and broad’ long-term approach to homelessness, it set out four simple but ambitious goals: to prevent homelessness; improve services; create exit points to secure longer term housing; and stop the cycle of homelessness.
As a first step, a Steering Group appointed by the Government and led by Tony Nicholson, CEO of the Brotherhood of St Laurence, prepared a Green Paper: Which Way Home? A New Approach to Homelessness. Released in May, it laid the groundwork for public discussion and proposed several options for reform. A central argument was that the homelessness problem could only be solved by engaging the whole community and by a joint effort to integrate responses with wider social support services. At the time of writing, the Federal Government’s response, a White Paper on homelessness, was still in preparation.

Meanwhile, in April, the independent National Youth Commission (NYC) published its report Australia’s Homeless Youth, and a million ABC viewers tuned in to its dramatic companion documentary, The Oasis.

Over the following months the Government’s White Paper and a national plan of action for the years leading up to 2020 were developed.

In all this material, discussion and evidence, it is crystal clear that the response to homelessness needs to be ‘more than just a bed and a hot meal’. But when it comes to the most vulnerable homeless people – those with serious mental health and substance abuse issues – even securing somewhere safe to sleep can be a nightly challenge.

Homelessness and substance use: which comes first?

‘Contrary to popular perception, while alcohol and drugs can keep people on the streets, they are not the main pathway to homelessness. Alcohol and other substances are often used to medicate depression and despair.’

CEO of Wesley Mission, Rev Keith Garner, at the launch of the report More than a bed: Sydney’s homeless speak out.

There has long been a debate about which comes first, substance abuse or homelessness. While public perceptions have generally been that substance abuse is a major cause of homelessness, recent research does not bear this out. Studies and agency data on the primary causes of homelessness differ somewhat in emphasis, but in general they support the contention that for most homeless people problematic substance use is an effect, not a major cause, of becoming homeless.

The latest SAAP data indicates that, the most common reasons given by clients for seeking help from SAAP agencies in 2006–07 were: problems in interpersonal relationships (45% of support periods), including domestic violence (22%); and relationship or family breakdown (10%). The next largest categories were accommodation issues (18%) and financial reasons (14%).

The category of health issues accounted for 9.4%, within which problematic drug/alcohol/substance use was just under 6% and mental health/psychiatric illness 2.5%. Men aged 25 years and over most commonly reported drug, alcohol or substance use as their main reason for seeking assistance (14% of support periods).

Generally there were only small variations across states and territories in these proportions. One exception was in NSW, where problematic drug, alcohol or substance abuse was the main reason for seeking assistance in 14% of support periods, much higher than the 2%-5% range reported elsewhere.

Quantifying the extent to which people with a mental health or problematic substance use issue appear in the SAAP population can be difficult, because there is no single data item that allows easy identification of clients with these issues. Also, for a variety of reasons, the prevalence of mental health and substance use issues is likely to be under-reported.

According to Australia’s Welfare 2007, in 2005–06, around 13% of clients within the SAAP system (rather than new clients seeking assistance) reported a mental health problem and a similar proportion reported a problematic substance use issue. Around 6% reported both a mental health and problematic substance use issue.

In 2008, the Wesley Mission interviewed 206 homeless people at six shelters across inner-Sydney about their wellbeing and way of life. It found that almost three-quarters (71%) identified the ‘housing crisis’ as the major reason for their homelessness. Looking deeper, 88% said accumulated debt and unexpected financial difficulties were underlying factors leading to that crisis.

Once homeless, 59% identified drug and alcohol abuse and mental illness among factors that made it hard to overcome homelessness. Almost 20% of this group had been living on the streets for 5–10 years and two-thirds had used crisis accommodation up to six times.

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But public perception appears to differ markedly from research evidence on cause and effect. A survey of 993 people in Melbourne in 2006 by Hanover Welfare Services revealed that 91% identified substance abuse as the primary cause of homelessness and 79% believed homeless people had only themselves to blame.

For their 2005-06 study, *Homelessness and substance use: which comes first?* Dr Guy Johnson and Professor Chris Chamberlain gathered information on 4291 homeless ‘households’ in Melbourne. They found that of the 43% who reported substance use problems, a third had these problems prior to becoming homeless for the first time and two-thirds developed them after becoming homeless. Johnson and Chamberlain described drug use as ‘an adaptive response to an unpleasant and stressful environment’ and pointed out that drug use creates new problems for many.

Their data also revealed the particular vulnerability of younger people. While 14% of people who had their first experience of homelessness at 19 or older subsequently became involved in substance use, the figure for those 18 and under was 60%.

**When drugs are the reason**

When substance use is the pathway to homelessness, how does it develop? Johnson and Chamberlain identified three stages: a break with the mainstream labour market; loss of support from family and friends; and, finally, the acquisition of new social networks.

The findings of Project i, a five-year study spanning 2000-2004 of young people aged 12-20 in Melbourne (and Los Angeles), who had recently become homeless, suggested that personal substance use is perceived by many young people as an important reason for leaving home prematurely.

On the other hand, the report *Australia’s Homeless Youth* found evidence that a strong contributor to youth homelessness was parental substance abuse. It was given evidence from drug and alcohol treatment centres of a high correlation between drug and alcohol problems and mental health problems or trauma in young homeless people’s lives. It also found that homelessness is far worse among Indigenous young people than non-Indigenous young people and that they are more likely to come to the attention of law enforcement and legal systems. Consistent with the broader health picture of Indigenous people, they are also likely to be in worse health than their non-Indigenous homeless counterparts.

**Effects of substance use on homeless people**

‘Affordable housing and relationship breakdown were found in the study to be leading causes of homelessness. Drug and alcohol addiction and mental health issues were found to often keep people in homelessness.’

*More than a bed: Sydney’s homeless speak out, July 2008.*

Johnson and Chamberlain point out that when people are homeless they adapt to ‘survive’. Drug use is a common form of adaptation, being used both to cope with a hostile environment and to meet the human need to ‘belong’, in this case to fit in with the homeless subculture where drug use is common and accepted.

Typically, the places available to homeless people, including boarding houses and squats, are dangerous. Using drugs may be the only thing residents have in common. Increasing use can, in turn, lead to entrenched homelessness: their study found that 82% of people with substance use problems had been homeless for 12 months or longer, while only 50% of those without these problems had been homeless for that long. This is also consistent with the findings of Project i that, while there was not a straightforward causal relationship, exposure to street culture and unstable housing influenced substance use.

*Australia’s Homeless Youth* reported that homeless youth with drug and alcohol use problems have difficulty accessing or remaining in supported accommodation. It found that substance use can limit young people’s access to services,
inhibit their ability to control their lives and have serious legal and health consequences. Substance use and mental health issues were often co-occurring and SAAP agencies reported difficulty obtaining timely specialist help for their clients.

Denial of access to emergency accommodation services is a core problem for substance users of all ages.

Data from the NSW Ombudsman’s 2001-02 inquiry (NSW Ombudsman 2004) showed that, of those excluded from SAAP services in the six months prior to being surveyed, 470 people were excluded because of problematic substance use, 290 because of mental illness and 275 because of violent behaviour.

The Ombudsman’s inquiry included an in-depth survey of obstacles to accessing SAAP services, which showed potential clients can be excluded through practices such as banning, blacklisting, eviction and background checks. There have been similar findings in Queensland and Victorian studies.

Single men’s agencies appear to face the heaviest burden in dealing with clients with high and complex needs. This sector is one of the most likely to provide short accommodation periods and has a much higher eviction rate than for other groups, with men exiting early because of violent conduct, intoxication or substance abuse.

Many homeless people cannot even consider giving up substance use prior to being accommodated and supported. As one service reported to the NYC inquiry, to get crisis housing, substance users may be required to give up drugs, when their drug use is ‘the best, most pleasant thing in their life’. The right housing and support services can help young people reduce or give up problematic substance use.

Similarly, a study of 180 young people in New Mexico between 2001 and 2005 reported how difficult it was for homeless youth to cease alcohol and other drug use when they were not getting their most basic needs met.

Patterns of substance use among homeless people
Several studies suggest that homeless people have higher rates of problematic substance use and mental health issues than people in the general community. At the same time, the evidence suggests a complex picture: for example, the NYC inquiry found a substantial number of young people reported no recent substance use.

A 2003 study of 210 homeless people in Sydney found that ‘homeless people were six times more likely to have a drug use disorder and 33 times more likely to have an opiate use disorder than the Australian general population’.

Young people often report polydrug use patterns, using tobacco, alcohol, cannabis, amphetamines and opiates. Some drugs are particularly problematic in terms of the behaviours induced, e.g. crystal methamphetamine (‘ice’).

Johnson and Chamberlain found that the most common drug used was heroin, with a minority using alcohol or prescription drugs. Other recent findings indicate that drugs have displaced alcohol as the most abused substance among the homeless, particularly among the young.

Conclusion
Homelessness and problematic substance use intersect in complex ways we still only partially understand. Among the most vulnerable in our society are those of all ages who, in becoming or remaining homeless, are caught up in the social and personal crises associated with problematic substance use, mental health difficulties, or both.

