COLLABORATION IN ACTION
Aboriginal & Torres Strait Islander Peoples’ Complementary Action Plan

DRUG COURTS
What they do & how they work

CANNABIS & COMORBIDITY
A mental health perspective

CIGARETTE WARNING LABELS
New warnings are overdue

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CANNABIS
A CAUSE FOR CONCERN?
Editorial by Margaret Hamilton, Chair, Editorial Reference Group, Of Substance

In this issue of Of Substance we tackle one of our most commonly used psychoactive drugs – cannabis – from two different perspectives: deregulation on the one hand, and concern about its associations with mental illness on the other. These are both current and pressing issues in Australia.

Over time, cannabis has come to be viewed as one of the less harmful drugs, which many find pleasurable and use with few side effects; however, there is now growing concern that some people are clearly in trouble with it.

Will this be a substance causing such pleasure and pain in ten years time? Probably. All psychoactive substances have the potential to enhance relaxation and pleasure for some. Many of this drug’s psychoactive effects are desired and, as a result, cannabis is and will continue to be a popular choice. Like alcohol, many Australians use cannabis and experience no apparent harm. Some report benefits. NSW and Queensland drug courts; it is still too early to say whether this approach actually has benefits for the clients over and above alternative approaches.

The cautions and warnings of the severe negative health problems with cannabis – occasionally with acute, associated negative effects, or through long-term development of dependence. Some people who use it regularly will develop significant health and social problems. For others with a predisposition to instability or illness, cannabis will potentiate these effects and be one link in a chain leading to significant mental health problems.

Simon Lenton, from the National Drug Research Institute, provides an update on the legal status of cannabis, with particular reference to Western Australia as it follows South Australia, ACT and the Northern Territory in moving to decriminalise the substance.

The cautionary and warnings of the severe negative consequences of cannabis use for some people, as described in another article by Professor Beverley Raphael, a leader and well-respected clinical scientist in Australia, are cogent and warrant attention.

These articles are not contradictory. One is grounded in discussion of population-wide policy considerations based on sound evidence. The other arises from clinical experience and sound research evidence of negative effects.

Policies, programs and importantly, the general community, need to recognise and understand these two issues. We must be ready to address them through sensible public policy, and with appropriate responses for those who are harmed by their use of cannabis.

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES’ COMPLEMENTARY ACTION PLAN
START FROM THE GROUND AND WORK UP

INTERVIEW BY JEFF MOSS, SEE-SAW EDUCATION & TRAINING, PERTH

Ted Wilkes: A voice of experience

If you are an Aboriginal person, you are not likely to have lived your life without seeing the adverse and, in some cases, the severe adverse effects that drug use has had on our communities – alcohol in particular,” says Ted Wilkes. “Alcohol is a killer of our people. I see it continually.”

Born in the south-west of Western Australia, Associate Professor Ted Wilkes is a Nyungar man and has been involved in Aboriginal affairs all of his working life. A recognised Aboriginal leader and activist, he sees himself as a social scientist with a focus on the social determinants of Aboriginal health.

Four years ago he was chosen to chair the national reference group that produced the Aboriginal and Torres Strait Islander Peoples’ Complementary Action Plan 2001-2006 (Action Plan), released in mid-2003 as part of the National Drug Strategy.

Ted Wilkes brought to the group a broad and substantial background in Aboriginal health and related issues. Between 1980 and 1986 he was the coordinator of Curtin University’s Centre for Aboriginal Studies in Perth. For the next 16 years (1986-2002) he served as director of the Perth-based Derbarl Yerrigan Health Service (formerly known as the Aboriginal Medical Service).

Currently, he is an Associate Professor in the area of Aboriginal health at Curtin University’s Centre for Development Health and is founding chairperson of the Kulunga Research Network based at the Telethon Institute for Child Health Research.

Drugs of concern

To determine priorities, the reference group went through a process of examining each drug type and any drug related social action that was already being tried in different communities in the various states and territories. It was clear that the use of particular substances was prolific only in some communities, while other drugs were an issue more generally. Ted Wilkes observes:

Our recognition of the significance of drugs other than alcohol became greater as we did our research. The social impact of smoking, for example. Smoking is so entrenched in our communities that some of us were both bemused and bewildered about how we might make recommendations regarding it.

I’ve also become more than aware of alcohol use in our communities. We did not diminish the impact that alcohol has on our communities – it continually.’

So representations of the reference group visited communities in the Kimberley, the Northern Territory, parts of Queensland and the Torres Strait Islands.

Having been involved in developing the national Aboriginal Health Strategy during 1998-99, Ted Wilkes found some of these visits painful:

Going back to those communities after 10 years – and seeing if they had improved or whether the infrastructure had improved – was more than an eye-opener. I was actually devastated in some places in terms of not seeing changes and not seeing any positive developments. I recognised that something was truly wrong.

This first consultation phase was completed early in 2003. The second phase, during March-April, involved circulating for comment the findings from the first round of consultations.

Complementary plan needed

Following the development of the current National Drug Strategic Framework in the late 1990s, a number of different action
Wilkes stressed that:

Flexibility became a guiding factor. When it came to making recommendations, flexibility was the way you fix it up. According to Ted Wilkes:

So far, so good

Will the Action Plan have an impact? According to Ted Wilkes, the Action Plan has an impact.

We may find that the systems are still not robust enough to seek the appropriate partnerships with Aboriginal people. The systems are still very much protective of the taxpayers' dollar, and if the systems are over-protective of the taxpayers' dollar then Aboriginal community control and Aboriginal self-determination might not be able to be manifested through this process. Mainstream systems may then negate proper improvement in the quality of life of our people.

But what I am seeing in a practical sense is promising. Most of the states and territories have recognised that this action plan has come from a national effort. People are sitting around together at the State and Territory level to develop the application of this plan in their State or Territory.

If Aboriginal and non-Aboriginal people involved in these forums are able to recognise what we mean by Aboriginal community involvement, Aboriginal community participation, Aboriginal community control, and Aboriginal self-determination – and we can marry those into action plans addressing alcohol, tobacco and illicit drugs could not always reflect and deal appropriately with the specific issues that concern Aboriginal and Torres Strait Islander peoples. In recognition of this, the Australian Government Department of Health and Ageing conducted national consultations and developed an Action Plan to complement the Framework and other National Action Plans. The result of this is the Aboriginal and Torres Strait Islander Peoples’ Complementary Action Plan 2003-2006. This article summarises some of the key aspects of the Action Plan. The interview with Ted Wilkes (pages 3-4) gives an overview of the Plan’s development.

A holistic approach

The Action Plan takes into account that Aboriginal and Torres Strait Islander peoples and their local communities want to be involved in developing and having community control over action plans addressing alcohol, tobacco and other drugs (ATOD) in local areas. The Plan ensures that these plans are specific to their needs. A local process will ensure culturally appropriate planning that takes into account the setting and dynamics of each community. It is important that remoteness, traditional practices, access to services and drugs, safety and law enforcement are all considered when formulating community based strategies.

Six key result areas:

1. CAPACITY BUILDING

The first key result area is to enhance the capacity of individuals, families and communities to address current and future substance misuse issues and promote their own health and wellbeing. To achieve this it is important to strengthen community leadership, responsibility and expertise so that communities can enhance and promote their own health. It is also important that communities are empowered to work collaboratively with a wide range of partners. At a more strategic level, social and economic policies need to address the systemic patterns of social disadvantage.

2. CHALLENGES FOR GOVERNMENT

The second key result area encourages a whole-of-government approach. This will require that all levels of government cooperate and work together with community-controlled services and other non-government organisations. It is important that the role of all sectors is clear. Government departments as diverse as police, health and education are encouraged to work together and take a more holistic approach to working with communities.
3. BETTER ACCESS TO PROGRAMS

The aim of the third key result area is to improve access to the full range of services that address the impact of ATOD issues. This includes better access to primary health services for those in remote communities as well as better access to health care for those who are incarcerated. Other strategies include access to police diversion, pre-sentencing programs and legal aid. Community police could be given opportunities to further their careers by being included under state and territory police structures. This would also widen their powers in response to control of supply issues. Cultural competence training could also be a core component of all police academy training.

4. MAKING A RANGE OF STRATEGIES AVAILABLE

Multi-faceted approaches are needed to respond appropriately to substance misuse, according to the fourth key result area. Health, legal and education strategies need to be well integrated. Far more emphasis needs to be placed on family and clan group-based approaches to prevention and intervention, with an acknowledgement of the cultural, spiritual, language and traditional aspects of communities. Essential health services must be provided to everyone and people should not be discriminated against because of their substance use.

5. WORKFORCE INITIATIVES

The need for funding is picked up by the fifth key result area. Well-planned and strategic workforce development initiatives could enhance the capacity of community-controlled, and mainstream organisations, to provide quality services. They could also help break down the complexity of the issues and help people to move forward in implementing the Action Plan. The Plan acknowledges that funding will be essential to facilitate the necessary changes to the workforce to provide better health care to communities.

6. OWNERSHIP AND SUSTAINABLE PARTNERSHIPS

The sixth key action area recognises the need for monitoring and evaluation to begin to provide an evidence base for the future. The Action Plan suggests that this will work best if Aboriginal and Torres Strait Islander peoples are able to both set the agenda and participate in research and evaluation. Access to training for community representatives in research methods is also seen as important.

A more strategic and effective approach is needed to ensure that Aboriginal and Torres Strait Islander peoples are informed of the outcome of evaluations of community-designed initiatives. To ensure this happens the results need to be provided in the context of the whole story, including the process, the design of the intervention as well as the findings of the evaluation.

Dissemination of the Action Plan

The Action Plan is currently being widely circulated. The test now is to encourage the collaboration and discussion needed to address the many challenges in delivering better health outcomes for Aboriginal and Torres Strait Islander peoples. The greatest challenge is to deliver better outcomes for those living in remote areas.

To date the Australian Government has allocated $10 million towards the Tough on Drugs Indigenous Community Initiative. These funds will assist to build community capacity to help break the cycle of drug use present in many communities. Now the states and territories need to respond to the Action Plan and work with local communities and the Australian Government to address the challenges presented by this Plan.

