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RESEARCH DIGEST
Latest findings from around the world

NALTREXONE IMPLANTS
A clinician’s view

CUSTOMS AND DRUGS
Detecting illicit entry

METHAMPHETAMINES
Skills to handle difficult clients, plus new research into treatment
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Editor’s letter

Welcome to the July 2006 issue of Of Substance.

In the past year, methamphetamine use has had a rising profile in the mainstream media. And in many ways, this publicity is not surprising. Annual surveys such as the illicit Drug Reporting System show that methamphetamines are readily available and generally, of medium to high purity. Anecdotally, treatment providers are also reporting an increase in the number of clients they see who are experiencing the, at times, aggressive and violent side effects of methamphetamine use.

In this issue, writer Libby Topp discusses methamphetamine treatment issues with some of Australia’s leading researchers and clinicians in the area. They assure us that while working with these clients can be difficult, treatment providers do have the core skills and resources needed to meet the challenge. Libby also discusses some of the pharmaceutical approaches being trialled for methamphetamine problems, as well as sharing first-hand accounts from treatment providers.

To be effective in their work, clinicians rely on good research to show them the methods and approaches which are most likely to produce positive outcomes. With this in mind, Of Substance introduces our Research Digest, a regular feature which will highlight some of the latest drug research findings from around the world. We have also included an article which encourages readers to think critically about research: how to interpret it and how much weight to give individual studies.

At a political level, there has also been much activity in the past few months. We have seen the launch of Australia’s first National Cannabis Strategy, coupled with the release of the latest National Alcohol Strategy, May’s Federal Budget allocated more funds to the alcohol and drug treatment field. We also take this opportunity to introduce readers to Dr John Herron, the new Chair of the Australian National Council on Drugs.

As always, we are keen to report the latest in workplace issues, so we look at how the new Federal WorkChoices legislation is likely to affect the AOD workforce.

These are just a few of the many topics raised in this issue of Of Substance. We hope you find the information valuable and relevant to your work. We always welcome reader feedback and letters via email at editor@ancd.org.au.

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Posing Questions
Professor Margaret Hamilton OAM, Chair, Multiple and Complex Needs Panel, Victoria

Alcohol is the preferred drug of most Australians. Our culture means that as a community, we associate alcohol with almost all social, political, sporting, organisational and celebratory events. At times, this use is excessive, so it is natural that alcohol-related trouble or harms will arise.

If we could prevent intoxication, many of alcohol’s other harmful effects might be taken care of. It is therefore reasonable to put this at centre stage in addressing alcohol-related harm.

In the past, we have often focused on campaigns targeted at population subgroups such as youth. While these campaigns are important, it is time that we recognise that if we are to effectively address alcohol-related harm, then we must examine our own use of alcohol as adults. We must look at the frequency and extent of our own drinking and at our attitudes and expectations about alcohol.

So, it is pleasing to see that the Ministerial Council on Drug Strategy has endorsed the National Alcohol Strategy 2005-2009. This strategy focuses on matters that are currently at the heart of community concern: intoxication, safety and amenity, health impacts and the cultural place, and availability of alcohol in our community. This new alcohol strategy calls on all levels of government, non-government, business and private interests to respond to alcohol issues.

The health and safety costs of problematic alcohol consumption are just one of the areas which must be addressed in this response. We must also tune into the additional cost to each of us. These include the extreme costs of loss of life through to the additional costs of impost on insurance premiums; fear and anxiety provoked by drunken behaviour; and the ‘clean up costs’ for public events to deal with the mess left, in part, by alcohol consumption.

I think the Australian community is ready for a reassessment of the place of alcohol in our day-to-day lives, and it is up to adults to lead the way. Like many others, I want to be able to enjoy an occasional drink, while avoiding those around or dear to me being intoxicated, troublesome or harmed by their (or my) alcohol consumption.

Highlights from the May Federal Budget:

Improved services for people with alcohol and other drug (AOD) problems and mental illness
$3.9 million over five years

Funding will go to the NGO sector to provide extra training for the AOD workforce to better assist clients who also have mental health problems. The funding will also be used to identify and implement best practice models for intervention for clients with substance use and mental health co-morbidities.

Alerting the community to links between illicit drugs and mental illness
$21.5 million over four years

This measure will involve public information and education activities targeting the general population to promote a better understanding of the link between illicit drugs and mental illness to prevent the onset of drug-induced mental illness.

Croc Festivals — additional funding
An additional $2.1 million in 2005-06

The ‘Croc Festivals’ for Indigenous and non-Indigenous young people in rural and remote areas promote healthy, positive lifestyles and aim to improve educational and employment outcomes. This funding is additional to the $1.2 million over four years provided for the Croc Festivals under the 2002-03 Budget measure.

DrinkWise Australia — contribution
$5 million in 2005-06

DrinkWise Australia was established by the alcohol beverage sector and is a collaboration between industry and the community. DrinkWise Australia aims to bring about a healthier drinking culture by focusing on initiatives that minimise the harm associated with alcohol in the community.

Drug and alcohol treatment services
$9.0 million in 2005-06

The Government will provide $9.0 million in 2005-06 in infrastructure grants for 17 geographically diverse AOD treatment services provided by non-government organisations.

Counsellors on university campuses
$19.8 million over four years

This grant will establish a network of counsellors on university campuses to focus on the needs of people with substance abuse problems, including identifying the early onset of psychosis. The counsellors will also provide family support services and arrange referrals to appropriate specialist and mainstream community services.

Illicit drug use — combating emerging trends
$14.4 million over four years ($23.7 million to continue the National Illicit Drugs Campaign (NIDC) and $10.7 million to enhance the National non-anaesthetic use of cannabis awareness program)

Funding will provide for a third phase of the NIDC to communicate drug prevention messages to discourage illicit drug use and increase community awareness of the harms caused by psychostimulants. This includes research into attitudes, knowledge and behaviours regarding drug use in Australia to ensure the ongoing impact and relevance of the communication materials.

National Cannabis Control and Prevention Centre
$14.4 million over four years

This new centre will be established in 2007-08 and will develop training programs for the health workforce on the treatment of cannabis use, maintain an information database on scientific studies of cannabis use and monitor public attitudes on the use of cannabis.

National Safe Use of Alcohol Strategy
$25.2 million over four years

A national media campaign will aim to discourage the abuse of alcohol, increase awareness of the impact of intoxication, and encourage long-term cultural change to reduce alcohol-related harm in the community. The funding will provide for a television, radio and print campaign targeting the general public, education materials to support the campaign, and a revision of the Australian Alcohol Guidelines to align with the latest information and research.

Asia-Pacific Illicit Drug Initiative
$1.6 million over four years

Funding will establish an expert advisory committee on regional drug issues, and maintain and update data on drug-related issues within the Asia-Pacific region. The committee will provide specialist advice to the government on regional drug issues and is expected to include representatives from the Department of Health and Ageing, the Department of Foreign Affairs and Trade, AusAID and the Australian National Council on Drugs.

Strengthening Indigenous communities — reducing substance abuse
$55.2 million over four years

The government will continue with and expand a whole-of-government strategy to reduce the incidence and impact of substance abuse, including petrol snifing, in Indigenous communities. This funding will support the continued roll-out of the National Youth Substance Abuse Prevention Strategy, the National Indigenous Drug and Alcohol Action Plan, and the Driving Change National Indigenous Road Safety Initiative.

Mental Health and Alcohol Co-morbidity
$15.7 million over four years

This funding will encourage people with mental illness to seek help with their alcohol problems and help people with alcohol problems to seek mental health assistance. It will also provide a $1.5 million over four years contribution to the National Mental Health smoking prevention program.

Funding will continue the National Indigenous peer-influencer program, which is one of the few evidence-based drug prevention programs targeting Indigenous young people.

Of Substance, vol. 4 no. 3 2006

GUEST EDITORIAL

ALCOHOL
IT’S ABOUT US

PROFESSOR MARGARET HAMILTON OAM, CHAIR, MULTIPLE AND COMPLEX NEEDS PANEL, VICTORIA

NEWS

2006-07 Federal Budget outcomes

Illicit drug use — combating emerging trends
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Alcohol strategy adopted

The National Alcohol Strategy 2005-2009 was endorsed by all state and territory governments at the Ministerial Council on Drug Strategy meeting in May.

Alcohol costs the Australian community considerably more than the last documented estimate of $7.6 billion in 1998-99. In addition to the very real costs of the death of 1000 people each year from excessive alcohol consumption, and another 65 000 who are hospitalised, this strategy suggests that other costs that might not ordinarily be included need to be considered. These include the cost of alcohol-related fires, the additional insurance premiums associated with alcohol and the costs of local government to clean up around late-night opening licensed venues. Australians’ consumption of alcohol remains high by world standards, despite declining since the 1980s.

The Strategy provides an action plan to meet its goal of preventing and minimising alcohol-related harm to individuals, families and communities in the context of developing safer and healthier drinking cultures in Australia.

Four priority areas have been identified for action within the Strategy: They are:

- intoxication – suggested measures include increasing community awareness and understanding about the impact of intoxication;
- public safety and amenity – actions include preventing and reducing alcohol-related injuries, reviewing and disseminating best practice guidelines, and increasing the capacity of local communities to address alcohol-related public health and safety issues;
- health impacts – enhancing nurses’ capacity to address alcohol-related health problems; and promoting primary health care settings as opportune places for health promotion, and prevention and treatment of alcohol use problems;
- cultural place and availability of alcohol – strengthening regulations around alcohol availability; investigating the relationship between price and reduced drinking; monitoring promotions, implementing social marketing campaigns, and developing a vision for long-term cultural change to reduce alcohol-related harm and to develop safer drinking practices.

The National Alcohol Strategy is based on a literature review and the findings from 23 consultation forums which were held with more than 1000 people around Australia. It reflects the principles of the National Drug Strategy 2004-2009 and builds on the previous alcohol strategy.

To view the complete National Alcohol Strategy, visit www.alcohol.gov.au.

MCDS: May meeting snapshot

The Ministerial Council on Drug Strategy, the peak national policy and decision-making body for licit and illicit drugs, met in Perth in May to consider national drug issues. The Council comprises the Australian Government and state and territory Health and Law Enforcement Ministers, including Justice and Police Ministers, and the Australian Government Minister for Education.

Key issues endorsed by the ministers included Australia’s first National Cannabis Strategy, 2006-2009 (see p. 16), and the National Alcohol Strategy 2006-09.

Ministers at the meeting also discussed:

- Monitoring of alcohol advertising, and moved to establish a Monitoring of Alcohol Advertising Committee
- Standard alcohol drinks logos initiative, endorsing a voluntary national standard drink logo for alcohol products, which was developed in partnership with the alcohol industry
- Fatal alcohol spectrum disorder, with ministers moving to commission a working party to progress this issue on a national level
- Inhalants abuse, commissioning a working group to further progress this work
- Amphetamines, with a new national strategy to be developed

The full MCDS meeting Communiqué is available at www.nationaldrugstrategy.gov.au/councils/communique_150506.htm

CounsellingOnline

‘CounsellingOnline’ at www.counsellingonline.org.au is a new website recently launched by Turning Point Alcohol and Drug Service, Victoria, and funded by the Commonwealth Department of Health and Ageing as part of the National Illicit Drugs Strategy.

