

OF SUBSTANCE

JANUARY 2008 VOL. 6 NO. 1

THE NATIONAL MAGAZINE ON ALCOHOL, TOBACCO AND OTHER DRUGS

POST TRAUMATIC STRESS DISORDER

A challenge for AOD treatment

APSAD 2007

Highlights from the
Auckland conference

COMPULSORY TREATMENT

Not always the answer

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Jenny Tinworth



Kate Pockley

Editors' letter

Welcome to the first 2008 issue of *Of Substance*. There will be a lot happening in the drug and alcohol sector this year, and as always, we're looking forward to keeping you up to date.

In November, *Of Substance* was privileged to attend the Combined APSAD and Cutting Edge conference in Auckland, New Zealand. This was truly one of the highlights of 2007. With more than 700 delegates, the conference focused on the meeting of nations, cultures and substance use issues. We're sure many delegates came away not only with updated research and practice knowledge, but with a sense of a common spirituality that taps into all humanity. Turn to page 17 to read our report on a truly unusual conference.

In recent months, there have been major developments in the Northern Territory with the Australian Government acting in Indigenous communities in an attempt to improve the lives of children and their families. After wading through a plethora of publicity about the intervention, we have drawn together a straightforward account of what initiatives are occurring in Australia's outback.

People who use drugs and come into contact with the criminal justice system are also a vulnerable population, both in Australia and around the world. In this issue, we turn our attention to the treatment needs of criminal offenders, and to the harsh realities of life for South East Asian residents who are experiencing drug problems.

These are just a few of the many articles that we bring you this month. As usual, we provide updates on a wide range of topics: co-occurring mental health and drug problems, the latest studies into Australian drug use, treatment approaches and workplace issues.

It is also time to wish Kate well as she takes a break from *Of Substance* for a period of maternity leave. We look forward to welcoming her back in early 2009. In her absence, Jenny will be the full-time editor.

As always we welcome your feedback. Please visit us at www.ofsubstance.org.au or email us at editor@ancd.org.au.

Happy New Year!

Jenny Tinworth and Kate Pockley
Managing Editors

GUEST EDITORIAL

A LOST OPPORTUNITY

SCOTT WILSON, DIRECTOR, ABORIGINAL DRUG AND ALCOHOL COUNCIL (SA) & CO-DEPUTY CHAIR, NATIONAL INDIGENOUS DRUG & ALCOHOL COMMITTEE.



Australia has voted and we have a new Labor administration.

A tragedy of the 2007 election was the relative silence by both major parties in the areas of Indigenous issues and substance abuse across the board. Rewind to June 2007, when Anderson and Wild's report *Little children are sacred* was released by the NT Government. It attracted immediate attention by both politicians and the media which demanded a range of responses. These responses ignored the underlining basis of the report's recommendations, which were all about community consultation and action.

This report was used by the former federal government to instigate a range of initiatives that are discussed by others in this issue of *Of Substance* (see pages 10-13). But we then heard on a daily basis that recognition of Customary Law, having permits for some Aboriginal lands and a range of other conditions were the only reasons we had all this abuse and dysfunction occurring in communities. Finally, a Federal election came and went with no real debate on these or other issues confronting Indigenous people. This was certainly a missed opportunity to address long neglected community and substance misuse problems.

Nationally, there is a complete lack of facilities for Aboriginal people. Facilities that focus on families and programs which support people to achieve the outcomes they want. What services are available are based on models best suited to meet the needs of the organisational deliverer. If an Aboriginal person fails within these systems, it is seen as the fault of the Aboriginal person.

The impact of drugs and alcohol on Indigenous families is huge and unfortunately has been spreading across communities Australia wide. We as community people find it difficult to deal not only with the traumas of constant death and dying, but also a high rate of imprisonment due in part to substance abuse.

A result of some of the useful things that might come out of the NT interventions is that the Australian community at large might finally accept that alcohol is a drug and it should be treated as such. That as part of the health checks in community, assessments for fetal alcohol spectrum disorder and other issues are recorded and addressed. Those people who get caught up in consuming alcohol in dry zones are addressed through the NT Police Diversion Initiative rather than given fines.

However, opportunities were missed in this election cycle and the challenge for all of us is to remind the new government that we need help but we also want to be consulted on what that help might look like.

NEWS

NHMRC reduces safe drinking levels



A revised draft of the *Australian alcohol guidelines for low risk drinking*, released in October 2007 by the National Health and Medical Research Council, recommends men and women consume no more than two drinks a day, while young people under 15, pregnant women and women who are breastfeeding are advised not to drink at all. Until now, men have been told they could consume up to six drinks a day, and women four, without risking harm.

The draft is intended to give Australians clear guidelines on how to avoid, or minimise, the harmful consequences of drinking alcohol – both the immediate effects of each drinking occasion and the longer-term effects of regular drinking. They do not represent a 'safe' or 'no-risk' drinking level; rather, they are 'advisory' levels that will enable healthy adults to maintain a low risk of alcohol-related harm.

Comment on the draft was invited from a wide range of groups and individuals (including health professionals, community groups, professional and educational organisations, policy makers, the alcohol industry and the general public) during a 60-day consultation period in late 2007. Submissions are now being considered by a working committee. For more information visit: www.nhmrc.gov.au/consult.

Bumper world opium crops in 2007/08

In a report presented at the 2007 Australasian Drug Strategy Conference, the Australian Federal Police noted that ideal weather conditions and improved technology in Afghanistan saw opium poppy production there rise 17% last year, with a further 30% rise expected in 2008. Afghanistan is the world's largest producer of opium, accounting for 93% of the world's total. Experts warn that this is likely to result in an increased flow of high-grade heroin into Australia.

The quantity of heroin imported into Australia has almost doubled in the past two years, jumping from 40 kg in 2005-06 to around 70 kg in 2006-07. Low-grade supplies are being supplemented by higher concentrations, a trend reported in the 2007 IDRS figures (see story pages 20-21). The UN Office on Drugs and Crime has also confirmed a dramatic increase in poppy yields in Burma. Papers from the conference are available at: www.police.qld.gov.au/adsc2007.

Drugs and driving in Australia

An internet study of drugs and driving behaviour in Australia has shown that 51.3% of respondents who had used cannabis and 52.7% of those who had used methamphetamines in the last 12 months reported driving within three hours of drug use. For ecstasy users the figure was almost 37.5% and for benzodiazepines, 30.3%.

The more regularly people used one of these drugs, the more likely they were to have driven under the influence of it. For instance, 90% of daily cannabis users have driven directly after smoking.

The study, conducted by the Australian Drug Foundation in partnership with Turning Point Alcohol and Drug Centre, with funding from AAMI, also shows that while users and non-users both perceive that driving under the influence of alcohol is risky, users are much less likely to perceive driving under the influence of illicit drugs to be risky than non-users. Only 30% of cannabis and methamphetamine users think that driving while affected by the drugs is dangerous.

Respondents also reported being well informed about the effect of alcohol on driving ability, but were much less informed about driving under the influence of cannabis, methamphetamines, ecstasy and, particularly, benzodiazepines. Researchers said random illicit drug testing is still in its infancy and it is too soon to tell if it works as a deterrent.

To view the full report visit: http://adf.org.au/article.asp?ContentID=Response_drugdriving_survey.



NEWS CONTINUED

IN BRIEF...

NSW Liquor Law reform

There will be no increase in standard trading hours for hotels and bottle shops in NSW under a rewrite of the state's Liquor Act, and a doubling of penalties to venues and staff for the irresponsible service of alcohol.

NSW Premier Morris Iemma said the rewrite of the Liquor Act would: provide the community with greater protection from alcohol-related crime; double penalties for the irresponsible service of alcohol; introduce new offences for antisocial behaviour; reduce red tape and costs for industry; and increase access to the licensing system for councils and residents.

Key elements of the new Liquor Bill include:

- a new Casino, Liquor and Gaming Control Authority to deal with applications for liquor licences and extended trading hours, and impose penalties in disciplinary matters
- simplifying liquor licence categories, reducing costs and providing greater flexibility for a wider variety of licensed venues
- restaurants will be able to serve alcohol without a meal by making a low-cost application
- a new Community Impact Statement for new liquor licences and applications for extended trading hours for high impact venues
- areas suffering from chronic alcohol abuse to be declared 'restricted areas' with greater controls on the sale and supply of liquor
- new provisions to support and encourage live music including cheaper and simpler liquor licences for entertainment venues
- a new process for Liquor Accords to ban troublemakers from multiple licensed venues, and new offences to deal with drunk and unruly patrons
- increased penalties for underage drinking and intoxication offences
- expanded powers to ban irresponsible liquor products and promotions.

National Cannabis Centre

The Australian Government has provided \$12m over four years for the establishment of the National Cannabis Prevention and Information Centre (NCPIC), which aims to reduce the use of cannabis in Australia by preventing uptake and providing the community with evidence-based information and interventions.

The Centre is led by the National Drug and Alcohol Research Centre (NDARC), and includes a national consortium of expert partners. The management committee is headed by former Parliamentary Secretary to the Minister for Health and Ageing, Trish Worth. Professor Jan Copeland (NDARC) has been appointed as Director.

Youth more aware of danger of illicit

Research commissioned by the Department of Health and Ageing shows awareness of the damage caused by illicit drugs has risen significantly among Australia's young people over the past seven years. Ninety-one per cent of 15- to 24-year-olds now understand that 'speed' and meth-amphetamines make people aggressive (up from 35% in 2000) while awareness that speed is addictive has risen from 54% to 91%. More than 80% of young people also understand that regular use of marijuana and ecstasy are linked to mental health issues. The full report can be viewed at <http://www.health.gov.au/pyne>.

Anti-smoking commercials aid quitting

A study commissioned by the Cancer Council Victoria, shows almost half (46%) of smokers who had successfully quit in the five years preceding their 2005 study believed commercials such as the 'Sponge' commercial had contributed to their quit attempt. This was more than double the proportion of those citing other quitting aids such as nicotine replacement therapies and advice from health professionals.

Quit Victoria has also called on the Commonwealth Government to investigate ways to address the problem of online tobacco promotion following reports that popular internet sites including YouTube, Facebook and MySpace are being used to promote smoking to teenagers.

Homicides linked to drugs and alcohol

Almost two-thirds of homicide victims have alcohol or drugs in their bodies when they are killed and 60% of those who die in a fight are intoxicated, according to Professor Shane Darke of the National Drug and Alcohol Research Centre. Professor Darke's 10-year study found that 68% of male homicide victims had a substance such as alcohol, cannabis, heroin, ice, cocaine or benzodiazepines at the time of death, with 46% testing positive to alcohol, 24% to cannabis and 10% to stimulants.

ADF chief retires

The CEO of the Australian Drug Foundation, Bill Stronach, has announced his retirement after 18 years in the role. ADF Chairman Rick Swinard said Bill has served with great distinction and made an outstanding contribution, not only as CEO of the Foundation but in the alcohol and other drug field generally, both within Australia and internationally.

AOD skills for DoCS staff

The NSW Department of Community Services (DoCS) has established a specialist Drug and Alcohol Expertise Unit designed to enhance the skills of DoCS caseworkers dealing on a day-to-day basis with family environments where parents have significant drug and alcohol issues. CEO of the Network of Alcohol and other Drugs Agencies (NADA) in NSW, Larry Pierce, said up-skilling frontline caseworkers will allow them to make informed decisions regarding early intervention in family situations.



Care for kids

I would just like to bring your attention to a pilot service that was implemented in 2005 via the Department of Human Services, Victoria. The program is called Alcohol & Other Drugs Parenting Support Service, and its main aims are to broker links between AOD & Family Support services to better assist parents with AOD issues, and especially, their children.

The service provided support to AOD staff around working with parents, the needs of parents in a family context, and the needs of their children. It also provided training to staff on how to better engage their clients in relation to the impact their substance use has on their children, and providing support in treating the individual within a family context. Two pilot programs operated in two regions across Victoria and significant evaluation was undertaken early this year in regards to the validity and importance of the service.



My reason for bringing this to your attention is in relation to the article in the July issue of *Of Substance* ('Who is caring for the kids?'). I agree that more needs to be done in this area and pilots like these need to be supported and hopefully duplicated in other regions of Victoria, and eventually nationally. The biggest issue we had when implementing this service was that AOD agencies are only funded to work with individuals and therefore children are not counted statistically. This limits the options available to women when wanting to address their substance use, and was one of the biggest barriers for service for women with dependent children. Until the funding bodies address this issue, then more and more children will be falling through gaps and an increase of notifications and statutory intervention will occur.

I applaud the introduction of Good Practice principles and also suggest that you take a look at the work that Odyssey House in Victoria has done in this area. The AOD Parenting Manual for workers is one such document that is exciting in its approach, but more importantly, is practical and innovative.

