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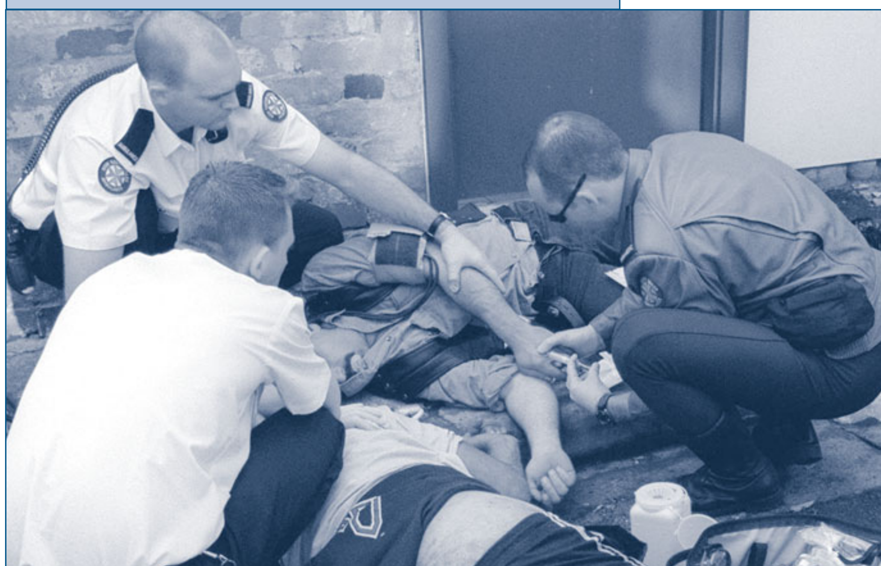
issuing **forth**

Naloxone for peer administration – time to consider again?



ed**space**

Welcome to the Christmas edition of CentreLines.

In *Headspace*, Acting Director Dennis Gray examines issues in alcohol and research policy at a time when governments and the research community are focusing on the issue. The challenge in addressing the significant negative impact of alcohol on the Australian population lies not in finding workable solutions but in implementing the workable solutions we already know about.

In *Issuing Forth*, Simon Lenton suggests that if naloxone provision for peer administration is going to be a viable addition to existing resuscitation training, overdose prevention education and outreach interventions, then now is the time to trial training and pilot interventions.

Alcohol and other drug research in Australia has traditionally focussed either on alcohol or on illicit drugs. *Project Notes* outlines a new project that will investigate the concurrent use of alcohol and party drugs.

This edition of CentreLines, the last for 2004, also includes a brief wrap of the 2004 annual APSAD conference, co-hosted by NDRI and the Drug and Alcohol Office in Fremantle in November.

Best wishes to all for a happy and safe festive season and we hope to see you fit and well in 2005.

Vic Rechichi
Editor

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CentreLines is a joint publication from the National Drug Research Institute, Perth and the National Drug and Alcohol Research Centre, Sydney. It is published bi-monthly and produced alternately by each centre.

headspace

Issues in alcohol research and policy

At the time of writing:

- the Victorian Parliament's Drugs and Crime Prevention Committee is conducting an 'Inquiry into Strategies to Reduce Harmful Alcohol Consumption;
- in Western Australia, a review of the *Liquor Licensing Act* is underway; and,
- the Northern Territory Government is considering comments on its proposed *Alcohol Framework* document.

In addition, a team of NDRI staff members – led by Associate Professor Wendy Loxley – has just completed a paper on issues in alcohol policy and their implications for future research[1]. Given this, it is perhaps timely to reflect on some of the issues.

The National Alcohol Indicators Project (NAIP), led by Tanya Chikritzhs and Professor Tim Stockwell, provides a convenient starting point. In general, it appears that in the early 1990s there were declines in per capita consumption of pure alcohol, which then levelled off. Unfortunately, following the High Court decision that declared collection of liquor licensing fees by state and territory jurisdictions unconstitutional, most jurisdictions ceased collecting wholesale sales data on which these estimates of per capita consumption are based. This makes it difficult to track national trends beyond that time. However, data from the Northern Territory and Western Australia show a slight increase in consumption since the late 1990s.[2] A casual observer might ask: 'If there appears to have been a general decline in consumption, what is the cause for concern?' The answer to this lies in the patterns concealed by the simple statistical means.

