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Monitoring drugs in New Zealand 29
A new system tackles the unique challenge of measuring illicit drug use in a small nation.

Opinion piece: the Alcohol Beverage Code 12
Is the adjudication system for alcohol advertising flawed?

People in the field: Frank Hansen 14
Of Substance interviews the past chair of the Intergovernmental Committee on Drugs about his long career in police drug investigation, and about changing police and community attitudes.

Juveniles in detention 16
The latest research into illicit substance use by young people in detention.

Insights from neuroscience 18
New studies in this field highlight the impact drug use can have on adolescent brain development.

Agency snapshot: psychosis and drug use 20
A Victorian dual diagnosis service explores the use of cannabis and amphetamines among its clients.

Spotlight on Asia-Pacific 22
Dealing with drugs: illicit and their impact.

Australian training changes attitudes. 24
Research committee snapshot: psychosis and drug use

Research techniques: ethnography 26
We continue our series exploring different ways of conducting research.

It’s my life: ethics in consumer research 28
Giving people who use drugs a say about how they are studied.
Editors’ letter
Welcome to the April issue of Of Substance. It is well known that the injection of diverted pharmaceutical drugs has serious health consequences. It comes as something of a surprise then to find some health professionals arguing that, in places where pharmaceutical misuse is high, there may actually be less harm than in markets dominated by the use of illicit substances. Yet that is exactly the view which ENTRY Top has encountered in this issue’s cover article. Also in this issue, we look at how the field of neuroscience can play an important role in understanding the physical effect of alcohol and other drugs (AOD) on the brain, particularly amongst adolescents. Australia has often lagged behind the rest of the world in this area of study. This feature highlights the vital role it can play in shaping future AOD policies. As always, Of Substance continues its strong focus on research issues, with reports on studies by the Australian Institute of Criminology into juvenile crime and substance use, and a study by the NEXUS Dual Diagnosis Service from Victoria into cannabis and amphetamine use among clients experiencing psychotic symptoms. We also discuss ethical issues which need to be considered when conducting research with people who use illicit drugs, as well as the world of ethnographic research techniques. From illicit we turn to licit drugs, with a look at areas of the Northern Territory where restrictions have been placed on community access to alcohol. We couple this with an article by Geoff Munro in which he discusses the effectiveness of the national alcohol advertising code of practice.

In this issue, we also turn our eyes to neighbouring nations, with an article exploring responses to drug use in the Asia-Pacific region and a new system of monitoring illicit drug use in New Zealand.

Of course, we once again bring you the latest in news and recent releases from the Australian AOD field, and continue the discussion started in our letters page, which we introduced last issue.

We hope you enjoy this issue, and of course look forward to your comments and feedback.

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GUEST EDITORIAL
COMORBIDITY: A DIFFERENT PICTURE
WAYNE HALL, DIRECTOR, OFFICE OF PUBLIC POLICY AND ETHICS, INSTITUTE FOR MOLECULAR BIOSCIENCE, UNIVERSITY OF QUEENSLAND

Comorbidity between substance use and mental disorders most often elicits the image of a young person with a psychosis who is dependent on cannabis, amphetamines or both. Patients with such dual diagnoses are difficult to treat and hence are given an understandable priority by their families and the mental health staff who treat the distress and disability that these disorders cause. These patients dominate the client load in many specialist mental health services, as the audit of a dual diagnosis service in this issue shows.

But dual diagnoses have overshadowed the very different patterns of comorbidity found among the clientele of specialist addiction treatment services (Hall & Farrell 1997). Anxiety and affective disorders are the most prevalent, and the potentially most remediable, forms of comorbidity among persons seeking treatment for addictive disorders (Merikangas et al. 1998; Hall et al. 2001). Australians with alcohol and drug dependence have high rates of affective and anxiety disorders that predict a poorer prognosis, and are more difficult to treat, and that are more likely to become chronic and disabling. These types of comorbidity are particularly over-represented in addiction clinical services because persons with these mental disorders are more likely to seek treatment (Andrews et al. 2001).

Addiction services should improve their ability to diagnose and treat patients with comorbid mental disorders by using reasonably short, valid and reliable screening tests to diagnose anxiety and depressive disorders among their patients (Dowe et al. 2002). Services either need to develop some in-house expertise in treating the more common of these disorders or cultivate good relationships with mental health professionals who can treat them.

Super-specialty services for dual diagnosis, as have been advocated in the United States and implemented in some Australian states, are an expensive option probably best reserved for teaching hospitals and research centres until better evidence is available on their effectiveness and cost-effectiveness. In the meantime, we need to trial and evaluate screening and referral and compare its cost-effectiveness against conventional management and treatment of mental disorders in addiction settings with staff with mental health expertise. The recent federal funding to improve mental health services for young people provides an opportunity to undertake this much-needed health services research. The results of these trials should improve cooperation between specialist addiction and mental health services that were separated in most Australian states over 10 years ago.

For a full list of references cited in this editorial, email: editor@ancd.org.au.

NEWS
John Herron appointed ANCD Chairman
In February 2006 the Prime Minister announced that Dr John Herron would become the new Chair of the Australian National Council on Drugs (ANCD). Dr Herron, who has just completed an appointment as Australian Ambassador to Ireland and the Holy See, replaces Major Brian Watters who retired in April 2005 after being elected to the International Narcotics Control Board.

Dr Herron was also previously a senator in the Federal Parliament with his most recent appointment in the parliament being Minister for Indigenous Affairs. He is a Fellow of the Royal Australasian College of Surgeons and the Australian Medical Association. Previously Dr Herron has been a president of the Bennelong Society, a group devoted to the improvement of the welfare of Aboriginal people; patron of the Queensland Council of Family Associations; a board member of the National Seniors Foundation; and a foundation member of the Down Syndrome Association of Queensland. He has worked as a volunteer doctor for CARE Australia in a Rwandan refugee camp. In announcing his appointment, the PM stated: “I look forward to working with Dr Herron in addressing the many complex and challenging issues in our fight against drugs. It is a fight that must be won.”

In a press release issued by the ANCD, members welcomed Dr Herron and particularly looked forward to working with him on gaining a greater level of budgetary support for drug and alcohol programs in Australia, and in particular utilising his experience and expertise to address problems being faced by Indigenous communities.

Mental health on the national agenda
The Council of Australian Governments (COAG) met in February to discuss a number of issues of national importance, including mental health. COAG recognised that mental health is a major problem for the Australian community, and noted that additional resources will be required from all governments to address the issues. COAG has called for an action plan to be developed by June 2006 which should include:

• a renewed focus on promotion, prevention and early detection and intervention – including reducing the impact on mental health of substance abuse, including illicit drugs (such as cannabis and amphetamine-type substances) and alcohol;
• getting the balance right between hospital care, community and primary care and the best type of accommodation for people who are unable to manage on their own;
• improving and integrating the care system to enable the right care to be accessed at the right time, including mental health services, primary care, general practice, private psychiatric services and emergency department services.
INCB: Annual report on Oceania

The International Narcotics Control Board released its annual report on 1 March 2006, including its series of regional snapshots. For the Oceania region, it reported:

The illicit cultivation and abuse of cannabis continue to be serious problems in most countries in Oceania, including Australia, Fiji, Micronesia (Federated States of), New Zealand, Papua New Guinea and Samoa.

The illicit manufacture of amphetamine-type substances also continues to be a problem in Oceania. Australia and New Zealand have continued to detect and dismantle large numbers of clandestine laboratories. There is some evidence that clandestine laboratories are increasingly being used for the illicit manufacture of both methamphetamine and MDMA (ecstasy), especially in Australia. There are indications that Oceania may be emerging as a trans-shipment area for consignments of crystallized methamphetamine (commonly called ‘ice’); the abuse of that drug may also be increased in the region. Trafficking in and abuse of MDMA are becoming significant problems in countries in Oceania, in particular in Australia and New Zealand. It appears that New Zealand is increasingly being used as a major trans-shipment area for illicit drugs destined for Australia and the United States.

Canada’s federal prisoner tattoo program

Canada has opened tattoo parlours in six federal prisons in a bid to curb the spread of blood borne diseases. The Ottawa Citizen reports that for $5, federal prisoners can be tattooed by trained fellow prisoners. Racist or gang-related designs are prohibited. The contentious pilot project is the first of its kind in Canada and is believed by some to be the first in the world.

By making tattoos openly accessible, officials hope to control the spread of infectious diseases like hepatitis C and HIV, said a Correctional Service Canada (CSC) spokesperson, Michele Pilon-Santilli. ‘I know we’ve had some criticism from individuals,’ she said. ‘The bottom line is this is a public health issue. It’s harm reduction.’

The project began in August when sites were chosen from each federal region. The total cost of the program is estimated at $700 000 Canadian ($586 551 US). The tattoo parlours were scheduled to operate only until 31 March, 2006, however the Public Health Agency of Canada (PHAC) was applying for funding to extend the program.

Canada is also considering whether to hand out clean needles to injection-drug using inmates. CSC and PHAC have signed an agreement to analyse the risks and benefits of a prison-based needle exchange program.

