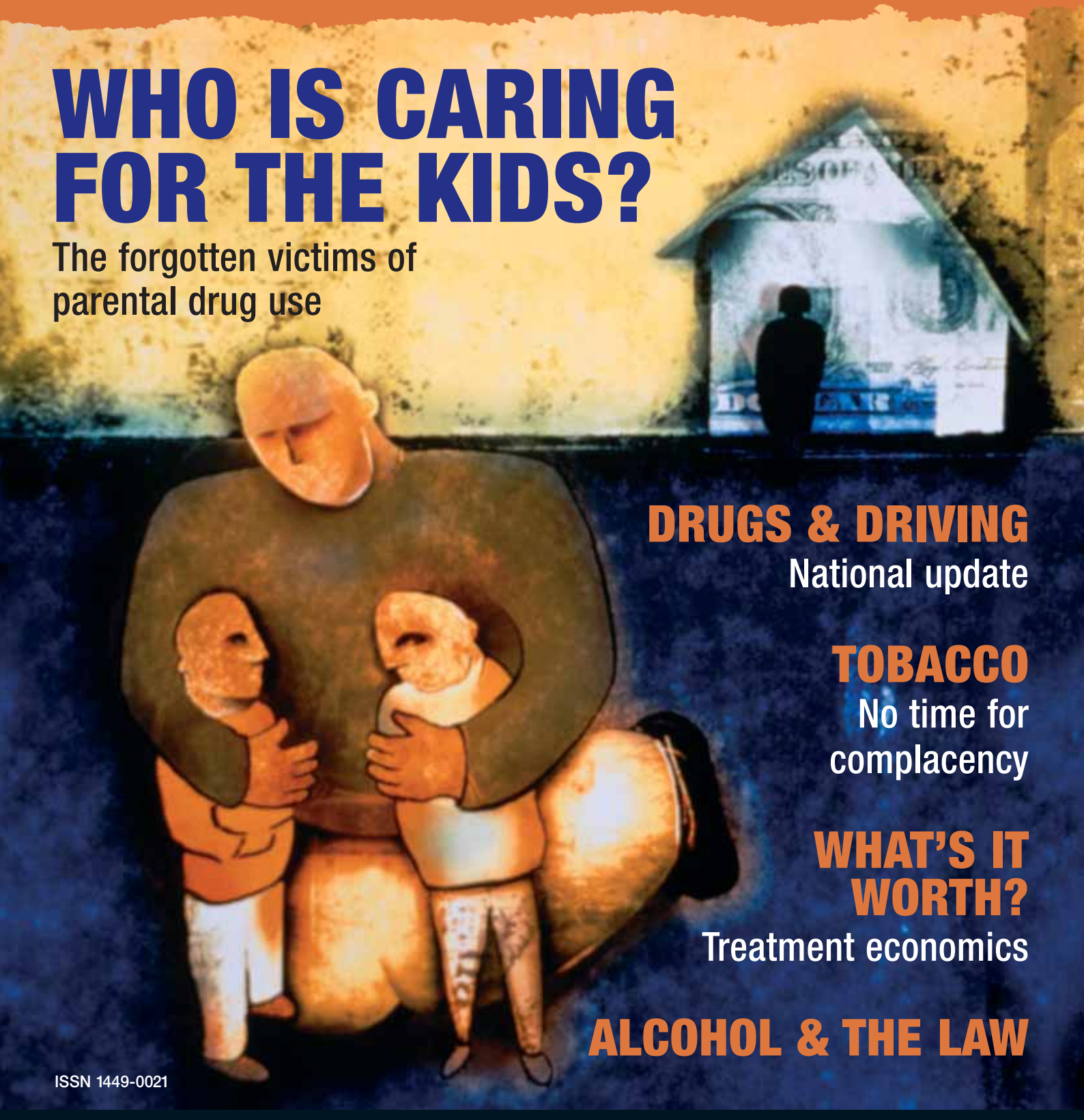
OF SUBSTANCE

JULY 2007 VOL. 5 NO. 3

THE NATIONAL MAGAZINE ON ALCOHOL, TOBACCO AND OTHER DRUGS

WHO IS CARING FOR THE KIDS?

The forgotten victims of parental drug use



DRUGS & DRIVING

National update

TOBACCO

No time for complacency

WHAT'S IT WORTH?

Treatment economics

ALCOHOL & THE LAW

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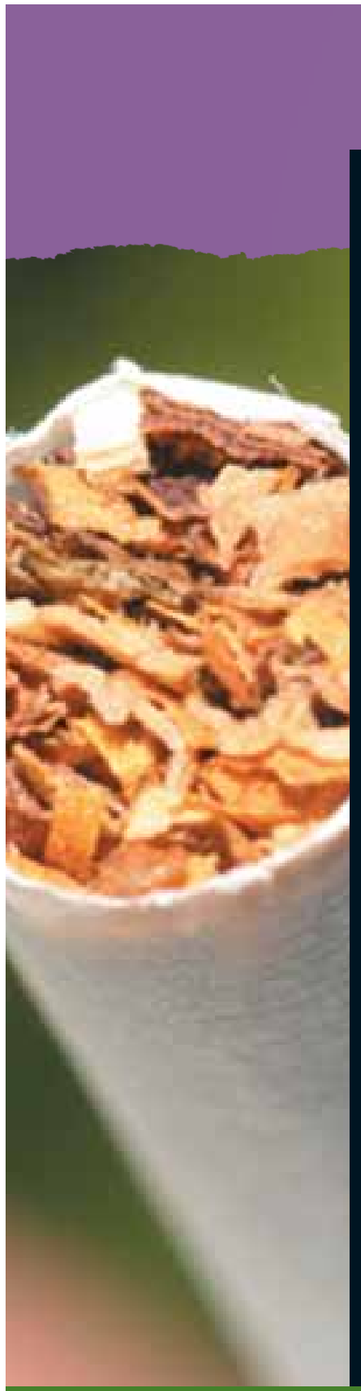

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Jenny Tinworth


Kate Pockley

Editors' letter

Welcome to the July 07 issue of *Of Substance*.

Our early experiences with our families do much to shape the people we become. So it is disturbing to discover that a recent report has shown around 10 per cent of Australian children live in homes where drugs and alcohol are misused. While no doubt many of the parents in these families are committed, loving and involved in their children's lives, there is concern that the attitudes, beliefs and behaviours of those young people will be forever influenced by the substance use they witness. In this issue, we explore some of the issues for children in these families, and the role of the AOD sector in helping them.

We also revisit the subject of tobacco, which often takes a back seat to other substances and their impacts. There is good news about declining smoking rates, but experts warn this is not a time to become complacent about the harm caused by tobacco use. Our regular research digest also features four recent studies on the variety of factors influencing people's addiction to nicotine.

It seems that there is also much we can learn from the tobacco control movement about tackling the problems caused by alcohol. We look at the highlights from the Thinking Drinking II conference which was held in Melbourne earlier this year, and also look at whether public attitudes to alcohol are likely to change if legal action is taken against alcohol manufacturers about some of the harms caused by their product.

These are just a few of the many articles in this issue of *Of Substance*. We welcome your feedback via email at editor@ancd.org.au. We also invite you to visit our website at www.ofsubstance.org.au.

Jenny Tinworth and Kate Pockley
Managing Editors

GUEST EDITORIAL

ALCOHOL INDUSTRY ADOPTS TOBACCO TACTICS

TODD HARPER, CHIEF EXECUTIVE OFFICER, VICHEALTH

It's often said that 'smoking and drinking go together' and when you examine the tactics of the tobacco and alcohol industries in advocating policies to reduce the harms caused by their products, the similarities are worrying.

The tobacco industry has long opposed the most effective measures in tobacco control such as smoke-free environments, social marketing campaigns targeting adults, bans on advertising and better consumer information. These initiatives, backed by solid evidence across many countries, are proven to be effective in reducing tobacco use.

Instead, the industry supports strategies that target children – school campaigns, penalising children for buying tobacco and marketing campaigns targeted at children – all of which show little evidence of effectiveness and may in fact backfire completely.

The parallels with the alcohol industry are disturbing – from opposing the introduction of random breath testing in the 1970s and 1980s, through to opposing appropriate consumer labelling of alcohol products, as well as stricter controls on alcohol advertising and a better tax system for alcohol.

We know that strategies changing the visibility, availability and culture of alcohol and tobacco products among *adults* are likely to be most effective. However, instead of supporting these, the alcohol industry favours less effective strategies that target children.

Has the alcohol industry taken its lead from the tobacco industry when it comes to influencing policy? The tobacco industry has long sought to muddy the research debate by funding industry-friendly groups in research and organisations like the Butt Littering Trust, that allows the tobacco industry to shed socially responsible crocodile tears for the environment, while averting its eyes from the misery of 15 000 Australian deaths each year from tobacco use.

We know that the alcohol industry invests in groups such as DrinkWise, which advocates a more benign, even voluntary-to-industry, approach to policy. Such approaches are likely to do little to address alcohol harms but may help to buy the industry a more socially responsible reputation.

The tobacco industry's tactics wasted time and resources that could have been directed to policies and programs that would have been most effective in changing the culture of tobacco use including smoke-free environments, advertising bans and quitting campaigns targeting adults. We can't allow the same to happen in the alcohol debate – strategies must be based on the best evidence of what is effective – strategies that change the culture of drinking in our community and in particular, the behaviour of adults.

We need to ask the question – is the alcohol industry part of the solution, or part of the problem?

NEWS

2007-08 Federal Budget outcomes

Highlights from the May Federal Budget include:

Strengthening the NGO Treatment Grants Program
$79.5 million over 4 years in addition to the annual budget already allocated to this initiative.

More treatment for methamphetamine abuse
$22.9 million over 2 years for NGO treatment services to better equip their services (infrastructure, staffing and resources) to provide treatment for amphetamine-type stimulant users.

Strengthening drug prevention education
An additional $9.2 million over 2 years for the National Illicit Drug Campaign – with an updated booklet for every household and new television commercials.

Continuing the Indigenous Communities Initiative
$18.4 million over 4 years (includes $14.6 million of new funding) – to assist local communities to develop local solutions for substance use problems.

Family centred primary health care
$38.2 million over 4 years to provide better access to health care for Aboriginal and Torres Strait Islander families and communities in rural and remote locations throughout Australia.

HIV & STI National Prevention Program
$9.8 million over 4 years for a national campaign to encourage safer sex practices.

Continuation of funding of the Hepatitis C Education & Prevention Initiative
This program will continue to be funded for a further 4 years.

Additional training for border security personnel
$0.8 million over 4 years for training of border security personnel to enhance the detection and analysis of precursor chemicals. Training will be provided to Customs officers who undertake detection and sampling of precursor chemicals and to officers from the Australian Quarantine Inspection Service and the Australian Federal Police.

Drug Use Monitoring in Australia
$1.9 million over 4 years for the Australian Institute of Criminology to continue data gathering and analysis on the relationship between illicit drugs and crime.

Enhanced Australian Federal Police investigative capacity
$5.9 million over 4 years (including $0.1 million in capital funding over 2 years from 2007-08) to enhance the capacity of the AFP to investigate offences involving amphetamine-type substances, including methamphetamines.

Enhanced role in Oceania
$0.7 million over 4 years to enhance drug detection and prevention in the Oceania region. Customs will work with other border agencies to detect and prevent the diversion of precursor chemicals used in the manufacture of illicit drugs.

Improved intelligence and analysis
$20 million over 4 years (including $0.2 million in capital funding in 2007-08) to increase the Australian Crime Commission's capability to produce tactical and strategic intelligence, investigate the development of new illicit drugs, and analyse drug use trends, production methods for these drugs and the harms generated.

National Illicit Drug Strategy – enhanced technical capacity
$16.2 million over 4 years to expand the Australian Crime Commission program that investigates illicit drug trafficking and other major crimes.

Snapshot of drug use in Australia 2006

A report on drug use in Australia, by the Australian Institute of Health and Welfare, reveals that almost 100 000 Australians (0.6%) have used methamphetamines in the last week, with the greatest usage (1.8%) occurring in the 20-29 year age group.

Of those aged 14 years and older, 3.2% had used methamphetamines in the last 12 months and 9.1% had used it in their lifetime. Almost 7% of 14-19 year olds had used methamphetamines in their lifetime compared to 21% of 20-29 year olds, 16% of 30-39 year olds and 3.6% of those over 40. Most methamphetamine users also take other drugs concurrently. Approximately nine in 10 people (87%) aged 14 years and over had consumed alcohol with methamphetamines. Next most commonly, 68% of recent users had used cannabis and 49% had used ecstasy concurrently.

The report, *Statistics on Drug Use in Australia 2006*, also reveals high levels of risky drinking. Almost 10% of Australians aged 14 and over drink at risky or high-risk levels for long-term risk and 35% drink at risky or high-risk levels for short-term risk (binge drinking). The report contains data on patterns of drug use, international comparisons, drugs and health, special population groups and crime and law enforcement. New features include methamphetamine use, drug use among prisoners and juvenile offenders, and alcohol use in the workforce. It can be accessed at: www.aihw.gov.au/publications.

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IN BRIEF...

Illicit Drug Data Report 2005–06

The Illicit Drug Data Report, produced by the Australian Crime Commission, provides a comprehensive overview of the illicit drug situation in Australia for the 2005-06 financial year. The report provides information on arrests, seizures, detections, purity levels and prices of illicit drugs over the period. In 2005-06, over six tonnes of illicit drugs were seized by Australian law enforcement in more than 55 000 seizures. This includes 4482 kilos of cannabis, 1296 kilos of amphetamine-type stimulants, 46 kilos of cocaine and 29 kilos of heroin. The full report is available at: www.crimecommission.gov.au/.

New training options

Macquarie University's Department of Psychology has introduced new professional development courses for AOD workers. One-day workshops include 'Drugs and Mental Health', 'Harm Reduction', and 'Indigenous Counselling'. Postgraduate Certificate in Social Health, Postgraduate Diploma in Social Health, and Master of Social Health programs are also available. For more information visit: http://online.mq.edu.au/pub/PSYMSH/.

Amphetamines strategy under way

A draft National Amphetamine-Type Stimulants Strategy is being produced on behalf of the Ministerial Council on Drug Strategy. Dr Toni Makkai (Executive Director, Australian Institute of Criminology) and Professor Steve Allsop (Director, National Drug Research Institute, Curtin University of Technology) have been contracted by the Department of Health and Ageing to develop the draft.

