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The development of a culturally sensitive questionnaire related to Alcohol and other Drug use among Aboriginal and Torres Strait Islander women.

by

Paige Dowd

Submitted as part of course requirement for Honours Degree

Supervisor's Signature: ________________________
Date of Submission: ____________ 2000
Foreword

There are many issues relating to the reasons why I chose this research project. Unfortunately I have lost a number of my close relatives to the use and misuse of Alcohol and other Drugs (A&OD), and their effects.

It is hoped that the information provided in this Thesis, along with the developed questionnaire, will impact on the attitudes and patterns of A&OD use not only for Aboriginal and Torres Strait Islander women, but all women. It is hoped that Aboriginal and Torres Strait Islander women in particular will use their inner spiritual powers, strength and cultural beliefs to help motivate them to quit. It is also hoped that this Thesis will give women the strength to try, for the sake of their health, their children’s health, their families’ health as well as the future health of Aboriginal communities to kick their habits or at least decrease consumption, especially when pregnant.

I do not intend to offend or degrade Aboriginal and Torres Strait Islander women who do use A&OD, however. I merely want to provide you with the facts!
Abstract

This Thesis is Phase 1 of a larger study addressing the use and misuse of Alcohol and Other Drugs (A&OD) by Aboriginal and Torres Strait Islander women particularly during pregnancy. It notes that specific statistics relating to this target group are not readily accessible owing to the under-identification of Aboriginal and Torres Strait Islander women through the information-gathering methods which have been in use for a number of years. The study reviews the literature on A&OD and its effects in general and notes that there is a need for literature specifically designed to inform Aboriginal and Torres Strait Islander women about this issue. A historical overview explains colonisation stress and its social impacts on Aboriginal and Torres Strait Islander communities. Participatory research is used as a means of involving Aboriginal and Torres Strait Islander women in focus groups with the aim of developing a culturally sensitive questionnaire which could be implemented in Phase 2 of this study. The questionnaire developed aims to address underidentification problems by making available a culturally sensitive tool, aimed specifically to cater for the target group, raising awareness, creating.
discussion and generally educating community members about the extent of this problem. This research is one possible stepping stone on the way to heightened awareness of the importance of community consultation as a means of cultural re-empowerment. In conclusion the research study was a positive process benefiting both the participants and the researcher.
Acknowledgements

I would like to acknowledge and thank:

- All of the Aboriginal and Torres Strait Islander Women who participated in this research study, without you this research study would not have been possible.

- All the Aboriginal and Torres Strait Islander women who contacted me in support of this research study.

- All of the Aboriginal and Torres Strait Islander men who contacted me in support of this research study. Your concerns and support confirm that this is not only an issue for Aboriginal and Torres Strait Islander women but the community as a whole.

- My Supervisor Dr Zakia Hossain for the time that you have provided throughout this research study, your valuable research skills and your commitment towards Aboriginal and Torres Strait Islander women's health
• Honors Co-ordinator Dr Freidoon Khavarpour for the support that you have provided throughout this research study.

• Yooroang Garang - School of Indigenous Health Studies for the use of your administrative equipment and financial support.

• All staff at Yooroang Garang especially, Susan Page for your support and encouragement in the beginning. John Grootjans for your advice and support throughout the entire research study process. Shayne Williams for your moral support, valuable research advice and community knowledge. There should be more Indigenous academic staff like yourself, without your academic skills, encouragement and cultural input this research study would not have been completed in such detail.

• My tutor Dr Valerie Delpech for the time that you have allowed for this research study, the encouragement, support and friendship over the past two years. The valuable writing and research skills that you have taught me have enabled me to produce the quality of information that is included within this Thesis.
• My Tutor Vee Spak, the experience and wisdom that you possess have demonstrated the wealth of knowledge that you have developed over time. You have provided me with an abundance of your precious time and this has enabled this Thesis document to be of the quality that it is.

• All of my co-students for your support and friendship throughout my studies.

• Aboriginal Housing Company Directors and Staff for your support in this research study. Without your administrative support this Thesis would not have been possible.

• EORA Centre in Redfern for the support and provision of the meeting room for all Focus Group discussions at no cost. Your generosity has enabled this research process to be a success.

• ATSIC State and Regional Office Staff particularly Alan Hedger, Lisa Dunshay and Jenny Riley for your personal, professional and
administrative support. Thank you also for the provision of the Information folders.

- Carly Sutherland and Richard McGlone for helping with preparation and provision of food for Focus Group participants.

- Nanny Rose for the fond memories of your mothering throughout my child-hood life. My grandfather Jack for the fond memories that you have enable my mother to pass on to us about the “Ponda Rosa”.

- My Grandmother Jopherette, although I never had the opportunity to connect with you physically, you have been with me spiritually.

- My Nanny Julia for rearing my father and instilling your wonderful ways in him.

- My poppy Cecil for the fond memories of the times we used to spend together.
• All of my grandparents for your; courage, love and strength during the depression, and for persisting with society and surviving the battles in this struggle.

• Mum and Dad for the stability that you have provided throughout my life. I will never forget the support and guidance that you have given me. Your loving, sharing and caring ways have helped me to wade through life. I am also grateful for and appreciate your cultural beliefs, morals and stories that you have shared with me during my life.

• My sister Naomi, brother in law Paul and their children Paul Junior (PJ), Alicia, Luke and Dane for their support and assistance with Djanni and Máia.

• My sister Leah (sissy) and brother Brian (Bud), for just being there.

• The Mc Glone whanau, especially Nanny Wiki for the endless aroha she shows her mokos, Máia and Djanni.
• Rick, Djanni and Máia for giving me the inspiration to go to University. Thanks also for putting up with me during the hard times especially the last two months prior to completion. My life would have no meaning if I didn’t have my boys to share it with.

• Special thanks also to Rick for your artistic skills in drawing the picture on the cover of the information folder for me. This picture has meaning and provides me with an unexplainable feeling every time I look at it. I hope that this picture provided a mutual feeling to all especially the women.

• Lastly, I would like to acknowledge all of you Aboriginal and Torres Strait Islander women, who have or want to have children. I know it’s hard being a mother, however I have also learnt that it’s hard being a child. I am hoping that this research study will help you to understand how important it is to give your child or children;

The right-start in Life!
Dedication

This Honours Thesis is dedicated to my family members who are no longer with me, of whom some have suffered poor health conditions as a result of the misuse and abuse of A&OD, or their associated effects.

I also dedicate this Honours Thesis to the family members that were unfortunate to have lost their lives, as a result of poor health conditions directly associated with the copious impacts of the invasion, social injustice and the profuse inequalities that Aboriginal and Torres Strait Islander people are continually facing.

Although you are no longer with me, you will always be apart of my family and me. You have left us, however your fond memories are imbedded deep within in my heart and soul.
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(Research Questions, Background, Aim, Objectives, Focus Group Process, How the Research will be conducted)

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CHAPTER 1
Background

1.1 Introduction

This project is the first phase in a larger study of Aboriginal-and Torres Strait Islander women which aims to collect data on the patterns of use and knowledge among Aboriginal and Torres Strait Islander women, particularly during pregnancy.

The inspiration for this research topic came from the time in 1998 when I was trying to find statistics for an assignment about the effects on Aboriginal and Torres Strait Islander women particularly during pregnancy. This coincided with my own pregnancy, which was another factor that sparked my interest in the subject.

At that time I found it completely impossible to find specific statistics I needed relating to Aboriginal and Torres Strait Islander women. This was astonishing to me as I realised this was a major problem for our women nationally, and yet there was no official recognition of the problem and it was not being investigated or documented. The question in my mind was that if the research was not being done and
the statistics not being collated, how would it be possible to develop policies and programs which could effectively address the issues and / or alleviate the associated problems.

Having experienced one difficult premature birth has given me an insight into the difficulties babies can experience as a result of their mother’s lifestyle and lack of awareness or knowledge about the effects of their actions on their unborn child. This could also impact later, on the mother, father and whole family, if feelings of guilt arise, or if the child dies or is removed because it is regarded as being at risk.

In this first phase, a culturally appropriate questionnaire was designed and piloted with a group of Aboriginal and Torres Strait Islander women during three focus group discussions.

In Phase 2, which is not a component of this Thesis, the findings of this project will be used to survey a large group of Aboriginal and Torres Strait Islander women in New South Wales (NSW).
A list of the abbreviations that have been used throughout this Thesis is included in Appendix 15.

A glossary of terms is included in Appendix 16 in order to help Aboriginal and Torres Strait Islander women and general readers to understand unfamiliar words and terms.

1.1.1 Overview of Thesis

Chapter 1

Sets the context of the study by providing a literature review and general overview of the history, effects and social impact of A&OD on Aboriginal and Torres Strait Islander communities and women, particularly during pregnancy.

Chapter 2

Provided the methodology used for this project and the reasons for choosing participative research methods.
Chapter 3

Provides responses to the 3 focus group discussions held and an analysis of the process.

Chapter 4

Provides the results section, a discussion of the methodology used and its appropriateness for the purposes of the research, as well as comments on its cultural sensitivity.

This chapter also includes the conclusion, summarising the outcomes of the research process, recommendations for implementing the information-gathering tool are also been included.
1.2. LITERATURE REVIEW

The literature which was reviewed covered issues of the impact of colonisation on Aboriginal and Torres Strait Islander individuals and communities as underlying factors contributing to general lack of wellbeing in Aboriginal and Torres Strait Islander communities. There is a problem of under-identification of Aboriginal and Torres Strait Islander women in the general literature.

1.2.1 Historical Context

Aboriginal people were dispossessed of their land without any benefit of treaty, agreement or compensation. The loss of their land meant the destruction of the Aboriginal economy, which was based upon hunting and foraging. The loss of land threatened Aboriginal culture which all over Australia was based upon land and relationship to the land (RCIADIC 1991, p 7).

Aboriginal people have been disadvantaged as a result of colonisation and the impact of policies of assimilation,
disempowerment, dispossession, loss of independence and loss of self esteem which has been forced upon them by this country’s history (RCIADIC 1991, pp. 7-11).

The extent of massacres, cruelties, policies of protectionism, the establishment of missions, identity certificates, movement passes, as well as the forced removal of children, are issues that have impacted on Aboriginal and Torres Strait Islander people, exacerbating their disadvantages (Saggers & Gray 1991, p. 384 cited in Jopson 1999, p. 7).

In this process Aboriginal cultural and spiritual beliefs were disrupted. Continuing poor relations between Aboriginal and non-Aboriginal people have been influenced by racism.

Not until the 1967 Referendum, when the Commonwealth was given power to legislate for them, were Aborigines given the right to vote, or to be admitted as Australian citizens (Bates and Linder - Pelz 1987, pp. 39 - 40).
Both Aboriginal substance misuse and racism are highly emotive and politically sensitive issues. In Australian society people with alcohol or drug problems experience significant discrimination from all sectors – economic, political, social and welfare. Altogether it is hardly surprising that the result is a highly marginalised and discriminated against minority; a fact that raises issues of racial intolerance and human rights violations both within the wider community and the alcohol and drug field.

Racism is a common attitude today. It is also a term that is much bandied about. Few people enjoy being labeled racist, but perhaps more than we intend to or realise, many of us act in a racially intolerant or ethnocentric way. The origins of racial intolerance lie predominantly in the ignorance, misconceptions and stereotypes that emerge from the majority of the non-Aboriginal population (Davis 1998, pp. 84 - 86).

Despite these factors, discussion of A&OD issues in relation to the Aboriginal population tend to draw on stereotypical images of groups of drunken Aboriginal men in a public park drinking cheap alcohol and
disturbing the peace. This pervasive stereotype is emotive and retards any real efforts to resolve the problems. Stereotypes are generally born of ignorance and prejudice. They reinforce intolerance and discrimination— a vicious cycle to break (Hamilton, Kellehear and Rumbold (1998, pp. 84 & 89).

The Aboriginal Health situation at present, combined with housing inadequacies, high unemployment rates and the lack of education amongst Aboriginal people are major factors that have contributed to the slow and painful destruction of partial and, in some areas, whole Aboriginal communities (RCIADIC 1991, pp. 7-11).

Researchers believe that these factors have contributed to the current poor status of Aboriginal and Torres Strait Islander peoples' health. With the breakdown of Aboriginal communities, many Aboriginal people lose their way, resorting to excessive drinking, leading to violent behaviour and other traumas in society (RCIADIC 1991, p. 11).
The belief that alcohol problems affecting Aboriginal and Torres Strait Islander communities are a dramatic consequence of colonisation, racism and social disadvantage is widespread amongst researchers, Aboriginal and Torres Strait Islander Health Workers and Aboriginal and Torres Strait Islander people. Consequently, the recovery of culture and spiritual healing as a means of treatment is strongly advocated by Aboriginal and Torres Strait Islander people working in the treatment field (Health and Aged Care 1998, p. 50).

1.2.2 Demographics and Current Health Status of Aboriginal and Torres Strait Islander people.

Aboriginal Australians are a marginalised minority group. In 1971 Aborigines were counted in the census for the first time, and it was found that less than 1% of the population were Aboriginal. In 1989 approximately 1.5% of the overall Australian population was Aboriginal. According to the ABS summary booklet (1999b, p.2) results from the most recent Census in 1996, revealed that Indigenous people made up about 2.1% of the Australian population. Three-quarters live in towns and cities and the remaining one -

Since the redefinition of the term “Aboriginal”, which asks people to define themselves as Aboriginal or Torres Strait Islander, statistics show there has been an increase in population (Bates and Linder-Pelz 1988, p. 40). A notable factor is that these statistics are drawn from those Indigenous people who identified at the time of the census.

While the past two decades have seen significant government expenditure and some health improvements, Aboriginal health remains worse than that of other Australians, as does their socioeconomic status (National Aboriginal Health Strategy Working Party (NAHSWP) 1989; Thomson 1989, cited in Hamilton, Kellehear and Rumbold (1998, p. 86).
Life expectancy of Aboriginal and Torres Strait Islander people in Western Australia (WA), South Australia (SA) and Northern Territory (NT) is 20% lower than that of non-Aboriginal Australians, particularly in the age bracket 25 - 54 years. Life expectancy for Indigenous Australians is also lower than in most countries of the world, with the exception of central Africa and India. In fact Aboriginal and Torres Strait Islander people in Northern, Central and Western Australia have a lower expectancy than any other Indigenous minority within first world countries (Kunitz 1994, pp. 24 - 25 cited in Moloney and Mozley 1998, p. 2).

1.2.2.1 Patterns

Reid and Trompf (1991) have stated that,

“To date very little work has been undertaken that attempts to characterise the patterns of drug and alcohol abuse among Aborigines” Reid and Trompf (1991, p. 193).

Patterns of substance use are difficult to identify in any community and much of the research into Aboriginal substance misuse has suffered from problems of methodology, including biased sampling and consumption quantification difficulties. It is difficult to make generalisations from existing research because most of the work to
date has been conducted in remote and isolated communities.

However the small amount of data from studies of urban Aboriginal people suggest that drinking patterns among urban Aboriginal people are similar to those in non-urban groups (d'Abbs et al 1994; Perkins et al 1994, cited in Hamilton, Kellehear and Rumbold (1998, p. 87).

Interestingly, alcohol consumption patterns among both urban and non-urban Aborigines are similar to those of other indigenous groups, especially Maori’s and American Indians (Brady 1991; Hunter 1992, cited in Hamilton, Kellehear and Rumbold (1998, p. 87).

The studies that have been completed tend to show a lot of variation from community to community, but the trends tend to hold true across surveys. Women are often non-drinkers while men are more often drinkers, especially young men in the 21-30 year age group. The older the man becomes the more likely it is that he will drink alcohol (Khan et al. 1990; Flemming et al. 1991, cited in (Hamilton, Kellehear and Rumbold (1998, p. 87).
The most worrying pattern is the method of consumption. Of those that do drink, an alarming number consume alcohol at harmful or hazardous levels. Binge drinking is also a common method of consumption.

The consequences of these patterns of alcohol consumption are both direct and indirect and include the adverse consequences of excessive alcohol consumption seen in any population. The social status and cultural traditions of Aboriginal people exacerbate these consequences and produce some problems specific to Aboriginal people.

1.2.3 Lack of Data for Aboriginal and Torres Strait Islander People.

Needs, trends and other relevant Health issues are identified through data collection systems that provide an understanding of disease profiles in the community. This enables funding agencies and service providers to identify, develop and implement appropriate strategies and action plans.
Australian health authorities have expressed concern about Aboriginal and Torres Strait Islander health and health statistics. One problem with interpretation of data relating to Aboriginal and Torres Strait Islander peoples has been the lack of good information on their demographics. It wasn’t until 1996 that all States and Territories collected Aboriginal and Torres Strait Islander statistics. Advances in quantifying the Aboriginal and Torres Strait Islander populations are essential to improving mortality and morbidity statistics (Health and Aged Care 1998, p. 177).

There have been numerous initiatives in relation to improving the quality of health statistics relating to Aboriginal and Torres Strait Islander people. In 1996 a workshop on best practice and quality assurance for Indigenous identification in administrative health data was held, resulting in the formation of a Working Party to oversee initiatives aimed at evaluating and improving identification in a range of health data collections (Health and Aged Care 1998, p. 177).

Consultation and co-operation with communities is essential when developing data collection systems. This would ensure that...
confidentiality and privacy concerns are addressed, particularly in relation to how the data is accessed and used by government departments. Data then needs to be presented to communities and organisations in an understandable and useable format. The use of graphs and visual graphics would aid when literacy and numeracy skills are not well developed.

Data are now slowly becoming available through various sources. The Australian Bureau of Statistics (ABS), over the past four years with finances being made available from Aboriginal and Torres Strait Islander Commission (ATSIC) and State and Territory governments, has embarked on a number of major statistical collections in relation to Aboriginal and Torres Strait Islander people. In 1997 and 1999 the ABS in conjunction with the Australian Institute of Health and Welfare (AIHW) published reports on "The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples" which aimed to provide statistics and information that will allow the monitoring of indigenous health and welfare over time (ABS & AIHW, 1999, p.7). Aboriginal and Torres Strait Islander communities, the Commonwealth Government and Aboriginal health services have
also undertaken studies where resources have permitted (Moloney and Mozley 1998, pp.1 - 2).

Under-identification of Indigenous mothers and babies has been noted. A study in Victoria by Robertson (1994, cited in ABS 1997, p. 61) questioned 54 midwives on how they actually filled in a perinatal form and whether they had difficulty with the question on Indigenous Identification. Most midwives revealed that they felt uncomfortable asking the question and they felt that the question might have an adverse effect on their relationship with the women. For these reasons the quality of Indigenous identification statistics collated from perinatal forms completed by the midwives or the doctor are questionable.

The reported number of Aboriginal or Torres Strait Islander mothers giving birth in NSW increased from 1,456 in 1993 to 1,842 in 1997. Part of this increase is likely to be due to an increased willingness of Aboriginal and Torres Strait Islander mothers to identify as Aboriginal or Torres Strait Islander (NSW Health Department 1997b).
The NSW Midwifes Data Collection statistics collected in 1996 found that 2% of all babies born in NSW during 1996 were to Aboriginal and Torres Strait Islander mothers and 25% were from the New England area. One in five Aboriginal and Torres Strait Islander mothers were teenagers whilst three quarters were aged between the ages of 20 and 34 years. Furthermore over 10% of the Aboriginal and Torres Strait Islander babies born were premature, which is one and a half times higher than the overall NSW rate. It was also reported that 60% of the Aboriginal and Torres Strait Islander mothers smoked during pregnancy, with only 21.1% of all the mothers in NSW smoking at that time. (The NSW Midwifes Data Collection 1996, cited in Nichols and Hurley 1999, pp. 24 - 25).

1.2.4 Health Effects of Alcohol and Other Drugs

The effects of alcohol consumption can impact upon the health of others, for example through road trauma caused by drink driving, and alcohol related violence (English et al. 1995 cited in the Report of the New South Wales Chief Health Officer 1997, p. 73). In addition to this it contributes to the social dysfunction of the user, and may result
in neglect of children and the destruction of the family unit (NAHS 1989, p. 192 cited in Abbott 1988, p. 12, National Association for Prevention of Child Abuse and Neglect (NAPCAN) 1999). This harm is mainly emotional or psychological but occasionally can be physical. It states that the misuse of drugs can affect the way people parent and care for their children indicating that more than a third of children with a parent who misuses drugs suffer some form of child abuse or neglect. However not all parents who use drugs abuse or harm their children although persistent drug misuse by a parent does have detrimental effects on the wellbeing of children. The formation of a person's identity and self-esteem can be affected very strongly by experiences that occur in the earliest years of life. If these experiences are negative as a result of a drug-using parent, then the effects can be long lasting. The high prevalence of alcohol consumption in adolescents may be related to parents acting as negative role models for their children. Whilst surveys addressing this question have involved fairly small sample sizes, they still indicate this trend quite strongly with 59-83% of young men drinking alcohol, and this number may be increasing (d'Abbs et al. 1994, cited in Hamilton, Kellehear and Rumbold (1998, p. 87).
The effects of Alcohol and Other Drugs misuse of children are listed in a NAPCAN brochure entitled, Drug and Alcohol Misuse in Families Hurts Children Too! (see Appendix 13).

Foetal Alcohol Syndrome (FAS), Foetal Alcohol Effects (FAE), Alcohol Related Neuro developmental Disorders (ARND) and Alcohol Related Birth Defects (ARBD) are all disorders associated with pregnant women consuming alcohol (Disability Information and Resources Centre Inc. 2000, p. 1).

Across a range of ARBD, FAS is seen as the most severe and FAE as less severe, with a whole range of defects in between. The effects of the syndrome are irreversible.

Research was carried out in 1987 in Perth, W.A., to assess women's knowledge of how alcohol and tobacco affects the foetus. Of the 1000 women surveyed, it was found that only 30% had received advice from doctors concerning alcohol and 44% had received medical advice on smoking during pregnancy. Only 22% of the women had heard of FAS. The report also noted that about 30% of
women believed that alcohol consumption above the recommended Australian guidelines for pregnancy was completely safe for the baby. A similar percentage of women stated their intention to drink in a future pregnancy (Blaze - Temple, Carruthers, Binns & Knowles, 1992, p.32). More than three drinks per day several times per week have been recorded as the amount responsible for producing a spontaneous abortion and a range of ARBD. An American study found that doctors were less likely to tell Afro - American women to quit smoking and drinking during pregnancy than to tell white women (Guyan, 2000, FAS Fact Sheet 1998, p.2).

A 1981 Tasmanian report recorded that 56% of women drank alcohol during pregnancy, and 10% of the drinkers consumed three to six drinks per week or more. Adverse effects on the foetus of maternal alcohol consumption include: growth retardation, neurological abnormality, facial dysmorphology and damage to major organ systems (Blaze - Temple et al). Specialist Education Services (2000, p. 1) include other effects such as damage to the central nervous system, intellectual disability, behavioural problems, language disorders as well as cardiac and skeletal abnormalities.
Although FAS statistics are not published for Australia, the W.A. Birth Defects Registry records about 1.5 cases of FAS each year, which may seem to be quite low. However researchers have noted that true ARBD is under-diagnosed and often misdiagnosed as the symptoms are similar to some other conditions (Blaze-Temple et al, p.32, NOFAS 1998, p. 2).

Claire Guyan (2000) report notes that:

"Alcohol passes undiluted from the mother's bloodstream to the baby's. The baby then excretes it into the amniotic fluid, creating an alcoholic bath which increases with each drink the mother takes" (Guyan, 2000, p.1).

At present the current literature does not provide adequate data on the incidence of FAS among Aboriginal and Torres Strait Islander women. As a result of this limited data, it is evident that there is a need for further research into this area with Aboriginal and Torres Strait Islander women.
1.2.5 Alcohol and Other Drugs use and effects among Aboriginal and Torres Strait Islander people.

Statistics from the 1994 Urban Aboriginal and Torres Strait Islander Peoples Household Survey supplement are provided by the Centre for Education and Information on Drugs and Alcohol (CEIDA) on their web page. The statistics show that 62% of the Aboriginal and Torres Strait Islander community drank alcohol compared with 72% of the general urban population. However those who drink alcohol consume much higher quantities than the general population. It was shown that 54% of urban Aboriginal and Torres Strait Islander people are current smokers, compared to 29% of the general population.

Illicit drug use is more widespread among the Aboriginal and Torres Strait Islander urban community than in the general population, with 50% having tried an illicit drug compared with 38% in the general community. The survey also revealed that 24% are current users compared with 15% in the general population.

A&OD misuse is a well-known cause of ill health among non-Aboriginal communities throughout the world, Aboriginal and Torres
Strait Islander people throughout Australia, as well as other Indigenous races such as the Maori people and the Native Americans. Alcohol misuse affects health in a number of ways. These include acute physical effects, such as intoxication, alcohol overdose and chronic physical effects, such as cirrhosis and heart disease. The effects of alcohol stretch far beyond the individual. In Aboriginal society this may be even more marked due to cultural traditions of sharing. The fact that so many Aboriginal people live below the poverty line further exacerbates the effects of alcohol excesses. Alcohol and other substance misuse contributes to family breakdown, domestic violence and financial and legal problems.

Alcohol abuse is a significantly recorded health problem in Aboriginal deaths and is reported for 27% of all deaths. Aboriginal relative mortality risks are greatest between the ages of 35 and 44, and are the peak years for reporting alcohol use as a significant problem (Julienne et al. 1993, p. 6, cited in Reid and Trompf (1991), p. 204).

The NSW Adult Action Plan (1998, p.3) states that the high level of morbidity and mortality associated with excessive alcohol use has
seen alcohol become acknowledged as a serious public health issue in NSW.

June Hurley, an Aboriginal Health officer for the Aboriginal Maternity Service at the Gunnedah Health Service believes the following are attributable factors to the high morbidity and mortality rates amongst Aboriginal mothers and children (Nichols and Hurley 1999, p.26).

- no or low antenatal care
- a high percentage of tobacco usage and abuse
- high adolescence pregnancy rates
- poor nutrition habits and,
- various other health problems associated with poor lifestyle factors (Nichols and Hurley 1999, p.26).

Nearly all Aboriginal and Torres Strait Islander respondents of the NDS, HS, UATSIPS (1994, p.52) nominated alcohol as the biggest problem in their area and generally for Aboriginal people. It was found that over 62% of the general population of Aboriginal and
Torres Strait Islander people drink alcohol and males tend to be more hazardous drinkers than females (NDS, HS, UATSIPS 1994, p. 1).

The New South Wales (NSW) Health Department has adopted a policy approach of harm minimisation with respect to the use of alcohol, involving a range of strategies including demand reduction, supply control, controlled use, safer use and abstinence (Report of the New South Wales Chief Health Officer 1997, p 73).

In 1995, the Minister for Health, Dr Andrew Refshauge, held a meeting to establish the partnership between the Government and the Aboriginal Health Resource Co-operative (AHRC). It was suggested that each community in NSW develop its own Local Aboriginal Health Plan.

As a result, in January 1997 the Wellington Aboriginal Corporation Health Service (WACHS) and the AHRC invited the Department of Public Health and Community Medicine to work with them. They examined how the local health service resources could be better
used to promote the health and well being of the Wellington Aboriginal and Torres Strait Islander community.

A recent community survey was interviewer administered to 270 local Aboriginal and Torres Strait Islander people. The main health problems identified were illicit drugs (88%), alcohol (84%), diabetes (75%) and blood pressure (66%). Results provided a broad picture of self assessed health and the barriers to health services faced by Aboriginal and Torres Strait Islander people. Furthermore, this assisted the development of the local Aboriginal and Torres Strait Islander Health plans whilst adding valuable information that can be utilised by the key stakeholders in the community to determine how the community thinks health services should be provided. This work is a positive example for other Aboriginal and Torres Strait Islander organisations who wish to ensure community participation and consultation in the development of their local health care plans (Wiseman et al. 1999, pp. 21 - 23).
1.2.5.1 Smoking

People who smoke cigarettes have a higher risk of getting certain diseases. These diseases include heart disease, stroke, lung disease and cancer. These diseases cause many deaths among both Indigenous and non-Indigenous people. However Indigenous people are up to eight times more likely to die from these diseases when compared to non-Indigenous people.

Respondents to the NDS, HS, UATSIPS (1994, p. 23) and Cunningham (1998, p. 19) found that;

“Aboriginal and Torres Strait Islander people don’t seem to be fully aware of the risks of cigarette smoking”.

It was documented in the NDS, HS, UATSIPS (1994, p. 23) that 5% did not think smoking could damage their health, and 31% thought that a pack or more a day could be safely smoked. It was also noted that current smokers and drinkers held these misconceptions.
Lake (1989) surveyed tobacco as well as alcohol use among 102 patients of the Aboriginal Medical Service in Adelaide, finding that 78% of the men and 64% of the women surveyed smoked tobacco. Men smoked an average of 22 cigarettes a day, while women averaged 20 cigarettes (Lake 1989, p. 20 cited in Reid and Trompf 1991, p. 202).

Of the participants surveyed for the NDS, HS, UATSIPS (1994), awareness of passive smoking was highest amongst women, younger persons, and non-smokers (NDS, HS, UATSIPS 1994, p. 23). Additionally mothers who smoke cigarettes are more likely to have babies with low birth weight. Indigenous babies are about twice as likely to have a low birth weight than non-Indigenous babies (ABS 1994, cited in Cunningham 1998, p. 18).

The incidence of smoking among Aboriginal and Torres Strait Islander peoples is almost twice that of the general community NDS, HS, UATSIPS 1994, p. 25). The ABS (1999, pp. 52-54) has revealed Indigenous adults are more likely to smoke and to be overweight or obese than other Australians.
Moloney and Mozley (1998, p. 1) report that Tobacco smoking is a significant cause of premature death and disease among Aboriginal and Torres Strait Islander people. Circulatory diseases (heart disease, stroke) respiratory diseases (emphysema, chronic bronchitis and pneumonia) and cancer are the major causes of disease and death for non-Aboriginal, as well as Aboriginal and Torres Strait Islander people. Deaths from these causes are 3-4 times higher, with circulatory diseases 7-8 times higher within Indigenous communities. These remain the highest causes of disease. Death from cancer is twice as high within Indigenous communities and similarly with statistics for Maori people (New Zealand Bureau of Statistics, undated).

In 1994, 60.3% of Aboriginal and Torres Strait Islander mothers reported smoking at some time during pregnancy, and seemed to be unaware of the health risks of this (Cunningham 1998, p. 19). In 1995 it was reported that 60.9% women smoked during pregnancy, and in 1996 there was a slight increase in consumption with 61.4% women smoking. The most recent reports stipulate that 60.8% of the
women smoked during pregnancy in 1997 (NSW Health Department 1997c).

Of the mothers who smoked during pregnancy, about 3% stopped smoking in the second half of pregnancy and about 50% smoked more than 10 cigarettes per day in the second half of pregnancy (NSW Health Department 1997a).

Smoking in the second half of pregnancy poses great risks to the health of both the mother and the baby. In 1997, the proportion of Aboriginal and Torres Strait Islander mothers who smoked varied from 23.2% in the Illawarra area to 45.2% in the Northern Rivers Area (NSW Health Department 1997c). 62.2% of Aboriginal and Torres Strait Islander mothers commenced antenatal care before 20 weeks gestation compared with 84.8% of the non-Aboriginal and Torres Strait Islander mothers (NSW Health Department 1997d). The New Zealand Bureau of Statistics reported similar findings among Maori women (New Zealand Bureau of Statistics, undated).
A survey on the exposure of young Koori children in Melbourne to cigarette smoke was conducted by the Victorian Aboriginal Health Service (VAHS, 1993a) as part of a community awareness campaign. Parents of children under five years of age were asked for permission for a urine sample to be collected and tested. One child only from each household was tested. There were a total of 100 children sampled for the levels of Cotinine. Of the sample it was found that 93% of Melbourne Koori children under five were exposed to cigarette smoke, and half of these were heavily exposed. The younger babies aged under 12 months showed 30% exposure to cotinine levels. The cotinine levels were greater than 500ng/ml, which is rated as a high exposure category. Only 2% of the children aged between 3 and 5 years showed exposure whereas toddlers aged between 1 and 3 years of age showed 6% exposure (VAHS 1993a, p. 4).

Despite figures that are available reflecting the detrimental health effects smoking has had and continues to have on the Aboriginal and Torres Strait Islander people, funding is not made available to obtain
accurate data and culturally appropriate programs have not been established (Moloney and Mozley 1998, p. 2).

1.2.5.2 Analgesics

"There is only limited available research on analgesic use by Aborigines, the most detailed being Kamien’s work in Bourke (Kamien 1978, cited in Reid and Trompf 1991, p 193).

Kamien found that analgesic use by Aboriginal people was more common among women than men and that 68 out of 92 households revealed 142 separate containers of analgesics (Reid and Trompf 1991, p. 202). A survey of Northern Territory Aboriginal Communities completed by Watson et al. (1988, p. 202) found that 76 % of Aboriginal people surveyed took analgesics and benzodiazepines, it was again found that more women than men took tablets of this kind.

1.2.6 Crime Related Effects of Alcohol and Illicit Drugs

Experience of alcohol related crime is higher among the Aboriginal and Torres Strait Islander community than in the general population (NDS, HS, UATSIPS 1994, p. 38).
At the National Women & Drugs Conference (1994) held in Sydney, Pat O’Shane was a guest speaker who spoke in relation to Women and Drugs from the perspective of the judicial system. Pat stated that "Women's involvement in the criminal justice system is usually (though not always) as victims of crime". She went on to note that the level of alcohol related crime against women had not changed significantly, in spite of the many discussions, studies and programs which had been undertaken. It was her belief that agencies are under-resourced and governments do not allocate funds in the areas of need. She concluded that "The rich and powerful are supported whilst the dispossessed and needy are left to look after themselves" (Campbell and Ellis 1995, p. 10 - 11).

Pat O'Shane's views are backed by the NSW Adult Action Plan research which reported that a high proportion of "reported acts of violence, such as sexual assaults and homicide, are committed by individuals who had previously consumed alcohol". (NSW Adult Action Plan, 1998, p. 10).
In 1991 the Bureau of Justice statistics reported on demographic and personal characteristics of 5,675 women and men held in state and federal prisons in the United States. The study found that women and men differed on drug use patterns, pre-arrest marital status; and employment status. There were a higher percentage of women imprisoned for drug charges, and women were more likely to report being under the influence of a major drug at the time of their offence. The report also revealed that women were less likely to be employed in the month before the arrest than men, and in addition women were more likely to have children under the age of 18 years. This report further substantiated results of earlier reports which indicated that women offenders were more likely to be involved in illicit drugs than men (Bureau of Justice Statistics 1992 cited in Kevin 1995, p.2).

Despite higher usage rates of illicit drugs than in the general community, the issue of illicit drugs as a cause of concern was less than the concern expressed about alcohol (NDS, HS, UATSIPS 1994, p. 3).
The ABS (1999, p. 36) has revealed that almost 19% of adult prisoners in 1997 were identified as Indigenous, and Indigenous adults were over 14 times more likely to be in prison than non-Indigenous adults. Like Aboriginal and Torres Strait Islander adults, Aboriginal and Torres Strait Islander children are also over-represented in the juvenile justice system. About 41% of children in corrective institutions for children identified as Aboriginal and Torres Strait Islander in the 1996 Census (ABS 1999, p. 35, cited in Jopson 1999, p. 72).

Kevin (1995) examined the patterns of drug use of imprisoned women, their treatment needs and the effectiveness of the Drug and Alcohol services in reaching those women with drug and alcohol problems. Kevin (1995, p. 9) revealed that 16% of the 130 women surveyed in 1993 reported that they were of Aboriginal background. Of the total women surveyed, 62% were under the influence of a drug at the time of their most serious offence while 46% of the total sample consumed drugs and 5% had consumed alcohol only, whereas 11% had consumed both alcohol and other drugs (Kevin 1995, p. vi).
Kevin noted a disturbing finding that by the age of 13 years 8% of the women had reportedly tried heroin, whilst 11% had tried tranquilisers, and 5% of the women had tried either amphetamines, barbiturates or hallucinogens. Kevin also found that 82% of the women reported smoking tobacco on a daily basis. The majority of these women smoked a packet or more of cigarettes per day and 6% of the women had tried tobacco before they were 10 years of age. The second most commonly used drug by women on a daily basis was heroin followed by cannabis, benzodiazepines and alcohol. It was reported that 61% of these women had not matriculated from high school although 62% had achieved a school certificate (Kevin 1995, pp. 11 - 18).

Furthermore the Alcohol and Other Drug Services of the Department of Corrective Services, requested a pilot of the Alcohol and Other Drug Screen (AODS) to improve the level and quality of information on new inmate receptions (Kevin 1997, p. iv). Several locally based studies have recommended that inmates on reception to NSW correctional centres be routinely screened for the presence of A&OD problems, with a view to identifying risk cases for referral to treatment

Additionally Kevin (1997) sampled 395 inmates (293 male and 102 females), 71% of the males and 79% of the females reported being intoxicated at the time of offence. Of the females, 56% reported intoxication from drugs, 11% from alcohol and 12% from both drugs and alcohol. Furthermore, 27% of the males reported intoxication from drugs, 25% from alcohol and 19% from both drugs and alcohol. The drugs most commonly used by the female sample before imprisonment were heroin 54%, benzodiazepines 34% and alcohol 31% whilst males reported 54% alcohol, 43% cannabis and 30% heroin prior to imprisonment. Of the sample of females 96% reported that they smoked cigarettes compared to 76% of all males. A higher percentage (70%) of the females reported needle use compared to 37% of the males. Of those who used needles 26% of males and 23% of females reported sharing behaviour (Kevin 1997, pp. 14 - 15).

The ABS (1999, p.58) has revealed that injecting drugs with contaminated injecting equipment is a risk factor for blood-borne
diseases such as hepatitis B and C, and Human Immunodeficiency Virus (HIV). The National Drug Strategy (NDS) estimated that about 2% of urban Indigenous people were currently injecting drugs compared with about half a per cent of the general population. A survey of hepatitis C prevalence among injecting drug users attending needle exchanges in 1995-96 found that about 70% of the Indigenous injecting drug users were infected with the virus. Edwards et al. (1998, p.16) mentioned that community workers worry that young mothers and pregnant women are sometimes injecting illegal drugs, which has serious consequences for both mother and baby.

The National Centre in HIV Epidemiology and Clinical Research (NCHECR 1998 cited in ABS 1999, p. 58) disclosed that of 100 HIV cases notified among the Indigenous population from 1992-97, 12 were among people exposed to injecting drug use. Of these, nine were exposed to male homosexual contact.

Hall states,

"Many dependent heroin users in contact with law enforcement and treatment agencies engage in high rates of drug dealing and property crime to finance their drug use."
Their criminal activity usually begins before their heroin use, but the development of heroin dependence intensifies criminal activity and entrenches users in a criminal lifestyle” (Hall 1996, p.10).

Criminologists have been long interested in the relationship between unemployment and crime but have historically spent much more time examining the effect of unemployment on criminal behaviour than the effect of a criminal conviction on an individual’s employment prospects. This second issue is particularly salient for Australian Aboriginals who are over represented among both the unemployed and those who have been arrested.

In addition the economic and social costs of low employment for Indigenous Australians are significant and represent a major problem for policy – makers in Australia (Hunter 1999, p. 7).

Low employment is a similar problem among the Maori people of New Zealand, in particular the women who continue to be over-represented among the officially unemployed, accounting for 49.3% of all unemployed people in 1996, but only 45.7% of the total labour force.
In New Zealand the unemployment rate for men doubled from 5.1% in 1986 to 10.2% in 1991, while the rate for women rose from 9.1% to 10.8%. In 1996, one in five women aged 15 - 19 years were unemployed. In each age group the unemployment rate was higher for women than men except those aged between 50 and 64 years. Not surprisingly 7% of the women in the labour force in 1996 who had an educational qualification were unemployed compared with 12.3% of those without qualifications. In general, the higher the level of qualification gained, the lower the unemployment rate (New Zealand Bureau of Statistics, undated).

Preliminary analysis of the 1994 National Aboriginal and Torres Strait Islander Survey (NATSI) indicates that arrest is one of the major factors underlying the poor employment prospects of the Indigenous population (ABS 1996a; Hunter 1997 cited in Hunter and Borland 1999, p. 1).

'are still dying in prison and police custody at high levels, sometimes in circumstances which Amnesty International believes may have amounted to cruel, inhuman or degrading treatment'. ATSIC (1999, p.19).

There have been a large number of initiatives undertaken by various Australian Governments. There have also been substantial criticisms of the way recommendations from the Royal Commission have not been implemented. At least one review referred to the failure to adequately implement recommendations as "a massive lost opportunity" to reduce Aboriginal and Torres Strait Islander over-representation in the criminal justice system and to reduce the number of deaths in custody. The Royal Commission recommendations still provide the potential for significant reductions in Indigenous custody levels. To date this reduction has not occurred (ATSIC 1999, p. 19).

1.3. Identifying Research Needs

Aboriginal organisations have shown that they value the contributions that can be made by research, be it ethnographic, epidemiological or clinical in orientation (Reid & Trompf 1991, pp.208 - 209).
While it is acknowledged that substance use by Aboriginal and Torres Strait Islander people has been researched, findings have not necessarily led to improvements in the health status of Aboriginal and Torres Strait Islander peoples.

Many strategies to address substance use have not worked because they have not been culturally appropriate and have been implemented without consultation with communities. Such strategies have not empowered Aboriginal people or community development. However research needs to be directed at identifying or examining wider social impacts and economic costs of substance use (e.g. domestic violence, injuries and subsequent primary and tertiary health care and crime). It is also important that research seeks to identify issues at the whole-of-community level and to examine holistic approaches to addressing substance misuse. Assessment of the effectiveness of education and intervention programs, both mainstream and Indigenous, is essential. It is also important that data is effectively disseminated and presented to Aboriginal and Torres Strait Islander communities and organisations in an understandable and useable format.
Research should target specific groups within the community especially women and youth, with a view to investigating appropriate treatment and rehabilitation programs for women and young people, utilising Aboriginal and Torres Strait Islander role models and positive adult motivators.

The availability of specific statistics on A&OD for Aboriginal and Torres Strait Islander mothers and children are not abundant. There is a lack of adequate relevant documentation and research delving into this topic, producing the much needed statistics that could provide evidence to the government and funding bodies on their importance.

The Royal Commission into Aboriginal Deaths in Custody (RCIADIC) 1991 report and a recent review of the Commonwealth’s Aboriginal and Torres Strait Islander Substance Misuse Program conducted by the Department of Health and Aged Care are among the many reports to mention these issues. I see it as part of my future and the future of other Aboriginal and Torres Strait Islander women, children
and communities to provide research that may lead to improved Aboriginal Health.

The recommendations listed below are of relevance to my research and have been considered in the methodology used for this project.

The Royal Commission into Aboriginal Deaths in Custody (RCIADIC 1991) included the following recommendations:

That if Aboriginal people identify it as a priority the Ministerial Council on Drug Strategy (MDC), as the body which manages the National Campaign Against Drug Abuse (NCADA) which is now the National Drug Strategy (NDS) to:

"act to develop and implement, in conjunction with Aboriginal people and organisations, an ongoing program of data collection and research to fill the many gaps which exist in knowledge about Aboriginal alcohol and other drug use and the consequences of such use" (RCIADIC 1991, p. 45).

The areas identified as needing attention were:
• Information about alcohol consumption among urban Aboriginal groups;

• Information about alcohol consumption among Aboriginal and Torres Strait Islander youth;

• Longitudinal data in all areas

• An emphasis on good quality data utilising standard methodology and definitions; and

• Evaluation research which assists in developing improved Aboriginal prevention, intervention and treatment initiatives in the alcohol and other drugs field (RCIADIC 1991, p. 46).

It was also recommended,

"That Aboriginal people be involved at every level in the development, implementation and interpretation of research into the patterns, causes and consequences of Aboriginal alcohol use and in the application of the results of that research" (RCIADIC 1991, p. 45).
1.4. Research Questions

This project is the first phase in a larger study of Aboriginal and Torres Strait Islander women which aims to collect data on the patterns of use and knowledge among Aboriginal and Torres Strait Islander women particularly during pregnancy.

In this first phase, a culturally appropriate questionnaire was designed by and piloted with a group of Aboriginal and Torres Strait Islander women during three focus group discussions.

The findings of this project will be used to survey a large group of Aboriginal and Torres Strait Islander women in NSW. This will be Phase 2, which is not a component of this Thesis.

