

OF SUBSTANCE

JULY 2008 VOL. 6 NO. 3

THE NATIONAL MAGAZINE ON ALCOHOL, TOBACCO AND OTHER DRUGS



SMOKING

A case for harm reduction?

DUAL DIAGNOSIS \$\$

Delivering the goods?

DRUG DEATHS

Why they matter

SCHOOLS

Testing times?

STAFF SHORTAGE

Empty offices,
waiting clients

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BIGGER AND BETTER: BUMPER 36-PAGE EDITION

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Jenny Tinworth

Editor's letter

Of Substance has grown. That's what you have told us, and that's what we have responded with – a bigger and better 36-page issue, up four pages from our usual 32.

Our staff, and the independent evaluating team, owe a special thanks to the many readers and sector experts who took the time to contribute to our recent evaluation. You were generous with your praise of the magazine's content, and had some helpful suggestions about how we can continue to grow and contribute to making your work more effective. To read about the evaluation findings, see page 33.

In this issue, we turn to the subject of tobacco use. Australia has done well in reducing its smoking rates, with the number of smokers falling and fewer young people taking up the habit. However, it is important that we don't rest on our laurels – there is still much to be done to reduce the number of smokers and the risks of smoking. 'Harm reduction' isn't a phrase we hear associated with tobacco. We ask whether it should be.

We also report key findings from the latest National Household Survey, as well as examine the impact of a recent focus on 'comorbidity' or the co-occurrence of mental health and substance use problems, which impacts many of the clients seen by staff in the AOD sector.

There is plenty of concern for the wellbeing of Australian young people. In this issue, we discuss drug testing in schools, and look at the misleading messages society is giving young people about the way they use alcohol and other drugs.

And finally, among the many features in this issue, I'm proud to introduce our newest series. Called 'Drugs around the world', we will be exploring the policy approach taken by several countries towards drugs. In other places, policies can be very different to our own, and make for interesting reading and discussion. With the Olympics next month, we thought it fitting to focus on China and the way that country handles the tension between a hardline approach to drug use and the enormous challenge of keeping HIV at bay.

I hope you enjoy this issue of *Of Substance*. As always I welcome your feedback – email editor@ncd.org.au. All our past issues are also available by visiting www.ofsubstance.org.au.

Jenny Tinworth
Managing Editor

TRUTH LIVES IN DEATH DATA

SHANE DARKE, PROFESSOR,
NATIONAL DRUG AND ALCOHOL RESEARCH CENTRE



The article on the value and importance of data on drug-related deaths in the current edition raises an issue that is too often unrecognised. Such data are crucially important, yet I do not think their value is broadly appreciated. We have some of the most extensive and reliable death data of any country in the world, which is one of the reasons that we have been world leaders in this kind of research.

What has such data told us to date in the substance abuse field? I could speak of major advances in our understanding of opioid overdose, of the effects of cocaine on the heart, of how drugs relate to homicide and suicide, or of how these data actively inform our knowledge of drug trends.

In order to understand the value of the data available in Australia, however, let us look at heroin overdose as a prime example. As recently as the early 1990s, a series of myths dominated our thinking: people who died from heroin overdose were young and inexperienced; they died too quickly to intervene; it was due to excess purity; it was due to impurities; alcohol and other drugs had nothing to do with it.

When my colleagues and I started looking at the actual deaths themselves, all of these accepted 'truths' turned out to be false. Cases were typically older, rapid death was not the norm, purity was only moderately related, impurities were of no relevance at all, and alcohol and other drugs were crucially important. The implications were enormous, and directly led to interventions that have been carried out here and around the world. We were in a unique situation to make major advances in our understanding of what causes overdose. This would not have been possible but for the quality of the Australian data.

Of course, there are issues regarding the reliability of these data and, indeed, of any data. There will always be some 'noise' in the data, no matter what it is. What is important is to recognise the value of what exists in this country. The data available for researchers in Australia is vastly superior to that recorded in other major countries, such as the US or UK. We can track nationally, for instance, the number of opioid-related deaths across time and state. No such studies would be possible in the UK, for example.

In my opinion, the cost of performing autopsies and toxicological analyses is money well spent, and has led to lives being saved. We are world leaders in the collection of such data. It is important that we maintain this quality, and actively use the data to inform research, policy and clinical practice.

NEWS

2008 Federal Budget outcomes

Highlights from the May Federal Budget include:

National Binge Drinking Strategy

\$53.5 million over 4 years to reduce binge drinking and its associated harms around the nation – from existing funding.

'Alcopops' legislative change

An increase in the excise and excise equivalent customs duty rate applying to 'other excisable beverages not exceeding 10 per cent by volume of alcohol' from \$39.36 per litre of alcohol content to the full strength spirits rate of \$66.67 per litre of alcohol content, on and from 27 April 2008.

Closing the gap in Indigenous health

\$49.3 million over 4 years through the Coalition of Australian Governments (COAG) to improve access to drug and alcohol services. This doubles the previous 2006 COAG commitment – new funding.

\$14.5 million over 4 years in the Indigenous Tobacco Control Initiative to help tackle high rates of smoking in Indigenous communities – from existing funding. \$9.8 million for 22 remote communities to receive support and assistance from a local Aboriginal family and community worker and/or a safe house and a mobile child-protection team based in Darwin will continue to support families in remote communities. \$9.5 million for alcohol diversionary activities for young people between 12 and 18 years of age offering a range of safe and healthy alternatives to drinking and other substance abuse.

Additional funding for the National Tobacco Strategy

\$15 million over 4 years to help reduce the health problems caused by smoking and to reduce smoking rates among young people – new funding.

Illicit Drug Use National Education Strategy – targeting people using methamphetamines

A national education and marketing strategy to encourage 'ice' users to quit – from existing funding.

Links Between Drug Use & Mental Illness Community Campaign

\$9.7 million in savings expected.

National Psychostimulants Initiative

\$4 million in savings expected.

RecLink Program

\$2.3 million over 4 years to improve the lives and opportunities for Australians suffering from drug and alcohol abuse, mental illness, social discrimination and homelessness – new funding.



Model code of conduct for national sporting organisations
\$20.1 million over 4 years to implement a model framework and code of conduct for national sporting organisations to address the issue of illicit drug use by athletes – from existing funding.

National Advisory Council on Mental Health

To be established from existing funding.

Mental health nurses training subsidy

\$35 million over 4 years to increase the number and value of postgraduate mental health nurse and psychology scholarships – new funding.

Night patrols

A total of \$17.7 million has been allocated for community night patrols over the 2008-2009 financial year. Night patrols to make remote Indigenous communities safer and more secure for families and children will continue as part of the Australian Government's commitment to implementing the Northern Territory Emergency Response. The additional funding will enable the continued operation of night patrol services in the 73 communities covered by the response.

Australian Federal Police

The AFP will receive funding of \$47 million to deploy additional sworn members to assist in capacity building and narcotic roles in Afghanistan; and the deployment of 66 additional officers as part of the Northern Territory Emergency Response.

Australian Crime Commission

The Australian Crime Commission will receive a further \$4.2 million to continue the work of the National Indigenous Violence and Child Abuse Intelligence Task Force.

Australian Customs Service

Australia's port security and border protection capabilities will be strengthened by \$16 million over the next 4 years to increase its container examination capacity at four key regional seaports.

Ten-point NT plan

Modifying Northern Territory Intervention legislation to maximise protection of children from abuse, without racially discriminating against Indigenous people, is one of the major elements of a ten-point plan outlined in the *Social Justice Report 2007*.

The report, produced annually by the Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner, considers the impact of government activity on Indigenous people's human rights. Commissioner Tom Calma said the new Australian Government had emphasised the importance of ensuring the NT Intervention was consistent with Australia's human rights obligations. However, as long as the NT Intervention allowed racially discriminatory actions it would lack legitimacy among Aboriginal people and communities, as well as in broader Australian society. For full details visit www.humanrights.gov.au/social_justice/sj_report/sjreport07/.

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NEWS AND RESOURCES

National Preventative Health Taskforce

The Australian Government's new National Preventative Health Taskforce, announced in April, will tackle the major health challenges caused by tobacco, alcohol and obesity and will deliver a National Preventative Health Strategy by June next year.

The announcement followed a report released by Health Minister Nicola Roxon showing the annual social costs of tobacco, alcohol and illicit drugs have reached \$56.1 billion per annum (2004-05 figures) – a dramatic rise from \$34 billion in the 1990s.

According to *The costs of tobacco, alcohol and illicit drugs to Australian Society in 2004/05*, tobacco accounts for the lion's share at \$31.5 billion, alcohol for \$15.3 billion and illicit drugs for \$8.2 billion. Alcohol and illicit drugs acting together cost another \$1.1 billion. The figures include flow-on costs such as crime and lost productivity at work.

Chaired by preventative health expert Dr Rob Moodie, Professor of Global Health at the Nossal Institute for Global Health, University of Melbourne, the taskforce will advise governments and health providers on preventative health programs and strategies, focusing on the chronic diseases currently caused by obesity, tobacco and alcohol.

It will also advise the Commonwealth on the framework for Preventative Health Partnerships, which will form part of the Australian Health Care Agreements being concluded this July between the Commonwealth and states and territories.

To see the full drug costs report, visit www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/home.

Harm reduction vital to combat HIV in Asia

A new report from the Independent Commission on AIDS in Asia has found that, even after two decades, HIV/AIDS remains the most likely cause of death and work days lost in the 15-44 age group in Asian nations.

Redefining AIDS in Asia – crafting an effective response, states that nearly five million people are living with HIV in Asia, with 440 000 people acquiring the infection in 2007 and 300 000 dying from AIDS-related illness in the same year.

The report predicts that, without urgent action, by 2020 there will be almost eight million new infections in adults and children in the Asia-Pacific, and a 500 000 increase in the annual death toll. It urges governments to provide a comprehensive package of harm reduction, including needle exchange programs and opiate substitution treatment, and says counterproductive 'war on drugs' programs should be abandoned.

DVD for young men

Six Mates. Six Stories is a new DVD for young men and their teachers and carers. Produced by Western Australia's City of Melville, the DVD features six short films centred around a group of 17-year-old males each facing issues such as self-esteem, sexuality, suicide, relationships, crime and drink-driving.

To order contact Janet Armarego on (08) 9364 0280 or email jarmarego@melville.wa.gov.au.

Youth homelessness doubles over 20 years

Australia is experiencing its highest level of economic prosperity since the 1970s and the lowest unemployment for several decades, yet in the last 20 years the number of young homeless people has doubled.

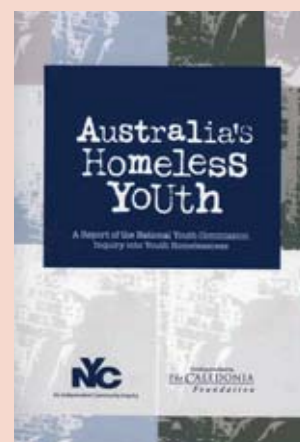
Australia's homeless youth, the report of the inquiry by the National Youth Commission into Youth Homelessness, published in April, has found that about 36 000 Australians under the age of 25 do not have stable accommodation. They live on the streets, in supported accommodation, or 'couch-surf', staying wherever they can for the night.

The report calls for a \$1 billion funding increase over the next decade to provide more accommodation and early intervention programs to tackle the complex causes of youth homelessness, which include mental health and substance abuse issues and family breakdown.

The findings showed that Indigenous young people are more likely than non-Indigenous to be homeless. Mental health

issues and drug and alcohol use are more prevalent among homeless youth than among young people as a whole. The serious consequences for homeless youth with drug and alcohol problems include access to supported accommodation, damage to already fragile relationships and encounters with the criminal justice system.

The Australian Government prepared a Green Paper on homelessness for comment by the end of May, with a long-term national response scheduled for September. It has meanwhile allocated an extra \$150 million for new homes for homeless families and individuals. Full report: www.nyc.net.au.



Mind your head

Mind your head – some things you might want to know about drugs and mental health is a new resource for young people struggling with alcohol and drug issues and mental health problems.

The 56-page book addresses the effects of different drugs on mental health, health concerns such as anxiety, depression, psychotic episodes and suicide, strategies for looking after mental health, and getting help. It is aimed at the 15-25 years age range and others (including teachers, parents and allied health workers) wanting to know more about the relationship between mental health and substance use. *Mind your head* was developed by Moreland Hall, the Nexus Dual Diagnosis Service, and the Substance Use and Mental Illness Treatment Team. For further information contact Laurence Alvis or Andrew Milnes on (03) 9386 2876.

Online GP education on alcohol consumption

Helping patients reduce their alcohol intake is the focus of a new online education series for general practitioners. Sponsored by the Heart Foundation, the learning modules are offered on the Royal Australian College of General Practitioners (RACGP) web-based learning platform – www.gplearning.com.au.

The learning activities aim to boost GPs' skills in tackling the growing social and health problems associated with alcohol abuse, according to RACGP President Dr Vasantha Preetham. Alcohol-related issues in patients can include binge drinking among young people, alcohol consumption during pregnancy, and confusion over what constitutes a 'standard drink'.

New ADF drugs and driving website

Our community is poorly informed about the impact of illicit drugs on driving ability, according to a report compiled last year by the Australian Drug Foundation and insurer AAMI into attitudes towards drug driving. More than 50 per cent of survey respondents in the *Drugs and driving in Australia* report who used cannabis, and almost 53 per cent of methamphetamine users, reported driving within three hours of drug use.

To help people understand the risks of getting behind the wheel while drug-affected (including alcohol-affected), the Australian Drug Foundation's DrugInfo Clearinghouse has redeveloped its Drugs and Driving website, with support from the Transport Accident Commission. The revamped website offers guidance on safer driving, the effects of different drugs on driving ability, the relevant legislation, and where to find more information. Visit: www.drugsdriving.adf.org.au.

IN BRIEF ...

New Chief Executive for Australian Drug Foundation

The Australian Drug Foundation's new Chief Executive Officer is John Rogerson, succeeding Bill Stronach who has retired after 18 years in the post. Mr Rogerson has been Deputy CEO since 1998 and is behind the Foundation's Good Sports alcohol accreditation program, which involves over 2200 sporting clubs nationwide and has proven a highly effective strategy for changing drinking behaviour in Australian society.

Greenough Prison anti-smoking trial

Greenough Regional Prison in Western Australia is to be the first prison in the state to operate a 12-month trial ban on indoor smoking. With around 80 per cent of prisoners addicted to nicotine, the trial is being implemented in stages to minimise negative impacts on both prisoner health and staff safety. Sudden nicotine withdrawal can have serious adverse effects, particularly on those taking medications for certain mental health conditions.

Boost for mental health respite care in WA

Respite services for carers of people with severe mental illness, psychiatric disability or intellectual disability in Western Australia will get \$5.3 million from the National Respite Development Fund established by the Australian Government. Over \$2 million is to go to the Pilbara and Kimberley regions, where centre-based respite and a mobile service will be offered to carers of people with mental illness and intellectual disability.

Review of Victoria's Turning Point Centre

The recommendations of an independent review of the Turning Point Alcohol and Drug Centre, Victoria's respected centre for alcohol and drug research and treatment, are being considered by the Brumby Government. The centre's charter and mandate have been assessed in the light of changing alcohol and other drug use trends and possible changes to the centre's strategic direction and priorities.

Misuse/abuse of benzodiazepines and other pharmaceutical drugs

A Victorian parliamentary inquiry last year into the misuse/abuse of benzodiazepines and other pharmaceutical drugs examined the nature, extent and culture of misuse/abuse; the short- and long-term consequences/harms; the relationship between these drugs and other forms of licit and illicit substance use; and the adequacy of existing strategies. The final report is available at www.parliament.vic.gov.au/dpcp/default.htm.

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.

