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Welcome to the July issue of *Of Substance*.

When I began work in the alcohol and other drugs sector in the ’90s, it wasn’t unusual to hear colleagues talk about clients who had been asked to leave treatment because of misdemeanours – dirty urines, missed appointments, aggression, etc.

These days, attitudes towards the expulsion of clients have changed. While people are still asked to leave on occasion, services do more to ensure they are moved to another treatment provider or support service.

In our cover article, we discuss the issues around the ‘involuntary discharge’ of people from treatment. Is it ethical? Are the very elements of a client’s non-compliance with treatment symptomatic of the condition they need help with? What are the needs of staff?

We also turn our attention to several distinct population groups within the community. On page 18, writer Angela Rossmanith explores alcohol and its impact on the elderly. Meanwhile on page 24, Libby Topp discusses another group, people who inject opiates, and explains the push to provide the lifesaving antidote naloxone to their friends and families for use in an overdose situation. Likewise, we also profile work that will hopefully decrease the level of smoking among Indigenous Australians.

These are just a few highlights from this issue of *Of Substance*. We’ve added to our service with the recent launch of an online eBulletin. This electronic newsletter will keep you posted with updates between print issues of the magazine. To receive a copy in your inbox, visit www.ofsubstance.org.au.

In closing, I’d like to extend a special thanks to the members of *Of Substance’s* Editorial Reference Group, who have been involved in guiding our content for the past four years or more. With the announcement of a new term and membership of the Australian National Council on Drugs, the editorial group also starts another chapter, and we will farewell some members and welcome a few new faces. I would especially like to acknowledge the work of our retiring chairperson, Professor Toni Makkai.

As always, we love to hear from readers via our website at www.ofsubstance.org.au or by emailing editor@ancd.org.au.

Jenny Tinworth
Managing Editor
Mental health services were the big winner in May's Federal Budget. Other measures which will directly affect the alcohol and other drugs (AOD) sector include a detoxification and treatment agency at Wagga Wagga NSW, and the establishment of the Australian Charities and Not-For-Profits Commission. The budget also introduced new initiatives to help people with disabilities including drug, alcohol and mental health problems, join the workforce.

Mental health services:
The budget announced a $1.5 billion injection of funds into mental health services – many of which cater to clients with comorbid AOD issues – over the next five years. In particular, the government will invest $419.7 million over five years to expand mental health services for teenagers and young adults with more funding to the successful ‘headspace’ and Early Psychosis Prevention and Intervention Centres (EPPIC) programs, which also offer AOD services. Other announcements of note included establishing both a national e-mental health portal and a National Mental Health Commission.

Drug and alcohol services:
Aspects of the $1.8 billion budget announced to improve health services in regional and rural communities (as part of the Department of Health & Ageing funding) will go towards AOD services, such as a $3.4 million detoxification and treatment agency at Wagga Wagga NSW.

The budget also included a rationalisation of programs in the AOD budgets at the Department of Health & Ageing – there were no changes in the funding levels but the new system is expected to provide increased flexibility for movement of funds between programs and initiatives with reduced reporting being the rationale for these changes.

Complex needs groups:
The Australian Government will provide $4.7 million over three years to run pilot projects designed to improve employment services to job seekers with multiple disadvantages, including those with a lack of recent work experience, mental health issues, drug and alcohol dependency and homelessness.

Not-for-profit sector:
The Budget has made an allocation for the establishment of an Australian Charities and Not-For-Profits Commission (ACNC), which will commence operations from 1 July 2012. The government will provide $53.6 million over four years to establish the one-stop-shop for the support and regulation of the NFP sector.

Health Budget:

Equal pay case decision
The national workplace relations tribunal decision in May – that hundreds of thousands of social and community service workers have been underpaid for years compared to their public sector counterparts – could pave the way for a pay rise of as much as 30 per cent. More than 200 000 non-government workers employed in sectors funded by federal and state governments – including disability services and aid agencies – will be affected by the decision. While unions have hailed the announcement as a milestone, business groups are fearful of the implications of such a large pay rise claim.

There will be further hearings by Fair Work Australia in August after more submissions to determine the pay increases.

New Cancer Council research released in April shows the majority of people support stripping cigarette packs of their branding and colour. Seven out of ten people (72.6%) approve of plain packaging (smokers and non-smokers combined). Additionally – over half (56.9%) of smokers approve of plain packaging. The Cancer Council Victoria research is based on a survey of 4500 Victorian adults in November 2010.

Health Minister Nicola Roxon revealed in April what cigarette packaging could look like from next year under newly unveiled plain packaging legislation. If the bill is passed, it will be mandatory for all cigarettes to be sold in plain packs by June 2012.

Changes to supply of alcohol to minors in Victoria
The Baillieu government has introduced legislation banning adults from supplying alcohol to a minor in a private home unless parental consent is given, handing decision-making power to parents over access to alcohol by their children, Minister for Community Services Mary Wooldridge said. Legislation introduced by Minister for Consumer Affairs, Michael O’Brien, into Parliament will amend the Liquor Control Reform Act 1998 (Vic), changing the way people under 18 years of age obtain access to alcohol in private residences. Mr O’Brien said the change would hand back control to parents and open the discussion of alcohol consumption between parents and their children.
New CEO for NACCHO

The National Aboriginal Community Controlled Health Organisation Board recently announced the appointment of Donna Ah Chee as NACCHO’s new CEO. Ms Ah Chee has served as the Deputy CEO of Central Australian Aboriginal Congress in Alice Springs for the last 11 years. She is a Bundjalung woman from the far north coast of NSW and has lived in Alice Springs for over 20 years. Ms Ah Chee has been involved in the Aboriginal Medical Services Alliance Northern Territory (AMSANT) and, at the national level, with NACCHO for many years. She has served on many Northern Territory and national bodies, and is a member of the Australian National Council on Drugs and its National Indigenous Drug and Alcohol Committee (NIDAC).

New ANCD membership

The Federal Government announced in April the new membership of the Australian National Council on Drugs (ANCD). Prime Minister Julia Gillard welcomed the addition of several new members to the ANCD who will bring new perspectives on ways to reduce harm caused by drug and alcohol misuse. They will join a number of experienced members of the ANCD – which will continue to be chaired by Dr John Herron.

Established in 1998, the ANCD draws members from a wide variety of backgrounds, who have experience in areas covering law enforcement, the health, education, NGO, research and social welfare sectors and the community sector. The Council’s membership will next be reviewed in 2014. For the full list of ANCD members, go to: www. ancd.org.au/about-ancd/the-prime-ministers-2011-announcement.html.

Australian researcher joins INCB

In April, the Economic and Social Council (ECOSOC) held elections in New York for the International Narcotics Control Board (INCB) for a five-year term (2012–17).

The INCB consists of 13 members who are elected by the ECOSOC and who serve in their personal capacity, not as government representatives. Three members with medical, pharmacological or pharmaceutical experience are elected from a list of persons nominated by the World Health Organization (WHO) and ten members are elected from a list of persons nominated by governments. From among the five candidates nominated by WHO, the ECOSOC elected Professor Wayne Hall, from the University of Queensland’s Centre for Clinical Research.
Resources

NADA NGO toolkit

The Network of Alcohol and Drug Agencies (NADA) has developed a Policy Toolkit to guide non-government drug and alcohol services to develop and review operational policy documents and support their formal quality improvement program.

The toolkit contains 103 templates, including 37 policies and 66 supporting documents. It provides practical policy development templates related to three areas:

- governance and leadership (e.g. financial management policy, risk management policy)
- administration and support (e.g. human resources management policy, communications policy)
- service delivery (e.g. child protection policy, suicide and self-harm policy).

While the toolkit does not replace the need for an organisation to develop policies, it will assist in developing and reviewing policies and in an organisation’s quality improvement program. The toolkit has been a collaborative project between the Australian Government Department of Health and Ageing-funded Cross Sectoral Support and Strategic Partnerships Project and the NSW Health-funded Sector Development Program.

For more information contact NADA on: 02 8113 1320 or visit: www.nada.org.au.

New look DrugInfo website

The redesigned Australian Drug Foundation (ADF) DrugInfo website (www.druginfo.adf.org.au) was recently launched at the 6th International Conference on Drugs and Young People. The new DrugInfo website and email alert service continues to provide quality-assured, evidence-based information relating to alcohol and other drugs. The website has been streamlined and optimised to make finding information quicker and easier.

Tips and tricks

The National Drug Sector Information Service has published its third edition of Tips and Tricks for New Players: A guide to becoming familiar with the alcohol and other drug sector (T&T). In this third edition, familiar sections like the lists of organisations and acronyms are included but the definitions list has been expanded and thoroughly referenced to provide a reliable resource for readers. Other sections are slightly different from previous editions and an area has been devoted to continuing professional development in acknowledgment of the needs of AOD workers who are using T&T for perhaps the second or third time. Finally, the new edition has added a section authored by experts or representatives of organisations within the sector.

The publication is available online via: http://ndsis.adca.org.au/ndsis_publications.php.

Clearing the smoke

The National Cannabis Information and Prevention Centre (NCPIC) has produced a new DVD entitled Cannabis Facts: Clearing the Smoke. The aim of the DVD is to provide the alcohol and other drugs (AOD) sector and allied health workers with evidenced-based information about the drug. The DVD is accompanied by an education and training package that can be downloaded from the NCPIC website www.ncpic.org. Copies of the DVD can also be ordered on the website. The DVD can also be used as a stand alone resource for the sector; however it is not suitable or intended for screening with secondary school students.

Comorbidity/Dual diagnosis for families

In recognition of the important role that families have in supporting recovery from co-occurring mental illness and substance misuse, the following information pack has been designed: Allies for Recovery: Information and support options for families living with mental illness and alcohol & drug use in Tasmania.

This new information pack and various other comorbidity resources can be downloaded from: www.utas.edu.au/sociology/CRU/cru.html.

New Drug Policy Modelling Program monograph

This new monograph reviews drug policy in Australia from 1985 to 2010. It examines the development of Australia’s drug strategies and then compares this approach to that of other countries. It provides an analysis of trends and patterns of drug use and harms in Australia and considers what may account for these changing patterns, including the role of government intervention. The monograph critically examines how policy makers, stakeholders and the mix of competing ‘voices’ in the Australian drug policy arena shape and influence the nature of drug policy. It is a tool for policy makers, practitioners and researchers alike.

A PDF version of the monograph is now available on the DPMP website: www.dpmp.unsw.edu.au.

The Australian (illicit) drug policy time line, also developed by the DPMP, provides a list of key events, policy and legislative changes that have occurred in Australia between 1985 and 31 December 2010. Events are listed by territory level. To help repeat users of the time line, all events added in the last six months are highlighted in yellow.