The following research questions will be used in Phase 2 of the overall research study, however they were utilised as a point of reference for collection of materials whilst performing the literature review for this study.
1. What is the currently available literature on A&OD use and misuse among Aboriginal and Torres Strait Islander women in particular during pregnancy?

2. Is the literature currently available on A&OD culturally sensitive for Aboriginal and Torres Strait Islander women?

3. What is the level of A&OD use among Aboriginal and Torres Strait Islander women particularly during pregnancy?

4. Do Aboriginal and Torres Strait Islander women perceive A&OD misuse as a significant problem?
1.5. Aim

To conduct three focus groups consisting of Aboriginal and Torres Strait Islander women, with the aim of piloting a culturally sensitive questionnaire on the use and misuse of A&OD among Aboriginal and Torres Strait Islander women particularly during pregnancy.

Focus group 1 consists of 17-29 years and Focus group 2 consists of 30 year old women and older. The groups were categorised specifically to draw out issues relevant to younger and Elder women. Focus group 3 was allocated to Aboriginal and Torres Strait Islander Health Workers and Health professionals to allow for professional opinions.
1.6. Objectives

1. To collect, review and explore the current literature on A&OD in relation to pregnancy and Aboriginal and Torres Strait Islander women.

2. To develop a pilot questionnaire based on the literature findings.

3. To recruit Aboriginal and Torres Strait Islander women to participate in focus group discussions.

4. To conduct three focus groups consisting of Aboriginal and Torres Strait Islander women, to test the pilot questionnaire, and provide feedback on its cultural sensitivity.

5. To use the findings of the focus groups to produce a culturally sensitive questionnaire.
CHAPTER 2
Methodology

2.1 Introduction

According to Polgar and Thomas (1995, p.109) Qualitative Field Research involves the investigation of specific individuals in their social settings. "Qualitative" refers to the nature of the data or evidence collected. Qualitative data consists of detailed descriptions, based on language or pictures recorded by an investigator. "Field" research indicates that the investigation is preferably carried out in the natural environment in which the phenomenon occurs, rather than in controlled laboratory settings.

There are many epidemiological studies that may be classified as either quantitative or qualitative research methods. Two types of quantitative research methods include Analytical Studies and Descriptive Studies. Common descriptive study types that can be used in the research are case reports, case series, cross sectional and correlational studies.
The aim of this research is to collect as much in-depth information as possible on a topic. Information collected will be the base for developing a culturally sensitive questionnaire. In this case a Qualitative approach was more suitable. The developed questionnaire will be the study tool used to collect quantitative data in the second phase of the overall research project.

2.2 Focus group design.

This research involves conducting three focus group discussions. A focus group is a data collection technique that provides a means of collecting a wide range of data, as well as providing insights into the attitudes, perceptions and opinions of the participants. Data collection also involves observations of the respondents during the discussion (Phan & Fitzgerald 1996, p. 4).

Information is often solicited with open-ended questions and respondents are able to choose the manner in which they respond.
Phan & Fitzgerald (1996, pp. 13 - 15) and Polgar & Thomas (1995) between them list the advantages and disadvantages of focus groups and these will be kept in mind to see if they impact on the process.

Literature shows that there are very few culturally appropriate studies on A&OD use and misuse during pregnancy amongst Aboriginal and Torres Strait Islander women. This has made it difficult for researchers to determine the structure and contents of a culturally appropriate questionnaire (Andrews et al (1996), Commonwealth Department of Health and Aged Care (1998), Reid and Trompf (1991) and Walley (1995)).

The use of focus groups will involve the participation of Aboriginal and Torres Strait Islander women with the research processes, with a view to empowering them, increasing ownership and providing group collaboration. The use of the focus group 's input into refining the questionnaire will facilitate discussion of the broader A&OD issues relevant to Aboriginal and Torres Strait Islander women, particularly during pregnancy.
2.3 Questionnaire design

The basic questionnaire was developed by the researcher to be utilised in the focus group discussions (see Appendix 4 (a)). The questionnaire consists of a combination of open and closed questions, a format which is supported by Neutens and Rubinson (1997, pp. 103 – 104). The questions are simple and precise, using plain English, in line with suggestions mentioned in Polgar & Thomas (1995).

The steps employed in developing the questionnaire resemble the construction model outlined in Polgar & Thomas (1995, pp. 127 - 128).

The Questionnaire construction and evaluation involved the following steps:

I. The information being sought was defined after the researcher investigated the available related sources, conducted
discussions with Aboriginal and Torres Strait Islander women and completed an extensive literature review.

II. The researcher drafted a questionnaire. This will be presented to the Aboriginal Health and Medical Research Council (AH&MRC) Ethics Committee and the University of Sydney Human Ethics Committee (USHEC), Honours Co-ordinator, Thesis Supervisor and Tutor. Their suggestions will be considered and the final draft completed.

III. Questionnaire test piloting will be accomplished by conducting three focus group discussions.

IV. Editing of the questionnaire will be performed after the focus group discussions are complete.

V. Administration of the questionnaire will be accomplished during Phase two of this research study.
Table 2. demonstrates the Advantages and Disadvantages of using a questionnaire, Polgar and Thomas (1995).

<table>
<thead>
<tr>
<th>Advantages of Questionnaire</th>
<th>Disadvantages of Questionnaire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quick and cheap</td>
<td>If self-administered the respondents must be literate.</td>
</tr>
<tr>
<td>Collects large amounts of information from people over a wide area</td>
<td>Return of Questionnaire if mailed out can delay data collection.</td>
</tr>
<tr>
<td>Guarantees confidentiality and often anonymity for the respondents</td>
<td>Questionnaire may be misplaced.</td>
</tr>
</tbody>
</table>

2.4 Ethical Approval

There has been a shift in the focus of the control of research in Aboriginal communities. Ethical guidelines from places like the AH&MRC Ethics Committee and the USHEC, literature reviews from...
researchers, communities and funding bodies, now highlight the role of Aboriginal and Torres Strait Islander communities in dissemination of the research and their findings.

These approaches have allowed Aboriginal and Torres Strait Islander communities to increase their knowledge of ethical procedures, improving their awareness of the benefits of research and maintain firmer control of research studies Backhouse (1999, pp. 20 - 21).

Writers such as Hall and Kid (1978) cited in Backhouse (1999, pp. 20 - 21) have promoted the use of participatory research where communities benefit from involvement in the process of research as well as the outcomes of the research.

There is literature available that supports participatory research among Aboriginal and Torres Strait Islander people and communities. In addition, the literature available relating to the importance of ethical considerations clearly demonstrates the need for researchers to collaborate with specified ethical requirements.
An example of this is shown in Williams (1992), where Williams has declared that,

"Historically, Aboriginal and Torres Strait Islander people have been subjected to a range of inappropriate, unacceptable, devious and degrading research methodologies. We have been, and still are, frequently considered to be objects for research and continue to be put under the microscope of the social scientists. Researchers have tended to conform to this neo-colonial and paternalistic mentality and, in most cases, gained individual rewards through professional advancement" (Williams 1992 cited in Williams 1999, p. 9).

The ethical guidelines that apply to this research are;

I. Conforms to available related ethical guidelines.

II. Is designed to meet the requirements of both Ethics Committees.

III. Includes information describing the proposed research study.

IV. Will be evaluated considering the following documents;

(b) *Guidelines on Ethical Matters in Aboriginal and Torres Strait Islander Health Research* suggested by the National Health Medical Research Council (NH&MRC) (1991).

(c) *NSW Aboriginal Health-Information Guidelines* (NSW Aboriginal Health Partnership, NSW Health / AH&MRC) (1998).

(d) *Guidelines for research into Aboriginal Health* (AH&MRC Ethics Committee) (1999).

(e) University of Sydney Human Ethics Committee (2000).

Endorsement was sought for this research study from the following Ethics Committees,

I. The AH&MRC Ethics Committee

II. The USHEC
This research study has met Ethical requirements and has been endorsed by the AH&MRC Ethics Committee and the USHEC (see Appendix 5 (a) and (b)).

2.5 Recruitment of Participants

Advertising of this research study has not been extensive due to lack of funds. However the recruitment of Aboriginal and Torres Strait Islander women was accomplished in a number of ways including;

I. A flyer (see Appendix 1) was faxed or posted to organisations listed in Appendix 14.

II. The Koori Mail featured a story on this research study, which appeared in the 3 May 2000 issue (see Appendix 6).

III. Participants were also recruited by Snowball technique.
2.6 Eligibility of participants

Interested Aboriginal and Torres Strait Islander women who reside in Sydney and surrounding areas were encouraged to complete an expression of interest application (see Appendix 7).

Eligible Aboriginal and Torres Strait Islander women who sign the consent form were considered for participation in one of the proposed focus group discussions (see Appendix 2 (a)). It is proposed that each focus group would consist of up to 10 Aboriginal and Torres Strait Islander women. All successful applicants will be sent a Focus Group Notification letter (see Appendix 8).

2.7 Focus Group Process

The focus group discussions were conducted at the Eora Centre situated at 333 Abercrombie Street, Redfern. The three focus group discussions were held in the same week, the first being on the 15th May, the second on the 17th May and the third and final on the 19th
May 2000. All focus group discussions were held between 10am and 12 noon.

The criteria for each focus group were chosen to enable maximum results. Focus group 1, 17 - 29 years and Focus group 2, 30 years plus were age categorised specifically to separate the younger women from the Elder women. This is aimed at providing all participants with an equal opportunity to have their say, without feeling as though they had to conform to other participants in the group. Focus group 3 was allocated to Aboriginal and Torres Strait Islander Health Workers and Health professionals to allow for professional opinions.

Prior to the focus group discussions participants were advised of the intention to audio - tape the focus group discussions and encouraged to sign a consent form prior to the proposed focus group discussion. The consent form was included in the information package (see Appendix 11), most of the consent forms were signed and returned to the researcher prior to the focus group discussion as suggested by the AH&MRC.
All selected participants were sent an information package during the week prior to the proposed focus group discussions. This enabled participants time to read information regarding the research project, familiarising themselves with the research project and the proposed process of the focus group discussion.

2.8. Focus Groups Format

On the day of the focus group discussion the researcher briefly explained the information packages and a short period of time was allocated for questions.

The participants were offered an identification number for coding purposes to ensure anonymity in order to protect identity and maintain confidentiality. The participants were advised to write their code on the sticker, the code number was then to be mentioned before a participant speaks for protection of identity and transcription purposes. It was requested that the sticker was worn and each participant was advised to refer to other participants by that code.
The Research Study Information Sheet (Appendix 3(a)) and the questionnaire (Appendix 4 (a)) were given to all participants for completion. Each questionnaire was coded with an identification number by the researcher, and participants were reminded not to place their names on them. Data collected from completed questionnaires during the focus group process was not analysed. This process was a "mock survey" focusing on the familiarisation of the Aboriginal and Torres Strait Islander women, with the questionnaire.

The focus group discussion began directly after the completion of the questionnaires. The researcher directed the focus group discussion in a semi-structured manner. This method was used to control discussions from straying off the subject. It was anticipated that this method would allow flexibility for participants to discuss related issues of importance to them.
2.9 Focus Group Content

The focus group collective was asked the following questions related to the questionnaire.

1. What do you think about the set of questions that you have been asked to answer?
2. Are there any other questions you would like to include in this questionnaire?
3. Will you be interested in changing any of these questions you have responded to?
4. Are there any other women's age groups that should be involved in this Research Study?
5. Is this Questionnaire suitable to gather relevant information?
6. Should I have done this research study another way?
7. Do you think you will benefit from this discussion?
   If yes, how? and If no, why?
8. Any other issues of concern?
It was proposed that in a case where social and emotional wellbeing issues arose, the participants would be provided with a telephone number for professional assistance. Local Drug and Alcohol workers, Mental Health workers and Social workers were aware of this project and were on call to assist or counsel any women who did wish to discuss issues that arise from the focus group discussions.

On completion of the focus group discussions all participants were presented with a Focus Group Information Folder (Appendix 12) and an appreciation certificate (Appendix 9) for acknowledgment of their involvement. An appreciation certificate was also provided to all of the Organisations and individuals that have assisted with the process of this Research Study (see Appendix 10).

2.10 Analysis

As mentioned previously the focus group discussions were to be recorded using audio-tape, with prior permission from the participants. The transcription of audio-tapes will be by "Key point transcription". This technique was also used by Phan & Fitzgerald
(1996, p. 28). All key points mentioned on the tape will be listed and the numeric counter will be noted at each key point. The aim of the listing will aid efficient future referencing. Quotations will be recorded in a verbatim fashion. The researcher, chief investigator and tutors will review the tapes and all of the key points will be compared.

All information will be stored with the researcher during the active transcription phase and on completion stored for a period of five years at the University of Sydney with the Chief Investigator in a locked cabinet. The information will be destroyed in accordance with the University of Sydney policy. Any person wishing to access the information will need prior approval from the Chief Investigator.

Focus group discussion results may be included within this Thesis document providing the focus group participants prior endorsement.
CHAPTER 3
Results

3.1. Focus Group 1

17 - 29 years

I. Introduction

Focus Group 1 was held at the EORA Centre situated at 333 Abercrombie Street in Redfern between 10am and 12 noon on Monday 15th May 2000 and began at approximately 10.15am. Technical problems with audio equipment delayed commencement of the discussion.

There were a total of 6 participants present on the day.

I. I introduced myself to the group and gave a brief description of the research study. The questionnaire and the expected outcomes were discussed. Participants were then asked to introduce themselves.
II. The participants were given an opportunity to decide how their identity would be disguised. However they preferred to refer to each other on a first name basis.

III. The researcher introduced Dr Valerie Delpech, and explained that Dr Delpech was her Tutor.

Response

I. Introduction

No further action required for I. and II.

II. One of the participants stated that she had felt uneasy about Dr Valerie Delpech's presence, as it was "Black Women's Business".

The researcher advised the participants that Dr Delpech was present at her request and was providing moral support. It was explained that Dr Delpech has been assisting the researcher from the beginning.
The other participants discussed this comment and it was agreed that Dr Valerie Delpech was welcome.

II. Comments

1. One of the participants asked, “Who would be listening to the tapes?” and it was made quite clear by all participants that “No men were to listen to the tapes”.

2. Another participant asked, Whether the supervisor was male or female?

3. A participant questioned why the supervisor was not an Aboriginal or Torres Strait Islander woman?
Response

1. The answer was that the Researcher, Supervisor and Tutor would be listening to the tapes.

2. The participants were advised that the present supervisor was a female, however not an Aboriginal or Torres Strait Islander woman.

3. An Aboriginal academic female was previously the Supervisor however her time availability was not suitable. I explained that because Dr Zakia Hossain had extensive research experience and was available at times to suit me I had chosen her as my Supervisor. The women then agreed that she would be accepted.

3.2. Focus Group Discussion

1. The researcher made many attempts to record the discussion however for some unknown reason the audio equipment would not record.
II. All participants were provided with a questionnaire and time was allowed for participants to complete.

III. On completion of the questionnaires 8 questions were asked.

Response

I. The researcher decided that the discussion would not be taped. To ensure conformity the researcher decided that no focus group discussions would be taped.

II. The questionnaires were collected.

III. Recorded the following comments.

1. What do you think about the set of questions that you have been asked to answer?

I. The length of the questionnaire was not seen as a problem and most of the participants agreed that printing it back to back
would decrease the visual effect of how many pages the actual questionnaire consisted of.

II. It was agreed that the font was to be made larger so it was easier to read.

Response

I. No Action required

II. The font was changed to size 14. The questionnaire was printed back to back.

2. Are there any other questions you would like to include in this questionnaire?

I. The participants requested that question 24 and 25 were to be combined.
II. A new question was to be developed asking, Whether the women accessed the services? The following question was developed by the participants:

Q.25 Do you access these community-based services?

Response

I. The questions were combined and has become Q 31 of the revised questionnaire.

II. The question that was developed by the participants has been included as Q 31(a) in the revised questionnaire.

3. Will you be interested in changing any of these questions you have responded to?

I. Q 2.

Married Up was to be added next to De-facto.
Are you employed? (Full time / Part time / Casual). Should be set up in the same format as question 2. It was recommended that employed, unemployed, student and carer (children / elders / other) be the new options with a box beside them.

II. Q 4. It was suggested that the original question be changed.

III. Q 11. How often do you drink alcohol? The participants requested that the options be changed. The options were to be changed to include once a fortnight, sometimes and hardly ever.

IV. Q 12. It was suggested that space be provided next to the option "Other".

V. It was decided that Q 16 and Q 17 be combined using one table and the revised would become Q 16.

(a) Tobacco / Smokes were to be deleted.
(b) Inhalants (Petrol / Glue / Aerosol) were to be added

(c) Valium was to be added under Serepax

(d) Harry / Smack were to be added next to Heroin.

(e) Goey was to be added next to Speed

(f) Metholated Spirits was to be added to the table.

(g) Other option was to be added to table with a space provided for writing.

(h) It was also suggested that a time frame of last month, last year and last two years be added to the table.

VI. Q 17. It was decided to add the following question,
Q 17. Have you used any drug not mentioned in Q 16?

☐ Yes  ☐ No *If Yes, please list.*

VII. A participant quoted that page 3 of the questionnaire (Q18 to Q24) "Is perfectly fine”.

VIII.  
(a) Other participants thought that "Uncertain" was not a word that was often used by Aboriginal and Torres Strait Islander women.

(b) It was quoted that, "More culturally appropriate language needs to be used".

(c) The participants then agreed that "Uncertain" was to be replaced by "Don't Know". This was to apply to the whole document.
IX. Q 24 and Q 25. The participants discussed these questions and it was decided that Q 24 and Q 25 needed to be combined, the combination would then become a new question.

Response

I. The suggestions were included and the revised question has remained as Q 2 in the revised questionnaire.

II. The question was reworded and requests included. This question has remained as Q 4.

III. Q 11 in the original questionnaire was amended to include the recommendations of the participants and this has become Q 17 in the revised questionnaire.

IV. This question has been modified and has now become Q 18 in the revised questionnaire.
V. Q 16 and Q 17 were combined including the additions requested and this question has now become Q 23.

VI. The amendments that were suggested regarding Q 17 were included however is now Q 23 (a) in the revised questionnaire and changed to the following as requested.

VII. No action required

VIII.

a) The word "Uncertain" was replaced by "Don't Know". This was applied to the whole document.

b) The question was revised to include culturally appropriate language.

c) “The option “Don’t Know” replaced the option “Uncertain” in Q 18 as well as throughout the entire document.
IX. Q 24 and Q 25 were combined and a new question was developed. This question is now Q 31 and Q 31 (a) of the revised questionnaire.

4. Are there any other women’s age groups that should be involved in this Research Study?

1. All participants strongly agreed that Aboriginal and Torres Strait Islander women were having babies as early as the age of 15 and that the age on the questionnaire should be lowered to accommodate this age.

Response

1. The lower age option was included and the revised questionnaire includes an option for 17 years and under. This question has remained as Q 1 of the revised questionnaire.
5. Is this Questionnaire suitable to gather relevant information?

I. All participants agreed that the questionnaire was suitable to collect the information required. It was quoted, "Big Yes".

II. All participants agreed and it was quoted that "it was about time that Researchers involved the community in the consultation process".

Response

I. No action required

II. No action required
6. Should I have done this research study another way?

I. It was stated that "Face to face would have been more appropriate". The researcher explained that time and costs were associated with the choice of using a questionnaire.

II. The participants discussed the research method used for this study (Focus Group) and it was agreed that it was appropriate. The following comment was made by a participant

"Has to advocate for a survey by Koori women"

Response

I. I agreed with the participants. However it was explained that time and cost effectiveness had to be considered when choosing the research method

II. I agreed that this survey had to involve Aboriginal and Torres Strait Islander women for its success.
7. Do you think you will benefit from this discussion?

If yes, how? and If no, why?

All participants strongly believed that they had benefited by attending the discussion. The ways in which the women believed they had gained were, in personal increased personal awareness as well as at a social, educational and skills level.

Response

The following quotes were recorded as requested.

a) "Pleased to know about the project".

b) "Pleased to know that Indigenous women are being consulted at the planning stage of the project".

c) "Good to know that research on our people is being generated by Aboriginal people so it is done appropriately".
d) The following are comments and quotes were made,

e) "It opened my eyes up".

f) "It was a real eye opener"; "I learnt a lot from being involved, especially about the Ethics stuff".

g) "The information package was excellent and it will not only benefit me but my family as well".

h) "Yes, it was good to be involved"

i) "Educational information to take home"

j) "I felt like I belonged"

k) One participant mentioned that, "she felt better for contributing to the health of Indigenous women".
8. Any other issues of concern?

The women discussed the topic and its relevance to Aboriginal and Torres Strait Islander women.

I. It was agreed that the topic needed a sub title that was shorter in length.

II. It was also suggested that the sub title could be placed on the cover of the information folder and questionnaire.

III.

IV.

V. The title should include culturally appropriate language. The current title was discussed and it was decided that the word "appropriate" be replaced with the word "sensitive".

IV. One of the participants said that the following should be done "to encourage as many women as possible to at least pick the questionnaire up and have a look at it".
a) The questionnaire format was discussed and it was decided that the font was to be made larger.

b) The content of the questionnaire was to be printed back to back.

V. A participant asked who designed the cover of the Information folder?

VI. Some of the participants agreed that the cover was a beautiful picture

VII. It was suggested that a woman should have designed it

VIII. A number of the participants thought that it was great that a man had offered his skills.

IX. The following was a quote made "his involvement has demonstrated that the Alcohol and other Drug issue is not just a Aboriginal and Torres Strait Islander women's problem, in fact it is a joint family and community problem".
X. One of the participants suggested that, "a competition could be held amongst younger children, particularly school age girls to develop a cover or symbol" for the cover in the next phase.

XI. All of the women consulted, expressed that this research study be respected as "Women's Business" and "such tapes, transcripts and other material were not to be viewed or heard by males".

XII. In response to the above point a participant quoted that "This is Traditional and appropriate".

XIII. The following question was added because the participants thought that the issue of "Why women aren't accessing services?" was of concern.

XIV. It was suggested that the cover of the Information Folder could have a story included on the back explaining the picture.
Response

I. The participants did not come up with a sub title.

II. To date a subtitle has not been devised however it is envisaged that a sub title will be developed.

III. The word “appropriate” was changed to “sensitive” in the research study title.

IV.

a) The font was changed to size 14.

b) The content of the questionnaire was printed back to back.

V. The researcher revealed that it was a male who did the cover.

VI. No action was required.
VII. The participant made sure to mention that the comment was not made to offend the man or the researcher, however that it would have been more appropriate.

The researcher explained that at the time the cover was completed there were no funds available to pay any one to design a cover and that time availability was also an issue. It was explained that the man who completed the information folder cover was the father of the researcher's children. It was also explained that the researcher requests the design for the information folder cover.

VIII. No action was required.

IX. No action was required.

X. This suggestion is currently being explored for Phase 2 of this research study.

XI. To date all of the information collected has been respected and protected as “Women’s Business”. This will continue until
completion of this research study. The information will then be destroyed as requested. The research study consent form was amended to include that this research study was Women's Business.

XII. No action was required.

XIII. Q 31 (a) was included to accommodate for the participants concerns.

XIV. To date a story has not been included on the back of the information folder. This will be completed by Phase 2.
3.3. Analysis:

The original proposal was to tape the discussion and up until half-way through we all thought this was taking place. When I checked at the break, I found that nothing had been recorded. As this was the third tape recorder that had been tested and tried it was taken as a "message" that discussions should not be put on tape. I decided to abandon any further attempts at taping and I used my written notes.

I would have preferred ten women in the group. Seven had agreed to participate but six actually attended on the day as one called in to apologise. All feedback was positive. In particular having such a good response from the younger age group was very encouraging. Three of the group were aged under 24 and 3 were aged under 29.

The participant's seemed to be impressed by the questionnaire. Their comments were valid, relevant and constructive. They stuck to the point in discussions. Issues they raised and discussed were also resolved by them. Because they were seeing the questionnaires with a fresh point of view, they suggested useful changes to questions
which I was glad to adopt. However I retained the original form of the questionnaire for Focus Group 2.

They thought the title of the research study was too long and all agreed that there should be a shorter title in culturally appropriate language. I am still working on this item.

The women asked that the target age group for this survey should be lowered so that women under 17 years of age could have access to it. I responded by saying that I had to comply with the ethics guidelines laid down by the University of Sydney.

The question of the women's fear of lack of confidentiality when accessing community-based health services is a major issue of concern because it stops women from making use of services that are essential for their health and wellbeing. Even these young women recognise that this is a major problem, and while everyone acknowledges it no-one has a solution.
Fear of their ability as a mother being evaluated was another concern when accessing community-based health services, as were notification issues i.e. whether health workers would report them to other government services such as Department of Community Services (DOCS).

Participants felt that face-to-face interviews would be more appropriate and effective, but they appreciated that time and money had to be considered when choosing information-gathering methods.

They requested that the information should be treated as "women's business" and saw it as traditional and appropriate to do so. The women were very happy to receive the information folders I had compiled as they felt they could use them in their studies, in work or with their families. I also included in the folder an Appreciation Certificate which the women felt they could include in their resumes. I provided lunch as a means of thanking them for coming and taking part and they expressed their appreciation of this.
In response to Valerie's being present, the person who raised a query about this non-Aboriginal woman being there said she felt it was important to raise the point. However once I explained the reason then everyone accepted it. No-one was offended by the comment.

I told the women that the drawing on the front of the Information Folder was done by a man and this group had no problem in accepting this as a gesture of support for the researcher.

The facilities provided by the Eora Centre were excellent. The staff were very helpful and all of this contributed to the success of the day.

In conclusion some of the women's comments were:

"All feel better for contributing to health of Indigenous women. They were pleased to know about the project."

"Pleased to know Indigenous women are being consulted at the planning stage of the project."

"Good to know that research on our people is being generated by Aboriginal people so it is done appropriately."
3.4. Focus Group 2

30 years plus

I. Introduction

Focus Group 2 was held at the EORA Centre situated at 333 Abercrombie Street in Redfern between 10am and 12 noon on Wednesday 17th May 2000. The discussion began at approximately 10am.

There were a total of 7 participants present on the day.

I. I introduced myself to the group and a brief description of the research study, the questionnaire and the expected outcomes were discussed. Participants were then asked to introduce themselves.

II. The participants were given an opportunity to decide how their identity would be disguised however preferred to refer to each other on a first name basis.
III. Then the questionnaire was handed to participants who then completed them.

Response

No action required.

II. Comments

No comments made regarding introduction.

Response

No response required

3.5. Focus Group Discussion

I. It was explained that I would not be taping the discussion and I requested consent forms from women who had not yet handed them in. This created a discussion.
II. The women present disagreed with wording on the form which stated "I__________ am aware that the focus group discussion will be audio-taped for accurate documentation and that all information will be treated as confidential and anonymous. The tapes and information collected will be stored for a period of five years in accordance with the University of Sydney policy and then destroyed".

III. The women did not want the consent form to state that the discussion was going to be taped because this was no longer true.

IV. The second problem they had was that they did not want the information to be stored at the University of Sydney, or for five years.

V. They requested that a clause be put into the new consent form to say that "documents collected will be community owned and
research in any Aboriginal and Torres Strait Islander community will be owned by that community".

VI. All documents to be stored with the AH&MRC (not University of Sydney).

VII. "Women's business"

(a) No ethnic men involved from grass roots to management

(b) Aboriginal and Torres Strait Islander men’s involvement would be considered, as they are culturally appropriate, but only as a last resort if no appropriate Aboriginal and Torres Strait Islander women available.

(c) This will be up to the discretion of the researcher.

Response

I. I explained that I would not be taping the discussion.
Some women had already signed the consent forms and these are still in my possession. The participants requested that the forms were not to be handed in. I agreed.

A new consent form was developed, including all suggestions and presented to all participants for their response. (see Appendix 2 (b)).

1. What do you think about the set of questions that you have been asked to answer?

They replied that:

I. The format was simple and

II. That the "yes / no" questions are good.

III. All the questions that have "other category" should have space provided for writing
IV. Font should be made bigger, especially for questions which include "if no, go to".

V. Questionnaire pages should be printed back to back.

Response

I. No action required

II. No action required

III. Space provided as requested

IV. Font changed to size 14, and "If no, go to questions size 16

V. Questionnaire pages have been printed back to back.
2. Are there any other questions you would like to include in this questionnaire?

I. New question to read: If you are not drinking now, but drank in the past, for how long in the past did you drink alcohol?

II. Q4. They wanted to read as:

a) "How many natural children have you given birth to?

b) How many of these children are living?

c) How many of these children are still in your care?

d) How many children have you reared?"

III. New question: Did or do your caregivers (mother / father / uncle / aunty / grandparents / other) who raised you drink alcohol?

☐ Yes  ☐ No  ☐ Don't Know

IV. New question before Q 14: "How old were you when you first got drunk?"
Response

I. New question included and is now Q 21 of revised questionnaire

II. Suggestions for Q 4 were accepted and changes made to revised questionnaire.

III. New Question was included and is now Q 15

IV. New question was included and is now Q 20 (b).

3. Will you be interested in changing any of these questions you have responded to?

I. Q 3. They wanted to include "student" and "home duties (mother, carer, wife)".

Page 123 of 193 The development of a culturally sensitive questionnaire related to Alcohol and other Drugs use among Aboriginal and Torres Strait Islander women, © Paige Dowd, 2000
II. Q 7. They wanted to add:

"Have you ever smoked cigarettes? □ Yes □ No

III. Q 8 "Are you currently a smoker?" □ Yes □ No

IV. Q 9 "Do you smoke socially?" □ Yes □ No

V. In Q 11 they requested that the word "seldom" be replaced by "sometimes".

a) Options to be changed to:

□ Once a week
□ Once a fortnight
□ More than 3 days a week
□ Hardly ever

VI. In Q 12 they wanted the wording changed to;
a) "What type / s of alcohol do you drink?" (add line)______________
b) "Do you drink more than one type of alcohol in one drinking session?"

c) "Number your alcohol preferences (from 1 - 6)

☐ Beer
☐ Spirits
☐ Wine
☐ Cocktails
☐ Mixers / subzero etc
☐ Other

VII. Q 13. To become Q 14 and change options to read:

☐ 1 - 3 glasses
☐ 4 - 6 glasses
☐ 6 - 8 glasses
☐ 9 or more glasses
VIII. Q 14. To be changed to Q 11. They also commented that some women would find it hard to remember how long they had been drinking alcohol.

IX. Q 15. Add: "Don't know" as an option

X. Q 16. Add:

- a) Diet pills
  - □ No □ Yes □ Uncertain
- b) Panamax / panadol
  - □ No □ Yes □ Uncertain
- c) Coke (with caffeine)
  - □ No □ Yes □ Uncertain
- d) Cocaine
  - □ No □ Yes □ Uncertain

XI. Women commented that the participants who fill out the questionnaire would find it difficult to complete if family was close by.

XII. Another comment was that when administering the questionnaire this question should be asked one-on-one and not in a group.
XIII. Q 22. They wanted to change the question to read:

a) Do you do any of the following activities? And to add under "Other", e.g. (sport/exercise) (add line) ________________

XIV. Q 17 Are you currently using any of the above drugs?

☐ Yes    ☐ No

a) They wanted the table in Q 17 deleted and replaced with the following options:-

☐ Daily
☐ Weekly
☐ Fortnightly
☐ Monthly
Response

I. Suggestions regarding Q 3 were accepted and changes made.

II. Question was added and is now Q 9 (a).

III. Suggestions were acknowledged and the new question reads:
"Are you currently a tobacco smoker?" □ Yes □ No. This is now Q 10 of the revised questionnaire.

IV. The suggestion was added and is now Q 12

V. The suggestion was accepted and the wording was changed.

The question became Q 17.

VI.

a) Was revised and is now Q 18

b) Suggestion was added and is now Q 18 (a).

c) Suggestion was added and is now Q 18 (b).
VII. The question was revised and is now Q 19.

VIII. Question was changed and became Q 20 (a)

IX. The change was made to include the option "Don't know".

X. Suggested additions were made and the question is now Q 23 in the revised questionnaire.

XI. No action required. However the suggestion was noted.

XII. The comment regarding Q 16 was noted and will be considered in Phase 2 administering phase.

XIII. Q 22 was amended to include suggestions and is now Q 29 of the revised questionnaire.

XIV. Q 17 was deleted.
The options requested were included and this question has become Q 23 (a).

4. Are there any other women’s age groups that should be involved in this Research Study?

I. Participants discussed age boundaries and were concerned that women drink alcohol and women get pregnant prior to 17 years.

a) They wanted to include younger age groups, from 12 years onwards.

b) The women wanted categories listed as:

- 12 - 15 years
- 16 - 18 years
- 19 - 24 years
II. The participants realised that parental consent forms would have to be designed and used when administering the questionnaire.

III. If 12 - 17 year old women wanted to participate they would have to be assured that their information is totally confidential and parent consent would be needed.

IV. These younger age groups should have an opportunity to involve parents with their questionnaire.

V. The participants agreed that this would have to be a separate session from other women wishing to participate.

Response

I. Participants discussed age boundaries and were concerned that women drink alcohol and women get pregnant prior to 17 years.
a) The questionnaire was revised to include younger age groups.

b) All new age categories were not was included. The question has been worded to "17 years & Under".

II. The parental consent form has not been designed however will be, if Ethical endorsement is received regarding the lower age inclusion.

III. If the lower age groups are endorsed by Ethics committees, all participants wishing to take part will be assured that their inclusion would be totally confidential.

IV. The option will be included pending approval of Ethics committees. The need for parental consent will be explained prior to participation of women under the age of 17 years.

V. The option to involve parent will be given in Phase 2 providing the participation age is lowered.
The administration of the questionnaire in Phase 2 has not been finalised however an option for parental involvement in a separate session will be considered as requested.

5. Is this Questionnaire suitable to gather relevant information?

I. The participants said, "yes".

Response

I. No action required.

6. Should I have done this research study another way?

I. "No"
Response

1. No action required.

7. Do you think you will benefit from this discussion?
   If yes, how? and If no, why?

1. Everyone was positive that they would benefit.

Other comments made were:

a) "Opened my eyes up"

b) "Awareness"

c) "Yes, it was good to be involved"

d) "Information package was educational"

e) "It was an opportunity to socialise"

f) "It was good to be involved in the research"

g) "Made them feel they belonged"
Response

All comments were recorded and have been noted.

8. Any other issues of concern?

I. The women accepted the information folder cover.

a) There was no offence taken by the fact that a man had drawn the picture.

b) It was seen as a support base for women's issues and the researcher.

II. Consent form would not be signed by Focus Group 2 as they want the information to be stored with the AH&MRC.
Response

I. No action required.
   
   a) Comments were recorded and accepted by the researcher that the information folder cover could be used.

   b) The researcher agreed that the information cover design was seen as a support base for women's issues and the researcher.

II. A new consent form was designed and was redistributed to all participants for endorsement. The new consent form was also resubmitted to the USHEC and the AH&MRC. The researcher consulted the AH&MRC and advised of the request. The AH&MRC ensured that the request was within reason and was verbally accepted.
3.6. Analysis

A total of 10 women were recruited however 7 women were present on the day with 3 women calling on the morning to apologise.

The group of women were happy that the discussion was not taped. They were a very positive and supportive group, who felt strongly that this research study was Aboriginal and Torres Strait Islander Women’s Business only. They were adamant that they wanted no involvement of men. They claimed the information that they were supplying, and wanted the information to be protected in culturally appropriate and sensitive ways. The information collected was seen by them to be their property, and ownership should remain with participants, Aboriginal and Torres Strait Islander women and organisations that have been involved.

Gathering these women into one group which was run by an Aboriginal person created a sense of empowerment in that they felt they had total control of the process and the outcomes of the research study. There was a strong sense of trust and openness.
between myself and the participants. Their questioning of the contents of the consent form, was an example of how they were willing to question policies of information storage, which had been put in place by government authorities. They refused to sign the consent forms until these changes were made, and demanded that new consent forms which incorporated their suggestions should be developed.

Their stance was an uplifting experience for all of us as it demonstrated that we no longer have to just accept being told what to do, but can take our own action to change policies to ones that suit the community’s needs.

The women who took part were from a diversity of backgrounds and this reflected in their answers to the questions I asked. For example Question 2 (Are there any other questions you would like to include in this questionnaire?) drew a response which provided an excellent new question Q 4 (a) (b) (c) and (d). This may have been as a result of the women’s varied social and employment backgrounds and life experiences.
With Question 3, I was not surprised that they wanted to include "student" and "home duties" as options. However after "home duties" they specified that "mother, carer, wife" should be added. This reflected the fact that there were more mothers and students in this group and that they had a greater awareness of these categories and the duties involved.

They also added to the categories in Q 12 because, as they pointed out, there was a greater variety in drinking practices than I had allowed for in my original question.

With Q 13 they changed the options because they felt the options originally listed would make women feel as though they might be judged or stereotype themselves as heavy drinkers and possibly be dishonest in their answers.

Q's 16 and 17 were combined by them to make Q 23. The point they made was important, as they felt it was necessary to find out not only if the drug was used but how much was used and how regularly. They constructed the question in such a way as made it possible to
get more information whilst cutting back on the content of the question.

Q 4 created a lot of discussion. The women wanted the age group to be lowered to 12 years. Their suggestion seems valid as they realise it is a fact of life that younger Aboriginal and Torres Strait Islander girls under the age of 17 are having babies. They felt concerned from their knowledge of the history of the Stolen Generations, and the community's fears as a result of this, about how information regarding minors can cause ethical and legal implications. However the participants agreed that a way around this was to have a parental consent form supplied. They felt it would be good to have the support and co-operation of the professional Aboriginal and Torres Strait Island Drug and Alcohol, Welfare, Aboriginal Education Assistants and other relevant workers in the field. They also felt it would be necessary to administer the questionnaire individually to minors, with an option that parents could be involved in the process with their child.
The women's reactions to their part in this focus group gave me a sense of the importance of this research study. They took it seriously and showed great generosity and willingness to refine the questions so as to improve the quality of the information gathered.

A check list compiled from suggestions by Phan and Fitzgerald (1996) and Polgar and Thomas (1995) states that focus groups may display a disadvantage if participants become emotional. In this case emotions were highly charged and this was actually an advantage because the emotions were positive and they were a part of the feeling of unity in this group.
3.7. Focus Group 3

Aboriginal Health Workers & Health Professionals

I. Introduction

Focus Group 3 was held at the EORA Centre situated at 333 Abercrombie Street in Redfern between 10am and 12 noon on Monday 19th May 2000. The discussion began at approximately 10.20 am.

There were a total of 10 participants present on the day.

I. I introduced myself to the group and a brief description of the research study, the questionnaire and the expected outcomes were discussed. Participants were then asked to introduce themselves.

II. The participants were given an opportunity to decide how their identity would be disguised however preferred to refer to each other on a first name basis.
III. Then the questionnaire was handed to participants who then completed them.

Response

I. Introduction

I. No action required.

II. No action required.

III. The questionnaires were collected

II. Comments

No comments regarding introduction

Response

I. No action required.
3.8. Focus Group Discussion

Introduction

Step I to VII listed in Focus Group 2 Discussion pg 118 -120 were repeated for this group.

Response

Response from this group coincided with response from Focus Group 2.

The following 8 questions were asked and participant's responses have been included;
1. What do you think about the set of questions that you have been asked to answer?

I. The font size needs to be bigger

II. The age of participants may be a problem especially under 16 years of age.

III. A protocol needs to be developed by an Aboriginal and Torres Strait Islander child protection agency or child protection workers in the main stream.

IV. The questionnaire needs to have a clause stating that, “Confidentiality will be kept”

V. A definition of confidentiality should be included in Questionnaire document.

VI. Why this Research is being conducted
VII. Reasons for gathering the information

Response

3.8. Focus Group Discussion

I. The font size was increased to 14.

II. I amended the questionnaire to include the age groups specified.

III. No action required however the suggestion was noted.

IV. This clause was included to the Research Study Important Information sheet that is a part of the questionnaire document.

V. The consent forms were restructured and presented to participants for endorsement.
VI. and

VII.

The reason why this research and information gathering was being conducted have also been included in the questionnaire document.

1. Are there any other questions you would like to include in this questionnaire?

   I. It was requested that the following question be added regarding smoking.

   a) Are you currently a tobacco smoker?

   b) How many times have you tried to give it up? It was requested that this question be placed after Q 12.

   c) Was pregnancy a reason for giving up smoking?
d) Did or do your care-givers (mother / father / uncle / aunty / grandparents / other) who raised you, smoke?

II. The participants requested that the following question be added regarding Drugs.

a) If you are not currently using drugs, did you stop because you were pregnant? Yes and No options were to be included.

b) Did or do your care-givers (mother / father / uncle / aunty / grandparents / other) who raised you, use illegal drugs? Yes, No and Don't know options were to be given.

III. The participants requested that the following question be added regarding alcohol.

a) How old were you when you first drank Alcohol?

b) Is pregnancy the reason for you giving up drinking alcohol? Yes and No options were to be included.
c) Do you know that Alcohol and other Drugs use can affect you and your baby during pregnancy?

d) Did or do your care-givers (mother / father / uncle / aunty / grandparents / other) who raised you, drink Alcohol? Yes, No and Don't know options were to be given.

IV. Do you have any Health problems or conditions? If yes,

a) Are you on prescribed medication to treat this / these health problems / conditions?

b) What is the name of the medication?

V. Have you ever attended any of the following treatment programs? Yes and No options were to be included.

☐ Drug detox program

☐ Alcohol detox program

☐ Quit smoking program

☐ Alcohol Anonymous

☐ Community / Rehabilitation program
IV. Regarding the revised Q 4, it was requested that the following questions be added,

a) Did you attend a pregnancy care program / s for any of these pregnancies? was requested to be included as Q 4 (b).

b) How old are your children that are still in your care? Should have options 0 - 7 years, 8 - 15 years, 16 years and over included as Q 4 (c).

Response

The suggested questions were added to the revised questionnaire and they are.

I.

a) The question, Are you currently a tobacco smoker?, was included in the questionnaire? This is now Q 10.
b) How many times have you tried to give up smoking? The options Nil, 1 - 2 times, 3 - 4 times and more than 5 times were also included. This is now Q 14 of the revised questionnaire.

c) The following question was included regarding the suggested question. Did you give up smoking because you were pregnant? The options yes and no have been included. The question is now Q 11 of revised questionnaire.

d) The question, Did or do your care givers (mother / father / uncle / aunty / grandparents / other) who raised you, smoke?, was included in the revised questionnaire with the smoking related questions (Q 8).

II.

a) The question was included and is now Q 23 (b).

b) The question The question, Did or do your care givers (mother / father / uncle / aunty / grandparents / other) who raised you, use
illegal drugs?, was included in the revised questionnaire with the drug related questions Q 23 (c).

III.

a) The question was included in the revised questionnaire and is now Q 20 (a).

b) The question was included and is now Q 21 (b).

c) This question was included and is now Q 25 of the revised questionnaire.

d) This question was included and is now Q 15.

IV.

Do you have any health problems or conditions? Yes and No options were given. If yes please, write them here; and space was provided for answer. Is now Q 7 of revised questionnaire.
a) Are you taking prescribed medication to treat this / these conditions?, was included in the revised questionnaire and is now Q 7 (a).

b) What is the name of the medication? This question is now a part of Q 7 (a).

V. The question was included in the revised questionnaire and is now Q 4 (b).

VI. The question, How old are your children that are still in your care?, was included with 0 - 7 years, 8 - 15 years and 16 and over options. This question is now Q 4 (c).

2. Will you be interested in changing any of these questions you have responded to?

I. One of the participants suggested that when administering the questionnaire, the researcher should include the use of visual aids to show the different drugs for Q 20.
a) Q 20. The options daily, fortnightly, monthly and weekly be included on the table.

II. Do you know the effects of A&OD whilst pregnant? True, false and don't know options were to be included.

III. Question 17 was to be deleted.

Response

The questions were amended accordingly, all focus group suggestions were considered.

I. Visual aids may be used for administration of question Q 20 in Phase 2 however this can not be confirmed at this time. Q 20 of the original questionnaire is now Q 23 of revised questionnaire.

a) Q 20. The options daily, fortnightly, monthly and weekly were included on the table in revised questionnaire Q 23.
II. The question Do you know the effects of A&OD whilst pregnant? True, false and don't know options were included. This question is now Q 25.