The site will support existing alcohol and drug counselling and treatment services by offering free text-based confidential support and referral. Secure, immediate and anonymous if preferred, this new service is suited to clients not yet ready for face-to-face sessions, or those who find it difficult to access services due to location or hours of work. Clients will be supported to discuss their concerns and then referred to on-ground services as appropriate.

CounsellingOnline is staffed by trained counsellors and operates 24 hours per day, seven days per week. It can be used by anyone throughout Australia with a concern about their drug or alcohol use, or by people with concerns about people close to them.

For more information contact the Drug Info Clearinghouse on 1300 85 88 84 or druginfo@adf.org.au

Of Substance welcomes correspondence from all our readers on topics raised in the magazine, or subjects of interest to the field. Please submit letters of up to 150 words to editor@ancd.org.au.

Of Substance, vol. 4 no. 3 2006
Disadvantaged people at higher risk of ill health

Disadvantaged groups experience more severe and more long-term health problems than other Australians, according to a report released jointly by the Queensland University of Technology (QUT) and the Australian Institute of Health and Welfare (AIHW) in April.

The report, Health Inequalities in Australia: morbidity, health behaviours, risk factors and health services use (Health Inequalities Monitoring Series Number 2), looks at where people live, their income, education and occupation, and finds that being disadvantaged puts people at much higher risk of health problems.

‘Regarding smoking, men and women aged 25 to 65 with no tertiary education were two to three times more likely to smoke than men and women with a university degree. Measures to address these significant health inequalities could include improved living and working conditions, community involvement in health initiatives and changing health-damaging behaviours,’ said report co-author Dr Gavin Turrell, of QUT’s Institute of Health and Biomedical Innovation.

The report found that people living in the most disadvantaged areas visited the GP more often than other Australians, but made significantly fewer visits to dentists or medical specialists. The report is available to download via www.aihw.gov.au/publications/index.cfm/title/10272.

When former Federal Government Minister John Herron was packing to return from a three-year stint as Australia’s ambassador to Ireland and the Holy See, he was anticipating discovering the joys of retirement on Brisbane’s golfing greens.

And when he wasn’t putting, he thought he might take to the road on his Yamaha 650cc motorbike.

Either that, or he and wife Jan would enjoy visiting their nine children in cities as far-flung as London, Perth, Melbourne, Canberra, Brisbane and Sydney.

That was in January. However, all that changed when he received a letter from Prime Minister John Howard asking him to become the Chair of the Australian National Council on Drugs (ANCD), a position which became vacant in early 2005 with the retirement of Major Brian Watters. For the now 72-year-old former Minister for Aboriginal and Torres Strait Islander Affairs, the appointment takes him full-circle to his roots as the son of a publican in North Queensland.

From the age of two until 16, the young John Herron grew up around the Central Hotel in Townsville. From that day forward, drug and alcohol issues have impacted on his work.

At the age of 18, Herron won a Commonwealth scholarship to study medicine. He went on to become a surgeon. Among his patients were road accident victims, often the result of alcohol-related crashes.

‘In about 1963, one of my jobs was to work with the police to examine drunken drivers,’ he says. ‘Those were in the days when there were no blood or breath tests. I was paid two guineas for each driver I examined.’

This experience and his observation of many people who used amphetamines for weight loss or study purposes, stimulated his interest in alcohol and other drug issues.

Herron forged a career in medical circles, working in England before heading the Queensland Melanoma Project which was a world first in investigating the epidemiology of melanoma. He also became the state’s branch president of the Australian Medical Association and the Queensland Chairman of the Royal Australasian College of Surgeons and Australian Association of Surgeons.

However, asked to stand for the Federal Senate in 1990, Herron swapped surgery for the role of a politician. ‘I’m also looking forward to continuing to have the very close relationships with Australian services in my role as ANCD chair.

When it comes to the use of well-known terms such as “harm minimisation”, John Herron is careful about his use of them. “Harm minimisation means different things to different people. I think it means treating addiction as a medical problem. If it extends to advocating injecting rooms, then that’s something different. I’ve observed injecting rooms in Switzerland and the Netherlands and I do not support them.”

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OF SUBSTANCE INTERVIEW:
ANCD CHAIR JOHN HERRON
JENNY TINWORTH

OF SUBSTANCE online
We’re proud to announce the launch of our new website www.ofsubstance.org.au. The site is full of useful links, including: current and previous issues, subscription information and notes for contributors.

We look forward to your visit, and to any feedback on how we can improve the site.

OF SUBSTANCE cherry picks the latest Australian and international research and news in alcohol, tobacco and other drug issues. Published quarterly, printed copies are now available free of charge to healthcare professionals, workplaces and community organisations in the Asian/Pacific region.

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OF SUBSTANCE online
Of Substance, vol. 4 no. 3 2006

INTERVIEW:
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INTERVIEW:
In this issue, Of Substance is pleased to bring you edited excerpts from Drug & Alcohol Findings (The Findings Partnership, London, England). Findings is a magazine devoted to highlighting evidence on the effectiveness of interventions to treat, prevent or reduce drug and alcohol problems (for more information visit www.drugandalcoholfindings.org.uk/).

The following excerpts are from the ‘Nuggets’ section of Findings, which features summaries of the latest international (including Australian) research into drugs and alcohol. These items were adapted by Of Substance, with agreement from Findings, from Issue 14, Winter 2005.

SAFER INJECTING CENTRE NO ‘HONEYPOT’

Featured study:

Findings:
Australia’s only medically supervised injecting centre (MSIC) has confounded fears that it would prove a ‘honeypot’ for drug use, dealing and crime. The facility opened in May 2001 in Sydney’s Kings Cross – a neighbourhood notorious for drug use, prostitution and gambling – offering injecting a medically supervised site in which to inject, plus harm reduction and referral services. Police records for just over two years before the opening were compared against roughly 18 months afterwards. Despite a spike due to a national heroin shortage starting four months beforehand, the rest of Sydney’s Kings Cross was 409 overdoses, of which in a year at least four to nine would otherwise have been fatal. However, given its small capacity the centre made no discernable impact on the local overdose rate.

Elsewhere researchers have demonstrated decreased health risks for injecting centre users and improvements in the local environment due to less public injecting and drug-related litter.

Practice implications:
To be used, centres need to be conveniently located, which will often mean near or within business and residential districts, but usually they will only be considered if these areas also have a pre-existing concentration of drug-related activity. In such areas, relatively small centres with adequate security need not cause a problematic increase in numbers of drug users or in related crime, and can reduce the offence and alarm caused by public injecting and injecting-related litter, as well as contributing to the overall health of injectors. Compared to needle exchanges (which they should supplement, not replace), injecting centres offer a greater opportunity to reduce infection spread and foster safer injecting techniques, potentially reducing the need for medical care. They also offer more opportunities to engage injectors in therapeutic and social re-integration initiatives with a view to ending dependent drug use.

Additional reading:

In context:
The study suggests the small increase in the number of drug users congregating near the centre concerned some in the community, but also that it probably represented displacement from other areas (implying no net increase in public nuisance), and did not result in an increase in drug-related crime. After the centre opened, residents and businesses saw fewer people injecting and fewer discarded syringes, and this may partly account for the reduced drug-related crime. This included a reduction in the proportion of local residents and workers who believed such facilities attract drug users to the area. However, all this must be seen in the context of a tightly controlled, limited capacity service with some security presence at the entrance.

An evaluation of the first 18 months of the centre reported 56 861 visits by 3810 registered users, who experienced 409 overdoses, of which in a year at least four to nine would otherwise have been fatal. However, given its small capacity the centre made no discernable impact on the local overdose rate. Elsewhere researchers have demonstrated decreased health risks for injecting centre users and improvements in the local environment due to less public injecting and drug-related litter.

SUPPORT KEY TO GP’S ADVISING HEAVY DRINKERS

Featured study:

Findings:
Screening and brief intervention for risky drinking is a major plank in the new English alcohol strategy. A World Health Organization trial in six countries including England has shown that personal contact and ongoing support are needed to encourage even modest levels of intervention by GPs, but also that this could cumulate into a program which reaches most of the practice’s patients. Generally, the intervention involved receptionists asking all adult patients to complete the AUDIT screening form and take it in with them to the doctor. Those scoring at least as hazardous drinkers were to be given five minutes of advice based on a package called Drink Doctor. Three ‘sales’ strategies were tried on 3436 GPs (729 in England) to persuade them to order the free package. The first was a mailed promotional leaflet; the second, a ‘telemarketing’ phone call following a set script; the third, a similar script delivered during a practice visit. For the last two, staff were trained to anticipate and respond to objections. GPs who ordered the package were then randomly allocated to no further action or to one of two strategies to encourage them to implement it over the following 12 weeks: a training session for the GPs, and their receptionists; this plus ongoing support in the form of regular phone calls or visits.

The most effective marketing strategy (telemarketing) led 72% of English GPs to order the package and the most effective implementation strategy (Drink Doctor plus support) led 71% of these to start using it. Despite this support, typically just 11% of patients were screened and just 4% of all patients thought to be at risk were given the recommended advice. However, the top quarter of practices screened at least 27% of patients and advised 18% of all patients at risk.

In context:
Earlier reports on the English arm of the study showed that telemarketing was the most cost-effective way to get GPs to order the package, while training plus support was the most cost-effective way to encourage them to use it. Similar conclusions were reached by a British study of practice nurses. Across all relevant studies in Britain and elsewhere, continued support has emerged as a key to implementation.

The weak link resulting in low intervention rates was the failure to screen, principally the responsibility of receptionists. In England, receptionists in practices which undertook the program were twice more likely to end up as regular users than doctors to feel it was demanding and outside their normal work role, and became more negative over the course of the trial. GPs elsewhere have found that such programs disrupt rapport with patients because they impose a pre-set alcohol agenda rather than this emerging from the concerns which prompted the consultation. As fresh patients were screened (a system was set up to ensure nobody was screened twice), over a whole year the low 12-week intervention rates recorded in the study could nevertheless cumulate to an appreciable percentage of at-risk patients being screened, in the best quarter of English practices, possibly approaching 80%.

Practice implications:
Poor implementation and deterioration in attitudes in the study may be clues that this style of intervention is inappropriate in primary care. Rather than universal screening, official and expert thinking in England now favours targeted screening of patients whose complaints suggest drinking problems, or of all patients seen in clinics for these complaints and during consultations where screening would be expected, such as new patient registrations and health checks. In these circumstances, asking about drinking emerges naturally rather than as a potentially awkward diversion.

The WHO study and others suggest training and ongoing support are essential, with a special focus on those responsible for initiating the process by doing the screening. Receptionists may be more likely to embrace this role if treated as health care professionals in their own right and given commensurate training. Alternatively, which proved feasible in British trials, involving an alcohol worker in the practice to undertake screening and to counsel patients referred by GPs.

HARM REDUCTION FOR SCHOOL SMOKING

Featured study:

Findings:
Compared to other lessons, school programs aiming to improve social and decision-making skills have been most consistently successful in preventing smoking, but this may have been because they have not been compared against programs which include harm reduction objectives.

This possibility is suggested by a study in Western Australia which randomly assigned 30 secondary schools to normal lessons on smoking or to a new harm reduction curriculum. Whilst this embraced abstinence, it also tried to make itself relevant to all the pupils (half had already smoked) by helping smokers stop or cut down. Delivered in health education classes by the teachers, it consisted of eight lessons over two years. School nurses too were trained to counsel pupils who wanted to stop or cut down.