Consultation forums are currently taking place in every jurisdiction of Australia. A consultation paper, *'National Amphetamine-Type Stimulants Strategy Consultation Paper'*, and other information related to the Strategy are available at: www.ndri.curtin.edu.au.

Crystalline methamphetamine or 'ice'.

NSW crime statistics 2006

Figures released by the NSW Bureau of Crime Statistics and Research show that the major categories of crime across NSW either fell or remained stable over the 24 months to December 2006. The only criminal offence that became more common in the past two years is malicious damage to property which increased by 4.3 per cent – a substantial proportion of these offences were committed by intoxicated males in the vicinity of licensed premises.

There was a substantial decline in recorded incidents of use/possession of heroin and significant increases in use/possession offences involving ecstasy, amphetamines and cocaine. The full report can be accessed at: www.lawlink.nsw.gov.au/boscar.

New information available online:

- Papers from the First International Conference on Illicit Drug Use, convened by Drug Free Australia, are now available online at www.drugfree.org.au.
- The 2006 Annual Report of the International Narcotics Control Board is now available online at: www.incb.org/incb/en/annual_report_2006.html.

Birthday celebrations:

- The National Drug and Alcohol Research Centre, is celebrating its 20th anniversary with a special two-day event combining the 2007 Annual Symposium and National Drug Trends Conference. The event will be held on Monday 15 October and Tuesday 16 October at the Powerhouse Museum in Pyrmont, Sydney. The theme is the 'past, present and future' of alcohol and other drugs research.
- The Kirketon Road Centre (KRC), Sydney, recently celebrated 20 years of health service provision in the Kings Cross community with an open day and symposium. The symposium was opened by Dr Denise Robinson, Chief Health Officer and Deputy Director-General of NSW Health, who recognised the KRC's pivotal role in service delivery, public health, research and innovative responses to emerging issues in NSW over the past 20 years.

Did you see that report?

ADCA's National Resource Centre has a monthly listing of recently released Australian reports and other items of interest to the AOD sector. Full text links are provided where available. Visit: www.adca.org.au/resource/index.htm/.

Drug modelling online

The Drug Policy Modelling Program (DPMP) now has a dedicated website: www.dpmp.unsw.edu.au. The site contains links to all major drug databases in Australia, tools for policy makers and researchers (such as an Excel spreadsheet with 108 interventions) and links to Australian drug policy strategy documents.

Re: Drugs, alcohol and Indigenous imprisonment

After reading your article, 'Drugs, alcohol and Indigenous imprisonment' (April 2007, by Don Weatherburn), I was compelled to respond. I agree with the author that Indigenous inmates are a reflection of economic and social disadvantage. The author is correct to say '... if it were only as simple as this'. If only it were as simple as throwing buckets of money to fix the cultural, economic and social domains that lead to the revolving-door syndrome I see in prisons.

I have been in prison for the last 16 years, and the last three years in an Indigenous prison in North Qld. I have studied Addiction through Curtin University (WA). I've been involved in conferences dealing with Indigenous people in prisons, and have helped compile papers forming recommendations which have gone on to the Department of Corrective Services.

I also agree with the adage of '... to find out what is happening now, we must find out what did happen'. What did Indigenous people do before alcohol, and when it was introduced, how were they educated on harm modification? Alcohol culture has ingrained itself, and will eventually destroy a race of people. An Indigenous inmate I know was recently released, and four weeks later was back in prison. I asked him, 'What went wrong?' He replied, 'I know I have an alcohol problem, but I don't know what to do about it.'

This person needed a drug and alcohol course in prison, but economic restraints mean they aren't available. But there are other problems he would face, even if he could do a course. Would he really comprehend the teachings? Would he be given after care – the essential part of recovery from any disadvantage, particularly substance abuse?

Inmates are released from prison on the streets outside the local hotel, and farewelled with 'We'll see you soon'. For Indigenous inmates, but also for others, many stay in a state of hopelessness when they are released, and then get caught in the revolving door back to prison. There are multiple solutions needed to fix these multiple problems. We especially need partnerships with addicted persons to help them see they are worthwhile humans whose life is valuable, so that they may teach others who need help too.

Colin Priest, North Qld

Drug detection and screening in schools

To examine the efficacy and impact of drug detection and screening measures in schools, the National Centre for Education and Training in Australia (NCETA), Flinders University, has been contracted by the Australian National Council on Drugs to undertake an independent, comprehensive and critical review of the issues.

The review has two key objectives:

i. To examine the positive and negative impacts and implications of the range of drug detection and screening measures currently available for schools.

ii. To assess the viability and effectiveness of alternatives to drug detection and screening programs for schools.

Input is sought from relevant stakeholders in the community such as parents, teachers and principals, students, AOD experts (researchers and clinicians), police, criminal justice workers, youth services workers, legal experts, civil liberties commentators, policy advisors, politicians and health economists. Submissions must be received by **5 pm EST, Friday, 27 July 2007.** Download the submission pro-forma and the guidelines for submissions from the NCETA website at www.nceta.flinders.edu.au. For further information please contact NCETA at (08) 8201 7535 or email nceta@flinders.edu.au.

Illicit drugs cost Australian business $3.3 billion a year

A report prepared for the Australian Drug Law Reform Foundation has found the total cost to Australia each year of illicit drugs is $6.7 billion, of which $3.3 billion is borne by business – representing around 2% of corporate profits. The report's authors, Prof David Collins (Macquarie University), Prof Helen Lapsley (University of Qld), and Prof Robert Marks (University of NSW), found that the cost is incurred through lost productivity, absenteeism, crime, road accidents and even through resources being drawn from legitimate businesses into the illicit drug market. Most of this cost is passed on to consumers in terms of higher prices or lower wages. The report found the cost of crime attributed to drug use was $3.248 billion, while crimes where both drugs and alcohol were a factor cost a further $1.31 billion. Health care costs were $74 million, while road accidents attributable to drugs cost $612 million. Businesses bear 20% of these costs. The full report, entitled *Illicit Drugs Damage Australian Business*, can be viewed at: www.adlrf.org.au/.

Of Substance welcomes correspondence from all our readers on topics raised in the magazine, or subjects of interest to the field. Please submit letters of up to 150 words to editor@ancd.org.au.

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NEWS CONTINUED

ANCD membership for 2007-2010

The Prime Minister announced the new appointments to the Australian National Council on Drugs (ANCD) in April.

Chair & Executive positions:

Dr John Herron (Chairman) (Qld)

Commissioner Mick Keelty (Deputy Chairman) – Australian Federal Police (ACT) (ex-officio)

Prof Margaret Hamilton – Chair, Multiple Complex Needs Panel (Vic.)

A/Prof Robert Ali – Clinical Director, DASSA & WHO Collaborating Centre (SA)

Mr Garth Popple – Executive Director, We Help Ourselves (NSW)

Member positions:

Ms Jo Baxter – CEO, Drug Free Australia (SA)

Mr David Crosbie – CEO, Mental Health Council of Australia (ACT)

Dr Michael Cohen – President, Palmerston Association (WA)

Prof Ian Hickie – Director, Mind & Brain Institute, Sydney University (NSW)

Mr Jeff Linden – Magistrate (NSW)

Dr Toni Makkai – Executive Director, Australian Institute of Criminology (ACT)

Prof Richard Mattick – Director, NDARC (NSW)

Dr Tamara McKean – Flinders University Medical School (SA)

Ms Courtney Morecombe – Adelaide Lord Mayor's Office (SA)

Lt Colonel Geanette Seymour – Chief Secretary, Salvation Army (NSW)

A/Prof Ted Wilkes – National Drug Research Institute (WA)

Dr Dennis Young – Executive Director, Drug Arm (Qld)

Ex-officio positions:

Mr Andrew Blair – President, Australian Secondary Schools Principals Association (Vic.)

Mr Keith Evans – Chair, Inter-Governmental Committee on Drugs (SA)

2006 IDRS and EDRS findings

The Illicit Drug Reporting System (IDRS) and the Ecstasy and Related Drugs Reporting System (EDRS, formerly known as the PDI) monitor the price, purity and availability and patterns of use of illicit drugs, as well as acting as an early warning system for emerging markets.

Key IDRS findings for 2006 include:

1. Decrease in prevalence and frequency of heroin use in most jurisdictions. Access still 'easy' but becoming more difficult. Price per cap mostly stable. More reporting of 'low' purity.
2. Increased use of ice/crystal in all jurisdictions. Use of speed powder stable or decreasing, patterns of base use stable. Prices stable. All three forms 'easy' or 'very easy' to access, and availability stable. Ice/crystal most often reported to be of 'high' purity, speed powder 'low' or 'medium'. Base reports mixed. Use of speed form as frequent as ice use. Ice use more sporadic. The proportion of people who inject drugs who nominated methamphetamine as their drug of choice has not increased over the past several years.
3. Cocaine use highest in NSW. Price has remained stable. Access 'easy' or 'very easy', availability stable. Frequency of use increasing in NSW but low and sporadic elsewhere.
4. Cannabis market stable. Use common in all jurisdictions. Hydroponic cannabis (more potent) is more dominant than bush cannabis. Both forms 'easy' or 'very easy' to obtain, prices stable. Use of hashish increased in ACT, WA and Qld, and use of hash oil increased in WA and Qld.
5. In the context of reduced heroin availability and low purity, many people who inject drugs are using a broad range of drugs including diverted pharmaceuticals such as morphine, buprenorphine, methadone, ocycodone and benzodiazepines, either instead of or as well as heroin. Morphine is the most commonly injected pharmaceutical.

Bulletins summarising the findings of both projects can be found at: http://notes.med.unsw.edu.au/NDARCWeb.nsf/page/PubBulletins. National and jurisdictional reports for 2006 are available free on the NDARC website in downloadable pdf versions.

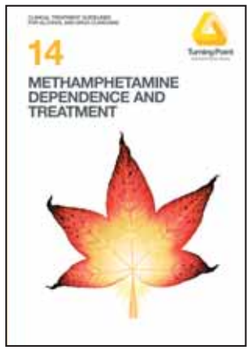
Abuse of alcohol-based mouthwash in Alice Springs

Alcohol-based mouthwashes, which contain eucalyptus oil and can cause convulsions and even death if consumed in large doses, have now been removed from the shelves of supermarkets and pharmacies in Alice Springs after a recent five-fold surge in sales.

Dr John Boffa from the Central Australian Aboriginal Congress and the People's Alcohol Action Coalition says the increase in mouthwash sales was a recent phenomenon, following several months after price-based alcohol restrictions came into effect in the Territory in October 2006. These restrictions saw heavy drinkers shift to beer, which they could buy for one-third of the cost of cask wine and port. However, at $9 per 500 ml bottle, the equivalent of 20 standard drinks at around 30 cents each, mouthwashes offered an even cheaper option. Boffa is concerned that a product containing more than 20% pure alcohol was being sold without regulation. He says it should come under the Liquor Act and be sold as an alcoholic product. He believes the removal of the product will see heavy drinkers shift back to beer. Since the introduction of price-based restrictions, there has been an 11% reduction in alcohol consumption and dramatic decreases in assaults and alcohol-related hospital admissions.

NEW RESOURCES

Methamphetamine treatment guide



Turning Point's latest clinical treatment guideline, *Methamphetamine Dependence and Treatment*, is now available. The resource includes a set of useful tools for clinicians to address acute presentations as well as dependence and harms, and is designed to be used in conjunction with other publications in the series. The publication is available as a free download from the Turning Point website at: www.turningpoint.org.au/library/lib_ctgs.html.

HOPE for families

The Australian Red Cross, NSW, HOPE program has produced a free training resource for the use of family members, carers or friends of people using drugs, as well as people who use drugs and new workers to the AOD field who want to learn how to recognise, manage and help prevent heroin and other drug-related overdoses and crises.

The HOPE program is fully funded by the Centre for Drug and Alcohol, NSW Health. Email requests for information to: onguy@redcross.org.au.

Alcohol and pregnancy

Doctors and other health professionals who care for pregnant women are being encouraged to talk openly to women about the dangers of alcohol in pregnancy.

The Alcohol and Pregnancy Project at Perth's Telethon Institute for Child Health Research has launched a range of resources for health professionals to help them in dealing with the issue of alcohol use in pregnancy. Project leader Professor Carol Bower says 'The most important message is that no alcohol in pregnancy is the safest choice. The amount of alcohol that is safe for the fetus has not been determined.' The 'Alcohol and Pregnancy: Health Professionals Making a Difference' packs can be downloaded from: www.ichr.uwa.edu.au/alcoholandpregnancy.

Alcohol management and withdrawal

A new interactive CD ROM and web-based training package has been produced to improve general hospital and community clinicians' knowledge, skills and ability to detect alcohol problems and manage withdrawal using the Clinical Institute Withdrawal Assessment of Alcohol Scale (an assessment tool for monitoring withdrawal symptoms which takes about five minutes to administer). The resource has been developed by Dr Adam Winstock, Senior Staff Specialist, Drug Health Services (SSWAHS) with support from the Alcohol Education and Rehabilitation Foundation. It is available free at www.ciwa-ar.com.

Guidelines for sales of volatile substances

The WA Drug and Alcohol Office, in conjunction with WA Police and the Retail Traders Association of WA, has developed a kit to help prevent the misuse of legal but dangerous volatile substances available over shop counters.

The Volatile Substance Use Kit for Retailers explains to retailers how to sell volatile substances responsibly and highlights the dangers of products such as aerosols and solvents. It includes a strengthened Code of Conduct that bans sales to children and recommends that products be kept behind the counter or in locked cabinets. Copies of the kit can be downloaded at www.dao.health.wa.gov.au or by phoning the Coordinator of the Volatile Substances Program, Angela Rizk: (08) 9370 0362.

Skills for the AOD sector

The *Pocket guide to a skilled workforce*, published by the NSW Community Services and Health Industry Training Board (CSH ITAB) is a guide for skilling AOD workers using the national vocational education and training system.

It details the Certificate IV and Diploma in Alcohol and Other Drugs Work and suggests pathways to gaining qualifications. Copies can be obtained from CSH ITAB. Email: itab@csh-itab.com.au.

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RESEARCH DIGEST

COMPILED BY LIBBY TOPP

In this issue, we focus on recent research into young people and nicotine dependence.