III. Question 17 was deleted.

3. Are there any other women’s age groups that should be involved in this Research Study?

I. All participants present agreed that the age be lowered to include women aged under 17 years.

II. The participants discussed how the age needed to be lowered, to include younger women who are having babies.

III. The participants discussed that the inclusion of the younger women would benefit them and this research study providing factual statistics.
Response

I. The age was lowered to include women aged under 17 years in Q 1 of revised questionnaire.

II. No further action required

III. No further action required

4. Is this Questionnaire suitable to gather relevant information?

I. The participants agreed unanimously that the use of the questionnaire was an acceptable way of collecting the information needed.

II. The following comment was made "Most women would probably get shy or shamed it you were to tape them"
III. Whilst another participant stated, "Actually I feel better that this discussion was not taped".

IV. The following questions were asked about the research,

a) "How are you going to do this research?"

b) "How are you planning to administer the questionnaire?"

c) "What area the research was going to cover?"

d) "NSW needs to do something like this, as most of the other research that has been done is in WA or other states".

e) How many women would be surveyed?

Response

I. No action required.
II. No action required

III. No action required

All issues relating to taping and face to face interviews will be incorporated in Phase 2.

IV.

a) In response to the question, "How are you going to do this research?", the Methodology for this research study was explained.

b) I responded to the question, "How are you planning to administer the questionnaire?" by explaining that I would utilise local community members and professionals to help me distribute and collect the questionnaire. It was also mentioned funding for the next phase was being sought.
c) "What area the research was going to cover?", it was explained that the current proposal was cover the state of NSW.

d) No action required

e) It was also asked how many women would be surveyed? The response was that I wasn't sure at this stage.

5. Should I have done this research study another way?

I. All participants agreed that involving them in this research study process and the conduction of the focus group discussions, was the right way to conduct Aboriginal and Torres Strait Islander research.

II. The following quotes were made,

a) "the involvement of other Aboriginal and Torres Strait Islander people, in this case women" was the proper way of conducting research.
b) "Especially if it involves our people" (Aboriginal and Torres Strait Islander people).

III. The discussion about this question was very brief and to the point.

Response

I. No action required. The group's comments were noted.

II. No action required. The group's comments were noted.

III. No action required.

6. Do you think you will benefit from this discussion?
   If yes, how? and If no, why?

I. All participants agreed that they had benefited in some way.

   The following quotes were written on the board as requested.
a) "Proactive Way"

b) "Influence Policy Development"

c) "Learning to question Doctors about prescribed drugs?"

d) "Community Awareness"

e) "Having the opportunity to be involved in the development of Aboriginal and Torres Strait Islander Research"

f) "Educational especially the Information Folders".

g) "Inspiring for other Aboriginal and Torres Strait Islander women to see perseverance of the researcher undertaking a difficult project on our behalf"

II. It was also mentioned that as a result of their involvement other Aboriginal and Torres Strait Islander women would benefit.
Response

I. No action required. All quotes were recorded.

II. I explained how important their participation was and that we were all helping other Aboriginal and Torres Strait Islander women.

7. Any other issues of concern?

I. New Consent Form

a) All of the participants present on the day questioned the Consent Form. The following issues raised were;

b) Refusal to sign the consent form. The participants did not agree with the confidential information that was collected being stored at the University of Sydney, nor did the participants agree to the information being stored for the period of five years.
c) That the information collected be stored at the AH&MRC and not the University of Sydney.

d) That the information be stored and destroyed after the Researcher has completed Thesis Document.

e) The paragraph regarding Taping be deleted as the discussion was no longer being taped by the Researcher.

f) If conflict between the AH&MRC and the Researcher. The AH&MRC and the Researcher are to have an understanding of memorandum. The participants present stated that, "In a case of conflict the researcher has the support of the participants to make the final decision".

g) That a paragraph be included stating that, If Aboriginal and Torres Strait Islander men were to be involved, that person was to be made aware of confidentiality and anonymity.
II. In Phase 2 the Researcher would need to provide training to research assistants and presenters regarding administration of the questionnaire.

III. Care should be taken when administering the questionnaire to women in institutions / care. One of the participants suggested that Q 4 may be too sensitive for some women, especially for the women in institutions / care. Need to involve Link Up and appropriate services if this question is included.

IV. The participants believed that the involvement of Aboriginal and Torres Strait Islander women would provide, "Self determination, especially for the Aboriginal and Torres Strait Islander women involved".

V. The women agreed that the Researcher would need to involve a counselor in the research process, especially when administering the questionnaire and collecting the data.
a) It was suggested that this would be of benefit to all Aboriginal and Torres Strait Islander women, researcher and research assistants.

b) The participants were concerned that the research study may impact on the women emotionally, psychologically, spiritually and culturally, surfacing issues beyond the Researchers expertise.

VI. One of the participants present requested that the researcher write the following statement on the board. That this research study is

a) “Women reclaiming women’s space” and

b) “Aboriginal women’s business”

VII. It was requested that a paragraph be included into the consent form resembling I. and II.

VIII. It was suggested that the cover of the Information Folder could have a story included on the back explaining the picture.
Response

I. (a to g) A new Consent form was developed incorporating the issues of concern. These suggestions will be considered in Phase 2.

II. No action required. This issue was recorded and will be considered in Phase 2.

III. No action required. This issue was recorded and will be considered in Phase 2.

IV. No action required. This issue was recorded and will be considered in Phase 2.

V. (a and b) No action required. This issue was recorded and will be considered in Phase 2.

VI. (a and b) No action required. This issue was recorded and will be considered in Phase 2.
VII. The quotes were noted, the consent form and the Research Study Important Information sheet was adjusted to include them.

VIII. It is planned that the cover for the Information folder will have a story included on the back explaining the picture.
3.9. Analysis

There were ten participants in the focus group. All were employed in professional roles, with a majority being health professionals.

Prior to conducting Focus Group 3 I felt slightly weary and unsure of my reception by a more experienced group of women who were also professionally qualified. I felt that my age might be a barrier for gaining respect for my aspirations for this research study. In fact, the participant’s response to the work was warm and supportive as well as intelligent and insightful. The women expressed their appreciation for having research carried out that they felt was meaningful and necessary.

The participant’s response to the Focus Group process and to the aims of the research was completely positive. Again this was an empowering experience as they acknowledged my efforts, and appreciated being included in the consultation and development stages of the research.
A comment was made by one participant that; "Aboriginal and Torres Strait Islander women being invited and involved at this stage of the research process was a symbol of self-determination".

Although Focus Group 3 completed the original questionnaire used by the previous two groups, with this Focus group I experimented by also showing them the revised edition of the questionnaire that was compiled in accordance with the suggestions of Focus Groups 1 and 2. After the original questionnaires were completed the participants were handed the revised questionnaire; both versions were in front of the participants for the course of the discussion. This may have caused confusion as, for instance, referring the participants to, say, Q 20 would cause the participants to hesitate as to which questionnaire I was referring to. The numbering format on the revised questionnaire was another reason for confusion, as there were errors in the final printout.

Many of the comments from Focus Group 3 reinforced the feedback and suggestions from the other two groups.
The participants suggested that professional counsellors should be involved in administering the questionnaire in Phase 2.

The participants felt strongly that the age limit should be lowered to under 17 years. All participants were aware of the ethical guidelines and legal implications, and suggested that protocols should be developed by an Aboriginal and Torres Strait Islander child protection agency, or child protection workers in the mainstream.

The participants felt that the revised Q 4 might be too sensitive for Aboriginal and Torres Strait Islander women in institutions/care. It was suggested that Link Up and appropriate services be involved for women in that situation who are willing and eligible to participate.

The participants suggested that a story be added to the back of the picture on the cover of the information folder and questionnaire, to give other women an understanding of why a male drew the picture.

It was also suggested that when administering Q 22 of the revised questionnaire, visual aids should be used to demonstrate the
appearance of the different drugs, so as to help Aboriginal and Torres Strait Islander women easily identify a drug by its appearance even if they did not know its name.

Also, in relation to Q 22 the participants agreed that there should be additional questions to ask,

"Do you have any health problems or conditions? If Yes –
Are you on prescribed medication to treat this / these conditions?
What is the name of your medication?"

In relation to smoking there were very good suggestions as to other questions that might be added, including,

a) "How many times have you tried to give up?
b) What were your reasons for trying to give up?
c) Was pregnancy a reason for giving up smoking?
d) Did or do your caregivers (mother / father / uncle / aunty / grandparents / other) who raised you, smoke?
Question (d) was added, as results will help the researcher determine whether or not the women were exposed to passive smoking.

The participants also agreed that similar questions should also be asked in relation to drug and alcohol use.

The comments and questions relating to Q 4 (b and c) were included in the revised questionnaire. These were included because the participants thought that answers provided would be more useful when analysing results in Phase 2.
CHAPTER 4
Discussion

4.1. Results

A culturally sensitive questionnaire which has been refined by input from community Aboriginal and Torres Strait Islander women and community members has been produced (see Appendix 4 (b)). It is suitable to be used for the collection of quality information valuable to Aboriginal and Torres Strait Islander women, health professionals and policy makers.

It is estimated that use of this questionnaire could provide specific statistics relating to A&OD among Aboriginal and Torres Strait Islander women, that are currently limited or unavailable.

The involvement of the participants in the focus group discussions and in the consultation process generated a unanimous positive reaction. There was also an empowerment that came about as a result of the women's realisation that they could voice their opinions,
question policy, alter processes and make a difference to the outcomes.

Focus groups were chosen as the preferred method of involving Torres Strait and Islander women in the research processes. The method had multiple benefits because it elicited what participants required from the questionnaire in order to complete it well; the attitude of the participants to the aims of the research and the refinement of the questionnaire to make it a more culturally sensitive and effective research tool.

There were differences between the perspectives of each of the focus groups. For example Group 1 were less concerned about issues of the consent form than Groups 2 and 3. This may be because members of Groups 2 and 3 were older and more experienced. Groups 1 and 3 both mentioned the fact of a man doing the cover drawing, and accepted that it was a symbol of support. Group 3 brought up the question of sensitivity of some of the questions for women in institutions. This showed a high awareness of women involved in the justice system and was a valuable insight. In general
Groups 2 and 3 provided more in-depth discussion and this seemed to be a reflection of their greater experience and knowledge of the issues.

All of the focus groups shared a common attitude of being positive about the aim of the research. The participants liked the Information Folder as a way of introduction for them into the process. Everyone agreed that running focus groups was the best way to carry out consultation, encourage discussion and receive feedback. The participants were very willing to ask questions, give their opinion and engage in discussion. The participants showed that they treated the research subject seriously and were keen to get the questionnaire refined to a high standard so that it would work well for Aboriginal and Torres Strait Islander women. This was demonstrated when they all agreed that the look of the questionnaire could be improved by using a bigger font. As well, their awareness of the need to change the wording of questions to make language more culturally sensitive, was helpful. They all felt concerned about the need for this type of information to be gathered about younger women and their babies, particularly from women under 17 years, because more awareness of
the effects of FAS was needed. They shared the opinion that the research involved Women's Business and that a study such as this and others was needed to provide specific statistics about Aboriginal and Torres Strait Islander women's health. This point agreed with the findings of the 1998 Health and Aged Care report.

All of the advantages of conducting focus groups listed in Phan and Fitzgerald (1996) and Polgar and Thomas (1995) were realised. Only one disadvantage was experienced and that was with the recording of information due to breakdown of audio equipment.
4.2. Limitations

This was a pilot study only.

The number of women involved was small (23). I would have preferred to have 30 women take part.

Receiving ethical endorsement by the AH&MRC and the USHEC was a lengthy process which took over seven months. This limited the time available to complete the research study.

The lower age limit of 17 was seen as a limitation by the participants and researcher, however ethical policy had to be maintained.

Lack of taping facilities limited record keeping.

Lack of office facilities and lack of administration support, particularly during focus group discussions and follow-up, made the process more stressful and increased time-related pressures.
Promotion of the study was minimal and the time lag between advertising and commencement of the focus groups was only two weeks.

Lack of availability of funds up-front limited the researcher’s ability to involve women from distant locations and remote areas, as well as causing inability to carry out normal administration, i.e. faxing, mailing, colour photocopying, binding, transport (petrol costs), paying organisations to access information in booklet or report form, etc.

Time availability of Supervisor was severely limited, owing to other work commitments. Tutor’s time was also limited because of other projects, students and full-time work.

Change over of Honours Co-ordinators during the course of the research study created difficulties because of their different attitudes, opinions, workstyles and viewpoints.

Lack of continuity of office administration staff at Yooroang Garang caused difficulties when trying to get information and access facilities.
4.3. Self Evaluation

While carrying out this research study I have made many discoveries. One was the valuable experience of carrying out an extensive literature review. Apart from developing skills in accessing information by electronic sources, and effectively using the resources of free information from government departments and community organisations, I also gained skills in operating library databases and systems.

Learning how to locate and network with resource people in the community has provided me with a wealth of first-hand information related to my topic. The realisation of how undervalued these people are as keepers of knowledge has increased my respect for people who, although they may not have a piece of paper from any institution, are more than qualified to impart wisdom and uphold cultural values.

In surveying A&OD literature and talking to Researchers, academics, Aboriginal and Torres Strait Islander health workers and Aboriginal and Torres Strait Islander people from amongst urban, rural and
remote communities nationally, I have become aware of a growing opinion that there is a need to return to traditional practices and beliefs such as cultural and spiritual healing. These practices, combined with the invaluable input of community elders and support from the entire community, would aid with the long and painful process of combating A&OD misuse. My view has been reinforced that there is a real need to involve Aboriginal and Torres Strait Islander communities and community members, and particularly women, in health related research and policy development. An example of this was the valuable response of participants in the focus groups, who gave so generously of their time and accorded the research study a high degree of importance because they believed its aims and objectives were worth promoting.

I believe that I have been guided along a path and on this journey my cultural values and spirit have been awakened.

As The NACCHO stated,

"Improving Aboriginal health is not just about improving the physical well being of an individual. It is about working towards the social, emotional and cultural well being of the whole community in which each individual is able to achieve their full potential as a human being" (NACCHO 1997, p. 7)
4.4 Conclusion

This research study has been a positive process which has benefited both the participants of the focus groups and the researcher. It led to a process of education for the Aboriginal and Torres Strait Islander women who took part. The study fulfilled its aims of piloting a culturally sensitive questionnaire among Aboriginal and Torres Islander women on the subject of the use and misuse of alcohol and other drug particularly during pregnancy, as Phase 1 of a larger study aiming to collect data on the knowledge of the effects of A&OD and patterns of use.

This research study has examined the issues related to the use and misuse of A&OD among Aboriginal and Torres Strait Islander women particularly during pregnancy. It has reviewed the literature available on this subject and found that data that specifically details the number of Aboriginal and Torres Strait Islander women involved is currently not available because the methods for information gathering tend to under-identify Aboriginal and Torres Strait Islander mothers and babies, leading to a lack of valid statistics relating to perinatal and
postnatal mortality and morbidity rates. This has masked the extent of the problem.

The questionnaire that has been developed in the course of this research study aims to address this problem of under-identification by making available a culturally sensitive tool, aimed specifically to cater for the target group. As the effects of the use and misuse of A&OD are highly visible within Aboriginal and Torres Strait Islander communities, and the social impact is well documented as part of the day to day experience of Aboriginal and Torres Strait Islander people, it is estimated that a tool such as this would not only be useful for information gathering but would also raise the awareness of the respondents, create discussion and generally educate community members about the extent of the problem. By this means Aboriginal and Torres Strait Islander people might be encouraged to generate community based solutions. Although this questionnaire alone does not address the historical factors which have caused high levels of dysfunction amongst Aboriginal and Torres Strait Islander families and communities (dispossession, assimilationist policies and disempowerment), it is one possible stepping stone on the way to a
heightened awareness of the importance of community consultation as a means of cultural re-empowerment.

4.5 Recommendations

a) That the researcher implements the culturally sensitive questionnaire in Phase 2 of the proposed research study.

b) That researchers include Aboriginal and Torres Strait Islander women in every stage of a research study that is investigating issues relevant to them.

c) That relevant government health organisations increase involvement of Aboriginal and Torres Strait Islander women in policy development, as well as in the processes involved with implementation and evaluation.
d) That the wider community acknowledges the importance of policy flexibility and those policies should be revised regularly to accommodate for the changing needs of Aboriginal and Torres Strait Islander women.

e) That Aboriginal and Torres Strait Islander organisations, communities and individuals continue to acknowledge the importance of undertaking and participating in research, especially relating to Alcohol and Other Drug and Feotal Alcohol Syndrome.
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APPENDIX 1
Attention Aboriginal and Torres Strait Islander Women

My name is Paige Dowd; I am an Aboriginal woman originally from Coonabarabran, NSW, Gamilaroi country. I am a fourth year Honours student at the University of Sydney (Cumberland College) in the Faculty of Health Sciences, Yooroang Garang, The School of Indigenous Health Studies. As part of my course, I am required to complete a Thesis project of approximately 15,000 words.

The research topic is The development of a culturally appropriate questionnaire related to Alcohol and other Drugs use among Aboriginal and Torres Strait Islander women.

The aim of the study is to conduct three focus groups consisting of up to 10 Aboriginal and Torres Strait Islander women, to test pilot and evaluate a questionnaire designed by the researcher. The focus groups will provide feedback and suggestions on the cultural appropriateness of the questionnaire and it's contents. The questionnaire being developed is aimed at gathering information on opinions, attitudes and perceptions of Aboriginal and Torres Strait Islander women with regard to A&OD use and misuse during pregnancy.

Participation in this Research Study will be voluntary. Participants will be 17 years and over at the time of interview. For recruitment purposes this advertisement has been made available to venues such as Aboriginal and Torres Strait Islander organisations; non-Aboriginal and Torres Strait Islander A&OD organisations; mainstream government departments; including ATSIC; Hospitals; NSW Department of Health; Centrelink and local Health Clinics for example.

The Aboriginal and Torres Strait Islander women involved in the focus group discussions will be asked to complete the questionnaire. A set of eight questions will be presented to the focus groups, and participants will then be asked to comment. The focus group comments may be used as quotes within the body of the Thesis.

The focus group discussion will be audio-taped, subject to prior approval of the participants. The information gathered from the questionnaire and the focus group will be treated as confidential and anonymous, this information will be stored for a period of five years and then destroyed in accordance with the University of Sydney policy. To access this information, prior approval of the Chief Investigator (Dr Zakia Hossain) would be needed. The Research Study has met the guidelines for ethical research for the University of Sydney Human Ethics Committee and the Aboriginal Health and Medical Research Council (AH&MRC) of New South Wales (NSW). There will be no obligation for any participants to partake in the entire research project. Participants may decline to answer part of, or the entire questionnaire, or decline to participate in the focus group discussion at any time.

Any person with a concern or complaint about the conduct of a research study can contact the Manager of Ethics and Biosafety Administration, University of Sydney on (02) 9351 4811.

Aboriginal and Torres Strait Islander women who reside in Sydney and surrounding geographical areas who are interested in taking part in this project should contact Ms Paige Dowd Co PO Box 170, Lidcombe, NSW 1825 or

Phone: (02) 93519393 Mobile: (0404) 200629 Fax: (02) 93519400 Email: pdowd@primus.com.au

Your participation is greatly appreciated.
APPENDIX 2 (a)
Consent Form

For Research Study:

The development of a culturally appropriate questionnaire related to Alcohol and other Drugs use among Aboriginal and Torres Strait Islander women.

Investigator:

Ms Paige Dowd
Co / PO Box 170
Lidcombe, NSW 1825

Phone: (02) 93519393 Mobile: (0404) 200629 Fax: (02) 93519400
Email: pdowd@primus.com.au

I________________________am aware that the focus group discussion will be audio-taped for accurate documentation, and that all information will be treated as confidential and anonymous. The tapes and information collected will be stored for a period of five years in accordance with the University of Sydney policy and then destroyed.

I________________________also agree to be interviewed for the above named project under the conditions explained.

SIGNATURE
DATE

Witnessed by researcher________________________

SIGNATURE
DATE

The development of a culturally appropriate questionnaire related to Alcohol and other Drugs use among Aboriginal and Torres Strait Islander women.

Dowd, @2000

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APPENDIX 2 (b)
Consent Form

For Research Study:

The development of a culturally sensitive questionnaire related to Alcohol and other Drugs use among Aboriginal and Torres Strait Islander women.

Researcher: Ms Paige Dowd
Co / PO Box 170
Lidcombe, NSW 1825
Phone: (02) 93519393
Mobile: (0404) 200629
Fax: (02) 93519400
Email: pdowd@primus.com.au

I am aware that this Research study is being conducted by Ms Paige Dowd, a 4th year Aboriginal Honours student enrolled in the Bachelor of Health Sciences (Aboriginal Health and Community Development) program, offered by Yooroang Garang: School of Indigenous Health Studies, within the Faculty of Health Sciences, The University of Sydney. The supervisor for this Research study is Dr Zakia Hossain, School of Behavioural and Community Health Sciences, The University of Sydney.

I have been advised that the researcher will record the issues discussed during the focus group discussion in writing. I have been advised that issues of importance to the focus group collective will be documented and may be included as quotes in the final thesis. Providing prior approval of each participant. The researcher has advised me of the intended use of the information collected and I have been assured that all information will be treated as confidential and anonymous.

I agree that the information collected will be stored at the premises of the Aboriginal Health and Medical Research Council (AH&MRC) and that the information will be destroyed at the discretion of the researcher and the AH&MRC on the completion of the final Thesis document.

I consider it culturally appropriate, sensitive and ethical that all information collected during the focus group discussions will be owned by the Aboriginal and Torres Strait Islander participants and communities that have participated in this research. This research study must be respected and protected as, “Aboriginal and Torres Strait Islander Women's Business”.

I am of the understanding that the information collected (raw data) will not be revealed to any Aboriginal and Torres Strait Islander male, non - Aboriginal and Torres Strait Islander male or female, other than the supervisor, tutor or
selected Yooroong Garang: School of Indigenous Health Studies staff members prior to the approved published document. This will be up to the discretion of the Researcher only. If a discussion occurs the Researcher will not expose the name or any other personal details relating to any participant. Confidentiality and anonymity of participants will remain at all times.

I am aware that a hard copy of the final Thesis document will remain at Yooroong Garang: School of Indigenous Health Studies and in the University of Sydney Library and that this copy will be viewed by staff, other students and the general public.

If at any time prior to the destruction of the information collected should a focus group participant or community member wish to access this information, the Researcher and the AH&MRC must endorse prior written approval collectively. The Researcher and the AH&MRC will be responsible for the total protection of all personal details related to each involved participant, ensuring anonymity.

I____________________ agree to be interviewed for the above named project under the conditions explained.

SIGNATURE________________DATE_____

Witnessed by researcher Paige Dowd

SIGNATURE________________DATE_____

The development of a culturally sensitive questionnaire related to Alcohol and other Drugs use among Aboriginal and Torres Strait Islander women. © Paige Dowd, 2000

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APPENDIX 3 (a)
You are invited to participate in a Research Study, title *The development of a culturally appropriate questionnaire related to Alcohol and other Drugs use among Aboriginal and Torres Strait Islander women*. This study is being conducted by Ms Paige Dowd, a 4th year Aboriginal Honours student enrolled in the Bachelor of Health Sciences (Aboriginal Health and Community Development) program, offered by Yoorroang Garang: School of Indigenous Health Studies, within the Faculty of Health Sciences, The University of Sydney.

The aim of this research study is to conduct three focus groups, each consisting of up to 10 Aboriginal and Torres Strait Islander women, to test pilot and evaluate a questionnaire. The focus groups will provide feedback and suggestions on the cultural appropriateness of the questionnaire and its contents. The questionnaire being developed is aimed at gathering information on opinions, attitudes and perceptions of Aboriginal and Torres Strait Islander women with regard to A&OD use and misuse during pregnancy.

Participation in this Research Study will be voluntary. Participants must identify and be accepted in their community as an Aboriginal and Torres Strait Islander and in addition must be 17 years and over at the time of interview. Recruitment of Aboriginal and Torres Strait Islander women will be achieved by advertisements being made available to venues such as Aboriginal and Torres Strait Islander organisations; non-Aboriginal and Torres Strait Islander organisations; mainstream government departments; including ATSIC; Hospitals; NSW Department of Health; Centrelink and local Health Clinics for example.

The Aboriginal and Torres Strait Islander women involved in the focus group discussions will be asked to complete the questionnaire attached. This process is a "mock survey" focusing on the familiarisation of the Aboriginal and Torres Strait Islander women with the questionnaire. It is hoped that this process will benefit the focus group discussions and outcomes. The following eight questions will be presented to the focus groups, the participants will then be asked to comment.

1. What do you think about the set of questions that you have been asked to answer?
2. Are there any other questions you would like to include in this questionnaire?
3. Will you be interested in changing any of these questions you have responded to?
4. Are there any other women's age groups that should be involved in this Research Study?
5. Is this Questionnaire suitable to gather relevant information?
6. Should I have done this research study another way?
7. Do you think you will benefit from this discussion?
   If yes, how? and If no, why?
8. Any other issues of concern?

The focus group discussions will be audio-taped, subject to prior approval of the participants. The information gathered from the questionnaire and the focus groups will be treated as confidential and anonymous. The information collected will be stored for a period of five years and then destroyed in accordance with the University of Sydney policy.
may be used as quotes within the body of the Thesis. The Research Study has been approved by the University of Sydney Human Ethics Committee and the Aboriginal Health and Medical Research Council of New South Wales (AH&MRC). This study has met the guidelines for ethical research. There will be no obligation for any participants to partake in the entire research project. Participants may decline to answer part of, or the entire questionnaire, or decline to participate in the focus group discussion at any time.

Any person with concerns or complaints about the conduct of a research study can contact the Manager of Ethics and Biosafety Administration, University of Sydney on (02) 9351 4811.

For further information you can contact
Associate Investigator:

Ms Paige Dowd
Co / PO Box 170
Lidcombe, NSW 1825

Phone: (02) 93519393 Mobile: (0404) 200629 Fax: (02) 93519400
Email: pdowd@primus.com.au
Research Study

Important Information

You are invited to participate in a Research Study, title *The development of a culturally sensitive questionnaire related to Alcohol and other Drugs use among Aboriginal and Torres Strait Islander women*. This study is being conducted by Ms Paige Dowd, a 4th year Aboriginal Honours student enrolled in the Bachelor of Health Sciences (Aboriginal Health and Community Development) program, offered by Yooroang Garang: School of Indigenous Health Studies, within the Faculty of Health Sciences, The University of Sydney. The supervisor for this Research study is Dr Zakia Hossain, School of Behavioural and Community Health Sciences, The University of Sydney.

The Research Study has been approved by the University of Sydney Human Ethics Committee and the Aboriginal Health and Medical Research Council (AH&MRC) of New South Wales (NSW) meeting the guidelines for ethical research.

The aim of this research study is to conduct three focus groups, each consisting of up to 10 Aboriginal and Torres Strait Islander women, to test pilot and evaluate a questionnaire. The focus groups will provide feedback and suggestions about the questionnaire and its contents for the development of a culturally sensitive questionnaire. The questionnaire being developed is aimed at gathering information on opinions, attitudes and perceptions of Aboriginal and Torres Strait Islander women with regard to Alcohol and other Drug (A&OD) use and misuse during pregnancy.

Participation in this Research Study will be voluntary. Participants must identify and be accepted in their community as an Aboriginal and Torres Strait Islander and in addition must be 17 years and over at the time of interview. Recruitment of Aboriginal and Torres Strait Islander women will be achieved by advertisements being made available to venues such as Aboriginal and Torres Strait Islander organisations; non-Aboriginal and Torres Strait Islander organisations; mainstream government departments; including Aboriginal and Torres Strait Islander Commission (ATSIC); Hospitals; NSW Department of Health; Centrelink and local Health Clinics for example.

The Aboriginal and Torres Strait Islander women involved in the focus group discussions will be asked to complete the questionnaire developed by the
researcher. This process is a "mock survey" focusing on the familiarisation of the Aboriginal and Torres Strait Islander women with the questionnaire. It is hoped that this process will benefit the focus group discussions and outcomes. The following eight questions will be presented to the focus groups, the participants will then be asked to comment.

1. What do you think about the set of questions that you have been asked to answer?
2. Are there any other questions you would like to include in this questionnaire?
3. Will you be interested in changing any of these questions you have responded to?
4. Are there any other women's age groups that should be involved in this Research Study?
5. Is this Questionnaire suitable to gather relevant information?
6. Should I have done this research study another way?
7. Do you think you will benefit from this discussion?
   If yes, how? and If no, why?
8. Any other issues of concern?

The Researcher will record issues discussed in writing during the focus group discussion. The issues of importance to the focus group collective will be documented and may be included as quotes in the final Thesis document, providing prior approval of each participant. The information gathered from the questionnaire and the focus group discussions will be treated as confidential and anonymous. The information collected will be stored at the premises of the AH&MRC and the information will be destroyed at the discretion of the researcher and the AH&MRC on the completion of the final Thesis document.

The researcher will ensure that all information collected will be protected in a culturally sensitive manner and ethical requirements will be implied to ensure that all information will be owned by the Aboriginal and Torres Strait Islander participants and communities that have participated in this research. The research study will be respected and protected as Aboriginal and Torres Strait Islander Women's Business.

I am of the understanding that the information collected (raw data) will not be revealed to any Aboriginal and Torres Strait Islander male, non-Aboriginal and Torres Strait Islander male or female, other than the supervisor, tutor or selected Yooroong Garang: School of Indigenous Health Studies staff members prior to the approved published document. This will be up to the discretion of the Researcher only.
If a discussion occurs the Researcher will not expose the name or any other personal details relating to any participant. Confidentiality and anonymity of participants will remain at all times.

I am aware that a hard copy of the final Thesis document will remain at Yooroong Garang: School of Indigenous Health Studies and in the University of Sydney Library and that this copy will be viewed by staff, other students and the general public.

If at any time prior to the destruction of the information collected should a focus group participant or community member wish to access this information, the Researcher and the AH&MRC must endorse prior written approval collectively.

The Researcher and the AH&MRC will be responsible for the total protection of all personal details related to each involved participant, ensuring anonymity.

There will be no obligation for any of the focus group participants to participate in the entire research study. Participants may decline to answer part of, or the entire questionnaire, or decline to participate in the focus group discussion at any time.

Any person with concerns or complaints about the conduct of a research study can contact the Manager of Ethics and Bio-safety Administration, University of Sydney on (02) 9351 4811.

For further information you can contact:

**Researcher:** Ms Paige Dowd  
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**Email:** pdowd@primus.com.au

*The development of a culturally sensitive questionnaire related to Alcohol and other Drugs use among Aboriginal and Torres Strait Islander women.*

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APPENDIX 4 (a)
Questionnaire

This survey is confidential, please do not write your name.

Please tick YES or NO, TRUE, FALSE or UNCERTAIN or CIRCLE the appropriate answer. If the question is not applicable, please tick NO.

Q 1. What is your age group?
   - 17 - 24
   - 25 - 32
   - 33 - 40
   - 40 Plus

Q 2. What is your marital status?
   - Married
   - Single
   - De-facto
   - Divorced / Separated
   - Widowed

Q 3. Are you Employed [Full time / Part time / Casual]?
   - Yes
   - No

Q 4. How many children do you have?

Q 5. Are you currently pregnant?
   - Yes
   - No
   If No go to Q 7

Q 6. What is your pregnancy stage?
   - 0 - 3mths
   - 3 - 6mths
   - 6 - 9mths

Q 7. Do you smoke cigarettes?
   - Yes
   - No
   If No go to Q 10

Q 8. How many cigarettes do you smoke per day?
   - 1 - 4
   - 5 - 9
   - More than 10

Q 9. How long have you been smoking?
   - less than 1 year
   - 3 - 5 years
   - 10 or more
   - 1 - 2 years
   - 6 - 9 years

Q 10. Do you drink alcohol?
   - Yes
   - No
   If Yes go to Q 16
   If No go to Q 16

The development of a culturally appropriate questionnaire related to Alcohol and other Drugs use among Aboriginal and Torres Strait Islander women. Dowd, @2000
Q 11. How often do you drink alcohol?
- [ ] One day a week
- [ ] 2 - 3 days a week
- [ ] More than 3 days a week
- [ ] Seldom

Q 12. What type of alcohol do you drink?
- [ ] Beer
- [ ] Spirits
- [ ] Wine
- [ ] Other

Q 13. When you drink, how many glasses do you drink per day?
- [ ] 1 - 2 glasses
- [ ] 3 - 4 glasses
- [ ] 5 - 6 glasses
- [ ] More than 6 glasses

Q 14. How long have you been drinking alcohol?
- [ ] less than 1 year
- [ ] 1 - 2 years
- [ ] 3 - 5 years
- [ ] 6 - 9 years
- [ ] 10 or more
- [ ] 10 or more

Q 15. What is a safe amount of Alcohol that can be drunk per day?
- [ ] Nil
- [ ] 1 - 2 Glasses
- [ ] 3 - 4 Glasses
- [ ] 5 - 6 Glasses
- [ ] More than 6 Glasses

Q 16. Have you used or had any of the following drugs in the last 2 years?
- [ ] Tobacco
- [ ] Snow Cones
- [ ] Codeine
- [ ] Serepax
- [ ] Methadone
- [ ] Heroin
- [ ] LSD
- [ ] Trips
- [ ] Speed
- [ ] Ecstasy / Eckies
- [ ] Marijuana / Dope / Yandi / Pot
- [ ] Caffeine / Coffee / Tea

Q 17. Are you currently using any of the following drugs?
- [ ] Tobacco / Smokes
- [ ] Snow Cones
- [ ] Codeine
- [ ] Serepax
- [ ] Methadone
- [ ] Heroin
- [ ] LSD
- [ ] Trips
- [ ] Speed
- [ ] Ecstasy / Eckies
- [ ] Marijuana / Dope / Yandi / Pot
- [ ] Caffeine / Coffee / Tea
Q 18. Are you aware of any danger for Alcohol and drug use whilst pregnant?

☐ Yes   ☐ No   ☐ Uncertain

Q 19. Certain drug use during pregnancy can result in babies having breathing problems.

☐ True   ☐ False   ☐ Uncertain

Q 20. When pregnant women drink alcohol there is a risk that their child may be affected with learning disabilities?

☐ True   ☐ False   ☐ Uncertain

Q 21. Are you aware of any Alcohol or Drug information services in your Community?

☐ Yes   ☐ No   ☐ Uncertain

If YES,
Could you name one or a few of them: __________________________________________

Q 22. Do you do any of the following activities? e.g.

Walking

☐ Every day  ☐ Most days  ☐ Less than once a week  ☐ Never

Going to the gym

☐ Every day  ☐ Most days  ☐ Less than once a week  ☐ Never

Swimming

☐ Every day  ☐ Most days  ☐ Less than once a week  ☐ Never

Other, please specify ____________________________

☐ Every day  ☐ Most days  ☐ Less than once a week  ☐ Never

Q 23. How would you rate your fitness?  

(Please circle the preferred choice)

Excellent  Good  Moderate  Fair  Poor

Q 24. Are you aware of the programs that operate in your community that can improve your overall health and general fitness?

☐ Yes   ☐ No   ☐ Uncertain

If YES,
Q 25. Could you name a few?

________________________________________________________

Thank you for your interest and time in completing this survey

The development of a culturally appropriate questionnaire related to Alcohol and other Drugs use among Aboriginal and Torres Strait Islander women.  

Dowd, @2000
SISTERS, TAKE CARE OF BABY, FOR THEY ARE OUR FUTURE AND OUR HOPE.
Questionnaire

This survey is confidential, please do not write your name.
Please tick YES or NO, TRUE, FALSE or DON'T KNOW.
If the question is not applicable, please tick NO.

Q 1. What is your age group?
   □ 17 Years & Under
   (You can write your age if you wish) _____
   □ 18 - 24
   □ 25 - 32
   □ 33 - 40
   □ 41 Plus

Q 2. What is your marital status?
   □ Married
   □ Single
   □ De-facto / Married Up
   □ Divorced / Separated
   □ Widowed

Q 3. Please tick the box / s that apply to you,
   □ Employed Full Time
   □ Employed Part Time
   □ Employed Casual
   □ Student Full Time
   □ Student Part Time
   □ Community Development Employment Project (CDEP).
   □ Carer (Elders, children or other)
   □ Unemployed
Q 4.
(a) How many natural children have you given birth to? ______

(b) Did you attend a / pregnancy care program / s for any of these pregnancies? □ Yes □ No

(c) How old are your children that are still living with you?

□ 0 - 7 years
□ 8 - 15 years
□ 16 years and over

(d) How many children have you reared apart from your own? ______

Q 5. Are you currently pregnant? □ Yes □ No
If No go to Q 7

Q 6. What is your pregnancy stage in months? ________________

(a) Have you been to see a doctor / other health provider to confirm your pregnancy? □ Yes □ No

(b) If Yes, Did your doctor / other health providers give you advice or information on the effects of Alcohol and other Drug use during pregnancy? □ Yes □ No

(c) Are you attending a pregnancy care / education program; □ Yes □ No
If No why?
Q 7. Do you have any Health problems / conditions?  
□ Yes    □ No

If Yes, Please write them here;

__________________________________________________________

(a) Are you taking prescribed medication to treat this / these conditions?  
□ Yes    □ No

If Yes, Please list which medication / s.

__________________________________________________________
Smoking

The following questions are related to smoking? (Q8 to Q 14)

Q 8. Did or do any of your care-givers who raised you, smoke?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don't Know</th>
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<tbody>
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<td>Grandparents</td>
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<td>Sister</td>
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<td>Brother</td>
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<td>Other</td>
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<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Don't Know</td>
</tr>
</tbody>
</table>

Q 9. Have you ever smoked tobacco / cigarettes?  

**If No, go to Q 15.**

(b) Have you ever attended any of the following treatment programs?  

**If yes, tick appropriate box / s.**  

**If Other please name program / s in space provided.**

- Quit smoking program
- Smoke-ender’s program
- Other program ____________________________
Q10. Are you currently a tobacco / cigarette smoker?  □ Yes    □ No

If Yes,

(a) How many cigarettes do you smoke per day? _____________

Q 11. Did you give up smoking because you were pregnant?  □ Yes    □ No

Q 12. Do you smoke socially?    □ Yes    □ No

Q 13. How long have you been smoking? Please write your answer in terms of years and / or months.

Years  _______________

Months _______________

Q14. How many times have you tried to give smoking up? ________
Alcohol

The following questions are related to alcohol? (Q15 to Q 22)

Q 15. Did or do your care - givers who raised you, drink alcohol?

<table>
<thead>
<tr>
<th></th>
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<th>No</th>
<th>Don't Know</th>
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<td>Other</td>
<td>□</td>
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</table>

Q 16. Do you currently drink alcohol? □ Yes □ No

If No go to Q 21,
If you have never drank Alcohol go to Q22,
If Yes,
Approximately how long have you been drinking alcohol? Please write your answer in terms of years and / or months.

<table>
<thead>
<tr>
<th>Years</th>
<th>Months</th>
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</table>

Q 17. How often do you drink alcohol?

□ Hardly Ever
□ Sometimes
□ Once a fortnight
□ One day a week
□ More than 3 days a week

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Q 18. What type / s of Alcohol do you drink?

(a) Do you drink more than one type of Alcohol in one drinking session? □ Yes □ No

(b) Number your Alcoholic preferences (For example 1 being most popular and 8 being the least popular).

- □ Beer
- □ Spirits
- □ Wine
- □ Methylated Spirits (Metho)
- □ Alcoholic Cider
- □ Mixer / s (Sub Zero, Lemon Rusky)
- □ Other ________________________

Q 19. This question refers to preference number 1 in previous question. When you drink, how many glasses do you drink per day? ________________________

Q 20.

(a) How old were you when you first drank Alcohol? ___________

(b) How old were you when you first got drunk? ___________

Q 21. If you are not drinking Alcohol now, but have drank in the past. How long did you drink for? ________________________

(a) Have you ever attended any of the following treatment programs? □ Yes □ No

If yes, tick appropriate box / s
If program not listed add in space provided

- □ Alcohol detox program
- □ Alcohol Anonymous (A A) Program
- □ Community / Rehabilitation program
- □ Other ________________________

The development of a culturally sensitive questionnaire related to Alcohol and other Drugs use among Aboriginal and Torres Strait Islander women. © Paige Dowd, 2000
(b) Is pregnancy the reason for you giving up drinking alcohol?
   □ Yes     □ No

Q 22. What is a safe amount of Alcohol that can be drank per day?
   □ Nil
   □ 1 - 2 glasses
   □ 3 - 4 glasses
   □ 5 - 6 glasses
   □ More than 6 glasses
   □ Don't Know
Drugs

The following questions are related to Drugs. (Q 23 to Q27)

Q 23.

Have you used any of the following drugs in the last 5 years? (Please tick appropriate box or boxes).

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<th>DRUG</th>
<th>□ No</th>
<th>□ Yes</th>
<th>□ Don't Know</th>
<th>□ Daily</th>
<th>□ Weekly</th>
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<th>□ Fortnightly</th>
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</tbody>
</table>

The development of a culturally sensitive questionnaire related to Alcohol and other Drugs use among Aboriginal and Torres Strait Islander women.

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(a) Have you used any Drugs not mentioned on the previous table? □ Yes □ No

If Yes? Please list

(b) If you are not currently using Drugs, Did you stop because you were pregnant? □ Yes □ No

(c) Did or do your care-givers who raised you, use any of the drugs listed in Q 23.?

<table>
<thead>
<tr>
<th>Mother</th>
<th>□ Yes</th>
<th>□ No</th>
<th>□ Don't Know</th>
</tr>
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<td>□ No</td>
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<td>□ Yes</td>
<td>□ No</td>
<td>□ Don't Know</td>
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<td>□ Yes</td>
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<td>□ Don't Know</td>
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<td>□ No</td>
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<tr>
<td>Other</td>
<td>□ Yes</td>
<td>□ No</td>
<td>□ Don't Know</td>
</tr>
</tbody>
</table>
(d) Have you ever attended any of the following treatment programs? □ Yes □ No

If Yes, please tick appropriate box / s.
If Other please name program / s in space provided.

□ Methadone Program
□ Community Drug Rehabilitation
□ Other _____________________
Q 24. Certain drug use during pregnancy can result in babies having breathing problems.

☐ True
☐ False
☐ Don't Know

Q 25. Do you know whether Alcohol and other Drugs use can affect you and your baby while you are pregnant?

☐ Yes
☐ No
☐ Don't Know

Q 26. When pregnant women drink alcohol there is a risk that their child may be affected with learning disabilities?

☐ True
☐ False
☐ Don't Know

Q 27. Have you heard of Fetal Alcohol Syndrome (FAS)?

☐ Yes
☐ No
☐ Don't Know
The following questions are general questions. (Q 28 - 31)

Q 28. Are you aware of any Alcohol or Drug information services in your Community?

☐ Yes
☐ No

*If YES,* Could you name one or a few of them:


Q 29. Do you do any of the following activities? ☐ Yes ☐ No

<table>
<thead>
<tr>
<th>If Yes, Please tick appropriate box /s.</th>
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</thead>
<tbody>
<tr>
<td>Walking</td>
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<tr>
<td>☐ Never</td>
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<tr>
<td>☐ Less than once a week</td>
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<tr>
<td>☐ More than once a week</td>
</tr>
<tr>
<td>☐ Most days</td>
</tr>
<tr>
<td>☐ Every day</td>
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</tbody>
</table>

Q 30. How would you rate your fitness?

☐ Poor
☐ Fair
☐ Moderate
☐ Good
☐ Excellent

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Q 31. Are you aware of the programs that operate in your community that can improve your overall health and general fitness?

☐ Yes
☐ No

*If Yes, Could you name a few?*

(a) Do you access these community base services?

☐ Yes  ☐ No

*If No, Why?*

Thank you for your interest and time in completing this survey.

The development of a culturally sensitive questionnaire related to Alcohol and other Drugs use among Aboriginal and Torres Strait Islander women.

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APPENDIX 5 (a)
Aboriginal Health & Medical Research Council of New South Wales

AH&MRC ETHICS COMMITTEE

Ms Paige Dowd
6/76-82 Woids Avenue
Hurstville NSW 2220

Dear Ms Dowd,


Concerning your request for our Ethics Committee to evaluate and support the above-mentioned epidemiological research proposal the Committee responds as follows:

The Ethics Committee is committed to professional projects in essential epidemiological and medical research that increase scientific knowledge, demonstrate benefit to our communities and provide transfer of skills to our medical workforce.

