

OF SUBSTANCE

MARCH 2012
VOL. 10 NO. 1

THE NATIONAL MAGAZINE ON ALCOHOL, TOBACCO AND OTHER DRUGS

SMOKING CESSATION: Is NRT the answer?

THERAPEUTIC
COMMUNITIES:
CHANGING WITH
THE TIMES

EMERGING DRUGS:
POLICY PITFALLS

MARDI GRAS
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PARTY HARD,
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Editor's Letter

Welcome to the March issue of *Of Substance*.

The nature of addiction has long been debated. Is it biomedical or psychological? A combination of both?

This debate is the elephant-in-the-room which sets the scene for our cover article, *Smoking cessation: Is NRT the answer?* When *Of Substance* decided to explore the role of nicotine replacement therapies (NRT) in helping smokers quit, we found passionate advocates of these medical treatments, which include gums and patches. We also found experts who were equally as outspoken in their belief that other approaches to quitting smoking have been hijacked by a focus on NRT. Turn to page 10 for Angela Rossmanith's overview.

It is the complexity and diversity of debates such as these that makes the alcohol and other drug (AOD) sector such a fascinating place to work. This issue highlights just a few of the many diverse areas that are part of substance misuse. We look at how non-AOD – focused services such as hospital emergency departments can better work with people who frequently present affected by substances. We also explore the continued evolution of therapeutic communities – the treatment centres that thousands of people access each year for months at a time, yet for many, these communities remain an area of little knowledge.

On the policy front, Adam Winstock considers the consequences of banning emerging drugs and whether other options are available. Likewise, Ann Roche discusses the mishmash of liquor licensing legislation across Australia, which influences the way licensed premises serve alcohol and how police and the community respond to it.

These are just a few topics in this issue which I hope you will find informative and thought provoking.

As always, I love to hear from readers, at editor@ancd.org.au.

Jenny Tinworth
Managing Editor

Guest editorial

Alcohol: What is the way forward?

Ann M Roche,
Professor and Director of the
National Centre for Education
and Training on Addiction



Alcohol has received greater attention over the past year or two than perhaps at any other time in public health history in Australia. Issues of concern have tended to focus around problems of excess consumption and associated harms to individual drinkers, their friends and family, and the wider community, workplaces and society overall. Considerable media coverage has emphasised growing consternation in relation to young people, women, unborn children, older people and other vulnerable groups in the community. Similar unease has been highlighted internationally among both developed and developing countries.

There is no doubt that we are witnessing significant shifts in relation to alcohol. What we drink, where we drink and who drinks has changed dramatically over recent decades. These changes continue unabated. It is easy to tender simplistic explanations about why such changes are occurring, and to proffer prepared one-size-fits-all solutions. The reality is however that what we are witnessing is vastly more complicated than many commentators might lead us to believe. The solutions required are similarly intricate.

On one hand, there is a multi-layered array of recent social changes, within which alcohol is integrally entwined: to wit, young people mature earlier and demand greater freedoms; older people live longer and more healthily; the pursuit of pleasure has become a core social value; and the rights of the individual are revered, while the fundamental need for social connectedness and to belong is often threatened. Overlaying this social tumult is the unprecedented emergence of big business, the night-time economy and international market forces. The coalescing of elements involved in the production, manufacture, promotion and distribution of alcohol products has reached an all-time high. Confronting issues pertaining to alcohol inevitably means altercation with economic powerbrokers.

To move forward necessitates an understanding of not only these diverse issues, but also their multifarious interplay and inter-relationships. No amount of descriptive epidemiological data will be sufficient to forge a way forward. Nor will simply transposing strategies from one public health arena (e.g. tobacco) to alcohol be adequate. A more sophisticated and nuanced understanding of both what is simultaneously occurring on many levels, together with a genuine desire to seek innovative and consensus-based strategies for change is needed. Conflict and polarisation is not going to achieve tolerable progress in this complex, contested and controversial area. However, clever, skillful, authoritative collaboration just might.

News

FWA decision brings equal pay closer



Community sector workers will receive a historic pay rise after Fair Work Australia's (FWA) decision in February to approve a Government and Australian Services Union equal pay claim. The submission, first lodged in 2010, set out a case for rewarding workers in the social and community services sector pay rises of up to 65 per cent. In November 2011, the Government announced it would provide more than \$2 billion to deliver the pay rise to 150 000 eligible workers – the majority of whom are women.

Community groups, welfare organisations and unions have praised the submission for its stand on equal pay for people who undertake work in jobs like caring for people with disabilities, counselling families in crisis and working with victims of sexual assault. With FWA's approval, the increases will be phased-in over eight years, starting on 1 December 2012 – however the details of how the states and Commonwealth will implement the increases have yet to be finalised.

Tobacco plain packaging update

The Australian Parliament passed its tobacco plain packaging legislation on 21 November 2011, meaning all tobacco products sold in Australia will need to be in plain packaging from 1 December 2012. Tobacco companies immediately launched legal actions against the Government, with Imperial Tobacco Australia's challenge to the legislation set down for three days of

hearings in front of the Full Bench of the High Court of Australia from 17 April 2012.

Meanwhile the Government's updated and expanded graphic health warnings for tobacco packaging commenced on 1 January 2012, along with its new year announcement of the listing on the Pharmaceutical Benefits Scheme of two new lower-strength nicotine patches.

ACT overdose management program

A new overdose management initiative was launched in the ACT in December 2011. The program will train 200 participants over two years to respond to an opioid overdose, including the administration of Naloxone – which temporarily reverses the effects of heroin and other opiate drugs – in an effort to help to reduce the number of deaths associated with opioid overdoses. The program has been developed by the Canberra Alliance for Harm Minimisation and Advocacy, together with the Alcohol, Tobacco and Other Drug Association and the Expanding Naloxone Availability in the ACT committee.

FASD inquiry



Fetal Alcohol Spectrum Disorder – or FASD as it is commonly referred to – is the subject of a new inquiry by the House of Representatives Standing Committee on Social Policy and Legal Affairs. The Committee will inquire into the incidence and prevention of FASD, with three main areas of investigation: prevention strategies; intervention needs; and management issues. The Committee has noted that submissions will be accepted throughout the duration of the inquiry. **For the full terms of reference and advice on making submissions go to the Committee's website at www.apb.gov.au/spla.**

Tackling alcohol problems in NT

In November 2011, the Australian and Northern Territory (NT) Governments announced new initiatives to tackle the priority issues for Aboriginal people living in remote communities in the NT. The NT Government will continue to develop its Enough is Enough laws to help curb problem drinking, through its current alcohol restrictions, and by strengthening penalties for grog running. The Australian Government is proposing new legislation to complement these efforts, by strengthening the arrangements for local alcohol management plans to be put in place if they meet stringent guidelines on harm reduction and the protection of vulnerable women and children. The Government also intends to strengthen efforts to tackle alcohol abuse with a new income management measure. Under this measure, NT authorities will be able to refer people for income management for alcohol related problems, on a similar basis to the way this currently occurs under the child protection measure.

Second Sydney Drug Court



The NSW Government announced in November 2011 that it will set up a second Drug Court in Sydney and establish 300 beds for the treatment of prisoners addicted to drugs. A second metropolitan Drug Court initially will sit at the Downing Centre one day per week and involve 40 participants per year.

Of the 15 000 people received into custody in 2007–08 in NSW, almost 60 per cent were under the influence of drugs or alcohol when they committed their most serious offence; 71 per cent had committed drug or alcohol related crimes; 54 per cent had a history of injecting drug use; and 36 per cent were injecting drugs around the time of their offence.

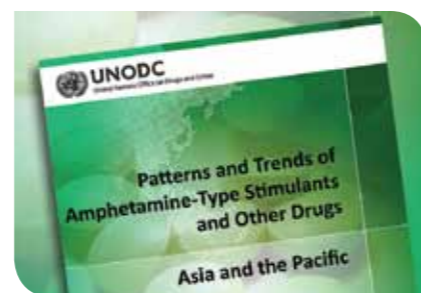
Federal funding of needle exchange banned again in US

In December 2011, the US Senate voted to reinstate a ban on federal funding for needle exchanges. The funding had only been in operation for two years however the ban was restored when spending appropriation bills approved by the House also had attached to them bans on funding for both domestic and international access to needle exchange programs. This occurred despite the Centers for Disease Control and Prevention, American Medical Association, National Academy of Sciences,

American Public Health Association, and other scientific bodies supporting needle exchange programs as highly effective at preventing the spread of HIV/AIDS and other infectious diseases. Eight federal reports had also found that increasing access to sterile syringes saves lives without increasing drug use.

Methamphetamine on the rise in Asia

According to a report released in November 2011 by the United Nations Office on Drugs and Crime (UNODC), East Asia and South-East Asia are major centres for the illicit manufacture of amphetamine-type stimulants (ATS). There has been a significant expansion in the manufacture, trafficking and use of methamphetamines in the past five years. This, plus the increasing involvement of transnational organised



criminal groups in the trade of ATS, poses a growing threat to security and public health in the region, warns the report, *Patterns and Trends of Amphetamine-Type Stimulants and Other Drugs: Asia and the Pacific*. It highlights the latest patterns and trends with regard to ATS, as well as other illicit drugs in East and South-East Asia. It also provides an overview of the situation in the neighbouring regions of South Asia and the Pacific. **For the full report, visit: www.unodc.org/unodc/en/publications.**

community-based drug treatment episodes provided across Australia in 2009-10. **Download the report at: www.aibw.gov.au/publication-detail?id=10737420496.**

AIHW's compendium of drugs statistics was also released in November. *Drugs in Australia 2010* brings together the most recent national information about use of tobacco, alcohol and other drugs, treatment services, drug-related health issues, and drugs in the context of crime and law enforcement. Of note from this report, in addition to the 147 000 community-based drug treatment episodes there were 104 614 hospital stays reported with a drug-related principal diagnosis in 2009-10, and more than half (58%) of these involved alcohol use. **Download the report at: www.aibw.gov.au/publication-detail?id=10737420497.**

Report calls for action on alcohol warning labels

Research released in November 2011 by the Foundation for Alcohol Research and Education (FARE) and carried out by Galaxy Research has shown support for the introduction of health warning labels for alcohol products. The research found that 58 per cent of people were supportive of health warnings being applied

to alcoholic beverages, with 86 per cent being in favour of a FARE label warning about the dangers of drinking while pregnant. Other findings showed a marked preference for labelling to be mandated and regulated by government and a majority of respondents were in favour of the warnings being on the front of bottles. **For the full report, visit: www.fare.org.au/wp-content/uploads/2011/11/FARE-Alcohol-Health-Warning-Labels-Attitudes-and-Perceptions_FINAL1.pdf.**

Latest findings from the DUMA program

The latest data from the Australian Institute of Criminology's Drug Use Monitoring in Australia (DUMA) program shows that the continuing decline in methamphetamine use since 2004 has ended, with rates of use among police detainees increasing in both 2010 and 2011. Twenty-one per cent of police detainees in 2011 tested positive to methamphetamine – up from 16% in 2010 and 13% in 2009. Self-report data also indicates that methamphetamine is considered by users to be higher in quality and easier to obtain in 2011 compared with earlier years. **For more information, visit: www.aic.gov.au/en/publications/current%20series/rip/21-40/rip22.**

New Federal Health Minister

The Hon Tanya Plibersek MP was appointed to the Cabinet position of Minister for Health in December. She takes over from Nicola Roxon, who held the position from 2007 to December 2011.

Award for Tanya Chikritzhs

Alcohol policy expert Tanya Chikritzhs was recognised as one of Australia's top researchers at the National Health and Medical Research Council annual awards ceremony in Canberra in December. Associate Professor Chikritzhs received an Achievement Award after her Career Development Fellowship (CDF) application was ranked first nationally in the Population Health Level 1 category. The CDF scheme aims to further develop Australian health and medical

researchers early in their career, and to encourage the translation of research outcomes into practice. Ms Chikritzhs leads the Alcohol Policy Research Team at the National Drug Research Institute, Curtin University, Western Australia.

Ted Wilkes recognised

Aboriginal health researcher Associate Professor Ted Wilkes has been awarded the Public Health Association of Australia (PHAA) President's Award for 2011. Also from the National Drug Institute, Professor Wilkes has been recognised for his many outstanding contributions to public health in Western Australia and nationally over more than 25 years, his commitment to campaigning for better health, and his strength and integrity as a public and community health leader.