Michelle Hall
Former Program Manager
Alcohol & Other Drugs Parenting Support Service
Connections, Victoria

Alcohol and the law: painful lessons

Following the death of our son Leigh in 1999 after a private gathering where highly concentrated Imitation Vodka Essence was given to him, my wife and I sued the manufacturer of the essence. The case was settled out of court and, as part of the settlement, the terms of the agreement are confidential.

We believed that Leigh's death should have been prevented. We felt betrayed by several parties including:

- manufacturers who put what we believed to be a dangerous product on the market
- federal and state governments who failed to adequately control this class of product despite known problems
- the mother who hosted and catered for the party, and Leigh's friends.

We could not accept Leigh's death as one of those things that 'just happen'. We needed to fight someone but which of the above or all of them? This was compounded by:

- state law that, while it prosecuted the mother for supplying two other boys with the same alcohol that led to Leigh's death, deemed that the actual supply to Leigh was legal because that took place inside her residential property
- state laws that defined this essence as liquor but federal laws that did not.

Ultimately, we decided to sue the manufacturer, and we have to accept the numerous complexities that ensued including a somewhat difficult chain of causality or liability. We understand that our case was some sort of milestone in this country. Notions of public interest were not the sole motivator in our action although we were aware of interest and support from various alcohol advocacy groups.

While we hope that no other child dies as a result of drinking alcohol, we fear it is only a matter of time before another despairing family attempts to seek redress through the courts. Perhaps it will take many tragedies before a real breakthrough is achieved. Until then we hope any lessons to be learned from our experiences will provide valuable information for those who follow.

Bruce Clark
West Melton, 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.

NEWS AND RESOURCES

Alcohol restrictions: what works?

A comprehensive response to questions about what works, and where, in relation to alcohol restrictions in Australia has been produced by the National Drug Research Institute. *Restrictions on the sale and supply of alcohol: evidence and outcomes* looks at the effectiveness of past and existing restrictions placed on the sale of alcohol; identifies current best practice in relation to the use of restrictions; identifies key factors determining the effectiveness of restrictions to both metropolitan situations and regional and remote communities; and identifies the restrictions most likely to result in meaningful and/or sustainable reduction of alcohol-related harm. In particular, the two-year study shows that alcohol restrictions are most effective in reducing alcohol-related problems in Indigenous communities when properly enforced, supported by the community, and complemented by measures that address the underlying causes of alcohol misuse.

For more information visit: www.ndri.curtin.edu.au.

Dual diagnosis DVD

A new interactive DVD provides a user-friendly resource for clinicians to learn about working with clients who have comorbid mental health and substance use disorders. Produced by Richard Clancy (Clinical Nurse Consultant in Dual Diagnosis) and Margaret Terry (Snr Clin Psych and Service Director Dual Diagnosis) with support from NSW Health and the University of Newcastle, the DVD follows three cases over many episodes of treatment in a variety of treatment settings utilising audio, video, text, interactive and internet-based resources. Nested levels of complexity make this a learning tool for workers new to the field as well as those who have been working in the field for some time. For more information contact: richard.clancy@hnehealth.nsw.gov.au.



FASD national website

Following the introduction of Australia's first fetal alcohol diagnostic and support service, arbias and the National Organisation for Fetal Alcohol Spectrum Disorders has launched a national website providing comprehensive local and international information: www.nofasrd.org.au.

Support for AOD services with CALD clients

The Drug and Alcohol Cultural Support Service (DACS) is a free telephone advice and consultation service for NGO AOD treatment services across NSW. The service is designed to provide culturally appropriate information on working with culturally and linguistically diverse clients.

The service will provide:

- information to staff on the cultural impacts for a client in treatment
- information about support services
- resources on specific cultural issues
- referral to support services
- some limited joint case management by skilled bicultural workers.

For more information, contact the Drug and Alcohol Multicultural Education Centre: (02) 9699 3552.

Australian Indigenous HealthInfoNet

This website contains material about Indigenous health issues for the use of policy makers, service providers, researchers, students and the general community. It includes detailed overviews of specific health topics, regularly updated overviews and summaries of Indigenous health status, clinical guidelines, and answers to FAQs about alcohol, illicit and inhalant drugs, available resources, policy and strategy documents, organisations and projects.

The *Australian Indigenous Health Bulletin* journal and the 'e-message stick' listserv are also accessible from the site: www.healthinfonet.ecu.edu.au/.

AIVL website

'Wizz Wize' is a new website targeting people who use amphetamine-type substances, providing up-to-date information aimed at reducing the risk of blood borne virus transmission, particularly hepatitis C and drug use related harm. It also presents alternatives to injecting as well as protective tips for managing 'coming down' and dealing with adverse drug reactions. Visit www.wizzwize.com.au.



Anti-drug campaigns work by provoking people close to users

MARGARET HAMILTON*



Do shocking and confronting campaigns that accurately represent the dangers of illicit drugs really work?

After many years working on campaigns designed to raise awareness about the effects illicit drugs can have, including the recent 'ice' television commercial, I am struck by how difficult it is to explain them.

My colleagues and friends are often critical in their responses, which include: This is over the top. Why bother? Mass communication is ineffective. What about more damaging and prevalent substances such as alcohol and all the trouble that causes? This won't stop users using drugs.

Colleagues are right to challenge the use of expensive means to communicate messages, influence attitudes, beliefs, expectations and sometimes behaviours. They are right to be sceptical. They are right to wonder whether these campaigns make a difference. But they are usually wrong in their commentary. I have sometimes looked at prepared advertisements for drug campaigns. I can initially react in a similar way to my colleagues and think that they are sometimes irrelevant, inaccurate – often exaggerated – portrayals of the real world.

I have to remember that I am not the primary target audience.

In my role with the Australian National Council on Drugs, I have had the opportunity to work carefully and systematically with many others in helping to guide the development of the current illicit drug campaign. I have come to learn that what I see is not what the primary target audiences see; the messages that I get are not the same as they get; and I have affirmed by theoretical understanding that we need to go to careful testing with target audiences to appreciate just what an image or advertisement contains, what impact it has and what possible effects.

There is no doubt that illicit drugs are in our community and relatively readily available. The nature and extent of this availability varies. Fortunately, most young people are not interested in using them – sometimes because they are scared of what they will do to them, and sometimes because they have seen friends negatively affected by them. Those who do use them, or have used them, are also sometimes fearful of them. Sometimes they are not, and continue to use them. A strategy like this one is targeting the majority of the population – in this instance primarily young people who have not used these drugs and are disinclined to use them. The purpose is to reaffirm their inclination not to use them; to reinforce the potential harm and problems associated with these illicit drugs.

But the campaign is not only designed to reach the potential user. The intent is also to provide a stimulus for parents and responsible adults to talk with their children and young



people about drugs more openly and to seek information to facilitate these conversations. We can underestimate the power a parent can have when talking clearly and concisely with their children about illicit drugs.

We know from the previous phases of this campaign many more parents felt empowered to talk with their young people about drugs; young people did think the ads credible and remembered them. These are good outcomes.

For those who would benefit from help to change their drug use, the campaign provides help for them to find a route to support if they seek it. This group is not, however, the primary audience for these television advertisements. It is not expected that all young people currently using ice or other amphetamines, cannabis/marijuana, heroin or other illicit drugs will stop in response to these ads. Perhaps some will be helped to do so, through indirect measures and conversations they will have that might be prompted by this campaign.

This campaign has included the involvement of a number of scientists, public servants, medical staff from accident and emergency departments and other health professionals including nurses, drug treatment workers, parents, school teachers, a dentist as well as young people and professional associates expert in the development and evaluation of health-related campaigns. All have been active in developing the current illicit drug campaign images and portrayals. This has also included testing ideas from enthusiastic amateurs including politicians and, where found wanting in evaluation and testing, these ideas have appropriately been abandoned.

Research shows those campaigns about illicit drugs, and tobacco and alcohol, have an important place in the spectrum of preventative measures available to help protect young people from unwise choices. We simply need to remember not to make the mistake to see the advertisements or messages through only our own eyes.

***Professor Margaret Hamilton is Chairwoman of the Campaign Reference Group of the Australian National Council on Drugs.**

This article first appeared on 29 September, 2007 in the Weekend Australian.

RESEARCH DIGEST

LIBBY TOPP

In this issue, we focus on recent research into the health and welfare of prisoners – in custody and once released.

HIGHER MORTALITY RATES FOR FORMER INMATES

Featured study

Kariminia, A, Butler, TG, Corben, SP, Levy, MH, Grant, L, Kaldor, JM & Law, MG 2007. Extreme cause-specific mortality in a cohort of adult prisoners: a data-linkage study, *International Journal of Epidemiology*, vol. 36, pp. 310-16.

Findings

The first of two articles by Kariminia et al. (see next article following) reports results from the largest ever investigation of mortality among people who have been imprisoned. Using sophisticated data linkage strategies, the prison records of all adults who underwent full-time custody in NSW between 1988 and 2002 (76 376 men and 8820 women) were linked to the National Death Index (NDI). The NDI database contains information on all deaths in Australia. Linking the two datasets allowed standardised mortality ratios (SMRs), or death rates due to specific causes, to be calculated among the cohort of former inmates. SMRs were estimated by comparing (i) the number of deaths by different causes observed among the imprisoned cohort over an average of 7.7 years of follow up since they were first incarcerated, with (ii) the number of expected deaths, based on actual deaths which occurred among the entire NSW population during the 15-year study period. These ambitious and complex analyses allowed the authors to (i) describe the relative importance of the main causes of death among imprisoned people; (ii) compare inmate mortality with that of the general NSW population; and (iii) examine mortality trends over time.

Ninety-four per cent of the 5137 deaths (4714 men, 423 women) among the inmate cohort occurred following release from custody rather than during incarceration. Overall SMR (from all causes) was 3.7 for men and 7.8 for women, meaning that, compared to a member of the NSW general population, male former inmates were almost four times more likely, and female former inmates almost eight times more likely, to die during the study period. Excess mortality was particularly high among those aged 18-44 years.

Compared to the general population, SMRs were markedly increased among the inmate cohort for deaths due to mental and behavioural disorders (men: 13.2; women: 62.8). This category included deaths related to drug overdose, which principally accounted for the excess mortality. After aggregating drug-related deaths to include all deaths where the underlying cause was inferred to be directly related to drug use, the researchers identified 1477 (31%) deaths in men and 197 (47%) deaths in women, equating to drug-related SMRs of 12.8 for men and

50.3 for women. These results clearly indicate that people with a history of imprisonment, particularly at younger ages, are at a considerably greater than expected risk of death, and that their high mortality is attributable primarily to drug use and mental health problems.

The SMR for homicide was 10.2 in men and 26.3 in women, suggestive of the violent, risky lives led by this group. Aboriginal men were 4.8 times, and Aboriginal women 12.6 times, more likely to die than the general NSW population, a pattern compounded by the huge over-representation of Aboriginal people in custody.

Between 1988 and 2002, overall SMR declined significantly in both men and women, largely due to reductions in drug-related deaths among men and women, and suicide among men. Although an encouraging finding, the study was unable to determine whether this trend represents improved access to drug dependence and/or mental health programs over the study period, as measures of services received by prisoners were not included in these analyses.

SUICIDE RISKS FOR RELEASED PRISONERS

Featured study

Kariminia, A, Law, MG, Butler, TG, Levy, MH, Corben, SP, Kaldor, JM & Grant, L 2007. Suicide risk among recently released prisoners in New South Wales, Australia, *Medical Journal of Australia*, vol. 187, pp. 387-90.

Findings

In the previous article, Kariminia et al. demonstrated that suicide risk in ex-prisoners was much higher than among the general population. Recent international studies have found that the initial adjustment period directly after release is a time of particular vulnerability. In the Australian context, Kariminia et al. applied sophisticated statistical modelling strategies to the linked dataset described above, replicating the international findings by showing that the highest risk for suicide occurred in the first two weeks after release.

Among the 76 376 men and 8820 women imprisoned in NSW between 1988 and 2002, there were 795 and 49 suicides, respectively. Men had higher rates of suicide both during incarceration and after release. Most suicides occurred after release, at an average age of 33.6 years. Among men, the risk of suicide during the first two weeks after release was almost four times higher than the risk after six months; and was almost 14 times higher among men aged 45 years or older. Although risk declined during subsequent weeks, it remained significantly higher among men aged 35 years or older.

Among men who were admitted to a prison psychiatric hospital, the risk of suicide directly after release was almost three times as high as men with no admission history. Although admission is an imprecise measure of psychiatric illness, these findings indicate a need to expand criminal justice mental health programs, and to better resource post-release housing and vocational training services.

Among women, there was no increased risk of suicide directly after release, possibly due to better family relationships and support networks, and because many women prisoners resume the role of primary caregiver to children after release. Aboriginal Australians had a lower risk of death from suicide than other prisoners, and their rate of suicide did not increase in the immediate post-release period. Aboriginal people may have better community support after release, possibly protecting them against suicide.