RESEARCH DIGEST

LIBBY TOPP

Cannabis is the most commonly used illicit drug in Australia. In this issue, we look at its links with Indigenous communities, adolescents and school students, as well as examining withdrawal syndromes.

INDIGENOUS USE

Clough, AR, Lee, KSK, Cairney, S, Maruff, P, O'Reilly, B, d'Abbs, P & Conigrave, KM 2006. Changes in cannabis use and its consequences over three years in a remote indigenous population in northern Australia, *Addiction*, vol. 101, no. 5, pp. 696-705.

In the first longitudinal study of cannabis use in any Indigenous population, three-year follow-up interviews and assessments were conducted among 13-36 year old Aboriginal people in remote Arnhem Land communities, 550 kilometres east of Darwin. The study aimed to describe cannabis use since its rapid uptake among these populations during the late 1990s; and to examine changes in use over time.

Participants selected both randomly (N=161; 80 males and 81 females) and opportunistically (N=104; 53 males and 51 females) were recruited for the study. Cannabis and other drug use was determined by triangulating proxy assessments (conducted by up to five local Aboriginal health workers, interviewed separately), medical records, and self-report interview data. Proxy assessments, which draw on health workers' intimate knowledge of their communities, have been validated against self-reports in the same population.

Among the random sample, there were fewer cannabis users at follow-up than at baseline, with the reduction more pronounced among females and among males aged 16 or older at baseline. Although there was no direct evidence for a reduction in use among the opportunistic sample, these participants reported a decrease in the adverse psychological effects of cannabis use, including fragmented thought processes, memory disruption, difficulties controlling use and auditory and visual hallucinations. This pattern of results is consistent with a decline in use. Notably, those who used cannabis at both baseline and follow-up were at greater risk than those who had never used it to have suffered auditory hallucinations, suicidal ideation and imprisonment.

More than half of those interviewed at follow-up attributed their decreased use to a reduction in cannabis availability. The authors speculate that the apparent decrease in availability and use may be, in part, a manifestation of strategic policing efforts in response to public attention drawn to the surge in cannabis use in remote communities. Regional structural changes may also have impacted, including efforts by the local mining company to create and support local Aboriginal employment and training, along with initiatives to provide opportunities for youth, reduce petrol sniffing, and divert offenders away from the criminal justice system. Community criticism of local residents who have accrued wealth and influence by selling drugs to their impoverished neighbours

may also help account for the decline. Notwithstanding the reduction, however, the authors caution that the continued high prevalence of cannabis use warrants continued emphasis on supply reduction.

LEAVING SCHOOL EARLY

Lynskey, MT, Coffey, C, Degenhardt, L, Carlin, JB & Patton, G 2003. A longitudinal study of the effects of adolescent cannabis use on high school completion, *Addiction*, vol. 98, no. 5, pp. 685-92.

The question of whether adolescent cannabis use may impair educational attainment is of both community and public health concern. This longitudinal study examined the extent to which weekly cannabis use during mid-adolescence (Years 9 and 10) may increase the risk of failing to complete high school. The study used prospective data collected from students of 44 Victorian high schools who completed computer-based, self-administered questionnaires at six-monthly intervals beginning in Years 9 or 10, and continuing until they were aged, on average, 20.7 years. The longitudinal research design allowed the researchers to statistically control for the effects of a range of other variables potentially associated with early school-leaving. This study examines the 1601 participants who completed the final wave of data collection.

Results showed that compared to other students, those who smoked cannabis weekly or more often in Years 10 and 11 were significantly less likely to complete high school. The association was strongest among younger students and progressively diminished as age increased: in Year 10, weekly cannabis users were 5.8 times more likely to leave school; in Year 11 they were 3.2 times more likely; and by Year 12 they were 2.0 times more likely to leave school.

Among those who initiated weekly cannabis smoking at younger ages (Years 10 and 11), the relationship between regular cannabis use and early school-leaving persisted even after controlling for a range of potential confounders, including other drug use, psychiatric morbidity, parental education and antisocial behaviour.

By the time students were in Year 12, when other variables were taken into account, there was no evidence of an effect of weekly cannabis use on educational attainment. The authors speculate that the mechanism underlying the relationship at younger ages may be an association between early cannabis use and precocious transition into adult roles, including early school-leaving. Much of the influence of early cannabis use on a range of outcomes may be attributed to the social context in which adolescent cannabis use typically occurs, namely, among delinquent and drug-using peers. Results are consistent

with the proposition that as cannabis use becomes more prevalent with increasing age, it is no longer associated with outcomes indicative of anti-conventional lifestyles, including early school-leaving. Consistent with previous research, it is specifically early onset drug use that is associated with adverse outcomes.

BRIEF INTERVENTION WITH ADOLESCENTS

Martin, G & Copeland, J 2008. The Adolescent Cannabis Check-up: Randomized trial of a brief intervention for young cannabis users. *Journal of Substance Abuse Treatment*, vol. 34, no. 4, pp. 407-14.

The clinical symptoms of cannabis dependence are reported twice as frequently by adolescents as by adults. Young people (14-15 years) appear more likely to suffer adverse psychological consequences of regular cannabis use than their 20-21 year old counterparts. Substantial numbers of young people are at risk of developing cannabis dependence, and increasing numbers are presenting for treatment in Australia and internationally. Nonetheless, 'treatment-seeking' young people are generally referred or coerced into treatment by their parents or the juvenile justice system; few actively seek treatment for themselves. Building on promising feasibility studies, this randomised controlled trial examined the efficacy of a motivational enhancement brief intervention for reducing cannabis use and related problems among young people who were not necessarily seeking treatment or attempting to change their use.



Forty adolescents aged 14-19 years, recruited via media advertising and through referrals from youth services and the juvenile justice system, were randomly assigned to either the two-session brief intervention or a delayed treatment control. The intervention consisted of a detailed assessment interview, followed a week later by a feedback and skills session delivered in a motivational interviewing style. Although limited by small sample sizes, the follow-up rate three months later was 80 per cent for both conditions.

Compared to young people in the control condition, participants who received the brief intervention reported greater reductions in frequency and quantity of cannabis use, along with greater decreases in the number of dependence

symptoms reported. The proportion of the intervention group meeting diagnostic criteria for cannabis dependence fell from 100% at baseline to 65% at follow-up. Although the effects were relatively modest, this study recruited and retained a sample of regular, non-treatment-seeking cannabis users, the majority of whom were dependent. Importantly, a group of young people who otherwise may not have come into contact with treatment services was engaged. Results indicate that a brief motivational intervention with non-treatment-seeking adolescent cannabis users may be effective in reducing cannabis use and dependence, even among young people who are not currently seeking treatment.

WITHDRAWAL SYNDROMES

Vandrey, RG, Budney, AJ, Hughes, JR & Liguori, A 2008. A within-subject comparison of withdrawal symptoms during abstinence from cannabis, tobacco and both substances. *Drug and Alcohol Dependence*, vol. 92, no. 1-3, pp. 48-54.

A reliable cannabis withdrawal syndrome has been documented, characterised by increased irritability, anxiety, depressed mood, restlessness, anger and aggression, sleep disturbance and strange dreams, appetite disturbance and weight loss. Less common symptoms include headaches, physical tension, sweating, stomach pains and general physical discomfort. Although their relationship with cannabis use makes it likely these symptoms represent a 'true' withdrawal syndrome, the clinical significance of cannabis withdrawal – in essence, whether withdrawal motivates relapse to cannabis use during quit attempts – is yet to be established. Accordingly, and unlike tobacco withdrawal, cannabis withdrawal is not included in current international psychiatric classification systems. This study estimated the clinical significance of cannabis withdrawal by comparing it with nicotine withdrawal, a syndrome of known clinical importance.

Forty-two heavy users of both cannabis and nicotine were recruited through media advertising into the study, although only 12 completed the entire protocol; most of those who did not complete failed to achieve the required periods of abstinence or discontinued voluntarily. All participants underwent three conditions: five-day periods of cessation from cannabis only, tobacco only, and cannabis and tobacco together. These conditions were interspersed with nine-day periods of 'smoking as usual'. Participants attended 30-minute laboratory sessions every weekday for a range of self-report, physiological and behavioural measures, along with urine and breath tests.

Overall withdrawal discomfort and symptom severity experienced by participants during cannabis abstinence was similar to that during tobacco abstinence, leading the authors to propose that the two syndromes are of comparable severity. There were substantial differences between participants in ratings of general discomfort across the three abstinence syndromes. Nonetheless, discomfort and individual symptoms including aggression, anger and irritability appeared to be more severe during simultaneous abstinence compared with abstinence from either drug alone, although this effect was relatively short-lived (two days). The authors argue that cannabis withdrawal is a clinically significant syndrome, comparable in magnitude to tobacco withdrawal, and should be included in future revisions of international psychiatric classification systems.

SMOKING

A CASE FOR HARM REDUCTION?

LIBBY TOPP

Despite the decreasing prevalence of tobacco use, smoking remains the single greatest preventable cause of death and disease in Australia, and its associated social and public health costs continue to rise. Harm reduction, as one strategy for tackling this issue, is enshrined as a key plank of the National Tobacco Strategy 2004-09, but opinion is divided about its success to date and its role in the future.

Few *Of Substance* readers would be unfamiliar with the harm reduction philosophy which acknowledges that despite legal, social or moral sanctions, some illicit drug use is inevitable. This pragmatic public health approach encompasses attempts to reduce the risks of those who use illicit drugs, rather than seeking to eliminate use altogether. Together with demand reduction and supply reduction, harm reduction is a key tenet of Australia's illicit drug policy and enjoys broad support from a range of stakeholders.

It is perhaps curious, then, that public health advocates for a harm reduction approach to tobacco find themselves in a similar situation to the needle and syringe program advocates of two decades past, facing passionate opposition from those with an abstinence-only orientation to tobacco control. Despite recent statements supporting tobacco harm reduction from influential public health bodies – including the British Royal College of Physicians, the Royal Australasian College of Physicians, the Royal Australian and New Zealand College of Psychiatrists, and even qualified support from America's conservative Institute of Medicine – those whose philosophy starts from 'every cigarette is doing you damage' and 'there is no safe level of smoking' struggle to believe that supporting any form of tobacco and/or nicotine intake might serve public health interests.

As Simon Chapman, Professor of Public Health at the University of Sydney and a long-time advocate of condoms and clean needles, cautions, 'there is an overly seductive simplicity in drawing neat analogies with other areas of harm reduction when it comes to tobacco'.

'Many contend that at the dosage levels smokers seek, nicotine is a relatively innocuous drug, commonly delivered by a uniquely hazardous device, cigarette smoke.'

The term 'tobacco harm reduction' is used in a variety of contexts, with little agreement on the range of strategies it may encompass – a lack of clarity that may contribute to a polarisation of views. Terminology may be lamentably inconsistent, says David McDonald, Director of the Canberra-based consultancy Social Research and Evaluation Pty Ltd and Fellow of the National

Centre for Epidemiology and Population Health, but the logic underlying the approach is nonetheless clear.

Tobacco smoking is sustained by nicotine addiction. Although debate around nicotine toxicity continues, many contend that at the dosage levels smokers seek, nicotine is a relatively innocuous drug, commonly delivered by a uniquely hazardous device, cigarette smoke. Modern cigarettes use sophisticated technology to provide rapid absorption and a fast nicotine 'fix' while using less tobacco, and many more additives, than their predecessors. Alternative nicotine delivery systems to cigarettes exist, some of them significantly less harmful than smoking. Accordingly, a pragmatic public health approach to tobacco control would encourage nicotine users to move down the risk continuum by choosing safer alternatives to smoking, without demanding abstinence (Sweanor et al. 2007).

A RANGE OF STRATEGIES

Reducing the toxicity of tobacco smoke

A range of strategies are discussed under the umbrella of 'tobacco harm reduction', some attracting more debate than others. Few consider that mandating reductions in tobacco smoke toxicants, substantial proportions of which arise from modifiable industry curing and processing techniques, should not be pursued: indeed, some deem it 'negligence' not to act. Closely related discussions concern the prohibition of design features related to marketability such as additives to make cigarettes more flavoursome or less harsh. Achieving these seemingly straightforward goals is enormously complex, however, due to the regulatory frameworks governing tobacco worldwide. Although debate has long raged over whether tobacco should be regulated in the same way as pharmaceutical delivery devices, no regulations are applied to tobacco smoke emissions.

Until recently, the limitations of machines traditionally used to measure cigarette smoke toxicants, which do not provide valid estimates of human exposure due to the variability in smoking behaviours (e.g. intensity of the 'drawback'), impeded progression towards effective tobacco product regulation. In 2007, however, the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) presented performance standards for cigarettes, and a strategy to use them to mandate a reduction

in the toxicant yields for cigarette smoke. Many consider that governments have few reasons to delay recognition of the WHO recommendations and the development of long-overdue systems of tobacco regulation.

Medicinal nicotine products

A second class of tobacco harm reduction strategy is the use of nicotine replacement therapy (NRT). The broad range of NRT products (including transdermal patch, gum, lozenge, inhaler) are subject to stringent legislative regulations, a situation many find astonishing given the lack of tobacco regulation. Rigorously evaluated over some decades by regulatory authorities in many countries, most agree that, although the use of NRT may entail some risk, it remains significantly less hazardous than cigarette smoking. Central to the continuing debate around NRT products is their use in withdrawal versus long-term maintenance. Despite their indication for short-term withdrawal management to promote smoking cessation, there is significant evidence that some former smokers successfully maintain abstinence from cigarettes through long-term NRT use. Some argue that the risk is not dangers inherent to NRT products, but that they are not used at a sufficient dosage for sufficient time and so result in users reverting to cigarette smoking.

Others point out that although the range of nicotine replacement products differs widely with respect to dosing characteristics and form, a broader spectrum of products is both possible and warranted to accommodate tobacco users' diversity of needs and preferences. For example, there is no true inhaler which delivers nicotine to the lung with the same efficiency as the cigarette. The lack of attraction of many smokers to current NRT products necessarily limits the effectiveness of this approach. An additional angle to the replacement debate focuses on whether nicotine should be deregulated so that the tobacco industry competes with 'clean' nicotine used not just therapeutically but also recreationally, to prevent people from ever initiating smoking.

Smokeless tobacco products

The use of smokeless tobacco products attracts significant controversy in the tobacco harm reduction arena, and most types of smokeless products cannot be sold in Australia. Smokeless products fall into two main categories: oral chewing tobacco and snuff. Snuff may be moist and taken orally, or dry and inhaled nasally.

While some products used in parts of the developing world appear particularly harmful, evidence suggests that use of the Swedish moist snuff known as snus ('snoose') is significantly less harmful than cigarette smoking. Snus, which does not promote excessive spitting, has been widely used in Sweden as an alternative to cigarettes for two decades, and has undoubtedly contributed to that country's low prevalence of smoking and smoking-related disease. The Swedish experience inspires optimism in some that promotion of snus may reduce overall tobacco-related disease should enough long-term smokers be persuaded to switch to snus from cigarettes.

Whether snus produces more benefit than harm will depend on who in the population uses it. If snus were to be used primarily by people who would otherwise not have initiated smoking, or

by ex-smokers who would otherwise have quit smoking, total net harm might be increased. If its use was confined to current smokers who would not otherwise have quit tobacco, the effect would clearly be a net benefit. Proponents argue that the latter pattern of use has been observed in Sweden, and might be replicated in other countries.

Simon Chapman contends that Sweden's snus experience is shaped by culture-specific factors that may not transfer to other nations, and is particularly concerned that the tobacco industry would use snus advertising as a means of subverting global advertising bans, and to promote dual use (smoking and snus) through slogans such as 'When you can't smoke, snus'.



