ADCAnews
ALCOHOL AND OTHER DRUGS COUNCIL OF AUSTRALIA
ISSUE 52 DECEMBER 2010

Best Wishes for a safe and enjoyable Festive Season

New ADCA Board Ratified

The Annual General Meeting (AGM) of the Alcohol and other Drugs Council of Australia (ADCA) on 25 November ratified the election results for the new ADCA Board which held its inaugural meeting in Canberra on 26 November.

The Patron of ADCA, Professor Ian Webster AO, welcomed the calibre of the new ADCA Board at a time when all Governments are addressing priorities for national healthcare reform.

Professor Webster said that focussing on critical issues such as alcohol-related harm, now assessed at cost $36 billion a year, necessitated urgent and significant investment in prevention, treatment and the non-government organisation (NGO) sector.

"I know these people very well and have a high regard for their ability and expertise which will greatly assist ADCA as the national peak body for alcohol and other drugs," Professor Webster said. "On this occasion, can I also acknowledge the contribution by the outgoing Directors, Professor Jenny Fleming, Mr Moses Abbatangelo, Mr Larry Pierce, and Mr James Pitts."

At the close of nominations on 23 September 2010, Professor Robin Room, Director of the AER Centre for Alcohol Research at the Turning Point Alcohol and Drug Centre, and Adjunct Professor John Mendoza, Co-Director of Connetica Consulting Pty Ltd, were re-elected unopposed as President and Vice-President respectively.

From the 21 nominations received for the remaining five vacant Board Director positions, one former Director, Mr Tony Trimingham OAM, the founder of Family Drug Support, was re-elected along with the following four new Board Directors:

ADCA Life Members Mr Bill Wilson and Mrs Jean Little caught up on their past work for ADCA at the Annual General Meeting in Canberra on 25 November 2010.

Dr Alex Wodak AM, a physician, has been Director of the Alcohol and Drug Service, St Vincent's Hospital in Sydney since 1982. His major interests include the prevention of alcohol and drug problems, treatment of alcohol and drug dependence, HIV control, and prisoner health and drug law reform.

Dr Wodak helped establish the National Alcohol and Drug Research Centre (NDARC), the NSW Users AIDS Association (NUAA), and the Australian Society of HIV Medicine (ASHM).

He is President of the Australian Drug Law Reform Foundation and was President of the International Harm Reduction Association (1996-2004). Dr Wodak helped establish the first needle syringe program and the first medically supervised injecting centre in Australia when both were pre-legal, and often works in developing countries on HIV control among injecting drug users.

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New ADCA Board Ratified

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Associate Professor Alison Ritter BA (Honours), MA (Clin Psych) PhD started working in the alcohol and other drug field in 1988, and has moved through full-time clinical work, policy work with Government, clinical research and now policy research.

She has worked in both the alcohol and illicit drugs areas and has contributed significant policy and practice developments for the sector. Alison is currently the Director of the Drug Policy Modelling Program, an Associate Professor at the National Drug and Alcohol Research Centre, and also holds adjunct appointments with the Regulatory Institutions Network, the Australian National University, and the Key Centre for Ethics, Law, Justice and Governance at Griffith University in Queensland.

Alison is the past-present of the Australasian Professional Society on Alcohol and Drugs (APSAD), Executive Editor of the Drug and Alcohol Review, Vice-President of the International Society for the Study of Drug Policy, and has served on many NGO Boards including the VAADA Board and the SHARC Board.

Associate Professor Lynne Magor-Blatch is the Executive Officer with the Australasian Therapeutic Communities Association, and an Associate Professor with the University of Canberra, where she is works with the Masters of Clinical Psychology program.

Lynne has been in the alcohol and other drugs field for more than 35 years, having commenced at Phoenix/ Alpha House and the Ley Community in the United Kingdom in 1974.

Her experience is primarily in the NGO sector in residential therapeutic community treatment, in school and community drug education and prevention, community development, counselling, and forensic services.

Lynne has also worked in the ACT Government Policy Unit, and as Secretariat Manager to the National Mental Health Working Group and the National Comorbidity Taskforce.

She is the National Convenor of the Australian Psychological Society's Psychology and Substance Use Interest Group, and Chair of the newly-established Illicit Drugs in Sports Reference Group, an Australian Government Initiative established as part of the National Education and Prevention Action Plan to tackle illicit drug use in sport and the broader community.

Dr Stefan Gruenert DPsych (Counselling), BA (Hons), Diploma Community Services (Alcohol and Other Drugs) is Chief Executive Officer of Odyssey House in Victoria.

He a registered psychologist with more than 12 years experience working in the alcohol and other drug sector as a clinician, researcher, policy officer and manager.

Stefan has worked as a senior counsellor in a range of settings and conducted research on community alcohol use, men's issues, intimacy, family work, social anxiety, treatment interventions, and fathers.

In addition, Stefan has been actively involved in promoting change to better address the needs of children and families affected by problematic substance use, and is a committee member of the Family Alcohol and Drug Network (Fadnet), the Victorian Drug and Alcohol Advisory Committee, the APSAD Scientific Committee, and the Australian Psychological Society Substance Use Interest Group.

He is passionate about community level prevention and reducing the stigma that people who struggle with alcohol and other drug addictions face.

ADCA's two currently serving independent Directors appointed by the Board on 1 April 2009, Mr Mick Palmer AO APM, and Ms Violet Bacon, have been confirmed in their roles for a further two years.

Mr Palmer, a Barrister at Law, is the Federal Government's Inspector of Transport Security who formerly served as Commissioner of the Northern Territory Police, Fire & Emergency Services, and as Commissioner of the Australian Federal Police.

Ms Bacon is an Aboriginal (Yamatji) Assistant Professor working in the Discipline of Social Work and Social Policy at the University of Western Australia.

