

centre lines

A bi-monthly newsletter published alternately by the National Drug Research Institute (NDRI), Perth and the National Drug and Alcohol Research Centre (NDARC), Sydney

NDRI (27)

May 2009

issuing **forth**

Using lessons from the past to help inform our future



Original staff of the National Centre for Research into the Prevention of Drug Abuse (now NDRI) 1986

edspace

Welcome to the May issue of *CentreLines*. In September 2006, to mark the twentieth year of its operation, the National Drug Research Institute (NDRI) hosted a two-day international research symposium in Perth. A number of papers from the event, *Responding to drug problems: Lessons from the past, future challenges and opportunities*, have recently been published in a special section of the journal *Drug and Alcohol Review* (volume 28, number 2, March 2009).

To tie in with this publication, *Issuing Forth* has been contributed by Professor David Hawks who reflects on the establishment of NDRI and its intended role in the context of the first national drug strategy, the challenges it faced in the early years, and how the lessons learnt then are still helping to inform the alcohol and other drug sector today. Professor Hawks is Honorary Professorial Fellow at NDRI, having served as its Director between 1987 and 1995.

As previously advised, the distribution arrangements for *CentreLines* are changing, moving away from printed copy towards predominantly electronic circulation. Thank you to those readers who have provided NDRI with their email address and are now receiving *CentreLines* electronically. If you have not yet provided your email address and wish to continue receiving *CentreLines*, we encourage you to do so as soon as possible. For further information, please see the back page of this issue.

For more information about NDRI's research and other activities, please visit ndri.curtin.edu.au.

Rachael Lobo
Editor

Funded by the
National Drug Strategy

Registered by Australia Post –
Print Post Publication No
PP236697/00013
ISSN 1034-7259

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NDRI
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headspace

Reflecting on our past to help shape our future

When we are looking where to go, we are frequently, and appropriately, reminded to look where we have been.

NDRI is pleased to see the recent publication, in the journal *Drug and Alcohol Review*, of several papers from our twentieth anniversary symposium, which explored our history and future challenges. Other commitments prevented Professor David Hawks, the Institute's Director from 1987-1995, from being at the event. In *Issuing Forth*, we have taken the opportunity to invite Professor Hawks to reflect on the establishment of the National Drug Research Institute more than two decades ago, and to remind us of some of the key issues that were prominent in debates

about drug use at the time. His reflections are particularly instructive because, in addition to leading our early research endeavours, Professor Hawks was intimately involved in alcohol and other drug policy development in his earlier appointment as a senior state government official.

At a time when we are preparing for a new National Drug Strategy, and when we are seeing much community debate about alcohol policy, Professor Hawks' piece reminds us that research is but one player in policy decisions. We have all recently seen the diverse interests that have been brought to bear in the debate on alcohol, and many of the challenges today bear a remarkable similarity to events



20 years ago. One observation, however, is that today law enforcement is taking a much more active role in debate about alcohol's impact. This is not surprising: law enforcement, and our emergency departments, are continually exposed to the adverse outcomes of risky alcohol consumption. **cl**

Steve Allsop
Director

issuing forth

The first 10 years of NDRI – How green was our valley?

This article documents the establishment of NDRI and its intended role in the context of the first National Campaign Against Drug Abuse (now National Drug Strategy) in the mid-1980s. It reflects on the challenges the Institute faced in the early years, and how the lessons learnt then are still helping to inform the alcohol and other drug sector today.

While many of the initiatives which together comprised the first drug strategy had their origins in the 1985 drug summit called by then Prime Minister Bob Hawke, it would be a mistake to assume that this event was progenitor to all concern for alcohol and drug related problems in Australia. There had been several official enquiries, notably the Senate enquiry chaired by Senator Margaret Guilfoyle, which had highlighted the prevalence of alcohol related problems. There were also a number of committees reporting to the National Health & Medical Research Council (NHMRC) and the Standing Committee of Health Ministers which included alcohol related problems in their purview. It must be remembered that the use of illicit drugs was barely acknowledged before 1980.

