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issuing **forth**

Drug use and mental health: the need for an integrated approach

contents

edspace 1

headspace 2

Steve Allsop raises the challenge of managing co-occurring drug and mental health problems.

issuing forth 2

Dan Lubman from Orygen Youth Health at the University of Melbourne discusses drug use and mental health, and the need for an integrated approach.

project notes 4

- **National prison entrants' bloodborne virus and risk behaviour survey**
- **Analysis of Indigenous child deaths**

abstracts 5

Summaries of recently published articles

recent publications 7

staff list 8

edspace

Welcome to the final issue of *CentreLines* for 2008. Drug use and mental health has been a significant focus for NDRI this year, with a new book, *Drug Use and Mental Health: effective responses to co-occurring drug and alcohol problems*, edited by NDRI Director Professor Steve Allsop, being launched in September.

In *Headspace*, Professor Allsop introduces the challenge of providing adequate care to people with both drug and mental health disorders. This is followed by *Issuing Forth*, in which guest contributer Dr Dan Lubman discusses the need for an integrated approach to the identification and management of people with co-occurring drug and mental health problems. Dr Lubman is a Consultant Psychiatrist and Associate Professor at the ORYGEN Research Centre, University of Melbourne, where he heads a clinical research unit that investigates problematic substance use and co-occurring mental health issues in youth. He is also a member of NDRI's Board of Management.

NDRI would like to advise readers that, as of the next issue (April 2009), the distribution arrangements for *CentreLines* will be changing, moving away from printed copy towards predominantly electronic circulation. We hope that you wish to continue receiving *CentreLines*; in order to do so, please ensure that you provide us with your email address. For further information, see the back page of this issue.

We hope that you enjoy this issue of *CentreLines*, and offer you our best wishes for 2009. For more information about NDRI's research and other activities, visit our website at www.ndri.curtin.edu.au.

Rachael Lobo
Editor

NDRI
national drug research institute

headspace

The challenge of co-occurring drug and mental health problems

That a large proportion of people affected by drug problems also experience mental health problems, and vice versa, is not a contentious observation, nor is it a new phenomenon. What is remarkable is that it remains a challenge - for individuals and families who experience such constellations of problems, for clinical service providers, police and other services, and for our systems of care. As I have noted elsewhere the key problem of "dual diagnosis", as it has been described, was crystallized by Dr Stephen Jurd when he commented that the duality is in the system, not the individual.

In *Issuing Forth*, Dr Dan Lubman has identified some of the key challenges and frustrations. One could be forgiven for believing that services have been designed precisely to achieve the worst outcomes for individuals, families and the community. Current policy, prevention strategies and treatment initiatives appear to be funded to work within the problems of a flawed system.

If we doubt the research evidence about the problems, simply ask the staff, and affected individuals and families what it is like to have to navigate our systems of care. Attempting to invest in effective prevention in the current context is even more challenging, despite quality evidence consistently indicating that a significant proportion of the predictors of hazardous drug use, mental health problems and a range of other health and social problems, are common across conditions.

Recent increases in funding and changes in practice are welcome. However, as discussed by Dr Lubman, the majority of that investment has not necessarily gone where it might have most impact. A large number of people who experience co-existing drug and mental health problems attend primary health care services. A large number of the prevention and early care interventions are best located in schools, communities and mainstream and primary health care services. These are where we should be targeting a large proportion of our efforts.