TOBACCO-FUNDED PREVENTION ADVERTISING

Featured study

Wakefield, M, Terry-McElrath, Y, Emery, S, Saffer, H, Chaloupka, FJ, Szczypka, G, Flay, B, O'Malley, PM & Johnston, LD 2006. Effect of televised, tobacco company-funded smoking prevention advertising on youth smoking-related beliefs, intentions and behaviour, *American Journal of Public Health,* vol. 96 no.12, pp. 2154-60.

Findings

In the United States, the tobacco industry has funded television campaigns targeting both young people and their parents, intended to communicate that young people should not smoke. Youth-targeted campaigns have featured the message that young people do not need to smoke to fit in with their peers; and have included slogans such as 'tobacco is whacko if you're a teen'. Parent-targeted campaigns focus on the message that parents should talk to their children about not smoking.

This study related young people's smoking beliefs, intentions and behaviours to their exposure to smoking prevention television advertising. Smoking-related data were collected during 1999-2002 through the Monitoring the Future (MTF) study, an annual survey of nationally representative samples of students in grades 8 (average age 14 years), 10 (16 years) and 12 (18 years), which is group administered in school settings. Objective media monitoring data were used to estimate the average number of youth-targeted and parent-targeted smoking prevention advertisements *potentially* viewed by 12-17 year olds in a given geographical area during the four months preceding a specific school's participation in the MTF. (*Actual* exposure for any given individual would vary according to actual television viewing.) Statistical analyses allowed the researchers to estimate the effect of each additional advertisement viewed, on average, in the four months leading up to survey administration, on young people's smoking beliefs, intentions and behaviours. Analyses also included variables such as cigarette price, extent of smoke free legislation, and student socio-demographic characteristics.

There was little relation between tobacco company sponsored *youth-targeted* advertising and young people's smoking outcomes. Indeed, tobacco company youth-targeted advertising was withdrawn from US television in early 2003. In contrast, among students in grades 10 and 12, each additional viewing of a tobacco company *parent-targeted* advertisement during the four months leading up to the survey was, on average, significantly associated with a range of adverse smoking-related outcomes. These included: lower perceived harm of smoking (students were asked whether they believed that people risk 'great harm' to themselves by smoking ≥ 1 pack of cigarettes per day); stronger approval of smoking (students were asked whether they disapproved of people smoking ≥ 1 pack of cigarettes per day); stronger intentions to smoke in the future (students were asked whether they would 'definitely not' be smoking in five years); and a greater likelihood of having smoked in the preceding 30 days.

Whereas exposure to tobacco company youth-targeted smoking prevention advertising generally conferred no benefit to young people, exposure to parent-targeted advertising may have *harmful* effects, especially among students in grades 10 and 12. The authors suggest that authority messages specific to teenagers are rejected by those who are making the transition to adulthood, typically between ages 15 and 17 years. They argue that facilitating productive interaction between parents and adolescents about drug use requires more intensive interventions than simple encouragement through the mass media.

DO GENES PLAY A ROLE IN NICOTINE DEPENDENCE?

Featured study

Haberstick, BC, Timberlake, D, Ehringer, MA, Lessem, JM, Hopfer, CJ, Smolen, A & Hewitt, JK 2007. Genes, time to first cigarette and nicotine dependence in a general population sample of young adults. *Addiction*, vol. 102, pp. 655-65.

Findings

This study examined the genetic contribution to the variety of types of nicotine dependence among a nationally representative sample of 1154 Americans aged 18-25 years who were from twin, full sibling and half-sibling pairs. Previous research has suggested that the heritable (genetic) influence on smoking behaviour varies depending on the smoking stage (i.e. initiation, persistence and dependence), with increasingly heritable contributions as smokers increase their use. Heritability has also varied with age, and the way that dependence is defined and assessed.

In this study, the magnitude of genetic and environmental influences on nicotine dependence was inferred by comparing the degree of correlation between the scores of siblings of different genetic relatedness. Nicotine dependence was assessed using the Fagerström Test for Nicotine Dependence (FTND), a questionnaire composed of two items related to physiological aspects of smoking (number of cigarettes per day and time to first cigarette after waking, both of which assess a smoker's desire to maintain blood nicotine levels); and four items related to behavioural features of heavy smoking (e.g. difficulty refraining from smoking in forbidden places; smoking when ill in bed).

Results suggested that among this young adult, general population sample, both genetic and individual-specific environmental risk factors contributed to nicotine dependence. Physiological aspects of nicotine dependence appeared to be largely genetically influenced, whereas observed variation in behavioural measures of dependence was relatively more influenced by individual-specific, environmental experiences. One particular item – urgency to smoke after waking – was both the most heritable and the best index of an underlying genetic vulnerability to nicotine dependence. In other words, differences in the time smokers take to smoke their first cigarette after waking appear to relate more directly to differences in nicotine dependence than either the behavioural aspects of smoking or a quantity measure. Results have implications for future research by demonstrating that 'time to first cigarette' is the single best measure in the FTND for examining the genetic contribution to nicotine dependence.

CHILDHOOD ABUSE A LIKELY CAUSE OF SMOKING

Featured study

Al Mamun, A, Alati, R, O'Callaghan, M, Hayatbakhsh, MR, O'Callaghan, FV, Najman, JM, Williams, GM & Bor, W 2007. Does childhood sexual abuse have an effect in young adults' nicotine disorder (dependence or withdrawal)? Evidence from a birth cohort study, *Addiction*, vol. 102, pp. 647-54.

Findings

This study examined the association between childhood sexual assault (CSA) and nicotine disorder in young adulthood. Previous research has demonstrated that CSA is associated with many symptoms of psychiatric disturbance including drug use, as well as early onset of regular smoking. Participants were 2150 young adults from a Brisbane birth cohort, followed up at age 21 years. Retrospective self-reports of CSA were used to divide the sample into three groups based on their experience of: no abuse (reported by 76% of the sample); non-penetrative abuse (16%); or penetrative abuse (8%). According to the *Diagnostic and Statistical Manual of Mental Disorders* (4th Edition), 13% of the sample met diagnostic criteria for nicotine dependence, and 9% for nicotine withdrawal; together these groups were classified as having a nicotine disorder. A range of potentially confounding variables which had been assessed at various points throughout the 21-year follow-up period was also included in the analyses.

Consistent with earlier findings, results showed that young adults who experienced CSA before age 16 years were at greater risk of nicotine disorder at 21 years, particularly those who experienced penetrative sexual abuse. Although the study was unable to specify precise causal pathways, the relationship between CSA and later nicotine disorder was independent of family demographic and socio-economic characteristics, parenting style, maternal lifestyle, marital transition, childhood behavioural adjustment and mental health. Results highlight the need to intensify public health efforts to address drug use among those who have experienced CSA, as well as the importance of early intervention, so that emerging risky behaviours may be targeted at the earliest stages.

SMOKING AND CHILDHOOD DISADVANTAGE: ANOTHER LINK

Featured study

Fergusson, DM, Horwood, LJ, Boden, JM & Jenkin, G 2007. Childhood social disadvantage and smoking in adulthood: results of a 25-year longitudinal study, *Addiction*, vol. 102, pp. 475-82.

Findings

This study, part of the Christchurch Health and Development Study, a longitudinal study of the health, development and adjustment of a cohort of New Zealand children born in mid-1977, examined the relationship between exposure to socio-economic disadvantage in childhood (0-10 years) and the development of cigarette smoking by age 25 years. Among 994 participants, it sought to document the extent to which linkages were mediated by (i) cognitive factors including intelligence and educational attainment; (ii) exposure to parental and peer smoking role models; and (iii) behavioural adjustment in childhood. Measures of childhood social disadvantage included family socio-economic status at birth, based on paternal occupation; parental education levels; family material living standards averaged over the period 0-10 years; and family income level averaged over the same period. Potential mediating factors assessed included child cognitive ability at 8-9 years; adolescent conduct problems from age 14-16 years; educational achievement at 18 and 21 years; parental smoking between 0-16 years; and peer smoking at 16 years.

Sophisticated statistical modelling clearly suggested that the higher rates of cigarette smoking among young adults from socio-economically disadvantaged backgrounds arise from an accumulation of conditions that were more common in children from disadvantaged backgrounds. The mediating factors which increase the likelihood of later smoking include lower measured intelligence and poorer school achievement (together estimated to account for 56% of the relationship between childhood social disadvantage and later smoking); higher rates of adolescent conduct problems (11%); and greater exposure to parent and peer smoking (26%). Supplementary analyses suggested that these conclusions are robust and do not depend on the choice of socio-economic indicators or the age at which smoking was assessed. Results suggest that efforts to reduce population prevalence of smoking should focus not only on individual behavioural factors, but also the social factors that contribute to socio-economic inequalities.

OF SUBSTANCE
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Who is CARING FOR THE KIDS?

JANE MUNDY

There have been increasing calls for the needs of young people, who are living in families where there is parental misuse of drugs and alcohol, to be treated as the sector's core business and funded appropriately.

People working in the alcohol and other drugs (AOD) sector have long been aware of the tension that exists between their responsibility towards their primary client and their knowledge that other family members – especially children – may be adversely affected by their client's behaviour. This tension is compounded by the move, by some state governments, to introduce mandatory reporting of children at risk. In addition, limited resources often mean workers can focus only on their primary client.

In a major report, *Drug Use in the Family: Impacts and Implications for Children*, released in May, Professor Sharon Dawe, Griffith University, says a dramatic shift in priority and a change of perspective at a policy, organisational and clinical level is needed if improved outcomes for children raised in substance-misusing families are to be achieved. Dawe and her co-authors undertook the comprehensive report in an attempt to disentangle the complex issues surrounding the estimated 10 per cent of Australian children who live in households where there is AOD misuse or dependence.

The report found that while significant progress has been made in some states towards rationalising the delivery of services for children, there has been no consistent national policy approach and no set of national principles describing best practice. There is no reference made in the Commonwealth National Drug Strategy to the needs of children raised in substance-misusing families and this raises concerns about the low priority given to the issue at a political level. The National Strategy for the Prevention of Child Abuse and Neglect, currently under development, provides an opportunity to develop such a policy.

The report also states that every jurisdiction should regard the needs of children whose parents are clients of AOD services as a priority area. Yet the only states to enshrine this objective in its policies are NSW, WA and SA. Almost all states have well-developed guidelines for considering parental substance misuse as part of a child protection risk assessment framework, but few have adequate guidelines for sharing information and coordinating treatment planning between child protection services and AOD services.

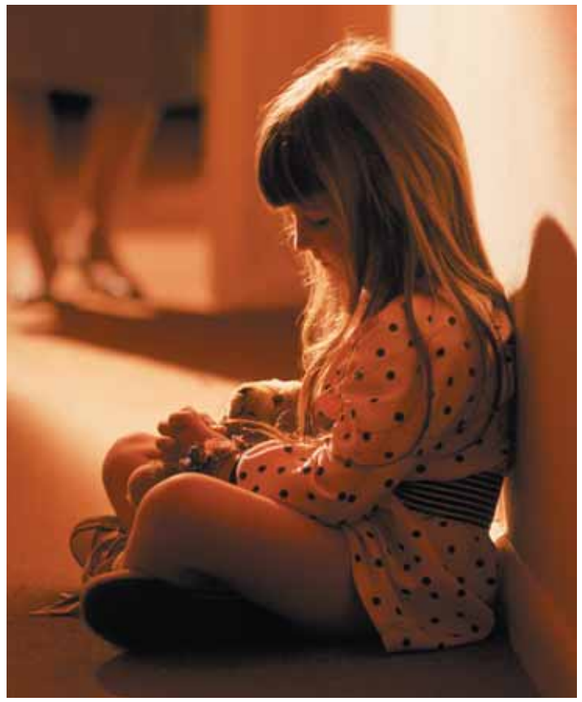
Who should deliver services to children?

So is the AOD sector best placed to deliver services to the children of substance-misusing families and should children's outcomes be seen as the sector's core business? Dawe says yes.

'The drug and alcohol sector is the one with the best access to the target group,' she says. 'Parents with dependence issues rarely access other services such as antenatal programs and so they only get picked up by other sectors if child protection is involved,' she says. 'But in order for the sector to take on this role, there needs to be a shift to thinking that core business includes improving outcomes for families rather than for individuals in isolation. AOD workers must have access to, and expertise in, delivering intensive family-based interventions and parenting resources developed specifically for this population. Funding must also be made available to undertake these interventions and workers' caseloads must be kept low.'

Dawe says present family-based treatments provided within the context of AOD treatment agencies are very limited.

'Caseloads are huge and so case management is often limited to crisis intervention. This situation must change to enable more specifically trained workers to provide family interventions and this will entail small caseloads. NSW, Qld and WA have had some success in doing this but it is piecemeal and caseloads are still too high.'



Given that any or all of the child protection, AOD, and mental health sectors may be involved in any one case, should the AOD worker be the one to take on the case management role?

'Not necessarily,' says Dawe. 'The important thing is that one of these agencies takes on the case management role but it need not necessarily be the AOD worker in every case. In one case it may be more appropriate for the child protection worker or the mental health worker to do so but ideally all agencies should be working with the same treatment model. Communication is the key. Workers should be sharing information and progress, attending case conferences and operating together as members of a case management team.'

Best practice

While the report's authors agree there is no single treatment program that is right for all families, they have developed a set of principles of good practice that provide a benchmark for determining program content. These practice guidelines should be used as a starting point in developing a set of national guidelines.

Central to best practice is the principle that effective programs must attend to the multiple needs of the family and not just the parent's substance misuse. It should not be assumed that children will automatically benefit indirectly through the support offered to their parents. In addition, high rates of depression and anxiety found in people in AOD treatment services are often tied up with parenting problems. Family-based interventions help all members of the family: parents show reductions in stress and depression and children have fewer behavioural problems.

Interventions must also be sensitive to the variety of ways in which drug use impacts on parenting capacity and on parents' changing levels of availability and sensitivity. Families should be treated on a case-by-case basis, taking account of all factors that might impinge on parenting including domestic violence, family hostility and tension. Other important considerations include the frequency and intensity of parental drug use over time, the age and development of the children, and the broader social and environmental stresses faced by the whole family. Engaging the family for an adequate period of time is also critical for achieving and maintaining change.