Of particular relevance is the fact that a committee comprising the heads of the various state alcohol and drug authorities was already formulating a national alcohol policy, an activity which was given added impetus by the decision of the drug summit, however reluctantly taken, to include alcohol in its terms of reference.

The summit called for in April 1985 had been preceded by a number of meetings, some statutory and others professional, the purpose of which was to define the agenda. Of particular note was a meeting convened by DANA (Drug and Alcohol Network Australia) at which Dr Neal Blewett, Federal Health Minister from 1983-1990, gave an invited address. It must be remembered that in his comments and the publicity that followed the summit, Prime Minister Hawke had especially emphasized the dangers presented by the use of illicit drugs. While not disputing that alcohol and tobacco also contributed to the burden of ill health, it was illicit drugs, or so it was suggested, which presented the greatest threat.

The paper presented by Dr Blewett at the DANA Conference clearly stated that Australia's drug problem principally derived from its use of alcohol and tobacco and any national campaign which did not acknowledge this was fraudulent. In addition, Dr Les Drew, the Commonwealth Department's Medical Advisor on alcohol and drugs, had compiled statistical evidence relating to the incidence and prevalence of alcohol and drug related morbidity and mortality which substantiated Dr Blewett's assessment.

The summit itself was a curious affair. The whole meeting, in which only Premiers were permitted to speak, took place in less than a day and was essentially convened to agree a communiqué which proposed the establishment of a Ministerial Committee



on Drug Strategy to have oversight of the first National Campaign Against Drug Abuse. Quoting from the communiqué: "The campaign was to focus particularly on illegal drugs", but of particular relevance to the initiation of NDRI, it was agreed: "In principle that one or more *centres of excellence* would be established".

The first meeting of the Ministerial Council on Drug Strategy held in Brisbane was to prove pivotal in defining the terms of reference of the campaign. The alcohol and tobacco industries, while noting that the campaign was to encompass problems relating to the use of these drugs, must have taken comfort from the emphasis to be given illicit drugs. One can only surmise that they had lobbied the Prime Minister's office to this effect. Certainly informed newspaper comment at the time suggested this. When in the course of the meeting each Health Minister was invited to speak to the terms of reference, Barry Hodge, who was then Western Australian Minister of Health, made reference to Dr Blewett's speech to DANA in which he explicitly stated that any campaign which sought to address Australia's drug problem would have to include Australia's dependence on alcohol and tobacco. Barry Hodge read the statement out exactly as Dr

Blewett had written it and sat down. One can only imagine that, whatever his private views, Dr Blewett was under enormous pressure to toe the Prime Minister's and Government's line and was highly embarrassed to have his personal view resurrected in this company.

Needless to say, alcohol and tobacco were included and moreover were given considerable prominence in the campaign. Standing committees to draft national health plans in relation to alcohol and tobacco were some of the first established, and the plan relating to alcohol, albeit in a somewhat diluted form, was the first adopted.

In accordance with the communiqué issued at the drug summit, States were invited to submit proposals to be the site of one or more of the centres of excellence. In Western Australia (WA) we took the view that if there was to be only one such centre, as suggested by the amount of money allocated, it would almost certainly be located in Sydney which was seen to be the epicentre of the drug epidemic. We were, however, tipped off that the Health Department would in fact entertain funding two centres, in response to which WA Alcohol and Drug Authority staff drafted a submission emphasizing the importance of prevention and in particular the legislative, regulatory and educational levers available to effect prevention. It was argued that virtually no epidemiological data in relation to Australia's alcohol and drug problems existed and WA, having a centralised health record system and highly concentrated population, made it an ideal epidemiological laboratory. While Sydney, as predicted, was the site chosen for the treatment research centre, WA was successful in its application and Perth was chosen as the site for the second centre, albeit with a smaller budget.

In order to effect some independence from government it was decided that centres should be established within universities, though receiving dedicated funding from the Commonwealth. Both Curtin University of Technology (which had only recently been accorded University status) and the University of Western Australia (UWA) expressed interest. While the decision to locate the centre at Curtin struck me as paradoxical at the time, if only because UWA housed a School of Medicine and already accommodated a number of NHMRC units, including one specializing in epidemiological research, the decision has proved to be beneficial.