Suicide during incarceration receives considerable attention from authorities, with programs, policies and even architectural considerations designed to minimise the risk. In contrast, less attention and resources are devoted to the post-release period, when the duty of care shifts from custodial authorities to the community. This shift is rarely formalised, and former prisoners often return to the community with few supports in place. As demonstrated here, despair and death are all too frequently the outcomes.

HIGH RATES OF MENTAL HEALTH DISORDERS IN RECENT INMATES

Featured study

Butler, T, Andrews, G, Allnut, S, Sakashita, C, Smith, SE & Bassoni, J 2006. Mental disorders in Australian prisoners: a comparison with a community sample, *Australian and New Zealand Journal of Psychiatry*, vol. 40, pp. 272-6.

Findings

This study compared the mental health of a consecutive sample of 916 new prisoners received into the NSW correctional system with that of a community sample of 8168 Australian adults derived from the 1997 National Survey of Mental Health and Wellbeing. Consistent with earlier research, the prisoner sample was younger, less well educated and more likely to be male than the community sample. The two samples were screened using the same psychiatric diagnostic interview schedule for drug use, anxiety, mood and personality disorders, and symptoms of psychosis, making the results directly comparable.

After statistical adjustment to account for the demographic differences, the past 12-month prevalence of any psychiatric illness was 80% in prisoners and 31% in the community. Compared to the community sample, prisoners were almost 12 times more likely to have experienced symptoms of

psychosis, 11 times more likely to have been drug dependent (particularly opioid and/or amphetamine dependent), and nearly nine times more likely to have suffered a personality disorder. They also reported significantly higher levels of psychological distress, disability and impairments in functioning as a result of mental ill health. Equivalent levels of physical functioning were reported, however, suggesting that there was no attempt by prisoners to exaggerate poor health. Findings confirm that many offenders who suffer mental health disorders are channelled into the corrections system. Priorities lie in diverting some minor offenders away from the criminal justice system, and expanding community post-release support services, particularly for inmates suffering mental health disorders.

HEP C INFECTION RATES INCREASE IN PRISON

Featured study

Butler, T, Kariminia, A, Levy, M & Kaldor, J 2004. Prisoners are at risk for hepatitis C transmission, *European Journal of Epidemiology*, vol. 19, pp. 1119-22.

Findings

This study followed up prisoners who participated in the 1996 NSW Inmate Health Survey to determine the incidence of hepatitis C virus (HCV) infection. From the 1996 sample of 789 inmates, 193 individuals were identified as being in detention in 2001. Of this group, 90 prisoners who were not infected with HCV when tested in 1996 were subsequently screened for HCV infection again in 2001. Of this group, 37 had re-entered the correctional system following time in the community, and 53 had been detained continuously since the first survey. Sixteen of these 90 individuals tested positive to HCV infection in 2001, yielding an overall incidence of infection of 7.1 per 100 person years. This means that for every 100 years imprisoned people who are HCV negative are followed up (e.g. following each of 10 prisoners for 10 years), we will observe 7.1 new HCV infections.

When statistical techniques were used to account for the effects of variables such as age and gender, the single most important influence on HCV infection was a history of injecting drug use. Among people who inject drugs, the incidence of HCV infection was 19.3 per 100 person years, compared with 1.5 for people not injecting. Six of the 16 people who contracted HCV had been detained continuously since their first HCV test, three of whom reported initiating injecting drug use in prison. Thus, although prisoners who had been at liberty during the study period were more likely to become infected with HCV than those who were continuously detained, this study unequivocally demonstrates that transmission of HCV occurs within prisons, with injecting drug use as the major risk factor. Tattooing is a secondary route of transmission among people not injecting.

Whereas most people who inject drugs limit their injection frequency in prison, when they do, the scarce supply of clean injecting equipment means sharing of contaminated equipment is inevitable. The high background prevalence of HCV infection among prisoners – approximately 40 times higher than in the community – indicates that transmission must be expected while drug injecting occurs. Consideration should be given to the provision of clean injecting equipment in prisons, as has successfully occurred in some European prisons.



FROM CHRONIC TO ACUTE: THE EMERGENCY RESPONSE IN THE NORTHERN TERRITORY

CAROL MAJOR

On 15 September 2007, interim laws governing the consumption, sale and transportation of alcohol were introduced into the Northern Territory as part of a National Emergency Response aimed at protecting the welfare of Indigenous children.

The emergency measures, which include banning alcohol in prescribed areas and restricting the amount of alcohol brought into Indigenous communities, were triggered by the findings of a territory inquiry into allegations of child sexual abuse in Indigenous communities (*Little children are sacred: report of the Northern Territory board of inquiry into the protection of Aboriginal children from sexual abuse*). While the emergency response covers a wide range of concerns, this article focuses on measures aimed at the restriction of alcohol, a drug that has played a key role in the breakdown of Indigenous communities.

Central to the report findings are that the combined effects of poor health, alcohol and drug abuse, unemployment, gambling, pornography, poor education and housing, and a general loss of identity and control have contributed to violence and sexual abuse in many forms. The authors stated that it was clear that most Indigenous people were willing and committed to solving the problems.

The report also stated that efforts to tackle the issues had been thwarted by a lack of communication and coordination between government agencies, and a lack of funds and resources to ensure long-term commitment to effective programs. The report concluded that all of these concerns had reached a critical point and were now an issue of 'urgent national significance'.

After reading the report the then Prime Minister, John Howard and the Minister for Families, Community Services and Indigenous Affairs (FACCSIA), Mal Brough, announced national broad-ranging emergency measures on 21 June 2007. The aim was to protect children, stabilise communities, normalise services and infrastructure, and provide long-term support to build better communities (see box on page 11: Protecting kids and communities).

However, with the exception of child protection, some communities were already in the advanced stages of planning and implementing strategies for many of these issues prior to the Emergency Response, and there has been some concern that the immediate action instigated by the *Little children are sacred* report may duplicate or override plans developed by Indigenous communities. On the other hand, there are others who feel that any impetus to galvanise action in Indigenous communities is a blessing.

Implementation

Approximately 70 Indigenous townships in the NT are covered by the Emergency Response. The word 'township' refers to groups



of 100 people or more who are residing on land owned under the *Indigenous Land Rights Act 1976* (NT) or on Community Living Areas (a form of freehold title given by the NT Government). Town camps in or near major NT centres are also included.

A Northern Territory Response Taskforce using combined expertise in medicine, government, law (including army) and business was formed to oversee implementation and advise the Prime Minister. In the first stages of implementation teams of people with expertise in service delivery and working with Indigenous communities were deployed to communicate the government action, examine the situation on the ground and make assessments regarding what is needed within each community in terms of physical infrastructure (such as water supply, sewerage and so on) housing, health needs, policing infrastructure and other services. These teams began their assessments in Alice Springs, progressing their way through the NT with the support of police and the Australian Defence Force, in particular its Norforce Unit.

Operations have been facilitated by the acquisition of five-year leases over main townships. Changes to the permit system on Indigenous land have also been made to allow government, community development and service groups into common publicly used areas that previously required permission and lease agreements from Land Councils and traditional owners.

Acquiring leases and changing the permit system has created concern among some Indigenous people who fear that the changes could diminish their ownership and authority over land, and allow access by development companies with entrepreneurial interests only. Other people, including the authors of the *Little children are sacred* report, have also expressed reservation regarding measures being put in place, although so far reports from the government agencies involved indicate that the majority of Indigenous communities are pleased with developments (see FACCSIA media releases).

Alcohol Management Plans

In the *Little children are sacred* report, alcohol was described as the 'gravest and fastest growing threat to the safety of Indigenous children'. Concern was expressed over the 'rivers of grog' flowing into communities and the associated harm. As part of the initial implementation of the Emergency Response, legislation was quickly drafted to ban people from possessing, selling, transporting and drinking alcohol in the prescribed areas covered (see box story: Alcohol bans and penalties). However, it was noted that some Indigenous communities had already taken steps to address alcohol-related harm and had put their own management plans in place. These Alcohol Management Plans (AMPs) – an NT government initiative – are negotiated through intensive consultation with Indigenous and non-Indigenous members of the community and tailored to fit local needs.

As the Emergency Response was being launched, AMPs were in place in the Tiwi Islands, Groote Eylandt, Alice Springs and Maningrida. Plans were also being finalised in Katherine, Tennant Creek, Nhulunbuy, Palmerston and Timber Creek, with discussions underway in other locations.

Mindful that these plans were in place, the Australian Government's total ban on alcohol was modified so that all existing licences and individual 'permits to drink' that were part of AMPs were retained and reviewed. In some cases, changes to the licence arrangements within these plans were made, such as limiting trading hours, increasing the provision of hot food and limiting or banning the sale of takeaway alcohol.

Getting the mix right

Problems associated with alcohol and drug misuse in Indigenous communities has been the subject of some ongoing research and many of the issues described in the *Little children are sacred* report have been documented elsewhere. For instance in its 2006 report, the Alice Springs Town Camps Review Taskforce (ASTCRT), established to investigate social conditions and governance arrangements, noted that pure alcohol consumption in the Northern Territory in 2004-05 was 17.8 litres per capita, which is well above the national average of 9.79 litres. (ASTCRT).

The ASTCRT reviewed many of the factors related to the misuse of alcohol and pointed out the importance of addressing core issues in parallel. Such issues include reducing supply, creating pricing strategies targeting the sale of low-cost, high-alcohol content products and establishing both community development programs and appropriate alcohol and drug treatment and rehabilitation interventions.

The ASTCRT report also included the results of a liquor trial conducted in the area in April 2002. The trial examined the results of a range of measures including light beer only in premises during morning hours and a ban on the sale of alcoholic beverages in containers larger than two litres. While some of the measures were successful, others squeezed the problem into new areas. For instance some drinkers switched to fortified wine because it had a greater kick for the volume bought.

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PROTECTING KIDS AND COMMUNITIES

The stated aim of the Australian Government's Emergency Response is to protect children, make communities safe, and to create a better future for Indigenous people. Key measures include:

Health and education

- health checks offered for all children
- school breakfast and lunch to be provided
- restrictions on the sale, transportation and consumption of alcohol.

Improving safety and justice

- provision of additional police, including infrastructure and resources
- supplying extra funding for legal services, community night patrols and interpreter services
- pornography banned.



Cleaning up communities

- providing materials and trades expertise to repair homes, fix fences, remove old cars etc., with people in the townships performing most of the work.

Changes to welfare payments

- half of welfare payments quarantined to be spent on food, rent and other essentials. Welfare payments to parents or carers linked to child school attendance.

Re-skilling opportunities

- Community Development Employment Programs (CDEP) to be gradually replaced with 'real' jobs, training and mainstream employment programs.

continued from page 11

Experiments such as this demonstrate the importance of having a clear understanding of the effects of harm-minimisation strategies and the importance of collecting and sharing data upon which to base decisions. Strategies to address Indigenous alcohol and drug misuse also need to look at it as a group problem in Indigenous culture as well as an individual problem, and tailor treatment and rehabilitation intervention to accommodate both.

Treatment and rehabilitation

Increased funding and resources for the treatment of alcohol related problems are part of the Emergency Response. There are currently 11 drug and alcohol treatment and rehabilitation services in the NT. Recommendations made in July 2006 by the Intergovernmental Summit on Violence and Child Abuse in Some Indigenous Communities (2006) will provide the NT with a further \$15.9 million over four years to increase these services in regional and remote Indigenous communities.

The Australian Government Department of Health and Ageing is also implementing an \$11.4 million package to address withdrawal, treatment and rehabilitation across the NT. These measures include:

- provision of hospital beds for medical detoxification
- establishing Alcohol and Other Drug (AOD) Response Teams
- increasing capacity to existing AOD treatment and rehabilitation services
- establishing a 1800 hotline to provide immediate AOD clinical advice to health professionals.

The first two AOD Response Teams were sent to the Katherine District and Tennant Creek hospitals. The AOD teams specialise in treatment and withdrawal and work in collaboration with existing NT Government Health Services to provide hospital based treatment and community outreach.

Respecting the process

While an increase in resources has been welcomed, there are still challenges in ensuring effective strategies are implemented. And while there are many who feel that the Australian Government's call to action has at least galvanised will to address long-standing issues, there are others who express concern that in the rush to solve the problems, the recommendations of previous evidence-based research – particularly with alcohol use – are being ignored.

There is also concern that coverage of the issue has tended to dismiss the efforts of Indigenous people to solve their own issues, when much of the problem is the result of years of inadequate policy and government neglect. There is a risk of myths being reinforced through such reporting, such as the idea that alcohol misuse is only a problem for Indigenous people in the NT and that a focus on law and order is the best response. Yet, easy access to alcohol and inducements to drink more, such as alcohol on credit, discounting, sales to intoxicated people and so on, is of concern to the entire Australian community, particularly those within it who are vulnerable.