Reference


T he Cannabis Control Bill 2003 passed the Western Australian Parliament on September 23. The Bill, which is the legislative backing behind the Cannabis Infringement Notice (CIN) Scheme, allows for the first time in 2004. This will make Western Australia (WA) the fourth Australian jurisdiction, after South Australia (SA), the Australian Capital Territory (ACT) and the Northern Territory (NT), to adopt a ‘prohibition with civil penalties scheme’ for minor cannabis offences. The scheme is based on recommendations of the Western Australian Health Minister’s Ministerial Working Party on Drug Law reform comprising representatives from the legal profession, health, medicine, justice, law enforcement and research.

Under the scheme, minor cannabis offences will remain illegal and be treated much like speeding in a motor vehicle, still unlawful, actively discouraged, and penalised. Compared to similar schemes elsewhere in Australia (see box), the amounts eligible for a notice in the CIN scheme will be comparatively low and the fines comparatively high. Possession by an adult of up to 10g would attract a $150 fine, possession of up to two plants would attract a $200 fine, and possession of a used bong a $100 fine.

The scheme differs from other Australian prohibition with civil penalties schemes in a number of ways. Unlike the SA scheme it provides support for police to charge people they believe are trying to flout the intentions of the scheme by using the infringement levels as a cover for dealing activities, and it limits the number of plants eligible for an infringement notice to two per household, to deter collective growing.

Hydroponically cultivated cannabis plants will not be eligible for an infringement notice. A similar exclusion has recently been adopted in SA. Under the WA scheme regales sellers of smoking paraphernalia and hydroponics equipment. One of the key issues is that there is only 50% of those given a notice pay the fine by the due date. The WA scheme aims to deal with this issue in two ways. Firstly, those eligible for an infringement notice must supply evidence as to their identity (e.g. driver’s licence) to facilitate follow-up of fine defaulters. Secondly, those given a notice will have the option to pay their penalty in full within 28 days, or complete a specified cannabis education session within the same period.

The education option ought to be attractive to those of limited financial means who appear to be a large proportion of those who fail to pay their fines in the SA scheme. Under a government amendment to the Bill, cannabis users caught for the third time in three years will not get the option of paying a fine. They will have to complete the education session or face a criminal charge. Repeat offenders, who are often dependent on the drug, are more likely to respond to education and complete their education service than they are to a criminal conviction.

Unlike the cannabis cautioning schemes currently in place in five Australian jurisdictions the WA scheme aims to address the supply side of the cannabis market by moving cannabis supply away from large-scale, criminal suppliers by using the Cannabis Infringement Notice to expiate usually results in conviction)
**POINT OF VIEW**

**COMORBIDITY**

**CANNABIS AND COMPLEXITY**

PROFESSOR BEVERLEY RAFFAEL AND DR SALLY WOODING

Recent research, as well as anecdotal evidence from clinicians in Australia and overseas, has highlighted the complex issues surrounding mental health problems and comorbid substance abuse. This has encouraged more discussion between mental health and alcohol and other drug service providers.

This article highlights the significant mental health risks associated with cannabis use and abuse. Cannabis is the most commonly used illicit drug in Australia. For some clients it may only be one of a number of drugs taken. This issue of poly-substance use also further complicates the clinical picture.

Cannabis has traditionally been seen as a relatively harmless substance, widely used and part of the culture of theBaby boomers generation. The feelings generated for some users include euphoria, wellbeing and sexual stimulus and have become part of expectation.

This possibly contributes to the widespread view that cannabis is not as harmful as other recreational drugs. The effects of cannabis have perhaps been seen as less harmful than the outcomes associated with highly prevalent alcohol use, and injecting drug use.

Consequently there has been less investment in developing and evaluating interventions. Current research however supports the notion that cannabis is not a harmless drug and does pose a number of acute and chronic health risks to the individual and to society (Adston 2001).

From a mental health perspective all drug problems may occur and does pose a number of acute and chronic problems and comorbid substance abuse. The prevalence of cannabis use is higher among those with psychotic disorders, even after adjusting for age, gender, and other mental health problems (Degenhardt & Hall 2001).

### Initiation begins in school

The last household survey also indicates that just over a third of adolescents have used cannabis at least once and almost 25% have used it in the last year. Victorian longitudinal research, with year nine students, has reported that many adolescents initiate cannabis use while still at school (Coffey et al. 2000). This research also highlights the possibility of occasional use continuing into dependence. Transition to regular cannabis use was more likely for boys, for whom availability and peer use were determinants (Coffey et al. 2000).

For girls, high-dose alcohol use and antisocial behaviour were more likely to predict daily use. Cigarette smoking was also found to be an important predictor of both initiation and persisting cannabis use.

### Effects of cannabis use

Cannabis may be used for effects which can include euphoria, depersonalisation, a drowsy or trance like state (somnolence), and altered perceptions of time and space.

There is evidence that cannabis use produces a range of effects including: amotivational and/or dependence syndrome, cognitive impairments, and is related to acute toxic psychosis or psychosis that exists beyond intoxication (Degenhardt & Hall 2001).

### Prevalence

Cannabis is the most widely used illicit drug in Australia. The most recent household survey (2001) reports that a third (33%) of those over 14 years and 60% of those between 20 - 29 years have used cannabis.

The prevalence of cannabis use is higher among people with mental health problems particularly psychotic disorders (Degenhardt et al. 2000). In their Australian sample, Jahansky and others (2000) found that one in four (24%) people with psychotic disorders in contact with treatment services had used cannabis at least weekly in the past 6 months. Rates of problem cannabis use are high among those with psychotic disorders, even after adjusting for age, gender, and other mental health problems (Degenhardt & Hall 2001).

There is also growing evidence of an association with depression and anxiety (for more recent research on these associations see the boxed information on pages 10 and 11).

### The need for interventions

Regardless of the complex nature of the association between cannabis use and mental health problems (including psychosis or schizophrenic), there are good reasons to adopt a population health approach addressing prevention, early detection and intervention. Population health approaches are the conceptual basis of both mental health and alcohol and other drug strategies.

More specifically, Rey and Tennant (2002) argue that the demonstrated dose-response relation shown in recent studies for both schizophrenia and depression highlight the importance of reducing the use of cannabis. In their study, Van Os and others (2002) estimate that lack of exposure to cannabis would have reduced the incidence of psychosis or schizophrenia requiring treatment by 50%.

Research on psychiatric patients with problem substance abuse has found symptom worsening or relapse (Salyers et al. 2003), a higher rate (Haywood et al. 1995) and duration of hospitalisation (Grace et al. 2000), homelessness or housing instability (Drake et al. 1991), poor compliance with medication (Pristach & Smith 1990), poor response to antipsychotic medication (Salyers et al. 2001), poor social functioning (Salyers & Messer 1993), increased burden upon the sufferer's family (Clark 1994) and increased treatment costs (Barthels et al. 1995). These findings indicate that problem substance use, including cannabis use in psychosis, adversely affects outcome and adds to the already significant economic burden attributable to schizophrenia (Hall et al. 1985).

Recent research by Carr and others (2002) estimates that, in the urban Australian population, schizophrenia, in its most costly of psychotic disorders, 'consuming approximately $21 600 per patient per year in mental health costs, and accounting for total costs of $51 600 per patient per year' (p. 6). On a population basis this equates to approximately $601 million per year in mental health care and $1.44 billion per year in total costs. Taking the figures noted above (Van Os et al. 2002) if 50% potential decrease of schizophrenia linked to cannabis aetiology were dealt with, this suggests a potential cost saving of up to $720 million annually in Australia.

Of primary importance is the fact that cannabis use does have a number of significant associated harms. It is not a soft or safe option and its notable comorbidity with psychotic and non-psychotic illnesses make it a significant and growing public health issue – a fact increasingly reflected in both the national and international scientific literature.

**Conclusions**

Mental health and alcohol and other drug services need to deal with the issue of comorbidity for clients (particularly young people) with cannabis use and mental health problems. There is a need for more systematic and collaborative program implementation, and an evaluation to improve outcomes in this area.

Programs developed to this point have not been assessed in a qualitative fashion, leaving clinicians and researchers uncertain about the efficacy of their intervention and the effective components of treatment. In comparing good clinical care with active treatment, programs need to be developed which bring clarity to this issue. If active treatments with counselling components prove to be effective then healthcare workers could be encouraged to use a more targeted approach. Such an approach could be tailored and delivered to health service providers for use with appropriate clients.

There are a number of national, state and territory initiatives to address comorbidity issues between cannabis and mental ill-health. Additionally, there has been some discussion in the literature as to the efficacy of a number of treatment approaches. These initiatives and treatment approaches, including assessment and barriers to care, will be discussed in future issues of Of Substance.
CANNABIS AND PSYCHOSIS

Evidence supports the hypothesis that cannabis use exacerbates the symptoms of schizophrenia. A number of retrospective and prospective studies have supported this conclusion even after controlling for confounding variables. This hypothesis is also biologically plausible, psychotic disorders involve disturbances in the dopaminergic neurotransmitter systems and cannabinoids, such as THC (delta-9-tetrahydrocannabinol), the principal psychoactive ingredient of cannabis, increase dopamine release (Adams & Martin 1996).

Cannabis use may increase the risk of psychotic disorders and result in poor prognosis for those with an established vulnerability to psychosis. A number of hypotheses have been put forward to explain the association between cannabis use and psychosis (Hall & Solowij 1998; Hall & Degenhardt 2001; McKay & Tennant 2000). The more widely proposed hypotheses are that:

- cannabis use precipitates psychosis among those vulnerable to developing the disorder
- cannabis use worsens symptoms or prolongs the illness
- those with schizophrenia use cannabis to self-medicate psychiatric symptoms, or medication side-effects
- the association results from other common risk factors (such as personality or family history of schizophrenia) or confounding variables (such as drug use or poor compliance with antipsychotic medication)

A higher risk of developing schizophrenia (Andreason et al. 1987) or relapse of psychotic symptoms (Linszen et al. 1994) has been found by the few longitudinal prospective studies that have examined these hypotheses, however it is noted that studies such as these usually have some methodological difficulties.