Included in the criteria used by the Committee to evaluate applications for proposed research and publications of statistical data on Aboriginal health are the following principles which are contained within the AH&MRC publication Guidelines for Research into Aboriginal Health.

i. that in accordance with the priorities set out in the National Aboriginal Health Strategy and the Report of the National Workshop on Ethics of Research in Aboriginal Health, research proposals must advance scientific knowledge so as to result in demonstrated additional benefit to Aboriginal communities.

ii. that there be Aboriginal community control over all aspects of the proposed research including research design, ownership of data, data interpretation and publication of research findings.
iii. that the research to be conducted in a manner sensitive to the cultural principles of Aboriginal society.

iv. that Aboriginal communities and organisations be reimbursed for all costs arising from their participation in the research process.

v. that Aboriginal communities and organisations should be able to benefit from the transfer of skills and knowledge arising from the research project.

Furthermore, the Committee assumes that applicants of research proposals and epidemiological publications of Aboriginal health are conversant with the following documents.

1. Report of the National Workshop on Ethics of Research in Aboriginal Health (NAIHO) [1987]

2. Guidelines on Ethical Matters in Aboriginal and Torres Strait Islander Health research (NH&MRC) [1991]

3. NSW Aboriginal Health – Information Guidelines (NSW Aboriginal Health Partnership, NSW Health/AH&MRC) [1998]

4. Guidelines for Research into Aboriginal Health (AH&MRC Ethics Committee) [1999]

The Committee has evaluated your project and provides the following suggestions and comments:

(i) It is noted that the title of the thesis limits the study to “Koori women.” If this is not intentional it may be necessary to widen the name of the topic to by replacing ‘Koori’ with ‘Aboriginal women’ enabling Aboriginal women from other parts of NSW, e.g. Murris as well as other parts of Australia to participate. The statement on page 1 of the Thesis Proposal, namely, that “A&OD misuse is a well-known cause of ill health among Koori people throughout Australia” may also need clarification in light of the fact that advertising material for the project is directed at women within the wider Aboriginal community.

(ii) Statistics used in Thesis Proposal. Whilst some useful statistics concerning alcohol use by the Aboriginal and Non-Aboriginal communities are incorporated into the brief it should be noted that more recent material is available from the Australian Bureau of Statistics e.g. the second edition (1999) of the 1997 report The Health & Welfare of Aboriginal & Torres Strait Islander Peoples. (ABS catalogue 4704.0 or AIHW catalogue No. IHW3)

(iii) It is suggested your usage of an acronym for Aboriginal and Torres Strait Islander peoples comply with the ATSIC Chairperson’s
recommendation to all government departments that the acronym “ATSI” not be used as it is culturally inappropriate.

(iv) With regards to the actual project which is presumed to be:

(a) “Developing an ultimate appropriate questionnaire that can be used for further A&OD surveys at a later date”; and

(b) Piloting “the Proposed Questionnaire with a pilot group of 6-8 Koori women to discuss the appropriateness of the questionnaire.”

the committee notes the following:

(1) 4.1 of the application mentions that all subjects are over 17 years of age whilst the brief and 5.4 mentions 18 years of age.

(2) Recruitment of subjects from A&OA centres might not be necessarily representative in terms of an objective evaluation of the questionnaire.

(3) The limitation of numbers within the initial focus group, whilst helpful, may be insufficient to draw definitive conclusions on the suitability or relevance of the questionnaire.

(4) The agreement by participants for the recording of the group session would need to be obtained individually, prior to participation within the group, to avoid conformity by peer group pressure.

(5) The merits of the focus group are not immediately apparent. Whilst the 5 evaluation questions are astute to determine attitudes and reactions to the questionnaire this could quite as easily be ascertained through individual responses. There could arise social and emotional well-being matters that cannot be addressed in open forum, compounded by the absence of trained grief and loss counselling personnel. Conversely, pertinent information could be suppressed within a group situation, distorting response. It may also be counter-productive to have pregnant women speak collectively about any implied irresponsibility with regard to vulnerability to unborn children, hence affecting the objectivity of process.

(6) The advertising of food provision for subjects participating in a one-hour discussion session could also be vulnerable to the criticism of lack of scientific objectivity due to alleged inducement.

(7) The comment that the aim for the focus group will be “to ascertain the opinion of Koori women regarding knowledge, attitudes and usage of A&OD patterns among Koori women, particularly during pregnancy.” is certainly
presumptuous, unscientific from an epidemiological perspective and beyond the scope of this project.

(v) **Consent Agreement.** Whilst the audio-tapes are to be kept for five years before destruction 6.4(d) there is no reference to this fact in the Consent Form or Subject Information Sheet. There would need to show cause why such audio records, once utilised and transcribed, could not be destroyed.

Concerning 7.4(a), since essential criteria are not in the Consent Form itself but on the two subsequent documents, each numbered separately, either the information should be within the Consent Form or alternatively, the subsequent documents should become part of the Consent Agreement by chronologically numbering them within the document for which the applicant is providing consent.

(vi) You have mentioned the possibility of subsequent publication. The applicant is referred to the Council’s ethical requirement to evaluate such documents from a cultural perspective prior to publication.

(vii) **Questionnaires.**

(a) Q1 What is the minimum age of the women in this project? The application states 17 years; the brief has 18 years and the implication of this question is that they are 16. Or are these only meant for the focus group? The legal implications of 16 year old pregnant subjects should flag caution here.

(b) Q3 & Q4 Unidentified information when it relates to Aboriginal communities can be potentially identifiable. Inclusion of towns would have to be very carefully handled and there would need to be justification for their insertion. It is already known where D&AO services are available.

(c) There is no considered benefit that could arise from including “tribal or language grouping” in this particular questionnaire and it could lead to misinterpretation and misinformation.

(d) Q14 There should be a provision for the category ‘Seldom’.

(e) Q17 This question needs to be seen in synopsis with Q14 as types of alcohol and the number of standard volumes used (glasses) are essential in determining actual limits and misuse.

(f) Q18 The question is considered redundant as the subsequent questions could be seen as insensitive and discourage an objective response.

(g) Q19 The question should be rephrased to something like: “What is a safe amount of alcohol that can be drunk per
(h) Q20 This question would be redundant in light of (g).

(i) Q21 Is there some epidemiological reason for only selecting one drug use? Knowledge of multiple drug use could be quite significant.

(j) Q22 This should be depersonalised and to encourage an objective response it should be rephrased to something like “Are you aware of any danger for alcohol and drug use whilst pregnant?”

(k) Q23 This question should be rephrased to read: “Certain drug use during pregnancy can result in babies having breathing problems.” (True) (False) or (Uncertain rather than “Don’t know”)

(l) Q24 This question should be rephrased to read: “Where pregnant women drink alcohol there is a risk that their child may be affected with learning disabilities.” (True) (False) or (Uncertain)

(m) Q25 This question should be rephrased to read: “Are you aware of any Alcohol or Drug information services in your community?”

(n) Q26 The word “Exercise” is ambiguous and there would need to be more specific detail for any definitive response, e.g. walking etc.

(o) Q28 It is not considered advisable to include this area of questioning in this particular questionnaire.

(p) Q31 This question is considered redundant as it is a leading type question. Since Q29 incorporates the concept of ‘improvement’ that question should provide sufficient information for the purposes of the study.

The Ethics Committee has given careful consideration to your research proposal and grants endorsement subject to the above-mentioned qualifications being complied with. To expedite your research schedule, should an amended application incorporate these qualifications there is no need to await the Committees prior approval. Please forward the amended document for the Committee’s endorsement at its next meeting.

On behalf of the AH&MRC Ethic Committee,

Yours sincerely

Stephen Woods
Chairperson

21st March 2000
APPENDIX 5 (b)
Dr Z Hossain
School of Behavioural and Community Health Sciences

19 April 2000

Dear Dr Hossain

Title: The development of a culturally appropriate questionnaire related to alcohol and other drug use among Aboriginal and Torres Strait Islander women.

Ref No: 99/12/70

Thank you for your correspondence dated 6 April 2000. After considering your request to conduct additional procedures/ minor variations relating to the above protocol, it was the Committee's opinion that there were no ethical objections to this work being carried out, and therefore recommends approval to proceed. Approval was granted subject to the following:

- The final letter of approval from the AH&MRC should be lodged with the Ethics Office prior to commencement of the study.

The following variations were approved:

- Change in project title and minor amendments to the design, analysis and aim of the study as recommended by the AH&MRC
- AH&MRC recommended amendments to the Subject Information Statement and Consent Form.
- AH&MRC recommended amendments to the Advertisement.
- AH&MRC recommended amendments to the questionnaire.

This additional information will be filed with your original application.

In order to comply with the National Health and Medical Research Council guidelines, and in line with the Human Ethics Committee requirements the Chief Investigator's responsibility is to ensure that:

1. The individual researcher's protocol complies with the final and Committee approved protocol.
2. Modifications to the protocol cannot proceed until such approval is obtained in writing.
3. The confidentiality and anonymity of all research subjects is maintained at all times, except as required by law.
4. All research subjects are provided with a Subject Information Sheet and Consent Form.
5. The Subject Information Sheet and Consent Form be on University of Sydney letterhead and include the full title of the research project and telephone contacts for the researchers.
6. The following statement appears on the Subject Information Sheet:

   Any person with concerns or complaints about the conduct of a research study can contact the Manager of Ethics and Biosafety Administration, University of Sydney, on (02) 9351 4811.

7. The standard University policy concerning storage of data should be followed. While temporary storage of audiotapes at the researcher's home or an off-campus site is acceptable during the active transcription phase of the project, permanent storage should be at a secure, University controlled site for a minimum of five years.
8. A progress report is provided by the end of each year. Failure to do so will lead to withdrawal of the approval of the research protocol and re-application to the Committee must occur before recommencing.
9. A report and a copy of the published material is provided at the end of the project.

Yours sincerely,

Professor Barry Baker
Chairman
Human Ethics Committee

cc. Ms P Dowd 6/76-82 Woids Avenue Hurstville NSW 2220
Consent Form

For Research Study:

The development of a culturally appropriate questionnaire related to Alcohol and other Drugs use among Aboriginal and Torres Strait Islander women.

Investigator:

Ms Paige Dowd
Co / PO Box 170
Lidcombe, NSW 1825

Phone: (02) 95470435   Fax: (02) 93519400
Email: pdowd@primus.com.au

I ___________________ am aware that the focus group discussion will be audio-taped for accurate documentation, and that all information will be treated as confidential and anonymous. The tapes and information collected will be stored for a period of five years in accordance with the University of Sydney policy and then destroyed. I____________________ also agree to be interviewed for the above named project under the conditions explained.

SIGNATURE _______________________________
DATE __________________

Witnessed by researcher _______________________________

SIGNATURE _______________________________
DATE __________________

The development of a culturally appropriate questionnaire related to Alcohol and other Drugs use among Aboriginal and Torres Strait Islander women.
Research Study

Important Information

You are invited to participate in a Research Study, title The development of a culturally appropriate questionnaire related to Alcohol and other Drugs use among Aboriginal and Torres Strait Islander women. This study is being conducted by Ms Paige Dowd, a 4th year Aboriginal Honours student enrolled in the Bachelor of Health Sciences (Aboriginal Health and Community Development) program, offered by Yoorong Garang: School of Indigenous Health Studies, within the Faculty of Health Sciences, The University of Sydney.

The aim of this research study is to conduct three focus groups, each consisting of up to 10 Aboriginal and Torres Strait Islander women, to test pilot and evaluate a questionnaire. The focus groups will provide feedback and suggestions on the cultural appropriateness of the questionnaire and its contents. The questionnaire being developed is aimed at gathering information on opinions, attitudes and perceptions of Aboriginal and Torres Strait Islander women with regard to A&OD use and misuse during pregnancy.

Participation in this Research Study will be voluntary. Participants must identify and be accepted in their community as an Aboriginal and Torres Strait Islander and in addition must be 17 years and over at the time of interview. Recruitment of Aboriginal and Torres Strait Islander women will be achieved by advertisements being made available to venues such as Aboriginal and Torres Strait Islander organisations; non-Aboriginal and Torres Strait Islander organisations; mainstream government departments; including ATSIC; Hospitals; NSW Department of Health; Centrelink and local Health Clinics for example.

The Aboriginal and Torres Strait Islander women involved in the focus group discussions will be asked to complete the questionnaire attached. This process is a "mock survey" focusing on the familiarisation of the Aboriginal and Torres Strait Islander women with the questionnaire. It is hoped that this process will benefit the focus group discussions and outcomes. The following eight questions will be presented to the focus groups, the participants will then be asked to comment.

1. What do you think about the set of questions that you have been asked to answer?
2. Are there any other questions you would like to include in this questionnaire?
3. Will you be interested in changing any of these questions you have responded to?
4. Are there any other women's age groups that should be involved in this Research Study?
5. Is this Questionnaire suitable to gather relevant information?
6. Should I have done this research study another way?
7. Do you think you will benefit from this discussion?
   If yes, how? and If no, why?
8. Any other issues of concern?

The focus group discussions will be audio-taped, subject to prior approval of the participants.

The information gathered from the questionnaire and the focus groups will be treated as confidential and anonymous. The information collected will be stored for a period of five years and then destroyed in accordance with the University of Sydney policy. Comments

The development of a culturally appropriate questionnaire related to Alcohol and other Drugs use among Aboriginal and Torres Strait Islander women. Dowd, @2000

Page 2 of 6
may be used as quotes within the body of the Thesis. The Research Study has been approved by the University of Sydney Human Ethics Committee and the Aboriginal Health and Medical Research Council of New South Wales (AH&MRC). This study has met the guidelines for ethical research. There will be no obligation for any participants to partake in the entire research project. Participants may decline to answer part of, or the entire questionnaire, or decline to participate in the focus group discussion at any time.

Any person with concerns or complaints about the conduct of a research study can contact the Manager of Ethics and Biosafety Administration, University of Sydney on (02) 9351 4811.

For further information you can contact
Associate Investigator:

Ms Paige Dowd
Co / PO Box 170
Lidcombe, NSW 1825

Phone: (02) 95470435   Fax: (02) 93519400
Email: pdowd@primus.com.au
Attention Aboriginal and Torres Strait Islander Women

My name is Paige Dowd; I am an Aboriginal woman originally from Coonabarabran, NSW, Gamilaroi country. I am a fourth year Honours student at the University of Sydney (Cumberland College) in the Faculty of Health Sciences, Yooroang Garang, The School of Indigenous Health Studies. As part of my course, I am required to complete a Thesis project of approximately 15,000 words.

The research topic is The development of a culturally appropriate questionnaire related to Alcohol and other Drugs use among Aboriginal and Torres Strait Islander women.

The aim of the study is to conduct three focus groups consisting of up to 10 Aboriginal and Torres Strait Islander women, to test pilot and evaluate a questionnaire designed by the researcher. The focus groups will provide feedback and suggestions on the cultural appropriateness of the questionnaire and its contents. The questionnaire being developed is aimed at gathering information on opinions, attitudes and perceptions of Aboriginal and Torres Strait Islander women with regard to A&OD use and misuse during pregnancy.

Participation in this Research Study will be voluntary. Participants will be 17 years and over at the time of interview. For recruitment purposes this advertisement has been made available to venues such as Aboriginal and Torres Strait Islander organisations; non-Aboriginal and Torres Strait Islander A&OD organisations; mainstream government departments; including ATSIC; Hospitals; NSW Department of Health; Centrelink and local Health Clinics for example.

The Aboriginal and Torres Strait Islander women involved in the focus group discussions will be asked to complete the questionnaire. A set of eight questions will be presented to the focus groups, and participants will then be asked to comment. The focus group comments may be used as quotes within the body of the Thesis.

The focus group discussion will be audio-taped, subject to prior approval of the participants. The information gathered from the questionnaire and the focus group will be treated as confidential and anonymous, this information will be stored for a period of five years and then destroyed in accordance with the University of Sydney policy. To access this information, prior approval of the Chief Investigator (Dr Zakia Hossain) would be needed. The Research Study has met the guidelines for ethical research for the University of Sydney Human Ethics Committee and the Aboriginal Health and Medical Research Council (AH&MRC) of New South Wales (NSW). There will be no obligation for any participants to partake in the entire research project. Participants may decline to answer part of, or the entire questionnaire, or decline to participate in the focus group discussion at any time.

Any person with a concern or complaint about the conduct of a research study can contact the Manager of Ethics and Biosafety Administration, University of Sydney on (02) 9351 4811.

Aboriginal and Torres Strait Islander women who are interested in taking part in this project should contact Ms Paige Dowd Co / PO Box 170, Lidcombe, NSW 1825 Phone: (02) 95470435  Fax: (02) 93519400  Email: pdowd@primus.com.au

Your participation is greatly appreciated.
APPENDIX 6

Community Legal Education and Participate in Law Reform Activities.

After hours work will be required. Salary is in the range $34,820 - $38,300 pa.

The Client Liaison/Administrative Worker will be required to provide the first level of assistance to the clients of Koori Women’s Legal Service. This worker will assist clients to access other agencies and services, network extensively with other Aboriginal and generalist agencies, provide community legal education and participate in law reform activities.

Salary is in the range $32,329 - $50,167 pa.

Aboriginal Family Violence Legal Service.

This position is to provide legal services to Aboriginal women and their children. It will not provide outreach services, but will work closely with the Rural Women’s Outreach Program to ensure the effective provision of legal services to Aboriginal women in Port Augusta and in the region.

Salary is in the range $30,080 - $42,417 pa.

Coordinator/Community Worker

We are looking for a Solicitor with a demonstrated commitment to improving justice for women. The Solicitor will be required to provide direct casework services to women, develop and deliver community legal education, participate in law reform activities and contribute to the legal reform activities of the Women’s Legal Service.

Salary is in the range $33,239 - $51,967 pa.

Solicitor

We are looking for a Solicitor with particular skills working with Aboriginal women and family violence. After hours work and extensive travel will be required. The Solicitor will be required to provide direct casework services to women, develop and deliver community legal education, participate in law reform activities and contribute to the law reform activities of the Women’s Legal Service.

Salary is in the range $32,329 - $50,167 pa.

The Coordinator/Community Worker will be required to manage the day-to-day affairs of the Service. She will be responsible for all the operations of the Service and will work closely with the Solicitor and the Community/Para-Legal Worker.

Salary is in the range $33,239 - $51,967 pa.

Community/Para-Legal Worker

We are looking for a Community/Para-Legal Worker with particular skills working with Aboriginal women and family violence. The Community/Para-Legal Worker will provide legal services to Aboriginal women and their families located in Port Augusta and the surrounding areas.

Salary is in the range $31,180 - $42,250 pa.

Client Liaison/Administrative Worker

We are looking for a Client Liaison/Administrative Worker with particular skills working with Aboriginal women and family violence and who has administrative skills.

Salary is in the range $30,080 - $42,417 pa.

Confidential

The Women in each focus group will discuss and evaluate questions proposed for the questionnaire. All information collected will be treated as confidential and all participants will remain anonymous.

Confidential

The development of a culturally appropriate questionnaire related to ‘Alcohol and Other Drugs use among Aboriginal and Torres Strait Islander Women’ is the topic of the thesis for Sydney University honours student Paige Dowd.

Ms Dowd is a fourth year honours student completing a Bachelor of Health Science (Aboriginal Health and Community Development) at University of Sydney, and was awarded a Loaning Garang 12 School of Indigenous Health Studies scholarship to complete a Masters in Applied Epidemiology (MAE) degree conducted by the National Centre for Epidemiology and Population Health (NCEPH) at the Australian National University (ANU). Ms Dowd is seeking interested Aboriginal and Torres Strait Islander women who were awarded a Loaning Garang 12 School of Indigenous Health Studies Scholarship to participate in the MAE course on epidemiology.

Ms Dowd says it has been ‘a hard struggle’ to study and raise two children, but ‘something is keeping me going’. Part of that ‘something’ is the frustration that has built up inside of me during the whole process of this research study,” she said.

This research study was chosen as there seems to be very little research in this particular area relating to Aboriginal and Torres Strait Islander women.

Women wishing to be one of the 20 involved in Ms Dowd’s proposed focus groups, can telephone (02) 9351 9393 and request an expression of interest form. Alternatively, they can write to Paige Dowd C/O PO Box 170 Lidcombe, NSW 1825, or request by fax (02) 9351 9400 or by sending an email request to pdowd@peppab.com.au

Expressions of interests will be accepted until 5pm on May 9. Focus group discussions will be held this month.

Women needed to help with this research

Paige Dowd – seeking interested Aboriginal and Torres Strait Islander women to take part in three focus group discussions.

NSW

The development of a culturally appropriate questionnaire related to ‘Alcohol and Other Drugs use among Aboriginal and Torres Strait Islander Women’, and the incidence of premature births among indigenous women appears to be increasing. It seems that a lot of women are not aware of the drugs of danger use during pregnancy,” she said.

Ms Dowd speaks from experience – professionally and personally. She is a former ATSC employee who had a life-changing experience when she was on a national evaluation of ATSC-funded programs. She saw first-hand the wide range of health problems associated with drug and alcohol misuse by Indigenous women.

Ms Dowd is a mother of two, with sons aged 3 and 17 months. She was raised in Coonabarabran, NSW, and now resides in Sydney.

Ms Dowd claims to have lost loving family members to drug and alcohol use and misuse. “I almost lost my youngest son due to a premature birth,” and I was doing all the right things,” Ms Dowd, a non-smoker and non-drinker said.

My youngest has been in hospital 10 times, as a result of his premature birth, which has placed enormous pressure on me, especially with my studies.”

Ms Dowd says it has been ‘a hard struggle’ to study and raise two children, but ‘something is keeping me going’. Part of that ‘something’ is the frustration that has built up inside of me during the whole process of this research study,” she said.

This research study was chosen as there seems to be very little research in this particular area relating to Aboriginal and Torres Strait Islander women.

Women wishing to be one of the 20 involved in Ms Dowd’s proposed focus groups, can telephone (02) 9351 9393 and request an expression of interest form. Alternatively, they can write to Paige Dowd C/O PO Box 170 Lidcombe, NSW 1825, or request by fax (02) 9351 9400 or by sending an email request to pdowd@peppab.com.au

Expressions of interests will be accepted until 5pm on May 9. Focus group discussions will be held this month.
FOCUS GROUP DISCUSSION
EXPRESSON OF INTEREST APPLICATION
FOR
Aboriginal and Torres Strait Islander women who reside in Sydney and surrounding geographical areas.

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PREFERRED FOCUS GROUP
(Please tick appropriate box)

1. 17-29 years 15th May 2000
2. 30 years plus 17th May 2000
3. Health Professionals 19th May 2000

DATE
TIME 10 am to 12 noon
VENUE

NOTE:

a) If the researcher receives less than 10 expressions of interest for either of the three proposed focus group discussions, the applications received will be automatically deemed participants.

b) If the expressions of interest received are more than 10, a sampling technique will be used to reduce selection bias.

c) If on any occasion a proposed focus group has insufficient numbers (less than 3) the researcher will endeavor to recruit women to ensure that each focus group will consist of at least 5 women, this is to ensure the validity of the focus group discussion.

The development of a culturally appropriate questionnaire related to Alcohol and other Drugs use among Aboriginal and Torres Strait Islander women. Dowd, @2000

Expressions of Interest will only be accepted up until 5 pm on the 9th May 2000.
APPENDIX 8
Dear

RE: Focus Group Discussion

Congratulations you are a successful applicant, you have been chosen to participate in Focus Group _ being conducted on the _ May 2000 between 10am and 12 noon at the Eora Centre situated in Redfern.

Enclosed is an information package consisting of relevant information regarding the Research Study and the Focus Group discussion.

If you wish to accept, you are advised to sign the enclosed consent form. The signed consent form is justification that you wish to participate abiding by the research criteria listed and that you have no objections to the discussion being audio - taped. The consent form must be returned by fax or in person to the researcher as soon as possible. All consent forms are to be received before the focus group discussion.

The focus group discussion has been limited to no longer than two hours. Children will not be permitted to attend, interruptions may disrupt the discussion and inhibit the quality of taping.

This research study and its results could be very beneficial for Aboriginal and Torres Strait Islander women. You are a very important part of this research study and without your participation this research study can not be completed.

If at any time you no longer wish to participate, you should contact Ms Paige Dowd immediately. This would eliminate the chance of under representation at the focus group discussion and your notification would allow for another participant to take your place. The final results may be affected if participants were absent on the day.

Should you have any inquiries, you are urged to contact Ms Paige Dowd on mobile (04) 04200629 or at home on (02) 95470435. You may also contact Ms Dowd at the University of Sydney, please see contact details listed below.

P.O. Box 170, Lidcombe, NSW 2141, Australia,
Telephone. (02) 9351-9393, Fax (02) 9351-9400
Thank you for your interest, I am looking forward to meeting you, don't forget to bring the information folder!

I hope this letter finds you in good health,

Ms Paige Dowd
7-May-00
APPRECIATION CERTIFICATE

THIS IS TO CERTIFY

PARTICIPATED IN
FOCUS GROUP DISCUSSION
NO: 1 DATE: 15TH MAY 2000

FOR

THE DEVELOPMENT OF A CULTURALLY
APPROPRIATE QUESTIONNAIRE RELATED
TO ALCOHOL AND OTHER DRUGS USE
AMONG ABORIGINAL AND TORRES STRAIT
ISLANDER WOMEN.

THANK YOU FOR THE VALUABLE INPUT

PAIGE DOWD

Date: ________
APPRECIATION CERTIFICATE

THIS IS TO CERTIFY

PARTICIPATED IN
FOCUS GROUP DISCUSSION
NO: 2 DATE: 17TH MAY 2000

FOR

THE DEVELOPMENT OF A CULTURALLY
APPROPRIATE QUESTIONNAIRE RELATED
TO ALCOHOL AND OTHER DRUGS USE
AMONG ABORIGINAL AND TORRES STRAIT
ISLANDER WOMEN.

THANK YOU FOR THE VALUABLE INPUT

PAIGE DOWD

Date: ___________________
APPRECIATION CERTIFICATE

THIS IS TO CERTIFY

-------------------

PARTICIPATED IN
FOCUS GROUP DISCUSSION
NO: 3 DATE: 19th MAY 2000

FOR

THE DEVELOPMENT OF A CULTURALLY
APPROPRIATE QUESTIONNAIRE RELATED
TO ALCOHOL AND OTHER DRUGS USE
AMONG ABORIGINAL AND TORRES STRAIT
ISLANDER WOMEN.

THANKYOU FOR THE VALUABLE INPUT

PAIGE DOWD

Date: __________
APPRECIATION CERTIFICATE
THIS IS BEING PRESENTED TO

---------------------

IN ACKNOWLEDGEMENT OF THE SUPPORT AND ASSISTANCE THAT YOU HAVE PROVIDED TO

PAIGE DOWD

FOR

THE DEVELOPMENT OF A CULTURALLY APPROPRIATE QUESTIONNAIRE RELATED TO ALCOHOL AND OTHER DRUGS USE AMONG ABORIGINAL AND TORRES STRAIT ISLANDER WOMEN.

THANK YOU

PAIGE DOWD

Date: ___________
# INFORMATION PACKAGE

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Brief Methodology

1. Background

Phase I of a larger study aiming to collect data on the knowledge, opinions, attitudes, perceptions and patterns of use among pregnant Aboriginal and Torres Strait Islander women.

2. Project Aim

To conduct 3 focus groups consisting of up to 10 Aboriginal and Torres Strait Islander women in each group, with the aim to test and evaluate a questionnaire on the use and misuse of A&OD among Aboriginal and Torres Strait Islander women during pregnancy.

3. Project Objectives

1. Collect, review and explore relevant literature
2. Develop questionnaire
3. Recruit women to participate in focus groups.
4. Conduct 3 focus groups and test questionnaire.
5. Use the findings to produce a culturally appropriate questionnaire.

4. Focus Group Process

- The focus group discussions have been scheduled for the 15th, 17th and 19th May 2000. The three focus group discussions will be held between 10am and 12 noon.

- Focus group 1, 17-29 years
- Focus group 2, 30 years plus
- Focus group 3 will be for Health Workers and Health professionals to allow for professional opinions.

- The chosen location where the focus group discussions will be held is the Eora Centre situated in Redfern.

- Focus Group 1 & 2 have been age categorised specifically to separate the younger women from the elder women. Aimed at providing all participants with an equal opportunity in having their say.

- Participants must be eligible, meeting the research criteria. The criteria are as follows:
Brief Methodology

1. Must be an Aboriginal and Torres Strait Islander woman who resides in Sydney and surrounding areas.
2. Must be an Aboriginal and Torres Strait Islander woman 17 years or over at the time of the proposed focus group discussions.
3. The Aboriginal and Torres Strait Islander women must sign the consent form to be considered to participate in one of the proposed three focus group discussions.
4. Must be an Aboriginal and Torres Strait Islander woman who:
   - Has previously, or is currently employed as a health worker or a health professional.
   - Who is currently enrolled or who holds qualifications in some type of health related professional courses (Courses run by Aboriginal organisations, Government organisations such as TAFE or University).
   - The criteria for each focus group were chosen to enable maximum results.
   - Participants will be advised of the intention to audio - tape prior to the focus group discussions.
   - The consent form has been included in the information package. Participants will be encouraged to sign a consent form. This was suggested by the AH&MRC to avoid conformity by peer group pressure.

All selected participants will be sent an information package during the week prior to the proposed focus group discussions.

- This will enable all participants time to read information regarding the research project, familiarising them with the research project and the proposed process of the focus group discussion.

The information packages will consist of:

- Verification of Ethical Approval
- Brief Methodology
- Research Study Important Information
- Consent Form
- A Sticker (for code name)
- Writing pad & pen.
5. How the research will be conducted?

On the day of the focus group discussion the researcher will:

- Briefly explain the information packages
- A short period of time will be allocated for questions.
- The participants will be given an identification number for coding purposes to ensure anonymity. This is aimed at providing confidentiality. The code number will be written on the sticker provided. The code number will be mentioned before a participant speaks for protection of identity and transcription purposes. Participants will be referred to by their code.
- The Questionnaire will be given to all participants, who will then be asked to complete them. Questionnaires will be coded with identification numbers. Data collected from completed questionnaires will not be analysed.
- This process is a "mock survey" focusing on the familiarisation of the women, with the questionnaire. It is hoped that this process will benefit the focus group discussions and outcomes.
- The focus group discussion will begin directly after the completion of the questionnaires. The discussion will be directed in a semi-structured manner. To control discussions from straying off the subject. This method will allow flexibility to discuss related issues of importance.
- The focus group collective will be asked 8 questions related to the questionnaire.
- If social and emotional well being issues arise, participants will be provided with a number for local professional assistance.

1. Drug and Alcohol workers
2. Mental Health workers
3. Social workers

- On completion all participants will be provided with,

1. A&OD information
2. General health related information
3. Appreciation certificate for acknowledgment of involvement.
Brief Methodology

The translation of audio - tapes will be by "Key point transcription" Phan & Fitzgerald (1996, p. 28). Key points mentioned on the tape will be listed. The numeric counter will be noted at each key point. The aim of the listing will be for efficient future referencing.

- Quotations will be transcribed in a verbatim (word for word) fashion.

The tapes will be evaluated by:

1. Researcher
2. Chief investigator
3. Research assistant / s
4. Key points will be compared.

- The audio - tapes and written notes recorded will be utilised in the Honours Thesis.

1. Stored with the researcher during the active transcription phase.
2. Stored with the Chief Investigator Dr Zakia Hossain as per the Standard University of Sydney policy.
3. All information collected, will be destroyed after a five-year period in accordance with the University of Sydney policy.

- Any person wishing to access this information will need prior approval from the chief investigator.

- The qualitative data collected will be transcribed, analysed and results will be determined.

- Researcher proposes to use either of these Data base systems,

1. STATA or
2. The Statistical Package for the Social Sciences (SPSS)

- Focus group results to be included in final report will be forwarded to the participants for their endorsement.

- The draft report will be,

1. Completed
2. Forwarded to supervisors, Honours co-ordinator and tutor.
3. Suggestions will be considered

- Final report will be completed and submitted for marking by the 30th June 2000.
Brief Methodology

- The final marked report will be dispatched to:
  1. Aboriginal and Torres Strait Islander women who participated
  2. Aboriginal organisations who participated
  3. AH&MRC Ethics committee
  4. The USHEC
  5. Yooroang Garang School of Indigenous Health Studies.

- The information collected is aimed at filling some of the gaps that are obvious in A&OD literature.

- The developed questionnaire will be utilised for a further research study during the completion of a Masters in Epidemiology degree.
Attention Aboriginal and Torres Strait Islander Women

My name is Paige Dowd; I am an Aboriginal woman originally from Coonabarabran, NSW, Gamilaroi country. I am a fourth year Honours student at the University of Sydney (Cumberland College) in the Faculty of Health Sciences, Yooroang Garang, The School of Indigenous Health Studies. As part of my course, I am required to complete a Thesis project of approximately 15,000 words.

The research topic is The development of a culturally appropriate questionnaire related to Alcohol and other Drugs use among Aboriginal and Torres Strait Islander women.

The aim of the study is to conduct three focus groups consisting of up to 10 Aboriginal and Torres Strait Islander women, to test pilot and evaluate a questionnaire designed by the researcher. The focus groups will provide feedback and suggestions on the cultural appropriateness of the questionnaire and its contents. The questionnaire being developed is aimed at gathering information on opinions, attitudes and perceptions of Aboriginal and Torres Strait Islander women with regard to A&OD use and misuse during pregnancy.

Participation in this Research Study will be voluntary. Participants will be 17 years and over at the time of interview. For recruitment purposes this advertisement has been made available to venues such as Aboriginal and Torres Strait Islander organisations; non- Aboriginal and Torres Strait Islander A&OD organisations; mainstream government departments; including ATSIC; Hospitals; NSW Department of Health; Centrelink and local Health Clinics for example.

The Aboriginal and Torres Strait Islander women involved in the focus group discussions will be asked to complete the questionnaire. A set of eight questions will be presented to the focus groups, and participants will then be asked to comment. The focus group comments may be used as quotes within the body of the Thesis.

The focus group discussion will be audio-taped, subject to prior approval of the participants. The information gathered from the questionnaire and the focus group will be treated as confidential and anonymous, this information will be stored for a period of five years and then destroyed in accordance with the University of Sydney policy. To access this information, prior approval of the Chief Investigator (Dr Zakia Hossain) would be needed. The Research Study has met the guidelines for ethical research for the University of Sydney Human Ethics Committee and the Aboriginal Health and Medical Research Council (AH&MRC) of New South Wales (NSW). There will be no obligation for any participants to partake in the entire research project. Participants may decline to answer part of, or the entire questionnaire, or decline to participate in the focus group discussion at any time.

Any person with a concern or complaint about the conduct of a research study can contact the Manager of Ethics and Biosafety Administration, University of Sydney on (02) 9351 4811.

Aboriginal and Torres Strait Islander women who reside in Sydney and surrounding geographical areas who are interested in taking part in this project should contact Ms Paige Dowd Co / PO Box 170, Lidcombe, NSW 1825 or Phone: (02) 93519393 Mobile: (0404) 200629 Fax: (02) 93519400 Email: pdowd@primus.com.au

Page 1 of 1 The development of a culturally appropriate questionnaire related to Alcohol and other Drugs use among Aboriginal and Torres Strait Islander women. Dowd, @2000

Your participation is greatly appreciated.
Consent Form

For Research Study:

The development of a culturally appropriate questionnaire related to Alcohol and other Drugs use among Aboriginal and Torres Strait Islander women.

Investigator:

Ms Paige Dowd
Co / PO Box 170
Lidcombe, NSW 1825

Phone: (02) 93519393 Mobile: (0404) 200629 Fax: (02) 93519400
Email: pdowd@primus.com.au

I ________________ am aware that the focus group discussion will be audio-taped for accurate documentation, and that all information will be treated as confidential and anonymous. The tapes and information collected will be stored for a period of five years in accordance with the University of Sydney policy and then destroyed.

I ________________ also agree to be interviewed for the above named project under the conditions explained.

SIGNATURE
DATE

Witnessed by researcher

SIGNATURE
DATE
You are invited to participate in a Research Study, title *The development of a culturally appropriate questionnaire related to Alcohol and other Drugs use among Aboriginal and Torres Strait Islander women*. This study is being conducted by Ms Paige Dowd, a 4th year Aboriginal Honours student enrolled in the Bachelor of Health Sciences (Aboriginal Health and Community Development) program, offered by Yooroang Garang: School of Indigenous Health Studies, within the Faculty of Health Sciences, The University of Sydney.

The aim of this research study is to conduct three focus groups, each consisting of up to 10 Aboriginal and Torres Strait Islander women, to test pilot and evaluate a questionnaire. The focus groups will provide feedback and suggestions on the cultural appropriateness of the questionnaire and its contents. The questionnaire being developed is aimed at gathering information on opinions, attitudes and perceptions of Aboriginal and Torres Strait Islander women with regard to A&OD use and misuse during pregnancy.

Participation in this Research Study will be voluntary. Participants must identify and be accepted in their community as an Aboriginal and Torres Strait Islander and in addition must be 17 years and over at the time of interview. Recruitment of Aboriginal and Torres Strait Islander women will be achieved by advertisements being made available to venues such as Aboriginal and Torres Strait Islander organisations; non-Aboriginal and Torres Strait Islander organisations; mainstream government departments; including ATSIC; Hospitals; NSW Department of Health; Centrelink and local Health Clinics for example.

The Aboriginal and Torres Strait Islander women involved in the focus group discussions will be asked to complete the questionnaire attached. This process is a "mock survey" focusing on the familiarisation of the Aboriginal and Torres Strait Islander women with the questionnaire. It is hoped that this process will benefit the focus group discussions and outcomes. The following eight questions will be presented to the focus groups, the participants will then be asked to comment.

1. What do you think about the set of questions that you have been asked to answer?
2. Are there any other questions you would like to include in this questionnaire?
3. Will you be interested in changing any of these questions you have responded to?
4. Are there any other women's age groups that should be involved in this Research Study?
5. Is this Questionnaire suitable to gather relevant information?
6. Should I have done this research study another way?
7. Do you think you will benefit from this discussion?
   If yes, how? and If no, why?
8. Any other issues of concern?

The focus group discussions will be audio-taped, subject to prior approval of the participants. The information gathered from the questionnaire and the focus groups will be treated as confidential and anonymous. The information collected will be stored for a period of five years and then destroyed in accordance with the University of Sydney policy. Comments
may be used as quotes within the body of the Thesis. The Research Study has been approved by the University of Sydney Human Ethics Committee and the Aboriginal Health and Medical Research Council of New South Wales (AH&MRC). This study has met the guidelines for ethical research. There will be no obligation for any participants to partake in the entire research project. Participants may decline to answer part of, or the entire questionnaire, or decline to participate in the focus group discussion at any time.

Any person with concerns or complaints about the conduct of a research study can contact the Manager of Ethics and Biosafety Administration, University of Sydney on (02) 9351 4811.

For further information you can contact
Associate Investigator:

Ms Paige Dowd
Co / PO Box 170
Lidcombe, NSW 1825

Phone: (02) 93519393 Mobile: (0404) 200629 Fax: (02) 93519400
Email: pdowd@primus.com.au

The development of a culturally appropriate questionnaire related to Alcohol and other Drugs use among Aboriginal and Torres Strait Islander women. Dowd, ©2000
Dr Z Hossain
School of Behavioural and Community Health Sciences
19 April 2000

Dear Dr Hossain,

**Title:** The development of a culturally appropriate questionnaire related to alcohol and other drug use among Aboriginal and Torres Strait Islander women.

**Ref No:** 99/12/70

Thank you for your correspondence dated 6 April 2000. After considering your request to conduct additional procedures/minor variations relating to the above protocol, it was the Committee's opinion that there were no ethical objections to this work being carried out, and therefore recommends approval to proceed. Approval was granted subject to the following:

- The final letter of approval from the AH&MRC should be lodged with the Ethics Office prior to commencement of the study.

The following variations were approved:

- Change in project title and minor amendments to the design, analysis and aim of the study as recommended by the AH&MRC
- AH&MRC recommended amendments to the Subject Information Statement and Consent Form.
- AH&MRC recommended amendments to the Advertisement.
- AH&MRC recommended amendments to the questionnaire.

This additional information will be filed with your original application.

In order to comply with the National Health and Medical Research Council guidelines, and in line with the Human Ethics Committee requirements the Chief Investigator's responsibility is to ensure that:

1. The individual researcher's protocol complies with the final and Committee approved protocol.
2. Modifications to the protocol cannot proceed until such approval is obtained in writing.
3. The confidentiality and anonymity of all research subjects is maintained at all times, except as required by law.
4. All research subjects are provided with a Subject Information Sheet and Consent Form.
5. The Subject Information Sheet and Consent Form be on University of Sydney letterhead and include the full title of the research project and telephone contacts for the researchers.
6. The following statement appears on the Subject Information Sheet: Any person with concerns or complaints about the conduct of a research study can contact the Manager of Ethics and Biosafety Administration, University of Sydney, on (02) 9351 4811.
7. The standard University policy concerning storage of data should be followed. While temporary storage of audiotapes at the researcher's home or an off-campus site is acceptable during the active transcription phase of the project, permanent storage should be at a secure, University controlled site for a minimum of five years.
8. A progress report is provided by the end of each year. Failure to do so will lead to withdrawal of the approval of the research protocol and re-application to the Committee must occur before recommencing.
9. A report and a copy of the published material is provided at the end of the project.

Yours sincerely,

[Signature]

Professor Barry Baker
Chairman
Human Ethics Committee

cc. Ms P Dowd 6/76-82 Woids Avenue Hurstville NSW 2220
Dear Ms Dowd,


Concerning your request for our Ethics Committee to evaluate and support the above-mentioned epidemiological research proposal the Committee responds as follows:

The Ethics Committee is committed to professional projects in essential epidemiological and medical research that increase scientific knowledge, demonstrate benefit to our communities and provide transfer of skills to our medical workforce.

Included in the criteria used by the Committee to evaluate applications for proposed research and publications of statistical data on Aboriginal health are the following principles which are contained within the AH&MRC publication *Guidelines for Research into Aboriginal Health*.

i. that in accordance with the priorities set out in the *National Aboriginal Health Strategy* and the *Report of the National Workshop on Ethics of Research in Aboriginal Health*, research proposals must advance scientific knowledge so as to result in demonstrated additional benefit to Aboriginal communities.

ii. that there be Aboriginal community control over all aspects of the proposed research including research design, ownership of data, data interpretation and publication of research findings.
iii. that the research to be conducted in a manner sensitive to the cultural principles of Aboriginal society.

iv. that Aboriginal communities and organisations be reimbursed for all costs arising from their participation in the research process.

v. that Aboriginal communities and organisations should be able to benefit from the transfer of skills and knowledge arising from the research project.

Furthermore, the Committee assumes that applicants of research proposals and epidemiological publications of Aboriginal health are conversant with the following documents.

1. Report of the National Workshop on Ethics of Research in Aboriginal Health (NAIHO) [1987]

2. Guidelines on Ethical Matters in Aboriginal and Torres Strait Islander Health research (NH&MRC) [1991]

3. NSW Aboriginal Health – Information Guidelines (NSW Aboriginal Health Partnership, NSW Health/AH&MRC) [1998]

4. Guidelines for Research into Aboriginal Health (AH&MRC Ethics Committee) [1999]

The Committee has evaluated your project and provides the following suggestions and comments:

(i) It is noted that the title of the thesis limits the study to “Koori women.” If this is not intentional it may be necessary to widen the name of the topic to by replacing ‘Koori’ with ‘Aboriginal women’ enabling Aboriginal women from other parts of NSW, e.g. Murris as well as other parts of Australia to participate: The statement on page 1 of the Thesis Proposal, namely, that “A&OD misuse is a well-known cause of ill health among Koori people throughout Australia” may also need clarification in light of the fact that advertising material for the project is directed at women within the wider Aboriginal community.

(ii) Statistics used in Thesis Proposal. Whilst some useful statistics concerning alcohol use by the Aboriginal and Non-Aboriginal communities are incorporated into the brief it should be noted that more recent material is available from the Australian Bureau of Statistics e.g. the second edition (1999) of the 1997 report The Health & Welfare of Aboriginal & Torres Strait Islander Peoples. (ABS catalogue 4704.0 or AIHW catalogue No. IIW3)

(iii) It is suggested your usage of an acronym for Aboriginal and Torres Strait Islander peoples comply with the ATSIC Chairperson’s
recommendation to all government departments that the acronym "ATSI" not be used as it is culturally inappropriate.