Strategies must also take account of the perspectives of all those involved in the family, not only mothers. Most current understanding of parenting issues in substance-misusing families draws heavily on the perspectives of mothers, yet the perspectives of other family members, including grandparents and fathers, are often pertinent. AOD workers have a unique and privileged opportunity to work with fathers who typically do not access other services. Children themselves must also be given the opportunity to voice their experiences so they can begin to develop an understanding of their parent's substance misuse and work through their own issues.

A critical factor for workers in deciding how best to intervene is the presence of concurrent parental mental health issues which together may impact more on child outcomes than substance use alone. Training AOD workers to address mental health issues,

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PRINCIPLES OF GOOD PRACTICE

These principles are informed by the research outlined in the report, *Drug Use in the Family: Impacts and Implications for Children.*

Good practice principles for funding bodies and/or organisations:

1. Recognise the importance of addressing the needs of children of substance misusers and regard this as core business.
2. Recognise the importance of this work and provide organisational support for such work to take place.
3. Endorse a treatment model that addresses many aspects of families' lives, e.g. a play group should be part of a range of family-focused interventions aimed to enhance parent's social support and improve parental functioning.
4. Develop interagency practice guidelines that enable staff across different agencies to work together in a safe, ethical and helpful way.
5. Be responsive to the needs of families to ensure treatment engagement.

Good practice principles for clinicians:

1. Undertake training in empirically sound treatment models for improving outcomes in substance-misusing families.
2. Implement regular clinical supervision.
3. Allow adequate time to provide intensive family-focused interventions.

Good practice principles for treatment content:

1. No single treatment is appropriate for all families.
2. Families must have immediate access to treatment programs.
3. All treatments should include a thorough assessment of the family's functioning across multiple domains. The family should be involved in assessing their needs and the design of services.
4. Effective programs must attend to the multiple needs of the family, not just the parent's substance use.
5. Treatment plans must be continually assessed, monitored and modified to ensure that they are meeting the changing needs of each family.
6. Clinicians must work actively with all systems that are impacting on families' functioning.
7. Families must be engaged for an adequate period of time to achieve and maintain change.
8. Clinicians must work to develop a sound therapeutic alliance with each family.
9. Treatment programs need to be evaluated to determine whether they are achieving their aims and objectives.

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THE PARENTS UNDER PRESSURE PROGRAM

The PUP Program has been developed by Griffith University's Professor Sharon Dawe and Dr Paul Harnett (University of Qld). It is an intensive, multi-component, family-focused intervention designed to improve child behaviour, decrease parental stress and improve family functioning by helping parents improve their own mental health, and learn skills to improve their children's behaviour.

It consists of 10 structured modules delivered weekly by a trained PUP therapist in the family's home. The program is based on standard behavioural parenting techniques; learning to manage and control negative behaviour, in particular anger and frustration, is considered to be a key requirement before parenting skills can be implemented.

The early part of the program addresses the parent's negative view of themselves and encourages them to acknowledge their children's positive attributes. The middle section focuses on problems such as anger, anxiety and depression and encourages parents to find alternative coping strategies to substance use. The final phase helps parents learn non-punitive parenting methods and encourages them to develop social and community support outside the drug-taking community.

Empirical support for the program

The program has been evaluated in families where there are complex problems. A series of single case studies have been conducted with families on methadone maintenance, families referred from child protection services and with women leaving prison. A randomised controlled trial was also undertaken with parents on methadone maintenance. In this study, the relative effectiveness of the intensive, multidimensional approach of the PUP program was compared to a brief behavioural parenting intervention and standard care.

At six months follow-up, families reported significant improvements in terms of parental functioning (including potential for child abuse), parent-child relationships, child behaviour, and methadone dose. There was a modest improvement in the brief behavioural parenting group. However, no such improvement was found in those families receiving standard care (notably in this group there was a significant increase in child abuse potential). Families also reported high levels of satisfaction with the program.

The program has been used successfully in NSW and is being introduced in Qld drug and alcohol treatment services.

Reference

Dawe, S & Harnett, PH 2007. Reducing child abuse potential in methadone maintained parents: Results from a randomised controlled trial, *Journal of Substance Abuse Treatment*, vol. 32, issue 4, pp. 381-90.

continued from page 11

as well as improving liaison between AOD and mental health services, are essential to increasing the use of such treatment options by substance-misusing families and producing more positive outcomes.

Many factors place children at risk

Dawe stresses that the issue of children in substance-misusing families is not single-faceted. 'Parental misuse is clearly a risk factor for children but it may be only one of a multitude of other problems including parental psychopathology, poverty, high rates of domestic violence and sexual abuse, low levels of education, social isolation and violence. 'It is the cumulative exposure to multiple risk factors that creates the greatest vulnerability in children, so attempts to improve outcomes must look at all aspects of a child's life,' she says. 'Tackling drug use in isolation is unlikely to be effective.'

The report also notes that substance misuse does not automatically result in diminished capacity to parent adequately – even parents leading quite chaotic and inconsistent lifestyles can be very concerned and loving parents. Similarly, not all children of substance-misusing families will go on to replicate their parents' using behaviour, especially if a child has other 'protective factors' working for them. The two key factors are a warm, supportive and nurturing parental relationship where firm behavioural limits are established and consistently maintained, and engagement in school and other community activities. When working with families, AOD workers should try to capitalise on these protective factors.

Children from Indigenous families

In a separate chapter dealing with children of Indigenous parents, the report stresses that reducing supply, and providing 'safe houses', night patrols and sobering-up shelters are important to ensuring the safety of women and children exposed to violence associated with drunkenness and other substance use. However, these are short-term emergency measures only and do not address the fundamental causes of the problem. Substance misuse is often the final outcome of societal and personal alienation, the dynamics of which are complex and cannot be resolved by dealing with the substance misuse alone. The huge task is to address the well-being of the entire community while at the same time addressing the needs of the individual who is abusing a substance. Recognising the right of Indigenous people to promote, develop and maintain their own institutional structures, distinctive traditions, customs, practices, procedures and pathways to empowerment and self-determination is pivotal to this.

The impact of alcohol

Dr Delyse Hutchinson, National Drug and Alcohol Research Centre, has conducted a review of the literature on the impact of alcohol abuse on children. As with substance misuse in general, the literature details evidence of negative child development outcomes from early childhood through to adolescence, ranging from cognitive, social, emotional and behavioural disorders, to issues of health and safety. In relation to family functioning, the literature confirms that parental alcohol problems can result in poor family cohesion, elevated levels of conflict and violence within the family, disruptions in family organisation and routines, and economic and employment problems.

At a developmental level there is a high correlation between parental alcohol use disorders and children's outcomes including attention deficit hyperactivity disorder, impulsive and antisocial personality disorder, and anxiety and depression. Children from families where both parents report alcohol abuse, and those characterised by multiple risk factors, are at greatest risk.

There is also a well-documented range of physical, cognitive and mental health problems in children whose mothers consume alcohol at high levels during pregnancy, including fetal alcohol spectrum disorder. Hutchinson agrees that alcohol use disorders are just one of many social, family and individual risk factors linked to problems in family life, and these factors often co-occur.

Opportunities for interventions

Hutchinson says taking a developmental approach to understanding the effects of parental alcohol abuse and dependence acknowledges that there are also multiple pathways and opportunities for intervention. Interventions at specific time points may be warranted with different families (e.g. treatment for mothers drinking heavily in pregnancy, promotion of healthy parent-child relationships in infancy, and parent education regarding monitoring adolescent alcohol use). Brief and economical interventions may be suitable for families experiencing less severe drinking problems or those characterised by few compounding risk factors, while families affected by multiple risk factors are likely to require more intensive, longer term, integrated support. Multiple interventions may be warranted with high-risk families.

Future issues of *Of Substance* will explore the implications of mandatory reporting and the other tensions around this complex topic.

Reference

Dawe, S, Atkinson, J, Frye, S, Evans, C, Best, D, Lynch, M, Moss, D & Harnett, P November 2006. *Drug Use In The Family: Impacts and Implications for Children*, ANCD Research Paper 13.

KALEIDOSCOPE

Kaleidoscope is a six to eight-week program run by Holyoake (Centacare, Sydney) for children aged 5-17. The key message of the program is that the parent's substance abuse is not the fault of the child and the child cannot fix the problem. The focus is on managing the child's own behaviour. The program includes:

- approximately six same-age participants per group
- group meetings aim to provide a safe, supportive environment for sharing experiences, exchanging ideas and developing solutions
- mutual support among group members, reducing each individual's sense of isolation
- weekly topics include: feelings; chemical dependency; family dynamics; coping with stress; communication; responsibility; decision-making; setting limits; and self-esteem
- 12-week concurrent 'Relationships in focus' program for parents.

For more information, email: holyoake@centacare.org.

SKATE: SUPPORTING KIDS AND THEIR ENVIRONMENT

This Geelong-based program for children aged 6-18 is a joint initiative between Glastonbury Child and Family Services, Bethany Community Support and Barwon Health Drug and Alcohol Services, Vic.

It incorporates:

- eight-week structured children's group providing emotional support, coping and problem-solving skills, plus linkages to other community services
- extended family group (either weekend or over nine sessions), focused on adult family members
- brokerage funds to support case plans for substance use recovery, providing opportunities to children for linkages to education, employment and community, and assisting to break the cycle of generational substance abuse
- outreach to families not linked with other AOD treatment services.

The positive outcomes for children undertaking the program include:

- reducing isolation, sharing experiences with other children
- learning about illicit drugs, the cycle of recovery, the impact of drug use
- understanding issues such as responsibility and setting boundaries
- improvements in measures of anxiety/stress/depression
- reducing incidence of rule breaking and aggressive behaviour
- more positive sense of self.

For more information visit: www.glastonbury.org.au.

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ALCOHOL AND THE LAW: CAN HEALTH WIN?

PETER GORDON AND JOHN GORDON*

'Tobacco litigation has transformed the prospects for tobacco control, first in the United States and more recently worldwide. It has forced tobacco companies to sit at the bargaining table with tobacco control advocates, has produced settlements under which the industry is committed to paying about $10 billion each year to reimburse American states for healthcare expenditure caused by tobacco, and it has generally put the industry on the political defensive.' – Professor Richard Daynard, 2000.

Legal action for a better society?

A couple of years ago, Kraft and McDonald's announced that they were changing the way they were going to do business. Consumers were going to be better informed, products were going to be healthier, portions smaller.

A great result for individual consumers, and for society generally. And what was one of the acknowledged drivers of these welcome changes? It was the perceived threat of lawsuits.

Litigation in the United States and in Australia has been one of the major societal forces in the promotion of product safety and consumer protection, with respect to a myriad of products ranging from exploding motor cars to asbestos cement, from contaminated blood products to tobacco. But there is little or no track record of success for litigation in moderating the behaviour of manufacturers and marketers of alcohol. No-one can point to landmark decisions which have changed the operating or marketing practices of manufacturers overnight. It is timely to ask ... why is it so?

The question invokes the much broader issue of the varying roles that the private right of legal action has and may play in influencing outcomes in any public health scenario. Why, for example, have plaintiff lawyers managed to close down the asbestos industry but not the heroin trade?

Litigation is not the only answer

In the biggest battle ground of public health – the battle with big tobacco – to what extent do Professor Daynard's observations about the role of litigation account for the reductions which have been made in smoking rates in Australia and overseas? The answer is that no one mechanism for regulatory influence of threats to public health will achieve optimal or desired outcomes.

For all of the achievements of lawyers aligned with the anti-smoking movement around the world over the past 20 years, it would be foolish to deny the critical role that has been played by progressive governments in imposing regulation, advertising restriction, point-of-sale restriction, age limits and pack design. Equally important has been the partnership role of educators, both public and in the home, and the role of public health advocates.

Given the wealth and resources of the tobacco industry, little could have been achieved without a sound and ongoing catalogue of scientific and medical evidence, demonstrating the nature and extent of the dangers of smoking.

Considerable achievements have been made in Australia and many parts of the world in the last decade in reducing the incidence of smoking and it is clear that it has been the synergy of these various modes of education, advocacy, regulation and enforcement which have significantly influenced this outcome.

In countries like Australia, litigation has played its role, and its role has included many factors: exposure of many of the iniquities of the industry; huge unprecedented financial accountability; and – equally important though seldom dwelt upon – the general deterrent effect upon industry of the knowledge that it may be held accountable in courts in suits brought by affected citizens.

In the USA, the list of victories against the tobacco companies by state governments (who recovered hundreds of billions from tobacco companies in compensation for money spent by states in treating patients with tobacco-caused illnesses), individual smokers and, more recently, even the Federal Government (alleging conspiracy and racketeering), continues to grow.

Learning from tobacco litigation

What lessons and potential does this history of tobacco litigation offer for the regulation of other drugs of addiction, like alcohol?

The Trauma Foundation at the San Francisco General Hospital, after the US states had successfully extracted a multi-billion dollar health care costs settlement from Big Tobacco, were optimistic: 'The states' tobacco lawsuits provide us with important lessons for alcohol. The greatest benefit of the tobacco litigation was not any of the legal awards and settlements, but public health gains made possible by court supervised discovery of industry documents.

'The similarities between tobacco and alcohol promotion are clear. Both products are aggressively marketed to children. Both cause disease and death. In addition to long-term disease, alcohol use can also result in immediate damage, unintentional injuries, drink-driving collisions, domestic violence and crime, thus creating huge criminal justice as well as health costs.' Against this optimism, however, there has been the singular lack of success in lawsuits against alcohol manufacturers alleging product liability and failure to warn. No claim has been successful on this basis.

There have been many cases in the United States where action has been taken against alcohol manufacturers, seeking damages for marketing to underage children and a failure to warn of the potential harm or addiction caused by alcohol. Despite the cases' similarity to successful litigation against tobacco manufacturers, none have been successful.

Reasons for failure

In dismissing the suits, the courts identified some consistent problems with the claims filed. Several cases failed to identify

an injury to the plaintiffs themselves upon which the suit could be founded. The courts generally held that the parents of underage drinkers had not suffered physical injury, and that they also held the responsibility to monitor their child's exposure to alcohol advertising, for discussing issues and for influencing the way they spent money. Advertising was not considered illegal or at fault if it appealed to children as well as adults.

Manufacturers were not seen to be responsible for sales to underage drinkers because such sales occurred through retail stores or bars, thus were not made by them. One judge affirmed that advertisers are under no duty 'to disclose either inherent dangers of consuming alcoholic beverages, or that alcohol would not make fantasies come to life. Nor [do they] have a duty to disclose that underage drinking is illegal.'