The DPMP will continue to update the time line every June and December: www.dpmp.unsw.edu.au/sociology/CRU/cru.html.
A voice of concern

I am writing with concern about the publication of Gary Christian’s letter in Of Substance magazine’s March 2011 issue. Mr Christian, and the Drug Free Australia (DFA) he represents, has been called to account on his representation of the facts in respect of the Medically Supervised Injecting Centre (MSIC) many times. His reference to DFA’s academic analysis of the KPMG evaluation of the MSIC uses the age-old strategy of criticising research on questionable grounds and raising methodological or statistical objections to research outcomes he doesn’t like. His letter to Of Substance was designed to influence readers by distorting the arguments and research that have shown the MSIC to be a successful model for such a facility. I hope that your readers are open-minded enough to know that there are other well-researched points of view on this topic.

Jerome L Gelb
Armadale, Victoria

AA & NA: Not for everyone

I’ve just been reading the March 2011 issue, with the article on NA and AA [AA & NA: In step with today’s treatment?]. I’m glad that this issue has been discussed so openly on your pages as I am one of the people who struggles with those models.

I am very glad that these organisations are helpful to many people, but I find many aspects of the 12-step program difficult in my situation. I have found that a trauma model for therapy in many areas of mental health, including substance abuse has been most beneficial to my recovery.

It’s nice to know that these issues regarding AA and NA are being talked about for others who may feel the same way.

Emma McDonald
Mawson, ACT
It is pleasing to see that all state and territory governments have indicated a strong commitment to the new 2010–2015 National Drug Strategy (NDS) and improved governance arrangements. Retention of the three pillars – demand reduction, supply reduction and harm reduction – as the overarching structure for the NDS provides the most effective mechanism to determine drug and alcohol policies and priorities, while maintaining the underlying tenet of harm minimisation.

As the national peak for the alcohol and other drugs (AOD) non-government organisation (NGO) sector, the Alcohol and other Drug Council of Australia (ADCA), believes the new NDS is strengthened by the identification of alcohol and pharmaceuticals as key priorities. This is a first for the NDS, meaning that the NDS now covers all drugs.

While disappointed that the Ministerial Council on Drug Strategy will cease on 30 June, ADCA was pleased that the proposed framework will ensure that AOD policy issues are represented at the highest level, through continued partnerships between health and law enforcement portfolios.

ADCA sees the new governance arrangements for the NDS as an opportunity to work closely with the Australian National Council on Drugs to facilitate the development and implementation of NDS policies.

This means that the NDS will need to be worked through collaboratively with a number of stakeholders and related working groups so that the Intergovernmental Committee on Drugs, which will manage the ongoing work of the NDS, can take full account of diverse views and consumer interests. The consultation must be genuine and not be a forum for government officials only.

Achieving this will require committed leadership and direction from all peaks with their member bodies, and the many organisations that make up the AOD NGO sector. We can’t afford to be seen as a dysfunctional rabble, especially when the main priorities for the sector are clearly more resources, particularly for prevention, and growing, retaining, mentoring and attracting quality people into the workplace, combined with addressing pay inequity within the sector.

The NDS must also be seen as an essential plank of the Health Reform Agenda. The strategic message of the NDS is that it be linked to the recommended outcomes from other major Federal Government-directed reviews, such as the Henry Review into Australia’s Future Tax System, the Productivity Commission’s Study of the Contribution of the Not-for-Profit Sector and Treasury’s Scoping Study for a National Not-For-Profit Regulator.

*David Templeman is the CEO of the Alcohol and other Drug Council of Australia.*
Breastfeeding: Surprise finding


Tobacco use by mothers significantly impacts the health of their children and breastfeeding. Childbearing women who smoke expose their unborn babies and children to the effects of passive smoking, including increased incidence of respiratory infections, ear infections and asthma; reduced lung function; and increased rates of medical consultation and hospitalisation for respiratory illness during the first 18 months of life. Increased risks of sudden infant death syndrome and diabetes are also associated with maternal smoking. In addition, studies have repeatedly shown that women who smoke are less likely to initiate breastfeeding, and those who do, breastfeed for shorter periods. Thus, the babies of women who smoke may be deprived of or have reduced exposure to breastfeeding’s health benefits, which include protection against respiratory infections.

Designed to be comparable to a previous study of breastfeeding among a broader sample of women giving birth in two Perth public hospitals in 1992–1993, the Perth Aboriginal Breastfeeding Study (PABS) investigated the breastfeeding patterns of 425 self-identified Aboriginal mothers who gave birth at six Perth public hospitals between May 2000 and July 2001. Women were interviewed in hospital and at regular intervals post delivery. Follow-up proved challenging, with just 56% of women remaining in the study at 24 weeks. Nevertheless, there were no significant baseline differences in key variables between women who were and were not retained in the study.

At discharge, 67% of women smoked, with a slight decline to 61% at 24 weeks. These proportions were higher than among the non-Aboriginal mothers who participated in the earlier Perth study, reflecting the high smoking rates among Indigenous people. Younger Aboriginal mothers were more likely than older ones to smoke. At discharge, 89% of women were breastfeeding, declining to 56% at 24 weeks. In contrast with most previous research, there was no adverse effect of smoking on initiation or duration of breastfeeding: women who smoked and those who didn’t were equally likely to be breastfeeding at discharge and to still be breastfeeding at 24 weeks. Likewise, there was no dose-response relationship between the number of cigarettes smoked per day and duration of breastfeeding – lighter and heavier smokers were equally likely to still be breastfeeding at 24 weeks. The authors considered it nevertheless likely that the high rates of smoking among Aboriginal mothers contributes to their higher rates of low birth weight babies. They also argued that although women should be encouraged to stop smoking during pregnancy and breastfeeding, women who continue to smoke should be encouraged to breastfeed nevertheless. Breastfeeding confers protection against infectious disease in infancy and in particular against respiratory infections associated with environmental exposure to cigarette smoke.

Students and smoking


Preventing Indigenous adolescents from smoking may reduce tobacco-related harm among future generations of Indigenous adults. This study compared trends in smoking prevalence between 1996 and 2005 among self-identified Indigenous and non-Indigenous participants in the Australian Secondary School Alcohol and Drug
Survey, triennial national surveys of large, random samples of students of Government, Catholic and Independent schools. Each survey year, three to four per cent of students identified as Indigenous. Students were divided into groups based on different smoking intensities, and also indicated their intentions to smoke within the next 12 months.

Students were divided into younger (12–15 years) and older (16–17 years) groups. As school attendance is compulsory only until the age of 15, school-based surveys provide an effective way of collecting data from representative samples of younger students, but early school leavers are not captured in these surveys and other research indicates these adolescents are more likely to smoke. Given lower school retention rates among Indigenous students, results for older Indigenous students are likely to underestimate levels of smoking among older Indigenous adolescents in general.

Smoking was more common among Indigenous than non-Indigenous students. Across all smoking intensities, prevalence of smoking was lower among both Indigenous and non-Indigenous students in 2005 than in 1996; however, the patterns of decline differed between groups. Among younger Indigenous students, most of the decrease occurred between 1996 and 2002, with only small additional declines between 2002 and 2005; likewise, among older Indigenous students, there were significant declines between 1996 and 2002 but no further decreases in subsequent years. In comparison, among non-Indigenous students in both age groups, declines occurred more steadily, including between 2002 and 2005.

Smoking decreases among Indigenous students between 1999 and 2002 coincided with increased state and federal tobacco control activity during this period, including media campaigns, price increases, advertising restrictions and public smoking legislation. Investment in such activities declined after 2002; smoking prevalence concurrently stabilised among Indigenous students but continued to decrease among non-Indigenous students. These results suggest that tobacco control strategies are effective among Indigenous and non-Indigenous adolescents. However, when tobacco control efforts decrease, their beneficial effects are maintained among non-Indigenous adolescents but weaken among Indigenous adolescents.

In addition, while average intention to smoke – an indicator of receptivity to smoking – was lower in 2005 than found in 1996 among all student groups, intention was consistently higher for Indigenous than non-Indigenous students, possibly because smoking is a normative behaviour among Indigenous communities. Cessation programs targeting Indigenous adults may have beneficial effects on adolescent smoking.

A challenge for health workers


Research indicates that health professionals’ credibility with patients is influenced by their own smoking. High rates of smoking among Aboriginal Health Workers (AHWs) have been identified as a key barrier to implementation of Indigenous-specific cessation programs. AHWs provide essential health information in Indigenous communities, and personal tobacco use may make AHWs uncomfortable about offering smoking cessation advice. This study implemented focus group and survey methodologies to measure AHW smoking and readiness to offer community members cessation advice; and to document barriers to quitting among both AHWs and the broader Indigenous community.

AHWs across two southern NSW health services completed a tobacco survey in 2000, 2001 and 2002. With a response rate of 79%, 81% of respondents were female, with an average age of 40 years. An average of 62% reported currently smoking, indicating that AHWs are more likely to smoke than the general Indigenous population, possibly due to stress related to the high expectations of their community and of non-Indigenous health workers. The proportion who reported smoke-free homes ranged from 46% in 2000 to 58% in 2001 and 55% in 2002. Ninety-three per cent were aware that passive smoking poses health risks. Most AHWs who smoked said they were considering quitting or taking action to do so.

Eighty per cent reported providing cessation advice in a professional capacity; reasons cited by those who hadn’t included inadequate training or resources, and discomfort due to personal tobacco use. Some non-smoking AHWs also expressed discomfort around offering cessation advice as they felt they lacked understanding of nicotine addiction. Three-quarters were interested in attending cessation intervention training, with previous research indicating that professional training prompts AHWs to consider a quit attempt. Stress was the most commonly reported barrier to quitting among AHWs themselves; for the broader Indigenous community, stress, addiction, withdrawal and lack of support and information were considered significant barriers.

Five key themes emerged during focus group discussions among four women AHWs who smoked. They felt that their community was not fully aware of smoking-related health risks; that stress was the main reason for elevated smoking prevalence among Indigenous Australians and an important motivation underlying smoking among AHWs themselves; that a lack of family and co-worker support for quitting poses a substantial barrier because exposure to other people’s smoke undermines quit attempts; that Koori-specific cessation interventions would help establish support networks between community members attempting to quit; and that as smokers themselves, it would be hypocritical to provide cessation advice to other smokers. They would, however, feel comfortable discussing with parents the dangers of children’s exposure to passive smoke or to pregnant women. Together, results suggest that providing Koori-specific cessation support groups may make AHWs more likely to attempt to quit, and may then feel more comfortable referring community members to attend.
But there was a bigger problem – custody of Jill’s four children was conditional on her staying on methadone and there was no option of detox because she was on a very high dose, says Sarah Lord, of Harm Reduction Victoria’s Pharmacotherapy, Advocacy, Mediation and Support (PAMS) service.

