Turning Point
Alcohol and Drug Centre Inc.

Submission to the

PARLIAMENTARY INQUIRY INTO SUBSTANCE ABUSE

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Prepared by:

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Turning Point Alcohol and Drug Centre

Turning Point is a research and development centre based in Melbourne. We are unique in Australia, with a foundation of service delivery which informs our research and allows us an opportunity to test approaches and disseminate the results of research. It also means that we are very much in the real world; among clients who are drug users. We are thus familiar with the patterns and trends in both drug use and harm associated with drug use.

Turning Point is

- responsible for a 24 hour telephone service as well as
- providing treatment for people seeking help. We run a
- secondary needle exchange program and have a
- number of projects in partnership with local government and other organisations.

We see what is happening on the ground.
We conduct research with the expertise of more than 30 researchers covering

- epidemiology (population based trends in drug use and problems including health, road trauma, legal trouble and other impacts),
- evaluation (of programmes in the community as well as conducting randomised controlled trials of new pharmacotherapies which show promise in treatment),
- development and trialing of other new interventions (such as working with family members of clients) and
- community development research.

Turning Point is committed to trying to ensure dissemination of research and the uptake of this in practice. To help with this we have an education and training focus and we are involved in

- tertiary education courses in many disciplines (including medicine, nursing, social work, psychology and education as well as some training with police and ambulance officers) and
- regional training activities including targeting GP's at local levels, pharmacists, district nurses and corrections officers - especially in the juvenile justice area.

Turning Point's research, education, training and clinical approaches as well as our involvement in policy development and advice in this area is constantly informed by the mix of evidence from sound research (our own and others') and evidence from our own day to day experience.

SUMMARY

Turning Point Alcohol and Drug Centre

Turning Point is a research and development centre based in Melbourne. We are unique in Australia, with a foundation of service delivery which informs our research and allows us an opportunity to test approaches and disseminate the results of research. It also means that we are very much in the real world; among clients who are drug users. We are thus familiar with the patterns and trends in both drug use and harm associated with drug use.

Turning Point reports / materials:

In relation to the specific terms of reference of the Committee, we have a range of reports which we could make available. (See Appendix 2).

This submission might best be read as a context setting piece rather than a summary or referenced document with clear recommendations for action. We hope that the Committee might seek further information by accessing our various reports or seeking other information.
Areas covered include:

1. An integrated approach to the use of all psychotropic drugs.
Maintaining an **integrated approach to the use of legal and illegal drugs** is important and helps to keep the use of illicit drugs in perspective.

2. The Continuum of drug use : from initiation to problematic and dependent use and back again.
It is apparent that there are many people who move in and out of use of various drugs and even among those who become dependent, the patterns of use often include periods of more or less use and abstinence.
It is logical and sound to approach drug use as a continuum : from no use to dependent/problematic use.

3. Harm minimisation.
The concept of harm minimisation underpins the current Australian approach to drugs. This is one way we give effect to the recognition that drug use is a continuum from no use to dependent use. It allows for a sound balance of practical responding which is, at the same time, humane.
We need ongoing efforts to intervene in the supply of drugs through law enforcement and legal sanctions, the demand for drugs through prevention, education and treatment programmes and a sustained effort to reduce the harm associated with drug use where interventions such as those associated with the manner of use, the location of use or behaviours associated with drug use is required.

4. Drug use - just one of life's troubles (including implications for primary prevention).

Research and experience increasingly suggest that the various social and behavioural problems of our era are connected. Many of the emerging themes associated with these phenomena appear to relate to a mix of :

- structural determinants including the increase in the differential between wealth and poverty,
- limitations of access to opportunities for meaningful, valued and status linked social identities which most of us acquire through employment, and
- a reduction in the sense of place and "connectedness" or membership of social groups such as families and links to locality.

In approaching any or all of these societal problems it will be increasingly important to examine their commonalities.

5. Partnerships in responding to drug use:

Inter-disciplinary and inter-departmental:
Australia has achieved a level of cooperation between different sectors of the response matrix which provides a role model to the world. The capacity to work together between, for example, law enforcement and health at both national and local level is now accepted as a feature of our policy and programme response to drug use.

Service providers and service users:
It has been possible to engage drug users and those with direct experience of the policies and programmes we have developed in round table discussions.

Government - National, State/Territory and Local:
Many years have evolved a structure which can facilitate the cooperation and consistency of policies and programmes between different levels of government. This coordination and cooperation is essential.
It is clear that local level government is increasingly concerned with the impact of drug use; especially as it effects public amenity, perceptions of safety and public health. There is a need to determine a process and possible structure for inclusion of local government in national policy development.

Government / non-government :
Considerable effort has gone in to establishing new structures which can support the involvement of the non-government sector in providing policy advice as well as in provision of direct services. (eg: ANCD)
The various 'Expert Advisory Committees' especially afford an opportunity to tap some of the breadth and depth of expertise in Australia and here advice is generally strongly evidence based.

Specialist / non-specialist or generic services:
While the intent to cooperate between the specialist sector and generalist services locally is clear, the practice sometimes proves inadequate.
Even when there is experience supporting the importance of drug (including alcohol use) in the aetiology of other social problems such as child neglect and abuse, the actual practice often ignores or cannot readily deal with this aspect of the presenting problems. Similarly, there have been difficulties in

getting some drug treatment programs to be actively involved in appropriately seeking information and assessing / managing child abuse issues

One area of particular need is the link between mental health and drug specific services.

International partnerships:
The extent of readily accessible information about our countries involvement and partnerships beyond Australia seems limited.

6. Treatment.

The key facts which underpin Australia's approach to drug addiction and drug treatment are:

- Drug addiction is a chronic relapsing condition, like asthma and diabetes, and usually requires life-long care;
- Treatment works and reduces drug use, crime and psycho-social dysfunction
- The costs of providing treatment are significantly off-set by the savings associated with its outcomes
- Providing treatment achieves a significant reduction in drug related costs for significantly less investment than law enforcement.

There is no one treatment type that will suit all individuals. Treatment for a drug problem involves many domains: the physical (withdrawal services and diagnosis and treatment of other physical problems); the psychological (counselling and psychotherapy as well as assessment of co-occurring psychiatric illness where present); and the social (rebuilding relationships, employment and so on). Treatment can take place in a variety of settings, such as community health centres, specialist residential drug treatment services, or through a general medical practice.
Turning Point has competed a review/report on the Treatment Service system in Victoria in 1999.

7. Research and development:

Australia is recognised as one of the leaders in research in this area internationally. Since drug related issues raise enormous community interest and emotion, research is essential to help inform public debate. Some of the most important questions in this field are always going to be hard (and thus expensive) to answer. eg: What is the best value for investment between the different responses to drugs? We need a clear research and development programme if we are to be developing the next generation of responses (and not just trying to find solutions to yesterdays problems).