A HUMAN RIGHTS ISSUE

Such motivations to withhold the use of potentially life-saving harm reduction strategies are inexcusable to some. Drawing on principles of the Universal Declaration of Human Rights, the doctrine of informed consent, and the moral obligation of companies to fully inform customers about their products, Kozłowski et al (2003) argued that it is paternalistic to deny smokers their fundamental right to accurate information about safer forms of tobacco use for fear that population nicotine use may increase.

They suggest that the potential for net harm of NRT and smokeless tobacco products is not convincing enough to justify suspension of advice about reduced risks to individuals from these products. A recent panel of experts used sophisticated statistical modelling to estimate a 90 per cent risk reduction in the relative risk of certain smokeless tobacco products including snus compared to cigarette smoking (Levy et al. 2004). The essence of the human rights perspective is that the consumer who rejects (or cannot achieve) abstinence, but will use a product that reduces risk by 90 per cent, should not be prevented from making that choice.

LACK OF EVIDENCE

Although debate on policy and legislative reform will continue indefinitely, clinicians may perceive an immediate parallel in the harm reduction strategies that might be provided to a dependent

HOW MIGHT A HARM REDUCTION APPROACH TO TOBACCO TRANSLATE TO ADVICE FOR CLIENTS?

In a recent issue of *Of Substance*, Renee Bittoun, of the Nicotine Addiction Unit at the University of Sydney, advocated a harm reduction approach to treating ‘treatment-resistant’ smokers. She suggests that clinicians maintain a hierarchy of strategies for dealing with this ‘difficult group’ of clients, beginning with a goal of permanent cessation and then progressing through a range of harm reduction alternatives, including nicotine replacement therapy.

According to Bittoun, other harm reduction strategies might encompass:

1. Temporary abstinence, where smokers use NRT in situations that are smoke free, such as nicotine patches during a long flight. Cravings and other withdrawal symptoms are relieved, cigarette consumption is reduced,

and compensatory smoking prevented. Smokers learn they can manage without tobacco for several hours and this may increase motivation to quit altogether. Aim to lengthen periods of abstinence.

2. Nicotine-assisted reduction to stop, a strategy for easing into quitting. Set a target of 50 per cent reduction, advise clients to replace every second cigarette and use NRT to manage cravings. This might involve, for example, alternating smoking a cigarette with any form of NRT such as gum, lozenge, sublingual tablet or inhaler.

3. Exercise, a harm reduction strategy that improves a smoker’s life expectancy by lowering the risk of heart disease and lung cancer. Brisk walking can reduce the urge to smoke.

smoker, with those that we provide to compulsive drug injectors. Few clinicians would argue that a 50 per cent decrease in the frequency and/or quantity of heroin injected would not be of benefit. A similar tenet underpins the clinical strategies advocated by some for ‘treatment-resistant’ smokers that many readers will find intuitively appealing (see panel).

Nonetheless, little systematic evidence suggests that reducing cigarette intake leads to improved health outcomes. A 21-year prospective study of nearly 20 000 people in Copenhagen demonstrated no decrease in mortality among smokers who reduced their daily cigarette intake by 50 per cent compared to continuing heavy smokers. A recent Cochrane review failed to identify any randomised controlled trials (RCTs) which demonstrated benefits of reducing daily cigarette intake 50 per cent or more, perhaps because exposure to smoke does not decrease proportionally to the number of cigarettes smoked.

For David McDonald, however, the absence of evidence from RCTs does not constitute evidence of an absence of effect. (Indeed, RCTs were not required to prove the lethality of cigarettes). ‘It is a key public health tenet that if there is a dose-response relationship between a substance and its harms, as there appears to be for tobacco, then there is a *prima facie* case for attempting to reduce the dose,’ he points out. ‘Yet when it comes to tobacco, the validity of this fundamental public health truism is questioned.’

‘The Swedish experience inspires optimism in some that promotion of snus may reduce overall tobacco-related disease should enough long-term smokers be persuaded to switch to snus from cigarettes.’

Although the historical reasons for the strident zero tolerance approach to tobacco are complex, he suggests that contrary to public health’s professed evidence-based philosophy, ‘some individuals prominent in the tobacco control lobby have adopted advocacy roles that reflect their own personal morals and values rather than the evidence. For some, the central public health philosophy can be rejected in this area because the opposition (i.e. the tobacco industry) is perceived as so powerful that any means justify the anti-smoking ends.’

MORE OF THE SAME?

For proponents of the current approach to tobacco control, the risks of implementing harm reduction strategies with unknown consequences are simply too great. The earliest attempt to reduce harm by reducing tar yields in ‘low-tar’ and ‘light’ cigarettes did not produce the expected mortality decrease due to smokers’ compensatory smoking behaviour, and probably led to reduced quitting and undermined prevention efforts in young people due to the false perception that low-tar cigarettes were safer.

The debacle contributed significantly to the highly adversarial relationship between public health and the tobacco industry, with industry’s lack of transparency and openness in this harm reduction venture engendering high levels of mistrust and ambivalence in the health community. Contemporary stakeholders are understandably reluctant to repeat the low-tar fiasco.

Some point to the substantial achievements of Australia’s tobacco control efforts as evidence that with sustained and increasing investment in the existing prevention and abstinence-oriented cessation strategies, smoking prevalence will continue to fall in the absence of expanded harm reduction policies and programs. Others predict an alternate scenario, in which smoking prevalence will inevitably reach a lower limit due to the existence of a significant group of treatment-resistant, intractable (‘hard core’) tobacco dependents who cannot, or will not, achieve abstinence. Analogous to the chronically relapsing heroin user, among these smokers, ‘more of the same’ policy responses would be unable to further impact on smoking rates; only a change in approach would continue to drive prevalence down.

Simon Chapman rejects the idea that cessation is an impossible goal for some, citing research which demonstrates that almost one-third of smokers describe themselves as ‘occasional’ or ‘social’ smokers, and that prevalence of daily consumption continues to fall, facts he describes as ‘incompatible with the “hardening” hypothesis’.

In contrast, some suggest that we may already be approaching the limits of effectiveness of current tobacco control efforts. These arguments are lent weight by economic analyses demonstrating that although tax increases and higher prices decrease the

number of cigarettes smoked, they have no effect on nicotine consumption, as smokers compensate by extracting more nicotine per cigarette (i.e. by drawing more deeply). Given that smoking a cigarette more intensely is detrimental for health, potentially limited marginal returns on this policy question the utility of further tax increases, the cornerstone of current tobacco control activities.

‘There is significant evidence that some former smokers successfully maintain abstinence from cigarettes through long-term NRT use.’

A different legislative focus has been implemented in California, where tobacco consumption was rapidly reduced with an aggressive campaign that ‘denormalises’ the tobacco industry and promotes the dangers of passive smoking so as to undercut the acceptability of smoking. The stated approach was to ‘speak to’ the non-smokers as much as the smokers.

But is increasing marginalisation and stigmatisation of smokers a desirable health outcome? David McDonald argues that because some tobacco control advocates allow their stance on this health issue to be dictated by their values and morals, it follows that a smoker becomes a ‘bad’, morally weak person, and it is imperative that we remember, and communicate that intractable smokers are valued members of society. The increasing stigmatisation of smoking contrasts with illicit drugs, where the AOD field works hard to reduce stigma, and accepts that increasing marginalisation leads to decreased health outcomes.

A FUTURE FOR HARM REDUCTION?

Gray et al (2005) argue that our understanding of nicotine’s role in tobacco use and disease indicates a need for long-range policy that is based on nicotine. With the underlying premise that a ‘realistic and long-term approach ... must include major elements of harm reduction’ (p. 161), their ultimate goal is for ‘clean’ nicotine – that is, nicotine free enough of tobacco toxicants to pass regulatory approval – to overtake tobacco as society’s primary source of the drug. They propose a comprehensive, nicotine policy which envisages, over the course of 30-45 years, (i) reducing the attractiveness and addictiveness of existing tobacco-based nicotine delivery systems and (ii) providing alternative sources of clean nicotine as competition for tobacco. Implementing such an ambitious policy would clearly require significant political will, believed by some to have been sorely lacking.

Drawing attention to the huge economic significance of tobacco to national governments, Kozlowski et al (2003) paint the pessimistic but perhaps realistic portrait of tobacco control policy being driven by ‘compromises among various powerful factions, only a few of which care a whit about science ... (no new law will) risk too much change in the status quo ... at best, science is a gadfly in this process’.

David McDonald, however, favours a more optimistic perspective. Australia’s acceptance of a balanced approach between harm reduction, supply reduction and demand reduction in illicit drug policy gives him faith that pragmatism will inevitably triumph in efforts to attain the greatest possible reductions in tobacco-related death and disease.

Seeing himself as an advocate not for tobacco harm reduction per se, but instead for evidence-based policy, he says: ‘We will reach a point, when smoking prevalence is perhaps around eight per cent or ten per cent, where our approach will not reduce prevalence any further. When that time comes, will we stop caring about the health of individuals? Of course not! We will implement the policy changes required to keep prevalence falling, and the evidence will force us to clearly appreciate the separation between the drug of dependence (nicotine) and harmful tobacco-based delivery devices. The focus will at last truly become the elimination of tobacco-related death and disease, rather than the elimination of nicotine dependence.’

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For a full list of the references used in this article, email editor@ancd.org.au.

DRUG USE IN AUSTRALIA

BRONWYN DUNCAN

The drugs most accepted by, available to and used by Australians in 2007 were the licit drugs: tobacco and alcohol. Overwhelmingly, the use of illicit drugs was not accepted and increased penalties for their sale and supply were supported. Most people did not want illicit drugs legalised, and they were more likely to associate these, rather than licit drugs, with a 'drug problem'.

These are some of the conclusions of the *2007 National Drug Strategy Household Survey - First Results*, released in April by the Australian Institute of Health and Welfare. A more detailed analysis will be published later this year.

Conducted between July and November 2007, the survey included over 23,000 Australians aged 12 or older. These represented 49.3% of the eligible survey sample of 47,421 people – a slightly higher response rate than for the 2004 survey.

Interpreting the data

Most of the survey analysis refers to people aged 14 years or older, to allow consistent comparison with earlier results. A limitation of the data is that the sample was based on households; homeless and institutionalised persons and those living in non-private accommodation were excluded.

The *First Results* report makes comparisons with 2004 data and indicates major trends since the early 1990s. It provides prevalence and population estimates, but cautions about the statistical reliability of some data. It warns that data is based on respondents' self-reporting rather than empirical testing and that illicit drug use may be underestimated because 'illicit drug users ... are, in part, marginalised and difficult to reach. Accordingly, estimates of illicit drug use and related behaviours are likely to be underestimates of actual practice'.

Drug use patterns and trends 2004-07

Between 2004-07, daily smoking rates fell from 17.4% to 16.6% (an estimated 2.9 million current daily smokers). The proportion never smoking increased substantially (total 55.4%, males 50.9%, females 59.8%). Although 44.6% had smoked 100 or more cigarettes or equivalent at some time, only 19.4% were recent smokers.

The mean number of cigarettes smoked per week was highest in the 50-59 age group (125). The average age at which smokers

DEFINITIONS

'Illicit drugs' means illegal drugs (such as cannabis), prescription or over-the-counter pharmaceuticals (such as analgesics/pain-killers or tranquillisers/sleeping pills) used for illicit purposes, and other substances used inappropriately (such as naturally occurring hallucinogens and inhalants). 'Recent use' is equivalent to 'use in the previous 12 months' and the terms are used interchangeably. Both terms refer to the 12 months preceding the survey.

KEY FINDINGS

The survey reports that, despite some fluctuations, between 1993-2007 the proportion of people recently using a drug fell for tobacco and cannabis, but rose for alcohol. The findings on illicit drugs were mixed: while there were fewer recent illicit drug users overall in 2007 compared to 2004, recent use of cocaine and ecstasy, particularly in some age groups, appeared to have increased. The report also found that the mean ages for first using most licit and illicit drugs changed very little between 1995 and 2007. Although tobacco, alcohol and illicit drug use all fell between 2004-07, the report notes that some results are still concerning, especially for teenagers and young people.

took up tobacco remained stable between 2004 and 2007 (just under 16 years).

Alcohol

Alcohol had recently been consumed by 83% of respondents. The proportions of 'abstainers' (never had a full serve of alcohol) increased from 9.3% (2004) to 10.1% (2007), with a greater change among males than females. The proportion drinking daily declined between 2004 and 2007 from 8.9% to 8.1%. Males (10.8%) were almost twice as likely as females (5.5%) to drink daily.

The proportion of daily drinkers increased with age; the peak was for those aged 60 or older. Among 12-15 year olds, 67.5% had never consumed a full serve of alcohol. However, around 22% of teenagers reported drinking at least weekly. The average age at which people had their first full serve of alcohol remained stable between 2004 and 2007 (17 years).

Illicit drugs

Illicit drugs had been used recently by 13.4% of respondents – a significant fall from 15.3% in 2004. Decreases in recent illicit drug use were even more marked for 14-30 year olds.

Cannabis: Between 2004 and 2007 the decline was significant in the proportion of those recently using cannabis – from 11.3% in 2004 to 9.1% in 2007.

Methamphetamine: Recent use declined from 3.2% in 2004 to 2.3% in 2007. For both males and females, there were significant falls between 2004 and 2007 in the 14-19 age group, and in the total figure for all users (4% to 3% for males, and 2.5% to 1.6% for females). Recent use was most likely in the 20-29 age group (7.3%, 0.2 million). The two most common forms taken were powder (51.2%) and crystal methamphetamine (ice) (26.7%).

Ecstasy: 0.6 million (3.5%) had used recently. Of 20–29-year-olds, 11.2% (0.3 million) used recently, the highest prevalence for any age group. For males in the same age group, 13.8% or 0.2 million used recently, the highest prevalence for any group. One in 20 (5%, 0.1 million) teenagers used recently.

Inhalants: 0.4% had used recently. Between 2004 and 2007, the proportion using inhalants remained (statistically) unchanged across all age groups, with males three times as likely as females to have used them.

Cocaine: 1.6% had used recently. Males were more than twice as likely to have used recently than females (2.2%, 0.2 million and 1%, 0.1 million respectively). The proportion of both males and females recently using cocaine increased. Significant increases in recent use between 2004 and 2007 were seen for all males (from 1.3% to 2.2%).

Heroin: Less than 1% of people who had ever used heroin were recent users. Although use increased among 14–15 year old males, from 0.1% in 2004 to 0.5% in 2007, the change was not found to be statistically significant. The male 20–29 age group contained the highest proportion and number of all age groups of recent heroin users (0.7%, 10 700).

Injecting drugs: Respondents who had recently injected one or more illicit drugs named methamphetamine as the most common drug injected (67.7%), followed by heroin (39.7%).

Availability

Alcohol and tobacco were the most accessible drugs: 89.3% were offered or had the opportunity recently to use alcohol, while the figure for tobacco was 49.2%. The most accessible illicit drugs were cannabis and painkillers/analgesics — 17.1% and 15.4% respectively were offered or had the opportunity to use them recently for non-medical purposes.

Attitudes and perceptions

Tobacco

Regular use of tobacco by adults was approved by 14.3% and was associated with a drug problem by 2.6%. Public support for measures to reduce tobacco-related problems increased between 2004–07. The highest support (90.1%) was for stricter enforcement of laws against supplying tobacco products to minors, while the lowest (65.7%) was for increasing tax on tobacco products.

Alcohol

Regular use of alcohol by adults was approved by 45.2% (and not opposed by a further 33.8%) and was associated with a 'drug problem' by 10.5%. There was greater support for enforcement measures than for bans and taxation increases.

Illicit drugs

The proportion approving regular use of illicit drugs was generally low. However, 23.2% either approved or 'neither approved nor disapproved' (6.6% and 16.6% respectively) the regular use of cannabis by adults. Similar proportions approved (10.4%) or 'neither approved nor disapproved' (13.3%) the illicit use of painkillers/analgesics.