Silos of funding create silos of intervention and care. We need integrated policy, prevention and treatment effort. This means creating integrated effort from the very beginning – through funding formula, contracts and performance indicators. It will not be sufficient to rely on the goodwill, enthusiasm and skills of a few – no matter how committed they are. As stated elsewhere:

"It is not so much that services need to take on additional responsibilities, but that they are helped to respond more effectively to issues that affect a large proportion of their existing client base"[1]. **cl**

Steve Allsop

1. **Allsop, S.** (ed) (2008) Drug Use and Mental Health: Effective responses to co-occuring drug and mental health problems. IP Communications, Melbourne p10.

issuing forth

Drug use and mental health: the need for an integrated approach

Over the past decade, there has been growing interest among researchers, clinicians and policymakers about the link between drugs and mental disorders[1]. The issue has become particularly relevant for health departments and treatment services, given the documented high rates of co-occurring mental health and substance use disorders among individuals presenting for treatment across mental health and Alcohol and Other Drug (AOD) settings[2]. Such presentations are clinically challenging, as those with co-occurring disorders typically report a greater severity of substance use or mental health issues, non-adherence with treatment, poorer clinical and functional outcomes, as well as increased morbidity and mortality.

Despite the high prevalence of co-occurring disorders and their detrimental impact on treatment outcomes, the current service system remains limited in its capacity to effectively meet the needs of such individuals. Within Australia, mental health services and AOD agencies remain segregated (clinically and often politically), and typically have ill-defined relationships with each other or other health providers. As such, clear clinical pathways for the management of co-occurring disorders across the service system are typically lacking, resulting in a fragmented model of care that promotes either sequential (each disorder addressed separately one after the other in different services) or parallel (each disorder addressed at the same time but by different therapists in separate services) treatment approaches.

While sequential or parallel approaches can be appropriate for individuals with one severe disorder and mild problems in the other domain, cooperation and coordination between services is essential[3]. Recently, there have been increasing calls for the mental health and AOD sectors to form closer links and work together to ensure that sequential or parallel approaches are more effectively delivered. Although encouraging closer cooperation between services is a critical first step, core differences between sectors (eg disparities in service philosophies, models of care, clinical focus and service constraints) are rarely addressed.

The issue is further complicated by differences in the types of co-occurring conditions that are most commonly managed within these sectors. Public mental health services typically focus on providing care to individuals with 'serious mental illness'. Currently, this has been operationalised as a focus on individuals with low-prevalence conditions (such as schizophrenia and bipolar disorder) who have associated risky behaviours or high needs. Research among these populations reveals that the most commonly abused substances are alcohol, tobacco and cannabis[2]. In contrast, high-prevalence mental disorders

(such as depression and anxiety) are the most frequent co-occurring conditions encountered within AOD settings[2], while low-prevalence substance use disorders (such as opiate and amphetamine dependence) are a common focus. These differences in client profiles mean that simply improving referral pathways between sectors will not necessarily result in improved treatment outcomes for clients with co-occurring disorders. Indeed, a focus on these sectors in isolation may even increase levels of friction between services, especially if expected requests for assessment or ongoing treatment are not forthcoming. As such, comorbidity initiatives must encourage a broader service system response that includes federally-funded programs, particularly as the bulk of high prevalence disorders (such as depression, anxiety, alcohol abuse and nicotine dependence) are predominately treated within primary care, with the assistance of medicare-funded psychiatrists and allied health professionals.

Improving the level of communication and cooperation across service settings should be a key priority for the health system, particularly as the interaction between drug use and mental disorder is complex, and both disorders have major influences on the treatment and outcome of the other condition. In this regard, there is growing evidence that more integrated treatment approaches (where both conditions are addressed simultaneously) appear to offer better outcomes[3]. However, this requires all services to promptly screen and assess for co-occurring disorders, as well as provide relevant evidence-based interventions. To date, mental health assessments have not been routinely conducted within AOD services, nor substance use assessments within mental health settings, although recent state and federal initiatives have begun to promote this practice.