(iv) With regards to the actual project which is presumed to be:

(a) "Developing an ultimate appropriate questionnaire that can be used for further A&OD surveys at a later date"; and 
(b) Piloting "the Proposed Questionnaire with a pilot group of 6-8 Koori women to discuss the appropriateness of the questionnaire."

the committee notes the following:

(1) 4.1 of the application mentions that all subjects are over 17 years of age whilst the brief and 5.4 mentions 18 years of age.

(2) Recruitment of subjects from A&OA centres might not be necessarily representative in terms of an objective evaluation of the questionnaire.

(3) The limitation of numbers within the initial focus group, whilst helpful, may be insufficient to draw definitive conclusions on the suitability or relevance of the questionnaire.

(4) The agreement by participants for the recording of the group session would need to be obtained individually, prior to participation within the group, to avoid conformity by peer group pressure.

(5) The merits of the focus group are not immediately apparent. Whilst the 5 evaluation questions are astute to determine attitudes and reactions to the questionnaire this could quite as easily be ascertained through individual responses. There could arise social and emotional well being matters that cannot be addressed in open forum, compounded by the absence of trained grief and loss counselling personnel. Conversely, pertinent information could be suppressed within a group situation distorting response. It may also be counter-productive to have pregnant women speak collectively about any implied irresponsibility with regard to vulnerability to unborn children, hence affecting the objectivity of process.

(6) The advertising of food provision for subjects participating in a one-hour discussion session could also be vulnerable to the criticism of lack of scientific objectivity due to alleged inducement.

(7) The comment that the aim for the focus group will be "to ascertain the opinion of Koori women regarding knowledge, attitudes and usage of A&OD patterns among Koori women, particularly during pregnancy." is certainly
presumptuous, unscientific from an epidemiological perspective and beyond the scope of this project.

(v) **Consent Agreement.** Whilst the audio-tapes are to be kept for five years before destruction 6.4(d) there is no reference to this fact in the Consent Form nor Subject Information Sheet. There would need to show cause why such audio records, once utilised and transcribed, could not be destroyed.

Concerning 7.4(a), since essential criteria are not in the Consent Form itself but on the two subsequent documents, each numbered separately, either the information should be within the Consent Form or alternatively, the subsequent documents should become part of the Consent Agreement by chronologically numbering them within the document for which the applicant is providing consent.

(vi) You have mentioned the possibility of subsequent publication. The applicant is referred to the Council’s ethical requirement to evaluate such documents from a cultural perspective prior to publication.

(vii) **Questionnaires.**

(a) Q1 What is the minimum age of the women in this project? The application states 17 years; the brief has 18 years and the implication of this question is that they are 16. Or are these only meant for the focus group? The legal implications of 16 year old pregnant subjects should flag caution here.

(b) Q3 & Q4 Unidentified information when it relates to Aboriginal communities can be potentially identifiable. Inclusion of towns would have to be very carefully handled and there would need to be justification for their insertion. It is already known where D&AO services are available.

(c) There is no considered benefit that could arise from including “tribal or language grouping” in this particular questionnaire and it could lead to misinterpretation and misinformation.

(d) Q14 There should be a provision for the category ‘Seldom’.

(e) Q17 This question needs to be seen in synopsis with Q14 as types of alcohol and the number of standard volumes used (glasses) are essential in determining actual limits and misuse.

(f) Q18 The question is considered redundant as the subsequent questions could be seen as insensitive and discourage an objective response.

(g) Q19 The question should be rephrased to something like “What is a safe amount of alcohol that can be drunk per
day? With provision for ‘Nil’ and various other options for the numbers of glasses per day.

(h) Q20 This question would be redundant in light of (g).

(i) Q21 Is there some epidemiological reason for only selecting one drug use? Knowledge of multiple drug use could be quite significant.

(j) Q22 This should be depersonalised and to encourage an objective response it should be rephrased to something like “Are you aware of any danger for alcohol and drug use whilst pregnant?”

(k) Q23 This question should be rephrased to read: “Certain drug use during pregnancy can result in babies having breathing problems.” (True) (False) or (Uncertain rather than “Don’t know”)

(l) Q24 This question should be rephrased to read: “Where pregnant women drink alcohol there is a risk that their child may be affected with learning disabilities.” (True) (False) or (Uncertain)

(m) Q25 This question should be rephrased to read: “Are you aware of any Alcohol or Drug information services in your community?”

(n) Q26 The word “Exercise” is ambiguous and there would need to be more specific detail for any definitive response, e.g. walking etc.

(o) Q28 It is not considered advisable to include this area of questioning in this particular questionnaire.

(p) Q31 This question is considered redundant as it is a leading type question. Since Q29 incorporates the concept of ‘improvement’ that question should provide sufficient information for the purposes of the study.

The Ethics Committee has given careful consideration to your research proposal and grants endorsement subject to the above-mentioned qualifications being complied with. To expedite your research schedule, should an amended application incorporate these qualifications there is no need to await the Committees prior approval. Please forward the amended document for the Committee’s endorsement at its next meeting.

On behalf of the AH&MRC Ethic Committee,

Yours sincerely

Stephen Woods
Chairperson

21st March 2000
Sisters, take care of baby. For they are our pride and joy.

XOXOXOX
<table>
<thead>
<tr>
<th>DOCUMENT</th>
<th>SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Appreciation Certificate</td>
<td>Paige Dowd</td>
</tr>
<tr>
<td>2. Alcohol and other Drugs Information</td>
<td>Blue Section</td>
</tr>
<tr>
<td>2.1 Effects of Drugs</td>
<td>CEIDA</td>
</tr>
<tr>
<td>2.2 Information Pamphlets</td>
<td>CEIDA</td>
</tr>
<tr>
<td>1. Caffeine</td>
<td></td>
</tr>
<tr>
<td>2. Tobacco</td>
<td></td>
</tr>
<tr>
<td>3. Amphetamines</td>
<td></td>
</tr>
<tr>
<td>4. Cocaine</td>
<td></td>
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<td>5. Minor Tranquillisers</td>
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<tr>
<td>6. Ecstasy</td>
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<td>7. Heroin</td>
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<td>8. Cannabis</td>
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<tr>
<td>9. Alcohol</td>
<td></td>
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<tr>
<td>10. Methadone</td>
<td></td>
</tr>
<tr>
<td>11. Hallucinogens</td>
<td></td>
</tr>
<tr>
<td>12. Volatile Substances</td>
<td></td>
</tr>
<tr>
<td>3. Pregnancy and Drugs Information</td>
<td>Yellow Section</td>
</tr>
<tr>
<td>3.1. Introduction</td>
<td>ADP</td>
</tr>
<tr>
<td>3.2. Pregnancy and Drugs</td>
<td>ADP</td>
</tr>
<tr>
<td>3.3. Smoking and Pregnancy</td>
<td>NSW Quit Campaign</td>
</tr>
<tr>
<td>4. Alcohol and other Drugs Statistics</td>
<td>Pink Section</td>
</tr>
<tr>
<td>4.1. Statistics</td>
<td>Drug - Arm</td>
</tr>
<tr>
<td>4.2. Drug and Alcohol Statistics</td>
<td>CEIDA</td>
</tr>
<tr>
<td>4.3. Heart, Stoke and Vascular Diseases Australian Facts 1999 Highlights.</td>
<td>National Heart Foundation</td>
</tr>
<tr>
<td>4.4. Quitters Page</td>
<td>Quit</td>
</tr>
<tr>
<td>5. General Health Information</td>
<td>Green Section</td>
</tr>
<tr>
<td>5.1. Get the good eating habit</td>
<td>National Heart Foundation</td>
</tr>
<tr>
<td>5.2. Facts on walking for pleasure and health</td>
<td>Active Australia: Heart Foundation</td>
</tr>
<tr>
<td></td>
<td>NSW Sport and Recreation</td>
</tr>
<tr>
<td></td>
<td>NSW Health</td>
</tr>
</tbody>
</table>
| 5.3. Exercise: You only have to take it regularly not seriously. | Active Australia: 
| | Heart Foundation 
| | NSW Sport and Recreation 
| | NSW Health 

| 5.4. Helping families Protect their children from Drugs | NSW Health 
| 5.5. The story behind the campaign - A new approach | Quit 
| 5.6. Nicotine Replacement therapy Explained | Quit 

## 6. Information Booklets

| 6.1. Project material for Students | National Heart Foundation 
| 6.2. 5 Fun ways to Health and Fitness | Kellogg’s 
| | Achper 
| | National Heart Foundation 

| 6.3. Quit Kit | Quit 

### Abbreviations Explanation

| ADP | Alcohol and Drugs Program |
| CEIDA | Centre for Education and Information on Drugs and Alcohol |
| ACHPER | Australian Council for Health, Physical Education and Recreation |
| AH&MRC | Aboriginal Health & Medical Research Council |
| USHEC | University of Sydney Human Ethics Committee |
ALCOHOL AND OTHER DRUGS INFORMATION
<table>
<thead>
<tr>
<th>Substance</th>
<th>Immediate effects</th>
<th>Use with pregnancy</th>
<th>Continued heavy/regular use</th>
<th>Ways of taking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td>Lasts 1/4 - 2 hours. Increased heart &amp; pulse rate.</td>
<td>Harmful</td>
<td>Heart &amp; lung disease, cancer, high blood pressure, bronchitis &amp; breathing difficulties.</td>
<td>Smoking</td>
</tr>
<tr>
<td>Caffeine</td>
<td>Lasts 2 - 4 hours. Increased alertness. Large doses can delay sleep.</td>
<td>Doctors advise less than 4 cups tea/coffee per day.</td>
<td>Restlessness, upset stomach. Can be harmful for people with heart problems.</td>
<td>Oral</td>
</tr>
<tr>
<td>Amphetamine Speed</td>
<td>Lasts 4 - 8 hours. Highly stimulating. Excitement, increased activity &amp; decreased appetite. Large doses delay sleep.</td>
<td>Harmful</td>
<td>Inability to sleep, restlessness, headaches, aggression. Can cause severe mental or emotional disturbances.</td>
<td>Snorting Injecting Anally Oral</td>
</tr>
<tr>
<td>Cocaine</td>
<td>Can last up to 4 hours. Feeling of self confidence &amp; power, increased energy &amp; decreased appetite.</td>
<td>Harmful</td>
<td>Loss of concentration &amp; motivation. Dizziness, aggression &amp; mental disturbances. Can cause psychiatric complications. Snorting can lead to tearing of the nasal wall.</td>
<td>Snorting Injecting Oral Anally</td>
</tr>
<tr>
<td>MDMA Ecstasy</td>
<td>Can last up to 6 hours. Increased blood pressure, confidence &amp; a feeling of closeness with others. Sensation of floating, anxiety, nausea &amp; paranoia can occur.</td>
<td>Harmful</td>
<td>Sensation of floating &amp; other disturbed perceptions. Can cause convulsions, irrational behaviour, insomnia, depression.</td>
<td>Oral Injecting Anally</td>
</tr>
<tr>
<td>Alcohol</td>
<td>Slurred speech, loss of inhibition, relaxation, feelings of happiness &amp; wellbeing or depression. Large doses can cause unconsciousness or hangover.</td>
<td>Harmful</td>
<td>Can result in brain &amp; other nervous systems damage, heart, pancreas, stomach &amp; liver damage &amp; sometimes death. Withdrawal can produce sweating, tremor, convulsions &amp; delirium.</td>
<td>Oral</td>
</tr>
<tr>
<td>Minor tranquilisers</td>
<td>Lasts 12 - 24 hours. Relief of anxiety &amp; tension, drowsiness (possible sleep), lack of muscle coordination, blurred vision. In some cases excitement.</td>
<td>Harmful, Use only under medical supervision.</td>
<td>Depression, lack of muscle and speech coordination. Withdrawal symptoms such as anxiety, insomnia, tremor &amp; convulsions can also occur while on a stable dose.</td>
<td>Oral Injecting Anally</td>
</tr>
<tr>
<td>Valium, Rohypnol, Serepax</td>
<td>Opioids</td>
<td>Harmful</td>
<td>High risk of overdose; HIV and hepatitis if sharing needles. Withdrawal symptoms are anxiety, sweating, cramps, runny nose, vomiting, insomnia, pain.</td>
<td>Oral Injecting Smoking Snorting</td>
</tr>
<tr>
<td>Heroin, Morphine, Codeine, Pethidine, Methadone, Opium</td>
<td>Lasts 4 - 24 hours. Relief of pain &amp; anxiety, feelings of wellbeing, decreased awareness of outside world. Vomiting, drowsiness &amp; sleep in some. High doses can cause unconsciousness &amp; death.</td>
<td>Harmful, Use prescribed preparations only under medical supervision.</td>
<td>Respiratory complications. Can decrease concentration &amp; memory. Psychiatric problems possible if schizophrenic condition already exists.</td>
<td>Oral</td>
</tr>
<tr>
<td>Cannabis Marijuana</td>
<td>Can last up to 5 hours. Relaxation, laughter, increased appetite, slowing down of time, loss of concentration, decreased coordination &amp; blood shot eyes. Can be hallucinogenic.</td>
<td>Long-term effects are still to be assessed.</td>
<td></td>
<td>Oral Smoking</td>
</tr>
<tr>
<td>Inhalants &amp; Solvents</td>
<td>Lasts 1 - 3 hours. Petrol sniffing effects can last up to 6 hours. Feelings of happiness, relaxation &amp; drowsiness. Large amounts can cause illness &amp; possibly sudden death.</td>
<td>Harmful</td>
<td>Liver, kidney &amp; brain damage can result. Suffocation caused by plastic bags, choking on vomit.</td>
<td>Inhalation</td>
</tr>
<tr>
<td>LSD Magic mushrooms Trips</td>
<td>Lasts 6 - 12 hours. Hallucinations ie seeing, hearing, feeling or thinking things that don’t exist. Anxious feelings, panic &amp; nausea can occur.</td>
<td>Harmful</td>
<td>Can increase the risk of severe mental disturbances. Can cause ‘flashbacks’ (where the drug experience can recur at anytime.)</td>
<td>Oral</td>
</tr>
</tbody>
</table>

**Injecting**

HIV and hepatitis B & C infection can occur if sharing injecting equipment. Injecting with dirty syringes can cause abscesses and blood poisoning. New injecting equipment should be used every time.
In NSW, ADIS (Alcohol and Drug Information Service). They provide a 24 hours, 7 days confidential service which includes advice, information and referral to local agencies.
Ph: (02) 9361 2111; country areas free call 1800 42 2599.

Community Health Centres (see main section of White Pages), general practitioners, general hospitals and private counsellors can also provide assistance and advice.

ALSO AVAILABLE FROM THE CEIDA INFORMATION CENTRE: A range of leaflets and booklets on drugs, drug-related issues and HIV/AIDS. For more information phone (02) 9818 0488.

CEIDA is also actively involved in professional development and public education and has one of the largest research libraries for the drug and alcohol professional. Connexions, the bi-monthly magazine on drug issues is published by CEIDA.

You can contact CEIDA on: Ph: (02) 9818 0444 (business hours) or for NSW country callers 1800 816 210.
TTY service for hearing impaired people: (02) 9818 2993
Fax: (02) 9818 0441
Postal address: Private Mail Bag No.6 Rozelle NSW 2039
Street address: Rozelle Hospital Grounds, Balmain Road (opposite Cecily Street), Rozelle NSW.

DrugLinks Website: http://www.ceida.net.au - your electronic connection to the world of alcohol and other drugs information.

The CEIDA Information Centre has wheelchair access.

Published by CEIDA, the Centre for Education and Information on Drugs and Alcohol.

CEIDA is administered by Central Sydney Area Health Service and is funded by the NSW Health Department.
Many people think of caffeine as something in coffee. It is also found in many other common substances. These include:

- tea
- cocoa
- chocolate
- cola.

Caffeine is defined as a drug because it affects the central nervous system. It is categorised as a stimulant drug because caffeine speeds up production of nerve impulses. Scientists first separated caffeine from coffee in 1820. In its pure form, it consists of bitter tasting white crystals. The amount of caffeine in a product depends on both the substance and on the way it is prepared.

In coffee beans, caffeine content will depend on the strain of the coffee plant.

- The Arabic strain contains about 1% caffeine and is grown in Central and South America.
- The Robusta strain contains about 2% caffeine and is grown in Africa and Indonesia.

In tea, the caffeine content depends on the strength of the brew. Caffeine content in tea can be as high as 5%.

The caffeine content in a cup of coffee, however, is usually higher than tea. This is because it takes a lot more coffee beans to make a cup of coffee than tea leaves to make a cup of tea.

How much caffeine in a 'cuppa'?

Most researchers now agree that there is very little risk of harm when less than 600mg of caffeine is consumed a day. At times of anxiety or stress, or during pregnancy, many doctors now recommend consumption of less than 200mg a day (2-4 cups of coffee or tea).

<table>
<thead>
<tr>
<th>Substance</th>
<th>Strength</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>INSTANT COFFEE</td>
<td>60-100mg per cup</td>
<td>according to amount used</td>
</tr>
<tr>
<td>FRESH COFFEE</td>
<td>80-350mg per cup</td>
<td>caffeine content depends on the type of beans and method and strength of brew</td>
</tr>
<tr>
<td>DECAF. COFFEE</td>
<td>2-4mg per cup</td>
<td>packaging usually indicates strength</td>
</tr>
<tr>
<td>TEA</td>
<td>8-90mg per cup</td>
<td>caffeine content depends on strength of brew</td>
</tr>
<tr>
<td>COLA DRINKS</td>
<td>35mg per 250ml serve</td>
<td>cola drinks often contain a lot of sugar too</td>
</tr>
<tr>
<td>COCOA AND HOT CHOCOLATE</td>
<td>10-70mg per cup</td>
<td>other chemicals in the product can vary the caffeine content</td>
</tr>
<tr>
<td>CHOCOLATE BARS</td>
<td>20-60mg per 200g bar</td>
<td>chocolate also contains a lot of sugar</td>
</tr>
<tr>
<td>Some prescription and over-the-counter medicines</td>
<td>20-100mg per dose</td>
<td>NO DOZ and some medicines (cough, headache and slimming preparations) contain caffeine</td>
</tr>
</tbody>
</table>
HISTORY OF CAFFEINE

Caffeine in tea was first documented by the Chinese emperor Shen Nung in 2737 BC. It was listed in the Chinese dictionary around 300 AD.

Coffee originally came from Ethiopia and was introduced to Arabia and the rest of the East in the 4th century AD. Europeans were seen consuming coffee in 1573 by the Dutch explorer and adventurer Reuvels. The Egyptians banned coffee in the 16th century and condemned it as a socially and morally destructive drug.

A sweet chocolate drink was served to the Spanish Conquistadors by the Aztec emperor, Montezuma in 1519.

Tea was first introduced in England in 1657 and it was viewed, together with coffee and chocolate, as 'effeminate, corrosive and debilitating'. Even in 1897 Dr Kellogg declared "the nervousness and peevishness of our times are chiefly attributed to tea and coffee." This did not stop tea becoming an English institution.

Milk chocolate bars were invented in Switzerland in 1876 and cola drinks originated around the end of the 19th century.

The words caffeine and coffee come from the Arabic qahwah (pronounced kahveh in Turkish).

EFFECTS OF CAFFEINE

The effects of caffeine will vary from person to person depending on:

- the amount of caffeine taken
- the way in which it is taken
- the person's body e.g. size, weight, health
- the person's mood
- the person's experience with the drug (the stimulant effect may be very noticeable to first time caffeine drinkers)
- the circumstances in which caffeine is taken e.g. with food, in social gatherings, with other drugs.

NOTE: Research suggests that tobacco smokers metabolise caffeine twice as fast as non-smokers.

Immediate effects

When taken in drink form, caffeine produces a number of mild effects on the body.

- Increases general metabolism and body temperature
- Increases urination
- Increases alertness
- Stimulates the secretion of gastric acid.

In large doses, caffeine can produce (especially in non-users) headaches, jitters, nervousness and even delirium.

In very large doses (10g or more) caffeine can produce high blood sugar and urinary acid levels.

NOTE: A regular cup of coffee or tea contains approximately 60-100mg of caffeine. So 10g of caffeine is equivalent to 100-200 cups of coffee or tea.

Long-term effects

There is no evidence of caffeine producing any toxic effects if consumption is below 600mg a day. Consumption above this level may cause insomnia, anxiety, depression and stomach upsets.

CAFFEINE AND SLEEP

When caffeine is taken before going to bed, it usually:

- Delays and shortens sleep
- Reduces the deep sleep cycle
- Increases the amount of dream sleep early in the night, but reduces it overall.

CAFFEINE AND PREGNANCY

Most drugs can affect an unborn child. Research has found some links between very large doses of caffeine and miscarriage, premature delivery and stillbirth. This is not a problem for women who consume average quantities of caffeine during pregnancy. Doctors recommend no more than 2-4 cups of coffee or tea a day (approximately 200mg of caffeine) for pregnant women.
WHY DO PEOPLE USE CAFFEINE

Caffeine stimulates thinking, helps keep you awake and prevents fatigue. This is why we have coffee breaks and consume so much coffee, tea, cola etc.

Some people use caffeine to keep awake. NO DOZ is a non-prescription drug available from chemists. It is taken orally and each tablet contains 100mg of caffeine. It is sometimes used by students staying up late, when studying for exams, or by people who work late shifts. Also, GUARANA is another preparation containing caffeine used to keep people alert. It is made from the seeds of *Paullinia Cupana* and is available from health food shops as a stimulant drink. It also comes in capsule and gum form and it is often consumed at dance parties.

Research suggests that caffeine can help the body burn fat quickly which is why caffeine is used in weight-loss products. It is also commonly used as an appetite suppressant.

Caffeine is also used in sports to improve alertness and quicken reaction time. It stimulates breathing and heart rate and increases the force of muscle contraction. Caffeine is permitted in sports but only in small amounts. The banned urine level is over 12 micrograms of caffeine per millilitre. That would be equivalent to drinking approximately 5-10 cups of coffee within 1-4 hours.

ONGOING RESEARCH

Ongoing research is not conclusive but suggests that consuming above 600mg of caffeine a day may make some heart problems worse and may contribute to palpitations. Also, people with anxiety disorders (e.g. panic attacks, agoraphobia) should avoid caffeine as it can make the problem worse.

TOLERANCE AND DEPENDENCE

Tolerance to caffeine means that a person needs more and more of the drug to get the same effects as they did with smaller amounts. When this person chooses to stop or dramatically cut down their caffeine intake, withdrawal symptoms can occur. These include severe headache, irritability and a general feeling of tiredness.

Dependence means caffeine is central to a person’s thoughts, activities, emotions and actions.

CAFFEINE QUIZ

The following statements will test your knowledge about caffeine. Answer true or false

1. Coffee originally came from Ethiopia.   T or F
2. Caffeine is present in sleeping pills.   T or F
3. Caffeine reduces dream time.            T or F
4. The effects of caffeine depend on your body weight.   T or F
5. There is more caffeine in a cup of tea than in a cup of coffee.   T or F
6. There is less caffeine in instant coffee than in fresh coffee.   T or F
7. Milk chocolate bars contain caffeine.   T or F
8. Caffeine decreases urination.            T or F
9. More than 600mg of caffeine a day can lead to insomnia.   T or F
10. Caffeine does not pass through the placenta and into the fetus. T or F
11. You cannot become dependent on coffee.  T or F
12. Feeling tired can be a withdrawal symptom of caffeine.   T or F
In NSW, ADIS (Alcohol and Drug Information Service). They provide a 24 hour, 7 days confidential service which includes advice, information and referral to local agencies. Ph: (02) 9361 2111; country areas free call 1800 42 2599

<table>
<thead>
<tr>
<th>NSW Cancer Council</th>
<th>National Heart Foundation of Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>153 Dowling Street</td>
<td>PO Box 572</td>
</tr>
<tr>
<td>Woolloomooloo NSW 2011</td>
<td>Darlinghurst NSW 2010</td>
</tr>
<tr>
<td>Ph: (02) 9334 1900</td>
<td>Ph: (02) 9219 2444</td>
</tr>
</tbody>
</table>

QUITLINE
13 18 48

ALSO AVAILABLE FROM THE CEIDA INFORMATION CENTRE:
A range of leaflets and booklets on drugs, drug-related issues and HIV/AIDS. For more information phone (02) 9818 0488.

CEIDA is also actively involved in professional development and public education and has one of the largest research libraries for the drug and alcohol professional. Connexions, the bi-monthly magazine on drug issues is published by CEIDA.

You can contact CEIDA on:
Ph: (02) 9818 0444 (business hours)
or for NSW country callers 1800 816 210
TTY service for hearing impaired people: (02) 9818 2993
Fax: (02) 9818 0441
Postal address: Private Mail Bag No.6 Rozelle NSW 2039
Street address: Rozelle Hospital Grounds,
Balmain Road (opposite Cecily Street), Rozelle NSW.

DrugLinks Website: http://www.ceida.net.au - your electronic connection to the world of alcohol and other drugs information.

The CEIDA Information Centre has wheelchair access.

Published by CEIDA, the Centre for Education and Information on Drugs and Alcohol.

CEIDA is administered by Central Sydney Area Health Service and is funded by the NSW Health Department.
A SHORT HISTORY OF TOBACCO

The dried leaves of the tobacco plant have been used as a mood altering substance in many different cultures for hundreds of years. Tobacco was introduced to Europe by the explorer Columbus in the 15th century and soon became very popular. Until the mid-19th century it was smoked in pipes and cigars, sniffed as snuff and chewed.

Cigarettes, as we know them, were first manufactured in the US in the 1880s. The supply of cigarettes to soldiers during World War 1 and aggressive advertising techniques are believed to have contributed to the marked increase in smoking in the Western world. Tobacco consumption reached a peak in the 1950s and has gradually declined in the general population. Despite the decline, about 19,000 Australians die each year of smoking-related diseases.

DIFFERENT METHODS OF USE

The vast majority of tobacco is smoked in cigarettes. Other methods of use include pipes, cigars and chewing tobacco.

The effects on health of smoking tobacco vary depending on which of these is used. Because cigarette smokers inhale more deeply than those using cigars and pipes, their lungs are more directly exposed to irritants in the smoke. Also, cigar and pipe tobaccos differ chemically from cigarette tobacco because of different methods used in their processing and curing.

The rate of deaths associated with some cancers - of the mouth, throat, and larynx (voice box) - are similar in both pipe/cigar smokers and cigarette smokers. In addition, there is a definite relationship between pipe smoking and lip cancer. With these exceptions, cigar and pipe smokers are less likely to experience smoking-related illnesses than are cigarette smokers.

WHO SMOKES?

The majority of Australians are now non-smokers. Over the past 50 years, there has been a significant decline in the number of men who smoke while the number of women smokers has remained about the same. In 1945, 72% of men and 26% of women were smokers. Recent statistics show that 27% of men and 23% of women smoke. Women now smoke at similar rates to men - about 19 cigarettes a day compared to 22 for men. A survey of drug use by NSW secondary school students in 1992 showed that smoking rates among boys and girls had increased to 17.3% and 21.9% respectively (as compared to the 1989 survey result of 12.8% and 16.9% respectively).

WHAT'S IN TOBACCO SMOKE?

Nicotine

Nicotine is a poison. Swallowing two or three drops of pure nicotine can kill an adult. When used as a concentrated insect spray, nicotine is 10 times more toxic than DDT. Voluntary agreements with the tobacco industry ensure that the amount of nicotine in Australian made cigarettes is limited to 1.4 mg.

It takes 7.5 seconds for nicotine to act on the brain after inhaling cigarette smoke. The initial effect is stimulation followed by a relaxed feeling about half an hour later. The absorption of nicotine and its distribution to the brain and other body organs and tissues is very rapid. Regular intake is needed to maintain a certain level of nicotine in the body.

Nicotine causes the narrowing of blood vessels, in turn affecting circulation and causing blood pressure to rise. Just one or two cigarettes will cause a significant increase in heart rate, a rise in blood pressure and a decrease in circulation in body extremities like fingers and toes. This is why regular absorption of nicotine through smoking cigarettes may increase the possibility of heart attack in people with chronic heart problems and can initially contribute to these problems.

Tar

Tar is also released - in the form of particles in the smoke - when a cigarette burns. It is the main cause of lung and throat cancer in smokers and also aggravates bronchial and respiratory disease.

Tar and other elements in tobacco smoke reduce the flexibility of the small air sacs in the lungs. It is this effect which causes "smokers' cough", shortness of breath and wheezing. The yellow staining of the fingers and teeth of smokers is also caused by tar.

An average smoker, on one packet a day, inhales more than half a cup of tar from cigarettes each year. The benefits of switching to low tar cigarettes are limited when compared to quitting. Studies show that smokers who switch to low tar brands tend to smoke more cigarettes or inhale more deeply.

Carbon monoxide

Carbon monoxide is an odourless, colourless and very toxic gas. It is found in car exhaust fumes and smoke from fires as well as tobacco smoke. Smoking cigarettes causes a greater concentration of carbon monoxide in the lungs than breathing in polluted air.

When the blood reaches the lungs, an exchange of gases takes place - the body gets rid of carbon dioxide and takes in more oxygen. Blood takes up carbon monoxide more readily than oxygen, and in a smoker this means that the blood leaves the heart with less oxygen to supply the cells of the body. High levels of carbon monoxide in the blood are typical of people who smoke. These increase the risk of developing circulation problems, such as hardening of the arteries and coronary heart disease.

Other chemicals

Small amounts of more than 4,000 other substances can be found in cigarette smoke, including some which are toxic and 43 which have been identified as being carcinogenic (causing cancer). Some of the substances found in cigarette smoke are acetone, ammonia and hydrogen cyanide.
The effects of smoking vary from person to person. For example, they depend on the person's gender, health, working environment and hereditary factors.

**Immediate effects**
- increased pulse rate
- temporary rise in blood pressure
- acid in the stomach
- kidneys produce less urine
- brain and nervous system activity stimulated then reduced
- weaker appetite, taste and smell
- paralysed cilia (small, hair-like filaments that line the airways and lungs)
- decreased blood flow to body extremities like fingers and toes
- dizziness; nausea; watery eyes

**Long term effects**
- shortness of breath; coughing
- stains on fingers and teeth
- narrowing and/or hardening of blood vessels, particularly in the heart and legs
- increased risk of respiratory infections e.g. colds, pneumonia, chronic bronchitis
- increased risk of emphysema (a chronic, progressive lung disease)
- increased risk of heart attack and coronary heart disease
- increased risk of cancer of lungs, mouth, larynx, pharynx, oesophagus (gullet), bladder, kidney, pancreas and cervix
- increased risk of peripheral vascular disease due to decreased blood flow in blood vessels in the legs
- speeds up some of the physical signs of ageing, such as dry skin and wrinkles
- affects female fertility; women who smoke are more likely to be infertile or take longer to conceive than women who do not smoke
- inhibits the development of Parkinson's Disease

**TOLERANCE AND DEPENDENCE**
Tolerance of nicotine means that a person needs increasing quantities of nicotine to get the same effects as they did before with smaller amounts.

Dependence on smoking means it becomes central to a person's thoughts, emotions and activities. A dependent person may find it difficult to stop smoking and may experience withdrawal symptoms when they stop or cut down on their nicotine intake. These symptoms will vary from person to person. They can include: increased nervousness and tension; changes in sleeping patterns; stomach and bowel disturbances; loss of concentration; muscle spasms; changes to taste; speed up some of the physical signs of ageing, such as dry skin and wrinkles; affects female fertility; women who smoke are more likely to be infertile or take longer to conceive than women who do not smoke; inhibits the development of Parkinson's Disease.

**SMOKING AND PREGNANCY**
Studies have indicated that smoking during pregnancy can lead to miscarriage, stillbirth and illness of the child in early infancy. It has also been associated with the sudden infant death syndrome (cot death). Babies of women who smoke weigh about 200 grams less than babies of women who don't. This is because the carbon monoxide inhaled from cigarettes cuts down on the amount of oxygen reaching the foetus in pregnant women. The long term effects of this low body weight on the development of the child are not known.

**SMOKING AND OTHER DRUGS**
Women taking the contraceptive pill and smoking run a greater risk of having a heart attack or stroke. Smoking and using alcohol is thought to lead to an increased risk of mouth cancers.

**GIVING UP SMOKING**
Up to 80% of smokers want to quit because they know the negative health effects of smoking. An added incentive is saving money. At today's prices the average smoker, on one pack a day, could save up to $2,500 a year if they stopped.

Within two days of quitting, the nicotine and all of its by-products have left the body. After a day the body gets rid of the carbon monoxide and breathing improves. Within ten years of giving up, the risk of getting smoking-related illnesses falls to almost the level of someone who has never smoked. The risk of suffering many diseases falls even sooner. For example, the risk of suffering from coronary artery disease drops sharply 12 months after stopping. Quitters experience a sense of personal achievement after successfully breaking the habit.

The first step in giving up smoking is wanting to be a non-smoker. Most smokers try several times before quitting completely. Many people have found it easier to quit "cold turkey" rather than cutting down gradually. Any gradual reduction should be towards a firm quitting date no more than two weeks away.

**WEIGHT GAIN**
Weight gain is not an automatic result of stopping smoking. If people put on weight it is usually because they eat more when they have stopped smoking. There is also evidence that a person's metabolism slows down when they stop using nicotine. This means that a person could put on weight without an increase in the amount they eat. To prevent weight gain, most quit smoking programs recommend a change in diet. Regular physical exercise also keeps weight down and adds to the health benefits of quitting smoking.
PASSIVE SMOKING

Passive smoking is a term used to describe the effect of tobacco smoke on people who do not smoke but spend time with smokers. Mainstream smoke is smoke drawn through a cigarette into a smoker's mouth and lungs. Second hand smoke is the smoke exhaled (breathed out). Sidestream smoke is the smoke that drifts off the end of the cigarette into the air and is completely unfiltered. Some poisons in tobacco smoke are much more concentrated in sidestream smoke than in mainstream smoke.

There is evidence on passive smoking that it is a significant cause of lung cancer in non-smokers and acute asthma attacks in asthma sufferers. Children of smoking parents also have an increased risk of Sudden Infant Death Syndrome (SIDS) and serious chest illnesses such as pneumonia and bronchitis.

The effects of passive smoking will depend on how long the non-smoker spends in a smoke-filled environment, how well the air flows in the area, and how many cigarettes are being smoked.


SMOKING AT THE WORKPLACE

Exposure to passive smoking or Environmental Tobacco Smoke (ETS) by non-smokers has been linked with lung cancer, coronary heart disease, respiratory illnesses and asthma in children. The Smoking Regulation Act 1997 aims to protect the community from passive smoking in enclosed public places. The Act is based on an air quality standard that will be defined by regulation. The Act will come into effect five years after the air quality standard is defined.

During the five year period there will be an active strategy of encouraging venues to become smoke-free. This will include work with non-government organisations to provide appropriate support and resources to the hospitality industry.

SMOKING AND THE LAW

The law relating to smoking in NSW covers some public places where smoking is not permitted - in the auditoriums of cinemas and theatres and in public halls and lifts. The sale of tobacco products to anyone under 18 years of age is prohibited. Retailers must request and sight proof of age before selling tobacco products. Members of the public who witness a sale to a person under the age of 18 can report this to the NSW Health Department on (02) 9391 9111 or to their nearest police station. Smoking by those handling food for sale, or in a place used for handling food for sale, is illegal.

There is a total ban on smoking on metropolitan buses and trains. Smoking is only permitted in designated areas on ferries and trains. Taxi drivers are not permitted to smoke at any time while carrying passengers. Drivers or passengers must not smoke at anytime when the taxi displays 'no smoking' signs. Smoking is also banned on all domestic flights.

Federal laws make the provision of health warnings on tobacco products compulsory and have banned television, radio and print-media advertising tobacco products. Billboard advertising has been banned in NSW. Sports sponsorship by tobacco companies is illegal unless an exemption is granted.

In 1998, further amendments to the Public Health Act restricting tobacco advertising come into effect. This new Act sets out the legal requirements for tobacco advertising, the storage and display of tobacco products, price boards and ticketing, location of vending machines, signage, sale and supply of confectionary, toy and trick cigarettes and the powers of authorised officers.

QUIZ

Circle the correct answer/s to each of the following questions.

1. The main ingredient in tobacco on which smokers become physically dependent is:
   (a) carbon monoxide  (b) tar  (c) nicotine  (d) ammonia

2. Tar is the ingredient in cigarette smoke which is the main cause of:
   (a) heart disease  (b) lung cancer  (c) poor circulation  (d) bad breath

3. Women who smoke have additional health risks to men who smoke particularly if they:
   (a) don't exercise  (b) take the contraceptive pill  (c) live in the city  (d) have children

4. Passive smokers receive the most ill-effects and health risks from:
   (a) the smoke breathed out by the smoker - second hand smoke  (b) smoke from a pipe or cigar  (c) the smoke drifting off the end of a lit cigarette - sidestream smoke  (d) kissing a smoker

5. The risk of suffering from a chronic heart disease drops sharply after giving up smoking for:
   (a) 10 years  (b) 3 months  (c) 2 years  (d) 12 months

6. Children of parents who smoke have increased risk of:
   (a) developing serious chest illness like bronchitis  (b) failing school  (c) becoming smokers themselves  (d) cancer of the nose

7. Smoking cigarettes causes a greater concentration of a certain poisonous substance in the lungs than breathing in polluted air. That substance is:
   (a) nicotine  (b) tar  (c) ammonia  (d) carbon monoxide.

(d) 2 (e) 6 (f) 5 (g) 4 (h) 3 (i) 2 (j) 1

SAMSUNG
IN EMERGENCIES
CONTACT YOUR
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HOSPITAL OR CALL
FOR AN AMBULANCE

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Ph: (02) 9818 0444 (business hours)
or for NSW country callers 1800 816 210.
TTY service for hearing impaired people: (02) 9818 2993
Fax: (02) 9818 0441
Postal address: Private Mail Bag No.6 Rozelle NSW 2039
Street address: Rozelle Hospital Grounds, Balmain Road (opposite
Cecily Street), Rozelle NSW.

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connection to the world of alcohol and other drugs information.
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CEIDA is administered by Central Sydney Area Health Service and is

INFORMATION

What are amphetamines?
Effects
Dependence & tolerance
More information & help

AMPHETAMINES

“speed”
Amphetamines are a group of drugs commonly known as "speed". Amphetamines bought on the street are usually in the form of white or yellow powder, manufactured illegally. They can also be sold as tablets or as a liquid in capsules. Amphetamines can be swallowed, inhaled ("snorted") or injected.

When bought illegally, amphetamines are often mixed with other substances. These substances can have unpleasant or harmful effects.

Amphetamines are stimulants. They directly affect the central nervous system by speeding up the activity of certain chemicals in the brain. Other stimulants include caffeine and cocaine.

A SHORT HISTORY

Amphetamines were developed in the US during the 1920s. By the 1960s they were used by doctors in Australia to treat depression, obesity and a range of other conditions. Today amphetamines are only prescribed for a small number of uncommon medical problems. These include uncontrollable sleeping fits (narcolepsy) and some types of hyperactivity in children.

WHO USES AMPHETAMINES?

People use amphetamines illegally for different reasons. Some use the drugs to stay awake for work or study. Some use them to try to improve their performance in sport. Others use them to get "high" and dance all night.

In the 1995 National Drug Strategy Household Survey, 6% of people surveyed had ever tried amphetamines and 2% had used amphetamines within the past 12 months.

The effects of amphetamines will vary from person to person. They will depend on:
- how much of the drug is taken; the way in which the drug is taken
- the person's size, weight and health
- the person's mood
- the person's experience with the drug or similar drugs over a period of time
- whether the drug is taken with other drugs
- and whether the person taking the drug is alone or with other people, at home or at a party, and so on.

Immediate effects of a single dose

These effects can occur rapidly after a single dose of amphetamines. They can last anywhere from a few hours to a few days.
- reduced appetite
- increased rate of breathing and pulse
- increased blood pressure
- enlarged pupils
- increased alertness
- extreme feeling of well-being; greater self confidence and energy
- inability to sleep
- hyperactivity; talkativeness
- anxiety; irritability; suspiciousness; a threatening manner
- panic attacks

Drugs can affect people's behaviour in many ways. Because amphetamines can give a person greater self confidence, there can be a higher risk of having unsafe sex (for example, sex without a condom). This is one of the most common ways of becoming infected with HIV (Human Immunodeficiency Virus) the virus which causes AIDS.

Some people react to amphetamines in an unpredictable way. For example, small doses can produce an over-dose like response.
Effects of higher doses

Increasing doses of amphetamines can produce:
- sweating
- headaches
- restlessness
- shaking
- irregular breathing
- pale skin
- dizziness
- feelings of being powerful or superior
- repetitive movements
- very rapid or irregular heartbeat

Some users may become hostile and aggressive. Higher doses may even induce psychosis (a serious break with reality - hallucinations and delusions).

Effects of continued use

The use of most drugs, particularly at high doses, over a long period of time, is likely to cause some health problems. Some of the specific problems that can occur with long term amphetamine use are:
- malnutrition
- reduced resistance to infection
- violence, often for no apparent reason
- emotional disturbance
- periods of psychosis

Effects related to methods of using

People who inject amphetamines risk becoming infected with the Human Immunodeficiency Virus (HIV), the virus which causes AIDS, hepatitis B and C and other infections such as blood poisoning (septicaemia) if they share needles with other people or use needles which are not clean.

Long term injection of amphetamines can result in:
- blockage of blood vessels (caused by the substances sometimes mixed with illegally bought amphetamines) which can lead to major damage to the body’s organs

Overdose

As amphetamines are often mixed with other substances, it is not possible to know exactly what drug is contained in samples bought on the street. It is also difficult to know what dose of the drug is being taken. When amphetamines are used for medical purposes, they are usually prescribed in doses of about 5-10mg (about the same amount as a small pinch of salt).

Acute amphetamine poisoning (overdose) can cause a number of effects including:
- irregular heartbeat
- heart attack
- a very high fever
- burst blood vessels in the brain

Some deaths have occurred as a result of amphetamine overdoses.

Amphetamine psychosis may also occur as a result of either a single high dose of amphetamines or a period of taking high doses of amphetamines. Symptoms include hearing voices, delusions, suspicion and fear of persecution.

Tolerance and dependence

People can develop tolerance to amphetamines. This means that a person needs higher doses of the drug to achieve the same effects as they used to get with smaller amounts.

Some people can also become dependent on amphetamines. The drug can become central to their thoughts, emotions and activities. They use amphetamines compulsively and find it difficult to stop using or to reduce the amount they consume.

Withdrawal

Withdrawal symptoms occur when a dependent person stops using the drug or severely cuts down the amount they use. Withdrawal symptoms from amphetamine use include: fatigue; hunger; deep depression and lack of energy; exhaustion followed by long but disturbed sleep; irritability; agitation; anxiety; craving for a “high”.

People withdrawing from any drug including amphetamines are advised to contact their local community health centre or doctor for
AMPHEMATINES AND OTHER DRUGS

Amphetamine users may take other drugs as a way of coping with some of the undesirable effects of amphetamines. Some people take drugs such as minor tranquillisers, alcohol or heroin to help them sleep. This sometimes results in a "rollercoaster" dependence on several drugs: for example, some people need amphetamines each day to get them going and minor tranquillisers each night to get them to sleep. This type of dependence can lead to a variety of serious physical and psychological problems.

AMPHEMATINES AND PREGNANCY

Most drugs have some effect on the unborn child. There is some evidence that babies of amphetamine-using mothers may have withdrawal symptoms from amphetamine use.

Pregnant women who use amphetamines have a higher rate of miscarriages, premature labour and other complications. Some studies also show that the babies of amphetamine-using mothers tend to be underweight.

It is not yet known whether the children of mothers who used amphetamines during their pregnancy experience long term problems in mental or physical growth, but initial studies give some cause for concern.

AMPHEMATINES AND THE LAW

Illegal use, possession or supply of amphetamines carries heavy fines and/or prison sentences. Penalties range from a $2000 fine and/or two years in prison to a $500,000 fine and/or imprisonment for life.

AMPHEMATINES AND DRIVING

In New South Wales it is against the law for anyone to drive under the influence of drugs, including amphetamines. Breaking this

Q U I Z

Test your knowledge
The following 14 statements will test your knowledge about amphetamines.
Answer true or false.