We must confess to a growing sense of unease as we read through these dismissals. Although some of the claims seemed to have some fairly fundamental problems, some of the claims were not so substantially dissimilar to allegations brought against tobacco companies, which as we have seen, have been relatively successful.

We also noted that the claims were brought without the benefit of the vast libraries of internal company documents that marked the success of litigation against tobacco companies, and we wondered what might be in the archives of the major alcohol producers (or what had been destroyed over the years on advice from attorneys who were advising the tobacco industry).

And we wondered whether maybe the alcohol claims were being judged on an altogether different standard to tobacco or asbestos claims. Was the starting point for a claim against a tobacco or asbestos company one of presumptive guilt, where alcohol manufacturers are still afforded the benefit of the doubt?

The real breakthrough for redressing the tobacco companies and making them accountable came when the US states took on the tobacco companies seeking to recover the costs of treating tobacco-caused illness. It was from this litigation that the vast archives of tobacco documents were uncovered and made publicly available. And it was from this litigation that the real issue of tobacco abuse was brought front and centre – the cost to the community of the massive promotion of, and addiction to, such dangerous products as tobacco and nicotine.

The same is undoubtedly true of alcohol. And it may be that the real path to accountability of alcohol manufacturers lies in the hands of the US state governments to replicate their litigation claiming the health costs of treating alcohol-caused disease and trauma in the community.

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Action in Australia

The prospects for such litigation in Australia must be considered remote. The state governments rejected a plan put forward about six years ago by some attorneys-general to pursue tobacco health care cost recovery litigation. Claims for damages for personal injuries caused by misleading and deceptive conduct by corporations pursuant to the Trade Practices Act 1974 (except for tobacco-caused injuries) have been abolished by the Commonwealth Government in a massive over-reaction to the so-called 'insurance crisis'.

Moreover, recent litigation seeking to make a supplier of alcohol responsible for its conduct has been unsuccessful in Australia. This high water mark for the promotion of the doctrine of 'personal responsibility to the exclusion of corporate responsibility' was in the case of *South Tweed Heads Rugby Club v Cole* (see panel). The NSW Court of Appeal found that the club did not have any duty of care to an intoxicated patron who was injured shortly after leaving the club.

Interestingly, the courts in Canada have, however, found a duty of care of the type rejected in the Cole case. On at least three occasions, those courts have found that hotels have had a duty of care for the safety of an intoxicated patron after they left the premises.

A tipping point?

In 2000, Malcolm Gladwell first published his fascinating book *The Tipping Point*, which has influenced a great deal of public health thinking ever since. Its simple theory goes like this ...

> Three characteristics – contagiousness, the fact that little causes can have big effects, and that change happens not gradually but at one dramatic moment – are what shape change in society, or habits, fashion trends, public health threats and phenomena.

In a sense, the greatest potential for litigation in alcohol manufacturer behavioural control is in its potential to act as a central component in change – to be a tipping point. All it may take to create the change is one memorable, successful claim against an alcohol manufacturer. We may yet see litigation play that role in alcohol abuse. And it is our aim to help create that tipping point.

Lawyers like us are looking at the alcohol industry. We are looking at the schoolies rock concert promoters who get truckloads of cheap pre-mixed drinks into their festival grounds; and we are looking at the manufacturers who supply them, knowing the 'alcopop' is to be pumped out into their young audience like Big Tobacco did back in the sixties.

We are looking at the privateers who ship barrels of beer into Indigenous communities on pension day and parcel it out until the pension money is gone. We are looking at the big pubs and clubs who get the footy team boys in for a big pay TV fight, and award the best 'skullers' of the night.

Such scenarios may well provide for the imposition of liability to the supplier of alcohol in these circumstances. There is nothing in the existing common law of Australia which would prevent it. Such a scenario may well provide a tipping point for alcohol manufacturers or vendors to be proven liable for alcohol-induced harm. Until then, litigation deferentially takes its place behind other social policy regulators; government regulation, education, and medical and public health lobbying in the fight against the excesses of the alcohol industry.

**** Peter Gordon and John Gordon write from Melbourne law firm Slater & Gordon. This article is a summary of Peter Gordon's keynote presentation at the Thinking Drinking – From Problems to Solutions Conference in Melbourne, February 2007.***

Club found to have no duty of care to intoxicated patron

On the evening of 26 June 1994, Ms Cole was seriously injured when she was struck by a car driven by Mrs Lawrence. Ms Cole had been drinking at the South Tweed Heads Rugby Club premises and had consumed a large quantity of alcohol throughout the day. Ms Cole was refused service at the bar in the afternoon because of her intoxicated state. Ms Cole stayed at the club and its surrounds for the day and was ejected between 5.30 and 6 pm for being intoxicated. The club had offered to call a taxi for Ms Cole as well as offering her the use of the club bus and driver. One of the men Ms Cole was with had told the club manager that he would look after her. At some time after this she left the club.

Mrs Lawrence's vehicle hit Ms Cole at around 6.20 pm. Ms Cole suffered serious injuries from the accident and has continuing disabilities. Initially, the trial judge held that Mrs Lawrence's liability for Ms Cole's injuries was 30 per cent. The club's was also assessed at 30 per cent. Ms Cole was found to have contributed 40 per cent to her injuries. However, the NSW Court of Appeal found that the club did not owe any duty of care to Ms Cole and in any event had breached none owed to Ms Cole.

This finding against a duty of care was subject to one important caveat reserved by the Court which may well prove important for future litigation against alcohol manufacturers and vendors in this country: '... There may, however, be circumstances which bring about a different result. For example, it may be that where a person is so intoxicated as to be completely incapable of any rational judgment or of looking after himself or herself, and the intoxication results from alcohol knowingly supplied by an innkeeper to that person for consumption on the premises, the scope of the duty of care of the innkeeper will be extended to require reasonable steps to be taken for the protection of the intoxicated person.'

The Court of Appeal also recognised a second possible qualification on the absence of a duty of care. It is that the situation may be different where injury is caused, not to the intoxicated patron but to a third party injured as a result of that patron's intoxication.

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THINKING ABOUT DRINKING, AGAIN

GEOFF MUNRO*

Over 300 people attended the *Thinking Drinking II: From Problems to Solutions* conference in Melbourne in February 2007. The meeting was designed to continue the momentum for cultural change derived from the first *Thinking Drinking* gathering in 2005.

How to reorient drinking values and social customs was a key challenge, and recognition of the need for health advocates to coordinate their efforts was a major outcome. A number of keynote speakers presented on a wide range of issues.

Sandra Kirby spoke about a social campaign conducted by the Alcohol Advisory Council of New Zealand (ALAC) that impressed many delegates. ALAC hopes to change New Zealanders' expectations of alcohol by stigmatising drunkenness, summed up by the message 'It's not the drinking, it's how we're drinking'. (For more information, see *Of Substance*, April 2007, vol. 5, no. 2 at www.ofsubstance.org.au.)

WA's Professor Mike Daube described the successful tobacco control effort over three decades as a template for action over alcohol. He said advocates need to establish a limited set of demands, support it with sound evidence, and promote it assiduously. Professor Daube warned that the alcohol industry should not be considered as a collaborator because it was dominated by the profit motive and would never agree to measures that would threaten consumption levels.

While Professor Daube's speech met with much support, his argument on that point was challenged. On a panel devoted to advocacy, former CEO of Odyssey House Vic., David Crosbie, and professional lobbyist Gabriel McDowell suggested that on some issues, such as taxation, it was possible for public health advocates to join with some sectors of the alcohol industry. A former representative of Lion Nathan, Mr McDowell told the audience that advocates had to choose campaign issues carefully: 'You won't get anywhere unless you take the public with you'. He thought there were two issues capable of rousing public interest: violence fuelled by drinking and the capacity of offenders to use intoxication as a defence within the legal system.

Social justice campaigner Reverend Tim Costello said it was vital for politicians to understand the full economic cost of alcohol problems and suggested one way to do that is to have the Productivity Commission undertake a comprehensive study. In the same session Federal Senator Andrew Murray suggested public health advocates should lobby for an end to political donations by big business corporations as the capacity to pass funds to the major political parties gives 'Alcorp' unmatched influence with politicians.

A new approach was also outlined by Peter Gordon, of the law firm Slater & Gordon which pioneered litigation against tobacco companies. He said it was time for persons who were damaged by their own or another's drinking to hold accountable manufacturers and retailers when they fail to maintain a duty of care towards their clients. (For more information about litigation issues, see page 14.) Melbourne University's John Fitzgerald predicted that in a time when familial and social structures are

breaking down the alcohol industry will present drinking as representing a form of sociality, a crucial human need.

Christopher Doran of the University of Qld presented research that showed one aspect of the economic value of underage drinking. On a conservative estimate, Australian teenagers in 2002 spent over $200 million on alcohol, on which the Commonwealth Government collected approximately $112 million in tax revenue. Yet in return only $17 million was spent on alcohol interventions for adolescents.

Themes within the program's concurrent sessions included school education, community prevention, emerging health issues, taxation and marketing, density of licensed premises, advocacy, policy development, Indigenous issues, treatment, intoxication and licensing.

A team from Minds at Work ran a parallel stream, inviting delegates to spend time discussing issues with independent thinkers who are not part of the alcohol and other drugs field. In the final session, Minds at Work guided delegates through creative thinking exercises designed to open up new options for the field to consider.

Thinking Drinking II was organised by the Australian Drug Foundation and Community Alcohol Action Network. The premier sponsor was the AER Foundation, with additional sponsorship from ALAC. Other supporters were the Victorian Health Promotion Foundation; Department of Education Vic., Department of Human Services and Premier's Drug Prevention Council; the Ted Noffs Foundation; Turning Point Alcohol and Drug Centre; Beyond Blue: the national depression initiative; the National Drug Research Institute; and the Commonwealth Department of Health and Ageing.

Further reading

Presentations given at *Thinking Drinking II* are available on www.adf.org.au and a full report will be published on the website at a later date.

**** Geoff Munro was the Conference Director of*** Thinking Drinking II.

OF SUBSTANCE
THE NATIONAL MAGAZINE ON ALCOHOL, TOBACCO AND OTHER DRUGS

TOBACCO
NO TIME FOR COMPLACENCY

JANE MUNDY

Australia's report card midway into the 2004-09 National Tobacco Strategy is an impressive read. But now is not the time to rest on our laurels.

Australia can be justifiably proud of its record on tobacco control. The 2004 National Drug Strategy Household Survey (NDSHS) shows that only 17.4% of Australians aged 14 or over now smoke daily, a drop from 19.5% in 2001 and from around 35% in 1983 (Makkai & McAllister 1998), while the percentage of people who have never smoked has risen from 50.6% in 2001 to 52.9% in the most recent (NDSHS) survey.

Western Australia is the best-performing jurisdiction with a figure of 15.5% of people aged 14 or over who are daily smokers, with Tasmania (21.5%) and the Northern Territory (27.3%) faring worst. In New South Wales (where $10 million was spent on anti-smoking strategies in 2005-06), latest figures show a drop to 17.7%, down from 20.1% in 2005 – the greatest decline ever recorded in any state in one year (Firth 2007).

Importantly, the downward trend is also continuing among young people. Nationally, only 7% of secondary school students aged 12-15 and 17% of 16-17 year olds smoked in the week before the 2005 Australian School Students Alcohol and Drug Survey was conducted, while more than 90% of students believe smoking is harmful to health and 87% are aware of the dangers of passive smoking. Western Australia is leading the way here, too, with only 5% of 12-15 year olds (down from 15.2% in 1999) and 9.8% of 16-17 year olds (down from 21.4% in 1999) now smoking – the lowest recorded levels since the first school survey in 1984.

But experts warn that, encouraging though these figures may be, this is no time to become complacent. Smoking still remains the greatest single preventable cause of premature death and disease in Australia, killing almost 20 000 people each year and costing the community an estimated $21 billion per annum.

President of the Australian Council on Smoking and Health, Professor Mike Daube says Australia's success represents 'one of the great public health triumphs of our time'. Together with Canada, some parts of the US and Nordic countries, we are now world leaders in the field. He attributes our success to the fact that we have been working at it for almost 30 years, and to a 'unanimity of purpose and thinking' and a comprehensive approach involving high taxes on tobacco, public education, cigarette advertising bans, graphic health warnings, restrictions on smoking in clubs and pubs, the marketing of smoking cessation products, as well as 'lively and imaginative' advocacy. 'Smoking is definitely on the way out and if this trend continues at the present rate, we could reach as close to 0% smoking as is feasible within 15 years,' he says. 'Not so long ago I would have said this was impossible, but in view of the latest figures, it's not out of the question. In 1999 we launched a new phase of our public education campaign in WA called Target 15 which aimed to reduce smoking rates to 15% by 2015. This was regarded as really ambitious at the time but we're there already.'

This view is supported by other tobacco control organisations. National health group Action on Smoking and Health (ASH) says it is realistic to have prevalence rates down to 10% by 2010. In 1995, Quit Victoria predicted male smoking rates would hit zero around 2022, with women following by 2034.

'We have been hearing for years that we will always have a significant group of hard-core resistant tobacco dependents, but I don't agree,' says Daube. 'The figures show that more people are not taking up smoking in the first place and there is no evidence that this trend will stop. Once rates fall below 10% I believe they will drop like a stone. In 10 years time, there should be only a very tiny minority of Australians smoking.

'Only then can we afford to get starry eyed – in the meantime, we mustn't take our foot off the accelerator. The moment we become complacent, the tobacco industry will be ready to pounce – we have seen this happen in some parts of the US. We should be saying there is a huge public health gain still to be made so let's work even harder.'

In addition to a large overall reduction in units of tobacco consumed (in total, per capita and per smoker), the 2004-09 National Tobacco Strategy aims to achieve reduced uptake among young people, increased cessation by established smokers, reduced exposure for non-smokers, reduced harm for use and dependence, and greater equity for disadvantaged groups. It aims to do this through further use of regulation, increased promotion of Quit and smoke-free messages, improved services and treatment for smokers, more support for parents and educators, endorsement of policies that address causes of disadvantage, tailoring policies for disadvantaged groups, and supporting focused research and evaluation.

National Tobacco Strategy – some highlights at a glance

The Australian Government worked with states and territories to develop a National Tobacco Strategy which was endorsed by the Ministerial Council on Drug Strategy on 12 November 2004. The National Tobacco Strategy provides a comprehensive framework for action and assists jurisdictions (including the Australian Government) to develop their own action plans on tobacco.