Recently, we conducted a survey examining beliefs regarding appropriate interventions for mental disorder in youth among 305 psychiatrists, 258 general practitioners, 292 mental health nurses and 375 psychologists[4]. Participants within each professional group were presented with a vignette describing a young person with depression and co-occurring alcohol misuse and were asked a wide range of questions, including what they thought was wrong with the person in the vignette. While a diagnosis of mood disorder was identified by at least 84% of professionals, rates of reported co-occurring alcohol use disorders were substantially lower (26-60%), particularly among older professionals and psychologists. These findings highlight a further obstacle to effective service provision; namely, a general lack of skills and experience in the assessment and management of co-occurring mental health disorders across service settings. This workforce deficiency relates to the limited number of AOD placements offered within general practice, psychiatry, nursing and allied health training programs, as well as the few opportunities for direct 'on the job' training and supervision in the assessment and treatment of co-occurring disorders. Both state and federal comorbidity responses must invest in addressing these deficiencies, as well as ensuring that the assessment and management of co-occurring disorders becomes a core competency within undergraduate and postgraduate health curricula. A greater number of clinical practice placements for trainee mental health professionals within the AOD sector will also increase the likelihood that more clinicians will choose to pursue a career within this field.

Building a local model of integrated care

Orygen Youth Health (OYH) is an innovative publicly-funded youth mental health service that offers comprehensive assessment and early intervention to young people (aged 15-25 years) with a broad range of mental health problems. At any one time, approximately 800 adolescents and young people are being treated within the service from a catchment area (in the northwestern region of Melbourne) totalling around 880,000 people. OYH combines the provision of clinical services with innovative research (OYH Research Centre), education and dissemination strategies to create a unique learning environment focused on developing accessible evidence-based approaches to emerging mental disorder and its consequences in young people.

Over the past 5 years, we have been working closely with youth AOD services in our region (Youth Outreach Team [YOT] at DASWest, Youth Substance Abuse Service and Moreland Hall) to develop a more integrated response for young people with co-occurring issues[3]. This approach has necessitated identification of common areas of collaboration rather than conflict, regular meetings with senior management, and working closely with staff to break down perceived negative barriers and attitudes. The process has been facilitated by a number of clinical grants that has enabled us to embed experienced mental health clinicians within local AOD services to facilitate 'ownership' of the process at each site, with the aim of providing true integration.

In the early phase of the initiative, we developed a youth-friendly mental health screening tool based on a number of existing brief validated measures that assessed for acute symptoms of psychological distress (K10)[5], self harm, suicide risk, depression, anxiety, psychosis and mania[6]. We included the K10 in this screening package as it can be repeatedly administered to monitor progress, and is widely used within primary care settings. The adoption of well-validated screening and assessment tools that are meaningful across sectors (including primary care) is critical for building capacity across the service system, as it ensures more effective communication.

All workers were trained in mental health screening, and were offered ongoing support by embedded clinical psychologists. The screening tool was subsequently piloted with 84 young people who were attending these services in order to assess its acceptability[6]. Feedback from young people indicated that over 70% felt comfortable completing the measure. The mental health screening tool was revised based on feedback from the young people and AOD workers, and universal mental health screening was subsequently implemented to ensure young people with co-occurring disorders were correctly and promptly identified.

Recently, we reported on the adoption of mental health screening within a youth AOD service (YOT DASWest) over the past 2.5 years[7]. During this period, 87% of eligible young people were screened, with 100% screened during the last 3 months of the evaluation period. Young people identified as at-risk on screening were reassessed by an embedded clinical psychologist, and were subsequently offered up to 12 weeks of adjunctive psychological treatment (integrated cognitive behavioural therapy [CBT]), in addition to standard AOD treatment, if appropriate. Referral to the mental health clinician offered a tangible reason to screen and a clearly defined clinical pathway. In addition, young people with severe depression/anxiety and co-occurring substance use were referred to OYH, where they were offered an integrated 20-week CBT program. While implementing universal mental health screening is clearly achievable within AOD settings, our findings suggest that agencies must provide suitable training, clinical support and clear referral pathways to ensure that screening becomes a sustainable process. We are still evaluating the effectiveness of our comorbidity model; however preliminary results are encouraging, suggesting that young people offered integrated CBT have improved mental health and substance use outcomes at the end of treatment and at 6-month follow-up.