The National Centre for Research into the Prevention of Drug Abuse (as it was then called) was the first of Curtin's designated research centres and was to become one of its most prominent. It was highly valued, with its Director and eventually its Deputy Director being offered tenured positions, while those in Sydney continued to be tied to the periodicity of Commonwealth funding.

The Commonwealth was unduly impatient to get the centres of excellence established, and so Professor Colin Binns, Head of Public Health at Curtin, was seconded as Acting Director together with his departmental secretary and a number of his staff, some of whom were subsequently appointed to substantive positions within the Centre. In addition to finding the Centre rental premises in South Perth, Professor Binns initiated its first research projects and established the Centre's first computer network. Meanwhile the University advertised the Director's position to which I was eventually appointed. So the Centre in Perth, for all the ambiguity evidenced about the importance of prevention, was the first of the two Centres to be established and I was the first to be appointed to a Professorial Chair in Addictions in Australia.

While the Centre's initial emphasis was on looking at the means of preventing alcohol related problems in the years following the drug summit, it had become clear, if only because of its link with HIV-AIDS, intravenous drug use was a priority area. The Centre was to pioneer investigatory methods which relied on recruiting users who were not known to the formal services, whether through snowballing, advertising in night clubs and rave parties or direct advertising, and in this way ninety percent of users unknown to established services were sampled.

Even before the Centre moved to larger premises in South Perth it was obvious there was a need to devise a method of cataloguing our accumulating mass of reprints – initially employing a means of self help devised by a librarian on loan from the State Reference Library, but subsequently by appointing our own librarian. Our reliance on computers had become such that we also needed to appoint our first systems analyst, advice from the University's Computer Centre being too tardy for our accelerating needs.

Having survived our first review, held somewhat prematurely 11 months after the Centre was initiated, we were much better prepared for those which followed at roughly three yearly intervals. The formulation of our forward research planning was undertaken as a collegiate exercise attended by everyone over several days, the purpose of which was to consider where the greatest gains could be achieved tempered always by what the Commonwealth would pay for. The initiative however rested with us. Thus we developed programs in collaboration with a number of communities, evaluated school based educational programs, initiated studies of Aboriginal populations employing Aboriginal co-workers, and established a database which enabled us to plot the effect of changes in alcohol's availability.

In deliberating about our program of work our intention was always to discern the

statutory, legislative and educational levers which bore on the prevention of drug related problems. In the case of alcohol they were more easily discerned since being a legal drug its availability, pricing and advertising were at least nominally under government control. In the area of illicit drugs the levers were harder to discern. By definition the drugs in question were not legally available and so could not be controlled by such means as taxation and licensing. Even education regarding their safe use was controversial. It was argued that to educate people about their use was to condone their use. The advent of HIV/AIDS and its link to the sharing of needles and unprotected sex made education at least in some areas more acceptable. Surprisingly there was little objection to making needles and syringes available to users, even those not in treatment, while making condoms readily available was in everybody's interest.

Arguments raged as to whether heroin should be made available in any circumstances at all. Despite the recommendation of a working party that heroin should be made available to a very circumscribed population of users and only on an experimental basis, Prime Minister at the time John Howard vetoed the proposal. Less contentious, at least initially, was the adoption of civil penalties for personal use of cannabis. South Australia, having been the first to decriminalize personal use, has proved a rich resource for comparative research which continues even today.

US research, principally by the Prevention Research Centre in California with which the Centre maintained close links, suggested that if properly resourced and empowered local communities could address their drug problems. This led to a series of initiatives including those undertaken in Geraldton, Mirrabooka and Fremantle.

The problems posed by the use of alcohol and increasingly cannabis and solvents in Aboriginal communities were always apparent but difficult to address. At various times the Centre has employed Aboriginal workers as Research Associates both as a means of gaining access to such communities but also by way of providing a mentoring role.

A defining characteristic of the Centre in the first ten years was the belief that it should both undertake research which was relevant to policy but also advocate the policy implications of that research. This is a difficult balancing act if one is not to fall captive to one or other of the political interest groups, but it was our belief that it was one of the Centre's responsibilities as a publicly funded research centre. During this period the Centre, together with the Sydney Centre, was recognised as a World Health Organization Collaborating Centre.

