

Families and Friends for Drug Law Reform (ACT) Inc.

committed to preventing tragedy that arises from illicit drug use

PO Box 36, HIGGINS ACT 2615, Telephone (02) 6254 2961

Email mcconnell@ffdlr.org.au Web <http://www.ffdlr.org.au>

NEWSLETTER

June 07

ISSN 1444-200

NEXT Meeting – no meeting in June

The next FFDLR meeting will be held on July 26. The normal June meeting was replaced by the Drug Action Week Forum and thus there will be **no June meeting**.

Drug Action Week Public Forum held on 18 June 2007

Parental substance abuse, parenting capacity and child protection: always a three way tug of war? Presented by Dr Sue Packer, AM, FRACP

Dr Packer at the forum said:*[there is a] mutual obligation between generations ... [and] ... the safety of every child is the responsibility of everyone associated with the child's life and no one person is to blame. I believe these are two excellent principles to guide the development of more effective services for children of substance abusing families.*

If you were unable to attend Dr Packer's presentation it can be found on our website at ffdlr.org.au.

Editorial

This week the Prime Minister announced a state of emergency in respect of the Northern Territory indigenous people. There is little doubt that something different needs to be done for the appalling state of affairs of those people. And the many reports over many years have been saying just that. This is not unlike the many reports on drugs that still languish on the shelves in government offices.

Here is something of what the PM had to say that caught my attention:

These measures are going to be overseen by a taskforce of eminent Australians. It will include logistics and other specialists and child protection experts. The measures involve a number of actions. Firstly in relation to alcohol the intention is to introduce widespread alcohol restrictions on Northern Territory Aboriginal land for six months. We'll ban the sale, the possession, the transportation, the consumption and (introduce the) broader monitoring of take away sales across the Northern Territory.

Law and order will be a central focus of the measures I've announced. There will be an immediate increase in policing levels, they're manifestly inadequate. The existing laws even with their shortcomings are not being adequately enforced.

So we are to have a prohibition (of sorts) on alcohol for certain people in our community enforced by law and order.

There are many who are sceptical about whether this will prove to be workable – particularly given the failure of prohibition and law and order approaches to stop some other drugs.

Greg Barnes (on Crikey, Thursday, 21 June 2007) is one of those sceptics:

This is no less than a declaration of martial law. Let's not mince words here – this is a Prime Minister who is prepared to suspend the rule of law and democracy simply to get a cheap headline.

Mr Howard justifies his crude tactics – of dubious legality – on the grounds that this is a national emergency. While there is no doubting the social and economic problems in Aboriginal communities today, to describe it as a national emergency and to immediately impose draconian prohibitions is simply playing the crude politics of race.

Does Mr Howard think that banning the sale, possession, transportation and consumption of alcohol on Aboriginal lands in the NT will actually work? He knows as well as anyone that prohibition never works and that all he has done today with his crass announcement is to create an opportunity for a thriving black market in booze.

Jack Waterford, Editor at Large wrote similarly in the Canberra Times (23 June 2007):

Put more policemen on the streets, and intervene more actively against drunkenness, drug abuse, fighting and lack of care for children, and one may make people safer, and help some survive. Make alcohol harder to get (actually alcohol is already banned in most remote communities, but not in the towns) and, with a great deal of police work, one may reduce drinking, while they are on guard.

If we broaden our view and ask “what else is going on here?” There are “*stacks of reports: piling up hundreds of metres*” [Jack Waterford], this government has been in office for over 10 years and until now has done little about dealing with the problem.

There is of course an election looming but the opposition is ahead in the opinion polls. This “state of emergency” may just be the rabbit that many say the PM needs to pull out of the hat if he is to have any chance of winning the next election.

The PM's strategy is very clever. Who could be opposed to saving the children? Any who spoke up could be accused of supporting child abuse in much the same way as those who support harm minimisation are accused of being “pro-drug” and wanting to sell drugs to our children.

The strategy could remind one of the Tampa and children overboard where the opposition was too quick to say “me too”, leaving the electors with no clear indication of the

difference between the two parties who then decided to vote for the one that knew rather than the alternate.

There is an element of that in this "crisis". The opposition this time has also been quick to support the PM's move as Hansard from the Parliament on 21 June indicates:

Mr RUDD (2.00 pm)—*My question is to the Prime Minister. I refer to the Prime Minister's policy announcement just before question time, outlining his response to the crisis of child abuse in Indigenous communities, as revealed in the report Little children are sacred. I indicate to the Prime Minister that I will do whatever I can to work with him to address this response to the crisis of child abuse in Australian Indigenous communities.*

Greg Barnes again:

Given the preparedness of this Prime Minister to suspend the rule of law for base political motives – he did it with Tampa in 2001 – today's announcement should come as no surprise. But let's hope the ALP finds some backbone to oppose this latest assault on rights and freedoms, as opposed to 2001 when it played ball with the Tampa law.