More recent findings from Andreason et al.’s cohort confirms the earlier findings that ‘cannabis and not other drugs, is associated with later schizophrenia and that this is not explained by prodromal symptoms’ (Zammit et al. 2002).

Other recent research found that cannabis use increased the risk of both the incidence of psychosis in psychosis-free persons and a poor prognosis for those with an established vulnerability to psychotic disorders (Van Os et al. 2000). In this study, length of exposure to use of cannabis predicted the severity of the psychosis, which was not explained by other drugs. Participants who showed psychotic symptoms at baseline and used cannabis had a worse outcome, implying an additive effect.

Another recent study by Zammit and others (2002) reported that ‘cannabis use was associated with an increased risk of developing schizophrenia, consistent with a causal relation’. In this study, cannabis was associated with an increased risk of developing schizophrenia in a dose dependent fashion both for subjects who had ever used cannabis, and for subjects who had only used cannabis and no other drugs. The finding was most significant for the group who had used only cannabis more than 50 times.

Research on adult outcomes from a birth cohort in New Zealand showed that 10% of cannabis users by age 15 developed schizophrenia or disorders by age 26 compared with 3% of the remaining cohort. The same study found that individuals who had used cannabis three times or more by age 15 or 18 were not more likely to have schizophrenia or disorder at age 26, although they showed an increase in ‘schizophrenia symptoms’ (Arseneault et al. 2002). Other studies have shown that cannabis use amongst adolescents increases the relative risk of developing schizophrenia by 2.4 times and up to six times in heavy users (Zammit et al. 2002).

CANNABIS AND DEPRESSION/ANXIETY

There are suggestions that depressed individuals are more likely to use cannabis and that consumption of cannabis is associated with increases in anxiety, depression, and suicide attempts. In an Australian household sample of 1,261 adolescents (13-17 years), Rey and others (2002) found that those who used cannabis had more internalising and externalising problems than those who did not. Cannabis use was associated with greater (self-reported) levels of depression and delinquency, and (parent-reported) difficulties with attention. Females with depression scores in the top 10% of the sample were five times more likely to have used cannabis than females in the bottom 50%. Among males who used cannabis 14% qualified for a diagnosis of depressive disorder compared to 6% who had not used it. The parallel figures were 18% and 6% for females (Rey et al. 2002). Adolescents using cannabis reported higher rates of drinking alcohol, smoking cigarettes and of trying other substances. However, they did not use services more often.

Other research in American, Australian and New Zealand populations has also found strong evidence for links between cannabis use and the risk of major depression. In a 15 year longitudinal study, Bovasso (2001) reported that at follow up, cannabis increased the risk of major depression fourfold. Use of cannabis was specifically associated with an increase in suicidal ideation and a reported lack of pleasurable feelings (anhedonia).

Patton and others (2002) report a dose-effect relation between cannabis use and anxiety or depression in a cohort of 1,601 young people who were followed from age 14-15 for seven years. Assessment was conducted at regular intervals with repeated measures. This link was stronger for young women than men although further research is needed in this area. A dose-effect relation between cannabis use and anxiety or depression was reported (Patton et al. 2002). In their statewide (Victorian) sample of students, these researchers found that 60% of participants who used cannabis by the age of 20, and 7% were daily users. Daily use in young women was associated with a fivefold increase in the odds of reporting a state of depression and anxiety after adjustment for intercurrent use of other substances. Weekly or more frequent cannabis use in teenagers predicted an approximately twofold increase in risk for later depression and anxiety after adjustment for potential baseline confounders (Patton et al. 2002).

Baseline depression and anxiety did not predict later cannabis use in either study (Bovasso 2001; Patton et al. 2002) and thus did not support the self-medication hypothesis. In the New Zealand study no association was found between cannabis use at age 15 and depressive disorder at 26, however, young people who used cannabis three or more times by age 18 were more likely to have a depressive disorder at age 26, even after the use of other drugs was controlled for (Arseneault et al. 2002).

References


For a complete reference list please contact the Managing Editor.
Drug courts have been established in New South Wales and Western Australia. Two specialist youth drug courts have also been established in New South Wales and Western Australia. The New South Wales and South-East Queensland pilot drug courts have now been evaluated.

**Background**

Drug courts, which developed in the United States in the late 1980s, have emerged as one response to the growing problem of drug use and drug-related crime in Australia and elsewhere. They are part of a trend in judicial administration which has seen the development of what have been termed ‘problem-oriented’ courts, other examples include mental health courts, domestic violence courts, Aboriginal courts and community courts. They represent a move away from a focus on individuals and their criminal conduct to offenders’ problems and their solutions (Freiberg 2001).

**What is a drug court?**

A drug court administers cases referred from other courts where the offender pleads guilty and the judicial system supervises drug treatment and rehabilitation as part of the sentencing process. The essential features of a drug court are that it:

- deals with a specified class of offenders
- integrates drug treatment services within a criminal justice case processing system
- provides early intervention
- uses a non-adversarial approach
- has a dominant and continuing role of the drug court judge
- uses frequent substance abuse testing
- involves frequent contacts with the court
- provides a comprehensive treatment and supervision program and a system of graduated sanctions and incentives

(United States, Department of Justice, Drug Courts Program Office 1997: 7, 9)

**Drug courts in Australia vary widely in their legal basis and jurisdictions**

While the term ‘drug court’ describes the overall philosophical approach to dealing with drug-related crime and drug-affected offenders, it does not convey the fact there are considerable differences between the courts in Australia. Three of the Australian jurisdictions have provided their drug courts with a separate legislative foundation, one as a special Act effectively establishing the drug court as a separate entity, - Drug Court Act 1999 (NSW) - and two as sentencing dispositions available in special divisions of the Magistrates’ Court - Drug Rehabilitation (Court Diversion) Act 2000 (Qld); Sentencing Act 1991 (Vic) - as amended by the Sentencing (Amendments) Act 2002 - South Australia operates under its general bail legislation - Bail Act 1985 (SA) - which provides judicial officers with wide discretion in dealing with offenders brought before the courts. Western Australia is primarily a bail-based scheme though changes have been foreshadowed in relation to the use of deferred sentencing powers under the Sentencing Act 1995 (WA).

**Aims of the drug courts**

Whereas most of the United States drug court programs target offence and offender populations at the lower end of the seriousness range, the majority of Australian programs are aimed at serious cases. Makkai observes that in Australia, the drug courts:

- have chosen to focus on the hard end of offenders – those with a long history of property offending. There are a range of factors that have been important in ensuring this focus. The first is that drug treatment courts are seen as the ‘last’ option before incarceration in a range of diversionary strategies… The second reason is undoubtedly the costs associated with the establishment and maintenance of the drug treatment court. A third reason is the desire to reduce any likely impact of net widening through police prosecuting drug offenders who should be dealt with via less costly diversionary schemes (Makkai 1998).

In Victoria, Queensland and New South Wales, before imposing an order, the alternative of imprisonment must be real, not nominal.

**Eligibility and pre-conditions**

In order to be eligible for referral to a drug court the offender must plead, or indicate that they intend to plead, guilty. Though this may superficially seem unfair, it means that the court’s resources are not diverted from its main task of supervision and treatment. In most jurisdictions, in the referring court, the offender can challenge the nature, number and seriousness of the charges they are facing.

In order to qualify, an offender must be dependent on drugs or alcohol and the court must also be satisfied that the dependency contributed to the commission of the offence. Victoria is the only place in Australia where alcohol is included in the eligibility criteria for its drug court, though it would be expected that the court will initially focus on illicit drug use.

**Sentence structure**

The sentencing structure varies in different jurisdictions. New South Wales, Queensland and Victoria are the most similar with post-conviction, sentence-based drug court programs. After a guilty plea, assessment of eligibility and acceptance into the program, the drug court convenes the offender and imposes a sentence which must be one of imprisonment. Once the offender has successfully completed the program then the court considers the offender’s participation in the program along with any sanctions imposed and any time spent in custody before imposing the final sentence. The final sentence can not be harsher than the initial sentence unless more offences have been committed in the meantime. There is a time limit set in Victoria for this to occur in however there is no time limit in New South Wales or Queensland.

**Drug court teams**

A feature of the drug court is that a ‘team’ of professionals work with the drug court judge. This team consists of people from a disparate range of professions including people from legal, health, law enforcement and correctional backgrounds. These people traditionally have conflicting interests so it is a challenge to bring them together in a case management approach. The team works together to help determine eligibility, deal with legal or logistical matters such as outstanding charges, to monitor an offender’s progress, to formulate treatment plans and services, recommend program conditions or changes to them, advise weekly contact with probation officer and fortnightly report back to court.

1. Re-integration (six months) - offenders are expected to remain drug and crime free, remain in home, social and domestic environment, have either found employment or are ready to, and be fiscally responsible. Fortnightly urine testing, fortnightly contact with probation officer and monthly report to court.

The level of supervision decreases with each phase and an offender can proceed and regress through the stages. In New South Wales, all three phases must be completed before the participant can ‘graduate’ from the program. This has created problems for the drug court program as theoretically a person could be on the program indefinitely. A time limit is set in Victoria, there the program must terminate after two years.

**Programs**

Many of the longer-term drug court regimes have adopted a phased program which requires the participant to progress from one stage to another, dependant on progress. The New South Wales program is typical and was originally intended to take 12 months to complete. The three phases are (Freeman, Karski and Doak 2000: 2; Tiplin 2002: 10).

1. Initiation and stabilisation (three to four months or longer) - in this time offenders are expected to: reduce drug use, stabilise their health, cease criminal activity, complete a relapse prevention program, become engaged in counselling and show a commitment to rehabilitation. Their urine is tested twice weekly with one additional contact visit and they report to court weekly.