Vale Owen Westcott, 1946-2011

In the early days of needle syringe programs in Australia, Owen Westcott worked at the new needle syringe program in Redfern. From this, he

moved in 1997 to the NSW Department of Health, where he worked as the manager of the department's harm minimisation unit until 2008 and was the lead officer for the needle syringe program and the Medically Supervised Injecting Centre. Westcott moved to Newcastle in 2008 where he continued to work for people who inject drugs.



Vale Owen Westcott

He was also very involved in behind-the-scenes preparation for the NSW Drug Summit in 1999. Westcott prepared briefings for several health ministers which set out a compelling case for the ministers to support it – on the grounds of benefits to public health, social well-being and the economic interests of NSW. His work was widely admired and appreciated by people who inject drugs, clinicians, researchers and other government officials.

This is an edited version of an obituary by Alex Wodak published in the Sydney Morning Herald on 27 October 2011.

More Australians seek treatment for alcohol use



Increasing numbers of Australians are using drug treatment services for alcohol use, according to a report released in November 2011 by the Australian Institute of Health and Welfare (AIHW). *Alcohol and other drug treatment services in Australia 2009-10: report on the National Minimum Data Set*, shows that alcohol was the principal drug of concern reported in almost half (48%) of the 147 000

It's your magazine – have your say!

It's time to review *Of Substance*.

We want to hear from people who read *Of Substance* and also those who don't, so pass the survey on to your friends, staff and colleagues – anyone who might have an interest in the field.

The online survey will take about five minutes and all your answers are completely confidential and anonymous. Your responses will help us find out how we're doing with our readership, how to attract new readers and to ensure the magazine continues to run articles that are relevant and interesting to you.

We are looking for your opinions about the content and format of *Of Substance* magazine and the eBulletins and how we might improve them in the future.

Go to: <https://www.surveymonkey.com/s/ofsubstancemag> to complete the five-minute survey.



LeeJenn Health Consultants has been asked to undertake an evaluation of *Of Substance* magazine. This online survey is one component of the evaluation. We will be talking to service providers and other readers over the telephone, as well as looking at readership data and reviewing similar publications in other areas. If you have any questions about the survey you can call Nicole Lee or Linda Jenner at LeeJenn Health Consultants on 1300 988 184 or email Kate Pockley at kate@ancc.org.au.



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Resources

Cannabis resource for youth



The National Cannabis Prevention and Information Centre (NCPIC) has launched the 'Clear Your Vision' print and web-based resource targeting 'at-risk' youth with cannabis-related issues. The booklet resource is designed to be used by young people in consultation with healthcare/AOD workers, accompanied by a facilitator's manual. The website is designed for young people to work through under the guidance of a counsellor or healthcare/AOD worker to gain information about cannabis, its use and potential harms, and to be guided in a way to plan and implement a cessation or reduction of their cannabis use. *Visit: <https://clearyourvision.org.au>.*

Understanding the Mental State Examination

The Perth Co-occurring Disorders Capacity Building Project has developed a new training resource for the alcohol and other drug (AOD) sector – *Understanding the Mental State Examination (MSE): a basic training guide*. The free DVD and accompanying booklet is an instructional training tool that is designed to build the capacity of AOD clinicians to complete a baseline MSE on their clients. It contains three visual case study scenarios that clinicians can use to test their knowledge and skills in conducting an MSE. Although designed primarily for the AOD sector, trainers, educators and clinicians working in the mental health field may also find this resource useful. *To request an order form for this resource, email: mail@palmerston.org.au.*

Drugfields professional development website

The Alcohol and other Drugs Council of Australia (ADCA) has established 'Drugfields' – a free web service dedicated to the Australian alcohol and other drugs (AOD) workforce. The Drugfields website provides desktop access to information about the AOD sector, professional development and education opportunities, and a professional toolkit. The toolkit equips users (including those with special interests) with professional AOD information and features 'Research in Brief', a joint venture with the National Drug and Alcohol Research Centre to deliver AOD research in a short, easy-to-read format. A monthly email subscriber service providing professional development information is also available. *Visit: <http://www.drugfields.org.au/>.*

Online NSP Directory and Legal Guide

A new website, launched by the Australian Injecting and Illicit Drug Users League (AIVL), provides two valuable sources of information for people who inject drugs. The directory is a state and territory listing of needle and syringe program (NSP) services. Where possible the directory provides the contact details, address, hours of operations and equipment supplied. A link with Google maps will help users find directions to service locations. The legal guide is a reference to state and territory NSP and drug-related laws that are relevant for people who inject drugs. It provides access to information such as possession of needles and syringes, disposing of used equipment, rights relating to police questioning, illicit drugs and sex work, etc. *The legal guide can be downloaded as a PDF. Visit: www.nspanlegal.aivl.org.au.*

Guidelines for managing volatile substance use

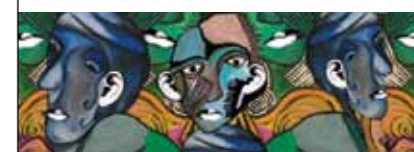
Australia's first *Consensus-Based Clinical Practice Guideline for the Management of Volatile Substance Use in Australia*, developed by the National Health and Medical Research Council, was launched in October 2011. It includes a quick-reference summary, to support health workers treating clients in this

challenging area. Volatile substance use (VSU) – inhaling solvents, gases and aerosols for intoxication – is a significant problem in some Australian communities. People who use volatile substances, such as petrol or glue, often have special needs not met by conventional drug and alcohol treatment strategies. The guideline and quick-reference summary are intended for use by health professionals including doctors, nurses, Aboriginal health workers, Ngangkari (traditional healers), alcohol and other drug workers and allied health professionals. *Visit: www.nbmr.gov.au.*



**Challenging Conversations:
 Creating an inclusive system**

15-16 May 2012, Hotel Grand Chancellor Hobart



Those working in the Alcohol, Tobacco and other Drugs and related sectors are invited to join us in Hobart for **ATDC 2012 Challenging Conversations: Creating an inclusive system**.

The conference will provide an opportunity for those in attendance to engage in conversations that challenge the way we think about our industry and provide our services.

The Hon Michael Kirby and the Social Inclusion Commissioner for Tasmania, **Professor David Adams** will provide the keynote presentations. Attendees will also hear from a wide range of speakers and panellists from around Australia who will share their expertise through plenary, interactive and participatory presentations.

To view the program, or to register for the conference, go to www.atdc.org.au and click through to the conference website. Early Bird registrations close 13th April 2012.

A selection of studies probes the issue of homelessness, and examines its complex relationship with alcohol and other drug use and mental health.

Libby Topp



International snapshot of homelessness and mental health

Fazel, S, Khosla, V, Doll, H & Geddes, J 2008. The prevalence of mental disorders among the homeless in Western countries: systematic review and meta-regression analysis. *PLoS Medicine*, vol. 5, no. 12, e225.

Strong relationships exist between homelessness and poor health, but reliable estimates of the prevalence of major mental disorders are lacking. Homelessness has been studied in many countries by researchers using different methods, samples, definitions, and statistical analyses. This study uses systematic review and meta-analysis to 'pool' the findings of previous surveys of mental disorders among homeless populations. Applying strict eligibility criteria around definitions and methods, the authors collated 29 studies reporting on a total of 5684 homeless people recruited from shelters, soup kitchens and the street, in the US, UK, Europe and Australia. Participants were assessed for psychotic illness, depression, personality disorders and substance use disorders, using either a clinical examination or validated psychiatric diagnostic instruments.

Substance disorders were the most common diagnoses: across the 29 studies, up to 59% of participants were diagnosed as alcohol dependent; and up to 54% were dependent on at least one illicit drug. In any six-month period, 38% of homeless people worldwide are alcohol dependent, and 25% are dependent on illicit drugs. In addition, 23% of homeless people suffer personality disorders; and 13%

experience psychosis. In contrast to such markedly elevated rates relative to the general population, a total of 11% of homeless people worldwide were estimated to suffer with depression, similar to general population prevalence. Given the high suicide rates among homeless people, a substantial proportion of suicidal behaviour among this group may be affected by risk factors other than depression, most likely alcohol dependence and/or psychosis.

The benefit of family ties

Kemp, PA, Neale, J & Robertson, M 2006. Homelessness among problem drug users: prevalence, risk factors and trigger events. *Health and Social Care in the Community*, vol. 14, no. 4, pp. 319-28.

The separate literatures on homelessness and drug misuse demonstrate similar risk factors for both, including family dysfunction, physical or sexual abuse, poor school performance and crime. In addition, homelessness is a risk factor for drug misuse, and drug misuse is a risk factor for homelessness. When the two occur together, they can reinforce each other and cause or intensify other harms including legal, financial, and family problems, physical and mental ill health, and increased rates of risky drug injection practices, self-harm and suicidal behaviour. Episodes of homelessness are longer among problematic drug users than other homeless people. This study documented prevalence of and risk factors for homelessness among 877 drug treatment entrants (mainly heroin consumers) in Scotland.

Participants were interviewed twice, an average of eight months apart. Thirty-six per cent were homeless at one or both interviews, a rate far exceeding homelessness among the general population.

Comparisons between participants who were and were not homeless at one or both interviews showed that the 'homeless' group were more likely to: not be in a relationship or living with children; indicate problematic alcohol use; report recent injection and recent incarceration; have divorced, separated or never-married parents; have poor family relationships; and derive income from illegal activities. Although many of these risk factors are common to homeless people in general, recent drug injection is clearly specific to people who inject drugs, indicating that drug-taking behaviour is itself a risk factor for homelessness. Movements into homelessness were associated with recent loss of custody of children, other recent family problems, and deteriorating general health; movements out of homelessness were associated with not having recent family problems. The authors argue that relatives of problem drug users should be assisted to help them cope with the stress of having a drug-dependent family member.

Homelessness more likely to lead to drug use

Johnson, TP & Fendrich, M 2007. Homelessness and drug use: evidence from a community sample. *American Journal of Preventive Medicine*, vol. 32, supplement 6, s211-s218.

Substance use disorders are commonly considered to be a cause of homelessness, a notion captured in the 'social selection' model which suggests that homelessness represents the endpoint of the gradual depletion of an individual's economic and social resources as a result of their substance dependence. In contrast, the 'social adaptation' model focuses on substance use as a consequence of homelessness. Here, homelessness constitutes an environment where drugs are readily available and their use is an accepted practice into which people may be socialised and/or pressured, and which may serve as a coping mechanism for an uncertain and chaotic lifestyle. Evidence supports both theories: the presence of either homelessness or substance use predisposes an individual to the other; and many risk factors are common to both. This study examined whether homelessness precedes drug use or vice versa by interviewing a random community sample of 627 adults aged 18-40 years in Chicago regarding their histories of drug use and experiences of homelessness.

Preliminary statistical analyses provided some support for the social selection model. An association between age of first drug use and recent homelessness was demonstrated (21% of those who had used drugs before age 19 had also experienced homelessness during the decade preceding interviews, compared to 12% of those who did not report early drug use). Likewise, 67% of those who had been homeless before age 19 also reported drug use in the preceding year, compared to 33% of those with no early experiences of homelessness. However, when more sophisticated statistical techniques were used, age of first drug use no longer predicted recent homelessness. Such results are consistent with the idea

that drug use often comes after homelessness, rather than vice versa; and fit with participants' self-reports: only 8% mentioned substance use as a trigger for their homelessness. These results suggest that prevention of homelessness may also contribute to prevention of drug use; and homelessness interventions are an opportunity to prevent as well as treat problematic drug use.

Homelessness a risk factor for HCV infection

Craine, N et al. 2009. Incidence of hepatitis C in drug injectors: the role of homelessness, opiate substitution treatment, equipment sharing and community size. *Epidemiology and Infection*, vol. 137, no. 9, pp. 1255-65.

People who inject drugs (PWID) are at high risk of hepatitis C virus (HCV) infection. Chronic HCV infection is the leading reason for liver transplants in many countries and represents a significant health and economic burden. The rate at which people acquire a health condition is known as the 'incidence' rate. Unlike prevalence, which is the proportion of people who have ever caught HCV, incidence is the rate at which people are currently acquiring the virus. Incidence is the important indicator for evaluating current prevention efforts, and in epidemiological terminology, is expressed as a 'rate per 100 person years'. Following 10 people for 10 years accumulates '100 person years' of observation.