In this up coming elections, as voters, we must be very careful what we wish (and vote) for.

The Ethics of Harm Reduction

Dr John Kleinig will deliver a lecture entitled, "The Ethics of Harm Reduction" on **Wednesday 27 June 2007** at 8.00pm in the Burgmann College Chapel, ANU (off Daley Road) Acton. Admission is free.

Dr Kleinig is Director of the Institute for Criminal Justice Ethics and Professor of Philosophy, John Jay College of Criminal Justice, City University of New York. He also holds the Charles Sturt University Chair of Policy Ethics. John Kleinig is the author of 9 books and in 2006 he edited with Stanley Einstein, "Ethical Challenges of Intervening in Drug Use: Policy, Research and Treatment".

New Code of Ethics for AOD sector launched

As part of Drug Action Week (18-22 June), the Alcohol and other Drugs Council of Australia (ADCA) launched Making Values and Ethics Explicit, a new Code of Ethics for the Australian Alcohol and other Drug Field, in Canberra today (Tuesday, 19 June 2007).

An electronic copy of the publication is on ADCA's website: <http://www.adca.org.au/publications/>

At the launch ADCA Patron, Professor Ian Webster AO, said the new Code of Ethics was a milestone event which provided key statements and resources to guide the AOD workforce while promoting applied ethics engagement as a mechanism for responding to the many challenges in this sector.

Professor Webster put the question "How often do we ask ourselves what should I do or what is the right thing to do?" commenting that questions

about values and ethics are fundamental in all specialty areas of health. "Just as AOD practice must be evidenced based, it should also be explicitly values-based and align with accepted values and ethics of the field," Professor Webster said. "This a new tool for all of us in the AOD field - workers, clients - and will ensure we treat people better."

"The research by Craig Fry, who at the time was a Senior Research Fellow at Turning Point in Melbourne and now at Monash University, was invaluable in compiling the new Code of Ethics."

Prisons, hepatitis C and harm minimisation

Michael H Levy, Carla Treloar, Rodney M McDonald and Norman Booker; MJA 2007; 186 (12): 647-649

The Australian response to illicit drugs is directing a disproportionate burden of drug-related illness, including hepatitis C virus (HCV) infection, into the prison system. Not only is the prevalence of HCV high among prison entrants, but other prisoners are also at risk of contracting HCV while incarcerated. Given the mobility of prisoners between the community and prison, the public health repercussions of prisoner health, for the whole community, are potentially great.

The National Drug Strategy promotes harm minimisation. In contrast, prison policies promote zero tolerance and abstinence-based treatment programs. Australian prisons are not without risk to prisoners and their families; nor to prison officers — in 1991, a prison officer who had been stabbed with a syringe by a mentally ill prisoner subsequently developed AIDS and died.

The highly politicised and insensitive industrial environment in prisons compromises the implementation of harm-minimisation strategies and allows misconceptions to thrive and unfounded fears to remain uncorrected. The following are two examples:

- Exploratory and anonymous discussions around the issue of prison-based injecting-equipment exchange have been avoided by prison officers and then defended by the employing custodial authorities.
- Despite high levels of community acceptance for body art and skin piercing, a planned prison-based tattoo pilot project for Victorian prisoners has never been implemented, due to opposition from prison officers (the idea was "blasted by jail guards").

There has been an absence of bipartisan and consensus-

seeking policy development between the health and custodial sectors in Australia. Despite three national reports calling for changes to blood-borne virus prevention in Australian prisons, there is still only piecemeal implementation of harm-minimisation programs. A federal government report noted that "the implementation and evaluation of prevention efforts for hepatitis C infection in prisons have

Stop Press

FFDLR had been concerned about some aspects of the legislation establishing the ACT's first prison and other correction's managed facilities.

One major concern was about the appointment of the doctor responsible for health treatment in correction facilities. The original Bill vested responsibility in Corrections Management not Health as FFDLR believed should occur.

However FFDLR is pleased to note that during debate on the Bill the ACT Attorney General moved an amendment to vest the responsibility for appointment of the doctor with the Department of Health. The amendment was agreed by all.

Although not all FFDLR's concerns were addressed and the prison may not live up to expectations, nevertheless FFDLR welcomes that change and thanks the ACT Attorney General, Simon Corbell for making it.

lagged behind efforts in the community". Importantly, the document stated that "unless concerted efforts are directed towards the control of hepatitis C transmission among prisoners, it is unlikely that the hepatitis C epidemic in the broader community will be brought under control".