‘The client had no car to get to a pharmacy in another town so we had to be very creative. We found a nurse in a community health centre in the next town who picked up a measured dose of methadone and drove to meet her at the community health centre in her home town three times a week. This lasted for three months until the client moved to another town,’ she says.

While Jill wasn’t denied treatment for heroin dependence, it was a near miss, says Lord, and highlights one of the difficulties of keeping complex clients in treatment, especially in rural or regional areas where service delivery is often limited.

‘If someone is terminated from treatment at one pharmacy in a country area and there’s no other pharmacy available, it’s a problem,’ she says.

Exactly how many clients of drug and alcohol services are discharged from treatment each year for non-compliance isn’t clear. Although almost 3000 episodes of discharge for non-compliance in 2008–09 are listed in *Alcohol and other drug treatment services in Australia 2008–09: Report on the National Minimum Data Set*, this figure doesn’t include clients treated with opioid pharmacotherapy alone.

The reasons why clients are involuntarily discharged can depend on the setting.

‘In residential services the grounds for involuntary discharge may include breaking a serious or “cardinal” rule which has been established to ensure safety and equitable treatment of clients. In a therapeutic community these cardinal rules are: no violence, no threat of violence, no use of alcohol or unprescribed drugs, no stealing and no unsanctioned sexual relations between clients,’ says Associate Professor Lynne Magor-Blatch, Executive Officer of the Australasian Therapeutic Communities Association.

As for pharmacotherapy treatment, NSW Health’s *Opioid Treatment Program: Clinical guidelines for methadone and buprenorphine treatment*, for example, lists violence or threat of violence against staff or clients, property damage or theft, diversions, drug dealing on or near the dosing location or ‘unacceptable disruption to the local amenity’ as possible reasons for discharge. But, like the national guidelines – the *National Pharmacotherapy Policy for People Dependent on Opioids 2007* – the NSW policy makes it clear that transferring the client to another service is an alternative option. Rapid dose reduction or abrupt cessation of treatment is warranted only in cases of violence, assault or threatened assault says the NSW policy.

**Is it ethical?**

But some workers in the drug and alcohol sector question the ethics – and logic – of denying clients treatment as a result of behaviour that may be symptomatic of their problem.
‘In my experience, exclusion criteria address the kind of chaotic or erratic behaviour which can be a result of the problem services are attempting to treat,’ points out Dr Jurgen Hemmerling, a dual diagnosis clinician with Albury Wodonga Health. ‘Treatment is about helping people modify their behaviour and live in society – should the fact that they’ve threatened someone be a reason to deny them treatment?’

‘I think it’s about managing things better. If someone is threatening violence then they can be charged by the police. I think the service’s attitude could be, “we’re getting you charged with assault, but we’ll see you tomorrow”,’ he says, suggesting that services post signs clearly saying that violence is unacceptable and that police charges are an option, as in hospital accident and emergency units.

Hemmerling’s view is echoed in It’s time to stop kicking people out of addiction treatment, the 2005 paper published by William White of the Lighthouse Institute in Bloomington Illinois. ‘We know of no other major health treatment for which one is admitted for treatment and then thrown out for becoming symptomatic in the service setting. For other chronic health care problems, symptom manifestation serves as a confirmation of diagnosis or feedback that alternative methods of treatment ... are needed,’ argued White and his co-authors.

Clients leaving opioid maintenance treatment in a planned way are twice as likely to achieve abstinence than those who drop out of treatment or have it withdrawn, says the UK National Treatment Agency’s Towards Successful Treatment – a good practice guide, while 75 per cent of clients who are involuntarily discharged from treatment return to using heroin, according to the World Health Organization.

Why clients misbehave

There are factors in pharmacotherapy settings including waiting times, withdrawal of takeaway doses and fees charged in private pharmacies that can contribute to outbursts of anger from some clients that may result in involuntary discharge, say consumer advocacy organisations.

‘Sometimes people are kept waiting for their dose and there can be a build-up of frustration that can lead to the client being excluded. Long waiting times can be a problem, especially if people are trying to get to work,’ says Sione Crawford, Community Programs and Services Team Manager of the NSW Users and AIDS Association (NUAA). ‘There’s no excuse for violence but some people are just out of jail or aren’t used to waiting politely in line.’

Some clinics also have features reminiscent of prison conditions – like waiting for a buzzer before being allowed to go through a door – which Crawford believes can add to the tension.

‘A large percentage of clinic staff handle clients well, but staff can also get burnt out. You may have had trouble with ten clients on a particular day but it’s the eleventh challenging client who then gets the brunt of the worker’s own frustration and it can escalate. But at the end of the day the worker has an obligation to help clients stay in treatment – it’s unrealistic to expect all clients to behave impeccably.’

GETTING KICKED OFF TREATMENT: A BRIEF HISTORY

Attitudes to expulsion within the alcohol and other drugs sector have changed over time. Of Substance asked three long-term treatment providers to reflect on their experience of involuntary discharge.

James Pitts, CEO, Odyssey House Sydney: ‘When I began here in 1978, the prevailing ethos was that you were a drug addicted person who had to demonstrate motivation to change. If you were deemed to have a negative attitude because you challenged the rules, there was a much greater chance of being asked to leave. Things changed with the introduction of harm minimisation in Australia in 1985. There was more flexibility and it became easier to get into treatment and harder to get thrown out. We have become more tolerant and we understand addiction much more now.’

Lynne Majgor-Blatch, Executive Officer, Australasian Therapeutic Communities Association: ‘Things have changed over the years to become more accommodating – the cardinal rules in therapeutic communities haven’t changed much, but the black and white-ness has and there’s more flexibility in how rules are enforced.’

Jennifer Holmes, Clinical Services Manager, Sydney Medically Supervised Injecting Centre: ‘When I first started in pharmacotherapy treatment over 20 years ago, the thinking was that resources were precious and not to be wasted on people with no motivation. If someone didn’t turn up for their dose after three days, we took them off the books. Now people are followed up to make sure they’re still okay. Services have become more risk aware. I think there’s now more emphasis on protecting the service providers and the program – the needs of the program can sometimes outweigh those of the individual. The situation has changed: it’s not so much better or worse than in the past – it’s just different.’
But community pharmacies, not public clinics, provide most maintenance doses for people on opioid pharmacotherapy in Victoria where it’s possible that at least one person is asked to leave a pharmacy dispensing program every day, according to PAMS.

While most of the estimated 13,500 people on opioid pharmacotherapy in Victoria usually have no problems with their program, says Lord, some do – 663 of them asked PAMS for help last financial year, often because of difficulty paying pharmacotherapy dispensing fees.

‘The $5 to $8 per dose dispensing fee is a problem for some clients – $70 a fortnight is a lot of money for someone on a Centrelink benefit. Arguments can erupt and a pharmacist may say “come up with at least $20 tomorrow or don’t come back”. The main goal of PAMS is keeping people on a program if that’s what they want,’ says Lord, adding that PAMS often has to source financial assistance to help clients pay dispensing fees.

Although clients can be terminated for inability to pay, as well as for violence, shoplifting dose diversion, or missing too many doses, she adds, most people manage to resume dosing with PAMS’ help.

‘In most cases where a client has been banned from a pharmacy program, we re-negotiate new conditions with the current pharmacy or negotiate a “trial” at a new pharmacy. But it would be an improvement if there were a safety net service where clients can always get a dose, ideally a free dose, if things go wrong,’ she says. ‘It would give you time to sort something out and ensure program continuity. There would be less risk of someone overdosing, returning to illicit use, dropping out of treatment altogether or committing a crime.’

Diversion of methadone and buprenorphine is another reason people may be involuntarily discharged says Nicky Bath, General Manager of NUAA. ‘But it’s important to be sure of the reasons for diverting. Some people may be selling their dose, but it may be that they prefer to take small amounts of their dose through the day rather than all at once. Sometimes couples can’t afford doses for both partners so they share a single dose,’ she says.

Conflicting needs

In residential services when someone breaks the rules, you’re always weighing up the needs of the individual against those of the community, says Lynne Magor-Blatch.

‘A person may need to be in treatment but in circumstances where there has been violence if the person is going to be a threat to others, you have to look after the community first.

‘But it’s not all black and white. Every situation needs to be looked at case by case. With some drug use, such as amphetamines, you can get violence and threats of violence and you have to cut people some slack – this recognises that sometimes the person may lack impulse control. On the other hand if it were a residential service with children you might not be so flexible,’ she adds.

Magor-Blatch recalls an incident where a client in treatment, accompanied by her children, used an illicit drug. Technically she should have been discharged but the children’s father had just died and the family was very distressed. Discharging the client meant losing the opportunity to work with the children and risking the family being broken up, so it was decided to issue an administrative discharge – meaning a discharge on paper that was a rap over the knuckles, but allowed her to remain in treatment.

‘You need to have some standardisation but also be prepared for flexibility, although the use of substances in residential settings is usually more black and white – clients are not only putting their own recovery at risk but also that of other people, and in a therapeutic community you’d probably find the others would want them to leave too. Sometimes in these circumstances you’d say “you need to leave but you can go into detox and then come back”,’ she says.
‘CLIENTS LEAVING OPIOID MAINTENANCE TREATMENT IN A PLANNED WAY ARE TWICE AS LIKELY TO ACHIEVE ABSTINENCE THAN THOSE WHO DROP OUT OF TREATMENT OR HAVE IT WITHDRAWN.’

‘It’s hard to make the decision to discharge someone. You think “what will happen to them? Will it set their recovery back? What if this was their only chance to get into treatment?” On the other hand when someone is discharged it can be part of the process that helps them change. If you look at the stages of change it may be the event that pushed them forward from contemplation into action.’

Avoiding involuntary discharge

Most people interviewed for this article said that involuntary discharge from residential settings and pharmacotherapy clinics was a last resort and efforts were made to find clients alternative services. But there was also an acknowledgment that alternative services aren’t always there.

‘If there’s anything that could be done better to reduce the risk of involuntary discharge, it would be to have specialist staff and facilities to deal with more difficult patients – but they’d be needed in rural areas too,’ says Dr Allan Quigley, Director of Clinical Services with the Next Step Drug and Alcohol Services in WA.

‘We’ve always seen involuntary discharge as very serious because clients are often worse off when they come back. But clients have to learn there are consequences so that they think about the implications of their behaviour. In my experience, if clients are treated fairly they’ll accept the consequences. I think when unfair treatment occurs it’s likely to be lack of experience on the part of the staff. That’s why clinical review processes and supervision are important. But it’s also about having policies that don’t set clients and staff up for conflict – there’s an inherent tension in pharmacotherapy programs that can set clients up for frustration.’