8. **Workforce development.**

There is a need to develop and extend the specialist wokrforce in this area. In addition we need to plan and implement programs to extend the willingness, capacity (through both knowledge and skill development) and supported

opportunity for more appropriate recognition of drug related aspects of presentation in the general health and welfare, education, law enforcement service sector. In some cases this requires examination of impediments such as financial disincentives.
It is extremely difficult to recruit appropriately qualified and experienced staff in this sector currently; related in part to expansion and a lack of workforce development over the past 5 years.

9. Diverse people in diverse places need targeted responses.

In this field as in others, it is necessary to recognise that Australia is geographically 'big' with many different people and different living circumstances who require some generally available combined with specifically tailored responses.

10. Involving Families.

The tendency to want to 'involve the family' is logical and well founded. Families may be critical to interventions at different stages in the 'drug using career'. It is important to recognise that their needs vary and the current call for family involvement needs significant 'unpicking'. Some of the community discussion proceeds without consideration of the quite different stages/needs sub-groups.
There are many families who are keen to be involved in helping to prevent the uptake of drug use. These families are vulnerable to 'quick fix', ''look good', drug specific programmes; some of which are quite expensive. We do not have sound, independent evaluations of such program's to provide evidence based advice at this time in Australia. In prevention, research from other countries suggests that it might be resources and effort applied in the very early years of a child life that offer most promise. It is important that we conduct our own research in exploring these findings over time.
Historic traditions in treatment programs have not been good at involving families. Turning Point is currently finalising an initial report on involving families in treatment

11. **Heroin overdose deaths.**

Turning Point as been associated with research relating to heroin overdose deaths and we are involved in programs with the ambulance service. Over the past year we have initiated a pilot program trying to find ways of responding to those who survive a heroin overdose.

Appendix 1 : Treatment initiatives - responding to opiate dependent people (especially brief summary of substitute pharmacotherapy programmes).

Appendix 2 : Turning Point Research Activities

Introduction:

We at Turning Point welcome the Inquiry of the House of Representatives Standing Committee on Family and Community Services. In our experience, this area always benefits from attention from leaders who take the time to become well informed and to understand the complex and sometimes apparently contradictory elements of drug policies and programmes.

Drug use is a phenomenon of human existence and while much of it is functional or even pleasurable for many users, consumption of drugs in certain circumstances by some users causes enormous trouble and problems for the user, those around them and the whole community.

The overall policy framework of the Australian approach to drug issues is an important backdrop to the specific terms of reference of the Committee. This submission will therefore comment on elements of the Australian approach to drugs; identifying areas of strength and weaknesses and respond to the overarching question : Drug Abuse - How are we handling it?

Turning Point reports / materials:

In relation to the specific terms of reference of the Committee, we have a range of reports which we could make available. These include :

the **Victorian Drug Statistics Handbook** which details the patterns of use of all of the important legal and illegal drugs and patterns of harm associated with this use.

a number of program **evaluations** including specific treatment types and

a range of **treatment guidelines** within Victoria which could be generalisable to other States.

Specific research and review projects include **workplace specific** reports (for the Commonwealth Dept. Health & Aged Care).

We are currently finalising an initial report on **involving families in treatment**. This includes a small survey of clients; development of **guidelines** for such treatment and a report on our experience of running a small pilot project offering family participation in treatment.

Currently we are involved in a pilot project trying to develop responses to those who survive **heroin overdose experiences** who constitute a very high risk group for overdose death. We are trying to find ways of responding to the group in the hope of preventing this outcome in the future.

We would be happy to make our reports available to the Committee. Where relevant these are either identified in the submission text or in a list at the end. Further information would be available on request and, if appropriate, we would welcome a visit from the Committee or any of your members.

Some features of the Australian approach to drug use: How are we faring?

The following areas will be addressed in this submission:

1. An integrated approach to the use of all psychotropic drugs.

2. The continuum of use : from initiation to problematic and dependent use and back again.

3. Harm minimisation.

4. Drug use - just one of life's troubles (including implications for primary prevention).

5. Partnerships in responding to drug use:
   Inter-disciplinary and inter-departmental
   Service providers and service users
   Government - National, State/Territory and Local
   Government / non-government
   Specialist / non-specialist or generic/generalist services
   International partnerships

6. Treatment.

7. Research and development.

8. Workforce development.

9. Diverse people in diverse places need targeted responses.

10. Involving Families.

11. Heroin overdose deaths.

This submission might best be read as a context setting piece rather than a summary or referenced document with clear recommendations for action. We hope that the Committee might seek further information by accessing our various reports or seeking other information.

We particularly welcome the focus on the social and economic costs of substance abuse and assume that the Committee will be needing both descriptive data and examples of policy and program responses which might reduce these costs.

1. An integrated approach to the use of all psychotropic drugs.

Maintaining an **integrated approach to the use of all psychotropic drugs** (those which when taken can influence how we feel, think and/or behave) is important and helps to keep the use of illicit drugs in perspective. Tobacco and alcohol remain the most used drugs of concern and net most harm In Australia in human, economic and health terms. Further, it is clear that there are associations between the use of legal products such as tobacco and alcohol and the uptake of illegal drugs. If we want to stop young people starting, perhaps the first place to start is to stop them taking up cigarettes. There is evidence linking early tobacco smoking with an increased likelihood of taking up marijuana use for example. Delaying or preventing 'starting' can be the aim for preventing both legal and illegal drug use and problems; especially for tobacco and illegal drugs.

In addition, most people presenting for treatment have problems with more than one drug. The era of single drug use has passed. Most have problems with their use of alcohol as well as illegal drugs such as heroin and many more than in the general population smoke cigarettes. Even among heroin injectors, most will die from the effects of their tobacco smoking rather than their heroin use (though current trends in infection rates of Hep C might mean earlier death from liver disease; often exacerbated by alcohol consumption).

New drugs are likely to continue to emerge. The more recent phenomenon of party or 'rave' style drugs and image and performance enhancing drugs are merely the most recent example. Increases in international communications, travel and trade will facilitate the spread of an increasing diversity and quantity of these products. It is difficult to police them notwithstanding the increasingly sophisticated means available to do so.

In this context policies that focus on single drugs or differentiate programmes by the legal status of the products use are difficult to sustain.

Keeping conceptual, policy and programme approaches to illicit drugs clearly in the context and framework of the approaches to legal products is sensible and represents one of the great strengths of the Australian approach to drugs over the past decade. It is admired and envied by people from most overseas countries.

2. The Continuum of drug use : from initiation to problematic and dependent use and back again.

While the media might suggest that most (especially young) people are using a cocktail of legal and illegal drugs, the facts suggest otherwise. Most young people do not use illegal drugs. Even among those who try them, the majority do not move on to persistent use. Alcohol consumption among teenagers is far more widespread than illegal drug use. Much of the alcohol use among teenagers has potential to cause harm - with weekend binge drinking being the norm. This is the current target of the National Youth Alcohol Campaign.