Registrations for FebFast 2011 open on 1 January...

"It was a really good learning curve...I'm so grateful and happy that I found FebFast..." (Leanne, aged 26)

Registrations for FebFast 2011 open on 1 January and the organisers are calling for people to stand up and be part of this national health and charity initiative.

FebFast, which over the past three years has attracted more than 10 700 people, and raised more than $1.7 million, invites participants to sacrifice alcohol during February, and help to raise funds to support youth alcohol and other drug services.

In 2009, a Master of Social Health student, Vanessa Kennedy, who now works as a Research Officer at the Australian Drug Foundation, undertook a study which looked at young people's experiences of FebFast.

She wanted to find out what motivated them to participate, what impact FebFast had on their alcohol-related attitudes and behaviours, and what were their FebFast experiences and thoughts about the initiative.

Vanessa defined young people as those aged 18 to late 20s, and as a result found

that the experience of an alcohol-free month can lead to significant attitudinal and behavioural change.

Specifically, the study found evidence that FebFast can help young people to step back and see alcohol in a different light, reaffirm their desire to reduce their alcohol consumption, succeed in reducing their alcohol consumption, reduce drinking alcohol out of habit, feel capable of enjoying social occasions without needing to be intoxicated, establish a social life that does not revolve around alcohol consumption, feel in control of their drinking behaviour, and establish techniques for maintaining control over their alcohol consumption.

To register for FebFast 2011 from 1 January, log onto www.febfast.org.au .

From the CEO's desk

Reflecting on 2010, the year has been very significant for ADCA, especially in our maintaining an energetic and well-informed presence, bringing credibility to the alcohol and other drugs (AOD) non-government organisation (NGO) sector.

The highlight of this was ADCA's specific and targeted involvement in the 2010 Federal Election. With a minority Government now in place, this presents ADCA with an enormous opportunity to influence and help to deliver the National Healthcare Reform Agenda.

Importantly, ADCA's focus has, and will continue to be, a critical and relevant peak NGO operating at the national level, but at the same time being cognisant of the AOD sector's requirements.

This mandate has been genuinely reflected in ADCA's performance over the last 12 months with ADCA being recognised as the 'go to' organisation with a sound reputation on delivery in the interests of the sector and the broader community.

I would like to reiterate the sentiment expressed by the President of ADCA, Professor Robin Room, in his end of year note to myself and staff.

Our advocacy role, the specialist services delivered by the National Drugs Sector Information Service (NDSIS), our policy statements, and the highly successful management of Drug Action Week have been instrumental in helping to raise crucial issues in relation to excessive consumption of alcohol and the misuse of other drugs, including pharmaceuticals.

It is felt that these factors contributed to the 21 high calibre nominations received for the new ADCA Board election, and the subsequent well contested election.

The building of strong relationships within and outside the AOD NGO sector has also been a feature of our work to enhance strategic partnerships, and can be seen in many aspects of the way ADCA's Federal Council and Policy Forum arrangements have come together with unity and collaboration.

I am looking forward to managing the many and varied future challenges facing ADCA, challenges which will continue to require the tremendous work undertaken by the ADCA team.

2010 actually began on a strong note with ADCA's standing as the national peak and reputation being confirmed in a statement by the Minister for Health and Ageing, the Hon Nicola Roxon MP as "...representing the non-government organisations in the alcohol and other drugs sector".

This led to ADCA contributing to many studies and national debates initiated around prevention, hospital and medical reform, and the consultation process for the new national drug strategy, all of which are intrinsically linked to reducing the burden of chronic disease and pain in our society.

The debate on strategies to reduce alcohol-related harm will continue, as key elements of this concern have become frequent features of community and law enforcement attention.

ADCA's Patron, Professor Ian Webster AO, and Australian and New Zealand Police Commissioners joined forces on 14 December to launch the third Operation Unite for 2010. This is a combined policing operation conducted across Australia and New Zealand focusing on alcohol misuse, violence and anti-social behaviour, and an initiative that ADCA is proud to support.

We continue to maintain a leading role in providing regular commentary in all avenues of media and conversation relating to the harms from AOD misuse. This extends across many areas of public concern, in areas such as domestic violence, families, child protection, and welfare.

In 2010 there is no doubt the not-for-profit sector continued to be under increasing pressure in the face of a competitive marketplace, shrinking numbers of volunteers, and greater competition for resources, donations and support because of the global financial crisis.

ADCA, and indeed the AOD NGO sector, certainly was not immune from these pressures, and as the year progressed, it became even clearer of the need to manage resources wisely and make the most of opportunities when they arose.

On the international scene, ADCA maintained effective representation through the International Federation of Non-Government Organisations (IFNGO) and the International Council on Alcohol and Addictions (ICAA), especially relevant when addressing matters such as a global alcohol strategy/ policy.

Domestically, ADCA continued to foster very positive and productive relationships with all levels of Government, and this is particularly reflected in links with the Department of Health and Ageing (DoHA), which continues to provide strong financial support to ADCA.

As always, ADCA looks to draw from the experience and expertise of our wider membership base to keep actively engaged with the Federal Government's Healthcare Reform Agenda which will have a significant focus on prevention and health in the years to come.

Many challenges for ADCA in 2011 will centre on effective debate and contribution on health reform, especially achieving a greater level of investment in prevention measures for communities in need.

In closing, I wish to sincerely thank ADCA Life Members, Jean Little and Bill Wilson, for joining the new ADCA Board and staff at the Annual General Meeting in Canberra on 25 November 2010. They are an inspiration and we welcome the opportunity to work with them and the new Board in 2011 and beyond.

David Templeman, ADCA Chief Executive Officer

Suicide and suicide prevention on the political agenda

A PERSPECTIVE FROM ADJUNCT PROFESSOR JOHN MENDOZA

In the recent Federal Election, suicide and mental health were among the most prominent health and social issues in the campaigns of the three major parties – Labor, Coalition and the Greens.