2. Consolidation and early re-integration (three months) - offenders are expected to: remain drug and crime free, stabilise their home, social and domestic environment, address major life issues and remain in good health. Weekly urine testing,
on changes to program phases and on rewards and sanctions, including prison and advise on whether or not the program should be terminated for success or lack of it (Drug Court of New South Wales 2000). The team usually meets prior to each sitting of the drug court to review the cases and remains in court during proceedings (Tiplin 2002: 65).

Testing regimes
Urine testing, especially random testing, has emerged as a key component of drug treatment court programs. It is often the only objective measure available to the court to measure compliance with the abstinence conditions (NSW Drug Court Review 2000: para 9.2; Tiplin 2002: 50). Testing is used in clinical management to help the therapist evaluate the offender’s progress (Toronto Drug Treatment Court 2002). The frequency of testing varies in different stages of the different programs.

Termination
The drug court program may end positively or negatively. It will end positively when the person has met the program conditions and aims or progressed through all of the required stages. This can take an indefinite period in New South Wales and Queensland, however, the drug treatment order (DTO) must terminate after two years in Victoria. The Victorian court can decide, if the person has substantially completed with the conditions of the program, to cancel the treatment and supervision part of the Drug Treatment Order, which effectively brings the whole order to an end - Sentencing Act 1991 (Vic), s.18ZK.

A person may fail on the program because they breach its conditions, commit further offences, find it too onerous or are unwilling to continue, for whatever reason. For example, in Victoria the DTO may be terminated if the offender commits further offences (s.18ZN), if their circumstances were not accurately presented at the start, if the offender is no longer able or willing to comply, or if he or she has breached the curfew, community work or residential conditions of the order (s.18ZP).

Evaluations and outcomes
All of the drug court programs were introduced on a pilot basis, their continuation being subject to satisfactory evaluation. Evaluations include effectiveness evaluation (reduction of recidivism, reduction in re-arrest rates, reduction in substance abuse, improvements in health and social outcomes, reduction in imprisonment rates of target groups, reduction in supervision requirements), process evaluation (how people perceive of the program, the Court and its goals, satisfaction levels, analysis of program implementation, client characteristics, drug court operations and services, program compliance, program quality and program completion) and cost-benefit analysis (Belenko 2001:9).

Evaluations have been published on both the New South Wales pilot and the Queensland one.

Main findings from the South-East Queensland evaluation

Referrals to the pilot phase of the South-East Queensland drug court ended on 31 December 2002. During the pilot, 555 people were referred for assessment to the drug court, in all, 97 refused to participate and 129 were ineligible. There were 65 people who were still in the assessment phase, 34 of whom had failed to appear and had outstanding arrest warrants. Intensive drug rehabilitation orders (IDRO) were issued to 264 people.

Of these people, one had withdrawn, 113 had their orders terminated and 23 people had failed to report and had outstanding arrest warrants. There were 83 active participants and 44 graduates (Makkai & Veraar 2003). By the end of September 2003, after the cut off date for the evaluation, 70 people had graduated from the program.

The evaluation concluded that the people who completed the drug court program had reduced recidivism compared with those who were terminated and those who received custodial sentences. Most of those who complete the program do not re-offend and those who do re-offend take longer to do so compared to the other groups. Overall when looking at pre- and post-program offending reductions are greatest for those who graduate from the drug court (Makkai & Veraar 2003).

The evaluators note that those terminated from the program re-offend sooner than either graduates or those in the comparison groups. The evaluators suggest that risk assessment tools could be developed to identify these people most at risk of being terminated from the program early. The assessment could be used to recommend that those most at risk be supervised more intensely or perhaps not referred in the first place.

The evaluators note that there will be more conclusive results about the success of the drug court when the next phase of the evaluation is complete. There is a study underway to follow up the first 100 people who graduated and to investigate their criminal record at 24 months after graduation.

While waiting on this longer term evaluation the Queensland drug court program has been expanded to include two more locations in Northern Queensland which began operation in November 2002. The current pilot phase will continue until 12 December in 2004.

Main findings from the New South Wales evaluation

In February 2002, the New South Wales Attorney-General announced that the drug court would continue beyond its pilot phase.

Data from New South Wales show that to March 2002, 608 persons had been accepted onto the drug court program. In all, 162 offenders were participating in the program and 446 offenders ended their participation with the program and received a final sentence. Of the 446 offenders who had exited the program, 87 (19.5%) had successfully completed the program and received a non-custodial final sentence and 359 (80.5%) had been removed from the program and received a custodial final sentence.

Of the 87 offenders who had successfully completed the program and received a non-custodial sentence, it does ‘work’. The New South Wales process evaluation found that most respondents agreed that the major factor in the drug court program was ‘the level of structure and support provided’ (Tiplin 2002: 80). It was the unique combination of services and resources which were the keys to success, comprising team work, cooperation between agencies and continuity of care and supervision. Part of the success was due to the court structure and regime and the provision of coerced treatment.

In each jurisdiction, the powers of a drug court, its target groups and levels of intervention, will be dependent upon what other options are available to police and court from the time of arrest through to sentence. The courts represent only one in the state’s repertoire of responses to what appears to be an intractable social and legal problem. If they are to remain, they must find their appropriate niche in their own societies and within their own unique legal framework. They must also prove that they are at least as effective as imprisonment and not significantly more costly.

Conclusion

The pilot drug courts, even if they all have positive evaluations, will not of themselves provide an answer to the drug/crime problem. However, what they might do is signal some significant changes in the way courts operate, particularly in relation to their non-adversarial approach, early intervention, access to services, on-going judicial supervision and interaction, inter-agency cooperation and the like.

A major challenge is to determine which of the elements of the drug court program make it ‘work’, if indeed it does ‘work’. The New South Wales process evaluation found that most respondents agreed that the major factor in the drug court program was ‘the level of structure and support provided’ (Tiplin 2002: 80). It was the unique combination of services and resources which were the keys to success, comprising team work, cooperation between agencies and continuity of care and supervision. Part of the success was due to the court structure and regime and the provision of coerced treatment.

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A study found that 43% of those who entered the drug court program were terminated for further offences or for non-compliance with program conditions (Lind et al. 2002: 63). However, in relation to recidivism, the study also found that drug court participants were a range of offenders than the control group and their offending rate was also lower (Lind et al. 2002: vii).

The evaluation also found significant decreases in drug use during the supervision period and this was maintained for some period of time (Freeman 2002: 22). The health and wellbeing of participants in the program were significantly improved. Overall, the evaluation found that the average cost for drug court participants was slightly less than for a comparable group who were not put on the program but sent to prison instead (Lind et al. 2002).
PAYING THE PRICE

REMUNERATION & WORKFORCE DEVELOPMENT

KATE POCKLEY

Our first issue of Of Substance looked at how alcohol, tobacco and other drug (ATOD) services are beginning to take note of contemporary concepts of workforce development (WFD). These concepts are inclusive of, but also look beyond, traditional notions of training and development, and now address wider structural and system issues.

Remuneration of staff is a crucial component in services’ ability to implement WFD strategies. Levels of remuneration help define the ATOD workforce. The sector has long suffered from relatively low levels of salary and rewards for workers. This makes it difficult for services to retain professional staff and continue to develop and deliver quality treatment methods.

A number of recent studies have highlighted the issue of remuneration for ATOD workers, and how this affects the sector.

Workforce development study highlights remuneration

In our previous article we profiled the National Review of Workforce Development Practice, being funded by the Alcohol Education and Rehabilitation Foundation (AERF), to explore workforce development issues for the sector. The consortium undertaking this project includes the Alcohol and other Drugs Council of Australia (ADCA), the National Centre for Education and Training on Addiction (NCETA), the Network of Alcohol and Other Drug Agencies (NADA), the Victorian Alcohol and Drug Association (VAADA), and the Western Australian Network of Alcohol and Other Drug Agencies (WANADA).

One of the most pressing issues arising from consultations with NGO services around the country is the capacity for agencies to attract and retain qualified staff. Carol Bennett, Executive Officer of VAADA, outlines the problems as they affect Victoria.

In Victoria’s case, this stems from poor resourcing of the sector due to historically very low levels of funding. Agencies are unable to provide adequate pay and professional development opportunities due to inflexible funding arrangements (unit costing), especially when compared to the same jobs in other sectors (or government). This was the key issue to emerge from conversations undertaken with Victorian alcohol and other drug agencies as part of the AERF study.

VAADA conducted a forum with 61 participants (representing 18 agencies, six of whom were based in rural and regional areas) as part of the study. The Victorian peak body also conducted 13 key informant interviews with managers of large, small and rural agencies as well as training organisations, government policy makers and specialist workers.

These findings echo similar study results emerging from other jurisdictions. ‘In Western Australia, remuneration for staff has long been identified as a significant barrier to WFD. It impacts more broadly on WFD than recruiting and retaining staff’, says Arthur Toon, Acting Director of WANADA. Toon says that this view has been reinforced by the consultations recently undertaken by WANADA for the AERF study.

The positive outcomes to increasing salary levels are significant. ‘Improving remuneration enables the secondment of professionals from a range of specialist areas, which enhances partnerships between services and enables specific skills to be shared and developed with other staff. Better pay also acknowledges the commitment and calibre of staff employed, improving morale and career development, and sends a message of professional worth through the sector’, Toon adds.

Managing with less

These comments correspond with the results of a survey undertaken by NCETA, on behalf of the National Alcohol Strategy (Wolinski et al. 2003). Surveying managers of alcohol and drug treatment agencies around Australia, it found that financial constraints had specific implications for the capacity of services to engage in workforce development – particularly for rural/remote and NGO services.

The report highlights:

The conundrum of recruitment and retention of staff in specialist treatment agencies compounds workplace pressure. Recruitment and retention are significant workforce development issues.

The NCETA report noted that budgetary constraints ‘affected managers’ ability to fund appropriate staffing levels, resulting in high client/staff ratios and heavy staff workload.

A critical issue for the non-government sector

Funding levels, coupled with low award wage levels, only compound this issue for NGOs. From a NSW perspective, ‘the issue is critical because in terms of attracting qualified people to the sector, and keeping them there once employed, [NSW] NGOs simply cannot compete with government and other agencies’ salary levels and benefits’, says Larry Pierce, Executive Officer of NADA.