Further use of regulation

Australian Government initiatives include the implementation of new graphic health warnings, ongoing monitoring of the *Tobacco Advertising Prohibition Act 1992* and a Voluntary Agreement for the Disclosure of the Ingredients of Cigarettes.

States and territories legislate to limit smoking in public places and workplaces and, while legislation varies between jurisdictions, there has been a greater trend toward consistency in recent years. In Vic. smoking in licensed premises will be completely banned from July 2007 while all enclosed licensed hospitality venues in SA will be completely smoke-free after 31 October 2007.

In NSW, smoking in indoor areas of licensed premises will be completely banned from July 2007 (but will still be permitted in outdoor areas). Western Australia has introduced a licensing scheme for all sellers of tobacco products and there is also a ban on tobacco advertising and promotion. In Qld smoking is banned at a range of venues and the display of tobacco products at retail outlets is severely restricted. All enclosed public spaces in the ACT are non-smoking.

Promotion of Quit and smoke-free messages

The Australian Government committed $25 million over four years for a National Tobacco Youth Campaign to address youth smoking rates. There are extensive advertising and promotional campaigns in all states and territories emphasising the Quit message. Campaigns include the 'Nobody Smokes Here Anymore' campaign in QLD, the 'Bubblewrap' campaign containing a message about emphysema in NSW and VIC, and the 'Make Smoking History' campaign in WA.

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TREATING 'TREATMENT-RESISTANT' SMOKERS

RENEE BITTOUN*

There are many possible treatment strategies with this difficult group of clients. Your hierarchy of strategies should begin with permanent cessation and then progress through a range of harm-reduction alternatives. There is little evidence to demonstrate what works best with whom. Try every strategy for which there is substantiated evidence and combine them if necessary:

- **Nicotine replacement therapy (NRT)** is most often used in Australia for smoking cessation, however more patients are requiring higher doses of nicotine as 'replacement' to bring about a successful outcome. Intensive interventions with NRT are both safe and effective. We know that 25% of Australians smoke while on NRT and that NRT suppresses their nicotine intake. It is therefore less harmful to smoke while using NRT than smoking without it. Reducing smoking in this manner may also be a gateway to quitting.
- **Temporary abstinence** is common where smokers use NRT in situations that are smoke-free, such as nicotine patches during a long flight. This is safe and should be encouraged as harm-reduction. Cravings and other withdrawal symptoms are relieved, cigarette consumption is reduced and compensatory smoking prevented. Smokers learn they can manage without tobacco for several hours and this may increase motivation to quit altogether. Aim to lengthen periods of abstinence.
- **Alternative tobacco products** may be less harmful than cigarettes but they are still tobacco and contain nicotine. There is no conclusive evidence that they reduce morbidity or mortality.
- **Nicotine assisted reduction to stop (NARS)** is a strategy for easing into quitting. Set a target of 50% reduction, advise client to replace every second cigarette and use NRT to manage cravings. British Action on Smoking and Health advocates daily alternating smoking a cigarette with any form of NRT such as gum, lozenge, sublingual tablet or inhaler.
- **Exercise** as a harm reduction strategy improves a smoker's life expectancy by lowering the risk of heart disease and lung cancer. Brisk walking also reduces the urge to smoke.

** Renee Bittoun writes from the Nicotine Addiction Unit, Department of Psychological Medicine, University of Sydney.*

OF SUBSTANCE
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NICOTINE VACCINE

WAYNE HALL*

A nicotine vaccine is a novel approach to smoking cessation that induces the immune system to produce antibodies that bind to nicotine, preventing it from crossing the blood-brain barrier and acting in the brain. Vaccination against nicotine could reduce relapse to smoking by weakening the effects of nicotine during the first few months after quitting when most smokers relapse. A vaccine could be circumvented by increasing the nicotine dose, but reducing the rewarding effects of nicotine may be enough to make a lapse less likely to lead to a return to daily smoking.

Nicotine vaccines are currently being trialled for cessation by three companies in Britain, Switzerland and the USA.

The term 'vaccine' inevitably prompts questions about its preventive use in children. Even if we set aside the ethical issues, the preventive use of a nicotine vaccine is unlikely to be effective. First, existing vaccines provide limited periods of protection, requiring booster injections perhaps every two or three months during adolescence.

Second, the fact that the vaccine could be circumvented by higher doses of nicotine means that vaccination could be counter-productive if adolescents were prompted to test its efficacy. Third, it would be costly to universally vaccinate children against nicotine with a vaccine of modest preventive efficacy. If a nicotine vaccine is approved for cessation it may be used 'off label' by a physician acting at the request of a parent to prevent a child from smoking. It is difficult to see how this can be prevented, other than by educating physicians and parents about the limitations of this approach.

** Professor Wayne Hall writes from the School of Population Health, University of Queensland.*

Further reading

Hall, W 2005. Will nicotine genetics and a nicotine vaccine prevent cigarette smoking and smoking-related diseases? *PloS Medicine,* vol. 2, no. 9, e266.

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CLINICAL TREATMENT GUIDELINES: SMOKING CESSATION

Smoking cessation – working with clients to quit is part of the Clinical Treatment Guidelines series developed by Turning Point Alcohol and Drug Centre, Victoria.

The Guidelines focus on smoking cessation intervention within the specialist alcohol and drug setting, but are suitable for use by other health professionals managing clients with alcohol and drug problems. Practical guidelines include intervention strategies, service strategies, World Health Organization framework for intervention, guidelines for intervention in AOD practice, and when to introduce smoking cessation. A final section covers clinical resources. The Guidelines are designed to be used in conjunction with other publications in the series. These include *Working with cannabis users*, *Working with polydrug users*, and *Methamphetamine dependence and treatment.*

Publications can be ordered directly from Turning Point. Phone (03) 8413 8413 or email info@turningpoint.org.au.

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Cessation services and treatment of tobacco dependence

Cessation services are managed through state and territory Quitlines. The Australian Government provides subsidised access to pharmacotherapies by making Zyban available through the Pharmaceutical Benefits Scheme. Nicotine replacement therapy (NRT) was deregulated on 1 May 2004, resulting in some NRT products now being available in supermarkets.

Tailoring of programs to disadvantaged groups

The Australian Government has provided funding for the establishment of the Centre for Excellence in Indigenous Tobacco Control (CEITC), which is working on implementing initiatives to address smoking cessation issues in Indigenous communities. Funding has also been provided to undertake projects related to smoking and mental health issues. Programs in place that target Indigenous and culturally and linguistically diverse groups include the 'SmokeCheck' program in NSW and QLD, the 'Event Support Program' (ESP) in QLD and the 'No More Bundah' quit smoking program in the ACT.

Support for youth, parents and educators

In the May 2005 Budget the Australian Government committed further funding to tobacco initiatives. These included the National Tobacco Youth Campaign and $4.3 million for a smoking and pregnancy initiative aimed at assisting women who are pregnant or planning pregnancy to stop smoking.

States and territories also provide a range of programs for youth, parents and educators which include the 'Don't be a Sucker 2005' youth program in NSW, the School Based Youth Health Nurse Program in QLD and the Vic. Department of Education and Training is piloting a Smoke-free Schools Guide, which recommends that schools be smoke-free environments, including the school grounds.

What more should we be doing?

Firstly, Mike Daube says the government must be prepared to spend more. The economic argument for doing so is irrefutable: in public health terms, around $8.6 billion has already been saved through declines in rates of illness and disability, and total economic benefits are estimated to exceed expenditure by at least 50:1. 'The Federal Government collects almost $7 billion per annum from the importation and sale of tobacco products in Australia and spends less than 0.5% of this doing anything to prevent people smoking,' Daube says. 'I'd like the government to commit $100 million per annum at the very least.'

Then there are taxes: 'Ours are high but they could be even higher – we know higher cost is a disincentive, particularly for kids.' And marketing: 'We should be moving towards plain packaging which contains nothing but health warnings, and cigarettes should be kept under the counter and not be visible. Western Australia has almost achieved this now. And we must keep up pressure on pubs and clubs – several states are lagging behind. One of the most encouraging developments is that young people's image of smoking is changing: they are reporting that they don't like the idea of sticking a burning substance into their mouths, and they are seeing smoking increasingly as something only a minority does. We should be doing more to encourage this.'

Daube also says certain groups such as the Indigenous community must be more specifically targeted with anti-smoking programs. Around 50% of adult Indigenous Australians are daily smokers: it is difficult for them to quit when the majority of their friends and family smoke, when they may not know anyone who has quit successfully, and when they live in a culture of sharing. More research and evaluation of tobacco interventions for Indigenous people, such as NRT, is needed.

One-fifth of pregnant women still smoke regularly and smoking rates remain significantly higher for those who are less well educated and among some sections of the non-English-speaking community. Interventions are also needed that target young people with mental health issues (an estimated 90% of patients with schizophrenia smoke), while smoking rates are as high as 80-90% among those in treatment for other AOD issues. Above average smoking rates prevail for AOD workers themselves. More work also needs to be done in relation to the 37% of children aged 0-14 years who live in households with one or more regular smokers, and among the 75% of smokers who still see quitting as something they will do one day but not in the next month (the percentage of ex-smokers has risen only marginally from 26.2% in 2001 to 26.4% in 2004).

Passive smoking remains an issue, with Qld and Tas. the only states to receive Smokefree's 'very good' or 'good' rating. South Australia, NSW and Vic. are rated 'poor' because of their late deadlines for imposing total indoor bans, and loopholes in legislation. The NT, the only jurisdiction still to set a deadline for an end to smoking in totally enclosed areas of licensed premises, is rated 'very poor'. Other areas of concern include advertising and sales over the internet, widely feared to promote the update and use of tobacco especially by young people by offering cigarettes at greatly reduced prices. An Intergovernmental Committee on Drugs (IGCD) Working Group has been established to report on this.

Other IGCD Working Groups have been set up to look into establishing nationally consistent guidelines on the point-of-sale of tobacco products and to analyse the effectiveness of anti-smoking advertisements in cinemas.

Funding still needed

Anne Jones, CEO, ASH Australia, agrees more money should be spent on tobacco control and argues that the Federal Government is shirking its responsibilities by leaving state and territory governments to pick up the costs. She says the results that have been achieved so far in tobacco control in Australia are due largely to the success of mass media campaigns, and the extent to which these results can continue to improve is directly proportional to the amount of money governments are prepared to commit to campaigns like these in the future. 'Although government investment in reducing smoking rates has improved in recent years, it's still too low given the scale of the problem. Per capita, federal and state funding of anti-tobacco measures is outstripped three to one by comparable OECD countries such as the US, Canada and New Zealand.

'Anti-smoking campaigns receive less funding than any of the other major campaigns such as breast cancer and youth suicide. Despite overwhelming evidence of the damage smoking does to public health and the economy, there is an attitude that we have done a lot already and there is no need to do much more. Yet we know the more the momentum keeps up, the more smoking rates will come down. Other chronic diseases such as diabetes are now receiving priority funding, yet smoking, which is poorly funded, is a risk factor for all chronic diseases, including diabetes.'

Jones says the funding onus should be on the Commonwealth. 'It's a tragedy that the Commonwealth puts so little money into tobacco control. They are the ones collecting tobacco taxes but they are leaving funding to the states. The smallest states like Tasmania and the NT have a very low investment and consequently these are the states where smoking rates are highest.' She says ASH supports full funding of almost $200 million per annum (as recommended by the National Expert Advisory Committee on Tobacco) for the Australian National Tobacco Strategy 2004-09, to which the Commonwealth and all states are signatories. This represents a per capita expenditure of $10 per annum. She would like to see more money spent on implementing the National Tobacco Strategy including nationally coordinated cessation programs in all health care settings such as hospitals and general practices, as well as more funding for mass media campaigns which have proven results.

Jones believes the Commonwealth is also not taking enough steps to regulate the tobacco industry. 'Cigarettes are legal and the tobacco industry is seen as a legitimate industry, but this doesn't mean tobacco products should not be regulated,' she says. 'One example of where regulation is needed is banning additives that are being used to make cigarettes more palatable with new smokers, but this is not being done and you have to ask why.'

The Australian Government believes that while national campaigns are part of the solution to raise awareness of the negative health effects of tobacco, we also need measures to assist health professionals at the coalface. Current measures include subsidised access to pharmacotherapies, smoking 'Lifescripts' resources for GPs to assist patients when providing lifestyle advice, and resources for Indigenous health workers to address smoking cessation issues in Indigenous communities. Tobacco policy is a partnership between all tiers of government. Other stakeholders, including non-government organisations, also play a significant role.

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OF SUBSTANCE
THE NATIONAL MAGAZINE ON ALCOHOL, TOBACCO AND OTHER DRUGS

1 CLIENT, 2 NEEDS:
HEP C AND THE AOD CLIENT

LIBBY TOPP

In the April 2007 edition of *Of Substance*, we discussed the issues around increasing access for alcohol and other drug (AOD) clients to blood borne virus (BBV) screening, monitoring, vaccination and treatment. We highlighted the need for enhanced funding and workforce development so BBV services can be better integrated into AOD settings. We focused on the need to improve uptake of antiviral therapy for chronic hepatitis C (HCV) infection among people who inject or have injected drugs as this group comprises more than 80% of people infected with this virus; and looked at advances in the treatment of HCV.

In Part 2 of our feature on integrating the BBV and AOD sectors, we present three case studies of AOD settings in which specific initiatives have successfully increased the number of BBV services provided to clients. Although the individual models differ, their results clearly indicate that achieving better integration is possible, and an outcome towards which the AOD sector should strive.

KRC: PRIMARY HEALTH CARE

As discussed in the April edition, primary health care facilities are widely recognised as settings in which it is feasible to increase access to and uptake of BBV services. In Sydney's Kings Cross, the Kirketon Road Centre (KRC) provides a primary health care service delivery model in which it has been possible to 'scale up' services to meet the emerging needs of its target population – people who inject drugs.

Established in 1987 to prevent transmission of HIV and other BBVs among people who inject drugs, commercial sex workers and at-risk young people, the KRC provides a range of services including general medical and dental care, opioid pharmacotherapies and dosing, a needle and syringe program, sexual and reproductive health services, outreach programs, counselling and client support groups.