The first of these patterns is the way alcohol is consumed. In another NAIP Bulletin – based on national survey data which are known to under-estimate consumption – it has been estimated that 24 per cent of alcohol consumed is consumed in a manner that poses high risks of short-term health harms (e.g. injury, assault).[3] That is, eleven or more standard drinks a day for men and seven or more a day for women.[4] In addition, 20 per cent of alcohol is consumed in a manner that poses high risks of long-term health harms (e.g. liver disease, stroke). That is, consuming in excess of 28 standard drinks a week for men and 14 a week for women. Among both males and females, the percentage of alcohol consumed in a high risk manner for acute harm is significantly higher.

Of particular concern is risky and high risk consumption among young people. The proportion of alcohol consumed at risky and high risk levels for both acute and chronic harm among those aged 18–24 exceeds that among people in higher age groups. Furthermore, the proportion of alcohol consumed at a risky or high risk levels for acute harm is greatest among those aged 14–17; and in recent years the amount of alcohol consumed in a risky or high risk manner has been greater among females in this age group.[3,5]

When the NH&MRC alcohol guidelines are applied to drinking among people aged 65 years or over, the proportion of alcohol consumed at risky and high risk levels is less than that among those in younger age groups – although, about 16 per cent of people aged 60 years or more consume alcohol on a daily basis compared to only three percent of those aged 20–29.[3] However, the NH&MRC guidelines were developed for a broad age spectrum population. Given some evidence of a decline in tolerance to alcohol among older people and the deleterious consequences of combining alcohol consumption with prescription medications, it may be that application of the guidelines to older people does not provide an appropriate indication of risk. This is an area that warrants further research.

Another pattern concealed in population averages of per capita consumption is that among Indigenous Australians. Data from various sources indicate that among Indigenous people those who currently consume alcohol do so at levels of risk that considerably exceed those in the general Australian population.[6] Unfortunately, most sources of data on Indigenous alcohol consumption have important limitations and the best data on which estimates can be made are now over ten years old.[7] In the absence of more recent studies, our estimates of consumption are only a broad approximation.

These risky consumption patterns are reflected in the resulting harms. Acute harms are experienced disproportionately by young people. It has been estimated that, in the period 1993–2002, approximately 2640 people aged 15–24 died from alcohol-attributable injury and disease. Over 90 per cent of these deaths were caused by injuries – including those from motor vehicle accidents, suicide, and assault. In addition, between 1993–2001 approximately 90,000 young people were hospitalised for acute alcohol-attributable injury.[1]

The epidemiological data indicate that alcohol-related deaths – particularly from chronic conditions – peak among males in the 65–69 age group and among females in the 70–74 age group.[1,8] However, given the largely unknown impact of those factors referred to earlier, the impact of alcohol on mortality and hospitalisations is, again, an area that warrants further research.

On average, Indigenous Australians live about 20 years less than their non-Indigenous counterparts and alcohol makes a significant contribution to this reduced life-expectancy. The leading alcohol-caused death and hospital admission rates among Indigenous people are similar to those among their non-Indigenous counterparts – liver cirrhosis, road injuries, assault, alcohol dependence, fall injuries. However, Western Australian data indicate that these estimated rates are at *least* double, and often much greater, among Indigenous people.[6] It is also likely that these rates are under-estimates as they are based on ætiologic fractions calculated for the non-Indigenous population in which rates of harmful drinking are lower.[7]

It is clear from this brief summary that alcohol continues to have a significant negative impact both on the Australian population as a whole and on particular segments of it. What can be done to address this? There are some clear answers in the publications *Alcohol: No Ordinary Commodity* and *The Prevention of Substance Use, Risk and Harm in Australia* – two thoroughly researched reviews that clearly identify workable strategies to reduce alcohol-related harm.[9,10] Nevertheless, there are many social, political and economic obstacles to the successful implementation of these strategies. Thus the question can be more usefully re-phrased: 'what can be done to facilitate the adoption of these workable strategies and to ensure their effectiveness?' It is in this that the challenge of Australian alcohol policy lays.