It is apparent that there are many people who move in and out of use of various drugs and even among those who become dependent, the patterns of use often include periods of more or less use and even abstinence.

The treatment career for those who seek help is rarely a straight line to controlled use or abstinence. The more common phenomenon is a number of periods of withdrawal followed by varying lengths of time remaining abstinent. This is similar to the experience of those stopping tobacco smoking; it is rare for quitting to last forever on a first attempt.

It is logical and sound to approach drug use as a continuum : from no use to dependent/problematic use. We can aim to stop initiation at one end and to support cessation at the other. In between there are many interventions available which can reduce the likelihood of harm and it is important to include these in our approach. Suggestions that we need clearer goals related to 'no use' of certain drugs are simplistic. In the treatment domain, this has historically been enormously difficult. Once a client starts to use again, what is the clinician to do? Reject them within some sort of 'contract' which relates to 'abstinence only'? Similarly, as a parent, while you can urge not taking up the use of any of these drugs by your children, what are you to do if they start? Reject them and avoid any other response which might reduce the harm associated with their use? Neither a responsible clinician nor any parent can manage this black/white dichotomy. The all or nothing response is dysfunctional and can be tragic.

3. Harm minimisation.

The concept of harm minimisation underpins the current Australian approach to drugs. This is one way we give effect to the recognition that drug use is a continuum from no use to dependent use and it allows us to conceptualise various interventions that have been very successful in curbing some of the harm and costs to users. their families, those who work with them and the general community.

The concept has suffered considerable attack in recent times. It is a complex phrase and lacks clear understanding in the general community. Simple examples offer one way for people to better understand the concept. In our experience, an opportunity to explain and discuss the notion of harm minimisation leads to general community members support. It allows for a sound balance of practical responding which is, at the same time, humane.

Harm minimisation is defined in the National Strategic Framework for Drug Policy and elsewhere we at Turning Point have written about it extensively in a book published by Oxford University Press - Hamilton, M. Kellehear, A and Rumbold, G (1998) Drug Use in Australia - a Harm Minimisation Approach

Harm minimisation aims to improve health, social and economic outcomes for both the community and the individual. The concept can be meaningfully

applied to the manner in which policing is conducted at local level and In other areas, treatment informed by harm minimisation is a vital component of a humane response, and one that Australians have shown they support.

We need ongoing efforts to intervene in the supply of drugs through law enforcement and legal sanctions, the demand for drugs through prevention, education and treatment programmes and a sustained effort to reduce the harm associated with drug use where interventions such as those associated with the manner of use, the location of use or behaviours associated with drug use is required.

While there is some intellectual attraction in the alternative model or approach of more active regulation, mediation or management of drug markets, Australia would need a better informed community to engage in considerable public debate before such an approach could be comprehensively explored. It is worth noting that some of the most successful policies in reducing tobacco smoking in Australia relate to manipulation of price (allowing for the collection of taxes which help sustain the effort), advertising and promotion and laws and regulations regarding who can be a legitimate seller/purchaser of these goods.
None of these measures are available to us in relation to illegal drugs.

4. Drug use - just one of life's troubles (including implications for primary prevention).

Research and experience increasingly suggest that the various social and behavioural problems of our era are connected. We have seen the emergence of task forces, inquiries, Royal Commissions and the like to examine the phenomena of problems such as homelessness, youth suicide, metal illness, child neglect and abuse, juvenile crime and drug use.

Many of the emerging themes associated with these phenomena appear to relate to a mix of

- structural determinants including the increase in the differential between wealth and poverty,
- limitations to access to opportunities for meaningful, valued and status linked social identities which most of us acquire through employment, and
- a reduction in the sense of place and "connectedness" or membership of social groups such as families and links to locality.

In approaching any or all of these societal problems it will be increasingly important to examine their commonalities. This includes attention to synergies in any new primary prevention programmes including community information campaigns. It also suggest a need to recognise and attend to the links between economic and taxation policies (both general and specific such as alcohol taxation policy) to these problems as well as to the more obvious education, health, welfare and legal policies.

It is clear that these linkages are especially relevant to the Committee terms of reference.

5. Partnerships in responding to drug use:

Inter-disciplinary and inter-departmental:
Australia has achieved a level of cooperation between different sectors of the response matrix which provides a role model to the world. The capacity to work together between, for example, law enforcement and health at both national and local level is now accepted as a feature of our policy and programme response to drug use.

Experience of the value of having high level law enforcement knowledge together with health at national policy forums (such as writing the new draft Illicit Drug Action Plan) and, at the same time, meet with the local community police representatives in Fitzroy to work out a joint strategy for managing particularly difficult individual drug users and protocols which will facilitate their access to and proper use of treatment facilitates is greatly valued. These relationships are vital to an integrated approach to drug use. They require support and nurturing at every level.

Service providers and service users:
In addition, it has been possible to engage drug users and those with direct experience of the policies and programmes we have developed in round table discussions. This provides a perspective which can remind us that good intentions are not enough and can often be ill-informed or misconstrued. Recently when meeting with a range of stakeholders regarding the issue of the possible trial of injecting facilitates in Melbourne, we were reminded that the notion of 'safe' in this context suggests different things to different groups. Local residents want to be 'safe' from the public nuisance associated with public drug trade and drug use such as inappropriate disposal of injecting equipment, interruption to their use of public space and facilitates, their risk of being a victim of crime; health service providers tend to think of 'safe' as being either a place where the risk of injecting related harm such as infection spread or overdose is removed or reduced; police think of 'safe' in this context as a 'safe house' - immune from general apprehension or prosecution for criminal activity while drug users themselves are seeking safety from the violence and hassle from fellow drug users.

Government - National, State/Territory and Local:
Many years have evolved a structure which can facilitate the cooperation and consistency of policies and programmes between different levels of government. This coordination and cooperation is essential. While the Ministerial Council on the Drug Strategy (MCDS) forms a structure which allows such an opportunity with its supporting structure of the Inter-Governmental Committee on Drugs (IGCD) it is difficult to comment on its operation since it is somewhat remote from the general public interested in drug matters.

Over the past 14 years, it has however survived changes in government at both national and state/territory level and the maintenance of such a structure would seem to be essential.

It is clear that local level government is increasingly concerned with the impact of drug use; especially as it effects public amenity, perceptions of safety and general public health. Some locations are more affected that others. There is a need to determine a process and possible structure for inclusion of local government in national policy development. The current structures appear to be a little impermeable in this regard.

Efforts of the Capital City Lord Mayors group to establish some link with National policy and programme bodies are embryonic. While this group clearly do not represent local government, they do have some specific reasons for seeking involvement. Some effort might be necessary to involve a more representative opportunity for local government as well as those with particular interests such as the Capital cities group.