Before the lessons, baseline measures were taken from 4636 pupils mostly aged 13-14. By the end of the following year when the lessons had been completed, 21% in ‘usual-lesson’ schools were currently smoking (past month) and 12% were smoking regularly (four+ days in the past week). With the new program, the figures were 14% and 6%. Taking into account differences between the pupils, those in usual-lesson schools were twice as likely to be smoking as those in the program.

In conclusion:
Compared to other lessons, school programs aiming to improve social and decision-making skills have been most consistently successful in preventing smoking, but this may have been because they have not been compared against programs which include harm reduction objectives.

This possibility is suggested by a study in Western Australia which randomly assigned 30 secondary schools to normal lessons on smoking or to a new harm reduction curriculum. Whilst this embraced abstinence, it also tried to make itself relevant to all the pupils (half had already smoked) by helping smokers stop or cut down. Delivered in health education classes by the teachers, it consisted of eight lessons over two years. School nurses too were trained to counsel pupils who wanted to stop or cut down. Before the lessons, baseline measures were taken from 4636 pupils mostly aged 13-14. By the end of the following year when the lessons had been completed, 21% in ‘usual-lesson’ schools were currently smoking (past month) and 12% were smoking regularly (four+ days in the past week). With the new program, the figures were 14% and 6%. Taking into account differences between the pupils, those in usual-lesson schools were twice as likely to be smoking as those in the program. Compared to other lessons, school programs aiming to improve social and decision-making skills have been most consistently successful in preventing smoking, but this may have been because they have not been compared against programs which include harm reduction objectives.

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TREATING DIFFICULT CLIENTS: GETTING BACK TO BASICS

For some months now, the mainstream media has regularly run stoires with headlines such as ‘The Ice Age’, focusing on the increased use of the potent form of crystalline methamphetamine known as ‘ice’ or ‘crystal meth’, and the strikingly visible psychiatric harms experienced by many heavy users of the drug. Most such stories have highlighted the perception that although treatment for heroin dependence has long been available, many frontline workers feel under-equipped to implement appropriate management strategies and offer effective intervention options to methamphetamine users, and that unless this situation is urgently addressed, the general public will remain at the mercy of these unpredictable individuals.

Media distortion?

Many workers in the alcohol and other drugs (AOD) field are pragmatic enough to accept that any means of raising awareness confers some benefit, and attention serves to apply pressure to policy makers and funding bodies to address and prioritise issues. But with respect to this particular matter, experts are concerned that the current media attention may have persuaded some in the field itself that our efforts to provide services to methamphetamine users are inadequate and ineffectual. The good news is, according to many experienced AOD workers, this is far from the case.

The AOD field as a whole should have more confidence that we have something to offer

Professor Steve Allsop, Director of the National Drug Research Institute at Curtin University, argues that the methamphetamine issue is so salient because it highlights the traditionally difficult demarcation between drug and alcohol, and mental health services, and the longstanding problem of the shunting of clients between the two. ‘Because both sectors are under-resourced and generally working to full capacity at all times,’ he says, ‘the introduction of an unfamiliar group of complex clients can prejudice clinicians against that group, and impair their capacity to effectively deal with them. Complex clients take more time and effort, are difficult to engage, and their outcomes may be poorer than other clients. Perhaps even unconsciously, clinicians can hold prejudiced attitudes towards such clients that could be changed by developing their confidence that they do know how to work with them, and that their more complex needs do not necessarily mean they are going to be disproportionately burdensome.’

Complex clients

Jo Lunn, Clinical Director of Kedehal Rehabilitation Services at Wollongong in NSW, a service which has seen increases in the proportion of admissions of problematic methamphetamine users, agrees, but points out that research clearly shows that the risk factors for relapse to drug use are the same for both drug-dependent clients and clients suffering comorbid mental health problems. She argues that many generalist AOD workers possess the skills to engage with these clients and to implement cognitive behavioural therapy (CBT) and other psychosocial therapies to help them achieve their therapeutic goals, but that they may lack confidence that the same approach as they take with other clients is appropriate for this unfamiliar group.

‘In many cases,’ she says, ‘today’s more complex clients might actually be better off in residential AOD services rather than in mental health services set up for crisis situations. AOD services tend to offer longer programs which allow more time for the client to stabilise, to develop therapeutic alliances and address their complex psychosocial needs. However, undeniably mental health services and AOD services working in partnership will attain the best outcomes for the clients.’

Dr Nicole Lee, Head of Clinical Research at Melbourne’s Turning Point, agrees that although there is a common perception that problematic methamphetamine users may be more complex, this may be due to the fact that clinicians are unsure how to best manage and treat these clients, rather than because they are inherently unmanageable or untreatable. Dr Lee suggests that the lack of knowledge is, in turn, attributable to a lack of effective dissemination of research results and their translation into clinical practice. She points to a substantial body of evidence which demonstrates the efficacy of motivational interviewing (MI) and CBT for this group, of which few in the field seem aware.

Research findings

Baker et al. (2005) found a significant reduction in amphetamine use and associated improvements in other behavioural and mental health outcomes among their sample of people presenting for treatment, even those given the relatively low-level intervention of an assessment, provision of a self-help booklet, and scheduled follow-up sessions. Results led them to recommend a stepped-care approach for this population.

Research has long shown that many problematic methamphetamine users do not present to traditional AOD services, in the belief that these cater for heroin users but have little to offer stimulant users, who cannot be prescribed a methadone equivalent (see ‘Pharmacological interventions’ on p. 12). However, stimulant users do present in other settings – GPs, emergency departments, psychiatric units – and with appropriate training and referral networks, it may be possible for some frontline workers in these settings to deliver at least the first tier of treatment, which is particularly suited to non-treatment settings, with referral to AOD services for two to four sessions of MI and CBT should the first tier prove inadequate. Brief interventions appear to be most appropriate due to the transient nature of this population. ‘They tend to be in a hurry,’ Dr Lee wryly observes.

Dr Lee suggests that in the future, specialist services should be developed which address methamphetamine use and its associated problems, particularly polydrug use, and mental and physical health problems. She also highlights the need for the upskilling of generalist services, not only in terms of clinicians’ therapeutic and intervention skills, but also in terms of policies and procedures. ‘Management must be involved,’ she says. ‘Developing the capacity of the workforce to cope with these users and offer them attractive and appropriate intervention options must be considered the core business of every worker in the AOD field.’

Marketing services

Dr Rebecca McKetin, Research Fellow at the National Drug and Alcohol Research Centre, also advocates for the development of specialist services for this group, emphasising the importance of being seen to address their needs. Dr Mark Montebello, Staff Specialist in Psychiatry at Sydney’s Langton Centre, agrees. Langton conducts stimulant-specific treatment clinics two afternoons a week, using the same staff (including a mental health nurse) to ensure service cohesion. These clinics are well-attended, yet Dr Montebello readily acknowledges, ‘It’s all about marketing. The service is not fundamentally different from what we offer to all clients, but we call it stimulant treatment, so stimulant users feel that we must have something to offer them, and they present and find that we do.’

Jo Lunn is straightforward in her assessment of the belief of many in the field that they are ill-equipped to cope with this type of client. ‘A workforce which is scared of a particular client group is unlikely to be successful in engendering hope in those clients. AOD workers must engage with their methamphetamine users and have as much hope for that client as for any other.’ Undoubtedly, research will help guide us in our attempts to better attract, engage and retain this population in treatment.

In the meantime, we can confidently rely on our core skills to offer problematic methamphetamine users a beneficial experience of intervention services – from undertaking a comprehensive assessment through to providing education on harm reduction strategies; from de-escalating hostile interactions through to increasing a client’s readiness to change through motivational interviewing; from intensively case-managing a client during times of crisis through to offering support for their family; from making appropriate referrals to other services through to the simple act of demonstrating empathy through reflective listening. As Frances Kay-Lambkin reminds us, ‘Applying our core counselling skills in any situation is the best that can be expected of any clinician, and any clinician who applies those skills, regardless of the outcome, should be confident that they have acted appropriately and in the best interests of their client.’
PHARMACOLOGICAL INTERVENTIONS

When it comes to developing and trialing medications to treat methamphetamine users, James Shearer, Professor of Pharmacology at the University of Adelaide, says that researchers inevitably model their approach on the opioids, where we have been relatively successful at providing treatment. But, although this is a reasonable strategy, and there is some evidence, in that “withdrawal versus maintenance” paradigm will be shown to hold entirely true for stimulants of any sort remains to be determined,” he says.

James Shearer, a doctoral candidate at the National Drug and Alcohol Research Centre who is currently managing a randomised controlled trial (RCT) of the novel central nervous system stimulant modafinil for methamphetamine and cocaine users, agrees. “We must develop new ways of conceiving of pharmacotherapies for stimulant users,” he says. In his RCT, clients are prescribed modafinil for 10 weeks, a program of similar duration to that employed for both nicotine replacement therapy (NRT) and bupropion for smoking cessation.

“So under our current understanding, people ask, are you thinking about withdrawal, or maintenance?” Shearer argues that the medication regimen does neither, and that our conceptions of pharmacological interventions for stimulant users may be better informed by the NRT framework, rather than opioid pharmacotherapies. “Intuitively, it makes sense,” he says. “After all, nicotine and methamphetamine are both stimulants, but we often try not to make this basic connection because our views are so clouded by the legislative distinctions between licit and illicit drugs.

As the pursuit of effective pharmacotherapies continues, the extant literature remains notable for its failure to identify any strongly promising agent (see Shearer & Gowing, 2004), most experts agree that it is likely that combinations of pharmacological and psychological treatments will prove to be the most effective. Although there is some evidence in relation to the relative importance of each component, Shearer observes that the salience and value of the pharmacological versus psychological therapeutic components of an integrated treatment will vary across individuals.

Turning Point’s Dr Nicole Lee remains cautious about the potential for pharmacotherapies for stimulant users. “Even with the extensive research conducted over two decades in the US on pharmacotherapies for cocaine dependence, nothing stands out for stimulants like methadone or buprenorphine for opiates,” she says. Dr Mark Montebello, who is currently trialing a non-selective serotonin reuptake inhibitor (SSRI) anti-depressant already on methamphetamine dependence at Sydney’s Langton Centre, believes the search must continue. “People addicted to drugs like heroin, alcohol and nicotine that have pharmacotherapies available for their treatment have vastly improved outcomes compared to drugs like methamphetamine, cocaine and cannabis, which do not,” he emphasises.

For Dr Lee, the true benefit of effective pharmacotherapies is likely to be in increasing the range of treatment options available to problematic methamphetamine users, and attracting them to treatment. “Even if trials demonstrate the efficacy of pharmacotherapies, it is likely they will be primarily adjunct therapies that help to engage and retain users in therapies with a psychological focus,” she says. Dr Rebecca McKetin, from NCETA agrees, describing one of the limitations of pharmacotherapeutic approaches for this group as being that, “by the time those suffering from psychosis and those already on anti-depressant medications have been excluded [due to the potential for drug interactions], you’re missing much of the target population.”