Dennis Gray

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Naloxone for peer administration – time to consider again?

With the Australian injecting drug market currently dominated by high purity crystal methamphetamine, or "Ice", it might seem like a strange time to be again talking about the provision of naloxone hydrochloride (or Narcan®) to heroin users and their peers to assist prevention of morbidity and mortality from heroin–related overdose. However, to the contrary I believe this might just be the very time for a revival of the discussion. Research shows that most heroin-related fatalities occur in the company of others, mostly other users, and there is ample opportunity in which to intervene as instant death following injection is rare [e.g.1,2]. While calls have been made since the early 1990's to provide naloxone to heroin users and their peers for administration at overdose [e.g. 3,4,5], this strategy has yet to be implemented in Australia.

Historically we have seen waves of stimulant use followed by waves of depressant use and so on, with cycles varying in length but possibly between 5-7 years. Perhaps we could see ourselves in Australia as about half way through, or on the down side curve, of the latest cycle of stimulant use. There are indications of increasing heroin availability in some states in national monitoring systems such as the Australian Needle and Syringe Survey (1999-2003) [6].

If naloxone provision for peer administration is going to be a viable addition to existing resuscitation training, overdose prevention education and outreach interventions then now ought to be the time preliminary work is done to trial training and pilot interventions in feasibility studies. A recent controlled trial in Victoria found Intra-nasal administration of naloxone was not quite as effective as intramuscular administration but the intra-nasal form was sufficient to reduce the effects of opioids [7]. The non-injectable administration of naloxone is likely to be more acceptable for use of the drug by non-medical personnel.

With the escalation in the number of heroin-related overdoses and concomitant fatalities witnessed in Victoria prior to the recent heroin shortage in Australia [8], the Department of Human Services undertook to investigate the feasibility of naloxone provision. Conducted by Kim Hargreaves and myself in 2002 and published in November 2003, the report *Naloxone for overdose: Consideration of a trial of naloxone provision for peer or worker administration in Victoria, Australia* [9] aimed to establish whether a trial of naloxone provision in Victoria, for peer or worker administration, could potentially assist in reducing the number of heroin-related deaths observed in the jurisdiction.

Provision of naloxone to heroin users and their friends and family for assistance in managing opioid overdose, often referred to as 'peer administration', is just one of two options for increasing access to the drug. The other is for naloxone to be made available to outreach workers and other non-medically trained personnel for use at overdose. Both formal and informal examples of these models of naloxone administration are in place in a number of places around the world, but few have been subject to comprehensive evaluation. Having reviewed the published and 'grey' literature and conducted key informant interviews with Victorian stakeholders from research, the emergency medical field (both hospital and ambulance), drug and alcohol services, the health department and user groups we concluded that in 2002 a trial of peer administration was warranted in Victoria as many of the questions identified in our earlier work [10,11,12] remained unanswered and we believed there were a number of factors recommending a trial of peer rather than worker administration.

During 2003 a meeting of senior researchers from NDRI and Turning Point revisited the issue and decided that given the continuing low rate of heroin availability and overdoses across the country, a cross-jurisdictional trial of peer naloxone of the type suggested in this report was not feasible at that time, but should be re-considered should the availability and or purity of heroin in Australia increase. It may still be premature to recommend an inter-jurisdictional trial of peer administration of naloxone. However, now is the time to reconsider preliminary pilots with high risk groups to develop protocols which can be expanded if and when we see an increase in heroin supply and associated morbidity and mortality.