For years, our government and non-government agencies have tried to solve the problem of homelessness. It’s a source of widespread frustration and even despair that they have had very limited success. This year, a new round of focused energy and a commitment to social inclusion have placed homelessness, and the people caught up in it, centre stage on the political agenda. Perhaps, as a result, our whole community will finally engage – and respond effectively.

Watch for the January 2009 issue of Of Substance, when we discuss current responses to homelessness and substance use, including innovative practice, as well as the Federal Government’s White Paper recommendations.

Key references
For full list of references, please email editor@ancd.org.au.
How can health services reach vulnerable young people before mental illness or substance abuse – or a combination of both – becomes chronic and disabling? Creating youth-friendly ‘one-stop shops’ where any 12- to 25-year-old can get help is one solution offered by Headspace, the National Youth Mental Health Foundation.

Founded by a consortium including Orygen (a youth mental health service and research centre in Melbourne), the Brain and Mind Research Institute at the University of Sydney, the Australian Psychological Society and the Australian General Practice Network, Headspace was launched in 2006, with a brief to reform mental health services for young people, and more than $60 million in funding from the Australian Government.

Since then, Headspace has established 30 one-stop centres – called Communities of Youth Services – in metropolitan, regional and rural areas of Australia. Staffed by workers experienced in working with young people, the centres offer multiple services including medical, mental health and drug and alcohol services in the same spot, all free or with a Medicare rebate.

These Communities of Youth Services aren’t new services – instead Headspace has drawn on $37 million of its funding to enhance existing local services and make them more cohesive, says Headspace CEO Chris Tanti, explaining that improved integration of services helps prevent young people from slipping through the cracks. One example is Peninsula Headspace in Melbourne’s Frankston and Mornington Peninsula area, a consortium of 23 services including GPs, psychiatric services, drug and alcohol services, employment services, local councils and community health services.

The difference Headspace has made is that there’s now more focus on early intervention and a better chance of picking up problems, says Charlie Stewart, director of the South Eastern region of the Youth Substance Abuse Service, now part of the area’s Headspace consortium.

‘Young people aren’t going to front up to a psychiatric service, but if they’re seeing a GP who says “I’ve got someone next door who might be able to help”, you have more chance of treating them. In the past we made appointments for people and they didn’t turn up. It’s early days yet, but we have a lot of people using the service. Sixty to 80 per cent of young people we work with have mental illness and a problem with drug abuse too – Headspace makes it easier to cope with both,’ he says.

Meanwhile in Sydney’s outer suburbs of Campbelltown and Macarthur, figures from Headspace’s first year of operation in the area show 949 new occasions of service – a number that breaks down to 317 young clients using Headspace services. That’s in addition to people accessing mental health services routinely provided by the area health service. The average age was 17.

Twenty-two per cent of referrals were from families, 11 per cent were self-referrals and 12 per cent were referred by schools – signs that Headspace is engaging with the community, says Bradley Whitwell, co-ordinator of the National Youth Program for the Brain and Mind Research Institute.

The need for reform in mental health services for the 12 to 25 age group is because the years spanning adolescence and the early 20s are a prime time for mental illness to begin – and with it the potential for disrupting education and employment, and derailing lives, says Tanti. Around 75 per cent of people who develop a serious mental illness have their first episode before the age of 25. But while young people have the greatest need for help with mental health, they’re the least likely to get it – more than 60 per cent don’t get the help they need, according to the national depression initiative beyondblue. Although it’s not clear how many young people have both mental illness and a problem with substance abuse, their numbers are thought to be high and research suggests that their treatment outcomes are poorer than for people diagnosed with mental illness alone.

‘Historically it’s been difficult for young people to access mental health services partly because of the health system structure,’ explains Patrick McGorry, Professor of Youth Mental Health at Melbourne University and Chair of Headspace’s Executive Committee.

‘In Child and Adolescent Mental Health Services, the services are for 0 to 18 year olds, while adult services are for the 18 to 65...
The website itself (www.headspace.org.au), which in August was attracting around 2000 hits daily, provides fact sheets (bullying and anxiety are the most frequently downloaded topics) and is interactive. Young people are invited to submit their personal stories, all of which are published – the site receives around 50 a week.

‘Those that suggest someone is beginning to struggle or is at high risk of mental illness are contacted by a psychologist via email. Anyone at immediate risk of abuse, suicide, or who has threatened suicide is referred to Lifeline or the Kids Help Line. But the psychologist will keep up the interaction and let them know of services in their area,’ Evans says.

Another problem is that the system has traditionally been geared to people with a significant mental illness, Tanti points out.

‘Most people with depression and substance abuse problems can’t get a service until they’ve reached the extreme end,’ he says. ‘What’s needed in mental health is a system similar to university counselling services where the only criterion for accessing a service is that you attend the university. You don’t have to be hearing voices, but perhaps you’re starting to struggle.’

‘Headspace is trying to get in before psychotic symptoms appear but also to try to treat the broad spectrum of mental health problems among young people, using an integrated approach that can tackle comorbidity,’ adds McGorry. ‘The problem has been the system of treating substance abuse and mental illness separately in a sequential way. The tragedy is that while you might get treatment for one problem, you might not get treatment with the other, but with Headspace you get it together in one place.’

Another obstacle to treatment has been young people themselves who often find it difficult to recognise whether they have a problem with mental health because they have no frame of reference, says Tanti.

That’s why Headspace is trying to boost young people’s mental health literacy via an awareness campaign run through the internet – including sites like MySpace and ninemsn, the Headspace website, youth concerts and TV ads. The campaign soft pedaled on the use of the term ‘mental health’ – while its title ‘National Youth Mental Health Foundation’ appears on ads and on its website, the print is small and discreet. Rather than referring specifically to mental health, the ads aim to get young people to think about how they feel, explains Headspace’s acting director of communications, Karalee Evans.

‘We’re working on getting in early before people get labels of psychosis on their heads. If you imagine a ladder of stages towards mental illness, we’re trying to get in two steps before people become depressed.’

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References


In May 2008 the Ministerial Council on Drug Strategy approved the first ever National Corrections Drug Strategy for Australia, a truly remarkable achievement of cooperation between government correctional authorities.

The strategy acknowledges the need to have a balance between reducing the supply of drugs in correctional settings; reducing the demand for drugs by prisoners, detainees and parolees through treatment and education, and reducing the harm that drug use can cause, particularly the transmission of HIV and hepatitis C.

In a review of Australian prisons’ drug policies and programs commissioned a few years ago, the Australian National Council on Drugs (ANCD) found that many prison systems did not provide the necessary range of drug treatment options. In many cases, prisoner access was extremely limited to the services that were available. There was a dominating focus on supply reduction efforts and not enough integration with the community sector for treatment and harm reduction programs. Given what we already know about the very high levels of drug use of people before they enter correctional systems and the continuation of drug use problems among many while in custody or on parole, this is not a well-balanced approach.

Australia’s effective and pragmatic responses to drug use and its associated harms in the community have long been heralded. However, this wasn’t replicated in adult prisons, juvenile detention centres and community corrections (probation, parole, etc). The result of this was a chain with a very weak link in our national approach to drugs. People caught up in problematic drug use which resulted in criminal convictions were potentially being exposed to a range of harms and risks, undoing any good work undertaken in the community-based sector. This is why this new strategy is an important milestone in Australia’s approach to addressing drug use.

The National Corrections Drug Strategy which was supported and assisted in its development by the ANCD in consultation with all correctional authorities provides a unique opportunity to see correctional authorities work towards implementing a range of policies and programs to also reduce the demand and harm from drugs, as well as working better with the community based programs that often see the same people.

The strategy includes a specific objective to increase the access to evidence based treatment and other health-related services for offenders, as well as another to reduce risk behaviours associated with drug misuse by offenders. If in coming years we see a commitment to this and the other objectives within the strategy, it will result in people within our correctional system getting access to a range of effective prevention, treatment and harm reduction programs that are taken for granted in the community.

**A FEW FACTS**…”

- The number of offenders in custody in Australia increased from over 15 000 in 1992 to more than 24 000 in 2005 (an increase of over 50%) with more than 35 000 people entering a prison somewhere in Australia each year (excluding periodic or weekend detainees).
- The average length of sentence for offenders in custody is less than 12 months.
- On average it costs between $50 000 and $73 000 per year for each offender in custody.
- Research estimates between 41% and 70% of violent crimes are committed under the influence of alcohol.
- Comorbid substance use disorder and mental illness is common among offenders in custody. Sixty-six per cent of females and around 50% of males in custody with a substance use disorder also have a mental disorder (psychosis, anxiety disorder or affective disorder) were the statistics reported in one Australian jurisdiction.
- Approximately 60% of offenders report drug use on at least one occasion during their current term of imprisonment. Around 33% of people who inject drugs continue to inject drugs in prison. A smaller percentage of people also begin using drugs and injecting drugs for the first time when in prison.
- The level of hepatitis C in prisons is estimated to be up to 17 times greater than in the general community.

The agreement within the strategy that care and treatment for offenders should continue after exit from the correctional system could also mean a greater engagement with community-based services – further strengthening the weak link that exists now.