Illicit drug use was primarily associated by 85.2% with a 'drug problem' (largely unchanged from 2004), but the proportion associating methamphetamine with a problem trebled from



5.5% to 16.4%. Together, the perception of cannabis and heroin as problem drugs declined by a similar amount.

Support for measures relating to cannabis use in medical settings remained relatively unchanged. Over two-thirds (68.6%) supported the use of cannabis for medical purposes and 73.6% supported a clinical trial related to treating medical conditions.

Support for measures relating to the use of heroin increased between 2004 and 2007, and in both years, support was strongest for measures relating to detoxification (73.4% and 78.8% respectively) and use of naltrexone (68.0% and 74.7%).

Risk and harm

Alcohol

Alcohol was consumed in a way considered risky or high risk to long-term health by 10.3% of respondents. Those aged 20–29 were most likely to do so.

At all ages, more people drank at risky or high-risk levels for short-term harm than for long-term harm. Males 20–29 years were the most likely group to consume alcohol at least weekly at risky or high-risk levels for short-term harm. More than a quarter of 14–19-year-olds risked short-term alcohol-related harm at least once a month. 2004 data on alcohol-related health risk was not provided.

Tobacco

While there was a significant decline from 2004 in daily smoking in the 16–17 year age group, females were almost twice as likely to be daily smokers (7.4%) than males (4.1%).

Perpetrators and victims of drug-related harm

One in eight (12.1%) admitted to driving a motor vehicle and one in 17 (5.7%) admitted to verbally abusing someone while under the influence of alcohol. Driving a motor vehicle while under the influence of drugs other than alcohol was reported by 2.9%.

People were more than twice as likely to be victims of alcohol-related incidents as of incidents related to other drugs: 25.4% had been verbally abused, and 4.5% physically abused, by someone under the influence of alcohol. For drugs other than alcohol, the figures were 11% (verbal abuse) and 2% (physical abuse) respectively.

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DUAL DIAGNOSIS DOLLARS: DELIVERING THE GOODS?

MEREDITH BUTLER

Over the last three to five years, Australian governments have sought to improve treatment responses to co-occurring mental health (MH) and substance (AOD) use problems.¹ Two Commonwealth initiatives – the National Comorbidity Initiative and the Improved Services for People with Drug and Alcohol Problems and Mental Illness initiative (Improved Services) – represent the most significant injection of new money to date.



Approximately \$3.5 million per annum is provided to 2010-11 for the National Comorbidity Initiative. Some projects are completed, while others are still being rolled out. The Improved Services initiative with its emphasis on capacity-building within the alcohol and drug non-government (NGO) sector, kicked off in January 2008 and projects are funded for three years. Key projects in these initiatives are listed in Table 1 (see page 17).

A range of comorbidity projects also operate outside these initiatives and continue to be supported by other government funding and research or educational grants. At the time of publication, any changes to key directions and priorities in national comorbidity policy awaited a decision by the new Australian Government.

A variety of contexts

State and territory responses to comorbidity are at different stages of development.

Funding models, clinical culture and service structures of the mental health and alcohol and drug treatment sectors are dramatically different (from each other and from the clinical services offered in primary care). The role of NGOs in treatment and support is also very different.

The mental health budget is eight times that of the alcohol and drug sector and mostly funds acute mental health services – less than 10 per cent goes to the community sector in most jurisdictions. By contrast, the vast majority of the (much smaller) alcohol and drug funding goes to NGOs (for example, in Victoria it's around 90 per cent). Jurisdictional differences, such as isolation in rural NT/WA or the absence of a peak body in NT/ACT, can make it difficult for services to develop statewide responses.

A challenge for project managers, service providers and workers in all sectors seems to be how to keep up with the sudden upsurge of activity around comorbidity while pursuing what may be, in many cases, quite substantial organisational and practice change.

Developing a framework for integrated care

There's nothing new about responding to co-occurring disorders. Health and community service workers have been responding (more or less effectively) to the multiple and complex needs of clients for years. These include a wide range of 'co-occurring issues' – housing, financial, legal, general health – as well as mental health and substance use problems.

The challenge now is to develop an integrated national framework across very different service system models and a range of jurisdictions – state, federal, private – all of which are currently doing their own thing. Senior Specialist with Drug and Alcohol Services South Australia, psychiatrist Michael Baigent is heartened by the Commonwealth comorbidity funding, but identifies four key requirements necessary for achieving effective integrated care:

- a uniform policy approach
- an expectation of assessment for comorbidity in all sectors as 'core business'
- adequate levels of knowledge about treatments and effects
- organisational models of care that overcome system barriers.

Building a robust evidence base to inform comorbidity practice, through increased opportunities for research and data collection/analysis is another key element in developing effective responses.

Community-based workers point to the need to value the 'bottom-up' work that's already being done and continue to support community solutions that work within a coordinated national approach. Fostering open, respectful and clear communication between all sections of the treatment service system(s), including consumers and carers, is critical.

Gary Croton is a clinical nurse consultant at Eastern Hume Dual Diagnosis Service in north-eastern Victoria and instigator of the Dual Diagnosis Australia and New Zealand website. He has worked in dual diagnosis capacity-building since 1998 and welcomes Commonwealth funding of a range of strategies to address treatment system responses for people with a range of co-occurring problems. He cautions, however, that changing complex practice behaviours is not easily achieved and requires 'the strategically planned, cross-sectoral, robust implementation of top-down and bottom-up strategies towards well-defined, locally-grounded goals'.

WA Substance Users Association Outreach Worker Paul Dessauer points to the recent introduction of treatment referral workers into a traditional acute MH service in WA as one

¹The terms 'comorbidity' and 'dual diagnosis' are used in place of 'co-occurring mental health and substance use problems' throughout this article.

positive step towards taking client-directed models of care 'into the system': addressing harm reduction for both MH and AOD issues, setting up effective referral pathways and role modelling an holistic approach to dual diagnosis.

New models of care/culture change

Separate histories of service and policy development across MH, AOD and primary care, combined with very different clinical and non-clinical language and practice approaches, make application of common priorities difficult. Practitioners are required to 'step outside their comfort zone' and challenge their own practice and assumptions to discover new ways of working.

This is particularly noticeable for dual diagnosis teams working across sectors, says Statewide Dual Diagnosis Training Coordinator for Victoria, Greg Logan. While there are many people within MH committed to integrated service delivery and partnerships, the nature of acute MH services makes effecting change difficult. The AOD sector, being smaller and less rigidly defined in terms of service provision, may be able to embrace change more easily.

Non-government MH services, while similarly community oriented, make up a very small proportion of the MH sector, are not generally involved in treatment and have received very little funding under the National Comorbidity Initiative.

David Crosbie is head of the Mental Health Council of Australia. He sees some movement towards a 'middle ground', with MH services understanding the need for more holistic responses while the AOD sector develops a more evidence-based and clinical approach to its work. However, this shift is very slow. 'Traditionally clinical MH services operate like ambulances at the bottom of a hill – picking people up as they crash. Because they don't have enough ambulances and there are bodies out there, that's where they focus most of their resources. There's much less attention paid to trying to get guard rails onto the mountain to stop people falling off.'

There is a momentum building for change, though, says Shane Sweeney. He is the Program Manager of SUMITT, one of four regional dual diagnosis teams established in 1998 under the Victorian Dual Diagnosis Initiative. 'People are starting to understand that dual diagnosis is not going away and that if we are serious about our AOD practice, we will include this.' But, he says, "comorbidity" is more often about complex responses than complex clients. At the moment, the client has to integrate their own treatment – we need to minimise the duplication of assessment and history-taking and increase the knowledge and skills of AOD staff to provide truly integrated care.'

Consumers and carers

Many in both the MH and AOD sectors believe that the involvement of carers and consumers has long been lacking in planning the delivery of services. They emphasise that this is even more critical when dealing with comorbidity.

'After 15 years of MH reform, consumer/carer participation in policy and treatment planning still generally happens as an afterthought and funding to MH NGOs remains grossly inadequate,' says Isabell Collins, the Consumer Chair of the National Mental Health Consumer and Carer Forum.

In the AOD sector, research by the Australian Injecting and Illicit Drug Users League shows consumer participation in health services improves the quality and targeting of health services, improves health outcomes for consumers of health services and increases the likelihood of consumers staying engaged with services (Madden 2006).

However, consumer advocate and carer Michael Burge (whose daughter has a dual diagnosis) believes it will take more than the current initiatives to shift the 'old school' MH system, which he says is territorial and entrenched. Meanwhile, for people with comorbidity problems, he says falling between services can increase stress leading to possible self-harm or suicide or incarceration in prison, and creates added stress on family and carers.

A range of further barriers to treatment compound the complexity of dual diagnosis for many Indigenous clients. Developing culturally appropriate, consumer-focused approaches for Indigenous and other culturally and linguistically diverse clients needs to be a core priority of any national comorbidity initiative.

Capacity-building

The important role of AOD NGO peak bodies in advocacy, workforce development and sector representation has been recognised in the Improved Services initiative. This funds NGO peaks in all states and territories (or other supporting bodies) to develop workers' skills and adapt service delivery models to the diverse needs of people in each state or territory.

Jo Khoo is the Improved Services Coordinator for the NSW Network of Alcohol and other Drug Agencies (NADA). She is excited about the opportunities the funding provides and believes capacity-building is the key to supporting comorbidity treatment. Yet many NGOs are already working to capacity and wonder how they will deal with more. This is true for GPs as well. 'We need to have a good sober look at capacity and how we build it – some capacity-building activities are more effective, sustainable and evidence-based than others,' Khoo says. Staff and management often lack the time to make linkages, develop good policy and procedures, and engage in ongoing workforce development in the use of new practice tools and approaches.

Other barriers may be as basic as finding suitable people to fill the sudden increase in dual diagnosis positions or lacking appropriate service infrastructure (e.g. safe observation rooms or single accommodation in residential services).

NADA's Executive Director Larry Pierce agrees there's only so much capacity you can build in non-government sectors without an equal injection of funding to provide ongoing service development and cross-sector partnerships. He also believes state and Commonwealth competitive tendering funding models form a critical barrier to achieving sustainable sector-wide responses (e.g. less than half of the AOD specialist services in NSW were funded under the Improved Services initiative in the first round).

Developing the workforce

Nicole Lee is Clinical Research Head at Turning Point Alcohol and Drug Centre. She led the development of the PsyCheck mental health screening tool and brief intervention and believes it's important to see capacity-building in the fullest sense. This involves a 'whole-of-workforce' development focus that includes

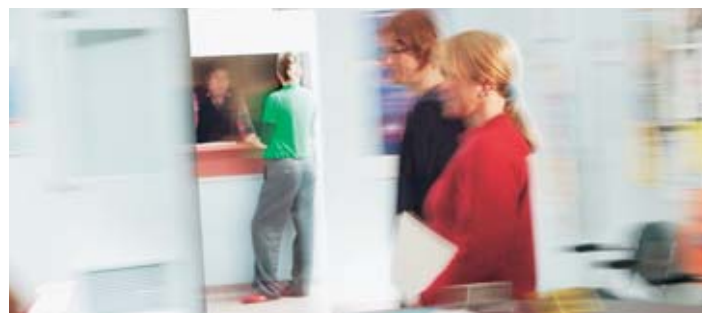
training at all levels and promotion of agreed procedures, effective supervision and clear clinical and referral pathways. In this framework, specialist dual diagnosis clinicians work closely with services to help them assess *all* areas of their operation and address identified gaps. The aim is to skill up existing workers to opportunistically address comorbidity and manage complex needs as part of a 'no wrong door' approach, not just 'refer on' to a de facto third treatment sector. Also critical, says Lee, is support for organisational and systemic change to address structural, cultural, attitudinal and service design barriers to achieving good practice. Having a champion to lead and guide practice and policy change from *within* the service is a key ingredient for success.

Greg Logan points to two other examples of activities with great potential for workforce development:

- **Partnerships for education** – partnering with educational institutions to develop study opportunities for AOD/MH workers. Victoria has partnerships at all levels of post-secondary education, while a number of states are developing similar links. This approach is also reflected in the Commonwealth-funded Comorbidity Professional Development Scholarships, coordinated by the National Centre for Training on Addiction.
- **Cross-sector rotations/placements** – or 'seeing how the other half works'. This can be a powerful tool for increasing workers' knowledge, skills and confidence and for developing cross-sectorial collaboration. Christa Grapentin is AOD Manager of a Community Residential Withdrawal Unit at Melbourne's Youth Substance Abuse Service and one of the first participants in the Victorian Reciprocal Rotations Project. Her three-month rotation through five acute MH settings gave her a better understanding of the pressures and structural challenges facing workers in the 'other' sector and a language with which to build linkages and better communicate with MH crisis teams.

REFERENCES AND FURTHER INFORMATION

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- Dual Diagnosis Australia and New Zealand – has a wealth of reference materials: www.dualdiagnosis.org.au.
- National Comorbidity Initiative projects www.health.gov.au. Many projects: are listed on an archived website, accessible via this link.
- Madden, A 2006. Treatment Service Users (TSU) Project, presentation delivered at the 2006 APSAD Conference, Cairns.
- VAADA Jan-Feb 08 Newsletter – summary of DoHA projects: www.vaada.org.au/news/items/2008/03/202166-upload-00001.pdf.
- Victorian Dual Diagnosis Initiative: www.health.vic.gov.au/drugservices/pubs/dual_diagnosis.htm.



Issues and gaps

Some issues that are still to be addressed through Commonwealth or state comorbidity initiatives have been identified as:

- **Service development** – there is concern this is not keeping pace with capacity-building, which may become unsustainable.
- **Workforce needs** – such as retaining specialist dual diagnosis workers within the AOD sector. While these positions have been funded across all states/territories, several of these are yet to be filled and anecdote suggests that AOD dual diagnosis workers are being lost to the better-remunerated MH sector.
- **Top-down/bottom-up approaches** – how do we balance these and retain the flexibility to fund a range of responses within often fixed and institutional settings? What are Commonwealth and state government roles within this equation – to lead? To resource? To support?
- **Duplication of effort** – the development of comorbidity practice guidelines in Victoria, Queensland and NSW and a range of cross-sector training and placement projects – additional to the Commonwealth initiative projects – represents unnecessary duplication of effort. The failure to apply learnings from previous experience to inform new projects is seen by many as a waste of resources and a barrier to achieving best practice.
- **State/Commonwealth strategic planning and transparency** – how are decisions made and what mechanisms are in place for input into the strategic planning equation?

Consultation between state and federal governments is fundamental, says NSW AOD Service Head, David McGrath. 'With reference to the previous Commonwealth Government, there has been minimal consultation with the states across the whole range of AOD services, I believe... making it hard for states/territories to fit in with Commonwealth initiatives.' McGrath says there has been a substantial shift in the level of Australian Government consultation with the states since November 2007, which he sees as a reason for optimism in relation to future joint framework development.

A spokesman for the Australian Government Department of Health and Ageing said that in support of this shift, it is leading the establishment of a National Comorbidity Collaboration consisting of senior Australian Government and state and territory AOD and MH officials.