Sometime in the first ten years we persuaded the Australian Medical Society on Alcohol

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and Drugs, as it was then called, to convene its first Annual Conference in Western Australia and moreover to cajole the Kettil Bruun Society to hold its first meeting in the southern hemisphere. The fact that the two conferences were held in the grounds of the University of Western Australia with the visitors accommodated in St Georges College at a time when the International Film Festival was in full flight may have added to their attraction. Some of our visitors even swam in the Swan River at Matilda Bay.

While not an ancillary of the Centre, the Alcohol Advisory Council continued during this time to advocate a public health orientated policy in relation to alcohol and in this regard was dependent on the Centre for its research credibility. During its relatively brief existence the Alcohol Advisory Council enjoyed a close working relationship with the Centre and frequently acted as its media outlet in relation to such matters as a rational taxation system for alcoholic beverages and standard drink labelling.

A comprehensive assessment of the achievements of the drug summit would require a longer paper than is permissible in this context. On the research front however it can be claimed that where previously we had to depend on research undertaken overseas, the extrapolation of which to the Australian situation was always contentious, we now had the capacity to undertake research for ourselves. Moreover we had the opportunity to undertake comparative research which took advantage of the relative independence, in legislative matters, of the different Australian states. While a junior partner to treatment, prevention was on the agenda. The argument that we couldn't wait until the condition developed before seeking to prevent it had been won if only because the cost of treating some of the conditions consequent upon drug use were prohibitively expensive.

While from the vantage point of over 20 years hence it seems unexceptional to have alcohol accepted as a drug, for it to be included in

any national drug strategy was a considerable achievement. Enormous pressures were exerted to keep it off the agenda and subsequently to dilute the more effective of the strategies for preventing its misuse, and still are.

Finally, prevention, except in the form of public or school based education, had been very much an afterthought until the drug summit. Strange as it may seem, society's first response to problems associated with drugs is to attempt to treat them when they arise rather than to consider what might minimise their occurrence in the first instance. While treatment will always be a necessary part of any civilised society's response to such problems, their prevalence and chronicity will always recommend that we make every effort to prevent them in the first instance. **cl**

David Hawks

**Honorary Professorial Fellow,
National Drug Research Institute &
Emeritus Professor Addiction Studies,
Curtin University of Technology**

project notes

A multi-site investigation of the social meanings of alcohol misuse among young adults in recreational settings

**David Moore, Jeremy Northcote,
Jocelyn Grace**

This research project, funded by the AER Foundation, focused on drinking amongst young adults in Perth. It involved participant observation in eight networks of young adults (aged from 18-25 years old), in-depth interviews with a subsample of participants, and stakeholder interviews with venue managers, policy makers and staff from alcohol and other drug agencies. We focus here on the material concerning young adults.

We found that drinking alcohol was central to social interaction across the eight groups of young adults observed and interviewed in the study. In other respects, however, there was considerable diversity between them – in how much alcohol they consumed, their tastes in venues and music, whether they also used drugs other than alcohol and their alcohol-related risk practices. While few of the interviewed participants had ever felt themselves to be in danger of being harmed when going out drinking, they were not unaware of the risks associated with doing so, as demonstrated by the range of strategies they employed to reduce harm. They also

acknowledged the negative physical effects of alcohol and other drug consumption, and took some measures to minimise them. The strategies used to avoid harm focused around transport (ie not drinking and driving) and mutual reliance between friends, with female participants being most consistent in employing these strategies.

As with harm minimisation approaches to illicit drug use, identifying and reinforcing the strategies that are currently being used by young adults may hold potential for reducing alcohol-related harm. Those identified in this study include:

- planning transport, having a designated driver or using public transport;
- actively preventing, trying to prevent, and chastising friends for drink-driving;
- avoiding venues with violent reputations, and choosing venues where staff and patrons are relaxed and friendly;
- staying with, and looking after, friends and partners, including avoiding and defusing arguments and fights amongst friends, other patrons and/or security staff;
- eating before drinking and later in the night;
- drinking water between alcoholic drinks;
- if taking drugs, taking care in procuring them, and understanding their effects (eg dehydration) and the risks associated with combining them with alcohol.