Simon Lenton

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project notes

National Alcohol Indicators Project

Tanya Chikritzhs, Richard Pascal, Tim Stockwell, Susan Donath and Sharon Matthews

Funded by the National Drug Strategy, the National Alcohol Indicators Project (NAIP) is a nationally co-ordinated project aimed at tracking and reporting on trends in alcohol related harm in Australia at national, state and local levels. A first for Australia, the development of a nationally coordinated source of data on alcohol consumption and related harms has arisen from the need for an efficient monitoring system on alcohol and increasing concern over levels of alcohol-related harm in the Australian community. One of the main objectives of the project is to produce and disseminate summary bulletins which highlight the major points from each research area. Each bulletin is also accompanied by a technical report.

The first, second, third, fourth and fifth NAIP bulletins were released in December 1999, May 2000, November 2000, May 2001 and April 2002, respectively. The first documented rates of deaths between 1990 and 1997 and hospitalisations between 1993/94 and 1996/97 caused by hazardous/harmful alcohol consumption. The second identified trends in alcohol-related serious road injuries between 1990 and 1997. Bulletin three reported on patterns of alcohol consumption in Australia in 1998 and bulletin four documented trends in per capita adult alcohol consumption in the 1990's. The fifth bulletin documented trends in alcohol-related violence for all states and territories of Australia from 1991/92 through to 1999/00. In November 2003, a major report was compiled that updated alcohol-attributable mortality and morbidity estimates and drinking patterns for all Australian states and territories from 1990 to 2001. Most recently, the sixth bulletin in the series was released in November 2004 and documented trends in alcohol consumption and related harms in Australian youth (15-24 year olds) between 1990 and 2002.

For the sixth NAIP bulletin, death and hospital admission records for people aged 15-24 years were examined. The aetiologic fraction method was applied to estimate alcohol-attributable mortality and morbidity. The report highlighted that between 1993 and 2002, an estimated 2,643 young people aged 15-24 years died from injury or disease caused by risky and high risk drinking. Over the nine years between 1993/94 and 2000/01, more than 100,000 young people were hospitalised for conditions attributable to risky and high risk alcohol consumption. Moreover, after a nationwide decline in alcohol-attributable death rates during the 1990s, several jurisdictions appeared to show increased numbers of alcohol-attributable deaths in the last few years. Road injuries, suicides, assaults and drowning accounted for over 90% of all alcohol-attributable deaths in young people. Alcohol-related falls, alcohol abuse and alcohol dependence were also common reasons for hospitalisations among young people.

A comparison between Indigenous and non-Indigenous death rates showed that Indigenous youth were more than twice as likely as non-Indigenous youth to die due to alcohol-attributable injury and disease. Furthermore, trends in death rates for young Indigenous people have shown little change between 1990 and 2002, despite a steady decline in alcohol-attributable death rates for their non-Indigenous counterparts. Finally, the report notes that young people living in regional and rural areas were 70% more likely to die from risky drinking than those living in cities.

AER Foundation PhD Scholarship: Concurrent Alcohol and 'Party Drug' Use Amongst Young People

David Moore and Simon Lenton

The National Drug Research Institute has been awarded a PhD scholarship by the Alcohol Education and Rehabilitation (AER) Foundation to investigate the social, cultural and economic contexts, and related harms, of concurrent use of alcohol and 'party drugs' (eg, amphetamines, ecstasy, ketamine and GHB) amongst young people.

Alcohol and other drug research in Australia has traditionally focused either on alcohol or on illicit drugs but rarely on the interaction between them. National monitoring systems have detected rises in the prevalence of both alcohol and party drug use amongst young people. The level of harms associated with their use has also increased. In the past, the use of party drugs was primarily part of a distinct 'rave' counter-culture, where alcohol was usually shunned. However, in recent years, as rave culture has become more mainstream, and parties held in licensed venues, concurrent use of alcohol and party drugs has become a part of dominant youth culture. An ethnographic/qualitative approach will explore whether concurrent use of alcohol and party drugs can exacerbate both the risks and harms associated with alcohol or any of these drugs when used in isolation. The findings will be used to recommend possible interventions for the prevention of risks and harms associated with concurrent alcohol and party drug use.