Conclusion

While questions remain around the relative size and distribution of components of the Commonwealth comorbidity funding and the transparency with which such funding decisions are made, the general feeling seems to be that 'new money is new money and not to be sneezed at', although its limitations should be clearly identified. What is clear is that there are people engaged across all areas of the AOD/MH/primary care sectors who are passionately committed to improving comorbidity responses and welcome new opportunities to do so. There is also much enthusiasm for newly funded projects which make possible new partnerships

Table 1: Overview of comorbidity funding*

COAG National Action Plan on Mental Health (2006 – 2011): Improved Services for People with Drug and Alcohol Problems and Mental Illness Initiative (Improved Services) <ul style="list-style-type: none"> • AOD NGO capacity-building grants • Cross Sectorial Support and Strategic Partnership 		\$73.9 million www.mentalhealth.gov.au
AOD NGO capacity-building grants (\$29.9 million to May 2008)		87 NGOs (first round) – started January 08 Second round to be announced
Cross-sectorial Support and Strategic Partnership (12 months initial funding)		State/Territory AOD NGO peaks (or other supporting bodies)
National Comorbidity Initiative Funding of approximately \$3.5 million per year to 2010-11 (A selected list is provided below – contact DoHA for a full list of projects)		www.health.gov.au
Consumer and Carer Comorbidity Involvement in Treatment Planning CD-ROM [Health Outcomes International]		Launched at 2007 ANEX Conference
Qualitative Treatment Experience Study: Barriers and Incentives to Treatment for Illicit Drug Users with Mental Health Comorbidities and Complex Vulnerabilities [LMS Consulting, NCHSR & AIVL]		Study completed August 2006 NDS Monograph published in 2007
‘Can do’ Managing Mental Health and Substance Use in General Practice [AGPN] STREAM 1 – national training resources: <ul style="list-style-type: none"> • Teams of two networking units • ‘Can do’ AOD clinical education module STREAM 2 – training program for GPs/allied health/carers of young people at risk of DD. www.agpncando.com		December 2007 to January 2009 In 2007, 34 Divisions ran 90 networking workshops with over 1600 participants, while 13 Divisions ran clinical education training with over 250 participants
Comorbidity Professional Development Scholarships [NCETA] www.nceta.flinders.edu.au/projects/comorbidity.html		The first grant round opened on 15 October 2007 and resulted in 21 successful applicants. The second round opened on 5 February 2008 which resulted in 41 approved applications
PsyCheck MH Screening Tool for AOD workers [Turning Point]		Development completed – nationwide training underway
Comorbidity Service Model Evaluation [Australian Institute of Primary Care] A minimum of 15 service delivery models for comorbidity treatment in AOD and MH		Due for completion May 2009
National Comorbidity Clinical Guidelines [NDARC]		The guidelines are expected to be finalised in mid 2008 followed by a national dissemination
Clinical Supervision of Postgraduate Psychologist Trainees in AOD services [Australian Psychological Society]		12 placements have been implemented for Semester 1 of 2008. The APS is currently arranging placements for Semester 2
Review of the Comorbidity of mental disorders and substance use: A brief guide for the primary care clinician.		Due to be completed June 2008
Clinical review of Dual Diagnosis Primary Care Guide		Draft report with DoHA Due to be completed end July 2008
Other initiatives addressing comorbidity include: <ul style="list-style-type: none"> • National Youth Mental Health Foundation – ‘Headspace’ • A range of comorbidity research projects at key research centres around Australia • Office for Aboriginal and Torres Strait Islander Health programs • State/federal funding – a range of local MH and AOD comorbidity initiatives 		

*Updated 22 May 2008. Source: Australian Government Department of Health and Ageing.

and pathways for workforce development and other forms of capacity building.

Gail Ward is the Improved Services Project Manager for VAADA (the Victorian AOD peak body). She is very optimistic about the future of comorbidity treatment and points out it's not just about funding. 'It's about believing we can make a change for clients/consumers with comorbidity problems. This must remain

our central focus.' It's important to recognise how far we've come, says Queensland researcher Professor David Kavanagh.

'We now have a level of understanding that was unthinkable 10 years ago. At times it's discouraging but we are moving forward, slow though it may be.' Michael Baigent looks forward 'to the day when we don't think about dual diagnosis at all but just treat the person before us in whatever way they need'.

ALCOHOL: ACTION APLENTY

Since *Of Substance* published the findings of its public opinion survey on alcohol attitudes in April, much has happened at a federal level in relation to alcohol.

The Rudd Government has announced a \$53 million program to tackle binge drinking and raised the tax on 'alcopops' or 'ready-to-drinks' from \$39.36 per litre of alcohol content to \$66.67 per litre of alcohol content. This tax was later referred to the Senate's Community Affairs Committee for review.

Meanwhile, the Senate Inquiry into the Alcohol Toll Reduction Bill has received submissions from a large number of interested parties. The Inquiry was due to make its report in June.

Representatives from the health sector and alcohol industry share their thoughts on the *Of Substance* opinion survey and current events around alcohol.



THE POLICY ADVISOR

JOHN HERRON, CHAIR, AUSTRALIAN NATIONAL COUNCIL ON DRUGS

There is little doubt in my mind that the *Of Substance* opinion survey published in the April issue contributed greatly to the flurry of activity in dealing with alcohol misuse in Australia.

It was followed by the Alcohol Education and Rehabilitation Foundation's unprecedented sponsorship of the Alliance Against Alcohol-Related Violence which united a great number of the major organisations calling for action.

The media was immensely supportive – no doubt a reflection of public interest and concern. Shortly afterwards Health Minister Nicola Roxon announced increased taxation on 'alcopops'. Her action was criticised by alcohol producers and retailers but welcomed by many of us involved in this area as an important first step. Providing most of the taxation return is put into services for people affected or at risk of alcohol misuse, it is a win-win situation.

However, it needs to be followed by a general overhaul of taxation on alcohol. At present there is a hodge-podge of differential taxes on different drinks. The logical step would be to tax drinks according to the volume of alcohol they contain.

State and local governments have a part to play as well in relation to the number of liquor outlets and their trading hours. Local governments have a particular concern as they are often responsible for cleaning up the mess from alcohol misuse such as graffiti, destroyed street signs, other acts of vandalism and vomit.

Where do we go from here?

Legislative change will only be accepted if it has community support.

Media campaigns have to be continuous and unrelenting to be successful in changing public opinion. For this to occur we need the public to actively express their support through letters to editors, speaking on talkback radio and if we have the opportunity, speaking at community forums. Every bit helps.

While the majority of people are sensible with their drinking, there obviously needs to be a public education program regarding the dangers of binge drinking. A television campaign along the lines of that pursued in New Zealand would be a start whereby graphic scenes of the consequences of binge drinking are regularly depicted.

Parents and carers also need to be educated that the behaviour of the children in their care is also their responsibility. It is not just an issue for governments, schools and police. Unfortunately the behaviour of some children is too often a reflection of the behaviour of their parents.

A recent development in some therapeutic communities is to involve the family before the actual client is treated as almost invariably the client returns to the family after discharge. If the family is trained in the best methods of support then the client is less likely to relapse. Similar action could be taken in relation to treating people with alcohol misuse problems.

If an intoxicated person comes to the attention of the police the family could be notified immediately and be given the opportunity to help with rehabilitation. This has been successfully introduced in some countries. Why don't we try some new approaches here? As Edward de Bono said 'the risk of doing nothing is greater than the risk of doing something'.

THE HEALTH WORKER

DR ALEX WODAK, DIRECTOR, ALCOHOL & DRUG SERVICE,
ST VINCENT'S HOSPITAL, NSW

Virtually every Australian has a family member or close friend with a past or present serious drinking problem. Also, every year millions of Australians experience nasty verbal or physical anti-social behaviour from someone who has had too much to drink. But despite the almost universal personal experience of these quite negative complications from alcohol, community attitudes to grog are generally surprisingly permissive. Many assume (wrongly) that almost nothing can be done to reduce the harms done by alcohol to our community. Attempts to reduce the huge health, social and economic costs of alcohol, even when based on solid evidence, are usually dismissed as the interfering attempts of 'wowers' to impose a nanny state. The community, politicians and the alcohol beverage industry strongly support mass education campaigns about the damaging effects of alcohol, despite compelling evidence to the contrary that benefits are at best minimal and temporary.

Community attitudes are in stark contrast to the picture built from decades of research. Each year in Australia, alcohol causes about 3500 deaths and costs the economy \$15 billion. There is a strong consensus among researchers around the world about what does and what doesn't work to reduce the problems associated with alcohol. This literature was summarized recently in the excellent World Health Organization book *Alcohol: no ordinary commodity*.

Why the two very different perspectives? The drinks industry in Australia spends over a million dollars a day advertising not only its product, but also trying to create the perception that alcohol is risk free. This extremely powerful industry employs hundreds of thousands of staff and pays billions in taxes. It donates very generously to governing and opposition parties. Along with the tobacco industry, the drinks industry in the United States even supports the 'Partnership for a Drug Free America' to foster the view that safe alcohol has nothing in common with dangerous illicit drugs. The 2007 Commonwealth Parliamentary 'Inquiry into the impact of illicit drug use on families' derided expert witnesses who argued that alcohol and tobacco and illicit drugs were 'all of a piece'. The (then) Prime Minister, Bob Hawke, also took this view in 1985 but was successfully opposed by the majority of his Cabinet.

Leadership or followship?

Australia has been a pioneer in many effective responses to alcohol including compulsory seatbelts, random breath testing, thiamine fortification of flour, automatic indexation of alcohol taxation and low-alcohol beer. At the time, most of these measures were vigorously opposed by powerful interest groups including the drinks industry. But imaginative political leaders and government officials managed to thread these measures through the political maze over years or decades. The art of politics includes the critical skill of providing leadership to the community while seeming to be closely in touch with community aspirations and values.

As this survey shows, there is sufficient community support for political leaders concerned about the harms of alcohol to introduce effective and evidence-based prevention strategies.

In the face of rapidly increasing alcohol-related problems in Britain, alcohol taxes were raised in the March 2008 Budget by 2% above the CPI for the next four years. Opinion polls in the following days showed overwhelming community support.

As US presidential candidate Barack Obama reminds us, 'yes we can'.

THE INDUSTRY VOICE

STEPHEN RIDEN, DISTILLED SPIRITS INDUSTRY COUNCIL
OF AUSTRALIA

The survey in April's edition of *Of Substance* had some useful information about Australians' understanding of binge drinking and standard drinks, but otherwise contained few surprises.

It is hardly surprising that most Australians (79%-90%) are concerned about binge drinking as most Australians recognise or at least conceive 'binge drinking' as inherently harmful. Similar concerns and survey results would be found if the question was asked about speeding or teenage drug taking.

Similarly, it is not surprising to see a low level (14%-17%) of understanding or awareness of the National Alcohol Guidelines. The guidelines are sensible advice about daily and weekly drinking patterns that unfortunately have been woefully under-promoted by the Commonwealth Government. Contrast that result with the much higher awareness of blood alcohol levels. This demonstrates what can be achieved with enduring public awareness campaigns about what people should and should not do.



Advertising regulation is in fact a quasi-regulatory scheme, not self regulatory as the article described. Also, the article was wrong to state that complaints about alcohol advertising are 'adjudicated by a primarily industry-based panel'. In fact, complaints are adjudicated by a completely independent panel, headed by Professor Michael Lavarch, Executive Dean of the Law Faculty at Queensland University of Technology and a former Commonwealth Attorney-General in the Keating Government.



being heightened by activists and the media. It is fair to ask if the public and politicians are being manipulated into knee-jerk reactions, leading to alcohol policies and funding arrangements that are not supported by evidence.

THE ADVOCATE

GEOFF MUNRO, DIRECTOR, COMMUNITY ALCOHOL ACTION NETWORK

Australians want more restrictions on the advertising of alcohol. The triennial National Drug Household Survey asks respondents whether the ban on alcohol advertising on television should be extended from 8.30 pm until 9.30 pm. In 1998, 72% of the sample supported the extension; in 2001, 69%; in 2004, 71%; and in 2007, 72%. It is a remarkably consistent trend. By that standard the Alcohol Toll Reduction Bill, which calls for an extension until 9 pm, has overwhelming support.

The *Of Substance* poll provides another snapshot of public opinion on alcohol advertising. It queried respondents on measures regarding pre-vetting of advertisements and protecting minors from exposure to advertising. Three-quarters of respondents (77%) believe advertising should be previewed by an independent authority. It seems only one in ten (11%) have confidence in the current arrangement in which advertisements are previewed by an industry-appointed panel.

The response indicates a deep dissatisfaction with the state of advertising and a desire for stronger control, which might be met by the Alcohol Toll Reduction Bill's proposal for a government-appointed panel if it is empowered to adopt a more stringent attitude.

An identical proportion (77%) think advertising should be restricted to locations, publications and times that are less accessible to minors. Again, the public is ahead of the 'self regulators': the ABAC concentrates on advertising content and is virtually silent on location and placement, except for the ban on daytime television, and that is evaded easily by sponsorship of sport. A code that tried seriously to protect children from alcohol advertising would not allow advertisements on billboards, and on public transport vehicles and shelters in which patrons cannot avoid focusing on the promotions.

The *Of Substance* result is confirmation that the general public does not accept the alcohol industry's claims that the present system is working. ABAC is an inadequate system that ignores important marketing issues, does not address many adequately, and is too easily evaded. Since a public health representative was added to the pre-vetting and complaints panels after a government-inspired revision in 2004, the alcohol industry has described ABAC as a 'quasi-regulatory' system, which means it has conceded self-regulation failed. 'Quasi-regulation' fares no better.

The relevant provisions of the Alcohol Toll Reduction Bill would improve the accountability of the ABAC, but they would not overcome its basic defects. It is time for a 'root and branch' re-assessment of alcohol advertising and alcohol marketing more generally. The *Loi Evin* in France, which limits advertisements to an objective description of the product, and does not allow alcohol brands to sponsor sport, is a model to which Australia should aspire.

There are four other adjudicators, all of whom are independent. Two of the five adjudicators are appointed by the Commonwealth. A panel of three adjudicators take part in each adjudication, one of whom must have been appointed by the Commonwealth.

The Alcohol Beverage Advertising Code (ABAC) Scheme specifically states that adjudicators must not be employed or connected to the alcohol industry in any way, and cannot have been employed by the alcohol industry in the last five years.

The public's response to the question about alcohol advertisements being pre-vetted by an independent body was based on a fallacy that this is not already the case. Over 98% of alcohol advertising (by expenditure) is independently and confidentially pre-vetted through the Alcohol Advertising Pre-vetting Scheme which is part of the ABAC Scheme. Pre-vetters are appointed under similar conditions of independence to the adjudicators. The wording of the advertising question is actually a case of 'push polling'.

Strong support for restricting the placement of advertising where it is less likely to be seen by people under 18 is also to be expected. But it is impossible to stop advertising 'leaking' to unintended audiences. The alcohol industry already takes great pains to place advertising where it can be seen by mainly legal age purchasers. This is not always entirely successful and billboards are a particular problem. The simple fact is that the alcohol industry does not have the marketing resources to waste by placing adverts where fewer people who can actually buy the product will see it.

Alcohol advertising is already heavily restricted. What is behind the respondents' concern is that the public does not know what regulation exists.

It is obvious that there is a clear disconnect between the public's levels of concern and the latest National Drug Strategy Household Survey results. The survey, released in late April, clearly show that long-term trends for youth binge drinking, for both males and females, are heading down. This is not to deny that there is a binge drinking problem, just that to call it an 'epidemic' or 'crisis' is wrong.

Alcohol policy should be evidenced based and the evidence shows a long term decline in drinking, yet concerns are

SCHOOLS AND DRUGS

Preventing and resolving drug problems is an ongoing challenge, especially when they occur among the very young, such as schoolchildren.

TIME TO TEST?

ANN ROCHE*

The National Centre for Education and Training in Addiction's (NCETA) recent work examining the effectiveness of drug testing in schools and its wider implications is a good example of how we wrestle with possible intervention options.

The Australian AOD field is characterised by many positive attributes, including courage and innovation. This is balanced, and in some instances tempered, by our strong adherence to the principles and application of evidence based practices.

NCETA was commissioned by the Australian National Council on Drugs (ANCD) to look at what the available evidence told us about school drug testing's effectiveness in deterring drug use and in detecting problematic use at an early stage. Our team was drawn from a wide range of disciplines and backgrounds and set out to explore the issue from as many perspectives as were relevant and appropriate.