The focus on Indigenous offenders and the ever increasing proportion of the correctional population they make up also presents an opportunity for change.

This also raises another important component of wider law enforcement and correctional strategies which is the provision of alternatives to prison and detention centres. If we can divert people committing crimes as a result of their drug and alcohol dependence or mental health problems into treatment and rehabilitation centres, it will not only save the community a lot of money, it is also likely to lead to fewer people committing crime in the future. Treating the causes of crime is always going to be more beneficial to the community.

Otherwise we face the prospect of following the USA where, despite only accounting for five per cent of the world’s population, more than two million prisoners (or 25 per cent of all prisoners in the world) are bursting at the seams of prisons and which have become an incredible financial and social burden. Prisons cost a lot of money to run. For every adult we send to prison, we have to set aside about $60 000 each year. Basically, while the National Corrections Drug Strategy acknowledges we need to work more effectively with people in the correctional system, we also need to help that system by being more judicious in the number of people we send there.

*Gino Vumbaca is the Executive Director of the Australian National Council on Drugs.

PRISONERS NEED A SAY

BRETT COLLINS*

This new ‘strategy’ is the easy top-down approach that always fails, especially in prisons. To not involve prisoners as thinking people, working through their needs is entirely missing the point. Prisoners want to be healthy, happy and free, able to sustain themselves and their families. They are the natural allies to deal with the most important reason for their being in prison. But administrators of prisons and health never involve them in the analysis or the process of implementation. This new strategy is not a serious document of goodwill.

It avoids the hard issues. Australia doesn’t even exchange needles and syringes – unlike the Netherlands, Germany, Spain and even the Ukraine and Albania. One dirty needle infects scores of prisoners – our hepatitis C rate is 50 per cent across the system.

Prisons are a part of a cycle of disempowerment where the isolation and loss of personal autonomy contribute to increased drug use both inside and after release. The breakdown of relationships caused by the abuse of visitors in the name of the ‘war on drugs’ is a big part of that isolation.

Drug law enforcement in prisons is totally destructive and has been shown to be ineffective everywhere in the world no matter how draconian the security. Prisoners move from cannabis to heroin due to its easy concealment and rapid absorption by the body. Pot can show up in a random urine test for a month after smoking a joint.

Families don’t visit due to strip-searching or are banned arbitrarily on a dog’s sniff despite a search yielding nothing. Publicity about concealment in babies’ nappies and grandmothers’ hairdos has allowed the degrading of family members, rather than appreciation for their commitment essential to the prisoner’s resettlement.

An average of one prison officer a month suffers a needle-stick injury due to the demands that they regularly search for contraband needles. This results in dozens of imprisoned addicts sharing the same rusty, pitted needles. An AIDS scare in Silverwater Jail a few years ago showed the breadth of the problem.

Networks of gangs and officers are well documented. The tighter the supply of illicit drugs, the more profitable it becomes for officers to smuggle them in and the more corrupt and destructive the system becomes. In practice, drugs make a quiet prison with easy management.

Real change needs prisoners empowered to take control of their addictions and the harm it causes. Those prisoners who want to reduce or eliminate their illicit drug use should be supported by peer education and mutual support groups from the wider community.

* Brett Collins is president of Justice Action, a community-based organisation of criminal justice activists.
In the past year, there have been journal and newspaper reports of people experiencing health problems, or even dying, from the abuse of some painkillers which are sold over the counter in pharmacies. Few studies about the subject exist and many of the reports are anecdotal, so it is difficult to assess the size of the problem, or whether changes need to be made in the way we market and sell analgesics.

What do we know?

According to reports from Melbourne’s Angliss Hospital (Dutch, 2008) and the Southern and Eastern Health Service in Victoria (Frei, 2007), the drugs involved are combination ibuprofen/codeine phosphate products, such as Nurofen Plus and Panafen Plus. In both centres, daily intake was around 24-48 tablets. Patient numbers were small, with just two and 29 cases respectively.

Complications from the abuse included gastrointestinal bleeds, perforated ulcers, anaemia, hypokalaemia (low concentrations of potassium in the blood causing neuromuscular disorders), renal failure and peripheral oedema. Opiate addiction, due to the codeine in the products, was also a problem.

Those being treated did not match the profile of individuals generally seen by drug treatment services. Dr Matthew Frei’s study of 29 people included 23 cases of codeine phosphate dependence in users of over-the-counter (OTC) ibuprofen 200 mg/codeine phosphate 12.8 mg analgesics. Seven people had used for up to two years, 11 for up to five years, and three for more than five years. The majority of cases (15/23) reported a painful condition (such as a headache) as the reason for use. Half the sample was over 35 years of age. Only eight had a history of illicit drug use (mainly cannabis): most had never injected drugs, had limited previous contact with drug and alcohol treatment services, and did not necessarily identify as drug addicted.

Treatment

Approximately one-third of the cases in Frei’s study were initiated on methadone and buprenorphine, and as a result almost all ceased or markedly reduced their use of OTC compounds. Hospital presentations and complications were also reduced. Although most cases had not had any previous form of treatment, and were not the usual kind of patients who would commence on methadone or buprenorphine, Frei says these treatments appear to work for them in the same way as they do for heroin/illicit opioid users.

Other treatments are the same as for any substance abuse/substance dependence type patient: brief interventions, counselling, developing skills around relapse prevention, and educating about harms from drug use. Frei has also occasionally detoxified people from codeine analgesics, but he says the very wide availability and affordability of OTC codeine compounds makes this form of treatment unlikely to have outcomes as promising as opioid pharmacotherapy.

An unseen problem?

In discussing his study, Frei concluded that a ‘small but significant’ number of opioid analgesic-dependent clients, with substantial medical comorbidities, are being referred to hospital liaison or specialist clinics, and that such cases are probably under-reported.
Dr Martin Dutch, the emergency registrar at the Angliss Hospital agreed. ‘Misuse of these medications appears to be an emerging cause of significant morbidity in patients with codeine addiction,’ he said in his report in last January’s Medical Journal of Australia.

Comments on an online forum for people addicted to codeine (http://mc2.vicnet.net.au) suggest the problem is more widespread. Forum contributors say the issue is not discussed openly, is frequently not acknowledged by doctors, and is felt by sufferers (many say they have been addicted for years) to be shameful and embarrassing. The forum claims to have been contacted by 4000 Australians over a four-year period.

The manufacturers’ view

The product information contained in each packet states when the product should not be taken (e.g. in the presence of conditions including stomach ulcers; liver, heart and kidney disease; thyroid and prostatic problems; by those who consume regular and heavy amounts of alcohol; and by those on a range of other medications including certain antidepressants). Significantly, it warns: ‘Products containing codeine should not be taken for prolonged periods. Codeine may be habit forming’.

In a statement following the release of Dutch’s report, Reckitt Benckiser, the manufacturer of Nurofen Plus, said in most states the product can only be purchased from pharmacies where there is always a qualified pharmacist available who can advise on its correct use. Reckitt Benckiser points to a study involving thousands of patients which showed ibuprofen at non-prescription doses, when taken as directed for short-term, occasional use, exhibits a lower incidence of gastrointestinal (GI) side-effects than aspirin and the same level of GI side-effects as paracetamol (Moore et al. 1999).

Reducing harm

Given that numbers presenting for treatment appear to be low, should further action be taken to reduce harm? If so, what would that action look like?

Marketing restrictions (including discrete placement on shelves, more prominent warnings on packs and controls over online sales), and better surveillance and awareness by pharmacists at the point of sale may be ways of limiting the harm caused by abuse of ibuprofen/codeine. The maintenance of more adequate dispensing records might also make it difficult for consumers to obtain the product in multiple batches, from multiple outlets. Other measures might include more vigilant reporting of adverse reactions and reformulation of the product.

Reducing pack size may also help. In Britain, following the death of a 49-year-old woman in March 2007 after taking up to 64 Nurofen Plus tablets a day for two years, doctors called for large-scale research into the extent of addiction to OTC painkillers. Consequently, the maximum pack size was restricted to 32 tablets.

Tightening legislative requirements so that these products are available only on prescription is controversial. Kos Sclavos, president of the Pharmacy Guild, says it is a difficult balancing act to make sure they are accessible to those who legitimately need them, without making them too easy to get for those who might misuse them. In an address to the National Press Club in July, Sclavos suggested a notification system similar to that used for pseudoephedrine medications should be used for these opioid analgesics (see box above).

Professor of pharmacy at the University of Tasmania, Greg Peterson, believes regulation should be taken further and ibuprofen/codeine analgesics should not be available over the counter. ‘Ibuprofen is fine if used in low doses, but about 20 per cent of people should not take it at all because they have a history of heart disease, stomach problems, asthma, are pregnant or elderly, so these drugs need to be prescribed by doctors who can take a detailed medical history,’ he said.

References


In part two of our series on international drug policy, Of Substance looks at the drugs and policies which have shaped the English approach to illicit drugs.