At baseline and 12 months later in this study, PWID across Wales were interviewed and provided a dried blood spot which was tested for exposure to HCV antibodies. The 17 participants who were HCV-negative at baseline but HCV-positive at follow-up are the 'incident cases'. Risk factors for acquiring HCV during that period were examined. Incidence was higher among participants who were homeless during follow-up compared to those who maintained stable housing (11.9 versus 2.7/100 person years). In other words, participants who had experienced any homelessness during the 12 months between baseline and follow-up were significantly more likely to acquire HCV during that period. Other risk and protective factors were also documented. Participants who were in opioid substitution therapy (OST) at follow-up were less likely to have acquired HCV, whereas people who had shared injecting equipment were more likely to have acquired HCV. Residence in more highly populated areas (e.g., Cardiff versus smaller towns) was also associated with a higher incidence of HCV.

These results indicate that PWID who are homeless are at higher risk of HCV infection than their stably housed counterparts. Other research suggests that this is likely to be because homeless PWID are, unsurprisingly, more likely to inject in public spaces; and that public injecting is associated with frequent and hasty injecting and sharing of injecting equipment. Homelessness among PWID leads to their spending more time in environments where risk behaviour is elevated and, HCV acquisition is more likely. Consequently, stable and affordable housing should decrease injecting risk behaviours among PWID, which may in turn reduce the risks of HCV transmission.

Smoking cessation:

Is NRT the answer?

Angela Rossmannith

The health benefits of quitting smoking are well established. A substantial body of research shows that some benefits are immediate and others are seen in the long term, and includes evidence that the risks of cardiovascular disease, cancers of the mouth, throat, oesophagus and lungs, and age-related macular degeneration are all reduced after smoking cessation (Bakhru & Erlinger 2005; Peto et al. 2000; Doll et al. 2004; Vingerling et al. 1996). What's more, life expectancy increases even when quitting occurs at a later age (Taylor et al. 2002).

There is an ongoing debate in the health sector about how best to manage tobacco dependence and withdrawal. Indeed there is much debate about the nature of addiction itself – whether it should be viewed as a biomedical or a behavioural disorder – and the differing approaches to treating tobacco dependence is a good case illustration of this larger addiction question.

This article will focus on the debate regarding the methods of smoking cessation, centring on the use of medication. While the use of medication as a first-line approach is championed by some in the field, others argue that medical approaches to the quitting of smoking are either over-emphasised, or completely unwarranted.

Types of medication

The best known and most widely used medication for smoking cessation is nicotine replacement therapy (NRT). Its purpose is to slowly deliver nicotine – the drug in tobacco that can cause dependence – in order to lessen the effects of withdrawal symptoms while a person moves through the process of reducing or stopping smoking.

The first available NRT was nicotine gum, which was offered on prescription in Australia in 1984. The nicotine patch became available in 1993, and the nicotine inhaler,

lozenges and sublingual tablets followed. The products were sold over-the-counter in pharmacies until 2005, when they began to appear in supermarkets.

Bupropion is a non-nicotine medication sold under various brand names such as Clorprax and Zyban. Originally used as an antidepressant, it was found to reduce smoking cravings. Bupropion was introduced into Australia in 2000 and became available on the Pharmaceutical Benefits Scheme (PBS) in 2001. It requires a prescription from a GP and users must participate in a counselling program for it to be subsidised under the PBS.

Varenicline (known as Champix) reduces cravings for tobacco products and also decreases the brief pleasurable effect associated with smoking. It was introduced to Australia in early 2008 as a prescription medication. Like bupropion, it is available on the PBS to smokers undertaking a counselling program.

PROPORTION OF PEOPLE WHO SUCCESSFULLY QUIT WHO BELIEVE THAT QUITTING AIDS CONTRIBUTED TO THEIR ATTEMPT.

Anti-smoking television commercials	46%
NRT or other medications	21%
Advice from health professionals	21%
Self-help materials	13%
Telephone Quitline	7%
Internet sites	5%
No aid contributed	33%

NB: This table shows the extent of the use of aids, not the effectiveness of smoking cessation. Respondents could nominate more than one aid. Source: Brennan et al. 2007. CBRC Victorian Household Survey.

Questioning the use of medication

'The medicalisation of smoking cessation commenced in earnest when NRT first came on the market,' says Simon Chapman, Professor and Director of Research at the School of Public Health, University of Sydney. 'Since then we've had various forms of NRT and more recently other drugs which have been prescribed to large numbers of people by their doctors.'

'Yet in the 20 or so years between the early 1960s when evidence first emerged that smoking was harmful, and the early 1980s when drugs became available, there were millions of people around the world who quit smoking without any assistance at all. We should never forget that.'

Clearly, you don't need drugs to quit smoking, Chapman says. 'The great majority of people who are ex-smokers quit smoking without any assistance, and that includes heavy smokers. Yet unassisted cessation is given barely any attention. It is drowned out by the megaphoning of the message that if you want to quit smoking the most sensible way to do it is to take drugs.'

Everything to help

Smoking is a life-threatening behaviour and so it's incredibly important to help people stop smoking, says Renee Bittoun, Adjunct Associate Professor and Director, Smokers' Clinics, School of Medicine at the University of Sydney. 'Whatever it takes, that's what you have to do.'

And for many today, what it takes is medication, she says. 'Smokers who quit spontaneously are usually not heavily dependent. For those who are heavily dependent on nicotine it is valuable to give them medical treatment. There is strong evidence from placebo-controlled trials over many decades that you can at least double your efficacy if you treat them medically.'

Increasingly she is seeing smokers who simply cannot stop smoking, Bittoun says. 'We see people with co-morbidities such as mental illness who can't even stop over a period of time. We use a harm reduction agenda for them. That means reducing the harm by smoking less and using pharmacotherapy at the same time. For example, it's safer to wear a patch and smoke at the same time than smoking without wearing a patch.' Smoking less, helped by the slow release of nicotine from the patch, means less exposure to tobacco smoke which contains the many chemicals that are harmful to health.

Best practice

While chemical dependence is a factor in 90% of smokers, they don't all need to be introduced to another drug to quit, says Professor Matthew Peters, Professor of Respiratory Medicine at the School of Advanced Medicine, Macquarie University, and Chair of Action on Smoking and Health (ASH).

'It's not inconsistent to say that some people with a true chemical dependence

can quit without drug treatment,' he says. 'Someone who has never seriously tried to quit should be encouraged to quit and should make their first serious attempt without drugs. That's not a universally held view, but I think you don't know if it's going to be difficult or easy for you to quit smoking until you've had a go. Telling people there's no way they can successfully quit without using a drug is creating a barrier we don't want to create.'

In cases where a person is determined to quit smoking but fails, particularly if they experience strong cravings, then a

NEW NRT STUDY SPARKS FRESH DEBATE

According to a five-year study of American smokers and non-smokers, nicotine replacement therapies (NRT) were no more effective in their attempts to give up smoking than going 'cold turkey'. About one-fifth of those who had recently quit had used nicotine patches, gum, inhalers or nasal sprays to support their attempt. But the products made no positive difference to the chance that they would stay away from tobacco, while heavily addicted smokers who used them without also getting professional counselling were most likely to relapse.

The study, released by the Harvard School of Public Health and the University of Massachusetts in January, and which polled ordinary people about their nicotine replacement therapy use, contrasted with the results of clinical trials in which the chance of successful quitting was doubled or trebled in people prescribed the drug compared to those given a placebo.

On release of the report, some media sources were quick to question the basis for the Australian government's subsidy of NRTs. The federal government spent more than \$9 million on nicotine replacement patches in 2011 – after a Pharmaceutical Benefits Scheme subsidy was approved from last February. Smokers receive a maximum 12 weeks' supply and must commit to counselling.

However, a number of Australian health experts have questioned the study. Simon Chapman said clinical trial participants might have been influenced by receiving free medications and care during the study. Renee Bittoun said many long-term smokers metabolised nicotine unusually quickly, meaning the dose in a regular patch was too low, which could also affect results.

The CEO of the Cancer Council NSW, Andrew Penman, said the US study showed 'over-reliance on a treatment-based strategy is unwise,' and taxation and legal changes combined with social marketing campaigns were crucial to provide an environment amenable to quitting.

Either way, the release of this new report highlights the continuing debate on the effectiveness of NRTs in smoking cessation.

Reference
Alpert, HR, Connolly, GN & Biener, L 2012. A prospective cohort study challenging the effectiveness of population-based medical intervention for smoking cessation, *Tobacco Control*, published online on 10 January as 10.1136/tobaccocontrol-2011-050129.

combination of appropriate counselling and a suitable drug treatment is best practice, Peters says.

Levels of addiction

The extent of dependence on tobacco can be determined by a range of diagnostic tools, including measuring the frequency and quantity of tobacco that's consumed. Psychological and physiological dependence can be estimated through questionnaires for smokers, the best known being the Fagerstrom Test for Nicotine Dependence. Answers to a set of questions are marked, with a score of six and above pointing to high dependence.

According to the NSW Government's *Nicotine Dependence and Withdrawal Factsheet*, the higher the score, the more likely a person will benefit from using NRT or other medication to help with withdrawal symptoms and to quit. A score higher than five would indicate the need for a higher dose of NRT, while a score of four or less would indicate the need for a lower dose.

Smoking within 30 minutes of waking, smoking more than 15 cigarettes a day, and a history of withdrawal symptoms in previous quit attempts are indications of nicotine dependence, according to the Royal Australian College of General Practitioners.

BRIEF INTERVENTIONS

According to the Royal Australian College of General Practitioners, health professionals should identify smokers, assess their smoking status, and offer them advice to stop smoking at every opportunity.

Brief interventions for smoking cessation should include at least one of the following:

- Simple advice to stop smoking
- An assessment of the smoker's commitment to stop
- An offer of pharmacotherapy and counselling where appropriate
- Self-help material and referral to more intensive support such as Quitline



Source: Zwar, N, Richmond, R, Borland, R, Peters, M, Stillman, S, Litt, J, Bell, J & Caldwell, B 2007. *Smoking cessation pharmacotherapy: an update for health professionals*, The Royal Australian College of General Practitioners, Melbourne.

'There are smokers and smokers, just as there are drinkers and alcoholics,' says Bittoun. 'Not everyone who smokes is addicted to it, just as not everyone who drinks is alcoholic. At the Smokers' Clinics we intensively treat heavily dependent smokers with medication because we know that the medications work and that they save lives. We give people lots of pharmacotherapy and lots of behavioural interventions. We do everything we can to help people stop.'

In a study based on a survey of smokers and ex-smokers, it was found that a significant number of attempts to quit were unplanned. What was surprising was that these spontaneous attempts at quitting were more likely to succeed than pre-planned attempts, which are usually advised to improve chances of success (Ferguson et al. 2009). One of the reasons for the success, the researchers concluded, was that the unplanned quitting was more common among less-dependent smokers, who may find the prospect less daunting and therefore in need of less forward planning.

Not everyone agrees that it is mainly light, non-addicted smokers who have already quit, leaving those still smoking as 'hard' smokers and needing medication to stop smoking. Contrary to that 'hardening hypothesis' is data on smoking in 50 US states for 2006-2007. In those states where smoking was less common, people who continued to smoke showed significantly fewer of the markers for 'hard smokers' (Chapman & MacKenzie 2010).

Effectiveness

Surveys on smoking status undertaken every year in Victoria since 1984 offer valuable information about trends in attempts to quit smoking. For example, the percentage of regular smokers who ever made a quit attempt was 81% in 2005, and the percentage of regular smokers who made multiple attempts to quit increased from 38% in 1998 to 43% in 2005.

Between 2000 and 2005, 30% of the Victorian smokers who tried quitting were successful, while the other 70% relapsed.

A review of 132 trials of NRT, involving 40 000 people, found evidence that all forms of NRT made it more likely that a person's attempt to quit smoking would succeed (Stead et al. 2008). In most of the studies, people smoked more than 15 cigarettes a day, and the review found that NRT increased chances of quitting by 50-70%.

Professor Chapman advises caution in accepting these results. 'These results come from clinical trials where under experimental conditions some people are given the active drug and others are given a placebo. And yes, those trials do sometimes show a greater effect than with the placebo. But clinical trials are not the same as real-world use of drugs, where the results are diminished. My advice would be that in real-world conditions using drugs may be a little better than not using drugs, but it's really not all that much different. You don't have to use drugs if you don't want to.'