The Australian National Council on Drugs has recognised the role that prisons play in the hepatitis C epidemic. A 2002 position paper specifically recommended the provision of educational programs on drug use, hepatitis C and other bloodborne infections for inmates and custodial staff and the provision of bleach for cleaning injecting equipment.

The 2003 review of the first National Hepatitis C Strategy made the following recommendations:

- That the lessons learnt from the application of harm-reduction strategies in custodial settings in other countries be explored for implementation in Australia;
- That custodial staff be provided with training about HCV in an occupational health and safety context;
- That broad support be given to initiatives designed to divert illicit drug users away from incarceration and into non-custodial alternatives; and
- That nationally consistent standards for education and prevention be implemented in custodial settings.

Current practice

Health education is the most widely employed method of preventing blood-borne viral infections. Prisoners are informed of the risks of infection and transmission, but are not provided with the means of applying this knowledge. The provision of condoms, lubricants, and programs to combat sexual violence recognises the fact that sexual activity does occur in prisons. Pharmacotherapies have been shown to be effective in reducing major risks, harms and costs associated with untreated opiate addiction, and are also associated with reduced viral hepatitis transmission and lower mortality in the immediate post-release period.

The Australian situation is characterised by inconsistent application of harm-minimisation strategies and slow adoption of successful programs between jurisdictions — the first prison-based methadone maintenance program was initiated in New South Wales in 1986, the second in South Australia in 1999.

Two initiatives that could potentially minimise the contribution prisons make to the HCV epidemic in Australia deserve consideration: the provision of sterile injecting equipment and the establishment of professional tattoo parlours in prisons.

Prison-based needle-exchange programs

In 2001, 49% of female prisoners and 48% of male prisoners in NSW reported that they had used illicit drugs while in prison. Of those prisoners with a prison drug-use history, 43% of women and 24% of men had injected while in prison. The specific risks of injecting in a prison environment have been highlighted in anthropological and epidemiological studies.

Since 1992, several jurisdictions in other countries have introduced prison-based exchanges of injecting equipment. Five of six German prison needle-exchange programs were closed for local political, not operational, reasons.

In 2001, a position paper supporting the exchange of injecting equipment by prisoners was developed by the peak injecting drug users' organisation. It has not been considered by any of the eight Australian jurisdictions.

At a 2005 workshop (Prisons and blood-borne viruses: old challenges, new solutions. Consortium for Social and Policy Research on HIV, Hepatitis C and Related Diseases; 2005 Nov 25, Sydney), the case for prison syringe-exchange programs was made. The provision of bleach and methadone is not a sufficient response to the risk of HCV transmission via syringe-sharing among prisoners. Prison syringe-exchange programs reduce the risk behaviours and prevent disease transmission related to injecting drug use. They are safe for prisoners and for prison staff. They have other positive outcomes on prisoners' health, such as increased referral to treatment services, fewer overdose events, and reduced polydrug use. Syringe-exchange programs do not increase drug use or initiation of injecting among non-injectors, they do not undermine abstinence-based programs, and are adaptable to differing prison environments using a variety of distribution methods.

In January 2007, the Queensland State Coroner noted the inability of custodial authorities to keep drugs out of prison, and consequently recommended that an injecting-equipment exchange be provided to prisoners (in Queensland), in addition to access to pharmacotherapies. The Queensland Department of Corrective Services rejected the Coroner's recommendations.

Safe tattooing in prison

The 2001 New South Wales inmate health survey reported that 60% of female prisoners and 58% of male prisoners in NSW said they had at least one tattoo. Of those with tattoos, 37% of the women and 42% of the men had had at least one tattoo done in prison.

The Canadian Corrections Service initiated a pilot tattoo project in August 2005 with an understanding that regulated tattooing would implement higher infection control standards than the existing peer-run clandestine activity. The infection control standards set for the prison pilots exceeded those currently in the Canadian community, but would be consistent with Australian standards. The trial ceased in September 2006. A number of benefits were identified, including better control of tattooing equipment and enhanced education opportunities for both inmates and staff.

Conclusions

As long as Australia fails to provide prison prevention programs for blood-borne viral diseases at community and international standards, our public health and human rights will both be compromised.

The increasing body of evidence supporting harm-minimisation programs for prisoners may soon be tested in an Australian court, with the possibility of Australian jurisdictions being mandated to implement programs that they are poorly prepared for.

The highest priority for federal and state governments is to address the inconsistencies in the way proven harm-minimisation practices are applied across the eight jurisdictions. When that has been addressed, the evidence from prison-based harm-minimisation programs overseas

should be applied in Australia. Our prisons will then be safer to work in, reside in and return from.