Literature review

We started in the traditional academic way of systematically reviewing the evidence in the peer-reviewed literature. We soon found that to be substantially lacking. There was remarkably little that had been published on this issue. This was in spite of over 10 years of interest and activity, in the United States in particular. We were quite perplexed by the lack of peer-reviewed literature and also the total absence of quality evaluation research.

Practical issues

We also examined the issue from pragmatic perspectives. We undertook an extremely detailed assessment of the actual costs of implementing drug testing in school settings. We found that if just 10 per cent of the national school population were randomly urine-tested three times each year, the cost would be \$91 million. If every schoolchild were given a saliva test once a year, the cost would be \$302 million.

The examination of the practicalities of testing implementation also involved consideration of test accuracy and the issue of false positives, which would be expected to occur at a rate of at least 10 per cent.

A question of ethics

Another important issue was the legality of testing school students. We examined a range of issues including schools' duty of care, students' rights to privacy and their right to refuse

DRUG TESTING IN SCHOOLS - KEY FINDINGS

The report Drug testing in schools – evidence, impacts and alternatives found:

- Most drug tests are insufficiently reliable for testing in a setting such as schools.
- The cost of testing is very high.
- Current levels of regular illicit drug use are very low.
- Evidence indicates that drug testing is an ineffective deterrent.
- Highest prevalence of drug use occurs among high-risk and vulnerable groups of children, including the poorer academic performers and Indigenous students, indicating that punitive and inquisitorial methods of deterrence are ill-advised.
- Effective mechanisms already exist to intervene with high-risk students and/or their families.

access to their bodies. We compared the rights of the child in Australia to the rights of the child in the United States. It is perhaps not well known or well appreciated that the Australian legal framework differs substantially in this regard from that of the United States. Importantly, Australia is a signatory to the UN's International Convention on the Rights of the Child and confers greater privacy rights on children than the United States does.

Community consultation

Another part of our investigations involved key stakeholder submissions and a community survey. In both instances, approximately two-thirds of respondents either did not support or expressed strong concern about the prospect of drug testing children in the school setting. No matter which way we looked at the issue of drug testing in schools we could not identify a case to be made to support it – as much as some might view it as having potential merit, there simply is not the evidence available to support it.

** Ann Roche is the director of the National Centre for Education and Training on Addiction and was the lead author of the ANCD report Drug Testing in Schools – evidence, impacts and alternatives.*

Reference

National Centre for Education and Training on Addiction 2008. *Drug testing in schools – evidence, impacts and alternatives*, Australian National Council on Drugs, Canberra. www.ancd.org.au.

TESTING THE POLICY

JENNY TINWORTH

While politicians, teachers and the community may debate the pros and cons of testing students to detect drug use, testing is already a standard procedure in some schools.

Melbourne Grammar is one such school. Headmaster Paul Sheahan emphasises that testing is part of a comprehensive rehabilitative drugs policy.



'Drug testing is carried out infrequently and only when behavioural indications are that a student is using drugs,' he says. 'In such a case, parents are called to the school for interview and the drug-testing regime is explained to them as part of a rehabilitation program. In almost every case where parents and students have agreed to be on the drug-testing program the

outcomes have been successful in that the student has been able to remain in the school while on the rehabilitation program.'

Tests are carried out by a paediatrician selected by the school, with parents required to meet all costs. If a test is positive, the paediatrician addresses the positive test as part of a rehabilitation plan. Cannabis is the drug most likely to be detected, however the school is generally not told which drugs have been found.

Mr Sheahan says while students' reactions to being tested vary, the most common attitude is one of relief. 'By the time their drug use is detected, many of them acknowledge their need for assistance. Our program is very much about rehabilitation, not punishment.'

Has testing influenced the drug-using behaviour of students at the school? Mr Sheahan says it is difficult to attribute changes to any one factor such as testing. 'It is clear that far fewer students are using drugs in schooltime or arriving at school drug-affected than was the case ten years ago. Many variables can be attributed to this shift, so I wouldn't suggest the school's drug policy is the single reason. I think students are better educated about drugs and many have had first-hand experience of others' lives being ruined by drugs.'

OPINION:

TWISTED MESSAGE MISLEADS YOUNG MINDS

PAUL DILLON*

If you believe the media you would quite honestly believe that we now have the 'worst group of young people in the history of young people'.

Current affairs programs and radio shock jocks love to tell tales of young people out of control, that we have higher rates of drug use than ever before and that drinking rates are through the roof.

Yet, if you look at the recent National Household Survey, as well as most other indicator data, the opposite is most probably true, with many Australian studies suggesting reductions in youth drug use.

Now that's not to say that we don't have a problem. There is drug use occurring and unfortunately those who do experiment tend to do it at a younger age, putting them at much greater risk. However, as far as illegal drugs are concerned, we are talking about a small group.

This media focus on the minority is giving young people a distorted perception of drug use among their peers. They

are often convinced drug use is the norm, even though that is not their personal experience. Members of the majority who don't use often feel like aliens amongst their peers, when the opposite is the actual reality.

It would be more helpful to young people if the focus was on those who don't use rather than those who do. The group that undoubtedly receives the least attention are the abstainers. An interesting fact that is rarely discussed is that between 20 and 25 per cent of school-based 16-17 year olds have never drunk alcohol. The number of young people who have never used illicit drugs is much higher, yet we never talk about them.

As we continue to focus on the number of young people who are involved in substance use, whether it be drinking alcohol or using illicit drugs, we completely ignore those who have made healthy choices and as a result we succeed in making them feel even more alienated than they already do.

*** Paul Dillon writes from Drug and Alcohol Research and Training Australia.**

YOUTH AND ALCOHOL: CHALLENGING THE STEREOTYPE

CLARISSA HUGHES*

Underage drinking has received a great deal of publicity lately. The topic is often framed as a 'youth binge-drinking crisis' or 'epidemic', with articles on risky alcohol consumption by young people featuring frequently in national and regional newspapers. Media coverage suggests that 'everyone is doing it'.



Resistance to health messages

Young people are not unquestioningly accepting of health promotion messages. They may be annoyed by the perceived hypocrisy of adults who 'preach' to them about the dangers of alcohol. They may regard prevention programs as 'boring' and 'unrealistic' (Farrington et al. 2000). Warnings about catastrophic and long-term harm may be viewed with scepticism, or dismissed as irrelevant.

Risk education is essential, but it will not necessarily translate into behavioural change. The development of a 'sociology of drinking' which acknowledges the many ways in which 'drinking is a social as well as an individual act' (d'Abbs 2002), can potentially enhance harm minimisation efforts involving young people (Hughes et al 2008). Arguably, much is to be gained from a better understanding of the creation (and perpetuation) of 'local cultures' that are supportive of risky alcohol consumption (Cook 2005).

Changing the norm

One prevention approach which aims for cultural change is 'social norms'. Rather than focusing on risk, social norms interventions investigate the way young people are influenced by their perceptions of what others think and do. Research indicates that young people consistently overestimate the alcohol consumption of their peers, and may therefore feel pressure to conform to an (albeit false) image of 'normal' alcohol-related behaviour (Hughes 2006).

Social norms interventions involve four key phases:

- collection of data about alcohol use and attitudes
- generation of positive, data-based 'key messages'
- dissemination of the 'key messages' via a media campaign
- evaluation of the impact of the campaign.

A team of researchers at the University of Tasmania is conducting Australia's first 'trial' of the social norms model. The Social Norms Analysis Project (SNAP) is a two-year, collaborative project funded by the Alcohol Education and Rehabilitation Foundation. The main SNAP target groups are students in Years 7 to 10 at four rural public high schools.

Student data was collected at the trial schools using a self-administered anonymous survey in mid-2006 and twice in 2007 (in first term and again in third term). On the basis of the survey results, school-specific positive 'key messages' (such as 'seven out of ten Lakeside High Students rarely or never drink alcohol') were generated, and disseminated via school-based media campaigns. These campaigns utilised colourful merchandise including posters, mouse-mats, drink bottles, wrist bands, rulers, badges and fridge magnets.

Although final evaluation results are not yet available, SNAP has had a measurable impact to date. Changes between the first and second rounds of data collection include a statistically significant decline in the mean perceived frequency of the students' friends consuming alcohol and getting drunk. Such attitudinal change is a vital first step. If students realise that risky drinking is not as prevalent as they thought, there will be less 'pressure' for them to conform to the image of a 'bingeing teen'.

Sharing the model

SNAP has generated enormous interest in the social norms approach, and many schools and communities are now keen to undertake their own interventions. The Tasmanian team is developing '4Real' – a social norms guide for Australian high schools, as part of its commitment to strengthening community capacity through the provision of information, support and training. It is also investigating alternative data-collection methods (including online surveys and electronic 'clickers') and application of the approach to different target groups and other issues (such as alcohol-related parenting and illicit drug use).



The social norms approach is a refreshingly positive addition to the health promotion toolkit. It encourages young people to question their taken-for-granted assumptions about what is 'normal'. Rather than focusing on risk and perpetuating the stereotype of the 'bingeing teen', it supports and affirms young people by focusing on the healthy choices about alcohol that most of them make, most of the time. For more information, email tiles@utas.edu.au.

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CHINA: GRAPPLING WITH CHANGE

DAVID STEPHENS*

In this issue of *Of Substance*, we introduce a new series looking at the approach to drug issues taken by different countries around the world. This month, we examine the tension between Chinese drug policy and efforts to halt the spread of HIV.

Located in eastern Asia, China is one of the fastest-growing economies in the world, although eight per cent of the population still live below the poverty line. Injecting drug use emerged in the late 1980s and early 1990s, coinciding with rapid economic development.

Trafficking of illicit drugs through China has increased substantially, primarily along the 200-kilometre border with Burma. There is evidence of significant domestic production of amphetamine-type substances and use particularly among young people along China's richer eastern seaboard. China has also now become a major source for many south-east Asian and Pacific countries. Supply reduction efforts have focused on areas along China's southern borders and China cooperates with Burma and Laos to implement alternative crops programs in these countries.

National drug control legislation and implementation

China is a party to a number of international and regional drug control agreements including the 1988 UN Drug Convention, and the Association of Southeast Asian Nations (ASEAN) declaration for a drug-free ASEAN by the year 2015. China's Ministry of Public Security (MPS) is in the third year of implementing the key drug control policy platform known as the 'National People's War on Illicit Drugs', which began in

2005 at the initiative of Chinese President Hu Jintao. The MPS has designated five campaigns as part of this effort:

- prevention and education
- treatment and rehabilitation
- drug source blocking and interdiction
- 'strike hard' drug law enforcement
- strict control and administration, designed to inhibit the diversion of precursor chemicals and other drugs.

In November 2005, China passed an Administrative Law on Precursor Chemicals as well as an Administrative Regulation on Narcotic Drugs and Psychotropic Substances. More recently the Anti-Drug Law of the People's Republic of China came into effect on 1 June, 2008. The law contains measures requiring drug users to undergo community-based detoxification (maximum period three years), and to be provided with vocational training and employment assistance.

The law also provides for public security departments to 'direct forced isolation treatment' for those deemed to be in non-compliance with community detoxification procedures for a period of two years. The law also allows for methadone maintenance treatment.

Lead agencies

In China, three agencies have primary responsibility for controlling the licit/illicit drug markets: the Ministry of Public Security, the State Food and Drug Administration, and the General Administration of Customs. All three are part of the National Narcotics Control Commission that oversees drug policy in China. At the provincial level, drug control is the responsibility of the drug control departments of public security authorities, co-administered by other government departments with the collaboration of mass organisations.

Drugs, HIV and harm minimisation

The drug control approach embodied by the laws and policies noted above, sits uncomfortably alongside HIV law and policy which emphasise a harm reduction approach to drug use. The government has been moving for several years to a more forthright acknowledgment of the HIV/AIDS epidemic in the country and to promoting policies for prevention and treatment. These include the 2006 Regulations on AIDS Prevention and Treatment and the National HIV action plan 2006-2010 which together provide measures supporting methadone maintenance and needle and syringe programs.

Population (2007 estimate)	1,321,851,888
Median age	33.2 years
Alcohol use	Increasing, particularly among women and professionals
Tobacco use	World's largest consumer. Tobacco accounts for 13 per cent of male deaths
Number of illicit drug users	1,050,000 (official figure) 6 million – 12 million (estimated)
Illicit drug use	Injecting drug use has increased since 1980s. Most popular drug is heroin. Other drugs include benzodiazepines, other opiates, cannabis, amphetamine-type substances, ecstasy ('shaking head pill'), ketamine
Typical profile of a person who injects illicit	Male, aged under 35 years. Women are likely to be younger (use by females is increasing)
HIV prevalence among people who inject drugs (2005)	44%, although in some provinces, it is more than 80%

DRINKING: OLD WAYS, NEW TRENDS

PETER D'ABBS & GAN XING FA*

China is home to one of the oldest drinking cultures in the world, with archaeological evidence pointing to beverages being fermented from around 7000 BC. It is also a rapidly changing drinking environment. Between 1961 and 2003, per capita consumption of alcohol by persons aged 15 and over in China increased from 0.49 litres of absolute alcohol per year to 5.2 litres (WHO 2007).

Change on this scale suggests that traditional drinking practices and norms have almost certainly also changed, but little is known about the nature of these changes. To explore this issue, we undertook a two-stage study. In stage one, we conducted a small-scale, qualitative study in Shanghai, involving 56 interviews with members of 20 families and six focus group interviews with a total of 103 people in and around Shanghai. The main purpose of the first study was to gain an understanding of ways in which alcohol use was changing, and to provide a basis for a larger quantitative survey (d'Abbs et al. 2005).

Stage two involved a quantitative survey (N = 3103) carried out in June-July 2006 in three areas: Shanghai municipality, Shandong province (a relatively well-off province to the north of Shanghai) and Jiangxi province (a much poorer area to the south of Shanghai).

The survey utilised a self-completed questionnaire. Respondents who had drunk alcohol in the past 12 months (68% of males and 31% of females) were asked to describe their three most recent drinking occasions, as well as answer questions about changes in their drinking patterns, use of alcohol for medicinal purposes, experience of alcohol-related problems, and perceived benefits of alcohol use.

The findings tell a story of both change and continuity. For example, most of the alcohol consumed in Shandong and Jiangxi, in keeping with traditional practice, consisted of beer or wine, whereas Shanghai drinkers revealed both a

predilection for a traditional regional favourite – yellow rice wine – and a shift to table wines. Many drinkers reported high levels of alcohol consumption per drinking occasion, with male government workers and party officials topping the list with a self-reported mean per drinking occasion equivalent to 71 ml of absolute alcohol.

At the same time, the findings on drinking settings and occasions point to continuity in cultural patterns. Over one-third of all drinking occasions described by respondents were associated with family gatherings, one-quarter with meeting friends or former classmates, while a little under one-fifth (19%) were work-related. Almost two-thirds of all drinking occasions described (63%) took place in the respondent's or a friend's home, and another one-third in a restaurant. The findings suggest the association of drinking with sociability and food remains strong.

Future alcohol control policies and educational programs in China will need to be informed by knowledge of contemporary trends in drinking cultures and practices. We hope to contribute to increasing this knowledge through these and future studies.

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By the end of October 2007, 397 methadone maintenance treatment (MMT) clinics were open in 22 provinces and 88 313 drug users had joined the MMT program. By the end of 2008, there are plans for more than 1000 MMT sites serving 300 000 clients (UNGASS, 2008).

At the end of 2006, there were 729 needle and syringe sites and by the third quarter of 2007, 49 108 people had joined needle exchange programs. There are plans to establish 1400 needle and syringe programs by 2008. Unlike MMT, needle and syringe programs in China were first launched by non-government organisations or international donors, and only later received government support. Although lawful, harm reduction activities still attract the attention of local law enforcement agencies (UNAIDS, 2007).