There is an urgent need for culturally appropriate, evidence-based strategies that can be communicated in credible and effective ways to young adults. Delivering messages that acknowledge the agency of young adults, and that are relevant to them, is an essential complement to approaches that seek to reduce alcohol-related harm by reducing the overall availability of alcohol, improving the safety of licensed premises and providing adequate and safe public transport.

Aboriginal and Torres Strait Islander cannabis intervention project

**Dennis Gray, Ted Wilkes, Simon Lenton,
Steve Allsop, Julia Butt, Michael Doyle**

The cannabis intervention project is a two-year collaboration between NDRI and four Indigenous community controlled health services. The project, funded through the National Cannabis Prevention and Information Centre (NCPIC), aims to develop, pilot and disseminate cannabis intervention protocols for Indigenous primary health care settings.

To date there have been few studies specifically focusing on cannabis use among Indigenous Australians. However, the limited evidence available indicates that consumption has increased significantly in the past decade, with a concomitant rise in both direct and

indirect negative health consequences. Further, to date little has been written about cannabis interventions for Indigenous people. Thus, the project aims to address both a gap in research and in service provision.

The initial focus of the project has been the development of practical treatment protocols and clarification of the importance of cannabis as a health issue. The first step was to consult with staff of the four participating health services (including health workers, GPs, nurses, social workers, psychologists) using both questionnaires and focus groups. The consultation gathered information regarding: perceived levels of use among clients, harms caused by cannabis, current clinical practises, attitudes towards treating cannabis use, and ideas for developing treatment responses to cannabis use. In addition, the consultation was aimed at ensuring local needs were identified and addressed.

Following the consultation a workshop was held with members of the NDRI project team, members of the four participating health services and two experts. In looking at the capacity of health services, the complex health needs of Indigenous communities, and the lack of attention to date on cannabis use, the workshop participants concluded that the project would be a starting point in terms of raising the issue of cannabis use and cannabis related harms. In reviewing the consultation findings and considering the experience of those present, it was determined that cannabis use affects nine key areas of community health and wellbeing (mental health, finances, unborn children, parenting and family, the relationship to aggression and agitation, the prevalence of cannabis dependence, withdrawal, the relationship to school attendance and lifetime wellbeing, the relationship of cannabis to nicotine smoking) and as such warrants an increase in clinical attention. The workshop also recognised the need to provide workers with training and support in addressing cannabis use.

The primary outcomes of the workshop were the development of an intervention strategy and implementation strategy. The intervention strategy aims to be flexible to adapt to regional and structural differences, and to fit within existing services. The implementation strategy recognises that the introduction of a new task and a new health message into clinical services can be a difficult process for both staff and clients. Consequently the strategy is graded and allows for awareness raising among staff and clients.

The next step of the project is a six month pilot test of the intervention protocols and implementation strategy. This will be an iterative process whereby changes will be made in response to the needs of the participating health services. Following the pilot a second workshop will be convened

in which the outcomes are discussed and resources finalised. The final step of the project will be the dissemination of the resources to other Indigenous community controlled health services.

Illicit Drug Reporting System

Jessica George, James Fetherston, Simon Lenton, Laura Santana

The Illicit Drug Reporting System (IDRS) is an annual study conducted in every jurisdiction of Australia, and designed to monitor trends in illicit drug use and markets. It is coordinated nationally by the National Drug and Alcohol Research Centre (NDARC) and funded by the Australian Government Department of Health and Ageing. Presented here is a summary of the key findings from the survey of 100 regular injecting drug users conducted for the Western Australian (WA) IDRS 2008.

The 2008 sample was on average 37 years of age, 62% male, and with an average 10 years of education. Fewer respondents were unemployed in 2008 (61%) compared to 2007 (78%). Some 37% of the 2008 sample were in drug treatment, mostly opioid pharmacotherapies. A prison history was reported by 45%, while the proportion reporting arrest in the last 12 months fell from 41% in 2007 to 28% in 2008. The average age of first injection remained unchanged at 19 years. The proportion injecting daily or more frequently fell from 57% in 2007 to 30% in 2008. Most reported injecting weekly or less often.