This is particularly salient for NGO services that employ staff on the Social and Community Services Award (SACS). ‘This award is uncompetitive in relation to NSW Health Department and Area Health Service awards. Government grant programs are indexed to CPI but do not adequately address the salaries and wages bills and on-costs of NGO’s, says Pierce.

In 2002, WANADA held a well-attended forum on wage parity. ‘From that forum it was made clear that, without significant changes to the state awards that services need to comply with, decisions about improving remuneration ultimately rest with individual organisations’, says Arthur Toon. ‘A whole of sector strategy is needed to reduce any competitiveness between services based on remuneration.’

A current contentious issue for Victoria is the implications of moving to three year contracts (rather than the traditional annual). While this arrangement has been sought for some time, the potential sting in the tail for services is that government grants will not fund basic cost of living increases (CPI) and possibly wage increases, and may also be dependent on ‘productivity gains’ – a move that may disadvantage many programs. ‘This is a hot issue [for Victoria], and one that VAADA is engaged in resolving’, says Carol Bennett.

Looking forward

Given that a number of studies have pointed to the quality of interaction between service providers and their clients as an indicator of efficacy of treatment, the need to attract and retain qualified staff in the sector by providing adequate levels of pay, flexibility (through terms and conditions of employment) and professional development is paramount (Ritter 2002; Najavits & Weiss 1994).

This is an issue that the ongoing AERF-funded study will focus on. The collaboration outcomes to date will be officially launched at VAADA’s annual conference on 2 December 2003. The launch will involve AERF representatives, each state peak body involved in the project and NCETA. An announcement will be made at that stage regarding the possibility of a national forum to be held early next year to take the project forward.

Many programs operate in environments that constantly demand improvements, including incorporation of evidence-based practice, especially as clients’ treatments needs become increasingly complex. To do this, services need skilled and committed staff. Hopefully, initiatives such as those arising from this study, and the NSW Summit on Alcohol Abuse (see separate story), will go some way towards addressing this critical WFD issue.

References


THE NSW SUMMIT ON ALCOHOL ABUSE MADE WORKFORCE DEVELOPMENT A PRIORITY – The challenge will now be to turn policy into action

The NSW Alcohol Summit, held in August 2003, debated workforce development alongside other high priority issues such as community engagement, harm minimisation and alcohol dependence disease and treatment. However, this was one area where in participants all agreed on the need for urgent action.

The Summit’s WFD Working Group gathered experts and interested parties from across Australia to make a series of recommendations to the Summit. Highlights of these recommendations included ratifying the establishment of a Drug and Alcohol Workforce Development Council – a national first – that will oversee the development of a state-wide Planning Framework for the drug and alcohol workforce. Other key initiatives to be addressed by the Framework include:

• a review of the training and development opportunities across the state (including regional and remote areas)
• a profile and audit of the current AOD services across NSW
• continuing government funding of and ongoing support for the development of workforce development strategies across the government and NGO sectors
• establishing community controlled and culturally appropriate training programs for frontline workers.

The ATOD sector will be waiting to see if the establishment of this Council represents a shift by the NSW Government to a more progressive WFD model. It will be interesting to see what developments arise from this important aspect of the Summit.


The National Review of Workforce Development Practice, being funded by the Alcohol Education and Rehabilitation Foundation (AERF), to explore workforce development issues for the sector.

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The current warnings on tobacco products were introduced in 1995 as regulations made under the Trade Practices Act 1974, the Trade Practices (Consumer Product Information Standards) (Tobacco) Regulations. Policy responsibility for the regulations rests with the Consumer Affairs arm of Treasury.

A review of health warnings on tobacco products was one of the actions identified under the National Tobacco Strategy 1999 to 2003-04.

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A review is currently being conducted jointly by Treasury and the Australian Government Department of Health and Ageing with the assistance of a Technical Advisory Group. The first step in the review was an evaluation of the existing health warnings conducted in 2000, which showed that they had lost their impact and needed to be renewed to include new consumer information on the health effects of tobacco.

As a second stage of the review a discussion paper was developed which canvassed options for change with the community and industry sectors. This paper was released in April 2001.

The Australian Government Department of Health and Ageing has also carried out two stages of market research. This included research into consumer reaction to a range of health warnings including graphics and associated explanatory messages. It is now expected that new regulations will be approved by the end of 2003.

Catriona Bonfiglioli interviewed Anne Jones, Chief Executive Officer of Action on Smoking and Health (ASH), for Of Substance about what the proposed changes to cigarette warning labels should include.

The new system for health warnings on cigarette packets should have built-in flexibility, according to Anne Jones. Packet warnings need to be modifiable so smokers’ attention can be recaptured by new warnings incorporating the latest evidence on tobacco-related disease, Ms Jones said in an interview with Of Substance.

The current regime is too cumbersome, requiring years of bureaucracy, cabinet approval and parliamentary action to introduce change. The price is a system where warnings are out-of-date and effectively invisible to smokers and the tobacco industry benefits from the lack of effective anti-smoking messages, Ms Jones said:

We need to have a system where the Chief Medical Officer should be able to review the latest evidence and then require that there be another warning updated on the cigarette packets, rather than waiting almost another decade before updating the warnings...

Advertising people are very experienced at getting through to target audiences and we need to make sure that we haven’t got some old fashioned, out of date, worn out message on cigarette packets because we’ve got a very cumbersome legislative framework.

Ms Jones said she supported Commonwealth proposals to update the content of the health warnings, add powerful images of smoking diseases and increase the size of the warnings to a minimum of 50% of the pack cover.

She said it was important that the warnings included the major risks of smoking – cancer, heart disease, stroke, premature babies – but attention should also be drawn to other impacts such as other cancers, oral cancer, erectile dysfunction, diabetes, premature ageing and gum disease.

Consumer rights

Consumers had a right to be informed about short, medium, and long-term risks of smoking. Warnings about lesser effects should not replace those about cancer and heart disease but could be included in a set of rotating messages, Ms Jones said:

Variety is important because you don’t want to just entranch the view that the effects of smoking are off in the future because smokers will say ‘I’ll stop before then, I’ll stop before I get the big C or before I become a parent.’

Many were not aware that smoking could cause immediate harm, for example smoking can damage arteries even in young people, she noted:

There are some real and immediate effects...You are actually clogging up your arteries, but, because you can’t see it, you’re thinking nothing’s happening.

Highlighting short and medium term risks may have more resonance amongst younger smokers, a key issue in a country with 267,000 secondary school students aged between 12 and 17 already smoking weekly and 40,000 children taking up smoking each year.

Ms Jones said many smokers were aware of the lung cancer risk but did not realise they were putting themselves at risk of cancer of the cervix, penis, bladder and kidney. Australia needed a comprehensive anti-smoking campaign using packet warnings, mass media and niche marketing campaigns backed up by excellent support services and affordable cessation aids for the many smokers who want to quit. ‘We should be providing the best possible quit smoking support services that we can.’

Images are more effective than text alone

Striking images such as an image of a tiny premature baby lying on a hospital bed, as seen on Brazilian cigarettes, were more effective than text alone. Ms Jones said:

You can imagine what smoking in a household does to the health of that child who can’t move away and whose tiny lungs, the size of a walnut, are being filled up with toxic tobacco smoke and at least 40 cancer causing agents.

Resistance to change

Canadian health warning pictures were found to increase smokers’ desire to quit. Ms Jones said at least 50% of cigarette packets’ surface should be devoted to health warnings in accordance with the World Health Organisation’s Framework Convention for Tobacco Control.

The information line telephone number of cigarette packets should be replaced with the Quitline number so smokers can talk to a person rather than a recording device.

Tobacco manufacturers should be banned from using ‘light’ or ‘mild’ as descriptors on packets or using lighter packet colours to infer lighter cigarettes. Ms Jones said ‘there is no such thing as a safe cigarette and there is no evidence whatsoever that light or mild is actually any safer’.

Ms Jones said the tobacco industry might resist the changes to the warnings, lobbying for delays or watered-down warnings and by stockpiling cigarettes with the old warnings.

She noted that Australia’s doctors, dentists and other health professionals could make a major contribution to reduced smoking levels by ensuring that every smoker was identified, assessed and offered treatment. ‘We need to have smoking seen as a chronic relapsing disorder: medicalise it, treat it.’

We’ve got to ensure that there can be no use of grey areas in the legislation by tobacco companies to still try and con smokers into believing that a lighter, milder cigarette is going to be somehow safer or a better alternative.

Allowing cigarettes to be labelled light or mild might give the nine out of ten smokers who have tried to quit the false idea that smoking light or mild cigarettes might reduce their risks without their having to quit smoking. Ms Jones noted:

The use of ‘light’ and ‘mild’ is misleading because most consumers know that light milk, light beer, light cheese implies a safer version of that product... There is no such thing as a safe cigarette... It’s been one of the biggest consumer frauds perpetrated on Australian consumers who smoke.

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W

hat’s the international drug control system got to do with me? Plenty; if you are an Australian concerned with controlling the availability of illegal drugs, preventing their use, and addressing the harms they inflict. Australia’s drug laws must comply with international standards set by international treaties or conventions.

The United Nations International Drug Control Programme (UNDCP) began in 1991. It is now known as the United Nations Office on Drugs and Crime (UNODC). It does the public service work of a complex set of UN committees under the UN General Assembly, including the Commission on Narcotic Drugs and the International Narcotics Control Board.

The head office of the UNODC is in Vienna. Worldwide, the UNODC employs 350 staff. Liaison Offices are located in New York and Brussels. There are also 22 field offices in developing countries. The Regional Centre for East Asia and the Pacific, located in Bangkok, has a coordinating role in this region. Globally:

...the Drug Programme works to educate the world about the dangers of drug abuse. The Programme aims to strengthen international action against drug production, trafficking and drug-related crime through alternative development projects, crop monitoring and anti-money laundering programmes. UNODC also provides accurate statistics through the Global Assessment Programme (GAP) and helps to draft legislation and train judicial officials as part of its Legal Advisory Programme. (unodc.org/unodc/en/about.html)

The UNODC relies on donations, mostly from governments, for 90 percent of its budget. Donors say what the funds can be used for and there is little flexibility. The work done tends to reflect the views and policies of the larger donors (particularly the USA, Italy and Sweden). Although Australia is a small donor, since the mid-1980s we have had a significant voice in policy discussions about the global drug control system.