In future issues of our magazine we will continue to track developments and report on the challenges of this major initiative as it is implemented on the ground.

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Intergovernmental Summit on Violence and Child Abuse in Some Indigenous Communities, 2006. Papers relating to this Summit can be found at www.atsia.gov.au/Media/media06/4606.aspx.

Fact sheets on the Emergency Response are available on the FACSIA website: www.facsia.gov.au.

People are also able to drink, possess and transport alcohol on a boat if they enter a prescribed area and are engaged in recreational boating or commercial fishing. (The exception does not apply to a river bank or beach.) People can also drink, possess and transport alcohol if they are engaged in a recreational activity with a tourist operator.

Takeaway alcohol

All licensees and their employees in the NT must view proof of a customer's identity when purchases of over \$100 are made or when more than five litres of cask or flagon wine are bought in one transaction. Valid forms of ID include passports, Australian driver's licence and the NT proof of age card. People selling the alcohol must view the ID and record the name, address and the area where the alcohol is intended to be consumed. The maximum fine for failing to comply is \$37 400 for licensees and \$6600 for employees.

The legislation will be continually reviewed and modified.

ALCOHOL BANS AND PENALTIES

Under the NT Emergency Response, laws have been enacted to ban alcohol in prescribed areas and restrict the amount of alcohol brought into communities. This means if you drink, possess, supply or transport alcohol in a prescribed area covered by the Emergency Response you could face a \$1100 fine for a first offence. If you are found with amounts of 1350 ml or more in these areas, you can be charged with trafficking and may face a \$74 fine or 18 months in prison.

Exceptions to this law included those people transporting alcohol over long distances to another destination outside of the prescribed area. In this case the alcohol must have its original seal intact.



OPINION: CUTTING ALCOHOL ABUSE AND VIOLENCE

DONNA AH CHEE*

The major barrier to addressing excessive levels of alcohol consumption and harms in Aboriginal communities is not a lack of desire by Aboriginal people, but the lack of willingness of policy makers to implement measures that we know work in reducing the supply and availability of alcohol. Such measures are not generally popular, or for obvious reasons supported by the alcohol industry.

As Australia's internationally renowned alcohol policy researcher professor Robin Room says, 'What's popular doesn't work, and what works isn't popular'.

The most effective strategies include increasing the price of alcohol, especially cheap bulk alcohol, reducing takeaway trading hours and reducing the density of alcohol outlets. Why is it that decision-makers continue to favour strategies that are known not to work, such as alcohol education or legislating to stop drinking in particular locations? Meanwhile, the advertising, promotion and availability of alcohol targeting young people by the alcohol industry continues all but unchecked.

Alcohol treatment and rehabilitation services by themselves are never going to be sufficient to address the excessive alcohol consumption in Aboriginal communities. It is time for policy makers to do what is needed, not what is popular with the community or the alcohol industry.

As the deputy director of the local Aboriginal health service, I can attest that there have been immediate health and social benefits for the whole community, especially Aboriginal people, since October last year when Alice Springs introduced restrictions on the supply of alcohol.

Since cheap bulk alcohol was removed from the market for the first four hours of takeaway trading, along with other restrictions, we have seen a 10 per cent reduction in alcohol consumption and a consequent reduction in harms such as assaults and alcohol-caused hospital admissions. As predicted by research, the heaviest drinkers are now shifting to beer because this is the cheapest form of alcohol left on the market, and this is less harmful.

However, the community in general doesn't like paying more for commodities, and in this sense alcohol is just another commodity. In spite of this, restricting the supply of alcohol using a minimum-price benchmark (which sets an agreed minimum price for all alcohol products) is potentially a more popular approach than using volumetric taxation (which sets taxation levels based on the actual volume of alcohol in each product) – because the former approach only affects the price of cheap, poorer-quality alcohol rather than higher-quality alcohol products.

The harm in any alcoholic beverage is due to the price per standard drink of pure alcohol it contains. So spirits, at 40 per cent alcohol by volume, are considered much less

harmful than cask wine – at 9.5 per cent alcohol by volume – because the pure alcohol in a bottle of spirits sells at about three times the price per standard drink when compared to a cask of cheap wine. The alcohol industry already knows that price is the principal driver of consumption, but now the general public should understand that if it wants to see reductions in alcohol-caused harms, then it needs to demand policy makers use price as a lever.

Total takeaway trading hours are also vitally important. The more hours, the more harm. A study just published in the August edition of the UK-based *Emergency Medicine Journal* (2007; 24:532) has shown the extent to which England's introduction of 24/7 takeaway alcohol sales has further increased harm at a large central London hospital. This adds to the wide array of international evidence that shows a direct relationship between the increasing liberalisation of takeaway sales and harms.

The introduction of one takeaway alcohol-free day per week was shown to be effective in Tennant Creek in the Northern Territory, and this is a measure that should be introduced in other Aboriginal communities and towns where there are substantial alcohol problems.

To maximise the effectiveness of this approach, all the normal Centrelink payments should be made on this day as well – and this is now administratively possible due to electronic payments. Takeaway hours on other days should also be reduced. This should be combined with reducing the amount of takeaway alcohol licences given in any location.

These types of supply reduction measures are not popular with many who gain financially from alcohol sales, because they impact on their profits. They are also initially not popular with the general community, but there is evidence to suggest that this is partly due to the misinformation about what actually works. Many people in the general community believe that alcohol education works, and that this – along with better treatment services – is all that is needed without anyone having to be inconvenienced by restricting alcohol availability. If only this were true.

There is also the mistaken belief that reducing supply equates to prohibition and that it will prompt heavy drinkers to shift to more harmful drugs. As long as there is still ready access to alcohol, this does not occur. People keep drinking, but in a less harmful way; this is the goal of supply reduction.

Supply reduction measures are the most effective way to deal with the very high levels of alcohol consumption in many Aboriginal communities, and are also the key missing link in the current policy response. We cannot afford to wait any longer before these types of measures are broadly applied. Over time supply reduction becomes popular because it works and it is seen to create safer, healthier communities for everyone.

**Donna Ah Chee is deputy director of Congress in Alice Springs and a member of the ANCD National Indigenous Drug & Alcohol Committee.*

This article first appeared in the Weekend Australian, 20 October 2007.

COMPULSORY TREATMENT: IT'S NOT THE ANSWER

GINO VUMBACA, EMMA PRITCHARD, JANETTE MUGAVIN & AMY SWAN*

In releasing a major report on compulsory treatment, the Australian National Council on Drugs (ANCD) has highlighted that rather than forcing people into treatment, it is far better to give offenders the option of being diverted into drug treatment.

The new report *Compulsory treatment in Australia* states that compulsory treatment should only be used in very limited circumstances. In contrast, the report says much greater emphasis needs to be placed on diversion programs.

The ANCD has used the report to highlight that diversion programs can reduce drug use, reduce crime and save millions of dollars, and that governments should substantially increase their support and commitment to these programs. The ANCD says earlier evaluations of diversion programs confirm there is clear evidence that diversion can lead to lower crime rates, lower court and law enforcement costs and better health outcomes.

Many prisoners are identified as having drug and alcohol problems, and prisons are far less likely to offer an appropriate environment to treat drug use. As an alternative, diversion is more likely to be successful in the long term. The Australian Government is currently allocating more than \$60 million a year to diversion programs. The ANCD has also highlighted some improvements that could further enhance the success of diversion programs. These include a national evaluation of

cannabis cautioning schemes so that the effective components can be incorporated into all such schemes.

Following the publication of the report, the Howard Government announced an extra \$165 million for the National Illicit Drug Diversion Initiative.

* *Gino Vumbaca is the Executive Director of the Australian National Council on Drugs, while Emma Pritchard, Janette Mugavin and Amy Swan are the authors of Compulsory treatment in Australia.*

Reference

Pritchard, E, Mugavin, J, Swan, A 2007. *Compulsory treatment in Australia*. Australian National Council on Drugs, Canberra.

Definitions

The ANCD has defined 'compulsory treatment' as when an individual has no choice about being mandated into drug treatment. An example of this includes an inmate being ordered to undergo a treatment program while in prison. 'Diversion programs' are seen to be voluntary because individuals can make a choice about whether they enter treatment for their substance use or go through the criminal justice system.

ANCD RECOMMENDATIONS

The key ANCD recommendations in response to the new report *Compulsory treatment in Australia* include:

1. Undertaking a national evaluation of cannabis cautioning schemes to ascertain the effective components of a successful scheme.
2. Introducing a nationally consistent and effective cannabis cautioning scheme across all jurisdictions.
3. Increasing government investment in drug and alcohol treatment services.
4. Providing a nationally consistent accreditation system for drug and alcohol treatment programs.
5. Providing ongoing support including expanded Illicit Drug Diversion Initiative (IDDI) training and education for all police, including new recruits, and magistrates.
6. Preparing and distributing regular reports on the developments and achievements of the IDDI, including actual case studies.
7. Expanding the criteria for diversion programs to include people with alcohol misuse problems.
8. Examining all diversion exclusion criteria in consultation with relevant groups, especially Aboriginals and Torres Strait Islanders.
9. Focusing diversion programs to better address the needs of Indigenous offenders and reduce their over representation in prisons.
10. Expanding court diversion programs to all jurisdictions.
11. Encouraging the exploration of strategies and programs to provide a continuity of drug treatment for drug using offenders being released from prisons and juvenile detention centres.
12. Establishing an appropriately constituted panel (including non-government sector representation) to review and update the current IDDI framework for endorsement by all governments.

KEY FINDINGS

Compulsory treatment in Australia

- That any compulsory treatment legislation should clearly state the intended outcomes of the legislation.
- That all jurisdictions should work in collaboration towards development of a nationally consistent approach to compulsory treatment.
- That the short-term model of involuntary care recommended by the New South Wales Standing Committee on Social Issues (2004) be used as a starting point for developing a national approach to civil commitment.

Key features:

Duration: 7-14 days

Target population: persons with substance dependence who have experienced or are at risk of serious harm, and whose decision-making capacity is considered compromised

Purpose: stabilisation; comprehensive assessment; restoring decision-making capacity; linking into long-term care (e.g. guardianship); encouraging and linking into voluntary treatment system

Criteria: four criteria must be met before a decision to commit a person to involuntary care can be made:

- severe substance dependence, as diagnosed by an internationally recognised tool such as the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM IV); substance dependence or use alone is not sufficient
- serious harm to self (including injury, illness and self-neglect) experienced, or immediate risk thereof
- lack of capacity to consent to treatment
- treatment plan outlining expected benefit and rationale for proposed period of involuntary care.

Treatment type: detoxification in a secure medical facility.

- That alternative models of care be developed to assist the people with complex needs and/or antisocial behaviour. In this context, evaluative information on emerging programs to serve this group in South Australia and Tasmania, as well as the Multiple and Complex Needs Initiative in Victoria, might be informative.

Diversionary programs and practices in Australia

- That consideration be given to expanding existing diversion programs by amending eligibility criteria to include problematic/dependent alcohol use.
- That provisions excluding certain offenders be further examined in consultation with relevant groups, especially Aboriginals and Torres Strait Islanders.
- That if violence is retained as an excluding factor, the terms 'violence' and 'violent' be clearly defined and limited to 'serious violent offences'.

- In some jurisdictions, mental illness can render an offender unsuitable for AOD diversion; in others, AOD dependence can render an offender unsuitable for mental health diversion. There is the potential for high numbers of dually diagnosed offenders to fall between the diversion nets.

- That the issue of unsuitability for diversion due to mental illness be revisited and discussed, including discussion and clarification of:

- whether AOD diversion or mental illness has primary jurisdiction for dual diagnosis clients when these two diversions operate together
- how the courts may best sit as both a drug court and a mental health court
- the training needs of magistrates regarding AOD and mental health issues
- the potential establishment of general problem-solving courts with authority and resources to address multiple issues, including AOD, mental health and homelessness issues.

- That consideration be given to expanding court diversion programs to all jurisdictions to overcome inequality in sentencing options and thereby access to treatment options.

- That systematic monitoring and evaluation be maintained, including consideration of possible net-widening.

- That guidelines to identify and minimise net-widening be developed.

- In a climate where AOD treatment services available to the general community can be in short supply and wait lists can be lengthy, it is arguably inappropriate and unfair to give preferential treatment to people referred via the criminal justice system. There is concern that this potential for displacement of voluntary clients creates 'perverse incentives' for people to access treatment via the criminal justice system.

- That ongoing monitoring of the demand for and the availability of treatment services in each jurisdiction be a part of the evaluation of diversion programs to avoid displacement of voluntary clients.

- That the specific skill development needs of professions participating in compulsory treatment and diversion programs be identified.

- That protocols that include clear articulation of lines of responsibility be available.

- That principles of best practice be developed and disseminated.

- That a clearing house maintain information and educational materials in these areas.

Indigenous Australians

- That programs designed specifically to meet the needs of Indigenous Australians be further developed.