Farewell to Jenny Hefford

In late February 2006, Ms Jenny Hefford (Assistant Secretary – Drug Strategy Branch – Australian Government Department of Health and Ageing) took up a new position in the Department as the Assistant Secretary of the Policy and International Branch. This change marked the completion of a three-and-a-half year appointment managing drug and alcohol policy at the Australian Government level.

During her time in the Drug Strategy Branch, Jenny formed effective working relationships with a range of stakeholders across the alcohol and other drug (AOD) sector. In addition, she successfully managed a number of initiatives that have proven to be beneficial for the AOD sector, including the introduction of this magazine.

The Of Substance Board of Management would like to thank Jenny for her support. The magazine has received from the Australian Government and wish her well with her new endeavours. Ms Alison Rosewell will be Acting Assistant Secretary of the Drug Strategy Branch until the position is filled permanently.

Australian seniors killed by their drinking

Alcohol has killed more than 10 000 Australians aged 65 and over in the past 10 years, according to figures released in December 2005 by the Australian National Drug Research Institute (NDRI), Perth.

Contained in three National Alcohol Indicators Project bulletins, the figures show an estimated 10 592 Australians aged over 65 died from causes directly attributed to alcohol between 1994 and 2003. And between 1994 and 2002, more than 110 000 Australian seniors were hospitalised due to alcohol-attributable causes – an average of 30 a day.

NDRI senior research fellow Dr Tanya Chikritzhs said the main causes of death in males aged over 65 were alcoholic liver cirrhosis and stroke, while stroke was the main alcohol-attributable cause of death among older females. Falls were the number one cause of alcohol-attributable hospitalisations for all over-65s.

Dr Chikritzhs said alcohol-attributable hospitalisation rates were increasing in most states and death rates were increasing in a number of states – worrying trends given the ageing of the population. ‘While we need to focus on the alcohol harm experienced by young people, significant numbers of older Australians are drinking at levels risky to their health,’ she said.

‘These figures indicate alcohol-related harm among older Australians will have growing implications for the health system, and Australian society, and show the need for evidence-based policy developed specifically for this older age group.’
The diversion of prescribed pharmaceuticals has long been associated with serious health problems, particularly among people who inject drugs. The risk of polydrug overdose and injection-related problems (such as abscesses, blocked blood vessels, heart and skin inflammation) means many alcohol and other drug professionals are keen to identify strategies that might prevent this diversion and these harms.

At first glance, then, it might seem a somewhat surprising proposition that drug markets which are dominated by the illicit use of pharmaceutical preparations such as morphine, methadone, buprenorphine and benzodiazepines, may in fact be characterised as creating less total harm than markets dominated by illicit powders such as heroin.

Yet this is the stance taken by some experts in jurisdictions such as Tasmania and the Northern Territory (NT), where prescribed pharmaceuticals have traditionally dominated illicit drug markets. And in regions such as the outer Melbourne suburbs of Frankston, where drug workers believe diverted buprenorphine is now the drug most frequently injected, some argue there is less net harm than in the late 1990s when heroin dominated the market.

Incirli et al. (2006) recently defined diversion as ‘the unlawful channelling of regulated pharmaceuticals from legal sources to the illicit marketplace’. Polydrug use is a key factor in the rise of Australian illicit pharmaceutical markets. The University of Tasmania’s Dr Raimondo Bruno describes people who inject illicit drugs as ‘very flexible in the types of drugs they use. If they use one type of pharmaceutical opiate, they typically also use others, and generally, benzodiazepines as well’. This type of ‘resilience’ means that efforts directed towards reducing the supply of one type of pharmaceutical may lead unintentionally to increased use of another, as may have been the case following the withdrawal of Temazepam gel caps in Australia, which was associated in Tasmania with increased use and injection of Alprazolam.

Other factors that may contribute to the growth of diverted pharmaceutical markets include: (1) a sizeable licit supply of prescription and controlled medications; (2) the routine prescription of benzodiazepines and opioids to alleviate drug-related symptoms, such as anxiety, insomnia or withdrawal for people who inject illicit drugs; (3) the inherent instability of illicit drug markets, compared to the constant availability of pharmaceuticals; (4) the potential profits from selling prescription drugs because of their relatively low pharmacy dispensed cost; (5) the reduced legal risks in supplying and possessing prescription drugs compared to illicit drugs; and (6) the impact of new technology in facilitating prescription fraud.

PHARMACEUTICAL DIVERSION:

ACCIDENTAL HARM REDUCTION?

Monitoring pharmaceutical diversion

According to Dr Bruno, the monitoring of pharmaceutical diversion faces many challenges, including problems with timely access to existing datasets; inconsistency in coding of drugs in those datasets (brand names, generic names, or an overall drug class) and privacy concerns related to integrating health and law enforcement data on issues such as the identification of doctor shoppers. Moreover, most data about diversion are drawn from studies of people who inject illicit drugs.

...there are people who access diverted pharmaceuticals who use them orally and/or do not attract the attention of authorities, yet little is known about patterns of diversion among these groups.

Although this subpopulation represents the most chaotic and visible group who misuse these drugs, there are people who access diverted pharmaceuticals who use them orally and/or do not attract the attention of authorities, yet little is known about patterns of diversion among these groups.

How does diversion occur?

We know relatively little about the methods by which pharmaceuticals are diverted to the black market, although Darwin academic Dr Bridie O’Reilly suggests supply is driven mainly by small-scale diversion from legitimate prescriptions, doctor shopping and forged prescriptions, rather than through organised thefts from pharmacies or points of manufacture, or via other sources such as internet pharmacy or importation.

Dr O’Reilly says prescription drugs are relatively easy to obtain from a diffuse network of users, friends of users, dealers and suppliers, some of whom also sell other drugs, such as methamphetamine, heroin and/or cannabis. There is little, if any, involvement of organised criminal groups, and the violence and criminality that typically characterise heroin markets are absent. Dr O’Reilly cites this feature as a significant advantage of a pharmaceutical-dominated market.

Policing pharmaceutical diversion

Dr O’Reilly’s research indicates that many NT drug law enforcement personnel regard pharmaceuticals as having little impact on policing. Involvement in crime is generally perceived to be less than for illicit drugs, and there is no difference between the policing of people who are intoxicated, regardless of whether they have used licit or illicit drugs.

Dr Bruno emphasises that there are some difficulties associated with policing pharmaceutical misuse. In particular, because the drugs are prescribed, it is legitimate for some people to possess them, whereas the possession and use of illicit drugs is always an offence. Police officers often receive little training in relevant scheduling and legislative considerations; and their understanding of psychopharmacology and interactions between pharmaceuticals and illicit drugs means their potential to respond in an informed way depends on the education and training they receive (see panel on page 8).

Benefits of a diverted pharmaceuticals market?

Dr O’Reilly has found that, like users themselves and many health workers, some law enforcement personnel believe a market dominated by pharmaceuticals provides some protection against the emergence of a heroin trade, and that because distribution is controlled largely by users and user-dealers, the market is less chaotic than one dominated by illicit powders. Indeed, she argues strongly that the ready availability of morphine in the NT can be conceived as a harm-reduction measure. Morphine users can regularly access the drug from licit sources, simultaneously have other health issues addressed, and need not engage in criminal activity to support their drug use.

Supply reduction might have unintended consequences

Dr O’Reilly believes that restrictions on morphine prescribing in the NT, which increase the cost of illicit morphine, could shift more people into the illicit trade, leading to deteriorating health outcomes and increased crime to support the higher costs. Further restrictions may also result in drug substitution, including illicit drugs such as methamphetamine, rather than an overall reduction of drug use.

Research conducted by Dr Bruno on the Tasmanian illicit drug market over a number of years likewise leads him to predict that reduced supply of diverted pharmaceuticals may have unplanned negative consequences.

He suggests some people who inject diverted pharmaceuticals would increase their criminal activity in order to pay the higher price associated with reduced supply, and would increasingly target and intimidate those legitimately receiving pharmaceuticals. Increased regulation of pharmaceuticals has the potential to make legitimate treatment harder to access for genuine pain and palliative care patients. Successful supply reduction would also likely increase demand for already-stretched treatment services.

Moreover, because many people who inject drugs in Tasmania use pharmaceuticals in place of heroin (due to its low availability on the local market), decreased availability may be conducive to the establishment of a local heroin market or increased use of stolen opium poppies or methamphetamine. These scenarios could lead to health and policing issues that may be more demanding than the current scenario.

Alternative view

However, not all experts agree that markets dominated by the illicit use of pharmaceuticals are associated with less total harm
than those in which illicit powders predominate. Dr David Jackson, formerly the Clinical Director of Alcohol and Drug Services in Tasmania’s Department of Health and Human Services, argues ‘in Tasmania, the harm currently being caused by pharmaceutical opioids and poppy products is so overwhelming that one must consider whether people who inject would be safer using heroin.’

Dr Jackson’s concerns relate to the injection of sustained release opioid preparations such as Kapanol, MS Contin, Oxycotin, Phystopine and Xanax, a practice strongly associated with injection-related problems. Despite pill filters being available to people who inject, not all users theoretically these harms are reduced.