China's pragmatic approach to harm reduction has advanced despite the problems associated with anti-drug control law enforcement. Nevertheless, until there is greater harmonisation between these policy domains and a related engagement by

local law enforcement agencies in support of harm reduction programs, progress will remain uneven.

*** David Stephens is an HIV researcher and development practitioner with extensive experience in the Asian region.**

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WHERE HAVE ALL THE STAFF GONE?

JANE MUNDY

Vacant positions remain unfilled, and clients wait for treatment. Why is there a shortage of staff in drug services?

It is difficult to estimate the number of people working in the alcohol and other drug (AOD) sector in Australia. However, a National Centre for Education and Training on Addictions (NCETA) survey conducted in 2003 estimated the number working in specialist agencies (excluding those who work in a generalist health setting) to be in excess of 10 000.

The only state/territory analysis of the field is a profile of the ACT AOD workforce, conducted in 2006 for ACT Health by consultancy Social Research and Evaluation to help clarify personnel resources, their development needs, and the costs of implementing a workforce development strategy. Because of the variations in workforce characteristics across jurisdictions, and across different workplaces, it is not possible to extrapolate from it and no national profile has been completed.

Similarly, data is not available on the nature or extent of staff shortages. However, Professor Ann Roche (NCETA) says anecdotal reports indicate that across the country, agencies are having increasing difficulty recruiting appropriately qualified staff. The shortage is most marked in rural and remote settings and it is likely there are variations from state to state – for example, WA in general is experiencing extreme recruitment pressure in all fields because of the resources boom.

Roche says the non-government (NGO) sector probably fares less well than the government sector as agencies often have fewer resources to offer staff and pay rates are generally much lower.

‘There is a view that NGOs recruit less qualified and experienced staff, train them up and then they leave to take better paying jobs in the government sector,’ she says. ‘However, the counter view is that many people prefer to work in the NGO sector, even for lower pay, because of the flexibility it offers.’

Why is there a staff shortage?

The current staff shortage in part reflects the near full employment situation within Australia generally, but it is also a function of shortages in particular workforce groups, such as nurses. In addition, the types of workers required in substance use services have changed over the past decade as the nature of AOD work becomes increasingly challenging, AOD issues become more complex, and the range of substances with which workers have to contend and the knowledge base they must get to grips with expands rapidly.

There is a greater need for more highly qualified staff as many organisations require a high level of sophistication in their staff to provide the services clients need. For example, there has been a substantial expansion in the role of pharmacotherapies in treatment which necessitates the employment of staff with qualifications that allow for diagnosis, prescription and administration of



drugs. In addition there is increasing emphasis on issues such as comorbidity that require the skills of more highly trained (and often differently trained) personnel. The reasons for the staff shortage pertain both to recruitment and retention.

Recruiting good staff in the first place can be frustrated by a lack of suitably qualified applicants, inadequate salaries, the stigma of working in the AOD field, inadequate funding of positions, and a perceived lack of clear career paths and opportunities.

Retaining staff can involve many of the same factors. A recent NCETA study found the three main reasons why people leave the sector are inadequate salaries, a lack of opportunities for career development, and work-related demands and stress. These factors can lead to low levels of job satisfaction, commitment and motivation – resulting in high staff turnover (Duraisingam 2005).

Ann Roche regards stress as one important factor impacting on staff shortages, applying to workers across the AOD field in general, and to NGOs in particular.

A comprehensive survey of 1400 AOD specialist frontline workers, including nurses, AOD specialists, psychologists and social workers, was conducted by NCETA in 2006. Called *Satisfaction, stress and retention: an examination of critical workforce development needs of AOD specialist frontline workers*, it aimed to identify individual and organisational factors impacting on stress, job satisfaction and staff turnover. Most AOD workers reported high levels of job satisfaction derived from working with clients and doing work of value to society. However, nearly one in five workers reported above average levels of stress, 54 per cent have thought about leaving and 31 per cent plan to look for a new job over the next 12 months.

Other factors impacting on recruitment and retention include short and insecure funding arrangements which mean only short-

term contracts can be offered on a project-by-project basis; the high number of NGO workers who leave for higher-paying government jobs; difficulties of working in rural or isolated areas; poorly resourced workplaces and infrastructure; work overload and time pressure; a lack of public recognition of the value of the work they do, coupled with lack of feedback, support and rewards; the challenges of managing conflicting role requirements and responsibilities such as mixing administration and clinical work; not enough autonomy and too much managerial control.

Implications

When there is a shortage of staff and/or rapid turnover, the major losers are service consumers. More Australian research is needed, however US studies show that a well-resourced and stable workforce is essential for providing effective treatment and prevention services and is associated with more positive client outcomes including higher rates of participation in formal treatment programs, greater satisfaction with treatment and more confidence in meeting drug management goals and avoiding relapse. Teams with higher levels of worker burnout are associated with lower levels of client satisfaction with both their treatment and therapist.

Ann Roche says staff shortages create a danger that the AOD field will not continue to progress at an appropriate rate. There may be limitations to the implementation of best practice by many services; closure or reduced size and capacity of others; redirection of available funds to other (non-AOD) services if the field cannot use funds allocated to it; and delays in the establishment of new services. Roche says there are examples of new pharmacotherapy clinics not getting started because of difficulties in staff appointments. All these difficulties are exacerbated in rural and remote areas.

Other problems for AOD organisations include the costs of replacing and retraining staff; lost productivity; depleted morale of other workers; more stress and pressure on remaining staff; lack of cohesive teams and mentors; and loss of organisational 'memory' which impacts on current work practices.

Managers shoulder much of the burden. In 2005, NCETA's Burnout Project found that the majority of AOD managers were satisfied with their jobs and committed to their organisations. However, eight per cent of managers indicated experiencing high levels of burnout and one in five expressed intentions to look for a new job outside the AOD field. Over two-thirds had difficulty recruiting staff. The key predictors of managers' wellbeing were a perception that staff were pulling their weight, adequate managerial skills and training, high levels of support from employers, high levels of autonomy, manageable workloads, adequate rewards for performance, and a safe and pleasant physical work environment.

Addressing the shortage

Recruitment is largely a jurisdictional responsibility and as such each jurisdiction has a different approach. Some states have been more proactive than others, working with universities to get students to do their clinical placements at their service and offering them employment once they graduate. Other states have worked to increase the skill level of their volunteers. Many of the factors acting against staff recruitment and retention – such as the nature

and intensity of AOD work and, to a large degree, remuneration – cannot easily be changed at local level. However, many of those relating to workplace operations and career development are more amenable. NCETA nominates eight strategies that managers can apply to help retain effective workers:

1. Maintain good supervisor-worker relationships which allow for open communication and expression of ideas and opinions.
2. Provide professional development opportunities that give workers the chance to develop their knowledge, skills and abilities.
3. Provide workers with challenging and varied work and give them autonomy to make decisions and organise how they go about their work.
4. Ensure adequate clinical supervision.
5. Offer rewards and recognition (salary rises and promotion) for good work. If monetary rewards are not feasible, consider alternatives such as opportunities to work on projects of interest.
6. Support workers' capacity to balance work and family life.
7. Provide new or potential workers with realistic work expectations in regard to promotional opportunities, professional development opportunities and career mobility.
8. Conduct exit interviews to identify organisational issues or problems.

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Resources

Stress and burnout: a prevention handbook for the alcohol and other drugs workforce. Available to download at www.nceta.flinders.edu.au/pdf/stress-n-burnout/stress-n-burnout.pdf

An intervention to improve worker wellbeing. A 12-week intervention to improve workers' job satisfaction and wellbeing by involving workers in the process of identifying and implementing strategies to address personal stressors. Available to download at www.nceta.flinders.edu.au.

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CANNABIS: A CLOUD

A unique partnership between Queensland Police, James Cook University and peak bodies of remote Indigenous communities, including elected local government members, was recently formed to reduce cannabis-related harms in Cape York and Torres Strait in Far North Queensland.

To ensure proposed strategies are community owned and supported, an intensive six-month police-funded community and key stakeholder consultation phase was recently completed.

The first seizures of commercial quantities of amphetamine-type stimulants (ATS) destined for Cape York and Torres Strait communities took place in early 2007. Although those charged were non-Indigenous, the seizures raised serious concerns that these drugs were being used by Indigenous community members.

Previously, cannabis producers/importers have focused their dealings on regional centres. Now, they are making considerable profits from selling cannabis at inflated prices into remote Indigenous communities. There are concerns that this expansion of the cannabis trade to these communities provides a potential vehicle for trafficking in ATS (Delahunty & Putt 2006).

Learning from the NT

In Arnhem Land in the Northern Territory (NT), community development strategies were implemented along with stepped-up supply reduction strategies by police to address high rates of cannabis use.

A follow-up study (from 2001 to 2004) demonstrated a modest reduction in cannabis-related harms, particularly the more acute mental health symptoms including suicidal ideation and psychosis (Clough et al. 2006). While the abuse of ATS was documented in just a few isolated cases in 2001, there was no evidence for ATS use at follow-up in 2004.

Follow-up studies in the NT communities are continuing with an important component being the provision of direct feedback of research findings on cannabis use to the study communities and the involvement of local Indigenous researchers. Cannabis-use prevalence estimates in community populations and associated harms were presented back to the Arnhem Land communities



utilising pictorial representations, local language and concepts of life stages, numbers and quantities. The response of: 'Wa! Ningeningma arakba akina da!' (Oh! Now I know, that's it!) typified the reaction people tended to give when they first saw the data presented, suggesting a sudden realisation of the significance of cannabis issues locally (Lee et al. 2008).

Based on the above model of ongoing community engagement, Detective Senior Sergeant Mick Dowie and James Cook University's (JCU) Associate Professor Alan Clough developed the 'Weed It Out' project. This project proposes the provision of community-based interventions featuring demand-reduction initiatives, over a four-year period, alongside targeted policing efforts to reduce cannabis availability and use in Cape York and Torres Strait communities.

Proposed strategies include:

- raising awareness of the widespread use of cannabis and its mental health effects
- providing ongoing feedback about research findings to each community

- providing information about the legal aspects of cannabis use and trafficking.

Community consultations

It was envisaged that a wide-reaching community consultation process would enable the project team to gauge individual community perceptions and level of concern regarding cannabis and other drug-related issues. It would also allow the team to obtain a sense of each community's readiness and capacity for change and to gain formal support from community leaders.

The JCU research team and Queensland police officers visited 16 communities across Cape York and the Torres Strait region. Both planned and opportunistic discussions and meetings were held with community members (including elders, young people, Justice Group members), local government authorities and key service providers.

Consultation feedback

In 2005-06 in eastern Arnhem Land (NT) communities 61% of males and 58% of females (aged 13-36 years) were using cannabis weekly and most users (88%) reported symptoms of cannabis dependency (Lee et al. 2007). According to Cape York and Torres Strait people, rates of cannabis use in their communities 'will be the same or higher here'.

The consultations identified a number of themes (see Table 1). Many residents were worried about the early uptake of cannabis and adverse mental health effects including dependence and psychosis. There were concerns that other drugs were being used or tried in some of the communities. The NT strategies were enthusiastically endorsed, particularly provision of direct ongoing feedback to the com-

OVER OUR COMMUNITY

JAN ROBERTSON & ROBYN DOWIE*

Table 1. Themes which emerged from community consultations

Concerns re prevalence, early uptake & associated harms	Concerns for future	Concerns for future
<ul style="list-style-type: none"> • More overt use, kids starting to use earlier. <i>'There is a cloud hanging over our community.'</i> • Women worried about children making bucket bongos from discarded drink bottles. • <i>'It would be good to see people with normal eyes (not red eyes).'</i> • <i>'I see my countrymen in withdrawal and have episodes of psychosis.'</i> • Cannabis-dependent youth refusing opportunities to travel outside communities: <i>'don't want to leave the dope.'</i> 	<ul style="list-style-type: none"> • Concerns for youth regarding <ul style="list-style-type: none"> – the threat of incoming ATS – using stronger cannabis – effects on their career pathways – health impacts particularly mental health. • Possible drug substitution due to proposed tightening of alcohol restrictions in the region. • Management of cannabis dependency and withdrawal. 	<ul style="list-style-type: none"> • People in the community are <i>'missing good information about the harms associated with drugs ... to be aware of the misconception of soft and hard drugs'</i>. • Need for improved understanding of drug-related mental health issues. • Need for proactive rather than reactive strategies to deal with substance misuse issues: <i>'We need to draw the line; say: these are the factors, these are the causes, these are the consequence. We need to make informed choices.'</i>
Community suggestions for action	Lamenting lack of power	Future directions
<ul style="list-style-type: none"> • The whole community needs to have a voice in the project. • Recruitment of <i>'trustworthy'</i> local research assistants. • Formation of local reference groups to assist the researchers and police <i>'to filter culturally sensitive issues'</i>. • Target parents: <i>'What happens to your child if they smoke cannabis?'</i> 	<ul style="list-style-type: none"> • <i>'It is the big dealers who are ruining our community.'</i> • Identity of local dealers known but they are <i>'seen as entrepreneurs and use their power to strip (punish) informants'</i>. • We are all parents and fathers and I get frustrated ... <i>'We are thinking "How am I to stop them?"'</i> • People are not attributing any responsibility for drug-related dysfunction in the community to the dealers. 	<ul style="list-style-type: none"> • <i>'The role of the communities is to take ownership of the problem.'</i> • <i>'Dealers need to be named and shamed.'</i> • <i>'We as a community have to start working with the police and we have to be honest with the police for the future.'</i>

munity, locally developed resources and employment and training of local researchers.

The public nature of most of the consultations enhanced community confidence to raise the level of discussion about cannabis and other drug use. Community members were provided a neutral forum from which to challenge the normalisation of cannabis consumption, the acceptance of selling cannabis to raise revenue and the silence over the activities of the handful of dealers who are sometimes in positions of responsibility and power.

In December 2007 and January 2008, the 28 major communities comprising the Indigenous populations of the Cape York and Torres Strait regions formally agreed to implement strategies to reduce cannabis availability. The Regional Organisation of Councils of Cape York (ROCCY) and the Island Coordination Council signed partnership agreements with the Queensland Police Service.

Other drugs use

There are concerns that when there is a reduction in availability of one drug there may be a corresponding increase in use of another drug. In Far North Queensland, there has been a recent history of alcohol restrictions in remote Aboriginal communities to reduce alcohol-related harms. Current expansion of existing alcohol restrictions raises concerns about an increased consumption in cannabis, meaning that 'Weed It Out' is timely because there is a concurrent focus on reducing the supply of a number of drugs into these remote communities.

Future directions

Further discussions regarding 'Weed It Out' will be held following changes brought about by recent Queensland local government elections. Currently the Queensland Police Service and James Cook University are assembling the resources required to implement the various project components.

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DRUG DEATHS: WHY THEY MATTER

JANE MUNDY

When police arrive at the scene of a car accident, they find the 46-year-old male driver dead. At first, it appears a combination of speed and loss of control led to the car slamming into a tree. However, investigations reveal a series of confounding factors. The driver has already experienced one heart attack, and he is known to occasionally use illicit drugs. The last reported sighting of the man was drinking with friends at a pub some hours earlier. Toxicology reports do indeed reveal the presence of alcohol and amphetamines. What role, if any, did they play in the fatal crash?

Were the man's driving skills impaired by some degree of intoxication? Was driving speed an issue, or did a heart attack result in a loss of control leading to the collision? If so, did a history of alcohol and drug use contribute to the attack?

Determining causes of death is not simple. If drugs are involved, they add to the complexity. A 'drug-induced' death is defined as any death where the underlying cause is directly attributable to drug use, including pharmaceuticals (i.e. an acute episode of poisoning or toxicity to drugs, including accidental overdoses, intentional self-harm and assault).