- That exploration of effective processes, treatments and models for Indigenous Australians be ongoing.

SE ASIA: LOCKED UP

SONIA BEZZICCHERI & GINO VUMBACA*

A United Nations review has shown the policy of incarceration of drug dependent people is widespread in South East Asia's Greater Mekong sub-region.



The review, by the United Nations Office on Drugs and Crime (UNODC), looked at HIV/AIDS and custodial settings in China, Thailand, Vietnam, Myanmar, Cambodia and Laos. All except Cambodia reported large populations of inmates in 'compulsory drug treatment centres'.

These centres are increasing in both number and capacity across the region. For example, China has 764 compulsory drug rehabilitation facilities and 168 Rehabilitation through Labor Camps with a population of 220 000 and 120 000, respectively. Laos has three centres with 900 residents; Myanmar has 66 centres with a population of about 1500; Thailand had 39 centres in 2004 increasing to 49 centres in 2005 with 2400 inmates (as well as 17 'training centres' for youth with a population of a further 3500). In Vietnam, there are 100 000 people in 80 compulsory treatment centres, outnumbering the 55 000 in the country's prisons.

Inmates with a problematic drug dependence history are over represented in prisons across South East Asia. In Thailand, where there are often reports of serious overcrowding problems in prisons, around 70 per cent of prisoners are reported to have a drug use history.

Compulsory centres

There are high rates of HIV among people who inject drugs in this region. As a result, providing drug treatment rather than incarceration has been



accepted in some areas. For example in Thailand, this approach has become national policy with the *Drug Addicts Rehabilitation Act* providing judges with a larger range of sentencing options for minor drug-related offences. However, these sentencing options rarely result in evidence-based drug treatment being offered.

No country reported on the availability of pharmacotherapy programs such as methadone or buprenorphine maintenance. In most places, peer education is generally the only form of drug treatment available.

In regard to HIV/AIDS prevention for people who use drugs, education, information and communication material were the only measures reported as being available. Condoms and syringes were unavailable in all centres in all countries. This situation exists despite acceptance by many authorities that the main HIV transmission routes – men having sex with men, injecting drug use, tattooing and violence – do occur in these centres.

Despite the high number of people who are HIV positive in the centres, only Thailand reported providing free antiretroviral treatment to HIV positive offenders in any of the custodial settings under review.

Similarly, there were no reports of any links to aftercare services. Although outreach services to prisons by non-governmental organisations were reported by Cambodia, Myanmar and Thailand, the involvement of civil society and organisations representing people with HIV/AIDS in prisons and compulsory treatment centres, were rarely highlighted.

Finally none of the countries surveyed reported that the services for drug dependence within compulsory treatment centres or prisons were ever evaluated.

Findings

The findings from the review are concerning:

- evidence-based drug dependence treatment and appropriate HIV/AIDS prevention and treatment are seldom offered in compulsory treatment centres
- incarceration of drug dependent people in compulsory treatment centres poses public health risks due to widespread injecting drug use, tattooing, body piercing, unprotected sex and violence
- after care/appropriate follow-up is rarely provided, further increasing public health risk when people are released
- where known, relapse rates are as high as 100 per cent.

The report highlights the need for further research and the implementation of evidence-based interventions that respect human rights and aid their recovery, as well as that of their partners and the wider society.

*** Sonia Bezziccheri is the Associate Adviser (HIV/AIDS) at the UNODC Regional Centre for East Asia and the Pacific. Gino Vumbaca is the Executive Director, Australian National Council on Drugs.**

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Images courtesy of Alessandro Sarti, UNODC Good Will Ambassador

2 NATIONS, 10 CULTURES?

DOUG SELLMAN & ROBERT STEENHUISEN*

THE COMBINED APSAD AND CUTTING EDGE ADDICTION CONFERENCE, NOVEMBER 2007

APSAD 2007 was an historic coming together of Australia and New Zealand's two main alcohol and other drug conferences. Held in Tamaki-makau-rau (Auckland), the theme posed the question: 'Two Nations, Ten Cultures?'

The ending turned out to be the highlight; a culmination of three days of multiple presentations consisting of 12 keynote addresses, nearly 300 papers across 17 diverse streams, over 100 posters, ten workshops, 20 lunchtime meetings, six NZ politicians engaging in debate about drugs, and a memorable conference dinner including a hilarious after-dinner speech by Geoff Robinson, and acknowledgment of the great influence of Australian drug treatment pioneer James Rankin, before dancing (pronounced 'darning') continued into the night.

The conference ending was preceded by a moving keynote address by Siale 'Alo Foliaki, honoured by singing and dancing from his accompanying Pacifica Caucus group, which set the mood. When Scekar Valadian sat down on stage and began to play his didgeridoo, timelessness descended on us all. Soon, his ancestors' voices began to appear in the music and when a Maori karanga rang out, all the departed joined us and just for a moment we were One, in Heaven, past, present and future. Organising committee member Ann Roche spoke of the experiences of transcendence as one of the major features of this conference in her closing reflection.

The conference's first two keynotes could not have been more contrasted. Charles O'Brien, an international pioneer in addiction research, illustrated the beginning of the age of individualised pharmacotherapy based on our unique genetic make-up. Lloyd Geering at 89, one of New Zealand's greatest thinkers, then explained what Charles was doing in this new Culture Era, the Secular Age, that requires us to make decisions for ourselves and 'play God' in contrast to earlier eras.

Later, Simon Adamson drew out Charles O'Brien's assertion that addiction is a brain disease, but suggested it is only understandable in the wide context provided by the diversity expressed at the conference.

A trio of heavyweight Indigenous keynotes included Charlotte de Crespigny/Scekar Valadian (SA), Tracy Westerman (WA) and Mason Durie (Rangitane, Ngati



Kauwhata) which provided the backbone to an Indigenous stream of papers and five Maori workshops, along with an Indigenous lunchtime discussion group. The apparent tension between a deep spiritual valuing of old Indigenous knowledge and the rather frantic and competitive striving for new scientific knowledge in the modern world was resolved in the challenge to be inclusive and respectful of both paradigms.

The remaining five keynotes included Robin Room who comprehensively set the scene for various and varied discussions about alcohol policy and the

tension between the market and public health. Robert Cloninger outlined his famous model of personality and character but moreover explained how happiness and wellbeing is the result of character development – self-directedness, cooperativeness and self-transcendence – a triad well known in AA circles as 'Trust God, Clean House, Help Others'.

A highly engaging Peggy Compton explained opioid dependence in the context of pain and attracted multiple questions, which spilled over into her lunchtime discussion group. Max Abbott was the keynote feature of a dedicated gambling stream and he drew attention to the values of modern society. John Challis reassuringly explained how the addiction field really can move towards better levels of integration with the mental health field if the consumer is held at the centre and the system as a whole is there supporting change. A monograph containing elaborated abstracts of the keynote addresses and several other key papers will be assembled.

Mason Durie actually attempted to answer the question: Two Nations, Ten Cultures? He knew Tuhoë was definitely one of the Nations (recent NZ news) but said he was struggling to think of the other! We found the answer in Lloyd Geering's profound words on the first day; the current transition of humankind to one Global Family – ko ngai tatou katoa te ropu nui o te Ao. The unity that springs from a genuine respect and celebration of difference is an experience we'll all travel with now, having participated in the Combined APSAD and Cutting Edge Addiction Conference, 2007.

***Doug Sellman & Robert Steenhuisen were the co-chairs of the APSAD 2007 organising committee.**

Images courtesy of the Australasian Professional Society on Alcohol and other Drugs

DUAL DIAGNOSIS: WHERE TO FROM HERE?

JANE MUNDY

NOTES FROM THE ANEX CONFERENCE, SEPTEMBER 2007

The Anex Illegal Drugs and Mental Health Conference, held in Melbourne in September 2007, provided an opportunity to examine current research, discuss initiatives and explore collaborative responses in these challenging areas. More than 400 delegates attended the conference, with a strong representation of consumers and carers.

Anex CEO John Ryan says the conference broke new ground in the debate around the future relationship between the alcohol and other drugs (AOD) and mental health (MH) sectors, and highlighted the need for courage in facing the considerable issues involved, particularly in light of the increasing demand for services and consequent tightening of eligibility criteria. He believes workers in both sectors are still coming to terms with how to manage the AOD and MH nexus, and anxious about their ability to provide adequate services for dual diagnosis clients. Clients themselves fear being tarred with each other's brush and dislike the idea that 'dual diagnosis client' might be an even more stigmatising label.

Two services, or one?

David Murray, Executive Director, Youth Substance Abuse Service, cautioned against creating yet another diagnostic set. 'The main thing is that clients get a helpful response at their first port of call. They don't care about labels and definitions, they just want help,' he says.

Some delegates saw the division between MH and AOD as irrelevant and believed we should be thinking about how to deal with people as people, without labelling and marginalising them. They saw the issue as complex, often characterised by the presence of more than one kind of mental illness and the use of more than one drug, with additional issues around homelessness, unemployment, brain injury and structural disadvantage. Others saw the need to retain the delineation between MH and AOD for the purpose of managing and providing services, and believed the issue should be around how the two sectors can best work together. David Crosbie, CEO of the Mental Health Council of Australia, says he sees no need for a dichotomy and has always thought of the two sectors as one. 'It should be about all of us becoming more responsive to the needs of the whole client,' he says.

Dr Ruth Vine, Acting Executive Director, Mental Health and Drugs Division, Victorian Department of Human Services, says dual diagnosis should be the core business of both specialist mental health and drug and alcohol services, and that responsibility for 'mainstreaming' dual diagnosis within each sector should sit with each individual service. She says the key elements are partnerships, co-consultation and supervision, reciprocal rotations and placements, workforce education and training, and strong leadership. At the same time there must be major service reform in terms of where and how services are provided.

Funding for skilling workers and providing services specifically tailored to the needs of dual diagnosis clients was seen as a major issue. Since up to eight times as many dollars presently go to MH than to AOD, can the AOD sector afford MH expertise?

Professor David Kavanagh (University of Queensland) says there is agreement in the treatment literature that best practice for dual diagnosis clients is a single service run by a single case manager. However, he says it is very difficult to have sufficiently close communication to make shared case management by AOD and MH services practical in more than a very few cases. It is also too expensive to have a lot of people involved; most of the people that are seen by an MH or AOD service don't fulfil priority service criteria for the companion service; and the services have very different emphases and modes of operation. So in many cases, attempts to refer for joint management are almost bound to fail.

'Given that we have a separation of mental health and AOD services, the sensible thing is to have an agreed focus for each of them,' he says. 'If someone comes to an AOD service, and has a serious alcohol or other drug problem, someone from



NSPs celebrate their 21st anniversary with a cheque for \$7.7 billion, presented to Senator Brett Mason, representing the savings made by the program by preventing the transmission of HIV and hepatitis C.

Image courtesy of Mark Ferris

that service should be the primary person involved, even if the person has a run-of-the-mill mental health problem (anxiety or depression). Similarly, if someone comes to an MH service, and has a serious mental health problem, someone from that service should be the primary person involved, even if the person has a run-of-the-mill AOD problem (mild dependence which does not need detoxification and probably not drug substitution or other pharmacotherapy). That leaves a small number with serious problems in both areas, who may well need conjoint management. At the moment, many services have not yet learned that essential lesson.'

Delegates generally agreed that the focus in dual diagnosis should be on developing systems of care for people who are presently being bounced from one sector to another because they don't fit the service criteria of either. There was consensus on the need to address this problem by improving the reach and quality of care within both sectors.

Many services throughout Australia are now taking the initiative by designing and implementing their own dual diagnosis programs. John Ryan says he sees some interesting shifts taking place, with mental health moving away from a 'clinical' approach and towards a more holistic approach, and drug and alcohol moving towards a more clinical model and pushing for more clinical skills. 'There is good potential for both sectors to collaborate and learn from each other and for policy and funding to be appropriately apportioned to take advantage of the cross-overs,' Ryan says.

A role for NSPs

The conference also marked the 21st anniversary of needle and syringe programs (NSPs) in Australia. While long recognised as

a public health triumph in the field of HIV/AIDS, the significant role to be played by NSPs in providing services to people who inject drugs, and who have concurrent mental health issues, is also being increasingly acknowledged.

'NSPs provide a gateway opportunity to gain access and deliver services to dual diagnosis clients,' says Ryan. 'NSP workers are in a unique position to engage with clients and build up a trusting relationship in which it becomes more possible to address their other needs. There are more than 3000 NSPs across Australia, offering one million occasions of service each year – this gives us a huge and cost-effective opportunity for intervention.'

'There are no comprehensive mental health strategies for NSPs, no comprehensive workforce development strategy for skilling workers to operate at local level, and no minimum data statistics on the field. There is also a severe shortage of funds which don't go close to addressing the level of need.'