In 2008 methamphetamine replaced heroin as the drug most often injected in the past month (43% vs. 32%) and most recently injected (42% vs. 34%). While heroin remained the most nominated drug of choice (49% in 2008 vs. 54% in 2007), there was a significant increase in the proportion nominating methamphetamine as their favourite drug (15% in 2007 to 35% in 2008).

Heroin: In 2008, 86% of IDU reported lifetime use of heroin (90% in 2007) and 59% reported recent use (56% in 2007). Average days of use in the last six months significantly decreased from 87 days in 2007 to 61 days in 2008. While there was no increase in the number who reported ever overdosing on heroin (44% in 2007 vs. 43% in 2008), there was an increase in the proportion reporting overdose in the past 12 months from 3% in 2007 to 12% in 2008. The median price of recent purchases of one gram of heroin was \$600 (\$650 in 2007). Availability was reported as either 'easy' or 'very easy' by 93% of IDU in 2008 compared to 71% in 2007. Ratings of 'low' purity decreased from 47% in 2007 to 21% in 2008.

Methamphetamine: Lifetime (93% in 2007 vs. 98% in 2008) and recent (70% in 2007 vs. 74% in 2008) use of any form of methamphetamine was comparable across

years. There were significant increases from 2007 to 2008 in lifetime use of speed (90% vs. 97%) and crystal (78% vs. 90%), while recent use of speed (61% in both years) and crystal (56% vs. 61%) were comparable. In contrast, from 2007 to 2008 there were significant decreases in lifetime (45% vs. 26%) and recent (23% vs. 13%) use of base. Average days of any methamphetamine use in the past six months significantly decreased from 74 days in 2007 to 49 days in 2008. The median price for one point of all forms of methamphetamine remained \$50. Availability of all forms was rated as either 'easy' or 'very easy' by most respondents. The greatest proportion of respondents rated purity of speed and base as 'medium' and crystal as 'high'.

Illicit use of pharmaceutical opioids: From 2007 to 2008 significant decreases in recent illicit use of methadone (24% vs. 14%), physeptone (19% vs. 7%), morphine (45% vs. 31%), and oxycodone (44% vs. 23%) were observed. No significant changes were observed in recent illicit use of buprenorphine ('Subutex') (19% vs. 18%) or buprenorphine-naloxone ('Suboxone') (15% vs. 12%).

Summary: Findings from the 2008 WA IDRS indicate changing drug use patterns among IDU in Perth. Frequency of injection decreased, with most IDU reporting injection 'weekly or less'. Methamphetamine was more frequently nominated than heroin as the drug most often injected in the past month and as the most recent drug injected. There were also significant increases in the proportion reporting lifetime use of speed and crystal, while both lifetime and recent use of base significantly decreased. While lifetime and recent use of heroin were comparable to last year, there was a significant decrease in the average days of heroin use among recent users. There were significant decreases in use of other opioids, including recent illicit use of methadone, physeptone, morphine and oxycodone.



Ecstasy and related Drugs Reporting System

Candice Rainsford, James Fetherston, Simon Lenton

The Ecstasy and related Drugs Reporting System (EDRS) aims to identify emerging trends in patterns of use and markets for these drugs. It is coordinated nationally by the National Drug and Alcohol Research Centre (NDARC) and funded by the Australian

project notes continued...

Government Department of Health and Ageing. Presented here is a summary of the major findings from interviews with regular ecstasy users (REU) for the 2008 EDRS in Western Australia (WA).

The sample recruited for the 2008 study was mostly similar to that of previous years. Although the 2007 sample was atypical in some ways, the gender distribution of the 2008 sample was comparable to that of 2007, with 48% of the current sample male (55% in 2007). There was however a significant decrease in average age of the sample to approximately 23 years from 26 years in 2007, although this did not differ significantly from the average age found in samples before 2007. A significant increase was seen in the proportion currently in full-time employment (from 24% in 2007 to 55% in 2008). Overall the demographic characteristics of the 2008 sample were comparable to samples before 2007.