With the recent establishment of headspace, Australia's National Youth Mental Health Foundation, we are currently expanding these initiatives to the primary care sector to create a more integrated service system. This linkage between primary care, youth AOD and mental health services will hopefully ensure that young people with co-occurring disorders are less likely to fall through the gaps in service provision. By allowing referral to allied health practitioners and psychiatrists through the Better Outcomes in Mental Health initiative, we hope to create a sustainable model of service delivery that best meets the needs of those with co-occurring disorders.

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While we are encouraged by our progress to date, further development, implementation and evaluation of integrated treatment approaches will depend upon continued investment by state and federal departments working in tandem. We have come along way in the past decade in our response to comorbidity. If we continue to work together as partners, we can build an integrated service system that is accessible, responsive and effective in meeting the needs of those with co-occurring disorders. **cl**

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project notes

National prison entrants' bloodborne virus and risk behaviour survey

Tony Butler and
Cerissa Papanastasiou

The 2004 & 2007 National Prison Entrants' Bloodborne Virus and Risk Behaviour Survey Report was launched in September at the 20th Annual Australasian Society for HIV Medicine (ASHM) Conference in Perth. The report is unique in the world as it provides ongoing surveillance on the prevalence of blood-borne viruses amongst the prisoner population in Australia. Monitoring these viruses among prisoners is important as many are unaware they are infected and possibly contributing to the transmission of blood-borne viruses. Routine screening strategies for blood-borne viruses varies across Australia in terms of both scope and coverage.

The survey took place over a two week period in October 2007 and included 740 prison entrants at 17 prison receptions across Australia. Findings from the national survey showed that the prevalence of hepatitis C among prison entrants was highest in NSW with 42% and lowest in WA (21%). Women prisoners were more likely to have hepatitis C than men. Prisoners are underserved with regard to treatment for hepatitis C infection - a population that would benefit from a comprehensive prison-based treatment programme. The incidence of hepatitis B remains elevated at just under 30% nationally. This population is at greater risk of hepatitis B infection as many people showed no evidence of immunity against hepatitis B when screened for the virus showing that more should be done to vaccinate this population against infectious diseases such as hepatitis B. The prevalence of HIV was low at less than 1% in all states, and for both sexes.

Amphetamines were the most frequently reported drug last injected by prison entrants and tobacco smoking was highlighted as being at epidemic proportions in this population - around 90% of prisoners surveyed reported that they currently smoked tobacco!

Incarceration is an important, but under-utilised, public health opportunity to initiate health interventions amongst this highly marginalised population group.

The report, *National Prison Entrants' Bloodborne Virus and Risk Behaviour Survey Report 2004 & 2007*, can be downloaded in PDF format from the NDRI website: www.ndri.curtin.edu.au.

Analysis of Indigenous child deaths

Sherry Saggers, Teresa Hutchins, Dennis Gray, Ted Wilkes and Katie Francis

Children who experience chronic neglect may suffer poor physical and mental health throughout life, behavioural problems, low school attainment, and even death. Recent media reports have highlighted shocking cases of child neglect in non-Indigenous and Indigenous communities, and governments across Australia are exploring the effectiveness of service responses to these and other cases. A research team comprising Sherry Saggers, Teresa Hutchins, Dennis Gray and Ted Wilkes from NDRI and Edith Cowan University was contracted by the Western Australian Child Death Review Committee to undertake a group analysis of Indigenous child deaths where chronic neglect was present. Katie Francis was employed to work on the project.

A comprehensive literature review highlighted the detrimental impact of much behaviour on children's development, despite the difficulty of reaching universal definitions of neglect. There is constant tension between the rights of children to the same protection and support as adults, and the minimising of harms against children by service workers anxious to strengthen existing families. Known risk factors of poverty, low educational levels, family violence, substance misuse, and mental health problems are exacerbated among Indigenous communities by intergenerational harms associated with dispossession, institutionalisation and the separation of children from their families.