Looking to the future

John Ryan says despite the challenges, the conference was optimistic about the future. 'In the end we are all in this to keep people alive and well, so we have to overcome the barriers,' he says. Anex will be submitting the findings of the conference, together with recommendations, to the National Comorbidity Initiative Advisory Committee for consideration in planning and responding to Australia's needs and will continue to take a national leadership role in representing the critical needs of frontline services in collaboration with government and non-government agencies.

Conference presentations can be found at: www.anex.org.au/conference/presentations.htm.

PROFESSIONAL DEVELOPMENT SCHOLARSHIPS

The National Centre for Education and Training on Addiction (NCETA), Flinders University, is coordinating the Alcohol and Other Drugs (AOD) and Mental Health (MH) Comorbidity Professional Development Scholarships Program, which has been developed as part of the Australian Government's National Comorbidity Initiative. A total of approximately \$1.9 million (GST exclusive) has been allocated to the program.

There is a pressing need for specialist training and resources to assist workers in non-government agencies that provide AOD and MH services to identify, manage and/or refer people with co-occurring mental health problems and drug and alcohol-related issues. Accordingly, the Comorbidity Professional Development Scholarships Program aims to:

- build expertise in the detection and treatment of mental health problems for workers who currently provide AOD-related client services
- build expertise in the detection and treatment of AOD-related issues for workers who currently provide MH-related client services
- facilitate the capacity of non-government organisations

who provide AOD- and/or MH-related client services to release staff for professional development.

Only existing, not-for-profit, incorporated, non-government owned organisations and/or their staff whose role substantially involves providing services to clients with AOD- or MH-related issues can apply for professional development scholarships under this program.

The proposed professional development activity for which funding is applied must be directly relevant to one or more of the following:

- alcohol and other drugs (where the applicant provides mainly MH-related services)
- mental health (where the applicant provides mainly AOD-related services)
- AOD/MH comorbidities.

The first of two scholarship rounds has now closed. The second opens on 5 February 2008 and closes on 3 March 2008. Awards will be announced on 5 May 2008.

For information: www.nceta.flinders.edu.au.

DRUG USE SNAPSHOT: THE 2007 IDRS AND EDRS FINDINGS

JANE MUNDY

Heroin use has increased among people who regularly inject drugs in larger capital cities in Australia, while crystal methamphetamine ('crystal' or 'ice') use appears to have either stabilised or reduced among both people who inject and people who regularly use ecstasy.

This is among the findings of research carried out for the 2007 Illicit Drug Reporting System (IDRS) and the Ecstasy and Related Drugs Reporting System (EDRS) studies. The two studies are conducted annually. This year's findings were presented at the National Drug Trends Conference held in Sydney in October.

Crystal methamphetamine use among people who regularly inject drugs dropped from 57% to 46% between 2006 and 2007. Particularly large decreases were noted in capital cities that had documented high levels of use in previous years, such as Perth (76% in 2006, to 56% in 2007), Brisbane (55% to 39%) and Canberra (88% to 80%).

In addition to the changes in patterns of crystal methamphetamine use among people who inject, similar trends were documented among people who use ecstasy, where nationally use dropped from 49% to 33%, with decreases reported in all capital cities. Researchers said these changes do not appear to be due to a decrease in availability or increased price of the drug. Similar proportions of both groups reported that crystal methamphetamine was 'very easy' to obtain in 2007 compared to 2006.

However, there were reports from both people who use drugs and key experts that there may be a growing stigma associated with the use of methamphetamine (particularly ice), as some people increasingly saw others experience negative consequences from its use.

Associate Professor Louisa Degenhardt, from the National Drug and Alcohol Research Centre (NDARC), which coordinates the projects, said this year's collection of data suggests that people who inject may be returning to old patterns of heroin use, with

availability increasing slightly in areas with established heroin markets. However, patterns of use, price, purity and availability did not appear to be approaching those documented in 2000, before the onset of the heroin shortage.

As well as changes in the use of heroin across the country, the 2007 study has shown that one in five (21%) people who inject reported recently using 'brown' coloured heroin. Brown heroin can result from a different production method than is typically used to produce white heroin and requires a different method of preparation for use.

THE 2007 IDRS FINDINGS

This overview highlights the general national trends for key drugs, in terms of levels of use, availability and purity.

Heroin

Heroin is the preferred drug of 52% of people who inject. Increases in use were noted in most states and territories, with the exception of Tasmania and the Northern Territory. There was a notable rise in the number of days on which participants had injected in the previous six months (72 days in 2007, compared to 40 days in 2006), while in Sydney the median days of use increased from 72 to 96 out of the past 180. It was generally considered that heroin was easy to obtain, and while reports of perceived purity had increased, most users still considered it to be quite low.

Methamphetamine

Methamphetamine was the drug of choice of 21% of IDRS respondents. Use of any form of the drug decreased slightly from 79% of the national sample in 2006 to 74%, with decreases noted in all states except Tasmania and NT. Frequency of use (of any form) had declined slightly among those using weekly or more, although the proportion of daily users remained stable at around 5%. Data were collected on three forms of the drug:

1. Speed powder – use was stable nationally, with increases in Tasmania and Queensland. It was rated by participants as 'very easy' or 'easy' to obtain and purity was low.
2. Base – a slight decrease in use was seen nationally (from 38% in 2006 to 32% in 2007), with stability in some jurisdictions and decreases in others. It was considered 'easy' to obtain and purity was rated as 'medium' or 'high'.
3. Ice/crystal – use decreased nationally from 57% in 2006 to 46%, and to varying extents in all states/territories except NT where it remained stable. Purity was 'high' or 'medium' and it was 'easy' or 'very easy' to obtain.



Substance photos courtesy of Australian Customs Service and the National Drug and Alcohol Research Centre.

THE STUDIES

Both the IDRS and EDRS are conducted by researchers in capital cities across Australia. While neither study is representative of Australian illicit drug use in general, both are designed to monitor drug trends and highlight issues that may require further investigation. Both surveys have similar methodologies. Information from three sources is pooled to provide information about drug trends:

1. People who regularly use illicit drugs – the IDRS interviews people who regularly inject illicit drugs, while the EDRS interviews people who regularly use ecstasy. Each study interviews between 100 and 150 people in each capital city.
2. Key experts – the IDRS interviews people who work in the illicit drug sector or have a good knowledge of the

illicit drug market while the EDRS also interviews other groups of people who have regular contact with people who use ecstasy.

3. Analysis of routine data sources – including treatment data collections, ambulance callouts to drug overdoses, customs reports and police arrests.

Each study draws on the knowledge of distinctly different groups of people who use drugs. The IDRS taps into markets accessed by people who inject, and these individuals generally list heroin as their preferred drug.

The EDRS sources people who are more likely to nominate ecstasy as their favourite drug. IDRS respondents are likely to be older (IDRS mean: 36 years, EDRS mean: 25 years), unemployed, to have been in prison and currently receiving treatment for their drug use.

Cannabis

Cannabis was the drug of choice of 6% of respondents, with use remaining stable nationally. Hydroponic cannabis was very easy to obtain and believed to be of high potency, while bush cannabis was easy to obtain and thought to be of medium potency.

Cocaine

Cocaine was the drug of choice of 3% of people who inject. Its use is almost negligible outside NSW where 63% of respondents had used the drug in the preceding six months. In NSW, the drug was perceived to be of 'medium' purity and easily available.

Other drugs

Injection of pharmaceutical drugs continued to be an issue of concern, with injection of methadone remaining stable nationally (30% of respondents had injected it in the last six months, the same as 2006). Nationally, 25% had used methadone prescribed to someone else, and for buprenorphine, this figure was 18%. The proportion reporting recent use of morphine was 53%, oxycodone 30%, and benzodiazepines 66%. This includes both prescribed and non-prescribed use. Alcohol and tobacco use was also common.

THE 2007 EDRS FINDINGS

The EDRS provides an overview of ecstasy and related drugs such as methamphetamine, cocaine, ketamine, GHB, MDA and LSD.

Thirty-nine per cent of EDRS respondents nominated ecstasy as their drug of choice. Responses indicated ecstasy was generally consumed in a pill form and used with other drugs such as alcohol, cannabis and amphetamines. The majority of respondents also reported using other drugs while they were coming down from ecstasy. See Table 1 for an overview of the ways in which ecstasy was used by regular consumers.

Ecstasy was regarded as 'easy' or 'very easy' to obtain and perceived purity was 'medium' or of 'fluctuating' quality. Nightclubs were the most common location of use (76%) and the main route of administration was swallowing (93%).

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

- average prices ranged from \$30 to \$50 for a pill, depending on jurisdiction
- 68% of respondents purchased for themselves and others at the same time, buying an average of five pills
- on average, respondents had purchased ecstasy from three people in the last six months.

Table 1. Patterns among people who regularly use ecstasy

Mean age first used ecstasy	19
Median days used ecstasy in past six months	12
Use ecstasy (pills or powder) weekly or more (%)	27
Median tablets in 'typical' session	2
Recently binged* on ecstasy (%)	40
Use other drugs with ecstasy (%)	94
Use other drugs to come down from ecstasy (%)	82

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

The survey also revealed that ecstasy dealers were able to provide a range of drugs in addition to ecstasy to those wishing to buy them. The following drugs were also available from dealers: speed (56% of respondents could purchase this drug from their dealer), cannabis (68%), ice (43%), cocaine (38%), base (22%), LSD (28%), ketamine (16%), GHB (10%), pharmaceutical stimulants (6%), MDA (9%) and heroin (3%).

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Further reading

For further information, visit <http://ndarc.med.unsw.edu.au> (click on 'drug trends'), where previous years data are available and the 2007 results will be posted.

POST TRAUMATIC STRESS DISORDER

KATHERINE L MILLS*

There is growing evidence that people who are dependent on alcohol or other drugs (AOD) are often also suffering from post traumatic stress disorder (PTSD). Independently, both disorders are linked with considerable disability, including poor physical and mental health, and reduced occupational and social functioning. When the conditions are combined, these problems are compounded. Thus, individuals with this comorbidity present a significant challenge to AOD treatment providers.

What is PTSD?

PTSD is an anxiety disorder that may develop after a person has experienced a traumatic event such as a life-threatening accident, physical or sexual assault, combat, man-made or natural disaster, or after witnessing a serious injury or death. After this kind of experience, it is normal to have feelings of vulnerability, hopelessness, despair, numbness and/or devastation – normal response to abnormal events. For many people these symptoms will be severe and distressing, but will subside within a month or so. For others, however, these symptoms may persist or worsen, developing into PTSD.

PTSD has a characteristic set of symptoms: re-experiencing a traumatic event in the form of unwanted thoughts, nightmares, or flashbacks; avoiding people, places or events that might remind one of the event; difficulty feeling emotions and feeling 'cut off' or detached from others; and a heightened level of anxiety characterised by hypervigilance, increased irritability, and difficulty sleeping and concentrating.

How common is PTSD?

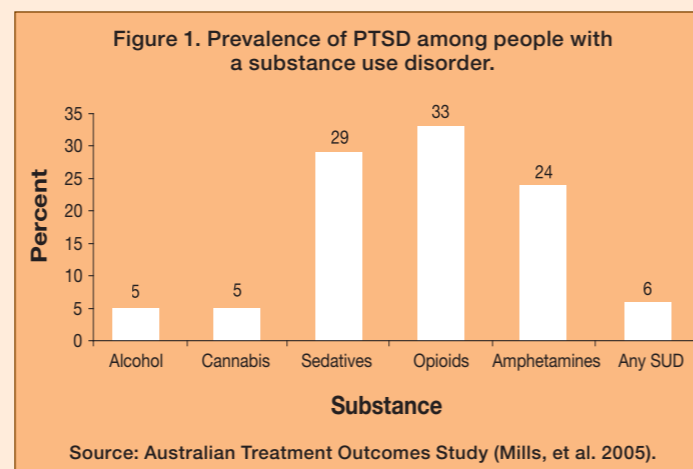
It is estimated that one per cent of the Australian general population currently has PTSD. The rate of PTSD among people with a substance dependence is considerably higher. Australian research indicates that these people are 6.5 times more likely to have PTSD than people who do not have a drug problem. The highest rates of PTSD were observed among those with opioid (33%), sedative (29%) or amphetamine use disorders (24%) (see Figure 1).

The Australian Treatment Outcome Study (ATOS) is the only Australian study to date to have examined the prevalence of PTSD among people receiving treatment. Among those being treated for heroin dependence, 31 per cent were currently experiencing symptoms of PTSD. Interestingly, for the majority of those with PTSD in the ATOS study, their condition was chronic, lasting on average 9.5 years. This differs to many other studies, which indicate that in approximately half of all PTSD cases, symptoms remit within three months following trauma exposure. It is generally believed that chronic PTSD is more difficult to treat than acute PTSD.

Why is PTSD so common in this group?

There are four major theories explaining the common co-occurrence of PTSD among people who have AOD problems:

- Self-medication – dependence occurs because of the repeated use of substances to relieve the symptoms of PTSD.