1. Amphetamines act on the body as a stimulant. t or f
2. Amphetamines are used for some medical conditions. t or f
3. Amphetamines are in the same group of drugs as alcohol. t or f
4. Amphetamines can be bought over the counter at the chemist. t or f
5. The effects of amphetamines on an individual's body vary according to the situation. t or f
6. When a person takes amphetamines they may feel sleepy. t or f
7. A person with amphetamine psychosis may hear voices. t or f
8. A person may develop a tolerance to amphetamines if they are needing more and more to get the same effects as when they used smaller amounts. t or f
9. When a person uses amphetamines they may feel more self confident and have a lot of energy. t or f
10. A person experiencing withdrawal symptoms from amphetamines may lose their appetite. t or f
11. Pregnant women who use amphetamines have a higher rate of experiencing complications. t or f
12. It is not an offence to drive under the influence of amphetamines. t or f
13. People never feel dizzy or restless when they take amphetamines. t or f
14. A person who has been using amphetamines over a long period of time may experience emotional disturbance. t or f

Answers: 1. t. 2. t. 3. f. 4. f. 5. t. 6. f. 7. t. 8. t. 9. t. 10. t. 11. t. 12. f. 13. f. 14. t.
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Cocaine comes in various forms but is most commonly seen in Australia as a white powder called cocaine hydrochloride. This powder is made by processing and treating the leaves of the coca plant with various chemicals. Cocaine in this form is sniffed through the nose (‘snorted’) or injected.

People who sell cocaine often mix or ‘cut’ the powder with other substances to increase their profits. These substances can have unpleasant or harmful effects.

Cocaine hydrochloride in its powder form cannot be smoked because the drug is destroyed at high temperatures. However, an extract of cocaine hydrochloride, known as freebase cocaine, can be smoked and results in quicker euphoric (‘getting high’) effects.

Crack is a type of free base cocaine sold in the form of small crystals or ‘rocks’. It is usually smoked. Crack has rarely been seen in Australia.

Cocaine is a stimulant. It directly affects the central nervous system by speeding up the activity of certain pathways in the brain. Other stimulants include caffeine and amphetamines.

**A SHORT HISTORY**

The coca plant grows in many parts of South America and for at least 2000 years South American Indians chewed coca leaves as a cultural and religious practice. They also chewed the leaves as a way of reducing hunger and fatigue. In 1855 a European scientist isolated the drug cocaine from coca leaves. Around 25 years later cocaine was used in European medicine as a local anaesthetic. It was used in many patent medicines towards the end of the 19th century and was an ingredient of Coca-Cola until 1903. It was used extensively in Australia and elsewhere as an anaesthetic - especially in dental surgery.

**WHO USES COCAINE NOW?**

Cocaine has been used for non-medicinal purposes since last century. It is now used very rarely in ear, nose and throat surgery. Although it was banned except for medicinal use in most Western countries in the 1920s, Australia still had the highest consumption of cocaine per person in the world in the 1930s.

Currently, cocaine is one of the most widely used illegal drugs in the US. In Australia the 1995 National Drug Strategy Household Survey found that about 1 per cent of people had used cocaine in the previous 12 months.

**WHAT IS COCAINE?**

**EFFECTS**

The effects of cocaine will vary from person to person. They will depend on:

- how much cocaine is taken
- the way in which cocaine is taken
- the person's size, weight and health
- the person's mood
- the person's experience with cocaine over a period of time
- whether cocaine is taken on its own or in combination with other drugs
- whether the person taking cocaine is alone or with others; at home or at a party; and so on.

**Immediate effects of a single low dose**

These effects can occur rapidly after a single dose of cocaine. They can last anywhere from a few minutes to a few hours.

- reduced appetite
- increased heart rate
- agitation
- sexual arousal
- increased body temperature
- enlarged pupils of the eyes
- increased alertness and energy
- extreme feelings of well-being
- inability to judge risks
- unpredictability and aggressive behaviour.

Drugs can affect people's behaviour in many ways. For example, a person experiencing the effects of drugs may be more likely to have unsafe sex (for example, sex without a condom) which is one of the most common ways of becoming infected with HIV, the virus which causes AIDS.

As cocaine is often 'cut' with other substances, users sometimes don't know exactly what drug they are getting and what dosage they are taking.
Effects of higher doses
Increasing doses of cocaine can produce:
- headaches
- dizziness
- restlessness
- violent and/or aggressive behaviour
- loss of concentration
- loss of interest in sex
- loss of ambition and motivation
- heart pain
- heart attack

Effects of continued use
Using cocaine over a long period of time can lead to behavioural problems and convulsions (fits) in some people. Regular use of cocaine can also lead to serious problems such as the drug becoming central to a person's life (see Tolerance and Dependence) or psychosis (see Overdose).

Effects related to methods of using
There are also a range of effects related to the method of taking the drug.
- Snorting cocaine can lead to nosebleeds, sinusitis and tearing of the nasal wall.
- Smoking freebase cocaine can cause breathing difficulties, a chronic cough, chest pain and lung damage.
- Injecting cocaine with used or dirty equipment, such as needles, increases the risk of becoming infected with HIV, hepatitis B and C, blood poisoning (septicaemia) and skin abscesses.

Long term injection of cocaine can result in:
- blockage of blood vessels (caused by the substances sometimes "cut" with cocaine) which can lead to major damage to the body's organs
- Inflamed blood vessels and abscesses.

A high dose of cocaine will vary from person to person. As little as 10mg of cocaine (about one-tenth of the dose users commonly inhale) has been known to kill individuals who have a particularly strong reaction to cocaine.

Acute cocaine poisoning (overdose) can produce the following effects:
- faster, irregular and weak heartbeats
- lung failure
- heart failure
- burst blood vessels in the brain

Cocaine psychosis, a serious psychological problem, may also occur as a result of either a single high dose of cocaine or a period of taking high doses of cocaine. Its symptoms include hearing voices, delusions, suspicion and fear of persecution.

Tolerance and Dependence
People can develop tolerance to the "feeling high" effects of cocaine. This means that a person needs higher doses of the drug to achieve the same effects as they used to get with smaller amounts of the drug.

Regular use of drugs such as cocaine can lead to a variety of health, social, legal, financial and relationship problems. Some people can also become dependent on cocaine. This means that the drug becomes central to their thoughts, emotions and activities. They use the drug compulsively and find it difficult to stop using or to reduce the amount they use.

Withdrawal symptoms occur when a dependent person stops using the drug or severely cuts down the amount they use. Withdrawal symptoms from cocaine use can include: deep depression; suicidal feelings; nausea; vomiting; shaking fits; fatigue; weakness; hunger; long but disturbed sleep; irritability; muscle pain; craving for the drug.

People withdrawing from any drug including cocaine are advised to contact their local community health centre or doctor for assistance.
**COCAIN AND OTHER DRUGS**

Cocaine users may use other drugs as a way of coping with some of the undesirable effects of the drug. Some people take drugs such as minor tranquillisers, alcohol, marijuana or heroin to help them sleep. This sometimes results in a "rollercoaster" dependence on several drugs: for example, some people need cocaine each day to get them going and minor tranquillisers each night to get them to sleep. This type of dependence can lead to a variety of serious physical and psychological problems.

Using combinations of drugs can increase the risk of overdose. Injecting heroin and cocaine at the same time, for example, is very dangerous. It can affect the area of the brain which controls breathing and can lead to coma or death.

**COCAIN AND PREGNANCY**

Drugs often affect the unborn child. There is some evidence that cocaine use in pregnancy can increase the chance of miscarriage, premature labour and other complications. Babies of cocaine-using mothers tend to be underweight and may experience withdrawal symptoms from the mother’s cocaine use. The occurrence of developmental and behavioural problems in these babies is still being researched.

**COCAIN AND THE LAW**

Illegal use, possession or supply of cocaine carries heavy fines and/or prison sentences. Penalties range from a $2000 fine and/or two years in prison to a $500,000 fine and/or imprisonment for life.

**COCAIN AND DRIVING**

In New South Wales, it is against the law for anyone to drive under the influence of drugs, including cocaine. Breaking this law carries penalties including disqualification from driving, fines and/or imprisonment. Cocaine also gives drivers a false sense of security. This can lead them to take risks which can result in traffic accidents.

**QUICK**

Test your knowledge

The following 10 statements will test your knowledge about cocaine.

Answer true or false.

1. The coca bush grows in South America.  t or f
2. Crack is a form of cocaine which is smoked. t or f
3. Cocaine is in the same group of drugs as heroin. t or f
4. In Australia, cocaine has been used in medicine mainly as a sedative. t or f
5. The effects of cocaine on an individual's body may depend on the person's mood. t or f
6. The immediate effects of cocaine use can include depression. t or f
7. A person with cocaine psychosis may become suspicious or hostile without any apparent reason. t or f
8. Cocaine use in pregnancy may increase the risk of miscarriages. t or f
9. If you drive under the influence of cocaine you may run the risk of losing your licence. t or f
10. Injecting cocaine with a used or dirty needle increases the risk of becoming infected with HIV or Hepatitis B & C. t or f
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NSW HEALTH

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**WHAT ARE MINOR TRANQUILLISERS?**

Most minor tranquillisers belong to a group of drugs known as 'benzodiazepines' (often called 'benzos'). There are over 30 specific drugs within this group. Each has a chemical or 'generic' name, and each is sold under at least one brand name. The different brand names in each group, as listed below, are exactly the same drug but made by different companies.

Minor tranquillisers are medically classified as sedatives (for calming), hypnotics (for inducing sleep) or anxiolytics (for relieving anxiety). In practice, they perform all of these functions. The main difference is in their length of action, which ranges from 4-6 hours to 2-3 days.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Brand Name</th>
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<tbody>
<tr>
<td>diazepam</td>
<td>Valium, Ducene, Antenex, Pro pan</td>
</tr>
<tr>
<td>oxazepam</td>
<td>Serepax, Murelax, Alepam, Benztran</td>
</tr>
<tr>
<td>nitrazepam</td>
<td>Mogadon, Alodorm, Dormican, Nitemed</td>
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<tr>
<td>temazepam</td>
<td>Euhypnos, Normison, Temaze</td>
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<tr>
<td>lorazepam</td>
<td>Ativan, Emoten</td>
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<td>flunitrazepam</td>
<td>Rohypnol, Hypnodorm</td>
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<tr>
<td>bromazepam</td>
<td>Lexitane</td>
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<tr>
<td>clonazepam</td>
<td>Rivotril</td>
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</table>

Minor tranquillisers are prescribed for the short term relief of:
- severe anxiety and sleeping problems
- muscle spasms (such as occurs in cerebral palsy)
- helping people cope with grief
- epilepsy.

Minor Tranquillisers are also used to sedate patients before surgery and in helping people withdraw from alcohol dependence.

**WHY THEY ARE PRESCRIBED**

**EFFECTS**

The effects of minor tranquillisers will vary from person to person depending on:
- the size of the dose
- the length of time over which they are taken
- the person's weight and age.

There is no one correct dose for minor tranquillisers. The strength, number and duration for which people are prescribed the drug will vary according to:
- age
- other drugs being taken at the same time
- general health
- the severity of symptoms
- whether the drug has been taken before, and for how long.

The prescribing doctor or a pharmacist is the best person to talk to for exact information about dosage.

**HOW DO THEY WORK?**

They are prescribed by doctors usually in a tablet or capsule form. The drug is absorbed into the bloodstream and circulates through the body. It acts on the central nervous system (brain cells and spinal chord), slowing down physical, mental and emotional responses. It also has a relaxing effect on the muscles.

Minor tranquillisers are usually prescribed for a short period because people can become physically and psychologically dependent on them.
The intensity and frequency of the following effects will depend on the dose and how long the person has been taking minor tranquillisers.

- relaxation
- drowsiness; sleep
- lethargy
- dizziness; confusion
- euphoria
- mood swings
- slurred speech/stuttering
- movement and judgment of distances can be affected
- blurred or double vision
- loss of short-term memory

Very high doses (i.e. overdose) can cause stupor or coma and, when taken in combination with other drugs, can even result in death.

### Long-term effects

The long term effects of minor tranquillisers can include:

- lethargy
- irritability
- nausea; headaches
- disturbed dreams
- loss of sexual interest or function

Chronic use of minor tranquillisers may lead to symptoms ranging from depression to lack of muscle and speech coordination.

### Tolerance and dependence

Tolerance to minor tranquillisers occurs when a person needs more of the drug to produce the same effects as first experienced with lower doses. This can happen within two weeks, and with minor tranquillisers used as sleeping pills, their effectiveness may wear off after three nights.

Dependence occurs when a person finds it difficult to stop. If they do stop, or even reduce their dose, they may experience withdrawal symptoms.

Many people who become dependent on minor tranquillisers will experience withdrawal symptoms. This happens when the dosage is reduced or when a person stops taking the drug completely. If someone has been regularly using minor tranquillisers for more than two or three weeks, they should not stop suddenly without consulting a doctor, pharmacist or health worker. Withdrawal from minor tranquillisers, if possible, should begin when there is some degree of stability in a person's life.

- Sudden withdrawal from these drugs is not advisable. People using very high doses may experience seizures (fits) or hallucinations if they stop suddenly. This also applies to people on therapeutic doses such as the elderly, or people who are chronically unwell or susceptible to convulsions. Lesser withdrawal symptoms such as anxiety, disturbed perception or phobias can also be very unpleasant and can prevent the desire to stop using. For these reasons, rapid withdrawal will require medical supervision and normally a brief stay in hospital.

- The gradual withdrawal technique is when the dosage is reduced, usually over two or three months, in consultation with the prescribing doctor or with people who have been specifically trained to deal with tranquilliser withdrawal. (Several Women's Health Centres in NSW have staff trained in this area.)

There are other alternative programs available where treatment may include massage, meditation, naturopathy, relaxation techniques, stress management and one-to-one counselling. A person can ask their doctor about alternatives or they can contact a Community or Women's Health Centre.

### Withdrawal symptoms

Withdrawal symptoms vary from person to person. Sometimes they do not show up until a week or more after a person stops taking minor tranquillisers. Symptoms include:

- disturbed sleeping patterns
- nervousness, tension
- senses distorted and heightened
- pain, stiffness, and muscular spasms
- panic attacks and increased anxiety
- feelings of depersonalisation and unreality
- flu-like illness
- increased menstrual bleeding and breast pain in women.

Many of the reasons why people take minor tranquillisers in the first place often reappear as part of the withdrawal process. It's important that people are aware of the withdrawal symptoms as this may help them tolerate the symptoms. Withdrawing at a stable period in one's life also helps.
It is wise not to use any drugs during pregnancy. Minor tranquillisers cross the placental barrier and accumulate in the unborn child when taken regularly (particularly in the latter part of pregnancy and during labour). Babies of mothers who have used minor tranquillisers for extended periods of time show a variety of symptoms such as respiratory distress and poor sucking. For the baby, abrupt withdrawal from the drugs at birth appears also to result in irritability, tremors, diarrhoea and other disorders. These drugs also pass from mother to baby during breastfeeding. This can affect the baby's nervous system leading to drowsiness, slow responses and feeding problems. Research also suggests that taking minor tranquillisers in the last three months of pregnancy may be associated with learning disorders in the child.

If you are using minor tranquillisers and are pregnant or are thinking of having a baby, it is advisable to talk with a doctor and/or health worker.

OTHER DRUGS

When combined with other drugs, minor tranquillisers can produce several hazardous effects, especially with:

- ALCOHOL which greatly reduces alertness and judgement of time, space and distance. Combining large amounts of alcohol and minor tranquillisers may result in death.

- OTHER SEDATIVES AND ANTI-HISTAMINES (cough, cold and allergy remedies), and OTHER PRESCRIBED DRUGS (e.g. lithium, methadone, anti-convulsants, antibiotics) which can result in unconsciousness and failure to breathe and can lead to death.

- ILLICITS such as heroin which can lead to an overdose or death.

If you are seeing more than one doctor, make sure you tell them you are taking minor tranquillisers. This is to prevent dangerous interactions with other medications.

In NSW it is illegal to drive while under the influence of a drug that adversely affects your driving ability. Minor tranquillisers affect driving ability. They also affect your ability to operate machinery or do other activities where you need to remain alert and in control. Taking minor tranquillisers in such circumstances increases the risk of accidents to yourself and others.

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THE LAW

Only doctors can prescribe minor tranquillisers as they are restricted substances as governed by the Poisons Act in NSW. Illegal use, possession, or supply of tranquillisers carries a fine of up to $2000 and/or two years imprisonment.

MINOR TRANQUILLISER QUIZ

Test your knowledge...
The following 12 statements will test your knowledge about minor tranquillisers.

Answer true or false.

1. Minor tranquillisers can be prescribed for epilepsy... T or F
2. Tolerance to minor tranquillisers can happen within 14 days... T or F
3. High doses used in combination with alcohol can result in death... T or F
4. It is illegal to drive under the influence of minor tranquillisers... T or F
5. Most minor tranquillisers belong to the benzodiazepine group of drugs... T or F
6. Minor tranquillisers are most often prescribed in tablet form... T or F
7. Sudden withdrawal can cause seizures... T or F
8. Minor tranquillisers speed up the central nervous system... T or F
9. Long-term use leads to increased sexual performance... T or F
10. Minor tranquillisers can only be prescribed by a medical practitioner... T or F
11. Minor tranquillisers can pass from a mother to her baby through breast milk... T or F
12. Sleeping tablets are a form of minor tranquilliser... T or F

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<tr>
<th>Statement</th>
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MDMA is commonly known as 'ecstasy'. It is usually sold as small tablets which come in a variety of colours and sizes. It can also come in powder form which can be inhaled through the nose ('snorted'). There have also been reports of people injecting themselves with MDMA.

As with other illegally bought drugs, people who buy MDMA are often buying the drug mixed with other substances. These substances can have a range of unpleasant or harmful effects. Also, they may not be buying MDMA at all.

MDMA stands for MethyleneDioxyMethAmphetamine. The chemical structure of MDMA is similar to the structure of both amphetamines ('speed') and some hallucinogens.

Amphetamines are stimulants. They directly affect the central nervous system by speeding up the activity of certain chemicals in the brain. Other stimulants include caffeine and cocaine.

Hallucinogens are drugs which can cause hallucinations - seeing, hearing, feeling or smelling things that do not exist. Hallucinogens include drugs such as LSD.

**A SHORT HISTORY**

MDMA was developed in 1914 by a German chemical company as an appetite suppressant. It was used by therapists in the US in the 1970s to help people explore their feelings for each other. It has only become available in Australia since the mid-1980s. Use of the drug is now illegal in this country.

**WHO USES MDMA?**

People who take MDMA may use it to dance all night, to experience its hallucinogenic effects or for a variety of other reasons. In the 1995 National Household Survey close to 1% of the population had used ecstasy and other designer drugs within the last 12 months.

**WHAT IS MDMA?**

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**EFFECTS**

Not all users will experience all of the effects described in this section. The effects of MDMA will vary from person to person. The effects on any person will depend on:

- how much MDMA is taken
- the way in which MDMA is taken
- whether it is taken with other drugs
- the person's size, weight and health
- the person's mood
- the person's experience with MDMA or similar drugs over a period of time
- and whether the person taking MDMA is alone or with others; at home or at a party; and so on.

**Immediate effects**

These effects can begin within an hour of taking MDMA. Most effects last up to six hours, but some may persist for up to 32 hours:

- increased blood pressure and pulse rate
- increased body temperature
- increased confidence
- feelings of closeness with other people
- sweating; dehydration
- jaw clenching, grinding teeth
- strong feeling of wellbeing
- nausea
- anxiety
- paranoid feelings (for example, fear of persecution or feelings of superiority).
It is important to keep sipping water to minimise the effects of dehydration. Recommended level is 500ml per hour if a person is active or 250ml if inactive.

Drugs can affect people's behaviour in many ways. For example, a person experiencing the effects of drugs may be more likely to have unsafe sex (for example, sex without a condom) which is one of the most common ways of becoming infected with HIV (the virus that causes AIDS).

People who inject MDMA risk becoming infected with HIV, hepatitis B and C and other infections such as blood poisoning (septicaemia) if they share needles with other people or use needles which are not clean.

**Effects of higher doses**

Increasing doses of MDMA can produce:
- hallucinations
- sensations of floating
- irrational behaviour
- convulsions ("fits")
- vomiting

There is no evidence that MDMA improves sexual performance. MDMA may also have a "hangover" effect - including loss of appetite, insomnia, depression, muscle aches and difficulty in concentrating - particularly on the day after the drug is taken.

**Long term effects**

The use of most drugs, particularly at high doses, over a long period of time is likely to cause some health problems. Little is known about the long term effects of MDMA. There is some evidence to suggest that long term use of MDMA may cause damage to the brain, heart and liver.

Studies here and in the US have found that few people seem to use MDMA for long periods. This is probably because other unpleasant effects of the drug increase as people take more of the drug more often. Some people who have used MDMA several times said they had longer "hangovers" and felt "burnt out" for longer periods each time they took the drug.

**OVERDOSE**

Acute MDMA poisoning (overdose) can occur. MDMA poisoning results in very high blood pressure, fast heartbeat and a very high body temperature.

Some people have had severe reactions to MDMA and there have been reports of deaths related to the use of MDMA in the US, the UK and Australia. Many of these were associated with overheating and dehydration.

MDMA is regarded as a dangerous substance for people with medical conditions such as heart or breathing problems and for people with depression or any other psychological disorder.

High doses of MDMA can produce strong hallucinations. People sometimes behave irrationally when they are experiencing hallucinations and their behaviour could be dangerous to themselves or others.

**TOLERANCE**

Tolerance occurs when a person needs higher doses of a drug to achieve the same effects as they used to get with smaller amounts of the drug.

Recent research suggests that people do develop tolerance to the pleasurable effects of MDMA. It appears that positive effects diminish while the negative effects increase with increasing use of the drug. People report needing to take more of the drug to experience the same positive effects, but this increases the unpleasant effects.
MDMA AND OTHER DRUGS

People who take MDMA may take other drugs as a way of coping with some of the undesirable effects of the drug. For example, they may take minor tranquillisers or cannabis to help them sleep after staying up all night. MDMA is also often taken with other drugs in a ‘party’ atmosphere.

Little is known about the effects of these combinations. However, combining MDMA with amphetamines ('speed') increases the effect on the heart and may increase the feelings of anxiety and paranoia. Taking other hallucinogens with MDMA can produce a psychotic reaction. Even the use of legal drugs such as alcohol with MDMA can have very serious consequences. In general, health risks tend to increase when two or more drugs, especially in large doses, are used together.

PREGNANCY

Most drugs have some effect on the unborn child. Little is known about the effects of using MDMA during pregnancy.

THE LAW

Illegal use, possession or supply of MDMA carries heavy fines and/or prison sentences. Penalties range from a $2000 fine and/or two years in prison to a $500,000 fine and/or imprisonment for life.

MDMA AND DRIVING

In New South Wales, it is against the law for anyone to drive under the influence of drugs, including MDMA. Breaking this law carries penalties including disqualification from driving, fines and/or imprisonment.

Test your knowledge

The following 10 statements will test your knowledge of MDMA.

Answer true or false.

1. MDMA has similar effects to depressants. T or F
2. MDMA is commonly sold as tablets which come in a range of colours. T or F
3. MDMA can be bought over the counter from a chemist. T or F
4. The effects of MDMA will vary according to the person's mood. T or F
5. MDMA can cause the body's temperature to increase. T or F
6. One of the 'hangover' effects of MDMA is improved concentration. T or F
7. Acute MDMA poisoning (overdose) can result in overheating and dehydration. T or F
8. Sipping water minimises the effect of dehydration. T or F
9. If you drive under the influence of MDMA you may run the risk of losing your licence. T or F
10. Injecting MDMA with used or dirty injecting equipment increases the risk of becoming infected with HIV or Hepatitis B & C. T or F

ANSWERS

In NSW, ADIS (Alcohol and Drug Information Service). They provide a 24 hour, 7 days confidential service which includes advice, information and referral to local agencies.
Ph: (02) 9361 2111; country areas free call 1800 42 2599

AIDS/HIV Information Line
Ph: (02) 9332 4000; country areas free call 1800 45 1600

NA (Narcotics Anonymous), a self-help organisation for people with drug problems Ph: (02) 9212 3444; 0055 29411

NAR-ANON, a self-help organisation for relatives and friends of people with drug problems Ph: (02) 9418 8728

Community Health Centres (see main section of White Pages)
general practitioners, general hospitals and private counsellors can also provide assistance and advice.

IN EMERGENCIES
CONTACT YOUR DOCTOR OR LOCAL HOSPITAL OR CALL FOR AN AMBULANCE

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CEIDA is administered by Central Sydney Area Health Service and is
Heroin belongs to a group of drugs called narcotic analgesics or opioids. These drugs are all very strong painkillers. Opium, morphine and codeine come from the opium poppy while pethidine and methadone are synthetically produced. Heroin ("smack", "skag", "hammer", "h", "horse") is usually manufactured from morphine or codeine by a chemical process and can be a much stronger drug.

Heroin usually comes in powder form. It can be different colours depending on how refined it is - white powder is generally more refined than brown or pink 'rocks' which look like a lumpy powder.

**WHAT IS HEROIN?**

Opium and its derivatives have been used for several thousand years by people in many different cultures.

Seeds from opium poppies have been found in ancient Egyptian tombs over 3,000 years old.

Four hundred years ago in Britain, many people used laudanum - an extract of opium - to help cure toothache and other pains.

With the discovery of morphine 200 years ago, people began to use it for pleasure and for the relief of pain.

By 1900 heroin was being sold as a cure for coughs. It was also considered to be a cure for morphine and opium dependence.

**HISTORY**

Only morphine, codeine and pethidine are still widely used for medicinal purposes. Methadone is used in Australia in the treatment of people who are dependent on heroin (see Methadone Fact Sheet). Opium and heroin are not legally available in Australia except under special circumstances for controlled research or the manufacture of medicinal drugs.

Because heroin is an illegal drug, it is difficult to estimate how many people use it regularly. In the 1995 National Drug Strategy Household Survey, 1.4% of the population had ever tried heroin and 0.4% had used heroin in the previous 12 months.

**WHO USES HEROIN?**

The effects of heroin will vary from person to person depending on:

- the amount and purity of the heroin
- the way in which it is taken
- the person's size, weight and health
- the person's mood
- the person's experience with heroin
- whether heroin is taken with other drugs
- whether the person taking the heroin is alone or with others.

**EFFECTS**

Heroin can be injected, snorted or smoked ('chasing') and is very quickly absorbed into the blood stream. Because it is a depressant it slows down the central nervous system. Some immediate effects can be:

- relief of pain (analgesia)
- feeling of well-being (euphoria)
- nausea and vomiting
- the pupils of the eyes become smaller
- shallow breathing
- constipation
- itching
- sleepiness.

With large doses the pupils of the eye narrow to pin-points, the skin is cold, and breathing and other central nervous system activity can slow down to the point where a person can slip into a coma and die.
Effects related to methods of using

Heroin and other opioids used hygienically and in pure form are not toxic to the body and appear to cause little damage to the body organs and tissues. However, street heroin is usually mixed with other substances such as glucose. Therefore, it is difficult for a person to know the strength of street heroin and this can lead to accidental overdose or death.

A major problem with heroin use is to do with the way it is used, especially if injected. Sharing injecting equipment - fits (needles and syringes), spoons, sterile water, filter, alcohol swab, tourniquet - greatly increases the risk of contracting infections such as blood poisoning, Hepatitis B and C and HIV (the virus which causes AIDS).

Effects of long-term use

With regular use over time some people may experience health problems such as:
- collapsed veins
- abscesses
- tetanus
- Hepatitis B and C
- heart, chest and bronchial problems
- loss of appetite, which could lead to malnutrition
- irregular menstruation and sometimes infertility (in women)
- pneumonia
- chronic constipation
- impotence (in men)
- overdose.

Tolerance and dependence

A person who continually uses heroin may develop tolerance and dependence. Tolerance to heroin or any other narcotic analgesic means that a person needs more and more of the drug in order to achieve the same effects as they did before with smaller amounts.

Dependence means that heroin becomes central to their thoughts, emotions and activities. A dependent person finds it difficult to stop using heroin or even to cut down the amount they use.

Withdrawal symptoms occur when a dependent person stops using heroin or severely cuts down the amount they use. These symptoms can begin to occur only a few hours after the last dose of the drug. Symptoms include:
- restlessness
- stomach and leg cramps
- yawning
- goosebumps
- a runny nose
- low blood pressure
- tears
- diarrhea
- a craving for the drug.

These symptoms get stronger and usually peak around two to four days after the last dose of the drug, then they begin to get weaker and usually subside after six to seven days. But some people may experience symptoms such as weakness, depression, poor stress tolerance and low self esteem for several weeks or months.

Sudden withdrawal from heroin very rarely causes death, unless the user is also withdrawing from other drugs and is in poor health. Withdrawal from heroin or other narcotic analgesics is much less dangerous than withdrawal from some other drugs like alcohol or minor tranquillisers.

Heroin and other drugs

Heroin can be dangerous when combined with other drugs, especially other depressant drugs like alcohol or minor tranquillisers. Depressant drugs slow down the body's systems and combinations can have increased effects. If the body's systems are slowed down too much, the result can be coma or even death.

Heroin and the law

Heroin is a prohibited drug in Australia. That means that it is against the law to possess, manufacture, supply and import or trade heroin (or any other illegal opioid).

The law has harsh penalties for these offences - in NSW these include fines between $2,000 and $500,000, and/or a term of imprisonment between two and 20 years. The severity of the penalty given will vary according to the quantity of the drug involved - the bigger the amount, the bigger the penalty.

Many overseas countries have much more severe penalties - including the death penalty - for people who break their drug laws.

Anyone who is convicted on a drug charge then has a criminal record. This can cause many other problems in life - from getting a job or a credit card to getting a visa to travel overseas.
The use of heroin during pregnancy can affect both the mother and the unborn child. Babies can also experience difficulties after birth. Women who are dependent on heroin have a higher risk of:

- pregnancy complications - including miscarriage, stillbirth and premature birth
- passing infections such as HIV, Hepatitis B and C or blood poisoning, on to the baby
- health and social problems during pregnancy and childbirth.

The unborn child has a higher risk of:

- becoming infected with HIV, Hepatitis B and C or blood poisoning
- becoming dependent on heroin.

Babies have a higher risk of:

- complications (infections, lung illnesses) in the first weeks of life
- poor health
- withdrawal when they are born and separated from the mother's blood supply which contains the heroin
- Sudden Infant Death Syndrome (S.I.D.S.).

Heroin interferes with a person’s motor and coordination skills, vision, speed of reaction, and perceptions of sounds, time and space. So it reduces a person’s ability to perform complicated tasks, like driving a car. It also interferes with thinking and decision making processes.

It is an offence in NSW for anyone to drive while under the influence of any drugs, including heroin. Breaking this law carries heavy penalties including disqualification, fines and even imprisonment. Any person who is arrested for a driving offence and then found to be affected by, or in possession of, heroin is then likely to be charged with a drug offence as well.

**HEROIN QUIZ**

Test your knowledge

The following 10 statements will test your knowledge about heroin. **Answer true or false.**

1. Opium comes from the opium poppy.  **T** or **F**
2. Heroin is manufactured from methadone.  **T** or **F**
3. Heroin use in pregnancy increases the risk of infections in babies.  **T** or **F**
4. HIV can be passed from an infected mother to her baby during pregnancy.  **T** or **F**
5. Immediate effects produced by heroin include a feeling of well-being.  **T** or **F**
6. Heroin is particularly dangerous if used at the same time as alcohol.  **T** or **F**
7. Heroin is a stimulant.  **T** or **F**
8. Death results most commonly from an overdose of heroin because of infection.  **T** or **F**
9. Heroin can be smoked.  **T** or **F**
10. Methadone is used legally to treat hepatitis.  **T** or **F**

**HEROIN AND PREGNANCY**

**HEROIN AND DRIVING**
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WHAT IS CANNABIS?

Cannabis is the short name for the hemp plant Cannabis Sativa. Marijuana, hashish and hashish oil come from this plant.

The chemical in cannabis which makes the user 'high' is called THC (Delta-9 tetrahydrocannabinol). THC affects the mood and perception of the user. It's a depressant drug, not a stimulant as many people think. THC is found in different concentrations all over the plant, and its location determines the potency. For example, the flowers have more THC than the stems or leaves.

WHAT IS MARIJUANA?

Marijuana is the most common illicit drug used in Australia. It is made from the dried flowers and leaves of the plant. Slang names include 'grass', 'mull', 'pot', 'dope', and 'yarnie'. Its colour ranges from greyish-green to greenish-brown. Its texture can be fine, like dried herbs, or coarse, like tea. Sometimes it contains seeds or twigs from the plant.

The strongest form of marijuana comes from the flowering tops, called 'heads'. Marijuana is usually smoked in hand-rolled cigarettes called 'joints' or water pipes called 'bongs'. Sometimes it is mixed with food such as cakes and cookies and eaten. Of all the cannabis products, marijuana contains the least THC and is the least potent.

HASHISH

Hashish is made from the resin of the cannabis plant. It is dried and pressed into small blocks and sold in solid pieces, which range in colour from light-brown to nearly black. 'Hash' is usually mixed with tobacco and smoked, but can also be used in food and eaten. It is more potent than marijuana and produces a more noticeable effect.

HASHISH OIL

Hashish oil is an extract of cannabis which is usually a thick and oily liquid, ranging in colour from golden-brown to nearly black. THC is very concentrated in hashish oil. A very small amount will produce marked effects. It is often spread on the tip or paper of ordinary cigarettes, and smoked. Hashish oil is the most potent cannabis product.

HOW DOES THC AFFECT YOU?

When smoking cannabis, THC is quickly absorbed into the bloodstream through the walls of the lungs. From there it is taken to the brain and this is when the 'high' effect of the drug is felt. This can happen within a few minutes and can last up to three to five hours. The amount of THC which gets into the bloodstream will depend on the potency of the cannabis. If cannabis is eaten, the absorption of THC into the bloodstream is much slower. It can take up to one hour to experience the 'high' effect and can last up to four to seven hours.

Another important feature of THC is its storage in the body. Our bodies have a water-based disposal system using blood and urine. Alcohol is soluble in water and a single drink can be excreted within an hour or two. THC on the other hand is not very soluble in water but very soluble in fat. It is quickly absorbed into body fat deposits from the bloodstream. Once in fat deposits it is released very slowly back into the bloodstream. For example, a single dose of THC can take up to one month to be eliminated from the body.

WHO USES CANNABIS?

Cannabis is the most widely used illegal drug in Australia. As it is illegal, it is difficult to know just how many people use it. The majority of people consume very little and smoke it only occasionally. A recent survey suggests that half of the population aged between 14 and 34 have tried cannabis at least once. The 1992 survey of drug use by NSW secondary school students found that about 30% of boys and 21% of girls said they had used cannabis at some time in their lives.

EFFECTS

The effects of cannabis will vary from person to person depending on:

- the amount and strength of cannabis taken
- the way in which cannabis is taken
- the person's size, weight, health
- the person's mood
- the person's experience with the drug
- whether the drug is taken with other drugs
- and whether the person taking the drug is alone or with other people, at home or at a party, and so on.

Immediate effects

Small doses

A small dose can produce the following immediate effects:

- feeling of well-being (euphoria)
- increased appetite
- loss of inhibitions
- increased heart rate
- loss of concentration
- reddened eyes
a tendency to talk and laugh more than usual
impaired balance and coordination
'tunnel awareness' - where a person focuses their awareness on one thing and ignores all others.

These effects usually lead to calm, reflective feelings and sleepiness. They may last three to five hours after smoking.

Large doses
Larger doses make these effects stronger and may also distort or sharpen a person's perception of time, sound, colour and other sensations. Large doses of cannabis can produce:
- confusion
- feeling of excitement
- restlessness
- hallucinations
- detachment from reality

Cannabis also effects and impairs:
- short-term memory
- logical thinking
- motor (movement) skills
- ability to perform complex tasks e.g. driving, operating machinery.

These symptoms usually disappear when the effects of cannabis wear off.

Long-term effects
The following is a list of common findings of research on long-term effects in some frequent and heavy cannabis users.

Increased risk of bronchitis, lung cancer and respiratory diseases.
Many cannabis smokers also smoke tobacco which increases their chances of health damage. Even if they only smoke cannabis, marijuana cigarettes have much more tar than tobacco. Also, cannabis smokers tend to draw the smoke more deeply into their lungs. This can be more damaging to the frequent and heavy user.

A change in motivation
Some frequent and heavy users of cannabis, especially young users, find that they begin to lose energy and drive, and interest in other activities. These symptoms may also be caused by other factors, such as puberty or boredom.

Decreased concentration, memory and learning abilities
There is evidence to suggest that long-term cannabis use may decrease a person's concentration and memory which are essential to learning. These effects can last for several months after cannabis use stops, but they do seem to be reversible.

Interference with sexual and hormone production
Some heavy users of cannabis experience a lowered sex drive, and they may have a lowered sperm count, or irregular menstrual cycles.

Psychological disturbances
Heavy doses of cannabis can produce brief and sometimes severe psychotic behaviour. This is more likely if the person already has a schizophrenic condition.

NOTE
- There has been no recorded deaths where cannabis has been the direct cause.
- Cannabis has been used medicinally for many centuries. In recent years, its therapeutic use includes the treatment of:
  - nausea in patients receiving cancer chemotherapy
  - glaucoma, a condition which damages the retina, where cannabis helps to reduce the pressure in the eye
  - stimulating appetite in AIDS patients;
  - epilepsy.

Cannabis can be dangerous when combined with other drugs like alcohol. The effects of cannabis are intensified, often in unpredictable ways when combined with other drugs. Using cannabis and alcohol together can be much more dangerous than using either drug by itself.

There is no evidence that cannabis use automatically leads to the use of other drugs.

Cannabis and other drugs

Cannabis and the law
It is against the law to possess, grow, manufacture, trade or use any cannabis products. In NSW the penalties for this includes fines between $2 000 and $500 000 and/or a term imprisonment between 2 and 20 years. The penalty given will vary according to the quantity of the drug involved - the bigger the amount, the bigger the penalty. The sale, supply or commercial display of any item for administering a drug, including water pipes (bongs) is prohibited. Penalties for this are fines of $2 000 and/or 2 years imprisonment. (Needles and syringes are exempt from this.) Anyone who is convicted on a cannabis charge will get a criminal record. This can cause difficulties in getting a job, credit and visas for overseas travel.
Cannabis and driving
Cannabis interferes with a person's motor and coordination skills, vision and perceptions of time and space. This can impair a person's ability to drive safely, especially when combined with alcohol.

Cannabis use cannot be detected by a breathalyser test. If the breathalyser test is negative for alcohol and a police officer suspects other drugs, such as cannabis, then the driver can be arrested and taken to a hospital for a blood and urine test. This will confirm whether there is THC, or any other drug, present in the driver.

In NSW, it is illegal for anyone to drive while under the influence of any drugs, including cannabis. Breaking this law carries heavy penalties - disqualification from driving for a set period, fines, even imprisonment. Anyone under the influence of cannabis, who kills or injures another person while driving a motor vehicle, can be sentenced to a term in prison.

TOLERANCE AND DEPENDENCE
Frequent use of high doses of cannabis may produce mild tolerance. Tolerance means that a person needs higher doses of the drug to achieve the same effects as they used to get using smaller amounts.

Frequent and heavy users of cannabis may experience a variety of health, social, legal, financial and relationship problems. They may also become dependent on cannabis. This may lead to a mild withdrawal, which usually consists of flu-like symptoms.

Note:
- Some people become dependent on cannabis.
- People not dependent on cannabis can still develop problems.

CANNABIS AND PREGNANCY
Most drugs can affect an unborn child. It is not wise to use any drugs during pregnancy. There is not much information about the effects of THC during pregnancy. It is known that THC does pass through the placenta and reach the baby. There is some evidence of a link between reduced growth of the baby in the uterus (weight and length) and the use of cannabis by pregnant women. Other studies indicate disturbed sleeping patterns amongst new-born babies. However, long-term studies of the effects of cannabis use during pregnancy are still to be assessed. THC, like many other drugs, also passes into the mother's milk. However, little is known about the long-term effects it may have on the baby.

CANNABIS QUIZ
Test your knowledge
The following 20 statements will test your knowledge about cannabis.
Answer true or false.

1. THC is largely responsible for the 'high' one gets from marijuana, hashish and hashish oil. t or f
2. Hashish oil usually contains the most THC. t or f
3. Marijuana is usually sold in the form of a very fine powder. t or f
4. The effects of cannabis are felt more quickly when it is smoked than when it is eaten. t or f
5. Memory is not affected by cannabis. t or f
6. People never feel anxious or upset after having taken cannabis. t or f
7. Cannabis use always leads to use of other drugs. t or f
8. The ability to drive is not affected by cannabis. t or f
9. Large doses of cannabis can cause people to see things that are not there? t or f
10. Normal people never have a bad reaction to cannabis. t or f
11. Past experience with cannabis can affect how a person reacts to this drug. t or f
12. The effects of cannabis are the same regardless of whether or not other drugs are taken along with it. t or f
13. Given equal amounts, cannabis has less tar than tobacco. t or f
14. There is no evidence that cannabis smoking contributes to lung cancer. t or f
15. Large doses of cannabis can cause people to become nervous and irritable. t or f
16. Cannabis does not impair a person's ability to drive safely. t or f
17. Some frequent cannabis users experience a reduced interest in sex. t or f
18. It is not possible to become dependent on cannabis. t or f
19. There are some people who have become so dependent on cannabis that they need professional help. t or f
20. People can estimate distances just as well after having cannabis as they can at other times. t or f
MORE INFORMATION AND HELP

In NSW, ADIS (Alcohol and Drug Information Service). They provide a 24 hour, 7 days confidential service which includes advice, information and referral to local agencies.
Ph: (02) 9361 2111; country areas free call 1800 42 2599

Alcoholics Anonymous (AA) is a self help organisation for people with alcohol problems. Ph: (02) 9799 1199 (24 hours); country areas free call 1800 442 947

Al-Anon is a self help organisation for family, relatives and friends of people with alcohol problems. Ph: (02) 9264 9255

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Alcoholic drinks contain the drug ethanol (ethyl alcohol). A drug is a substance which changes the way your body and mind work. Alcohol is a powerful drug. It is a depressant drug and not a stimulant as many people think. It slows down the activity in parts of the brain and the nervous system.

Alcohol is produced by fermentation - the action of yeast on liquids containing sugars and starches. Pure alcohol has no colour or taste. Alcoholic drinks vary in colour and taste because of the ingredients which are used to flavour them. For example, beer gets its colour from malt and its taste from hops. Wines get their colour and taste from the kinds of grapes (red or white) used.

Alcohol can be called a food because it provides energy (calories/kilojoules). However, it is a poor food as it contains no protein or vitamins. Alcohol does not need digestion. It passes straight into the bloodstream from the walls of the stomach and the intestine.

In 1991 Australia was ranked 11th in the world in terms of beer consumption (101.9 litres per person), 19th in terms of wine consumption (18.6 litres per person) and 32nd in terms of spirits consumption (1.1 litres per person).

The 1995 National Drug Strategy Household Survey found that 43% of the population drink alcohol at least once per week. Of those 14-19 year olds who drink regularly and occasionally, 25% of males and 30% of females are drinking at harmful levels. (More than 6 drinks on one occasion for males and more than 4 for females.)

Around 6,500 people died from the effects of alcohol in 1992. This represents about 26% of total drug-related deaths or 5% of deaths from all causes.

Laws about alcohol are made mainly by State Governments. These laws regulate who can sell and buy alcohol, and where it can be bought and consumed.

In New South Wales, it is no longer an offence to be intoxicated in a public place. But someone who is intoxicated in public and behaving in a disorderly manner, or likely to be harmed or to harm some other person or property, can be detained at a proclaimed place for up to 8 hours. It is an offence to sell alcoholic drinks to someone under the age of 18 or obtain them on their behalf.

The effects of alcohol will vary from person to person. They depend on: how much and how quickly the alcohol is consumed the person’s body build: size and weight. As well, the proportion of fat to lean is important as alcohol is absorbed evenly by all tissues in the body except fat, how good their health is, and particularly how well their liver works the occasion on which the alcohol is consumed eg with a meal; alone or at a party; after hard physical exercise whether the alcohol is consumed with other drugs age and gender - children, young people and women are usually more affected by alcohol than adult men. This is because they tend to have lower body weights, smaller livers and a higher proportion of fat to lean.

**Immediate effects**

- relaxation  
- slow reactions  
- feeling of well being  
- blurred vision  
- loss of inhibitions  
- slurred speech  
- flushing; dizziness  
- aggression  
- unclear judgement  
- vomiting  
- uncoordinated movements  
- unconsciousness

Heavy drinking over a short period of time can cause a hangover: headache, nausea, shakiness and possibly vomiting.