The considerable activity by Local Government in Victoria is documented in a recent report produced by Turning Point through funding provided by the Department of Human Services (Vic). The document 'Responding to Alcohol and Drug Issues: A summary of Local Government Activity in the Metropolitan Area (November 1999). In addition Turning Point is finalising a project funded by the Comm. Dept Health & Aged Care - Community Guidelines Kit and an associated web site which can assist and support local initiatives across Australia.

Given the apparent importance of local or group membership and 'connectedness' in prevention as well as the strength of support networks and local opportunities including housing for recovering drug users in post-acute treatment, local level activity might prove to be more important than has previously been recognised. Policy processes which draw upon the strategies and networks which have already been developed in many locations, including Municipal Drug Action Plans, Local Harm Reduction Networks, Municipal Health Planning and Community Safety Planning could be highly effective in generating sustainable and cooperative action.

Government / non-government :
Considerable effort has gone in to establishing new structures which can support the involvement of the non-government sector in providing policy advice as well as in provision of direct services. While the establishment of a structure such as the Australian National Council on Drugs can facilitate this involvement, it is important that these processes remain transparent and that the mixture of views are clearly apparent in this process.

The various 'Expert Advisory Committees' afford an additional opportunity to tap some of the breadth and depth of expertise in Australia. The advice from these Committees is very strongly evidence based and it would seem that these groups represent the strongest 'expert' forums currently in Australia. The Action Plans (some still formally in draft format as they are still to go to

the Ministerial Council on the Drug Strategy) would seem an obvious source of information for the Committee.

The relationship between government/non-government service providers varies from state to state/territory. With an increase in the tendency for government to become the purchaser of services with the non-government sector being the major providers of services, it is important to retain expert advice to government since it will often no longer be possible for usual government officers to be sufficiently close to service provision to observe, manage, experience and understand shifts and changes in the needs of and potential responses to drug users.

There is a need to develop clear guidelines, data, systematic consideration of necessary levels, location and type of services and the like if we are to systematically address drug use. In the past non-government (and sometimes in government) services have grown in many directions and for multiple reasons. Sometimes based on the experience and commitment of a charismatic individual, the entrepreneurial spirit of overseas programmes or as an extension of service provision in parallel fields, we now have a mix of service types, standards and access arrangements across Australia. Overall there has been an increase in the nature and amount of services available. It is not clear what the necessary menu should be in any locality nor just what information might be sued to inform this planning. Some states have moved to a formulaic determination of service need regarding the nature and spread of services (eg: Victoria) while others have not. Even where this has been done, there is little systematic evaluation of the fundamental assumptions on which the service system elements are based. In addition, over time, ad hoc decisions and new programme initiatives tend to run ahead of or outside the formula contributing to some erosion of the original planning principles.

Specialist / non-specialist or generic services:
While the intent to cooperate between the specialist sector and generalist services locally is clear, the practice sometimes proves inadequate. Most people with drug related trouble have multiple problems. They therefore seek help from a range of community based health, mental health, welfare, housing, employment, financial and legal services. They also invariably need them. They can often be particularly difficult to respond to. They can be demanding, uncooperative, disruptive and disrespectful. They are sometimes intoxicated and/or medically suffering a state of withdrawal. Either state makes it difficult to successfully access services.

Even when there is experience supporting the importance of drug (including alcohol use) in the aetiology of other social problems such as child neglect and abuse, the actual practice often ignores or cannot readily deal with this aspect of the presenting problems. Similarly, there have been difficulties in getting some drug treatment programs to be actively involved in appropriately seeking informaiton and assessing / managing child abuse issues.

The specialist treatment sector can never hope to respond to everyone who uses drugs who needs some service. In fact it is possible that only a minority attend the specialist sector since it is mainly seen as providing assistance to stop using drugs and often their wish is to get the problems attended to; not necessarily focussed on their actual drug use.

The debates in this sector about the place of specialist versus generalist services abound. It is necessary to recognise the importance of a strong specialist sector which can help to facilitate and support the generalist services to more adequately and appropriately respond. Without the back up of a specialist sector, work in this area is made more difficult. Merely the existence of the specialist sector however is insufficient to ensure smooth linkages for clients. Various programmes have been or are in the process of development to try and manage this mix better.

Turning Point has run a range of programs in conjunction with local general medical practitioners in an effort to find a systematic way of supporting them to respond to drug users. (Reports available). In addition we have run programmes in conjunction/partnership with homeless services to provide withdrawal outreach to people who use those services.

Incentives as well as guidelines and protocols appear to be necessary to make these work. A range of pilot or demonstration funding currently available might provide some further experience in this area (eg: GP's involvement with complex case management).

One area of particular need is the link between mental health and drug specific services. A range of National and State forums and pilot projects are currently underway. Sustainability of any initiative seems difficult in reflecting on past efforts in these areas.

International partnerships:

The extent of readily accessible information about our countries involvement and partnerships beyond Australia seems limited. There are significant implications of our commitment to and involvement in international drug policy making and in this context there are other audiences who are especially interested in our policy stance. This includes overseas, external/foreign affairs and diplomatic circles. Australia is an important partner with many other Nations in various international drug policy and programme initiatives through our signatory status to various International Conventions as well as our direct and indirect support of programmes through NIDS funding of work in other countries.

These international involvements occasionally emerge in national forums and debates but their operation and the extent to which the experience, expertise and views of experts and service providers from within Australia in this field are represented is unclear. There seems to be little connection between the diplomatic officers of government and the various structures offering advice on drug policy within the country. It would be unfortunate if our international

officers were not to have access to our own data, research, policy and program experience and instead rely on information sourced from elsewhere.

Comparisons with other countries have value. Too often the data is inadequate and comparisons difficult given the state of the data being used. Specifically relating to the Committees terms or reference, there have been very few analyses of the link between economic and social circumstances and the uptake and problems associated with drug use involving Australia. Such a project is needed. (The ANCD have commissioned a research project which will shed some light on this topic).

6. Treatment.

The key facts which underpin Australia's approach to drug addiction and drug treatment are:

- Drug addiction is a chronic relapsing condition, like asthma and diabetes, and usually requires life-long care;
- Treatment works and reduces drug use, crime and psycho-social dysfunction
- The costs of providing treatment are significantly off-set by the savings associated with its outcomes
- Providing treatment achieves a significant reduction in drug related costs for significantly less investment than law enforcement.

There is no one treatment type that will suit all individuals. Indeed, the greater the array of treatment types the more likely it is that individuals will successfully access and complete treatment. Treatment for a drug problem involves many domains: the physical (withdrawal services and diagnosis and treatment of other physical problems); the psychological (counselling and psychotherapy as well as assessment of co-occurring psychiatric illness where present); and the social (rebuilding relationships, employment and so on). Treatment can take place in a variety of settings, such as community health centres, specialist residential drug treatment services, or through a general medical practice.