The best way to avoid involuntary discharge is good governance – a process of continuously scrutinising work practices and working to improve them – says Associate Professor Adrian Dunlop, Area Director of Drug and Alcohol Clinical Services with the Hunter New England Local Health Network. ‘There are always going to be tensions in health services. There are occupational health requirements and staff needs, but services have to be patient-centred and clinical governance helps deal with this. But this can be a challenge for the NGO sector. When governments fund services there can be clinical governance, but NGOs have less funding, a minimum level of administration and may have staff with fewer qualifications and experience.

‘Things could be done better. I think we should have a goal of treatment for anyone who needs it, but abuse of drugs and alcohol, excluding tobacco, represents about six per cent of the burden of disease – however it receives only 0.1 per cent of health funding. The funding doesn’t reflect the need.

‘Spending time in the criminal justice system doesn’t do anything for people who have problems with drugs and alcohol either,’ Dunlop adds. ‘People can come out with difficult attitudes towards institutions – we can look to the Portuguese model where they lock up fewer people with drug and alcohol problems.’

At Rankin Court, the opioid treatment program at Sydney’s St Vincent’s Hospital, involuntary discharge is rare partly because the clinic has a system in place where complex patients with difficult behaviour can be dosed outside of normal working hours and when no other patients are around, says Nurse Unit Manager Catherine Andrews.

Andrews believes that engaging patients as much as possible during dosing hours can also help prevent problems developing.

‘You only see people for five or ten minutes but if they seem anxious, for instance, you can talk to them and ask if they’re okay. It can take a lot of time to build up trust when people have been marginalised and have had the rough end of the stick,’ she says. ‘If someone’s disruptive we try to find out why. We explain that we don’t want to have to transfer them to another service and they usually settle down.

‘I also think it would be great if we had a trained and paid worker from NUAA in the clinic – that way patients would have a consumer representative available.’

*Real names have not been used.

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Of Substance interview:
Michael Farrell, NDARC

THE NATIONAL DRUG & ALCOHOL RESEARCH CENTRE RECENTLY WELCOMED A NEW DIRECTOR. MICHAEL FARRELL HAS TRAVELLED FROM THE UNITED KINGDOM TO TAKE UP THE POSITION.

OS: Welcome to Australia. What is your background?
MF: I grew up in Dublin, Ireland. I did my basic medical training there and then moved to the UK. Later I trained in psychiatry and became very interested in working with alcohol problems. Over the past 20 years, I’ve been working at the King’s College in London, the Institute of Psychiatry and the National Addiction Centre, doing a mixture of both research and clinical practice around drugs and alcohol.

OS: What attracted you to working with drugs and alcohol?
MF: I think the fascinating thing is the breadth of the subject. It isn’t narrowly circumscribing. It covers everything from international policy, social policy, economics, politics. Then you get down to real science – not just basic biological sciences and pharmacology, but also molecular genetics and neuroscience. There’s a fascinating array of things. I’m interested in the way it permeates and burdens people’s lives. I want to challenge the belief that people don’t make dramatic recoveries. Because they do.

OS: When I began work in this area, it was in the era of [the first epidemic of] HIV/AIDS. That was an exciting challenge and a time when there were opportunities to look at things differently and to be innovative. There were big opportunities.
MF: One of the things that attracted me to Australia is that the research environment here has been really impressive and highly productive, locally as well as internationally. I think there are opportunities to push that a bit further. The research infrastructure that has been built over the last 15–20 years can be exploited and developed further to produce new research programs to address today’s challenges.

I have worked in both the treatment field and in research. I’ve also provided policy advice to governments in the UK, so I think there is an opportunity to bring all those experiences together here.

OS: Do you see any of those opportunities in the current environment?
MF: One of the things that attracted me to Australia is that the research environment here has been really impressive and highly productive, locally as well as internationally. I think there are opportunities to push that a bit further. The research infrastructure that has been built over the last 15–20 years can be exploited and developed further to produce new research programs to address today’s challenges.

I have worked in both the treatment field and in research. I’ve also provided policy advice to governments in the UK, so I think there is an opportunity to bring all those experiences together here.

OS: You’ve played a significant role in Europe and the UK with policy and the drug sector. Why have you left that to move to the other side of the world?
MF: It’s an exciting challenge. There are plenty of opportunities and resources here. Australia can be proud of its track record. It has a far more balanced and sensible policy view than many places, and there are very talented people here. When people see a problem here, there’s a readiness to tackle it, so that’s attractive. And it’s a beautiful place!
OS: What ties have you maintained with the European drug sector?

MF: I am still an editor in the Cochrane Collaboration Drug and Alcohol Group, and Chair of the Centre for Advisory Committee of the European Monitoring Centre for Drugs and Drug Addiction. I am a Visiting Chair in the UK Institute of Psychiatry. I still have a very big study going on there, where we are looking at people released from prison and tracking them over a long period of time. So that work will continue in my absence.

I think it’s quite useful to keep those connections, just in terms of keeping tabs on what people are doing. However, my work is here now and I won’t be going back often.

OS: What do you see as the differences between the policies of the UK and Australia?

MF: England is much bigger, more complicated, with a different social make-up. So they are important issues when trying to compare the two. Europe is also interesting from this point of view, as European policy is quite convergent, despite having very diverse cultures. That’s connected to the European Monitoring Centre for Drugs and Drug Addiction and policy forums which see information shared across jurisdictions.

The variant at the moment in the UK – and the same may apply in Australia – is there’s a sense that when you have achieved a certain amount, people take it for granted. For example, look at opiate dependence: we’ve now had a problem for many decades. There’s a growing maturity about the issue, and lots of work has been done to make a difference. But there’s not a sense of urgency any more, and when this happens, issues like this begin to slip down the political agenda.

The big issue in Europe and in the UK that doesn’t seem to have come here is around party drugs available over the internet, so-called legal highs, and head shops. These have caused enormous policy pressure in Europe and the UK, resulting in criticism of government policy for a failure to rapidly take some of these substances under control. I anticipate that, in due course, it will probably be a problem here too.

In the UK, the funding mechanisms supporting a lot of the therapeutic community and drug-free sector have been caught up with local authorities and have been substantially squeezed. So people’s access to drug-free rehabilitation has become more restricted. This has caused a schism between that and other community-based treatments. So if you are in one kind of treatment, you can’t readily access another type. I believe people should be able to have ready movement across the system. Australia seems to be more balanced in this area.

Another area which both countries need to focus on is that there are not enough structured approaches to help people to move on when they are on pharmacotherapies. We need to ensure that there are enough wraparound services, rather than this just being a script-and-go service. As some of these services move into their third or fourth decade, there is a big variety in quality being offered. I believe accountability, quality and governance will be real issues in the next decade.

OS: What do you see as the big issues for the next couple of years for NDARC?

MF: We must make sure we are dynamic, active and that we can hear what the issues in the broader community are, and respond to those. As a research centre, it’s very important that we are achieving a high level of excellence in our research. And ideally, new findings with significant implications so we are able to talk about rolling out from research to practice. We must make a real connection between what we do at the theoretical level, and what actually rolls out and what impacts the community as a whole, young people and users.

In terms of shaping policy, our work is to be honest brokers of good evidence, and to not be pushing a position. Our job is to be as critical as possible about the available evidence and help to advise.

If there is no data on something, we should be gathering data. When it comes to new treatment innovations, I think people who are alcohol- or other drug-dependent deserve the same protection as anybody else in society.

OS: What message would you give to people working in the drug and alcohol field in Australia?

MF: People are doing a good job. The culture of wanting evidence and research to help guide what’s been done is reasonably well embedded here. I think we need to join together more – to establish good collaboration across treatment systems that invites research and evaluation, and developing trial networks and systems that encourage self-evaluation is important.

In terms of research, we have a responsibility to get better and better at the studies we do, in relation to the questions that they answer. It’s not very helpful to have big studies that don’t answer any questions. So we need to be aiming for bigger clinical treatment studies that produce sound and robust findings that guide further development.

We need research for change’s sake, not for research’s sake.
The Alcohol Education & Rehabilitation (AER) Foundation’s Annual Alcohol Poll: Community Attitudes and Behaviours shows that in the past year, more people have come to regard alcohol as the most harmful drug when compared to tobacco and illicit drugs.

In 2010, 31% of respondents named alcohol as the most harmful drug. In 2011, this figure increased to 37%.

There was also a marked rise in the number of people who believe Australians have a problem with excess drinking – 80% of respondents agreed, up from 73% in 2010. This was coupled with strong support for more community-wide action to address alcohol problems (82%).

In particular, the report found that the majority of Australians were supportive of implementing policy measures, including: banning alcohol advertising on television before 8.30 pm (69%), banning alcohol industry donations to political parties (64%), introducing health warning labels (62%) and establishing an independent alcohol advertising regulatory body (58%).

AER Foundation CEO Michael Thorn said: ‘These figures paint a picture of an unhealthy drinking culture in Australia. The results show us that people largely see this issue as someone else’s problem, and that they are potentially unaware of both the short and long-term harms that can arise from the misuse of alcohol.

‘I urge people working within the alcohol and other drugs sector to use these findings to send consistent messages to governments, politicians and decision makers about the need to tackle alcohol policy reform and to support work at a grassroots level.’

Mr Thorn said the survey highlighted three areas of opportunity for policy makers.

‘Firstly, the Commonwealth has recently received the Blewett Report on food labelling and is promising action on its recommendations. Australians are supportive of the idea that alcohol products should be labelled with health warnings. This will increase awareness about the dangers associated with the harmful use of alcohol,’ he said.

‘Secondly, the government’s tax forum will be held later this year. This provides the perfect opportunity to implement a system whereby alcohol is taxed based on its alcohol content, as well as the introduction of a minimum floor price. The evidence is clear that price is strongly correlated with consumption levels and consequently pricing reform is vital.

‘And finally, the development of the Preventive Health Agency provides another opportunity to shape a reformist plan for cutting the harms caused by alcohol misuse. The government has identified alcohol as one of three priorities for action, so the time has come to make prevention a meaningful priority.’

Key findings of the Annual Alcohol Survey

**Alcohol consumption**

- alcohol is consumed by 84% of Australian adults
- while around half (52%) of all drinkers limit themselves to one to two standard drinks on a typical occasion, there
THE POLL: KEY FACTS

The AER Foundation’s Annual Alcohol Poll was conducted online in January 2011. The 1009 respondents came from across the country, with quotas applied to ensure the sample reflected the composition and geographical distribution of the Australian population. Participants were aged 18–64.