Dr Jackson reports that Tasmanian services observe many consequences, including instances where particles from tablets lodge in the lungs, causing inflammation and can progress to serious lung disease. Particles can also lodge in the liver and other tissues, causing inflammation. ‘Repeated injection of crushed and dissolved tablets can produce harms not seen with injection of heroin,’ he says.

Expansion of maintenance pharmacotherapy options

Sean Swift, who has worked at the SHARPS needle and syringe program in Melbourne’s Frankston for 10 years, agrees with Dr Jackson that although pill filters may reduce infection, they do not reduce vascular damage. Although SHARPS provides the extra equipment needed to inject pharmaceuticals, including filters (McGuinn 2001), Swift states that even long-term heroin users do not show the same kinds or levels of harm as pharmaceutical injectors. Many of his clients, among whom diverted buprenorphine is the primary drug injected, are ‘forced to resort to injecting in the groin or neck due to their vascular damage’.

However, Mr Swift is adamant that there are other benefits to Frankston’s changed drug marketplace that offset these injection-related harms. He observes that many of those illicit buprenorphine injectors could be legitimately maintained on the pharmacotherapy program, but choose not to enrol because ‘they don’t want to get addicted’.

However, having watched some of his long-term clients with a heroin habit, where it is impossible to really know what straightforward for detox services to predict the likely course of detoxification program, points out that clients are able to describe quite precisely the doses they have used, so that it is ‘relatively easy to find the appropriate dose for the individual.’

If we believe a pharmaceutical-dominated market is somehow ‘better’, does that justify letting doctors run rampant with prescriptions because we’re reluctant to risk heroin flooding back in? Dr Jackson considers that such a scenario has arisen in Tasmania, where ‘if someone does try to import and sell heroin, the police are down on them like a ton of bricks, but the black market pharmaceutical dealers seem to be ignored and make a tidy living out of their tax-free dollar per milligram enterprises’.

But, as Dr Brownscomb points out, ‘there are high rates of GP-induced opiate dependence out there, caused by a lack of prescriber awareness or unwillingness to say “no” to patients’, and the repercussions reach beyond current users to potential future users, because ‘ready availability means easy access for new recruits’. Accordingly, he strongly supports further tightening of regulations and closer monitoring of prescribers, but notes that such measures must be balanced against the risk of the emergence of a market dominated by illicit powders, with its own attendant set of harms.

This fine line, he says, highlights the fact that ‘true harm minimisation is all about the appropriate mix of harm reduction, supply reduction and demand reduction’. The complex arena of pharmaceutical diversion provides a graphic illustration of that adage.

References


Future Police Investigate’s Guide to Pharmaceutical Drug Trafficking and Use. For more information, contact Christine Vincent, christine.vincent@police.vic.gov.au.

For a complete list of the references used in this article, email: editorial@amc.org.au.
BACKGROUND

A recent surge in applications for restricted alcohol areas in the Northern Territory (NT) will take the number of restricted areas there to more than 100. The restricted area provisions of the current NT Liquor Act have presented remote Indigenous communities with the opportunity to re-enforce their own local efforts to control liquor and its attendant problems. The configurations of restricted areas take several forms, ranging from small areas of land surrounding single family outstations, where liquor is prohibited, up to large mixed communities with around 2800 residents, where liquor is available in accordance with liquor permits for the restricted area.

Figure 1 shows remote localities in the NT’s ‘Top End’ that were recently declared or which seek to become ‘restricted areas’ for liquor. Between 1979 and the end of 2005, just over 100 restricted areas were declared, pursuant to provisions of Part VIII – Restricted Areas of the NT Liquor Act. A variety of arrangements exist for controlling access to alcohol in these areas (NT Licensing Commission).

The significant strategies in meeting the needs of the resident Indigenous groups are considered in the following arrangements exist for controlling access to alcohol in these areas.

The configurations of restricted areas take several forms, ranging from small areas of land surrounding single family outstations, where liquor is prohibited, up to large mixed communities with around 2800 residents, where liquor is available in accordance with liquor permits for the restricted area. The configurations of restricted areas take several forms, ranging from small areas of land surrounding single family outstations, where liquor is prohibited, up to large mixed communities with around 2800 residents, where liquor is available in accordance with liquor permits for the restricted area.

The Yolngu communities of Groote Eylandt and nearby Bickerton Island.

The isolation of Anindilyakwa people from routine contact with the rest of the world ended abruptly in 1964 with the construction of a manganese mine and a residential township for its workers and associated facilities including two licensed clubs. Groote Eylandt and Bickerton Island were declared liquor-restricted in 1980. However, an area encompassing the mining township was unrestricted, as was one of the Indigenous communities on the eastern side of Groote Eylandt, which had alcohol restrictions except for beer.

These arrangements turned out to be highly problematic. Firstly, the community where beer could be possessed with no limits struggled for years to ‘ration’ the beer brought into the community. A weekly ‘ration’ was purchased from one of the licensed premises in the mining township and transported through the ‘dry’ part of the restricted area. The larger Indigenous community, closest to the mining town, also faced a struggle in that its residents obtained liquor in the town and brought the liquor, as well as the consequences of their intoxication, back to the community. Possession and consumption of liquor by problem drinkers in the mining township could not be controlled, and the behaviour of problem drinkers who moved back to their home communities was difficult for police and the community leaders to manage.

In 2003, the Anindilyakwa Land Council applied for modifications to the restricted area, such that possession and consumption of liquor outside the licensed premises was to be in accordance with a permit issued by the Licensing Commission with recommendations by a local assessment committee. This permit placed, among many conditions, an emphasis on responsible behaviour. It was also possible to build into a liquor permit provisions that allowed those who wished to consume beer from the ‘ration’ in the community on the eastern side of the island to continue to do so.

Non-Indigenous members of the community rightly felt that some of the privileges that exist in the rest of Australia would be eroded by the implementation of the restricted area on Groote Eylandt. However, through a process of community education sponsored by both the mining company and local police, together with the Licensing Commission’s formal public hearing process, these concerns were largely allayed.

While no formal evaluation of this initiative has been conducted, observations and reports from key community members suggest that the initiative has reduced many of the alcohol-related social problems on Groote Eylandt.

CONCLUSIONS

Access to alcohol generally is a conditional privilege, but one which many Australians have come to think of more as a right. Use in restricted areas in the NT by conditions permitting access to liquor have a cogent immediacy and can be designed to reflect local standards and expectations. The enormous flexibility of provisions of Part VIII – Restricted Areas of the NT Liquor Act allows the prospect of creatively regulating access to liquor in remote communities where alcohol-related violence and trauma continue to be a major social problem for Indigenous people (Gray 2009). It is an unusual circumstance for generalised regulatory policies to have sufficient flexibility to incorporate local needs and conditions.

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References


Since 1998 alcohol advertising in Australia has been governed by the Alcohol Beverages Advertising Code (ABAC). ABAC is a voluntary self-regulatory convention administered by four industry associations: the Distilled Spirits Industry Council, Australian Associated Brewers, the Liquor Merchants’ Association and the Winemakers’ Federation.

A review commissioned by the Ministerial Council on Drug Strategy (MCDS) in 2003 concluded the system was dysfunctional (NCRA 2003). It found too many advertising violations were not reported adequately (NCRA 2003). By contrast the industry had maintained the system represented ‘world best practice’ (Millburn 2002; Hudson 2003).

On the initiative of the MCDS, the industry agreed to amend the code in order to improve its efficiency and accountability. The revisions took effect from April 2004 and it is timely to consider whether the system has been improved.

ABAC requires advertisements to ‘present a mature, balanced and responsible approach to drinking’. Specifically, they are ‘not to have strong or evident appeal to children or adolescents’, nor depict ‘the consumption or presence of alcohol as contributing to personal, business, social, sporting, sexual or other success’, nor suggest alcohol contributes to a change in mood or environment (ABAC undated).

This article focuses on two advertisements against which the Community Alcohol Action Network (CAAN) lodged objections after April 2004. Our case is the advertisements, and their adjudication, demonstrate the system remains seriously flawed.

‘Woman on the staircase’ (Fig 1)

(Copyright J. Boag & Son)

This advertisement is featured on Boag’s website. CAAN objected formally on the grounds that the composition – the woman’s state of undress, her pose and the angle of the shot – associates the product with sexual success. The image infers the woman is open to and is even making a sexual advance, and the audience is expected to understand this is what the product is implicated.

The ABAC complaints panel dismissed the objection because the advertisement ‘does not display any personal or sexual interaction, nor does it show how the mood has been altered by the product’ (ABAC 2004). To do this, the panel had to read the advertisement literally, that is a lone woman cannot represent sexual interaction. But this denies that advertising methods evoke and convey meaning by allusion and association, by inference and implication. This is part of the grammar of advertising, understood by consumers and marketers alike: ‘You associate your brand with something desirable and your brand becomes desirable’ (Ferrier 2004).