Turning Point was commissioned by the Victorian Parliamentary Drugs and Crime Prevention Committee to complete a review/report on the Treatment Service system in Victoria in 1999.[1] There is an Executive summary and set of

[1] . We understand that this report might be made available to the Committee if it were requested directly. Since that Committee did not complete its work and final report prior to the 1999 State elections and since that Committee has not been recalled since that election, access arrangements for the report is a little unclear. It has however been possible for the Drugs Expert Advisory Committee (Vic) to access it and we expect that the current House of Representatives committee could do likewise.

recommendations (identifying strengths and limitations) of approximately 5 pages.

It includes addressing the following areas :

- demand for treatment and its supply
- attracting people to treatment
- population sub-groups
- service system elements including consideration of special circumstances such as prison and juvenile justice facilitates and programmes
- service system
- workforce
- research and development

Attention on the trailing of new pharmacotherpies in the treatment of opiate (and to a lesser extent alcohol and amphetamine) dependence is the focus of considerable research currently in Australia. Other treatments need to be explored including those that arise from the tradition of cognitive-behavioural interventions and community reinforcement approaches which can include significant others in interventions. (For information, a short piece on treatments of opiate dependence is included as an appendix. It focuses especially on substitute therapies/pharmacotherpies and the treatment of withdrawal).

7. Research and development:

Australia is recognised as one of the leaders in research in this area internationally. This is in part related to our efforts to have research and practice closely linked and the mix of research conducted - both quantitative and qualitative as well as descriptive, analytic, policy, programme evaluation and action research. There is still much to be researched and work needed to ensure the uptake of research findings in policy and programme development as well as in direct practice.

Since drug related issues raise enormous community interest and emotion, research is essential to help inform public debate. Much of the misinformation which fuels divisive public opinion occurs with the misuse of research from overseas. It is essential that we maintain our own strong research tradition in this field.

Getting the right balance between commissioned and investigator initiated research is important. In the past we relied too heavily on researcher led agendas; sometimes without attention to the needs of government and service providers. In recent years we are at risk of tipping the balance in the other direction. One of the consequences of commissioning research is that it is not always available in the public domain, sometimes not done under clear and transparent ethical conduct guidelines and those doing it are not always committed to growing the knowledge base and utilisation of the research in the field generally. There is a need for a mix of strategic research on specific topics and broader new knowledge building efforts.

Retaining and growing a critical mass of researchers with sound grounding in the drug area is important. Short term funding is an impediment to this endeavour.

Some of the most important questions in this field are always going to be hard (and thus expensive) to answer. eg: What is the best value for investment between the different responses to drugs? What is the impact and outcome of spending more, for example, on law enforcement compared, say, to drug education or treatment? Without long term, significant funding these questions will never be answered. We have the researchers and the willingness and interest to tackle these 'big questions' but have so far lacked the interest or commitment from government to support it. A project of this sort would require vision, careful cooperative planning between researchers and others from different research groups and a careful feasibility study to determine its viability and ultimate cost. It is a questions few ask since they know the answer is so difficult to obtain. instead we continue to have ill-informed debate about the matter and decisions are made in a vacuum of data; rather based on community opinion polling or its equivalent.

We need a clear research and development programme if we are to be developing the next generation of responses (and not just trying to find solutions to yesterdays problems).

8. **Workforce development.**

There is a need to develop and extend the specialist wokrforce in this area. In addition we need to plan and implement programs to extend the willingness, capacity (through both knowledge and skill development) and supported opportunity for more appropriate recognition of drug related aspects of presentation in the general health and welfare, education, law enforcement service sector. In some cases this requires examination of impediments such as financial disincentives.

The general services require the support and back up (for referral, advice, consultation, supervision and so on) of a vibrant and competent specialist sector.

Too often this aspect is forgotten or left too late. As a result it is extremely difficult to recruit appropriately qualified and experienced staff in this sector currently. It is therefore not surprising that some of the efforts to encourage partnerships between specialist services in the drug area and generic service in health and welfare are hard to implement and sustain.

Various National and State level needs analyses have been conducted and reported on. Their recommendations appear hard to implement; possibly because some actions required cross traditional domains and/or Departmental boundaries. Whatever the reason, unblocking them is essential.

9. Diverse people in diverse places need targeted responses.

In this field as in others, it is necessary to recognise that Australia is geographically ‘big’ with many different people and different living circumstances who require some generally available combined with specifically tailored responses.

This includes indigenous Aboriginal Australians in both inner metropolitan areas of large cities as well as those based in regional towns and more remote communities. These different groups have quite different exposure to drugs and while some communities have problems with solvent use (eg:petrol sniffing among young people), others are grossly impacted on by the patterns of use of alcohol. Injecting drug use is now a phenomenon among inner urban and regional/rural groups as well. In our efforts here at Turning Point to work with aboriginal clients we continue to try different models in partnership arrangements with aboriginal services. None have proven to be especially successful to date in sustainable service delivery, although we have had some individual successes. It does seem that persistence and patience as well as a willingness to continue to try might be the necessary, although not sufficient, ingredients.

Many of our clients are from culturally diverse communities based, as we are, in the inner city area. We have therefore included sub-studies of the acceptability and impact of the provision of new treatments (specifically the new pharmacotherapies) among clients form Vietnamese communities for example.

There are other sub-groups who require specific attention. These include women who, in addition to bearing the main expectation of care given to children and often other family members, find the absence of child care in many services an impediment to access.

Young people who are using drugs to the extent of requiring specialist treatment have special needs that necessitate careful thinking through. eg: Many are still closely connected to family although they might no longer be living at home. There might be negative implications of prematurely labelling young people as drug dependent by involving them in the specialist treatment system; yet they must have access to the best available responses. We are still developing our knowledge of the most appropriate systems to respond and the nature of the best response to this sub-group in Australia.

10. Involving Families.

The tendency to want to ’involve the family’ is logical and well founded. Clearly family of origin is an important determinant of risk for harmful drug involvement - both legal and illegal. While the precise mechanisms might be debated, few disagree that families form the fundamental building blocks for the future life course.

Families may be critical to interventions at different stages in the 'drug using career'. It is important to recognise that their needs vary and the current call for family involvement needs significant 'unpicking'. The interests, opportunities and needs of a family with young children keen to prevent their children's involvement with illegal drugs for example, is quite different to the family who have discovered/realised that a family member is using such drug regularly or the needs of a family where a family member has died as the result of a drug overdose. Some of the community discussion proceeds without consideration of these quite different stages/needs groups.