England has a population of about 51 million and is part of the United Kingdom, which has devolved aspects of its government – including drug treatment – to the separate administrations with responsibility for Northern Ireland, Scotland and Wales. Criminal law and international aspects of drug policy for each jurisdiction remain under the control of the central government at Westminster. Drug control is based around the Misuse of Drugs Act (1971) along with an assortment of amending and subsequent legislation.

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<th>Population (2007 estimate)</th>
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<tr>
<td>People with problematic drug use</td>
<td>330,000</td>
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<tr>
<td>Most popular illicit drugs</td>
<td>Cannabis, opiates, cocaine</td>
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<tr>
<td>HIV prevalence among people who inject drugs</td>
<td>5%</td>
</tr>
<tr>
<td>Hepatitis C prevalence among people who inject drugs</td>
<td>40%</td>
</tr>
</tbody>
</table>

Opiate use in Britain dates back to the 1800s and cocaine initially became popular in London towards the end of the First World War. Since the 1950s, a range of drugs have become popular including cannabis, amphetamine sulphate and ecstasy. Heroin injecting burgeoned in the 1970s and is typically concentrated in those communities with the greatest levels of social deprivation. More recently, crack cocaine use has spread across the country but remains most common in London and other metropolitan cities. Methamphetamine use remains rare. Rates of drug use and drug-related deaths are among the highest in Europe and it is estimated that there are about 330,000 ‘problem drug users’ (users of opiates, crack cocaine or injectors).

England was one of the earliest countries in the world to introduce needle exchange and did so before HIV became established within its population. Consequently, an epidemic spread of HIV/AIDS among people who inject has so far been prevented and prevalence remains below five per cent. Hepatitis C was already endemic among injectors when needle exchange programs were introduced. Nevertheless, in global terms prevalence is still relatively low at around 40 per cent.

Lead agencies

The national drug strategy is coordinated through the Home Office and the original 10-year strategy from 1997 has just been revised. Its four main strategic areas are: young people, communities, treatment and supply reduction. The new drug strategy has some changes of emphasis but retains the same broad approach.

Nationally, drug treatment is managed through a special health authority – the National Treatment Agency for Substance Misuse (NTA). In turn, local responses to drug use are coordinated through multi-agency partnerships that correspond with local government boundaries and that have representation from health, local government and criminal justice agencies – Drug Action Teams. Originally, their role was restricted to illicit drugs but many have now become Drug and Alcohol Action Teams and coordination of responses to alcohol problems has been added to their role, reflecting escalating concern about binge drinking, public order problems and rising alcohol consumption across the population.

The UK also collaborates with the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) – an EU body that harmonises epidemiological monitoring and disseminates information about harm reduction and demand reduction programs. As such, there are many similarities between services in England, the rest of the UK and Western Europe, as well as other Commonwealth countries such as Australia, Canada and New Zealand.

Treatment/harm reduction

National guidance conceives all ‘treatment’ as ‘harm reduction’ and has an integrated definition that embraces responses such as needle exchange through to abstinence-based residential rehabilitation programs. Adult drug treatment provision is defined through a national framework – ‘Models of Care’. Drug Action Teams commission services in line with Models of Care and national clinical guidelines. Although there is some scope to shape services according to local needs, services broadly reflect this national framework and within any locality there is
generally some provision of: needle exchange; community prescribing from specialist teams and through ‘shared care’ with people’s family doctors, typically involving oral opioid substitution treatment (methadone/buprenorphine); psychosocial interventions; structured day programs; inpatient detoxification; and residential rehabilitation.

Variations in the way services are provided reflect factors such as whether the population is concentrated (metropolitan/urban) or dispersed (rural), which often require different configurations of delivery. In some areas of higher need, specialist services are commissioned to reflect local drug cultures and meet the needs of particular groups such as people who inject steroids or use crack cocaine.

Similarly, some local areas have commissioned services to meet the specific needs of cultural minorities (e.g. South Asian, Caribbean or Somali populations).

Historically, the Rolleston Report (1926) gave rise to what became known as the ‘British System’, characterised as a medical approach to dependence where people are prescribed their drug of choice. This led to modest levels of morphine/heroin prescribing for a small number of middle-class opiate users. However, with dramatic increases in heroin use among the urban poor during the 1970s and the availability of methadone treatment, this approach has become increasingly marginal.

Today, diamorphine (heroin) prescribing in England is rare. This may change again, when results from a current national study are available (the Randomised Injectable Opioid Treatment Trial – RIOTT), but even if the results are favourable, the eligibility for injectable diamorphine or methadone would be restricted to the minority of people who have exhausted all other treatment options.

Although a small number of ‘injecting rooms’ were briefly available in London during the late 1960s, these did not resemble such services as they are now understood. They were very informal in their organisation and ultimately closed because they became hard to manage. To date, the government has resisted calls for pilot implementation of drug consumption rooms based on contemporary models that focus more clearly on enhancing health and reducing public nuisance.

Currently, there is considerable discussion about the extent to which treatment services effectively assist people to achieve ‘recovery’ and become drug free, with debate around how recovery should be defined. Few commentators now dispute the need for services that address the immediate risks of drug use or support people to become drug free. However, there is disagreement as to whether the balance of service provision is right and, in particular, whether there is an over-reliance on long-term opioid prescribing and under-provision of services such as residential rehabilitation. To some degree, this debate reflects political divisions: the New Labour government has overseen extensive roll-out of prescribing services but the Conservative opposition is more supportive of abstinence-based programs.

Services for young people are also overseen by Drug Action Teams. These are separate from adult services and typically include (a) targeted prevention work with vulnerable youth e.g. young offenders, children in care and children who are truanting or excluded from school; and (b) psychosocial interventions such as keyworking/counselling. In contrast to adult treatment that focuses on heroin/cocaine/crack, young persons’ services largely work with people whose problems involve cannabis or alcohol as problem heroin use is still relatively rare among people aged under 18.

Criminal justice

The UK does not apply the death penalty but has the second highest incarceration rate in Western Europe (148 per 100 000. In comparison, Australia’s rate is 132 per 100 000). This includes many people convicted of drug offences. Drug treatment in prisons has lagged behind that in the community but there is now an ‘Integrated Drug Treatment System’ that has elements of the treatment provided in the community (such as substitute prescribing and psychosocial interventions) and which places a growing emphasis on continuity of treatment and throughput.

There are, however, no needle exchange programs in English prisons and the ongoing, high rate of imprisonment means that the prison service is under considerable strain, which undermines therapeutic programs.

During the past 10 years, drug policy within the UK has been characterised as shifting from the health agenda to a crime prevention agenda. As part of this there has been legislation and policies to introduce court-mandated treatment that targets persistent and prolific offenders (predominantly people committing acquisitive crimes such as theft and burglary). This has been accompanied by a marked increase in spending on treatment and a corresponding increase in the number of offenders receiving community treatment. Drug courts have also been piloted and their provision is now being selectively extended.

Evaluation practices

Since the launch of the first drug strategy, treatment evaluation has developed from a simple focus on numbers in treatment and indicators such as waiting times, towards an outcomes focus that measures proxy outcomes such as retention in treatment and the number of treatment episodes that have planned endings. Most recently, the NTA has introduced a ‘Treatment Outcomes Profile’ (TOP) that is used on entry to treatment and at 12-week intervals. This captures data on: substance use; injecting risk; crime; and health and social functioning. Despite the amount spent on drug control, the impact and cost-effectiveness of supply reduction measures receives comparatively little scrutiny.

*Neil Hunt writes from The Centre for Research on Drugs and Health Behaviour, London School of Hygiene and Tropical Medicine and The European Institute for Social Services, University of Kent, UK.

References


Legalised gambling exploded during the 1990s as governments around the world began to recognise the economic benefits. In Alberta, Canada, funds gained from gaming rival the province’s revenues from crude oil. Electronic gaming machines (EGMs) are now in Norwegian petrol stations and shops, and more recently the Singapore Government scrapped its long-standing ban on gambling to strike deals for two multi-million dollar casino developments.

Closer to home, and in what was once the more conservative state of Victoria, Premiers Joan Kirner and Jeff Kennett relaxed gambling laws to boost the economy. A casino was built in Melbourne, and clubs and hotels introduced EGMs into the recreational mix. EGM numbers also increased in other states and territories, although Western Australia chose to restrict licensing to its casino.

New South Wales has long been home to gambling. Poker machines, the forerunner of EGMs, first appeared in clubs in 1956. Numbers slowly increased and then in 1997 gambling really took off. EGM entitlements were substantially increased in clubs and extended to hotels. Today, with a per capita rate of approximately one EGM per 50 adults (Office of Liquor and Gaming 2007), New South Wales has arguably the highest density of EGMs outside of gaming destinations such as Las Vegas. It didn’t take long for associated problems to arise.

‘The substance abuse field may have much to learn from gambling addiction.’

There are many parallels between gambling and alcohol consumption. Both earn revenue through taxes. Both fuel employment and other industry. Both are enjoyed by the majority of partakers with little negative effect. However, as with those who get into trouble with alcohol, some people gamble more than intended and a smaller proportion are labelled pathological gamblers. They lose their jobs, relationships and sometimes resort to crime. Research indicates that people in some sectors of the community – those with low incomes and other vulnerabilities, are more likely to get into trouble.