Approaches to quitting

A person has got to really want to stop smoking to consider quitting, says Chapman. 'It can't be just a whim. You've got to work on it and take the decision seriously. People are not only

IN REAL WORLD CONDITIONS, USING [NRT] DRUGS MAY BE A LITTLE BETTER THAN NOT USING DRUGS, BUT IT'S REALLY NOT ALL THAT MUCH DIFFERENT. YOU DON'T HAVE TO USE DRUGS IF YOU DON'T WANT TO.



chemically addicted but also psychologically addicted, and so it's no surprise that many people relapse. That's normal, but the main message is if you really do want to, you can.'

Proof of this lies in the high success rate of quitting among people who are told by their doctor they need to stop smoking because of a health condition or disease, he says. Smokers are often told about how difficult it is to stop, yet, in a British study of ex-smokers carried out before the advent of medication, 53% said it was 'not at all difficult' to stop, 27% said it was 'fairly difficult', and only 20% reported it as 'very difficult' (Marsh & Matheson 1983).

A supportive counselling strategy is an essential part of quitting, says Peters, and he cites programs provided by Quitline as an example. 'In general, the success rate increases with the intensity of the counselling. Smoking is not just a chemical dependency but it's also about context: the rituals, the sensory stimulation, the lights and the smell. The counselling helps a person organise their life during the phase when they're trying to quit so as to maximise their chances.' He gives the example of a woman who told him her habit was to get up, go to the bathroom, have a coffee and then go out onto the verandah to have a cigarette. 'My advice was to get up, do what she needs to do, and go for a walk; that would break the context of her first morning cigarette and increase her chances of successfully quitting.'

Duty of care

Smoking is more common in people who seek treatment for alcohol or other drug problems than in the general population (Degenhardt & Hall 2003; Frosch et al. 2000). In one study in Newcastle, NSW, 92% of inpatients with drug-related problems were smokers.

It is a matter of duty of care for AOD workers to address their clients' smoking, says Bittoun. 'It would be negligent of them not to, because smoking is the most likely cause of death, rather than alcohol or heroin use. It can't be the last drug of treatment because smoking can affect other drugs and medications their patients take. If a professional doesn't know that, then they have not kept up to date with the literature.'

'For example, what many professionals and others don't know is that there is an interaction between smoking and drinking coffee,' she says. 'Caffeine comes in many forms, and many drug and alcohol clientele drink caffeinated drinks such as the energy drinks. When people attempt to quit or reduce smoking, their blood caffeine levels rise, making them very agitated and unable to sleep. They mistakenly attribute this agitation to the quitting of smoking or the nicotine patches rather than the elevated caffeine levels in the blood.'

Tobacco smoke can also affect liver enzyme activity, Bittoun says, and so smokers need more pain relief, more insulin, more anti-psychotic drugs, more methadone. They also need more alcohol for the same effect. 'We're now saying that if you stop or reduce smoking even while using NRT, it will reduce the alcohol you consume.'

* To obtain a list of references used in this article, please email: editor@ancd.org.au.

USEFUL WEBSITES

QUIT NOW

This is an Australian Government site set up as part of its National Tobacco Campaign. It promotes Quitline, a telephone information and counselling service available in every state and territory for those interested in quitting smoking.

Quitline: 13 78 48 – 13 QUIT
www.quitnow.gov.au

SMOKENDERS

A commercial quit smoking service, founded in the US in 1969 and established in Australia in 1981, that utilises counselling and motivational techniques without NRT.
www.smokenders.com.au

ACTION ON SMOKING AND HEALTH (ASH)

A health lobby group that aims to cut smoking rates, extend smokefree areas and end tobacco promotion.
www.ashaust.org.au

Back again?

Drugs, emergency care and the frequent presenter

Euan Donley*

PEOPLE WITH ALCOHOL AND OTHER DRUG (AOD) RELATED PROBLEMS ARE COMMON, AND SOMETIMES FREQUENT, PRESENTERS TO PRIMARY HEALTH CARE SERVICES LIKE HOSPITAL EMERGENCY DEPARTMENTS (EDs) AND GENERAL PRACTICES. THIS ARTICLE WILL LOOK SPECIFICALLY AT EDs, AND THE EXPERIENCE OF THE AUTHOR, EUAN DONLEY, IN FINDING PATIENT PATHWAYS SUITABLE FOR INDIVIDUALS WHO FREQUENTLY PRESENT AFFECTED BY SUBSTANCES.

Patients who have a drug or alcohol problem are responsible for a disproportionate number of visits to emergency departments (EDs), and are likely to have complex psychosocial issues including heavy alcohol use and psychiatric illness. Collecting data on these presentations to EDs can be problematic as the substance misuse may not be the final diagnosis. For example, a person who has fallen and injured themselves while intoxicated may be given the diagnosis of a broken wrist. Thus, in many EDs, under-estimations of their substance – in particular, alcohol – presentations are likely. Of concern for EDs, Lesjak et al. (2008) noted in a study that five per cent of their presentations revealed people had consumed alcohol prior to the event that brought them to the ED. The same study showed that 15 per cent of police attendance to incidents was alcohol-related. Indig et al. (2010) also estimated five per cent of the presentations to their ED were alcohol-related.

Free choice or removing liberties?

The right for people to decide on their own treatment is well established in the AOD field, and free choice can lead to better outcomes (Magill et al. 2010). This is an important philosophy in addictions recovery, and should not be undervalued. However, there is a section of the population which has a long history of poor engagement in treatment.

In Victoria, legislation has been introduced to address this group; the *Severe Substance Dependence Treatment Act 2010* came into effect in March 2011 and allows for involuntary detention and treatment of people with severe substance dependency. Given this, it is worth considering the clinical advantages there may or may not be in removing certain liberties from the severely AOD dependent that have evident and predictable risk, and how this model might benefit consumers.

The case study of Sean** (see box below) highlights the complexities of finding the best treatment paths, and/or removing a client's right to self-determination.

THE COMPLEX CASE OF SEAN

Sean, a male in his mid-20s, first presented to an outer Melbourne ED late in 2005, intoxicated and homeless. Sean again presented to the ED in early 2006 with a blood alcohol level of 0.47%. This was the first of his 21 presentations for that year and this number does not include presentations to other EDs. It was common for him to consume a slab (24 x 375ml cans) of full-strength beer per day, or sometimes beer with a litre of vodka. Each time he would arrive by ambulance, intoxicated and often homeless. At all times he was seen and cleared by the medical team (with no acute illness requiring hospitalisation). Numerous times the social worker referred him to community AOD services but Sean would not follow up. The social worker also exhausted all local crisis housing options over many presentations.

On other occasions, Sean presented to the ED intoxicated and suicidal. On each of these occasions, when Sean had sobered he claimed he was not suicidal, did not

want admission, and usually agreed to enter inpatient detoxification. But Sean would either self-discharge or abscond from detoxification once transferred. Multiple referrals were made to community and brain injury case management, neuropsychological services, and complex care. Eventually a case manager at the Hospital Admissions Risk Program (HARP) – a medium-term case management service available in Victoria – accepted Sean, but he never engaged. There was no known regular GP but a corrections worker was eventually found, who stated he had also made multiple referrals to AOD and crisis housing services, but Sean would not engage with those services either.

Sean began presenting following intentional overdoses on panadol and valium while intoxicated, and lying near train tracks. Numerous psychiatric triage assessments found each time that the overdose was not planned. He was remorseful and requested inpatient detoxification. He did not present as depressed, suicidal or psychotic, and declined psychiatric admission. Sean was not considered appropriate to receive involuntary treatment under the *Mental Health Act 1986* as essentially he had a substance problem and not an acute psychiatric illness.

Eventually Sean stayed in the hospital just long enough for a preliminary review by a neuropsychologist, who noted that Sean had low intellectual functioning but was not intellectually disabled. This was likely to be due to excessive alcohol misuse, and current acute withdrawal.

Sean did not fit involuntary status under the current mental health act and was deemed not to have a mood disorder or psychiatric illness. His risk of significant self-harm or death through misadventure appeared likely. A decision was made at a case conference with the ED, the HARP and AOD services that a joint Victorian Civil and Administrative Tribunal (VCAT – a civil tribunal) application would be made requesting a guardian and administrator with the Office of the Public Advocate (OPA). For VCAT to refer to the OPA, the ED needed to demonstrate that Sean had a disability, that this disability impacted his ability to make a decision, less restrictive means had been exhausted, and a decision needed to be made.

An independent guardian and administrator at the OPA were then appointed, primarily to manage Sean's finances but to also assist him in finding stable housing, and were still involved in 2008 when this service disengaged. Sean had made no application to have the order revoked, and VCAT had continued to uphold them.

Outcomes for Sean

Sean stayed at his new residence thanks to understanding staff. ED presentations ceased and he obtained a GP. There was also no apparent escalation in antisocial behaviour or deliberate self-harm. He joined a sporting team, and with his administrator saved money to have an interstate holiday. Sean also began volunteer cleaning work. His case manager noted a great improvement in his quality of life and was able to discharge him from their service in 2007.

Patient pathways

Hospital EDs often face the ethical dilemma of legal duty of care versus the right to self-determination and human rights. This case study highlights that in some cases, the removal of certain personal and social liberties can result in a medium-term positive outcome.

A hospital or acute bed does not magically equal engagement by a patient. Acute hospital beds are also generally short term and in this case did not show any change in long-term and established patterns of behaviour. Although organised by an ED, this was ultimately a community-based intervention, and management may fit better using a rehabilitation-type or community-based model. However, this single case study alone is not sufficient to discount any benefits to medium or longer-term detainment for treatment, especially when risk-taking behaviour is very high.

The potential for a rise in anti social behaviour is real, and proper consideration should be given to violence prediction risk models (Conroy & Murrie 2007; Maden 2007). A person's mental health status should also be cautiously considered. Continued suicidal intent, significant depressive features, personality disorders or other psychiatric phenomena could increase the likelihood of an adverse outcome (McNeil & Binder 2005) or escalating risk-taking behaviours. Family supports should also be considered.

EDs appear to have a window in which people who use substances may present with symptoms that can identify them as substance dependent – and therefore needing specialised care – and by taking the time to understand these symptoms can make a difference. However this window appears to close very quickly with the frequent presenter, and they relapse.

It is beneficial for EDs to continue to collate data on frequent presenters and use a team of medical, nursing and allied health professionals from within the hospital or community, to provide comprehensive assessment and treatment plans. Phillips et al. (2006) found ED case management teams did have a positive effect on psychosocial factors, but ED frequent presentations actually increased – perhaps due to the rapport frequent presenters can develop with EDs. Still, as they note, EDs are well placed to deliver care to complex patients.

However, EDs are not case management services and accurate and comprehensive assessment is still required. Assessments should involve collaborating systems; a community-based team (such as HARP) that responds to EDs, and can provide comprehensive assessment and management of the frequent presenter with substance dependency.

The importance of self-motivation and determination should not be underestimated, and any move to remove liberties should be considered with extreme caution. Dealing with the human condition is complex and no 'one-for-all' approach is suggested.

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** Identifying details and dates have been changed.

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Changing with the times

Jenny Tinworth



'THE TC PROCESS IS ONE OF SOCIAL LEARNING AND SOCIAL DEVELOPMENT. A BASIC TENET OF THE TC IS THAT SUBSTANCE USE IS A COMPLEX CONDITION COMBINING SOCIAL, PSYCHOLOGICAL, BEHAVIOURAL AND PHYSIOLOGICAL DIMENSIONS. IT IS A SYMPTOM OF UNDERLYING SOCIAL, PSYCHOLOGICAL AND/OR BEHAVIOURAL ISSUES WHICH NEED TO BE ADDRESSED IF RECOVERY IS TO OCCUR.'

(GOWING ET AL. 2002)

'Community as method'. Begin any discussion about therapeutic communities (TCs), and this single phrase will pepper the conversation. It is the catchery which sets apart the therapeutic community from all other modalities on the alcohol and other drug treatment spectrum.

While residential TCs across Australia may differ in their client mix, resident numbers and program length, all share common themes:

- **Staged approaches**, beginning when a newcomer transitions into the TC. Over time, residents progress through three stages, gradually taking on increasing responsibility within the community as their recovery and personal growth progresses. These stages are generally known as Induction & early treatment, Primary treatment, and Re-entry.
- **Medium to long-term residential stay**. TC programs usually last between three months and two years, with the majority somewhere between three and nine months, followed by aftercare programs.
- **Group meetings**, where residents challenge each other about interactions and behaviours, encouraging personal growth. Through the use of consequences and rewards, recognition is given to both positive and negative behaviours. Group meetings also use therapeutic

strategies to explore issues such as negative patterns of thinking and community-based learning.