Advocating a combined treatment approach, Professor White points out that, in general, methamphetamine users are a less homogeneous group than heroin users, and consequently, service providers will more successfully attract the entire range of such users when they can offer a variety of intervention options. He further suggests that we may find in the future that psychotherapy is a more important component of methamphetamine treatment than for heroin because dependence on the two drugs is maintained by somewhat different motivations. Heroin dependence is strongly driven by the need to avoid or move withdrawal, and dependent users don’t necessarily feel intoxicated after using. But for even severely dependent methamphetamine users, the pleasurable effects of the drug still motivates them to maintain their use. It’s this aspect that may not be treated effectively with medication”, and that may instead require a primarily psychological approach.

While acknowledging the importance of psychosocial therapies, Professor White believes that development of a pharmacological agent which effectively eases the discomfort of methamphetamine withdrawal remains essential. While benzodiazepines are more well prescribed, he argues that they are not specific enough. “It was only recently that clonidine was the accepted medication for opioid withdrawal, but it was discounted because it wasn’t a great solution – it’s not specific enough. Managing the irritability and aggression that often characterise methamphetamine withdrawal with Valium is virtually the equivalent of this. It will do, but it’s far from ideal. Currently, we can use buprenorphine for opioid withdrawal with great success, and likewise, the hope would be to identify an agonist for methamphetamine that will mimic its pharmacological effects to some extent, but not so strongly that its discontinuation will be associated with its own rebound effect.”

Trials to date seem to suggest that in general, the more ‘agonist’ the effect of a drug, the less effective it is. Professor White suggests, “An antagonist may prove to be a better drug.” But while naltrexone (an opiate antagonist) has not proved very effective as an intervention for heroin dependence, once again the point is that whereas we can and should learn from our experience of other drugs, the paradigms which make sense of opioid treatment may not be particularly relevant for stimulants.

* For more information about, or to refer a client to, the methamphetamine treatment trial currently being conducted at the Langton Centre (Sydney) and in Perth, please phone Dr Mark Montebello on (02) 9332 8777.

References and further reading


Please contact the editors for additional reading list this article.

METHAMPHETAMINE USERS: AN E.D. EXPERIENCE

David Spain

As an active emergency physician confronted regularly by methamphetamine users, I thought it time to bust some myths. Most of the information below came from a small study involving 62 patients that we undertook at the Gold Coast Hospital over recent years (funded by the Psychostimulants Initiative, Australian Government Department of Health and Ageing).

The aim of the study was to pick the clients with the worst uncontrolled behaviour due to suspected psychostimulant use to trial a sedation protocol. The group selected were unable to be calmed down by verbal means, time-out strategies or oral sedation. In particular, we were looking at safe usage of higher doses of midazolam, a sedative benzodiazepine agent.

Myth 1

All uncontrollable clients are on amphetamines or methamphetamines.

Truth: Only about 30% were in this group. 52% were on marijuana, alcohol or other prescription and illicit drugs. Often they took more than one drug and typically were hard players using large amounts of the above substances. Eighteen per cent were typically just angry people and admitted no drug or alcohol abuse.

Myth 2

They all need, and tolerate, massive doses of sedative agents.

Truth: Seventeen per cent needed only standard doses of sedative agents. Seventy-five per cent were sedated with one or two larger than normal doses. The rest were difficult to sedate with benzodiazepines even in very high doses.

Myth 3

The police bring in all these clients with physical restraint.

Truth: The police bring in about 42% of these clients, and the ambulance about 41%. The rest come by private means. Most come to police attention and are often escorted for assessment to the emergency department by various third parties. Behaviour often escalates again while awaiting or during assessment.

Myth 4

Expert opinion recommends benzodiazepines (or other sedative agents) as ideal and safe for use in this group.

Truth: There have been few studies to date but so far there is no ideal agent or dose. Like most drug therapy, all these agents have risks and side effects. The behaviour of this group is often also risky and extreme, with suicidal or homicidal tendencies common. Physical restraint also is with suicidial or homicidal tendencies common. Physical restraint also is
‘METH WHISPERING’: DEALING WITH CHAOTIC CLIENTS

DAVID CALDICOT

Things are clearly not well with ‘Michael’, a 22-year-old man in the seclusion room of our Emergency Department. He is standing in the corner of the cubicle, holding a foam chair high above his head, directed towards the uniforms at the door. He screams incoherently, his skin shines with a thin veneer of sweat, but there are no obvious track-marks. He has abrasions over his wrists from the handcuffs that he was brought in with.

Time for a quick decision. Eight security guards are waiting outside the room, with a nurse armed with a 10 mg syringe of lorazepam. If we rush him, someone might get hurt. In his eyes there is fury, pain, and there is pleading. He looks homicidal and psychotic, but those terms aren’t exactly ice-breakers.

‘Tell me what I can do for you .. ’ I begin the mantra. It’s certainly the first time he’s heard that tonight.

‘You can start by telling those guards to f*** off away from the door.’

‘Not a problem, but it’s a bit stuffy in here. I think we ought to keep that door open .. ’ I point to the door. ‘It’s okay lads, we’re cool here, ’ I say. ‘This is the guards’ cue to take some steps back out of view. I turn to Michael.

‘Better?’

‘Yeah, ’ he grunts grudgingly, pointing his finger.

‘You look strung out, buddy.’

‘You have no idea, ’ he chuckles humourlessly.

Another high-risk manoeuvre coming up. I move towards him, closing in on his personal space. Being tall I can use body language to both reassure and give the impression that I’m not nervous – it’s a lie I’ve had some practice at. I put my hand on his bare shoulder, it’s hot, worryingly hot. He flinches, and then relaxes.

‘I’m David, one of the emergency doctors here. I reckon you could do with something to take the edge off.’

‘I’m not having an injection!’ he shouts. His paranoia is clear. Wrong direction. I back-pedal.

‘Ahhh, you’d be too hard to give an injection to, even if I wanted to, Michael, ’ I say. If we actually did need to jab him, he’d be held down, and he’d be injected in the quadriceps, through his jeans. Nothing elegant, nothing clever, just large volume, it’d hurt and it’d certainly end the possibility of any therapeutic relationship between doctor and patient.

‘What do you want?’ I continue. ‘On the menu today we have olanzepine wafers, a variety of antipsychotic pills and benzo’s – but you can have as big a dose of benzo’s as you want.’

‘Benzo’s, don’t f***** touch me,’ he sulks.

‘Trust me, the way I give them, you’ll be “touched”.’

The word ‘trust’ is placed in the conversation, along with the promise of drugs. We’re speaking the same language.

‘You look parched. ’ White, viscous spittle had accumulated at the corner of his mouth. ‘ Fancy a cup of tea?’ Small acts of personal service are frequently noticed and appreciated.

‘Yeah .. ’

‘OK. I’m going to make you a cup of tea and bring you 200 mg of Valium. This is going to take me five minutes. Can you chill out here for that long?’ In reality, it wouldn’t take me nearly that long, but his part of the deal is to try and marshal his remaining self-control. And so a small headway is made in sorting out this latest patient.

Around Australia, doctors working in emergency departments are dealing with similar scenarios with increasing frequency, and little in the way of evidence-based guidelines or guidance. Sometimes the scenarios are easier, sometimes they’re more difficult, but the cumulative effect is taking its toll on medical and nursing personnel, sometimes physically, nearly always psychologically. Appropriate widespread monitoring of the extent of the problem in the acute phase is not occurring, and toxicological assessment is non-existent. The impact of the acutely drug-induced psychotic patient also negatively impacts on the care of other patients in terms of the resources that need to be diverted away from them.

An opportunity exists for collaboration between physicians and addiction specialists to deal with this new and rapidly emergent problem, especially in the ED setting.

Dr David Caldicott works at the Royal Adelaide Hospital

MENTAL HEALTH SCREEN AND INTERVENTION: PSYCHECK

NICOLE LEE

It is now recognised that among clients in alcohol and other drug (AOD) treatment, mental health conditions are the norm rather than the exception. And most of these clients with a ‘dual diagnosis’ have one of the high prevalence disorders: depression, anxiety or somatic problems.

However, most research and professional development is focused on managing low prevalence psychotic disorders, leaving a potential skill gap, especially when AOD clinicians do not have a background in mental health treatment.

In an effort to better address this issue, Turning Point Alcohol and Drug Centre initiated the PsyCheck Project, an implementation trial designed for AOD workers to help them identify and intervene with clients who have a dual diagnosis. Funding for the project came from the Australian Government Department of Health and Ageing, Drug Strategy Branch under the National Comorbidity Initiative.

The PsyCheck screening tool was developed and validated in an earlier study (Jenner et al. 2001). It comprised a World Health Organization-developed mental health screen (the ‘Self Reporting Questionnaire’), a suicide risk assessment, a brief mental health history and some mental health probes.

The intervention was based on a cognitive behavioural model and centred around four ‘sessions’ that could be tailored to a client’s needs. Several therapeutic options were offered within each session so clinicians could choose one strategy or multiple strategies depending on their clients’ needs. The cognitive behavioural model was chosen as an ideal vehicle to integrate mental health and substance use treatment, given that best practice in both areas is based on this model.

The trial and evaluation

Five agencies across three states (Victoria, NSW & Qld) participated in the trial project, spanning both rural and metropolitan areas and including counselling services, pharmacotherapy services and community health centres. At each site, managers and supervisors were consulted about the implementation of the program, and clinicians were invited to participate in the study. Those taking part were trained in using the screening tool and the intervention, and also offered group or individual weekly supervision.

During clinical supervision, the clinicians developed a clinical formulation of each client’s presenting problems, focusing on the underlying mechanisms maintaining the problem. A comprehensive treatment plan was then developed. To evaluate the project, in-depth interviews were conducted with clinicians, managers and the clinical psychologist supervisors. Random file audits were also conducted before and after the trial to examine rates of detection and reporting. The evaluation showed that clinicians felt more confident in using screening and assessment instruments, in detecting mental health problems in their clients and in providing a basic integrated mental health and substance use intervention.

Clinical supervision was found to be central to the success of the project, and improvements in practice were best where management support was greatest, making these two aspects critical to future implementation.

Resources for workers

A toolkit was produced for the study and further developed as a result of the feedback from the trial. It contains the screening tool (the PsyCheck) and users guide, comprehensive clinical guidelines centered on a four-session program with extension material and worksheets, guidelines for managers on how to implement such a program into a service, and training guidelines for supervisors/managers/trainers to train new staff.

The resource is specifically designed for use by AOD workers, with or without experience in mental health assessment or intervention. The four training modules are designed to run for half a day each. In the dissemination trial we are providing supervision and support and recommend this as routine for clinicians.

This would involve the supervisor watching at least one session, either live or taped, and providing regular face-to-face clinical supervision for the clinician.

The extension material is delivered as additional modules that address either the same issue (e.g. depression symptoms) in a different way or additional mental health related issues that clinicians may come across (e.g. sleep problems). The extension material gives further flexibility to the clinician to tailor the intervention with confidential beginner clinicians with mountains of material to wade through.

Ideally the toolkit would be supported by good clinical supervision, which would enhance its usefulness, but it is designed to be self-directed. It will be available in August 2006. For further information, contact Dr Nicole Lee, Turning Point Alcohol and Drug Centre Ph (03) 8413 8416, fax (03) 9416 3420; email: Nicole.lee@turningpoint.org.au

* Dr Nicole Lee is Program Leader, Clinical Research, Turning Point Alcohol and Drug Centre, Victoria.