ADHD and Stimulant Medication Abuse

by Wendy Richardson, MA, MFT, CAS

(The following [edited] article has been adapted from her book, *The Link Between ADD & Addiction, Getting the Help You Deserve*, (1997) Piñon Press, and her new book *When Too Much Isn't Enough, Ending The Destructive Cycle of AD/HD and Addictive Behavior*, released in January (2005) Piñon Press.)

Treating adults and children with medication has been, and continues to be the subject of great controversy. Even in the face of years of scientific research, advances in understanding how these medications work, and significant improvement in the quality of life for millions around the world, there are still those who question, doubt, and attack the role that medication provides in the treatment of AD/HD.

Even more controversial is treating recovering alcoholics and addicts with stimulant medication. The "evils" of Ritalin have been the target of the media for years. Fear, which is often caused by the lack of accurate information, fuels anti-Ritalin and anti-medication groups. The media, which thrive on controversy, have recently been providing more accurate and scientific information when covering medications to treat AD/HD. Non-biased information that is based on sound research with proven results diminishes fear of the unknown, and squelches myths about the effective use of medication to treat AD/HD.

Stimulant Abuse and Addiction

There has been a flurry of high profile media about the abuse of stimulant medications. Many focus on young people abusing Ritalin, Adderall, and Dexedrine. The truth is; these medications can be abused and the abuser can become addicted. Unfortunately the media tends to draw erroneous conclusions, such as, the use of stimulant medication to treat AD/HD causes drug addiction.

Most cases of stimulant abuse are among adolescents and adults who are not being treated for AD/HD. Adderall and Dexedrine, are abused by people who are trying to get a high similar to speed. Ritalin, however, is often abused as a last resort because it doesn't give the user the euphoria they crave.

Although rare, dependent drug users and alcoholics abuse stimulant medication by taking more than prescribed, or by grinding it up to inhale or to mix with water and inject. Some of these people learned how to present as though they had AD/HD in order to obtain stimulants. In most cases, these people had been given large prescriptions with little or no ongoing treatment for AD/HD or addiction.

Facts About Stimulant Medication

Unfortunately, many still hold the inaccurate belief that treating AD/HD with stimulant medication leads to substance abuse later in life, when in fact the opposite appears to be true.

Untreated AD/HD is a risk factor for developing a substance use disorder later in life.

Treating AD/HD with stimulant medication appears to reduce risk of later substance use disorders by half.

Taking Medication Versus Street Drugs

Here are some important differences between taking prescribed medication and using street drugs.

Stimulant medication is taken orally, at specific times, in dosages that do not create a "high" or euphoria.

Due to the low dosage and lack of euphoria, most people do not develop a tolerance to stimulant medication.

The dosage and quality of medication will not vary. Street drugs can be diluted or cut.

Street amphetamines produce a "high" as a result of much higher doses, and the route of administration (smoking, snorting, injecting).

The intense euphoria produced by high doses of street amphetamines can lead to addiction.

Unlike street drugs, intake of stimulant medication will be closely monitored by the doctor and other support system members.

Conclusion

Many substances including sugar have the potential to be abused by certain individuals. A genetic predisposition for addiction is not the only cause of addiction. Who becomes addicted and who doesn't is determined by a variety of factors. Environment, stress, trauma, life circumstances, and coexisting conditions such as depression, anxiety, post traumatic stress disorder (PTSD), and AD/HD are important contributing factors.

Stimulant medication such as Adderall, Dexedrine, and Ritalin are abused by those who are drug seeking, or addicted. Most people who take stimulant medication to treat their AD/HD do not abuse it. The greater problem is that they forget to take it.

Research indicates that those with untreated AD/HD are at greater risk to self-medicate with substances. Stimulant medication has a protective effect for some with AD/HD and decreases self-medicating. Medication should not be used as the sole treatment for AD/HD. A comprehensive treatment plan is the most effective way to avoid medication abuse or addiction.

The STEPPING STONES course **A PRACTICAL COURSE TO HELP FAMILY MEMBERS COPE WITH DRUG AND ALCOHOL ISSUES**

When: Friday 3 August 07, 5:30pm to 9:00pm

Saturday 4 Aug 07, 9:30am to 5.00pm

Friday 17 Aug 07, 5:30pm to 9:00pm

Saturday 18 Aug 07, 9:30am to 5.00pm

Plus drug information night

Monday 13 August 2007, 5:30pm to 9:00pm

Where: Calvary Hospital, Seminar Room

To register **phone 6207 9977**

Most families have influence over the drug user. This influence may be strengthened when the family understands the process, & accepts support itself.

Topics covered include: coping with stress and anger, tips about communication and about boundary/limit setting - all in order to maximise your health, so that you have the resources to maximise the help getting to the substance user

Cost \$30.00 per family (includes manual **GUIDE TO COPING**)

Run by Alcohol & Drug Program and Ted Noffs Foundation