Several key definitions have been used throughout the Alcohol Poll report:

- Gen Y: aged 18–29 years
- Gen X: aged 30–44 years
- Baby Boomers: 45–64 years
- Regular drinkers: consume ten or more standard drinks per week
- Moderate drinkers: consume one to nine standard drinks per week
- Occasional drinkers: consume less than one standard drink per week.

are a large number of Australians who continue to drink alcohol at harmful levels

- there was a significant increase in the number of regular drinkers who think Australians have a problem with alcohol, with 78% of regular drinkers reporting this, up from 59% in 2010.

Drinking to get drunk

- the majority (61%) of Gen Y drinkers consume alcohol to get drunk
- almost one in ten Australians drink alcohol to get drunk once or more a week
- 17% of drinkers admit to drinking to get drunk at least once a month, and with 10% drinking to get drunk at least once a week
- people from households with incomes over $90,000 are more likely than those from households with incomes below $40,000 to drink alcohol to get drunk (37% compared to 25%).

Alcohol as the most harmful drug

- 37% of Australians perceive alcohol to be the most harmful drug compared to tobacco and illicit substances, up from 31% in 2010
- this is more than double those who perceive tobacco to be the most harmful drug (17%)
- Baby Boomers are more likely than Gen X and Gen Y to perceive alcohol as the most harmful drug (41%, compared to 37% for Gen X and 32% for Gen Y).

Alcohol as the biggest health threat to Australians

- 19% of Australians perceive alcohol to be the greatest health threat, compared to obesity (52%), tobacco (17%) and diabetes (8%)
- as with the 2010 survey, the greater the quantity of alcohol consumed on average, the less likely people are to perceive alcohol as a health threat. Just 8% of regular drinkers consider alcohol to be the biggest health threat, compared to 34% of non-drinkers
- consistent to 2010 findings, there were no differences between Baby Boomers (19%), Gen X (19%) and Gen Y (19%) on the perception of alcohol as the greatest health threat.

Alcohol-related violence

- over five million Australians (41%) have been affected by alcohol-related violence. This includes 2.6 million who have been a victim of such violence
- of the 41% of people who have been affected by alcohol-related violence, 30% had a family member or friend affected and 19% have been directly affected
- women and men are equally as likely to have reported being a victim of alcohol-related harm (19% for each).

Awareness of health conditions associated with alcohol misuse

- most Australians associate illnesses such as cirrhosis of the liver (88%), liver cancer (69%) and heart disease (55%) with alcohol misuse
- however, fewer Australians are aware of the link between alcohol misuse and stroke (44%), mouth and throat cancer (24%) and breast cancer (11%).

Knowledge and awareness of the Australian Guidelines to Reduce Health Risks from Drinking Alcohol

- just over half of all Australian adults (54%) are aware of the NHMRC’s Guidelines to reduce health risks from drinking alcohol, but relatively few (12%) are familiar with the content
- 10% of all Australian adults are aware that the Guidelines had been updated in 2009.

Alcohol and drinking while pregnant

- 80% of Australians believe consuming alcohol while pregnant can be harmful to the developing fetus and 72% believe drinking alcohol while breastfeeding is harmful to the baby
- fewer than half of women who have been pregnant or breastfed recall having had a health specialist raise with them the harms associated with drinking alcohol (42%).

Perception of individual consumption

- the majority of Australian drinkers (69%) are comfortable with how much alcohol they consume
- 23% of Australian drinkers sometimes feel they have too much to drink
- 7% of Australian drinkers admit to being uncomfortable about how much they drink.

Perceptions of alcohol availability at the local level

- 48% of Australians feel that they do not have enough say in the number of licensed venues in their community, which is twice as many as those who feel they do have enough say (24%)
- 5% of people have made a complaint about a licensed venue in their local area
- people with children aged 13–17 years are twice as likely to have made a complaint about a licensed venue (9%).

To order a free copy of the report, or for more information visit: www.aerf.com.au or call (02) 6122 8600.

Of Substance, vol. 9 no. 2 2011 17
WHILE THE BINGE DRINKING OF YOUNG AUSTRALIANS CAPTURES HEADLINES, THE PROBLEMATIC USE OF ALCOHOL BY PEOPLE AGED 60 YEARS AND OVER HAS ESCAPED THE SAME ATTENTION. YET OLDER PEOPLE ARE MORE LIKELY TO DRINK DAILY THAN YOUNGER PEOPLE ARE, THEY ARE MORE LIKELY TO BE TAKING MEDICATIONS THAT INTERACT ADVERSELY WITH ALCOHOL, AND CHANGES IN THEIR PHYSIOLOGY MAKE THEM MORE VULNERABLE TO THE EFFECTS OF ALCOHOL.

More than one in five men and more than one in ten women aged over 60 years drink alcohol every day (AIHW 2007). And it is estimated that every year 600 Australians aged between 65 and 74 die from injury and disease caused by ‘risky and high-risk drinking’, while another 6500 are hospitalised, most commonly after falls associated with alcohol use (Chikritzhs & Pascal 2005).

‘This older age group is the hidden population when it comes to alcohol consumption,’ says Simon Ruth, Director of Complex Services at Peninsula Health in Victoria. ‘They often face identity and role transitions at this time – they retire, their children move away, and some start to drink to fill the empty hours.’

It is also possible that while people do not increase their consumption of alcohol, as they age their ability to tolerate the same amount decreases. Ageing is accompanied by a decrease in total body water and an increase in fat, both of which leave the body less able to absorb and metabolise alcohol. The result is higher concentrations of alcohol in the blood than before (Department of Health and Ageing 2010).

Mixing alcohol with medications

Prescribers and dispensers need to exercise caution when providing medications to any age group, says Dr Barbara Hunter, Senior Research Fellow at Victoria’s Turning Point Alcohol and Drug Centre. It should be standard procedure to inquire about the alcohol consumption behaviours of individuals, and to provide caution about the possible interactions between specific medications and alcohol, she says.

Older people are among the greatest consumers of prescription drugs. Most older Australians use at least one drug on a daily basis, with many using multiple drugs (Elliott 2006). Older patients are also significant users of complementary and alternative medicines, with up to 41 per cent using them for chronic conditions such as joint pain or circulation problems (MacLennan et al. 2006).

Prescribers of medications are often unaware of other drugs their patients use (Atkin 1998). Part of the reason is that older people often underestimate the number of medications they take and under-report to their GP.
How much is too much?

Current guidelines for safe alcohol consumption by older Australians are inadequate, says Stephen Bright, Psychologist at Peninsula Health in Victoria. The appendix of the NHMRC Guidelines identifies older adults as a high-risk group, yet there are no specific guidelines for this age group.

Dr Deirdre McLaughlin, Research Fellow at the School of Population Health, University of Queensland, agrees. ‘Our research on the impact of alcohol on mortality in older Australian adults indicates that the current guidelines of two standard drinks (where a standard drink contains 10 grams of alcohol) per day for men and women may not be appropriate for older adults,’ she says. ‘Gender and age-specific guidelines, possibly also including recommendations for alcohol-free days, may be beneficial in this age group.’

Pouring practices

It is common for people to underestimate the amount of alcohol they pour and consume, says Dr Celia Wilkinson, Senior Lecturer in the School of Exercise, Biomedical and Health Sciences at Perth’s Edith Cowan University.

‘If older people under-report their alcohol consumption, then it’s easy to underestimate the extent of risk in their drinking practices,’ she says.

In a study involving 844 current drinkers aged 65 to 74 years, she asked participants to pour their ‘usual’ serving of alcohol into their ‘usual’ drinking vessel. Participants were then asked about the volumes they poured. Dr Wilkinson reported that based upon her research older men poured drinks that were 32 per cent larger than a standard drink, and for older women the figure was 16 per cent.

A social context

Another area that needs consideration relates to changes in the living arrangements among older Australians. ‘Anecdotal evidence tells us there may be potential differences between the alcohol consumption of people living in private residential dwellings and those living in alternative accommodations,’ says Dr Wilkinson.

What shifts any changes in social context and living arrangements may have on drinking practices is as yet unknown and this is an area that Dr Wilkinson and

SCREENING FOR RISKY ALCOHOL USE

Screening for ‘at-risk’ alcohol use among older people has been problematic in Australia, says Psychologist Stephen Bright of Peninsula Health in Victoria: ‘The most widely used tool, the Alcohol Use Disorders Identification Test (AUDIT), has low sensitivity among older people.’ The AUDIT was developed by the World Health Organization, and while it detects a broad spectrum of drinking risks and harms, it does not address the effects of alcohol on older people who may suffer medical conditions and use medications.

However, the Alcohol-Related Problems Survey (ARPS) was developed at the UCLA Medical School in the United States in 2002 to address the growing need for a screening measure for adults who were 65 years and over. It detects whether an older person is abusing or dependent on alcohol and, according to its authors, ‘it also aims to detect the much larger population of older adults who are at risk of or are experiencing problems because of their use of alcohol alone or in conjunction with their comorbidities, medication use, and functional status’ (Fink et al. 2002).

The ARPS is a self-administered questionnaire. ‘The ARPS has greater sensitivity than the AUDIT, and takes into account various factors to determine a person’s level of risk such as gender, medical history and use of medications, as well as how much and how often a person drinks,’ says Bright.

An expert panel developed the scoring rules for the ARPS, identifying indications for harmful, hazardous, and non-hazardous drinking in older adults. The panel determined that:

- a non-hazardous drinker is an older person who has one drink or less a day and has no medical problems that would be complicated because of alcohol use
- a hazardous drinker is an older person who takes flurazepam (a sleeping medication), for example, and drinks three drinks two to three times a week
- a harmful drinker is an older person who has peptic ulcers, for example, and drinks four drinks each day.

This method of developing clinical indications for harmful and hazardous drinking was used ‘because there is limited scientific data available regarding the magnitude of risk from alcohol use in combination with comorbidity and medication use’ (Fink et al. 2002).

‘But there is a forty per cent discrepancy in what constitutes “a standard drink” between the US and Australia,’ says Bright, ‘so we’ve worked with the developers of the ARPS to adapt it, recalibrating the algorithms and the medications for the Australian context. An Australian ARPS will be available online very soon.’
colleagues from Edith Cowan University, the National Drug Research Institute and the Palmerston Association will be investigating later this year as part of a grant from the Alcohol Education Research Foundation.

The effects of alcohol
In one Australian study, moderate alcohol intake appeared to be associated with longer survival in men aged 60 to 74 years and in all elderly women (Simons 2000). However, only a small body of research indicates some health benefit associated with alcohol consumption, says Turning Point’s Dr Barbara Hunter.