Reference

National Cannabis Strategy 2006-2009

Jennifer McLaren, Jane Blurton

As outlined in the January 2006 issue of Of Substance, Australia’s first national strategy addressing cannabis use and its associated harms was developed during 2005 and 2006, through a comprehensive consultation process. The National Cannabis Strategy 2006-2009 (the Strategy) was endorsed by the Ministerial Council on Drug Strategy on 15 May 2006.

Need for a strategy

Data collected by the Australian Institute of Health and Welfare show cannabis use has fallen since 1998 among the general population. However, hospital and treatment data show that problems associated with cannabis are increasing. This may be related to the decreasing age of initiation into cannabis use, since earlier onset of substance use is known to be associated with a higher risk of developing problems (Degenhardt et al. 2000). This rise in demand for treatment for cannabis-related problems is occurring in the context of increasing evidence of the relationship between cannabis and adverse outcomes. These outcomes include physical harms, such as respiratory problems, psychological harms and social harms. It was against this backdrop that the decision to develop a national strategy for cannabis was made.

Objective

The objective of the Strategy is to ‘reduce the availability and demand for cannabis, and minimise related harms within the Australian community’. To meet this objective, 70 actions under four main priority areas were identified. The priority areas represent a continuum of responses suitable to different groups (see figure 1).

Responsing to problems associated with cannabis

The final priority area aims to provide effective and accessible interventions, tools, treatments and support for those who develop problems associated with their use. An example is to develop clinical guidelines on methods of intervention for cannabis dependence.

The Strategy also outlines ways forward for building the evidence base (e.g. further research on the harms associated with cannabis use for specific population groups), improving partnerships (e.g. cooperation between health, education and law enforcement) and developing the workforce (e.g. supporting ways for alcohol and other drug workers to detect mental health problems, and for mental health workers to detect cannabis problems).

The MCDS has asked the Intergovernmental Committee on Drugs to develop four or five key areas of national priority from the Strategy for its consideration. The Strategy document is currently being printed and will be available by calling the Drug Strategy Branch of the Australian Government Department of Health and Ageing on (02) 6289 7470.

Books Dispel Cannabis Myths

Jenny Tinworth

Two new books about cannabis have been published by the Australian National Council on Drugs (ANCD).

Cannabis – your questions answered and the accompanying Evidence-based answers to cannabis questions: a review of the literature were released in May.

With 1.8 million Australians using cannabis each year, the books are designed to provide evidence-based information to both members of the public and the health community. Chairman of the ANCD, Dr John Herron, said the books were needed to dispel misinformation in the community about cannabis and its effects.

Cannabis – your questions answered looks at 13 key questions about cannabis, addressing subjects as diverse as patterns of use, legal status, potency, physical health effects, mental health, issues for young people, treatment, passive smoking, links between tobacco and cannabis, its effect on driving skills, which people may be vulnerable to problems and the role of cannabis as a ‘gateway drug’ to other illicit substances.

As I see it, there are three public mental health issues:

• Firstly, in some communities and in some settings cannabis is used so intensively as to produce chronic intoxication, swamping normal intellectual, emotional and social functions in many people. In these circumstances the negative impacts on the social development of young people may never be reversed.

• Secondly, some people are so sensitive to the psychoactive constituents of cannabis that their thinking, feeling, anxiety and motivation can be tipped over at low exposure levels. For these people the experiences can be disturbing with troublesome, suspicious thoughts and paranoia, and yet for others, the mental state can be strangely comfortable.

• Thirdly, at the heart of the scientific and political debate is the relationship of cannabis to ‘true’ psychotic illness. Here disordered thinking, perceptual changes and disturbed behaviour, commencing in young people, resemble – but are not necessarily – schizophrenia. The unanswered question is whether these are new cases of schizophrenia or the unmasking of a dormant mental illness.

Questions such as these generate controversy and heat, but sensible answers can be found in the publications recently released by the Australian National Council on Drugs (see article above).

These publications call on hard evidence to help clarify information about cannabis. They are joined by the recently adopted National Cannabis Strategy which maps a sensible approach to public policy and public health.

A PHYSICIAN’S OPINION

Professor Ian Webster

Cannabis has been known since the Mesolithic Age, and in some countries, it has long been part of social life, just as alcohol is in Australia.

Our naiveté about marijuana was broken by the youth culture of the 70s which flowed from the ‘Beat Generation’ and the widespread use of illicit drugs in the US. In Australia, cannabis use increased from that time, peaking in the 1990s; since then its use has gradually declined. According to the 2004 National Household Survey, about one in 10 of the whole population have used cannabis recently; and about one in three will have used it at some time in their lives. Between the ages of 20 and 39 years, about half have used cannabis and in adolescents (14 to 19 years), about one in four will have used cannabis at some time.

So, with cannabis use so prevalent in the community, it is not surprising that many questions and opinions have grown around its use. Some argue that cannabis should be used for the treatment of medical conditions such as HIV-related or cancer-related wasting, chemotherapy-induced nausea, and in pain management. Others believe that today’s cannabis is more potent than that of earlier times.

There is no doubt that cannabis has many effects on the body, including causing respiratory problems. However, society’s primary concern is about its impact on mental health and behaviour.
Since 2001, we have been monitoring patterns of cannabis use and the extent to which it is associated with poor mental health in a collection of remote Aboriginal communities in Arnhem Land in the Northern Territory. The five-year follow-up looking at cannabis use in this region is currently underway. This article provides a snapshot of some harms resulting from widespread cannabis abuse; the role of supply control in reducing harmful effects; and prospects for a community-driven approach to address widespread cannabis abuse.

Rapid rise in use

Data published in the *Medical Journal of Australia* in 2002 indicated a rapid rise in cannabis use in remote Aboriginal communities in Arnhem Land in the preceding five years, with evidence of expansion and elaboration of cannabis supply links. Other Indigenous communities across the NT’s ‘Top End’ anecdotally reported a similar rapid increase in cannabis use. This was confirmed by surveys in eastern Arnhem Land communities which indicated that among those aged 11-36 years, 63%-75% of males and from 20%-31% of females had at some time used cannabis, with most of these continuing to use cannabis at least monthly (Clough et al. 2004).

We are unsure of the reasons precipitating the availability of cannabis in these communities. However, it is clear that there has been a sudden realisation by networks of dealers that considerable profits remain readily available. Rapid rise in use

Harms from cannabis use

Community level harms:

- It has been estimated that the financial burden of the cannabis trade can consume, and eventually export, around 16% of a community’s total available cash resources (Clough et al. 2004).
- Violence, in the form of domestic or family violence, is a feature that has become associated with cannabis abuse in these localities. When cannabis supplies become short, or when people who use perceive they may run out, they will exert pressure, often manifested in violence against their immediate family members, to either furnish more cannabis or the cash to purchase it. Anecdotal accounts reveal cannabis abuse now rivals alcohol abuse as the principal reason for admitting victims of family violence to the crisis accommodation facility in the regional centre in eastern Arnhem Land.
- It is not clear what is understood by the community regarding the effects of prolonged cannabis use. There is anecdotal evidence of caregivers giving money to young people to purchase cannabis ‘to calm them down’. This response occurs in an environment where there is significant background of ongoing emotional trauma and health concerns; and limited or no health promotion or education regarding cannabis.

There are virtually no services available to treat the effects of cannabis abuse and dependence outside the primary health care centres in each remote community. Services are generally limited to crisis care with little opportunity to develop community-driven health promotion programs or undertake training in brief cannabis interventions. Clinicians have few options when confronted with patients suffering acute psychosis from cannabis abuse. The more severe cases need to be evacuated to inpatient mental health care facility in Darwin where they quickly become asymptomatic and are then returned to community environments where cannabis remains readily available.

Harms to the individual:

- Individual cannabis users may be spending from 30%-60% of their weekly income on cannabis (Clough et al. 2004).
- To meet their other needs, cannabis users then rely on their extended families. A recurring and disturbing behaviour pattern has emerged wherein cannabis abusers who are denied money from their families, will then exert emotional pressure by threatening self-harm. While this has not been systematically studied, it appears many of these threats have been carried through to a completed suicide.

• We have documented subtle and familiar adverse mental health effects in people who use cannabis in eastern Arnhem Land. As the dosage of cannabis increases, there is an increased likelihood the individual will suffer fragmented thought processes including confusion and indecision; difficulties controlling use, indicating cannabis dependence; memory disruption; and auditory and visual hallucinations (Clough, D’Abbs et al. 2005).

Supply control crucial

We recently reported a modest reduction in cannabis use between 2001 and 2004, but with a persisting high prevalence of use, especially amongst males in some eastern Arnhem Land communities (Clough, Lee et al. 2006). The principal reasons for quitting cannabis use were found to be that cannabis had become more difficult to obtain and that new family responsibilities led users to reform their substance use habits generally.

It has been estimated that the financial burden of the cannabis trade can consume, and eventually export, around 16% of a community’s total available cash resources.

We also observed a reduction in the more prominent symptoms earlier observed in cannabis users including a reduction in the reporting of fragmented thought processes and impaired memory; fewer cannabis users reported difficulties controlling their consumption; fewer had sleeping difficulties; and fewer suffered hallucinations. The primary reason for the reduced occurrence for each of these groups of symptoms provided by the user was that reduced level and frequency of cannabis use was because it had become harder to obtain. Clinicians reported a decrease in the occurrence of adverse psychological symptoms of cannabis use in their patients, and community members confirmed a general reduction in the availability of cannabis and in local dealing in the substance.

Data collected so far in the five-year follow-up indicates that when cannabis supply is limited, drug substitution is prevalent with a small group of people, who use daily, turning to petrol and also to a lesser extent kava. However, the majority go without cannabis and try to ‘keep busy’ when supply is limited.

In the communities where there had been a reduction, there had been increased attention by police to intercept the flow of drugs and illicit alcohol into the communities from around 2001. While personal factors also influenced the decision of individuals to moderate or quit cannabis, juvenile diversion programs and substance misuse programs were also implemented. None of these measures could succeed to reduce harmful levels of cannabis use in isolation. In these settings, tight controls of supply are required along with complementary measures to divert young people from the use of substances such as cannabis. This can be through increased recreational, education or training opportunities. There is a need for community-wide health promotion and education programs with evaluation of their effectiveness. Ongoing monitoring and evaluation of the prevalence and levels of cannabis use are required in these populations.

Indigenous researchers address abuse

The research team has expanded considerably during the course of the project to include researchers indigenous to each community. Their perspectives have influenced the current direction of the project. There are plans to explore prospects for developing a common understanding about conducting epidemiological research in this setting and for adopting a community feedback approach to inform future community-driven cannabis interventions. The researchers’ enthusiasm has been infections and has resulted in a groundswell of community interest in addressing cannabis abuse in these communities. As one researcher said: ‘We like talking and hearing the stories from our people, so we can help them with this [cannabis]. It takes hold of your mind and it is hard for them to stop. We did not know they had so many problems from that [cannabis], fighting and mental health way. We knew it was hard for them. It is good to hear their stories ... We can hear the stories and then help our people.’

For more information contact Kylee Lee, email kskle@bigpond.com.au or phone 0411 371 830.

References


HOSPITAL-BASED BRIEF INTERVENTIONS: OPPORTUNITY KNocks

JEFF BROWNSCOMBE*

Brief interventions (BI) aim to identify current or potential problems with substance use and motivate those at risk to change their behaviour. They are an eclectic mix of information, advice and opportunistic conversations, ranging in length from five to 30 minutes. A four-armed randomised controlled trial conducted by the World Health Organization (WHO), involving 32,000 patients across ten nations found that any BI (including five minutes of advice) resulted in an approximately one-third reduction in alcohol consumption at nine months follow-up (WHO 1996). A well-known literature review found that BIs for alcohol are more effective than no intervention, show similar impact to more extensive interventions and enhance the effectiveness of subsequent treatment (Bien et al. 1993).