All three parties made major policy announcements on these issues.

The Gillard Labor Government has recently commenced implementing its Suicide Prevention Program which commits the Government to an additional $277m in spending over four years.

On the funding, this is the largest ever investment in suicide prevention in Australia and builds on the current level of spending of just over $26m per annum. It came about following the Senate Community Affairs Inquiry into Suicide in Australia.

In responding to the committee's report *"The Hidden Cost",* the Federal Minister for Health, the Hon Nicola Roxon MP, said the new monies were targeted to four key areas:

- a boost to frontline services for people at greatest risk of suicide – more funding for access to the psychological and specialist psychiatry services, and more funding for the non-clinical services that people at risk of suicide and with serious mental illness often so desperately need
- suicide prevention and crisis intervention services – more funds for Lifeline, including making mobile calls toll-free and support for young people affected by a suicide in their school community, to reduce the "suicide clusters"
- programs targeting men - more funding for workplace programs for men and campaigns which target men; and
- $66m targeting school-based programs and some funding for online and web-based counseling services.

The package of measures addresses a number of recommendations from the Senate Report, but disappointingly misses the two most significant recommendations focusing on improved data collection and anti-stigma programs. Suicide data across Australia is poor in all jurisdictions with the exception of Queensland. Anti-stigma programs would complement improved data collection processes by reducing the guilt and shame often associated with suicide and deliberate self-harm.

The Government has provided funding to a number of worthy initiatives, but many of which have never previously been tagged as suicide prevention such as the Personal Helpers and Mentors Program, and the Day to Living Programs set up by the former Howard Government.

More curious are the amounts of money allocated to important interventions such as suicide hotspots (just $9m over four years), and the men's health and wellbeing program (again just $9m over four years).

Those who have run national social marketing campaigns would know $9m per annum is barely adequate for high impact, while the $9m for hotspots would only address the infrastructure requirements at three sites.

And while suicide clusters do occasionally involve school age children and youth, most clusters occur in indigenous communities. There remains no outreach or crisis intervention and bereavement support for these communities.

There is also nothing specific in the package to address the issues involving alcohol and other drugs and suicide, an issue discussed ***below*** and on ***page 5.***

Most disappointing is the fact that a mere $8.1m of the total new funding or just 3.2 per cent will be spent in this financial year.

Equally disappointing is the lack of investment in research. Suicide prevention only received $700 000 in research funding last year out of the National Health and Medical Research Council budget of $625m.

Those of us with an interest in suicide prevention will need to continue to advocate for more effective use of scarce resources and a fairer share of research funds.

SUICIDE, ALCOHOL AND OTHER DRUGS USE

At Sydney Opera House to mark World Suicide Prevention Day on 10 September this year, a new report on suicide and suicide prevention was launched by Australian of the Year, Professor Pat McGorry and myself.

This was on behalf of Lifeline Australia, Suicide Prevention Australia, Inspire Foundation, OzHelp Foundation, The Salvation Army, Centre for Mental Health Research, the Australian National University (ANU), and the Brain and Mind Research Institute, University of Sydney.

The report, *Breaking the Silence,* is a comprehensive review of suicide and suicide prevention focusing on what we know and what responses we need to take to more effectively address this major social and public health issue.

It dedicates a significant discussion on the relationship between alcohol and other drugs and suicide. An edited excerpt from the Report follows on ***page 5.***

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Suicide, alcohol and other drugs use

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ALCOHOL

Alcohol is the most commonly used and abused substance and a major cause of death, injury and illness in Australia.

In 2007, 32 per cent of people aged 14 years and over drank at risky or high risk levels for short term risk such as injury, acute pancreatitis, suicide and death. A further 10 per cent of persons in that age range drank at risky or high risk levels for long-term health problems. This was the result of high levels of regular daily drinking.

The National Alcohol Indicators Bulletin No 12 discussed alcohol-attributable death and hospitalisations from 1996 to 2005, and over those years, alcohol-related suicides were the third-leading alcohol-related cause of death for males.

This study also reported that alcohol-related suicide attempts were the fifth most common cause of hospitalisation for females in Australia (NDRI, 2009).

Co-occurring substance use and mental health problems is a major drug and alcohol issue. According to the National Survey of Mental Health and Wellbeing, more than half of Australians seeking help for mental health problems also have substance use problems (Teesson, M., Hall, M., Lynskey, M., & Degenhardt, L. 2000).

Both substance misuse and mental health are known risk factors for suicide and their co-occurrence further increases the risk. Complicating the approaches to address this comorbidity issue is the lack of integration between alcohol and other drugs and mental health services (Hamilton, M 2009).

Approximately 80 per cent of people who complete suicide are over the legal drink-driving alcohol limit. Alcohol increases impulsivity, reduces complex thought/ problem-solving ability, increases aggressive behaviour, and reduces pain perception, all of which may increase the risk of suicide.

SUBSTANCE USE AND SUICIDE

A study conducted in 2006 looking at suicide deaths in Queensland found that 60 per cent of self-harm victims had at least one drug present in their system at time of death.

Of the drugs recorded at death, alcohol was present in over 80 per cent of drug completed suicide incidents (Oei et al., 2006). Furthermore, people who are alcohol dependent have been shown to have higher rates of suicide than the general population.

Similarly, another research paper in 2006 found alcohol was present in 33-69 per cent of suicide reports from a sample of nations. The report also found a strong association between high levels of alcohol consumption per capita and high numbers of suicide per capita (Sher, 2006).

Data from the National Drug and Alcohol Research Centre found that two-thirds of violent suicides, those by gun, cutting or hanging, had a psychoactive substance in their blood. Again, the most common factor is alcohol, followed by poly-substance abuse (Darke et al., 2009).