- **Access to self-help programs**. Residents are encouraged to become involved with self-help organisations, such as Alcoholics Anonymous, Narcotics Anonymous and SMART Recovery.
- **Work therapy and pre-employment skills training**. Residents perform all of the chores in the TC, including cooking, gardening, cleaning and work programming.
- **Drug-free**. The use of alcohol and any illicit drugs is prohibited where a drug-free life is the treatment goal. In nearly all Australian TCs, opioid replacement pharmacotherapies such as methadone and buprenorphine are not catered for.

TCs differ from other residential rehabilitation programs in their focus on the role of the community in achieving recovery (NSW Health, 2007).

TCs in Australia and New Zealand

In Australia, TCs date back to the 1970s, with early centres including Odyssey House and We Help Ourselves (WHOS). These organisations are still major providers of TC treatment services. Most early staff came from the

ranks of people in recovery. However, TCs now employ many staff with a non-recovery background but who have professional health or welfare qualifications.

While the exact number of Australian TCs is unknown, the peak representative agency, the Australasian Therapeutic Community Association (ATCA) has 38 members who run 66 TCs across Australia and New Zealand. Twelve of those TCs are based in prisons.

In the 2010/11 financial year, ATCA members recorded 9000 separate admissions, including 1700 in prison settings. Among the five members that provide residential family programs, 240 children accompanied their parent into treatment. The TCs also provide non-residential services such as family support, with an additional 23 000 people accessing these programs.

'Modifying' the experience

In the past, a hallmark of the TC model has been its strict adherence to a rule-based hierarchical structure. Residents who managed to adapt to the early weeks of a strict routine vastly different from their former drug-using lifestyle, might stay for up to two years. In the early days of TCs in Australia, dropout rates were as high as 70 per cent.

However, in the past 15 years, there has been a trend towards the modification or 'enhancement' of TCs, to better meet client needs. This enhancement has been expressed in different ways in different settings. Typical enhancements include:

- **Shorter stays**. Most TCs have reduced their program length significantly, with 90 days a common time frame. Aftercare may be offered after the TC stay, with residents living in group houses, halfway houses or elsewhere in the wider community.
- **Non-residential day treatment TCs**. Slightly less intensive, residents do not live onsite, but attend the TC each day. This is often a good option for residents who are in the re-entry phase of their TC experience.
- **Family accommodation**. TCs have traditionally been an individual experience. However, some are able to treat couples or provide accommodation for parents and their children.
- **Prescribed medications**. Many TCs now accept residents taking a range of medications, including drugs for mental health problems.
- **Harm minimisation philosophy**. While adhering to rules around no illicit drug use, some TCs provide harm-minimisation education (e.g. relapse, overdose information) and equipment (needles and syringes, condoms).
- **Opioid-replacement therapies**. Some TCs now cater for residents using pharmacotherapies such as methadone and suboxone. Their focus may be on helping residents to become abstinent from this medication, or in the case of one Australian TC, to help residents to stabilise on their pharmacotherapy while addressing the lifestyle and personal issues which make them vulnerable to using illicit drugs (see box, page 19).

DO TCs WORK?

In the early days of therapeutic communities (TCs), up to 70 per cent of clients left before completing treatment. Even today, retention rates stand at 50 per cent (Magor-Blatch 2011). A significant number of people who do leave TC treatment early return at a later date for another attempt.



Lynne Magor-Blatch

Thus it must be asked: Is the TC model effective? With such high numbers of residents leaving treatment, does it actually work? Is it cost-effective or should the treatment dollar be directed elsewhere?

While the TC model has too many variables to suit a randomised controlled trial which is the gold-standard of research, TCs have been studied and evaluated in other ways for over 40 years. At last year's Australian Therapeutic Communities Association (ATCA) conference in Western Australia, ATCA Executive Officer Lynne Magor-Blatch summed up the evidence for the model.

'There is ample evidence of long-term benefit, even for those who do not complete treatment, but who undertake a period of rehabilitation, even if they do not graduate,' she said. 'Many studies by a variety of researchers have shown the one factor repeatedly associated with better treatment outcomes is the length of stay in a treatment program – at least three months is ideal. Or in the case of shorter programs, the stay needs to be at least 28 days.'

Specific to the TC model, Magor-Blatch cites a number of major studies including the Australian Treatment Outcomes Study (2002) and the US Drug Abuse Treatment Outcome Study (1991–1993) showing a reduction in drug use and criminal offences, along with an increase in employment for past residents. A study by Hubbard and colleagues in 1997 showed major reductions in cocaine and heroin use (66 per cent), and a 50 per cent reduction in weekly or frequent use of alcohol and cannabis.

On a cost-effectiveness measure, Magor-Blatch says a number of studies in the past decade have shown significant savings from treatment, including that received in a TC.

In 2010, Pitts and Yates found that for a cohort of 345 people who used illicit drugs on a daily basis for a year, the costs of drug use, law enforcement, health care and welfare benefits would be \$62 767 332 (see Table 1).

In 2006, Darke et al. estimated that the cost of drug treatment was \$98 per person per day. Using these figures, the cost of 12 months' treatment for the 345 people in the Pitts and Yates study would be \$12 340 650, saving a total of \$50 426 682, or \$400 per person per day.

Cost Centre	Overall cost per annum
Drug purchasing (crime costs)	\$46 742 608
Enforcement and court costs	\$10 302 500
Healthcare costs	\$1 211 952
Welfare benefits	\$4 510 272
Total	\$62 767 332

Table 1. Cost of drug use, law enforcement, healthcare and welfare benefits. Source: Pitts Et Yates 2010 (cited in Magor-Blatch 2011).

Why the change?

Garth Popple, from WHOS, and ATCA executive officer Lynne Magor-Blatch have both spent many years working within TCs. They agree two key changes have driven the move to modify TC treatment: a change in the mix of people seeking assistance and the advent of HIV/AIDS and the resulting harm minimisation philosophy.

Opening the doors to women

In the early years, the TC environment was a very male-oriented place. However, in the past two decades, the number of women seeking treatment has increased. Many women have children, either in their care, or who have been removed for their safety by government agencies. 'The arrival of women, particularly mothers, meant the way programs operated had to change,' Magor-Blatch says. 'Programs needed to be shorter, arrangements had to be made for access visits with children and programs began that took clients accompanied by children.'

Harm minimisation

The arrival of HIV/AIDS and its threat to people who used illicit drugs had an even greater impact than the changing client mix.

Garth Popple became the general manager of WHOS in 1986, when the organisation's TC ran along very traditional TC models. 'From about that time, we began to see the impact of HIV/AIDS in other countries and to also have our first HIV-positive clients,' he says. 'That began a transition – we started to implement harm minimisation measures like HIV education programs, introduced needles, syringes and condoms to our bathrooms and educated people about practices that make drug use less risky.'

'We needed to acknowledge then that around 70 per cent of people eventually relapsed after leaving treatment. So we had to ask "should the health dollar just be for people who are lucky enough to get the message and stay abstinent? Or should we be looking out for all people who use drugs and come into contact with our service?"'

This shift in philosophy also led to perhaps the greatest modification of the TC programs – the introduction in some TCs of clients who were using opioid replacement therapies such as methadone and later, its alternative, buprenorphine (see box, page 19). 'In the '90s, there were about 30 000 Australians on methadone, and about half of them lived in NSW,' Popple says. 'We were constantly hearing that there was "no exit strategy" for people coming off methadone, so we thought we'd get involved.'

The impact of change

Lynne Magor-Blatch reflects that changes to the way TCs operate are often greeted with anxiety, particularly among staff. 'Sometimes it's harder for staff who have trained in a particular way to come to terms with these kinds of changes, whereas the residents themselves cope with the changes very well.' Often, once implemented, the negative consequences staff feared do not eventuate.

She nominates WHOS' Sydney campus as a prime example of how enhanced/modified TCs have become part of the



mix in treatment options. In Australia's only such co-location, the campus has four TCs in adjacent buildings: a drug-free men's program, a drug-free women's program, a methadone-to-abstinence mixed gender program and an opioid-stabilisation mixed gender program. While each TC runs its own autonomous therapeutic program, residents of all four TCs constantly interact and job share in the communal dining room and during campus activities.

However, enhancements to TC programs do have other implications for the workforce. As medications and pharmacotherapy treatments are added to the traditionally drug-free TC program, increased staffing and skill levels are required. Manager of the WHOS RTOD opioid-stabilisation program, Carolyn Stublely says, 'In comparison to a non-medicated TC, we need a higher level of staffing. The type of staff we're looking for may also change – we need people with stronger experience in working with complex clients, we need more case management skills, and like any TC, we need people who have good skills in group work. Our TC tends to attract clients who may have complex mental health issues, so we find that there is more staff interaction with each individual.'

The future of TCs

Lynne Magor-Blatch believes the enhancement and modification of the TC program will continue in years to come. As head of the Australasian Therapeutic Communities Association, she has seen an increase in inquiries from treatment services about how they can become a TC.

'Part of this is because drug and alcohol treatment agencies now need to go through an accreditation process. However, the usual hospital-based health standards don't really fit for residential rehabs and TCs. So we have developed our own TC standards and some states and territories have already adopted those. Thus service providers are coming to us and wanting to become members because our standards fit the way they want to work.'

She predicts there will be growth in the number of TCs which adopt a pharmacotherapy-to-abstinence or pharmacotherapy stabilisation model. 'We're in an environ-

THE BEST OF BOTH WORLDS? TC 'COMPLETERS' ON METHADONE

The first of its kind in Australia, the Residential Treatment for Opioid Dependence Stabilisation Program (RTOD) began at WHOS' Sydney campus in 2009. The 10-bed TC offers a therapeutic community experience to people who have been prescribed opioid replacement therapy and also want to address mental, physical and psychosocial issues in a residential treatment setting.

The RTOD is a radical departure from the traditional TC model in that not only are residents receiving pharmacotherapy treatment but they are not expected to reduce to abstinence from opioid-based drugs. While they are there, staff will help them find their optimal dose of methadone or buprenorphine, while addressing the lifestyle and personal issues that make them prone to using illicit drugs.

Manager Carolyn Stublely says that clients who attend the RTOD TC tend to have more complex issues than residents in more traditional TCs. 'These are often people who have mental health problems, including schizophrenia, bipolar and post-traumatic stress disorders,' she says. 'They are generally coming from very dysfunctional lifestyles and have poor social functioning.'

A study by the National Drug and Alcohol Research Centre looked at the first 18 months of operation, assessing the demographics and outcomes of the first 75 people who were treated at the RTOD (Campbell et al. 2010). It highlighted the poor social functioning of clients at intake, but noted relatively high rates of treatment completion and a successful stabilisation of clients on their pharmacotherapy and mental health medications. It showed there was little difference between men and women in terms of treatment outcomes.

The WHOS RTOD TC has a harm minimisation approach, and given that abstinence isn't the focus of the TC, clients do not access 12-step programs such as Alcoholics Anonymous and Narcotics Anonymous, which are traditional support networks

for TC residents. Instead, RTOD residents are encouraged to become involved with SMART Recovery, a self-help program which uses cognitive-behavioural therapies to look at addictive behaviours. SMART Recovery has a harm minimisation approach which celebrates any positive change around drug use, rather than focusing solely on abstinence.

In its day-to-day operation, the RTOD runs along the same lines as more traditional TCs. Community interaction remains the heart of the TC, with group meetings forming the core of treatment. While residents maintain their relationship with their pharmacotherapy prescriber, they have access to onsite medical support around dosing levels and are dosed within the program. In the aftercare phase of their residency, they are moved into dosing at a community pharmacy, rather than in a larger methadone clinic setting.

Stublely says that the complexity of clients requires an increase in the TC's case management strategy. 'This is a client group which has major issues with legal problems, homelessness, and a lack of education and employment skills. In the aftercare phase of their stay, one of our greatest challenges is helping them to become established in the wider community.'

While the RTOD is not designed to help clients achieve abstinence from pharmacotherapy treatment, a number of residents have used the RTOD as a stepping stone to coming off methadone or buprenorphine. They completed treatment in the stabilisation program, and at a later date, sought admission to WHOS' methadone-to-abstinence residential TC, MTAR.