Improving understanding of psychostimulant-related harms in Australia: An integrated ethno-epidemiological approach

David Moore, Paul Dietze, Lisa Maher, Gabriele Bammer, Michael C. Clatts

National drug surveys and surveillance systems have detected sharp increases in the use of 'psychostimulant' drugs such as amphetamines, ecstasy and cocaine. The level of harms associated with excessive use of these drugs, such as mental health problems and drug dependence, has also increased, as has the use of these drugs via injection. These increases in the prevalence of use and related harms have also been detected internationally.

Previous research on psychostimulant drugs, in Australia and overseas, has suggested that using these drugs in particular ways might be associated with a greater chance of contracting HIV and other blood-borne viruses such as Hepatitis C (eg, through sharing needles and syringes or other equipment associated with injecting drugs); sexually transmitted infections and other sexual health problems (eg, through unsafe sex); and of being involved in violent incidents. Despite this previous research, however, little is known about the specific social and cultural contexts associated with psychostimulant-related harms, and this has stymied the development of appropriate responses to prevent such harms occurring.

This research project will provide a greater understanding of the individual, social and cultural factors associated with psychostimulant-related harms through an innovative combination and integration of anthropological and epidemiological approaches known as 'ethno-epidemiology'. In order to access a diverse range of psychostimulant-using contexts, research will focus on three urban sites: street-based drug users in Sydney, club drug users in Melbourne and home-based, recreational drug users in Perth. These groups have been chosen because they have high prevalences of psychostimulant use. The research project will provide important data that will inform future interventions, improve multidisciplinary models for drug research, and build Australia's capacity to conduct cutting-edge public health research.

The Northern Territory's Living With Alcohol (LWA) program re-evaluated.

Tanya Chikritzhs, Tim Stockwell, Richard Pascal and Paul Catalano

The Living with Alcohol (LWA) program was a comprehensive strategy to reduce high levels of serious alcohol-related problems in the Northern Territory (NT). Officially implemented in April 1992, the LWA comprised a range of strategies such as: the provision of expanded treatment and rehabilitation services; education programs; and better control on alcohol availability. The LWA program was originally funded by a NT specific levy on the sale of alcoholic beverages with more than 3% alcohol content. The levy raised the direct price of a standard drink by about 5 cents.

The levy was repealed in August 1997, following a High Court ruling prohibiting the states from collecting license fees on the sale of alcohol, tobacco and petrol products. However, the programs and services provided by the LWA program remained operational until 2002, funded primarily by the re-routing of taxes subsequently collected by the Commonwealth government.

Earlier studies (Chikritzhs et al., 1999; Stockwell et al., 2001) evaluated the impact of the LWA program during the first four years of its inception (1991/92–1995/96), and found significant declines in per-capita alcohol consumption and alcohol-attributable mortality and morbidity. Overall, it was estimated that the LWA program was associated with a net saving to the territory of over $124.3 million.

The objectives of this re-evaluation were to: i) examine the impact of the LWA program and Levy over a longer time period, including several years after the alcoholic beverage Levy was removed (1985–2002); ii) examine the impact of the LWA program and Levy on both acute alcohol-attributable deaths (deaths resulting from episodic drinking to intoxication) and chronic alcohol-attributable deaths (deaths caused by long-term drinking at harmful levels); (iii) re-analyse the impacts of both the LWA program and the Levy using adjoining areas of northern Queensland and Western Australia as a control region; iv) take into account the impact of possible confounders, including the implementation of an additional levy on cask wine introduced in June 1995 (also removed in August 1997) and a change from a 0.08mg/ml legal blood alcohol level for driving to 0.05mg/ml (December 1994); v) to provide comparative estimates of the impact of the LWA program and Levy on Indigenous and non-Indigenous NT residents.

The results showed that the period during which both the LWA program and Levy were operational was associated with a significant decline in acute alcohol-attributable deaths in the NT. Trends in chronic alcohol-attributable deaths also declined significantly, but only in the final two years of the study period. A comparison of Indigenous and non-Indigenous death rates in the NT showed that while both groups experienced a decline in acute deaths during the levy period, a decline in chronic death rates was only evident for non-Indigenous residents. Further research is required to explain the selective impact of the LWA on chronic deaths.