In 1999 the Productivity Commission, the Australian Government’s principal review and advisory body on microeconomic reform policy and regulation, conducted a review of gambling in Australia. Expenditure on this activity had doubled over the decade to $11 billion and the majority of this money was being spent on EGMs.

While unable to draw a firm conclusion, the Productivity Commission believed there was sufficient evidence to suggest a relationship between accessibility to gaming machines and the proportion of problem gamblers in the community. The Commission also pointed a finger at state governments for failing to come up with effective regulations to help this group.

Nevertheless, the Federal Government concluded that the gambling industry was beneficial for Australia, and any harm varied with the mode of gambling, with EGMs causing the greatest number of problems. It was noted that more had to be done to help those at risk.

Three years after the release of the Productivity Commission’s report, Chairman Gary Banks took a look at the industry again (Banks, 2002). There had been gradual acceptance within the industry that existing measures to control problem gambling were inadequate. A national industry group, the Australian Gaming Council was established in 2000 and developed its own Responsible Gambling Code. Individual codes were also developed in separate states.
Banks felt that the Queensland version was arguably the most comprehensive because it was the product of a tripartite agreement between industry, government and community groups. The Queensland approach focuses on six areas. Examples of its harm minimisation strategies include:

- providing information – displaying information on gambling risks and the odds of winning major prizes
- interacting with customers and the community – networking with gambling support services and training staff to perform customer liaison roles
- exclusion provisions – giving support to self-excluded customers when practical and ensuring they are not sent promotional material
- physical environment – managing the serving of alcohol in ways that encourage customers to take a break in play
- financial transactions – limiting winnings paid in cash, ATMs not located in areas close to gambling machines
- advertising and promotions – ensuring all advertising complies with the Advertising Code of Ethics and does not misrepresent the probability of winning a prize.

Bank’s report also found indicators suggesting the growth in gambling expenditure in Australia was slowing, perhaps in response to measures being put in place. However the percentage spent on EGMs remained considerable.

**A cap on gaming machines**

Capping the number of EGMs has been seen as one way of combating associated problems. In New South Wales for instance any club or hotel wanting to increase their EGM entitlements must purchase them from another venue. EGM entitlements can only be bought in blocks of two to three, with one machine leaving the system completely. The aim in the longer term is to reduce numbers overall.

Transfers of EGM entitlements must also be accompanied by a social impact assessment study. The purpose of these studies is to weigh the economic and social benefit of having EGMs introduced to a particular community against the potential for harm. In terms of potential community benefit, social impact assessment studies look at the opportunities for employment raised by gaming.

They also look at how the revenue (typically raised by clubs) will be used for charitable purposes. It is hoped that a reduction in density and the number of EGMs overall will reduce access and gambling-related problems as a result. But is the method good science?

Professor Max Abbott, from the School of Psychology and Public Health at Auckland University of Technology questions the simplicity of the model. While he says that contact with gambling is required for people to develop gambling problems, there is also evidence that increased contact with gambling means that people will adopt behaviour that protects them from those problems (Abbott 2007). Research on this relationship indicates that increased EGM exposure and an increase in gambling-related problems seems to break down somewhere between six to ten machines per 1000 adults.

Abbott cautions against introducing simplistic harm reduction strategies (such as concentrating on access) based on the findings of unsophisticated measurements. Yes, there is an association between problem gambling and EGMs, but is access the main cause? In Victoria there are roughly 25 000 EGMs and in NSW there are about four times as many at around 100 000. However, Victoria has approximately the same expenditure on EGMs per capita, indicating there must be other factors influencing expenditure.

Abbott notes that Norway, a country that has a moderately high number of machines, rudimentary gambling information and few restrictions on age and access, has a relatively low problem gambling rate. This might have something to do with where EGMs are located. In Norway they are found in petrol stations, supermarkets and shopping centres where players are in full view of people doing other things. There are no seats and sometimes EGMs are located by external doors in freezing weather. Contextual factors may have an important part to play in reducing harm.

**Borrowing from other fields**

Gambling behaviour is often defined as ‘addictive’ when it is characterised by:

- a loss of control over the activity
- being preoccupied with gambling and having the money to do it
- thinking irrationally about the odds of winning
- continuing to gamble despite adverse consequences to self, family and work.

While the behaviour itself is unique, it shares symptoms with other disorders such as anxiety, depression, impulsivity and substance abuse. As such it has been considered a syndrome that responds best to a multimodal approach.

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In this framework, electronic gambling provides a clear example of conditioning, as the financial payout to participants help to encourage high levels of involvement.

Emotional reward also plays a role, although most theories on how they work have been too specified to date. Orford believes they fail to account for the diversity of rewards associated with any single form of appetite consumption, let alone the full range of excessive appetites. Furthermore, theories that search for a reward system in the brain often ignore the social context in which appetite acts take place.

‘There are many parallels between gambling and alcohol consumption. Both earn revenue through taxes. Both fuel employment and other industry. Both are enjoyed by the majority with little negative effect.’

Social psychologist Stanton Peele, a renowned and controversial writer on addiction issues whose most recent book is titled How to addiction-proof your child, agrees more focus could be placed on researching areas beyond the physiological that include values and self-control. Peele has recently been studying smoking and pointed out to Of Substance that while there is physiological proof to show that a depletion in nicotine drives a person to raise the levels again, nothing physiological predicts smoking cessation. Peele pointed out that the longer a person smokes the more dependent he or she becomes and yet it is the older smoker who is more likely to respond to cessation treatment. ‘As people become older their values change,’ said Peele. ‘They become more worried about their health and so they exercise self-control.’

**Striking a balance**

In his follow-up report on the gambling industry, Banks noted that more research was required into consumer protection measures. Such research would also require a deeper understanding of what drives gambling behaviour. Given the economic reliance on gambling and its recreational status, it appears we must strike a balance between putting in place measures that do not encourage excessive appetites and providing people with the skills to make intelligent choices. Peele agrees that such initiatives must protect those who for a number of reasons are unable to make intelligent choices at a particular time in their lives. At the same time we need to foster values and skills that develop self control.

**References**


Colin Farrell, a PhD student at Sydney University and consultant at Russell Corporate Advisory Services, a company that assists the club industry in building sustainable business, is deeply interested in what makes some people develop gambling problems and not others.

For the last three years he has been working with Associate Professor Elizabeth Cowley and fellow student Alex Li to determine at least one of the drivers. Farrell explains that nearly all past research has been conducted on severe problem gamblers, a group that represents only 2.4 per cent of New South Wales’ adult population. Yet findings from this small group are often applied to the community at large.

‘Severe problem gamblers are those who gamble at any opportunity,’ says Farrell. ‘If all gaming machines were removed from New South Wales, they would gamble on something else. Concentrating on this group does not shed much light on how the other 97.6 per cent might be lured into irresponsible behaviour.’

Russell Corporate Advisory Services decided to support this research and was awarded an Australian Research Council Industry Linkage Grant. The central hypothesis of the study is that some recreational gamblers who slip into irresponsible gambling engage in a mental game where memory is edited to justify playing again, even if the game has gone badly. Indeed, most of us engage in this sort of thinking now and again when it comes to activities that we really enjoy, such as shopping or eating gourmet food.

The researchers also considered the role of ‘counterfactual’ thinking, a term that describes the degree of happiness or disappointment in a result, based on what was anticipated might happen.

In a gambling scenario this means that normally a player who lost would be disappointed because the alternative would be to win. In the case of a win they would be happy because the alternative would be a loss. On this basis they would make decisions as to whether the game could get better or worse with most people deciding to quit when they were ahead or at least cut their losses.

However, might gamblers who really, really enjoyed the game engage in some distortion of this thinking? In other words, if they lost would they think that the next time they would win and if they won would they decide that the next time they would win more? If so, they would be continually motivating themselves to play again regardless of the reality of the experience.

The hypothesis was tested on real gamblers, who were selected at random. A room was set up to resemble the gaming experience and laptop computers were used to simulate gaming machines. The pattern of wins or losses was manipulated to test theories on how a potentially irresponsible gambler might edit his or her memory.

Following a simulated game, questions were asked on previous gambling behaviour: Had the participant ever spent more time at a gaming machine than intended? Had he or she ever spent more money than planned? Such questions were aimed at separating out those who may be more prone to irresponsible gambling from those who were not. A week later the participants were called back and asked how much they had enjoyed the previous game and whether they would like to participate again.

The responses confirmed the researchers’ theories. Recreational gamblers who were not prone to episodes of irresponsible gambling, in other words those who reported that they never spent money not intended or stayed longer than planned, had clear memories of wins and losses.

However, the second group, those who reported moments of irresponsibility in the past, were able to clearly remember their wins but were vague about the number and amount of losses.

Those with a tendency towards irresponsible gambling also showed a different belief system about how they could improve their performance in the game, even when the pattern of wins and losses had been manipulated in such a way as to make this rationalisation very difficult.
The winners of the 2008 National Drug and Alcohol Awards were announced at a gala dinner on 27 June at the Plaza Ballroom in Melbourne.