Ironically, Boag’s own explanation relied on the viewer making associations and drawing inferences about and from the image (however dubious these might be): ‘the presence of the product exudes an air of masculinity and a statement of control about her own destiny ...’ and ‘the imagery depicted is one of a fashion model whose femininity is juxtaposed by her association with the product’ (ABAC 2004). Neither statement is consistent with the type of literal reading preferred by the ABAC complaints panel.

However, the panel decided that the term ‘Love Potion’ that was featured on a link to the advertisement did suggest, in association with the image, that drinking the product would contribute to sexual success. On that basis the panel deemed the complaint ‘upheld’ (ABAC 2004). But if Boag’s removed ‘Love Potion’ from the link the image would be acceptable, so Boag’s did. The bizarre outcome means the complaint was officially ‘upheld’ (and will be cited as evidence that the system works), but the adjudicators approved the image and the advertisement remains on the website.

‘You’ve Been Warned’ (Fig 2) (Copyright Foster’s Group)

The second example is a television advertisement, ‘You’ve Been Warned’, for Cougar Bourbon that urged viewers to make a ‘home visit’ to a person who allegedly caused a popular advertisement to be withdrawn. ‘You’ve Been Warned’ took pains to prevent the viewer realising the story was fictitious by supplying a Victorian address for the alleged complainant while the advertisement was screened only in NSW – see panel on page 13 for transcript.)

CAAN argued this advertisement might intimidate people from submitting complaints about alcohol advertising and that would subvert the operation of the code. By implicitly inciting violence against complainants it breached ABAC section (a)(iii) that prohibits ‘promotion of offensive behaviour’.

The adjudicators dismissed the objection (ABAC 2005). It said ‘You’ve Been Warned’ was ‘inappropriate’ but did not breach ABAC because it deemed section (a)(iii) to refer to offensive adversarial conduct, not just harassment. ABAC did not expressly prohibit such intimidation. The panel conceded that ‘a common sense approach’ would find the advertisement ‘contrary to the spirit of the ABAC and the entire purpose of an open, transparent and publicly accessible complaints system’. It admitted it could interpret section (a)(ii) more expansively and find the advertisement guilty of promoting offensive behaviour, but it preferred to rely on the letter of the code rather than the spirit. So, ‘You’ve Been Warned’, which was withdrawn by Foster’s and which was regarded by the adjudicators as potentially subversive, was, nevertheless, found not to deserve censure under ABAC. Literalism ruled again.

In both cases the results point to major deficiencies in the code and how it is interpreted. First, there is a lack of definition of key concepts (such as sexual success, offensive behaviour, etc.) and a lack of criteria by which they might be identified, although the adjudicators’ legalistic interpretation may thwart any attempt to clarify the terms. Second, the literalism used by the adjudicators to explain the meaning of images will render any code irrelevant, because much advertising is not meant to be understood literally.

Continuing and systemic failure

These cases indicate ABAC continues to fail at every stage. Not only did the advertising ‘creatives’ and corporate brand managers design and approve these advertisements, the much-vaulted pre-vetting panel endorsed them prior to release (ABAC 2004; 2005) and, finally, the complaints panel certified them.

The industry continues to assert ABAC is the best code in the world (Broderick 2005). To add further insult it now alleges the system is no longer one of self-regulation but ‘co-regulation’ because the ABAC management committee and adjudication panel (Broderick 2003). Co-regulation would require, at least, equal numbers of government and industry appointees, and a shared construction of the code. Neither are features of ABAC, but the gambit highlights the industry’s relentless ‘spinning’ of the issue.

The French option

The ‘revised’ code shows no sign of civilising alcohol advertising. These latest examples will confirm the view of critics who argue that self-regulatory codes are always beset by disputes over terminology and continual ‘refinements’ (L대로y et al. 2005). It is probably unfair to expect the industry to regulate itself as it has tried for over 10 years without success (Hawks 1991).

Perhaps it is time to consider the French code ‘(loi Evin), introduced in 1991, which limits alcohol advertising to objective descriptions of the product (origin, ingredients, style, etc.) and requires people who appear in an advertisement to have been involved personally in making the product (Rignaud & Craplet 2004). Unlike the ABAC, the loi Evin has teeth: it prevented alcohol brands from sponsoring the World Cup (soccer) in France (Crpelet 2001). Adopting the loi Evin model would allow more transparency, reduce the prospect of illicit marketing strategies and contribute to honesty in advertising.

Geoff Munro is the Director of the Community Alcohol Action Network, Australian Drug Foundation.

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In 1979 Frank Hansen was a detective working in Sydney’s Paddington police station when he took the phone call that was to define much of his career. A former boss was on the phone. Now head of the NSW Police drug squad, the man was keen to once again work with his one-time colleague. ‘Frank, I’ve got an opening at the squad. Are you interested?’

For the young detective, the invitation was a surprise bend in the road. I had never aspired to join one of the “squads”, says Hansen. ‘They were usually very difficult to get into – applications were culled and people interviewed. Here I had the reverse happening. It would have been silly to knock it back.’

Thus began the police officer’s long involvement with drug issues. More than 25 years on, there have only been a couple of periods when his work was not centred around alcohol and other drugs.

**Giving police a voice**

As well as working as an operational detective in the Drug Squad, on his promotion to sergeant, Hansen took an active role in the Intergovernmental Committee on Drugs and an ex officio member of the Australian National Council on Drugs.

Drug policing over the years

Looking back, Frank Hansen reflects that the issues police faced in the early years had both similarities and differences to the drug issues of today. They were similar in the sense that we had heroin and cannabis, however police at that time confronted middle-level heroin dealers who sold drugs in ounces or multiple ounces.

Rarely seen today, block hash and hashish oil were among the drugs of concern for police in the late 1970s.

Today, police target a higher level of trafficker by using much more sophisticated technology. We also have enhanced working relationships between State Police and the Australian Federal Police and their overseas contacts.

Hansen moved out of drugs and into various positions in NSW Police Headquarters, including running the police Public Affairs Branch. At the Sydney Olympic Games, he was the venue commander of the main press centre. However, his involvement with drug issues was not over, and at the beginning of 2001, he was called on to bring his expertise with drug issues into the then heroin ‘hot spot’ of Cabramatta in Sydney’s west.

At the time, the area had become a trouble spot for the government, attracting mass media attention for its ready availability of cheap heroin and the number of out-of-towners who commuted there to buy drugs. Local businesses were experiencing problems with street-level drug dealing and people using drugs. Due to a public inquiry into the area’s drug issues and negative media which had damaged public trust in the local police, it became clear that there was a need to change the approach to drug policing.

Police should be acknowledged for the role they have played in ensuring public health programs such as needle/syringe and methadone programs have become commonplace.

Superintendent Frank Hansen was billed as the ‘drug expert’ who would solve the problem.

Today he laughs about that tag. ‘What expert?’ he says. ‘I hadn’t worked in a local police station since 1979. Now I was the Local Area Commander and had to run a station with up to 150 staff. I came to a station with industrial and police deployment issues. I gained a whole new respect for what we ask of our local area commanders.’

The Cabramatta years

After years of working with the Drug Squad and drug policy, Hansen moved out of drugs and into various positions in NSW Police Headquarters, including running the police Public Affairs Branch. At the Sydney Olympic Games, he was the venue commander of the main press centre. However, his involvement with drug issues was not over, and at the beginning of 2001, he was called on to bring his expertise with drug issues into the then heroin ‘hot spot’ of Cabramatta in Sydney’s west.

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Hansen gave a two-year commitment to Cabramatta. In that time, he instituted some strong measures to both deter those wishing to come to the area to buy drugs and removing the opportunities for dealers to do their business.

‘We approached the problems on the front foot,’ he says. ‘It was important that we had a high level of visibility, and we began to act against “drug houses” and to enforce “move along” legislation if people didn’t have a valid reason to be in the area. We also disrupted the drug dealing culture.

‘It was also vital to engage the public. We established the Cabramatta City Watch, which provided a place for community feedback and consultation. There were also a number of larger-scale public forums for the wider community.’

A number of measures were used to monitor the success of the new approach to policing. These included collecting local crime and opportunist crime statistics. Another useful measure was to record the number of stolen vehicles found within the area and also of local vehicles which were stolen and found outside the suburb. A fall in these numbers suggested that there was a drop in the number of out-of-towners commuting to the area to buy drugs.

While it may never be known exactly what mix of factors were at play and how much the new police measures contributed to those, the suburb began to lose media attention and drugs became less of an issue in the general community.

A familiar place

Today Frank Hansen is back in drug policy work, heading NSW Police’s drug policy unit and acting as a law enforcement advisor to the Australian National Council on Drugs. He is proud of the role police across Australia now play in drug issues: ‘Police are accommodating public health approaches exceptionally well. There might be occasional local problems, but health and police work together very well at all levels.’
Research into the link between drug use and crime has consistently demonstrated a number of key findings: criminal offenders report higher rates of psychoactive substance (drug) use than the general population; frequent drug use is linked to higher frequencies of offending; the majority of offenders commence both crime and drug use during adolescence; and adult offenders who were detained as a juvenile report more serious and frequent offending profiles and higher levels of drug use.