The drug control conventions

The UN’s drug control program operates within an alphabet soup of acronyms and UN jargon. Most important are the UN drug control conventions and the committee structure to which they are linked. (More detailed information is available on the web (www.unodc.org/unodc/en/about.html).)

Australia, along with most other nations, has signed the three main international drug control conventions: the 1961 Single Convention on Narcotic Drugs (as amended in 1972), the 1971 Convention on Psychotropic Substances; and the 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

The main purpose of the 1961 Convention is ‘...to limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs’. Countries that sign must include, in their criminal law, offences covering these and other areas, for a wide range of drugs listed by the Conventions.

The decision of the Australian Government to become a party to the 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances was the subject of great controversy at the time. This Convention came into force in 1991. Many saw this as being in conflict with Australia’s innovative and demonstrably effective harm minimisation approach. Others, however, thought it was crucial that Australia adopt the UN approach, even if it was in some ways counter to domestic policy.

The 1988 Convention introduced a radical shift in what the conventions covered. It required that signatory nations were ‘to establish as a criminal offence under its domestic law... the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption...’

This criminalised drug use as well as supply, just when Australia, along with other nations, was reviewing drug policy in light of the evaluations of the partial decriminalisation of minor cannabis offences in various jurisdictions.

The Conventions do however provide some flexibility. For example, there is some leeway given in what penalties should apply when the laws are broken by referring to constitutional limitations. Despite this flexibility, once Australia signs the Convention, the international community expects it to live up to its commitments or withdraw from one of more of the Conventions. Even with this flexibility the 1988 Convention makes it difficult for countries to consider progressive harm reduction strategies.

There is some evidence that criminalising drug use and drug users, as required by the 1988 trafficking Convention, may increase the spread of blood-borne viruses such as HIV and Hepatitis C. There is some evidence that criminalising drug use and drug users, as required by the 1988 trafficking Convention, may increase the spread of blood-borne viruses such as HIV and Hepatitis C.

Policies relating to demand

The treaty system’s purpose was to restrict the availability and use of drugs to medical and scientific purposes. The 1961 and 1971 Conventions mostly focused on controlling the supply of drugs. Illegal drug-producing nations, such as Mexico and Colombia, argued for a more balanced approach; they wanted the UN Conventions to also cover the demand for drugs. However, many nations, led by the USA, rejected this idea.

The poorer nations do not like being blamed for producing the drugs when they argue that the production is fuelled by the demand for illicit drugs from wealthy Western nations.

The UN General Assembly did adopt a Declaration on the Guiding Principles of Demand Reduction in 1998, however the US refused to endorse that. There was some discussion between the parties to the conventions about the best approaches to global drug control.

Recent debates about process and direction

In April 2003, the UN Commission on Narcotic Drugs (CND) conducted a high level Ministerial meeting. Its stated purpose was to ‘evaluate progress made and difficulties encountered’ in global drug abuse control. The outcome was a statement which reaffirmed participants’ commitment to the goals for global drug abuse control established by a Special Session of the UN General Assembly in 1998, including a commitment to eliminate or reduce significantly the illicit cultivation of the coca bush, the cannabis plant and the opium poppy, as well as the illicit manufacture, marketing and trafficking of synthetic drugs, by 2008. These goals were characterized by the slogan ‘A drug free world – we can do it!’

The Executive Director of UNODC, Antonio Maria Costa, more modestly entitled his progress report for the April 2003 meeting ‘Encouraging progress towards still distant goals’.

Many commentators have argued that the ten-year goals established in 1998 are wildly unrealistic and that the CND meeting failed to achieve its goals in that it did not conduct a genuine evaluation of progress towards achieving them, and failed to seize the opportunity to make adjustments to the international systems of drug control. The perceived inadequacies of the existing goals and implementation strategies have been documented by such groups as the Amsterdam-based Transnational Institute (Transnational Institute 2001, Jelima et al. 2003), and earlier this year the European Parliament was within one vote of resolving that the UN drug conventions be reviewed and changed so as to remove impediments to evidence-based policies in the area of drug harm reduction (Pike 2003). There are now substantial proposals for reform of the international controls system now in the Principal, who are seeking to provide a sounder basis for progress than some of the official resolutions emanating from the CND.

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A review of the need for clear guidelines

CRAIG L FRY, SENIOR RESEARCH FELLOW, TURNING POINT ALCOHOL AND DRUG CENTRE INC. VICTORIA

AIVL is to be commended on their National Statement. The statement encourages dialogue about issues largely ignored in the Australian alcohol and other drug (AOD) field, and calls for a consultative process to develop national ethical standards. The document is significant in a number of ways. It is consistent with the emergence internationally of applied ethical guidelines, which ‘unpack’ the practical aspects of research ethics challenges in specific settings (particularly research involving vulnerable groups). Concrete guidelines like these perform important educational and interpretive functions as companions to peak research ethics policies.

The statement is also similar in spirit to groundbreaking Australian work on consumer participation, and values and ethics in Aboriginal and Torres Strait Islander health research. Sustained lobbying and advocacy in these areas have delivered national guidelines that stakeholders may now use in conjunction with Australia’s National Health and Medical Research Council (NHMRC) ‘National Statement of Ethical Conduct in Research Involving Humans’ (www.nhmrc.gov.au).

The content of the AIVL’s Statement focuses on research ethics issues from the point of view of people who use illicit drugs. AIVL does not set rules but instead calls for debate on issues that arise in relation to: ethics committee review of drug research; participation and consultation in research into drug use; and research planning, conduct and dissemination. These are important issues to be debated.

There are other key issues missing from the AIVL statement including: participant payment and questions of inducement and voluntary consent; definitions of free and informed consent in the context of participant intoxication or other impairment; limits to collection and use of body samples; voluntary consent in dependent relationships (e.g. between clinical researcher and trial participant); and the need for access to research data and participants in field research. This is a good opportunity for AIVL and others (including Australian drug researchers) to highlight the need for clearer guidelines on drug research ethics. This should occur as a matter of urgency.

A National Statement

Until very recently, people who inject/use illicit drugs were seen as passive research subjects. Some people, possibly due to assumptions and stereotypes, had a view that people who inject/use illicit drugs were incapable of being meaningful participants or equal partners in the research process. Fortunately, key researchers and other stakeholders have been working to change this view. There is increasing interest both within Australia and internationally in the involvement of people who use illicit drugs in research and on the broader issues of ethics in health and medical research. With the growing interest in both of these issues, AIVL believed the timing was right to develop the ‘drug user perspective’ on ethical issues in illicit drug use research.

The key ethical issues

The AIVL National Statement does not set rules or provide checklists but rather it highlights some of the key issues. It covers a range of ethical issues in relation to planning, funding, approving, conducting and implementing research from the point of view of people who inject/use illicit drugs. Some of the key issues examined in the document include:

- **Human Research Ethics Committees (HRECs)** including the involvement of people who use illicit drugs in HRECs, the illegal status of research data, criminal law and illicit drug use research, free and informed consent in relation to illicit drug use research, peer-driven research and HRECs and the ethical issues with multi-site research projects.

- **Participation of illicit drug users** in research including participation and consultation as well as principles for participation and involvement.

- **Ethical issues in conducting research** including the ethics of planning and conducting research, storing, managing, analysing and reporting of data, dissemination of research findings and uses or applications of research data.

Future directions

Gaining recognition for the issues raised in the AIVL National Statement will now be a focus for AIVL. It will be forwarded to the Chairs of the Ministerial Advisory Committee on AIDS, Sexual Health & Hepatitis and the Australian National Council on Drugs requesting their support for a process to develop a recognised set of national ethical guidelines. A

A research perspective

WENDY LOXLEY, ASSOCIATE PROFESSOR NATIONAL DRUG RESEARCH INSTITUTE (NDRI), PERTH

AIVL has released a clear and useful statement which should fulfil its objective of contributing to a national discussion about Guidelines for ethical conduct in research with people who inject/use illicit drugs.

Below I outline my individual view, based on many years of research, with people who inject/use illicit drugs. Some of the key issues examined in the document include:

1. **A powerful way for drug users to bring forward relevant research** is to facilitate access to people who use illicit drugs and provide a point of contact for consultancy. The AIVL National Statement maintains, however, that obtaining advice, approval and information from individuals in drug user organisations does not constitute effective consultation and should not be seen as a substitute for ‘actual’ community consultation. It is difficult for researchers to consult with more than a few people who use illicit drugs. People who use illicit drugs are not always the same - researchers cannot consult with representatives of all subgroups and need ‘user’ organisations to speak for them, and/or conduct their own consultations.

2. While researchers may agree that research should be developed in consultation with people who use illicit drugs, and that people should be reimbursed for their time and expenses, the reality is that little money is available for researchers to develop projects to submit for funding. Even if projects get funded, funding bodies often slash budgets. Recently the National Health and Medical Research Council did develop a funding round for hepatitis C research which encouraged consultation with community groups. Perhaps all funders should be encouraged to do this.

3. Much research is commissioned which limits the choice of topic. If community groups want to influence what is studied, as well as how, they need to be included in the committees and departments that decide research priorities.

4. The issue about ethical issues and protecting the interests of participants in illicit drug use research was, as noted in the Statement, canvassed by NDRI at an earlier time (Loxley, Hawks & Bevan, 1997). Our major conclusion was that Certificates of Confidentiality, such as are issued to externally funded research in the USA, would offer legal protection to both participants and researchers. I still believe that such a solution should be developed in Australia. We have not seen that there do not seem to be any moves in that direction.