Brief interventions are a proven and cost-effective means of addressing substance-related harm and the hospital is an ideal place for delivering them. Smoking, harmful drinking and illicit drug use are all over-represented in hospital populations. For some, hospital is their only or only contact with doctors, nurses or allied health professionals. Referral pathways, from specialist AOD consultation to links with external agencies, are frequently available. Research suggests that hospital inpatients may be more amenable to behaviour change than others (Emmons & Goldstein 1992).

Hospitals have a frontline role in reducing drug-related harm, through managing injuries, overdose and the medical complications of drug use. However, their capacity to address some of the subtle aspects of substance-related harm, such as the timely delivery of brief interventions, is often quietly scoffed at. Hospital staff can seem trapped in the ‘acute’ mindset, forced to prioritise drug-related harm issues (after all, they still deal with ‘patients’, not the more progressive ‘clients’). Hospitals seem large, bureaucratic and difficult to change, with little room left in their tight budgets for any preventative or innovative programs.

However, many hospital workers incorporate BIs into their work in some way. The success rate of a single BI is small, in parallel with the often multiple steps required to overcome addiction. Yet the cumulative effect at a population level of multiple BIs is substantial.

Northern Territory review of brief interventions

In 2005, the Northern Territory Department of Health and Community Services examined the issue of hospital-based BIs. The NT Hospital-based AOD Brief Intervention Project (Browncombe 2005) proposed the central question: how can we raise the profile of BIs in NT hospitals? The NT has substantially higher rates of smoking, harmful alcohol use and drug use than the national average (AIHW 2004). NT hospitals are generally smaller, with larger geographical catchment areas and a higher proportion of Aboriginal clients compared to hospitals elsewhere in Australia. However, they share similar operational and cultural characteristics. Hence, the findings of this project may be of interest to all health workers wishing to see hospitals become more pro-active in addressing drug and alcohol issues.

As part of this project, two key BI services were identified and analysed: firstly, the Alice Springs Hospital, which uses ‘the green form’ with all admitted patients. This is a simple six-question screen for drinking, smoking and other drug use, and helps facilitate referral to an AOD worker and in some cases a treatment agency. Its effectiveness is limited by the high workload of AOD workers and variable interest and commitment from an already stretched hospital workforce with high turnover rates. However, it has been going since the late 1980s, making it a true survivor in hospital-based BI program terms.

Secondly, until four years ago, the Royal Darwin Hospital had a system whereby inpatients on selected wards were administered the AUDIT screening tool by a nurse or Aboriginal worker, followed by a BI. The discontinuation of this program (due in part to a lack of appreciation for what it did) was identified as a major loss, especially for engagement and referral of Aboriginal clients.

The project revealed widespread consensus amongst clinicians, managers and policy makers that BIs were substantially ‘underdone’ in NT hospitals and this should be addressed. This echoed WHO recommendations that BIs should become core skills for all health workers – rather than being left in the specialist domain, which is resource intensive and misses opportunities to integrate with medical care (Henry-Edwards et al. 2003). Hospital staff frequently felt their knowledge and skills were lacking around AOD issues. Many expressed a sense of hopelessness around perceived treatment failures. Attempts to do ‘everything possible’ for patients could be counterproductive when delivering BIs, where a ‘leave the ball in their court’ approach is sometimes more successful. There was a clear demand for training, though information needed to be delivered in short sessions, to fit with nursing in-services or resident doctor’s education, rather than delivered in longer modules.

The project report noted that interventions for Aboriginal people are often best delivered by Aboriginal workers. This is a significant challenge given Aboriginal workforce shortages and the drive for cost-effectiveness. However, non-Aboriginal staff may still play a crucial role in facilitating behaviour change. Screening tools such as AUDIT may be inappropriately invasive or long. There are numerous customised resources for Aboriginal people, addressing differences in literacy and worldview – yet infrequently used by hospital staff.

It is encouraging to note that numerous systems changes occurred during the study period. A referral form to the QUIT telephone line came into operation, training and resources were provided to hospital staff, and ‘brief intervention’ was added to the scroll-down menu in the emergency department electronic discharge process. Additional funding was suggested (though yet to be received) for a specialist AOD nurse and an Aboriginal AOD worker in major hospitals. Northern Territory hospital services still have a long way to go to fully integrate BIs as standard admission and discharge services, however we are hopeful that the project’s report recommendations and tools like the ‘Tips for Hospitals’ (see box above) will encourage hospital staff to incorporate BIs as part of their primary care.

* Jeff Browncombe is a Public Health Registrar, NT Department of Health and Community Services, Darwin.

References


Browncombe, J 2005. NT Hospital-based AOD brief interventions project, NT Department of Health and Community Services, Darwin.


NALTREXONE IMPLANTS: A CLINICIAN’S VIEW

DR MARTYN LLOYD-JONES

A brief history

Naltrexone has been available to treat opioid dependence since 1984. A synthetic, long-acting opiate antagonist, it blocks opiates by binding to the brain’s mu receptors. Without the antagonist, these receptors receive opiates and allow the body to experience their effects.

Naltrexone is well absorbed through the gastrointestinal tract and the effects of a single dose last between 48 and 72 hours. However, compliance rates for people taking oral treatments is notoriously poor. As a consequence there has been interest in exploring alternative ways of delivering the drug. Implantable forms of naltrexone have been in development since the late 1970s.

Naltrexone implant treatment has been the source of some controversy within the alcohol and other drug sector. However, naltrexone has been found to be a useful treatment for highly motivated patients who desire complete abstinence from opiates and who are participating in a relapse-prevention program. Such programs usually incorporate a monitoring component.

The proposed model for the success of using an opioid receptor antagonist is that the blocking of the mu receptors by the implant reinforces the belief that using opiates will be a fruitless exercise, resulting in a diminution of the desire to use opiates.

The use of implants

Whilst implants may offer some benefits over oral naltrexone treatment they can suffer from problems such as inconsistent drug release and delivery, as well as local tissue complications. There are a number of implants available worldwide, although in Australia the majority are produced by GoMedical Industries in Western Australia (WA). The GoMedical implants have been used under Commonwealth Therapeutic Goods Administration Compassionate Guidelines in WA since 2000.

In excess of 3000 naltrexone implants have been inserted in Australia. The GoMedical implant consists of naltrexone in poly- DL-lactide microphreses which are loaded into pellets. The doses available (1.7 g or 3.4 g) are believed to maintain adequate plasma levels of naltrexone and its metabolite 6-b-naltrexol for three and six months respectively.

Complications can arise

The Drug and Alcohol Consultancy Advisory Service (DACAS) is a 24-hour telephone advisory service operated by Turning Point Alcohol and Drug Centre in Melbourne. This service provides advice on drug/alcohol matters to health care professionals in Victoria, Tasmania and the Northern Territory. Over the last 24 months the service has received a number of calls relating to the use of naltrexone, in particular relating to complications arising in patients who had had a naltrexone implant inserted. These complications are not common but sometimes are serious. Some relate to an unrelated medical event occurring elsewhere in the body, some relate to the implant itself, and some to the presence under the skin of an implanted substance and some to a combination of the withdrawal complicated by the insertion of a long-acting opioid antagonist. In other words some parallels can be drawn to other medical events in the opioid withdrawal process itself, some to the opioid withdrawal process itself, some to the presence under the skin of an implanted substance and some to a combination of the withdrawal complications.

From a review of the calls to the DACAS service over the 6-month period ending in March 2005, 19 cases were identified in which the use of naltrexone, or the process of rapid opiate detoxification employed in order to begin therapy with naltrexone, had resulted in complications. Of these cases, 13 were related to naltrexone implants and eight were deemed to be significant clinical events where specialist advice was required to facilitate the management of the patient.

These scenarios included two in which patients were critically ill. In one instance a patient presented by ambulance to an emergency department having collapsed after becoming severely dehydrated following the insertion of a naltrexone implant three days previously. He had developed acute pre-renal failure and rhabdomyolysis and responded to fluid resuscitation after he had his implant removed. Another man developed severe withdrawal, complicated by aspiration of vomitus, leading to the development of acute pulmonary oedema. He required supported ventilation and the question arose as to whether he should have his implant removed.

Another case was described in which the client had presented to a doctor having had double implants inserted six months previously. He was unhappy with the two egg-sized swellings on either side of his abdomen and was seeking a surgical solution. Another five patients had presented to their doctors because of significant and persistent withdrawal symptoms two to five days after implant insertion. In one case, the patient had attempted to remove the implant themselves.

Managing withdrawal

These often clinically complex situations appear to occur for a number of different reasons. One prominent factor appears to be the management of the acute opioid withdrawal process itself. The treatment of persistent opioid withdrawal in these situations is not always simple and little evidence exists to guide the clinician.

A CLINICIAN’S VIEW

NALTREXONE IMPLANTS: A CLINICIAN’S VIEW

IMPLANTS PREVENT OPIATE OVERDOSE

Featured study:


Findings:

Opiate overdose incidents and fatalities can be eliminated during the active period of a naltrexone implant, reducing deaths among those unable to control their opiate use in any other way.

The best evidence of this has come from an Australian study of 361 patients implanted during rapid opiate detoxification under heavy sedation. About half had previously tried oral naltrexone which had not reduced their rates of opiate overdose. The implants were designed to block opiates for about six months.

Hospital records showed that in the six months before their implant, 20 patients had been treated for opiate overdose, while in the following six months, none were. This was partly offset by a post- implant increase in incidents involving only non-opiate drugs, especially sedatives, up from eight people to 16. Most occurred within the first 10 days, probably either the lingering effects of deep sedation or an attempt to self-medicate withdrawal symptoms. After six months the initial immediate risk would no longer be active, but in the following six months just three people were treated for opiate overdose, while sedative overdoses returned to their pre-implant level. By definition, none of the pre-implant overdoses were fatal, but this was also the case after the implants.

In context:

There are no randomised trials comparing naltrexone implants to other treatments. Results from studies to date cannot securely be attributed to the implants and may partly be due to the type of patients who select or are selected for treatment; in some studies, patients have been relatively socially integrated, are highly motivated and have had considerable experience across several countries suggesting that implants can help selected patients stay opioid-free more effectively than detoxification alone or detoxification followed by oral medication. Most importantly, while active and even afterwards, they have not yet been associated with the very high opiate overdose and death rates seen with oral naltrexone. However, deaths have occurred from other causes and other drugs, or from opiates after the implant has run out. A few patients develop complications at the implantation site which require treatment or removal, but no serious adverse incidents have been reported.

This is an edited except from Drug & Alcohol Findings (Findings Partnership, London, England). Findings is a magazine devoted to highlighting evidence on the effectiveness of interventions to treat, prevent or reduce drug and alcohol problems (for more information visit www.drugandalcoholfindings.org.uk). Adapted by Of Substance, with agreement from Findings, this article appeared in Issue 14, Winter 2005.