A recent German epidemiological study using data from two large national representative samples, looked at the association between average daily alcohol consumption, binge drinking, and alcohol-related social problems.

The social problems include poor educational or work performance, drink-driving, being a victim of dating violence, using illicit drugs and attempting suicide. The study found that the more frequent the binge drinking occasions, the more likely a person was to have such social problems (Kraus et al., 2009).

The occurrence of these social problems may further increase the risk of suicide, through the potential exposure to known risk factors eg sexual abuse, rape, physical health problems caused through injury, assault, violence, road traffic accidents, and other traumatic incidents.

Alcohol and/ or other substance abuse/ use can act as both a risk factor for suicidality, and also as a precipitant for suicidal behaviours.

Substance abuse disorders and addiction substantially increase the risk of experiencing mental health problems, including depression, schizophrenia, bipolar disorder, psychosis, and anxiety disorders, which are known to be one of the main risk factors for suicide, particularly when they occurs concurrently with substance abuse.

In addition, substance use and abuse themselves increase the risk of suicide, independent of the influence of mental illness. Substance use prior to a suicide attempt can also increase an individual's ability to engage in self-harming behaviour through a variety of mechanisms.

For example, alcohol consumption can reduce cognitive function and decision-making capabilities, increase impulsivity, reduce pain perception and increase aggressive behaviours.

Other legal and illegal substances can have similar and/ or alternative effects that may precipitate suicidal behaviour. Those drugs that have the propensity to elicit psychotic episodes eg methamphetamine, cannabis and heroin may also increase the risk of suicidality, through delusional thoughts or hallucinations.

Substance use disorders are much more common amongst men than women, and men who attempt suicide typically have higher rates of substance use and substance abuse disorders than women who attempt suicide.

This may suggest that men use substances, including alcohol, to both "self-medicate" ie attempt to cure or treat their mental health issues and/ or emotional pain rather than using other forms of "treatment", and also to assist them in carrying out their suicide plans ie give them the courage to go through with it.

Further details about men and suicide are provided in the full Report which can be downloaded from www.connetica.com.au.

Australian of the Year, Professor Patrick McGorry, and John Mendoza launched the *Breaking the Silence* report on World Suicide Prevention Day on 10 September 2010.

Dr Ethan Nadelmann Speaks on 'Drug Policy Reform'

Dr Ethan Nadelmann, Director of the United States (US) Drug Policy Alliance, visited Australia in late November and early December to undertake an extensive speaking and media program in Sydney, Melbourne, Brisbane and Canberra.

The trip was hosted by the Australian Drug Law Reform Foundation (ADLRF) and allowed Dr Nadelmann to engage with a wide cross section of audiences on his background and work in the field of drug law reform.

Dr Ethan Nadelmann is a key note speaker on policy reform in the US and internationally.

His credentials in drug policy are outstanding. He received a PhD in Political Science from Harvard and a Masters degree in International Relations from the London School of Economics before becoming an Assistant Professor of Politics and Public Affairs at the Woodrow Wilson School of Public and International Affairs at Princeton University.

Dr Nadelmann began working on drug law reform in 1994 with the philanthropic support of George Soros. He is now the Executive Director of the Drug Policy Alliance, the leading drug policy reform organisation in the US.

His extensive writings on drug policy reform have appeared in scholarly journals such as *Science, National Review* and *Foreign Affairs* as well as more mainstream publications such as *Rolling Stone.*

Dr Nadelmann's critiques of current drug control policies and his advocacy for alternative approaches have attracted international attention and helped to stimulate the growing international debate over drug policy.

Arguing that the "war on drugs" has been ineffective, counter-productive, and expensive, Dr Nadelmann believes that funding for health and social measures should be raised to the same high level enjoyed by drug law enforcement.

During his visit, he availed himself of the opportunity to discuss drug policy with senior law enforcement officials across Australia, and conducted a range of interviews with radio, television, and print media journalists, including a luncheon at the National Press Club in Canberra.

THE 7.30 REPORT ABC

7.30 Report Presenter, Ms Tracey Bowden

An interview on 23 November with Ms Tracey Bowden, a Presenter on the ABC's 7.30 Report, was considered incisive and the following transcript is reproduced courtesy of the ABC.

Ms Tracey Bowden: Elsewhere across Victoria today police launched one of the biggest anti-drugs operations the State has ever seen.

More than 600 officers raided a cannabis and heroin syndicate that police allege made $400 million in just the past two years.

But as police were claiming victory in that battle, a visiting expert on narcotics law was telling the National Press Club that the wider international war on drugs can't be won.

Ethan Nadelmann heads the George Soros funded Policy Alliance in New York. He says that privately more and more politicians, police and health authorities know prohibition of drugs can't succeed and in fact only benefits criminals.

And he argues a move to decriminalise soft drugs and regulate supply of narcotics in countries like Australia is only a matter of time.

I spoke to Ethan Nadelmann in Sydney.

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Dr Ethan Nadelmann Speaks on 'Drug Policy Reform'

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Q: *Ethan Nadelmann, who is winning the drug war? Is it in fact winnable?*

A: There's probably only two groups that are really benefiting from the drug war these days.

On the one hand, you have all the criminal organisations in Mexico and Afghanistan, in Australia, and in the United States that are making billions and billions of dollars. And so long as they're not getting caught or going to prison, they're benefitting.

And the other group that's benefitting essentially is the prison industrial complex. It's the hundreds and thousands – the millions of people around the world getting paid to enforce these laws, getting paid to put people in prison, getting paid, paid, paid, basically to keep arresting people in what's a bottomless pit.

In a way what's happened over the last few decades is that the organised criminals keep making more and more money, the law enforcement establishment keeps getting bigger and bigger.