Since 1999, the KRC has conducted a monthly hepatitis C clinic, providing specialist assessment and treatment, which operates largely within existing infrastructure, the only additional resource implication being the cost of the infectious diseases specialist physician. Screening for HCV and other BBVs is promoted for all clients, and subsequent monitoring of liver function is encouraged for those who screen positive. Those who are both eligible for and considering treatment are referred to the clinic. Although Dr Ingrid van Beek, the Director of the KRC, acknowledges that the centre is relatively well-resourced, she also believes that the principle of upscaling services through existing contact with hard-to-reach populations who are reluctant to access secondary and tertiary care, is more generalisable than current implementation rates would suggest. 'If an "at-risk" population is already attending a health care facility, be it a needle program or a methadone clinic, it is important not to ignore the immediate health promotion opportunities this also provides,' she says.

For more information, contact Ingrid van Beek, phone (02) 9360 2766 or email ivanbeek@ozemail.com.au.

TURNING POINT HEALTHY LIVER CLINIC: INTEGRATED MULTIDISCIPLINARY SERVICE

The KRC shares some characteristics with Turning Point Alcohol and Drug Centre in Melbourne's Fitzroy, a specialist AOD treatment centre providing pharmacotherapy, psychological and psychiatric services, harm reduction programs, legal and forensic services, and medical services, within an individualised case management framework. It has an onsite pharmacy and can accommodate comprehensive service provision for complex drug dependent clients with multiple psychosocial issues. Under the ASHM pilot community prescribers program (see *Of Substance*, April 2007), a Turning Point pharmacotherapy prescriber, Dr Nick Walsh, was registered to prescribe HCV treatment, and in September 2005, the opportunity was taken to establish an integrated service that addressed both opiate pharmacotherapy, and screening for and treatment of hepatitis infections.

The Healthy Liver Clinic (HLC) provides education and support; assessment of hepatitis serology and liver dysfunction; immunisation against hepatitis A and B; risk-reduction information; and treatment for HCV infection.

A multidisciplinary team contributes to the HLC, including the HCV and opiate pharmacotherapy provider, an advanced hepatitis clinician and manager, and a nurse. Specialist infectious disease and gastroenterology physicians from nearby hospitals provide monthly onsite clinics and an on-call service. Due to its location, the HLC can draw on other Turning Point resources, including the dual diagnosis service; AOD counsellors and nurses; and the onsite pharmacists. Recent data collected for an evaluation of the HLC suggests that the integrated, 'one-stop-shop' model of the HLC is popular with clients, and that convenient access to a wide range of staff and services under the same roof is perceived as one of its major strengths.

A relatively unique aspect of the HLC is the employment of a peer worker, Jenny Kelsall, in a shared position with VIVAIDS, the Victorian Drug User Organisation. Jenny is a key recruiting agent and the first point of call for HLC clients. Her position is a broadly defined education and support role during all stages of screening/assessment, monitoring and treatment; and includes identifying and addressing barriers to treatment and devising ways to respond more appropriately to clients' needs.

By empathising with clients and 'humanising' treatment, Jenny acts as a link between client and clinician, advocating for patients to their doctors, as well as explaining aspects of treatment to patients in language they can relate to. Jenny provides practical support in the form of transport to and from clinic appointments and support group meetings, but the majority of her time is spent talking to clients (including after hours) helping them to weigh up the benefits and disadvantages of treatment.

While singing the praises of her HLC clinical colleagues and their ability to communicate with and support clients, she describes the support worker role in the HLC as 'an integral part of treatment, because the drugs can be so savage. You can't just send clients away to deal with it alone, because it just sets them up to fail ... it can be a terrifying process, and without support, they'll get through on good luck, not good practice'.

For more information about the HLC, visit http://hlc.turningpoint.org.au.

CROSSROADS: THINKING OUTSIDE THE SQUARE

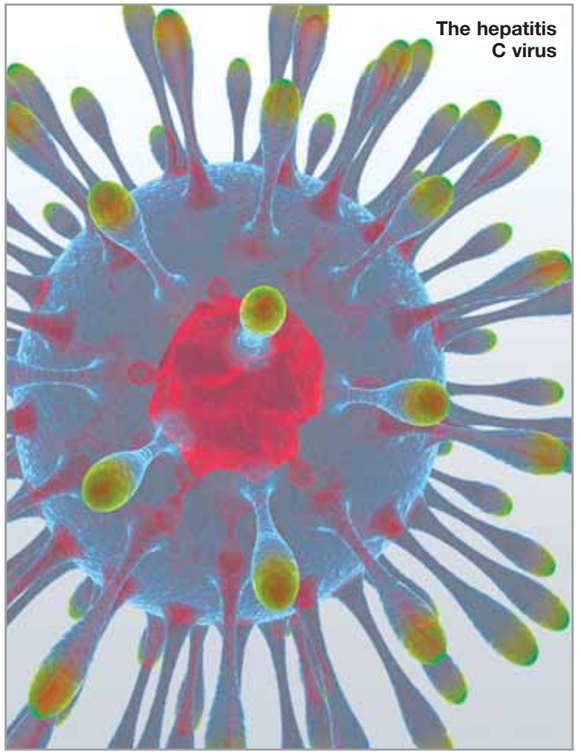
Whereas both the KRC and Turning Point are relatively well-resourced facilities, geographically located in street-based drug markets, and ensconced politically in the development of innovative policy and practice, a recent initiative in a New South Wales rural area proves that dramatic improvements in outcomes can be achieved with a willingness to 'think outside the square'.

In Queanbeyan, part of the Greater Southern Area Health Service, the opioid treatment program provides dosing and dispensing for clients at Crossroads, a stand-alone pharmacotherapy clinic. Despite NSW Health recommendations for BBV screening for opiate program clients, client demographic information indicated that Crossroads' clients were underrepresented in the Queanbeyan Sexual Health Service (SHS). Two previous efforts to improve Crossroads clients' access to the SHS had met with limited success. These included a sexual health nurse attempting to engage clients in the clinic's waiting room to attend the onsite clinical service, and establishing a referral pathway between AOD staff and the SHS, located in a different building.

A third project was planned, involving a sexual health nurse interacting directly with clients by working in a dosing capacity at Crossroads. The idea was for the nurse to establish rapport and trust with clients as she introduced the role of the service to clients. Although the nurse was working in an AOD capacity, the Sexual Health Service covered wages. The nurse was available for clients on a drop-in basis during dosing times, and AOD staff relieved the nurse in the dosary when seeing a client.

After the six-month trial, 40 new clients (77% of all Crossroads clients) had accessed the sexual health nurse, all of whom were provided with education and screening. Seven newly diagnosed cases of HCV infection were identified, seven clients went on to access a liver specialist, and all 13 eligible clients were vaccinated against hepatitis B. Client satisfaction rates were high, and 19 new clients stated that they would not have accessed the service were it not onsite at Crossroads. For the sexual health nurse, Shannon Woodward, involvement in the initiative was extremely rewarding. 'In a small service like Queanbeyan, we don't have clinical nurse consultants or liver clinic specialists, and yet we were able to really increase access to services for this group, with good clinical outcomes as a result,' she says. The ease with which the initiative was implemented surprised her, 'but after all, I wasn't doing anything differently to what I do in my normal clinic, I was just doing it elsewhere.' This progressive initiative, built upon a partnership approach, demonstrates convincingly that impressive results can be achieved without alterations to resource allocation.

For further information about the Crossroads' model, contact Shannon Woodward, phone (02) 6298 9233 or email: shannon.woodward@gsahs.health.nsw.gov.au.



The hepatitis C virus

Image courtesy of Elly Martin

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OF SUBSTANCE
THE NATIONAL MAGAZINE ON ALCOHOL, TOBACCO AND OTHER DRUGS

AUSTRALIA'S APPROACH TO DRUGS AND DRIVING

MEREDITH BUTLER

While roadside testing for alcohol has been in place for some time, testing drivers for drugs other than alcohol is relatively new. By the end of 2008, it is anticipated that all Australian states and the Northern Territory will have legislation and roadside testing programs in place targeting drugs as well as alcohol.

Concern about drug driving has become a major focus of international research, road safety, traffic management and law enforcement policy forums throughout the world. Two sets of findings are commonly cited as central to this concern:

- road crash blood-testing data, which shows a high incidence of impairing drugs (as well as alcohol) in the blood of drivers involved in crashes in which fatalities and/or serious injuries occur
- studies of driver attitudes that indicate low levels of public awareness of the risks of drug driving.

** For the purposes of this article, 'drug' refers to drugs other than alcohol, unless otherwise specified.*

DRUG DRIVING IN AUSTRALIA

Australian studies suggest that drug driving has been on the rise since at least the early 1990s. A 10-year study (1990–99) by Drummer et al. (2004) of 3398 drivers killed in road crashes in New South Wales, Victoria and Western Australia provided the impetus to governments to develop a coordinated response. The 2004 National Drug Strategy Household Survey added to this picture, with more than 60 000 Australians aged 14 and over (4.8% of males and 2% of females) reporting driving a motor vehicle 'under the influence' of drugs other than alcohol in the previous 12 months.

Other studies have shown that those more likely to report driving under the influence of drugs include males, dependent or early onset drug users, professional drivers, polydrug users and people who use drugs but believe that their risk of a crash would not change following their use. A survey in 2005 by insurer AAMI found almost one-quarter of young Australian drivers (22%) reported taking drugs other than alcohol (such as marijuana, cocaine, speed or ecstasy) before getting behind the wheel. Older drivers are an often forgotten at-risk group for drug driving despite their use of multiple prescription drugs.

In the first year of the Victorian roadside saliva testing trial, 13176 tests were performed by police, with approximately one in every 46 (2.2%) drivers testing positive to methamphetamine and/or THC. 'It was clear to us that the rate we were detecting drugs in that 12-month period far outweighed our expectations,' explains Professor Olaf Drummer from the Victorian Institute of Forensic Medicine.

Figures provided by the various state and territory governments for blood testing of drivers/riders killed in road crashes across the various Australian states seem to reveal an even more alarming picture:

- Vic. (2003-04) – drugs other than alcohol were found in approximately 30 per cent of drivers/riders killed
- SA (2003-05) – 22 per cent of drivers and riders killed in road crashes had detectable levels of either methamphetamines or THC or both
- NSW (1997-98) – around 24 per cent of drivers killed had drugs in their system
- Qld (2004) – alcohol and/or drug use was identified as a factor in nearly 35 per cent (104) of road deaths
- Tas. (1999-2003) – one-quarter of road deaths tested positive for illicit drugs
- NT – almost one in three people detained for driving offences tested positive to illicit drugs (DUMA pilot study)
- WA – the incidence of drugs (other than alcohol) detected in drivers who were killed has increased since 2002
- ACT – 21 out of 505 drivers (4.16%) involved in motor vehicle accidents in the ACT tested positive to one or more benzodiazepines and 2.18 per cent tested positive to one or more stimulants such as amphetamine, methamphetamine and MDMA (ecstasy). Evidence of cannabis use was found more often in the blood of injured drivers in the ACT than alcohol, a result which differentiates the ACT from all other Australian states.

(It should be noted that the interaction of alcohol in combination with other drugs is not differentiated in some of these figures and that the figures come from a range of studies, some of which include targeted surveys of specific regions and subgroups which may not reflect trends in the general population.)

A more recent study, conducted by Trauma Service and Emergency Department specialists at the Royal Adelaide Hospital, found evidence of high rates and severity of drug- and alcohol-related trauma in SA (Griggs et al. 2007).

DRUGS OF CONCERN

The main drugs of concern in relation to driving are alcohol, THC (the active ingredient in cannabis), amphetamine-type stimulants (ATS), opiates and benzodiazepines.

Victoria and most other states have chosen to limit random testing to three drugs: THC, methamphetamine and MDMA.

In the Victorian trial, these drugs were chosen because they were the most commonly found impairing substances, after alcohol, in the blood of drivers who were killed; they were not found in any Australian prescription medicine; and they could be reliably detected in oral fluid samples.

Tasmania is, at the time of writing, the only Australian state to extend roadside testing to five substances, including benzodiazepines and opioids. Queensland will become the second state to test a wider range of drugs in 2008. This broader testing range goes beyond the approach established by early Australian programs and raises a number of policy and operational issues, including the potential capture of legal drugs, including morphine and prescribed amphetamines. (A defence is provided under the Tasmanian legislation for a person who can prove they have been prescribed drugs containing either morphine or amphetamines; however, there has been criticism of the reversal of 'onus of proof' that this entails.)

AUSTRALIAN RESPONSES

In response to increasing concerns about drug driving, most Australian states and territories have developed strategies that target three main areas: detection and prosecution of drivers found to have illegal drugs in their systems while driving; detection and prosecution of drivers found to be driving under the influence of drugs; and public education campaigns about drug driving.

Some jurisdictions have had 'driving under the influence of drugs' testing (which tests driver impairment by a wider range of drugs and attracts higher penalties) for several years but the introduction of random roadside oral fluid testing in Australian states and territories since 2004 has attracted much public debate.

Random roadside saliva testing detects recent drug use rather than driver impairment (which critics say is inappropriate under road safety legislation). In Australia, it is characterised by a 'zero tolerance' approach in which no amount of the drug tested for is legally permitted to be present (although levels of sensitivity are set with the aim of avoiding false positives). Victoria had the distinction of starting the first roadside saliva testing trial of its kind in the world in December 2004. This trial (and subsequent program) formed the basis on which driver drug testing in Tas., SA, NSW and WA (from July 2007) have been established. Queensland and the NT are expected to follow within the next year.

ISSUES IN RESEARCH AND PRACTICE

Researchers point out that the study of drug effects (other than alcohol) on driving is complex for a range of reasons including the number of substances of potential interest, difficulties in estimating drug levels and purity, and the complexity of drug/subject interactions.

Swinburne University of Technology's Drugs and Driving Research Unit has been conducting controlled laboratory studies looking in detail at the various drug classes and driving variables affected by their use. In addition to testing a range of driving behaviours using driving simulators, they also test mood and cognition as they relate to driving. To date, the team have tested for alcohol, cannabis, alcohol and cannabis (combined), dexamphetamine and methamphetamine. They are about to embark on a three-year trial of MDMA and anticipate that, by the end of 2008, comparative data should be available on all the drug classes tested so far.