Researchers who accept this theory suggest individuals with PTSD use specific substances (e.g. heroin) to alleviate specific PTSD symptoms (such as emotional pain). The limited research available suggests a strong link between PTSD and heroin dependence compared with other forms of drug dependence.

- High risk – intoxication and a substance abusing lifestyle (particularly that which is associated with the use of illicit drugs) increases the risk of exposure to trauma, indirectly increasing the likelihood of subsequent PTSD.
- Susceptibility – people who use drugs are more susceptible to PTSD following exposure to a traumatic event, possibly due to a failure to develop effective strategies for coping with stress.
- Common factors – both disorders may share common psychological and biological traits, thereby increasing the likelihood that they will co-occur.

It is most likely that there are multiple pathways leading to this comorbidity. Regardless of which disorder is primary, both disorders maintain or exacerbate the other. For example, PTSD symptoms may promote and maintain the repeated use of drugs to relieve those symptoms. Repeated drug use, however, may interfere with the natural processing of trauma reactions or increase the likelihood of re-traumatisation.

Clinicians and PTSD

Compared to those with drug dependence alone, individuals who also have PTSD present for treatment with more extensive and severe drug use histories, poorer physical and mental health, and poorer social and occupational functioning. Thus,

it is not surprising that those with PTSD also have poorer treatment outcomes, including higher relapse and re-admission rates, more ongoing drug use, and poorer ongoing health and occupational functioning. It has been suggested that the increase in PTSD symptoms that frequently follows withdrawal from substances makes it difficult for sufferers to comply with treatment. People who have both PTSD and a drug problem represent a large number of people who may require additional treatment compared to those with a dependence alone.



Treatment options

At present, this comorbidity is most commonly treated sequentially, with people being shuffled between mental health and AOD treatment services. However, there is consensus in the literature that the conditions should be treated at the same time. Indeed, a large percentage of comorbid clients indicate that they would prefer to receive integrated, rather than sequential treatment, for these disorders (Najavits et al. 2004). However, there are very few options available.

A small number of integrated protocols have been developed in the United States, however, most have undergone little empirical testing. The most highly researched approach is 'Seeking Safety' developed by Harvard Medical School clinical psychologist Professor Lisa Najavits. 'Seeking Safety' is a 25-session therapy which aims to help people obtain safety from PTSD and substance use. Studies of 'Seeking Safety' have consistently shown positive outcomes among diverse populations. It may be delivered in either individual or group format. Further information about 'Seeking Safety' can be obtained at the website www.seekingsafety.org.

Another promising treatment approach is 'Concurrent Treatment with Prolonged Exposure' (COPE). COPE combines successful elements of existing psychological treatments for drug dependence and PTSD. The program consists of 13 sessions, and is based on cognitive-behavioural therapy and incorporates imaginary and real-life exposure to challenging situations. Preliminary research (Back et al. 2006) has shown that COPE can be used safely and is effective in the treatment of PTSD among individuals with cocaine dependence. Completers of the program demonstrated significant reductions in all PTSD symptoms and cocaine use from baseline to the end of treatment. This was maintained at six-month follow-up. Significant reductions in depressive symptoms were also observed.

Practical implications

It has been suggested that at the very least, services need to be trauma-informed. Trauma-informed services are not directly designed to address PTSD but are based on an understanding of PTSD and the way it can impact on AOD treatment. Educational programs aimed at increasing clinicians' awareness of the scale of PTSD among people with AOD problems is necessary, as well as skills-focused training to enable treatment providers to screen for the disorder and manage issues that may arise relating to this comorbidity, for both the client and themselves. One brief instrument which may be beneficial in assessing PTSD is the Trauma Screening Questionnaire by Chris Brewin (Brewin et al. 2002).

There is also a great need to increase communication, coordination, and advocacy between the delivery systems for treating each condition. This may include cross-training for staff, locating a PTSD specialist within AOD treatment services, or having a PTSD specialist at partnering agencies available for consultations.

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A randomised controlled trial of COPE is currently being conducted in Australia by the National Drug and Alcohol Research Centre in conjunction with the Medical University of South Carolina, the Centre for Traumatic Stress, and the University of Newcastle. To complete this study, the author is seeking people in Sydney who are currently suffering from comorbid PTSD and substance dependence. For more information, contact Dr Katherine Mills on (02) 9385 0253.

WORKING OUT A CAREER

JANE MUNDY

What do you want to be when you grow up? An AOD worker?

Working in the field of addictions is not usually at the top of many people's career wish-lists. Ask most people in the AOD sector how they got there in the first place, and how they have progressed, and chances are they will say it has been more by accident than design – a chance meeting, an unexpected job vacancy, a fill-in position that became permanent. Being in the right place at the right time.



GLENYS DORE

For Dr Glenys Dore, Acting Medical Director of North Sydney and Central Coast Area Drug and Alcohol Service, it was a case of no-one else really wanting the job.

Dr Dore was in the final 18 months of her five-year general psychiatry training at the University of Otago, New Zealand, in 1989 when the question of which registrar would

take on the six-month drug and alcohol placement came up. No-one put up their hand.

'Somehow I drew the short straw,' she recalls. 'I knew nothing about drugs and alcohol. I had never treated anyone with an addiction, I didn't even know what methadone was. My first patient, who was detoxing off benzodiazepines, promised me she would never use again and I believed her. That's how naïve I was!'

Dr Dore was uncomfortable with the punitive approach to treating addictions prevalent in some treatment programs at that time and was reluctant to stay in the field beyond her six-month placement. But her supervisor, an excellent teacher and role model, persuaded her to stay.

Then, as chance would have it, her medical director resigned suddenly (later it emerged that she had received a death threat from a violent patient) and Dore, not yet a fully qualified psychiatrist herself but now the next most experienced AOD doctor, was asked to step into the breach. As became the pattern in her career, she took up the opportunity and made the most of it.

Once qualified in psychiatry, and with no other options made available to her, she made the critical, career-defining decision to accept a position as medical director and consultant psychiatrist with D&A services and community mental health.

'Everything seemed to be pointing me towards the AOD field so I decided to accept the challenge of this new job and learn as much as I could about it. I went to all the conferences and workshops I could and did a lot of reading. I also did a lot of presentations which required thorough preparation and research. I acquired a

wealth of knowledge and experience and slowly I started to feel comfortable in the field and began to really enjoy it.'

Dr Dore came to Australia in 1997 to work in a large private psychiatric practice as well as a private pharmacotherapy clinic in Sydney where she continues to consult one session a week. Thus began another steep learning curve.

'The Australian AOD scene was very different. Hardly any heroin was getting into New Zealand at that time and I hadn't treated anyone with a heroin addiction before. In my new job, almost all the clients were using heroin. But although the substances were new to me, clients' issues and the therapeutic skills I needed to treat them were the same.

There are no case managers in the clinic so you have to do everything yourself – assessing patients' AOD and mental health issues, putting them on treatment programs, monitoring them, working on social issues, looking after their medical health and so on.'

Dr Dore then spent six years in charge of a 20-bed unit for young people with AOD and mental health issues at Macquarie Hospital in Sydney before joining the NS&CCA D&A Service in 2006.

She adheres to the old adage, 'first see, then do, then teach'. Teaching about your field and training others is one way of making sure you are completely on top of it, she says. In addition to her managerial duties, clinical work and research, she is now involved in teaching medical students and medical registrars who are training in psychiatry (she was honoured with the Best Teacher Award in Psychiatric Medicine in the Northern Clinical School in 2006).

She also teaches the Pharmacotherapy Accreditation Course which trains new doctors in prescribing medications for opioid dependence and assists the NSW Medical Board's health program for doctors who are themselves experiencing AOD and mental health issues. She is also Chair of the Pharmacotherapy Credentialing Subcommittee for NSW Health which approves doctors to be authorised prescribers of methadone and buprenorphine to treat opiate dependence.

Add to the mix several outstanding managers who have encouraged her and provided excellent role models, plenty of hard work, a slice of serendipity and more than a touch of good humour – and bingo! You have a career path.

TRISH HYLAND

Trish Hyland came to the AOD field circuitously more than 20 years ago, via her original training as a child care worker. Working in the Odyssey House therapeutic community, she had her first taste of the managerial area when she became coordinator of the parent and children program and later, coordinator of women's residential services. This led to her appointment as coordinator of Odyssey's new non-residential program and eventually to her 'big step' – program manager and second-in-charge of the organisation. Some of these positions were part-time, a factor she says enabled her to pursue her career while her own children were young.

'Deciding whether to take the clinical route or to go into management was a critical point in my career,' she says. 'By then I had had a lot of very varied experience in different roles within the organisation and developed a good understanding of the whole AOD field and I was beginning to see a career path for myself.'

In 1998, the University of Technology, Sydney, introduced a BA in Community Management, targeting managers in the community sector who had come up through the ranks but did not have qualifications. 'The field was changing rapidly around that time and I was also beginning to feel some pressure to get a formal qualification,' says Hyland. 'The course was meant just for people like me. It gave me skills and a theoretical framework, plus the confidence to move into other areas.'

A period as interim manager at Maryfields Day Recovery Service gave her a taste of managing and developing day programs and a subsequent position as project officer in the Drug Programs Bureau at NSW Health provided her first experience of how policy is developed and delivered within the sector.

Now Manager of WHOS New Beginnings Women's Service, a therapeutic community in Redfern, Sydney, Hyland says she is happy to be back at the coalface of AOD work. Most of her time is devoted to managing issues of accountability and quality improvement, as well as networking and lifting the profile of New Beginnings, and managing a staff of seven.

Hyland's advice to those wanting to progress their careers in the AOD field?

'Firstly, think about getting formal qualifications. Give high priority to workforce development but you may need to look beyond this. Be prepared to make sacrifices and don't always depend on your employer to provide education and training for you. Secondly, try to get as much experience as you can and always be on the lookout for opportunities. This is always easier in a big organisation, but if you are competent and enthusiastic, plenty of opportunities will come your way. And of course it helps if you are lucky enough to have had good managers, as I have, who will mentor you and encourage your career.'

'Yes, the first part of my own career was a bit ad hoc. But once I got a taste of new and different roles, plus had my first experience at middle management level, my goals became clear and I followed them.'

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A CHANGING FIELD

Professor Ann Roche from the National Centre for Education and Training on Addiction (NCETA) says many, if not most, people in the AOD field get into it by accident or serendipity.

‘With the exception of those who enter the field deliberately as a result of their own personal life experience, people don’t usually set out with a view to a lifetime career in AOD,’ she says. Instead they start off their careers in fairly conventional ways and stumble across the AOD field. This arouses their interest and then they go on to acquire training and practical experience.

‘However, career advancement paths do exist. For example, it is reasonably common for a nurse to progress to become a nurse unit manager and then an area manager for AOD Services or move into a bureaucratic position or into research. A generic clinical psychologist may progress into research and/or lecturing, while someone else might start in AOD education and then progress into health promotion and advocacy. Career paths are more defined in some areas of the field than others – if you come from a particular discipline such as psychology or social work and you have a specific skill set, doors will open. There is also a lot of traversing and zigzagging from one part of the field to another.’

Roche says the last two decades have seen a dramatic evolution and expansion of drug treatment and rehabilitation services in Australia. Where once services were largely charity and volunteer based and staffed largely by a handful of doctors and nurses,

service delivery is now underpinned by more sophisticated, scientific evidence-based practice.

Among many demands, workers must now be able to deal with a rapidly expanding and increasingly technical knowledge base, rapid shifts and changes in drug fashions, the increased complexity of AOD and mental health issues, an expanding range of treatment options and the pressing demand for treatment practices to be based on scientific evidence.

These changes have enormous implications in terms of who is recruited, what kind of work they are expected to do, and how to train them appropriately and retain them in the workforce.

Figures suggest that these days only one-third of people in the AOD field do not have some kind of formal qualification relevant to their work. Workers are keen to embrace the concept of further education and training (NCETA’s 2005 Survey of 1234 AOD workers found that better training and career opportunities would encourage them to remain in the service) but getting time off from their employment is hard and undertaking university studies at their own expense is increasingly prohibitive. Other than Edith Cowan University (Perth, WA) which offers an undergraduate Bachelor of Arts (Addiction Studies), most university training programs are at the postgraduate level for professionals who are already working in the AOD or a related field. There is, however, an increasing array of training options offered through registered training organisations.

HOW MANY AOD WORKERS ARE THERE?

It is difficult to estimate the number of people working in the AOD sector, says National Centre for Education and Training in Addictions (NCETA) Director Ann Roche.

In 2003, NCETA surveyed 318 agencies to help estimate the number of staff in Australia’s specialist AOD workforce. These responses were then extrapolated to give an estimate for the staffing of the 486 agencies listed in the Clients of Treatment Services Agencies (COTSA) database. The final estimate is that there are about 10 190 staff in the AOD workforce (see Table 1).