They're benefitting and everybody else is worse off.

Q: *You make it sound very easy – legally regulate it and everything will be fine. But what is your plan? How easy would that be?*

A: Well, I think the first thing is we need to transform nature of the debate.

I mean, so much of the debate in your country and mine is about which new law enforcement approach might work better.

But I think the really important debate is between those people who would say "Let's legalise the whole shebang", and those who say "'Let's not legalise but we need a much more sensible public health policy, one that focuses on reducing the death, the disease, the crime and suffering associated both with drugs and our failed prohibitionist policies".

Then you can ask, what are the best policies that we could have to reduce the harms of drugs?

And with that I would say, first of all with cannabis, take cannabis out of the criminal justice system. I mean, let's face it, we've justified the laws against marijuana forever, and ever as some great big *Child Protection Act* when everybody knows that the people have, who have the best access to marijuana, are in fact young people.

With respect to the harder drugs – heroin, cocaine, especially with heroin – I would say let's allow the hard core addicts, the people who are committed to using these drugs, who are going to get them from the black market no matter what we do, allow them to obtain it from legal sources, from clinics, from pharmacies, whatever it may be.

It's the heroin maintenance programs you now have in Europe and Canada, something that Australians once led in talking about.

I think those are two very pragmatic policies that could result in less death, less disease, less crime, and less waste of taxpayer money.

Q: *You are talking about substances here that can harm people physically and mentally, can kill people. How do you ethically overcome the idea of legalising them?*

A: Trying to create a drug-free society makes no sense. There's never been a drug free society. There's never going to be a drug-free society.

The real challenge for us is not "How do we keep these drugs at bay? How do we build a moat between these drugs and our children?"

The real question is "How do we accept the fact that these drugs are here to stay, and that the real challenge is to learn how to live with them so they cause the least possible harm and in some cases the greatest possible benefits?"

Q: *What do you do, say, when it reaches the point where there is the first death of someone who was a registered heroin user – so essentially the government has if you like provided the drug? What happens when the first person in that situation dies?*

A: Thousands and thousands of people are dying are overdoses, right? Heroin overdoses, pharmaceutical opiate overdoses. If we set up a legal program like they now have in the Netherlands, or they have in Germany, or Switzerland, or Denmark, or Canada... You know, so far by the way there have been no fatalities in those programs.

But if there was a fatality, I would say that would be one fatality in a program which has saved hundreds of lives, saved taxpayers millions of dollars, reduced the spread of HIV and Hep C. It would be unfortunate, but the odds are that that person likely would have died if that program had never existed in the first place.

Q: *We're told that drugs are very easy to get now. If they're legal does that mean they're going to be even be easier to get and therefore more people will try them?*

A: Well, I know at least in the United States that there are now at least three surveys in which teenagers say it is easier to buy marijuana than it is to buy alcohol. So if ever there was an indictment of the current marijuana prohibition policy, that seems to be it.

I mean, if marijuana were legalised it's not going to make it more available to young people because they already have easy access. What I'm saying is not "Let's have a free for all". What I'm saying is not "Let's eliminate regulations".

What I'm saying is "Let's regulate this stuff to reduce the harms associated both with drugs and with our drug control policies".

People make the mistake of assuming that prohibition represents the ultimate form of regulation when in fact prohibition represents the abdication of regulation.

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Dr Ethan Nadelmann Speaks on 'Drug Policy Reform'

Continued from page 7

It means that whatever you don't effectively prohibit is left in the hands of the criminals.

What I'm interested in is a sensible, intelligent, tough regulatory policy that reduces the harms of drugs and that also reduces the harms of our failed prohibitionist policies.

Q: *Californians recently voted against legalising marijuana. What does that tell you about where the public debate is, what the public view is at the moment?*

A: I and my organisation, the Drug Policy Alliance, were deeply involved in that campaign. We didn't start it, but we played a major role. And I have to say, I never expected the initiative would get 46.3 per cent of the vote.

I was prepared for much less than that, but if anything, the nature of the debate around legalising marijuana has been transformed in the last two years. Two years ago, that debate was considered a fringe issue. Now it's a mainstream political issue.

By and large, what you see in the United States is a growing sentiment that although marijuana may not be the safest drug for everybody, that we're better off taxing it, controlling it, and regulating it. And that arresting 800 000 Americans a year - over 40 per cent of all of our drug arrests – for marijuana possession makes no sense.

Q: *Now, while you're here in Australia you're going to be speaking to people behind the scenes, no doubt - police, medical people, maybe politicians. Do you have a sense that they want change?*

A: My sense is that the number of people in Australia, especially in the upper echelons, who privately believe it's time for a different policy, is growing.

It's true all around the world that the number of... that there's a growing disparity between what elected officials and other prominent individuals say publicly and what they will say privately. What's beginning to happen is that more and more people are finally beginning to say publicly what they would only previously say privately.

Look what just happened in Mexico, where not just the current President Calderón said "Okay, we need a debate on legalisation", but his predecessor Vicente Fox said "That's the answer", and his predecessor President Zedillo said "We need a bigger debate".

So what you're seeing is people beginning to cross over from expressing themselves privately to expressing themselves publicly. I think we're going to see that crossover happening in Australia in the next year or two as well.

Q: *Do you understand that for a lot of people that big stumbling block is the fact that these are substances that can cause psychotic episodes - can cause, potentially, schizophrenia? Legalising something like that troubles people.*

A: I think once you accept the reality that these drugs are here, whether we like it or not, once you accept that we have to find ways to better control them and to minimise their harms, then you begin to accept that criminalisation may not be the best way to deal with this.

I remember there's a Dutch scientist who was one of the first ones who showed that there may be some link between heavy use of marijuana at a young age and premature onset of schizophrenia.

Somebody said "So what does that say to you about legalising marijuana?".