The Awards recognise outstanding achievements by individuals and organisations in preventing and reducing harm from alcohol and other drug use. An estimated 10,000 people around Australia now work directly in the sector – dedicated professionals, researchers, volunteers and community organisations. Many more contribute within associated sectors.

The Awards are a collaborative effort of the Ted Noffs Foundation, Australian Drug Foundation, Alcohol and other Drugs Council of Australia and the Australian National Council on Drugs.

They were sponsored by the Alcohol Education and Rehabilitation Foundation, the Australian Government Department of Education, Employment and Workplace Relations, Victorian Department of Human Services, and supported by the Victorian Department of Education and Early Childhood Development and NSW Health.

Prime Minister Kevin Rudd was represented by Parliamentary Secretary for Disabilities and Children’s Services Bill Shorten and Australian National Council on Drugs Chairman John Herron. Mr Rudd also sent a letter endorsing the Prime Minister’s Awards for Excellence and Outstanding Contribution to Drug and Alcohol Endeavours.

‘There are many exceptional people and organisations that are dedicated to helping Australia tackle our drug and alcohol problems. These people and organisations represent education, health, families, youth, and law enforcement services, and I see these Awards as a fitting way to celebrate the positive contributions they make for all of us on a daily basis,’ his letter said.

### National Drug and Alcohol Awards 2008 — winners and finalists

**Prime Minister’s Award for Excellence and Outstanding Contribution in Drug and Alcohol Endeavours**
- **Winners:** Blair McFarland (Central Australia Youth Link-Up Service), Tony Trimingham (Family Drug Support)
- **Excellence for Law Enforcement**
  - **Winner:** Groote Eylandt Alcohol Permit Committee, NT
  - **Finalists:** Queensland Police Service Party Safe, Indigenous Peer Education Program (Queensland Corrective Services)
- **Excellence in Services to Young People**
  - **Winner:** Young Parents’ Project (Youth Substance Abuse Service)
  - **Finalists:** Residential Withdrawal Pathways Project (Youth Substance Abuse Service), DRUMBEAT (Hoyoake)
- **Excellence in Prevention**
  - **Winner:** ‘YOUTHinc: An Underage Alcohol Diversion Program’ (Cobaw Community Health)
  - **Finalists:** ‘Keep Your Head Together’ (Sydney West Area Health Service), ‘6’ DVD (City of Melville) Youth Solutions
- **Drug & Alcohol Honour Roll**
  - Graham Strathearn, Ingrid van Beek, Jim Rankin
- **Excellence in Media Reporting**
  - **Winners:** The Geelong Advertiser, Jill Stark (The Age)
  - **Finalist:** Insight: ‘Under the Influence’ (SBS)
- **Excellence in Research**
  - **Winner:** Dr Rosa Alati (School of Population Health, University of Queensland)
  - **Finalists:** The Methamphetamine Treatment Evaluation Study (National Drug & Alcohol Research Centre), Drug Policy Modelling Program Stage One (National Drug & Alcohol Research Centre)
- **Excellence in Treatment**
  - **Winner:** The Indigenous Outreach Program (Drug & Alcohol Services Association)
  - **Finalists:** The Stronger Families Project (Alcohol & Drug Foundation Australian Capital Territory Inc), Glenelg & Southern Grampians Drug Treatment Service
- **Excellence in School Drug Education**
  - **Winner:** Macleay Vocational College
  - **Finalists:** Trinity Grammar, Townsville Grammar
- **NIDAC Logo Competition**
  - **Winner:** Toby Dodd (Dreamtime Public Relations)
  - **Finalists:** Karen Briggs, Tony Laplanche
PRIME MINISTER’S AWARD: JOINT WINNERS

BLAIR McFARLAND: AT HOME IN HIS ‘SKIN’

Blair McFarland was a young man from Bathurst who found his ‘place’ in central Australia about 20 years ago. He’d been working in conservation in central and northern Australia, learning from Aboriginal people, when in 1987 he got his first job in probation and youth work, in an “ideal spot” – a one-man office in Papunya, NT.

From the start, Blair built a strong and trusting connection with Aboriginal communities. In 1988 he received his ‘passport in the Aboriginal domain’, his Aboriginal skin name, Tjapaltjarri. His son Paddy, now 17, also has a skin name, Jungrai.

This trust and belonging was the crux of what followed. In Alice Springs, with community support, Blair set up the Remote Area Night Patrol Service and in 2002 the Central Australia Youth Link Up Service (CAYLUS).

CAYLUS is a coalition of the Tangentyere Council and other local agencies that aims to aid their communities and deal with the scourge of petrol sniffing, which has affected every community in the region.

In June, Blair’s work for CAYLUS and the Opal Alliance was recognised with the 2008 Prime Minister’s Award for Excellence and Outstanding Contribution to Drug and Alcohol Endeavours. Earlier this year Blair was also named one of the Northern Territory finalists for Australian of the Year.

For the first year or so of CAYLUS, Blair was the sole worker and progress was dogged both by politics and shortage of money. Eventually he pulled together funds for a second worker and even a vehicle to reach communities spread over hundreds of kilometres.

In 2004 the Aboriginal Education and Rehabilitation Foundation gave a two-year grant and the staff now also includes a much-needed caseworker.

To conquer petrol sniffing, CAYLUS developed a simple model: reduce supply first, then tackle demand. Supply could be targeted by replacing normal unleaded petrol with non-sniffable, but more expensive, Opal fuel.

When a Federal Government-funded roll-out of Opal occurred in January 2007 the results were dramatic and immediate, says Blair, with the numbers of petrol sniffers dropping from around 500 to 20 ‘almost overnight’. The number of petrol sniffers is now small enough to be managed by local communities and caseworkers.

The second stage, demand reduction, means getting youth and employment programs into remote communities, but obstacles remain. ‘We have money for youth workers,’ says Blair, ‘but no facilities. We have $3 million from gold mining royalties but need at least another $6 million. Only long-term projects will secure the positive changes.’

In a couple of years Blair hopes to study to become a teacher. Meantime, he has just married his long time partner, Jenny Walker. ‘The award was a great honour,’ he says, ‘but the prize money was good too. It meant we could afford a wedding celebration.’

TONY TRIMINGHAM: A FIGHTER FOR FAMILIES

In July 1997, Tony Trimingham walked into a public meeting at Ashfield Uniting Church and came out with an organisation. A few months earlier, Tony had tragically lost his son Damien to a heroin overdose.

While still grieving deeply, he wrote to the Sydney Morning Herald, frustrated by the apathy and ignorance he had encountered. The letter became a feature, huge media attention followed, and a lot of families suffering like Tony’s turned up to the Ashfield meeting. Family Drug Support Australia (FDS) was born. ‘I never intended to start an organisation, but the momentum was overwhelming,’ he says now.

Eleven years on, Tony Trimingham’s dedication through FDS to helping the families of people who use drugs has been recognised with the 2008 Prime Minister’s Award for Excellence and Outstanding Contribution to Drug and Alcohol Endeavours.

FDS is non-profit, non-religious, and aims to help families deal with drug issues in a way that strengthens relationships and achieves positive outcomes. Left to work through issues alone, families often give up. When supported, they can be a force for positive change.

‘The toughest challenge was getting acceptance and funding,’ he recalls. ‘From the government down, families were forgotten. We were pioneers.’ Now 60, Tony has been the core of FDS since it began and admits it has consumed his life. A 24/7 telephone help line is run by Tony, his wife Sandra, a handful of staff and some 200 volunteers with first-hand experience of family members with drug dependency. With Sandra, Tony oversees four telephone changeovers daily, and often runs weekend training sessions. The organisation has always had a hard-working and supportive board of directors.

‘Our approach is to offer tips on coping and communication, and encourage each person to do what they think best for their situation. We never offer formulas – they don’t work,’ he says. About 70 per cent of people who contact FDS are women, mostly mothers. The family members they seek help with range in age from 10 to 50, with most under 26. Heroin was the biggest problem in the early years. Today, most calls are about cannabis, with crystal methamphetamine (ice) and alcohol, especially binge drinking, also common concerns.

A strong supporter of harm minimisation strategies, Tony laments knee-jerk reactions to complex drug issues. ‘We still get polarised attitudes, and lies about harm minimisation advocates. Claims that we’re anti-treatment and pro-drugs couldn’t be further from the truth. We’re not anti-law enforcement or going after big dealers. But we see no sense persecuting and criminalising people who use.’

Receiving the award was a bittersweet honour, as are the satisfactions of working for FDS. Above all, this has given some kind of meaning to the senseless death of his son. It has also taken him around the world, but, as he said at the awards presentation, ‘I’d trade it all for ten minutes with Damien’.

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Aboriginal communities and other stakeholders on Groote Eylandt have worked together for years to try to reduce the severe impact of alcohol since it first became easily available there in the 1960s. In July 2005, an Alcohol Management Permit System was implemented, requiring every person in the region, Aboriginal or non-Aboriginal, to hold a permit to buy or consume takeaway alcohol.