The findings from this re-evaluation present a strong argument for the efficacy of combining alcohol taxes with comprehensive programs and services designed to reduce the harms from alcohol.

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Public Conference

Community action as a means of preventing alcohol and other drug problems

This one-day conference will be convened in conjunction with the triennial Kettil Bruun Society thematic meeting to further develop the scientific understanding of community action as a means of preventing alcohol and other drug problems. It will feature presentations from a number of national and international researchers and project implementers. Presentation topics include:

- **Findings from international community action projects targeting alcohol and drug harm**
- **Dissemination of innovation to communities setting up local alcohol action projects**
- **Alcohol prevention programs in sporting clubs**
- **Identifying and managing risks associated with heavy drinking on US college campuses**
- **Brief interventions in community settings**
- **The role of the community in cannabis law reform**

Where: Perth, Western Australia
When: Friday, 4th March
Cost: A$165 (incl. GST), morning tea and lunch included
Conference Convener: Associate Professor Richard Midford
Convening Organisation: National Drug Research Institute (NDRI)
Please register your interest with Pauline Taylor-Perkins, email P.Taylor-Perkins@curtin.edu.au to receive conference updates and registration details.

APSAD national conference attracts 600 delegates

Co-hosted by the National Drug Research Institute (NDRI) and the WA Drug and Alcohol Office (DAO), the 2004 National Conference of the Australasian Professional Society on Alcohol and other Drugs (APSAD) was held in Fremantle from November 14 to 17.

Acclaimed as a great success by delegates, speakers and sponsors, the event attracted more than 600 delegates from Australia and overseas.

Under the overall theme 'Beyond the Drug', there were more than 140 free papers, 10 keynote addresses and 11 symposia presented.

Papers addressed a number of topics including: pharmacotherapies; co-morbidity; psychostimulants; indigenous issues; law enforcement; prisons; policy practice and research; harm reduction; prevention; cannabis law reform; and alcohol policy.

Among the many highlights of the event was an opening keynote address by indigenous clinical psychologist Dr Tracy Westerman (above) entitled 'Cultural differences or deficits - how to separate the two' and the outstanding paper presented as the James Rankin Oration by Professor Jason White entitled 'From neuroscience to treatment: what does the future hold?'.

This year's annual conference made travel awards valued at up to $2000 for new career researchers, representatives of drug consumer organisations and indigenous people working in the community sector.

Sponsored by AERF, NDRI and the OATSIH, these competitive awards brought speakers to the conference who would have otherwise not attended. We hope that this is a tradition that continues in future APSAD conferences as it brings vitality and recognises the significant contribution of these groups to the AOD field.

In a similar vein the inaugural APSAD awards were presented at the conference to Dr Kypros Kypri in the Early Career category, and Professor Jason White in the Senior Scientist Category.

Simon Lenton

APSAD 2004 National Conference co-convener (with DAO's Steve Allsop)

abstracts

Substance misuse and primary health care among Indigenous Australians

Dennis Gray, Sherry Saggers, D Atkinson, Phillipa Strempel

Australian Government Department of Health and Ageing, Canberra 2004

The purpose of this review is to put a primary health care approach to substance misuse among Indigenous Australians into the context of: patterns of use; the health harms associated with substance misuse; the underlying causes of higher levels of use in Indigenous populations; and the broader range of Indigenous substance misuse interventions.

Beyond 'subculture' in the ethnography of illicit drug use

David Moore

Contemporary Drug Problems, 2004, 31, (2), 181-212.