His response is "It says to me that's why we have to legalise, that marijuana, while it may be safe for most people who use it, it's too dangerous to be left in the hands of the criminals. We need to bring this above the ground where it (can) be effectively regulated in a responsible way. We can't rely on the criminals to effectively regulate substances which can be as dangerous as these are".

Q: *Is there proof that your model would work?*

A: There is proof from abroad that, for example, decriminalising marijuana and allowing people to obtain it legally for medicinal purposes is not associated with any great increase in use.

There is overwhelming proof published in the scientific journals that allowing committed heroin addicts to obtain their heroin legally from a legal clinic does reduce addiction, disease, crime, saves taxpayers money. Over whelming proof.

There is proof now coming from Portugal – a wonderful report out just this week in the British Journal of Criminology by Alex Stevens – that Portugal's policy of decriminalising possession of all drugs has not resulted in an increase in drug use, but it has resulted in a reduction in crime, reduction of HIV, Hep C and other drug related ills. So there's powerful evidence.

The thing I'm at a loss to understand is Australia, which 20 years ago took the lead in the world in saying "Let's have a heroin maintenance trial", and then abandoned it.

And now seven other countries are doing it and some have it as a matter of national policy, and in Australia you still have politicians saying "It would send the wrong message" as if the right message is "Let those people die" rather than institute a policy which has been proven to work in a half a dozen foreign countries.

That I don't get.

Ms Bowden: *Ethan Nadelmann, thank you for speaking to us.*

Dr Nadelmann: Thank you very much.

Ms Bowden: *Some provocative views there on a very controversial subject and that's the program for tonight.*

Sydney Medically Supervised Injecting Centre (MSIC): A decade on...

By Dr Marianne Jauncey BMed, MPH(hons), FAFPHM, Medical Director, Sydney MSIC

On the 27 October 2010, the *Drug Misuse and Trafficking Amendment (Medically Supervised Injecting Centre) Bill 2010* was passed through both Houses of the New South Wales (NSW) Parliament.

It was passed with greater bipartisan support than ever before, and means that after nearly a decade of successful operation the MSIC is no longer a trial.

The Legislation allows for ongoing operation of the MSIC, meaning a repeated vote in Parliament every four years is no longer required. The MSIC can hope that, after opening in 2001, finally in 2011 it may be treated as any other health service in NSW.

The final vote was 57/ 29 in the Legislative Assembly, including 10 non-ALP votes, and 22/ 15 in the Legislative Council, with six non- ALP votes.

NSW Liberal MPs were given a conscience vote, while the Nationals voted as a block to oppose the Legislation, and the Greens (also as a block) supported it. Parliamentary debate on the MSIC, particularly in the Legislative Council, was pretty ugly at times – and supporters of harm reduction and evidence based policy shouldn't be thinking it is all plain sailing from here.

As the year draws to a close, it's timely to reflect on where we've come, and where we might be headed.

The first official supervised injecting centre began in Switzerland in the 1980s, and now there are about 90 worldwide – including 25 just in Germany. But there are only two outside Europe – the MSIC in Sydney, and another similar service in Vancouver in Canada.

The service in Kings Cross was the first supervised injecting centre in the English speaking world and remains the only one in the southern hemisphere. And this lack of other centres outside Europe doesn't appear set to change any time soon.

Yet the last decade or so has seen the number of peer reviewed articles in leading scientific journals on the benefits of supervised injecting centres increase to over 50.

This is in addition to the 11 reports produced by five different organisations independently evaluating Australia's own MSIC, available at http://www.druginfo.nsw.gov.au/publications/nsw_government_publications/medically_supervised_injecting_centre2, and clearly documenting public health benefits.

In Australia we have been providing clean needles and syringes to people who inject drugs for nearly 25 years. We are lauded internationally as a leader in the field of harm reduction, and for maintaining such a low rate of HIV infection among intravenous drug users.

As Justice James Wood said in his 1997 Royal Commission into NSW Police, preventing drug users from obtaining and using illicit substances is "fanciful".

So in an open drug scene, where public drug use, drug overdose and discarded injecting equipment is concentrated and causing significant problems – why would providing a safer location be anything other than a pragmatic and compassionate approach?

Indeed, consensus from the medical and scientific community is now overwhelming in favour of the benefits of supervised injecting facilities.

They prevent death and injury associated with drug overdose, they put a vulnerable and hard-to-reach population in contact with the health service, they take public injecting off the street resulting in less syringes in the gutters, and they can help prevent the spread of blood borne viruses by providing clean equipment to those who inject drugs.

Supervised injecting centres have been shown to be cost effective, and can operate without negative impacts on crime in the local community.

MSIC is supported by a long list of internationally reputable scientific and medical organisations including the Royal Australasian College of Physicians, the Royal Australian and New Zealand College of Psychiatrists, the Royal Australasian College of General Practitioners, the Australasian College of Emergency Medicine, the Australian Medical Association of NSW, the Chapter of Addiction Medicine… the list goes on and is available at http://www.sydneymsic.com.

It shows that fringe groups still opposing the MSIC and pointing to a supposed lack of evidence to justify their anti-harm reduction stance have themselves lost all credibility.

It would be nice to think that with this win, we can look forward to more evidence based policy in the area of alcohol and other drugs.

The content of the Parliamentary debate however, was sobering enough to remind us – if we ever needed reminding – that evidence alone is rarely enough.

Optimistically though, local support for the MSIC is at record level highs among residents and businesses of Kings Cross. The people who live and work in the area most understand the issues from a local perspective and have seen the benefits of the MSIC for themselves.

And round the country, we know from the National Drug Strategy Household Survey that support for harm reduction measures, including supervised injecting centres specifically, is increasing.

So while political lobbying may be part and parcel of maintaining a viable health service these days, it is heartening to see the benefits from being engaged with one's own local community.