There are many families who are keen to be involved in helping to prevent the uptake of drug use. They will become involved in any programme that offers a 'solution' or some sense of 'inoculation' against future drug use of their children. We have not been good at tapping this resource of commitment, need and energy in any systematic manner in the past. More recently school programs have worked to include families in their endeavours in the broadly based drug education/prevention effort which is appropriate and probably the best systematic opportunity available.

These families are vulnerable to 'quick fix', ''look good', drug specific programmes; some of which are quite expensive. We do not have sound, independent evaluations of such program's to provide evidence based advice at this time in Australia.

Some research from other countries suggests that it might be resources and effort applied in the very early years of a child life that offer most promise. It is important that we conduct our own research in exploring these findings over time. A start has been made and should be explored and examined by the Committee (eg: Centre for Adolescent Health at the Royal Children's Hospital in Melbourne).

Historic traditions in treatment programs have not been good at involving families, even though there have been many examples of engaging family members from time to time and some special program's have been offered. The family was sometimes seen as the source of problems and too often left out. Some experienced quite punitive responses from treatment personnel.

Turning Point is currently finalising an initial report on involving families in treatment. This includes a small survey of clients of specialist treatment and an assessment of their needs vis a vis involvement of family or friends in treatment. We have developed guidelines for such treatment including record keeping protocols and conducted a small pilot project offering family (partner, mother or sister the most likely) involvement in treatment.

11. **Heroin overdose deaths.**

Turning Point as been associated with research relating to heroin overdose deaths and we are involved in programs with the ambulance service. Over the past year we have initiated a pilot program trying to find ways of responding to those who survive a heroin overdose. We hope that it might be

possible to prevent this very high risk group dying form a subsequent overdose. This program which is funded under the Tough on drug NGO Treatment programme, is proving difficult to implement. We are operating in new territory and there are no previous models of service delivery. We have learnt some of what not to do and have recently re-shaped the programme.

APPENDIX 1 - STRENGTHENING TREATMENT INITIATIVES TO REDUCE THE TOLL OF HEROIN USE

There are a variety of different treatment modalities for heroin dependence. The most effective, as demonstrated by extensive research, are substitution pharmacotherapies. Hence, the following brief review focuses predominantly upon maintenance treatments, however withdrawal treatments are briefly discussed.

Methadone maintenance

Despite its bad public image, methadone has been consistently shown to reduce heroin use, overdose risk, mortality, criminal behaviour and retain clients in treatment (Ward, Mattick et al. 1998). The all-causes mortality for a heroin user not in treatment is approximately 2% per year. This has been confirmed by long term follow up studies (Charpak and Bejanin 1992; Oppenheimer, Tobutt et al. 1994; Fugelstad, Annell et al. 1997). Clients in methadone maintenance die at less than 0.5% per year (Caplehorn, Dalton et al. 1994). This is in contrast to other treatments which are more expensive, ineffective and possibly even harmful. Withdrawal treatments, for example, have led to an increase in heroin related (mostly overdose) deaths (in one Australian study up to 8% at one year post withdrawal). Retention in maintenance treatment is important in reducing mortality, those leaving treatment have up to 8 times the risk of dying in one year as those staying in treatment (Zanis and Woody 1998). Naltrexone follow up data is patchy but seems to have comparable mortality to those not in treatment.

Increased availability of methadone maintenance

Despite the significant rise in the numbers of clients in methadone maintenance treatment in Victoria in recent years, there exist substantially more clients seeking treatment than there are treatment positions. This is evidenced by the difficulty Direct Line have in finding methadone prescribers for people. Given the broad estimates of heroin users in the state it is difficult to know the proportion of dependent users who are in treatment but efforts should be made to get this proportion as high as possible. Rather than setting limits for the number of treatment places however, it seems more sensible to set up a system capable of coping with increased demand if it arises (ie general practitioners). Substitution treatment should be available to all appropriate heroin dependent clients who seek it. Whatever method is used, this will require increased funding from the state. Medicare does not adequately reimburse for the long consultations, increased paperwork, irregular attendance and stress due to working with this group. Clients already pay a disproportionate amount ($1500 per year) given their generally low incomes.

Low threshold methadone maintenance is another method of successfully recruiting clients to methadone maintenance treatment that has been used both here (MAP) and overseas.

Increasing the number of methadone prescribers

Currently our doctors are uneducated about methadone (and drug and alcohol issues in general), overworked and poorly remunerated for complex clients. It is not surprising that there are only a few methadone prescribing doctors. Methadone is by far the most cost effective treatment for heroin dependence and the least subsidised. Doctors have to send themselves to training courses to become methadone prescribers because their basic medical training did not address the issue.

Increasing the number of methadone dispensing pharmacies

Any increase in the number of clients on methadone would need a similar increase in the number of pharmacies. Currently many methadone dispensing pharmacies are not taking

new clients as they are “full”. Access to pharmacies close to where the clients’ reside should also increase the retention in methadone maintenance treatment.

Subsidising client fees

Clients with health care cards have to pay $1300 - $1800 per year for dispensing fees in addition to the safety net cost of other medications. This is approximately 50% of the cost of the entire treatment and seems out of place in a medical system such as ours. The fees are for dispensing fees and thus not part of the PBS safety net for low income earners. This is a significant amount of money for many clients and is a constant source of problems for clients and leads to people attending erratically and dropping out of methadone treatment. Often this is due to poor financial management by clients who run out of money for methadone at the end of their two week payment period. Methadone itself is not on the PBS, but a “Section 100” drug, a schedule for drugs that are to be administered by hospitals free of charge. Further complicating this problem is that there is no framework for supervised dispensing of medications, and for the payment of such. If methadone was to be PBS listed, for example, the prescription would have to be written everyday to cover the cost of the dispensing. A system needs to be developed for the subsidisation of daily dispensing by community pharmacies.

Other maintenance treatments

LAAM

In randomised controlled trials, LAAM has been shown to have similar outcomes to methadone maintenance treatment (Ling, Charuvastra et al. 1976; Ling, Klett et al. 1976; Glanz, Klawansky et al. 1997). The advantage for clients is that it is more convenient, with most clients able to pick up as little as two or three times per week. This would also reduce the cost of supervised dispensing. It has the potential to encourage clients to stay in treatment longer and to accommodate some of those who do not tolerate methadone well. LAAM is being trialed by Turning Point as part of the New Pharmacotherapies Project.

Buprenorphine

Buprenorphine maintenance also has similar outcomes to methadone maintenance with the benefits of less than daily dosing for most clients (Ling, Charuvastra et al. 1998). As a partial agonist it is safer in overdose, has less withdrawal symptoms and less of the sedative effect than methadone. Buprenorphine also offers the potential of attracting a different set of clients into treatment and maintaining them there for longer. Taken over 5-6 days, buprenorphine is also a safe and effective medication for alleviating the symptoms of heroin withdrawal. Buprenorphine is being trailed by Turning Point as part of the New Pharmacotherapies Project.