It is for these reasons the research into the drug use and offending patterns of Australia’s detained youth forms an important piece to the national research agenda.

The Australian Institute of Criminology has undertaken a research study to examine the drug use histories of 371 young people aged between 11 and 17 years who were sentenced to or remanded in detention in all Australian states and territories (Prichard & Payne 2005). These voluntary face-to-face interviews included 25 females and 346 males with an average age of 16 years.

**Substance use**

Almost all juvenile detainees had used at least one drug prior to their current period of detention. The most common drugs used were alcohol (97%) and cannabis (94%), followed by amphetamines (50%), inhalants (37%) and ecstasy (33%). Two-thirds of the juveniles in this study had used more than one of these substances.

Regular or frequent substance use was self-defined and applied only to the six months prior to the current period of detention. Regular cannabis use was reported by a greater number of juveniles (61%) than was the regular use of alcohol (49%) or amphetamines (20%). One in three juvenile detainees (29%) had regularly used more than one drug type in the six months prior to their detention.

Consistent with previous research, this study also indicates that for all drugs other than alcohol the detainees reported markedly higher rates of ‘lifetime prevalence’ (or general behaviour) than youths in the general population (AIHW 2005):

- detainees were five times more likely to have ever used cannabis and ten times more likely to have used amphetamines;
- one in three detainees had tried inhalants compared to one in 50 youths in the general population; and
- detainees were six to ten times more likely to have tried ecstasy.

**Temporal order of drug use and offending**

Debates over the causal relationship between drug use and crime have relied heavily on a developmental approach and the examination of the temporal order in which they occur. This method is used to investigate White and Gorman’s (2000) taxonomy of drugs and crime and to determine whether drug use leads to crime, crime leads to drug use, or whether both drug use and crime coincide as a result of a set of common aetiological factors. In this study of juveniles, it was possible to compare the percentages of youths who (a) used drugs before they began offending, (b) began drug use and offending at the same time (i.e. within the same year) and (c) began drug use after their criminal behaviour started. The results indicate that approximately half of the juveniles had commenced offending before their first use of drugs (47%), one quarter had begun to use drugs in the same year as their first offence, and the remaining quarter were using drugs one or more years prior to their first offence. This pattern is similar to that seen amongst incarcerated adult males (Makki & Payne 2003).

In the present study, 70 per cent of youths reported that they were under the influence of drugs at the time of committing the offence leading to their current detention. This rate is higher than reported by incarcerated adult males (62%) and adult females (58%) in reference to the offences for which they had been imprisoned (Makki & Payne 2003; Johnson 2004). Additional analysis revealed that the prevalence of intoxication and the combinations of drugs being used at the time of offending varied by current most serious offence type (see figure 1). Regardless of whether they were intoxicated at the time of their last offence, one in five juveniles indicated they were sick, hurrying or ‘hanging out’ from a lack of drugs.

There is also some evidence to suggest that crimes committed by juveniles may also be motivated by the economic compulsive model. When asked about the reasons for committing burglary for example, 44 per cent of juveniles reported that it was to ‘obtain money to support a drug habit’. Similarly, 38 per cent of juvenile offenders who had sold illicit drugs also reported that it was to obtain money for their personal drug use.

Finally, the juveniles in this study were asked whether their personal use of drugs had impacted on their lifetime offending (their general offending behaviour). The majority (72%) agreed that their criminal offending was affected by their personal use of drugs. It was not possible in this study to quantify the systemic causes of drug-related crime, although previous research on adult male prisoners suggests that systemic violence as a cause of crime is rare in Australia (Makki & Payne 2003).

**Risk factors for drug use and crime**

This study was also designed to capture basic information about the risk factors associated with drug use and offending, including the juveniles’ history of abuse and neglect, family drug abuse and problems at school. In terms of prevalence, the results indicate that:

- around one in three juveniles reported being the victim of physical abuse (36%) or emotional abuse (27%);
- two-thirds reported that, whilst they were growing up, someone in their family drank too much alcohol or used illicit drugs and
- the majority reported truancy (90%), suspension (89%) and expulsion (59%) from school.

**Policy implications**

The results of this study indicate that for a large proportion of juveniles in detention, drug use plays an important role in criminal participation. Although the majority had not started using drugs until sometime after their first involvement in crime, the majority were intoxicated at the time of their most recent offence, seeking money to support their drug use habit, and reported that their personal use of drugs played an important role in their lifetime offending profile. Moreover, three factors emerged as important for identifying juveniles at high risk of serious offending and drug use - family drug use, childhood experiences of abuse and neglect, and problems at school.

The findings of this study highlight the importance of early intervention programs for breaking the cycle of drugs and crime – interventions that target not only the criminogenically behaviours of juveniles, but the environmental circumstances that may give rise to such activities. The role of the family emerges as a cornerstone for the transmission of pro-social behaviours. In the first instance, interventions should aim to reduce the prevalence of parental drug use, childhood abuse and neglect, as well as providing adequate support services for juveniles who do find themselves in such situations.

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DRUGS AND ADOLESCENT DEVELOPMENT:

Adolescence is a period of curiosity and risk taking, and it is therefore not surprising that experimental substance use is common during this period. However increasingly, we are learning that adolescence is a critical period of brain development, and that the adolescent brain may be more susceptible to the harmful effects of drugs than during adulthood.

These new findings raise questions regarding the relative safety of drugs during adolescence, as well as the adequacy of current public health responses. In the following sections, we will discuss how insights from neuroscience are beginning to advance our understanding of adolescent development, and why early-onset drug use may be associated with increased risk for later health problems.

What have we learnt about adolescent brain development?

In terms of social roles and responsibilities, adulthood officially begins when a young person reaches their 18th birthday. However, from a neurobiological perspective, recent findings are beginning to challenge conventional views around the duration of adolescence, suggesting that brain structure and function are not fully mature until the mid-20s. This concept is somewhat revolutionary, as traditionally clinicians have been taught that the brain reaches its adult size by age six, with limited capacity for subsequent new growth or regeneration.

Through advances in brain imaging techniques, such as Magnetic Resonance Imaging (MRI), a number of groups worldwide have acquired detailed pictures of the living brain, revealing how its size and function change during adolescence. We now know that there is a marked wave of tissue growth occurring throughout the brain during early childhood, followed by substantial remodelling during the teenage years. The changes observed throughout adolescence are thought to reflect extensive refinement (or pruning) of cortical synapses (the connections between nerves), a process that ensures that those connections associated with optimal functioning are strengthened, while less useful synapses disappear (Giedd et al. 1999). Pruning is accompanied by myelination (the development of a lipid sheath around axons in the white matter to speed neural conduction), a process that also makes the brain's operations more efficient.

These developmental changes appear to continue well into our 20s, suggesting that from a developmental neurological perspective, adolescence does not stop at age 18, but continues well beyond. The fact that this remodelling is especially pronounced in brain regions associated with regulating our emotions and behaviours is critical to understanding why adolescence represents such a period of risk.

Substance use and adolescent brain development

Certain substances, such as alcohol, are known to be neurotoxic in adults. For example, both autopsy and neuroimaging studies reveal that chronic alcoholics have smaller, lighter and more shrunken brains than similarly aged non-alcoholics drinkers. Recently, researchers have begun to investigate the effects of alcohol and other substances on brain structure and function during adolescence. Although the literature remains relatively sparse, preliminary findings are concerning, especially as there is growing evidence that addictive substances may lead to significant disruptions in brain development during adolescence.

Indeed, adolescents appear to be more vulnerable than adults to the effects of alcohol on memory-related brain function. While research is still limited, and the majority of studies conducted to date have been in adolescent animals, a recent US study supports the notion of enhanced vulnerability during adolescence. In this study, De Bellis and colleagues compared the hippocampal volumes of adolescents and young adults with alcohol use disorders to those of healthy matched controls (De Bellis et al. 2000). They found that the size of the hippocampus was significantly smaller in subjects with alcohol problems, and that its volume correlated positively with the age of first use and negatively with duration of use. These same researchers have recently found similar effects in frontal brain regions.

Recent data also suggest that nicotine may be neurotoxic during adolescence. Again, few human studies have been conducted, but results from Professor Slotkin’s laboratory at Duke University in the United States raises important public health concerns. Slotkin found that even brief exposure to nicotine in adolescent rodents produces lasting damage in distinct brain regions, even at dosages significantly lower than that typically consumed by regular smokers (Abreu-Villaca et al. 2003).

Importantly, these findings were not replicated in adult animals, even following high nicotine exposure for similar periods. These findings are particularly relevant given the high rates of cigarette smoking amongst individuals with mental health and/or substance use disorders, but further work is clearly needed to fully understand the nature of this relationship.

One class of drugs that are predominantly abused during adolescence are volatile substances. Although very few imaging studies have been conducted, findings to date suggest that chronic inhalant abuse can result in substantial structural brain abnormalities, as well as marked cognitive deficits (Lubman et al. 2006). Imaging studies of chronic users find that almost half have significant structural abnormalities. These results are particularly concerning as this population is often disengaged from and rarely access mainstream health services.