Because of its effects on judgement, concentration, vision and coordination, drinking is a common cause of accidents, particularly car accidents and drownings. Young people are particularly at risk. They tend to drink alcohol less regularly than adults so they experience many of the immediate effects more strongly.

Alcohol can kill by interfering with the brain’s control over breathing but people usually pass out before this happens.

**Long term effects**

Anyone who drinks a lot of alcohol, regularly, over a period of time, will probably experience some physical, emotional or social problems related to alcohol. Damage to some of the body organs can be permanent.

- poor diet  
- memory loss; confused thinking  
- stomach inflamations  
- heart and blood disorders  
- frequent infections  
- depression  
- skin problems  
- relationship problems  
- liver damage  
- poor work performance  
- brain damage  
- financial difficulties  
- damage to reproductive organs  
- legal problems
STANDARD DRINKS

Alcoholic drinks are not made up of only alcohol. Depending on the type of drink, the amount of pure alcohol varies from 2% to 60%. The stronger the drink, the higher the percentage of alcohol it contains. Because of this, it is useful to remember these measures called standard drinks.

These common servings all contain approximately 10g of alcohol = 1 standard drink

<table>
<thead>
<tr>
<th>Light Beer</th>
<th>Ordinary Beer</th>
<th>Wine</th>
<th>Spirits</th>
<th>Port/Sherry</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 schooner</td>
<td>1 middie</td>
<td>1 glass</td>
<td>1 nip</td>
<td>1 glass</td>
</tr>
<tr>
<td>425mls</td>
<td>285mls</td>
<td>100ml</td>
<td>30ml</td>
<td>60ml</td>
</tr>
<tr>
<td>2.7% alcohol</td>
<td>4.9% alcohol</td>
<td>12% alcohol</td>
<td>40% alcohol</td>
<td>20% alcohol</td>
</tr>
</tbody>
</table>

Note: Medium strength beer contains an average of 3.5% alcohol. A schooner of medium strength beer is just over one standard drink.

SENSIBLE DRINKING

To ensure good health, the National Health and Medical Research Council gives the following guidelines:

<table>
<thead>
<tr>
<th>STANDARD DRINKS a day</th>
<th>LEVEL OF RISK</th>
<th>STANDARD LEVEL OF DRINKS a day</th>
</tr>
</thead>
<tbody>
<tr>
<td>up to 2</td>
<td>Low risk</td>
<td>up to 4</td>
</tr>
<tr>
<td>2-4</td>
<td>Medium risk</td>
<td>4-6</td>
</tr>
<tr>
<td>more than 4</td>
<td>Harmful</td>
<td>more than 6</td>
</tr>
</tbody>
</table>

At least 2 alcohol free days a week for everyone

Binge drinking (drinking heavily over a few hours or drinking continuously over a number of days or weeks) is harmful. It makes the negative effects of alcohol on health more likely to occur. As well, it can lead to people putting themselves in dangerous situations. By increasing their confidence and reducing their inhibitions, it makes them take risks they would not normally take. At the same time, heavy drinking reduces their ability to think clearly and act in an appropriate way.

ALCOHOL AND DRIVING

Alcohol is involved in around one third of all road traffic deaths*. A person's ability to drive a motor vehicle or ride a motor cycle is affected by alcohol. In general, the higher a person's blood alcohol concentration (BAC), the greater the effect on a driver's or rider's skills. As a result, laws have been introduced limiting the amount a person can drink before driving or riding.

In New South Wales, the legal limit for drinking and driving for most drivers is .05 BAC. A limit of .02 BAC applies to L and P-plate drivers, drivers under 25 for their first three years of driving starting with the provisional licence, and drivers of heavy vehicles, public passenger vehicles and dangerous goods vehicles.

Penalties for being over the limit include disqualification from driving, fines and imprisonment. Anyone under the influence of alcohol, who injures or kills another person while driving a motor vehicle, can be sent to prison.

*Binge drinking (drinking heavily over a few hours or drinking continuously over a number of days or weeks) is harmful. It makes the negative effects of alcohol on health more likely to occur. As well, it can lead to people putting themselves in dangerous situations. By increasing their confidence and reducing their inhibitions, it makes them take risks they would not normally take. At the same time, heavy drinking reduces their ability to think clearly and act in an appropriate way.

BLOOD ALCOHOL CONCENTRATION (BAC)

Blood alcohol concentration (BAC) is a measure of the amount of alcohol in a person's blood. A breathalyser test measures the amount of alcohol in a person's breath and is an indication of BAC.

BAC is determined by how much a person drinks and over what period of time they drink. However, calculating how many drinks will put a person over the legal BAC limits for driving .05 or .02 - is not easy. Some people will reach higher BAC after drinking the same amount of alcohol.

These people include:
- women
- people in poor health
- people with an empty stomach
- people with a small build
- people who are overweight for their height

To keep your BAC under the legal limit, a good guide is 2 standard drinks (10g alcohol) per hour.
SOBERING UP

Sobering up takes time. About 10% of alcohol in the blood is discharged through breath, sweat and urine; the rest is broken down by the liver. The liver can only work at a fixed rate, getting rid of about one standard drink an hour.

Nothing can speed up the work of the liver, not black coffee, cold showers, exercise, vomiting or any other favourite remedy. Vomiting only removes the alcohol in the stomach that has not had time to be absorbed into the bloodstream - at most the last drink will be eliminated this way. Taking a shower or drinking black coffee may help someone who has been drinking to feel more awake, but it won't reduce their BAC. If a person has drunk more than a few standard drinks, as they sober up, they may feel OK but they can still be over the .05 driving limit.

TOLERANCE AND DEPENDENCE

Tolerance of alcohol means that a person needs increasing quantities of it to achieve the same effects as they did before with smaller amounts. Dependence on alcohol means that alcohol becomes central to a person's thoughts, emotions and activities. A dependent person finds it very difficult to stop drinking and may crave alcohol when trying to stop. Withdrawal symptoms occur when a dependent person stops or cuts down their drinking a lot. These symptoms include: anxiety; sweating; tremors; vomiting; convulsions; hallucinations.

Not all people who drink alcohol are dependent on it. Non-dependent people can still damage their health.

MIXING ALCOHOL WITH OTHER DRUGS

Combining alcohol with any other drug (including over-the-counter or prescribed medications) can be dangerous or cause discomfort. The negative effects of one drug may be greatly increased by the other. In case of medications it can also reduce their effectiveness.

Mixing alcohol with drugs which depress the body's systems (eg tranquillisers, sleeping pills, marijuana) can increase loss of judgement and coordination and even cause breathing failure.

ALCOHOL AND PREGNANCY

Regular drinking of any amount of alcohol during pregnancy can damage the health of both the mother and the baby. Heavy drinking can lead to miscarriage or the baby being born with foetal alcohol syndrome - slow growth patterns before and after birth, and mental disabilities. Doctors now strongly recommend that pregnant women or women who are trying to become pregnant should not drink alcohol at all.

QUIZ

Part 1. Circle the correct answer to these questions:
1. Alcohol is a food because:
   (a) it contains protein (b) it supplies vitamins (c) it contains kilojoules
2. Which of the following helps you to sober up?
   (a) strong black coffee (b) exercise (c) cold showers (d) all of these (e) none of these
3. Which of these drinks has approximately the same amount of alcohol as a nip of whiskey?
   (a) a middie of ordinary beer (b) a glass (120ml) of table wine (c) a glass (60ml) of port (d) all of these
4. What does "increased tolerance to alcohol" mean?
   (a) being able to drink a lot of alcohol (b) needing more alcohol to get drunk than before (c) being able to drink in a sociable manner (d) being sympathetic to heavy drinkers
5. In its effects on motor skills, alcohol acts:
   (a) as a depressant (b) as a stimulant (c) as an hallucinogen (d) none of these
6. Alcohol enters the bloodstream mostly from:
   (a) the intestine and the liver (b) the lungs (c) the kidneys
7. Which of these will affect a person's behaviour when drinking:
   (a) the situation (b) having a full stomach (c) the person's mood (d) all of these

Part 2. Write true or false next to these statements.
1. Alcohol is a drug.
2. Alcohol is a food.
3. Drinking black coffee speeds up the sobering up process.
4. All other things being equal, alcohol has the same effect on a big person as on a small person.
5. A middie of ordinary beer and a 120ml glass of white wine have about the same amount of alcohol.
6. You can drink yourself sober.
7. Alcohol makes people more wide awake.
8. Teenagers run greater risk when driving after drinking than adults do.

In NSW, ADIS (Alcohol and Drug Information Service). They provide a 24 hour, 7 days confidential service which includes advice, information and referral to local agencies.
Ph: (02) 9361 2111; country areas free call 1800 42 2599

AIDS/HIV Information Line
Ph: (02) 9332 4000; country areas free call 1800 45 1600

MACS - Methadone Advice and Complaints Service
A confidential and anonymous telephone service which operates Monday to Friday from 9.30am to 5pm (except public holidays). This service provides information, advice, referral and a forum for people seeking assistance with methadone policy and access to treatment.
Ph: 1800 64 2428 (free call)

ALSO AVAILABLE FROM THE CEIDA INFORMATION CENTRE:
A range of leaflets and booklets on drugs, drug-related issues and HIV/AIDS. For more information phone (02) 9818 0488.

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Fax: (02) 9818 0441
Postal address: Private Mail Bag No.6 Rozelle NSW 2039
Street address: Rozelle Hospital Grounds, Balmain Road (opposite Cecily Street), Rozelle NSW.

DrugLinks Website: http://www.ceida.net.au - your electronic connection to the world of alcohol and other drugs information.

The CEIDA Information Centre has wheelchair access.

Published by CEIDA, the Centre for Education and Information on Drugs and Alcohol.

CEIDA is a unit of the Central Sydney Area Health Service and is funded by NSW Health.
Methadone belongs to the same group of drugs as codeine, morphine and heroin. These drugs are called narcotic analgesics or opiates and are all strong painkillers.

In Australia, as in most other western countries, methadone is legal only within a treatment program. The methadone program helps improve the health and lifestyle of people dependent on heroin and other opiates.

Methadone treatment helps people break the routines and habits associated with opiate dependency. It is available in all states and territories in Australia (except Northern Territory).

Methadone in a treatment program is given out as a syrup, to be swallowed. It has a much longer life in the body than heroin. A single dose is effective on average for 24 hours, compared to heroin which can last for as little as a couple of hours.

Clients in methadone treatment are given a dose of methadone every day. The methadone is prescribed by a doctor. The size of the dose is determined according to the characteristics of each individual client. It is worked out so that the amount of methadone circulating in the bloodstream is enough to stop clients going into withdrawal.

Research has shown that methadone treatment improves the health of opioid dependent people in a number of ways.

- People are less likely to use heroin which may be contaminated with other substances.
- Methadone is taken orally, which makes it cleaner and safer than injecting heroin. This reduces the risks of using shared or dirty injecting equipment and becoming infected with hepatitis B or C or HIV.
- The routine involved in methadone treatment encourages people to lead a balanced and stable lifestyle - improved diet and better sleep.
- It makes people less stressed and anxious as they do not have to worry about when they will next 'score'.

Methadone treatment also improves the client's lifestyle.

- Methadone lasts longer in the body than heroin so it only has to be taken once a day.
- Criminal activities to obtain illegal drugs are reduced.
- Relationships and care for a person's family become more manageable.
- A person is more likely to hold down a job.
- It's cheaper. Methadone is free in public treatment programs while private methadone treatment programs require payment. However, these are relatively cheaper compared to the cost of illicit drug use. Whether public or private, the same policy rules apply to methadone treatment.
- Take-away doses of methadone are also available which help clients return to a more stable lifestyle. To be eligible, clients must meet the criteria as outlined by the Health Department as well as those of the methadone prescriber. Some of these include family commitments, illness and travelling long distances.

Who uses methadone treatment?

Methadone treatment is a voluntary program and is just one of the treatment options available to opioid dependent people. Other options include detoxification in a hospital or centre, rehabilitation in a residential centre, individual or family counselling and self-help groups.

A person can only become a client of methadone treatment after being assessed by a doctor who is an approved methadone prescriber. Generally the person should be over 18 years of age and be dependent on opiates. The assessment takes into account other characteristics such as their alcohol or other drug use and their psychological health.

Inmates or persons in detention, and people with serious medical conditions such as hepatitis B or C, or who are HIV positive, can also apply for methadone treatment. Pregnant women, and those with HIV/AIDS or hepatitis B, and their partners, are prioritised for methadone treatment.

Call ADIS or MACS (see back page) for the nearest methadone prescriber.
**HOW IT WORKS**

Clients are informed that as part of the program they will:
- receive daily doses of methadone taken orally at the methadone clinic or community pharmacy
- receive on-going counselling and other support services
- occasionally be asked for urine samples to check on the use of other drugs.

Clients usually begin the program at a dose which they feel comfortable. The dose is then carefully adjusted to meet the needs of each individual. It may take several days or a couple of weeks for the person to be stabilised on methadone. During this period the person is monitored. The dose is increased, where necessary, slowly.

When a client wishes to come off methadone, in consultation with their prescribing doctor, their dose is gradually reduced, usually over a period of three to twelve months, or sometimes longer. It depends on the size of the regular dose and the individual concerned.

Withdrawal in treatment is very slow because:
- it minimises the physical effects of withdrawing
- clients adapt to a methadone-free lifestyle more easily
- it minimises the chance of relapse.

During this time assistance and support from the prescribing doctor and other health workers is provided.

**EFFECTS**

The effects of methadone are essentially the same effects as heroin. Clients starting methadone treatment will not notice anything different. The following short term effects may be experienced when methadone is taken by people who are not dependent on opiates.
- relief of pain (analgesia)
- feeling of well being (euphoria)
- nausea and vomiting
- shallow breathing
- the pupils of the eyes become smaller
- below normal drop in body temperature
- slow blood pulse, low blood pressure
- heart palpitations

- problems with sexual functioning
- poor blood circulation

Methadone may also affect the client’s ability to drive a car or operate heavy machinery, particularly during the first few weeks of treatment until a client is stabilised on a dose.

**Long term effects**

Methadone, taken in pure form and regular doses as part of a treatment program, may produce the following long term effects:
- increased sweating (clients should drink at least two litres of water per day to avoid dehydration)
- constipation
- some men have reported impotence and delayed ejaculation
- some women have reported a loss of sexual desire and disrupted menstrual cycles
- some women have reported normal menstruation after experiencing irregularities on heroin and other opiates.

Most of these effects disappear with time, dose adjustment, dietary changes and general improvement in lifestyle.

**WITHDRAWAL**

Abrupt discontinuation of methadone treatment can lead to withdrawal symptoms. Usually they begin one to three days after the last dose. They can include uneasiness, yawning, tears, diarrhoea, abdominal cramps, goosebumps, a runny nose, difficulty in sleeping, joint pains and a craving for the drug. They reach a peak on the sixth day and may last up to a few weeks after that. Feeling lazy and a lack of appetite can last a while longer.
Like heroin and other opiates, methadone is a powerful drug. Clients must maintain their prescribed doses for legal and health reasons. If a client accidentally takes or is given more than their prescribed dose, they must let the medical or clinical staff know and follow any advice given them. Overdosing can be fatal.

Giving methadone to a person not on a methadone program is very dangerous. Even small amounts of methadone taken by someone not used to opiates can lead to an overdose. Take-away doses of methadone should always be stored in child-proof medicine cabinets or a locked cupboard in a high position.

Injecting methadone is a serious health risk. It increases the risk of overdosing and can lead to blood clotting, collapsed veins and other medical complications.

The use of other drugs with methadone, such as alcohol or minor tranquilisers (benzodiazepines) can also lead to an overdose. It is very important for clients to let their doctor or dentist know they are taking methadone, so that they don’t prescribe anything which could affect treatment.

Clients are advised to carry a card or note certifying that they are in methadone treatment. Prescribing doctors or clinics can provide these. Then, if the client is involved in an accident or any legal hassles, people have the correct information about them, and their health and safety can be protected.

If clients are travelling to another town or another state for a short period of time they may apply for take-away doses. They may also ask their doctor to arrange a temporary transfer to a methadone treatment program in the place they are visiting. A short period of time usually means up to one month. At least three weeks notice to their doctors is required so arrangements can be made.

Clients travelling interstate for longer than a month, or moving away permanently will need to be re-assessed for admission to a methadone treatment program near their new home. Their prescribing doctor or clinic will know how to go about this.

Clients who wish to travel overseas should speak to their doctor. Special arrangements will need to be made so clients can either receive doses in

PREGNANCY

Pregnant women who are dependent on opiates are encouraged to enter a methadone program - it is the treatment of choice. They also get a priority assessment even if the program is full. Pregnant women in methadone treatment are likely to have fewer complications during their pregnancy and childbirth than pregnant women who are using other opiates. Starting methadone treatment early in the pregnancy is recommended.

Like all opiates, methadone crosses the placenta to the unborn child. Many of the babies born to methadone dependent mothers go through withdrawal at birth. Their symptoms vary in length and strength. These can be successfully treated while the baby is still in hospital.

Research is continuing on the long term effects of methadone on the child during pregnancy. At this stage there is no indication that the effects are serious.

BREASTFEEDING

Health authorities encourage breastfeeding for women in methadone treatment. Women need to wean their babies slowly and avoid using alcohol and other drugs while breastfeeding.

No immediate ill effects have been noticed in the breastfed children of methadone treatment clients. Long term follow-up studies show that methadone exposure has little effect on early development and that the benefits outweigh any possible health risks.

METHADONE AND THE LAW

Under the Commonwealth Customs Act 1901 the importation of methadone is illegal and carries penalties of up to $100,000 and/or life imprisonment.

In NSW, methadone is classified as a prohibited drug. Under the NSW Drug Misuse and Trafficking Act 1985 the unauthorised possession, trade or manufacture of methadone carries heavy penalties which vary according to the amount of the drug involved. They range from a $5,000 fine and/or 2 years in prison to a $500,000 fine and/or imprisonment for life.

A doctor can only lawfully prescribe methadone after getting the authority of the Director-General of Health. Unauthorised prescription also carries heavy penalties. Injecting methadone, taking more than one dose at a time, or giving methadone to somebody else is illegal.

The laws governing the possession, use and prescription of methadone vary from state to state. Clients planning to travel interstate should find out what the laws are in the states which they are planning to visit.
In NSW, ADIS (Alcohol and Drug Information Service). They provide a 24 hour, 7 days confidential service which includes advice, information and referral to local agencies.
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CEIDA is administered by Central Sydney Area Health Service and is funded by the NSW Health Department.
Hallucinogens (also known as "psychedelic" drugs, ancient Greek for mind revealing) are drugs which change the way a person perceives the world. Hallucinogens affect all the senses and cause hallucinations - seeing or hearing things that do not exist. They can also distort a person's thinking, sense of time and emotions, and produce feelings of unreality.

There are many different kinds of hallucinogens. Some hallucinogens occur naturally, in trees, vines, seeds, fungi and leaves. Others are manufactured in laboratories.

Certain drugs (e.g., cannabis and MDMA) only produce hallucinogenic effects when used in high doses or in particular circumstances.

Hallucinogens have been used for thousands of years and in many societies for their mystical and spiritual associations. They became fashionable in America and Europe in the 1960s, as many young people were pursuing greater personal freedom and questioning old values and ideas.

Very few people use hallucinogens today. In the 1995 Household Survey, 7% of people surveyed had ever tried hallucinogens (particularly LSD) and nearly 2% of Australians had used hallucinogens in the last 12 months.

Hallucinogens are not usually taken on a regular basis but on occasions which may be weeks or months apart. This may be because tolerance builds up very rapidly, the effects require a long recovery time or the pleasurable effects are unpredictable.

The effects of hallucinogens will vary from person to person. They will depend on:

- how much of the drug is taken and the way it is taken
- the person's size, weight and health
- the person's mood
- the person's experience with hallucinogens or similar drugs over a period of time
- whether the hallucinogens are taken with other drugs
- whether the person taking the hallucinogens is alone or with other people, at home or at a party, and so on.

It is hard to know how the hallucinogenic experience or "tripping", as it is often called, will turn out. The effects of hallucinogens vary a lot, not only from person to person but also from occasion to occasion.

Some users find the effects pleasant, partly because they are new and interesting. Others find hallucinogenic effects unpleasant and disturbing.

A person may experience both positive and negative feelings during the same drug experience. Or the same person may react differently to the same drug on different occasions. This is partly due to the user's mood before taking the drug and partly because of the many other substances mixed with hallucinogens.

As hallucinogens bought on the street are usually manufactured in illegal laboratories, it is difficult to know either the strength of the drug or the nature of the substances mixed with it. Other drugs are sometimes sold as hallucinogens.

People who are hallucinating can have accidents or injure themselves and others as they become disoriented, see things that don't exist and their thought processes become mixed up.

Hallucinogens can be dangerous when combined with drugs like alcohol or amphetamines ("speed"). This is because the effects of both drugs are often increased in unpredictable ways.

In New South Wales, the use, possession or supply of any hallucinogenic drug (e.g., LSD, mushrooms or preparations containing psilocybin, MDMA and cannabis) carries heavy fines and/or prison sentences. Penalties range from a $2000 fine and/or two years in prison to a $500,000 fine and life imprisonment.

In New South Wales, it is against the law to drive under the influence of any drug, including hallucinogens. Breaking this law carries heavy penalties - disqualification from driving, fines and/or imprisonment.

Hallucinogens change the way in which the user perceives the world, including perception of speed, distance, colour and sound, so it is extremely dangerous for a user to drive or operate any kind of machinery.
LSD ("acid", "trips") is one of the most commonly used hallucinogens in Australia. It was first developed in a Swiss laboratory in the 1940s and explored as a treatment for some mental illnesses. In its pure state LSD is a white, odourless powder. LSD bought on the street is manufactured illegally and varies in strength. A very small amount is effective, so LSD is usually mixed with a lot of filler to make the dose big enough to take. It comes as liquids, tablets, capsules and squares of gelatine or blotting paper. Other drugs (see MDMA) are often sold as LSD.

**Immediate effects**

The effects of LSD begin within half an hour of taking the drug, are at their strongest in 3 to 5 hours, and last for up to 12 hours.

- Seeing things in a distorted way or that don’t exist. The person usually knows that what they are seeing is not real. Also, distorted perception of sounds, smells, touch and taste.
- Intense sensory experiences (e.g. brighter colours, sharper sounds)
- Mixing of the senses (e.g. colours are heard or sounds seen)
- Distorted sense of time (e.g. minutes can be as slow as hours; reliving old events)
- Distorted sense of space
- Distorted body image. Person feels as if they are floating or being pulled down by gravity.
- Boundary between self and surroundings becomes blurred
- Changed and intense thoughts
- Swings in emotions (from intense happiness to deep brooding)

A number of physical effects, mild to moderate in strength, sometimes occur. They include:

- Numbness
- Muscle weakness
- Twitching
- Dilated pupils
- Shakiness
- Poor coordination
- Nausea
- Vomiting
- Increased heart beat and blood pressure
- Increased body temperature and sweating, sometimes alternating with chills and shivering
- Abnormally rapid, deep breathing

**Bad Trips** While using LSD or "tripping", the person may experience strong feelings of anxiety or fear. The hallucinatory effects can be unpleasant (e.g. spiders crawling on the skin). Or they can be so intense that the person feels as if they are losing control and "going crazy".

Panic can lead to risky behaviour (e.g. running across a busy street). Also, paranoia (intense fear of persecution and feelings of superiority) sometimes develops. Again, this can cause the user to injure themselves accidentally (e.g. diving into rough surf). Some suicides have been reported.

When negative feelings dominate the experience it is described as a "bad trip". The reasons for bad trips occurring are not known. They are particularly common among first time users.

When a "bad trip" occurs the user needs to be reassured and calmed until the immediate effects have passed, although this can take many hours. Medical assistance is occasionally required if the user becomes violent toward themselves or others, or becomes excessively anxious.

Usually, the negative feelings go away when the drug wears off. However, there have been reports of users experiencing hallucinations, bizarre behaviour and paranoia for several days after taking the drug.

**Long term effects**

The most disturbing long term effect of LSD is the potential for "flashback" experiences.

A "flashback" is a spontaneous and unpredictable recurrence of the drug experience. Flashbacks can occur days, weeks and even years after the drug was last taken. They usually last for a minute or two and involve some kind of visual hallucination, mostly seeing shapes and patterns that don't exist.

Flashbacks can be sparked off by the use of other drugs or by stress, fatigue or physical exercise.

Regular users are more likely to experience flashbacks.

There is some evidence that heavy use of LSD can impair a user's memory and concentration. Using LSD may increase the risk of certain people developing severe mental disturbances.

**LSD and pregnancy**

LSD appears to be related to an increased risk of miscarriage. Studies have also suggested a link between a higher incidence of babies born with malformations and pregnant women who use LSD, but the evidence is not conclusive.

**Tolerance and dependence**

Tolerance of a drug means that a person needs more and more of the drug to get the same effects as they did before with smaller amounts.

Tolerance to the hallucinatory effects of LSD develops rapidly; it goes away quickly once regular use is stopped. Cross tolerance, when using a type of hallucinogen makes a person tolerant to the effects of other hallucinogens, can also occur between LSD and certain other hallucinogens (e.g. psilocybin "magic mushrooms").

Dependence on a drug means that it has become central to the person's thoughts, activities and emotions. LSD is not a drug that is used daily or very regularly as tolerance develops rapidly. Some users do become psychologically dependent on the drug but there are no physical withdrawal symptoms.
Psilocybin ("magic mushrooms") is the hallucinogenic chemical found in certain mushrooms. In its pure state, psilocybin is also a white powder. It is usually sold as dried mushrooms or in mushroom preparations.

People sometimes mistake poisonous mushrooms for those containing psilocybin. Certain kinds of mushrooms can cause death or permanent liver damage within hours of ingestion.

Psilocybin belongs to the same chemical family as LSD so its effects are quite similar. See LSD.

Other Hallucinogens

There are a number of plants that contain hallucinogenic substances. Many of these are poisonous as well.

Some people have experimented with plant materials and have become extremely ill, requiring treatment in hospital and some have died.

As a general rule, it is very unwise to ingest any substance when the effects of it are unknown and potentially harmful.

Hallucinogens sometimes used in other countries include PCP (phencyclidine or "angel dust"), originally developed as an anaesthetic, and mescaline, made from the pulp of the peyote cactus.

Drugs Which Can Cause Hallucinations

MDMA (Methylene Dioxymethamphetamine, "Ecstasy")

MDMA is manufactured illegally in laboratories. It comes in liquid, tablets or capsule form.

The effects of MDMA vary as the dose increases. At low doses its effects include greater confidence, feelings of well-being and closeness with other people, and sometimes anxiety. It also causes similar effects to amphetamines ("speed"), that is faster heart beat and increased blood pressure; sweating; grinding of the teeth; headaches; nausea.

In higher doses MDMA can cause hallucinations and sensations of floating, similar effects to LSD. Sometimes other hallucinogenic substances are mixed in with MDMA to increase the "tripping" effects.

Cannabis (marijuana, hash, hash oil)

At low doses cannabis is a depressant drug which slows down the body's systems.

Very strong cannabis preparations or large doses of it can cause mild hallucinogenic effects. These can lead to anxiety or panic in the user.

For more information see MDMA Fact Sheet No.6 and Cannabis Fact Sheet No.8.

Quiz

Test your knowledge
The following statements will test your knowledge about hallucinogens. Answer true or false.

1. Hallucinogens are drugs which sometimes change the user's perceptions of the world. t or f

2. The effects of hallucinogens on a person vary according to the person's health, personality, mood and expectations. t or f

3. Driving under the influence of hallucinogens can lead to traffic accidents. t or f

4. Mixing hallucinogens with another drug such as alcohol can cause the hallucinations to stop. t or f

5. The effects of LSD can include sleepiness. t or f

6. "Flashbacks" are lapses in concentration the day after a hallucinogenic experience. t or f

7. A person can experience positive and negative feelings during the one hallucinogenic experience. t or f

8. The same person can react differently to the same hallucinogen on different occasions. t or f

9. The first time a person uses hallucinogens the experience is always positive. t or f

10. Psilocybin is a hallucinogenic chemical found in the seed pods of lilies. t or f

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Ph: (02) 9361 2111; country areas free call 1800 42 2599

Poisons Information Centre provide treatment advice, information and referral 24 hours, 7 days a week. Ph: 13 1126.

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CEIDA is also actively involved in professional development and public education and has one of the largest research libraries for the drug and alcohol professional. Connexions, the bi-monthly magazine on drug issues is published by CEIDA.

You can contact CEIDA on: Ph: (02) 9818 0444 (business hours) or 1800 816 210 for NSW country callers.

TTY service for hearing impaired people: (02) 9818 2993

Fax: (02) 9818 0441

Postal address: Private Mail Bag No.6 Rozelle NSW 2039

Street address: Rozelle Hospital Grounds, Balmain Road (opposite Cecily Street), Rozelle NSW.

DrugLinks Website: http://www.ceida.net.au - your electronic connection to the world of alcohol and other drugs information.

The CEIDA Information Centre has wheelchair access.

Published by CEIDA, the Centre for Education and Information on Drugs and Alcohol.

CEIDA is administered by Central Sydney Area Health Service and is funded by the NSW Health Department.
A volatile substance is a compound which gives off vapours or fumes at room temperature. They are found in hundreds of products at supermarkets, newsagents and hardware stores. The most commonly used volatile substances come from:

- petroleum fuels
- aerosol sprays such as fly sprays
- hydrocarbons
- glue
- anaesthetic products
- nail polish removers
- typist correction fluid
- antifreeze
- paint thinners
- cartridge bulbs for whipped cream dispensers.

People inhale or “sniff” the fumes of volatile substances to get “high”, usually producing similar effects to drinking alcohol. Other terms used to describe volatile substances include “solvents” and “inhalants”.

HISTORY

Inhaling substances to create mind-altering effects has been practiced for thousands of years. Indigenous tribes burned and inhaled incense and spices to produce mild intoxication as part of religious rituals. In the 19th century people experimented with diethyl ether, chloroform and nitrous oxide (laughing gas). With the emergence of the chemical industry in the 20th century, many more products have become readily available in the home and the workplace.

WHO USES VOLATILE SUBSTANCES?

Inhaling or sniffing the fumes from volatile substances has become increasingly popular in recent decades by young people throughout the world. This is because they are easily available, cheap and legal. The kinds of volatile substances used will vary from one group or local community to another.

In the 1992 Survey of Drug Use by NSW Secondary School Students (Years 7-11), 2.6% of girls and 3.1% of boys used inhalants at least weekly, compared with alcohol (15.9% and 19.3%) and tobacco (19.0% and 17.6%).

Most young people will never try “sniffing”. Many of those who do will only experiment once or twice. Regular or habitual “sniffing” is rare but a small proportion of young people may become heavy users.

Studies in Australia show that most young people don’t sniff volatile substances because of its low profile in the drug culture. Even though volatile substances are cheap and accessible, alcohol and tobacco use amongst young people is far higher.

EFFECTS

The effects of volatile substances will vary from person to person depending on:

- how much is inhaled and of which substance
- how often volatile substances are inhaled
- the person’s experience with volatile substances
- the person’s mood
- the person’s size, weight and health
- whether the volatile substance is used with other drugs
- whether the person is inhaling alone or with others.

Immediate effects of sniffing

The effects of volatile substances are very similar to those of alcohol. The differences are that intoxication is immediate (1-5 minutes) with a rapid recovery (30-60 minutes after last intake). To maintain the “high” it is necessary to keep sniffing. Users often experience a hangover when the effects wear off.

Immediate effects of specific substances are listed in the table.

Long term effects

The long term effects of sniffing volatile substances are not well known. Few studies have been done because of the young age of most users.
Most evidence comes from studies on the effects of volatile substances found in the workplace. For most substances, effects can range from relatively mild and reversible symptoms to severe damage to such vital organs as the kidneys, liver and the brain. These are rare however and most symptoms appear to be reversible once the user stops sniffing. Evidence suggests that short-term use rarely causes long-term damage to the body.

Petrol sniffing is more likely to create health problems. This is because the lead found in some petrol accumulates in the body and can cause leukemia and other types of cancers. Other effects of petrol sniffing can also include:
- irreversible disease of the brain (encephalopathy)
- uncoordination of the muscles (ataxia)
- seizures
- abnormal jerky movements
- anorexia
- Sudden Sniffing Death Syndrome.

Petrol sniffing has had a devastating impact in some communities. These include: property damage; increased violence because of intoxication; family and social disruption; poor school performance and juvenile crime.

**DANGERS OF SNIFFING METHODS**

The harms most associated with volatile substances are in how and where they are sniffed. Volatile substances are commonly sniffed from plastic bags, drink containers, cloth or sleeves or sometimes sprayed directly into the mouth.
- Sniffers who sniff from plastic bags can pass out and suffocate if they place the bag over their heads.
- Sniffers can choke on their own vomit if they become unconscious.
- Some sniffers spray gases, like butane, directly into their mouths which can cause the throat to chill and swell, eventually causing suffocation.
- Some people may sniff in potentially dangerous places such as railway embankments, or may sniff alone in isolated places, or drown if they are near water. This is because the effects of volatile substances may cause disorientation and lead to accidents.
- Smoking and sniffing is dangerous as many of these substances are inflammable.

**Sudden Sniffing Death**

"Sudden Sniffing Death" is caused by heart failure which may happen if a person does strenuous exercise or has a sudden fright straight after sniffing. "Sudden Sniffing Death" is rare but it could happen to any user, be it the first time user or someone who has sniffed for years. It is usually associated with aerosols, butane gas, petrol and cleaning fluid.

If you encounter someone who you suspect has been sniffing, you should discourage any exertion. Encourage the person to relax and remain calm and if necessary, seek medical advice or call for an ambulance.

**TYPES OF VOLATILE SUBSTANCES**

There are many types of volatile substances but the main substances causing potential harm are toluene, butane and trichloroethane.

<table>
<thead>
<tr>
<th>VOLATILE SUBSTANCE</th>
<th>PRODUCTS</th>
<th>IMMEDIATE EFFECTS</th>
<th>DANGERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toluene</td>
<td>glues/solvents, paint/paint thinners, petrol (leaded and unleaded), varnish and lacquer</td>
<td>Similar to alcohol: euphoria, excitement, restlessness, slurred speech, weakness, uncoordinated movements, aggression, blurred vision, hallucinations (in some users), nausea, unconsciousness, vomiting</td>
<td>potential heart failure (Sudden Sniffing Death), accidents, choking on vomit, suffocation from plastic bags, fire and explosion risk, lead poisoning (from petrol)</td>
</tr>
<tr>
<td>Butane (hydrocarbons used as propellants in some aerosols)</td>
<td>cigarette lighters/ lighter refills, spray paints, deodorants, fly sprays</td>
<td>As above</td>
<td>potential heart failure (Sudden Sniffing Death), accidents, choking on vomit, suffocation due to spraying directly into mouth, causing larynx to go into spasm, fire and explosion risk</td>
</tr>
<tr>
<td>Trichloroethane</td>
<td>type correction fluids, degreasing agents, nail polish remover, dry cleaning fluid</td>
<td>As above</td>
<td>potential heart failure (Sudden Sniffing Death), accidents, choking on vomit</td>
</tr>
</tbody>
</table>
WHY DO THEY SNIFF?

Young people sniff volatile substances for a variety of reasons.

- It can be fun.
- They are easily available in the home.
- It is cheaper than alcohol.
- The element of danger makes it exciting.
- The attraction of experiencing new sensations.
- Because their friends do it.
- Boredom.
- Some users enjoy the hallucinations.
- It may help block out problems associated with their personal or family life: feeling inadequate; sexuality issues; low self-esteem and problems at home, at school or in the community.

TOLERANCE AND DEPENDENCE

Tolerance means that a person needs a higher dose of the drug to achieve the same effects as they used to get with smaller amounts of the drug. As volatile substances are usually sniffed sporadically (a few times a week rather than daily), the possibility of developing a tolerance and becoming dependent is very small. Also, most young people sniff for only a short period, so when they stop they rarely experience any withdrawal symptoms.

Frequent sniffing over a long period of time can produce physical dependence, similar to alcohol. Occasional and even regular users may experience a hangover when they stop. Very heavy users may experience headaches, muscular cramps and abdominal pain.

RESPONSES TO SNIFFING

There are a variety of approaches which parents, teachers or health professionals can take in dealing with volatile substance use. Prevention strategies in Australia have included educational programs and fear tactics. There is some evidence to suggest however that these approaches may have promoted use rather than discouraged it.

It has been suggested by experts that in some circumstances, doing nothing may be the most appropriate approach. The low profile of volatile substance use may be a protective factor, preventing awareness about substances, how they can be used and where they can be obtained.

Focusing on the local community and using local resources can be effective. Some communities are dealing with chronic petrol sniffing by replacing petrol with aviation gasoline (avgas - causes severe headaches and stomach cramps) and introducing accompanying strategies such as recreation, employment and training programs.

Treatment of individual users includes counselling which aims at changing behaviour, reducing the harm associated with sniffing and improving self image. This sort of treatment is only appropriate for the very small percentage of frequent and long-term users. Family counselling and support, as well as health care services, may also be provided.

VOLATILE SUBSTANCES AND THE LAW

Inhaling volatile substances in Australia is not illegal. In NSW it is not an offence to inhale or sell products containing volatile substances. There are however certain restrictions on the marketing of products which are likely to be misused. Some aerosol pain relief sprays, type correction and lighter fluids are labelled with a warning statement.

Other legislative measures considered, but not implemented, have included:

- limiting displays of products containing volatile substances
- age restriction on their purchase
- less user-friendly packaging
- adding irritant chemical or offensive odour to the products.

Some of these have been trialled overseas but are generally considered too impractical to enforce.
Pregnancy is a time of change for women and can sometimes be uncomfortable physically and stressful emotionally. It is a time when women try to take particular care of their health. Getting plenty of rest, exercise, and good nutrition are all aspects of a pregnant woman’s health. Drug use is another important aspect of a woman’s health during pregnancy.

Drugs that are of concern in pregnancy include: alcohol, tobacco, cannabis, amphetamines, heroin, cocaine, tranquillisers and sleeping pills, painkillers, LSD, Ecstasy and other designer drugs, glues and aerosols. Some prescription drugs can also be a problem during pregnancy, so discuss this with your doctor as soon as you know you are pregnant.

Drugs can be harmful to a developing foetus throughout the pregnancy but the first three months is considered the time of most risk because the major organs and limbs of the baby are forming. The placenta is the means by which all supplies of nutrients, water and oxygen pass through from the mother to the baby. All drugs taken during pregnancy will reach the baby through the placenta, however there is an enormous variation in babies’ responses to these drugs. The variation in response to drugs depends on the following factors:

1. The actual nature of the drug, whether the drug is a sedative (for example, benzodiazepines), or a stimulant (for example, amphetamines).

2. How often the drug is used and the dose taken.
3. Whether one or more drugs are used. Some drugs have a cumulative or combined action which is more likely to be harmful for the baby.

- 4. Each baby, for reasons that are not clear, seems to have its own response to different drugs. Mothers can use the same drugs in the same amount for the same duration or length of a pregnancy, and the babies can react differently. There appears to be something in each individual baby which allows this to occur. You may know someone who has had a healthy baby even though they took drugs during their pregnancy. You cannot assume that your baby will be healthy if you take drugs during your pregnancy. No one can predict how a baby will be affected.

- *ANTE-NATAL CHECKS*, the visits you make to the doctor, hospital or community health centre while you are pregnant are important. The best way to avoid or reduce complications and the risk to the baby is to have good ante-natal care. A much lower risk of obstetric complications occurs in women who attend ante-natal visits early in the pregnancy and continue to attend throughout the pregnancy. It is at these appointments that you could discuss with the doctor or midwife any drugs you may be taking. The information you give them will be confidential whether you are discussing legal or illegal drugs.

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Pregnancy and Drugs

A common complication in pregnancy, where the mother has been taking drugs or alcohol, is an increased incidence of premature labour, with babies often arriving more than six weeks early. Overall, babies born to mothers who are using drugs or alcohol are smaller than the average baby. Low birth weight babies often have breathing difficulties and are more vulnerable to infections. During a pregnancy where the mother has been using alcohol or other drugs, the baby needs to be carefully monitored at ante-natal visits. This is done by using ultrasound to check the baby's growth and other tests to check that the placenta continues to work well.

**WITHDRAWAL** is the reaction of the body to going without drugs on which it has become dependent to feel normal. Babies whose mothers have taken drugs during pregnancy may experience withdrawal. This will depend on the drug, the dose, the purity, how often it is used and the woman's general health. Drug withdrawal symptoms for the baby can occur both during the pregnancy and after birth. There are common signs and symptoms of drug withdrawal in the new-born baby regardless of which drug is used by the mother.

Withdrawal often develops after the first 24 hours of life. The babies are agitated and irritable, difficult to settle and suck poorly. They often have diarrhoea and scratch themselves; hiccups and coughs sometimes occur. Withdrawal can be so severe that the babies have convulsions if not treated.
babies have convulsions if not treated. In about 75% of cases the only treatment which is required is supportive care, that is, soothing the baby by bathing more often and feeding frequently. The baby is wrapped tightly in blankets to make him/her feel secure. If the irritability is extreme the baby may need medication.

- Although some drugs are excreted into breast milk, breast feeding may still be the right choice to make for feeding your baby. One important reason to consider breast feeding is the bonding that it can encourage.

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Smoking and pregnancy
Making healthy choices such as quitting smoking, eating healthy food and avoiding alcohol when you become pregnant will not only make you feel better, but it will give your baby a great start to life.
during pregnancy. Babies born with a lower than average birth weight are more vulnerable to infection and other health problems.

- Smoking during pregnancy increases the chances of the baby dying at or shortly after birth.

**After the birth**

- Maternal smoking may be a risk factor for Sudden Infant Death Syndrome (SIDS, or 'cot death').
- After a baby is born, the poisons the mother inhales through cigarettes are passed on to the baby through breast milk and through passive smoking.
- Babies of smokers are more likely to suffer from asthma and other respiratory infections than those of non-smokers.

### Common fears and fallacies

"There’s nothing wrong with having a low-weight baby – it just means a quicker and easier birth."

Having a low-weight baby does not make things easier for you or your baby at birth. A smaller baby is more likely to become stressed during birth, leading to a more complicated delivery. Further, labour with a small, under-weight baby is no easier or shorter than labour with an average baby.

"If I stop smoking I’ll put on too much weight."

Some women find that smoking reduces appetite, but at what cost?
What happens when you smoke?

The umbilical cord is your baby's lifeline. The flow of blood through this cord provides your baby with oxygen and all the nutrients it needs to grow. Every puff you take on a cigarette increases the level of carbon monoxide in your bloodstream. Carbon monoxide replaces oxygen in your blood, so the amount of oxygen made available to your baby through the umbilical cord is reduced when you smoke.

The nicotine in cigarettes increases your heart rate and your baby's heart rate. It also causes your blood vessels to narrow, reducing the flow of blood through the umbilical cord.

To prepare for breathing after birth, your unborn baby will be practising by exercising some of its chest muscles. Nicotine causes a reduction in these breathing movements.

So in combination, carbon monoxide and nicotine make it harder for your baby to get the oxygen and nourishment it needs, place unnecessary stress on its heart and reduce its breathing exercises. Cigarette smoke also contains many other poisons and harmful substances, to which you and your unborn baby may be exposed.

Other problems smoking may cause

During pregnancy

- Smokers have a greater risk of miscarriage.
- Smokers are more likely to have complications during the birth.
- The likelihood of having a low-weight baby increases if the mother smokes.
You will need more calories during pregnancy to cope with the increased needs of your growing baby and to maintain your own health. A weight gain of 10 to 13 kilograms has been found to be desirable for the development of a healthy baby. A balanced, healthy diet consists of eating moderately from a wide variety of foods. It is the quality of your diet that is important, not the quantity of food eaten.

"Smoking relaxes me, and being relaxed is better for my baby."

Smoking may calm you down, but it does speed up your heart rate, increase your blood pressure and depress your nervous system. Every puff you take on a cigarette increases the carbon monoxide in your bloodstream; this replaces oxygen in your blood, reducing the amount of oxygen available to your baby. This is not better for your baby.

"I’m already three months pregnant. What’s the point of stopping now – the damage is done."

It isn’t. If you quit now, your risk of having a low-weight baby will be similar to that of a non-smoker.

"Cutting down during pregnancy is good enough."