The RTOD's stabilisation program is certainly in demand. The waiting list for male clients is three months and only slightly shorter for women. The model has also attracted a high level of interest from other TC providers.

For more information about the WHOS RTOD program, visit www.whos.com.au.

ment where while methadone and other pharmacotherapies have an important role in drug treatment, it is being recognised that there isn't much of a way out of them. So TCs do have a role in providing that way out, and also for people who still need those medications and need to develop stability within their lifestyle.'

She lists women who have been placed on methadone during a pregnancy as one group which particularly needs these options. 'There are very few places for women with young children, who may have been on methadone for the early years of their child's life and now want to come off or stabilise their dose. Some TCs can take them, but they already have to be on a very low dose. Many of these women are required by welfare agencies to maintain stability in not using illicit drugs and in staying on their medication. So they don't want to jeopardise their child custody arrangements by changing treatment in a radical way without good support.'

She believes more enhanced TCs are also needed to support the justice system, as many judges are unable to order individuals into residential treatment because they are using methadone which is not acceptable in most TCs.

And finally, Magor-Blatch expects TCs will continue to contend with mental health comorbidity and complexity in the clients who seek TC treatment. 'We have always worked with complex clients, however, this may well increase.'

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Mardi Gras medical: Party hard, party safe

Gideon Warhaft

NOWHERE IN THE WORLD IS THERE ANYTHING QUITE LIKE SYDNEY'S GAY AND LESBIAN MARDI GRAS MEDICAL TEAM. BORN DURING THE HEADY DAYS OF THE LATE 1980s WHEN AUSTRALIA RESPONDED TO THE HIV EPIDEMIC WITH A PLETHORA OF HARM REDUCTION PROGRAMS, THE MARDI GRAS MEDICAL TEAM – AND ITS FAMOUS TENT – HAS BEEN CARING FOR PARTYGOERS AT MARDI GRAS EVENTS EVER SINCE.

Jem Masters, the team's coordinator since 2001, arrived in Sydney in 1987 for what he thought would be a year's working visit. A nurse working in accident and emergency in London with a particular interest in pediatric nursing, Masters came to Australia fleeing the disruption of the National Health Service during the Thatcher government era, as well as London's exorbitant living costs. Although his primary interest was in child and adolescent psychiatry, he found he needed a certificate in adult psychiatry to get suitable employment in Australia. He soon developed a love for looking after people with psychological illnesses and drug and alcohol issues. He also fell in love with Sydney, his home now for 25 years.

Responding to HIV

When Masters arrived in Sydney, the gay party scene was in full swing, but so were HIV and AIDS. 'You'd read the gay magazines each week and there'd be five, six pages of obituaries of the boys who were dying having contracted HIV,' Masters laments. 'So the gay community was being decimated. If you look at the community now, there's a whole generation of gay men who are no longer with us.'

Responding to this tragedy, a handful of medical professionals from the gay and lesbian community put together a medical team specifically to support their friends and lovers who were dying, who knew they would be coming to their last ever dance party. They procured

equipment that was 'begged, borrowed and misplaced', some of which, like the old beds from a psychiatric hospital, are still used in the medical tent today.

In 1997, after 10 years of attending dance parties, Masters joined the medical team's committee. 'I'd enjoyed the dance parties, but I felt I'd run out of steam and I wanted to do something to give back to my community. So I volunteered.' By 2001, Masters was the team's coordinator, a position he's held ever since.

Driven by volunteers

The Mardi Gras Medical Team today is highly organised, professional and a respected part of the Sydney Gay and Lesbian Mardi Gras organisation, but it is still staffed entirely by volunteers – it currently has 250 or so on its database. The criteria for working with the team include having a professional qualification as either a nurse or a doctor or being a senior first aider. Until two years ago volunteers had to be registered in New South Wales but since the establishment of a national registry for health care providers, the pool includes people from all over the country. Except for a brief period in the late 1990s and early 2000s, attracting volunteers has not proven difficult, even though it does entail giving up a few hours of serious partying. Some volunteers have used the service themselves in the past and so have a personal appreciation of the team's contribution.

Providing treatment

The medical tent is set up as a field hospital, equipped with five beds, as well as a variety of dressings, IV fluids and medications, some of which are prescribed by the team's medical officers as standing orders so that any of the registered nurses can administer medications. Perhaps the most commonly prescribed medications are antiemetic drugs to stop people from feeling nauseous and vomiting, 'because there's nothing worse than paying 140 bucks to go to a dance party only to start throwing up and having to go home. So whilst we don't condone substance taking at dance parties,' Masters emphasises, 'we make sure that people don't suffer and help them have a good night.'

Typically the team will triage people similar to a hospital emergency department, ascertaining whether a patron simply requires a bandaid or a panadol before being shipped back into the party, or whether they need to come inside the tent. 'If somebody is unconscious or drowsy we look at airway breathing, circulation, see what's going on. We make sure their Glasgow Coma scale is done and check their blood sugar levels so that if somebody is diabetic they're not either having a "hypo" or "hyper". So we look at all that side of things,' Masters explains. The team also keeps a treatment sheet, but includes only first names and age for confidentiality reasons. If the person needs to go to hospital, a duplicate is sent with them.

The team is staffed on the estimate that between 1.5 and 2.5 per cent of patrons will attend the medical tent during any given event. Any event with over 1000 patrons will have at least six volunteers per shift, with that number increasing proportionally at larger events.

On Mardi Gras night, the largest event the team services (with the exception of the Gay Olympics in 2000), there are four shifts over the whole night. 'Because it's not fair for people to give up their whole night,' Masters explains. 'So we will work in two-and-a-half to three-hour shifts. They will do just one shift and then the next team will arrive.' Volunteers adhere to a code of conduct that includes not being allowed to turn up intoxicated or under the influence of substances.

A joint effort

Masters speaks enthusiastically about the indispensable support from the medical team's collaborators, particularly the NSW Police and HIV health promotion organisation ACON. 'The police are fantastic, particularly from the Surry Hills command who we mainly deal with. They have gay and lesbian liaison officers who work with us. They perceive the medical tent as an emergency department and they treat us with the same level of respect as an emergency

department at St Vincent's or Prince of Wales. Working with the local command, seeing the level of support from the senior officers, is fantastic.'

But his greatest praise is reserved for the rovers of ACON's drug and alcohol team, who patrol each party looking for anybody in trouble. 'They're our eyes and ears wandering around the venues. They will see people who are in the bleachers or on the roadway. They might go up and talk to them about how they are feeling. If somebody's vomiting or has collapsed, they will radio through and we'll send out a retrieval team to bring that person back. They've got a really good working relationship with us.'

Trends

Although the role of the medical team has remained the same over the years, the substances it encounters have changed. Particularly notable, says Masters, is the shift towards GBL and GBH, drugs that can keep the team busy with their low margin of error in overdosing. There has also been a surge in people using LSD in the last couple of years, as well as 'triptasy' – a combination of LSD and ecstasy. Interestingly, Masters suggests that methamphetamines have not contributed much to the load of the medical team, despite the proliferation of them at dance parties over recent years.

One fascinating new trend encountered by the medical team is a phenomena called 'bucket listing' – older people who want to experience dance parties and try drugs before they die. 'In 2010 we had this older, married couple from Sydney's conservative North Shore,' Masters explains 'who were in their late 60s or early 70s, who wanted to go to a Mardi Gras party and try drugs. So they turned up and they took drugs of some description. The lady was having a fabulous time but her husband was hallucinating and was not very well and turned up at the medical tent for support.'

Masters is quite rightfully proud that to date the team has never lost a patron, although they have had some close calls. 'I remember a guy who came into the medical tent who had a temperature of 42,' recalls Masters. 'He'd been at the dance party for about six or seven hours. He'd been taking ecstasy and he was hypothermic and we were really concerned. We made sure that he had fluids, we tried cooling him down and then fast-tracked him through to the hospital.'

Of course, there could be no such thing as a Mardi Gras Medical Tent without the odd amusing anecdote, such as the young, would-be drag queen popping into the tent for a pair of boobs. So, with a bit of gaffer tape the team delivered a cleavage to this very flat-chested young man, although, as Masters understates, 'It would have been very hard to pull off later.'

MEDICAL PROFESSIONALS FROM THE GAY AND LESBIAN COMMUNITY PUT TOGETHER A TEAM TO SUPPORT THEIR FRIENDS AND LOVERS WHO WERE DYING FROM HIV – WHO KNEW THEY WOULD BE COMING TO THEIR LAST EVER DANCE PARTY.



Emerging drugs: Policy pitfalls

Adam Winstock*



IN NOVEMBER 2011, OF SUBSTANCE PROFILED THE EMERGENCE OF SO-CALLED 'LEGAL HIGHS' OR 'SYNTHETIC CANNABINOIDS', THEIR HISTORY, AND A RUSH BY GOVERNMENTS ACROSS THE GLOBE TO LEGISLATE TO CONTROL OR BAN THESE CHEMICAL SUBSTANCES. HERE, THE UK'S DR ADAM WINSTOCK REFLECTS ON THE IMPACT OF LEGISLATIVE BANS AND PONDERES WHETHER OTHER APPROACHES ARE POSSIBLE.

There was a time not so long ago when working in the drugs field was a bit predictable. The same drugs, the same legislative responses and the same involvement of serious organised crime. And although science did not always impact upon policy the way we might wish, at least we knew something about the risks and effects so we could inform policy makers of the facts and ensure that any incongruence was there for all to see. Over the last five years that has all changed, leaving everyone scrambling for a new default response that balances the need to protect individuals, their communities, their civil liberties and a bucket full of unknowns.

The emergence of 'novel psychoactive substances' has provided an opportunity to embrace new approaches to drug policy reform. In the face of declining illicit drug purity and ongoing government advertising campaigns highlighting the harms and consequences of drugs, it is hardly surprising that there was a marketing opportunity for alternative and, at least temporarily, 'legal' intoxicants. Often marketed via the internet, this form of distribution also offers new challenges for authorities.

With little scientific evidence available, and the emerging substances' ingredients and market constantly changing, developing credible and effective responses in such a climate is hard and there is not enough experience yet to tell us what the optimal responses are.

Policy responses

The response to new psychoactive drugs has varied between nations. Some have opted for control by banning or restricting under 'misuse of drugs' or similar Acts. Other countries have chosen other forms of control. These approaches, already commonly used for the regulation of legal intoxicants and everyday consumables, may offer a more effective public health response than existing criminal approaches. Some of these are outlined in Table 1.

The use of basic consumer and health protection laws is an interesting example, since these can be adopted for goods not covered elsewhere. Encompassing issues as diverse as product characteristics, labelling and instructions for use, consumer and health protection laws state that a product should not present any (or only minimal) risks under reasonably foreseeable conditions of use. It means marketers selling drugs as plant food and bath salts would have to be truthful about the intended purpose and declare the possible risks (paranoia, excessive agitation, hallucinations, etc). Other possibilities exist such as the adoption of food regulation or even cosmetic and fertiliser legislation.

One commonly adopted approach has been to declare a new psychoactive substance product as a medicine, requiring it to have marketing authorisation, which if withheld means the product cannot be marketed or supplied. For example the banning of the import and supply of Spice products using medicines legislations was adopted to avoid criminalising users in Austria and led to the rapid cessation of their open sale.

TABLE 1: OPTIONS FOR DRUG CONTROL OTHER THAN 'MISUSE OF DRUGS' LEGISLATION

<ul style="list-style-type: none"> • Unrestricted sale • Legal sale with age, place of sale and advertising restrictions • Government sale • Pharmacy-only sale (over-the-counter pharmacist sales) • Prescription-only access • Restricted sale without medical supervision • Restricted sale with medical supervision • Prohibition with civil penalties • Prohibition with diversion and education options • Prohibition with criminal penalties

Another approach was adopted by the New Zealand Law Commission in its *Recommendations for New Psychoactive Substances*, which required those wishing to sell a new psychoactive substance to demonstrate its safety before it could be manufactured, imported and sold.

Does banning drugs work?

In the absence of a systematic framework to assess the impact of legislation in different countries it is difficult to know what the impact of banning a drug is. While closing down or restricting shopfront sale will reduce street availability and public promotion of a substance, the impact of legislation on reducing total availability and use of internet-sourced substances is less clear. Monitoring global postal and courier services is no mean feat.