It excludes any death where drugs played only a contributory role (e.g. motor vehicle crashes and drownings); the deaths of newborn babies associated with the mother's drug use; any death where the underlying cause of death is a medical condition caused by long-term use (e.g. cardiomyopathy); and any death where the underlying cause of death is related to the use of alcohol, tobacco and solvents.

Why does the cause of death matter anyway? Knowing the exact reason is not going to bring an individual back to life.

It might, however, contribute to saving the lives of others.

Why is drug death data important?

Data concerning the causes and circumstances of deaths involving drugs are used by coroners, researchers, policy makers, the medical/scientific community, and the AOD profession at large. They are an easily understood and often dramatic way of demonstrating trends and can be used for many different purposes.

These purposes include: assessing the burden of disease in Australia; estimating the social costs of drugs; assessing the impacts of alcohol on Indigenous people; assessing the impact of drugs and other risk factors among released prisoners; treatment outcome studies; assessing the impacts of public policy; evaluating innovative preventive interventions; guiding policy analyses where the relative risk of mortality is an issue; and assessing the impacts of drugs in particular populations to provide an evidence base for new public policies.

Professor Shane Darke, from the National Drug and Alcohol Research Centre, says drug deaths are very complex and it is only by understanding more about the circumstances and causes of death that researchers like himself can begin to tease out the many contributing factors involved. Drug death data provides the essential fodder for this research.

The data are crucial in understanding the impact of individual substances on mortality, as well as how different substances used together (such as alcohol and heroin) can increase risk. 'For example, by looking at the figures for deaths involving both



heroin and alcohol, as well as studying toxicology reports, we have been able to show that concurrent use of alcohol greatly increases the risk of dying for a heroin user,' he explains.

Understanding the circumstances of death can also change policy: for example, when it was clear that fear of police involvement in drug overdose events was stopping friends calling for help, the policy was changed to require police to attend only in the case of death or violence.

Where do we get our figures?

There are multiple sources of mortality data in Australia. Some of the data sets are developed from the same source, such as the Registrars of Births, Deaths and Marriages in each state and territory, or from sources such as coronial inquests and autopsies.

The most commonly used data sets are:

- *Causes of Death* reports, produced annually by the Australian Bureau of Statistics (ABS)
- National Death Index from the Australian Institute of Health and Welfare (AIHW)
- National Mortality Database, also from the AIHW
- National Coroners Information Service (NCIS), which draws on coronial reports
- Departments of Forensic Medicine (DFM) collection, which records drug-related deaths determined through autopsies.

For a description of each data set, see Table 1 (page 32).

Accuracy of information

The ABS and AIHW collections are derived from medical certificates stating causes of death. The ABS codes this information according to the International Statistical Classification of Diseases and Related Health Problems (ICD-10) which provides for 'multiple causes of death' (i.e. the underlying cause of death as well as all other associated causes recorded on the death certificate).

ABS data, documented since 1964, is useful for long-term studies which show shifts in rates of usage over time, while the ICD coding system means, in theory at least, that data is internationally comparable. However, it is essentially a head-count only, without detail, and thus does not capture subtleties such as a death that is attributed to a heart attack where cocaine or other psychostimulants may have been used, or deaths where newer drugs like GHB are involved for which ICD has no coding.

However, the authors of *Australian Burden of Disease and Injury 2003*, released on behalf of the AIHW in May 2007, say the accuracy of ICD data is dependent on the availability and quality of clinical evidence at the time of certification; the thoroughness with which doctors and coroners record information on the death certificate; and the quality of the system used to transcribe information from death certificates and translate it to ICD codes. They believe the extent of distortions of cause of death information in Australia is around six per cent to ten per cent – although this is small by world standards.

They note the significant possibility of inappropriately assigning underlying causes. For example, 'tobacco dependence' may be given as an underlying cause when in fact this should be given as a 'risk factor' for more specific underlying diseases such as lung cancer and cardiovascular disease. This means that the true mortality attributable to these risks can be substantially underestimated.

The AIHW itself warns that analysing mortality data can be tricky. Data has become more complicated by classification systems changing over time as well as changes to data quality (such as Indigenous identification). Other sources of mortality data include the National Coroners Information Service (NCIS) and the Departments of Forensic Medicines, which respectively draw on data from coronial inquests and autopsies.

While the NCIS and DFM collections are more detailed in the information they provide, there are also hurdles in collating this data. Procedures sometimes differ between states – forensic pathol-

ogists and coroners classify differently and toxicology protocols vary. Some substances such as naltrexone are not routinely screened and this may result in an undercounting of some deaths, and a toxicology report is only obtained in about half of all autopsies.

Each of the five data sets has both benefits and shortcomings and sometimes data from one produces findings that beg further analysis using data from another. For example, ABS figures showed no increase in the number of deaths due to methamphetamines over the last few years, NCIS figures suggested a small and steady increase, and a closer examination of coronial cases pointed to an increased risk of death, not due to overdoses of the substance itself but to other problematic consequences of use.

A matter of interpretation

Defining drug related deaths is not straightforward because so many factors are involved. Differences in definitions are subtle and can result in a lack of consistency among data sets which can in turn make comparisons problematic. Should a 'drug death' be one where drugs are a 'part' or 'significant' cause? Should it be one where, without the drug, death would not have happened? Should it be any death where a drug may have only contributed? Or a death in which drugs have been definitely implicated as at least a part cause? The picture is further complicated when some sources refer to illicit drugs only while other definitions may also include prescription and non-prescription pharmaceuticals.

Associate Professor Jo Dufloy, Chief Forensic Pathologist at the Department of Forensic Medicine in Sydney, says the cause of death is obvious in some cases but in others it is not. He cites the example of a 50-year-old man who suffers a fatal heart attack where toxicology also reveals the presence of cocaine. Assuming the death is referred to the coroner and his body comes to the morgue (it might not do so because hospitals do not automatically screen for psychostimulant drugs in such cases), the problem is one of determining whether the man's heart attack occurred as a result of the presence of toxic levels of cocaine in his system or whether the cocaine was incidental to his death. 'It becomes a matter of interpretation and detective work,' says Dufloy. 'The problem lies in the grey areas.'

'How precise are we? We're not. We are 20-30% better at defining cause of death with an autopsy than without, but in an imperfect diagnostic world we do sometimes get it wrong. In a small population, getting even a couple of cases wrong can be important.'

Table 1. Sources of mortality data

Dataset	Body	Source	Use	Benefits	Disadvantages
Cause of Death Report	Australian Bureau of Statistics	Registrars of Births, Deaths and Marriages (drawn from death certificates)	Widespread use for information and research purposes.	<ul style="list-style-type: none"> • Long-term trend data (from 1964). • Internationally comparable because of worldwide ICD* coding on drugs. • Includes illicit, pharmaceuticals, alcohol and tobacco. • May show multiple causes of death. 	<ul style="list-style-type: none"> • Limited detail. • Doesn't capture deaths where drugs were only contributory (e.g. death in a motor vehicle accident). • No data on 'newer' drugs which don't have an ICD* coding. • Long time delay before data is available. • Classifications and data quality have changed over time.
National Death Index	Australian Institute of Health and Welfare (AIHW)	Registrars of Births, Deaths and Marriages (drawn from death certificates)	Used by epidemiologists for medical research.	<ul style="list-style-type: none"> • Long-term trend data (from 1964). • Internationally comparable because of worldwide ICD* coding on drugs. • Includes illicit, pharmaceuticals, alcohol and tobacco. • May show multiple causes of death. 	<ul style="list-style-type: none"> • Limited detail. • Long time delay before data is available. • Classifications and data quality have changed over time.
National Mortality Database	Australian Institute of Health and Welfare	Registrars of Births, Deaths and Marriages (drawn from death certificates)	Shows: <ul style="list-style-type: none"> • Mortality table (analyses cause of death) • Cause of Death table (analyses multiple or associated causes of death) Provides data for use by AIHW and external researchers.	<ul style="list-style-type: none"> • Long-term trend data (from 1964). • Internationally comparable because of worldwide ICD* coding on drugs. • Includes illicit, pharmaceuticals, alcohol and tobacco. • May show multiple causes of death. 	<ul style="list-style-type: none"> • Limited detail. • Long time delay before data is available. • Classifications and data quality have changed over time.
National Coroners Information Service	National Coroners Information Service	Coronial reports	Restricted to use by coronial staff and authorised researchers.	<ul style="list-style-type: none"> • Data available quickly. • Provides access to individual death reports, thus data may be more detailed. • Wider range of drugs reported than in other datasets (ie GHB and MDMA which do not have ICD* classification) 	<ul style="list-style-type: none"> • State/territory differences in the way information is recorded. • Some substances are not routinely screened (e.g. naltrexone) • Does not include tobacco.
Departments of Forensic Medicine	Departments of Forensic Medicine, attached to universities	Autopsies	Data is supplied to coroners and the Australian Bureau of Statistics and also used by external researchers.	<ul style="list-style-type: none"> • Data available quickly • Can compare drug trends with number of deaths • Includes illicit, pharmaceuticals, alcohol and tobacco deaths. • Wider range of drugs reported than in other datasets (ie GHB and MDMA which do not have ICD* classification). 	<ul style="list-style-type: none"> • Toxicology tests for drugs are not automatically carried out in autopsies. The attending pathologist must believe there is a need for a toxicology report.

*ICD: International Statistical Classification of Diseases and Related Health Problems.

Yet precise identification of the cause of death can be particularly important in certain circumstances such as when the presence of drugs in the victim's body is used as a defence in homicide cases, or in workplace accidents involving insurance determinations. Here the stakes are high.

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YOUR SAY: A GOOD READ...

LANCE SCHULTZ, MERIEL SCHULTZ, LOREN BRENER & CARLA TRELOAR*

Readers have told us that *Of Substance* is a valuable tool, keeping them up to date and providing quality information about the issues that matter in the Australian alcohol and other drug sector.

This was a key finding in the most recent evaluation of the magazine, conducted to assess the reach, value, content and style of *Of Substance*. The external evaluation was carried out by LMS Consulting and Associates in March 2008.

Many evaluation methods were used, including an analysis of the magazine's subscription data base, a large representative postal readers' survey (411 respondents of a sample of 1500), telephone interviews with readers (n=35) and non-readers (n=85), and key informant consultations (n=20).

LMS Consulting found:

- *Of Substance* provides a good account of current and emerging issues that are directly relevant to the Australian alcohol and other drugs (AOD) sector, especially front line workers. It is a good-quality magazine and is well written.
- Key informants considered there is a continuing need for a magazine like *Of Substance* to inform workers about the latest research in the field and thereby helping to improve standards in the sector.
- Key informants also considered *Of Substance* helped to build a good sense of collegiality among its readers.

Reach

Of Substance's subscription base now extends to all states and territories and comprises a fair representation of regional, rural and remote areas. *Of Substance* is reaching its main target group of AOD sector workers but continuing aggressive marketing to this group is important. Primary health care workers, GPs, mental health workers, researchers, friends and families of drug users and consumer representatives appear to be not as well represented.

Based on the reports from respondents in the readers' survey, *Of Substance*'s current readership is between 18 500 and 35 000. Downloads of the PDF version of each magazine potentially extend this readership by a further 3000 readers for each edition.

Website usage has grown significantly since the *Of Substance* website became operational in 2006. However, 50% of respondents said they would not read the magazine if it were only published online.

Value, style and content

Of Substance has a core (22%) of avid readers who read the entire issue. Most readers, however, read items of interest. More than 50% of the readers' survey sample always read, or mostly read, the main sections of the magazine (with the exception of letters / readers' responses). 'News/recent releases' and 'articles by experts' were the sections respondents reported they always/mostly read. The next most popular sections were 'research methods', 'experience

in other countries' and 'research digest', all receiving over 70% of responses in the mostly/always read category (76%, 71% and 70%, respectively).

Overall, the readers' survey found that:

- 93% of the survey participants agreed that the magazine addressed relevant drug and alcohol issues
- 91% reported the information published was of high quality
- over 90% considered *Of Substance* relevant to their work
- 89% reported that they enjoyed reading *Of Substance*
- 84% felt that the information presented was accurate and reliable
- 79% agreed the range of topics was sufficiently broad
- 76% agreed that the magazine prompted readers to think about more specific AOD issues
- 68% felt that *Of Substance* was effective in getting knowledge into practice
- 66% agreed that *Of Substance* represents the breadth of the drug and alcohol sector.

Key informant consultations

Key informants were complimentary about *Of Substance* and would like to see it continue as a national magazine. There was a view the material should be made more widely available to other sectors. Generally, respondents thought the content of the magazine was of high quality but could be enhanced by strengthening international context in articles, challenging the status quo more robustly, including a higher percentage of feedback from the AOD field and providing a stronger emphasis on practical examples of how frontline workers can respond effectively to patient and population health needs at the community level.

Recommendations

A number of recommendations were made about the future direction of *Of Substance*. These included:

- maintaining *Of Substance* in a free hard-copy quarterly format
- aggressively marketing to the sector and to related fields such as mental health, primary health care, youth and the community service fields
- raise awareness of its website
- challenge the 'status quo' more, creating greater debate about emerging key issues for those working with substance issues.

For more information about the evaluation, email editor@andc.org.au.

*Lance Schultz, Meriel Schultz, Loren Brener and Carla Treloar write from LMS Consulting, a consultancy which focuses on capacity-building and social justice.

Upcoming conferences

7-9 July 2008

**Beyond 2008 International
NGO drug policy forum**

Vienna, Austria

For more information visit:

www.vngoc.org

10-12 July 2008

**International Addiction Summit –
A Climate for Change**

Melbourne, Vic

For more information visit:

www.pacificcmc.com.

summit@pacificcmc.com

24-25 July 2008

**Winter conference. Substance use across
the lifespan: evidence & intervention**

Beechworth, Vic

For more information visit: [www.nhw.hume.org.au/
pages/services/mental-health-education-research-
team.php](http://www.nhw.hume.org.au/pages/services/mental-health-education-research-team.php)

27-30 August 2008

**2008 National SARRAH Conference.
Many paddocks: one herd**

Yeppoon, Qld

For more information visit:

www.sarrah.org.au

1-3 September 2008

**The combined 2nd International Conference
on Alcohol and Other Drug Related
Brain Injury and the Brain Injury Australia
National Conference 2008**

Melbourne, Vic

For more information visit:

www.arbias.org.au and www.bia.net.au

8-10 September 2008

The 1st world forum against drugs

Stockholm, Sweden

For more information visit:

www.wfad08.org

9-11 September 2008

**Australasian Therapeutic Communities
Association Conference 2008:**

'Advancing The Therapeutic Community Approach'

Byron Bay, NSW

For more information visit: www.atca.com.au

10-12 September 2008

**From Margins 2 Mainstream:
5th World Conference on the Promotion
of Mental Health and the Prevention of
Mental and Behavioral Disorders**

Melbourne, Vic

For more information visit:

www.margins2mainstream.com

15-16 September 2008

**1st global conference on methamphetamine:
science, strategy and response**

Prague, Czech Republic

For more information visit:

www.globalmethconference.com

18-19 September 2008

**2008 Joint Conference with the Travelsafe
Committee of the Queensland Parliament and the
Australasian College of Road Safety. Motivating
behaviour change among high risk road users:
What works and what doesn't work?**

Brisbane, Qld

For more information visit: www.acrs.org.au

20-22 October 2008

Viral Hepatitis Conference 2008

Brisbane, Qld

For more information visit: www.ashm.org.au

23-26 November 2008

**APSAD 2008 Conference: Evidence,
Policy and Practice. Australasian Professional
Society on Alcohol and other Drugs**

Sydney, NSW

For more information visit: www.apsad2008.com

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