‘The bulk of Australian and international research shows that alcohol consumption by older people is associated with a higher risk of falls and injuries, some chronic health conditions, including heart disease, hypertension and stroke; pancreatitis; liver damage; incontinence and gastrointestinal problems; osteoporosis; depression and anxiety; motor vehicle accidents; and an increased risk of suicide.’

The role of the GP
‘Older adults are more likely to go to a GP than the rest of the population,’ says Simon Ruth, who established Peninsula Health’s Older Wiser Lifestyles (OWL) program for seniors (see box on p21). ‘So GPs are a great resource in identifying a problem with alcohol. But there is a saying that you only have a problem if you drink more than your GP, so that can be a stumbling block.’

‘It is possible that while people do not increase their consumption of alcohol, as they age their ability to tolerate the same amount decreases.

Early vs Late-onset Drinkers
David Eckel*

Of those older people who do have an alcohol use disorder, it is important to assess if an early or late onset occurred in order to provide suitable treatment.

Early-onset occurs when drinking problems begin in the individual’s twenties or earlier, and potentially progresses and worsens with age. Neuroscience research has demonstrated that frontal lobe atrophy occurs with long-term heavy drinking, causing cognitive deficits. It has also been postulated that atrophy may occur in the cerebellum due to long-term drinking, contributing to a higher risk of falls and postural instability (NIAAA 1998; Sattar et al. 2003).

Late-onset drinkers may begin heavy drinking in their fifties or later in reaction to divorce, loss, trauma, retirement or illness (Moos et al. 2005; Sattar et al. 2003). Approximately 30 per cent of older people with an alcohol use disorder can be classified as late-onset drinkers, with increased disposable income, a surplus of free time and loneliness contributing to this phenomenon (Farkas 2004; Oslin 2004; Sorocco et al. 2006).

In contrast to late-onset drinkers who are more likely to be female, with a higher socioeconomic status and less severe cognitive deficits, early-onset drinkers are more likely to be male, with a lower socioeconomic status, often presenting with a family history of alcoholism and more severe cognitive deficits.

Overall, alcohol consumption generally declines in the elderly with approximately 50 to 60 per cent of older people maintaining abstinence. Possible causal factors for abstinence include illness, complications with medication, morbidity and diminished social opportunities to drink. (Moos et al. 2005; Moos et al. 2010; Oslin 2004).

*David Eckel is a Victorian alcohol and other drugs counsellor.
and so engaging GPs in the problem is difficult because they don’t have time.

‘Because GPs haven’t yet come on board, we’re investing time in community development – going to retirement villages to give education sessions on the interactions between medications and alcohol,’ says Ruth’s colleague Stephen Bright. ‘We’ve often had a 50 per cent referral rate from that, which indicates it’s very effective.’

**Early intervention**

The OWL program provides both early intervention and treatment services to older adults. The early intervention procedure involves individual feedback as well as education about how alcohol interacts with a client’s medications and state of health.

Using the Alcohol-Related Problems Survey (see box on p19), clients are identified as engaging in low, risky or harmful alcohol use. Those at risk are further identified in terms of whether they are considering changing their behaviour (‘contemplation stage’), or not yet considering change (‘pre-contemplation stage’).

Those in the low category receive Minimal Intervention: they attend a session that looks at what constitutes ‘a standard drink’ and guidelines for drinking from the NHMRC, and they are provided with information about the possible adverse effects of mixing alcohol with medications and/or health conditions.

Clients who fall into the risky category and are contemplating change are provided with a Brief Intervention: they receive all that is entailed in the Minimal Intervention as well as motivational interviewing, goal setting, analysis of behaviour, and skills in problem solving. If they are at the pre-contemplation stage of change then they are given gentle cognitive strategies to help move them forward. If this approach is unsuccessful, then harm reduction strategies appropriate to their age are discussed.

Those whose drinking is considered harmful are subject to a clinical review to decide the most appropriate treatment, which may be Brief Intervention or intense, client-centred AOD counselling.

Preliminary data collected in February 2011 shows that 59 adults aged between 60 and 95 years had participated in the early intervention program since it began in March 2010. Assessment using the ARPS indicated that of these, 69 per cent of participants were drinking at harmful levels and nine per cent at risky levels. Twenty-two per cent lay within the healthy range of alcohol intake, known as ‘healthwise’ drinking in the OWL program.

‘What is unique in working with this age group is how easy older adults are to work with,’ says Bright. ‘It is an anecdotal finding at this stage, but you provide information to older adults about how alcohol interacts with medications or a medical condition, and 90 per cent immediately make some behavioural change.’ Among individuals assessed as not at risk, it was found that they had changed their drinking habits already. ‘We’ve had a few articles in the local newspapers here, thinking that older people are more likely to read them than the rest of the population. We know it’s a good strategy.

Clients have come in for an assessment saying they drink less as a consequence of reading the article,’ Bright says.

*For a list of references cited in this article, email editor@ancd.org.au.*
AMONG NEW SOUTH WALES' LAW ENFORCEMENT APPROACHES TO DRUG USE, THE NSW DRUG COURT HAS PROVEN TO BE ONE OF ITS MOST SUCCESSFUL PROGRAMS. ESTABLISHED IN PARRAMATTA AS A PILOT PROGRAM IN 1999, THE DRUG COURT'S SUCCESS IN BREAKING PEOPLE OUT OF THE RECIDIVISM CYCLE OF PROPERTY CRIME AND OTHER NON-VIOLENT CRIMES TO SUPPORT THEIR USE OF DRUGS HAS SEEN IT HAILED HERE AND OVERSEAS.

It’s fair to say that when Roger Dive was a school student, thinking he’d end up either as a vet or a carpenter, presiding over Australia’s first Drug Court was well outside his horizon. After studying law at Macquarie University and sitting as a magistrate in various NSW country courthouses, he was appointed head of the NSW Children’s Court. To gain more insight into the issues now confronting him, he became a regular magistrate for five years on the Youth Drug and Alcohol Court. Here Dive acquired a taste for ‘solutions-focused’ judging, and saw the possibilities of positive, practical outcomes ‘which is not what happens in an ordinary court setting’.

Dive was delighted when he was offered the job of head of the NSW Drug Court. ‘You can’t go back when you’ve done this sort of work’, he explains. ‘When you’re a judge in an ordinary court, you really don’t get any good news. If you allow someone an opportunity not to go to jail and then they succeed, you never hear or see of them again. If they breach the order, then you are likely to see them again. Whereas if someone is graduating from the Drug Court, we have a graduation ceremony, and then we have lunch together with their family, often their parents and their partner and their children.’

A different approach to court

Inspired by the more than three thousand Drug Courts in the United States (although modelled quite differently), the NSW Drug Court exemplifies the solutions-focused court setting. For a start, people brought before the court are called ‘participants’, not ‘defendants’. And using drugs while on the program is expected to a certain extent. ‘We treat admitted drug use as a health issue. I do get a bit stern about unadmitted drug use, because if they’re not admitting to it then we haven’t developed honesty and trust, and they’re not engaged with treatment. The example I use with them is if they’re using but not telling their counsellor, well, that’s a wasted counselling session.’

Judge Dive has his own way of building trust with participants, a concept at the heart of the Drug Court
program: ‘If someone’s new, I’ll leave them sitting in the room for half an hour, so they get to see ten other people have their conversations with the judge. So they get the idea of what it’s like, what we’re likely to talk about, and how they handle it. They very quickly fall into that pattern.’

The program includes weekly ‘report-backs’, which are held in the formal setting of the court but are often light and chatty. ‘I might ask them: “Did you take the kids to the pool this weekend?” because I know that last weekend they were planning to do that. We might talk about sunscreen and how they got there and whether the kids enjoyed it.’

Softer sanctions

All this is not to say there aren’t rules, of course, and breached participants face a ‘sanction system’. Participants receive a day’s sanction for admitted drug use, but three days if that use is concealed. Those who continue to be dishonest about their drug use soon reach fourteen sanction days and find themselves back in custody. You can help create a drug-free period, because participants become focused on getting their sanctions down, not returning to custody, not letting their family down by going back to jail. And then suddenly they realise: “Hang on a minute, I’ve done four weeks without drug use.”

The Drug Court also has some flexibility in finetuning its program to best suit its goals. For example, the court once used Community Service orders as a punishment for breaches of the program, but found it was time consuming, unproductive and difficult for other agencies to manage. ‘As a team, we were finding it was ineffective. So it just evolved away without us ever taking a conscious decision to stop doing it.’

Judge Dive constantly cites his team when describing how the court works, and believes it to be at the heart of the court’s success. The team comprises Legal Aid, the Director of Public Prosecutions (DPP), the police prosecutor, Justice Health, the relevant Local Health Networks and Probation and Parole. Dive sees it as a close-knit bunch. ‘We’ve built a culture of cooperation and working together. We’ll have noodles around the kitchen table. DPP and Legal Aid literally share the kitchen. A lot of work is done over there.’

Good news stories

Asked if he could recall a case he thought particularly memorable, Dive doesn’t hesitate:

‘There are many good stories, that’s the joy of this jurisdiction. But there’s one that will always stick in my mind, about a man who had a significant social phobia. He found it very difficult even to come into the courtroom. He was a long-term drug user. He’d been living under the Harbour Bridge for some years. By the time he finished the program, he had a little internet business that was in its infancy but happening. He had a fiancée, he had a baby, he was reunited with his parents, he had a car, he had his driver’s licence, he had a roof over his head. It was an amazing turnaround. And I certainly won’t forget the graduation, because bearing in mind his social phobia, he’d written out his speech that he was going to make. But he managed to deliver it, and it was a long and touching speech. It was fantastic stuff, and you never forget that.’

Even those who fail the program can ultimately succeed in turning their lives around.

‘Only a couple of months ago, a man came in. He’d finished the program on a bad note about five years ago. He’d got locked up at the end of his program for a couple of years. But he came in to tell us that on release he’d put into practice all the things that he learned on the program, and he’s now been out for two or three years. And he just wanted to come and thank us and tell us he’d done it all. So in our statistics, he’s an absolute failure, but in fact he’s come back to tell us, “I’ve been three years clean, drug-free, and I wanted to come and thank you.” Which is extraordinary.’

Dive calculated a few years ago that about 57 per cent of participants didn’t return to jail, equating to a saving of about 67 years of jail at $250 per day. Given it saves the community a lot of money, why aren’t there more Drug Courts in NSW? ‘Of course, that’s a matter for government to decide. But I think it’s an inevitability that these types of programs will flow out. The cost of continuing to build and staff new jails is a real issue.’ Indeed, the Hunter Drug Court based in Toronto, NSW, opened in March, which he believes ‘is a huge step forward in NSW’.