'Subculture' has been an important conceptual and methodological tool in the ethnographic study of drug use and drug-related harm, particularly heavy drug use amongst marginalised populations. When researching those whose drug use is less all-consuming, however, this concept does not serve us so well. What term or terms might provide a better framework for the investigation of more intermittent drug use? I explore this question through attention to material gathered during three years of ethnographic research with drug users in Perth, Western Australia. I characterise my units of analysis as social 'scenes' oriented around sets of practices. These scenes are located on urban 'pathways'. Drug ethnographers need to reorient themselves, no longer seeking to describe and analyse normative subcultural values, beliefs and behaviours but rather focusing on the diverse nature of some drug scenes and their constitutive practices. It may be time to retire 'subculture' in the study of certain contexts of drug use.

Social Theory in Drug Research, Drug Policy and Harm Reduction

David Moore and Tim Rhodes

International Journal of Drug Policy (Double Special Issue)., 2004, 15, (5-6), 323-458.

This double special issue of The International Journal of Drug Policy brings together a number of contributions on contemporary social theory and its relevance for drug research, drug policy and harm reduction.

Commentary - Lies, damned lies and no statistics: A study of dysfunctional democracy in action

Tim Stockwell.

Addiction, (2004). 99, (9), 1090-1091.

Alcohol policy is one of the severest tests of a government's will to serve the public interest. There are such tempting reasons to ignore the otherwise compelling arguments in favour of public health, safety and order: tax revenues from a vibrant alcohol economy, generous donations to party funds from industry groups and also the belief that being soft on alcohol will win votes. Room's savage critique of the UK Government's Alcohol Harm Reduction Strategy for England and of its moves to relax UK licensing laws suggests it has failed the alcohol policy test badly.

Australia also has an election in the air. The 2004/5 federal budget confirmed this: $440 million allocated to a National Illicit Drugs Campaign over 4 years, $4 million to an Alcohol Harm Reduction Strategy and $360 million given back to wine producers in tax exemptions. Sound familiar? Yes, but at least we have a legal blood alcohol level in all states and territories of 0.05% enforced for the most part by rigorous random breath testing, tax incentives for low strength beers (there are almost 40 varieties with an alcoholic strength of less than 3.8% by volume) and state liquor laws that nod in the direction of public health and safety. This may partly explain why the UK has sky-rocketed up the per capita consumption league table from 21st in 1999 to 9th in 2004 (World Advertising Research Center, 2004) while Australia has slipped from 19th to 23rd. Since 1980 alcohol consumption in the UK has increased by 31% while it has fallen by 24% in Australia. While per capita consumption is a rather mixed indicator, meaning tax revenue, profits and jobs to some, in Australia alcohol-caused deaths and hospitalisations have also decreased substantially since 1990 (Chikritzhs et al, 2003). Is anyone watching in the UK?

Room documents the failure of the UK's new alcohol policies to resemble in any form those supported by research evidence (e.g. Babor et al, 2003). It also appears there were deliberate attempts to deceive the public by excluding evidence that was inconsistent with the government's position. A recent BBC TV Panorama special (6 June 2004) revealed that references to international studies showing adverse effects from increased alcohol present in earlier drafts were dropped from the final text. One such was a West Australian study showing that longer trading hours had doubled violent incidents at late night venues (Chikritzhs and Stockwell, 2002).

In a democracy it is obviously insufficient for there to be evidence that a particular policy will work for it to be implemented. However, in a healthy democracy, the facts about a problem and the relative merits of different solutions should at least be available for public scrutiny. There should also be active efforts by the government to listen to expert advice and to test community opinion on this without interference from parties with commercial vested interests. There are many evidence-based alcohol policies which enjoy strong public opinion (e.g. AIHW, 2002) but a democratic system in which policies and politicians can be bought does not produce governments that will listen.

Emergency room injury presentations as an indicator of alcohol-related problems in the community: A multilevel analysis of an international study

Deidra Young, Tim Stockwell, Cheryl Cherpitel, Yu Ye, S. MacDonald, Guilherm Borges and Norman Giesbrecht.

Journal of Studies on Alcohol, (2004), 65, (5), 605-612.

Objectives: The development of surrogate measures of acute alcohol-related injury for use in the evaluation of community-based prevention initiatives is described.