Fresh Start Advocates for 'treatment choices'

By Mr Jeff Claughton, Chief Executive Officer (CEO) of Fresh Start Recovery Programme

The Fresh Start Recovery Programme was founded by Dr George O'Neil in 1996 and for the past 14 years has focussed on helping families as well as individuals overcome addiction.

Based in Perth in Western Australia, Fresh Start's approach emphasises the importance of evidence-based medical intervention and building strong relationships and a stable home life which in turn empowers people in recovery to take up a responsible role in their community.

Fresh Start believes that everyone who is seeking to be free of addictions should have treatment choices. Among these should be the ability to choose a treatment program that focusses on recovery.

Fresh Start seeks to expand the choices available so that together with other treatment and rehabilitation programs, individuals and families affected by drug or alcohol dependencies can regain control of their lives.

Personal recovery from alcohol and other drugs (AOD) problems is a process of change through which an individual achieves abstinence, improved health, wellness, and quality of life.

Advocates of the recovery model understand that a multitude of factors within a person's social network at personal, family, community and national levels influence a person as they travel along their path to recovery.

The Fresh Start recovery model differs from the standard medical treatment and rehabilitation models in that it emphasises empowerment of the person, the importance of peer support, and the involvement of family members in helping the individual find recovery.

Rather than focussing on medical problems, the recovery model places the emphasis on the person and their family, using their strengths and assets to travel a path to wellness and recovery.

A typical recovery-focussed addiction program has three stages. Clients enter at the initial ***assessment*** stage which also determines the make-up of the second stage, ***treatment.*** The third stage is tailored to each client and involves providing them with the ***support*** they need to exit the program and fully integrate back into the community.

During the ***support*** stage clients may relapse and require further treatment – relapse prevention pharmacotherapies limit the frequency of this occurring.

The concept of recovery has had increasing recognition in the United State of America (US) and the United Kingdom (UK).

Now, the Western Australia (WA) Government has provided funding for recovery-focussed treatment, and established a Parliamentary *Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia* – for more information log onto www.parliament.wa.gov.au.

In WA over 4500 people have been part of a recovery-focussed approach to treatment. Antagonist pharmacotherapies have been successfully used for opiate detoxification and relapse prevention.

Long-acting antagonist pharmacotherapy is preferable as it eliminates the issue of patient compliance and then allows the patient to focus on restoring and establishing healthy relationships that can foster their recovery. This provides them with freedom from cravings while they work on changing their lifestyle for the better.

Recovery is not just about symptom management through medical intervention. It is about the person re-building a meaningful and valued life, where they can realise their aspirations, be treated with respect and dignity, and contribute to society. Ultimately recovery comes from the person, not the practitioner.

This shift of focus in addiction treatment is fuelled in part by debate surrounding agonist maintenance therapy.

Although maintenance therapy minimises the harm associated with unsafe injecting practices, there is increasing evidence that each year of opiate maintenance increases tolerance or the level of addiction.

Recent research published in the *British Medical Journal* suggests that maintenance therapy may prolong addiction rather than help people overcome it*.

This kind of research raises the question of whether placing people onto maintenance treatment programs such as methadone and buprenorphine is helping their recovery, or just prolonging their addiction.

In Australia, over 40 000 people are currently accessing methadone/ buprenorphine maintenance programs each day. Western Australia has the only government-funded alternatives to these maintenance programs.

As AOD service providers continue their battle against the growing problem of addiction in Australia, we must look to build up our armamentarium of treatment options.

All forces must be employed in the struggle against addiction and recovery-focussed treatment is a weapon of great power.

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* Kimber J, Copeland L, Hickman M, et al., Survival and cessation in injecting drug users: prospective observational study of outcomes and effect of opiate substitution treatment. BMJ 2010; 340: c3172.

NDSIS Update

Jane Shelling, Manager National Drugs Sector Information Service

Canberra has hosted a number of interesting alcohol and other drugs events/ presentations recently.

Dr Ethan Nadelmann, Director of the United States (US) Drug Policy Alliance spoke at the National Press Club, received wide media coverage, and at the recent Australasian Professional Society on Alcohol and other Drug (APSAD) Conference he led a discussion on drug law reform.

Professor David Pennington continued this drug law reform theme at APSAD delivering the 2010 James Rankin Oration on "The politics of illicit drugs: the war on drugs can never succeed, where should we go?"

Background on Dr Nadelmann, and the transcript from his interview on the ABC's 7.30 Report appears on pages 6, 7 and 8. Resources around international drug policy and reform can be found by logging onto websites for the Australian Institute of Criminology at www.aic.gov.au/crime_types/drugs_alcohol/illicit_drugs/international_policy.aspx, and the Drug Policy Modelling Program at www.dpmp.unsw.edu.au/dpmpweb.nsf/page/InternationalPolicyIssues.

RECENT ARTICLES FOCUSING ON INTERNATIONAL DRUG POLICY INCLUDE:

Hallam, Christopher, & Bewley-Taylor, David R. 2010. **Mapping the world drug problem : science and politics in the United Nations drug control system.** [Editorial]. International Journal of Drug Policy 21 (1).

McDonald, David Cleary, Geraldine; Miller, Mary-Ellen; Lai, Sally Hsueh-Chih; Siggins, Ian; & Bush, Robert. 2010. **Using theories of policy processes in evaluating national drug strategies : the case of the 2009 evaluation of Australia's National Drug Strategy.** [Paper delivered to the Fourth Annual Conference of the *International Society* for the Study of Drug Policy, Santa Monica, California, USA, 15-16 March 2010].

Ritter, Alison. 2010. **Illicit drugs policy through the lens of regulation.** International Journal of Drug Policy 21 (4).

Wodak, Alex 2009. **Harm reduction is now the mainstream global drug policy.** Addiction. 104: 3.