Results to date confirm that different drug classes affect people very differently – cannabis and amphetamines are not metabolised in the same way that alcohol is nor do they have the same effects on the person's responses. Dr Katherine Papafotiou, coordinator of the Swinburne Unit, says this was no surprise to researchers, however the implications for drivers are critical: 'Most of us know how alcohol affects us and makes us feel. But drugs act very differently to alcohol – this is the crucial public education message.'

Another issue for researchers is the implication of using different types of studies – experimental or epidemiological; case control or culpability – and the impact of variations in results on the development of testing programs and equipment. More recent studies, such as one by the Royal Adelaide Hospital in 2007, have included some case control, which researchers believe will have important implications for health, law enforcement, policy making and research in relation to the impact of drugs on a range of traumas.

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Professor Olaf Drummer from the Victorian Institute of Forensic Medicine was instrumental in setting up the Victorian roadside drug-testing trial and is an expert in the field of oral fluid testing and forensic toxicology. He points to some key issues and challenges for future research, including:

- establishing cut-off limits or thresholds for oral fluid testing and issues related to testing, legislating and enforcing 'per se' limits
- range of symptomatology – understanding symptoms of impairment specific to particular drugs
- defining impairment in relation to drug use and driving behaviours
- understanding the wide range of causal factors for road crashes and their relationship to drug use in drivers
- accuracy and reliability of testing devices – issues include establishing sensitivity, accurate detection of specific drugs and avoiding false positives to achieve better confidence in results.

Other issues often raised in relation to drug testing include:

- the implications of variations in the results of different types of studies (and how they are reported) for the development of testing programs and equipment
- the impact of current policing methods (e.g. targeting areas of suspected high use such as truck routes or rave party precincts) on testing results
- the speed at which Australia has introduced roadside saliva testing in (what many say is) the absence of a strong evidence base for specific strategies
- the use of road safety laws to police drug use activity rather than driving impairment
- privacy and civil liberties concerns – including disposal of samples collected, safeguards against the use of oral fluid or blood analysis results to establish offences unrelated to road safety, and limits on police powers to search vehicles or persons.

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DRUG DRIVING STATUS

VICTORIA

Legislation passed in December 2003 allowing the trial of random roadside drug testing (RDT) for active-THC and methamphetamine. The trial began in December 2004. In July 2006, MDMA was added and the Victorian program became permanent.

NEW SOUTH WALES

Legislation comes into force in December 2006 allowing random roadside saliva drug testing, charging motorists with driving under the influence of drugs if impairment suspected, and blood sampling for drivers involved in fatal traffic crashes.

The first conviction under the new roadside drug-testing laws was reported in March 2007.

SOUTH AUSTRALIA

RDT on THC and methamphetamine began in July 2006, with MDMA added in September 2006.

QUEENSLAND

RDT legislation passed in February 2007 and trials conducted. RDT program anticipated to start early 2008.

NORTHERN TERRITORY

In November 2006, the NT Government approved a range of Road Safety Taskforce recommendations for drug driving and an RDT program is anticipated to start in 2008.

TASMANIA

A 'live trial' of four or five devices for roadside testing began in January 2005, with two devices selected that together test for five drugs. Legislation was passed in July 2005 making it an offence to be found with drugs in the body if blood tested (13 drugs) or if positive result in oral fluid testing (5 drugs).

(Note: There is no program of stationary high-volume roadside drug testing in Tas. as in other states, which may be the reason for a higher rate of positive tests relative to other states.)

WESTERN AUSTRALIA

Legislation came into force in August 2007 to allow drug-impaired driving testing and random roadside saliva drug testing for THC, methamphetamine and MDMA .

AUSTRALIAN CAPITAL TERRITORY

RDT legislation was rejected by the Legislative Assembly for the ACT in 2005. Drug Driving Working Party established to consider the implications of RDT initiatives in other jurisdictions for the ACT.

See state and territory government websites for detailed information about legislation, roadside testing programs and penalties.

A DAY IN THE LIFE OF...

KAREN WARD, INDIGENOUS AOD SUPPORT WORKER, CYRENIAN HOUSE, PERTH

The alcohol and other drug workforce covers a wide spectrum of people and jobs. In this series, *Of Substance* introduces you to some of the personalities who work in this field and the work they do.

Of Substance: *What do you do?*

Karen Ward: I am an Indigenous AOD support worker in a therapeutic residential community in the outer northern suburbs of Perth, run by Cyrenian House. The 12-week residential program is designed for both Indigenous and non-Indigenous clients who want to change the way they use drugs and alcohol.

The program encourages a personal exploration of attitudes and behaviours and new lifestyle choices about drug and alcohol use, and the development of self-awareness and self-responsibility. It incorporates individual counselling, educational and therapeutic groups, social, recreational and work activities, and community re-entry skills. Residents can explore and identify issues in depth and develop practical long-term strategies.

Through an arrangement with the Drug and Alcohol Office, Cyrenian House and the Aboriginal Alcohol and Drug Service, eight new beds have recently been dedicated to Indigenous people.

OS: *Describe a typical day on the job.*

KW: My day starts at 8.30 am with a handover and briefing from the night staff. Sometimes I sit with the residents outside their rooms and yarn over a coffee. This helps me get to know them and encourages them to talk informally about their issues. Group therapy sessions, led by an 'MC', begin at 9 am – my job is to participate in these groups and encourage people to get involved. Women and children from the Saranna Women's Residential Program also take part in these groups.

After morning tea I help with educational programs and other therapeutic groups. I also help assess new clients, make follow-up calls, meet new residents and help them settle in, and liaise with their families. In the afternoon I help with clients' work programs, social and recreational activities.

OS: *Do you have any other duties?*

KW: I am helping to start a special Indigenous Program which will look at issues from a cultural perspective. One project I am working on is helping each client to develop a family tree as a starting point for moving forward in their lives. I also support residents in court and at medical and dental appointments, and attend Aboriginal network meetings in the area.

OS: *What challenges do you face?*

KW: My greatest challenge is working with mothers who do not have their children with them at all times. It is very painful for these women. You can't say 'I know how you feel' because you don't. I have three children of my own and I can't imagine how terrible it would be to lose them.

There is not much support for these women outside and they have to be strong, much stronger than I could ever be.

OS: *Where have you worked previously?*

KW: Cleaning, gardening, stacking shelves, teacher's aide – you name it! I got my start in the AOD field when I was still a single mum on the pension. I was given a 'work for the dole' job with the Noongah Patrol, a mediation service for Indigenous people on the streets, and then another job with a sobering-up centre in Midland run by the Aboriginal Alcohol and Drug Service.

My own life has not been much different from many of the clients I've worked with and I have a lot of compassion for them. I don't judge them and I'm not easily shocked! I ended up working full-time with Noongah Alcohol and Substance Abuse Service (NASA) for three years and during that time I also worked part-time for Mission Australia as a family support officer. Then I went to NASA's head office as a family support worker. My next job was at King Edward Women's Hospital where I was the Aboriginal Liaison Officer, assisting social workers and liaising with patients and their families. Then I got this job at Cyrenian House.

OS: *What training have you done?*

KW: When I first started at Noongah Patrol I had no training. I did an eight-week Community Services AOD Certificate 2 course through Mission Australia.

I am now doing a Certificate 3 Indigenous AOD and working towards my Certificate 4 in Community Services AOD which I will attain this month. I've also done one- and two-day in-service training courses in all sorts of things – mental health, Aboriginal legal issues, domestic violence.

OS: *Any advice for people entering the AOD sector?*

KW: Take time out for yourself. I like to read, walk, go shopping. Sometimes I need to have time alone. I love spending time with my kids and my beautiful 2-year-old granddaughter Tazma, maybe just watching a DVD together. On a professional level, don't be afraid to ask for help from your fellow workers and learn all you can from them.

OS: *When was the last time you took a holiday?*

KW: We had a fishing holiday in Geraldton last Christmas. Usually I just take odd days here and there for family reasons but I'm planning a couple of weeks in September just to veg out at home. I'm saving to buy a house so I've got a second job packing eggs at a chicken farm on Saturdays and Sundays – I do get pretty tired sometimes.

OF SUBSTANCE
THE NATIONAL MAGAZINE ON ALCOHOL, TOBACCO AND OTHER DRUGS

WHAT'S IT WORTH?
RESOURCES, TREATMENT & HEALTH

MARIAN SHANAHAN*

What is an economic evaluation?

An economic evaluation is an analysis which compares both the resources (costs) consumed by a treatment (program, procedure, or policy) and its outcomes (outputs, benefits, effects) with the costs and outcomes of another treatment. That is, an economic evaluation measures both the 'inputs' and the 'outputs' in the context of scarce resources. Drummond et al. (2005) suggest an economic evaluation should help to answer the following questions:

- Is this treatment worth doing compared with other things we could do with the same resources?
- Are we satisfied that the resources should be spent in this way rather than in some other way?

Either consciously or intuitively, we consider these questions every time we make a purchase. For example, if we chose car A over car B because, given our personal budget, we prefer the size, fuel economy or engine capacity of car A, we have considered the costs and benefits of our decision. An economic evaluation approaches questions of choice in a structured manner by first identifying the costs and outcomes, then measuring them and finally attaching a value to them.

There are two main types of economic evaluations:

1. Cost-benefit analysis (CBA) provides information on the costs and benefits in monetary terms, allowing the net benefit of a given program to be estimated. This can then be compared to the net benefit of another program. In theory, the results indicate the absolute benefit or value of a program to society. However, in practice many benefits are difficult to measure in monetary terms and thus CBA often includes only those costs and benefits that are easy to quantify. Costs and benefits which are often not captured in this type of evaluation include pain and suffering, and the value of human life, although economists have developed approaches to assist in valuing them.

2. Cost-effectiveness analysis (CEA) compares the costs and outcomes of at least two treatments (programs/policies, drugs) but here the outcome of interest is a single measurable one which is common across the treatments being compared. Outcomes are usually clinical in nature and may be intermediate (e.g. cases detected, abstinence achieved, heroin-free days, decrease in alcohol consumption or cases prevented) or final (life years saved, deaths prevented). If an intermediate outcome measure is used (which often occurs in short-term studies) there must be an identifiable link between the intermediate outcome and a final outcome, or it should be demonstrated that the intermediate measure is of some value in itself.

Cost utility analysis (CUA) studies are a variant of CEAs. A CUA focuses on changes in the quality of life as well as changes in quantity of life produced (or forgone) by a given treatment. One of the most common outcome measures for CUA studies is the Quality Adjusted Life Year (QALY). A QALY encompasses both changes in life years saved and quality of life. QALYs were developed as one method of encompassing multiple outcomes such as improvements in health status, life extension and side effects of treatments.

Where does the data come from?

Data can come from a number of sources but three key ones include the existing literature, a randomised controlled trial (RCT), or expert opinion. In choosing a data source the economist must consider the quality, comprehensiveness and generalisability of the data. Often data collected alongside an RCT must be supplemented by data from other studies or additional data collection to better reflect usual practice.

When economic evaluations of any type are undertaken, economists often prefer to use local data (whether this is health service, state or national) for outcomes, but even more so for costs. It is important to recognise that a decision to use local data yields results which are highly pertinent to the local situation, but these results may not be generalisable to other settings. This is particularly true if there is a difference across settings in the prevalence of the disease, the use of technologies, population structure, or the cost structure. A thorough assessment of each study is required before one can assume that the findings are transferable from one country to another.

What is perspective?

The relative value of the costs and benefits of a program may depend upon the perspective or viewpoint from which the evaluation is conducted. Studies may be carried out from a variety of perspectives including that of the patient, the provider, the health care system, government and the public sector or society as a whole. While a narrow perspective (that of the provider or funder) may be useful for planning purposes at the organisational level, economists prefer a wider perspective (such as whole of government) thus making explicit how the community's scarce resources are utilised.

Discounting: comparing the here and now with the future

In order that programs with long term benefits are assessed equitably (as society generally prefers seeing immediate benefits over future benefits), economists usually discount both costs and outcomes into the future. This is particularly important when the programs being compared have different timing of costs and outcomes (say an immunisation program or a drug prevention program is being compared to the costs and benefits of a methadone program where outcomes are more obvious) as the program whose benefits occur in the future might appear less attractive. Studies should report results both with and without discounting.

Why do we need economic evaluations?

Policy makers are continuously faced with decisions such as how to best use limited resources while obtaining the best outcome for individual clients and for society in general. For example: Should GPs provide brief intervention for smoking cessation or is it more cost-effective to implement telephone counselling? Which pharmacotherapy is the most cost-effective for alcohol-dependent patients? Should every patient enrolled in a methadone program have a case manager? Would stepped care be a more efficient use of resources than the status quo? These are just a few examples of the types of questions for which an economic evaluation can assist with decision-making.

Economic evaluations are particularly useful when a new treatment is both more effective but also more expensive. An economic evaluation produces evidence-based information on what exactly the increased expenditure is achieving, facilitating the decision-making process. Without evidence, decisions are often made with the rationale 'this is what we have always done', or the 'squeaky wheel gets all the resources', often resulting in inefficient allocation of resources.

In principle, an economic evaluation should be conducted on any new drug, technology or program upon implementation. Traditionally economic evaluation was only conducted once something was determined to be effective, however increasingly economic evaluations are being conducted alongside clinical trials permitting the collection of resource-use (cost) data during the trial.

Whose job?

Economic evaluations are traditionally conducted by or under the guidance of an economist or health economist. Some economic evaluations are complex and require in-depth knowledge of economics. More simple ones can be undertaken by clinicians or other researchers, who have an interest in the area, with the guidance of an economist.

Interpreting results

The results of an economic evaluation are presented in the form of an incremental cost-effectiveness ratio (ICER). The ICER is the difference in average costs (of the two treatments being compared) divided by the difference in their average outcome. Simply put, the ICER is the additional costs (savings) that one treatment imposes (gains) over another compared to the additional outcomes gained (lost) should one treatment be implemented over another. The ICER and the total costs of implementing the treatment for a given population should be essential pieces of information for decision-makers when planning the widespread introduction of treatments. However, to date the results of economic evaluations are not widely used in many policy settings. There are, however, some agencies which do require full economic evaluations. Two such examples are the Australian Pharmaceutical Benefits Scheme (PBS) and the National Institute for Clinical Excellence (NICE) in the UK. All submissions for listing on the PBS must have a completed cost-effectiveness analysis as part of their submission. NICE commissions economic evaluations on all new treatments and technologies. The ICER is only part of the decision-making process, as equity, total expenditure and implementation are also considered.

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For more information visit
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