Our analysis of 22 Indigenous child deaths revealed that the majority were aged one year or less, with most living with biological parents at the time of death. Almost two thirds of the group had more than three siblings, and three of the children had siblings who had died. Half the children were from remote communities and an additional third from rural regions. Identified causes of deaths included co-sleeping, drowning, vehicular accident, and homicide. All families had long histories of contact with the Department for Child Protection, including previous notifications of child abuse or neglect. All of the children who died were living in families with multiple risk factors, such as alcohol and other drug dependence, family violence, homelessness, mental health problems and financial hardship.

The service system response to these cases of neglect was inadequate, mostly, we believe, because of a focus on family centred practice

abstracts

that minimised potential cumulative harms for children and the proper assessment of their needs and wellbeing. In particular, while service workers recommended harm minimising drinking strategies to parents to protect children during drinking episodes, there was insufficient attention paid to the cumulative effects of substance dependence on parenting. In what has been called the 'start-again' syndrome, single instances of neglect, rather than long-terms patterns of neglect, were highlighted by workers. The absence of proper risk assessments in many cases, ad hoc case management record keeping, and inadequate interagency coordination and referrals were also noted.

Our recommendations for safer practice include recognition of the risk factors for neglect, the provision of targeted support such as treatment for substance dependence, routine child impact assessment, and an increased emphasis on early intervention through 'shared care' arrangements between families, statutory authorities, Indigenous child care agencies and communities. Strengths-based, family-focused practices must have children's wellbeing at their core. We acknowledge that the Department for Child Protection's current reform agenda for field service delivery, Indigenous engagement, whole of government partnerships and corporate support systems provides a more robust framework to address the concerns highlighted by this research. The success of these reforms is critical for the better protection of Western Australian children.

The report, *Group Analysis of Aboriginal Child Death Review Cases,* can be downloaded in PDF format from the NDRI website: www.ndri.curtin.edu.au.

Temperament, substance use and psychopathology in a prisoner population: implications for treatment

Stephen Allnutt, Lucinda Wedgwood, Kay Wilhelm and Tony Butler

Australian and New Zealand Journal of Psychiatry, 2008, 42, (11), pp 969-975

Objective: The association between temperament and drug use or temperament and psychopathology has previously been restricted to community clinical or non-clinical samples. The aim of the present study was therefore to examine these associations in a large cohort of Australian offenders using Cloninger's Temperament and Character Inventory (TCI). Methods: A total of 1322 prisoners from New South Wales (NSW) who completed all dimensions of the TCI and were screened for mental illness using the Australian National Survey of Mental Health and Wellbeing were included in the study. Results: A total of 15% of the sample fulfilled the criteria for a diagnosis for depression, 36% for anxiety disorders and 54% for a substance abuse disorder. Using logistic regression analysis, the TCI dimensions of harm-avoidance and low self-direction predicted depression. Being female, a poly-substance user and having high harm avoidance, persistence, self-direction and self-transcendence predicted anxiety disorders. Significant stepped trends across age, gender, and type of drug use were found for all TCI dimensions. Conclusions: The TCI is useful in identifying prisoners with a history of psychopathology and substance misuse. This tool also provides clinically relevant information about at-risk individuals and has the potential to guide the development of intervention programmes for inmates.

Privileging pleasure: Temazepam injection in a heroin marketplace

Robyn Dwyer

International Journal of Drug Policy, 2008, 19, (5), pp 367-374

Background: Pleasure and its pursuit provide the key explanatory frame in this ethnographic analysis of temazepam injection among a set of drug injectors who enthusiastically embrace high-risk practices. The foregrounding of pleasure challenges key assumptions of harm reduction: namely, the 'rational' subject and the privileging of health as a universal good. In this paper I problematise the concepts of pleasure and conventional understandings of rationality. Interrogating these concepts through the actions and accounts of temazepam injectors, I argue that the model of the subject implicit in harm reduction does not sufficiently account for their everyday social practices. Methods: The paper draws on ethnographic research among heroin user/sellers of Vietnamese ethnicity in a local Australian heroin marketplace. Results: Temazepam was used in combination with heroin to enhance the experience of intoxication. Intense intoxication was desired for the pleasurable bodily sensations and emotional feelings it produced. The transgressive and dangerous nature of the practice added to its pleasure. Injection of temazepam capsules was also one of the practices constituting as well as expressing central social and cultural processes of heroin use in this particular social field. Conclusion: Despite embodied awareness of the harms associated with temazepam injection, these people were prepared to sacrifice 'health' for the pleasures they perceived to be afforded by injecting the gel capsules. My ethnographic

abstracts continued...