BOOKS AND REPORTS INCLUDE:

Babor Thomas. **Drug policy and the public good.** Oxford: Oxford University Press 2010 (Available for loan)

Stephen Rolles. **After the War on Drugs: Blueprint for Regulation.** Transform Drug Policy Foundation 2009.

A major barrier to drug law reform has been a widespread fear of the unknown – just what could a post-prohibition regime look like? "After the War on Drugs: Blueprint for Regulation" answers that question by proposing specific models of regulation for each main type and preparation of prohibited drug, coupled with the principles and rationale for doing so. It can be downloaded at www.tdpf.org.uk/blueprint%20download.htm.

Need an AOD statistic?
Need help with information for a report or a project?
Just need to know?

ASK A LIBRARIAN

http://ndsis.adca.org.au/

A free service provided to the Australian AOD Sector by the National Drugs Sector Information Service

Dog Ear Café: How the Mt Theo Program beat the curse of petrol sniffing
By Andrew "Yakajirri" Stojanovski, launched in July 2010, Hybrid Publishers, Melbourne

"Dog Ear Café is a true-life adventure story about how one Aboriginal community beat the odds and defeated petrol sniffing.

It tells of the Mt Theo Petrol Sniffing Program: a story of culture clash, of two lines of fire that meet in the desert night, of partnerships that cross Australia's racial divide. Woven throughout are humour, taboos, bush mechanics, hope and tragedy.

In a colloquial and narrative manner, this book invites the reader to a deeper analysis of the assumptions behind white and black economics, Indigenous alcoholism, welfare dependency and the failure of well intended policy and programs. Hidden in the subtext is a mud map for reproducing successful partnerships with indigenous Australians.

The Mt Theo Program was founded in 1994, when half the teenage population of Yuendumu were sniffing. Eight years later no one sniffed, and ex-sniffers had become youth leaders and community workers. The elders of Mt Theo used their traditional bush knowledge to turn lives around."

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NDSIS Update

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Dr Maggie Brady

In February 2010, Dr Maggie Brady, from the Centre for Aboriginal Economic Policy Research at the Australian National University (ANU) wrote the following foreword for Dog Ear Café:

"This is a personal memoir with a difference. The author, Andrew Stojanovski, was in a unique position to write this book because he was a protagonist in – and largely the sustainer of – the Mt Theo petrol sniffing program of which he writes.

He tells the story of what has become a well-known 'outstation' based program, which succeeded in curbing the practice of petrol sniffing among young Aboriginal people at the Central Australian community of Yuendumu. There are some profound insights here that demonstrate how a frontline worker can actually make a difference to petrol sniffing – which has to be one of Australia's most intractable and challenging drug issues.

The Mt Theo program is quite a triumph, but the program met with many trials and tribulations along the way. His description of these tribulations is full of humour and is disarmingly honest – qualities that clearly must have helped him to thrive and survive as a bush youth worker.

But the book is also a narrative telling of the author's personal journey, how he found his way to Yuendumu in the first place, and his internal (at times almost spiritual) struggles to fulfil responsibilities both to his Aboriginal friends and kin as well as to his partner and later his family.

The author manages to thread another theme through this account. As someone who studied anthropology and who also had first-hand experience with government bureaucracies, Stojanovski is in a position to provide interesting interpretations of the social worlds of Yuendumu and of the departmental staffers who either impede or assist the program.

He does this in a remarkably unpretentious way by using real incidents or conversations to explicate complex traditions of kinship and avoidance and of joking and flirting relationships.

He writes of his role as having 'diplomatic immunity' from kinship obligations, and illustrates how important such neutrality can be. These concepts and examples of the social norms and expectations of daily life are at the very core of an anthropological world view, but instead of weighing the reader down with academic theory, he brings this 'anthropology' to life. It becomes real.

There is also solid policy advice in these pages for those who care to read between the lines. Personal relationships are paramount, both on the ground, and between the grassroots and the bureaucracy. Valuable programs can be threatened by petty officials.

Stojanovski describes many incidents, developments and improvised solutions to problems that seem to run counter to accepted ideological or bureaucratic wisdom. For example he questions the widespread assumption that petrol sniffers are 'addicted', when he knows from experience that kids who sniff in one place will refrain from doing so at another place where sniffing is not the 'done thing'.

He shows how offering and sharing tobacco is a way of building rapport and managing crises. His accounts of how he dealt calmly with threatening behaviour from time to time are masterful pieces of advice on defusing aggression and avoiding violence.

I found this a compelling read. As the author states in the introduction, by writing it he is fulfilling a cultural responsibility to pass on his knowledge, and there will be many who want to learn from the experiences documented here.

Many ordinary Australians, as well as those more directly involved with Indigenous policy or service provision, have heard about Mt Theo despite its isolation and size.

I believe the book will find an audience among both groups, as well as it being of great interest to those involved in youth work, juvenile justice and drug and alcohol prevention.

Stojanovski's account will also make an excellent primer for new frontline workers and for young anthropologists entering the field."

ADCA News is the member newsletter of the Alcohol and other Drugs Council of Australia (ADCA) and is published five times a year.

The views expressed by contributors to *ADCA News* are not necessarily those of ADCA. All URLs were correct at the time of printing. While contributions are welcome, final content is at the discretion of the Editor.

Editor: Brian Flanagan, Manager ADCA Strategic Communications and Policy, brian.flanagan@adca.org.au

Design: Kylie Smith Design

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Print Post Approved 248831/0003
ISSN 1446-8573

ADCA office contact details:
PO Box 269 Woden ACT 2606
1st Floor 17 Napier Close Deakin ACT 2600
Tel: 02 6215 9800 Fax: 02 6281 0995
Email: adca@adca.org.au
Web: www.adca.org.au