There are other unwanted consequences of using drug legislation to control novel substances. Once removed from the regulatory systems that allow taxation and restriction on sales all that we are left with is education and harm reduction. It is too early to determine whether serious organised crime has yet become involved in the remarketing and distribution of formerly legal highs. Some other potential unwanted consequences of utilising misuse of drugs legislation to control novel substances are outlined in Table 2.

Conclusion

Given the thousands of potentially marketable psychoactive compounds available, it is not surprising that control of one substance or group of substances is rapidly followed by the promotion of still legal yet highly effective alternatives. While new psychoactive substances pose a challenge to existing drug control regimes, their appearance also provides an opportunity to consider other regulatory frameworks. A primary aim of any drug control regime must be to protect individual and population well-being and health. It is increasingly recognised that there are unintended consequences associated with the criminalisation for drug control and consequently a desire to minimise these unwanted impacts. At a time of fiscal restraint and competing public health priorities the appearance of emergent psychoactive substances provides an opportunity to test alternative approaches to drug control.

For references and further reading, please email editor@ancd.org.au.

TABLE 2: UNWANTED OR UNINTENDED CONSEQUENCES OF USING 'DRUG MISUSE' LEGISLATION

Wider drug market	Individual	Nation and its resources
<ul style="list-style-type: none"> • Replacement of drug by other new untested compounds • Transition of newly banned substances to the illicit street market with possible involvement of serious organised crime rings • Displacement to the substances within the pre-existing illicit market • Loss of analogues being investigated for therapeutic potential 	<ul style="list-style-type: none"> • Criminalisation • Higher cost of substance • Lower purity of outlawed substance with potential increase in health-related harm • Necessary contact with dealers of other substances • Unregulated drug market • No possibility of consumer protection or quality control 	<ul style="list-style-type: none"> • Increased resources for enforcement • Loss of possible taxable revenue • Uncertain credibility of new legislation passed with limited information • Increased burden upon over-stretched law enforcement runs the risk of new laws never being effectively implemented

A CASE STUDY: MEPHEDRONE IN THE UK



One example of the impact of bans is found in the UK, where the available data on mephedrone bans provides a mixed picture. A small follow-up study of a clubbing sample conducted a few months after the ban on the powerful stimulant suggested that there has been a migration of mephedrone distribution from the internet to street dealers, a doubling of price and a perceived fall in quality. A larger follow-up conducted by Global Drug Survey in collaboration with *Mixmag* (www.globaldrugsurvey.com) suggested a marked reduction in, or cessation of mephedrone use in 40 per cent of over 1000 users, but also confirmed transition to the street-dealing market, an increase in price, falling purity and an increase in the use of illicit stimulants by 20-30 per cent of consumers.

This displacement back to traditional stimulants mirrors the suggestion put forward by Bird (2010) that the availability of mephedrone before it was banned in the UK may have contributed to a significant fall in deaths from cocaine and ecstasy in the first half of 2009. The wider data related to the impact of the mephedrone ban upon mortality-related issues remains unclear, but it is clear from post-mortem data that methcathinones (the active ingredient of mephedrone) were still around after the bans.

However death is not the only harm. Perhaps more relevant are the shifting views of users who, with time, may become more aware of a drug's harms among themselves and those they care for. The *Mixmag* study highlighted that among people worried about their friends' use of drugs, mephedrone was the most common drug to cause concern. It might be argued that the decision to control mephedrone as a drug with high abuse liability was the correct thing to do. My view is that there is not enough robust evidence to analyse at the present time to come up with a clear answer. And one nation's optimal public health response may be another's folly.

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Licensed premises: Lost in the legislation?

Ann M Roche*



The availability of alcohol from licensed premises has received growing attention over recent years, largely stemming from evidence that significant alcohol-related problems can be associated with these venues.

Many licensed premises are not necessarily problematic. Most are well run and operate within the law. However, the increased availability of alcohol in general, and especially where associated with cheaper prices and easier access to takeaway products, can exacerbate alcohol-related problems in the community: further highlighting the importance of both the role of liquor licensing legislation and its effective and appropriate enforcement.

An assortment of laws

Liquor licensing legislation in Australia is developed independently in each state and territory, and is characterised by a high degree of diversity and variation. The liquor licensing legislation, and the associated regulations, codes of practice and other industry standards, are highly complex and often difficult to enforce. However, all Australian states and territories contain statutory provisions that regulate:

- who may sell and supply alcohol
- the commercial practices of licensed premises
- offences and duties of licensees
- disciplinary procedures and penalties
- who may consume and access alcohol
- where alcohol may or may not be consumed and/or possessed.

Harm minimisation is a central tenet of the relevant legislation and regulatory mechanisms in each of Australia's

eight jurisdictions. But the legislation itself is often complex and challenging to enforce.

In addition, the legislation is continually changing to reflect shifts in commercial and community needs, priorities and concerns. This continual state of change makes understanding and enforcing the laws a significant challenge.

Australia's liquor licensing legislation also needs to be considered in the context of:

- the structures and resources available to implement and enforce it
- the decision-making and review processes
- licensee disciplinary processes, including the degree of specialist knowledge of judicial members involved in the process
- the extent to which its enforcement is a priority
- the ways in which key stakeholders perceive the objectives of the legislation
- the extent and nature of legislative powers that sit outside of liquor licensing legislation that can also be used to reduce alcohol-related harm
- the degree of influence that key stakeholders have over the nature and implementation of liquor licensing legislation.

Increased availability

Alcohol availability, as reflected in the number of liquor licences and licensed premises, has consistently increased over the past 10 to 15 years. Figure 1 shows the percentage growth in liquor licences or licensed premises in New South Wales, South Australia, Tasmania, Victoria and Western Australia.

FIGURE 1: PERCENTAGE GROWTH IN LIQUOR LICENCES IN NSW, SA AND TAS AND LICENSED PREMISES IN VIC AND WA



a) Reporting time spans vary across each jurisdiction.
b) VIC and WA figures show data for licensed premises not liquor licences.
c) Data were not accessible for the other jurisdictions at the time of writing.

The challenge of intoxication

Dealing with drunkenness, whether associated with licensed premises or not, is an increasing area of concern and a major drain on policing resources. Intoxication, however, is one of the most challenging aspects of the legislation at a conceptual and practical level. It is a critically important aspect of liquor licensing legislation in Australia, as well as one of the most contentious. On the one hand, continuing to serve alcohol to intoxicated patrons is associated with the potential for significant harm. On the other hand, it can be difficult for serving staff to assess a patron's sobriety. This is particularly the case in dark, crowded and noisy environments. Bar staff can also be intimidated by intoxicated patrons and may be under pressure from their employers to ensure speedy, efficient service and to maximise alcohol sales.

The liquor licensing legislation in all Australian jurisdictions contains provisions which make it an offence to serve alcohol to a drunken person. While serving and supplying an intoxicated and/or drunk person is an offence in every state and territory, jurisdictions define these terms in different ways and require different types of evidence to show an offence of intoxication. Moreover, the burden of evidence required to prove that the act of serving an intoxicated patron has occurred is often onerous.

The difficulties associated with proving the offence of serving alcohol to drunken persons on licensed premises are numerous and include:

- inadequate definitions of intoxication contained within the legislation
- the range of defences against the offence available for bar staff and licensees. For example, the licensee had taken reasonable steps to ensure that alcohol was not served to significantly intoxicated persons, or the person supplying the liquor believed that the person was not intoxicated
- the need to prove that a drunken person served alcohol on licensed premises was affected by alcohol and not another drug

- the challenge of proving the secondary supply (alcohol supplied to a patron by someone who was not a member of the bar staff) to drunken persons on licensed premises
- the need for police to remain on the licensed premises for a long period of time to observe drunken patrons being served alcohol
- police observations of drunken behaviour are not considered sufficient proof of drunkenness
- having offences related to the serving of alcohol to drunk patrons heard by non-specialist liquor licensing magistrates who do not have expertise in this area
- the relatively small penalties that can be associated with serving drunk patrons
- confusion between different definitions of intoxication for the purposes of liquor licensing legislation, road traffic legislation and legislation relating to public drunkenness.

Secondary supply to minors

Secondary supply of alcohol to under-age people is an issue that has recently received considerable attention. This involves the sale and/or supply of alcohol to under-age people, either on licensed premises or at other locations.

In all states of Australia, it is illegal for minors to be served alcohol and for adults to purchase alcohol on behalf of under-age people on licensed premises. However, until very recently there was no legislation that addressed the supply of alcohol to minors on private premises. Five states (Qld, NSW, Vic, TAS, NT) have now made it illegal for alcohol to be provided to minors by persons other than their parents/guardians, unless express permission to do so has been given by the parent. There have been a number of successful prosecutions in relation to secondary supply. One of the main benefits of this legislation was that it raised the issue of young people and alcohol and reflected perceptions of shifting community norms in regard to under-age drinking.

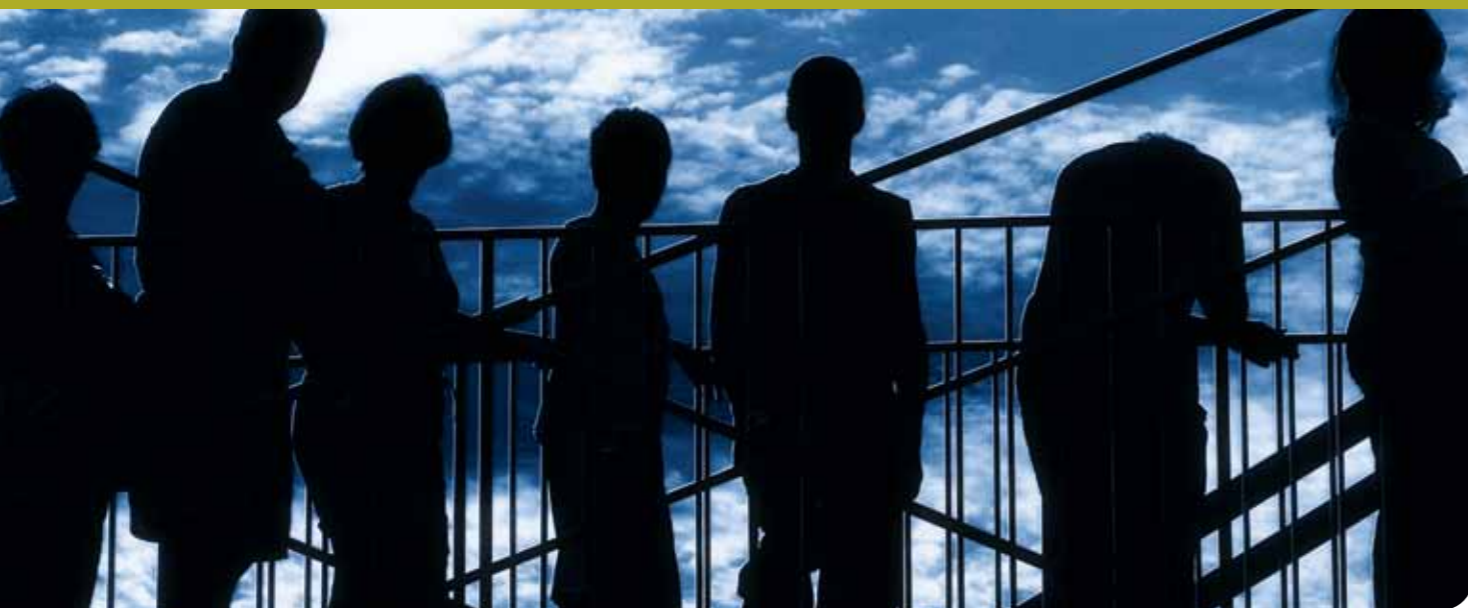
Legislative review and reform

In spite of the continually evolving nature of the laws, some aspects of the liquor licensing legislation are outdated and need review and fundamental reform. At a basic level, there would be advantage in the liquor licensing legislation being written in language that is easily understood by police, liquor licensing authorities, licensees and members of the public. There is also a need for better knowledge of the legislation by the various key players involved and greater scope for involvement in the drafting of legislation by those involved in its enforcement and/or those likely to otherwise experience the potentially harmful effects of excess availability.