analysis suggests that if harm reduction is to respond to high-risk practices such as these, then attention needs to be paid to the pleasures people derive from their practices, and to the social and cultural values these constitute and express.

Erasing pleasure from public discourse on illicit drugs: on the creation and reproduction of an absence

David Moore

International Journal of Drug Policy, 2008, 19, (5), pp 353-358

In 1988, sociologist Stephen Mugford argued that the dominant framework in the drugs field was the 'pathology paradigm' and that, as a consequence, considerations of 'pleasure' in relation to drug use were marginalised. As Mugford noted, an understanding of the subjective motives for drug use, including pleasure, is an essential part of any coherent response. Twenty years on, it appears that little has changed. In this paper, I consider some of the processes that may have contributed to the ongoing absence of discourses of pleasure in the drugs field. The paper is divided into three sections. In the first, following Bourdieu, I focus on drug research as a 'social field', arguing that power relations between research disciplines work against considerations of pleasure, and that researching pleasure does not generate useful forms of research capital. Second, I argue that harm reduction policy and practice, in its construction of a neo-liberal drug-using subject, limits opportunities for considering the role of pleasure in drug use. The final section explores the broader historical and contemporary context for drug research, policy and practice by considering the discursive formations that contribute to the legitimacy granted to particular forms of pleasure in the privileging of a 'civilised' body over a 'grotesque' body.

'This is not a rave!': changes in the commercialised Melbourne rave/dance party scene

Christine Siokou and David Moore

Youth Studies Australia, 2008, 27, (3), pp 50-57

Raves have been the subject of sociological research for many years, with their increasing commercialisation being a key topic of interest. However, little attention has been paid to how young people attending raves view the changes in rave culture. This article examines four of the changes associated with the commercialisation of the Melbourne rave/dance party scene. It also examines representations of past and present raves/dance parties articulated by a group of long-term rave/dance party attendees. Nostalgic representations of past rave forms can be read as claims to subcultural capital, to the possession of an 'authentic' rave identity.

What did you drink yesterday? Public health relevance of a recent recall method used in the 2004 Australian NDSHS

Tim Stockwell, Jinhui Zhao, Tanya Chikritzhs and Tom Greenfield

Addiction, 2008, 103, (6), pp 919-928

Aim: To (i) compare the Yesterday method with other methods of assessing alcohol use applied in the 2004 Australian National Drug Strategy Household Survey (NDSHS) in terms of extent of under-reporting of actual consumption assessed from sales data; and (ii) illustrate applications of the Yesterday method as a means of variously measuring the size of an Australian 'standard drink', the extent of risky/high-risk alcohol use, unrecorded alcohol consumption and beverage-specific patterns of risk in the general population. Setting: The homes of respondents who were eligible and willing to participate. Participants: A total of 24,109 Australians aged 12 years and over. Design: The 2004 NDSHS assessed drug use, experiences and attitudes using a 'drop and collect' self-completion questionnaire with random sampling and geographic (State and Territory) and demographic (age and gender) stratification. Measures: Self completion questionnaire using quantity–frequency (QF) and graduated-frequency (GF) methods plus two questions about consumption 'yesterday': one in standard drinks, another with empirically based estimates of drink size and strength. Results: The Yesterday method yielded an estimate of 12.8 g as the amount of ethanol in a typical Australian standard drink (versus the official 10 g). Estimated coverage of the 2003–04 age 12+ years per-capita alcohol consumption in Australia (9.33 ml of ethanol) was 69.17% for GF and 64.63% for the QF when assuming a 12.8 g standard drink. Highest coverage of 80.71% was achieved by the detailed Yesterday method. The detailed Yesterday method found that 60.1% of Australian alcohol consumption was above low-risk guidelines; 81.5% for 12–17-year olds, 84.8% for 18–24-year-olds and 88.8% for Indigenous respondents. Spirit-based drinks and regular strength beer were most likely to be drunk in this way, low- and mid-strength beer least likely. Conclusions: Compared to more widely used methods, the Yesterday method minimizes under-reporting of overall consumption and provides unique data of public health significance. It also provides an empirical basis for taxing alcoholic beverages in accordance with their contributions to harm and can be used to complement individual-level measures such as QF and GF.