Methods: An international collaborative study of alcohol and injury (the Emergency Room Collaborative Alcohol Analysis Project or ERCAAP) provided a subset of data on 8,580 Emergency Room (ER) presentations from five countries and 28 ER facilities.

Results: Presentations between 10pm and 5.59am (46%), between 12am and 4.59am (56%), on Fridays, Saturdays or Sundays (26%) and also among injured persons who were male (28%), aged between 18 and 45 years (24%) or unmarried (24%) were most likely to be alcohol-related against these criteria. Multi-level logistic regression models confirmed the significance of the above variables as predicting alcohol involvement prior to the injury event. The strongest predictor variable was presentation between 12 midnight and 4.59am with an odds ratio of 4.92 (Wald Test Chi Sq = 397.6, $p<0.001$). Being male had an odds ratio of 3.01 (Wald Test Chi Square = 247.25, $p<0.001$), presenting on a Friday, Saturday or Sunday night an odds ratio of 1.50 (Wald Test Chi Sq = 49.6, $p<0.001$), while being under 45 (OR=1.20, $p<0.05$) and being unmarried (OR=1.2, $p<0.01$) were less strong predictors. Combining all these values for variables raised the probability of prior alcohol involvement in such injury presentations to 0.65, though only 3.37% of all cases met these criteria, limiting applicability as a surrogate measure for intervention studies. Probabilities of prior alcohol involvement are presented with other combinations of values for the predictor variables.

Conclusions: Frequency of night-time injury presentations to ER facilities, in particular by males, can be used as a reliable surrogate measure of alcohol-related injuries for various epidemiological and evaluation purposes.

recent **publications**

MONOGRAPHS AND TECHNICAL REPORTS

Chanteloup, F. and Lenton, S. (2004). *WA Party Drug Trends 2003 - Findings from the Party Drugs Initiative (PDI). NDARC Technical Report No. 187.* NDARC, Sydney.

Gray, D., Saggers, S., Atkinson, D. and Strempel, P. (2004) *Substance misuse and primary health care among Indigenous Australians.* Australian Government Department of Health and Ageing, Canberra, Australian Capital Territory.

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Moore, D. and Dietze, P. (2004). *Responding to street-based heroin overdose, injecting drug use and sex work: A risk environment approach.* National Drug Research Institute, Curtin University of Technology & School of Health and Social Development, Deakin University.

Young, D.J., Midford, R., Playford, D. and Kite, E. (2004). *An evaluation of the impact of liquor licensing restrictions in the Western Australian Community of Port Hedland Pre intervention report*: 16 July 2004, Report for the Health Department of Western Australia. National Drug Research Institute, Curtin University of Technology.

ALCOHOL AND OLDER DRINKERS

Research project – call for key informants

Do you have an interest in the NHMRC Australian Alcohol Guidelines and Ageing? Celia Wilkinson, a PhD candidate from NDRI, is conducting research on alcohol use amongst older people. Part of her research involves exploration of the Australian Drinking Guidelines as they apply to 65-74 year olds. Celia is looking for key informants to interview on the topic. Each key informant would be sent a survey and then telephoned by Celia for a 15-minute interview. The results of the key informant interviews will be used to re-analyse data from the 2004 NDSHS on the prevalence of at risk drinking amongst 65-74 year old current drinkers. Celia is also conducting a large study examining the pouring practices of older drinkers. All key informants would be given a summary report of her research findings.

If you can help or recommend someone, contact Celia on 08 9266 1636 or celia.wilkinson@student.curtin.edu

PUBLISHED ARTICLES, CHAPTERS AND BOOKS

Clough, A., d'Abbs, P., Cairney, S., Gray, D., Maruff, P., Parker, R. and O'Reilly, B. (2004). Emerging patterns of cannabis and other substance use in Aboriginal communities in Arnhem Land, Northern Territory: a study of two communities. *Drug and Alcohol Review, 23*, 381-390.

D'Abbs, P. and Brady, M. (2004). Other people, other drugs: the policy response to petrol sniffing among Indigenous Australians. *Drug and Alcohol Review*, 23, 253-260.

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