Also of concern is the growing evidence that adolescents may be less sensitive to some of the behavioural effects of acute substance use. For example, adolescent rodents appear less sensitive than adults to the sedative effects of alcohol, as well as to its effects on motor coordination (Lubman et al. 2006). This means that adolescents are able to drink more alcohol before feeling sedated or unsteady, which is in line with the high rates of binge drinking reported among adolescents and young adults. If these results are correct, then young people may be able to ‘party harder’ while being at greater risk of disturbed brain and cognitive development.

Implications for public health policy

Does adolescent drug use cause mental health problems? This was the hot topic of 2005, and has been vigorously debated in scientific, public health and political spheres. While there are clearly polarised views on the relative safety of cannabis use within society, as well as the ideal legal framework for its regulation amongst adult users, it is its use within adolescent populations that is potentially of most concern. Indeed, recent studies suggest that early-onset cannabis use is associated with an increased risk for later psychopathology, particularly depression and psychosis.

One key study that offers a genetic explanation for the link between early cannabis use and an increased risk for psychosis was published last year by Caspi et al. (2005). Using data from a large birth cohort that has been comprehensively assessed at regular intervals for over 25 years, the researchers examined how specific polymorphisms of the COMT gene interact with cannabis exposure.

An important finding was that carriers of a certain variant of the gene were found to be more likely to experience psychotic symptoms and develop psychosis if they began to use cannabis during adolescence, whereas there was no increase in risk amongst individuals carrying another variant of the gene, nor amongst adult-onset cannabis users. The relationship between genetic predisposition, developmental stage and drug exposure is a critical factor here, and supports the notion that adolescence represents a critical period of vulnerability.

Conclusions

There is limited research examining the neurobiological effects of short- and long-term exposure to various substances (including alcohol, tobacco, inhalants and cannabis) on the human brain during adolescence. This must be a priority area for research, especially given the widespread experimental and recreational use of drugs within modern youth culture. A definitive link between adolescent substance use and later psychopathology will have major implications for public health policy, as well as funding priorities. This is an exciting time in neuroscience research, and we are hopeful that more accurate information will soon be available for young people regarding the risks of substance use during this critical developmental period.

Dan Lubman & Marion Vidal were with the ORYGEN Research Centre and Melbourne Neuropsychiatry Centre at University of Melbourne, Victoria.

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AGENCY SNAPSHOT
PSYCHOSIS AND DRUG USE
MICHAEL COLE AND KATHLEEN RYAN

The Northern NEXUS Dual Diagnosis service is one of four dual diagnosis services in Victoria, providing clinical consultation and training on dual diagnosis and facilitating linkages between alcohol and other drug services and mental health services.

Through our clinical consultations to mental health services, we observed a high rate of cannabis use by clients. In order to check the accuracy of these anecdotal observations, we undertook a data-mining exercise to gather further information.

Data mining
We selected a sample of 25 files of clients who had been referred to Northern NEXUS by mental health services because of their cannabis use and associated clinical and rehabilitation issues. The data collected from each file included demographic details, psychiatric diagnosis, information about their principal drug of choice and their patterns of use. We also looked at what each client had identified as the positives and negatives of drug use.

Findings and discussion

Age
Eighty-four per cent of the clients in the sample were aged under 30 years. This supports clinical experience and research that indicates cannabis use is particularly common amongst young people with psychosis. This also suggests that intervention as early as possible should be a clinical goal to limit the morbidity associated with cannabis use and psychosis (Hinton et al. 2002).

However, while the mean age of cannabis users was 28.1 years, the age range was from 18 to 46 years. Thus, it is important to be aware that cannabis use can be an issue for a wide range of age groups.

Gender
Men represented 72 per cent (18 clients) of the sample. It is important to be alert to the possibility of both males and females with a mental illness using cannabis, but being male may be a particular risk factor. Patton et al. (2002) indicate that depression and anxiety rates are higher for young women who use cannabis and the risk increases with amount. It would be valuable to explore more fully if young men are more vulnerable to exacerbation of psychosis consequent to cannabis use.

Diagnosis
Chart 1 shows the diagnosis of cannabis and amphetamine users in the sample. It reveals a substantially higher representation of people using cannabis with the diagnosis of schizophrenia than with any other psychiatric illness.

Pattern of use
Most clients in this sample used cannabis daily. This matches findings that heavy cannabis use has been found to increase the risk of relapse and continuing symptoms in first episode patients (Glennon et al. 2001; in Hinton 2002).

Perceived positives of use
File entries were examined for notes on the clients’ perceptions of both the positives and negatives of using particular drug(s). The most frequently noted positive aspect of using cannabis was that it was relaxing. The next most commonly occurring comments were that it enhanced mood, reduced anxiety or increased self-esteem. Common comments on the perceived positive effects of amphetamine use were gaining an enhanced effect or assisting with concentration, increasing motivation, increasing confidence and elevating mood.

Our findings were consistent with those of Spencer, Castle and Michie (2002) who identified dominant motivations that maintain substance use amongst individuals with psychotic disorders as being to cope with unpleasant effect, enhancement of effect, social conformity or acceptance. Relief of symptoms or side effects was identified as a less likely motivator for use amongst those with a dual diagnosis. Indeed, we found only one file in which it was noted that the client directly attributed their use to relief of the symptoms of their mental illness.

Perceived negatives of use
We also examined the clients’ perceptions of the negative consequences of their drug use. The most frequently noted negative aspects of using cannabis were related to short-term or long-term health consequences including weight loss or gain.

The next most frequently occurring theme for the clients was that cannabis use caused financial problems. This was followed by the concern that cannabis use caused strains in relationships with friends and family. Only one client was noted as directly attributing any increase in the symptoms of their mental illness to cannabis use.

This matches the finding that many people with psychosis are unconcerned about their cannabis use. So it makes sense that early sessions need to focus on engagement and rapport, not on confrontation or use reduction (Hinton et al. 2002) unless this is the client’s goal.

Clients who were using amphetamines also expressed concerns regarding health, financial and relationship impacts. These clients were also concerned about the after effects of amphetamine use, including feeling depressed, irritable or hungover. It would be interesting to explore whether cannabis use aided them in dealing with these effects.

This extraction of themes suggests the importance of exploring the function of the drug with the client. Exploring the positives and negatives of drug use can facilitate a conversation that might assist in enhancing a client’s motivation to address their drug use.

Amphetamine use
An unanticipated finding of the data-mining project was that 40 per cent of our sample concurrently used amphetamines and cannabis. In this group of clients, schizophrenia was again the most common psychiatric diagnosis. This finding is of particular interest and seems to support the recent proposition of Teesson and Proudfoot (2003) that ‘... elevated levels of amphetamine use amongst cannabis users in Australia may explain increased psychotic symptoms in this group’.

Summary
Our data-mining exercise reinforced the need for a number of clinical practices. The first is that it is important to always assess for the full range of drugs, as use of more than one drug is common. It appears especially important to assess young males with schizophrenia for cannabis and amphetamine use.

In our practice, clients and clinicians often readily identify cannabis use as problematic and impacting on the mental illness but amphetamine use is often overlooked or undisclosed. In our sample, 40 per cent were using amphetamines concurrently with cannabis even though cannabis use was the clinician’s reason for referral.

It is essential to explore with the client the function of their drug use. The exploration of both the positives and negatives of drug use provides valuable clinical information to assist in establishing the client’s view of their drug use, clarify their stage of change, to gain insight into what the client wants and then to formulate relevant and appropriate interventions. It mustn’t be assumed that because a client has a mental illness and a substance use disorder that they therefore use drugs to cope with the symptoms of the mental illness and/or the side effects of the treatment of the disorder.

Finally, our data mining shows that formal assessments provide a rich source of information, which if systematically audited, assists our understanding of and response to clients with a dual diagnosis.

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References
For a complete list of the references used in this article, email editor@ancd.org.au.
Illicit drug use in the Asia-Pacific region

Prevalence
As with much of the rest of the world, reliable estimates of the numbers of people using illicit drugs are rare in Asia and the Pacific. There are various official and unofficial estimates of the numbers of users, but few estimates have been derived by any reasonable systematic process. The prevalence of people who use illicit drugs in Asia ranges from less than 0.01 per cent to 4.6 per cent (Devaney, Reid & Baldwin 2006), in press). Brunei and the Pacific Island nations have no official or unofficial estimates of the number of people who use illicit drugs.

Drugs used
As found by previous studies (Reid & Costigan 2002), heroin is the drug of choice among entrants to drug treatment centres in China, Hong Kong, Macao, Indonesia, Malaysia and Vietnam; this is biased to some extent by the nature of the services offered, which focus on opiate dependence. Likewise, opium is still used in much of Asia, but its consumption has diminished, largely as a result of decreased availability and accessibility. Opium is still the main opiate used in Myanmar and Laos, but it is rapidly giving way to heroin and amphetamine-type stimulants (ATS).

The production and use of ATS is now well entrenched throughout South-East and East Asia, with particularly prominent use in Thailand, the Philippines, Myanmar, Indonesia, Brunei and increasingly in China. Cannabis use is widespread in Asia, often as the most, or second most, frequently consumed illicit drug.