Falls in public drunkenness, property crimes, incidents of disturbance and improvements in work attendance are some of the outcomes achieved in the past three years. Specifically, between 2004-05 and 2005-06, public drunkenness fell by 75%; the number of people placed in protective custody fell dramatically from 90 to 11; property crimes decreased by 52%; incidents of disturbance by 60%; and police callouts for aggravated assaults by 67%.

The number of adults admitted to correctional centres was the lowest in four years. Importantly, work attendance improved among Indigenous employees at the local mine, with absenteeism for Indigenous employees falling from 7.8% to 2.4%.

YOUTHinc is a youth-focused alcohol program aimed at harm prevention and reduction, and community education. It was developed by Cobaw Community Health with Victoria Police and Castlemaine District Community Health in rural Victoria, and operates in the Macedon Ranges and Mount Alexander shires. The program targets young people under 18 who have been picked up by police for drinking in a public place. They have the option of paying a fine or attending sessions that target the education and health needs of young people and include parents.

The program demonstrates that a local partnership between police and drug and alcohol agencies can work, resulting in a coordinated and consultative approach to young people and alcohol. It is also able to address the underlying concerns of young people and their parents about alcohol.

An evaluation has found that over half the participants in the program intended to change their behaviour, and 75 per cent reported changing to safer drinking. YOUTHinc has attracted statewide media interest and has become a model for similar programs that have begun across Victoria.
The National Honour Roll was created in 2006 to recognise people who have made a significant contribution to the drug and alcohol field over a considerable period. Three distinguished contributors have been chosen for 2008. They are:

**Dr Ingrid van Beek** is a public health and addiction medicine physician who has made a tireless and significant contribution to preventing and reducing drug-related harm and communicable diseases among marginalised populations. In 1989 she became Director of the Kirketon Road Centre in Kings Cross, Sydney, involved in prevention, treatment and care of HIV/AIDS and other transmissible infections among ‘at risk’ young people, sex workers and injecting drug users.

From 2000 until July this year she was on secondment as Medical Director of the controversial and ground-breaking Medically Supervised Injection Centre in Darlinghurst. She has since resumed her full-time position at the Kirketon Road Centre.

**Emeritus Professor Jim Rankin** is an Australian physician who, both in his own country and Canada, has made outstanding contributions as a researcher, educator, clinician and administrator to service development and professional education in the alcohol and drugs field since 1964. His extensive research experience focused on the epidemiology and prevention of alcohol- and drug-related health problems.

From 1994 to 2000 he concentrated on the development of drug and alcohol programs in NSW Area Health Services. He was foundation President of the Canadian Society of Addiction Medicine and the Australian Medical Society on Alcohol and Drugs (now APSAD), and the APSAD James Rankin Oration was established in his honour.

**Mr Graham Strathearn** is the former Chief Executive Officer of the Drug and Alcohol Services Council (now Drug & Alcohol Services South Australia). As CEO he assisted in making the Council a centre of excellence and innovation, leading the alcohol and other drug (AOD) field in evidence-based best practice.

He was involved in developing population strategies, as well as brief intervention and treatment strategies for alcohol-related issues and government-industry partnerships. He served as Chair and Deputy Chair of the National Drug Strategy Committee, and helped set up national centres of excellence in the AOD field. He is currently a member of the Alcohol and other Drugs Council of Australia Board.

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**Excellence in Media Reporting**

**FIGHTING WORDS ON ALCOHOL**

**JOINT WINNERS: THE GEELONG ADVERTISER AND JILL STARK (THE AGE)**

Press campaigns on alcohol-related issues and harm by Victoria’s oldest morning newspaper, the Geelong Advertiser, and Jill Stark, health reporter for the Age in Melbourne, have made them joint winners of the Media Reporting Award.

Over the past year a team of journalists from the Geelong Advertiser set about informing their local community about the health, social and economic impacts of excessive consumption of alcohol. ‘The Drink and Us’ theme was embraced by stakeholders in the Geelong region, particularly the Geelong City Council, local police, sporting organisations and the restaurant/hotel sector.

The Geelong Advertiser recently launched its ‘Just Think’ campaign, backed by the Geelong Football Club, with a simple message: ‘We are not saying don’t drink, Just Think.’

At the Age, Jill Stark’s series on alcohol-related issues began with a front-page article on the severity of an issue most experts said was being under-reported. It contained new figures revealing a rise in risky drinking across all age groups, and spoke of the impending health disaster alcohol abuse represented. Experts were quoted on the scale of the problem and potential solutions offered.

The story triggered a campaign of more than 40 articles on the issue and sparked debate on Australia’s drinking culture. Topics included marketing, particularly of alcopops, legislation and licensing, alcohol’s effects on pregnancy and alcohol-related brain injuries in young people.

There were also positive stories on programs such as the Youth Substance Abuse Service, FebFast and Good Sports. Several stories have been used as evidence in liquor licensing hearings, presented at health conferences, and cited in research papers.
Dr Rosa Alati has had a distinguished career focusing on alcohol and other drug studies and Indigenous health research.

A National Health and Medical Research Council Research Fellow at the School of Population Health and the Queensland Alcohol and Drug Research and Education Centre, University of Queensland, Dr Alati’s research interests are in the life course epidemiology of alcohol and other mental health disorders. The risk associated with alcohol consumption during pregnancy is one of her particular concerns. She has expanded understanding of the role played by alcohol and other drugs within our society, helping to build a sound evidence base for health and legislative changes. She has published over 30 papers dealing with alcohol and health issues and is regularly invited to speak at national and international conferences. Her work has attracted wide media coverage.

Dr Alati has also taught and researched in the field of Indigenous alcohol misuse, and has had considerable experience in working with Australian youth, traditional and non-traditional Indigenous people.

The Indigenous outreach team at the Alice Springs Indigenous Outreach Program helps people with drug and alcohol problems attend treatment programs and get back to their communities. By maintaining a constant presence around the town, seeing clients and keeping connected through family, outreach workers ensure regular follow-up with clients. Their approach is to sit with affected individuals and gently make inquiries about their substance misuse, and suggest ways they can reduce harm and lead safer, healthier lives.

The team has had a small but quite significant impact on reducing harm, even among people who continue to drink. Harm minimisation messages have had an impact on their clients, e.g. choosing to drink beer rather than tawny port, having a meal before a drinking session, and drinking water while consuming alcohol.

Some individuals and family groups have decided to abstain from alcohol, and the outreach program has provided them with case management and support to make this a reality.

Excellence in Research

IMPACT OF ALCOHOL ON HEALTH
WINNER: DR ROSA ALATI – SCHOOL OF POPULATION HEALTH, UNIVERSITY OF QLD

Excellence in Treatment

REDUCING HARM THROUGH OUTREACH
WINNER: THE INDIGENOUS OUTREACH PROGRAM, DRUG & ALCOHOL SERVICES ASSOCIATION

Excellence in School Drug Education

EDUCATION FOR YOUTH ON THE EDGE
WINNER: MACLEAY VOCATIONAL COLLEGE

Under the leadership of Principal Jan Easson, Macleay Vocational College in South Kempsey NSW targets the most disadvantaged youth, those who have been suspended or expelled from other schools or have troubling criminal histories.

Macleay currently enrolls around 80 students, of whom 60% are Indigenous and 50% male, approximately 25% with serious issues before the courts and 10% or more incarcerated annually. Its focus is to prepare students for life after school. Work placement is integrated into all vocational courses, and Year 11 and 12 students can learn work-related skills while preparing for the HSC.

Macleay’s students have a number of health issues, and with assistance from Kempsey youth development officer David Frederick, the College and the Mid-North Coast Area Health and Durri Aboriginal Medical Service have collaborated to develop a whole-school health program. It covers drug and alcohol education, harm minimisation and counselling.

A purpose-built clinic conducts health screening and programs on quitting smoking, depression and mental health, and parenting, including discussing the effects of drug and alcohol use during pregnancy.
NSPS DRAW AN OLDER CROWD

JENNY IVERSEN

Data from the annual Australian Needle and Syringe Program (NSP) survey indicates that people who use drugs and attend NSPs are getting older and have been injecting for longer periods. This is one of the findings from the annual Australian NSP survey.

During the late 1990s, the median age of NSP survey participants was stable at either 27 or 28 years. However, in more recent years, the median age of NSP survey participants has increased from 28 years (in 2000) to 35 years (in 2007).

In order to exclude the possibility of sample bias, researchers from the National Centre in Epidemiology and Clinical Research examined the median age of both NSP clients who agreed to participate in the NSP survey and those who declined to participate. They found that the median age of both survey participants and non-participant NSP attendees had increased since 2000 and concluded that overall, NSP clients were getting older.

Further examination also found that there was a corresponding increase in the duration of injecting among survey participants. In the late 1990s, the median number of years survey participants had been injecting was seven or eight years. However, this increased from eight years in 2000 to 15 years in 2007. This has been accompanied by a decrease in the proportion of new injectors (i.e., those injecting for three years or less) decreasing from 13% in 2000 to 5% in 2007.