Exposure of children and adolescents to alcohol advertising on television in Australia

Matthew Winter, Rob Donovan and Lynda Fielder

Journal of Studies on Alcohol and Drugs, 2008, 69, (5), 676-683

Objective: This article reports the extent to which children (0-12 years) and teenagers below the legal drinking age in Australia (13-17 years) were exposed to alcohol advertising on free-to-air television in Sydney, Australia, during the period from March 2005 to February 2006. Method: Exposure levels were obtained from weekly Target Audience Rating Points (TARPs) data generated by OzTAM, the official Australian television audience monitoring system. (The TARPs figure for an advertisement is calculated based on the number of individuals from a target audience [eg 13- to 17-year-olds] exposed to the ad as a proportion of the total number of individuals within the target audience, multiplied by 100). Exposure levels were obtained for four age groups up to 12 years, 13-17 years, 18-24 years, and 25 years and older for 156 different ads for 50 brands. Results: Adults 25 years and older were most exposed to alcohol advertising: approximately 660 TARPs per week. The level to which underage teenagers (13-17 years) were exposed to alcohol advertising was virtually identical to that of young adults (18-24 years): 426 TARPs per week vs 429 TARPs per week. Children (0-12 years) were exposed to approximately one in every three alcohol ads seen on average by mature adults (ages 25 years and older). Conclusions: This study found that Australian children and teenagers below the legal drinking age currently are exposed to unacceptably high levels of alcohol advertising on television. These findings suggest that alcohol marketers may be deliberately targeting underage adolescents. At the very least the findings highlight the need for action to be taken to reduce levels to which underage Australians are exposed to alcohol advertising on television. **cl**

recent **publications**

Monographs and Technical Reports

Butler, T. & Papanastasiou, C. (2008) National Prison Entrants' Bloodborne Virus and Risk Behaviour Survey Report 2004 & 2007. National Drug Research Institute, Curtin University of Technology, Perth & National Centre in HIV Epidemiology and Clinical Research, University of New South Wales, Sydney. ISBN: 1 74067 582 7.

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National Drug Research Institute

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Fran Davis	Business Manager
Colin Binns	Professor
Rob Donovan	Professor
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Andy Lee	Professor
Sherry Saggers	Professor
Tony Butler	Associate Professor
Bruce Maycock	Associate Professor
Richard Midford	Associate Professor
David Moore	Associate Professor
Ted Wilkes	Associate Professor
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Tanya Chikritzhs	Senior Research Fellow
Nyanda McBride	Senior Research Fellow
Susan Carruthers	Research Fellow
Owen Carter	Research Fellow
Jennifer Dodd	Research Fellow
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Ed Garrison	Research Fellow
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Fredrik Welander	Research Fellow
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Richard Pascal	Research Associate
Candice Rainsford	Research Associate
Anna Stearne	Research Associate
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Beatriz Cuesta Briand	PhD Student
James Fetherston	PhD Student
Rachael Green	PhD Student
Tina Lam	PhD Student
Amy Pennay	PhD Student
Christine Siokou	PhD Student
Nicola Thomson	PhD Student
Celia Wilkinson	PhD Student

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Kate Graham	Professor
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