The estimated or reported prevalence of drug use varies between the six Pacific Island countries (refer to box), but cannabis is by far the most common and widespread illicit drug used.

Government responses to illicit drug use
All Asian countries reviewed are parties to the 1961 Single Convention on Narcotic Drugs, the 1971 Convention on Psychotropic Substances, and the 1988 Convention against Illicit Trafficking of Narcotic and Psychotropic Substances. Some Asian countries have set goals to be ‘drug free’ by dates between 2010 and 2025; in recent years members of the Association of Southeast Asian Nations (ASEAN) (this includes all Asian nations under review, except China which is not a full member of ASEAN) have become signatories to the ASEAN and China Cooperative Operations in Response to Dangerous Drugs (ACCORD) for a ‘drug free ASEAN 2015’.

There is a general awareness among all countries in the Asian region of the negative effects that illicit drug use, production and trafficking can have on social welfare, and of their implications for the social, economic, political and security structures of a nation. Each Asian country reviewed shares a major policy goal: the reduction of drug use (often to zero), trafficking of drugs, cultivation of illicit crops and/or manufacturing of drugs. Strategies to achieve these goals involve the implementation of a range of supply and demand approaches: from intensive enforcement of laws, to community-based prevention approaches such as school-based education, to the provision of treatment and rehabilitation for drug users. The emphasis and intensity of these approaches vary in different countries, but in most countries there is a concentration on law enforcement approaches.

Law enforcement
As illicit drug production and consumption have increased, and as the perception of illicit drugs as major social problems has grown, national drug law enforcement agencies at all levels have launched increasingly intensive campaigns against illicit drug use and related crimes. The rising trend in the number of narcotic-related arrests in most countries in Asia therefore is the result of a spiralling nexus of increased production, increased consumption, increased public and political perceptions, and increasing law enforcement responses.

Arrests for drug-related crime in Indonesia have increased by 58 per cent per annum over the past five years, while in Vietnam the number of drug-related arrests has increased from 6651 in 1996 to 23199 in 2002. Thailand is the exception to this escalation, following its intensive ‘War on Drugs’, Thailand witnessed a sudden decline in drug-related arrests from an annual average of 220,000 people from the late 1990s to 2002, to 104,588 in 2003; a suggested explanation for the decline is the massive diversion of drug users into treatment and away from prosecution, and the collapse of drug cartels.

Rise in ATS seizures
Along with a general rise in arrests for drug-related crime, there has been a continuing increase in frequency and amounts of drug seizures, fluctuating depending on the type of drug. There has been a substantial rise in the seizures of ATS throughout the Asia-Pacific region: in 2004 a methamphetamine factory was identified in Fiji resulting in the seizure of 700 litres of liquid methamphetamine and enough precursor chemicals to produce an additional 1000 kilograms of methamphetamine.

Penalties for trafficking, producing and importing illicit drugs in Asia are generally harsh by western standards. The death penalty for production or trafficking in is in place in China, Vietnam, Malaysia, Brunei, Myanmar, Indonesia, the Philippines and Thailand, but not in any of the nations of the Pacific region. In some countries, the ‘War on Drugs’ has escalated in recent years: in China, for instance, during the International Anti-Drugs Day of 2004, more than 50 people were executed for drug-related crimes over a one-week period. The ‘War on Drugs Policy’ introduced in Thailand in 2003 saw the deaths of over 2500 alleged drug criminals over a three-month period.

In Asia, penalties associated with ‘narcotic’ crimes do not, at times, distinguish between different illicit drugs, nor often do they distinguish between drug users and drug dealers, and consequently those in possession of drugs can receive a similar penalty to that of a lower level trafficker, a relatively long prison sentence and a hefty fine.

In the Pacific, the principal law enforcement agencies are the Police and Customs and Excise Departments, Immigration. Due to a lack of resources, training and the constraints of ineffective legislation, the police and customs administrations have difficulties fulfilling their extended role as drug enforcement agents and generally cooperate with other countries on illicit drug enforcement as needed.

As of February 2006, there were 411 Australians either in foreign prisons, under arrest or on bail, and of these 126 are for drug-related offences (representing around 35 per cent). Source: The Australian Government Department of Foreign Affairs and Trade.

Treatment
There are treatment approaches for drug-dependent people in all countries in Asia, including medical detoxification, therapeutic communities, drug substitution programs, residential drug treatment programs, and in some countries the introduction of drug treatment programs into correctional and detention centres. Although drug treatment options are available, there are insufficient numbers of treatment and rehabilitation centres in most countries to cater for the numbers of drug users – overall it is likely that only ten per cent at best of all drug users gain access to residential drug treatment programs.

Many treatment facilities attempt to provide skills and/or vocational training, but the sheer number of drug users makes it difficult for many to get access to such programs; and the lack of opportunities after release decreases their desired sustained impact. Treatment approaches in most Asian countries to date consist mainly of traditional medicines and highly structured regimented approaches, with little innovation: psychological and behavioural counselling is rare, as is assisting drug users to reintegrate into the community following treatment. It is generally agreed that recidivism rates are very high.

Treatment services in some places are free or subsidised, but generally fees are payable by those detained, to be paid by the detaine or by families and friends; for those unable to pay, it is difficult to discover what arrangements are in place. Certainly in some places, incarceration in prison is the only option. Private voluntary treatment and rehabilitation centres appear to be
flourishing in some Asian countries, but the fees required are beyond the reach of the ordinary drug user and their family.

There is limited documented information, which is publicly available, on prevention and treatment interventions for drug users in the Pacific. Discussions with key informants point to the same conclusion, that, with the exception of the Northern Pacific, programs or interventions are not specifically tailored for drug users.

Harm reduction

Many drug users in Asia often share injecting equipment, practise high-risk sexual behaviours, and experience poor health, worsening with the length of drug use.

For the six Pacific Island countries, harms are related more to intoxication from alcohol and cannabis, as there is little to no injecting drug use. Of particular concern is the multiple untoward effects of alcohol: domestic, community and personal violence, accidents and injuries; unprotected, unwanted, or unplanned sexual activity; sexual violence and coercion; mental illness; substance use; and the disengagement from community life — and more.

While supply and demand reduction has dominated responses to illicit drug issues to date, some countries are increasingly considering harm-reduction approaches as well. For example, in Indonesia, demand reduction has recently been added to national policy as a third component, of equal priority with supply reduction and demand reduction. Malaysia, Thailand, Brunei, Hong Kong and Macao do not currently permit needle and syringe programs (NSPs). NSPs are in place in China, Vietnam, Cambodia, Indonesia, Myanmar and there is a small-scale needle syringe program in Cebu, the Philippines.

Most Asian countries recognise the benefits of using outreach and peer education. However, as with NSPs, such programs are in their infancy. Outreach and peer education programs (in some form) are in place in China, Malaysia, Vietnam, Indonesia, Myanmar, Cambodia, the Philippines, Thailand and Laos. China appears to have embraced outreach programs with vigour and recently the government announced that it hoped to expand outreach to 60 per cent of drug users within five years, through 210 additional outreach centres.

Substitution therapy programs are expanding in some Asian countries, while in others such approaches are under consideration. For example, in China, the current strategic plan is to have 1500 methadone maintenance treatment programs in operation by the end of 2007, to serving 30 000 clients. Substitution therapy is available (although often limited) in China, Hong Kong, Indonesia, Macao, Malaysia and Myanmar.

Madonna Dunne is a research fellow at Victoria’s Turning Point Alcohol and Drug Centre. Gary Reid is a research fellow and Simon Baldwin is a Project Manager at the Centre for Harm Reduction, also in Victoria.

References and further reading


Reid, G. & Coutteau, G. 2002. Revisiting the ‘Hidden Epidemics’ & Situational Awareness of Drug Use in Asia, as the context of HIV/AIDS. Centre for Harm Reduction. The Burnett Institute, Melbourne, Australia.


Trainees for the Drug Intervention Training are selected by the BNN and come from a variety of backgrounds: last year’s group had a cross-section of doctors, social workers, bureaucrats, educators and other treatment providers. One participant was from the non-government sector. Prior to the course, each participant spent three months in Indonesia studying an intensive English language course.

Australians are a research fellow at Victoria’s Turning Point Alcohol and Drug Centre. Gary Reid is a research fellow and Simon Baldwin is a Project Manager at the Centre for Harm Reduction, also in Victoria.

Trainees visit an Australian methadone clinic.

AUSTRALIAN TRAINING CHANGES ATTITUDE

JENNY TINWORTH

With HIV spreading rapidly amongst Indonesians who use illicit drugs, the country’s government is trying new approaches to lower the rate of illicit drug use.

Epidemiological projection models estimated that in 2003, over 80 per cent of new HIV infections in Indonesia would be amongst people who inject drugs (Pisani 2006). Staff at Jakarta’s RS DKO drug dependence hospital estimate that 48 per cent of injecting drug users seeking treatment there are infected with HIV/AIDS, and 90 per cent have hepatitis C. This compares with Australia, where just over one per cent of people who inject drugs are HIV positive (UNAIDS 2004).