The proportion of survey participants aged less than 25 years has also declined, from almost a third in 2000 to just 10% in 2007. It is important to note that the median age at first injection has remained stable at 18 years throughout the entire survey period from 1995 to 2007, so these effects are not the result of people starting to inject at later ages.

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The proportion of survey participants aged less than 25 years has also declined, from almost a third in 2000 to just 10% in 2007. It is important to note that the median age at first injection has remained stable at 18 years throughout the entire survey period from 1995 to 2007, so these effects are not the result of people starting to inject at later ages.

NSP survey data also indicates that there has been an increase in the proportion of people reporting previous or current opioid substitution therapy (OST). In the late 1990s, just over half the survey participants reported previous or current OST; however, in the most recent survey, conducted in 2007, 67% reported previous or current OST.

While assumptions cannot be made about people who inject drugs obtaining needles and syringes from other sources (such as friends, pharmacies and automatic dispensing machines), it is clear that those accessing public sector needle and syringe programs are getting older, have been injecting for increasing lengths of time and the majority have engaged with drug treatment services at one stage or another.

It is also apparent that this ‘ageing effect’ is exacerbated by a substantial decline in the proportion of young and new initiates to injecting attending NSPs.

Acknowledgment
The NSP survey is the result of a collaboration between many organisations and individuals and could not be conducted without the support of NSP clients and staff. For a list of the NSPs that participated in this survey, email editor@ancd.org.au.

*Jenny Iversen writes from the National Centre in HIV Epidemiology & Clinical Research.

References and further reading

Inhalants or volatile substances
Duncan, B. Drug use in Australia, vol.6 no.3, pp.12-13
Duncan, B. Prime Minister's Award: Joint winners – Blair McFarland: At home in his 'skin', vol.6 no.4, p.27

Injecting drug use
Duncan, B. Drug use in Australia, vol.6 no.3, pp.12-13
Iverson, J. NSPS draw an older crowd, vol.6 no.4, p.31
Mundy, J. Drug use snapshot: The 2007 IDRS and EDRS findings, vol.6 no.1, pp.20-21

International
Bezziccheri, S & Vumbaca, G. SE Asia: Locked up, vol.6 no.1, p.16
D’Abb, P & Gan, XF. Drugs around the world: Drinking: Old ways, new trends, vol.6 no.3, p.25
Dolan, K & Mathers, B. Women, drugs and Iran, vol.6 no.2, p.28
Hunt, N. Drugs around the world: England: Treatment & recovery, vol.6 no.4, pp.20-21
Stephens, D. Drugs around the world: China: Grappling with change, vol.6 no.3, pp.24-26

Law enforcement
Duncan, B. Excellence in law enforcement: Alcohol reduction through permits, vol.6 no.4, p.28

Media
Dillon, P. Schools and drugs: Opinion: Twisted message misleads young minds, vol.6 no.3, p.22
Duncan, B. Excellence in media reporting: Fighting words on alcohol, vol.6 no.4, p.29
Hamilton, M. Opinion: Anti-drug campaigns work by provoking people close to users, vol.6 no.1, p.7
Mundy, J. Play hard, party hard, vol.6 no.2, pp.20-23
Roche, AM. Young people and alcohol: A cultural shift? vol.6 no.2, pp.14-15
Schultz, L, Schultz, M, Brener, L & Treloar, C. Your say: A good read ..., vol.6 no.3, p.33
Tinworth, J. Alcohol: What people think, vol.6 no.2, pp.10-13

Mental health
Butler, M. Dual diagnosis dollars: Delivering the goods? vol.6 no.3, pp.14-17
Goodyer, P. Headspace, youth space, vol.6 no.4, pp.14-15
Harvey, M. A day in the life of ..., vol.6 no.1, p.27
Mills, KL. Post traumatic stress disorder, vol.6 no.1, pp.22-23
Mundy, J. Dual diagnosis: Where to from here? vol.6 no.1, pp.18-19
Mundy, J. Play hard, party hard, vol.6 no.2, pp.20-23

Multicultural issues
Nguyen, LM. A day in the life of ..., vol.6 no.2, p.29

Opioids
Compton, P. Treating pain, beating addiction, vol.6 no.2, pp.24-25
Dolan, K & Mathers, B. Women, drugs and Iran, vol.6 no.2, p.28
Duncan, B. Drug use in Australia, vol.6 no.3, pp.12-13
Mundy, J. Drug use snapshot: The 2007 IDRS and EDRS findings, vol.6 no.1, pp.20-21

Pharmaceutical drugs
Mundy, J. Drug use snapshot: The 2007 IDRS and EDRS findings, vol.6 no.1, pp.14-17
Mundy, J. Over the counter, down the hatch ..., vol.6 no.4, pp.18-19

Prevention
Ah Chee, D. Opinion: Cutting alcohol abuse and violence, vol.6 no.1, p.13
Brady, M. Opinion: The historical burden of prohibition, vol.6 no.2, p.7
Duncan, B. Excellence in prevention: Partners in diversion, vol.6 no.4, p.28
Major, C. From chronic to acute: The emergency response in the Northern Territory, vol.6 no.1, pp.10-12
Rossmanith, A. Secrets of prevention, vol.6 no.1, pp.28-29

Research
Duncan, B. Drug use in Australia, vol.6 no.3, pp.12-13
Duncan, B. Excellence in research: Impact of alcohol on health, vol.6 no.4, p.30
Mundy, J. Drug deaths: Why they matter, vol.6 no.3, pp.30-32
Mundy, J. Drug use snapshot: The 2007 IDRS and EDRS findings, vol.6 no.1, pp.20-21
Schultz, L, Schultz, M, Brener, L & Treloar, C. Your say: A good read ..., vol.6 no.3, p.33

Tobacco
Duncan, B. Drug use in Australia, vol.6 no.3, pp.12-13
Topp, L. Smoking: A case for harm reduction? vol.6 no.3, pp.8-11

Treatment
Compton, P. Treating pain, beating addiction, vol.6 no.2, pp.24-25
Dolan, K & Mathers, B. Women, drugs and Iran, vol.6 no.2, p.28
Duncan, B. Excellence in school drug education: Education for youth on the edge, vol.6 no.4, p.30
Duncan, B. Excellence in treatment: Reducing harm through outreach, vol.6 no.4, p.30
Hunt, N. Drugs around the world: England: Treatment & recovery, vol.6 no.4, pp.20-21
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Mills, KL. Post traumatic stress disorder, vol.6 no.1, pp.22-23
Mundy, J. Over the counter, down the hatch ..., vol.6 no.4, pp.18-19

Workforce development
Butler, M. Dual diagnosis dollars: Delivering the goods? vol.6 no.3, pp.14-17
Mundy, J. Dual diagnosis: Where to from here? vol.6 no.1, pp.18-19
Mundy, J. Where have all the staff gone? vol.6 no.3, pp.26-27

Young people
Dillon, P. Schools and drugs: Opinion: Twisted message misleads young minds, vol.6 no.3, p.22
Duncan, B. Excellence in services for young people: Helping young parents and children, vol.6 no.4, p.28
Goodyer, P. Headspace, youth space, vol.6 no.4, pp.14-15
Hughes, C. Schools and drugs: Youth and alcohol: Challenging the stereotype, vol.6 no.3, p.23
Roche, A. Schools and drugs: Time to test? vol.6 no.3, p.21
Roche, AM. Young people and alcohol: A cultural shift? vol.6 no.2, pp.14-15
Rossmanith, A. Secrets of prevention, vol.6 no.1, pp.28-29
Tinworth, J. Alcohol: What people think, vol.6 no.2, pp.10-13
Tinworth, J. Schools and drugs: Testing the policy, vol.6 no.3, p.22

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Växjö, Sweden  
www.vxu.se/ped/events/international_symposium

15-16 October 2008  
Partnerships for Social Inclusion Conference  
Melbourne, Vic  
www.public-policy.unimelb.edu.au

20-22 October 2008  
6th Australasian Viral Hepatitis Conference 2008  
Brisbane, Qld  
www.ashm.org.au

23 October 2008  
The changing face of therapeutic communities  
Sydney, NSW  
www.ndarc.med.unsw.edu.au/NDARCWWebsite/nfs/page/Seminar

24 October 2008  
Cognitive styles underlying risky decision making in substance abusers  
Melbourne, Vic  
www.turningpoint.org.au

27-28 October 2008  
National Conference on Injecting Drug Use  
London, UK  
www.exchangesupplies.org

5–7 November 2008  
Adolescent Health 2008  
Melbourne, Vic  
www.adolescenthealth08.com

21 November 2008  
Early alcohol and other drug treatment in Victoria 1870–1930  
Melbourne, Vic  
www.turningpoint.org.au

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Sydney, NSW  
www.apsad2008.com

23-26 November 2008  
Australasian Professional Society on Alcohol and other Drugs Conference 2008  
Sydney, NSW  
www.apsad2008.com

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Issues in the evaluation of pharmaceutical interventions  
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www.ndarc.med.unsw.edu.au/NDARCWWebsite/nfs/page/Seminar

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Email: editor@ancd.org.au  
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Or write to us:  
Of Substance  
Level 3, 439-441 Kent Street  
Sydney NSW 2000 Australia

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