Judge Dive’s advice for people working in the alcohol and other drugs sector is simple: ‘I think what you have to do personally, so you don’t burn out, is have a good program or services that you believe in that are the best you can possibly provide. Provide some excellence in whatever way you can.

‘Sometimes it’s assumed that the Drug Court has endless money and resources at our fingertips and we can make anything happen. But it’s like any program; we have to keep the program afloat by goodwill and hard work, and by working our way around the barriers that are always there. It’s like any business, any government service, any non-government service.

‘And in relation to participants, you need to be able to shrug off those who you couldn’t have done any more for, who just weren’t at the point where they can embrace it. And thoroughly enjoy the successes. Then I think you don’t burn out.

‘But if you’re not optimistic in life, it’s all a bit tiring, isn’t it?’
Fatal opioid overdose is the leading cause of death among people who use illicit drugs, exceeding deaths caused by HIV, hepatitis C and drug market-related homicides. Non-fatal overdoses are also familiar events for heroin users, who are likely to have not only experienced their own overdoses, but often have also witnessed those of their friends and peers. Opioids include heroin and synthetic drugs such as morphine, and overdose occurs when an opioid binds to the opioid receptors in the brainstem, which regulates breathing. The drug desensitises the brainstem to blood carbon dioxide levels so that breathing mechanisms are not triggered, leading to respiratory (breathing) failure.

Intervening before death

Australian studies indicate that nobody intervenes before death in 70 to 80 per cent of heroin overdose fatalities, despite substantial opportunities to do so. At least 60 per cent of fatal overdoses occur in a home, with somebody else present, and more than an hour after injection. Witnesses call an ambulance only in a minority of fatalities. Their reasons for not doing so include potential costs, previous negative experiences with hospital staff and fear of police involvement.

Overdose reversal

Opioid overdose can be rapidly reversed with naloxone hydrochloride, known more commonly by the trade name Narcan. Naloxone displaces opioids at the brainstem receptors, thus reversing opioid effects such as respiratory depression, sedation and low blood pressure. Naloxone has no other action; it does not result in intoxication and therefore has no abuse potential. Indeed, when given to tolerant opioid users, naloxone instead rapidly triggers opioid withdrawal. Consequently, black market demand and diversion seem unlikely. In the absence of opioids, naloxone has little effect and thus poses no risk to people who are not tolerant to opioids. Classed under Schedule 4 by Australia’s Therapeutic Goods Administration – meaning it can only be prescribed by a doctor and then dispensed by a pharmacy – naloxone has been used to safely reverse the effects of opioid intoxication in hospital and pre-hospital (ambulance) emergency settings for decades.

Naloxone can be injected into veins or muscles. With the appropriate technology, it can also be administered via the nose. Trials among ambulance paramedics indicate no difference in effect between the different routes of administration (Kelly et al. 2005). This will also be tested later this year in a trial of intranasal and intramuscular naloxone at Sydney’s Medically Supervised Injecting Centre (MSIC). MSIC Medical Director Dr Marianne Jauncey notes the unique capacity the service has to conduct such research under controlled conditions, and is optimistic that the trial results will add to the momentum behind calls for increased naloxone availability. She notes emphatically, ‘It is an absolute disgrace that Australia hasn’t introduced controlled naloxone distribution – we are seriously lagging behind in this area!’

Calls for wider naloxone distribution

In the face of increasingly high rates of heroin overdose throughout the 1990s, Australian experts began to call for trials of wider naloxone distribution. The logic was that witnesses such as heroin-using peers or family members could save lives by administering naloxone to reverse an overdose before an ambulance arrived. The momentum behind the proposal waned substantially following the 2001 heroin shortage and the associated decline in overdose rates. For Professor Simon Lenton, Joint Deputy Director
of Perth’s National Drug Research Institute (NDRI) and a longstanding advocate of wider naloxone distribution, the time to reinvigorate the debate is now. ‘The fact that overdose rates are currently lower than in the past is no excuse for complacency’, he argues. ‘We can’t wait for the next “glut” in heroin availability and the inevitable spike in overdose rates to consider improving the range of interventions that prevent people dying. Australian drug policy is characterised by a willingness to respond innovatively to reduce harm. Look at the bold pragmatism that led to our early uptake of needle and syringe programs. We need that courageous leadership in the case of naloxone distribution.’

**Countering concerns**

Lenton and Hargreaves (2000) canvassed the concerns around wider naloxone distribution, posing the following counter-arguments:

- Some users might engage in **riskier opioid use** if naloxone is available. This seems unlikely considering the unpleasant effect of naloxone in precipitating withdrawal among dependent opioid users.
- **Polydrug use**, particularly alcohol and benzodiazepines, is common in overdoses involving heroin. This should not preclude naloxone use. Reversal of the opioid effect could prevent fatalities, minimise associated morbidity, and provide time in which to administer other interventions.
- **Intoxicated administration**: the overdose witness who administers naloxone may often themselves be intoxicated. However, this is likely regardless of which intervention they attempt, and naloxone administration is no more complex than the ideal first responses of calling an ambulance and administering rescue breathing.
- Naloxone’s **shelf life** is 18–24 months. A trial would determine whether users replace expired stock.
- Naloxone’s **half life** is about 30–90 minutes, raising the possibility that re-sedation may occur, particularly when longer-acting opioids such as methadone have been used, or additional drugs are consumed following naloxone administration. Administration of subsequent doses of naloxone may be necessary, although emergency medicine experience suggests this is rare.
- **Solitary heroin users**: using heroin alone is a risk factor for overdose, as is allowing other users to ‘sleep off’ their intoxication. Naloxone could not impact on the death rate among solitary users. The dangers of solitary drug use and failing to monitor sleeping drug users must be addressed in educational programs around overdose and use of naloxone.

**Barriers to wider naloxone distribution**

Medico-legal complexities are the major barrier to increasing naloxone distribution, particularly if the proposal involves the provision of a drug for administration to a third party. Patients are not generally prescribed medication to administer to someone else. The prescriber may be concerned that they and/or the lay person who administers naloxone may be sued if the recipient does not recover or acquires a brain injury. However, where naloxone is prescribed to the person to whom it will be administered by a trained companion, these legal concerns no longer apply. Precedents for prescription of medications intended for peer administration have been established, including adrenaline injections for those at risk of anaphylaxis, and glucagon injections for severe insulin reactions among diabetics. In comparison to these drugs, naloxone is relatively safe with fewer associated risks. Early medical literature investigating the effects of naloxone administered in emergency departments and by paramedics indicated that cardiac complications such as seizures and arrhythmias could occur, but extremely rarely, and generally only among people with pre-existing heart conditions. These early reports may also contribute to the reluctance of many doctors to prescribe naloxone for administration by non-medical personnel.
The primary concern is around the potential of naloxone to undermine other overdose strategies, particularly calling an ambulance. Some evidence backs the legitimacy of this possibility. Lenton and Hargreaves (2000) emphasise that naloxone must be considered an additional intervention, rather than an alternative, to those already used. Distribution programs must be accompanied by comprehensive educational programs which stress that naloxone is just one part of an effective emergency response to opioid overdose, which also includes calling an ambulance and rescue breathing.

Likewise, in response to more recent concerns that naloxone might compromise entry into opioid substitution therapy, Simon Lenton willingly acknowledges that education programs accompanying naloxone distribution must emphasise that engagement in treatment offers the single most effective protection against overdose. ‘Education must make clear that naloxone is an intervention to be used as well as, not instead of, our current strategies,’ he says.

Evidence accumulates

Generally, controlled trials are considered ‘gold standard’ evidence demonstrating the impact of medical innovations. This recognition underlay the calls in the late 1990s for trials of naloxone distribution. However, randomised controlled trials are less feasible with many public health interventions, including some in the alcohol and other drugs field such as needle syringe programs. Furthermore, since 2000, many countries have implemented state-sanctioned distribution programs in the absence of such trials, including Canada, Germany, Russia, Spain, Norway, China, Vietnam, the UK and parts of the US. Evidence arising from this program implementation demonstrates that:

- opioid users, peers, family members and outreach workers can be trained to recognise signs of overdose and appropriately administer naloxone
- very few adverse outcomes have been reported
- naloxone programs can facilitate outreach, empower users and increase willingness to seek treatment
- most concerns about the intervention – including the possibility of unsafe naloxone administration, reintoxication or riskier drug use – appear to have been unfounded
- naloxone is safely administered through many programs operating under a range of models, and has helped save many lives (Lenton et al. 2009).

For Simon Lenton and others, this extensive implementation evidence means that the need for a controlled trial has now past, and Australia should instead move straight to establishing distribution programs. He once again points persuasively to the needle syringe program (NSP) analogy. ‘The foresight that saw the introduction and scaling up of NSPs in Australia before rigorous evidence of their effectiveness from controlled trials was available is the approach we need with naloxone. In fact there still isn’t a randomised controlled trial demonstrating that NSPs work, yet nobody doubts that they do. International evidence clearly indicates that naloxone is a safe and effective intervention. It astounds me that we are lagging so far behind in international terms in implementing it.’

What do consumers think?

Surveys of people who use heroin consistently demonstrate their positive attitudes towards naloxone distribution. High proportions of samples in Australia, the UK and the US report that they would administer naloxone to an overdose victim, accept naloxone treatment from a peer, carry it with them if trained in its use, and that they would have administered it to the victim of their last witnessed overdose if it was available. They also report high rates of willingness to undertake training in overdose prevention and naloxone administration. Reasons include beliefs that peer naloxone distribution may reduce morbidity and mortality by reducing delays to treatment, preservation of ambulance services for other medical emergencies, avoidance of authority involvement, improved response to overdose with resuscitation training, empowerment of people who use heroin to help others, and reduction of the longstanding physical and psychological impact of personal and witnessed overdose (Kerr et al. 2008).

‘It is an absolute disgrace that Australia hasn’t introduced controlled naloxone distribution – we are seriously lagging behind in this area!’
Moving forward: Models for the wider distribution of naloxone

International evidence indicates that distribution of naloxone to potential opioid overdose witnesses saves lives, in the absence of the adverse outcomes many once feared might eventuate. People who use drugs generally hold positive attitudes towards the idea and express a willingness to undertake training. Yet the drug is still scheduled only for use by medical personnel or requiring a prescription from doctors who may be hesitant to provide one.

What, then, are the options for Australian policy makers?

RESCHEDULING
Naloxone is an S4 drug, meaning it must be prescribed by a doctor and dispensed by a pharmacy. Professor Simon Lenton suggests that ideally, naloxone should be rescheduled to S3 so that it could be sold over the counter, as has been the case in Italy for more than two decades.