Training the workforce

Through the Australian Government’s Indonesia-Australia Specialised Training Project (Phase III (IASTP) and the National Narcotics Bureau (BNN) of Indonesia, Australian drug educators/researchers have been commissioned to train health workers, policy makers and law enforcement officers about drug intervention issues. The project is administered through AusAID.

Program coordinator/trainer Annie Bleeker sees the intensive three-month Australian course as the equivalent of a ‘mini masters in public health, specialising in alcohol and other drug issues’. The first Indonesian course with this title was held last year and similar training will be held annually through IASTP Phase III.

Bleeker was appointed by the Indonesian Ministry of Narcotics Affairs (Narcotics Bureau) of Indonesia and has been working in Indonesia since 1999. Estimates were around 10-15 per cent and now are finding upwards of 60 per cent in some of the big cities.

Since beginning work in Indonesia, Bleeker has seen the establishment of two pilot methadone programs in Bali and Jakarta and also the incorporation of a very effective harm reduction program in Bali’s Kerobokan Prison, where most of Asia’s drug offenders are being held. There are also several outreach programs and informal needle programs operating in major Indonesian cities such as Jakarta, Denpasar, Makassar and Bandung. The Indonesian HIV/AIDS prevention and Care Project has been instrumental in these initiatives.

‘So in many ways, things are progressing positively in favour of harm reduction, especially with the signing of a non-opioid treatment act. Everything under the sun is being considered in terms of harm minimisation activities amongst people who inject drugs,’ she says.

‘However, it is unfortunate that BNN policy subscribes to the assertions made by ASEAN and other agencies that Asia will be drug free by 2015. Every society that I know of is to a certain extent dependent on drugs whether they be medical, legal or illegal and I see our role as very much trying to get people to understand that we need to learn to live with drugs, and minimise the social, health and economic impact of drug use in the world, rather than the unlikely task of eliminating them.’

References


Ethnography is a research approach that describes the social organisation, culture, and geographic and political economy of human groups. This approach lies at the heart of anthropology.

In contrast to other research methods, ethnography relies on direct and sustained social contact with groups or cultures in their natural settings to identify insider perspectives and to describe the contexts that influence beliefs and behaviour.

In recent years, growing recognition of the importance of understanding local cultures as the contexts for public health research and intervention has increased the value of ethnography as a scientific method. For example, ethnographic research has made a significant contribution to understanding how and why injecting drug use can facilitate the transmission of blood borne viruses; such research has identified and described specific risk practices, and explored how features of social, cultural and structural environments mediate these risks.

How does ethnography work?

Ethnography involves collecting data and generating hypotheses or theories simultaneously. This enables researchers to investigate issues of significance as they emerge during the study. Data collection utilises observational fieldwork, in-depth interviews, social surveys and visual media such as photography and film.

However, ethnographic ‘facts’ are not like rocks, out there on the surface waiting to be collected and taken back to the laboratory for analysis. They are embedded in people’s lives, and the process by which meaning is constructed and facts interpreted means that ethnographers and the people they study need to share open and sustained social contact with groups or cultures in their natural settings. This approach lies at the heart of anthropology.

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What sort of findings can be produced?

Ethnographic data can be analysed, either manually or using database management software (such as NUD*IST), to identify emerging themes and examine regularities and variations in the relationships between and within categories. The end result is a ‘thick description’ of themes and issues related to the research question. These findings use direct quotes from participants; increasingly, funding bodies request that ethnographers add recommendations to their reports to assist in identifying priority areas requiring action.

Examples of ethnographic studies

An ethnographic study conducted in South Western Sydney in the late 1990s identified the emergence of a street-based injecting culture, drug acquisition routines, collective injecting episodes, impediments to obtaining and using sterile equipment, and law enforcement practices as key factors in creating and sustaining a high-risk environment for the transmission of blood borne viruses (Maher et al. 1998). These findings were subsequently confirmed by a prospective cohort study which documented high rates of incident HCV infection (44.1 per 100 person-years) in this environment (Maher et al. 2005).

A recent ethnographic study conducted in Dar es Salaam, Tanzania (McCurdy 2005) identified a new risk practice among sex workers who inject heroin. The practice, described as ‘flashblood’, involves injecting blood drawn from the vein of someone who has just injected, in the belief that blood with some heroin in it can avert withdrawal. While apparently driven by poverty and altruistic motives, this practice has the potential to have a significant impact on rates of HIV and HCV transmission in East Africa (McCurdy 2005).

References


Further reading


In 2005 New Zealand conducted the first wave of its new early warning drug survey, the Illicit Drug Monitoring System (IDMS). A central impetus in the development of the IDMS had been the rapid rise in amphetamine-type stimulant drug use since the late 1990s, specifically the use and local manufacture of methamphetamine.

The emergence of these synthetic stimulants presented challenges to agencies concerned with drug issues, prompting a call for more timely information on drug use and drug-related harm to form appropriate responses.

New Zealand Police funded researchers at the Centre for Social and Health Outcomes Research and Evaluation (SHORE), Massey University, to complete the initial development and first three waves of the IDMS from 2005 to 2007. Full reports and summarised research findings from the 2005 wave can be downloaded from the New Zealand National Drug Policy website (www.ndp.govt.nz) or from SHORE’s website (www.shore.ac.nz).

While the IDMS was modelled on, and designed to be compatible with, the successful Australian Illicit Drug Reporting System (IDRS) and Party Drug Initiative (PDI), there was a need to adapt and build on these existing approaches to best address New Zealand’s unique drug environment and drug issues of greatest concern. (For more information about the IDRS and PDI, see Of Substance, January 2006.)

Special issues

New Zealand has a small and widely dispersed client population with only one true metropolis – Auckland. Small centres presented challenges for the recruitment of frequent drug users as interviewers may know potential participants or participants may be concerned about being easily identified when inquiring about the study or completing an interview. Considerable effort was therefore put into the design of the first contact procedures for the study.

Another challenge was the potential safety issues that may arise from interviewing frequent methamphetamine users. Heavy methamphetamine use can cause aggression and paranoia and use of methamphetamine has been linked with a number of violent incidents in New Zealand, including a samurai sword attack and multiple homicides. Comprehensive interviewer training and safety procedures were developed to ensure interviews were conducted in a safe manner.

Innovative design

The principal design innovation of the IDMS is the interview of three separate populations of frequent drug users, rather than the interview of a single population. The three groups of frequent drug users are organised into three separate modules which can operate independently of each other or be combined into a single larger sample.

The three modules of the IDMS are: (i) the Methamphetamine Module, which interviews at least monthly methamphetamine users; (ii) the Hallucinogen Module, which interviews at least monthly ecstasy (MDMA) and LSD users; and (iii) the Cannabis Module, which interviews at least weekly cannabis users. Each individual module still draws on the three sources of data commonly used in drug monitoring systems: (1) interviews with frequent drug users; (2) interviews with key experts who have regular contact with drug users through their employment; and (3) the collation and examination of secondary data sources on drug use. The combined information from these three sources is used to identify emerging trends in drug use and drug-related harm.

Future challenges

The first wave of the IDMS was successfully completed without incident and was well received among those in the drug field and wider policy community. However, there are several areas where we would like to continue to develop the project.
Upcoming conferences & events

19–21 April 2006
9th Social Research Conference on HIV, Hepatitis C and Related Diseases ‘StigmaPleasurePractice’
National Centre in HIV Social Research (NCHSR)
University of New South Wales, Sydney
For more information visit http://nchs.arts.unsw.edu.au/conference2006.html

21–23 June 2006
Drug and Alcohol Nurses of Australasia (DANA) 2006 Conference ‘Bridging Evidence and Practice’
Four Points by Sheraton, Sydney
For more information visit www.danaconference.com

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24–26 May 2006
5th International Conference on Drugs and Young People ‘Culture and context of youth drug use across settings’
AJC Convention Centre, Randwick, Sydney
For more information visit www.adf.org.au

24–26 May 2006
Court Drug Diversion Initiatives Conference
Carlton Crest Hotel, Brisbane
For more information visit www.aic.gov.au/conferences/2006-drugDiversion/

23 June 2006
The 2006 National Drug and Alcohol Awards
Four Seasons Hotel, Sydney
For more information visit www.drugawards.org.au

25–26 May 2006
Court Drug Diversion Initiatives Conference
Carlton Crest Hotel, Brisbane
For more information visit www.aic.gov.au/conferences/2006-drugDiversion/

29–30 June 2006
24/7: Work-Related Alcohol & Drug Use A National Forum to Develop an Action Plan
Hilton Hotel, Adelaide
For more information visit www.nceta.flinders.edu.au/events/twenty_four_seven.html

15–16 June 2006
Creating Synergy III Conference: ‘Creating Synergy Between Drug & Alcohol & Mental Health Services’
University of Wollongong
For more information visit www.uow.edu.au/conferences/synergy3

3–5 July 2006
19th Annual Australian Winter School ‘Research, Policy, Practice’
Carlton Crest Hotel, Brisbane
For more information visit www.winterschool.info

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