5. Finally, on the question of consent, I agree with the AIVL National Statement. Institutional Human Research Ethics Committees in Australia should reach consensus. If some universities require research participants to sign consent forms, how do they expect them to talk honestly about illegal behaviours and believe that their response is confidential? At NDRI we fully explain each study and encourage participants to ask questions before consent is sought: then it is sought anonymously, either as a tape recording, or the interviewer signs a statement indicating the participant has understood and consented. If our Human Research Ethics Committee considers this to be ethical and legal, why can’t others?


Ethics in Research involving People Who Use Illicit Drugs

Promoting the perspective of people who use illicit drugs

ANNE MADDEN, EXECUTIVE OFFICER, THE AUSTRALIAN INJECTING & ILICIT DRUG USERS LEAGUE, CANBERRA

A first step in a process aimed at developing and establishing a set of national ethical standards, the Australian Injecting & Illicit Drug Users League (AIVL), has released a National Statement on Ethical Issues for Research Involving Injecting/Illlicit Drug Users. The document aims to promote discussion and encourage further action on ethical issues in injecting/illicit drug use research.

Initially AIVL intended to develop a set of national guidelines on ethical issues in research involving people who inject/use illicit drugs. After a comprehensive consultation AIVL decided instead to develop a national statement because the development of national guidelines would require the combined resources and expertise of all of the stakeholders.

It is hoped the AIVL National Statement will act as a springboard for a broader national ethical guidelines. Gaining recognition for the issues raised in the AIVL National Statement will now be a focus for AIVL. It will be forwarded to the Chairs of the Ministerial Advisory Committee on AIDS, Sexual Health & Hepatitis and the Australian National Council on Drugs requesting their support for a process to develop a recognised set of national ethical guidelines.

The Australian Injecting & Illicit Drug Users League (AIVL), has released a National Statement on Ethical Issues for Research Involving Injecting/Illlicit Drug Users, which is available for researchers to develop funding applications. The document is significant in a number of ways. It is consistent with the emergence internationally of applied ethical guidelines, which ‘unpack’ the practical aspects of research ethics challenges in specific settings (particularly research involving vulnerable groups). Concrete guidelines like these perform important educational and interpretive functions as companions to peak research ethics policies.

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The content of the AIVL’s Statement focuses on research ethics issues from the point of view of those who use illicit drugs. AIVL takes an important first step. In addition to securing support from the Ministerial Advisory Committee on AIDS, Sexual Health & Hepatitis and the Australian National Council on Drugs, other national bodies such as Australian Professional Society on Alcohol and other Drugs and the Alcohol and other Drugs Council of Australia also have a key role to play.

The release of the AIVL Statement falls within the Australian Health Ethics Committee 2003-2005 triennium – in which a consultative national review of the NHMRC National Statement on research ethics is scheduled. This presents a good opportunity for AIVL and others (including Australian drug researchers) to highlight the need for clearer guidelines on drug research ethics. This should occur as a matter of urgency.

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THE NSW SUMMIT ON ALCOHOL ABUSE

A personal reflection
DAVID CROSBIE, CEO, ODYSSEY HOUSE, VICTORIA

I am not sure whether I was sitting on the front bench for the government or the opposition, but either way it felt a little uncomfortable. The main chamber of the NSW House of Parliament is an imposing and impressive space. The assembled group of politicians, experts and luminaries from various parts of Australia and New Zealand, representatives of indigenous groups, young people, alcohol producers and retailers, family and friends still coming to terms with loss, people who had taken journeys of personal discovery – all recognised that here was a real platform for change.

The NSW Summit on Alcohol Abuse was one of those history-making moments that could rewrite the way governments and communities respond to a major aspect of everyday life. At times, I was moved by personal stories, impressed by research showing the extent and nature of problems, and intrigued by various arguments around the alcohol-related harm we all experience, and pay for.

The working group I was in proved challenging for me and a handful of other like-minded colleagues. The majority of our group seemed to be more focused on the well being of publicans and their industry than that of drinkers and their community. The only area where we agreed was the need to prevent young people drinking to excess. Unfortunately, the two favoured approaches within our working group, mass media campaigns and alcohol education, are the approaches the evidence base suggests are unlikely to be effective.

Colleagues who participated in other working groups had more positive experiences. Their groups showed a willingness to move beyond individual agendas and focus on developing substantial recommendations that could address the key problems and issues associated with reducing alcohol-related harm. There wasn’t always agreement, but there was a willingness to engage in discussion and draw on evidence.

Back in the main chamber to discuss the recommendations from the ten working groups, alliances came and went in debating over 100 amendments. They also adopted a colourful, and controversial discussions throughout the week.

The young people’s resolutions were fantastic and the key recommendations in this area included the power to make liquor accord provisions compulsory for licensees. Similar issues were raised in relation to self regulation and alcohol advertising, but recent moves by alcohol producers to tighten their self regulatory practices seem to have bought them some time. A close watch should be kept on how new guidelines and codes of practice are implemented by the producers and advertisers.

Like most participants I felt very privileged to have engaged in such a powerful exercise of democracy in action. Many people around Australia will be watching what happens as the NSW Government begins the challenging task of prioritising and implementing some of the recommendations. Indeed, the issue of how much money the government will allocate to the recommendations was one of many controversial discussions throughout the week.

While recognising that outcomes are the important measure of what events, I can only commend the NSW government and all those involved in the planning and running of the Summit. If this is an indication of the priority the NSW government attaches to addressing alcohol problems, NSW could become a national leader in reducing alcohol related harm.

Reference

Young people heard loud and clear
In fact, the proposal for a specialist alcohol hotline was just one of 66 resolutions put forward by young people that were passed at the Summit.

Almost 60 young people, aged from 13 to 22, from around the state came together and debated and developed resolutions to be put forward at the Summit. This was done at a pre-Summit Young People’s Alcohol Forum organised by the NSW Commission for Children and Young People.

They discussed a broad range of issues, including:• strategies to prevent abuse and harm• alcohol dependence and treatment• alcohol-related injury and trauma• alcohol related crime and anti-social behaviour• responsible supply and consumption of alcohol.

One of the key reasons the Forum was a success was because young people felt that it was a safe and confidential space for them. They could talk openly about their experiences and ideas without being judged.

Prior to the Forum, the Commission consulted with young people and organisations about what they thought were the important alcohol-related issues for young people, their families and their communities. They spoke about issues confronting them, like excessive alcohol consumption, having alcoholic parents or being physically or sexually assaulted by someone who’s had too much to drink.

Young people set the pace
GILLIAN CALVERT, NSW COMMISSIONER FOR CHILDREN AND YOUNG PEOPLE

Politicsian, the alcohol industry and health professionals sat around the same table and heard young people’s views at the recent NSW Summit on Alcohol Abuse.

At the Summit 16 young people debated motions, participated in working groups and spoke out in the media about the resolutions they proposed. And one of the key messages they had for drug and alcohol services is that they want them to be more youth friendly.

Young people said that kids with drinking problems need services that work for them. They want services to provide the help they need, when they need it. As one young person said, ‘The only time I can get to my counselling service is after school at 4pm but they shut before I can get there’.

Young people also said they don’t want to have to go from service to service depending on the type of problem they need help with. As one young girl said, ‘I had to prove I was stable to get into rehab but dual diagnosis meant that I couldn’t get mental health treatment because I was drinking. Services should be more flexible for young people’.

That’s why young people proposed the idea of a specialist, free 24 hour alcohol hotline, similar to the Kids Help Line, where they can talk confidentially, about multiple issues and at a time convenient for them.

In fact, the proposal for a specialist alcohol hotline was just one of 66 resolutions put forward by young people that were passed at the Summit.

Two young delegates, Zeh Behrend and Rohan Williams, presented the resolutions to the Summit. Some of the key resolutions from the forum aimed at reducing alcohol-related harm and promoting responsible drinking passed at the Summit were:

• promoting safe drinking levels, for example by incorporating straightforward messages on alcohol product labels
• requiring the liquor industry to set aside a percentage of its advertising budget for harm minimisation programs
• establishing an Alcohol Task Force to closely monitor the operation of the self-regulatory Alcohol Advertising Code
• making sure young people are involved in the implementation of those resolutions passed by the Summit.

The Summit was a great way to address young people’s concerns about alcohol in their community. It was also a great model for involving young people in the decision making that affects their lives.

I hope other states will follow the lead. The full details of the consultations with young people can be downloaded from www.kids.nsw.gov.au/ourwork/participation.html#young

Making a big impact at the Summit
The overwhelming message young people had from the Forum was that the best way to support them is by teaching them how to drink responsibly.

And from the Commission’s perspective, it was fantastic to see that this message, along with so many of the young people’s ideas, was given serious consideration.

As a young person from Sydney’s Northern Beaches said, ‘It was great to see young people working along side politicians, employees of the alcohol industry and experts in alcohol-related issues for the good of our community.’

The young people’s resolutions were fantastic and the fact that 66 of the 67 resolutions were passed shows how professional they were.

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Alcohol abuse
The use of amphetamine-type stimulants is increasing in Australia. While many people only use amphetamines occasionally, a significant minority develop dependent patterns of use including binge use and regular daily use.

A number of problems can arise from high-level amphetamine use, including psychotic behaviour, aggression, depression and anorexia (Vincent et al. 1998). While the increase in amphetamine use (Topp et al. 2001) and dependence has resulted in greater demands on treatment services, there is no ‘gold standard’ treatment model and there is an urgent need for evidence-based treatments.

Problematic drug use and dependence result from a complex process in which interacting factors (pharmacological, environmental and biological) influence drug-taking behaviour (O’Brien 2003). This complexity means that individuals who use drugs will have different patterns of risk and protective factors, different psychological and social problems, and varying cultural backgrounds. This indicates a need for interventions that are sufficiently varied and flexible to respond to the needs of clients, their severity of dependence, personal circumstance, motivation and response to interventions.

Psychosocial approaches
People who use amphetamines, in common with those who use other drugs, may not be aware of (or may deny) any problems associated with their drug use and consequently may not seek “help”. Many people who use drugs avoid seeking help because of the illegal status of the substances they use. People who use amphetamines do have contact with clean needle programs, primary health care providers, psychiatric services and emergency departments, but at present there is no effective model of intervention when these opportunities occur.