‘While these are the best figures we have, it is impossible to calculate the actual number of people who deal with alcohol and drug issues in the course of their work,’ Professor Roche says.

‘Our suggested figure is only for specialist agencies. This doesn’t

take into account anyone who works in a generalist health setting such as a community health centre or hospital. Funding variations and the number of

projects and programs which only run for a short time also make it difficult to get any clear picture of how many people work in this area.’

Table 1: Total number of staff working in 318 specialist treatment agencies and an estimate of staff within the 486 agencies listed on the 2001 COTSA database.

Type of staff	N	(%)	Total estimated staff
Therapeutic staff			
Nurses	1,206	26	1,834
AOD workers	873	19	1,334
Psychologists	400	8	611
Counsellors	272	6	416
Social workers	265	5	405
Other occupational groups	1,674	36	2,558
<i>Total therapeutic staff</i>	<i>4,690</i>	<i>70</i>	<i>7,167</i>
Other staff	1,811	27	2,768
Alcohol specific staff	167	3	255
All staff	6,668	100	10,190

A DAY IN THE LIFE OF...

MICHAEL HARVEY, COMMUNITY MENTAL HEALTH NURSE, MORLEY COMMUNITY MENTAL HEALTH TEAM, PERTH

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



Of Substance: *What do you do?*

Michael Harvey: I am a case manager with the Morley Community Health Clinic, in the Morley catchment area of the Swan Mental Health Service.

The clinic provides psychiatric assessment and treatment for adults between 18 and 64 years of age with serious mental illness and mental health problems, who are at risk of suicide or self-harm, have had recent inpatient admissions to psychiatric hospitals or are subject to the Mental Health Act of Western Australia. Up to one-third of our clients also have drug and alcohol issues.

We are a multidisciplinary team of 16, made up of psychologists, psychiatrists, occupational therapists, social workers, administration workers and mental health nurses.

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

MH: On arrival, the first thing I do is say hi to everyone. We work as a team and we are constantly dealing with people in crisis, so it’s important to put a lot of effort into supporting each other. Then I turn on the computer and read the daily report that comes in from the psychiatric liaison nurse in the Emergency Department at the Swan District Hospital. If any of my clients have been seen in Emergency in the last 24 hours, I follow them up to find out what happened and how I can help. After that I see what I can do for my other clients.

I have a caseload of around 25 – some of them come in to the clinic and I visit others in their homes, monitoring their mental state, giving depot injections, ensuring that medication is taken appropriately. I also do brief interventions and counselling, provide social contact and generally help them manage their illness while also offering support to their families.

I also network a lot with other agencies, especially drug and alcohol services. Many of our clients may use substances to help block out the distress, but this just compounds their problems. I find it beneficial when mental health services and the drug and alcohol services work closely together – it helps the client receive appropriate interventions and allows us to share our expertise.

OS: *What challenges do you face?*

MH: Mental ill-health is overbearing for people and often is enduring. You have a duty of care to do whatever you can to support them through their pain and help them develop resources and skills to cope. The challenge is to build up trust and professional rapport with the person so they feel they can turn to you for support when they are suffering distress from their illness. I have seen some people make

remarkable recoveries, and I have seen the resilience of the human spirit to survive.

There is always the potential for aggression and unfortunately this appears to be ever increasing. Clients can be unpredictable from day to day and you never know what you will find, but experience teaches you to spot the signs to maintain your own and other people’s safety.

OS: *Where have you worked before?*

MH: I started as a mental health nurse in Ireland when I was 19 years old and have worked in the mental health and drug and alcohol field for over 30 years, much of this in really serious, hard-core environments. My career has taken me from Dublin to London, the USA and Australia, working in diverse areas such as elderly care, the homeless, in acute psychiatric hospitals, forensics, methadone clinics and in the court system.

Working in a variety of multi-disciplinary teams with people who have different strategies and ideas is a great way of learning and enhancing your skills. The standard of care in Australia is among the best in the world. We are very innovative here, always pushing for advancements in treatment and prevention.

OS: *What advice do you have for others entering the field?*

MH: Always remember that you are part of a team and your team members are your greatest asset. It is also important to network with other agencies – this should be one of your primary roles, both for your clients and for yourself.

Burnout is part and parcel of this work. You should know how to recognise the signs and have strategies for dealing with it. Try not to take on too much and learn to say ‘no’. Know your own limitations and don’t place too high expectations on yourself. Realistically you can’t ‘fix’ someone’s problem – try to accept that if you can help them endure their suffering without adding to it then you have been successful.

Try to be respectful and non-judgmental towards your clients and keep a positive regard towards them, no matter how they may behave.

OS: *How do you relax?*

MH: I ride my bicycle 20 km in to work regularly (in a good week I ride in every day!). I also sit on my ‘safu’ (a little cushion) and meditate. And I love to travel. I’ve been all over the world, and to every continent except Antarctica. For my next holiday I am planning a trip to Chile with my South American wife.

YOUTH DRUG USE

Spooner, C, Hall, W & Lynskey, M 2001. *Structural determinants of youth drug use*, ANCD research paper No. 2, Australian National Council on Drugs, Woden, ACT.

This report was prepared for the Australian National Council on Drugs in 2001 by the National Drug and Alcohol Research Centre at the University of New South Wales, in collaboration with CJ Spooner: Planning, Research and Evaluation.

The aim was to examine the available literature investigating the influences of economic, social and physical environments ('macro-environmental factors') on youth drug use, and to consider how governments can address those factors to prevent drug use and harms through policies and programs.

Best strategies

Multi-modal strategies are the best approach to prevention. Ideally, they target the specific needs of a community, developing and implementing a range of strategies to reduce risk factors and promote protective factors.

Drug use is just one of a range of risk behaviours influenced by macro-environmental factors that include socioeconomic gaps, unemployment, social capital, the physical environment and social values and beliefs. A broader view would involve understanding how drug use is shaped by human developmental processes from birth, timing interventions at critical periods in child development and during transition periods in development. Because family, community and other social networks contribute to a child's development, they also require consideration.

The report calls for a shift in focus towards the positive, supporting young people to be 'happy, socially connected, and engaged in life'. Appropriate and culturally sensitive intervention programs are recommended to address social disadvantage among disadvantaged populations.

Least effective strategies

Strategies that isolate drug use as a problem are ineffective, as are simple 'one-shot' strategies and interventions. Drug education has had limited success, yet it is the preferred way to deal with drug problems among the general Australian population. School-based drug education has had disappointing results. Some methods are repeatedly employed, yet are ineffective or even counterproductive, such as trying to scare young people about drugs.

Judging effectiveness

Harm reduction approaches are easier to implement and evaluate in terms of effectiveness than drug abstinence, because behaviour changes can be measured within a specific target group in the short term.



SECRETS OF PREVENTION

ANGELA ROSSMANITH

What is prevention? How do we prevent drug and alcohol problems?

In Australia, three documents are considered particularly significant when it comes to planning preventive strategies. Each report is briefly described here, with a summary of the approaches to prevention each considers most and least effective.

CRIMINAL BEHAVIOUR

Developmental Crime Prevention Consortium 1999. *Pathways to prevention: developmental and early intervention approaches to crime in Australia*, National Crime Prevention, Attorney-General's Department, Canberra.

This project was conducted by an interdisciplinary team led by criminologist Professor Ross Homel, Griffith University, and was a joint initiative of National Crime Prevention (formerly the National Campaign Against Violence and Crime Unit) and the National Anti-Crime Strategy.

The aim was to explore in depth the notions of 'developmental prevention' and 'early intervention', focusing on what recent research revealed about the nature and causes of crime and its prevention. Specifically, the team aimed to review the literature on early intervention or developmental approaches to crime prevention; audit and evaluate existing social and health services and interventions; and formulate a framework for crime prevention programs.

A project based on the recommendations of this report was established in Brisbane in 2001 by a team led by Professor Homel at Griffith University, in partnership with Mission Australia. The progress of this community-based prevention program is outlined in the document *The Pathways to Prevention Project: the first five years, 1999-2004* (Homel 2007).

Best strategies

The developmental approach sees life as a continuing series of phases and transitions. Well-negotiated transitions create a pattern of cumulative protection. However, intervention is effective when it is targeted early in the pathway towards any life transition, such as the move from primary to high school.

Most effective are prevention programs focused on the key transition points, with 'booster shots' administered during the life course. The programs take a multi-method approach, with a variety of components appropriate to specific people and specific circumstances. The coordination of a mix of approaches is effective in the reduction of violence. An example is anti-bullying programs based on a whole-of-school approach incorporating 'situational techniques' (e.g. better supervision), social changes (e.g. changing a school's social climate) and specific developmental interventions (e.g. building self-esteem).

Least effective strategies

Prevention programs targeted at only one risk or one protective factor do not work.



Interventions aimed at exposing children to a different group of peers can be useful for those who are moderate in their level of disruption, but are ineffective with those who are more extreme and more entrenched in their behaviour. Criminal justice approaches emphasising punishments fail to reduce crime significantly. However, deterrence approaches work when they are 'low key' and respect human rights.

Judging effectiveness

The ideal way to judge effectiveness would be to note a decrease in the level of participation in crime in response to interventions that target child abuse and neglect. However, this evidence is not yet available.

Most long-term evaluations studied here were intended to improve the school performance of children from disadvantaged areas. Over time, changes were noted not only in school performance but also across a range of social behaviours. That is, crime prevention was not the express intention of the programs, but proved to be one of the long-term benefits. Observed changes may simply be changes in circumstances (and these may swing back), so it is important to check both for changes in individuals and in circumstances.

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Homel, R, Freiberg, K, Lamb, C, Leech, M, Batchelor, S, Carr, A, Hay, I, Teague R & Elias, G 2006. *The Pathways to Prevention Project: doing developmental prevention in a disadvantaged community*, *Trends and issues in crime and criminal justice*, No. 323, Australian Institute of Criminology.

Homel, R 2007. *The Pathways to Prevention Project: the first five years, 1999-2004*, Mission Australia and Griffith University, Key Centre for Ethics, Law, Justice & Governance, Brisbane.

GENERAL DRUG USE

Loxley, W, Toumbourou, JW, Stockwell, T, Haines, B, Scott, K, Godfrey, C, Waters, E, Patton, G, Fordham, R, Gray, D, Marshall, J, Ryder, D, Sagers, S, Sanci, L & Williams, J 2004. *The prevention of substance use, risk and harm in Australia: a review of the evidence*, The National Drug Research Institute and the Centre for Adolescent Health.

Now widely known as 'The Prevention Monograph', this document was commissioned by the Australian Government Department of Health and Ageing to inform a comprehensive prevention agenda in Australia as part of Australia's National Drug Strategy (NDS).

The authors take a broad perspective on prevention, and base their report on a major review of Australian and international literature. They identify the major patterns of use, risk and harm; look into the social and structural determinants of health and drug use, with a particular concern for Indigenous Australians; and review the evidence for a range of prevention strategies.

Best strategies

'Whole-of-population' strategies are effective in reducing and preventing the harms associated with alcohol and tobacco use by adolescents, especially when they target specific changes. For example, community action to restrict trading hours in high-risk communities, increasing enforcement of drink driving and liquor laws and restricting the availability of alcohol, have achieved positive results.

Law enforcement strategies are critical in effective approaches to prevention, for example, prohibiting the sale of tobacco and alcohol to minors. The taxation policies that keep the price of cigarettes high are highly effective, and a similar strategy is advised for alcohol. Preventive programs in childhood emerge as a valuable investment. Intensive strategies that include family intervention (to break the inter-generational cycle of drug use), preventive case management, and targeting young people most at risk appear 'promising' for preventing harms associated with illicit drug use. Brief interventions are effective because they are quick to implement and are inexpensive.

Least effective strategies

Community-based programs delivering drug-related information can exacerbate problems because of the risks in bringing together high-risk young people for drug education. Risks were also identified with peer interventions unless they are well implemented, with peer educators carefully selected and well supported.

Evidence also shows that 'once off' media campaigns are ineffective in influencing young people's attitudes towards drug use. School-based drug education can produce changes in students' knowledge, but the effects are short term unless they are supplemented by other strategies, such as community mobilisation or parent involvement.

Judging effectiveness

While examining the cost benefits of strategies is useful, it overlooks the intangible benefits which are difficult to put into monetary terms. The authors suggest 'monetising' a range of outcomes to fully appreciate the impact of interventions on cost reductions.

Upcoming conferences

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Sentencing 2008 Conference

National Judicial College of
Australia, Canberra

For more information visit:

<http://law.anu.edu.au/nissl/sentencing08.htm>

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Australian Institute of Criminology
RACV Club, Melbourne

For more information visit:

[www.aic.gov.au/conferences/
2008-YoungPeople](http://www.aic.gov.au/conferences/2008-YoungPeople)

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University of New South Wales, Sydney

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