Naloxone is no longer under patent, meaning there is little financial incentive for a pharmaceutical company to pursue rescheduling, but rescheduling could still occur under provisions which allow state health authorities, professional associations or the National Drugs and Poisons Schedule Committee to initiate the process.

OTHER STRATEGIES
While calling for key stakeholders to support rescheduling initiatives, Lenton argues that other less complex and protracted methods of increasing naloxone availability should be implemented in the meantime. ‘Whether or not we reschedule naloxone, there is a case for its distribution for non-medical administration as part of overdose prevention training to frontline workers such as NSP and outreach staff. It should also be made available to groups known to be at highest risk of overdose due to reduced tolerance. These include newly released prisoners and people leaving abstinence-oriented treatment programs.’ Indeed, the British Government is currently considering the proposal put by their Advisory Council on the Misuse of Drugs in April 2011 to provide prison inmates with naloxone on their release.

Two important strategies would increase access to naloxone while rescheduling initiatives are considered. The first is the enactment in all Australian states and territories of ‘Good Samaritan’ legislation to legally protect laypeople using naloxone in emergency situations, making them exempt from civil liability regardless of the outcome. Such laws exist in the UK and in some parts of the US (Lenton et al. 2009).

Indeed, Good Samaritan laws now operate in many Australian jurisdictions, although some of these (e.g. NSW and the ACT) require amendment as they expressly exclude persons who are affected by a mind-altering substance.

The second strategy is the establishment of prescription programs similar to those implemented internationally, under which people who use heroin are provided with a prescription for naloxone by a doctor (and under some models, a nurse), along with comprehensive training in the prevention, recognition and management of overdose, as well as in naloxone administration and follow-up care for the drug use and potential overdose witnesses such as their peers, families and/or outreach workers. These programs, with their many years of combined experience, provide Australia with a range of models to choose from. Lenton believes that, following 12–18 months of the monitoring and evaluation of such programs in Australia, the resulting evidence of the efficacy and safety of naloxone distribution in our own setting will support moves towards the ultimate goal of rescheduling.

ACT LEADS THE WAY
Progress towards such a program is well underway in the ACT. Following strong advocacy by the Canberra Alliance for Harm Minimisation and Advocacy (CAHMA), Anex and other influential stakeholders, the ACT Health Minister made public statements supportive of the provision of naloxone to opioid users. The ENAACT (Expanding Naloxone Availability in the ACT) Committee includes representatives of CAHMA, the Alcohol Tobacco and Other Drug Association ACT, ACT Health, the ACT Division of GPS, the ACT Ambulance Service, the Pharmacy Guild, Family Drug Support and researchers from the Burnet Institute and the National Drug Research Institute, along with other stakeholders. It aims to provide expert guidance and support to stakeholders to develop a program of expanded naloxone availability in the ACT.

ENAACT has commenced designing a distribution program that will involve the roll-out to 200 people who use opioids of a naloxone prescription and delivery through NSP workers of associated education and training programs around overdose and naloxone administration. Evaluation and communication strategies are also being planned.

For Simon Lenton, such progress ensures that the question of wider distribution of naloxone in Australia has finally become one of when, rather than if.

References


Aboriginal and Torres Strait Islander people experience a burden of disease two-and-a-half times that of other Australians. A large part of that burden of disease is due to chronic illnesses, such as cardiovascular disease, diabetes, cancer, chronic respiratory and kidney disease. This can be reduced by earlier identification, management of risk factors and improved management of the diseases themselves.

In late 2008, the Federal Government announced the Indigenous Chronic Disease Package, with the aim of reducing key risk factors for chronic disease, such as smoking, in the Indigenous Australian community.

**Indigenous smoking**

It is well recognised that many Indigenous Australians have a distinct relationship with tobacco which severely reduces life expectancy. One in five deaths among Indigenous Australians is caused by smoking. This is unacceptable.

Reducing smoking plays a significant role in closing the gap in life expectancy between Indigenous Australians and all Australians within a generation. If the smoking rate among Indigenous Australians was reduced to the rate of the non-Indigenous population, the overall Indigenous burden of disease would fall by around 6.5 per cent and save the lives of around 420 Aboriginal and Torres Strait Islander people each year. This equates to an additional four extra years of life expectancy.

**Tackling tobacco use**

In my role as National Coordinator – Tackling Indigenous Smoking, I am overseeing the roll-out of a national network of Regional Tobacco Coordinators and Tobacco Action Workers funded by the Australian Government to work with Indigenous communities to reduce the number of people smoking and to encourage people not to take up smoking. I am also involved with the Indigenous Tobacco Control Initiative, which is using innovative and culturally appropriate, community-based approaches to address smoking among Aboriginal and Torres Strait Islander communities. I expect the lessons learnt from these initiatives will assist in paving the way for a comprehensive national approach.

The Tackling Indigenous Smoking program includes:
- regional social marketing activity
- local smoking cessation campaigns and events
- increased access to smoking cessation support and to health checks
- enhancement of Quitlines
- regional/local role models and ambassadors
- the training of 1000 existing workers to deliver brief interventions.

**The workforce**

Over the next three years, teams comprising a Regional Tobacco Coordinator and up to three Tobacco Action Workers will be employed in 57 regions, thus providing comprehensive national coverage.

This workforce will use a team-based approach, complemented and supported by two Healthy Lifestyle Workers in each region to encourage healthy lifestyles – assisting people to become more physically active and improve their eating habits.

Since July 2010, work has begun in the first 20 regions. By 2013, the project will employ 340 people nationally. Their work will take a multifaceted approach across multiple settings to address individual, family and community tobacco use, and encourage healthy lifestyles at the local level.
Tackling Indigenous Smoking.

*Dr Tom Calma is the National Coordinator – indigenous-smoking-rate ctg/publishing.nsf/Content/national-action-to-reduce-

Australians more opportunity to live long and healthy lives.

By working with Indigenous Australian stakeholders themselves, we can halve the Indigenous expectancy. By working with Indigenous Australian stakeholders themselves, we can halve the Indigenous expectancy.

Reducing the number of Aboriginal and Torres Strait Islander people who smoke is essential in realising the goal of closing the gap in health status equality and life expectancy. By working with Indigenous Australian stakeholders themselves, we can halve the Indigenous smoking rate over the next decade and give Indigenous Islander people who smoke is essential in realising the goal of closing the gap in health status equality and life expectancy.

The project has a strong commitment to stakeholder engagement and community ownership. This community engagement and local input will be appropriately tailored to the region by the local teams. Where practical the teams are being employed through Aboriginal community-controlled health organisations. In other places, they will be employed through Divisions of General Practice, state and territory governments or other suitable organisations.

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While qualifications and experiences are beneficial, the tobacco action workforce has access to training, funding and other supports to help develop, strengthen and build the health workforce. The ‘Tackling Indigenous Smoking workforce is not clinical, but will play a health promotion role, working with community members to develop and implement smoking cessation social marketing campaigns, delivering community-based smoking prevention, education and cessation support activities tailored specifically to each community.

Local focus, national achievement

A significant challenge to the workforce is the recognition that each region is different and therefore, different mechanisms work in different regions. As a result, the program must be flexible, support innovation and tailored to meet the needs of local communities in aiming to raise awareness, provide education and challenge norms around smoking and other chronic disease risk factors.

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SMOKING FACTS

Smoking is responsible for one in five of all Indigenous deaths and is the most preventable cause of poor health and early death among Aboriginal and Torres Strait Islander people.

Approximately 50 per cent of the combined Aboriginal and Torres Strait Islander population are every-day smokers, more than twice the prevalence among the Australian population as a whole.

In 2006, Indigenous mothers were more than three times as likely to report smoking during pregnancy as non-Indigenous mothers (52 per cent compared with 16 per cent).

Indigenous Australian children (0–14 years) are more likely (28 per cent) than non-Indigenous children (9 per cent) to be exposed to tobacco smoke in the home.


One example is the Miwatj Indigenous Tobacco Control Project in the Northern Territory. The team collaborated with Skinnyfish Music and community members to produce six smoking cessation advertisements, at a cost of $10 000. These ads have now been posted on YouTube (www.youtube.com/watch?v=H2k83EL3a5M) and uploaded onto mobile phones to promote the messages within their communities. These advertisements have been ‘blue toothed’ across the region and beyond.

Another example is the community workshops run each week at Tharawal Aboriginal Corporation Aboriginal Medical Service in NSW. Stakeholders include women’s groups and men’s groups who run the community kitchen and garden projects, which assist to address healthy lifestyles. All activities are informed by discussion with community members, adding to their acceptability.

IN THE FIELD: TACKLING TOBACCO

The activities used by the Indigenous Tobacco Control Project vary across Australia, reflecting the needs and opinions of the communities where they occur.

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LAUNCH OF INDIGENOUS ANTI-SMOKING CAMPAIGN

The Federal Government has launched its first anti-smoking campaign aimed specifically at Indigenous Australians. One in two Aboriginal and Torres Strait Islanders smoke, and one in five dies from smoking-related diseases. The government says the new campaign is part of its plan to halve the number of Indigenous smokers by 2018. A new hard-hitting advertising campaign urging Indigenous Australians to break the chain and quit smoking hit the airwaves, newspapers and TV screens in March.

In launching the campaign, the Health Minister Nicola Roxon said the advertisements were deliberately personal – featuring a young Indigenous woman listing the friends and family members she’s lost due to smoking. The radio, television and print campaign will cost $4 million.

Tom Calma (see main article) says mainstream campaigns weren’t getting through.

‘What people want is something that they can relate to and so this is an attempt to be able to do that. A punitive-type message is not going to help. What we need to do is educate people so that they understand the relationship between smoking and poor health and disease and death.’
upcoming events

30 August
National Drug and Alcohol Research Centre (NDARC)
Annual Symposium
Sydney, NSW
For more information contact:
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m.downey@unsw.edu.au

3–4 October
2011 Contemporary Drug Problems Conference
Prato, Italy
www.ita.monash.edu

8–11 November
IFNGO Conference
Kuala Lumpur, Malaysia
http://www.ifngoconference.org

13–16 November 2011
APSAD 2011 Conference
Hobart, Tas
www.apsadconference.com.au

24–25 November 2011
National Hepatitis Health Promotion Conference
Brisbane, Qld
www.hepatitisaustralia.com

Have you seen the Of Substance eBulletin?
Get your dose of news and views between issues.
www.ofsubstance.org.au

Jobs of Substance
LOOKING FOR WORK THAT HAS MEANING?
check out
www.jobsofsubstance.com.au
A jobs website for people working in the health, welfare, community and non-profit sectors.
An initiative of Of Substance magazine.