Every bit helps, but even a few cigarettes a day mean many poisons will be in your growing baby’s food supply, and damaging your own health at a vital time. There is no safe level of smoking. It is never too late to quit because most foetal growth occurs late in pregnancy. This means that quitting at any time during pregnancy is likely to reduce the adverse affect of smoking on your baby.

**Breastfeeding**

If you breastfeed you are giving your baby a good start in life. Breast milk provides all the nutrition your baby needs for the first six months of life and the major part of nutritional requirements for the first year. It also helps protect your baby against infection.

As a breastfeeding mother, you have some control over your own and
your baby's environment - by not smoking and by limiting your alcohol intake.

If you breastfeed and smoke it's not ideal, but it's better than not breastfeeding. Your breast milk does protect your baby against infection but some of the nicotine and other poisons in cigarettes may be absorbed by your baby through your breast milk.

If you choose to bottle feed because you smoke, you will not be protecting your baby from possible infection, and when you smoke your baby will be passive smoking.

If you are having difficulty quitting, at least consider every cigarette and decide whether it's worth it to you. Try not to smoke just before or during feeds – perhaps go outdoors to smoke. If you can't give it up altogether, accept that for now, but keep working on it.

**Passive smoking**

Every time you smoke and you're with your children, they are smoking too. They are being exposed to the same dangerous chemicals as you. This is known as passive smoking.

Young children have smaller, more delicate lungs than adults, and are therefore more affected by tobacco
smoke and the chemicals it contains. When exposed to passive smoking they are likely to develop sensitive airways which make them more susceptible to a number of problems:
❖ chest illnesses including asthma attacks
❖ poor lung function and abnormally slow lung growth
❖ frequent coughs and more serious respiratory illnesses such as pneumonia and bronchitis.

The more heavily you smoke, the more likely your child is to suffer from these.

### QUIT TIPS

If you’ve decided to stop smoking, these tips may help you to quit for good:
❖ Phone the Quit Line on 131848 for a Quit Kit. When you phone the Quit Line you may also like to talk to a counsellor about successful strategies.
❖ Have a chat to your doctor and plan a quitting strategy together.
❖ Beat cigarette cravings by distracting yourself for the 5 to 10 minutes it takes for a craving to pass. When the urge to smoke strikes:
   - drink a glass of water slowly or munch on a carrot stick
   - ring a friend
   - sew or knit
❖ Exercise will help your body adjust to being without cigarettes. Your exercise doesn’t have to be strenuous to be effective - supervised yoga, swimming and walking are all beneficial and won’t harm your baby (see your doctor, though, before taking up any new exercise program).
❖ If your partner smokes, encourage him to consider quitting too.

Remember, phone the Quit Line anytime on 131848 if you feel you need some extra encouragement.
for advice and tips on quitting anytime

Produced for use throughout Australia by The NSW Quit Campaign

ISBN 0 7305 9482 3  Stock Code QLE.13
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ALCOHOL AND OTHER DRUGS STATISTICS
Summary Facts...

- Each year it is estimated that over 26,300 Australians died from drug-related causes, comprising about one-fifth of all deaths. Of these, 72 per cent were due to tobacco, 25 per cent to alcohol and 3 per cent to illicit drugs.
- In the 15 to 34 age group, 34 per cent were drug related.
- It is estimated that alcohol is a factor in 30 per cent of road traffic accidents.
- At any given time, more than 16,900 Australians are receiving services for drug and alcohol problems, including some 11,200 on methadone programs for opiate dependence.
- The Australian Bureau of Criminal Intelligence estimates that in 1992, approximately 33,000 arrests were for offences relating to heroin, amphetamines and cocaine.

Alcohol Facts...

- Alcohol is second only to tobacco as the major cause of drug related mortality in Australia with 6,500 deaths in 1992.
- Approximately one third of teenage drinkers in New South Wales and Victoria had participated in binge drinking (consumption of five or more alcoholic drinks in one sitting).
- Using 1990 prices, alcohol cost the community $6.9 billion.
- Australians on average spent $442 each on alcohol in 1992-93, representing 3.5 per cent of their total expenditure.

Tobacco Facts...

- Tobacco is the major cause of preventable drug related mortality in Australia with almost 19,000 deaths in 1992.
- 13 per cent of 14 to 19 years olds are occasional smokers while 26 per cent regularly smoke (with 3% of these regularly smoking 21 or more cigarettes a day).
- In 1988 the annual economic cost attributable to smoking was more than $6,842 million or 48 per cent of the cost of all drug abuse in that year. In 1992 dollar terms this represents a cost of $9,243 million.

Illicit Drug Facts...

- Illicit drug use remains a considerable cause of concern given the harmful effects associated in terms of health and social ramifications.
- The 1993 National Drug Strategy household survey reports that 36 per cent of 14 to 19 year olds have ever tried marijuana, six per cent have ever tried amphetamines and one per cent had ever tried cocaine.
- In 1992 there were an estimated 536 deaths due to illicit drug use.

Australian Drug Statistics...

Proportion of the population who have ever tried illicit drugs, drug type, 1985, 1988, 1991 and 1993


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<tbody>
<tr>
<td>Marijuana</td>
<td>28</td>
<td>28</td>
<td>32</td>
<td>34</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>9</td>
<td>6</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>9</td>
<td>6</td>
<td>5</td>
<td>4</td>
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<tr>
<td>Cocaine/ Crack</td>
<td>4</td>
<td>3</td>
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<tr>
<td>Hallucinogens</td>
<td>8</td>
<td>7</td>
<td>7</td>
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<tr>
<td>Heroin</td>
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<td>2</td>
<td>2</td>
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<td>Inhalants</td>
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<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Ecstasy/ Designer drugs</td>
<td>na</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Self injected (any illicit)</td>
<td>na</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Estimated consumption of tobacco products per person aged 15 years and over, Australia, 1988-89 to 1992-93

Source: Department of Human Services and Health based on ABS data.

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<tbody>
<tr>
<td>Cigarettes</td>
<td>1974</td>
<td>1985</td>
<td>1818</td>
<td>1825</td>
<td>1615</td>
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<tr>
<td>Loose Tobacco</td>
<td>108</td>
<td>106</td>
<td>115</td>
<td>107</td>
<td>99</td>
</tr>
<tr>
<td>Cigars</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>6</td>
<td>5</td>
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<tr>
<td>Totals</td>
<td>2 091</td>
<td>2 099</td>
<td>1 940</td>
<td>1 938</td>
<td>1 719</td>
</tr>
</tbody>
</table>

Contacting DRUG-ARM:

Email US: [ ] , or alternatively:

Phone: (07) 3368 3822
Fax: (07) 3367 1374
Postal: 83 Castlemaine St, Milton

GPO Box 590, Brisbane Q 4001
Drug and Alcohol Statistics

The following statistics are based on the 1998 National Drug Strategy Household survey.

Alcohol is one of the most widely used drugs in Australia. 80.7% of the population aged 14 years or more have consumed alcohol in the past 12 months, with 48.6% drinking at least weekly.

Tobacco is used regularly by 22.4% of the adult population, and occasionally by 4.0%.

Marijuana is the most commonly used drug after tobacco and alcohol. 39.3% of persons aged 14 or more have tried it, and 17.9% have recently used marijuana.

Analgesics is the next most frequently tried and used drug, with 11.4% having tried them, and 5.2% recently using them.

Hallucinogens come in next at 10% ever tried, and 3% have used in the past 12 months.

Amphetamines have been tried by 8.7% of the population, and used in the past 12 months by 3.6%.

Cocaine has been tried by 4.3% of the population, and 1.4% have used it in the past 12 months.

Designer drugs, particularly Ecstasy (MDMA) have been tried by 4.7% of the population, and used in the past 12 months by 2.4% of the population.

Inhalants have been tried by 3.9% of the population, and are currently used by 0.8%

Heroin has been tried by 2.2% of the population, and is currently used by 0.7%.

Illegal drugs have been injected by 2.1% of the population, and are currently injected by 0.7%.

The Australian Institute of Health & Welfare estimates that in 1997 tobacco was associated with over 18,000 deaths and almost 150,000 hospitalisations. Alcohol was related to almost 4,000 deaths and just under 100,000 hospital episodes. Illicit drugs were associated with 831 deaths and over 11,000 hospitalisations.

In the 1994 Urban Aboriginal and Torres Strait Islander Peoples Household survey supplement, 62% of the Aboriginal and Torres Strait Islander community drank alcohol compared to 72% of the general urban population. Those who do drink alcohol, however, consume much higher quantities of alcohol than the general population.

54% of urban Aboriginal and Torres Strait Islander people are current smokers, compared to 29% of the general population.

Illicit drug use is more widespread among the Aboriginal and Torres Strait Islander urban community than in the general population. 50% have tried an illicit drug compared with 38% in the general community, 24% are current users compared with 18% in the general population with marijuana being the most popular illicit drug.

More Information:

1998 Household survey

http://www.ceida.net.au/students/statistics.htm
www.alhw.gov.au
How to have: a healthy heart

Heart, Stroke and Vascular Diseases Australian Facts 1999

Highlights:

- Cardiovascular disease refers to heart, stroke and vascular diseases. Much progress has been made in the fight against cardiovascular disease in Australia. Death rates have fallen dramatically, some risk factors have improved, and there have been major advances in treatment and care.
- Death rates from coronary heart disease peaked in 1968 and have fallen since by over 60%. The fall in death rates was initially due to lower heart attack rates but, more recently, improved survival after a heart attack has played an important part as well.
- Death rates from stroke were fairly steady during the 1950s and 1960s and have since fallen by about 68%. A decline in attack rates is likely to have been the main reason for the fall in national stroke death rates.
- Nevertheless, cardiovascular disease continues to place a heavy burden on Australians in terms of illness, disability and death, and its health care costs exceed those of any other disease. These issues are expected to become more acute over the next decades with the growing number of elderly Australians, among whom cardiovascular disease is most common.
- About 2.8 million Australians, 16% of the population, had cardiovascular conditions in 1995.
- For a 40-year-old, the risk of having coronary heart disease at some time in their future life is 1 in 2 for men and 1 in 3 for women.
- For a 45-year-old, the risk of having a stroke before age 85 is 1 in 4 for men and 1 in 5 for women.
- Cardiovascular disease is ahead of cancers and other groups of causes of death in Australia in 1997, accounting for 52,641 deaths, 41% of all deaths.
- Coronary heart disease is the largest single cause of death in Australia, claiming 29,051 lives in 1997. Every day, around 80 Australians die from coronary heart disease.
- Stroke is Australia's second greatest single killer after coronary heart disease, claiming 12,133 lives in 1997. It is the leading cause of long-term disability in adults.
- People in lower socioeconomic groups are more likely to die from cardiovascular disease than those in higher socioeconomic groups.
- Indigenous Australians die from cardiovascular disease at twice the rate of other Australians. The difference is even greater among those aged 25-64, where Indigenous death rates were 7 and 9 times those of other Australian men and women respectively in 1995-97.
- Prevalence of rheumatic heart disease among Indigenous Australians is one of the highest in the world.
- Indigenous Australians are more likely to smoke tobacco, not participate in leisure-time physical activity, be obese and have diabetes than other Australians. These are all risk factors for cardiovascular disease.
- Much of the death, disability and illness caused by cardiovascular disease is preventable.
- In 1995, over 10 million adult Australians (about 80% of the adult population) had at least one of the following cardiovascular risk factors: tobacco smoking, physical inactivity, high blood pressure, or overweight. Four in 5 men and 3 in 4 women had at least one of these risk factors.
- In a 1995 survey, over 4.5 million adult Australians (over one-third of the adult population) reported doing no leisure-time physical activity in the 2 weeks prior to interview. People who do not participate in regular physical activity are almost twice as likely to die from coronary heart disease as those who participate.

• Almost 3.2 million adult Australians (around 24% of the adult population) in 1995 were at risk of developing cardiovascular disease and cancers from smoking tobacco products.

• Around 2.2 million adult Australians (17% of the adult population) had high blood pressure and/or were on treatment for the condition in 1995. High blood pressure increases the risk of cardiovascular disease by 2 to 4 times.

• Around 7.4 million adult Australians (56% of the adult population) were overweight in 1995. Almost 2.5 million (19% of the adult population) of those were obese. On average, men in 1995 weighed 3.6 kg more than their counterparts in 1980, and women 4.8 kg more. People who are overweight or obese have a higher risk of coronary heart disease, stroke, heart failure and type 2 diabetes.

• Over 350,000 Australians (2% of the population) in 1995 reported having type 1 or type 2 diabetes. People with diabetes are at an increased risk of developing coronary heart disease, stroke and peripheral vascular disease.

• Cardiovascular disease is the most costly disease for the health system in Australia. In 1993-94, it accounted for $3.7 billion, 12% of total direct health system costs.

• Cardiovascular diseases consuming most health system resources were coronary heart disease ($594 million), high blood pressure ($831 million) and stroke ($630 million).

• In 1996-97, there were 421,516 hospitalisations for cardiovascular conditions (8% of all hospitalisations).

• Although men and women aged over 64 represent only 12% of the total population, they account for almost 60% of hospitalisations for cardiovascular conditions.

• The average length of stay in hospital for cardiovascular conditions fell from 7.6 days in 1993-94 to 5.9 days in 1996-97.

• During 1994 there were 19,409 heart surgery procedures. By far the most common heart operation was coronary artery bypass grafting (CABG) at 14,941 procedures.

• There were 11,348 coronary angioplasty procedures performed in 1995. Data indicates that stents were deployed in one-third of these patients.

• A total of 11,878 computerised tomography (CT) brain scans and 4,478 carotid endarterectomies were performed for stroke during 1995-97.

• 40.65 million drug prescriptions for cardiovascular drugs were dispensed in the community in 1997. This represents one-fifth of all prescriptions.

• The cost of cardiovascular drugs amounted to $1,105 million, 34% of all costs for prescription drugs listed in the Pharmaceutical Benefits Scheme in 1997.

• Australian death rates from coronary heart disease rank towards the middle of the 17 countries compared (ranked tenth lowest for males and females). Coronary heart disease death rates tend to be lower in Asian and Mediterranean countries and highest in the Russian Federation.

• Stroke death rates in Australia are among the lowest of the 17 countries compared (ranked fifth lowest for males and females). The Australian stroke death rates for males were still one-third higher than those recorded in the United States. Females in France and Switzerland have the lowest death rates for stroke. Australian females have 1.4 times their rate.

Every cigarette

10 Facts about Smoking

1. Smoking is the largest single preventable cause of death and disease in Australia. There are around 50 tobacco caused deaths each day, 350 each week, about 18,000 each year.

2. Every month Australian tobacco companies lose at least 12,000 customers. Ten and a half thousand quit and fifteen hundred die of diseases cause by smoking.

3. 25% of the Australian population are regular smokers. 80% of them have tried to quit at least once.

4. A twenty-a-day smoker, aged 30, who started smoking at around sixteen has already breathed a kilo of tar into their lungs.

5. Tobacco smoke contains over four thousand chemicals, many of which are highly toxic and over 40 of which are known cancer causing substances. There is no safe 'low tar' cigarette and no known safe level of smoking.

6. Male smokers may produce less sperm and their sperm may have more abnormalities than a non-smokers. Women who smoke take longer to conceive and are more likely to have a miscarriage.

7. Successfully quitting usually takes a number of attempts. 40% of slip-ups occur in the first three days and 34% within two weeks. In 80% of slip-ups the smoker returns to full time smoking.

8. After quitting the body can rid itself of nicotine and carbon monoxide within twelve hours and nicotine by-products within a few days. Blood flow to the limbs improves within two months and lungs regain the capacity to clean themselves within three months.

9. Women smokers who use the pill increase their risk of heart attack, stroke, and other cardiovascular diseases about ten times.

10. Over 57,000 reports world-wide have examined the link between cigarette smoking and disease - making it the most researched cause of disease ever investigated in the history of biomedical research.

Every cigarette

Quit Tips

How fast your body recovers

How fast your body recovers

- In twelve hours, your blood is free of carbon monoxide.
- In two days, the nicotine and its by-products are out of your system.
- In around three months, your lungs regain the ability to clean themselves.
- In 10 years, your risk of lung cancer is more than halved and continues to decline over time.
- In a year, your risk of dying from heart disease has halved.

Quit tips

Write down your own personal reasons to quit in the space on the right hand refer to them if you ever feel tempted to light up.

Even the worst cravings only last a few minutes. If you can resist them during this time they will pass. Remember the 4Ds, they may help:

Delay

Deep breath,

Drink water,

Do something else.

Think of quitting as part of a new healthier lifestyle. Try to eat healthier foods and get more exercise, even if it's just taking the stairs instead of the lift, or walking to the shops.

It may also help to cut down on coffee, at least for the first few weeks as without nicotine in your system you absorb twice as much caffeine. The last thing you need when you're trying to beat cravings is to feel jittery and anxious.

Quitterline 131848

Telephone advice and assistance to smokers who want to kick the habit

Every cigarette

http://www.quitnow.info.au/quitterspage.html 11/04/00
Get the good eating habit

Heart Foundation
ACN 008 419 761 CE003 (REV1997)
Enjoy a wide variety of foods

Eat plenty of cereal and grain products (bread, breakfast cereal, rice, pasta) vegetables, fruits and legumes (dried peas and beans).

Eat moderate amounts of fish, lean meat, skinless chicken, or low-fat vegetarian substitutes, low-fat dairy products.

Eat small amounts of mono-unsaturated or polyunsaturated oils and spreads, and fat reduced spreads.

Keep to a healthy weight

Keep an eye on your waistline. If you need to lose weight or keep it down:

- keep physically active;
- eat less fat, oils, margarine and fatty foods;
- eat less sugar, confectionery, soft drinks and other sugar-containing foods and drinks;
- keep to two drinks or less of alcohol a day;
- fill up on plenty of cooked and salad vegetables;
- avoid ‘fad’ or ‘crash’ diets;
- follow the advice in the Heart Foundation’s booklet, The Healthy Weight Guide.

Eat fewer fatty foods

Easy ways to cut down on fat are:

- choose lean meat and poultry cuts, trim off fat, remove skin from poultry;
- eat more fish and vegetarian dishes based on dried beans, peas or lentils;
- use more low/reduced fat or skim milk dairy products instead of full cream varieties;
- eat fewer high fat foods, fried foods, takeaways, cakes, biscuits, pastries, chocolates, butter, margarines and oils;
- look for low/reduced fat products when shopping.

Eat more bread, cereals, vegetables, fruit and legumes

These foods contain fibre which helps fill you up. High fibre foods are usually good sources of vitamins and minerals.

Eat more:

- wholemeal breads and pastas
- wholegrain breakfast cereals
- wholewheat flour, corn, oats, barley, brown rice
- vegetables
- fruits.
The important Tick

When you shop, look for this symbol. It's your guide from the Heart Foundation to foods low in saturated fat and salt. All the foods have been independently tested for the Foundation before getting the Tick.

Try foods with the Tick for a taste of healthy eating.

For more information, contact the Heart Foundation in your state.

Use this guide to healthy eating

This guide will help you choose foods that will give you all the energy and nutrients you need for good health. It will also help you to avoid eating too much of the sorts of food that can push up your blood cholesterol, weight, and your risk of heart disease.

This is not just a 'diet', to be given up after a few weeks. It's a sensible, lifelong way of eating for your all-round health. It also provides a variety so you can enjoy your eating. So keep in shape with healthy eating and regular physical activity.
Go easy on high salt foods
Most of us use much more salt than we need. Eating less salt may help us have healthier blood pressure.

- Go easy on high salt food such as cured, canned or corned luncheon meats, salamis, sausages and meat pastes, smoked and canned fish, cheese, vegetable extracts, commercial sauces, many takeaway and snack foods.
- Check labels for salt or ingredients containing sodium – if available, choose brands containing ‘no added salt (or sodium)’ or ‘low salt’ or ‘reduced salt’.
- Don’t add salt to cooking or at the table. Garlic salt, vegetable salt and sea salt are all high in salt.

Go easy on alcohol
Alcoholic drinks provide extra calories, but no important nutrients. One or two drinks a day may do you no harm, but excessive drinking increases your risk of high blood pressure, heart disease and stroke, as well as many other problems.

- Keep your alcoholic drinks small and fill up the glass with water, soda, ice, or diet mixers.
- Keep a jug of water at the table when dining in or out.

Order now
The Heart Foundation Cookbook is packed with nearly 200 tasty low-fat recipes, for healthy eating.

$19.95 inc postage
Please fill in your details and mail or fax to the Heart Foundation in your state.
(See address details on the back of this brochure.)

Name:
Address: Postcode:
No. of copies @ $19.95:
Your donation: $ Total cost of your order: $

- Cheque/money order
- Visa
- Bankcard
- MasterCard
- Amex (please tick)

Card number: Expiry date:
Cardholder's name: Cardholder's signature:
Please allow 28 days for delivery
FURTHER INFORMATION

For further general information on exercise and other aspects of health contact the following:

**NSW Sport & Recreation**

Level 2 - MLC Building
105-153 Miller Street
North Sydney NSW 2060
Phone (02) 9923 4234

**Heart Foundation**

New South Wales Branch
343-349 Riley Street
Surry Hills, NSW 2010
Phone (02) 9219 2344

**NSW Health**

Health Promotion Branch
NSW Health Department
52 Miller Street
North Sydney, NSW 2060
Phone (02) 9939 9340
WALKING FOR PLEASURE AND HEALTH

An active way of life is important for all of us and becomes more important as we grow older.

Walking at a comfortable speed improves heart-lung function, it is also good for general fitness as well as being safe, cheap and convenient.

It can be enjoyed alone or with friends.

This booklet has been prepared by the
- NSW Department of Sport and Recreation
- NSW Health Department
- National Heart Foundation

To highlight the importance of walking as excellent exercise for heart health and for health in general.

WALKING IS GOOD FOR YOU

If you walk regularly you tend to:
- feel more confident, happy and relaxed
- control your weight better
- have healthier blood cholesterol level
- have lower blood pressure
- have stronger bones (less osteoporosis)
- be less likely to have a heart attack
- recover better from a heart attack
- be less likely to have a stroke
- be less likely to develop diabetes in middle age.

HOW OFTEN

Try to walk every day. Ideally, adults should get a total of 30 minutes or more of moderate exercise – like walking – on most (preferably all) days of the week. The more exercise you can do – the better – providing you follow the steps here.

HOW HARD?

Find the level that suits you best. You should still be able to talk (or whistle) comfortably as you walk.
GETTING STARTED
Walking is a great social activity. You can walk with a friend, join a club or you may prefer to walk alone. Whatever you do, the aim is for comfort and enjoyment while keeping active.

Before getting started, see your doctor if you:

• have not been active for some time
• have a history of heart disease or chest pains
• have diabetes
• are very overweight
• are a smoker
• have high blood pressure

STAYING MOTIVATED
• Walk with a friend or in a group, or with your spouse and family
• Use the times you walk to think and relax
• Plan your walks in advance
• Vary your walks
• Visit a national park or an historic landmark
• Visit a friend
• Walk the dog
• Join a walking club

10 IMPORTANT TIPS
1. Wear a broad brimmed hat and sunglasses, and use a broad spectrum sunscreen SPF15+ on exposed skin. Avoid the hottest times of the day, and keep to shaded areas.

2. Wear light, loose, comfortable clothing and well-cushioned flat-soled shoes.

3. Always let someone know where you are going and your expected time of return.

4. Walk steadily, concentrating on a steady heel toe action, letting your arms swing freely by your sides. After a while, you will develop the rhythm and stride most natural for your weight and height.

5. If you are going on a long or strenuous walk: drink water before you start and carry a supply with you, especially in hot weather. A small backpack is useful for carrying water, sunglasses, sunscreen and other useful items.

6. If your breathing becomes uncomfortable, slow down; and try not to stop completely if you have been walking briskly. Sudden halting can cause a feeling of dizziness or oxygenated blood drops with gravity away from the brain.

7. In cold weather, a hat prevents heat loss from the head.

8. Avoid walking immediately after meals and don’t walk if you have a fever or a bad cold.
9. If you are walking in the dark, wear light coloured clothing so motorists can easily see you.

10. You may feel some soreness in the early stages of your program, as your body adjusts to new demands being placed upon it. As your body adapts, the soreness will decrease. In addition, stretching before and after exercise can help to minimise soreness.

STRETCHING

It is desirable to stretch both before and after you go on your walk. Try the stretches below and remember you should always be warm before stretching:

- Ease into, hold and ease out of each stretch.
- Hold each stretch for a minimum of 20 seconds.
- Stretching should never be painful, although you may feel a mild discomfort.
- Never bounce while stretching.
- Perform stretches on both legs.

Stand with hands placed on wall for support. Put one leg behind keeping heel flat on ground. Keep other leg slightly bent with weight on back leg. Hold for 20 seconds. Repeat with other leg.

Sit on chair with both feet on floor. Turn arms, head and shoulder to grasp the back of chair. *Keep buttocks on chair. Hold for 20 seconds. Repeat on other side.

Prop leg against a tree or chair at a comfortable height with knee slightly bent, lean slowly forward to feel the stretch at the back of the thigh.
SORE FEET SHOW ON YOUR FACE

Your most important walking equipment is a pair of sturdy, comfortable lightweight walking shoes. If your feet feel good, you will walk well – and continue walking.

When choosing the right walking shoes, check for:

- uppers of high quality, breathable material, such as leather and/or nylon mesh
- comfortable padded heel collar
- firm heel counter (that cups the heel) to give stability for the entire foot and leg
- heel should be held in shoe, well cushioned and supported somewhat higher than the rest of the foot
- entire shoe should be designed to absorb shock
- substantial arch supports
- sole designed specifically to enhance smooth heel-to-toe motion
- toe box should allow ample room and toes should not be tight against any part of the shoe

WALKING AFTER A HEART ATTACK OR HEART SURGERY

If you have recently had a heart attack or heart surgery, exercise will play an important part in your recovery. Walking is safe and easy and you can begin with an easy stroll twice a day during the week after you leave hospital.

Use the chart below as your guide to getting into a regular walking program. But talk it over with your Doctor first.

<table>
<thead>
<tr>
<th>WEEK</th>
<th>TIME (MINUTES)</th>
<th>MINIMUM DISTANCE (METERS)</th>
<th>TIMES PER DAY</th>
<th>SPEED</th>
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<tr>
<td>1</td>
<td>5-10</td>
<td>250</td>
<td>2</td>
<td>Stroll</td>
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<td>2</td>
<td>10-15</td>
<td>500</td>
<td>2</td>
<td>Comfortable</td>
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<td>15-20</td>
<td>1000</td>
<td>2</td>
<td>Comfortable</td>
</tr>
<tr>
<td>4</td>
<td>20-25</td>
<td>1500</td>
<td>1-2</td>
<td>Comfortable/Stride out</td>
</tr>
<tr>
<td>5</td>
<td>25-30</td>
<td>2000</td>
<td>1-2</td>
<td>Comfortable/Stride out</td>
</tr>
<tr>
<td>6</td>
<td>30</td>
<td>2500</td>
<td>1-2</td>
<td>Comfortable/Stride out</td>
</tr>
</tbody>
</table>
WALKING FOR PLEASURE AND HEALTH

WALKING FOR PLEASURE CLUBS

Walking for Pleasure is a NSW Sport and Recreation program which promotes regular walking with a Walking for Pleasure club. The groups walk in locations such as National Parks, places of historical interest and beaches.

Participating in a Walking for Pleasure club is:

• Enjoyable
• Social
• Easy
• Accessible
• Healthy
• FREE to join

Walking for Pleasure Clubs have been set up all over New South Wales and see numerous people participating in regular walks on a weekly or fortnightly basis. Most Walking for Pleasure clubs start with a meeting of interested people and clubs operate on a casual basis, with members deciding where and when they want to walk.

There’s a Walking for Pleasure Club near you and it’s FREE to join! Phone 13 13 02.

OTHER USEFUL CONTACTS

Walking Clubs of NSW
Department of Land and Water Conservation
National Parks and Wildlife Service
National Trust
New South Wales (NSW) Office of Health

Volunteer centres, leisure centres, neighbourhood and community centres may have community walking groups that walk in local areas.

DEPARTMENTS REGIONAL OFFICES

CONTACTS

For more information about Walking for Pleasure clubs and programs contact NSW Department of Sport and Recreation on 13 13 02

METROPOLITAN REGIONS

Central/Northern Metropolitan Regional Office
1 Burwood Road, Burwood
PO Box 1032 Burwood NSW 2134

Metropolitan West Office
Parramatta Stadium, Cnr Victoria Road & O’Connell Street, Parramatta
PO Box 407 Parramatta NSW 2124

South East Metropolitan Office
Unit 1, 450 Forest Road, Hurstville
PO Box 15 Hurstville NSW 2220

South West Metropolitan Office
Suite 12, Library Plaza, 170 George Street, Liverpool
PO Box 522 Liverpool NSW 2170

COUNTRY REGIONS

Central Coast Regional Office
96зонinson Street, Gosford
PO Box 744 Gosford NSW 2250

Hunter Regional Office
117 Boll Street, Newcastle
PO Box 514 Newcastle West NSW 2302

North Coast Regional Office
Level 3, Manchester Unity Building, 29 Moresworth Street, Lismore
PO Box 716 Lismore NSW 2480

North West Regional Office
155 Martin Street, Tamworth
PO Box 552 Tamworth NSW 2340

Riverina Regional Office
33 Elizabeth Street, Wagga Wagga
PO Box 690 Wagga Wagga NSW 2650

South Coast Region
State Government Office Block, 34 Crown Street, Wollongong
PO Box 307 Wollongong East NSW 2520

Western Regional Office
Gnr Byng and McMahons Streets, Orange
PO Box 381 Orange NSW 2800
You only have to take it seriously.

Everybody's got time to be active

Have you got a spare 10 minutes? If so, you've definitely got enough time to start keeping yourself healthier and more active.

That's because the latest research shows that you only have to do some sort of physical activity for a short time every day to keep a whole stack of medical problems at bay.

Thirty minutes is all it takes, so long as you do it regularly - you can even do it over three short 10 minute breaks if that's easier for you.
Alternatively, find out what activities are happening at your local club and join in. You’ll find that staying active is never boring.

If you’re feeling ambitious, why not play some volleyball or tennis in your lunch break? Do a few stretches that you learnt in a yoga class years ago, or give a new sport a go.

There are hundreds of ways to give your body what it deserves and start feeling great today. And remember, we’re not talking about any major life changes. Nothing serious like that.

Research shows that even moderate physical activity can have great all-round benefits. So long as it’s regular, for 30 minutes most days.
It doesn’t have to cost a thing

The best thing about being active is that it’s often free and can be fun!

We’ve got miles of free oceans to swim in, parks to walk the dog, and gardens to dig.

Better still, you can exercise with friends, just by going for a short walk before dinner - or meeting half way between your two homes instead of taking the car!

Be creative, because ideas come free. You’ll find that once you get going, you’ll discover plenty of ways to do some kind of physical activity for only 10 minutes at a time. Things that are easy to do and cost nothing. And you’ll also find there’s an activity to suit every level of ability.

You’re never too old to feel good

Feeling too old to be active? Then take a few tips from us and you’ll soon feel young enough again.

The trick is to start off slowly and you’ll soon start feeling more capable.

Research shows that if you do some kind of physical activity for only 30 minutes a day regularly, you’ll be able to keep much healthier than you would if you just did nothing.

You’ll also find that your local GP supports the Active Australia campaign and can give you more information.

If you’ve had chest pains, serious weight problems, high blood pressure or diabetes, or if you’re a smoker, talk things over with your doctor first. And if you’re a man over 40 or a woman over 50 ask your GP’s advice before you start any vigorous exercise program.

Regularly, not seriously.
Say yes to exercise, no to disease

If thirty minutes is all it takes, it's got to be worth it! You won't just feel a whole lot better about yourself, you'll also reduce your chances of heart disease, stroke, colon cancer, diabetes and more.

There are so many ways to make it enjoyable and rewarding. And if you plan some physical activity on a regular basis, you've got something to look forward to every time.

So no excuses! Being active can be a whole lot of fun and it's easy to find a spare 10 minute slot here or there.

Here are some great ideas on what we mean by physical activity. You can walk the dog, walk down to the next bus stop on your way home, or take the long route to the shops.

Or you could put on some sun cream and go for a splash in the ocean - yes that's staying active and you'll feel great afterwards.

Play basketball with the kids, push a pram, fly a kite, climb the stairs a few times, ride a bike, go surfing, dig up some weeds in the garden, do an exercise class, or put on your favourite record and have a dance.

Get into it.
Get your friends into it

There's so much you can do for yourself. And we can help you. All you have to do is make a resolution to be more active on most days of the week.

There's no time like the present, so get things going today. Put down this leaflet right away. Ring up a friend, walk round there and start enjoying your new resolution to keep active on a regular basis. For a host of ideas on the activities that are happening in your local area, give us a call on 13 13 02.
Be Informed
- There are a lot of myths about drugs.
- It's important to obtain accurate information both for yourselves and your children.
- Be aware of where your local services are and what they provide. (There are phone numbers on the back of this leaflet).

Negotiate
- Young people need clear boundaries and limits to their behaviour.
- If you set boundaries together, there is a shared sense of responsibility.

Encourage your children to have a sense of self-worth
- Enjoy being a parent.
- Spend time with your children.
- Listen to them. Get to know their friends and something of their world.
- Assist in their transition from youth to adulthood.

Information
Who to contact FOR HELP
For assessment, counselling and referral in your local area contact ADIS

Ph: 02 9361 2111 or 1800 422 599

ADIS is a 24 hour alcohol and drug information service providing telephone counselling and referral.

Specialist Drug & Alcohol Services
Contact ADIS to direct you to services in your area.

Community Health Centres
Look in the phone book under Community Help and Welfare Services for your local centre, for assessment counselling and referral.

Self Help Parent Group
Family Drug Support Hotline a project of the Damien Trimingham Foundation
Ph: (02) 9818 6166

CEIDA provides education and information on drugs and alcohol across NSW.

Local Libraries - have a lot of information on a range of drugs that may be helpful to both parents and young people. Check with your local library to see if they have CD-Rom packages, books, videos etc... which may be helpful.

Web sites
NSW Health: www.health.nsw.gov.au
www.ceida.net.au

State Health Publication No: (DA) 970113
Further copies available from: Better Health Centre
Ph: (02) 9954 1153, FAX: (02) 9955 5196
email: RF18dch.health.nsw@nla.gov.au
What do you know about drugs

Most parents are anxious about drugs but don’t know much about them. Whether your children have experimented with drugs or not, they will be aware of them through friends and the media. The first step to protecting your children is finding out the facts.

DO YOU KNOW?

What to do if you think your son or daughter may be using drugs?
Where to go for help?

This leaflet provides some answers.

HOW DO YOU KNOW

IF YOUR CHILD IS USING DRUGS?

It is difficult to know for sure. Drugs affect people differently.

What you think may be a drug problem could just be a symptom of growing up so it’s important not to jump to conclusions.

However, there are some signs to watch out for:

• Unusual behaviour change over a long period of time.
• Mood swings
• Secrecy
• Trouble at school or with the police
• A sudden change of friends
• An unexplained need for money
• Long periods away from home.
• Increasing isolation

If you are concerned that your child may be using drugs, remember, there is help available.

WHAT CAN YOU DO AS A PARENT?

Be a good role model

Don’t fall into the ‘do as I say but not as I do’ trap.
Parents are powerful role models. Think about the messages you’re sending through your behaviour.
Story behind the campaign

Most anti-smoking advertising campaigns warn smokers they are at risk of ill-health or death. The latest hard-hitting campaign takes a new tack.

Instead of focusing on abstract concepts like risk and probability, it provides graphic images of the health damage smokers contribute to each time they light up.

WHY A NEW APPROACH?

Changes in the health behaviour of populations boil down to the decisions and actions of individuals. Yet public health campaigns directed at smokers have consistently focused on the sizeable tobacco-caused illness and death burden for the community overall with the hope that this information alone will affect individual smoking behaviour.

"We have endlessly broadcast the devastating statistics about the risk of smoking," said Dr David Hill, Chairman of the Ministerial-Tobacco Advisory Group (MTAG).

"This approach has met with limited success, one reason being that smokers sometimes translate warnings about risk into terms such as:

Smoking is like buying a ticket in a lottery that is drawn when you reach 70, and that's a risk I am prepared to take."

For this campaign, MTAG started its planning from the perspective of the individual smoker.

"The focus on this perspective led us to review more than a hundred Quit campaign studies of smokers conducted around Australia during the past decade," Dr Hill said. "A consistent theme from smokers was their call for new angles on health effects, and for information and graphic portrayals of how smoking affects the individual."

The campaign devised during the past year aims to help smokers recognise that every cigarette they smoke is doing damage, even though they cannot feel this at the time. It is an important message that has been absent from many previous campaigns. The damage seen in the advertisements connects the individual smoker personally with the dire statistics of tobacco-caused illness and death.

Dr Hill, a psychologist who heads the Centre for Behavioural Research in Cancer at the Anti-Cancer Council of Victoria, said psychological theories of behaviour change supported the latest approach.

"People's own experiences are far more likely to influence their behaviour than facts and figures, especially if that experience has had an emotional impact," he said. "The campaign is designed to personally involve the smoker by taking them on a journey through their own body. We believe that the advertisements will produce a strong and emotional response".

One of the advertisements being launched concerns the damage smoking causes to blood vessels and draws attention to the process of heart disease.

**ARTERY DAMAGE**

Arteries are the expressways for blood cells laden with oxygen to reach all parts of the body.

Smoking causes a build-up of fatty deposits in the artery walls and causes blood cells to stick to these walls and to each other.

A build-up of fatty streaks and fat-filled lesions impairs blood flow and reduces artery diameter, contributing to poor circulation, high blood pressure, heart disease and stroke.

Brainstorming sessions between cardiologists and the Sydney advertising agency Brown Melhuish Fishlock (BMF) led to the graphic representation of artery wall fat deposits seen in the television and press advertisements. The agency photographed actual autopsy specimens, created illustrative latex models of a major human abdominal artery and used computer imaging techniques in post-production to create a realistic effect.

The quantity of fatty material depicted resulted from cardiovascular research by Dr Henry McGill of San Antonio in Texas, and its appearance and consistency was arrived at through discussions with Sydney cardiologist, Dr David Celermajer.

The second advertisement focuses on the damage smoking causes to lung tissue and shows the progressive degeneration brought about by tobacco smoke.

**LUNG DAMAGE**

Smoking ravages the lungs in several ways. It paralyses and ultimately destroys the fine hair-like projections lining the airways which otherwise sweep debris such as foreign particles and phlegm from the lungs. Smoking also damages the fine alveolae or air sacs through which life-giving oxygen passes into the blood in exchange for the gaseous waste product, carbon dioxide.

The lungs of a smoker consistently function below their potential as a result and this has negative consequences for all body tissues.

The exchange of ideas between thoracic and respiratory specialists and BMF gave the agency the concept of filming within the body for the first time, resulting in the arresting experience of the viewer travelling along the airways into the lung surrounded by tobacco smoke. The agency created realistic models of lung tissue with ongoing advice from thoracic specialists and, once again, employed computer imaging techniques in the post-production phase.

**SCIENTIFIC BACKING AND ONGOING ASSESSMENT**

Scientists and medical experts have been involved in the campaign from an early stage and have verified that the advertisements are a fair representation of the

pathological impact of smoking on blood vessels and lungs.

The rigorous scientific approach has been extended to the assessment process. This will continue for the next six months to determine the impact of the campaign.
3) Tell your family and friends you are quitting.
   Ask for their understanding and support in helping you quit.
4) Talk to your doctor or pharmacist and find out what is available to help you quit.
5) Phone the Quitline on 131 848, for your free copy of the Quit Kit. The Quitline can provide counselling or help you to find services to help you quit in your local area.

For more information
Ask your GP, pharmacist or other health worker for more information on using Nicotine Replacement Therapy or call the Quitline on 131 848 for information on services you can use and tips on quitting. The Quitline is a 24 hour telephone counselling service.

Always store your Nicotine Replacement Therapy out of reach of children.

phone the Quitline on 131 848
**Nicotine Gum**

The major side effects of nicotine gum are hiccups, gastrointestinal disturbance, jaw pain and dental problems. These side effects may stem from over vigorous chewing. Chew slowly.

**Nicotine Patches**

The most common side-effect of the nicotine patch is a rash or itch at the site of the patch. This may be avoided by putting the patch on a different spot each time.

Users of 24 hour patches may experience sleep disturbance, nightmares and daytime sleepiness.

**All Nicotine Replacement Therapies**

Less common effects of all Nicotine Replacement Therapies include: sweating, nervousness, joint or muscular pain, dry mouth, indigestion or an upset stomach, abdominal pain and diarrhoea.

**Pregnancy**

Smoking when pregnant is dangerous to both mother and child, but there is no evidence to support the safety of Nicotine Replacement Therapy in pregnant women. Its use cannot be recommended.

**Heart Disease or Stroke**

You must check with your GP before using Nicotine Replacement Therapy if you have heart disease or have had a stroke.

Please tell your GP or pharmacist about any medical conditions or medications you are taking before using a Nicotine Replacement Therapy.
What is Nicotine Replacement Therapy?

Nicotine Replacement Therapy is a relatively new form of therapy to help smokers quit. Nicotine gum became available in Australia in 1984, and nicotine patches were introduced in 1993. These are the only two forms of Nicotine Replacement Therapy available in Australia at present:

Nicotine Replacement Therapy gum
(available in 2mg, 4mg.)

Nicotine Replacement Therapy patches
(available in 5mg, 7mg, 10mg, 14mg, 15mg & 21mg.)

Intra-nasal nicotine spray and Nicotine inhaler devices have not been licensed for general use in Australia.

How does Nicotine Replacement Therapy work?

Nicotine Replacement Therapy helps you to quit by reducing your physical withdrawal. Nicotine Replacement Therapy comes in gum and patches because nicotine is absorbed easily through the skin, the lining of a cheek, and the lungs.

It is important to note that Nicotine Replacement Therapy does not provide a complete quitting solution. You might still get some withdrawal effects from giving up smoking. Nicotine Replacement Therapy is most effective when used in combination with other strategies as part of an overall Quit plan.

There are some ideas to help you write your Quit plan, listed at the end of this leaflet.

Who should use Nicotine Replacement Therapy?

Research indicates Nicotine Replacement Therapy works best for people who smoke 10 or more cigarettes per day. Ask your pharmacist what kind of Nicotine Replacement Therapy program is most appropriate for you.

How do you get Nicotine Replacement Therapy?

Nicotine patches and gum are available over the counter at pharmacies. This means you do not need a prescription to buy Nicotine Replacement Therapies.

How to use Nicotine Replacement Therapy.

**Nicotine Gum**

Chew the Nicotine gum slowly until the taste becomes strong (approx. 1 min.). Rest the Nicotine gum between your gum and cheek. Chew the Nicotine gum again when the taste has faded.

Caffeine (eg. coffee and cola drinks) and acidic drinks (eg. orange juice) can decrease the absorption of nicotine chewing gum.

**Nicotine Patches**

Put the patch on a different spot each day.

Patches should be used for at least six weeks as patches are at their most effective during the first eight weeks of use. Using the patches for longer than eight weeks will not increase your chance of quitting.

Always read all the instructions that come with your Nicotine Replacement Therapy. Ask your doctor or pharmacist if you have any questions.

Are there any Side Effects to Nicotine Replacement Therapy?

Many people experience some withdrawal symptoms when giving up cigarettes. Nicotine Replacement Therapy will help limit the level of withdrawal you feel, but you may experience the following side effects when using a Nicotine Replacement Therapy.
How to write a Quit plan

You are most likely to be successful in quitting smoking if:
• you are highly motivated;
• you are expecting to succeed;
• you have a supportive environment;
• you have the skills to cope with adaptation and change.

1) Write a plan for giving up smoking.
   • Set a date for your Quit day.
   • Choose a day that will be low stress, but not too far away.
   • Make a list of the reasons why you want to quit.
   • When you have a cigarette, make a note of where you were, how you felt, how much you wanted the cigarette and what you could have done instead of smoking. This will help you to understand why you smoke and assist you in working out when you’re likely to crave and realistic things you can do instead of smoking in these different situations.
   For example, if you find that drinking alcohol makes you feel like smoking, avoid it in the short term, to give yourself a better chance of quitting.

2) Decide how you are going to quit:
   • cold turkey
     have no more cigarettes from your Quit date;
   • cutting down
     having fewer and fewer cigarettes each day, over a period of no more than two weeks from your Quit date;
   • using a Nicotine Replacement Therapy
     keep some level of nicotine in your system, to ease your withdrawal while you concentrate on other aspects of your smoking habit.