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Further reading

The National Centre for Education and Training on Addiction has recently completed a detailed examination of the liquor licensing legislation in Australia. *The full report will be available from www.nceta.flinders.edu.au.*



Figuring out the facts

Libby Topp

AROUND AUSTRALIA, DATA IS COLLECTED ON TOPICS THAT AFFECT THE ALCOHOL AND OTHER DRUG SECTOR. WHY DOES THIS DATA MATTER, AND WHAT ARE SOME OF THE ISSUES INVOLVED WITH COLLECTING AND ANALYSING IT?

Types and purposes of data

Across Australia, data is collected to monitor alcohol and other drug-related issues and trends. From hospital emergency departments and secondary schools, to therapeutic communities and police stations, this data forms the 'evidence' that helps policy makers decide on program directions and funding allocations. This evidence is vital to our sector because of its sensitive issues; with solid data, policies to address these issues can be developed more objectively. Alcohol and other drug (AOD) 'datasets' are managed by a range of agencies, primarily government departments and research institutions.

In terms of quality and comprehensiveness, Australia's drug information systems are among the world's best. There are many examples of how data collections inform AOD policy responses, and document their outcomes. For example, the removal of Temazepam gel capsules from the market in 2004 was a direct result of data from the Illicit Drug Reporting System and other research indicating that injection of this formulation, and the substantial associated harm, were prevalent among people who inject drugs.

Indicators and reliability

Among the important data sources for policy activity are 'outcome indicators', or measures of the achievement of the major objectives of a policy or program (Degenhardt & Dietze 2005). Ideally, outcome indicators allow for comparison of the situation before a policy or program is implemented, and again some time later, to measure progress. For example, Australia's 2004-2009 National

Drug Strategy aimed to 'reduce drug-related harm for individuals, families and communities'. One indicator used to measure this objective is the number of drug-related deaths. Likewise, a treatment program may state the objective 'a reduction in illicit drug use'. One indicator of the program's outcomes might be a client's number of drug-free urine samples in a given time frame.

Data sources vary in the extent to which they can be considered reliable and valid. For example, self-report survey data is often criticised because participants' reports cannot be verified (interestingly, authoritative literature reviews have demonstrated the reliability of drug users' self-reports); and difficulties also exist around accessing representative samples of participants. On the other hand, surveys are considered an efficient and cost-effective means of collecting specific and detailed information that is up-to-date and, when collected using consistent methods, is comparable and sensitive to trends.

THE REMOVAL OF TEMAZEPAM GEL CAPSULES FROM THE MARKET WAS A DIRECT RESULT OF DATA INDICATING THAT INJECTION OF THIS FORMULATION, AND THE ASSOCIATED HARM, WERE PREVALENT AMONG PEOPLE WHO INJECT DRUGS.



Some data sources provide information that when used in conjunction with other datasets can provide interesting indicators. For example, alcohol sales data provide a measure of the volume of alcohol sold in Australia; while it cannot tell us who drinks it, nor what consequences are experienced as a result of consumption, when used alongside other data, such as assaults in venues, it can give policy makers valuable guidance. Consequently, there is great value in having available many different data sources that can be compared against each other. Many factors influence data quality and usefulness, and each data source has limitations. When all limitations are considered and multiple data sources point to the same finding, the evidence becomes stronger, allowing more confident conclusions.

Levels of data collection

Different levels of data collection also contribute to a complete understanding of the patterns and consequences

of AOD use in Australia. For example, data can be collected at the level of an individual service for the purposes of quality assurance; at the state/territory level to monitor the outcomes of decisions around resource allocation; or at the national level to estimate rates of illicit drug use in the general population.

Likewise, depending on the purpose for which data is collected, the unit of measurement might be an individual, a family or an entire community. Although all such data sources are essential to serve their individual purposes, no single level of data will serve all stakeholders' needs. National level data on overdoses or general population rates of drug use are of limited use to a local service provider seeking accreditation through a quality assurance process. In addition, the usefulness of many data sources collected at the state/territory level is constrained by the different collection methods used in different jurisdictions, which prevent these data being collated into a meaningful overall picture (see pages 28-29).

SOME KEY AUSTRALIAN AOD DATASETS

National Drug Strategy Household Survey: Australian Institute of Health and Welfare (AIHW)

- Monitors general population prevalence of drug use
- Triennial surveys of large (25 000+) national samples of Australians aged 14+ years about their attitudes towards and use of licit and illicit drugs
- Limited utility for drugs with low prevalence of use due to small subsample sizes
- Household-based sampling excludes high risk groups (e.g., homeless people, prisoners); criticised for low response rates (<50%) and their potential impact on validity of results.

Australian Secondary School Alcohol and Drug Survey: Victorian Cancer Council

- Monitors licit and illicit drug use among high school students
- Triennial national surveys of large (30 000+) random samples of students in years 7-12
- Limited utility for drugs with low prevalence of use due to small subsample sizes; school-based sampling framework excludes risky adolescents due to truancy or dropout.

Causes of Death: Australian Bureau of Statistics (ABS)

- Monitors drug-related deaths
- Computerised database of information drawn from state/territory registries of births, deaths and marriages and coronial services classifying causes of all deaths in Australia
- Standard ABS presentation provides limited information because most drug-related deaths are not coded as such due to factors including the availability of toxicology results and the completeness of death certificates. No organisation is responsible for systematically undertaking the separate research needed to produce a comprehensive picture
- Criticised for delays in the availability of data on both licit and illicit drug-related mortality.

Illicit Drug Reporting System/Ecstasy and Related Drugs Reporting System: National Drug and Alcohol Research Centre

- Monitors price, purity, availability, patterns of use and associated harms of major illicit drugs
- Annual 'snapshots' of drug markets based on (i) interviews with large (900+) samples of regular illicit drug users in all capital cities; (ii) key AOD experts; and (iii) indicator data (e.g. overdose deaths, treatment episodes)
- Constrained by convenience sampling methods and changes in recruiters and recruitment methods between annual studies.

Drug Use Monitoring Australia: Australian Institute of Criminology

- Monitors recent drug use among large samples of police arrestees through self-reports and urinalysis
- Conducted quarterly at police watchhouses across six jurisdictions
- Provides evidence base for examining drug-crime relationships
- Restricted by eligibility criteria. (e.g. an arrestee cannot participate if they are deemed too uncooperative).

Alcohol and Other Drug Treatment Services – National Minimum Dataset: AIHW

- Monitors the type, utilisation and availability of treatment services
- Collates data on treatment episodes completed by publicly funded government and non-government specialist AOD services in all states/territories, (e.g. referral sources, drugs of concern, services provided)
- Excludes agencies whose sole activity is prescribing or dispensing opioid pharmacotherapy; or whose main function is accommodation (including sobering-up shelters) or health promotion (e.g. needle and syringe programs).

Data collected across other related sectors can all contribute to a knowledge base around drug use and related harms; for example, mental health, criminal justice, education, employment, housing, town planning, and child and family health can all contribute useful data that can have an impact on AOD policies. The challenges in synthesising such cross-sectoral information, are, however, substantial. Indeed, Australia is praised internationally for efforts to

underpin drug policies with evidence from just the health and law enforcement sectors.

Challenges of the data

Gaps in the data

Although research evidence is vital to informing policy making, relevant or good quality evidence is not always



PRACTICAL USE OF DATA IN A THERAPEUTIC COMMUNITY

James Pitts

James Pitts, CEO of Odyssey House, provides an outline of the types of data collected by an AOD service, as an example of the wealth of information collected at a grassroots level.

All AOD services who receive funding from state and federal governments are required to collect client and other data. How that data is utilised can enhance the quality of interventions offered by a service. Here are some examples of how Odyssey House uses the data we collect:

- Our Admissions Centre collects client demographic data that tells us about who is accessing the different program services, their ages, problem drug(s), mental health status, gender etc. This information helps us make adjustments to our services. A recent example of this has been the need to enhance our interventions for alcohol-dependent clients, who make up over 30% of our residential population.
- When clients enter the initial stage of the residential program, information is collected on educational achievements to determine tuition needs at our school learning centre. A vocational history helps determine appropriate job placements for clients while they are undergoing treatment. A psychiatric mental status

evaluation is also conducted which helps staff to identify issues that may need to be addressed urgently.

- Given the increasing frequency of comorbidity within our client population, we administer a number of clinical surveys to clients at various stages of their treatment. These include the Personality Assessment Inventory and the General Health Questionnaire. These surveys assist in the formulation of individualised treatment plans that are adjusted and updated as clients progress through their program.
- Other data is collected through surveys on consumer satisfaction; program interventions; and environmental factors.

Odyssey is required to supply data on a number of activities/ interventions we provide as part of our overall service delivery. We receive funding from both governments (state and federal) and private sources. We are required to provide data which supports the original submission depending on what that may be. Categories of data collection include: number of participants in a particular project; pre- and post-test questionnaire results; statistical data; and evaluations of the overall effectiveness of a particular project. The data collection required is usually commensurate with the amount of funding that is given for a particular project; larger grants require more detailed reporting on a more frequent basis; smaller grants, usually from trusts and foundations, require less reporting, such as once per year.

MENTAL HEALTH, CRIMINAL JUSTICE, EDUCATION, EMPLOYMENT, HOUSING, TOWN PLANNING, AND CHILD AND FAMILY HEALTH CAN ALL CONTRIBUTE USEFUL DATA THAT CAN HAVE AN IMPACT ON DRUG POLICIES.



available. Sometimes, scientific evidence is not seen as sufficient, appropriate or desirable in making policy decisions. Political pressures or the need for prompt responses to allay public concerns may lead to governments implementing interventions that are not consistent with the evidence.

Lack of synthesis of data sources

Despite Australia's comprehensive, high quality AOD data collections, the potential of these data is yet to be fully realised because there is no formal system for analysing and synthesising the data and other information into policy-relevant forms.

Commendable steps to overcome this problem are included in the *National Drug Strategy 2010-2015* document, under which an expert working group will be established to develop a National Drug Research and Data Strategy. There is a huge difference between having data available from separate data collections, and using them – strategically and in combination – to inform policy making. Important gaps in drug information still exist, and there are significant delays in producing policy-relevant findings from some key data collections.

Mining a wide range of data sources

Many workers and services in the AOD and related sectors collect data as part of their daily job, recording things like number of clients admitted, number of syringes provided, number of opioid overdoses attended. Services collate these data primarily for funding purposes – to apply for funding, to use it in the most effective way possible, and to justify how it is spent. At the individual service level, these data serve their funding purpose, but they also have the potential to be collated and used on a wider scale. A challenge for the new Standing Committee on Data and Research will be to find ways of bringing together small datasets like these more efficiently and effectively. A good example of this is prisoner health data; a huge amount of information is collected on every prisoner when they first enter custody, but so far this data has not been collated in a way that helps build an evidence base.

Jurisdictional differences in data collection

Much data informing AOD monitoring and policy making is collected at the state/territory level. The methods used by individual states often vary in terms of data definitions, time frames, database formats etc.

For example, many consider purity the best single indicator of illicit drug availability. The Australian Crime Commission (ACC) obtains data from the Australian Federal Police (AFP) and state/territory police services on the purity of their drug seizures, but the lack of common data standards means the ACC cannot provide a national overview of drug purity. Purity figures are not estimated from all seizures, only those that have been analysed at a forensic laboratory, and different state/territory police services have different criteria for which seizures are analysed. In some states/territories, figures represent drugs that were seized during the relevant period, and in others, figures are from drugs received at the laboratory during the period. The time between when a drug is seized and when it is analysed can vary from a few days to several months. There is no way to adjust for double counting of some seizures resulting from joint operations between the AFP and state/territory police services; and in the Northern Territory, seizures are not routinely analysed at all. A consistent and coherent national system for monitoring the purity of illicit drugs would be a significant advance.

In summary

Limited resources are available to address AOD-related issues, meaning that we can't implement all the interventions we would like. The strategies and approaches adopted by policy makers always come at the expense of alternatives. To make these decisions in a way that ensures the best possible outcomes for society requires that policy makers have access to quality data that indicates the extent of the problems and the effectiveness, and costs, of our responses. Evidence-based policy making requires above all else, evidence. Rigorous evidence requires quality data. Without such data, policy makers can make, at best, educated guesses around how best to direct resources. Australia has some of the world's best data collection systems, although substantial improvements to our AOD data collection system are undoubtedly possible. The ongoing challenge for people working in the sector at all levels – from grassroots to government – is to continually find better ways to collect data, and to use the data that is already collected more efficiently.

For a full list of references used in this article, please email editor@ancd.org.au.

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