Heroin Maintenance

The evidence from the Swiss trial is that heroin maintenance is feasible, safe and improved clients quality of life.

Withdrawal

Rather than being the “cure” for heroin dependence, withdrawal services can be viewed as a humane way of providing heroin dependent clients an opportunity to withdraw in relative comfort and to gain insights into the nature of their addiction in the process. Given that heroin withdrawal is not a dangerous condition, and that for most the most dangerous time is when heroin use is resumed with a reduced tolerance, most withdrawal can be managed at home. Responsible prescribing of medications reduces the risk further, ie. methadone reduction regimes, daily dispensing of opioids and benzodiazepines, and use of drugs with a low street value such as clonidine. Lofexidine and buprenorphine offer promise as effective medications that could safely be prescribed on an outpatient basis by general practitioners.

Residential withdrawal services have significantly decreased in Victoria over the last 5 years. Whilst this has been based on cost-effectiveness arguments, many clients require residential services because of their social circumstances. Long waiting lists continue to be highly problematic and very frustrating for workers, families and carers alike.

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Appendix 2 : Turning Point Research Activities (1994 - Current)

While there is some product/report on each of the following research/evaluation projects, some (few) are not readily available as they have been commissioned by government or private (NGO's) bodies.

1994

Author(s)	Title
Brooke, T., Rumbold, G., & Ritter, A.	Evaluative Review - Moreland Hall Community Drug Withdrawal Program. Final Report
King, T.	Geelong Community Health Services Inc. Residential Withdrawal Support Program: Evaluation
Hamilton, M. et al.	Evaluation of the Benalla HALL Program: Drug and Alcohol Prevention at a Local Level

1995

Author(s)	Title
Brooke, T.	Evaluation of Controlled Drinking Project
Brooke, T., Holgate, F., Odgers, P. & Rumbold, G.	Review of Post-Withdrawal Services: Final Report
Carnegie, J., Davis, J., Holgate, F., Hocking, S. & Brealey, L.	Standards in Assessment Practice
Dietze, P., King, T., Crowley, S. & Hamilton, M.	Alcohol and Other Drugs in the Workplace: A Review of Three Demonstration Projects
Holgate, F., O'Reilly, S., Carnegie, J., Murray, T. & McLaughlan, S.	Guidelines for the Delivery of Alcohol and Drug Specific Counselling Interventions
Keenan, M. & King, T.	A Framework and Methodology for the Evaluation of the Redevelopment of Alcohol and Drug Services in Victoria
Lang, E. & Storey, G.	Evaluation Methodology for the Health and Welfare Training and Support Services Program
Carnegie, J. & Ritter, A.	Health and Welfare Training and Support Services Program: A Framework for the Analysis of Alcohol and Drug Training Needs in the Victorian Generalist and Specialist Health and Welfare Sectors
King, T. & Zauder, D.	Health and Welfare Training and Support Services Program: Review of General Practitioner Drug and Alcohol Training Modules
Mellor, N. & Lintzeris, N.	Health and Welfare Training and Support Services Program: Specifications for an Alcohol and Drug Course for General Practitioners
Storey, G., Goldman, S. & Ritter, A.	Health and Welfare Training and Support Services Program: Towards a Strategic Plan for Linking General Practitioners with Alcohol and Drug Treatment Services
Patterson, S.	Inner City Project
Carnegie, J.	Drug and Alcohol Education and Training: Embedding Issues

Author(s)	Title
Dunlop, A., Koutroulis, G., Lintzeris, N., Odgers, P. & Kellehear, A.	A Qualitative Study of Client Perspectives on Non-Residential Withdrawal Treatment
Holgate, F. Fitzgerald, B. & Irwin, H.	Providing a Chronic Pain and Analgesia Service: Issues Arising
Johnson, L., Seall, S., Lintzeris, N., Muhleisen, P., Drosten, P. & Ezard, P.	Community Methadone Worker Project
Kellehear, A., Engelander, M., Lacy, R. & Lang, E.	The Presentation of Self in a Cannabis Treatment Setting: A Qualitative Study
Koutroulis, G., Lintzeris, N., Ezard, N., Muhleisen, P., Lanagan, A., Stowe, A. & Odgers, P.	Evaluation of Community Based Methadone Services in Victoria
Kutin, J., Lintzeris, N., Ezard, N. & Muhleisen, P.	Evaluation of Specialist Methadone Services
Rumbold, G. et al.	Using Population Based Data for Alcohol Service Planning and Monitoring: First Report of the Alcohol and Epidemiology Project (Year 1)
Lintzeris, N. et al.	Methadone Access Program

Author(s)	Title
Carnegie, J., Dunlop, A., Seall, S., Hocking, S. & Brealey, L.	Assessment Standards Validation Project, Part 1 - Specialist Alcohol and Drug Proforma
Carnegie, J., Dunlop, A., Seall, S., Hocking, S. & Brealey, L.	Assessment Standards Validation Project, Part 2 - Generalist Health and Welfare Alcohol and Drug Proforma
Engelander, M., Kellehear, A., Lang, E. & Lacy, R.	An Evaluation of Two Cannabis Treatment Interventions With Self-Defined Problem Cannabis Users: An Interim Report
Lang, E. et al.	Evaluation of a Single Session Intervention with Self-Defined Problem Cannabis Users
Koutroulis, G.	A Qualitative Study of Clinician's Perspectives on Non-Residential Withdrawal Treatment
Rumbold, G et al.	Alcohol Epidemiology project (Year 2)
Fry, C.	Blood Borne Virus Transmission Risk Assessment Questionnaire (BBV TRAQ)
Dietze, P. et al.	Development and Evaluation of MOTIV
Dietze, P. et al.	Evaluation of Transferability of MOTIV
Dietze, P. et al.	Evaluation of CBC Treatment and Testing Policy
Mellor, N.	Managed Care Development Projects: Linkages Between Alcohol and Drug Services and Mental Health Services; Linkages Between Alcohol and Drug Services and Child Protection and Juvenile Justice Services.
Brooke, T.	Evaluation of the 1996/1997 Controlled Drinking Project

Author(s)	Title
Brealey, L. & Ritter, A.	Acquired Brain Injury and Alcohol and Drug Problems: Evaluation of Service Needs
Brealey, L. & Lang, E.	Acquired Brain Injury and Alcohol and Drug Better Practice Project. Phase Two: Demonstration Projects
Montague, M., Alberti, S. & Brooke, T.	Evaluation of Community Drug Withdrawal Services
Alberti, S. & Swan, A.	Youth Outreach Services: A Report on Best Practice
Alberti, S. & Swan, A.	Community Residential Withdrawal Services: A Report on Best Practice
Dietze, P., Rumbold, G., Cooper, G. & Cvetkovski, S.	Non-Fatal Heroin Overdose Project
Rumbold, G. et al.	Measurement of Alcohol Use and Related Harm Within Victoria: Third Alcohol Epidemiology Report (Year 3)
Ritter, A., Kutin., J., Lintzeris, N. & Bammer, G.	New Pharmacotherapies Project: Feasibility Report. Expanding Treatment Options for Heroin Dependence in Victoria: Buprenorphine, LAAM, Naltrexone and Slow-Release Oral Morphine
Rumbold, G.	Illicit Drugs Reporting System (IDRS) - Pilot Phase
Rumbold, G., Fry, C. & Dwyer, R.	Illicit Drugs Reporting System (IDRS) - Melbourne Arm
Hanlin, K.	Survey of the Public Perception of the Victorian Household booklet