With regards to drug use patterns, average days of recent use of ecstasy fell to the lowest rate reported since data collection began, as indicated by a significant decrease to 13 days in 2008 down from 16 days in 2007. In contrast, greater amounts of ecstasy were typically used, with the proportion usually using more than 1 tablet in a session increasing from 54% in 2007 to 74% in 2008. There was no significant change in those reporting 'bingeing' (using for more than 48 hours without sleep) on ecstasy (29% in 2007 vs 22% in 2008).

Polydrug use was common across the 2008

sample, with the vast majority of respondents reported typically using other drugs both with ecstasy (97%) and during the period of recovery (90%). Alcohol and cannabis were the most frequently nominated drugs used on both occasions. Lifetime use of pharmaceutical stimulants (both illicit and licit) increased, from 71% in 2007 to 85% in 2008. In 2008 there was no significant change in lifetime, recent use or frequency of any form of methamphetamine in comparison to 2007, the only exception being crystal methamphetamine. Recent use decreased significantly from 52% in 2007 to 36% in 2008, and frequency of use also decreased from an average of 28 days in 2007 to 12 days in 2008. This represents the lowest rates of recent crystal methamphetamine use since data collection began, therefore suggesting that the patterns of declining use observed in previous years are continuing. Similar trends in decreasing recent use of crystal methamphetamine were also observed in REU samples for the EDRS in other jurisdictions. From 2007 to 2008 there was a significant increase in both lifetime (79% vs 90%) and past six months use (52% vs 69%) of tobacco.

Helping Change: the drug and alcohol counsellors' training program

Sue Helfgott, Steve Allsop (Editors)

In 2008 the Drug and Alcohol Office (DAO) and NDRI received funding from

the Commonwealth Department of Health and Ageing to update the Helping Change package, which has formed the basis for training volunteer counsellors in Western Australia since 1989. It has also been used in a wide variety of other training programs for paid and unpaid staff.

There are 21 modules in the updated package which includes three new modules: Drug use and pharmacotherapy; Mental health, substance use and childhood sexual abuse; and Amphetamines. All other modules were updated to incorporate new evidence and audio visual resources.

The Helping Change program has been used in various jurisdictions around Australia, including Moreland Hall and Turning Point in Victoria, Queensland Department of Health, Drug and Alcohol Services South Australia, New South Wales and the Northern Territory. The program has also been used in Jersey, United Kingdom, and the Maldives. In January 2009 Steve Allsop conducted training in Fiji using elements of the updated program.

The original Helping Change package was peer reviewed by Professor Richard Mattick (NDARC, NSW) and Peter Dwyer (NSW, TAFE). The updated package was reviewed by Associate Professor Amanda Baker, University of Newcastle. To enhance dissemination of the package, Sue Helfgott, Manager Workforce Development, DAO and Steve Allsop are considering a national train the trainer program for interested participants. **cl**

abstracts

'Kiddie drugs' and controlled pleasure: Recreational use of dexamphetamine in a social network of young Australians

Rachael Green and David Moore

International Journal of Drug Policy, 2009, doi:10.1016/j.drugpo.2008.12.002

Background: This article explores the recreational use of diverted dexamphetamine, a pharmaceutical stimulant, amongst a social network of young adults (aged 18–31 years) in Perth, Western Australia (WA). Prior epidemiological research indicates that there are high levels of dexamphetamine prescription, and use of diverted dexamphetamine, in this jurisdiction. Little research exists on the social contexts of diverted dexamphetamine use in Australia or overseas.

Methods: Ethnographic fieldwork was conducted over 18 months amongst a network of approximately 60 young adults who regularly used psychostimulants. Data collection involved participant observation conducted in natural settings including nightclubs and private parties. In-depth interviews were also conducted with 25 key contacts which explored drug use histories and themes emerging from fieldwork.