Brief interventions provide a promising approach for opportunistic contact. These approaches provide information about drug use and, in particular, how to reduce the risks of use. Brief interventions aim to increase awareness of the negative aspects of drug use and reasons for ceasing use, and encourage people to consider treatment. Brief interventions are described more fully elsewhere in this issue.

Psychological interventions aim to change people’s drug-using behaviour and, in conjunction with social services, address their emotional issues, practical needs and social interactions. Research into psychotherapeutic interventions will commence in South Australia in 2004. This research is one component of a major project being undertaken by DASC, under the supervision of Professor Jason White, which aims to enhance access to effective treatment services for young people who use amphetamine-type stimulants.

Pharmacological approaches
Management of amphetamine withdrawal
Withdrawal following amphetamine use is less well defined than opioid withdrawal and different in nature. Currently there is no established treatment for amphetamine withdrawal. In a systematic review of treatment for amphetamine withdrawal, Srisurapanont and colleagues (2003) found only two controlled studies that were relevant. Both involved the use of amineptine, an antidepressant that was withdrawn from the market by the parent drug company in 1999 because of reports of abuse.

Catherine McGregor is one of the investigators involved in a series of studies into amphetamine withdrawal undertaken by the University of Adelaide in collaboration with DASC and researchers in Chiang Mai, Thailand. Their first study sought to identify the nature, severity and time course of symptoms experienced during inpatient withdrawal following cessation of regular (at least monthly) use of amphetamines. It also provided a basis for the development of a new 16-item scale for the measurement of symptoms of amphetamine withdrawal (the Amphetamine Cessation Severity Assessment) currently undergoing validation studies.

In the second phase of this work, four medications (modafinil, mirtazapine, venlafaxine and bupropion) will be investigated for their capacity to treat amphetamine withdrawal symptoms. Any medications identified as potentially useful would be targets for subsequent randomised, placebo-controlled trials of efficacy.

Maintenance treatment
In recent years our treatment services have been geared towards depressant drugs – opioids, alcohol and cannabis. Treatment paradigms developed for people who use depressant drugs do not accommodate people who use stimulants particularly well. These factors, together with the lack of an effective pharmacotherapy for those who use stimulants, are thought to be partly responsible for the low numbers of people seeking treatment. Experience with opioid dependence clearly indicates that treatment retention is greatest with pharmacotherapies such as methadone maintenance, but equivalent treatment options are not available for people who use amphetamines.

Martick and Darke (1995) suggest that amphetamine maintenance treatment may be appropriate when amphetamine use is frequent (usually daily), attempts to achieve abstinence have been unsuccessful, dependence is evident, severe adverse complications have occurred and maintenance treatment is likely to cause less harm than continued illicit use. Risks associated with maintenance treatment include psychiatric and cardiovascular complications, particularly when additional illicit stimulants are consumed. Limited investigations of desamfetamine prescription undertaken to date (Shearer et al. 2002) suggest that there are modest gains in its favour, but more research is required.

The program of research being undertaken by DASC, directed at young people who use psychostimulants will investigate effective maintenance treatment strategies suitable for use in both specialist and primary health care settings.

Amphetamine psychosis
Psychosis is a significant adverse effect of chronic, high-level amphetamine use. In general the health system remains poorly prepared to deal with people who experience this effect. These people tend to fall in the gap between specialist psychiatric and specialist drug and alcohol services. In a systematic review of treatment for amphetamine psychosis, Srisurapanont and colleagues (2001) did not find any published controlled trials of treatments, indicating more research is needed in this area.

DASC was one of the sites and the coordinating centre for a study by the World Health Organization of methamphetamine-induced psychosis. The first phase of this study explored the nature of psychotic symptoms associated with methamphetamine use, clinical treatment approaches, and harms related to psychosis. A subsequent 18-month study based in Adelaide, that is about to commence, will trial different pharmacological approaches to the acute management of amphetamine-related psychosis presentations to hospital emergency departments.

Concluding remarks
Despite the relatively higher prevalence of amphetamine use, heroin and cocaine dominate addiction treatment research. The program of research outlined above will go a very small way towards addressing the gaps. There remains much to be done so that we can offer people who use amphetamines the choice of treatment options that is available to those who use opioids in Australia. Clean needle programs and substitution treatment for opioid users have helped Australia to maintain low levels of HIV infection. A trend of increasing amphetamine use by injection is a source of renewed risk for HIV as well as Hepatitis C. Acceptable, effective treatment for people who use amphetamines is needed urgently, along with strategies to address injecting and sexual risk behaviour.

Acknowledgements: Marie Longo and Kate Morefield contributed information and comments.

References
The increasing use of amphetamines has led to more people seeking treatment. All medical services need to be ready to deal with these presentations. People who use amphetamines include occasional or recreational users, situational or occupational users (such as shift workers), and abusers or dependent users. Some people inject the drug and may also use opioids or be on methadone programs.

People often present with the acute toxic effects of amphetamines. Their behaviour is often prominent and problematic. It can include increased physical activity, restlessness and anxiety, aggression (sometimes leading to hostility), euphoria, talkativeness and repeating simple acts or tasks. Mental state changes range from misperceptions to paranoia to frank psychosis. Symptoms of anxiety also occur (e.g. insomnia and panic attacks). Patients can complain of nausea, dizziness, dry mouth, blurred vision, headache, agitation, confusion and hallucination. Physical signs include dilated pupils, tachycardia (e.g. palpitations and perspiration), tremors, excessive sweating, increased blood pressure and body temperature, and a rapid or irregular pulse.

Dealing with the above spectra of effects is a therapeutic challenge, and literature is sparse in this area. The environment will influence the patient's pattern and severity, therefore environmental management is an essential consideration. Patients may benefit from being in a quiet room. Strategies like 'talking them down' and avoiding verbal (and physical) conflict are useful. Other considerations are the security of both patients and staff. This balancing act can be difficult in an emergency setting, and especially hard in a GP's surgery.

When such measures are inadequate, oral or intravenous (IV) diazepam may be used for sedation. Alloys of 5-10mg of diazepam while assessing response are usual. For those that remain particularly agitated, IV haloperidol may be used as an adjunct, usually at a dose of 5-10 mg, for its synergistic effect as many people who use amphetamines are tolerant to benzodiazepines. As both diazepam and amphetamine have a long duration of action, the former is a good choice, unlike a shorter acting agent such as midazolam. Such sedation should only be administered in an institution used to such treatment by expert staff as over-medicating can lead to major complications which may require admission to an intensive care unit. For patients outside hospital, rapid referral to the local community mental health service is advised rather than trying to deal with a potentially violent person.

More prolonged toxicity may induce a transient psychosis (usually resolving over a few days). Patients are often admitted to a psychiatric ward and do benefit from antipsychotic agents such as risperidone 1-2mg bd (twice a day) given over a period of days. A longer acting agent may be used if the psychosis is not transient but this is a specialised area.

The withdrawal syndrome described after a period of heavy and regular (dependent) amphetamine use is manifested by mood swings, agitation (to depression), apathy, variable sleep, lethargy and lack of pleasure. Intense cravings is another feature of the withdrawal syndrome. Withdrawal symptoms and their severity do vary, beginning about 24 hours after last use, and lasting up to four weeks (week one is generally the most severe). No medication is particularly effective for the amphetamine withdrawal syndrome. Short term use of benzodiazepines (i.e. for several days) may be indicated (with caution) for those with insomnia and/or agitation, however, the risk of dependence exists. Low dose tricyclic antidepressants are an alternative. Neuroleptics are generally only indicated for those with marked mental state changes.

Prompt feedback and brief intervention remain important steps at the appropriate time. Relevant and useful questions include:

- Do you know what the risks are of amphetamine use?
- What do you want to do about amphetamine use in the future?
- Do you know where to get help if you want it?
- Are you interested in hepatitis B vaccination and blood borne virus (HBV, HVC, HIV) testing?
- Are you aware of how to access needle syringe programs?

Such brief conversations can be followed by referral to local drug and alcohol services. Referral may lead on to the patient opting for other interventions such as cognitive Behavioural therapy, described elsewhere in this issue.

Many people who use amphetamines will never seek treatment, though a thorough history taking of patients presenting with symptoms such as depression, high blood pressure and anxiety disorders may uncover use of amphetamines as a contributing cause. The true extent of the disease burden related to amphetamine use, acute and chronic, is unknown and evolving.

Other chronic problems that can follow from amphetamine use include psychiatric disorders such as depression, possible cognitive impairment, cardiovascular complications such as myocardial ischemia or infarction, stroke or TIA (transient ischaemic attack) and endocarditis, anorexia leading to malnutrition, blood-borne viruses, dental, lung and kidney disorders which are beyond the scope of this article.

The author would like to thank Dr. Adrian Dunlop, Senior Medical Addictions Specialist from Turning Point for reviewing the article.
Upcoming conferences

18-20 April 2004
Club Health 2004
Melbourne
3rd International Conference on Nightlife, Substance Use and Related Health Issues
www.clubhealth.org.uk

20-24 April 2004
15th International Conference on the Reduction of Drug Related Harm
Convention Centre, Melbourne
www.ihra.net

5-6 May 2004
3rd Australian Drug Strategy Conference
Alice Springs Convention Centre
Contact Conference Coordinators ADSC. Secretariat@pfes.nt.gov.au

30 May-4 June 2004
1st Asia Pacific Institute of Addictions Recovery Works!
Current Trends in Addictions Prevention, Treatment & Rehabilitation Singapore
Email: admin@acedaytons-direct.com

5 July-8 July 2004
The 17th Annual Australian Winter School in the Sun
Solutions – Successes – Setbacks Carlton Crest Hotel, Brisbane
Contact Australian Drug Foundation Queensland
Email: winterschool@adfq.org

25-26 September 2004
Addictions 2004
Crossing Boundaries: Implications of Advances in Basic Sciences for the Management of Addiction Sunshine Coast, Queensland
www.addiction-conference.elsevier.com

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