Author(s)	Title
Brealey, L. & Lang, E.	Specialist Assessment Form
Storey, G. & Swan, A.	Mutual Self Help and Peer Support Services: Identifying the Therapeutic Ingredients in Drug Self Help Groups
Berends, L., Alberti, S., Brooke, T., Swan, A., Bowen, A. & Ritter, A.	Evaluation of Victorian Residential Rehabilitation Services
Swan, A. & Alberti, S.	Youth Assessment and Intervention Tool
Swan, A. & Ritter, A.	Clinical Treatment Guidelines for Polydrug Use
Engelander, M. & Lang, E.	Clinical Guidelines for the Treatment of Cannabis Dependency
Addy, D. & Ritter, A.	Clinical Treatment Guidelines: Relapse Prevention
Addy, D. & Ritter, A.	Clinical Treatment Guidelines: Harm Reduction and Controlled Use
Addy, D. & Ritter, A.	Clinical Treatment Guidelines: Motivational Interviewing
Dietze, P.	Non-Fatal Heroin Overdose Monitoring Project
Rumbold, G.	Drug Statistics Handbook
Cooney, D., Tyssen, E. & Lang, E.	Review of Drink Driving Guidelines
Ritter, A., Lintzeris, N., Kutin, J., Bammer, G. & Clark, N.	LAAM Implementation Trial (NPP)
Ritter, A., Lintzeris, N., Kutin, J., Bammer, G. & Clark, N.	Buprenorphine Implementation Trial (NPP)
Ritter, A. et al.	Methadone Withdrawal Using Burprenorphine (NPP)
Lintzeris, N. et al.	Heroin Withdrawal Using Burprenorphine (NPP)
Ritter, A., Tucker, T., Kutin, J., Bammer, G., Jackson, H. & Whelan, G.	Naltrexone Treatment Outcome Study - An Evaluation of Naltrexone Treatment in Combination with a 12-Week Counselling Program in Reducing Heroin Use and Improving Physical, Psychological and Social Functioning (NPP)

Author(s)	Title
Ritter, A., Kutin, J., Bammer, G. & Whelan, G.	Naltrexone Side-Effects Study (NPP)
Dunlop, A., Higgs, P. & Jordens, J.	Vietnamese Withdrawal and Post Withdrawal Study (NPP)
Brealey, L., Ritter, A. & Dietze, P.	Neuropsychological Effects of Methadone, LAAM and Buprenorphine (NPP)
Dunlop, A.	New pharmacotherapies and the Koori Community (NPP)
Harris, A. et al.	Health Economic Evaluation of New Pharmacotherapies (NPP)
White, J. et al.	Pharmacokinetics and Pharmacodynamics of LAAM and SROM (NPP)
Mellor, N.	Preventing Violence and Crime at Public Events Project: Implementing Good Practice
Ritter, A. et al.	DCPC Discussion Paper - Treatment Options
Lang, E.	Evaluation of the Regulation of Cannabis Possession, Use and Supply
Keenan, M.	Linkages Between Police and A&D Services
Lang, E. & Heale, P.	Evaluation of the Court Referral and Evaluation for Drug Intervention and Treatment (CREDIT) Pilot
Stockwell, T., Dietze, P., Rumbold, G., Chikritzs, T. & Hamilton, M.	National Alcohol Indicators Project
Ritter, A. et al.	National Evaluation of Pharmacotherapies for Opioid Dependency (NEPOD)
Rumbold, G., Fry, C. & Dwyer, R.	Illicit Drugs Reporting System (IDRS) - Melbourne Arm
Keenan, M., Lang, E., Brooke, T. & Lynch, J.	Self-Directed Learning Kit - Local Community Initiatives
	Cannabis and Driving
Drummer, O., Rumbold, G., Gerastomolous, J. & DeRidder, T.	Fatal Heroin Overdose Project

Author(s)	Title
Dietze, P., Lenne, M., Rumbold, G. & Fry, C.	A Survey of Patterns of Cannabis and Alcohol Use and Driving
Dietze, P., Jolley, D., Rumbold, G. & Bammer, G.	The Identification and Examination of the Risk Factors for Non-Fatal Heroin Overdose: Pilot

1999

Author(s)	Title
Dietze, P et al.	Non-fatal heroin overdose monitoring project
Rumbold, G et al.	Alcohol Epidemiology Project (Year 5)
Berends, L., Brooke, T. & Swan, A.	Evaluation of Victorian Supported Accommodation Services
Rumbold, G.	Drug Statistics Handbook
Keenan et al	Local community initiatives
Dietze, P., Jolley, D., Rumbold, G. & Bammer, G.	The Identification and Examination of the Risk Factors for Non-Fatal Heroin Overdose
Jonas, H.	Alcohol Consumption by Young Australian Women: Patterns, Harms and Influences
Rumbold, G., Lintzeris, N., Dolan, K., Loxley, W., Byrne, J. & Fry, C.	A National Survey of Hepatitis C Risk Practices Among Injecting Drug Users: An Overview of Risk Practices and Their Context
Berends, L., Montague, M., King, T. & Heale, P.	Drug Education for First Offenders (DEFOS): Evaluation
Grindrod, A. & Rumbold, G.	Direct Response to Overdose Project (DROP)
Lang, E. & Brooke, T.	Evaluation of Tasmanian Community Partnerships Initiatives
Rumbold, G.	Illicit Drug Trends and Data Needs in Victoria
Beale, A., Ritter, A., Addy, D. & Alberti, S.	Evaluation of StepOut
Khoo, K., Clark, N., Ritter, A. & Lintzeris, N.	Slow-Release Oral Morphine (SROM) as a Maintenance Therapy for Opioid Dependency (NPP)
Dietze, P., Rumbold, G., Redman, J., Triggs, T.& Lenne, M.	Substitution Pharmacotherapies and Automobile Driving: Implication for Public Safety
Rumbold, G. & Fry, C.	An Evaluation of the Effects of the Heroin Seizure in Port Macquarie Upon the Heroin Market in Melbourne
Lenne, M et al.	Blood Testing of Cannabis and Driving Participants
O'Sullivan, P.	Care, Collaboration and Innovation Project