Results: The use of diverted dexamphetamine, or 'dexies', was prevalent amongst the social network and integrated into local drug practices. The paper explores the ways in which dexamphetamine use is rationalised, negotiated and represented in the context of the use of alcohol and other psychostimulants such as methamphetamine and ecstasy. Two key aspects are emphasised. First, dexamphetamine use is seen as insignificant by network members

and is positioned as 'safer' in relation to the use of other drugs by virtue of its pharmaceutical status. Second, dexamphetamine plays an instrumental role in facilitating the pursuit of 'controlled pleasure' via the heavy consumption of alcohol and other drugs.

Conclusion: The findings of the paper have implications for harm reduction policy. In particular, dexamphetamine use facilitates heavy drinking and polydrug use amongst young adults, which may increase the harms associated with such use. Further, current interventions targeting young psychostimulant users, which emphasise their adulterated and illegal nature, may inadvertently contribute to the cultural construction of dexamphetamine as a relatively 'safe' drug.

Alcohol use and prostate cancer: A meta-analysis

Kaye Middleton Fillmore, Tanya Chikritzhs, Tim Stockwell, Alan Bostrom and Richard Pascal

Molecular Nutrition and Food Research, 2009, 53, pp 240–255

Past reviews have concluded that there is no association between alcohol use and prostate cancer incidence. We performed a meta-analysis of existing epidemiological studies finding, in contrast, evidence to suggest that prostate incidence is positively linearly associated with heavier alcohol use. This finding was largely due to the contribution of population case-control studies and those measuring men recruited before age 60. No relationship between alcohol consumption and prostate cancer was found for cohort and hospital case-control studies. Analyses of design effects modestly suggests that population case-control studies were probably better suited to identify potential alcohol-prostate cancer relationships due to the close temporal proximity of the measurement of level of alcohol consumption to diagnosis.

Future efforts should be made to exclude all ill subjects from control groups/baseline samples in addition to accounting for changes in consumption with advancing age and the onset of illness. The alcohol-prostate cancer association remained significant despite controlling for the degree to which studies endeavored to eliminate false negatives from their control groups.

Estimating alcohol-attributable mortality among Indigenous Australians: towards Indigenous-specific alcohol aetiologic fractions

Richard Pascal, Tanya Chikritzhs and Dennis Gray

Drug and Alcohol Review, 2009, 28, pp 196–200

Introduction and Aims: Past estimates of Indigenous alcohol-attributable health in Australia have been based on drinking prevalence estimates from the general population, rather than prevalence figures from the Indigenous population. The purpose of this paper is to demonstrate the efficacy of

using Indigenous-specific drinking prevalence to estimate alcohol-attributable deaths among Indigenous Australians.

Design and Methods: Estimates of Indigenous alcohol-attributable deaths between 2000 and 2004 were obtained using both (i) national general population drinking prevalence estimates and (ii) national Indigenous-specific drinking prevalence. Estimates were calculated using the 'aetiologic fraction' method.

Results: By using national general-population drinking prevalence figures, past reports on Indigenous health have under-estimated alcohol-attributable deaths for the national Indigenous population. Female deaths due to alcohol-attributable haemorrhagic stroke were estimated to be about four times higher and alcohol-attributable suicides among males were estimated to be 30 per cent higher than was previously held, when indigenous-specific drinking prevalence figures were used.

Discussions and conclusions: By substituting Indigenous-specific alcohol consumption prevalence estimates for general-population drinking prevalence, the accuracy of estimates of alcohol-related harm among Indigenous Australians can be significantly improved. **cl**

recent publications

Monographs and Technical Reports

Chikritzhs, T. and Allsop, S. (2009) Review: Trends in alcohol related hospital use by young people by Access Economics.

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National Drug Research Institute

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Tony Butler	Associate Professor
Tanya Chikritzhs	Associate Professor
Bruce Maycock	Associate Professor
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Rachael Green	PhD Student
Tina Lam	PhD Student
Amy Pennay	PhD Student
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Nicola Thomson	PhD Student

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Kaye Fillmore	Professor
Kate Graham	Professor
Tim Stockwell	Professor
Peter d'Abbs	Associate Professor
Wendy Loxley	Associate Professor
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