Whilst I do not believe that naltrexone is a bad treatment for opioid dependence – indeed in certain instances it is an excellent aid to abstinence – it is apparent that there needs to be more scientific study and validation of the process as well as patient selection for this treatment. Without this, there is a real danger that a good treatment will remain forever tarnished or that an indifferent treatment will be perceived (by some) as a panacea for all. Perhaps a good starting point would be for naltrexone implants to be inserted by those able to provide 24-hour care to their patients until such a time as their withdrawal symptoms have settled to a tolerable level.

* Dr Martyn Lloyd-Jones is a specialist in Addiction Medicine, St Vincent’s Hospital Melbourne, and is a DACAS consultant.

References


WORKCHOICES: WHAT IMPACT?
SONIA COOKE*

In March this year, the Federal Government introduced new legislation governing industrial relations. It seems most people who work in the alcohol and other drugs (AOD) sector will not be greatly affected. However, it is important for organisations, large or small, to be aware of the changes.

The WorkChoices Act

The Federal Workplace Relations Amendment (WorkChoices) Act 2005 came into effect on 27 March 2006 and aims to move towards a single national industrial relations system.

Who is covered?

The WorkChoices legislation will only apply to employers who are incorporated and whose trading or financial activities (to earn revenue) are ‘significant’ or ‘substantial’. It should be noted that state governments are challenging the legislation in the High Court. A decision is expected later this year.

The Government has recognised that non-profit organisations will require guidance in determining whether they fulfill these conditions, particularly whether they are engaged in sufficient financial or trading activities to be considered constitutional corporations. There will be some small organisations in the AOD sector which are either not incorporated or don’t meet the ‘significant’ or ‘substantial’ trading activity level. These organisations will not need to make any changes to their current employment conditions or work practices.

The impact of WorkChoices

The new legislation will impact workplaces differently depending on the terms and conditions of employment which existed for employees prior to March 27. The establishment of the Australian Fair Pay and Conditions Standard now guarantees minimum terms and conditions of employment, which override current award conditions if the Standard is more favourable. These new provisions include basic rates of pay, maximum ordinary hours of work, annual leave, personal leave, compassionate leave, parental leave and public holidays as outlined below:

Basic rates of pay and casual loadings – the Australian Pay and Classification Scales will be derived from a federal or state award that existed prior to 27 March 2006. It also provides a federal minimum wage of $12.75 per hour.

Hours of work – maximum ordinary hours of work are set at 38 hours per week, which can be averaged over a period of 12 months.

Annual leave – four weeks annual leave per year. Employees will be able to cash out two weeks annual leave, but it must be at their written request and employers will be able to reasonably refuse the request.

Personal leave – personal/carers’ leave (including sick leave) will be ten days paid and two days unpaid leave per occasion.

Compassionate leave – two days paid per occasion.

Parental leave – employees will be entitled to up to 52 weeks unpaid parental leave after 12 months continuous service. It also may apply to casual workers with 12 months continuous service.

Public holidays – employees are entitled to a day off on a public holiday. An employer can request an employee to work on a public holiday and the employee can only refuse to work if there are reasonable grounds to do so.

If the terms and conditions of employees before 27 March 2006 were determined by a state award, their terms and conditions will now be determined by a Notional Agreement Preserving State Award (NAPSA). The NAPSA contains all the terms and conditions which existed in the state award prior to the commencement of WorkChoices, unless any terms and conditions are less favourable than the new WorkChoices provisions (in which case they will be replaced by the WorkChoices provisions).

Termination of employment

Unfair dismissal legislation now exempts employers who employ up to 100 employees. This effectively means that employees can be dismissed for any reason, except those that are deemed to be unlawful (e.g. racial or sexual discrimination). For employers with more than 100 employees there can be no claim for unfair dismissal if employment is terminated for genuine operational reasons (i.e. redundancy), in addition there can be no claim for employees with less than six months service or if they are seasonal employees.

It is important to note that employee protection against unlawful dismissal will remain unchanged. That is, it willstill be illegal to dismiss someone on the basis of their race, religion, family responsibilities, physical or mental disability, pregnancy, sexual preference, gender, or similar discriminatory reasons.

Industrial Relations Commission

The Australian Industrial Relations Commission will no longer exercise compulsory powers of conciliation and arbitration, but will provide voluntary dispute resolution services.

Where to go from here?

The most important step to take is to determine whether your organisation is covered by the WorkChoices legislation and if it is to ensure the terms and conditions of employment for employees are at least as generous as the conditions now guaranteed by WorkChoices. For help and guidance you can refer to the government’s website at www.workchoices.gov.au. This website can also be used to help determine whether your organisation is covered by WorkChoices.

A DAY IN THE LIFE OF...

MARK BROWN, MANAGER, LOGAN HOUSE, KINGSTON, QLD

The alcohol and other drug workforce covers a wide spectrum of people and jobs. In the first of an ongoing series, Of Substance introduces you to some of the personalities who work in this field and the work they do.

Of Substance: What services do you offer at Logan House?

Mark Brown: Logan House is a 36-bed residential rehabilitation centre for males and females 18 years and older. We facilitate an intensive cognitive behavioural therapy program over a 12-week period. Clients participate in group sessions as well as having one-on-one counselling.

OS: Where do your clients come from? What kinds of treatment do they seek?

MB: Most of our clients come from south-east Queensland but we accept clients statewide and from northern NSW. We have seven designated beds for Drug Court clients and also have a high demand from custodial correctional centres to place clients. Clients are assessed as being acutely substance dependent, however as many as 50% of our clients also have mental health issues. Their primary drug of choice varies, but statistically the mix is alcohol (45%+ of clients), amphetamines (40-45%) and opiates (5%).

OS: How many people work with you?

MB: Logan House has 12 staff. This consists of the manager and two administration staff, four counsellor/trainers (all psychologists), and five night/weekend supervisors who work on a rotational shift basis. Volunteers also play a pivotal role, with final year psychology students assisting with admin, assessment, intake and eventually group work. Other volunteers help out with administration, transporting clients for medical appointments or other off-site activities.

OS: Describe a typical day at Logan House.

MB: ‘Dysfunction junction’ or ‘Fawtry Towers’: A day in management of a rehab centre is never dull. There is always something happening in terms of client management and counsellors busy with new clients being assessed for intake and admission. There can be existing clients leaving unexpectedly through to having to discharge a client for non-compliance of house rules.

OS: What are the challenges facing your service?

MB: There are numerous challenges, be it physical, monetary, or social. At present the organisation is part way through a major quality assurance review process. It has required many hours of individual and collective staff work to examine what we do, how we do it, why we do it and whether we have evidence for all of this. There are the challenges of: Do we make a difference? Do we actually help people overcome their addictions? Do we provide sufficient skills for clients to be able to move onto the next phase of their lives and cope with the many pressures that they may experience? And do we provide a safe and supportive environment that encourages clients to engage with the program, staff and other clients? Staff burnout is a major concern. There is a constant need to monitor workloads and work performance.

OS: What do you see as the challenges facing alcohol and other drug (AOD) treatment services in Queensland, or Australia for that matter?

MB: There are four other major non-government rehab centres in south-east Queensland, most offering different models of treatment, however we often seem to be competing for the same funding.

OS: Where do you get funding from?

MB: Funding comes from four main areas: State health (about 50%), the Federal Government (about 15%), contributions from residents via Centrelink payments (about 25%) and support from the local community.

OS: How long have you worked previously?

MB: I have been the manager at Logan House for nearly seven years. Prior to Logan House I worked for 15 years for another AOD agency (DRUG-ARM). Much of this time was spent working in the area of education and prevention so it became a whole new learning curve when I moved across into the treatment side.

OS: What kind of training (professional or other) have you done?

MB: I have an associate diploma in business majoring in management. After completing this I had an opportunity to enter university where I completed a BA in teaching, majoring in FET (adult education).

OS: And now for the important questions! How do you relax?

MB: I do enjoy gardening, mowing the grass, chasing weeds around the backyard etc., but when time is available, my wife and I go out fishing for the day.

OS: When was the last time you took a holiday?

MB: I did have a few weeks off last Christmas which was really nice, but am planning to go overseas to the UK in September. I would love to visit a couple of rehabs while I’m over there just to see how they operate.
Chances are that your image of Customs involves dogs frantically sniffing over airport passengers and luggage. However, Customs’ role in protecting Australia encompasses much more than this stereotype.

According to its 2004-05 Annual Report, it entailed processing 20 million people entering and leaving Australia; 68,000 international flight arrivals; 20,000 overseas ship arrivals; and reports concerning 7 million cargo imports and 2.6 million cargo exports.

In the same year, Customs monitored 120 million letters and 15 million parcels from overseas; oversaw imports worth $12.5 billion and exports worth $10.0 billion; patrolled 12 million square kilometres of offshore maritime area; and collected more than $7.5 billion in Customs duty, GST and passenger movement charges (Customs’ annual budget for this period was $879.9 million).

Border protection
Ilicit drug detection is considered part of Customs’ ‘border protection’ duties, which includes activities such as:

- risk assessment of vessels, aircraft, cargo, mail, air and sea passengers, and baggage
- intelligence, targeting and search activities
- surveillance of international airports, waterfronts and international mail centres
- land-based surveillance of the coastline, and aerial/marine surveillance and response.

In 2004/05, $304.02 million, or just over one-third of Customs’ budget, was allocated to border protection. Many items apart from illicit drugs and the precursor chemicals used in their manufacture, are intercepted at the border, including weapons, pornography, therapeutic drugs and substances; cash; wildlife; quarantine items; cultural or heritage goods, such as ANZAC emblems or ancient artefacts; and items which breach intellectual property rights, such as counterfeit DVDs.

The role of ‘gatekeeper’
Customs acts as a ‘gatekeeper’, balancing its community protection role with the need to ensure that legitimate movement of goods and people across the border are not unnecessarily impeded. Given the volume of border movements, and the fact that the great majority are lawful, it is not practical for Customs to examine every passenger or cargo consignment. Instead, Customs adopts a risk assessment approach, screening all border movements using a range of techniques. Illegitimate border activity may be identified as a result of profiling, analysis of information received from various sources, operational activity, or a combination of these.

Profiling is a filtering process involving a single or cluster of characteristics which, when grouped together, suggest a high-risk passenger or consignment. Developed over many years, these indicators of suspicious behaviour are constantly updated. Risk indicators include details such as the travel history or port of origin of a passenger, or the concealment potential or origin of a consignment of cargo.

Once a suspect passenger or consignment has been identified through profiling, further research or operational activity may be conducted to complete a risk assessment. Enduring cooperation between Customs and other domestic and international law enforcement agencies facilitates joint activity and information exchange that may assist in identifying and intercepting illicit cross-border activity.

Border protection technology
Border protection also requires advanced technologies designed to counter increasingly sophisticated concealment methods. Some of these technologies include:

- Gamma ray cavity detectors
- Ion mobility spectrometry
- Body scan imaging
- Container examination facilities
- Border protection technology

Prohibited goods can be concealed in hollows hidden in vehicles, small vessels and containers. ‘Bustee’ cavity detectors are handheld gamma ray devices used to detect changes in object density which might indicate concealed cavities.

Gamma ray cavity detectors
Protected objects can be concealed in hollows hidden in vehicles, small vessels and containers. ‘Bustee’ cavity detectors are handheld gamma ray devices used to detect changes in object density which might indicate concealed cavities.

Ion mobility spectrometry
Ion mobility spectrometry technology can detect drugs, chemical agents and explosives at concentrations of nanograms, or one-billionth of a gram. Portable IMS units are used to screen passengers, baggage, cargo and mail. The units collect particles by vacuuming with a filter, or wiping surfaces with a treated cloth.

Body scan imaging
Body scan is an x-ray system that produces a computerised image of a person, showing any concealed items. It provides a technological alternative to a conventional strip-search.

National waterfront closed-circuit television
Australia’s 37,000-kilometre coastline presents a challenge for border protection. A national waterfront closed-circuit television network in 58 ports around the country alleviates the need for staff to conduct a physical presence in remote ports. Automatic motion detectors ensure that cameras capture all activity.

Container examination facilities
Container examination facilities (CEF) are integrated facilities which house large x-ray systems and other technologies to enable the rapid inspection and physical examination of sea cargo.

If the x-ray reveals that further investigation is required, the container is unloaded for detailed physical examination. With the introduction of CEFs, Customs now examines seven per cent of cargo containers, compared to three per cent in Canada, and five per cent in the United States.

Table 1 below shows the quantities of selected drugs and precursor chemicals detected in CEFs between November 2002 and September 2005. Together, the detections of cigarettes, tobacco and alcohol represent over $60 million in revenue evasion.

<table>
<thead>
<tr>
<th>Drug/precursor</th>
<th>Amount detected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>185 kg</td>
</tr>
<tr>
<td>MDMA (ecstasy)</td>
<td>3061 kg</td>
</tr>
<tr>
<td>Opium</td>
<td>5.3 kg</td>
</tr>
<tr>
<td>Cannabis</td>
<td>693.8 kg</td>
</tr>
<tr>
<td>Ephedrine (precursor)</td>
<td>1150 kg</td>
</tr>
<tr>
<td>Safrone (precursor)</td>
<td>400 litres</td>
</tr>
<tr>
<td>Methyamine (precursor)</td>
<td>2800 litres</td>
</tr>
<tr>
<td>Cigarettes</td>
<td>more than 82 million sticks</td>
</tr>
<tr>
<td>Tobacco</td>
<td>156 657 kg</td>
</tr>
<tr>
<td>Alcohol</td>
<td>Approx. 29 955 litres</td>
</tr>
</tbody>
</table>

Table 1: Quantities of drugs and precursors detected in CEFs between November 2002 and September 2005

References and further reading

World’s biggest ecstasy boat, Melbourne, April 2005.
**Judging the Research:**

For busy health care professionals, keeping up with the literature in their specific field is becoming increasingly difficult. A quick PubMed search reveals that approximately 800 papers (in English), which contained “alcohol abuse/misuse”, “alcoholics” or “alcoholism” in the title/abstract, were published in 2005 alone. Though hardly an exhaustive search, this exercise indicates the extent of the literature base in the alcohol and other drugs (AOD) field. Above all, when there are contradictory findings across different studies, which studies can be trusted as a basis for clinical decisions? Given the magnitude of the “information overload” in the AOD field of research, the convenience of products marketed by pharmaceutical and biomedical industries is often difficult to resist. However, if best practice principles are to be employed, a critical examination and distillation of the available evidence is essential.

**What is critical appraisal?**

Critically appraising a article is not as simply reading it. Its purpose is to increase the effectiveness of reading by enabling individuals to identify good quality research and exclude studies that are too poorly designed to inform practice. Critical appraisal involves a systematic examination of research evidence to address three simple questions: 1. Is the study (or review) valid? 2. Are the results reliable? and 3. Will the results help my organisation?

Second, the type of study design used should be appropriate for the research question. However, in some cases study design is incorrectly reported. For example, closer scrutiny of a ‘randomised controlled trial’ may reveal that randomisation procedures were inadequate. Allocating every second patient to an intervention group may seem reasonable, but this method is prone to manipulation. Bias occurs when there is a systematic error in the way study participants have been selected for the study and/or in the way measurements have been taken or recorded (Choi & Pak, 2005).

Confounding occurs when another factor, which is related to the factor under investigation, also influences the outcome. A classic example of confounding occurs when evaluating the relationship between alcohol consumption and heart attack. Smoking, the potential confounder, is frequently associated with drinking alcohol and is a risk for heart disease. Bias and confounding can be recognised by checking a number of items shown in Table 1.

<table>
<thead>
<tr>
<th>Study validity (bias confounding)</th>
<th>Items to check</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Concealment of allocation to groups</strong></td>
<td>Randomisation by: random numbers table; coin flip; numbers from a hat</td>
</tr>
<tr>
<td><strong>Blinded assessment of outcome measures</strong></td>
<td>Participants, data collectors and/or data analysts were unaware of group allocation</td>
</tr>
<tr>
<td><strong>Follow-up of participants</strong></td>
<td>Participants were followed up to the end of the study; all were included in the data analysis, including ‘drop-outs’ and those ‘switching sides’ (intention-to-treat)</td>
</tr>
<tr>
<td><strong>Reliable outcome measures</strong></td>
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**Reliability of results**

The findings of a study may be exciting and appear to provide a long-awaited novel approach to a serious AOD problem. However, it is important to scrutinise findings carefully to determine if the effect is ‘real’ and not merely a chance event. In addition, it is important to know if the size of the effect is large enough to bring about a significant benefit. The factors that contribute to the reliability of results concern the way data has been analysed and the size of the sample from which data has been collected.

**Relevance**

Findings are only helpful to the practitioner or researcher if they are applicable to one’s local setting. The key element for ascertaining relevance is assessing the representativeness of the study population, setting and intervention. For example, if all clients with medical or psychological conditions were excluded from a study, the study population likely to be representative of the type of clients seen by the AOD practitioner? Similarly, caution should be taken when assessing the transferability of results from studies conducted in, say, American inner-city hospitals to an Australian suburban AOD treatment centre.

**Tools for critical appraisal**

Although the three crucial questions of validity, reliability and relevance are relatively simple, critical appraisal skills can take time and practice to develop. Fortunately, there is a plethora of tools available to make the task easier and more efficient for both the novice and experienced reader of research literature. Resources include pre-appraised literature (systematic reviews, Cochrane reviews, meta-analyses) guides for reading and interpreting medical literature and checklists for assessing the quality of different types of primary research (RCTs, cohort studies, case-control studies, qualitative studies).

**Systematic literature reviews**

Even when armed with a set of critical appraisal skills, it is seldom feasible for busy AOD professionals to critically evaluate every new intervention, program or product of interest. With checklists and critical appraisal tools at hand, the task is still time-consuming and daunting. A literature review is often a good place to start when a synthesis of up-to-date information is needed quickly. However, though useful for getting some background and a summary of a selection of the available literature, the traditional literature review is likely to reflect the views, including biases, preferences, values and experience, of the author(s).

When it is important to get unbiased information that has been comprehensively and critically appraised, a systematic literature review is better. Systematic literature reviews in health care aim to: 1. Condense and integrate empirically supported evidence gathered from a wide range of sources; 2. Minimise bias and the effects of chance; and 3. Generate inferences that provide a basis for decision-making (Egger, Smith & Altman, 2001).

The systematic literature review follows a transparent and replicable process that involves: 1. Developing a protocol or plan of the tasks required to address the research question, 2. Identifying the research, by using a logical and efficient search strategy to incorporate as much as possible of the available literature, 3. Selecting relevant studies according to the strict criteria detailed in the protocol, 4. Assessing study quality to determine the validity, reliability of results and applicability in real-world settings, 5. Abstracting and analysing data using a data collection form to maintain consistency, 6. Synthesising data on the basis of the strength of the evidence, size of the effect and relevance of the evidence, and/or quantitatively if studies are alike, and 7. Interpreting results based on the available evidence, giving more credence to findings from higher level, better quality studies (Egger et al. 2001). Using a systematic approach to evaluating research allows the reader to focus on the true quality of the study, rather than the quality of the way the study has been reported.

The key strength of the systematic literature review lies in its rigorous methodology, which uses explicit and replicable steps to reduce bias, thereby strengthening the basis for decision making. The limitations of this process are: 1. Results may still be incomplete; 2. Evidence may not exist; 3. Trials/studies may be poor quality; 4. Interpreting results may be inappropriate between different biases, ethics, complexity, and 5. Practice may still change despite evidence of effectiveness.

Ultimately, good critical appraisal skills foster better understanding of research and help to break down the barriers between research and practice.

**References**


**Useful resources**

* Users’ Guides to the Medical Literature: http://www.med.uab.edu/ebm/ebm.htm

* How to read a paper: series; http://bnj.bmj.com/journals/collections/reading.html


* The Cochrane Collaboration: http://www.cochrane.org/index.htm

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Table 1: Features of study quality and items to check for validity, reliability and relevance.

**Features of study quality**

<table>
<thead>
<tr>
<th>Item to check</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conformity of allocation to groups</td>
<td>Randomisation by: random numbers table; coin flip; numbers from a hat</td>
</tr>
<tr>
<td>Blinded assessment of outcome measures</td>
<td>Participants, data collectors and/or data analysts were unaware of group allocation</td>
</tr>
<tr>
<td>Follow-up of participants</td>
<td>Participants were followed up to the end of the study; all were included in the data analysis, including ‘drop-outs’ and those ‘switching sides’ (intention-to-treat)</td>
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<td>Reliable outcome measures</td>
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**Reliability of results**

Data were detailed so that statistical analyses and conclusions could be checked |

**Adaptive study sample size** | The sample was large enough to achieve a statistically significant difference between groups |

**Precision of results** | Estimates of the random variability of the data were provided (e.g. confidence intervals, standard errors) |

**Adaptability of losses to follow-up** | A proportion of participants lost to follow-up was small and unlikely to affect findings. Where losses to follow-up were >20%, their characteristics were described |

**Representativeness of the study participants** | Study participants’ characteristics were similar to the source population, e.g. entire source population, studies, case-control studies, qualitative studies |
Upcoming conferences

20 July 2006
NDARC Annual Symposium
Masonic Centre, Sydney
For more information visit
http://ndarc.med.unsw.edu.au/
NDARCWeb.nsf/page/Symposium

4-5 August 2006
The 7th International Mental Health Conference
‘Schizophrenia and Related Psychoses: A Clinical Update’
Holiday Inn, Gold Coast
For more information visit

10 August 2006
Family Alcohol and Drug Network (FADNET) 2006 Conference
‘Widening the Lens: Families in the AOD Picture’
John Scott Meeting House,
La Trobe University, Victoria
For more information visit
www.familydrughelp.sharc.org.au/fadnet

10-13 September 2006
ISBRA 2006 World Congress on Alcohol Research
‘From Science to Treatment’
The Sofitel Wentworth, Sydney
For more information visit
www.isbra2006.com

18-19 September 2006
2nd International Summer School on Inequalities and Addictions
‘Policy Responses to Alcohol, Drug and Other Gambling Issues’
The Conference Centre,
University of Adelaide, South Australia
For more information visit www.nceta.flinders.edu.au/
events/summer_school.html

25-26 September 2006
The NDRI 20th Anniversary Research Symposium
Acacia Hotel, Perth
For more information visit
www.ndri.curtin.edu.au

5 November 2006
National Drug Trends Conference
Cairns Convention Centre, Queensland
For more information visit http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/page/Conference

5-8 November 2006
2006 APSAD Conference
‘Drugs: Meeting New Challenges’
Cairns Convention Centre, Queensland
For more information visit www.apsad.org.au

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